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Factors Influencing Depression in Men: A Qualitative Investigation

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FACTORS INFLUENCING DEPRESSION IN MEN: A QUALITATIVE INVESTIGATION

DISSERTATION

A dissertation submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy in the College of Nursing
at the University of Kentucky

By
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Lexington, Kentucky

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ABSTRACT OF DISSERTATION

FACTORS INFLUENCING DEPRESSION IN MEN: A QUALITATIVE INVESTIGATION

The purpose of this qualitative descriptive study is to describe men's experiences of depression in order to provide direction for future research of the screening, diagnosing, and treatment of men's depression. Previous research indicates that men experience different depressive symptoms than women, and there is a possibility that men's depression is not being adequately captured by current screening standards, which would theoretically lead to a large number of men with unrecognized, undiagnosed, and untreated depression. If this is the case, this may explain the disproportionately low number of men diagnosed with depression compared to women, in contrast to the disproportionately high number of men who complete suicides. There is a need in the literature for descriptions of depression experienced by men in order to determine the adequacy of current psychometric screening tools and approaches to treatment which are currently in practice. This qualitative study seeks to begin to fill in this gap in the literature. Key findings indicate that intentionally and unintentionally hide their feelings of depression, and that men experience anger as an early sign of depression. In addition, men often do not recognize their distress as depression until someone else suggests they seek professional help; and men use various methods of distraction to cope with their distress, including excessive working, sleeping, eating, TV watching, and alcohol consumption. Recommendations for further research are discussed.

KEYWORDS: Depression, Gender, Men, Isolation, Anger.

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December 18, 2014_____
Date

FACTORS INFLUENCING DEPRESSION IN MEN: A QUALITATIVE INVESTIGATION

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December 18, 2014

I would like to dedicate this dissertation

to my husband, Dr. Andrew Mutua Mutiso, for his unwavering support and zealous encouragement for me to pursue my career and educational goals;

to my parents, Sharon Kaye Turner and Danny Clayton Cook, for guiding me early in life to "seek ye first;"

and to the men who participated in this study for openly sharing the most difficult times in their lives in order to advance our understanding of the complex syndrome of depression.

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CHAPTER ONE

Introduction

Unipolar depression affects an estimated 350 million people worldwide (World Health Organization [WHO], 2012). It contributes more to the global burden of disease than any other mental health problem (WHO, 2008a). Major Depressive Disorder (MDD) is the second leading cause of years lost to disability [(YLD) (Ferrari, Charlson, Norman, Patten, Freedman, Murray & Vos, 2013)], surpassed only by lower back pain. In 2010, MDD accounted for 8.2% (62 million) of all YLD worldwide (Ferrari, et al., 2013). In the United States, the lifetime risk for MDD is 16.6% (Kessler, Berglund, Demler, Jin, Merikangas & Walters, 2005), varying from 10% to 25% for women and 5% to 12% for males (American Psychiatric Association [APA], 2000). The prevalence for MDD in a 12 month period in the United States is about 7% (APA, 2013). Cost for treatment and loss of productivity is astounding.

Each year in the United States, $26 billion is spent on treating depression (Greenberg, Kessler, Birnbaum, Leong, Lowe, Berglund & Corey-Lisle, 2003), ranging from $1000 to $2500 for each depressed individual (Luppa, Heinrich, Angermeyer, Konig & Riedel-Heller, 2007). In addition, approximately $3113 is spent in direct healthcare costs for six months of treatment of MDD in patients over 60 years of age with 30% of the expenditure for hospitalization and long term care, and 70% for outpatient visits, consultations, emergency department visits, diagnostic tests, and pharmacological treatment (Katon, Lin, Russo & Unutzer, 2003).

In the United States, people who have been diagnosed with depression at some point in their lives are absent 68 million more days of work each year than those who

have never been diagnosed with depression (Witters, Liu & Agrawal, 2013). Thus, $51 billion annually is lost due to decreased productivity and absenteeism from work (Greenberg, et al., 2003). Approximately 1.4 million Americans draw federal disability income for mood disorders (Rampell, 2013).

Most alarmingly, depression contributes to an estimated 1 million deaths by suicide each year (WHO, 2012). Data from the Centers for Disease Control and Prevention (CDC) indicate men in the United States complete suicide four times more often than women (CDC, 2013). In 2011, 39,518 people committed suicide and of those, 31,003 (78%) were men (CDC, 2013). The U.S. Department of Health and Human Services (2010) estimates 60% of suicides are completed by people suffering from mood disorders, including depression. While 1% of women with a lifetime history of depression will die by suicide, 7% of men with a lifetime history of depression will die by suicide (U.S. Department of Health & Human Services, 2010). Between the ages of 20 and 24 years, men complete suicide more than six times as often as women (Suicide in the U.S.: Statistics and Prevention, 2009). Each year, more people die from suicide than homicide, with someone dying from suicide every 16 minutes. For men suicide represents the seventh leading cause of death, while it drops to the 16th leading cause of death for women (Suicide in the U.S.: Statistics and Prevention, 2009).

Significance of the Problem

Unlike infectious disorders or physical trauma which have rather straightforward etiologies and corresponding signs and symptoms, the etiologies of psychiatric disorders such as depression are less distinct. Depression is a complex condition with a myriad of

intricately woven contributing factors. Biological theories of depression suggest that disruption of the brain's neurotransmitters, hormonal shifts, and the body's response to medication, alcohol, illicit drugs, injury, or surgery are related to onset of the disorder (APA, 2013; Caspi, Sugden, Moffitt, Taylor, Craig, Harrington, McClay, et al., 2003). Environmental contributions to depression include major stressors such as trauma, loss, abuse, economic stress, divorce, or death of a loved one (APA, 2013; Helm, Newport, Mletzko, Miller & Nemeroff, 2008; Caspi, et al, 2003).

In addition to an often ill-defined mechanism of etiology, signs and symptoms of depression vary. Furthermore, there appear to be gender differences in the way depression manifests. Previous research indicates men's depression symptoms are different than women's depression symptoms (Kendler, Gardner & Prescott, 2006; Vredenburg, Krames & Flett, 1986; Smith, Kyle, Forty, Cooler, Walters, Russell, et al., 2008; Kornstein, Schatzberg, Thase, Yonkers, McCullough, Keitner, et al., 2000; Benazzi, 2000). It is possible that men experience signs and symptoms of depression that are less recognizable to clinicians, members of their support systems, and even to men themselves.

While prior studies indicate that men experience depression differently than women, the evidence regarding men's depression symptoms is inconsistent and sometimes contradictory, prompting further investigation. It is necessary to develop a better understanding of how men experience depression in order to recognize it earlier, treat it sooner, and prevent the tragic sequelae associated with untreated depression, including suicide.

CHAPTER TWO

Literature Review

A literature review was conducted using the CINAHL (Cumulative Index to Nursing and Allied Health Literature) database. CINAHL is an index of peer-reviewed journal articles covering the topics of medicine, biomedicine, allied health, nursing, and healthcare in general. The search was limited to research published in the last 15 years (1999-2014). Initially, the following key words/phrases were used: depression, depressive symptoms, male, and men. This yielded very few results, so the search was expanded to include the term gender. The following categories of articles were excluded from this review: those not written in languages other than English, studies with only female participants, articles that did not make clear distinctions about gender differences in the results, those that did not make clear distinctions between overlapping psychiatric comorbidities, and those that did not make clear distinctions between unipolar depression and bipolar depression. The following overview reveals an integration of the results of the remaining studies about unipolar depression in men. Although the evidence is inconsistent about the contribution of specific factors to male depression, a few patterns are visible at this stage of the investigation into male depression.

Depression and Gender

Males have lower incidence rates of depression, fewer and shorter episodes, and a less chronicity than for women (Essau, Lewinsohn, Seeley, and Sasagawa, 2010; Azorin, Belzeaux, Fakra, Kaladjian, Hantouche, Lancrenon, & Adida, 2014; Marcus, Young, Kerber, Kornstein, Farabaugh, Mitchell, et al., 2005). Typically, onset of depression in

men occurs in later ages (Azorin, et al., 2014; Marcus, et al., 2005) whereas onset occurs in earlier ages among women. Literature findings also suggest that age of onset of depressive symptoms predicts a more difficult course of depression in women than in men (Essau, Lewinsohn, Seeley & Sasagawa, 2010). Compared to depressed women, men are less likely to have received treatment (Kornstein, Schatzberg, Thase, Yonkers, McCullough, Keitner, et al., 2000).

Depressed men report fewer atypical symptoms and less symptom severity than depressed women (Marcus, et al., 2005; Smith, Kyle, Forty, Cooler, Walters, Russell, et al., 2008; Kornstein, et al., 2000). However, gender does not seem to influence differences in the areas of diurnal variation, and internalizing and externalizing symptoms (Kornstein, et al., 2000; Kendler, Gardner & Prescott, 2006).

Sleep and Lack of Energy

Depressed men report more initial insomnia and middle insomnia (waking in the middle of the night), whereas depressed women report greater severity of hypersomnia (Almeida, Alfonso, Yeap, Hankey & Flicker, 2011; Parker, Fletcher, Paterson, Anderson & Hong, 2014; Shiels, Gabbay, Dowrick & Hulbert, 2004; Hubain, Le Bon, Vandenhende, Van Wijnendaele & Linkowski, 2006). There is no gender difference with regard to early morning awakening (Smith, et al., 2008; Almeida, Alfonso, Yeap, Hankey & Flicker, 2011).

Depressed men have less REM sleep and report less energy than nondepressed men (Shiels, Gabbay, Dowrick & Hulbert, 2004; Hubain, Le Bon, Vandenhende, Van Wijnendaele & Linkowski, 2006). However, when compared to depressed women,

depressed men are less likely to report a decrease in energy and when they do, they report less severity (Marcus, et al., 2005; Parker, Fletcher, Paterson, Anderson & Hong, 2014). Some suggest there is no gender difference in terms of energy (Smith, et al., 2008; Kornstein, et al., 2000).

Appetite and Weight Loss

Depressed men report less severity of appetite and weight fluctuations when compared to depressed women (Parker, Fletcher, Paterson, Anderson & Hong, 2014). That being said, depressed men are more likely than depressed women to report weight loss; whereas depressed women are more likely to report an increased appetite and weight gain (Marcus, et al., 2005). In contrast, some study results indicated little or no gender difference with regard to appetite and changes in weight (Smith, et al., 2008; Kornstein, et al., 2000).

Mood

Depressed men experience similar levels of depressed mood, (Smith, et al., 2008; Kornstein, et al., 2000), but report less severity of depressed mood in the morning than depressed women (Parker, Fletcher, Paterson, Anderson & Hong, 2014).

Depressed men report lower self-esteem (Kendler, Gardner & Prescott, 2006) but are less likely to report feelings of vulnerability than depressed women (Parker, Fletcher, Paterson, Anderson & Hong, 2014). Depressed also men report less severe irritability than depressed women (Parker, Fletcher, Paterson, Anderson & Hong, 2014). Interestingly, there is no gender difference in endorsing anhedonia and the feelings of worthlessness and guilt among depressed people (Kornstein, , et al., 2000; Smith, et al.,

2008) but depressed men report less overall symptom severity of mood symptoms than depressed women (Parker, Fletcher, Paterson, Anderson & Hong, 2014).

Psychomotor Activity

Evidence is inconclusive regarding the impact of gender on the psychomotor activity of depressed people. Marcus and colleagues (2005) found that depressed men are more likely to report psychomotor agitation than depressed women. However, findings of a study by Smith, et al. (2008) indicated there were no significant differences. When using the Beck Depression Inventory (BDI) as the dependent variable, Kornstein and colleagues (2000) noted there was no significant difference in psychomotor changes between the two groups. However, when they used the Hamilton Rating Scale for Depression (HAMD) as the dependent variable, they noted depressed men tend to experience less psychomotor retardation than depressed women. When compared to depressed women, depressed men report less severity of the symptoms of "feeling paralyzed" and "finding it difficult to do basic things" (Parker, Fletcher, Paterson, Anderson & Hong, 2014).

Cognitive Disturbance

Compared to depressed women, depressed men reported about the same levels of cognitive and concentration disturbance (Smith, et al., 2008; Kornstein, et al., 2000; Parker, Fletcher, Paterson, Anderson & Hong, 2014). Marcotte, Alain and Gosselin (1999) reported that depressed men have less problem-solving abilities than nondepressed men.

Somatic Complaints

As expected, depressed men exhibit greater somatic preoccupation than nondepressed men (Shiels, Gabbay, Dowrick & Hulbert, 2004) but are less likely to report symptoms. Depressed men are less likely to report somatic (pain) symptoms and GI distress than depressed women (Marcus, et al., 2005). In addition, Kornstein, et al. (2000) reported that depressed men endorse less symptom severity than depressed women while Benazzi (2000) reported no difference between the two groups.

Family History

When compared to depressed women, depressed men are less likely to report a family history of affective disorders (Kornstein, et al., 2000) and more likely to report the loss of a parent in their childhood (Kendler, Gardner & Prescott, 2006). There seems to be no gender difference in childhood adversity (Kendler, Gardner & Prescott, 2006).

Previous Psychopathology

Compared to nondepressed men, depressed men are more likely to have a previous diagnosis of depression (Shiels, Gabbay, Dowrick & Hulbert, 2004). But compared to depressed women, they are less likely to have received treatment and have a later age at onset (Kornstein, et al., 2000).

Personality

When compared to women, men in general (not necessarily depressed) more frequently have comorbid hyperthymic temperaments, and less frequently have depressive temperaments (Azorin, Belzeaux, Fakra, Kaladjian, Hantouche, Lancrenon &

Adida, 2014). In a recently published investigation involving 3030 adult Caucasian male twins, depressed men were also determined to be more neurotic and less extraverted than nondepressed men (Fanouse, Neale, Aggen & Kendler, 2007).

Marcotte, Alain and Gosselin (1999) in their investigation of gender differences in adolescent depression (n=142 males, 164 females) defined *instrumentality* as a self-efficacy feature which influences an individual's reaction to stress (p. 35). They determined this personality feature was protective against depression. Depressed men are more likely to exhibit instrumentality than depressed women. When compared to their nondepressed counterparts, depressed men are less expressive, and exhibited less instrumentality (Marcotte, Alain & Gosselin, 1999). Gundy (2002) determined the personality feature "assertion of autonomy" is also protective against depression, but there is no difference between males and females.

Work

High levels of job stress and work dissatisfaction are predictors of depression in men, whereas private life dissatisfaction is a predictor of depression in women (Godin, Kornitzer, Clumeck, Linkowski, Valente & Kittel, 2009). For depressed men, the work role is more protective than for depressed women. Compared to depressed women, depressed men are more likely to report work-related inhibition or impairment (Kornstein, et al., 2000). When compared to nondepressed men, depressed men are less likely to endorse job enjoyment (Shiels, Gabbay, Dowrick & Hulbert, 2004). Depressed men are also less likely to be in paid work and more likely to be receiving public assistance (Shiels, Gabbay, Dowrick & Hulbert, 2004).

Relationships

For both depressed men and women, the partner role was found to be protective factor against depression (Plaisier, de Bruijn, Smit, de Graaf, ten Have, Beekman, et al., 2008). Compared to depressed women, depressed men are more likely to be married and less likely to endorse marital adjustment problems (Kornstein, et al., 2000). In their investigation of gender differences in unipolar depression (DSM-IV criteria) in the general population (n=4075), Lucht and colleagues (2003) determined that being separated, divorced, or widowed provided a greater risk for depression among men than among women. Finally, when compared to depressed women, depressed men report both less social support and less sensitivity to social support as a protective factor against depression (Kendler, Myers & Prescott, 2005). Depressed men are also less likely than depressed women to report interpersonal sensitivity (Marcus, et al., 2005).

Comorbidity

Depressed men are more likely than depressed women to report symptoms of Obsessive Compulsive Disorder, Alcohol Abuse, and Substance Abuse (Marcus, et al., 2005) yet depressed men are less likely than depressed women to report symptoms of Generalized Anxiety Disorder, Somatoform Disorder, and Bulimia (Marcus, et al., 2005).

Suicide as a Related Construct

In the U.S. during 2008-2009, 8.3 million adults (3.7% of adult population) reported having suicidal ideation during the year preceding the study (Crosby, Han, Ortega, Parks & Gfoerer, 2011). Approximately 2/3 of all depressed patients contemplate suicide at some point in their lives (Kupfer, Horner, Brent, Lewis, Reynolds, Thase, et al.,

2008). Some suggest depressed men and women experience similar rates of suicidal ideation (Smith, et al., 2008; Kornstein, et al., 2000). However, there is also evidence to suggest that depressed men are more likely to experience suicidal ideation than depressed women, but attempt suicide less frequently (Marcus, et al., 2005).

The APA (2013) has declared, "The possibility of suicidal behavior exists at all times during depressive episodes" (p. 167) and that being male is a primary risk factor for completed suicide. Risk factors for completed suicide for both genders include mood disorders, being single or living alone, feelings of hopelessness, comorbid Borderline Personality Disorder, and being male (APA, 2013). Depressed men who weigh less and are shorter in length at birth are at greater risk for completed suicide (Mittendorfer-Rutz, Wasserman & Rasmussen, 2008). Alcohol abuse/dependence, drug abuse/dependence, Cluster B Personality Disorders, short stature, higher levels of impulsivity and aggression, and being 75 years or older are all significant risk factors for completed suicide for men who are depressed (Mittendorfer-Rutz, Wasserman & Rasmussen, 2008; Dumais, Lesage, Alda, Rouleau, Dumont, Chawky, et al., 2005; CDC, 2010). Firearms are the most common means of completed suicide among males (56%) (CDC, 2010).

Discussion

While conducting this review, an issue was discovered which could be a potential pitfall when integrating literature concerning depression. Current literature is notoriously incongruent in terms of an operational definition for depression. Therefore, caution is urged when integrating depression research to assure that study definitions and variables are similar. In addition, the researcher should clearly determine: (1) whether the

dependent variable is depressed mood, a cluster of depressive symptoms, a clinical diagnosis of Major Depressive Disorder (MDD), another clinical depressive diagnosis, or any combination of these; (2) which episode and severity of symptoms are implied, if any; (3) the presence of physical or neuropsychological comorbidities; (4) which version of the DSM or ICD was used for diagnostic criteria; (5) which measure was used to quantify symptom severity, and (6) whether the author employed the measure correctly (i.e., did not use a screening tool for diagnosis). This can be illustrated in a hypothetical scenario: the results of Study A which uses the results of the BDI-I (1961, based on DSM-III diagnostic criteria, self-report, screening tool for depressive symptom severity) to determine current "diagnosis" of major depressive disorder in a group of psychiatric inpatients would not be immediately compatible with Study B which uses the relied upon clinical diagnosis by a psychiatrist using ICD-10 diagnostic criteria for MDD in a sample of outpatients seeking treatment for Panic Disorder.

Overall, this review of literature supports the proposal that men and women have different experiences with depression (Tables 2.1, 2.3, 2.4, 2.6). Evidence suggests that depressed men may experience more initial insomnia, indecisiveness, lower self-esteem, greater somatic preoccupation, and more suicidal ideation than depressed women. There is also evidence that depressed men experience fewer atypical features and fewer episodes of depression than depressed women. Depressed men are more likely to be married but less likely to have social support. Perhaps the most consistent finding of this review is that depression affects men's ability to function at and enjoy work more significantly than it affects women.

Until recently, there has been more research about women's experience of depression than men's. If our understanding of depression is biased toward women's experiences of depression, then perhaps commonly used measures for screening for and diagnosing depression are not sensitive to men's unique experiences of depression. It may also partially explain why women are diagnosed with depression twice as often as men (APA, 2000) and why men commit suicide five times more than women (Suicide in the U.S.: Statistics and Prevention, 2009). Men's depression may present in such a way that it is not recognized by clinicians, leaving depressed men untreated with devastating consequences. The purpose of the following chapter is to present a critical review and analysis of some of the more commonly used measures available to clinicians and researchers to screen for and diagnose depression and depressive symptoms.

Table 2.1 Comparison of Symptoms of Depressed Males vs. Depressed Females

Depressive Symptom	More	Less	Same
Insomnia			2
Initial Insomnia	1, 6, 7, 8, 9		
Middle Insomnia	6, 7, 8, 9		
Early Morning Awakening			1, 6
Hypersomnia		6, 7, 8, 9	
Sleep Changes		2	
Loss of Energy/Tiredness		3, 7	1, 2
Weight Gain			1
Weight Loss	3		2
Weight/Appetite Changes		7	2
Poor Appetite			1
Psychomotor Agitation	3		1
Psychomotor Retardation		2	
Psychomotor Changes			2
Cognitive Disturbance			2, 7
Poor Concentration			1, 2, 7
Depressed Mood			2
Early Morning Depressed Mood	7		
Dysphoria			1
Anhedonia			1, 2
Suicidal Ideation	3		1, 2
Feelings of Vulnerability		7	
Worthlessness/Guilt			2
Irritability		7	
Low Self-Esteem	4		
Mood Symptom Severity		7	
Feeling Paralyzed		7	
Somatic Preoccupation		3	
Somatic Symptom Severity		2	5

[1]Smith, Kyle, Forty, Cooler, Walters, Russell, et al., 2008

[2]Kornstein, Schatzberg, Thase, Yonkers, McCullough, Keitner, et al., 2000

[3]Marcus, Young, Kerber, Kornstein, Farabaugh, Mitchell, et al., 2005

[4]Kendler, Gardner & Prescott, 2006

[5]Benazzi, 2000

[6]Almeida, Alfonso, Yeap, Hankey & Flicker, 2011

[7]Parker, Fletcher, Paterson, Anderson & Hong, 2014

[8]Shiels, Gabbay, Dowrick & Hulbert, 2004

[9] Hubain, Le Bon, Vandenhende, Van Wijnendaele & Linkowski, 2006

Table 2.2 Comparison of Symptoms of Depressed Males vs. Nondepressed Males

Depressive Symptom	**More**	**Less**	**Same**
Tired/Little Energy	1		
Insomnia (all types)	2		
REM Sleep		2	
Cognitive Decline	3		
Chest Pain	1		
Somatic Complaints	1		
Sick > 3 mths in last yr	1		

[1]Shiels, Gabbay, Dowrick & Hulbert, 2004

[2]Hubain, Le Bon, Vandenhende, Van Wijnendaele & Linkowski, 2006

[3]Marcotte, Alain, & Gosselin, 1999

Table 2.3 Comparison of Symptom Quality of Depressed Males vs. Depressed Females

Symptom Quality	More	Less	Same
Frequency of Depressive Episodes		1	
Number of Depressive Episodes		1	
Frequency of Atypical Features		1	
Symptom Severity		2	3
Diurnal Variation			2
Internalizing Symptoms			4
Externalizing Symptoms			4

[1]Smith, Kyle, Forty, Cooler, Walters, Russell, et al., 2008

[2]Kornstein, Schatzberg, Thase, Yonkers, McCullough, Keitner, et al., 2000

[3]Benazzi, 2000

[4]Kendler, Gardner & Prescott, 2006

Table 2.4 Comparison of Work Variables of Depressed Males vs. Depressed Females

Work-Related Variable	More	Less	Same
Work-related Impairment/Inhibition	2		
Increased Job Stress	1		
Lack of Satisfaction	1		

[1]Godin, Kornitzer, Clumeck, Linkowski, Valente & Kittel, 2009

[2]Kornstein, Schatzberg, Thase, Yonkers, McCullough, Keitner, et al., 2000

Table 2.5 Comparison of Work-related Variables of Depressed Males vs. Nondepressed Males

Work-Related Variable	More	Less	Same
Job Enjoyment	1		
In Paid Work		1	
Claimed State Benefits	1		
Lived in Rental Property	1		

[1]Shiels, Gabbay, Dowrick & Hulbert, 2004

Table 2.6 Comparison of Relationship Variables of Depressed Males vs. Depressed Females

Relationship Variable	More Likely	Less Likely	Same
Married	1		
Separated (risk)	2		
Divorced (risk)	2		
Widowed (risk)	2		
Marital Adjustment		1	
Partner Role (protective)			3
Social Support		4	
Sensitivity to Low Social Support		4	
Interpersonal Sensitivity		5	

[1]Kornstein, Schatzberg, Thase, Yonkers, McCullough, Keitner, et al., 2000
[2]Lucht, Schaub, Meyer, Hapke, Rumpf, Bartels, et al., 2003
[3]Plaisier, de Bruijn, Smit, de Graaf, ten Have, Beekman, et al, 2008
[4]Kendler, Myers & Prescott, 2005
[5]Marcus, Young, Kerber, Kornstein, Farabaugh, Mitchell, et al., 2005

Table 2.7 Comparison of Personality Variables of Depressed Males vs. Nondepressed Males

Personality Variable	More	Less	Same
Extraversion		1	
Neuroticism	1		
Instrumentality		2	
Expressivity		2	
Problem-Solving Abilities		2	

[1]Fanous, Neale, Aggen, & Kendler, 2007
[2]Marcotte, Alain, & Gosselin, 1999

CHAPTER THREE

Operational Definition of Depression

There are two major nosological systems available to diagnose depression: the *Diagnostic and Statistical Manual of Mental Disorders, 5th ed.* ([DSM-5], APA, 2013) and *The ICD-10 International Classification of Mental and Behavioural Disorders* (ICD-10) (WHO, 1992). The ICD-10 is used more frequently in research originating from Europe, while the DSM-5 (and its predecessors) is used more frequently in research originating in the United States and non-European countries (Sadock, Sadock, & Kaplan, 2003). However, the authors of both nosological systems continue to work together to make them compatible (APA, 2000). These systems provide diagnostic guidelines based on the presence of clusters of clinical symptoms and the severity of impairment. Neither addresses etiological concerns directly, but there is speculation that future versions will do so (Narrow, 2007).

The DSM-5 provides the following criteria for diagnosis of a major depressive episode: a period of time no less than two weeks marked by five or more of the following symptoms (and must include at least one of the first two):

Table 3.1 DSM-IV Symptoms of Major Depressive Disorder

Persistent depressed mood
Anhedonia
Significant changes in weight
Significant changes in sleep pattern
Significant changes in psychomotor activity
Fatigue
Feelings of worthlessness/guilt
Diminished concentration
Rumination over death

If these symptoms cannot be better explained by another psychological or medical disorder, they are attributed to Major Depressive Disorder (MDD), which may be characterized as a single episode or as recurrent (more than one episode with a period of at least two months in the interval) (APA, 2013).

The ICD-10 defines a diagnosis of a severe depressive episode as a period of time, no less than two weeks, which cannot be attributed to the abuse of psychoactive substances or organic mental disorder, marked by depressive mood, anhedonia and increase in fatigability. In addition, at least four of the following must be present to confirm a diagnosis: decrease in emotional reactivity, early morning awakening, depression worse in the morning, psychomotor retardation or agitation, decreased appetite, weight loss of 5% in the past month, and decreased libido (WHO, 1992).

The majority of tools analyzed for this paper are not intended to diagnose depression. Rather, most are screening tools for the presence and severity of individual symptoms associated with MDD and the behaviors associated with those symptoms. In the literature reviewed for this paper, "depression" was nearly always used to denote the collection of psychological and physiological symptoms indicative of the diagnosis of MDD - as defined by the DSM-5 or any of its predecessors - or severe depression - as defined by the ICD-10 or any of its predecessors - while individual symptoms were referred to as "depressive symptoms."

Structured Interviews

Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I)

The SCID-I (First, Spitzer, Gibbon & Williams, 1997) is frequently used as the gold standard for depression diagnosis (Davison, McCabe & Mellor, 2009; Lowe, Kroenke, Herzog & Grafe, 2004; Lee, Yip, Chiu, Leung & Chung, 2001; Bernstein, Wendt, Nasar & Rush, 2009). The SCID-I is a clinician-administered semi-structured interview based on DSM-IV diagnostic criteria. It was developed for use in clinical settings to assist clinicians and researchers in making distinctions between DSM-IV subcategories (differential diagnoses) for adult psychiatric and general medical patients. The SCID-I takes 45-90 minutes to administer and has been found to be psychometrically sound (Lobbestael, Leurgans & Arntz, 2011; Gjerdingen, McGovern & Center, 2011). Specifically for the diagnosis of depression, the SCID-I demonstrates a Kappa coefficient of 0.66 (Lobbestael, Leurgans & Arntz, 2011). Because the SCID-I is based on the diagnostic criteria specified in the DSM-IV, its validity is dependent upon the validity of DSM-IV (Nezu, Ronan, Meadows & McClure, 2000).

Diagnostic Interview Schedule for DSM-IV (DIS-IV)

The DIS-IV (Robins, Cottler, Bucholz, Compton, North & Rourke, 2000) is a very structured interview designed to assist trained lay people in determining DSM-IV diagnoses in adults. The DIS-IV is the latest version of the DIS, which was originally used in the National Institute of Mental Health's (NIMH) Epidemiological Catchment Area (ECA) Program, for the purpose of determining the prevalence and incidence rates of psychiatric disorders in the United States. The DIS-IV provides both current and

lifetime DSM-IV diagnoses of psychiatric disorders and requires 90-120 minutes to complete. However, the DIS-IV is not often used by professional mental health clinicians whose training allows them access to more efficient and accurate means of diagnosis (Nezu, Ronan, Meadows & McClure, 2000).

Test-retest reliability was calculated for the depression module of the DIS-IV in a sample of 140 persons which was 44% female, 56% African American, with an average age of 36 years. Each person was interviewed twice and 35% demonstrated a positive diagnosis for a major depressive episode. Test-retest kappa coefficient was found to be .63 (range .49-.77) (Nezu, Ronan, Meadows & McClure, 2000).

A literature search did not reveal any research concerning the validity of the DIS-IV. Comparing the results of the DIS to other measures is difficult because few measures cover the entire range of diagnoses assessed by the DSM. Robins, Helzer, Croughan and Ratcliff (1981) compared results of the original DIS obtained by lay interviewers to results obtained by trained psychiatrists and found the results to be comparable. The original DIS also demonstrated high sensitivity (80%) and specificity (84%) for lifetime diagnoses of depression (Robins, Helzer, Croughan & Ratcliff, 1981).

Because structured interviews are quite lengthy, they are not always practical in either the clinical or research setting (Gjerdingen, McGovern & Center, 2011). If a definitive diagnosis of MDD (DSM-5) or severe depression (ICD-10) is not required, self-report questionnaires and those designed for administration by lay interviewers are often used to quickly assess the presence and severity of depressive symptoms. A brief assessment of some of the more commonly used measures follows.

Clinician-Rated Measures

Hamilton Rating Scale for Depression (HAMD)

The HAMD is one of the most frequently used depression assessment tools in the field of Clinical and Health Psychology (Lopez-Pina, Sanchez-Meca, & Rosa-Alcazar, 2009). Originally published in 1960, the HAMD is a 17-item scale designed for use by clinicians in the measurement of depressive symptom severity for those already diagnosed with depression. The HAMD was developed in the 1950's to provide clinicians with a tool to objectively assess the effectiveness of the first generation of antidepressant medications (Bagby, Ryder, Schuller, & Marshall, 2004). Shafer (2006) reports that the HAMD is the tool most often used by clinicians to assess symptom severity; it is also considered the "gold standard" against which other depression screening tools are evaluated (Williams, 2001). Currently the HAMD is the standard outcome measure used by pharmaceutical companies seeking to demonstrate the effectiveness of new antidepressants to the Food and Drug Administration (Hamilton Depression Rating Scale HAMD-IVR Version, 2007).

The HAMD provides an estimate for symptom severity, but cannot be used as a screen (Hamilton, 1960) nor does it provide or confirm a diagnosis of depression (Arean, 2006). The information from the interview is translated into an objective number in order to quantify initial symptom severity and provide a means of documenting changes in severity (Wehner & Stoner, 2001). Either a 5-point (0-4) or a 3-point (0-2) scale is used for rating interview items which concentrate more on somatic symptoms than on cognitive and affective symptoms (Shafer, 2006). For example, psychomotor retardation

(defined by Hamilton (1960) as slowness of thought and speech, impaired ability to concentrate, and decreased motor activity) is rated by the clinician on the following scale (Table 3.2):

Table 3.2 Example of 5-Point Rating Scale for HAMD

0 = normal speech and thought
1 = slight retardation at interview
2 = obvious retardation at interview
3 = interview difficult
4 = complete stupor

The items assessed via the 3-point scale include those items which have a narrower continuum of possibilities; for example, early insomnia is assessed on the following scale:

Table 3.3 Example of 3-Point Rating Scale for HAMD

0 = no difficulty falling asleep
1 = complains of occasional difficulty falling asleep
2 = complains of nightly difficulty falling asleep

As with previously mentioned instruments, a higher score indicates greater symptomatology. A cut-off score of 17 indicates mild to moderate depression. The HAMD is available in Dutch, English, Turkish, Spanish, Danish, Castilian, Arabic, French, Chinese, German, and Italian (Bagby, Ryder, Schuller, & Marshall, 2004), as

well as self-report and computerized versions. All references to the HAMD in this paper refer to the original tool.

Results from several meta-analyses suggest that the HAMD is a valid and reliable measurement of depressive symptoms with good overall levels of internal consistency, inter-rater and test-retest reliability. Concurrent validity of HAMD with BDI ranges from .27 to .89, and with CES-D= .65 (Bagby, Ryder, Schuller & Marshall, 2004). Sensitivity ranges from .45-.88; specificity ranges from .75 to 1.00; positive predictive value ranges from .37 to 1.00; negative predictive value ranges from .86 to .99 (Bagby, Ryder, Schuller & Marshall, 2004).

The HAMD demonstrates good internal reliability, ranging from .46 to .97 (Bagby, Ryder, Schuller & Marshall, 2004) in an early meta-analysis. More recently, a meta-analysis yielded a mean alpha coefficient of 0.789 (95%CI 0.766–0.810). (Trajkovic, Starcevic, Latas, Lestarevic, Ille, Bukumiris & Marinkovic, 2011). The HAMD has shown high test–retest reliability, with reports of mean coefficients ranging between .81— .98 (Bagby, Ryder, Schuller & Marshall, 2004) and 0.87 – 0.94 (Trajkovic, Starcevic, Latas, Lestarevic, Ille, Bukumiris & Marinkovic, 2011). With regard to inter-rater reliability, the HAMD demonstrated an average coefficient of .79 (95% CI .78-.79) (Lopez-Pina, Sanchez-Meca & Rosa-Alcazar, 2009); and in a more recent meta-analysis demonstrated kappa coefficient = 0.81 (95% CI 0.72–0.88) (Trajkovic, Starcevic, Latas, Lestarevic, Ille, Bukumiris & Marinkovic, 2011).

Primary Care Evaluation of Mental Disorders (PRIME-MD)

Previous research indicates people often seek help for mental health issues in the primary care setting (Oxman, Dietrich & Schullberg, 2003) and 30%-50% of depression

cases are not recognized by primary care clinicians (Tamburrino, Lynch, Nagel & Smith, 2009). The PRIME-MD (Spitzer, Williams, Kroenke, Linzer, deGruy, Hahn & Brody, 1994) was developed to help primary care clinicians recognize mental disorders. Underwritten by a grant from Pfizer, the PRIME-MD was designed to be user-friendly for primary care clinicians in the process of identifying the psychiatric symptomatology most commonly seen in adults in primary care settings: mood, anxiety, somatoform, alcohol, and eating disorders (Spitzer, Williams, Kroenke, Linzer, deGruy, Hahn & Brody, 1994). The PRIME-MD takes 5-10 minutes to complete and has two parts: a one-page patient questionnaire (PQ) which serves as an initial screen for the five mental health disorders, and a 12-page clinician evaluation guide (CEG) to facilitate accurate diagnosis of mental health disorders flagged by the PQ. The PQ consists of 26 yes/no questions inquiring about symptoms (which reflect DSM-III criteria for mental disorders) that were present during the past month. Questions #18 and #19 screen for depression:

Question #18: "During the past month, have you often been bothered by having little interest or pleasure in doing things?"

Question #19: "During the past month, have you often been bothered by feeling down, depressed, or hopeless?"

A positive response to either of these questions triggers further investigation by the primary care clinician.

Initial psychometric testing of the PRIME-MD involved a sample of 1000 primary care patients (Spitzer, Williams, Kroenke, Linzer, deGruy, Hahn & Brody, 1994). Findings generally supported the validity of psychiatric diagnoses made by primary care clinicians using the PRIME-MD assessment system. The specificity and

overall predictive power of physician diagnoses were consistently high for specific diagnoses, ranging from .84 to .99. Specific information about depression was not available. In a sub-sample of 431 patients, agreement between diagnoses of primary care clinicians and mental health clinicians yielded a kappa coefficient of .71 for all five mental health diagnoses, and a coefficient of .61 for major depressive disorder in particular (Spitzer, Williams, Kroenke, Linzer, deGruy, Hahn & Brody, 1994).

Construct validity of the PRIME-MD was supported by findings that patients who were diagnosed with mental disorders endorsed impaired functioning and increased health care utilization when compared to patients who did not receive PRIME-MD diagnoses. Concurrent validity of the PRIME-MD was supported by the strong relationships between the diagnoses of mood, anxiety, and somatoform disorders obtained using the PRIME-MD system and the corresponding patient self-rated severity scales (Spitzer, Williams, Kroenke, Linzer, deGruy, Hahn & Brody, 1994).

Montgomery-Asberg Depression Rating Scale (MADRS)

The Montgomery-Asberg Depression Rating Scale (MADRS) was developed to assess the severity of depressive symptoms with particular focus on the effects of antidepressant treatment (Montgomery & Asberg, 1979). The MADRS is a semi-structured clinician-rated interview that takes about five minutes to complete. The 10 items included in the MADRS were chosen for their sensitivity to depressive symptoms and accuracy of change estimates with hopes that it would be effective in distinguishing the subtle differences of effectiveness between antidepressants (Montgomery & Asberg, 1979). The items are rated on a seven-point scale with descriptions at even numbers to help guide the clinician's scoring. Ratings are based on the clinical interview, but the

authors advise that information from other sources (e.g., reports from family members) should be considered when available to allow for the best assessment of the patient (Nezu, Ronan, Meadows & McClure, 2000). Below is an example of an item from the MADRS to illustrate its general structure.

Item #1: Apparent Sadness

Representing despondency, gloom and despair (more than just ordinary transient low spirits), reflected in speech, facial expression, and posture. Rate by depth and inability to brighten up.

Table 3.4 Example of 7-Point Rating Scale of MADRS

0 – No Sadness.
1
2 – Looks dispirited but does brighten up without difficulty.
3
4 – Appears sad and unhappy most of the time.
5
6 – Looks miserable all the time. Extremely despondent.

In the original psychometric evaluation of the MADRS (1979), the MADRS correlated significantly both with the HAMD and clinicians' objective evaluations of patients. Subsequent research has revealed that overall the MADRS is more sensitive to treatment effect than the HAMD (Santen, Danhof & Pasqua, 2009). Further, nearly all of the individual items of the MADRS demonstrate sensitivity to treatment response, whereas there is significant variability of the sensitivity of the individual items of the HAMD (Santen, Danhof & Pasqua, 2009). The four-factor structure of the MADRS (sadness, negative thoughts, detachment, and neurovegetative symptoms) is stable across

time and gender (Quilty, Robinson, Rolland, De Fruyt, Rouillon & Bagby, 2013). The MADRS and each of its subscales can be used to effectively evaluate treatment response of the affective, cognitive, social, and somatic aspects of depression in both males and females (Quilty, Robinson, Rolland, De Fruyt, Rouillon & Bagby, 2013).

The sample used in the original psychometric evaluation of the MADRS (Montgomery & Asberg, 1979) was composed of 106 inpatients and outpatients between the ages of 18 and 69 years, with primary depressive illness. Patients were selected from both England and Sweden to reduce cultural bias in the selection of items. Interrater reliability was assessed between two English raters (r=.90), two Swedish raters (r=.95), and one English and one Swedish rater (r=.97). Interrater reliability was also assessed between psychiatrist and general practitioner (r=.97) and psychiatrist and nurse (r=.93), demonstrating interrater reliability between professionals (Montgomery & Asberg, 1979).

Self-Report Measures

Beck Depression Inventory (BDI)

First published in 1961 (Beck, Ward, Mendelson, Mock & Erbaugh), the Beck Depression Inventory (BDI) is a 21-item self-report tool to measure current depressive symptom severity. The BDI is written on a fifth to sixth grade reading level and takes 2-5 minutes to complete. The scores range from 0-63 with the following cutoff points: 10-19 indicates mild depression; 20-29 moderate depression; 30-63 severe depression.

Beck maintained that the original BDI was not designed to reflect any particular etiological or treatment theory of depression; rather, he indicated that the BDI's pool of items are a compilation of common depressive symptoms observed by mental health professionals (Beck, Ward, Mendelson, Mock & Erbaugh, 1961). In an updated version

of the BDI, the items assessing weight loss, body image change, work difficulty, and somatic preoccupation were exchanged for the symptoms of agitation, worthlessness, difficulty with concentration, and loss of energy (Beck & Gable, 2001) in order to be more compatible with DSM-III diagnostic criteria for MDD.

For the purpose of this discussion, information concerning the BDI will reflect the original instrument for two reasons. First, because the original BDI is in the public domain it is more frequently used in clinical and research settings. Secondly, because the original version of the BDI is used more frequently in practice and in research, we have a broader understanding of its psychometric properties.

Beck, Steer and Garbin (1988) published the results of their meta-analysis of over 1000 studies using the original BDI across the span of 25 years. The BDI has a mean internal consistency of .86 with a range of .73 to .92 and is available in English, Spanish, and German and several shortened forms (Beck, Steer & Garbin, 1988). The Cronbach's Alpha for split-half reliability is .93 (Stinton, 2005). Concurrent validity for the BDI fluctuates between .61 and .73 for samples in the United States and Europe (Bonilla, Bernal, Santos & Santos, 2004). Factor analysis identified four clusters of depressive symptoms measured by the BDI: negative attitudes or sadness, cognitive-behavioral, biological, and somatic symptoms (Bonilla, Bernal, Santos & Santos, 2004). These are all consistent with our current understanding of the construct of depression.

It is worth mentioning at this point that because the BDI was designed as a self-report item and the construct of depression is extremely subjective, a measurement for inter-rater reliability is not meaningful. In addition, since this tool is designed to measure

a person's current state of depressive symptoms, test-retest reliability assessment is not applicable since the severity of depressive symptoms would be different at the time of retesting. And if retesting were carried out within a few days or so, hypothetically capturing the same "severity of symptoms" experienced by the participant, there is the risk of contamination by recall bias.

Center for Epidemiological Studies – Depression Scale (CES-D)

Originally published in 1977, the Center for Epidemiologic Studies - Depression Scale (CES-D) was developed for the National Institute of Mental Health to estimate the prevalence of depressive symptoms in the general population (Stansbury, Ried, & Velozo, 2006). The CES-D is another self-report tool designed to detect the presence and severity of depressive symptomatology over the past week; it is not recommended for diagnostic purposes (CES-D, 2007). Items which capture the affective and somatic nature of depression were taken from previously validated depression measurement tools (Shafer, 2006).

Participants rate items such as "I was bothered by things that usually don't bother me" on the following four-point ordinal scale:

Table 3.5 Example of 4-Point Rating Scale of CES-D

0 = Rarely or None of the Time (Less than 1 Day)
1 = Some or Little of the Time (1-2 Days)
2 = Occasionally or a Moderate Amount of the Time (3-4 Days)
3 = Most or All of the Time (5-7 Days)

There are also four "positive affect" items which are reversed scored (e.g., "I felt I was just as good as other people.") The score may range from 0-60, with higher scores indicating greater severity of symptoms. A cut-off score of 16 or more indicates a higher likelihood of the presence of depression, and those participants scoring above this mark should be referred for further evaluation. The CES-D is available in Dutch, English, Spanish and Portuguese, and is available in various shortened formats (CES-D, 2007; Goncalves & Fagulha, 2004). For the purpose of this discussion, the discussion will focus on the psychometric properties of the original CES-D.

The original validation of the CES-D (Radloff, 1977) revealed a co-efficient alpha of .89 to .90 in the general population. Subsequently, a co-efficient alpha of .85 for the general population and .90 for psychiatric populations has been reported for the CES-D (CES-D, 2006). Sensitivity for major depression ranges from 60 to 99% and specificity ranges from 73 to 94% in younger populations (Beckman, et al, 1994, as cited in Beekman, Deeg, Van Limbeek, Braam, De Vries, & Van Tilburg, 1997). Test-retest reliability after 2 to 8 weeks ranges from .51 to .67 (CES-D, 2006). Factor analysis indicates the four positive affect items do not correlate well with a unidimensional concept of depression and the CES-D might be enhanced if these items were removed (Stansbury, Ried & Velozo, 2006).

Comparison of the Strengths and Weaknesses of Measures

The BDI, CES-D, HAMD, MADRS, PRIME-MD, SCID-I, and the DIS-IV as outlined above have been found to be valid and reliable in measuring particular aspects of depression. However, it is important that each one is used for the purpose for which it

was designed. The BDI, CES-D and HAMD are designed to measure depressive symptom severity, and can be used to screen for depression, as well as tracking change in symptom severity over time. The MADRS also measures depressive symptom severity, but is more sensitive to capturing the subtle changes of treatment response. The PRIME-MD is designed to detect the presence of symptoms of psychiatric conditions often seen in primary care settings and is useful for helping provide a differential diagnosis of depression. The BDI, CES-D, HAMD, MADRS and PRIME-MD should not be used to diagnose depression. The SCID-I and the DIS-IV are designed to diagnose psychiatric conditions, among them depression.

When evaluating the overall utility of each measure in clinical and research settings, several things should be considered. The BDI, CES-D, HAMD, MADRS and PRIME-MD are all in the public domain and have the advantage of being cost-effective. By comparison, the SCID-I and DIS-IV are expensive to administer. Adding to the cost of the measure itself, the SCID-I requires that it be administered by a mental health clinician. Considering that the SCID-I requires 45-90 minutes to administer, it generally becomes impractical to use in a large scale capacity in research. However, if a definitive diagnosis of depression is required, it may be necessary to use one of these two instruments. The DIS-IV, while more time-consuming than the SCID-I at 90-120 minutes, can be administered by a lay person, offsetting some of the expense.

The BDI and the CES-D are perhaps the most versatile of the measures examined in this review. Both can be administered in 5-10 minutes and scoring is also relatively straight-forward for these tests, which allows the administrator to rapidly interpret the results. The BDI is written on a fifth to sixth grade reading level, and the CES-D is

written on a third to fifth grade reading level. Both instruments are available in several languages. The quick, easy to read, self-report design of the BDI and CES-D facilitates their use as screening tools for depression in clinical settings and provides a good measure of symptom severity in research settings.

There are some common concerns associated with self-report instruments, such as the BDI and the CES-D. Among those potential problems is limited comprehension of the person completing the assessment. Illness, poor concentration, poor literacy, and limited vocabulary can interfere with comprehension (Moller, 2001). Therefore, the clinician should also use his or her clinical judgment when assessing someone suspected of having depression and not rely totally on screening tools.

The clinician-rated HAMD offers a more objective assessment of depressive symptom severity than self-report measures. The assumption is that mental health clinicians are skilled observers who have assessed and monitored the presentation of depression in a variety of patients, whereas the patient only has his own experience for comparison (Moller, 2001). However, since this type of assessment tool is designed to be administered and scored by a trained clinician, time does not always permit its administration in clinical settings. Moreover, the clinician rating of the HAMD is subjective, and the accuracy of the assessment depends on the expertise of the interviewer to obtain relevant and accurate information from the patient. The original HAMD did not include a standardized interview guide. Hamilton (1960) attributed the strong interrater reliability to the rigorous training of the clinician-raters. However, there is no assurance that those who currently administer the test have the same level of training, leaving the results open to clinician bias.

With regard to research utility in the area of medication efficacy studies, the HAMD and MADRS are the most appropriate measures to use. The HAMD was designed to be used with people who have already been diagnosed with depression and is particularly useful in tracking changes in symptom severity over time. At one time, the HAMD was the undisputed best option for tracking treatment response. However, there is evidence that the MADRS may be more sensitive to subtle changes in treatment response, prompting its use in research related to pharmaceutical testing.

Measure	Measurement of Focus	Target Population	Mins to Complete	Admin By	Fee?	Time-frame of Symptoms	Pros	Cons	Clinical Utility	Research Utility
SCID-I (1997)	Diagnosis of DSM-IV Disorders	Adults	45-90	Mental health clinicians	Yes	Lifetime	Diagnostic; Assesses for broad range of psychiatric conditions	Lengthy, Costly	High	Limited
DIS-IV (2000)	Diagnosis of DSM-IV Disorders	Adults	90-120	Lay people	Yes	Lifetime	Diagnostic; Assesses for broad range of psychiatric conditions	Lengthy, Costly	Limited	High
HAMD (1960)	Depressive symptoms	Patients diagnosed with depression	30	Mental health clinicians	No	Past week	Cost effective; Particularly useful in measuring changes in a patient's condition over time	Lengthy; Limited time-frame of assessment	Moderate	High
PRIME-MD (1994)	Differential Diagnosis of DSM-IV Disorders	Primary Care Patients	5-10	Primary care clinicians	No	Past 30 days	Cost effective; Quick; Particularly useful in primary care settings; Incorporates physical symptoms of depression	Emphasis on somatic symptoms may be at the expense of cognitive symptoms	High	High
MADRS (1979)	Depressive symptoms	Patients taking meds for depression	5	Mental health clinicians	No	Today	Cost effective; Quick; Particularly useful in gauging treatment response	Limited time-frame of assessment	High	High
BDI-I (1961)	Depressive symptoms	Adults	5-10	Self-report	No	Past 30 days	Cost effective; Quick	Emphasis on cognitive symptoms may be at the expense of somatic depressive symptoms	High	High
CES-D (1977)	Depressive symptoms	General Population	10	Self-report	No	Past week	Cost effective; Quick	Limited time-frame of assessment	Limited	High

Table 3.6 Comparison of Measures of Depression and Depressive Symptoms

Summary and Recommendations

Depression is complex cluster of disorders with a myriad of contributing factors. The measures most often used to identify depression in clinical settings usually only offer a global picture of depression and do not provide a look at the particular symptom clusters for individuals (Shafer, 2006). The distinction between psychiatric signs (e.g., crying) and symptoms (e.g., sadness) is much more vague compared to the clear distinction between signs and symptoms of the pathology of infectious diseases (bacterial colony growth vs. fever and chills) and physical injury (evidence of a fracture on x-ray vs. pain). The measures in this review provide a meaningful assessment of a limited subset of the multitude of symptoms associated with the syndrome of depression, but do not address any underlying pathology (Santen, Danhof & Pasqua, 2009). Current understanding of the syndrome of depression includes biological, situational, and sociological contributors, and there is no litmus test or biological scan which can detect it.

As our understanding of the full spectrum of signs and symptoms of the syndrome of depression broadens and deepens, the measures used in clinical and research settings must be adapted to reflect this. If we can identify behavioral, affective, and cognitive symptom clusters, this would theoretically improve assessment and assist in guiding treatment. For example, if it can be determined that the depressed patient also has a high anxiety component, then treatment could be steered away from Wellbutrin and similar antidepressants which aggravate the sympathetic responses common in anxiety. Similarly, if it can be determined that a depressed patient primarily has thought distortions (negative thinking, for example) then cognitive behavioral therapy can be

recommended earlier rather than later in treatment, preventing unnecessary suffering on the part of the patient. More important, because the effects of depression are so subjective, it is important to monitor anything else the client deems to be an important indicator of the severity of his depression (Arean, 2006).

Previous research indicates that men experience depression differently that women do. Much of the research in the past has focused on women's experiences of depression and it is possible commonly used measures of depression and depressive symptoms are biased towards women's expression of depression, leaving depression in men disproportionately unrecognized and untreated. It is the purpose of this qualitative investigation to add to our current understanding of the broad range of symptoms of depression by having men describe their experiences with depression.

CHAPTER FOUR

Introduction

The purpose of this qualitative descriptive study is to describe men's experiences of depression in order to provide direction for future research of the screening, diagnosing, and treatment of men's depression. Previous research indicates that men experience different depressive symptoms than women, and there is a possibility that men's depression is not being adequately captured by current screening standards, which would theoretically lead to a large number of men with unrecognized, undiagnosed, and untreated depression. If this is the case, this may explain the disproportionately low number of men diagnosed with depression compared to women, in contrast to the disproportionately high number of men who complete suicides. There is a need in the literature for descriptions of depression experienced by men in order to determine the adequacy of current psychometric screening tools and approaches to treatment which are currently in practice. This qualitative descriptive study seeks to begin to fill in this gap in the literature.

The pressing need for gender-specific research of psychological conditions was highlighted in *Age and Gender Considerations in Psychiatric Diagnosis: A Research Agenda for DSM-V* (Narrow, First, Sirovatka & Regier, 2007). This book is a compilation of a series of white papers solicited to aid the development of the new DSM-V and to provide guidance for future research which will contribute to future editions of the DSM. Addressing the subject of "Clinical Validators of Diagnoses," the authors state, "It is not possible to develop a comprehensive picture of sex/gender differences in the expression of a psychiatric illness when the symptoms probed are limited to those that are listed in

the current diagnostic criteria" (Yonkers, Narrow & Halmi, 2007; p. 122). In support of an agenda to guide cultural research on psychiatric diagnosis, Alarcon and colleagues (2002) emphasized the importance of asking the foundational question, "Are the right diagnostic categories and criteria being used?" The authors explain that if the scientific community conducts research using screening instruments that are based only upon current diagnostic criteria of depression, "it can never be known whether vast regions of related forms of distress (not captured by the criteria built into the diagnostic instrument) have been left out" (Alarcon, et al., 2002; p. 224). They conclude that innovative research which allows for alternative symptoms of depression is needed. Finally, in addressing potential resolutions to gaps in knowledge related to gender-specific issues of psychiatric disorders, the authors state, "Increased understanding of phenomenology and whether symptom expression differs in males and females is needed to inform the development of valid diagnostic criteria (Widiger & First, 2007; p. 135).

However, before phenomenological research is conducted, it is prudent to first ask men to describe their experiences of depression in detail using their own words. It is important to initially ask broad questions about men's experiences of depression so their answers are not limited by researchers' biases centered about current diagnostic criteria of depression. Understanding men's personal experiences of depression is important knowledge in itself as it can aid in recognition of depression in men. Secondly, it will provide a springboard for future gender-specific research in depression by (1) providing a fuller understanding of the phenomenon itself and help us to more precisely define diagnostic criteria for depression; and (2) providing knowledge to develop tools which

are more sensitive to depression as experienced by men. Therefore, the purpose of this qualitative descriptive study is to describe depression as experienced by men.

Study Design

A qualitative descriptive design was used in this investigation about men's experiences of depressive symptoms. A qualitative descriptive investigation seeks to describe a phenomenon by summarizing the everyday language of the participants' responses to a semi-structured interview guide (Sandelowski, 2000). The goal of a qualitative descriptive investigation is not strict interpretation, but description of the phenomenon experienced by the participants (Sandelowski, 2000). Qualitative descriptive methodology was chosen for this study because there is a fundamental lack of understanding regarding how men experience depression. There is a need to understand depression from the viewpoint and in the words of the men experiencing the phenomenon. Qualitative descriptive methodology provides the vehicle for exploring and articulating men's personal experience of depression. This methodology allows the participants' experience to guide the questioning and allows for the emergence of previously overlooked nuances of the phenomenon. Qualitative description allows the researcher "to collect as much data as they can that will allow them to capture all of the elements of an event that come together to make it the event that it is" (Sandelowski, 2000; p. 336) in contrast to quantitative surveys which are not designed for breadth and scope. Qualitative description is especially useful for practitioners because it allows for study of a particular phenomenon closer to its natural state, in that there is "no pre-selection of variables to study, no manipulation of variables, and no a priori commitment

to any one theoretical view of a target phenomenon... (allowing it) to present itself as it would if it were not under study" (Sandelowski, 2000; p. 337).

Data collection techniques in qualitative descriptive studies normally involve minimally structured open-ended interviews (Sandelowski, 2000). The interview guide used in this study (Appendix B) was constructed using the PI's expert knowledge of depression and depressive symptoms. Its semi-structured design allowed participants to freely describe their personal experience with depression, eliciting a rich full description of the phenomenon. Although the purpose of this study was to gather a straightforward descriptive summary of men's experiences of depression, common themes emerged during qualitative data analysis procedures. Sandelowski (2000) suggests outcome data should be organized in a way that best fits the "re-presentation" of the data. Findings for this study were organized as they relate to the most prominent theme revealed by participants' descriptions of depression: Isolation.

Inclusion and Exclusion Criteria for Participants

A purposive sample of 10 men was recruited to participate in semi-structured interviews that focused on their personal experiences of depression. The small sample size (n=10) is considered sufficient for a qualitative descriptive study, in part because sampling is homogenous (Sandelowski, 1995) provided saturation is achieved. Inclusion criteria were: males 18 years and older who have been diagnosed with Major Depressive Disorder, Major Depressive Episode, or Dysthymic Disorder, have agreed to participate in audio-taped, semi-structured interviews, and have the ability to speak the English language. Exclusion criteria included suicidal ideation in the last 30 days, non-English speaking, and previous diagnosis of Bipolar Affective Disorder, Schizoaffective

Disorder, Cyclothymic Disorder, Substance-Induced Mood Disorder, Mood Disorder due to a General Medical Condition, Adjustment Disorder, and Depressive Disorder NOS. Men with Bipolar Affective Disorder, Schizoaffective Disorder, and Cyclothymic Disorder were excluded because there is a fluctuation between depression and mania/hypomania for those diagnosed with these disorders, therefore, their experience with depression might differ fundamentally from those with unipolar depression. Substance-Induced Mood Disorder and Mood Disorder due to a General Medical Condition were excluded because their experience with depression may be fundamentally different because of the influence of the offending medical condition or pharmaceutical/illicit drugs. Men with Adjustment Disorder and Depressive Disorder NOS were excluded because by definition of these conditions they will not have had depressive symptoms longer than two weeks.

Institutional Review Board Approval

This study was approved by the University of Kentucky Medical Institutional Review Board (IRB). Letters of support to conduct research at each data collection site were obtained and submitted to the University of Kentucky Medical IRB (Appendix C). IRB-approved protocols were adhered to throughout the study.

Participant Recruitment Procedures

Participants were recruited from the two IRB-approved privately owned mental health agencies in the southeastern state where the study was conducted. Displays of the IRB-approved recruitment flyer (Appendix D) with PI contact information were placed in the lobbies of the two mental health agencies to recruit men willing to participate in this study. However, when no one contacted the PI after two weeks, permission was given by

owners of recruitment sites to sit in the front lobby and hand out a recruitment flyer to each man that entered the facility. I approached each man in the same manner, saying, "My name is Lori Mutiso and I am a PhD student at the University of Kentucky, College of Nursing. I am conducting a research study about men's depression. Here is a flyer that explains the study. If you are interested in participating in the study, please let me know."

Ultimately, this method of recruitment was not effective at one of the sites because of the characteristics of the setting and concern that it might unduly coerce men to participate in the study. Therefore, all ten participants were recruited from the larger agency.

Protection of Research Participants

Confidentiality and anonymity of study participants was assured by adhering to HIPAA standard of privacy, keeping study records in locked files, and erasing all identifying information from transcripts and audio taped interviews. Data analysis was performed on a secure laptop computer designated solely for this purpose. Data stored on this computer did not contain any identifying information as the participants were assigned a number instead.

Sampling Considerations

Once inclusion criteria were confirmed, purposive criterion-based sampling guided the overall selection of participants for this study. This sampling strategy is useful when interviewing participants who have experienced a common phenomenon (Creswell, 1998). Information-rich cases are chosen which will provide an opportunity to gain an in-depth understanding of the phenomenon (Sandelowski, 2000). The goal for this sampling strategy is not generalization (as it is with quantitative analysis). Rather, the ultimate goal

of purposeful sampling is to obtain cases that are deemed information-rich for the purposes of examining a particular phenomenon (Sandelowski, 2000). The phenomenon being examined in this study was men's experiences of depression.

Participants were selected for this study based on the criteria of being men 18 years or older who had a previous diagnosis of Major Depressive Disorder, Major Depressive Episode, or Dysthymic Disorder and having a willingness to describe their experiences with depressive symptoms. It was estimated that a sample size of 10 would be needed to reach data saturation of the phenomenon being studied.

Data Collection

The 10 participants for this study were recruited during a one month period. All screening, assessment and data collection activities took place in a private room at the recruitment site. For example, when men expressed an interest in participating in this study, they were first screened for eligibility by the PI who is a board certified Adult Mental Health Psychiatric Advanced Practitioner Registered Nurse, and if eligible, given information about the study. Those meeting eligibility requirements were invited to participate in the study. At this point, participants were asked if they preferred to participate in the semi-structured interview on that day or if they preferred to return to the recruitment site on another day. Nine of the men chose to have the interview conducted on the day of the screening.

The interview began with the PI reading aloud the IRB-approved "Consent to Participate in a Research Study" (Appendix E) as the participant followed along. Rights as a research participant were emphasized and participants were encouraged to ask questions at any time they arose and were assured they could stop the interview at any

point without repercussion. To determine each participant's comprehension of the purpose and potential risks of the study, the following questions were asked: (1) What is the purpose of this study? (2) What are you being asked to do? (3) What are the potential risks to you? Men wishing to participate in the study and having demonstrated a clear understanding of the purpose and risks of the study were asked to sign and date the Consent Form. A copy of the consent form was given to each participant. Completion of this step of the study process took about 15 for participants to complete. At this point, participants were given $25 for their time and instructed that even if they stopped the interview for any reason, they could keep the money. All interviews were completed as no participant stopped the interview process.

Next, participants were asked to complete the Beck Depression Inventory (BDI) (Appendix F) which assesses the level of depressive symptoms over the last two weeks. This form took approximately five minutes for participants to complete. When the BDI was completed, the PI totaled the score and looked at the participants' response to question #9, which assessed suicidality in the last two weeks. The available responses were:

0 I don't have any thoughts of killing myself.

1 I have thoughts of killing myself, but I would not carry them out.

2 I would like to kill myself.

3 I would kill myself if I had the chance.

All of the participants of this study chose "0 – I don't have any thoughts of killing myself." If any man had indicated 1, 2, or 3, the interview would have been halted at this

point for the safety of the participant and he would have been asked to speak with his mental health professional who was on site.

Participants were then asked to complete a brief Demographic Questionnaire (Appendix A). This form took participants about five minutes to complete. Data included race, current age, age at the first sign of depression, age at first diagnosis of depression, marital status, how many times married, number of children, level of education, level of income, and type of health insurance (public, private, none).

Next, the participant was asked if he had any questions before beginning the semi-structured interview (Appendix B). Next, the participant was informed that the digital voice recorder was being turned on, and it was placed on a desk directly in front of the participant. The audio-taped semi-structured interview was conducted to elicit information about the participant's experience with depressive symptoms.

Participants were observed by the PI during this interview and those observations were recorded in field notes. Observations included information about the participants' level of eye contact, tone of voice, rate and rhythm of speech, any unusual manner of dress, any obvious physical impairment, affect, whether the participant cried (and at what point) during the interview, and an overall general impression about the apparent ease or difficulty with which the participant could describe his experience with depression.

Each audio-taped interview lasted between 30 - 45 minutes. The semi-structured interview guide was comprised of 10 broad questions or statements:

1. Tell me about when you knew you didn't feel like your "real self."
2. Looking back, are there things that you now realize were going on before that point?
3. Talk to me about the time when you first realized you were depressed.

4. Think about the time when you felt the worst. Describe this to me.

5. Were you ever bothered about wanting to hurt yourself or other people?

6. Tell me how the people who know you would describe how you were ***before*** you depressed?

7. From your own experience, describe to me how men look and act when they are depressed?

8. Tell me what the following words make you think of:

    Depression

    Stress

    Anxiety

9. If some other man you know got depressed, what advice would you give him?

10. Tell me anything else you feel is important for me to know about you or your experience of being depressed.

At the end of the interview, participants were thanked for their time and allowed to ask any questions they had, or provide any observations that the interview did not specifically elicit. Participant 8 revealed, "I was honestly surprised that I wasn't asked about anything about how if affected my work or how the coworkers saw me." He revealed this was a significant struggle for him and he believed this was true for many other men as well.

Once the participant acknowledged there was nothing more he wished to report, the digital voice recorder was turned off. The participant was asked again if he had any questions about the study or how his information would be handled.

The average time spent with each participant was about an hour. Before leaving, each participant provided a phone number for use by the PI when conducting validity checks of data analysis, and if indicated, to explore for information deemed important for confirming themes.

Following initial analysis of data from the first two participants, the interview guide was modified to probe more deeply into the emerging themes of isolation, anger, and communication. In addition to the initial topical interview, Participants 3 – 10 were also asked if they had experienced a sense of isolation or the feeling of anger when they were depressed, and whether they believe that men who are depressed tend to hide their feelings. Those answering affirmatively were further prompted:

1. Describe to me the role isolation played in your experience of depression.
2. Describe to me the role anger played in your experience of depression.
3. Describe to me the reasons why some men do not express what is really on their mind when they are depressed.

The changes to the interview guide resulted in participants providing greater detail in their responses about these specific items.

Following analysis of the first interview, a de-identified summary of study findings was electronically mailed to each participant (Appendix G). Participants were contacted by phone to make them aware the summary was sent to them and a date was set to review findings with each participant over the telephone. The telephone interview lasted about 10 – 15 minutes for each participant. During this conversation, participants were interviewed to verify the PI accurately captured the intent of the participants' statements about their experiences with depression. Two participants did not return phone messages left by PI; three attempts were made to reach them.

Data Analysis

All 10 interviews were recorded via digital recorder. Digital audio files were given to a professional transcriptionist who was approved for this study by the Institutional Review Board of the University of Kentucky. In keeping with IRB protocol

regarding confidentiality, no identifying data were associated with the digital recordings. Each digital audio file was transcribed and labeled as Participant 1, Participant 2, etc.

The PI listened to the digital audio files twice while following each transcription in order to verify accuracy. As needed, minor corrections were made to the transcripts. Field notes were used to supplement this information. The PI made notes as ideas and questions emerged during the analysis.

Sandelowski (2000) advises qualitative content analysis be used to guide data analysis for descriptive studies. This method involves synthesizing verbal and visual data to produce a summary of the combined information. Whereas quantitative content analysis requires the application of a pre-existing set of codes to a set of data, qualitative content analysis is data-derived in that codes are systematically applied, but they are generated from the data themselves in the course of the study (Sandelowski, 2000). In fact, "qualitative research is generally characterized by the simultaneous collection and analysis of data whereby both mutually shape each other" (Sandelowski, 2000). During the process of qualitative content analysis, researchers are advised to "continuously modify their treatment of data to accommodate new data and new insights about those data" (Sandelowski, 2000).

As recommended above, simultaneous collection and analysis of data were performed throughout the data collection process in order to gauge the accuracy of emerging categories and themes across participant cases. For example, when Participant 1 was prompted to "Tell me about when you didn't feel like your 'real self'" he began by talking about how his stroke prevented him from interacting with the world in the way he did before the stroke. When prompted to "Talk to me about the time when you first

realized you were depressed" he began by talking about how he grieved for his deceased mother who had been a primary source of support for him. And when prompted to "Describe to me the time when you felt the worst" Participant 1 began to cry and describe how he was separated from the rest of his family who live in a distant state. The concept of being separated from others seemed to be an integral part of Participant 1's experience of depression. While interviewing Participant 2, I noticed he placed a similar emphasis on separation from others in relation to his experience with depression. This prompted me to explore the concept of Separation with future participants in this study.

Open coding (Strauss & Corbin, 1998) was used to identify the initial 36 categories found in the content of the transcripts. Initial themes or categories are needed in the beginning of the simultaneous data collection/analysis process in order to provide the guide the researcher toward more developed themes (Glaser, 1978). Initial categories were:

Table 4.1 Initial Categories from Open Coding

I had no friends	Anger at God
Death of a loved one	Anger for no reason
Working away from others	Extreme irritability of everyday annoyances
Living away from others	Feelings of injustice
Relationship distress	I am not fun or nice
I do not want to hurt others	Disassociating
Fear of physical harm	I do not measure up
Introversion	I made a plan to kill myself
Cognitive distortions about relationships	Loss of desire to participate socially
Anxiety	Fear of derision
I do not physically feel like socializing	I did not kill myself because it would hurt someone I love
I prayed to God to die	Fear of betrayal
Working excessively	Fear of not being understood
Drug/Alcohol misuse	Fear of no one caring
Watching television	I cannot communicate how I feel
Sexual relationships	Poor concentration
Staying busy	Being out of touch with one's true feelings
Intentional misrepresentation of self	Belief that men are not supposed to reveal their true feelings

Subsequently, axial coding (Strauss & Corbin, 1998) was conducted and the initial categories were reduced to the following seven themes:

Table 4.2 Final Categories from Axial Coding

No One Around To Talk To	Depressed Men Are Angry
Avoidance Coping Styles	Suicide: The Ultimate Isolation
I Don't Want To Be Around People	Not Communicating The Real Self
Other People Don't Want To Be Around Me	

The desired end-result of qualitative descriptive studies is "a straight descriptive summary of the informational contents of data organized in a way that best fits the data" (Sandelowski, 2000). In this study, an *in vivo* quote, "depression is being all alone," influenced the formation of a central them, Isolation. This theme of Isolation was not

intended to illustrate a causal pathway or to provide a theoretical explanation of all categories (Strauss & Corbin, 1998). Instead, the central theme of Isolation was used to anchor the seven interrelated categories that emerged from the participants' description of their experiences of depression.

Figure 4.1 Contributors to Isolation in Depressed Men

Scientific Rigor

Trustworthiness of data was assured by using techniques associated with the following concepts outlined by Lincoln and Guba (1985):

Credibility -	Confidence in the truth of the findings
Dependability -	Showing that the findings are consistent and could be repeated
Confirmability -	A degree of neutrality or the extent to which the findings of a study are shaped by the participant, as opposed to researcher bias

To enhance credibility and dependability, detailed field notes were taken during and after individual interviews. Participants were asked to clarify statements that were unclear. When individual interviews were complete, the PI listened to the digital audio files twice while following each transcription in order to verify accuracy. As needed, minor corrections were made to the transcripts. Most of these corrections were instances when the transcriptionist could not understand one or two words the participant said and typed "_____" to indicate this. The most significant correction was made to the transcription for Participant 4. At one point during the initial interview, Participant 4 mouthed the words "I am gay." This sentence was not picked up by the digital recorder. Field notes were used to supplement this information. The PI made notes as ideas and questions emerged during the analysis.

Confirmability is determined by the degree to which final themes of the qualitative content analysis are informed by the participants as opposed to the bias of the researcher (Lincoln & Guba, 1985).

Confirmability was promoted by an audit trail which was maintained throughout the study. The audit trail included documentation of all study procedures, field notes, and coding notes. The audit trail and coding were examined and verified as accurate by two researchers with expertise in depression and qualitative methods. In addition, participants were provided with a summary of study findings and main categories related to Isolation in the context of depression. After participants had an opportunity to review these summaries, "member checks" were conducted with eight participants to verify accuracy of the study findings and to confirm that the main categories described their experience of

depression. All eight participants agreed that the categories accurately captured their overall experience of depression.

CHAPTER FIVE

Description of Sample

All ten men who participated in the study had a previous diagnosis of Major Depressive Disorder. Ages of the participants ranged between 25 – 67 years (mean = 44.4 years; median 41.5 years). The sample was very homogenous in terms of race, income, and education (Table 5.1). Participants' scores on the Beck Depression Inventory (BDI) ranged from 6 – 28 (mean = 16.2; median = 16).

Table 5.1 Sociodemographic Characteristics of Sample

Participant	BDI	Age	Dx Age	Age of 1st Sx	Delay of Dx	Time Since Dx	Marital Status	X's Married	Children	Race	Education	Income	Insurance Type
1	28	47	46	46	0	1	Married	3	1	AA	AD	< $19K	Public
2	6	35	25	12	13	10	Married	1	2	C	BS	<$19K	Private
3	28	34	32	10	22	2	Single	0	0	C	Some College	<$19K	Private
4	17	36	12	5	7	24	Divorced	1	0	C	Some College	<$19K	Public
5	8	35	23	10	13	12	Single	0	0	C	AD	<$19K	Public
6	17	53	52	12	41	1	Single	0	0	C	MA	>$70K	Private
7	11	61	45	30	15	16	Married	2	2	C	MA	<$19K	Public
8	22	25	17	17	0	8	Single	0	0	C	Some College	<$19K	Private
9	10	67	25	23	2	42	Married	1	2	C	MA x 3	$20-35K	Private
10	15	51	16	5	11	35	Divorced	1	0	C	MA	$35-70K	Private

Findings

Data analysis revealed that Isolation was the core theme that characterized the experience of depression for the male participants of this study. The experience of Isolation increased depressive symptomatology, and conversely, depressive symptomatology increased Isolation (Figure 5.1). Primarily, Isolation was self-imposed by participants due to their depressive symptoms and avoidance coping style, but was also externally experienced due to their work and living situations. In this study, the main categories that describe the concept of Isolation include: No One Around to Talk To, I Don't Want to Be Around Other People, Other People Don't Want To Be Around Me, Depressed Men Are Angry, Avoidance Coping Mechanisms, Suicide: The Ultimate Isolation, and Not Communicating The Real Self. This chapter describes the seven subthemes and illustrates how each is related to the overarching theme of Isolation.

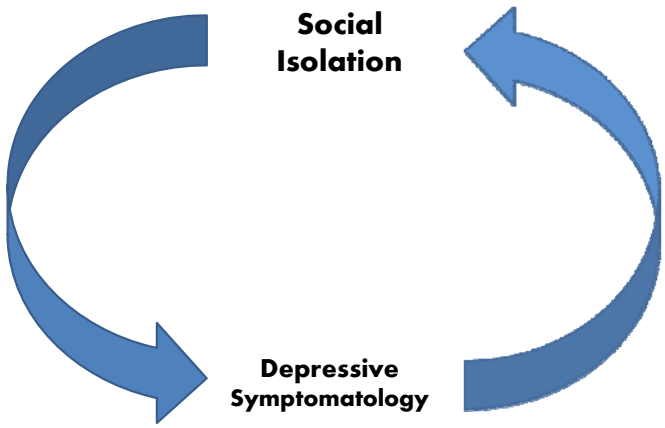

Figure 5.1 Cyclical Relationship Between Social Isolation and Depressive Symptomatology

Contributors to Isolation

"No One Around To Talk To"

One contributor to isolation and consequent depression among participants was the perception of simply no one with whom to engage. As one participant stated, "That's the worst...no one to talk to." Several participants mentioned they simply did not have many friends with whom to talk. Participant 6 stated, "I didn't have any friends, because I, you know, I just didn't have any friends." Death of a loved one was another reason participants felt alone. Participant 10 stated, "Now I don't want to see my folks die... all of a sudden, I'll be just me. And I'll be alone."

Participants described a variety of occupational scenarios that isolated them from other people including working long hours, working in a rural area, and traveling related to the job. In addition, isolation increased as a result of working in an area of the building away from others, and having a profession which required solitude, such as being a computer programmer, or confidentiality, such as being a counselor or pastor. Participant 6 stated, "You spend too many hours in retail, 60 hours a week you know. And when you do that, it's at the cost of other relationships... there's a cost associated with making, working while making a whole lot of money."

Participants also described various living situations that contributed to their perception that there was no one with whom to talk. Some participants lived in rural or isolated areas. One participant described how he lived in an area where primarily elderly people lived. There was no one his age to befriend him. Participants 6 and 8 had bedrooms that were in the basement of their homes and felt somewhat disconnected from the rest of the family when they were there. For a time when he was still in high school,

one participant lived in a separate house from the rest of his family while they were trying to sell it. Other participants lived in cities and states which separated them from their families and friends.

Relationship distress often contributed to symptoms of depression by increasing the perception that they were alone. In the experiences of the men participating in this study, relationship distress seemed to both contribute to isolation associated with depression and be exacerbated by depressive symptoms.

For example, Participant 2 described how the symptoms of depression strained relationships: "I was having a tough time. Lack of motivation, you know wanting to, didn't want to go in (to work) and have to speak to people and talk to people and I wanted to sleep all the time and it was causing a strain in the marriage and with our child." Participants also mentioned that relationship distress contributed to depression and isolation. Other participants included sexual difficulty, being shunned by one's family, and breakup, separation, or divorce from a significant other as factors that contributed to relationship distress, depression, and isolation. Finally, several participants described how teasing and bullying contributed. Participant 6 described, "I missed a lot of school. I didn't want to, I didn't like going to school because I was teased a lot and so I would fake illnesses and, in an attempt to stay home."

Avoidance Coping Style

During the individual interviews, participants often recounted the measures they used to cope with depression. Interestingly, many of the other participants also discussed means of coping with depression which could be categorized as avoidance. Avoidance coping is a manner of coping with stress by avoiding thinking about the situation, rather

than actively working to solve the problem. For example, a man who has recently moved to a new community may be lonely for a time. This man may work excessively in order to avoid thinking about his loneliness, rather than actively working to create relationships in his new community. Avoidance coping methods may provide a distraction from the depression, or give the illusion of social interaction and may serve to further segregate them from others. Participant 6 stated,

> I think that men typically don't know how to express their depression very well. They don't know how to cry. It's more socially accepted now for men to go to therapy but not so much when I was growing up... But now it's a little more likely to happen but I still think that men typically are, don't like to cry and they want to keep that and don't know what to do with those feelings so they're either going to get drunk. It could go one of two ways, they're going to become alcoholic and drink or find some other thing to numb or to fill that emptiness or they're going to throw themselves into work so you're either going to be a workaholic or an alcoholic. They're going to be some sort of "aholic." They're going to have some behavior that takes their mind off of whatever's causing them to be depressed.

One specific example of an avoidance mechanism that was described by several participants was watching television or videos excessively. When I asked Participant 4 how he coped with his depression, he stated, "I always withdrew to myself and watched TV, stayed home. I only had a few friends... I'm really big into TV and movies and stuff like that. I have a massive DVD and Blu Ray collection and digital movies and stuff and when I'm down, I find every comedy that I can possibly find and I'll watch them and,

just, but it's my own little safe zone, so to speak." Other examples of avoidance coping mechanisms that participants described were:

- sleeping excessively
- working excessively
- drinking alcohol excessively
- using illicit drugs
- eating excessively
- serial superficial sexual relationships
- pornography
- "staying busy"
- "going into my own little world"

"I Don't Want to Be Around Other People"

Another contributor to isolation and subsequent depression described by participants was lack of desire to be around other people. Participant 1 stated, "I'm at a point now where I'd just as soon rather be by myself. You know, I'd rather go into a room and, you know, shut the door and I'm just by myself...that's perfect." Participant 8 stated, "When I'm depressed, I'm gone. I'm not with my friends. You know, I don't hang out with them when I'm depressed. I guess they would say he's either here, and I guess normal...I'm present. Because if you're depressed then you're simply not there." Some of the reasons participants described for not wanting to be around others when they were depressed were being self-conscious, being shy or introverted, and straight-forward anhedonia.

Not surprisingly, several of the participants described how fatigue and physical discomfort that accompanies depression contributed to their isolation. Participant 8 stated, "Depressed people don't have the energy to even carry through with that whole act...I started failing all my classes and I pretty much just slept all the time and begged my mom not to let me, make me go to school that day and stuff like that." Participant 5 said, "I would make myself sick almost to the point where I would have physical symptoms whether it be vomiting, extreme headaches...I would prolong them psychologically so in order to stay out of school."

Also not surprising was the description from some participants how fear and anxiety contributed to their isolation. Some fears were specific, as in the case of Participant 6 who related, "The abuse from my father was worse because I was afraid of him and you know I would try to hide from him. And you know every boy needs to have that father figure that you know creates that self-esteem in them and I didn't have that from him." However, a few participants described a nebulous anxiety which accompanied their depression that affected their desire to socialize. Participant 7, who did not suffer from agoraphobia, described it like this, "You can never be too careful, that you're always at risk. You're never free from something. Something landing on you like a ton of bricks literally or figuratively, but even literally."

Another reason participants described for not wanting to be around other people when they were depressed was having a negative attitude about other people. Participant 8 said, "When I am depressed I'm always kind of negative and judgmental...I think the most recent depression that I had made me kind of realize it but I think their (friends) happiness kind of, I'm in such a bad mindset that their happiness disgusts me. And it

might be a culmination of jealousy and, but I tend to disapprove of most people when I'm in that mindset and you know and I see the things that they want to do and I think, no that's stupid, I don't really feel like doing that."

Interestingly, several participants described not wanting to hurt people as a result of the anger that accompanied their depression. In order to avoid hurting people, they simply avoided others. Participant 6 stated:

> I like to be by myself if I'm having a bad day or I'm depressed or even in a bad mood or just a little impatient. Then I will, rather than take it out on anybody else, I will like, I kind of know when I'm in my moods and I will try to keep from going off on anybody. When I'm in a bad mood, I have a tendency to, especially with the people that are closest to me, you know, you end up, it was just like with my dog. You tend to act, say have aggression or not, you know or short temperament if you will, you know, lack of patience, you know, irritability, I guess is what I'm looking for, towards the closest, the things that are closest to you. You will tend to act out.

"Other People Do Not Want To Be Around Me"

Several participants of this study indicated when they were ***not*** depressed that others enjoyed their company. Participant 2 stated, "Before depression, I had a lot of friends, fun to be, you know, people liked to be around me. You know, I was very personable." But participants thought when they were depressed, others did not want to socialize with them. I asked Participant 7 if the people around him could recognize that there was something wrong with him, and he stated, "Yes and no. They didn't say, what's wrong with you, but I could tell there was discomfort with me." Some of the participants described how the irritability that accompanied their depression drove others away from them. Participant 3 said, "If you ask anybody like the first word to describe me, they would say asshole...I was just really mean and I have no idea why." Participant 2 stated,

"I would find myself taking it out on other people, you know, just had a very short temper and you know not physically or anything. Just not being, no, you know, not being a pleasure to be around I guess." Interestingly, two of the participants described how their depression made them feel less fun. Participant 7 said, "Depressed men are very not fun...Before (depression) I was more spontaneous, I was more fun, lighthearted, more confident. Afterwards, serious, withdrawn, not fun, snappish. And I felt badly about it. It was difficult to control that. I just felt like I was always being squeezed."

Depressed Men Are Angry

Anger was a prominent theme in participants' descriptions of their experiences of depression. Anger was described by every participant of this study and seemed to equate anger with depression. Participant 8 said, "I think for the most part, men don't even know honestly that they are depressed. Unless they are in touch with their emotions. I think for the most part, the normal guy is either angry, self medicating somehow." Participant 10 said simply, "I see an angry man...He's depressed." Participants thought their anger contributed to their isolation. Participant 6 said, "I was very angry and when I was 10 years old or so I was very negative and I was, I think in an effort to protect myself and keep people away from me, I was just really, just really a nasty person to be around. I remember being always in a bad mood...I wasn't socializing well with others, I was not engaged with sports. You know, I would recluse to the basement as soon as I'd get home." Several participants described how they would sequester themselves in order to hide their anger from others or even to protect others from their anger. Participant 9 stated, "My relationship with my wife can be fairly volatile at times. I do carry a lot of anger and I don't always handle that well. I'll fly off the handle. I'll get mad. I'll get

angry. Usually then I beg forgiveness immediately. I mean, I feel contrite. Even though I do exhibit anger, I don't feel comfortable about exhibiting anger."

Some participants of this study stated sometimes they were angry for no reason. Participant 2 said, "I was just very irritable...I had a very short temper and would get angry over things with no reason, just being upset over anything." Other participants described becoming unduly angry over everyday annoyances, such as someone cutting them off in traffic. Two participants were angry and became visibly upset during the interview when they described the injustice they felt having depression. Participant 9 said, "I'm basically pissed off at God that I have this disease... I talk about my mother fucking disease that I have which expresses my feeling about it." Participant 8 said, "I've missed about a month's work in the past 3 months from my depression and anxiety and you can't really go to a superior and say I'm depressed. It's not the flu to them. It's not Ebola you know. It's nothing to them. They hear 'depression' but they really hear 'sad' and then they just think okay, quit being silly and get back to work. But depression is the exact same thing. It's unfair."

While discussing depression and anger, I asked participants to what degree they struggled with an urge to harm others. Several participants said this was a significant problem and fought to keep those ideations in check. Participant 5 said, "There was anger... I had, for the longest period of time, struggled to think about injuring others or taking out frustrations on others and being very manipulative, very deviant to the point of where I myself thought that it was dangerous and so something needed to be done...I can sit here and say that it is a miracle that something bad didn't happen."

Suicide: The Ultimate Isolation

While none of the participants of this study endorsed current suicidal ideation, several of them described that when they were severely depressed in the past, they did struggle with the desire to harm themselves. A few of the participants described a passive type of suicidal ideation. Participant 6 said, "I would and sit and pray for, you know for God to let me die, just go ahead and take me." Others described the detailed plans they had made to actively kill themselves with carbon monoxide or with guns. Participant 5 said,

> I was going through a divorce, maintaining 2-3 other relationships at the time trying to ease the pain of the divorce, so I was really stretching myself very thin and trying to work on top of that and eventually it just crashed. Everything just came down, fell down around me so to speak...There was a point where I had a gun laying out. Did I actually ever, there was a bullet in the chamber, yes. Did I actually put it to my head? Yes. Did I pull the trigger? Obviously not.

I asked each participant who struggled with suicidal ideation what kept them from carrying out their plan. Each participant described that they simply could not go through with suicide because it would hurt a loved one, usually their mother. It is very interesting in the light of the prominence that isolation played in these men's descriptions of their experiences of depression that they did not become statistics to suicide because of a relationship they had with someone.

Not Communicating the "Real Self"

Another finding that emerged during this study was that men put up a facade and did not communicate their "real self." I define this category as evasive, superficial, deceitful, or ineffective communication. This was a significant finding as every man in

this study endorsed this characteristic. This type of communication, which can be intentional or unintentional, seems to be an important contributor to the isolation experienced by the depressed men in this study. Participants talked about keeping a lot of things in, remaining stoic, and being evasive when asked outright if they were ok/depressed. Participant 5 gave this interest comparison between men who are depressed and those who are not:

> In my personal opinion you will see for example I'd say an average 30 year old working male, professional male, will carry themselves in a very confident manner. The mannerisms I think change (when a man is depressed), begin to, slumping when they're sitting, loss of eye contact, will evade some of the simple questions. Very evasive...maybe physically nervous you know, Jittery perhaps when you're asking the questions. Shifting in the chair. And people will try to get away from the topic...because they don't want that shield of strength shattered.

When asked to what degree do men struggle with the idea of not wanting their shield of strength shattered, Participant 8 stated:

> I think it's a huge problem...It's one of the most frustrating things I've had to go through like growing up is understanding that men just don't get it, like they don't get to just let go. They're always hiding something. I don't know. I wouldn't say it's for the macho effect. I just think that they're embarrassed of the fact that they are emotional.

Participants of this study described the many reasons for intentionally putting up a facade (shield of strength) and not communicating their "real self." Each of the reasons seems to demonstrate a lack of trust on the part of the participant. One participant said simply, "It's none of their business." Several participants were very concerned that if they shared their true feelings with another person they would either use that information against them or betray their confidence. Participant 3 said he advises depressed men "either go to a doctor or talk to one of your other friends, one of your other friends that'll listen and not spill your shit to anybody else. That's the biggest problem."

Several participants said they put up a facade and act as if they are fine because other people simply do not understand depression. Participant 2 complained, "A lot of people think that depression isn't a real thing. It's just something that you kind of use as an excuse." This lack of understanding from others contributed to their isolation. Participant 8 lamented, "I think they (my friends) don't understand what I'm going through and so I feel a little bit alienated because everybody's roaring and hollering and laughing and I'm kind of forcing myself to even smile, so I don't know. I feel like I've never been the type of person to put on a show for anybody so I feel like I'm even lying to myself and I don't like doing that. I feel more comfortable when I'm by myself."

Participants also said they kept their true feelings and thoughts hidden from others because they felt that others did not care about what they were going through or others did not want to be bothered by them. Participant 1 – "I can tell when people don't want to be bothered you know...and when you don't want to be bothered then that causes me to put my brakes on."

As expected, some described keeping their true feelings hidden related to the stigma of mental illness and fear of derision if they admit to having depression. Participant 8 said, "The coworkers give me a really hard time and it's insulting because they don't understand and I can't tell them and even if I did tell them, they wouldn't care. They would laugh." Participants described how the stigma of mental illness and the stereotype of a depressed man contradicts the expectation of society has that men should be strong and impregnable. Participant 10 said,

> We need society to open up and stop looking at the perfect man, the model man as this strong muscular and handsome and just does all this stuff and he kicks ass. We don't need that. We're just people. You don't have to call us faggots.

> I'm not gay. But I weep when I see a child abused...that pisses the shit out of me and it makes me depressed.

The participants of this study also described a belief that society allows women to have a support system on which to rely, but men are expected to be self-sufficient. Participant 6 stated, "Women are more in tune with themselves and with each other. And they have more support networks. Whereas men tend to gauge themselves against other men and you know it's a sign of weakness potentially if you have to go to therapy." And Participant 10 said, "Men are more apt to keep his feelings within himself, to feel ashamed for having those feelings, to believe that it's a weakness and therefore be reluctant to disclose them...whereas a woman may be able to do it much more readily and people not look at her and say she's weak."

Participants in this study not only described intentional means of miscommunicating their true feelings, they also stated that miscommunication could be unintentional. Participant 9 stated, "When I'm depressed, my interpersonal communication skills are not as well (sic)." Poor concentration is a known symptom of depression and this was described by participants to contributing to their inability to communicate effectively. Participant 8 said, "I think it was the cloudiness and I just couldn't grasp, get a hold of anything...I have a hard time doing things like that, structuring things in my mind." Participant 9 went as far to say that he is able to recognize that another man is depressed because they "Meander in their conversation... Not engaging...a lot of ambling around. Lack of focus. Lack of concentration, lack of good interpersonal communication."

Some participants described that some men don't communicate that they are depressed because they do not realize they are depressed. Participant 8 said, "I think for

the most part, men don't even know honestly that they are depressed...I think it's almost a ghost. It can sit in your whole life and you don't even know what it is and I think it's the most subtle thing." Participants explained they did not communicate because they did not think there was anything to communicate. Participant 3 thought, "There is nothing physically wrong with me. It's all in my head." Participant 6 said, "They didn't really you know take kids to doctors for, you know back then in the '70s so you know...So I didn't really know that there was anything wrong or different with the way I grew up until I started college and started getting around people that were normal...It never occurred to me that I should go to therapy."

Several participants said they did not have the vocabulary to describe to others how they felt. Participant 6 said, "I think that men typically will, don't know how to express their depression very well." Crying is a symptom of depression that is often more associated with women. When I asked the male participants of this study if this was a symptom they with which they struggled, they revealed something curious. Participant 6 said, "Men don't know how to cry... and don't know what to do with those feelings." Participant 9 said, "I think I keep my emotions under wraps quite a bit. It doesn't seem natural to cry. That doesn't come natural to me."

Participant 3 said that he had a difficult time getting help for his depression because of his personality. He described how his dry sense of humor often distracted healthcare professionals from the depressive symptoms he attempted to describe to them. He stated,

> Do I seem depressed? ... If you just ran into me and I'm, and we're having a conversation, you would have no clue that there was anything wrong with me whatsoever. And that was the biggest problem I had with the doctors.

> For the first part of it was because I mean, this is my personality. I can't do anything about this...You know tack on the extra pressure to your depression when you're like I can't even get the doctors to help me because they think I'm fine because I might make a joke.

One participant said he did not communicate that he was depressed because he felt people should "just know." He became quite emotional when he said, "It's just odd to me that no one in school ever, like ever pulled me in and said, why are you missing so much school...No one ever asked me. I was kind of angry now, well for a while...No one ever asked me, none of my teachers ever said, well what's the reason behind his behavior. He's not doing well in school. I was withdrawn. I was you know, missing you know school all the time...I had to be exhibiting signs ...Not one teacher, not one counselor ever asked me about my behavior."

Summary

Isolation is important in understanding men's experiences of depression. The central theme of Isolation anchors the seven subthemes which emerged from analyzing the descriptions of depression of the men of this study. Isolation was increased by depression, and conversely, depression was increased by Isolation. Participants described how having ***No One Around To Talk To*** due to living or working in an isolated area and relationship distress contributed to their depression. Participants also described how their use of ***Avoidance Coping Mechanisms*** complicated the isolation associated with their depression. Avoidance coping methods may provide a distraction from the depression, or give the illusion of social interaction and may serve to further segregate them from others. Examples of Avoidance coping mechanisms described by the participants of this study include watching videos excessively, sleeping, eating, and working excessively,

drinking alcohol and using illicit drugs, pornography, serial superficial relationships, "staying busy," and "going into my own little world."

Participants described that when they are depressed, many times ***I Don't Want to Be Around Other People*** because they did not feel like socializing due to the anhedonia, fatigue, physical discomfort, anxiety, and negative attitudes associated with their depression. Participants also described that they avoided being around others out of concern that they may hurt them in some way. Participants also described that at times ***Other People Don't Want To Be Around Me*** because their friends perceived them as being not nice and no fun. The participants of this study related that ***Depressed Men Are Angry*** and described the important role that anger played in isolating them from others. Participants described that men often do not recognize their depression, but they do recognize anger. Participants explained that sometimes they were angry for no reason or became unduly angry over everyday annoyances; sometimes they were angry with God for having depression; and some participants described how they struggled to control impulses to harm other people when they were angry.

Participants of this study described how they struggled with the desire for ***Suicide: The Ultimate Isolation.*** Some of the participants described elaborate plans they had made to kill themselves, while others prayed to God to let them die. Interestingly, even though they struggled with suicidal ideation, none of the men in this study had actually attempted suicide. Without exception, the reason they gave for not following through with their plan was the desire to protect a loved one (usually their mother) from the pain their suicide would bring. Even while struggling with depression and feelings of isolation, this relationship prevented them from committing suicide.

Finally, each man participating in this study described how ***Not Communicating The "Real Self"*** contributed to the isolation associated with their depression. This theme was defined as evasive, superficial, deceitful, or ineffective communication. This type of communication, which can be intentional or unintentional, seems to be an important contributor to the isolation experienced by the depressed men in this study. Participants of this study described the many reasons for intentionally putting up a facade and not communicating their "real self." Each of the reasons seems to demonstrate a lack of trust on the part of the participant. Participants described they struggled with fear that others would betray their confidence or ridicule them for having depression. They said that others often do not understand or do not care that they have depression. Participants also described that while women are allowed to rely upon a system of support, they feel that society expects men to be self-reliant, and this expectation is an important reason men do not communicate their true feelings to others. Participants in this study also stated that miscommunication could be unintentional. Reasons participants gave for this unintentional miscommunication were poor concentration associated with depression, not realizing they were depressed, not having the vocabulary to express their feelings, having a dry sense of humor, and the belief that people should "just know" they are depressed by their behavior.

CHAPTER SIX

Discussion

This qualitative descriptive study explored how men who have been diagnosed with depression describe their experience with depression. Ten men were interviewed and provided a description of what it means to be a man struggling to manage and cope with the symptoms of depression. Content analysis revealed the central role that Isolation plays in men's experience of depression. It also revealed a cyclical relationship between Isolation and depressive symptoms: Isolation increases depressive symptomatology and depressive symptomatology increases Isolation. It also revealed seven contributors to Isolation: No One Around To Talk To, Avoidance Coping, I Don't Want To Be Around Other People, Other People Don't Want To Be Around Me, Depressed Men Are Angry, Suicide: The Ultimate Isolation, and Not Communicating the "Real Self." This chapter will compare and contrast the key findings of this study with previous research conducted among men diagnosed with depression.

Beck's Cognitive Theory of Depression

Beck (1961) maintained that cognitive symptoms of depression precede the affective and mood symptoms of depression, rather than the reverse. Beck argued that automatic negative thoughts caused by cognitive distortions are the central mechanism of depression. He postulated that it is more likely that a negative view of oneself was the causal mechanism of depression, rather than depression causing a negative view of oneself. Beck proposed the existence of a self-perpetuating mechanism he called the Negative Triad (Figure 6.1) which he explained was a negative view of oneself, a negative view of the world, and a negative view of the future.

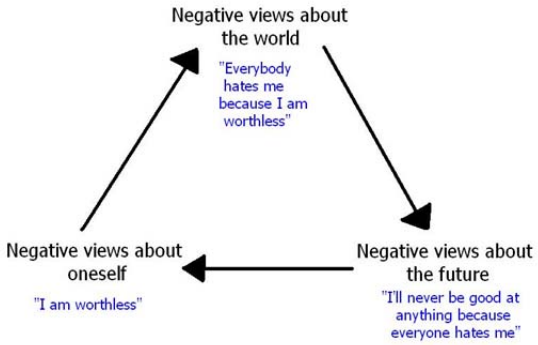

Figure 6.1 Beck's Negative Triad

Beck and colleagues developed the original BDI (Beck, Ward, Mendelson, Mock & Erbaugh, 1961) to screen for depressive symptoms. He maintained that the original BDI was not designed to reflect any particular etiological or treatment theory of depression; rather, he specified that the BDI's pool of items are a compilation of common depressive symptoms observed by mental health professionals (Beck, Ward, Mendelson, Mock & Erbaugh, 1961). In an updated version of the BDI, items assessing weight loss, body image change, work difficulty, and somatic preoccupation were exchanged for the symptoms ***of agitation***, ***worthlessness, difficulty concentration, and loss of energy*** (Beck & Gable, 2001) in order to be more compatible with DSM-III diagnostic criteria for MDD.

Content analysis of this study was consistent with items eleven and nine of the BDI. Item # 11 was related to Depressed Men Are Angry and #9 to Suicide: The Ultimate Isolation. Although there were some similarities between the items of the BDI and the findings of this study, significant differences emerged. This study revealed that there are potentially dangerous gaps in assessment of depressive symptomatology of men when using the BDI.

Item #11 of the BDI assesses for irritation and is most similar to this study's finding **Depressed Men Are Angry.** Item #11directs the user to score the following:

0 I am no more irritated by things than I ever was.

1 I am slightly more irritated now than usual.

2 I am quite annoyed or irritated a good deal of the time.

3 I feel irritated all the time.

Beck's assessment of irritation does not capture the range of angry emotions that participants described in this study. In addition to descriptions of being irritated, participants described jealousy and rage. Participant 5 described the rage that accompanied his depression and said it was a "miracle" that he did not hurt someone when he was depressed. Assessing for "irritability" does not capture this dangerous scenario, a scenario we are seeing play out in the American media all too often these days.

Content analysis of this study endorsed that depressed men sometimes entertain suicidal ideation. Item #9 of the BDI directs the user to score the following:

0 I don't have any thoughts of killing myself.

1 I have thoughts of killing myself, but I would not carry them out.

2 I would like to kill myself.

3 I would kill myself if I had the chance.

However, this does not capture the passive suicidal ideation expressed by several participants of this study. Participants described praying to God that they would "just die." Because of religious reasons and love of family, they said they could not entertain actively killing themselves as assessed by Item #9. However, at times there were

expressions of desperately wishing to die. This is a dangerous line of thought yet it is not assessed by the BDI.

Most importantly, the BDI offers no direct assessment of Isolation. Item #12 is the most relevant to the concept of Isolation and is scored from 0-3 in order of least to most severe:

0 I have not lost interest in other people.
1 I am less interested in other people than I used to be.
2 I have lost most of my interest in other people.
3 I have lost all of my interest in other people.

One finding of this study was that having a negative attitude about others contributes to the theme of **I Don't Want To Be Around Other People**. Having a negative attitude toward others is similar to Beck's concept of negative view of the world yet content analysis of this study revealed that the cognitions behind Isolation are much more complicated than "losing an interest in other people." Depressed men sometimes do not want to engage with other people because they do not physically feel well due to symptoms of depression. They may very well want to engage with others, but cannot do so because they are in pain or otherwise do not feel well physically.

This study also revealed that depressed men sometimes do not want to be around others thus the theme: **I Don't Want To Be Around Other People.** Participants' descriptions suggested they had "lost interest in other people," because they were afraid of being ridiculed, self-conscious about their appearance, or were afraid of being hurt by someone else. A new finding this study sheds light on about this theme is that participants

wanted to protect those around them from their negative attitude and/or aggression. Participants of this study described eight conditions that contributed to **I Don't Want To Be Around Other People**. "Lost interest in other people" was only one of those.

Another cognitive mechanism of Isolation was believing that "**Other People Don't Want To Be Around Me"** because they were not nice or not fun to be around. Again, this ideation is not captured by assessing for loss of interest in other people.

Moreover, sometimes there was no cognitive mechanism that contributed to the feeling of Isolation. Sometimes there is simply **No One Around To Talk To** due to living or work situations or relationship distress. This is a life circumstance which contributes to Isolation and thus depression. The BDI, which relies heavily on assessing negative cognitions, does not assess for this.

Gotland's Theory of Male Depression and the GMDS

Walinder and Rutz (2001) hypothesized depression in men goes largely undetected by clinicians because they tend to present with more atypical symptoms that are not covered by diagnostic criteria of the DSM-IV, ICD-10, or by the screening tools which are based on their criteria. They further theorize this subset of atypical symptoms,

male distress symptoms, combined with another subset of features commonly associated with incidence of depression, male depression symptoms, comprise a "male depressive syndrome:"

Male Distress Symptoms	Male Depression Symptoms
Displeasure	Difficulty making decisions
Irritability	Sleep problems
Self-pity	Tiredness
Behavior changes	Being burned out
Beings stress	Family history of depression,
Aggressiveness	suicide, or hopelessness
Overconsumption of alcohol/substances	

Participants in this study endorsed some of the characteristics of the male depressive syndrome; these included irritability, stress, aggressiveness, overconsumption of alcohol/substances, tiredness, and family histories of depression and suicide.

The Gotland Male Depression Scale (GMDS; 2001) is a self-report tool which assesses these 13 criteria via a four-point Likert scale, yielding a scoring rage from 0-39. Higher scores supposedly indicate greater severity of male depressive syndrome. The GMDS has three items which assess for anger. Each asks the user to score the following items using the Likert scale below:

Item #1: Lower Stress threshold/more stressed out than usual

Item #2 More aggressive, outward-reacting, difficulties keeping self-control

Item #5 More irritable, restless and frustrated

0 Not at all
1 To some extent
2 Very true
3 Extremely so

The GMDS seems to capture the broader range of anger described by participants of this study. Participants described irritability, jealousy, anger, and rage. Item #2 is used to assess difficulty keeping self-control. This would be useful when assessing whether a depressed man is at risk of harming himself or others. This is the first assessment I have seen that includes an assessment of self-control in the context of depression.

In addition, the GMDS makes some assessment of maladaptive coping skills, and participants described this as **Avoidance Coping Mechanisms**.

> Item #9 Overconsumption of alcohol & pills in order to achieve a calming & relaxing effect. Being hyperactive or blowing off steam by working hard and restlessly, jogging or other exercises, under or overeating

However, there are two significant problems with the wording of this item. First, there is lack of specificity because too many variables are assessed in this one question. Secondly, it goes beyond assessing for the presence of the coping mechanism(s) and asks the user for the reason behind using the mechanism. That being said, the spirit of this item does seem to be reflected in the sentiment of Participant 6 who said that depressed men

> don't know what to do with those feelings...they're going to become alcoholic and drink or find some other thing to numb or to fill that emptiness or they're going to throw themselves into work so you're either going to be a workaholic or an alcoholic. They're going to be some sort of "aholic." They're going to have some behavior that takes their mind off of whatever's causing them to be depressed.

Item #9 of the GMDS assesses for the presence of a variety of coping mechanisms including alcohol, drug use, food, working, exercise, and other activity. Participants in

this study stated that men use other avoidance type mechanisms to cope with depression including sleep, watching television/videos, pornography, sexual relationships, and retreating into their own little world. These coping mechanisms are not assessed by the GMDS and represent new findings.

Content analysis of this study revealed Isolation was a key concept in understanding the experiences of depression described by participants. Walinder and Rutz do not mention the concept of Isolation, either in their theory of male depression or the GMDS. However, there are two items that endorse related findings from this study. Participants described that when men are depressed, sometimes they do not want to be around other people because they do not want to hurt them either physically or verbally. The GMDS item below may partially capture this thought:

> Item #10 Do you feel your behaviour has altered in such a way that neither you yourself nor others can recognize you, and that you are difficult to deal with?

Participants also indicated that when men are depressed, sometimes they feel that other people do not want to be around them because they are "no fun" and "not nice." Item # 11 of the GMDS may partially capture this thought:

> Item # 11 Have you felt or have others perceived you as being gloomy, negative or characterized by a state of hopelessness in which everything looks bleak?

Finally, content analysis of this study revealed that depressed men often intentionally hide their true feelings from others whereas at other times, they simply are not able to express their feelings. Participants of this study spent a great deal of time describing the complicated reasons why men cope in this manner. Most suggested that

men intentionally hide their true feelings because of a lack of trust. Others described not being able to communicate their true thoughts and feelings. Lack of concentration is often included in depression assessments tools and previously been identified as a factor in poor communication among people who are depressed. However, participants of this study described many other explanations for not being able to communicate feelings including: not having the words to describe how they are feeling; thinking "it's just all in my head"; having a dry sense of humor that prevents people from taking their complaints seriously; and the belief that they do not have to verbally tell others how they are feeling because they should "just know by looking at them." Sadly, one participant described that his son had died two months ago and no one at work knew this because there were company policies in place that prohibited employees from sharing personal information.

Implications for Nursing Practice

This qualitative descriptive study has provided clinical knowledge useful for nurses and others who care for and treat men who are depressed, including their families and friends. Knowing the important role that Isolation plays in the experience of depression of men represents a new finding. Using this clinical knowledge will help in identifying men who are depressed. Whether men present for help in a mental health office or a primary care office, if there is cause to think they are isolated from others in some way, clinicians should assess for depression. Further, knowing the destructive cycle of Isolation and depression, if a man presents for depression, he should be assessed for characteristics of Isolation that could exacerbate his depression. Men who engage in solitary professions should be assessed for depression and taught to look for signs of depression so they know when to seek help.

When assessing men for depression, clinicians should be aware that some men do not have the words to express how they are feeling. Care should be taken to make sure they are clearly understood. Also clinicians should be aware that depressed men often do not reveal they are depressed due to a lack of trust of how they will be perceived. Time should be taken to build a solid therapeutic relationship for two reasons: (1) a depressed man will not disclose how he feels if he distrusts the clinician and; (2) the therapeutic relationship may be the only outlet the depressed man has. In addition, the therapeutic relationship may be the only protective barrier that prevents him from committing suicide.

Implications for Nursing Research

The knowledge generated by this study may provide additional understanding about populations who may be at greater risk for depression than. Examples include those living in rural communities, shut-ins, long term hospital patients, and retirees. Research indicates that members of the LGBT community are at particular risk for depression and subsequent suicide (Suicide Prevention Resource Center, 2008). Members of the LGBT community are marginalized in several ways that were described by participants of this study: being shunned by family, friends, or religious community; being bullied; and physical and verbal abuse. Future research should investigate the role that Isolation plays in the development of depression for these vulnerable populations.

Future research should move beyond describing gender differences and toward verifying or refuting gender-specific symptom subsets for depression. Samples should include depressed men, depressed women, non-depressed men, and non-depressed

women, excluding psychiatric comorbidities when possible, so distinctions can be made between depression-specific and-gender-specific symptoms or characteristics.

The findings of this study somewhat support Gotland's Theory of Male Depression. However, the external validity of the GMDS does not appear to have been adequately assessed in terms of external validity. For example, researchers attempted to validate the tool in a sample of 87 male alcoholics, with only one of the measures for diagnostic depression whether or not the patient was prescribed antidepressants by the treating clinician (Ziernau, Bille, Rutz & Bech, 2002). The other comparison criterion was the Major Depression Inventory (Olsen, Jensen, Noerholm, Martiny & Bech, 2003) which was designed to quantify symptom severity as well as provide information for diagnosis for depression using both the DSM-IV and the ICD-10. The authors reported correlation coefficients between .70 and .77; however, they fail to provide the levels of significance and by their own admission, significance levels fluctuated between .05 and .10 (Ziernau, Bille, Rutz, & Bech, 2002).

To complicate matters, several studies have recently been published using the "validated" GMDS as a measure of male depression syndrome in various populations. For example, Madsen and Juhl (2007) used the tool to support their assertion that men develop postpartum depression along with their wives/partners. Moller-Leimkuhler and colleagues (2004, 2007) have recently published the results of two large scale investigations (n=2,411; n=1,004 respectively) about male depression. The 2004 investigation (n=656 male; 1,755 female psychiatric inpatients) did not detect significant differences in depressive symptomatology between genders. However, since

comorbidities were not taken into consideration, the likelihood of co-occurring affective and personality factors raises concerns about confounding.

While the findings of this study support Gotland's Theory of Male Depression to some extent, future research should include a thorough validation of the GMDS. Initial research questions for future investigations include:

1. Can the GMDS be externally validated against DSM-V diagnostic criteria, the HAMD (a validated clinician-rated measure), the BDI-II (a validated self-report tool based on DSM-III criteria which favors cognitive factors 2:1), and the PHQ (a validated self-report tool which favors somatic symptoms of depression) in the same sample?
2. Can the GMDS discriminate depressed men from depressed women?
3. Can the GMDS discriminate depressed men from nondepressed men?
4. Can the GMDS discriminate depressed men from men with Bipolar Disorder? Alcohol or substance dependence? Personality disorders? Depression with psychological comorbidities? Subclinical depression?
5. Should our theoretical model for depression include:
    a. SUBJECTIVE EXPERIENCE (e.g., depressed mood)
    b. SUBJECTIVE EXPERIENCE + DEFENSE MECHANISMS (e.g., tendency to withdraw from others)

c. SUBJECTIVE EXPERIENCE + DEFENSE MECHANISMS + COPING MECHANISMS (e.g., overconsumption of alcohol)?

Study Limitations

The goal of this study was to describe the experiences of men's depression. Content analysis revealed a new finding in that Isolation plays a key role in men's depression. However, there are some study limitations.

First, the sample of men for this study was highly homogenous. Maximum variation sampling might have allowed for the exploration of the common and unique manifestations of depression (Sandelowski, 1995).

Secondly, while the study provided some useful insights into men's experiences of depression and is able to guide future research, it is not generalizable.

Conclusion

This qualitative descriptive method designed to explore men's experiences of depression led to the central finding that Isolation plays an important and dynamic role in men's depression experience. Isolation represents a new finding that will help to improve detection of depression in men and guide future depression research.

One of the participants of this study said, "Depression is sitting in a darkened quiet room with the ghosts of things that you did not have or achieve that are gone. It's sitting all alone in a dark room full of ghosts...You know, it's a rough world. It's a complex world. And when people start to look at other people with compassion in a complex world and work together, doctors, lawyers, accountants, social workers, and folks like yourself, and everybody just working together, then progress can be made."

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APPENDIX A

Demographic Questionnaire

How old are you today?

How old were you when you were first diagnosed with depression?

How old were you when you first realized there was something wasn't right about the way you felt?

What is your marital status today?
- Single
- Married
- Widowed
- Divorced

How many times have you been married?

How many children do you have?

What is your predominant race/ethnicity?
- African American
- Asian/Pacific Islander
- Caucasian
- Hispanic
- Native American

What is the highest level you achieved in education?
- Less than high school
- High school graduation/GED
- Some college
- College graduation
- Master's degree
- Doctoral degree

What was your personal income in the past year?
- <$19,999
- $20,000 - $34,999
- $35,000 - $69,999
- >$70,000

What is type of health insurance coverage do you have?
- Private
- Public
- None

APPENDIX B

Semi-Structured Interview Guide

1. Tell me about when you knew you didn't feel like your "real self."

    Tell me how you know something wasn't right.

    Describe to me how you felt.

    Describe to me the changes this caused in your life.

    Describe to me how you dealt with things, how you coped during this time.

2. Looking back, are there things that you now realize were going on before that point?

3. Talk to me about the time when you first realized you were depressed.

    Tell me how you know you were "depressed."

    Talk to me about what led you to seek out help.

4. Think about the time when you felt the worst. Describe this to me.

5. Were you ever bothered about wanting to hurt yourself or other people?

    Describe to me how bad you were bothered by these thoughts.

    Did you ever act on these thoughts?

        If yes, tell me about this.

        If no, tell me about what prevented you from acting on these thoughts.

6. Tell me how the people who know you would describe how you were ***before*** you depressed?

    Tell me how they would describe you ***after*** you began to feel depressed?

7. From your own experience, describe to me how men look and act when they are depressed?

8. Tell me what the following words make you think of:
    Depression
    Stress
    Anxiety

9. If some other man you know got depressed, what advice would you give him?

10. Tell me anything else you feel is important for me to know about you or your experience of being depressed.

APPENDIX C

March 5, 2014

Dear Office of Research Integrity:

This letter will serve as agreement with Lori Mutiso, ARNP-BC, a University of Kentucky College of Nursing PhD student, to assist with her dissertation project entitled "Qualitative Investigation of Men's Experiences of Depression" to be conducted at (REDACTED) in Lexington, KY. My role will be to allow recruitment of participants from this office; provide a private room for Ms. Mutiso to conduct her interviews; and to evaluate and provide treatment for any participants who express thoughts of hurting themselves or others during the course of Ms. Mutiso's interview.

I have knowledge of the project presented by the researcher. It is understood that up to 10 men may be recruited from this site to be participants in Ms. Mutiso's study. I understand that Ms. Mutiso will compensate each participant $25 for their time according to her IRB protocol.

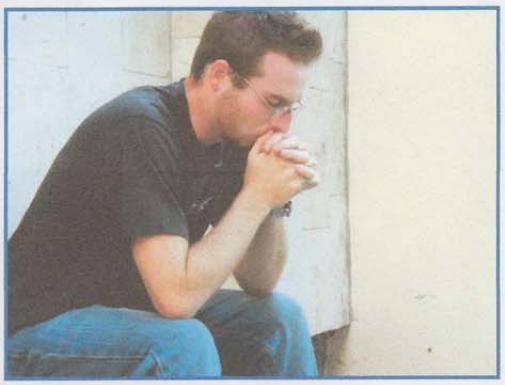
If I have any concerns or require additional information, I will contact the researcher and/or the UK Office of Research Integrity.

Sincerely,

Clinician Name (REDACTED)
Clinic Address (REDACTED)
Clinic Address (REDACTED)

APPENDIX D

UNIVERSITY OF KENTUCKY RESEARCH



Men Needed for Depression Research Study

Researchers at the University of Kentucky College of Nursing are conducting a research study to learn about men's experiences with depression.

You can participate in this study if you:

- are 18 years of age or older;
- have been diagnosed with depression; and
- speak English.

You will be asked to participate in an interview about your experience with depression. Eligible participants will be paid $25 for your time.

If you are interested in participating in this research study, please contact:
Lori Mutiso, ARNP-BC
Phone: 859-396-8803
Email: lori.mutiso@uky.edu

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APPENDIX E

Combined Consent and Authorization to Participate in a Research Study

QUALITATIVE INVESTIGATION OF MEN'S EXPERIENCES OF DEPRESSION

WHY ARE YOU BEING INVITED TO TAKE PART IN THIS RESEARCH?

You are being invited to take part in a research study about men's experiences of depression. You are being invited to take part in this research study because at some point in the past you have been diagnosed with depression. If you volunteer to take part in this study, you will be one of about 10 people to do so.

WHO IS DOING THE STUDY?

The person in charge of this study is Lori A. Mutiso, MSN, ARNP-BC, a PhD student in the College of Nursing at the University of Kentucky. She is being guided in this research by Patricia B. Howard, PhD, RN, CNAA-BC, FAAN. There may be other people on the research team assisting at different times during the study.

WHAT IS THE PURPOSE OF THIS STUDY?

The purpose of this study is to learn how men experience depression. By doing this study, we hope to learn how to recognize depression in men better.

ARE THERE REASONS WHY YOU SHOULD NOT TAKE PART IN THIS STUDY?

You should not participate in this study if you:

(1) are under 18 years of age

(2) have ever been diagnosed with bipolar affective disorder, schizoaffective disorder, or substance abuse disorder

WHERE IS THE STUDY GOING TO TAKE PLACE AND HOW LONG WILL IT LAST?

You will be asked to participate in an interview about your experiences with depression. You will be interviewed at the mental health care clinic where you are now a patient and where you learned of this study. The interview will last about 1 ½ – 2 hours.

Sometime in the next six (6) months, there will be a follow-up phone interview. Ms. Mutiso will call you to review her understanding of what you said during the first interview and clarify whether she understood you correctly. This second interview will last about 15 – 30 minutes.

The total amount of time you will asked to volunteer for this study is between 2 – 2 ½ hours over the next six (6) months.

WHAT WILL YOU BE ASKED TO DO?

The interview has 3 parts, and Ms. Mutiso will read the questions slowly, out loud for you. There are no right or wrong answers. The questions are about how you feel now and how you felt when you were depressed.

The first part of the interview is a list of 18 short demographic questions. This part should take about 5 – 10 minutes.

The second part is the longest and will last about 45 – 60 minutes. This is when you will be asked to talk about how you felt when you had depression. Ms. Mutiso has a list of 10 questions to help guide the conversation, but you can say whatever you like. You have the right to refuse to answer any of the questions if you wish and can stop the interview at any time just by saying so.

After the interview, you will be asked to complete the Beck Depression Inventory which has a list of 21 short multiple choice questions about your mood and thoughts over the last few days. This part should take about 5 – 10 minutes.

Sometime in the next six (6) months, there will be a follow-up phone interview. Ms. Mutiso will call you to review her understanding of what you said during the first interview and clarify whether she understood you correctly. This second interview will last about 15 – 30 minutes.

The total amount of time you will asked to volunteer for this study is between 2 – 2 ½ hours over the next six (6) months.

Encounter	Activity	Time Required
First Encounter: Enrollment and Interview (Face to face)	Eligibility to participate in the study will be determined Informed consent process will take place. Demographic questions will be asked. Questions about your experiences with depression will be asked. You will be given a multiple choice depression questionnaire (Beck Depression Inventory) about your mood and thoughts over the last few days.	1 ½ - 2 hours
Second Encounter: Follow-up Interview (Telephone)	Follow-up telephone interview will occur sometime in the next six (6) months. You will be given an opportunity to clarify information given during the first interview.	15 – 30 minutes

WHAT ARE THE POSSIBLE RISKS AND DISCOMFORTS?

To the best of our knowledge, the things you will be doing have no more risk of harm than you would experience in everyday life.

Although we have made every effort to ensure this process does not cause you any emotional discomfort, you may find some questions we ask you to be upsetting or stressful. You may end the interview at any time without any effect on your access to continued services from your provider.

In addition to the risks listed above, you may experience a previously unknown risk or side effect.

WILL YOU BENEFIT FROM TAKING PART IN THIS STUDY?

There is no guarantee that you will get any benefit from taking part in this study; however, you might learn information about yourself that is helpful to you. Your willingness to take part in this study will help us to understand more about how men experience depression.

DO YOU HAVE TO TAKE PART IN THE STUDY?

If you decide to take part in the study, it should be because you really want to volunteer. You will not lose any benefits or rights you would normally have if you choose not to volunteer. You can stop at any time during the study and still keep the benefits and rights you had before volunteering.

IF YOU DON'T WANT TO TAKE PART IN THE STUDY, ARE THERE OTHER CHOICES?

If you do not want to be in the study, there are no other choices except not to take part in the study.

WHAT WILL IT COST YOU TO PARTICIPATE?

There are no costs associated with taking part in this study other than what it will cost you to arrive at the place you choose for the interview. However, you will be compensated $25 for your time in participating in this study.

CAN YOUR TAKING PART IN THE STUDY END EARLY?

If you decide to take part in the study you still have the right to decide at any time that you no longer want to continue. You will not be treated differently if you decide to stop taking part in the study.

The individuals conducting the study may need to withdraw you from the study. This may occur if you are very depressed or become upset during the interview or indicate that you are having thoughts of wanting to harm yourself or someone else.

ARE YOU PARTICIPATING OR CAN YOU PARTICIPATE IN ANOTHER RESEARCH STUDY AT THE SAME TIME AS PARTICIPATING IN THIS ONE?

You may take part in this study if you are currently involved in another research study. It is important to let the investigator/your doctor know if you are in another research study. You should also discuss with the investigator before you agree to participate in another research study while you are enrolled in this study.

WHAT HAPPENS IF YOU GET HURT OR SICK DURING THE STUDY?

If you believe you are hurt in any way because of this interview, you should call Ms. Mutiso immediately at 859-396-8803. It is important for you to understand that the University of Kentucky does not have funds set aside to pay for the cost of any care or treatment that might be necessary because you get hurt or sick while taking part in this study. Also, the University of Kentucky will not pay for any wages you may lose if you are harmed by this study.

The medical costs related to your care and treatment because of research-related harm will be your responsibility; **or** may be paid by your insurer if you are insured by a health insurance company (you should ask your insurer if you have any questions regarding your insurer's willingness to pay under these circumstances); **or** may be paid by Medicare or Medicaid if you are covered by Medicare, or Medicaid (if you have any questions regarding Medicare/Medicaid coverage you should contact Medicare by calling 1-800-Medicare (1-800-633-4227) or Medicaid 1-800-635-2570.

A co-payment/deductible from you may be required by your insurer or Medicare/Medicaid even if your insurer or Medicare/Medicaid has agreed to pay the costs). The amount of this co-payment/deductible may be substantial.

You do not give up your legal rights by signing this form.

WILL YOU RECEIVE ANY REWARDS FOR TAKING PART IN THIS STUDY?

You will receive $25 to compensate you for your time in participating in this study. If you should have to quit before the interview(s) is/are finished, you will receive the full amount.

WHAT IF YOU HAVE QUESTIONS, SUGGESTIONS, CONCERNS, OR COMPLAINTS?

Before you decide whether to accept this invitation to take part in the study, please ask any questions that might come to mind now. Later, if you have questions, suggestions, concerns, or complaints about the study, you can contact the investigator, Lori Mutiso at 859-396-8803. If you have any questions about your rights as a volunteer in this research, contact the staff in the Office of Research Integrity at the University of Kentucky at 859-257-9428 or toll free at 1-866-400-9428. We will give you a signed copy of this consent form to take with you.

WHAT IF NEW INFORMATION IS LEARNED DURING THE STUDY THAT MIGHT AFFECT YOUR DECISION TO PARTICIPATE?

If the researcher learns of new information in regards to this study, and it might change your willingness to stay in this study, the information will be provided to you. You may be asked to sign a new informed consent form if the information is provided to you after you have joined the study.

WHAT ELSE DO YOU NEED TO KNOW?

There is a possibility that the data collected from you may be shared with other investigators in the future. If that is the case the data will not contain information that can identify you unless you give your consent/authorization or the UK Institutional Review Board (IRB) approves the research. The IRB is a committee that reviews ethical issues, according to federal, state and local regulations on research with human subjects, to make sure the study complies with these before approval of a research study is issued. If additional information becomes available during the study, we will share it with you.

AUTHORIZATION TO USE OR DISCLOSE YOUR IDENTIFIABLE HEALTH INFORMATION

The privacy law, HIPAA (Health Insurance Portability and Accountability Act), requires researchers to protect your health information. The following sections of the form describe how researchers may use your health information.

Your health information that may be accessed, used and/or released includes:

- Demographic information
- Personal history
- Mental health history and treatment

The Researchers may use and share your health information with:

- The University of Kentucky's Institutional Review Board/Office of Research Integrity.
- Law enforcement agencies when required by law.
- University of Kentucky representatives.
- UK Hospital
- Center for Clinical and Translational Science (CCTS)
- Mental health provider may be contacted if in the course of the project the researcher learns of a mental health condition that needs immediate attention.

The researchers agree to only share your health information with the people listed in this document.

Should your health information be released to anyone that is not regulated by the privacy law, your health information may be shared with others without your permission; however, the use of your health information would still be regulated by applicable federal and state laws.

You will not be allowed to participate in the research study if you do not sign this form. If you decide not to sign the form, it will not affect your:

- **Current or future healthcare at the University of Kentucky**
- **Current or future payments to the University of Kentucky**
- **Ability to enroll in any health plans (if applicable)**
- **Eligibility for benefits (if applicable)**

After signing the form, you can change your mind and NOT let the researcher(s) release or use your health information (revoke the Authorization). If you revoke the authorization:

- You will send a written letter to: Lori A. Mutiso, MSN, ARNP-BC, 2404 Larkin Road, Lexington, KY 40503 to inform her of your decision.
- Researchers may use and release your health information **already** collected for this research study.
- Your protected health information may still be used and released should you have a bad reaction (adverse event).
- You will not be allowed to participate in the study.

The use and sharing of your information has no time limit.

If you have not already received a copy of the Privacy Notice, you may request one. If you have any questions about your privacy rights, you should contact the University of Kentucky's Privacy Officer between the business hours of 8am and 5pm EST, Mon-Fri at: (859) 323-1184.

You are the subject or are authorized to act on behalf of the subject. You have read this information, and you will receive a copy of this form after it is signed.

_____ _____

Signature of research participant or *research participant's legal representative

Date

_____ _____

Printed name of research participant or *research participant's legal representative

Representative's relationship to research participant

*(*If, applicable)* Please explain Representative's relationship to participant and include a description of Representative's authority to act on behalf of the participant:

_____

_____

_____ _____

Name of [authorized] person obtaining informed consent/HIPAA authorization

Date

_____

Signature of Principal Investigator

APPENDIX F

Beck Depression Inventory
(page 1 of 2)

Choose one statement from among the group of four statements in each question that best describes how you have been feeling during the **past few days**. Circle the number beside your choice.

1	**0** I do not feel sad. **1** I feel sad. **2** I am sad all the time and I can't snap out of it. **3** I am so sad or unhappy that I can't stand it.	8	**0** I don't feel I am any worse than anybody else. **1** I am critical of myself for my weaknesses or mistakes. **2** I blame myself all the time for my faults. **3** I blame myself for everything bad that happens.
2	**0** I am not particularly discouraged about the future. **1** I feel discouraged about the future. **2** I feel I have nothing to look forward to. **3** I feel that the future is hopeless and that things cannot improve.	9	**0** I don't have any thoughts of killing myself. **1** I have thoughts of killing myself, but I would not carry them out. **2** I would like to kill myself. **3** I would kill myself if I had the chance.
3	**0** I do not feel like a failure. **1** I feel I have failed more than the average person. **2** As I look back on my life, all I can see is a lot of failure. **3** I feel I am a complete failure as a person.	10	**0** I don't cry any more than usual. **1** I cry more now than I used to. **2** I cry all the time now. **3** I used to be able to cry, but now I can't cry even though I want to.
4	**0** I get as much satisfaction out of things as I used to. **1** I don't enjoy things the way I used to. **2** I don't get any real satisfaction out of anything anymore. **3** I am dissatisfied or bored with everything.	11	**0** I am no more irritated by things than I ever am. **1** I am slightly more irritated now than usual. **2** I am quite annoyed or irritated a good deal of the time. **3** I feel irritated all the time now.
5	**0** I don't feel particularly guilty. **1** I feel guilty a good part of the time. **2** I feel quite guilty most of the time. **3** I feel guilty all of the time.	12	**0** I have not lost interest in other people. **1** I am less interested in other people than I used to be. **2** I have lost most of my interest in other people. **3** I have lost all of my interest in other people.
6	**0** I don't feel I am being punished. **1** I feel I may be punished. **2** I expect to be punished. **3** I feel I am being punished.	13	**0** I make decisions about as well as I ever could. **1** I put off making decisions more than I used to. **2** I have greater difficulty in making decisions than before. **3** I can't make decisions at all anymore.
7	**0** I don't feel disappointed in myself. **1** I am disappointed in myself. **2** I am disgusted with myself. **3** I hate myself.	14	**0** I don't feel that I look any worse than I used to. **1** I am worried that I am looking old or unattractive. **2** I feel that there are permanent changes in my appearance that make me look unattractive. **3** I believe that I look ugly.

15	**0** I can work about as well as before. **1** It takes an extra effort to get started at doing something. **2** I have to push myself very hard to do anything. **3** I can't do any work at all.	19	**0** I haven't lost much weight, if any, lately. **1** I have lost more than five pounds. **2** I have lost more than ten pounds. **3** I have lost more than fifteen pounds. (Score 0 if you have been purposely trying to lose weight.)
16	**0** I can sleep as well as usual. **1** I don't sleep as well as I used to. **2** I wake up 1-2 hours earlier than usual and find it hard to get back to sleep. **3** I wake up several hours earlier than I used to and cannot get back to sleep.	20	**0** I am no more worried about my health than usual. **1** I am worried about physical problems such as aches and pains, or upset stomach, or constipation. **2** I am very worried about physical problems, and it's hard to think of much else. **3** I am so worried about my physical problems that I cannot think about anything else.
17	**0** I don't get more tired than usual. **1** I get tired more easily than I used to. **2** I get tired from doing almost anything. **3** I am too tired to do anything.	21	**0** I have not noticed any recent change in my interest in sex. **1** I am less interested in sex than I used to be. **2** I am much less interested in sex now. **3** I have lost interested in sex completely.
18	**0** My appetite is no worse than usual. **1** My appetite is not as good as it used to be. **2** My appetite is much worse now. **3** I have no appetite at all anymore.		

SCORING

1 – 10: These ups and downs are considered normal.
11 – 16: Mild mood disturbance
17 – 20: Borderline clinical depression
21 – 30: Moderate depression
31 – 40: Severe depression
over 40: Extreme depression

APPENDIX G

October 28, 2014

Dear Participant:

Thank you so much for your time and for sharing your experiences about depression. I want you to know that I am humbly grateful for your openness and honesty. Sharing about painful experiences is difficult. It is my hope that I will use the memories and experiences that you described to me to help many other men in the world.

As many as 15% of people diagnosed with Depression eventually die by suicide. On average, women are diagnosed with depression twice as often as men, yet men die from suicide almost four times more often than women. Between the ages of 20 and 24 years, men complete suicide more than six times as often as women. Each year, more people die from suicide than homicide, with someone dying from suicide every 16 minutes. But for men the impact of suicide is significantly greater, representing the seventh leading cause of death. ***The valuable information you shared for this research study will be used not only to save these men from suicide, but to improve the quality of their lives.***

I want to take a minute to share with you what I learned from your stories and ***give you the chance to correct any misunderstandings*** that I have ***and to add anything*** you may have thought of after our interview was over.

After I finished talking to each of the participants of this study, I put all of that information together and listened to it over and over. The tapes were transcribed and I read the manuscripts many times. I learned several things, but there seemed to be one common theme:

Men who are struggling with depression are often

isolated **from other people.**

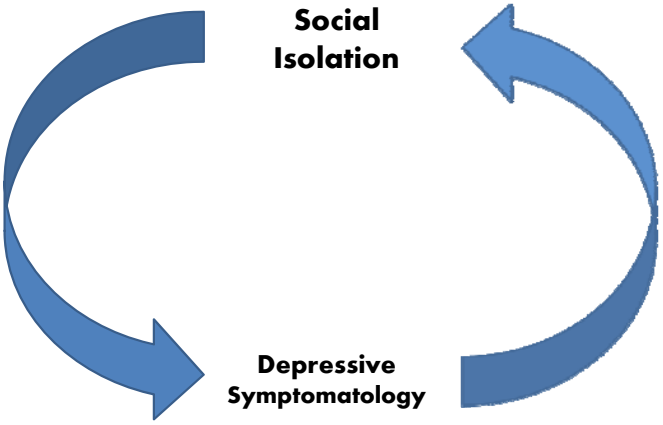
It seems to me after talking with you that

social isolation is a big problem for men who are depressed.

Isolation makes their depression worse

AND

their depression makes their isolation worse.



Things That Contribute to Isolation In Men Who Are Depressed

It seems to me after talking to each of you that there are many things that contribute to this isolation in men who are struggling with depression. The diagram below helps to describe the big picture as I saw it. The colorful outline below that gives much more detail. Please take a moment to skim the outline. Please tell me if you see something that sticks out or doesn't make sense to you. I want to be absolutely sure that I tell your story correctly.

This study is too small to be able to explain all of your struggle with depression. But hopefully, it captures an important part of it.

After you have a chance to think about this, I would like to speak to you and hear your thoughts.

Thanks again for your time and your important contribution to science.

Sincerely,

Lori Mutiso, APRN-BC

PhD Candidate at the University of Kentucky, College of Nursing

1. **When men are depressed, sometimes there is no one around to talk to because...**
    - A. They don't have any friends. They only have a few friends.
    - B. Someone they love died.
    - C. Their work situation keeps them away from other people because...
        - i. They work long hours.
        - ii. They work in a rural or remote area.
        - iii. Their work station is cut off from other people.
        - iv. Their job requires a lot of traveling.
        - v. Their job requires confidentiality.
        - vi. Their job duties require solitude and/or concentration.
        - vii. They are self-employed and/or working a "one man job."
    - D. Their living situation keeps them away from other people because...
        - i. Their bedroom or family room is in the basement.
        - ii. They live in another house away from the rest of the family or friends.
        - iii. They live in another city/state away from the rest of the family or friends.
        - iv. They live in a rural or remote area.
    - E. Their relationships are not what they want them to be because...
        - i. Their depression put a strain on their relationships.
        - ii. They experienced verbal, physical, or sexual abuse.
        - iii. They experienced a breakup, separation, or divorce.
        - iv. They experienced sexual difficulty.
        - v. They have been shunned by their family or friends.

2. **Often men cope with depression by distracting themselves with activities or other things such as...**
    - A. Sleeping too much.
    - B. Working too much.
    - C. Drinking too much alcohol.
    - D. Using illegal drugs.
    - E. Watching too much television or videos.
    - F. Eating too much.
    - G. Having several superficial romantic relationships.
    - H. Pornography.
    - I. Staying busy.
    - J. Going into their own little world.

3. When men are depressed, sometimes they don't want to be around other people because...

A. They have a negative attitude about other people.
B. They are self-conscious about their appearance.
C. They don't want to hurt other people physically or verbally.
D. They are an introvert or shy.
E. They don't feel well or are in pain.
F. They just don't feel like doing anything.
G. They are afraid of...
    i. Being hurt.
    ii. Going out into society.

4. When men are depressed, sometimes other people do not want to be around them because...

A. They are no fun when they are depressed.
B. They are not nice when they are depressed.

5. It seems to me that often when men are depressed, they get angry. Sometimes they are angry because...

A. Things just aren't fair.
B. God didn't heal them from depression.
C. They are jealous of happy people who do not have to struggle with depression.
D. For no reason they can think of; they are just angry.
E. Everyday annoyances aggravate them more than they should.
F. (Sometimes men who are depressed struggle with the desire to hurt someone.)

6. Suicide

A. Sometimes men who are depressed make a mental plan to kill themselves.
B. Sometimes men who are depressed pray to God to just take them.
C. An important reason why depressed men decide not to kill themselves is because their suicide would really cause pain for someone they love.

7. It seems to me that men who are depressed often *hide the way they are really feeling* because they do not trust other people. They are worried...

A. About the stigma of depression and mental illness.
B. Someone will betray their confidence.
C. Someone will use what they say against them.
D. Someone will think their depression demonstrates a lack of faith.
E. Other people would not understand what they are going through.
F. Other people do not care about them or what they are going through.
G. Other people will make fun of them or embarrass them.
H. It's just nobody's business what they are going through.
I. Because it's harder to talk to other men about depression than it is to talk to women.

J. Men are expected to be self-sufficient; if they tell someone they are struggling with depression,
the other person will think they are weak. But women are allowed to talk about how they really feel and people don't think they are weak.

8. It seems to me that men who are depressed often ***are not able to tell others* that they are depressed because...**

A. They have trouble concentrating or thinking clearly.
B. They do not have the words to describe how they are feeling.
C. They believe that other people "just know" they are depressed by just looking at them.
D. (It does not seem natural to some men to cry.)
E. Sometimes men don't even realize they are depressed; they think it's something minor that will go away eventually.
F. Some men have a dry sense of humor, and other people do not believe them when they try to get help for depression.
G. There are policies in place at their places of employment that prohibit them from sharing personal information with others.

Curriculum Vitae

Lori A. Mutiso

I. EDUCATION

Date	Degree	Area of Study	Institution
2008	Post-MSN	Psychiatric NP	University of Kentucky
2004	MSN	Family NP	University of Kentucky
2003	BSN	Nursing	University of Kentucky
1995	ADN	Nursing	Kentucky State University
1989	BA	English, Religion Psychology	Georgetown College

II. PROFESSIONAL REGISTRATION AND CERTIFICATION

Registered Nurse, Kentucky Board of Nursing
Adult Registered Nurse Practitioner, Kentucky Board of Nursing
Family Nurse Practitioner, American Nurses Credentialing Center
Psychiatric Nurse Practitioner, American Nurses Credentialing Center

III. PROFESSIONAL EXPERIENCE

Date	Title	Institution
2008-Present	**Adult Psychiatric Mental Health Nurse Practitioner**	**Private Practice Lexington, KY**
2006-Present	**Co-Founder, Board Member, Mentorship Coordinator**	**Esther Mwikali Mutiso Foundation Nairobi, Kenya**
2011 – 2013	**Group Therapy Facilitator**	**KY Center for Eating & Weight Disorders Lexington, KY**
2011 – 2014	**Board Member**	**Kentucky Refugee Ministries Lexington, KY**
2011 – 2012	**Research Assistant Kentucky Center for Smoke-Free Policy**	**College of Nursing, University of KY Lexington, KY**
2010	**Group Therapy Facilitator Masters in Counseling Program**	**Asbury Theological Seminary Wilmore, KY**

III. PROFESSIONAL EXPERIENCE (continued)

2008-2010	**Instructor, Clinical Supervisor Psychiatric/Mental Health Track**	**College of Nursing, University of KY Lexington, KY**
2004-2005	**Family Nurse Practitioner**	**Good Samaritan Foundation Lexington, KY**
2002-2004	**Registered Nurse Department of Psychiatry**	**Univ. of KY Chandler Medical Center Lexington, KY**
2001-2002	**Psychiatric Consult Nurse Department of Psychiatry**	**St. Joseph Hospital Lexington, KY**
1995-2002	**Registered Nurse Gragg 2, Gragg 3, Wendell 3**	**Eastern State Hospital Lexington, KY**
1995	**Treatment Nurse Long Term Care**	**Dover Manor Nursing Home Georgetown, KY**
1994	**Instructor Camp Rainbow**	**CONTACT, Inc. Frankfort, KY**
1993-1995	**Instructional Counselor Communications Skills Center**	**Kentucky State University Frankfort, KY**
1989-1993	**Adult Living Arrangement Provider**	**CONTACT, Inc Frankfort, KY**

V. PRESENTATIONS

National

Nov 2013 Academy of Psychosomatic Medicine, Tucson, AZ
Anxiolytic Medication is an Independent Risk Factor for Short-term Major Morbidity After Surgery. Lester, CC, Lommel, KM, Mutiso, L and Davenport DL

Feb 2007 Southern Research Nursing Society, Galveston, TX
Negative Thinking: Contributing Factors from the Family of Origin (Poster)

Local

Dec 2014 College of Nursing, University of Kentucky, Lexington, KY
Factors Influencing Depression in Men: A Qualitative Investigation

July 2011 College of Nursing, University of Kentucky, Lexington, KY
Choice Architecture: How to Change Things When Change is Hard

V. PRESENTATIONS (continued)

Sept 2009 Kentucky Refugee Ministries, Lexington, KY
Findings from a Qualitative Study to Determine Reasons for Continuing Community Support for International Political Refugees

Spring 2004 Primary Care Clinic, Kentucky Clinic, UKCMC, Lexington, KY
Routine Screening for Postpartum Depression Using the Edinburgh Postnatal Depression Scale

Spring 2002 Sigma Theta Tau, Spindletop Hall, Lexington, KY
Understanding the Relationship Between Hopelessness and Suicidality

Spring 2002 Cynthiana/Harrison County, KY Chamber of Commerce and Health Department
Comprehensive Public Health Assessment of Cynthiana and Harrison County