8-2006

Men's Experiences of Depression: A Phenomenological Investigation

Brian D. Spillman
University of Tennessee - Knoxville

To the Graduate Council:

I am submitting herewith a dissertation written by Brian D. Spillman entitled "Men's Experiences of Depression: A Phenomenological Investigation." I have examined the final electronic copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in Education.

Mark A. Hector, Major Professor

We have read this dissertation and recommend its acceptance:

William Calhoun, Schulyer Huck, Suzanne Kurth

Accepted for the Council:

Carolyn R. Hodges

Vice Provost and Dean of the Graduate School

(Original signatures are on file with official student records.)

To the Graduate Council:

I am submitting herewith a dissertation written by Brian D. Spillman entitled "Men's Experiences of Depression: A Phenomenological Investigation." I have examined the final electronic copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment for the requirements for the degree of Doctor of Philosophy, with a major in Education.

Mark A. Hector
Major Professor

We have read this dissertation
and recommend its acceptance.

William Calhoun

Schulyer Huck

Suzanne Kurth

Acceptance for the Council

Anne Mayhew
Vice Chancellor and
Dean of Graduate Studies

(Original signatures are on file with official student records.)

MEN'S EXPERIENCES OF DEPRESSION:

A PHENOMENOLOGICAL INVESTIGATION

A Dissertation

Presented for the

Doctor of Philosophy Degree

The University of Tennessee, Knoxville

Brian D. Spillman

August, 2006

DEDICATION

To Beverly, my beautiful and brilliant wife, and to Carter Elizabeth, my incomprehensibly wonderful daughter, I dedicate this completed dissertation.

Beverly, your confidence in my abilities and potential has often surpassed my own. Your ability to help me develop and implement plans that seem possible only in dreams inspires my soul. Your support helped me to *begin* this seemingly impossible project.

Carter Elizabeth, you were born to parents who needed you desperately, wished for you for years, and love you immensely. Everyone says you have “your daddy’s eyes”, but I know the truth. Your daddy has your eyes instead. Your smiles, giggles, and kisses give me a new perspective on life that is filled with gratitude and hope. Your presence, little bean, has helped me to *finish* this project.

Thank you both for enriching my life more than I ever thought I deserved, and even more than I ever could have dreamt possible.

ACKNOWLEDGEMENTS

I wish to thank my doctoral committee members for their guidance and support throughout this dissertation. Dr. Mark A. Hector, Dr. Bill Calhoun, Dr. Sky Huck, and Dr. Suzanne Kurth all devoted time and attention to helping bring this process to its current fruition. I am grateful to you all for your many helpful comments throughout this process and for your dedication to helping me grow and develop professionally.

Many thanks are due to the staff psychologists and clinical supervisors at Cherokee Health Systems who listened to my near continual ruminations on this project and offered valuable feedback. Thank you also to the men whose interviews form the basic data for this study. The research participants who volunteered for this study are amazing, brave men who are struggling, and I thank them for sharing their experiences with me.

I also wish to thank my dear friend and mentor Dr. Alfred Alschuler from my previous alma mater, Appalachian State University. Thank you Al, for knowing when and how to encourage and challenge me so that I could grow and develop in ways I never knew possible.

Finally, I wish to thank two other important people who made completing this study possible. To my wife and daughter, thank you so very much for your loving support throughout this process. Your strong belief in my abilities gave me the confidence to tackle this impossible task.

ABSTRACT

The purpose of this study was to understand and describe the experience of living with depression among a clinical sample of men. In order to participate in this study, men had to (a) define themselves as having depression, (b) be currently receiving psychotherapy for depression, and (c) have been diagnosed with depression by a mental health professional. In addition, men who were diagnosed with Bipolar disorder, or were currently suicidal or psychotic were not eligible for this study.

Ten men participated in phenomenological interviews by describing their experiences with depression. The interviews were transcribed, analyzed using methods developed from Colaizzi (1978), and then presented back to each individual participant for verification of validity.

A thematic structure emerged from this study that contained a ground and five figures, or themes contextualized by that ground. The experience of depression among these men was grounded in feeling *out of control*. From the ground of *out of control*, five figural themes emerged: *describing*, *symptoms*, *recognizing*, *course*, and *reactions*. Findings are discussed in terms of relevant current research.

TABLE OF CONTENTS

CHAPTER ONE: INTRODUCTION AND REVIEW OF LITERATURE

Mental health concerns such as depression have been researched for hundreds of years (Karp, 1996; Tharyan & Raghuthaman, 1999). The prevailing wisdom on depression states that nearly two-thirds of persons experiencing depression are women (Kessler, 2002). Clearly, men compose the remaining one-third of persons with this disorder, yet little is known about how those men experience depression (Cochran & Rabinowitz, 2000).

Undoubtedly there are similarities in the experiences among both men and women. In fact, the diagnostic system devised for assessing the presence of clinical depression does not list gender-specific differences present in the lived experience of depression (American Psychiatric Association [APA], 2000). However, increased attention has recently been focused on the influence of gender in shaping one's experience of the world (Pollack, 1998).

Journal articles within the field of Psychology contain few descriptions of how one's gender might affect the experience of depression. Even fewer studies have examined the experience of men's depression, and fewer still the experience of men's depression from a qualitative perspective. Cochran and Rabinowitz (2000) are one of today's leading research teams studying depression among men, and have suggested a research strategy for furthering our understanding of men's depression. Cochran and Rabinowitz have stated that "Simply asking men to discuss their experiences of depression may be the simplest and most direct route to increasing our empathy for and understanding

of that disorder" (p. 170). The current research project is a step toward increasing knowledge about the topic of men's depression, and focuses exclusively on the perspective of the individual man experiencing depression.

Depression

Depression is a way of being in the world that involves persistent feelings of sadness and a daily lack of enjoyment or sense of fulfillment. The diagnosis of depression is merely a summarization, or clinical shorthand developed by mental health professionals for a potential range of problems that a client might be experiencing. Typically, first-person narratives are gathered for the purposes of confirming that the client fits the existing framework for understanding depression (Beck, Steer, & Brown, 1996). It should be noted that one problematic result of using existing frameworks for identifying depression is that an individual whose experience does not neatly fit the designed categories may be overlooked and not targeted for interventions and treatment (Pollack, 1998).

When researchers use the term "depression," a specific meaning is intended. "Depression" refers to a specific group of symptoms defined by the Diagnostic and Statistical Manual for Mental Disorders (Fourth edition with text revisions), abbreviated as the *DSM IV-TR* (APA, 2000). The American Psychiatric Association's publication of the *DSM-IV-TR* is considered the gold standard for diagnosing depression. According to the DS*M-IV-TR*, the two principal elements of depression include depressed mood and loss of interest or pleasure. One of the two principal elements must be endorsed, along with at least four elements

from a list of other symptoms. The other seven elements from which any four may be endorsed concern a person's weight and appetite, sleeping habits, psychomotor activity level, energy level, self-esteem level, concentration abilities, and thoughts about suicide. The symptoms of depression can vary greatly among individuals, and not everyone with depression may exhibit every symptom (Kessler, 2002). The severity of the symptoms also can vary over time (APA, 2000).

The problem of depression and its toll on human life has been well documented (Cochran & Rabinowitz, 2000). Substantial research has been conducted to establish methods for quantifying depression, and to clarify the epidemiology of depression across populations (Kessler, 2002).

Prevalence of Depression

Depression is the most common of all psychological disorders in the United States today, disrupting the lives of millions of Americans (Kessler, 2002). Community surveys show that up to 20 percent of adults, and up to half of all children and adolescents, report depressive symptoms during recall periods between one week and six months (Kessler, Avenevoli, & Merikangas, 2001). Additionally, a meta-analytic study suggests that at least one of every six American adults has met the criteria for a major depressive episode at some time in their lives, and that one in four has met the criteria for major depression, minor depression, or recurrent brief depression (Kessler, 2002).

Epidemiology

The only nationally representative general population data in the United States based on a structured diagnostic interview format comes from the National Comorbidity Study (NCS) (Kessler et al., 1994). Results from the NCS show that 17.1% of respondents met the criteria for a major depressive episode over the course of their lifetimes. When the timeframe was narrowed to any twelve-month period, 10.3% met the criteria for a major depressive episode (Kessler et al., 1994).

Once the prevalence rates are divided by gender, an interesting trend emerges. Women outnumber men at an approximate 2:1 ratio. Lifetime prevalence rates for men and major depressive episodes are 12.7%, and twelve-month prevalence rates are 7.7%. Women experience prevalence rates of 21.3% (lifetime) and 12.9% (twelve-month) (Kessler et al., 1994). The American Psychiatric Association lists the prevalence of depression among women as double that of men (APA, 2000).

If according to prevalence rates of depression men appear to be better insulated from the problem of depression, consider the following suicide statistics from the National Institute of Mental Health (NIMH). The most recent statistics available (year 2000) indicate that men die by suicide more often than women, at a 4:1 ratio. Also, 73% of suicide deaths are white males, and white males commit 80% of all suicides involving a firearm. Men consistently choose more

lethal suicide methods, complete the attempt more often, and are dying at an alarming rate (National Institute of Mental Health, 2000).

Assessment of Depression

The DSM-IV TR criteria have become the most frequently used assessment for diagnosing depression (APA, 2000). Partially due to the large volume of persons requiring screening for depression, a multitude of quantitative assessments have been developed for the stated purpose of detecting the presence of depression, and objectively measuring the level of depression a person is experiencing (Kessler, 2002). However, neither the DSM-IV TR criteria nor two commonly used assessments of depression attend to how gender differences may influence reporting of depressive symptoms. One measure for assessing male depression is in the developmental stages (Gotland Male Depression Scale; Rutz, 2001), but has yet to receive any measure of broad support from the psychological community. Two commonly used paper and pencil assessments of depression are reviewed briefly below, and the one measure that is being developed to measure male depression is also described.

Beck Depression Inventory, 2nd Edition (BDI-2)

The Beck Depression Inventory, 2nd Edition (BDI-2) is the most widely used assessment instrument for detecting the presence of depression (Beck, et al., 1996). The BDI-2 consists of 21 items used to assess the intensity of depressive symptoms. Each item contains a list of four statements about a particular symptom of depression, arranged in increasing severity. Persons

completing the BDI-2 mark the statement most closely matching their experience, and the corresponding point values are totaled. Ranges of scores have been developed to correspond with the likely severity of the depression experienced by the person completing the assessment. The BDI-2 has been deemed valid and reliable for use with clinical and non-clinical populations aged 13 to 80 years old (Beck et al., 1996).

Physician's Health Questionnaire

The Physician's Health Questionnaire, or PHQ-9 is a nine-item assessment developed to help primary care providers such as nurses and physicians identify depression (Kroenke & Spitzer, 2002). Although the test contains half as many items as most tests for assessing depression, it has comparable sensitivity as selectivity compared to longer instruments. Scores on the PHQ-9 range from 0 to 27, as each of the nine items can be scored from zero to three based on how frequently a symptom is experienced. Cutoff scores are set at 5 (mild), 10 (moderate), 15 (moderately severe), and 20 and above (severe depression). Using the cutoff point of 10, the PHQ-9 has a sensitivity and specificity of 88%. The PHQ-9 takes less than 10 minutes to administer, and scoring consists of simple arithmetic (Kroenke & Spitzer, 2002).

Gotland Male Depression Scale

Although the BDI-2, PHQ-9, and clinical interview are by far more widely used; there is some developing interest in a male specific measure of depression. The Gotland Male Depression Scale (GMDS) (Rutz, 2001) was developed to assist

physicians in recognizing depression among men after other efforts to reduce the high male suicide rate in Gotland, Sweden had failed. Researchers used traditional mood and cognition items assessed on other depression scales, and added items assessing irritability, aggression, and substance abuse (Rutz, 2001).

The GMDS consists of 13 items; each rated on a four-point Likert scale from 0 to 3 based on the severity of the symptom being rated. Therefore the scale has a theoretical score range from 0 to 39. The total scores are then assigned the following rankings along with recommendations for pharmacological treatment: no depression (0-12), probable depression, consider antidepressants (13-26), and definite depression, prescribe antidepressants (27-39). The GMDS is currently being refined and evaluated for reliability and validity (Rutz, 2001; Zierau, Bille, Rutz, & Bech, 2002).

Perhaps one function of this dissertation will be to add to the understanding of male depression so that specific assessments can be made possible. Until specific knowledge of the processes underlying male depression is identified some doubt about the validity of the gender distribution of depression must exist. Additional factors surrounding the debate about the numbers of men versus women who are depressed are presented next.

Debate about the Prevalence of Men's Depression

The 2:1 female to male depression ratio has been called stable and well established (APA, 2000). There is however, some debate about the validity of the number of men experiencing depression. Terrence Real (1997) has written about

how depressed men often hide their illness, and how therapists and physicians may unwittingly engage in a form of cultural collusion that results in keeping men's suffering secret. Those therapists and physicians, if reared in the same culture that prohibits masculine suffering, may unknowingly minimize or avoid the issue of depression among men. Pollack (1998) has argued that men likely experience depression at similar rates as women, yet they are less likely to be diagnosed due to an overly narrow, feminized definition of depression. Basing his observations on clinical examples and psychodynamic theory, Pollack describes two basic categories into which depressed men may fall: hollow men and stuffed men. Hollow men, according to Pollack, are more likely to exhibit core features of emptiness, feel utterly depleted, and be angry. Stuffed men are those that are more likely struggling with guilty feelings, and are self-critical (Pollack, 1998). Both categories of stuffed and hollow men may not be targeted for treatment when presenting to therapists and physicians.

Gender Roles

The earliest and most widely cited characterization of men's gender roles was developed by David and Brannon (1976). According to these researchers, men's traditional gender roles could be sorted into four categories, each with corresponding mandates about how men should behave. Men should be as *sturdy oaks,* and remain emotionally stoic, and lack vulnerability. At work, men should be the *big wheel* that is preoccupied with work, achievement, status, and success. Failure is not an option. Interpersonally, men should *give 'em hell*, and

be forceful and aggressive. Finally, men should strictly adhere to the policy of *no sissy stuff*, and reject everything associated with femininity (David & Brannon, 1976).

Other characterizations of the male role appear similar. James Doyle (1983) defined the five primary elements of the male role as the *anti-feminine element*, the *success element*, the *aggressive element*, the *sexual element*, and the *self-reliant element*. Similarly, Ronald Levant (1995) described seven male role norms. These include *avoidance of femininity*, *restricted emotionality*, *nonrelational attitudes toward sex*, *pursuit of achievement and status*, *self-reliance*, *strength and aggression*, and *homophobia*.

Gender Role Conflict

Adhering to aspects of the male gender role, as traditionally constructed, discourage both awareness and expression of psychic pain (Pollack, 1998). Men consistently report that they believe they lack the culturally sanctioned permission to overtly express emotional distress (Cochran & Rabinowitz, 2000). The dissonance created between men's perceived appropriate behavior based on gender roles and men's experience of living in the world is termed gender role conflict (O'Neil, Helms, Gable, David, & Wrightsman, 1986). Four gender role conflict patterns or roles that may relate to men's problematic behaviors and lack of help seeking when distressed have been identified. The four patterns are *success, power, and competition*, *restrictive emotionality*, *restrictive affectionate behavior between men*, and *conflict between work and family relations*. The

Gender Role Conflict Scale (GCRS) was developed to measure these four roles (O'Neil et al., 1986).

Mahalik and Cournoyer (2000) have described how each of the four factors of the GRCS is related to cognitions that produce and maintain emotional difficulties. For example, the domain of *success, power, and competition* leads a man to overvalue achievement and dominance, and develop internalized messages that his personal value is dependant on his salary, job importance, or athletic achievements. Attitudes consistent with *restrictive emotionality* cause a man to avoid expressing feelings for fear of being seen as weak or unmanly. *Restrictive affectionate behavior between men* limits how close or intimate a man may be with another man for fear of being labeled homosexual. Finally, awareness of *conflict between work and family relations* leads a man to believe that a rewarding career and involved family relationships are incompatible.

Males often report feeling pressured to deny weaknesses and not display feelings of vulnerability. Men who conform to this cultural definition of masculinity tend to be reluctant to display symptoms of depression, and may tend to experience those depressive symptoms covertly. A connection may exist between being emotionally restrictive, and a negative state of mind that involves feelings of self-reproach, failure, guilt, and pessimism (Barbee, 1996; Shepard, 2002). Men with depressive symptoms are often under fire from within, by way of self-attacking cognitions and feelings of hopelessness. They are reluctant to express their feelings or seek help from a counselor due to their own

socialization, which causes men to be reluctant to seek help or disclose their suffering to others (Shepard, 2002). In a sample of college students, it was found that adherence to male gender roles appears to limit options such as seeking counseling for men experiencing depression (Good & Wood, 1995).

Traditional Men

Men who strongly endorse traditional gender roles and stereotypes have been termed *traditional men* (Brooks, 1998). Traditional men are often described in terms of their unwillingness and inability to participate in therapy (Campbell, 1996). Men endorsing these beliefs also tend to avoid and deny recognizing the signs and symptoms of depression. They seek help from therapists half as frequently as women. Traditional men are achievement-oriented, restricted emotionally, self-reliant, and restrict expression of same-sex affection. Traditional men are disenfranchised with psychotherapy because the tasks and methods of psychotherapy are seen as contrary to their gender role socializations (Brooks, 1998).

Men's Experiences of Depression

Sociologist David Karp (1996) describes depression from a symbolic interaction standpoint and presents direct quotations from the depressed persons. His analysis of these quotes however is led by the certain methodological biases present with that method. Regardless, the material expressed is compelling and has direct relevance to the current study (Karp, 1996).

Karp (1996) distills certain themes from these descriptions of depression. First, the interactions of illness and identity must be considered. Karp discusses how individuals must come to terms with being a depressed person. Second, the meaning of medications such as antidepressants must be considered. Third, individuals deal with coping and adapting with the illness and sick role. Fourth, the meaning of being depressed in the context of family and friends must be addressed. Karp contends that individuals seeking to understand depression must be aware of these themes (Karp, 1996).

Most germane to this research project are Karp's writings about his own experiences with depression. Karp begins by describing the contrast between his outside self and his internal self. He states, "By any objective standards I should have been feeling pretty good. I had a solid academic job at Boston College, had just signed my first book contract, I had a great wife, beautiful son, and a new baby daughter at home. From the outside my life was pretty good" (Karp, 1996, p. 4). However, Karp was struggling emotionally. He writes, "The two central feelings typifying my depression were frantic anxiety and a sense of grief. These feelings coupled to generate a sort of catastrophic thinking about events in my life...They were just insistently there, looping endlessly in my brain" (p. 7).

The detail provided by Karp of his personal experiences can be considered one primary source in the current quest for men's narratives of depression. Another important source that contains men's descriptions of depression and

their life world is found in autobiographies. Selected autobiographies of men who mentioned their experiences with depression are reviewed in the next section.

Autobiographies of Men Referencing Depression

Few Psychology journal articles have described how men experience depression. This study's literature review has been broadened to include selected autobiographies, which were hypothesized to be a readily available source of men's reflections upon their life experiences. Selected autobiographical accounts written by men between 1940 and 2005 were examined for references to personal experiences with depression. Autobiographies were located by searching bookstores, online listings of autobiographies, and internet searches for keywords like "depression" and "autobiography."

Across the autobiographies selected for this review, three major ideas seem to be present in most or all of the works. First, the men appear to present depression as a troubling event that requires some sort of fixing or repair in their lives. Second, most men refer to the notion that depression is considered shameful, and that stigma encourages hesitation in acknowledging its presence. Third, the men refer to their work often, and view depression as an impediment to productivity. The findings from these individual autobiographies are presented in chronological publication order. Whenever possible, the actual words of the men describing their experiences are presented.

The earliest autobiography located in my review of modern era books to have significant mention of depression was Leo Tolstoy's autobiography (Tolstoy,

1940). In his memoir, Tolstoy details the dejection he experienced in response to existential questions he formed about the meaning and purpose of life.

> At first I experienced moments of perplexity and arrest of life, as though I did not know what to do or how to live; and I felt lost and became dejected. But this passed, and I went on living as before. Then these moments of perplexity began to recur oftener and oftener, and always in the same form. They were always expressed by the questions: What is it for? What does it lead to? ... I felt that what I had been standing on collapsed and that I had nothing left under my feet. What I had lived on no longer existed, and there was nothing left (Tolstoy, 1940, p. 17).

Tolstoy describes feeling that life was little more than a cruel joke played on him, and remarks that his depression left him unable to enjoy his life's two loves: his family and his writing. For Tolstoy, questions about the meaning of life and a resulting failure to find an apparent purpose and meaning may have contributed to feelings of depression (Tolstoy, 1940).

Another prominent mention of depression in an autobiography is found in the work of Buzz Aldrin (1973). In his autobiography, Aldrin (1973) describes the difficulties he faced once he returned to earth after walking on the moon. Those struggles included facing the paparazzi and negotiating the demands of his newly acquired fame, and his struggle to follow his monumental accomplishment of reaching the moon. This difficult adjustment period contributed to feelings of depression in Aldrin. Aldrin reports staying in bed for days at a time and missing dinners with heads of state. His overwhelming feelings of fatigue and sadness were difficult for both Aldrin and his family to understand. Aldrin himself

characterizes the two-and-a-half years after his return from the moon in the following manner:

> I finally became helplessly lost within myself. The first indication was a noticeable shift in my moods. The last two and half years of my life – from the time I left the lunar quarantine quarters until I entered Wilford Hall – were characterized by depression, which occasionally deepened, then rose to a temporary high of optimism, only to sink again to a new low. There was no possible way of setting a goal that would match the goals already achieved (Aldrin, 1973, p. 304).

For Buzz Aldrin, the pinnacle achievement of traveling to the moon had an unexpected consequence. Aldrin returned unable to conceive of a next goal, or way to top that experience. Living with the notion that he had peaked was the catalyst that brought about his depression (Aldrin, 1973).

In another autobiography (Knauth, 1975), a prominent journalist with contributions to *Time* and *Life* magazines and who had helped begin *Sports Illustrated* magazine, wrote about his life experiences of struggling with depression. Knauth describes his experience of living with depression in the following excerpt:

> My life had turned inside out so that everything I saw was a photographic negative. Where there should have been joy, I could feel only an unending sadness. Where I should have felt hope, there was only despair. Where life with its continuing promise should have sustained me, only the oblivion of death attracted me now, for living had become a hell on earth (Knauth, 1975, p. 2).

Knauth explains his state of mind while depressed, and his need to feel as though he was a part of something larger.

> The way I figured it, a man *had* to be part of some organization just to exist; and I wasn't a part of anything now. I must have been mad, I

> thought, to arrange things like this. Just think! Nobody in any office anywhere was waiting to hear from me, no secretary was making travel arrangements to some fascinating place where a blockbuster of a story filled my attention; no editor was chewing his nails waiting for me to phone it. Sometimes these thoughts hit me with such unbearable poignancy that tears came to my eyes and soaked freely into the pillow in which I often buried my head, ostrich like, to shut out the world (Knauth, 1975, p.22).

Knauth discusses how he felt compelled to understand the reason for his depression. In the questions he found himself posing throughout sleepless nights, Knauth was often furious with himself for what he thought was a senseless predicament. Knauth also describes the hopelessness he suffered when realizing that his problems involved a sort of catch-22. “More realistically”, he states, “I understood that the only tool I could fight with – my mind – was the very part of me that was affected. Can a legless man get up and walk even if he knows walking will save his life? My mind was going; how could I use it to extricate myself from my despair?” (Knauth, 1975, p.35). Reflecting on his life experience with depression, Knauth later describes depression as an enriching life event that has increased his ability to be empathic with others (Knauth, 1975).

In the next autobiography reviewed, the psychologist Norman Endler (1982) detailed his own struggle with depression. Endler describes his depression in the familiar masculine terms. “Everything I did or tried to do sapped my strength. Everything became a monumental task and a test of personal competence, although I probably did things as well or almost as well as usual”

(Endler, 1982, p.10). Endler traces the beginnings of his depression to the loss of a research grant, and the sense of incompetence and unworthiness that followed. Ironically, Endler details how his depression was biochemical in nature, and not related to his psychological life. He does not return to the issues of shame or failure, but instead focuses on the biochemical (Endler, 1982).

An interesting autobiographical note is contained in O. Hobart Mowrer's collected papers (Mowrer, 1983). Published near his death, Mower alludes only briefly to his struggles with depression. He says, "It is no secret that, since early adolescence, I have had recurring difficulties with anxiety and depression." (1983, p. 319) Instead of describing his experiences of depression, Mowrer chooses to fill the next four pages with his struggles with hypoglycemia and does not again return to describe his struggles with depression. Often the view that depression is a weakness influences men to be reluctant to discuss its effects. One may only guess about Mowrer's reasons for not including that topic.

Additionally, novelist William Styron describes his experiences of depression as a storm, "a veritable howling tempest in the brain" (1990, p. 38). A large part of Styron's autobiography is an attempt to put words to the enigmatic experience of depression, and how hard it truly is to understand for persons who have not experienced depression (Styron, 1990).

Author John Bentley Mays titled his memoir *In the Jaws of the Black Dogs* and describes in this work his struggles with depression (1995). The first

sentences of the introduction set the tone for the book, conveying the hopelessness that arises from the recurrent nature of depression.

> This book is a life with the black dogs of depression. I have written it in a clearing bounded by thickets roamed by the killing dogs, sometimes wondering, in the writing, whether I would complete it before they returned on silent paws to snatch the text and me away. For the depressed can never be sure of anything, except the black dog's eventual return, and their terrible circling at the clearing's edge (Mays, 1995, p. xi).

Mays does not present a quick fix, or pat-sounding solution to the problem of depression. Despite his experiences with therapy and medications, he remained chronically depressed. His book details the factors that help support him during his struggles; namely involvement in worthy goals, working steadily, an abiding faith and spirituality, and interactions with loved ones (Mays, 1995).

Novelist and former mental health case manager Jeffery Smith (1999) has written a memoir detailing how depression has seriously impacted his life. Drawing examples from his relationships and work as a mental health case manager, Smith's book is a very personal narrative depicting the difficulties of living with depression. He writes, "each day passed as if it turned on some noisome crank, something slow and tortuous, to be endured and not engaged" (p.7). Bearing the burden of depression while working ultimately proved too overwhelming for Smith. He refers to his depression as *Mr. Shoulder* and *my familiar* in recognition of the constant negative filtering effect depression has on his self-confidence, almost as if a devil were standing on his shoulder whispering doubt and forecasting doom. Smith's book is also noteworthy for its

consideration of the natural history of depression, and its centuries-old history in art, literature, and science (Smith, 1999).

In a recent article in *Essence* magazine, Olympic sprinter Derrick Adkins described his experiences with depression. One of the greatest challenges Adkins describes is his journey toward learning to avoid being too self-reliant, acknowledge his pain, and accept help. The need to present an image of a strong man initially kept Adkins from seeking assistance (Adkins, 2001, 2002).

Adkins begins with the popular refrain among successful men. He lists his impressive accomplishments, such as winning a gold medal for the 400-meter hurdles in the 1996 Olympics, and earning a college degree in Engineering, and then wonders how he could have been susceptible to depression. Adkins states that a visit to a psychiatrist helped him to realize that his depression "was not due to any deeply rooted emotional issues but rather resulted from a chemical imbalance in my central nervous system" (Adkins, 2002, p. 69). He explains that many men are probably suffering unknowingly from depression. Although he espouses the value of counseling in developing a healthy response to depression, Adkins does not tell the reader if he has participated in therapy (Adkins, 2001, 2002).

Recently a memoir of depression topped the *New York Times'* bestseller list. Andrew Solomon's book titled *The Noonday Demon* met with critical acclaim for its treatment of the disorder from the perspective of a man who has endured chronic depression for years (2002). In this work, current perspectives on

depression are presented from disciplines as varied as law, literature, history, and art. Solomon's own personal experiences serve as the consistent thread throughout the work. The book's remaining central message was of depression's pervasiveness across boundary lines of class, race, and social levels, and of the persistent return of the symptoms despite some individual's attempts to avoid sadness and depression.

One of the most recent public figures to acknowledge his depression is National Football League Hall of Fame quarterback Terry Bradshaw (Bradshaw & Miller, 2003). Bradshaw discusses his battle with depression in a recent *Newsweek* article co-written with a Harvard physician. In that article, Bradshaw recounts the difficult time he had accepting that he may be depressed. Initially, he had no idea that depression may lie at the root of his problem. The article attempts to reframe help seeking as a masculine activity (Bradshaw & Miller, 2003).

Self-Help Books by Men Acknowledging Depression

Two self-help books have been written by men who have experienced depression. The books by Rosen (1993) and by O'Conner (1997) take differing approaches to managing depression, but share the hope of lightening depression's burden. Both authors acknowledge their personal struggles with the disorder.

David Rosen is a psychiatrist and Jungian analyst who himself has experienced depression. Rosen explains that individuals may transform the

destructive pull of depression's suicidal and self-destructive urges when it is realized that the death implied by suicide may be symbolic in nature. For instance, when individuals learn to adapt to changing situations and revise their self-concepts accordingly, the previously negative energy of depression becomes a healing, self-nurturing force that allows for individuals to shed ineffective views of themselves (Rosen, 1993).

Psychotherapist Richard O'Conner has written a self-help book on depression and openly acknowledges his own struggles with depression (1997). O'Conner presents a helpful and coherent narrative of his struggle with depression as well as a general orientation to the condition. He advocates for a treatment approach combining pharmacology and psychotherapy. O'Conner states clearly the importance of eliciting a first person view of depression, and casts his doubt on whether a person who has not lived with depression can understand the experience (O'Conner, 1997). Among the two self-help books written by men who have experienced depression, common themes were found. Both O'Conner (1997) and Rosen (1993) acknowledge their own depressions publicly and in their writings. Each contends their firsthand experiences with depression uniquely qualify them to recognize, understand, and help treat depression among men.

Previous Phenomenological Studies of Depression

A review of academic journals found only eight published qualitative studies of depression. Of those eight studies, only two dealt exclusively with

men's experiences. Although these previously conducted studies differ significantly from the proposed study, the existing qualitative studies of depressed persons are reviewed here.

Women Recovering from Depression

In a study of women previously hospitalized for depression, one research group investigated the recovery process. Depression was found to have significant impacts upon all areas of an individual's life, including family, work, and social functioning. Four categories emerged from the analysis of the interviews. The categories were *self-healing, managing, receiving social support, and finding meaning*. It was found that while working their way out of the depression, the women needed to undergo a cognitive and emotional understanding, which they subsequently translated to health-related actions. Recovery from depression was a growth experience, as the women developed skills and knowledge they had previously lacked. These findings reiterate that recovery is a continuing process with daily challenges and struggles (Skarsater, Dencker, Bergborn, Haeggstroem, & Fridlund, 2003).

Another qualitative study focusing on how women recover from depression made use of grounded theory for data analysis. The researcher interviewed 21 recovered-depressed women to illuminate the basic process by which women recover from depression. The research participants described the process of becoming strengthened through the challenge of depression, and the author summed the results up as "the woman searches within herself and

outside herself to determine the answer, and finds that she is a much more complex and capable individual than she had imagined" (Schreiber, 1996, p. 473). Schreiber stated that the focus of her research was to uncover the meanings and understandings women attach to their depression experience, and to explore recovery from depression with special attention to the participants' social context. A major finding was that women's recovery from depression might be intimately connected to the search for personal identity within a social context (Schreiber, 1996).

A third researcher (Steen, 1996) investigated the process of women's recovery from depression by using existential phenomenological methods. For the women in the study, depression was the existential byproduct of surviving through a previous stressful life period that persisted until they were able to learn more adaptive means of coping. The women in the study described such existential themes as *alienation, pain, adulthood crises, turning points*, and *becoming responsible for one's own nurturance* (Steen, 1996).

Concerning the lack of phenomenological studies aimed at improving our understanding of depression from the individual's point of view, Schreiber states that "Much like women with depression, we practitioners and researchers are wandering in the dark, unable to construct a full understanding of the phenomenon of women's depression (2001, p. 92). Schrieber's point about the need for research is only more poignant for the masculine subgroup that has heretofore been omitted from study.

Phenomenological Studies of Women's Experiences of Depression

Two studies were located that presented women's phenomenological experiences of depression. In the first study, Jambunathan (1996) presents a single woman's story. In the second study, Hedelin and Strandmark (2001) describe the experience of depression among elderly women.

Jaya Jambunathan (1996) became acquainted with a depressed woman named Ginny while Jambunathan was working as a nurse. In a recent nursing journal, the story of Ginny is presented by reproducing nearly four pages of Ginny's own words about her lived experience of depression. Unfortunately the researcher did not extract themes from this lengthy narrative by the researcher. Jambunathan underscores the need for nurses to exhibit understanding and compassion when dealing with depressed persons (1996).

A Swedish research team (Hedelin & Strandmark, 2001) investigated the experience of depression among elderly women and used phenomenological methods. Hedelin and Strandmark (2001) conducted qualitative interviews with five women ages 75 to 92 who had been identified through an outreach and education program. The findings underscore the difficulties the women faced while living with depression. Five themes emerged as figural against the grounds of *re-experiencing a severe personal insult*, and *increased sensitivity and vulnerability*. The five themes were *alienation and fear*, *meaninglessness, emptiness and hopelessness*, *self-searching and guilt*, *diminished vitality and*

physical pain, and a *state of tension between opposite poles* (Hedelin & Strandmark, 2001).

Although the Hedelin and Strandmark (2001) team did not research men's experiences, they did find that the experience of depression was highly salient for the five women they interviewed. Depression affected the entire life-world of the women in their study. Perhaps the effects of depression would also manifest in the lives of men in a significant and pervasive manner.

Other Qualitative Studies of Depression

Coyne and Calarco (1995) used focus group interviews to investigate the experience of depression among two gender-mixed groups composed of 10 women and 7 men. Using a list of 25 questions, the experience of depression was probed as it related to decision-making, close relationships, and other questions. The interviewers noted that the participation was uneven, and did not account for how the different genders participated in their study. However, the interviewers developed a questionnaire based on their focus group results and then administered that questionnaire only to the women interviewed. No mention is made of why the men were not included in this process.

Another research team (Skarsater, Dencker, Bergborn, Haggstrom, & Fridlund, 2003) interviewed a dozen men who had been hospitalized for depression in order to understand how these men had coped with depression in their daily lives. Four descriptive categories emerged from the semi-structured interviews. The themes were: *being unburdened*, *restoring one's health, feeling*

involved, and *finding a meaning*. The first category of *being unburdened* contained references to the difficulties men faced in their daily lives with depression and their own need to feel less encumbered by the disease (Skarsater, et al., 2003).

Within the second category of *restoring one's health*, the men described the various changes they attempted to implement in their own lives in order to limit the harmful effects of depression. Those changes involved developing an awareness of one's limits, and then either using existing skills or gathering new ones in order to live within the newly-discovered limits. The third category of *feeling involved* contained the men's references to their need to feel confirmed as a part of a society of peers who have similar experiences. The final category from this research project was *finding a meaning*. Men described how they had developed an ability to reflect on their experiences, accept their life situations, and how they were planning to anticipate their own futures (Skarsater, et al., 2003). General findings from this study outlined the process by which men cope with depression, including men's preference for informal support systems and their desire for increased contact with professionals familiar with the experience of depression (Skarsater, et al., 2003).

Heifner's Study of Male Depression

Christine Heifner (1997) conducted a qualitative study that focused on men's depression. In this grounded theory study, Heifner used a semi-structured interview to inquire about men's experiences of depression. In general, men's

issues of control, strength, and independence were found to be at odds with the vulnerability necessary to acknowledge the need for help and to seek treatment for depression. Heifner found that beliefs about being male are challenged by depression, and impede the process of treatment and recovery (Heifner, 1997).

Heifner (1997) approached the grounded theory project from a developmental interactive perspective, and therefore developed a model of how depression begins that emphasizes those very processes of development and interaction with others. Heifner found that men who are likely to develop depression begin with rigid, traditional gender roles, believe their acceptance by others is bound to their performance, and have difficulty connecting with others. These men learn that they must hide their fears and feelings of inadequacy, and when life demands become so increasingly stressful that this façade cannot be maintained, depression is the logical result (Heifner, 1997).

Chapter Summary

In summary, this chapter has reviewed literature about depression and its diagnosis, assessment, and distribution throughout the population. Depression is hypothesized to broadly affect both men and women across various walks of life. Although roughly twice as many women experience depression as do men, evidence shows that men's gender roles could contribute to a unique experience of depression. Existing first-hand accounts of male depression were located in autobiographies and show a glimpse of rich data that can be extracted from

further studies of male depression. Men's perspective on depression has been only minimally investigated by researchers.

No previous study has attempted to solicit firsthand descriptions of depression from men, and then find the common themes underlying those experiences. The current project investigates the experience of depression exclusively from the perspective of the depressed male. No preconceived notions or ideas about theory are used to interpret the data. The results obtained represent the actual words of the participants being interviewed. More information about this study's methodology will be provided next in Chapter Two.

CHAPTER TWO: METHODOLOGY

The essence of this project involves asking men to describe their own experiences of depression. When a person is asked to put into words any life experience, an individual is confronted simultaneously with the task of summarizing the meaning of the experience, and conveying that meaning. The individual asked to reflect on a lived experience must decide what is worthy of sharing. The process by which an individual judges what is important about his existence is called meaning. Secondly, the person being asked about a life experience must then convey that information to the person inquiring. The process by which the individual communicates the meaning of a lived experience is by narrative. In order to more fully understand these two interrelated phenomena, the concepts of meaning and narrative are briefly reviewed.

Meaning

In his classic work, *Existential Psychotherapy*, Yalom (1980) describes the prime importance of meaning for human existence. Human beings seem to require "firm ideals to which we can aspire and guidelines by which we can steer our lives" (p. 422). However, deciding on what meaning to ascribe to life events is often difficult, and Yalom underlines the paradoxical nature of the human search for meaning. Existential freedom rejects the existence of such absolutes in favor of worlds and selves that are socially constructed. Evaluating the meaning of one's life is indeed a significant problem and one that therapists confront frequently in clinical work. Individuals asked to recount their experience

with depression are likely to consider the meaning of their struggles, and a comprehension of existentialism is essential to understanding the information gleaned from this study (Yalom, 1980).

Narrative

In their seminal work on understanding narratives, Michael White and David Epston (1990) described the historical development of their use. White and Epston explain that the interest in narrative developed along with an appreciation that language allowed for human beings to describe and remember their experiences across lengthy spans of time. White and Epston explain that "Social scientists became interested in the text analogy following observations that, although a piece of behavior occurs in time in such a way that it no longer exists in the present by the time it is attended to, the meaning that is ascribed to the behavior survives across time" (White & Epston, 1990, p.9).

This new way of understanding lived experience lead theorists to consider how people organize and understand their amassed quantity of lived experiences. When individuals strive to make sense of their lives, they must arrange their own private experiences of the events of life in sequential chunks of time that provide coherent accounts of both their own lives and the world around them (White & Epston, 1990).

Other writers have contributed to understanding how narratives relate to meaning, particularly in the interpersonal context. Robert Neimeyer (1995) has written extensively on narratives and human understanding. He clearly outlines

the value of client narratives in constructing and communicating meaning by stating his belief that stories told by clients “have a vital intrapersonal function, namely, *to establish continuity of meaning in the client’s lived experience*” (Neimeyer, 1995, p. 233). Regardless of whether that person being interviewed is a psychotherapy client or research participant, narratives serve a vital function in understanding human lived experience. Because this study focuses on the lived meaning of depression, it makes use of methods derived from existential phenomenology that incorporate an awareness of the importance of both meaning and narrative.

Phenomenology and Hermeneutics

Phenomenology has been defined as an attempt “to describe phenomena, in the broadest sense as whatever appears in the manner in which it appears, that is as it manifests itself to consciousness, to the experiencer” (Moran, 2000, p. 4). Furthermore, the study of phenomenology helps to “to clarify how the object-world is humanly experienced and presents itself to our consciousness. As such, phenomenology attempts to understand more adequately the human condition as it manifests itself in lived experience" (Spinelli, 1996, p. 180).

The German philosopher Edmund Husserl was instrumental in developing the field of phenomenology and has influenced methods used by later phenomenologists. Husserl defined phenomenology as the studying of essences, while bracketing one's own consciousness to avoid interfering with the understanding of that essence (Husserl, 1931). The goal of Husserl's

phenomenology is to describe that essence purely, without the introduction of the investigator's assumptions. As Husserl's famous phrase states, phenomenological methods allow the investigator to return directly "*zu den Sachen selbst*," or to the things themselves (Husserl, 1931). Lived human experience is always a consciousness of a particular object (Husserl, 1970). Consciousness is always directed at something, and therefore exhibits an "intentionality" or intended object (Cohn, 1997; Valle, & King, 1978).

Heidegger was a student of Husserl, and extended the phenomenological method to include the existential nature of being. Through his philosophical writings, Heidegger fused the idea of intentionality with the awareness that humans exist in a social context to develop his idea of "being-in-the-world." Effectively, Heidegger brought together the approaches of phenomenology and hermeneutics to grapple with existential issues such as death, anxiety, society, and temporality (Heidegger, 1962).

Hermeneutics refers to the process of achieving an understanding of text by engaging in a rigorous reading and rereading of that text. The term "hermeneutic circle" refers to the movement of the researcher's attention from one part of the text to another, in an attempt to develop a deeper understanding by considering interrelations and contextual elements. Throughout the reading of the text, the researcher is constantly developing and refining understandings about the information (Pollio, Henley, & Thompson, 1997). By searching for the phenomenological meaning of one's experience in the world, the methods of

hermeneutics and phenomenology together give rise to the understanding of the essential mode of being which Heidegger called "Dasein" (Heidegger, 1962; Hein, & Austin, 2001; Moran, 2000).

Husserl offered two categories of answers to the problem of defining what a 'self' means. First, according to Husserl, one's ego, or concept of one's self serves to center one's consciousness. Every object is experienced in relation to one's self, in a sort of "egological self objectification" (Mensch, 1997, p.77). Second, the self is described as a dynamic, changing description of the contexts and situations in which one finds one's self. The two definitions explain "we are both our habits, our personal and social roles, and our ability to step out of them" (Mensch, 1997, p.77). The technique of phenomenology is therefore well suited to understanding the complex experience of an individual's mood state.

Blasi (1991) writes about the important benefits that the application of existential phenomenological methods could contribute to the understanding of personal experiences. To discuss the subjective personal experience, according to Blasi (1991), "it is possible, indeed necessary, to rely on common experience: All of us seem to behave, speak, and feel as if we experienced ourselves as subjects of our actions, speech, and feelings" (p. 20). Though underutilized, the phenomenological approach focused on experience can prove indispensable in understanding the subjective self.

Self-Reports of Data

One of the main concerns associated with accepting self-report data, however, is the notion that the person may not report the data in an unbiased manner, and may either purposefully or unintentionally misconstrue the results (Brown, 1976). For example, sometimes people are unaware of their limitations and may overestimate their skills and abilities. Such blind spots are both common and serious as found by Kruger and Dunning (1999). These researchers administered tests of humor, grammar, and logic to a sample of people. Subjects who scored in the bottom quartile on these measures seriously overestimated their performance and skills compared to their measured ability levels. In general, persons scoring in the 12th percentile estimated themselves to be in the 62nd percentile (Kruger & Dunning, 1999).

However, such concerns about accuracy have not precluded self-reporting from becoming the most widely used method of data collection. Most psychological tests use at least some element of self-reporting (Groth-Marnat, 1997). Walter Mischel (1968) points to the perplexing dilemma of attempting to avoid these subjective methods, because no one can truly perceive himself or herself in an entirely objective manner. The idea of incorporating phenomenological research methods into the field of psychology to address the dilemma addressed by Mischel has been discussed by Heinz Kohut (1984), among others. Kohut (1984) questions the suitability of the quantitative experimental method for studying psychological and mental events. It is the very

nature of psychology being accessible "only via introspection and empathy, that more or less precludes the use of the experimental method and the application of statistical proof" (p. 224). Through the use of phenomenological methods, the researcher is able to "temporarily suspend one's own frame of reference in service of taking the role of the other, as well as being able to go beyond this to be able to empathically grasp the wider context in which the experience of both therapist and client in interaction is taking place" (Bohart & Greenberg, 1997, p. 420).

Reliability and Validity of the Method

The phenomenological hermeneutic method is ideographic and descriptive in nature, and does not rely on the more traditional quantitative measurements of the concepts of reliability and validity. The method is reliable because it draws heavily on the experience of the client, and seeks to return directly to the client's experience through holding back the therapist's biases and prejudices.

Support for the claim that the phenomenological method of counseling is reliable and valid is provided in the following paragraph:

> Existential-phenomenology claims a more reliable and accurate basis for building an acausal, non-reductionistic and non-reifying philosophical psychology for understanding human nature. This is based on induction, drawing general inferences from particular inferences, and grounding in a priori essences, by first of all creating pure descriptions of actual sense experiences" (Owen, 1994, p. 262).

Quantitative research methodologies err in "trying to establish a numerical relation between a supposed small number of identifiable 'objective' influences,

and 'objectively' measure outcomes. Phenomenological psychology refutes this and concentrates on describing intersubjectivity, and comparing and discussing what is taken to exist" (Owen, 1994, 270). It is the subjective nature of client's descriptions that the quantitative researcher tries to reduce, which is precisely what makes the phenomenological researcher's data so rich and valuable.

Research Participants

The existential phenomenological method relies on information obtained by interviewing individuals about a common experience (Colaizzi, 1978). Polkinghorne (1989) has listed the requirements for selection as twofold. The requirements are that individuals must have had the experience being investigated, and be able to describe their experiences to the investigator. Individuals selected to be research participants for this survey met both of the above criteria.

Men currently receiving counseling for depression at a mental health center were recruited to participate in the proposed study. Agreement to recruit men actively engaged in therapy was obtained from a large private mental health service provider in East Tennessee. Participants in this study consisted of ten men participating in treatment for depression at a local community mental health center. Eight of the men were Caucasian, and two were African-American. Their ages ranged from 30 to 61 years old, and the average age was 46 years old. Participants both self-identified as having depression and have been diagnosed with depression by their treating psychologists. The men were selected from

active psychotherapy clients. Demographic data for the participants is summarized in Appendix A.

The referring psychologists were instructed to prescreen participants to insure that referred subjects were neither currently suicidal nor experiencing psychotic symptoms, and that the participation in this study was unlikely to harm the individuals. Furthermore, individuals diagnosed with Bipolar disorder were excluded from participating in the study, as it was hypothesized that the experience of Bipolar disorder might represent a significant difference from Unipolar depression. In order to assure that psychologists had enough information about the participants to make referrals consistent with these guidelines, psychologists were instructed to only consider referring men who have been in therapy for at least three sessions.

The referring psychologists briefly described the study, and emphasized that participation was voluntary. For the men who were interested in participating, the referring psychologist provided information on how to contact the primary researcher by phone. Once contacted by phone by potential research participants, the primary researcher described the study's aims and procedures and again emphasized the voluntary nature of participation. For interested callers, the primary researcher scheduled a meeting at a mutually convenient time and location that would ensure confidentiality.

At the arranged location and time, the researcher met with the research participant to describe the study. Each research participant read and signed the

Informed Consent Form that described the study's method, purpose, and related confidentiality issues. Research participants were given copies of the Informed Consent Form and any remaining questions were answered. Participants were informed that the study had passed Full Review by the Institutional Review Board at the University of Tennessee, and had been approved by the counseling agency's own Internal Review Board. Documents certifying those approvals are appended (Appendix B).

Participants were informed that aiding in the research project would entail two meetings. At the first, the phenomenological interview was conducted, and then a later meeting approximately one week later was scheduled for follow-up. At that second interview, the results of the first meeting, including a verbatim transcript of the interview and a summary of the major themes was presented to the research participant. Each participant was given the option to add to or remove any portion of his previous comments. Each of the ten men interviewed met with the researcher to follow-up on the results of the study.

Once informed consent was secured, and prior to beginning the interviews, the primary researcher administered the Beck Depression Inventory, 2nd Edition (Beck, Steer, and Brown, 1996) to each participant. In the interview each volunteer was asked to describe in as specific terms as possible his own experience of living with depression. No inducements were provided to encourage participation. Subjects were informed that they would be participating on a voluntary basis, their identity would remain confidential, and they could

withdraw at any time. Additionally, the researcher reiterated that participation was voluntary and the study would in no way affect a participant's ability to receive counseling services at Cherokee Health Systems. After the phenomenological interview was completed, questions were asked of each participant regarding his age, vocation, marital status, and whether he took antidepressant medications. Each participant read and signed a "no harm" statement indicating they were not feeling suicidal after the completion of the interview, and were given referral information for agency, local, and national resources for any further assistance desired.

The Interviews

The goal of phenomenological interviewing is to "obtain a first-person description of some specified domain of experience, with the course of dialogue largely set by the respondent" (Pollio, Henley, & Thompson, 1997). Each interview began with the researcher explaining the nature of the study, securing the appropriate permission signatures, and asking the research question. The research question used in this study was simply "In as much detail as possible, please tell me about your experience of depression." Further interview questions flowed from the dialogue, and were not prepared in advance. Using this framework, it was theorized that the information of primary relevance would emerge (Pollio, Henley, & Thompson, 1997). Interviewer comments and questions were meant to stimulate further description, while clarifying and summarizing presented data. The interviewer did not presuppose a theoretical

hypothesis about the data, but rather allowed the meaning to emerge from the information communicated (Kvale, 1983).

For the current project, the researcher met with each participant twice. During the first meeting, the interview was conducted and paperwork was completed. First meetings averaged an hour in length. During the second meeting, transcripts of the first meeting were reviewed and participants were given the opportunity to make any corrections. General themes emerging from the individual transcripts also were reviewed at this meeting. Second meetings averaged thirty minutes in length. At each meeting, participants were encouraged to take as much time as needed. No set time limit was enforced. Results from the interviews are presented in Chapter Three.

Bracketing

In order to facilitate a more authentic understanding of the interviews, a bracketing interview was conducted with the researcher before participants were engaged. A psychology doctoral student familiar with phenomenological interviewing conducted the bracketing interview, and later met with the researcher to discuss the results. Pollio, Henley, and Thompson characterize bracketing as the "attempt to identify and correct interpretations in which the phenomenological perspective has been co-opted by incompatible suppositions" (1997, p. 48). During the bracketing interview, the researcher was asked about the topic of depression, including his own personal experiences of living with depression. The results from that discussion were used to help the researcher

better understand his presuppositions about the topic and limit the imposition of personal meaning onto the interpretation of the data (Pollio, Henley, & Thompson, 1997). Results from the bracketing interview are presented in Appendix C.

Data Analysis

Qualitative interviews yield large amounts of data that can be difficult to interpret. The interviews from the current study amounted to more than one hundred typewritten pages. Pollio, Henley, and Thompson describe a three-step process in which text from interviews may be understood using a hermeneutical approach (1997). Hermeneutical approaches involve understanding portions of text in relation to other preceding and following texts. During the first reading of the transcript, meaning units are identified in the text. Second, the researcher summarizes the meaning units present to develop an idiographic interpretation of the meaning of the experience for the individual person. Third, the researcher summarizes the individual meanings in the context of all of the persons interviewed, and presents nomothetic interpretations. The researcher does not extend the meaning beyond the persons interviewed.

For the current study, interview data was analyzed using phenomenological methodologies that were developed primarily by Colaizzi (1978), and added to by others (Giorgi 1985, 2004; Polkinghorne 1989, 2005; Wertz 2005). The seven-step procedure outlined by Colaizzi was the primary inspiration for the procedure in this current study. The reader may refer to

Colazzi's entire chapter for more information (1978). Details about the specific procedure employed in this study are presented next.

First, the primary researcher conducted all interviews, and personally transcribed them as immediately after each interview as possible. Transcribing the interviews literally immersed the researcher in the data, and each transcript was read and reread for familiarity with the content presented. Transcribing and rereading the transcripts in their entirety allowed the researcher to better gauge how individual comments made sense in the greater organization of the interview. Moving from sentence to paragraph, to page and back to individual sentence is described in the literature as the *hermeneutic circle* (Pollio et al., 1997).

Next, the researcher reviewed each individual transcript and highlighted certain sections that seemed to pertain directly to the phenomena under investigation. This procedure is termed *extracting significant statements* by Colaizzi (1978), and is similar to the process of locating *meaning units* as described by Giorgi (1985). Once the significant statements were identified, the underlying individual psychological meaning of each individual section was considered. During this step, the researcher attempted to express each of the meaning units in his own words, paying careful attention to remain close to the original meaning expressed by the participants (Colaizzi, 1978). Colaizzi calls this step *formulating meanings* (1978).

Next, the researcher returned to the individual meaning units and produced *clusters of themes* based on similar content. In this step, effort was made to "allow for the emergence of themes which are common to all of the subjects' protocols" (Colaizzi, 1978, p. 59). The researcher again returned to the transcripts to ensure that the clusters of themes identified adequately captured the major ideas expressed in each interview. Any new information found, or ideas not matching the major themes found were cause for reconsideration of the above steps and a recycling through the process.

Next, individual quotes representative of the themes were selected and lifted from the context of the individual interviews. The individual themes emerging from each transcript, selected quotes supporting the thematic descriptions, and the entire transcripts were returned to the research participants for validation. Feedback on the accuracy and completeness of the thematic descriptions were solicited from all ten research participants. Each participant reviewed the general themes and made suggestions, which were incorporated into the data analysis. No major corrections were noted by any participant, and the general reactions to the transcripts were of surprise, relief, and interest. Participants were surprised to see the length of their own interviews, and reported feeling a sense of relief from reading their own experiences. The most common sentiment expressed was that there was something reinforcing for these men to be able to describe their experiences and have them understood by another.

Once several individual transcripts had been completed, the researcher began to look for themes that were present across participants. Some themes presented almost instantly in the first interview, and were appearing by the second interview. Most themes were clear by the sixth or seventh interview, and in fact, redundancy was established after the eighth interview. After the eighth interview, no new themes emerged and a reasonably good formulation of how the themes interrelated had been established. Two additional interviews were conducted to verify that no new themes materialized. After the tenth interview, data collection was judged to be complete.

A copy of one of the transcripts is provided in Appendix D. The transcript enclosed was randomly selected from this project's ten interviews by use of a random numbers table. Identifying information was deleted from all transcripts for protection of privacy, and therefore names and places mentioned by the research participant are replaced with general descriptors such as *NAME*, *CITY*, or *SCHOOL*.

Chapter Summary

In summary, data analysis methodology similar to those advanced by Colaizzi (1978) was selected after much deliberation. The researcher made use of previous research, his doctoral committee's opinions, and consulted with researchers and theorists in developing this methodology. Appendix E contains additional information about the researcher's deliberation process and reconsiders the need for interpretive groups in these projects.

For this project, the relevant literature was consulted, recent published articles were evaluated, and expert opinion was solicited. Articles of significance within the field of phenomenology supported this decision, as did locating successfully published current research articles. Major theorists consulted were also supportive. Though not everyone consulted agrees that any one methodology is best, a workable strategy was devised and an informed decision was made. It should also be noted that the father of phenomenology himself, Husserl, normally worked alone, and preferred to conduct his philosophical investigations *solus ipse* (Moran, 2000).

In Chapter Three, the results from the study are presented including the findings from the bracketing interview and descriptions of the major themes and sub-themes emerging from the data.

CHAPTER THREE: RESULTS

Analysis revealed that the thematic structure of the experience of depression among men consisted of one ground and five main themes. The ground against which the five themes appeared is the individual's own feelings of being *out of control*. The five main themes were 1) *describing,* 2) *symptoms,* 3) *recognizing,* 4) *course* and 5) *reactions*. The ground, *out of control*, contextualizes the five main themes and serves as a constant reminder of the unpredictability and powerlessness inherent in the experience of depression. The first theme, *describing*, outlines the men's difficulty verbalizing their experiences with depression. The second theme, *symptoms*, describes the specific symptoms that the men in the study most closely identified with depression. The third theme, *recognizing*, identifies the process by which men became aware of their changes in mood. The fourth theme, *course*, represents men's beliefs about how the effects of depression may change over time. Lastly the fifth theme, *reactions*, exhibits their responses to living with depression.

Figure 1 presents an illustration of the thematic structure and visually depicts the themes and ground. These themes are all interrelated, as often quotes made by study participants referred to multiple themes and confirmed the holistic view of depression as an illness affecting the whole person. Themes are presented and listed in the general order that they emerged from the interviews. In general, participants began by mentioning their difficulties *describing*

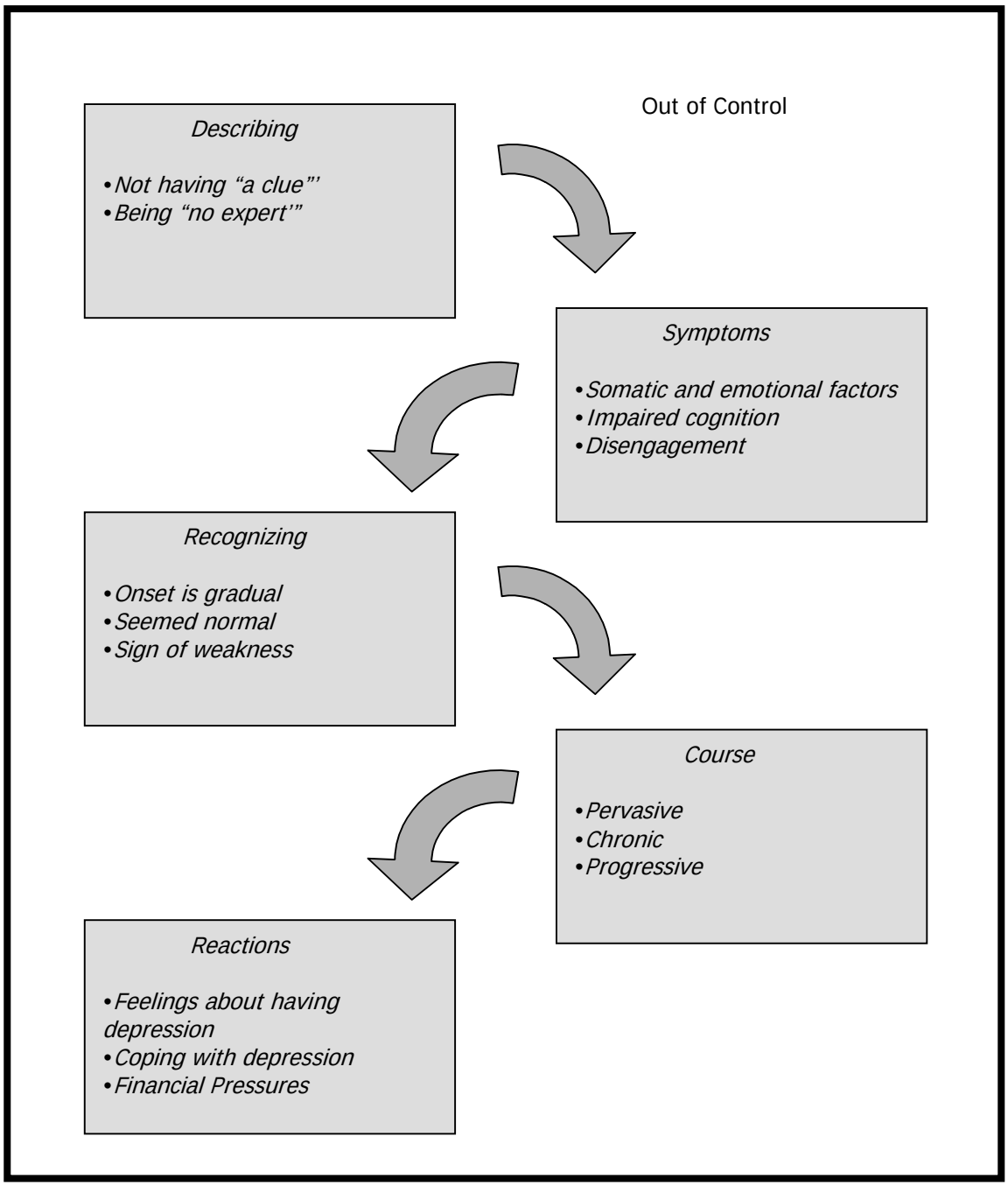

Figure 1: Men's Depression

depression, then went on to mention specific *symptoms*. Once the symptoms were described, there was a general acknowledgement that *recognizing* the presence of depression had taken place over time. Participants then described their expectations about the *course* of the illness, and then finally closed with their own *reactions* to having the problem. Certainly throughout the context of being *out of control* was obvious. No one theme is hypothesized to be of more importance that the other themes. The arrows going from one theme to another indicate how each theme had connections with the other themes. The ground is placed outside the themes to emphasize that it provides a context for each of the five main themes.

Within each of the five themes, there are sub-themes that help to clarify and describe the individual themes. Figure 2 presents an overview of the organization of the ground, main themes, and sub-themes emerging from this analysis of the experience of depression.

The following chapter explores the ground and the five major themes of this study, along with their relevant sub-themes. The words of the participants are presented whenever possible to elucidate the experience of depression among men while retaining the uniqueness of these descriptions. An explanation of how each theme relates to the ground follows the description of each individual theme.

Ground: *Out of control*

Theme One: *Describing*

Sub-theme A: *Not having "a clue"*

Sub-theme B: *Being "no expert"*

Theme Two: *Symptoms*

Sub-theme A: *Somatic and emotional factors*

Sub-theme B: *Impaired cognition*

Sub-theme C: *Disengagement*

Theme Three: *Recognizing*

Sub-theme A: *Onset is gradual*

Sub-theme B: *Seemed normal*

Sub-theme C: *Sign of weakness*.

Theme Four: *Course*

Sub-theme A: *Pervasive*

Sub-theme B: *Chronic*

Sub-theme C: *Progressive*

Theme Five: *Reactions*

Sub-theme A: *Feelings about having depression*

Sub-theme B: Coping with depression

Sub-theme C: *Financial pressures*

Figure 2: Outline of the Ground and Themes

Participant Demographic Information

In order to place the research participants' themes into an appropriate context, demographic information about the participants is shared next. Ten men were interviewed for this study. All were receiving therapy for depression at the time of participation, and all self-identified as having depression. Eight of the men were Caucasian, and two were African-American. Race was visually determined and then verified with each participant. Their ages ranged from 30 to 61 years old, and the average age was 46 years old. All names used in this study are pseudonyms to protect the privacy of the participants. Each participant approved his brief personal description presented below:

Ben is Caucasian, 61 years old, and works as a telemarketer. He has one-year sobriety in his recovery from alcohol dependence. Ben is divorced, and sees his adult son and daughter only occasionally. He lives in a shelter for homeless men but hopes to find his own apartment soon. He is an accomplished musician who has written symphonies and had his musical creations performed by entire orchestras. He has been taking antidepressants for over twenty years.

Gene is Caucasian, 38 years old, and works part-time in a factory. He is married and has two middle-school aged daughters. His family lives in a home owned by his mother. He has been taking medications for depression for two years.

Thomas is 37 years old, African-American, and works in a nursing home. He is divorced, and has three daughters with whom he is currently working to regain contact. He is in a residential treatment program, recovering from cocaine and alcohol dependence. He hasn't used in over a year, and has been taking antidepressants off and on for four years.

Ricky is 58 years old, Caucasian, and currently looking for work. He has previously been very successful in security sales, but lost his position with the market response to the Sept 11th attacks. He has been taking antidepressants for the last three years. He is divorced, and does not see his two adult children.

Dennis is 45 years old, Caucasian, and currently unemployed. He lives between the homes of several relatives. He has never been married, and has no children. He said that he was like his father, in that he was "good at getting women, but not good at keeping them." Dennis says that he has been taking medications for depression for his whole life.

Mike is 43 years old, Caucasian, and currently applying for disability status due to an injury sustained while working in a factory. He is single and has no children. Mike has been taking antidepressant medications for the last five years. His favorite thing to do is to visit a girlfriend's house, "cook a pizza" and watch her kids play.

Evan is 56 years old, Caucasian, and currently unemployed. He was previously very successful in automobile sales and indicated that he once "made more money than the President of the USA." He is divorced and has two adult children. Evan has been prescribed antidepressants for two years.

Jeremy is 46 years old, Caucasian, and self-employed. He asked that the study not describe any factors relating to his job out of fear that "maybe no one would hire me if they knew I was depressed." He is married, with two young children. Jeremy is one of only two participants from this sample not taking antidepressants. He says they are just a way to "cover up" problems, and fears they would interfere with his ability to work.

Tony is 48 years old, Caucasian, and recently unemployed due to mounting physical problems. He is currently appealing his denial for disability payments from the government. He has been taking antidepressants for the last three years. Tony is divorced, and does not often speak with his children.

Aldron, is 30 years old, African-American, and dually employed in the management and music industries. Aldron is gay though not currently in a relationship. He is not taking medications for depression at this time.

Description of the Ground: Out of Control

The themes emerging from this study all presented within the context of a larger, organizing experience referred to as the ground. The ground provides the context from which each of the themes emerged. In this study, participants described depression in terms of being *out of control*. The men in this study

described their struggles with the unpredictability and powerlessness inherent in the experience of depression.

The experience of being *out of control* was evident in each of the themes emerging from the data. As the men discussed how the act of *describing* depression is “difficult and confusing”, they simultaneously were developing the theme of having difficulty articulating their inner experiences. In their descriptions of the intrusive *symptoms* of depression, the men detailed both the deleterious effects depression had on their emotions, thinking, behaving, and physical selves, and their own inability to manage or avoid these symptoms. As the men described the insidious onset of depressive episodes that clouded their recognition (*recognizing*) of new episodes, they revealed their own perceived failures in self-awareness. The descriptions of men’s expectations about the *course* of depression leave an unmistakable impression of the powerlessness men feel when unable to step outside of the pattern of recurrent, worsening depressive episodes that devastate their lives. Finally, descriptions of men’s personal *reactions* to having depression reveal their emotional responses to the experience of being *out of control*.

Direct quotations are provided to illustrate the presence of the ground, *out of control*. As the men described their experiences with depression, their awareness of lacking control was ever-present. Although the following quotes contain different themes, the commonality is the underlying presence of the ground.

The following is a concise example of one participant's belief that he had lost a sense of control as a result of depression.

> It just basically got out of control and instead of me controlling it, it controls me at times. (Thomas)

Gene relates having depression to a "sign of weakness", and alludes to that sense of having lost control. Evan echoes that same sentiment. The image of Evan being resigned to wearing slip-on shoes is a particularly striking depiction of the erosion of control inherent in depressed men. Within the following quote, the researcher's words are presented in italics.

> Oh totally, you're an adult you're supposed to be able to keep yourself in control. I let this happen. *It was hard because depression was a sign of weakness?* That's what I felt like. (Gene)

> And, I always attributed mental problems to weakness… you just need to get over it. Pick yourself up by the bootstraps or something like that. But uh, mental problems to me is not being able to function, not being able to the do the things that I used to be able to do. Having to have help when I used to be able to do everything, totally, I didn't need any help from anybody, any source, any way. I could have fifteen things going at once and be in control. You know. But now I wear slip-on shoes so much of the time. (Evan)

The loss of control was described as pervading all areas of one participant's life.

> *One of the things I'm hearing is that depression feels like being out of control.* Exactly, its like I have no control over anything that I'm doing now. (Mike)

In the next two quotes the sense of hopelessness and finality that accompany depression, and how that sense of life becoming a "down hill ride" becomes synonymous with lacking control in one's life.

> I just feel like I've been let down because I lost my job because I was sick and I have no control over it, and that depresses me. What have we come to in life? I can't go and produce, and then I don't matter. (Tony)

> It's a down hill ride, the whole time. Every road you go down, no matter what the road you choose it's going to lead you to your grave, and that can be a depressing thing. (Dennis)

In conclusion, the experience of depression among men is closely tied to being *out of control*. The preceding quotes depicted a variety of situations all bound by a common ground. Additional information regarding how being *out of control* relates to the individual themes follows each of the five main theme's descriptions.

Theme One: Describing

The transcripts collected during this research project depict men actively struggling with forming their verbal descriptions of depression. The following quote was the very first sentence provided by the first participant interviewed for this project and underscores the difficulty inherent in verbalizing his account.

> I have never really been able to describe it very well. I knew that when I was thirteen, one day something hit me that I just felt bad, uh I felt unhappy. And, I realized that I always felt unhappy. I could never really describe it though. (Ben)

Another participant during the tenth and final interview conducted for this project began by providing a similar disclaimer for his accounting of depression.

> Well, describing it is really difficult and confusing. I don't know what to say. (Jeremy)

Yet another participant wondered if his depression might not be a manifestation of his selfishness. Those worries contribute to making the experience of depression hard to set into words.

> It's very hard to describe. It could be partly because of my own selfish wants and needs are not being met. (Aldron)

Quite literally from this project's beginning to end, the men referred to the difficulties they encountered in giving verbal form to the shapelessness of their depressive experience.

The men in this study found describing depression to be complicated and complex. Their accounts further clarify how such describing difficulties yielded problems in knowing how to proceed in the interviews, and led these men to reject viewing themselves as sources of expertise on their own experiences. Additionally, the men described how they hoped to somehow benefit themselves and others by forcing themselves to talk about depression even though it was difficult.

In the first theme of *describing*, the types of quotes generally fell into two separate, but related categories. Those two categories were deemed to be sub-themes of the first major theme. Names for the individual sub-themes in this study have been taken directly from the interview transcripts, and the individual sub-themes for the first major theme are indicated as *not having "a clue"*, and *being "no expert."* Examples relevant for both sub-themes follow.

Sub-theme A: Not having "a clue"

As described earlier, one significant aspect of the experience of depression is the difficulty the men had while trying to describe their depression. One particular aspect of that difficulty was the feeling of *not having "a clue"* about how to proceed. The men described different manifestations of this phenomenon.

One participant described his previous career as a sales manager at a large office, one in which he had previously been very successful and had earned financial rewards for his ability to close deals and manage many deals at once. He reflected back on registering at the local mental health center for therapy, and what that process was like.

> I had to take paperwork to (mental health center) yesterday and had to get my daughter to fill it out. The mind is so complex. You can't just do what you want and then you just sit there for no reason, no reason whatsoever. She says what's wrong? I say, well, I don't know. I don't have a clue. And, uh, I get tore up over nothing. (Evan)

Predictably, those difficulties of knowing where to begin presented themselves in the qualitative interviews as well. Each interview began with my request for the participants to describe their experience of depression. Occasionally participants were unsure how to proceed, and they were given reassurance and minimal directions. One such exchange went as follows. Again, the words of the interviewer are presented in italics.

> Uh ... You want me to talk about the effects of it or how I, I felt about it. I don't know what you're wanting. *I think either one of those would be*

> *fine. Why don't you start with what seems the most important right now.* (Ricky)

Here is yet another instance illustrating how the difficulty of describing depression was manifested. Ironically, the participant clearly grasps his inability to easily verbalize his experience. Again in this example, the ground of feeling *out of control* is evident in his response.

> Sometimes it surprises me, I'm reasonably intelligent and I'm sure of that, but I can't verbalize it. I can't talk about it the way some people do. With some people it just comes out and you're like "wow, how'd you do that? Can I quote you on that?" And I just can't figure out a way to express it, other than "leave me alone." I don't know. (Ben)

Another participant described how problems with communicating about his depression led to difficulties with his wife.

> I believe that's why she found it hard to communicate with me, and I found it hard to talk to her because I really didn't want to feel like shit because I really couldn't communicate with her. (Thomas)

Next, while attempting to put words to a frustrating and confusing aspect of depression, the participant became caught in his own words and suddenly expressed awareness of looking like a "crazy man." The ground of being *out of control* continues to be present.

> It (the depression) just basically got out of control and instead of me controlling it, it controls me at times. I have to get refocused on what I'm doing and then now it's to the point when they had doubt on their own, and I have to turn around and make amends. I'm sounding like a damn crazy man when I'm saying this I'm like 'shit what the hell!' (Thomas)

The following extended quotation displays how even the diagnostic label of depression is not helpful in communicating anything meaningful about his experience. For clarity's sake, the interviewer's words are in italics.

> It always seemed more basic, more basic yeah. I only seized on that explanation as an intellectual label. It's the only way I can describe to somebody else, "oh I'm depressed, I'm clinically, and chronically depressed. I'm on medication." It's just a piece of language to me. *Can you say some more about how depression is an intellectual piece of language?* Oh it's just in explaining it to others. Uh, it doesn't really explain what's going on with me, I really I've never been able to verbalize that very much very successfully it seems to me. It's just kind of a label as far as I'm concerned. *A label?* Yes, a very big one, a large one that covers a lot of territory. (Ben)

Considerable effort has gone to establishing a diagnostic and classification system of mental disorders that yields meaningful categories. All of the men interviewed in this study self-identify as having depression and also have been formally diagnosed with depression. However, for these men the diagnosis alone does not help to convey the specifics of their lived existence.

Sub-theme B: Being "no expert"

Meeting the interviewer at the door of his home, one participant quickly introduced himself and then seemed almost embarrassed to say that he wasn't sure he could be of help to me and with the study, because he wasn't sure if he could separate his depression from his life situations. In his case, the situation was the stressful day-to-day experience of living with chronic pain and enduring financial hardship. In his interview he described his difficulty knowing if his reactions were due to stress or depression.

> I thought I've just been under so much stress. I thought that this is another level of stress, it's not really depression. (Gene)

The men in this study had difficulty explaining their own experiences, and frequently relied on other sources of expertise to convey their information. One participant, evidently prepared in advance for his interview, brought a quote from a respected novelist to substitute for his own expertise.

> I ran across a great description a couple of days ago in reading; it's by this guy that is an alcoholic in recovery. He's a novelist. His descriptions manage to put his insights on paper pretty well from time to time. One of them is that depression or recovery or management of depression is like, uh, let me just read it, like "a gray neutral area like people have clipped all the sharp edges off their souls until they seem to be operating on the spiritual energies of a moth." (Ben)

Another participant (Tony) worried that he had been off track during the interview, and doubted his ability to be useful. After an intensely emotional interview he called his words *silly*.

> Well I probably went off track because I've got some frustrations, but I'm happy to help out. I don't know that I've been able to help any. I know I come up with some silly stuff. (Tony)

In closing another interview, the interviewer thanked a participant for sharing his expertise on the topic. His response was sharp. Participant Dennis said "I ain't no expert, I'm a drunk and a druggie that's read too much. He then went on to extend the role of "no expert" to all humans, referring to the difficulties inherent in understanding one's own species. When asked if he could talk about his experience of depression, he responded as follows:

> I can talk about it a little bit. I've dealt with it all my life. Maybe I understand it a little bit. But, the profession you're studying and all you

> may not believe this but I don't believe it's possible to possess a human mind and understand the human mind because you're working with the same equipment. (Dennis)

For the men in this study, *describing* depression is an experience that is difficult to communicate to another person. Although these participants have lived with the problem for many years, they still felt uncomfortable, and belived they had few qualifications to make comments about depression or their experiences.

Relationship of Theme to Ground

The ground is the backdrop against which the main themes become figural. For this study, the themes appear to all exist in the context of a ground of being *out of control* and these themes in this context were experienced as depression. The particular theme of *describing* figures prominently against the ground and underscores the hopelessness felt by the depressed men in this study. For the 10 men interviewed, they all shared the notion that they should maintain a high degree of personal control at any given time regarding their lives. When the men couldn't find an acceptable explanation for their problems, the experience took on the color of feeling *out of control*. As the men in this study described *not having "a clue"*, and *being "no expert"*, they expressed thematically the difficulties of describing depression, while further developing the ground of being *out of control*.

Theme Two: Symptoms

The second major theme to emerge from the data was the men's description of various *symptoms* of their depression. Most people tend to describe any illness they encounter using the nomenclature of symptoms. It is perhaps inevitable then, that one major theme to emerge would be the various depressive symptoms as recognized by the participants. It must be emphasized that the men who participated in this study reported symptoms of depression that ran the gamut of all possible DSM-IV symptoms. Their scores on the most widely used quantitative assessment of depression (BDI-2) were sufficiently high as to require broad endorsement of complaints, as well as serious impairment resulting from those individual symptoms. The specific scores and quantitative analysis of the BDI-2 information are summarized in Appendix F.

In reviewing the *symptoms* presented by the men in this study, three factors emerged. Although statements from participants sometimes contained references to multiple factors, the three factors in their various combinations did account for very nearly all the symptom statements presented in the transcripts.

The three sub-themes from this second major theme of *symptoms* are: *somatic and emotional factors*, *impaired cognition*, and *disengagement*. *Somatic and emotional factors* represent bodily and affective responses. *Impaired cognition* represents the mental slowing and dullness that often accompanies depression, as well as the impaired abilities to accurately perceive one's own attributes, alternatively called cognitive distortions. *Disengagement* represents

the tendency to isolate, avoid, and in the words of a long-time patient "hermit-ize" one's self. As will be displayed, the symptoms of depression influence the life worlds of the participants in their physical, cognitive, emotional, and behavioral domains.

The current section will describe the specific symptoms and sub-themes that emerged as figural in this particular group of men's experiences. The three sub-themes are interrelated.

Sub-theme A: Somatic and Emotional Factors

As an example of how one's emotional life is impacted by the symptoms of depression, one man reported its pervasive effect on his emotional life.

> You just, it (depression) just pretty much sucks the life out of you. It is the best way for me to put it. I just don't function normally how I do. My job, family life, just everything...it has affected everything in my life emotionally. (Jeremy)

One participant further described his depressive experience in terms of its emotional components. Note also the reference to being unsure of how to manage the symptoms, and its relation to the ground of being *out of control*.

> Well the first thought that came to my mind was that I feel sad all the time, I feel alone, and I feel angry. But most of all I feel alone. I felt all these feelings inside of me and I didn't know what to do with them. The greatest feeling that I ever got from it was being alone, and it is scary to be alone. (Thomas)

Anger and irritability were common emotions resulting from the experience of depression. In the following interview excerpt, the link between depression, somatic symptoms, and frustration is described.

> Just like two nights ago I was walking in the driveway and it was just like someone had turned off a light switch in my leg, I just fell. I got real depressed then. There was a piece of pipe laying on the driveway and I just beat the ground. I was like “God what is going on?” You know, its like this is crazy. I went back in the house and I was irritable with them (family members), you know ‘get out of the way .” (Mike)

The link between feeling physically drained, and depression was also described. Both the mental and physical aspects are exhausting and can take the ”physical heart” from those suffering. The following quote displays the interrelation of one’s body, especially the face:

> And, I would just have a look on my face and I wouldn’t even work 4 hours and I felt like I worked 14 hours. Seems like most of depression is has really just took, and of course I have a physical job, but it has took a lot of physical heart from me. The mental part, but the mental part is harder on me than the physical part working. (Jeremy)

Other well-documented ways that one’s physical body is affected by depression include variations in sleeping and eating. The following two quotes display how irregularities in sleeping and eating also cause changes in mood and self-esteem, and are linked to the other themes of *impaired cognition* and *disengagement*.

> I usually slept about four or five hours a night, now I sleep, I could sleep probably 12 or 14 hours a day. That is very unusual for me, I just don’t do that. The loss of interest in pretty much everything. My kids are probably the most important thing to me in my life and I don’t spend the time with them like I know that I should. I don’t have the energy, or the patience. I just don’t have the energy. I am tired all the time. I just feel bad. (Jeremy)

> I wasn’t really sure at first what it (depression) was. I just didn’t know what to do or what it was. It seemed like it started to snowball and got to the point that I started eating, seemed like I was hungry all the time. I started eating more than I normally ate and put on weight which made me feel even worse. The problems that, the actual problems that we had

> made me feel even more like putting weight on. It was just overall, I feel pretty miserable unfortunately. (Thomas)

Another participant used more traditional words to describe his emotional symptoms of depression. Anhedonia and sadness are among the most common complaints of depressed persons.

> I think the biggest thing that I've been finding is that I have no enjoyment in things that I used to enjoy, sadness and feeling guilty about things, just kinda sad. (Aldron)

The *somatic and emotional factors* of depression represent significant impediments to men's abilities to function as usual. The lack of predictability and difficulty in explaining the situation worsen and increase the sharpness of the symptoms. *Somatic and emotional factors* interrupt one's ability to concentrate and detract from attention that could be turned to routine matters, influencing the men to become further disengaged from their relationships and jobs. In the next section, attention will be focused upon how depression leads to *impaired cognition*.

Sub-theme B: Impaired Cognition

The participants in the research project described being aware of experiencing cognitive changes. Reported symptoms of depression included both interruptions in the ability to think clearly, and changes in the content of the men's normal thought patterns. Both types of symptoms have been grouped into the *impaired cognition* sub-theme.

Two of the men from this study used the word “cluttered” to describe how their minds appeared to them when depressed. In the first example, the metaphor of a computer shutting down mid-application captures the debilitating effects of such cognitive impairments.

> It’s like these computers, I believe some of them didn’t use to have a fan in them, and if they get too heated they’d just shut down and that’s just exactly how my depression is. It get so cluttered up there and nothing is going in or coming out and it goes ‘whirrrrrrrrrrrrrr’ and that’s when I find myself doing a lot of sleeping, can’t eat, and just going down and down and down and I just burn out. The mind can take but so much before it burns out and that’s what my depression is. (Thomas)

In this next example, the cluttered sensation forces dramatic changes in how the man is able to interact in the world.

> I am usually pretty quick witted with a response. But I could be thinking about something and doing something else and actually doing the two at the same time, but now I am lucky to concentrate on what I am working on at the time. My mind is not numb, but it is like it is cluttered. Like I can only see a certain area whereas before I could see all the way to the side. Now I can only see what is straight in front of me now. That is how my mind works. ... It takes an effort to follow a conversation whether it is me talking or it is them talking. It is an effort to consciously, to stay in that conversation without wandering or losing path of it a lot. (Jeremy)

For the men in this study, the cumulative effects of *somatic and emotional factors* of depressive symptoms, combined with changes in thinking to produce negative self-images. One participant summarized the sadness, and hopelessness he felt by saying the he was “lower than whale shit”, and went on to say that the symptoms of depression meant to him that his “life served no purpose.” That same participant explained that depression forces him to ruminate on his life’s

failures and poor choices, and how that pattern leads to a negative emotional state.

> It (depression) will stop your mind, it will. You can't concentrate on anything, you don't have any motivation to do anything. You just sit and dwell on things. Do you know what I'm saying? Like something that's been, just keeps running through my mind, when I was a kid we killed a dog. Me and a couple of other boys, I don't know why we done it. I done it because I was scared they'd think I was yellow. We took it out in the woods, tied it up and beat it to death. I mean that's just haunted my mind. I still hear that poor dog growling. That's a thought that sticks with you and comes to your mind sometimes. *Tell me how that's related to depression.* Well its just one of the things I feel bad about in my life, and that I can't see any cause for. (Dennis)

Another cognitive change appearing as symptomatic of depression was the tendency toward negative thinking. The men described anticipating negative reactions from people, and looking for the negative side of daily events. Unchecked, these patterns can develop into thoughts of suicide as the following quotes display. First, the pessimistic bias emerges in the private view of the world.

> To me depression is looking at the down side of everything, which you can't help but do it sometimes. As far as the way I'm feeling, I'm feeling pretty good today but they say the mind can make 'a heaven of hell or a hell of heaven .'' Depression is putting yourself through hell, looking at everything bad. Looking at the bad parts of life and not seeing the good parts. (Dennis)

> It's just like yesterday the lawnmower broke, and it's automatically my fault. But there was a gear inside of it you know that broke, and wasn't nothing I could do about it, but it was all my fault then. (Mike)

Next, the bias is extended to the individual's interactions in the world and becomes the expectation for the future.

> The depression, well when I'm depressed I just think what else is going to happen to me, you know. What's next? What's going to go wrong today? What's going to break? Who's gonna jump on me when I get home for something? (Mike)

Once the expectations for the future are seen as negative, the question of how long to tolerate that distress raises. These negative patterns and impairments in cognitions can become unbearable, forcing one to consider if they might be better off dead.

> You think well, "would I be better off just dead, is today a good day to just die and just end it all? You know I'm over it, how much more of this can I take?" (Mike)

The change in thinking is clear in the following example. This participant is describing how his focus has moved from "living" to "not dying."

> Most people think that people with mental problems get up in the morning and they say well I've just got to live through the day, just got to get through the day. Live through the day. There have been a lot of days where I just had to figure out a way not to die that day. (Evan)

Clearly, the change in cognition is a symptom infused with major significance to the men living with depression. The cluttered, blocked-up feelings and thoughts of suicide that the men describe within the context of their changes in thinking often overlap with their tendencies to disengage as well. Again, the concepts of impaired cognition and isolation are evident from this participant's description.

> Not being able to focus on anything, and thinking about that problem all the time. Obsession with trying to get them back into my life. Then during that period of time not being able to work, not being able to concentrate, no desire at all to do anything that was right, um maybe that's the wrong word but I just didn't care about anything around me, or the values I had been raised with. I just didn't care. So that was a part of the depression for me, it really changed the way I felt about life. (Ricky)

Impaired cognition presents itself as a depressed symptom in two primary ways. From the quotes presented, cognitive impairments present as both a cluttered sensation blocking normal thinking processes, and as a change in the content of thoughts themselves, to those that are increasingly negative. The symptoms disrupt normal functioning and appear to be very significant in the lives of the men participating in this study. One participant paraphrased the words of John Milton in *Paradise Lost* as a fitting description of depression's effect on thinking; as he stated, the mind "can make a hell of heaven." The metaphor of a fall from grace represents the depth of hopelessness and suicidal despair that can grow from depression.

Sub-theme C: Disengagement

One of the core *symptoms* men reported is of feeling the urge to distance themselves from others. The third and final sub-theme from the symptoms theme is therefore, *disengagement*. Men in this study were aware of disengaging from their work, families, and selves. Relations between the sub-theme of *disengagement* with other symptom sub-themes of *somatic and emotional factors* and *impaired cognition* are presented as well.

The experience of *disengagement* is described in confining terms, as in a shell that one "can't get out of", and a type of self-inflicted solitary confinement during which a person "shuts down."

> Well internally I just don't feel hmm, I can't get out of my shell. It feels like I'm in a shell that I can't get out of it. (Ben)

> I wasn't able to talk to my wife, I wasn't able to talk to friends, I wasn't able to communicate with guys on the job. Just basically I shut down, and allowed my mind to just converse with itself, you know and try and work things out by myself. Looking for answers on the inside, and that was kind of like solitary confinement. (Thomas)

The impairments stemming from isolation are apparent. In the following quote, one participant describes his difficulty with even the most basic of self-care tasks, feeding and dressing himself.

> Depression itself is just dark and I can't get up in the beginning of the day and motivate myself to do something, to change attire, to go to work, to feed myself. (Ben)

Once the symptoms of *disengagement* set in, even being around a group of friends can become too difficult to bear. The following quote illustrates the process of withdrawal that the men in this study saw as symptomatic of depression.

> Well, as far as it has affected me in the way I think and do things everyday. I don't want to get up; I don't want to be around people. I find myself more and more isolated. I want to stay in and just…really have no interest in getting out. Which I am a people person so that has always been my thing to be around people and that has changed. (Ricky)

The next three quotes come from two different men. Each described retreating at family gatherings, from their kids, and at home from their wives and families.

> Um, my sister wanted to have an Easter egg hunt here and I told her let me get back with ya. And, I called her and told her I'd rather not. And, I can't handle my own family. I don't like to be around, I don't like, I can't stand to be around crowds. (Evan)

> I don't know if it was standing in the way, but as far as actual depression it was making me where I just didn't care. I was just here. I was, you know I'd come in and most of my time I'd spend on the computer. (Gene)

> Well, not paying attention to the kids, I would rather go off and be on the computer doing stuff for myself instead of doing for the family. (Gene)

Even for men who had described being with others as important parts of their daily lives, the *disengagement* symptoms of depression produced radical changes in their feelings, action, and thoughts.

The linkages between the *disengagement* and *impaired cognition* are explored below. The following description of feeling "robotic" and merely "going through the motions" echoes both the *disengagement* as well as the *impaired cognition* components of depressive symptoms.

> My wife would say "Do you remember doing this?", and I'd think "I didn't do that." Some of it is sort of like a dream, and you know I'd go to work come home and do the same things, just robotic motions. Like I could go through the motions but in my mind really wasn't into what I was doing. (Gene)

In the following quote, a participant describes how his cognitive and emotional symptoms of depression led him to become more isolated and lose motivation.

> I think I've been more fearful, and the fear and paranoia have grown over time. I'm constantly living in fear. That's another thing that has changed. I never would have lived in fear before. I think depression is affecting my life because I just can't go out and go and do the things I used to do, and I'm not motivated to do the things I can do. (Aldron)

The negativity of thought content that also comprises the *impaired cognition* appears in the above quote. Self-condemnation appearing in concert with the eschewal of contact with others appears in the following quote:

> I seep down into that depression where I don't want to eat, I'm condemning myself, I just want to sleep I don't want to be around anybody. (Thomas)

In the following quote a participant explains further how depressive symptoms also increase one's desire to isolate from one's family. He contemplates suicide but rejects that notion for the harm that may cause his family.

> I've been patient to the point that where if I knew for an instant that if it wouldn't hurt my family ... if it wouldn't hurt my grandchildren that look up to me, if it wouldn't hurt anybody around me then I would be like the elephant walking to the graveyard; That's what I'd do. It's time. When I feel like that I am no more use to my family or to people around me, there's no need of me being around anymore. I'm just taking up oxygen. I don't want to be a burden to them. (Tony)

In the last set of quotes detailing the sub-theme of *disengagement*, the relation between isolation and *somatic and emotional factors* is explored. The following two quotes, describe the interplay between the various symptoms and sub-themes.

> Isolation is...there has been days, even as much as a week that I haven't gotten out of my home. And I find myself to be a very clean person, but I find myself not showering or shaving for maybe a couple of days and I look at myself in the mirror and I don't like the way I look...I don't like the way I feel, but yet I sleep a lot during those periods. I find myself sleeping for long periods of time, the staying awake for long periods of time. Sometimes I'll stay up for 24 hours and sleep for 16 or 18 hours. The isolation isn't because, I don't feel it is because of how embarrassed I am. I just want to think, I just really don't have the desire to be around people like that. (Ricky)

> The first things, what affected me the most was just sleeping. I was real tired. The work I do is very physical and I wasn't able to do that...even with these medical problems I could still do my job. Then I got myself to the point, I am real precise about being on time and work and it bothered me if folks were late or didn't show up and I got to the point where I didn't even go to work myself. (Mike)

The following examples display the similarities between the sub-themes of *impaired cognition* and *disengagement*. First, one participant notices the

impact on his cognition and the link to being “zoned out” and withdrawing from work.

> I would slow down at work, and think well is this just me being lazy or is this depression? There’d be times when I’d just be zoned out, I’d know what I’d supposed to be doing, and I’d know I guess where I was at, but it would be sort of a tunnel vision. (Gene)

Another participant describes how he has learned to accept the *impaired cognition*, and the *disengagement* that comes with it. In his case, he is disengaged from any semblance of a career and accepts lower-wage jobs that aren’t overly taxing.

> Depression has kept me immobile a lot. I’ve stayed in jobs that I really didn’t care anything about just because I was there and I could be myself, I didn’t have to think too much about anything. I could just go through the mechanics of things and not have to actually commit my mind to it. (Dennis)

Disengaging from the world of others, from work and interactions with friends and family members, appears as an important symptom in men’s descriptions of experiencing depression.

Relationship of Theme to the Ground

As stated previously, the ground is the backdrop against which the main themes present. For this study, the themes appeared to exist in the context of feeling *out of control*. The particular theme of depressive *symptoms* figures prominently against the ground and underscores the powerful impact that depression has on these men’s bodies, minds, and emotional lives.

All 10 men interviewed described adhering to the notion that they should remain in control of their lives at any given point in time. When the men

encountered life difficulties they could not change, the experience felt *out of control*. The men in this study described *symptoms* of *somatic and emotional factors*, *impaired cognition*, and *disengagement* that directly contributed to feeling *out of control*. In the words of one participant,

> It's like an out of body experience; it something I can't control. I can't grasp I can't hold on to it, and shake it and say "okay here's what I'm going to do about it." It has absolutely affected by abilities to make decisions, so I felt paralyzed. (Ricky)

The following participant (Evan) compares his functioning before and after depression stuck. Prior to depression he says, "I made more money than the President of the USA" and was in control of multiple tasks. Post depression he reflects, "Before I got depressed I could have 15 things going at once and be in control. You know. But now I wear slip on shoes so much of the time."

Theme Three: Recognizing

Men in this study reflected on how their awareness of depression unfolded gradually over time. In this theme titled *recognizing*, men presented information about how the onset of depressive episodes is difficult to recognize. Participants described a process by which they came to be aware of their depression. Specific sub-themes underlying the experience were *onset is gradual*, *seemed normal*, and *sign of weakness*.

Sub-theme A: Onset is Gradual

The transcripts indicate that the beginnings of depression are gradual and incremental, and are more likely to be observed as trends by looking back over

the past several months or years. The men in this study described becoming aware of depression slowly and gradually. They also reported that depression was easier to recognize in retrospect. The following example illustrates one man's experience of recognizing depression after a period of years. He recalls being 13 years old, and reflecting on his current and younger mood.

> I have never really been able to describe it very well. I knew that when I was 13, one day something hit me that I just felt bad, uh I felt unhappy. And, I realized that I always felt unhappy. Well just that times of happiness were really fleeting. Looking back on happiness, happiness just seemed so far away when I look back on it. It wasn't something I would carry with me. You know, I realized then that something was wrong. This is not what I saw in all the people around me or most of the people around me. There was just some sort of energy that I didn't seem to have, some force, some faith that I didn't have. I didn't look forward to anything. (Ben)

Another participant described how living through an abusive childhood led him to develop techniques for survival, and how he only later realized that part of his reaction was a development of depression. It was only after the birth of his third daughter that he could recognize the patterns that started 25 years ago.

> I don't know if it had anything to do with my childhood, or was it something that I just took up as far as a survival technique. I don't know where it came from, but I know what it felt like. It took me having my youngest daughter; I was there for raising her. I have three daughters, and I've been there throughout my youngest daughters' life and I'm watching her experiencing different things, how she feels and everything, and you know it's like I came to find out that "this wasn't right." You know, something inside of me is saying that the way I've been taught and all of these things that I've learned something wasn't right. A child should laugh, and smile, or be sad, or show some emotions and not keep them inside. It's kind of like by me watching people who wasn't depressed; it kind of taught me that you know something was wrong with me. (Thomas)

Another participant describes how depression arrived in conjunction with unexplained health problems. When Mike was injured in a work-related fall, even multiple visits to the physician failed to explain his physical state. After several months of pain and uncertainty about his health, Mike came to believe that his depressive symptoms were related to that fall.

> Yeah, well the doctors kept telling me there's really nothing wrong with me, and I kept telling them, well I have the sensations in my body, and that made me real frustrated and depressed and they'd say "well there ain't nothing wrong with ya." I knew something wasn't right, because before I fell I didn't have this problem. (Mike)

In the next quote, a participant (Tony) describes how he felt his depression begin over a period of time that included failing health and difficulties with work. When he was unable to simply find a new job and 'work' through the problem, he noticed his depression becoming a much more significant force. There is a relation between feeling *out of control*, and increasing feelings of depression.

> And, as the depression began to set in there, when I started losing jobs and I no more could provide the way that I should be able to do for my family, the depression began to set in and I was just like okay, I feel it hitting, and I feel it hitting a little at a time, like it was a small pain. But, I'll overcome this and I will start again and keep going. And it come to a point that it got worse and worse, each job that I would lose because either they sold out or something like that, that I'd have to start all over again and then I guess what brought, the straw that broke the camel's back was when I lost my job because I was sick, because I was actually to a point in my life which I hadn't went through before, that I wasn't able to do what I used to do. (Tony)

Even engaging in psychotherapy for depression didn't signal the presence of the problem for the following participant. He reports that even after seeing the

symptoms listed out in what was probably the DSM-IV he still required “a year or two” before he accepted the diagnosis.

> Well, I sort of tried to fight it, I mean, it’s like there is no way that could be me. Uh, you know I respected the doctors and I am sure this is what you think it is, but could it not just be stress. And, umm, if it was stress that might lead to depression. Um, my therapist took out a book and there was this list and everything she said to me, I was like, “I’m doing that; I’m doing that;” so I talked to her and said “we’ll try it and see how it works”. And, uh, I tell you it probably took a year or two before I actually knew; I’ll agree I have depression. (Gene)

This next participant underscores the difficulty recognizing the emergence of depressive symptoms. Even though his average number of hours slept per night tripled, and he began to withdraw from spending time with his children, he still wasn’t able to recognize the problem immediately.

> Well it is confusing. I really didn’t, for a while, I didn’t know what it was at first. I as usually slept about four or five hours a night, now I sleep, I could sleep probably 12 or 14 hours a day. That is very unusual for me, I just don’t do that. The loss of interest in pretty much everything. My kids are probably the most important thing to me in my life and I don’t spend the time with them like I know that I should. (Jeremy)

He goes on to explain that his awareness developed only after he was “pretty much down” and that he was able to recognize it much better in hindsight.

> Well, for myself I always handle situations pretty well…“crises”, emergencies, or whatever. I know from my experience dealing with all of this that the depression, I had depression a whole lot longer than I thought I did after I sit down and look at it. I didn’t realize that I was depressed until I got just pretty much down. (Jeremy)

Failing to detect a problem early on means missing the chance for early intervention. The feeling of being *out of control* is evident, as well as the sub-theme of a *sign of weakness*, which will be described below.

> Yep. Yeah, and probably if I had recognized it earlier I would have probably sought help before this point for sure. I didn't realize how bad the depression was. You're an adult you're supposed to be able to keep yourself in control. I let this happen. It was hard because depression was a sign of weakness. That's what I felt like. (Gene)

Even living with a wife whose depression was so serious that she made several suicide attempts didn't help the next participant recognize his own depression. Prior to personally experiencing depression, he held erroneous beliefs about what depression was like.

> At one point in time in our marriage, I always thought this, because I was brought up in church; I thought faith could overcome all things; and if you're depressed you could just stand up and God will take it all away, and everything's gonna be okay. My answer for the person would be "okay, I love you and God loves you, you just gotta hear that and go forward". (Tony)

> But, going through all of that and the way I concepted what depression was, and until my life and come to the point it is at this point of depression, now I know and understand what she felt. At that point, when I made a conclusion or judgment call I was going about it all wrong because I had no idea or conception what depression really was. (Tony)

Looking back on times before he recognized his own depression, the next man explains how the difficulty noticing the presence of depression makes the experience all the more problematic. In the quotation below, he is responding to the interviewer's prompt to describe the worst part of depression.

> (The worst part is) Not being able to explain it or recognize it and probably have to go through it alone. If you can't explain it and don't recognize it you can't have anybody, it is hard for anybody to help you...whether it is a spouse, a brother, an uncle or whoever. It is hard to go share this to have anybody to give you any kind of comfort because sometimes you don't realize you're even depressed or why you are depressed. I know I've been asked before why are you depressed and at the time I had no idea I was depressed. (Jeremy)

Sub-theme B: Seemed Normal

The men in this study often reported that depression was difficult to notice because their lives seemed to be no different from what they felt was a reasonable expectation. The men frequently discounted the possibility of depression, and were more likely to point to co-occurring stressful events as culprits for resulting changes. The following quotations display this pattern of attributing an internal mood state to external situations.

One participant described his neighborhood as being a depressing area filled with drug dealers, addicts, prostitutes and homeless people. In describing his home and surrounding area, he attributed some of his depression to living in what he calls “Crackville.”

> I hate to even drive home sometimes. I was at the airport the other day and they said, “what are you going to do,” and I said “well I guess I’m going to go back over to Crackville and be around that section of town,” because that’s where I live. Just going there makes me depressed. You know if I could get 100 miles away from here and 50 miles from the nearest person it would probably make me happier. (Mike)

Another participant described wondering if he wasn’t mistaking his normal bodily sensations, such as tiredness, for depression.

> Describing depression is difficult. I think I’m depressed; why do I think I’m depressed? Well because I’m so sad all the time. I think because I’m always coming or going to work, I spend so much time working. I don’t know if I’m confusing depression. Am I just really tired, or am I depressed? (Aldron)

Another participant described his family as “depressive” and explained how growing up with depression as a norm impaired his ability to recognize the depression.

> Absolutely, because it’s all I’ve known and I grew up in a depressive family. My parents were clinically depressed, it was my model and, well the family was fragment in that way. Nobody was very close. It’s all we had to look to each other for and about, and even outside the family. (Ben)

The next quote shows a combined awareness of familial factors as well as a focus on individual differences. The participant considers that perhaps it’s ‘normal’ for him to feel depression, since natural variation exists in mood states across people.

> I think it’s just normal for me to do that. Not everybody’s mind works the same. I’ve heard that my mother was diagnosed as manic-depressive or whatever they’re calling that now bipolar, they change terms every few years to make it look good. I think Lincoln was too but, I think a lot of what they classify as mental illnesses and things are just, well everybody’s mind doesn’t work in the same way. (Dennis)

Even when one participant used behavioral markers to measure his mood, recognizing depression was difficult. He describes how with treatment, his self-assessment changed from “doing all the same things as before” to a father that was “not spending time with my family.” He cites the improvement realized by psychopharmacology as responsible for his shift in thinking.

> I felt like I was doing all the same things as before, I felt like I was involved in the family, that I was trying to do the work, and at the time I wasn’t working but I was going to school. ... I guess it was after I got on the medicine I started thinking maybe this is depression, and I started feeling a little better. I realized wait, I’m not spending time with my family. (Gene)

In the final example from this subsection on the sub-theme *seemed normal*, the linkage between disappointment, rejection, and one's own shutting down as a protective mechanism is evident. The participant quoted below is clear to state and repeat that he was originally thinking of his behavior as a "normal thing to do" and that uncovering his own depression was a confusing process.

> Well I believe that it started as me cutting myself off from my own feelings, because of the feelings that I had for my mother and the closeness and everything that I had, and I saw that the attention and the love that she gave to me was all cut off and I wasn't getting it anymore. I also did the same thing, inside myself I cut it all off towards everybody else and I don't know, maybe I thought it was a normal thing to do. It's coming out now that it's not normal, and I'm like "shit how the hell do I do this? How do I turn it around?" (Thomas)

Individuals in this study described difficulties noticing depression due to the gradual onset of what appeared to be normal reactions to stressful or disappointing circumstances. The men who participated in this study identified one additional barrier to identifying their own depression, and to accepting the label of illness that accompanies the diagnosis. In the next section, the quotes describe the tendency to view depression as a *sign of weakness*. For the men in this study, that particular outlook seems to affect one's ability to recognize the symptoms as part of an illness.

Sub-theme C: Sign of Weakness

Most people will hesitate to accept negative roles. The men interviewed for this study describe having originally viewed depression and mental illnesses

as personal weaknesses. It is not surprising then, that they also found being aware of their own depression difficult.

One participant described his negative feelings about depression, which inhibited his acceptance of the illness. There are also linkages to the ground of feeling *out of control*.

> To me it was a sign of weakness. I worked from when I was in high school, to where I probably really didn't, but I felt like I had complete control over my mind body and soul. ... But I really felt like I had a handle on my mind, I could keep my mind focused on what I needed to do, envisioned where I'm gonna go, and when (depression) happened it was just like "was I kidding myself"? (Gene)

Another research participant described how he felt about mental problems in an abstract sense, and how he felt about depression when related to other people. Once he began to experience symptoms he felt a major change in his ability to manage his own affairs.

> And, I always attributed mental problems to weakness... you just need to get over it. Pick yourself up by the bootstraps or something like that. But uh, mental problems to me is not being able to function, not being able to the do the things that I used to be able to do. Having to have help when I used to be able to do everything, totally, I didn't need any help from anybody, any source, any way. (Evan)

This same participant became tearful during his interview. When asked if he needed a break, he said "There ain't nothing wrong with my boat." Eventually he did ask for the tape to be turned off and began sobbing. After a few moments, he collected himself and apologized profusely. This strong emotional reaction must have seemed to be further evidence of showing *signs of weakness* or being *out of control* to this participant.

Another participant described his view of depression as weakness. He states that being overly emotional is a weakness that leads to depression.

> I guess emotion overrides logic, and I have a very difficult time putting my mind above my emotions. Very emotional person, and I think that leads to depression. (Ricky)

In the following quote, Tony describes living with depression with a metaphor emphasizing his need to be "rock solid" and dependable for his family. He describes feeling as though he were a "crumbled cornerstone."

> Okay, as a male figure, and as I look at it as a male, you're always taught when you're young that you're the man of the house, and it's your responsibility to be there no matter what, you should be the strongest, you should be the cornerstone, and you should be able to hold everything together. Well that's not true. I find in conclusion that's not true at all. Because now I feel a failure, a crumbled cornerstone; not one that is there that someone could depend on. (Tony)

The men in this study described their view of depression as a *sign of weakness*. They explained that it was difficult to notice depression as many of their behaviors *seemed normal* at the time. They also indicated that the *onset* of depression *is gradual*. Next, the relationship of the theme of *recognizing* to the ground of *out of control* will be described.

Relationship of Theme to Ground

The major theme of *recognizing* and its constituent sub-themes emerged within the context of the awareness that depression is an *out of control* experience. The men described that depression arrived gradually and felt normal until they reviewed their lives in retrospect. Men thought their lives were under control, but they later realized this was not the case. The following quote was

presented earlier, but it bears repeating for it clearly exhibits the difficulties of identifying depression, its gradual onset, relation to weakness, and the ground of feeling *out of control*.

> Yeah, and probably if I had recognized it earlier I would have probably sought help before this point for sure. I didn't realize how bad the depression was. You're an adult; you're supposed to be able to keep yourself in control. I let this happen. It was hard because depression was a sign of weakness. That's what I felt like. (Jeremy)

The general notion that depression and mental problems are a *sign of weakness* caused these men some hesitation in accepting their problems. The identity of a person with mental problems was not commensurate with the view of self as being "in control" and therefore impaired the men's ability to notice their own experiences. The gradual onset, and the men's appraisal of their situations as being due to some normal event also contributed to difficulties of noticing the onset of depression.

Theme Four: Course

Men in this study reflected on how widespread the effects of depression had already become and also looked to the future of their illness. In the theme named *course*, the men described their views of depression as *pervasive*, a prominent disruptor of their lives that will likely be *chronic*, and a lifelong struggle that would likely worsen with time in a *progressive* nature.

Sub-theme A: Pervasive

The research participants in this study described the idea that depression is *pervasive*, impacting all areas of their lives. The participants were very direct

in reporting how widely they felt its effects. The quotes are brief, and the words used are generic and they are often absolute terms such as “overall,” “everything,” and “everyday.” For example, “It was just overall; I feel pretty miserable unfortunately” (Jeremy), and “Well, as far as it has affected me in the way I think and do things everyday” (Ricky). Another participant’s description of the omnipresent nature of depression is presented below.

> It definitely has affected the way I go about my everyday life. It’s changed the way I think, feel, do, everything. (Ricky)

Depression’s effects are broad and life changing. The wide-ranging impact on one’s mood is evident from the quote below. For this participant, depression brought about serious changes in personality and outlook.

> (Depression affected) just about pretty much everything. Any personality that I had or trait or whatever it wasn’t what it was originally. Now I am irritable all the time. It just changed my outlook on life unfortunately. (Jeremy)

One participant averred that his depression began following a failed relationship. Once his ties to his wife were dissolved, he subsequently lost contact with his children and depression ensued. He has difficulty separating his loss from the actual depression even today some 15 years later. He described the enduring effects and the all-encompassing changes in his life.

> Then when I lost my family, my children, my wife that was the most devastating thing that had ever happened to me, and still is. I’m still affected by it every day. My whole life changed because of that. (Ricky)

Another participant described becoming aware of the effects of depression gradually. The metaphor of depression described here is a monster that is *out of control* and creating havoc.

> I always said that's not who I am, and it's just these different characteristics that's a part of my past that I refuse to accept, but when it shows its ugly face every now and then, I guess I don't want to admit it. It hurts. It hurts. It just brings me down, because I guess I don't want to admit this is who I am, and this is what I am. It's hard for me to say this is just a part of me. I guess it's like the Dr. Jekyll and Mr. Hyde, showing that ugly face. Even though that beneficial, loving, caring and concerned person inside is saying no, this monster is outside just tearing every fucking thing up and there's no controlling it. I say, how can I separate myself, it's all me. I guess I just need to accept that it's all me. (Thomas)

Finally, this quote also displays depression's tendency to interrupt one's ability to function as usual, and the related loss of control that is strongly associated with depression for these participants.

> And, I always attributed mental problems to weakness... you just need to get over it. Pick yourself up by the bootstraps or something like that. But uh, mental problems to me is not being able to function, not being able to the do the things that I used to be able to do. Having to have help when I used to be able to do everything, totally, I didn't need any help from anybody, any source, any way. (Tony)

Participants described depression's effects as penetrating all areas of their lives. It appears that the impact of depression spreads broadly and develops gradually, much like the way ivy grows and winds around a tree. Over time, the roots grow stronger and sink deeper to eventually suffocate the host.

Sub-theme B: Chronic

Once the pervasive effects of depression were well established, the men moved on to considering the future *course* of the depression. As will be

presented below, the men expressed the view that depression is likely to be a *chronic* and *progressive* condition. As such, the men acknowledged they may likely struggle with depression for the rest of their lives.

The men described depression as a *chronic*, recurring situation they had faced for many years, and one they did not expect to someday vanish from their lives. As one participant phrased it, "It is like I am on a merry-go-round and I can't get off of it." (Jeremy) The quote below explains the process of coming to view an illness as part of a "constant battle" that will be going on for the foreseeable future.

> I can go through the day and seem like I'm okay, but there's this constant battle that's going on inside of me. I just can't focus and it brings on, I guess it depends on who wins the battle that's going on inside of me what determines whether I go into that depression, or if I stay focused. And a lot of times the pain is more than I can bear. (Mike)

Another participant likened recurrent depression to a small dog bound to a tree by a heavy chain. In his comments, the ground of being *out of control* is evoked also by his choice of metaphors.

> It's just like I used to see this dog that had a huge fucking chain around its neck, and it was just a little dog. They had him tied to a tree for like four or five years, and one day they were going to wash him and they took the chain off his neck and he just fucking ran. They thought "what's wrong with this dog?" but shit, I would do the same thing I would run. How would you like to spend the rest of your life tied to a fucking tree? That's how depression feels at times. (Thomas)

One aspect of acknowledging a problem as *chronic* involves considering that the problem may not be improved later in time, or that the problem may

disappear for some time and then recur. Dealing with those possibilities is discouraging and depressing, as the following quotes display.

In the first quote, the participant contemplates how his advancing age might indicate that no improvement is in store. In the second quote, the participant describes his experience with discontinuing his antidepressant during a temporary improvement in mood.

> I'm not a kid anymore in my late 40's, early 50's and feeling 33 and getting away with it. I really am 61, and I just really am getting bummed out about the prospect of this might be as good as it gets. Now I look back at memories and they're just kind of like a photograph that's being consumed by flame around the edges, just kind of going away. Is this really as good as it's going to get? It's discouraging, and depressing. (Ben)

> So, I went off of it. I did. I didn't tell the doctor anything. I just went off of it. And, uh for a while I was fine, my wife said I was fine, said everything was good. I think it was a combination of work and bills again. (Gene)

The return of depression is characterized as something that "creeps back in" and is likened to an addiction by the next two quotes. The *chronic* nature of the depression is evident, along with the *out of control* feeling implicit with being unable to avoid a recurring problem. The words of the interviewer are presented in italics below for clarity.

> A lot of people think once you kick it, you kick it. I don't think that's true. You don't just have it, kick it, and move on? *What happens instead?* It creeps its way back in. You can start thinking about how things were back in these days, remember when we had this, remember when we thought we were going to have this. And it creeps back in. (Gene)

> To me it's, it reminds me of talking to some of the folks here with alcoholism or drug problems, some sort of addictive issue. To me that's

> the way I feel about this. It's an addiction that I haven't been able to find an answer for. It goes way back to losing my family like I told you, but it has been a demon for me. (Ricky)

The preceding quotes illustrate that the men in this study view their depression as a *chronic* condition that may not improve, and may recur even if symptoms fade for a few weeks or months. The next sub-theme explores the possibility that the depressive symptoms may in fact get worse.

Sub-theme C: Progressive

The men in this study expressed the idea that their situations have been worsening with time, and the fear that they might deteriorate further. Using a stereotypically masculine term, one participant describes how he had "powered out" of depressive episodes three times in his past by working hard at his job. Underlying that experience, however, was the knowledge that the depressive periods are lasting progressively longer.

> I've done it in the past, when I've been in deep states of depression. Probably three times in my life. The first time took 13 months to get out of, and the second time took longer, and this time it's been four years. It's getting longer each time. (Ricky)

The next participant described that the idea that depression may worsen is frightening and debilitating. The next two quotes come from the same participant, describing his fears about his future.

> Progressive yeah, that's a scary concept but I think that's what frightens me more than anything. That it's chronic I sort of accept, and hope that it can be managed or positively chemically influenced, but if its progressive then boy howdy, that's scary. (Ben)

> I might get more debilitated, I've not been this debilitated ... I feel really debilitated now. If it gets any worse, I don't know, I guess the hospital's next. (Ben)

Tony reflects on how his depression has worsened with time. The cumulative effects of the *progressive* nature of depression have made it more difficult for him to feel a certain mastery of the world. He relates depression to a "weakness."

> Its gotten worse, it has become harder on me. It's got harder on me because as men, I know you're trying to study depression among men, then if most men are like me they want to be the superior, they want to be stronger at any thing, "that aint gonna get me down" sort of attitude. It (depression) shows your weakness. (Tony)

In the next quote, a man provides an example of how depression is *progressive*. He describes how a collection of normal-life events such as the death of elderly relatives has deepened his depression. Dealing with the death of family members brought about an awareness of his own mortality, and in his own words "put the cap on" his growing depression.

> It got worse just recently. I have unfortunately had quite a few deaths in my family. And, I have been dealing with a lot of death in the family and stuff and I guess it is gotten worse in the past six months. I have had seven people die. I was close to all of them and I guess it just sit back and look at it could be you...you are getting to the age that it could be you. Unfortunately there is a lot of it that is normal, but there is a lot that I have been going through the last couple of years and all these deaths pretty much put the cap on it. (Jeremy)

The *progressive* nature of depression is frightening, debilitating, and definitely contributes to the feeling of being *out of control* to the men in this study. The *pervasive* effects of depression make the situation impossible to ignore, although

the *chronic* nature of depression makes paying constant attention to the symptoms exhausting. As one participant described off-tape, dealing with depression is like “having one foot on the brake and one foot on the gas.” (Evan)

Relationship of Theme to Ground

Both the *pervasiveness* of influence and the course of an illness refer directly to the control retained by the experiencing individual. Problems such as depression that affect all areas of a person’s life tend to make the experiencing individual feel powerless in avoiding that problem. Also, problems that are *chronic* and *progressive* are impossible to avoid and are bound to worsen. The experiencing individual has no control in hoping to “get better.” In fact, the only expectation is the depressing notion that one can only get worse with time.

Theme Five: Reactions

One consistent theme arising from the interviews was the presence of the men’s personal *reactions* and personal feelings about their situations. The reactions can be viewed from three different aspects: *feelings about having depression*, thoughts about *coping with depression* by taking psychotropic medications and being in counseling, and a description of the *financial pressures* that both resulted from depression and contributed to deepening existing depression.

Sub-theme A: Feelings About Having Depression

One of the most prominent areas of personal reaction to emerge from the interviews was the men’s thoughts and *feelings about having depression*. The

following quotes illustrate the men's reactions to their depression. During one such interview, the participant began describing his reaction to having depression in an emotional manner by saying "I hate it. It's my worst enemy. I hate it and I don't understand it." He went on to clarify:

> I'm generally a happy person, and when I get in this position where I can't function and I don't have money to function, I don't have the desire to go to social events or whatever. I used to go to football games all the time. I haven't been to one in four or five years now. I just don't care about it. I watch them on television, but usually by myself. I pull myself out of social circles. If you don't have the money to go and do those sorts of things, but I am depressed about those things and I really am, but I cannot make myself do any better and that is just maddening to me. (Ricky)

Ricky's depression is his "worst enemy" and represents a maddening struggle. He went on to explain that perhaps someone who hadn't experienced depression might not truly understand. He cited the case of his friend's calling him "lazy" below:

> I don't know, I just know that if you haven't ever experienced where I am with it then it's very difficult to know. My friends look at me and say you've got all the abilities in the world, that's what I hear all the time. You've got ability to do anything that you want to do, personality wise, or I took four years of college and have been able to provide and support myself. But they look at me and say he's just, for whatever reason he's lazy. But I'm not. I mean, I work hard when I work, but I've got to have a purpose. And that's what I don't understand. I've got issues that I want to deal with and, understand what it's going to take and deal with them, but I don't do it. Its like beat myself up for something that I don't understand. (Ricky)

Another participant (Dennis) described a similar reaction of feeling misunderstood by people around him. He said, "They think you're doing something you can think yourself out of, or will yourself out of. I don't believe

that's true." This participant discussed the limited time allowed for each life, and the existential reality that death must necessarily follow life. His resigned, somewhat fatalistic reaction to having depression was best characterized by the following quote:

> Well you know that life is a losing proposition. It's a downhill ride, the whole time. Every road you go down, no matter what the road you choose it's going to lead you to your grave, and that can be a depressing thing. I suppose you have to learn not to fear death. Just accept that it's going to happen. (Dennis)

Another participant shared similar thoughts. He too has resigned to accepting depression as his "lot in life," but wonders if there isn't another way of being. He acknowledged that spirituality is a common pathway leading from the dense forest of depression, but explained that he is not satisfied with that route.

> Yeah it is my lot in life. It's where I am, but I'm not happy with it. I'm not. It seems to me there must be some other direction, some way to achieve that other direction. Spirituality is an out, but I've never been religious. I have faith in nothing. (Ben)

Later he returned to his frustration with depression and the blocked communication and procrastination that he experienced as a part of his depression.

> I don't know how to lay it out. I feel debilitated but on the other hand I know that I can do some things as well or better than anybody else. But, getting started is a bitch. I don't know. (Ben)

Another participant echoed the difficulties he faced with trying to get started on making improvements while all the while struggling to regain a sense of control. The ground is relevant to the following quote:

> I just want people to know that the world is depressing, and there are people who are trying to do better and the world won't let them. I don't want to take control of other people, I just want to take control of me. (Aldron)

In the next quote, Tony explains how he feels surprised and disappointed at himself for having depression. He finds it hard to believe that he has actually contemplated suicide.

> When I first started out, I would have never thought that I would have thought about taking my own life, but if there is one thing about it, I have thought about taking my own life. I feel like that I have failed my family. I have come to that. And, though I wouldn't want to do nothing else to hurt someone else, to hurt my family, I would rather take the pain on myself. (Tony)

Tony's reaction to having depression also reflects the ground of feeling *out of control*.

> I just feel like I've been let down, because I lost my job, because I was sick and I have no control over it, and that depresses me. What have we come to in life? I can't go and produce, and then I don't matter. (Tony)

Another participant made use of an open-ended prompt to similarly describe the frustration caused by his depression. The interviewer's words, again, are indicated in italics.

> *Anything else about depression?* Besides it sucks? *Tell me how bad it sucks to have depression.* It's something that maybe you feel like everybody around you knows about, but at the same time you could probably not point at somebody and say they've definitely got depression just because of one day. There are some people at work that are very very depressed I know, and I would not have known it if they hadn't told me. They're the happiest people at work. (Gene)

The apparent contradiction between believing one could be easily identified, yet being unable to see depression in other people leads to intensified worry,

isolation, and hesitancy to acknowledge the problem and to seek help. And finally, one participant discussed how communication and recognition difficulties make going through his experience more difficult and has also impacted his ability to seek help.

> Not being able to explain it or recognize it and probably have to go through it alone. If you can't explain it and don't recognize it you can't have anybody, it is hard for anybody to help you...whether it is a spouse, a brother, an uncle or who ever. It is hard to go share this to have anybody to give you any kind of comfort because sometimes you don't realize your even depressed or why you are depressed?" I know I've been asked before "why are you depressed and at the time I had no idea I was depressed. (Jeremy)

The men in this study described living with depression in colorful terms. They voiced their reactions memorably by calling it a "bitch," "my worst enemy" and stating, "it sucks" and is "maddening". Although one participant questioned if someone who hadn't experienced depression could truly understand the experience, these quotes give some indication to what the experience might be like.

Sub-theme B: Coping with Depression

It seems that the men being interviewed for this project were quite willing to share their opinions and reactions to using psychopharmacology and therapy to help cope with depression. Proportionally more men referred to medications than therapy in their interviews. Their reactions to medications and counseling follow.

In sharing his reaction to what was most helpful in his treatment, one participant mentioned receiving inpatient treatment for his depression. He seemed to value the sense of community that sprang from being surrounded by others with similar struggles in a group therapy environment. He did not report that same benefit from outpatient individual therapy, however.

> What has helped me more than anything was that I spent some time at (inpatient treatment program). I spent I believe a week in there and to talk to people with the same problem, well maybe not the same problem, but the same whatever. They were having mental problems. (Evan)

Evan goes on to explain the most satisfying aspects of that experience. The slowed pace, shared experience, and reduced sense of being isolated in his problems seemed quite a valuable lesson.

> Being able to talk with them and walk around that circle with them and listen to them and understand I wasn't the only one that had these problems helped me a lot. There have been several times that I have come awfully close, when I think I might need to go back for a while. But, somehow I just pull up my bootstraps more or less and I wade through it. And, (inpatient treatment program) has a good program over there. And, sometimes I just want to go over there to live. (Evan)

Another man described his preference for learning to deal with matters through using therapy instead of medications. He has not taken medications personally, but has firm ideas that using medications represents a "temporary fix." He contends that therapy seems more suited to offer the sort of help he is seeking.

> I have had some friends and family members that have had depression and the first thing that the medical doctor did was prescribe them something for the medication part of it. And, I saw it …about 60% of them that the medication did not work. They had the same problem and

> attitude as when they were on the medication trying to deal with the problem. I am not saying that medication doesn't work, it is just that everybody different. And, I think the medication, from what I say, and I can't say for sure cause I didn't take it, but what I personally experienced with the family members I think it is a temporary fix. It makes it go away as long as you are on it, but as soon as you are off of it it is back, you right back where you were. So if you don't deal with the problems, then the depression is going to be there no matter what kind of medication you are on. That is how I feel. (Jeremy)

Still another participant reports receiving no lasting benefit from "cognitive behavior modification." His assessment of therapy, at first, was that it rings as hollow as the preceding description of medication.

> I have found that counseling and therapy never seemed to really help much, except that I guess the catharsis, but cognitive therapy never seemed to do anything for me. I'd go through the motions and jump through the hoops, but I just felt like I was going through motions and jumping through hoops. Cognitive behavior modification, that's all it really was for me. (Ben)

He later goes on to explain that he has benefited from some more existentially focused therapy work. As he adjusted his focus toward working on daily meditations and mindfulness he has noticed some improvement.

> So far I think that the most I've experienced in managing depression is working on the spiritual level of a moth. Now that has made it easier, it has been easier I can't deny that, and I'm grateful for it. (Ben)

He also stated that the roots of his feelings toward therapy may be related to his earliest experiences with being offered counseling. Seeing his parents fail to benefit from therapy caused him to not "put much stock" in its helpful possibilities.

> I was aware, or had been aware of the fact for years that my mother and father were in "marriage counseling." It didn't seem to be doing much for

> a fragmented marriage and fragmented family. I didn't put much stock in that. Then psychiatry came into it, with Phenobarbital and things like that. You know that wasn't very attractive either with shock treatments. (Ben)

Another participant shared his skepticism toward the skills-training component of a CBT style treatment. He reported that a skills focus would be only helpful for a part of his needs, and would likely not benefit his depression.

> Would I benefit from skills training? Depression no, not so much, but anger. I don't feel the skills would keep me from being depressed, but it would certainly keep me from being angry and causing more damage. (Ricky)

Another participant described a particularly helpful moment in therapy. The presence of the ground of feeling *out of control* became figural in the therapy session, and in this participant's description of learning to cope with depression by using therapy.

> One therapist told me to color my own emotional day, and that's a part of what's going on for me. I should just take news as news, and move on. Things happen, things are happening that are not great. But I need to be in charge myself. I feel like I'm constantly struggling to do that. I want to make my world happy. But we all have to do that. (Aldron)

Finally, one participant praised the therapeutic relationship he has with his psychiatrist. He felt his doctor was a "good listener" and also helped him with medicines too.

> He (psychiatrist) is good. He is a good listener and he is good with medicine and I would hate to lose him. (Evan)

The men in this study reported their views on how therapy had helped them. Some reported positive experiences, and others were less enthusiastic

about its potential to help them. Next, the men's views on medicines are discussed.

One of the first components to emerge from men's descriptions of using antidepressants is an awareness of side effects. The men describe various side effects including sedation, impaired driving ability, blurred vision, dizziness, sexual side effects, feeling giddy, feeling controlled by medications, and decreased ability to dream. In the following quotes the men describe their side effects from taking medications for depression, and subsequent wonderings if they should continue with the medications. The interviewer's words are again in italics.

> I know that some of the medicines that (psychiatrist) gives me for the depression, I didn't like the effects of them*. Like what?* Like this one pill, I can't remember the name of it, but I took it when I got back from his office and I mean it KNOCKED ME OUT for like 14 hours. I didn't even wake up, and when I finally did I had a real weird feeling. Light headed, one day it was almost like it was real dim and there was something in my eyes. Sort of made me feel real weird. Pills are not the answer, just like pain pills are not the answer to my legs, there's gotta be some other thing. (Mike)

In what must have been a harrowing experience for the next man and his children, he actually drove his car into his garage and ripped the door from his vehicle. He believes this accident was due to the sedative effect of his antidepressant medication.

> So we went to the doctor, and they put me on medicine that really knocked me out. I didn't know where I was, probably didn't want to even know who I was, I mean I was just, I was just there. And, I was taking the kids to school and pulled out of our garage with the door wide open and basically tore it off the car, the door off of the car. (Gene)

Another man describes the sometimes effective, sometimes ineffective response he gets from his medication. He wonders if there might be a truly chemical explanation for depression, but is skeptical because of his inconsistent response to medications.

> Sometimes it helps, some times it don't. Sometimes it makes you giddy, and overly cheerful and there's all kinds of effects from it. Then if it works that would make you think it's all a chemical thing, you know and maybe chemicals have a lot to do with it but I don't know. (Dennis)

Another participant from this project described the long journey to find the right combination of medications, along with the various side effects. Ultimately he settled on a medication that didn't help as much as other medications have, but instead chose one that had fewer side effects.

> I take it. Sometimes I forget it. There have been six or eight different ones, or combinations of different ones and some I'd sleep all the time, and some I couldn't sleep at all. Some had terrible sexual side effects, some didn't help and some did but the side effects were just too damaging. So I've went up on my Wellbutrin and it does not seem to help me as much with the depression as some of the other ones but it has very little side effects, so that's what the doctors settled on to take. I was told that I'd probably be on it forever. (Ricky)

Rickey also explained that he is not ashamed to admit he takes medication. He cited the medical model in defending his choice. Still, he wishes he didn't have to take the medicines.

> No, I'm not embarrassed to tell anybody that I take it (medications). I've been told that it's a disease like cancer or anything else that they'd give you medicine for. There's nothing you can do to necessarily help the chemical imbalances, so yeah it's something I just accept that I do. I don't want to take it; I'd rather not take anything. But I do it, I take it every day. (Ricky)

However, not every patient found benefits to taking antidepressants. Even with trying various classes of medications, Ben's best result was climbing out of darkness into gray. His quote reflects the optimism that Prozac brought to the country.

> And managing it when I tried, up until the mid 1980s or so I tried all the tricyclic and antianxiety stuff and benzodiazepines and all those things. Just at times I would spiral farther down. The benzos did that to me, right away and kept me down there. But Prozac, beginning with the SSRI's turned around and it was really the only thing that got me going, and then is when I realized I think that, it seemed chemical. It seemed obvious to me that it was chemical, but in managing it the best I ever experienced was just a gray area, where I could climb out of the darkness into this gray area, where it was brighter, but it was still gray. (Ben)

One participant described his apprehension to take any antidepressants. Even though he had a prescription for one given to him, he was concerned about the potential impact on his ability to operate machinery necessary to function at his job site.

> I have not took any of them. I don't really know. I do have a prescription for it, but I never did take any of it. I don't do good on medication and the work I do I've got to be coherent. I understand I can't be groggy or anything. So, I just have never tried it. I am just one of those persons that I never been on dope, I don't reckon. (Jeremy)

Yet another participant focused quite a bit on his objections to medications. He disliked being dependent on the medications, and wondered if the improvement he noticed was truly due to the medications. He said, "I felt like this is not helping me; I'm sick of being on it; I've gotten caged on this." (Gene)

These objections eventually led to an incident during which Gene stopped taking his medications for six months. When life troubles returned, so did the depression and he felt he had to resume taking the medication. The remaining quotes in this section are his, and they reflect his feelings that the medications became a means of control that he resented.

> I started feeling like they were more of a control. I even told my wife that this is just a thing that I feel people are trying to control me. I didn't want that control. (Gene)

He went on to clarify that even though he was behaving in an improved way on the medications, he still felt as though he wasn't behaving better for the right reasons. For example, Gene noticed that when he was depressed he spent less time with his daughters. On medications, he was spending more time with his daughters. Gene began to question why he was able to make that change.

> Yeah I was doing maybe what I was supposed to be doing, I was going to work, I was coming home, being with the kids, being with the family which I enjoy. But I would like to be able to do that and not say "okay it's the medicine that let me do this, but it's me wanting to do this." (Gene)

For the men in this study, taking medication and participating in therapy to help cope with depression was an important theme. By virtue of the study design, all the men were involved in therapy at the time of the research interviews. Additionally, they all had been presented with options to take antidepressants, and each had decided for himself whether to take those pills. Response rates were not uniformly positive, and the taking of medication brought up weighty issues such as personal control.

Sub-theme C: Financial Pressures

The men described their reactions to *financial pressures* in two separate ways. *Financial pressures* were described as both a result of the disabling effects of depression, and also its cause. *Financial pressures* caused frustrations that contributed to increased feelings of depression. Examples of each type of statement follow:

One participant acknowledged that losing his job caused an adjustment that was "strongly financial" in nature. He noted that nearly every family these days had two working parents, and that he felt he "had to work" in order to adequately perform the role of father. His summary statement: "Seems like everything now is based on your finances" hints at the turmoil that job loss created for him. He continued on to say:

> At work they'd say he's smiling every day, he's friendly and he talks to the customers, everybody likes him. Why would he be depressed? Because you go from making 40-something thousand a year to not even 10 thousand. (Gene)

The following quote details the link between *financial pressures* and depressed mood, and the general disenfranchisement experienced by another participant.

> I have horrible credit. That depresses me. Again, I can't get anything that I want. When I go some place I have to pay some exorbitant interest rate. You end up paying $12,000 when someone else could get a much cheaper rate just because they have more money to begin with. And then I don't understand why I can't get a used car; they won't approve me for a used car. To me it's very, very discouraging. I think there are a lot of constraints in this world that don't allow for people to get better. If people are depressed, they want them to stay depressed. I think a lot of people who are poor are depressed. Because there are things that they want and they can't have them. (Aldron)

Another participant echoed the same theme. *Financial pressures* contribute to increased depressive symptoms.

> I get severely depressed when it comes to not having the abilities financially to do things. I'm not talking about going on cruises or expensive things. I'm talking about going out and having a meal at (restaurant), that's what I used to enjoy doing with my friends. I can't do that anymore. (Ricky)

For another participant (Tony), thinking of one's self as receiving help was incompatible with his long held view of being the one doing the helping. Especially financially, he was used to providing for others and not taking another person's assistance.

> I've always been the one who was depended upon, and now I'm sitting here and I'm thinking, boy I never thought I'd have to depend on somebody else to try and help me. (Tony)

The men interviewed in this project also noticed the increased *financial pressures* as a result of their depression. In the following example, a man who lost his job has increased depressive symptoms.

> (M)y financial situation has gotten terrible because of the depression because of the job loss. And, I had really no desire or understanding to find something...I can't find what I really want to do. And, I don't know whether that is because of the depression or not. I can't define it, it is something that I try to define, which is part of the reason that I am here. To try to help put that in to perspective as to why I haven't been able to focus on one (area). (Ricky)

He explains that *financial pressures* are "obviously" part of his depression.

> Financial issues obviously are, to me they are a part of my depression because of where I have been, making the kind of money I have made in my past I wouldn't be where I am today ... it is very depressing to me. (Ricky)

In addition, two participants described the difficulties of living in community-sponsored housing for homeless men (Ben and Thomas). Another described the pain of not being able to afford his granddaughter a breakfast item at a fast food restaurant (Evan). *Financial pressures* appear to be a significant issue for the men in this study.

Financial pressures appeared to both cause depressive symptoms and be the result of depressive symptoms for the men in this study. They commonly shared their responses of having financial problems, and this sub-theme emerged in the context of their personal reactions to their depressions.

Relationship of Theme to Ground

In the quotations from the theme of the *men*'s personal *reactions*, the presence of the ground of feeling *out of control* is evident across the sub-themes of *feelings about having depression*, *coping with depression* through medication and therapy, and *financial pressures* that both result from the debilitating aspects of depression and that worsen depression. The men's personal *reactions* lead to *feelings about having depression* that violated his ability to have control. The frustration the men expressed when describing living with depression echoes the *out of control* feelings that served as the ground for this study. Choosing whether to take medications, and deciding how to make use of therapy in *coping with depression* are important ways that the men reclaimed control in their lives. Even when medications improved one's behavior, one of the participants

reported resenting that improvement because it seemed his improvement was due only to the medication and not due to his own control.

Financial pressures appear to be strongly related to the men's perceptions of being in control. Having fewer financially means often corresponded to fewer options for the participants. One man described his inability to buy a cinnamon-raisin biscuit for his granddaughter, and the related shame that he experienced. For the men in this study, control was linked directly to the expression of men's personal *reactions*. Many of their personal reactions centered on the ramifications of feeling *out of control*.

Chapter Summary

Five main themes emerged from the descriptions of depression given by the men in this study. Those main themes were *describing*, *symptoms, recognizing, course,* and *reactions*. The ground of being *out of control* made the themes figural. No quotes were superior to other quotes in terms of importance or relevance, and many interrelations between the various themes and sub-themes are noted. In Chapter Four, the results from this study are discussed with regards to selected professional literature from the disciplines of Psychology, Sociology, and Medicine.

CHAPTER FOUR: DISCUSSION

The purpose of this chapter is to examine the results from the current study in comparison with research in the field. Major research findings for each theme are reviewed in terms of the relevant professional literature. The significance of the current study is discussed including the strengths of the study. Finally, recommendations for future study are made.

The purpose of the current study was to collect first-hand accounts from men with depression. Ten men were interviewed for this study, and each interview was transcribed and analyzed with phenomenological research methods. Five main themes and one ground emerged from the transcripts. The five main themes to arise from this study were: *describing*, *symptoms*, *recognizing, course*, and *reactions*. The ground from which the five themes emerged was the notion that depression is an experience of being *out of control*. In the next section of this paper, each theme and the ground will be discussed in terms of selected available literature.

Ground: Out of Control

In the context of this study, the men described depression as a state of unpredictability and powerlessness. The sense of being *out of control* was reflected in each of the individual themes, and served as the ground for this study. Much has been written about power and control in the context of men's lives, and selected literature that helps to explicate the ground is presented next.

Steinberg (1993) has written about the relation of control and power from a Jungian perspective. Wielding power serves a positive function for masculine identity, needs fulfillment, and mood (Steinberg, 1993). Men who have the power to impact their environment and life situations believe they can live their lives as they desire, and therefore experience the feeling of being in control. One who feels in control of meeting his own needs will therefore feel competent (Steinberg, 1993). For the men in this study, the converse was found to be true as well. As the men described the powerlessness they experienced with depression, they were simultaneously describing the ground of being *out of control*.

Men who determine their intrinsic value by measures of external power and control are bound for difficulty. As men are confronted by the perils of life they are disappointed to find that "the drive to establish potency in any of its various forms always shipwrecks on the shoals of finitude" (Keen, 1991, p. 103).

Once men perceived that their life situations were beyond control, they began to feel helpless. The discomfort of feeling helpless lead men to contemplate giving up on goals and plans once held dear. This process is termed *disengagement* (Carver, & Scheier, 2002).

Other options for managing difficult situations exist however. When individuals are faced with situations that are uncontrollable, they may choose to realign their goals and accommodate their existential limitations while still maintaining a stance of personal control. Much as a clinical supervisor of the

primary researcher noted in working with oppositional children, “Behavior is not managed; only contingencies” he said. Similarly, people who are able to maintain personal control look not to the situation expecting it to change, but rather change from within by modifying their own thoughts and feelings about the situation.

Some individuals are able to “find a meaningful life even in difficult circumstances” by finding personal empowerment in the most dire of situations (Thompson, 2002, p. 202). An example of one such person who was able to control his attitude toward his struggles in a Nazi prison camp is found in the autobiography of Victor Frankl (1963). An excellent review of the concept of personal control, including suggestions for enhancing individual control is found in Thompson’s (2002) chapter in the *Handbook of Positive Psychology*.

Theme One: Describing

The men interviewed for this study expressed their perceived difficulties in describing depression. Sub-themes of this major theme were that men expressed *not having “a clue”* of where to begin, and identifed themselves as *being “no expert”* regarding their situations.

The first theme to arise from the transcripts in this study was the consensus among men that *describing* depression is “difficult and confusing.” Difficulty in communicating first-hand accounts of depression has been noticed previously. For example, William Styron is an accomplished writer who penned such moving accounts of human drama as Sophie’s Choice. Styron wrote in his

memoir that depression is an “inexplicable agony,” and described his depression as “so mysteriously painful and elusive in the way it becomes known to the self – to the mediating intellect – as to verge close to being beyond description.” (1990, p. 7)

The men in this study described having difficulties describing depression. These struggles are all the more poignant when viewed in the men’s life context. Men do not generally find social support for developing increased facility with emotional matters (Cochran & Rabinowitz, 2000). Today one routinely sees men portrayed on television, in movies, and in commercials as emotionally incompetent. Such characters are presented for comedic value as being out of touch with their feelings, unable to converse on emotional levels with their spouses, and indifferent to subtle nuances of social situations and emotions (Heesacker, Wester, Vogel, Wentzel, Mejia-Millan, & Goodholm, 1999). Of course, persons with mental illnesses have historically been portrayed very negatively as well (Wahl, 1995).

American Psychological Association (APA) President Ronald Levant explains men’s difficulties describing emotional matter as “normative male alexithymia.” According to Levant, “normative male alexithymia” results from traumatic effects of male socialization. Social processes discourage men’s expression and recognition of the emotional and further alienate men from experiencing their own emotional lives. He considers the problem normative in the sense that it is seen frequently, and represents baseline functioning for many

individuals. According to Levant, “When men are required to give an account of their emotions and are unable to identify them directly, they tend to rely on their cognition to deduce logically what they should feel under the circumstances” (1998, p. 36).

The consequences of being unable to identify and express one’s emotional life are serious. It blocks men from making use of verbal methods of dealing with life stressors, and further isolates men from their families and significant others. With the verbal route of escape blocked, men are more likely to choose nonverbal processes such as “substance abuse, violent behavior, sexual compulsions, stress-related illnesses, and early deaths” (Levant, 1998, p. 37).

Theme Two: Symptoms

Depressive symptoms described included *somatic and emotional factors, impaired cognition, and disengagement.* During the interviews, participants endorsed *symptoms* of depression by describing bodily, emotional, cognitive, and behavioral changes. The particular symptoms men presented in their subjective accounts of depression are in agreement with empirical research findings. One author has summarized, “depressive disorders are ‘whole person’ illnesses; they affect the body, feelings, thoughts and behavior” (O’Connor, 1997, p. 29). O’Connor speaks both from the perspective of a researcher and a person diagnosed with depression. Although it is not surprising to find that symptoms are reported while describing any particular illness, the individual symptoms reported in this study are worthy of additional consideration.

Somatic and Emotional Factors

It is not surprising that the men in this study reported noticing physical and mood changes accompanying depression. Bodily changes and sensations are necessarily bound to the experience of emotions and affective responses. William James wrote that "bodily changes follow directly the perception of the exciting fact, and that our feeling of the same changes as they occur *IS* the emotion" (1890, p. 448 italics original).

When describing the lived experience of depression and its symptoms, the men in this study used terminology reflecting both bodily symptoms and affective responses. Again, the words of the men reflect current research findings. In a large-scale study of the internal consistency of the BDI-2, a group of researchers found the structure of depression reduced to two factors (Whisman, Perez, & Ramel, 2000). The two factors found underlying the symptoms of depression as measured by the BDI-2 were cognitive affective symptoms, and somatic symptoms of depression, and match this particular sub-theme nicely (Whisman, Perez, & Ramel, 2000).

Because men's expression of depressive symptoms are influenced by cultural and gender expectations, Pollack (1998) has argued for a masculine specific subtype of depression. Pollack's proposed criteria include symptoms not typically included in DSM-IV-TR (APA, 2000) listings. Increased withdrawal from relationships, over involvement with work activities, denial of pain, rigid demands for autonomy, angry outbursts, and depleted mood are among the factors he

advocates for using to screen for cases of hidden male depression (Pollack, 1998). Cochran and Rabinowitz (2000) further argue that men may present somatic concerns as a way of legitimizing their entry into help seeking roles. Generally men tend to avoid presenting on solely psychological grounds; it is theorized that perhaps the physical complaints serve to buffer against the awkwardness men feel when asking for help.

Impaired Cognition

A major part of the awareness of symptoms within the context of depression was the men's focus on how having depression impacted their cognitive functioning. This change was observed both in the content of their thinking, and also in their general ability to use their mental faculties in the thinking process.

Much of the research on how depression affects one's thought content comes from the work of Aaron Beck. Beck described a series of "inaccurate conceptualizations with depressive content" that lead to feelings of depression (Beck, 1967, p. 236). Such cognitive distortions influence men's everyday experiences and attitudes. The men in this study reported negative experiences that they felt were due to personal failures, and this affected them widely and pervasively. The cognitive distortions were so stable as to likely be permanently negative. In cognitive therapy, this particular pattern is called the primary triad and represents the core way that depression distorts one's thinking (Beck, 1967).

Particular cognitive distortions relevant for the male gender role have been identified (Mahalik, & Cournoyer, 2000). Typically, four factors are included in measures of gender role identification for men. These factors include valuing success, power and competition, advocating for restricted emotionality, restricting affectionate behavior between men, and valuing work over family relationships (O'Neil et al., 1986). Within each factor, masculine-specific cognitive distortions have been described. For example, the restricted emotionality factor leads to cognitive distortions such as "I cannot express my feelings because others will see me as weak," and "If I show tender feelings I am not a real man" (Mahalik, & Cournoyer, 2000).

Additionally, in the field of cognitive therapy and learned helplessness, three critical elements have been identified comprising a negative explanatory style contributing to depression (Seligman, 1990). Those three elements are permanence, pervasiveness, and personalization. Permanence means thinking about negative events in terms of *always* and *never*, instead of *sometimes* and *lately*. Pervasiveness relates to using general, blanket statements instead of specific, limited terms. Personalization means attributing the cause of the negative event to internal, personal descriptors instead of external situational factors (Seligman, 1990).

One area of controversy exists, however in the literature detailing depression's effects on developing a negatively distorted view of reality. Although Beck's (1967) seminal work described the distorting effect depression has on

thinking, some have claimed that depression leads to more realistic thoughts (Lewinsoh, Mischel, Chaplin, & Barton, 1980). According to the theory of *depressive realism*, persons with depression are more likely to accurately appraise their own lack of control when measured on random laboratory events. The debate about *depressive realism* currently rages, and a team of researchers has argued that the effects of contextual information on decision-making may ultimately defend Beck's position (Msetfi, Murphy, Simpson, & Kornbot, 2005).

As mentioned earlier, depression affects one's thinking in two main ways. The preceding section has described depression's negative influences on the content of thoughts and perceptual style. The next section will describe depression's effects upon one's mental faculties and cognitive abilities.

In the last quarter century, researchers have begun to understand the manner in which depression influences one's ability to make use of one's mental faculties. A review of research studies archived on two major academic indexing services for Psychology and Medicine (*Psychinfo* and *Medline*) viewed 25 years of articles investigating cognitive deficits in depression and argued that lowered mood and cognitive impairment should be considered as "comparably important manifestations of depressive disorders" (Austin, Mitchell, & Goodwin, 2001, p.206).

The specific cognitive impairments found have been in the areas of mnemonic deficits and executive impairments, and involve memory, recall of specific data, and decision-making abilities. The researchers are careful to state

that the cognitive deficits occur without regard for age, severity of depression, difficulty of task, motivation, or bias in responding. These changes in intellectual functioning appear to persist even after clinical recovery from the depressive episode, and are thought to represent intrinsic expressions of brain changes resulting from depressive illnesses (Goodwin, 1997). Indeed, one group of researchers has worded their results even more strongly to say "there is a diffuse impairment of brain function with particular involvement of the frontal lobes in outpatients with a nonpsychotic unipolar major depressive disorder" (Landro, Stiles, & Sletvoid, 2001).

Disengagement

The men in this study described their own tendency to hold themselves back from contact with previously enjoyable people, places, or activities in a type of self-imposed solitary confinement. Currently, the most popular view of this behavior, including strategies to modify its harmful effects, are found in the cognitive behavioral tradition. From a cognitive and behavioral perspective, *disengagement* is seen as a classic symptom of depression (Beck, 1967).

Disengagement is viewed as withdrawing from reinforcing activities, and that reduction in reinforcement which would have been received from positive activities is conceptualized as leading to depressed mood. Behavioral changes lead to neurochemical changes, and negative thoughts reinforce neural pathways causing structural brain changes. The antidote for such disengagement is focused effort on increasing one's activity level, and therefore access to

behavioral reinforcement (Hopko, Lejuez, Ruggiero, & Eifert, 2003; Beck, 1995). A treatment manual for implementing such behavioral activation is available, and details the steps in addressing the problem of *disengagement*. The treatment rationale is summarized neatly for the practitioner and client alike: "It is difficult to feel depressed and have low self-esteem if you are regularly engaging in activities that bring you a sense of pleasure and/or accomplishment" (Lejuez, Hopko, & Hopko, 2001, p. 261).

However, from an alternate perspective, the process of *disengagement* can be viewed entirely differently. From a social and motivational perspective, for instance, *disengagement* is viewed as a positive outcome for certain situations. Carver and Scheier (2005) define *disengagement* as a necessary part of life, involving the abandoning of pursuits in favor of higher priority tasks or the avoidance of impossible ones. In this literature, *disengagement* is seen as a self-corrective adjustment with the characteristics of a feedback control loop. The authors cite two possible positive functions of *disengagement* from tasks. First, the man who disengages from a task at which he is failing avoids the distress inherent in failing at that task. Second, the man who is unable to disengage from set goals literally finds himself stuck in time, acting as if his values and interests have not changed. Disengaging from goals and sometimes people in one's life allows for the updating of one's own preferences about one's life (Carver & Scheier, 2005).

It should be noted the men in this study did not describe their *disengagement* in positive terms. It is true that the men suffered as a result of their loss of contact with family members, jobs, and hobbies. At least from the behavioral activation perspective, their depressions were worsened by their *disengagement* as well. It is worth noting the core ambivalence present in the men's descriptions of their isolations, however. Perhaps it is not too far to hypothesize that there was some protective function served by the *disengagement*, and that protection on some level might have been comforting for the men who disengaged.

Theme Three: Recognizing

The onset of depressive episodes are difficult to recognize*.* The third major theme to emerge from the interviews was *recognizing*, and conveys an awareness that the onset of depressive episodes is difficult to recognize. The three related sub-themes are that with depressive episodes *onset is gradual,* are thought to be reactions that *seemed normal,* and were not initially accepted because of the belief that depression is a *sign of weakness.* In the next section, this portion of the results is discussed.

Becoming aware of one's experience occurs over time; it is a process, and is not an event that can be traced to one specific starting point. This was particularly true with the experience of recognizing the onset of depressive episodes for the participants in this research study. To some readers this phenomenon might seem counter-intuitive. After all, if depression is a disorder of

the individual's mood, who better to observe the change in mood than the experiencing individual? One might expect that individual to be the first to notice. Herein exists one of the many paradoxes of depression.

Not all experiences have immediately observable beginning points. Who can truly say at what moment a day's sunset begins, or at what moment a child becomes an adult? Yet surely after some elapsed time most would readily recognize the presence of the sunset, and would not hesitate to acknowledge the adult before them. Much is the same with understanding the beginnings of depression. It is not likely that one thinks at the first stirrings of self-doubt "aha, this must be depression beginning!" Rather it is only with its repeated experiencing and subsequent deepening of that experience that the possibility of depression is considered.

The men interviewed for this study did not immediately recognize depression when it arrived in their lives. There was instead a gradual onset, during which the symptoms gathered and built. Because of the subtleties of presentation, depression is usually noticed after a period of months or even years. During the early onset period, the men tended to view their lives as those that *seemed normal*, and attributed differences to more daily processes not typically associated with psychopathology. Upon recognizing the possibility of depression, the men in this study made mention of the fact that their view of depression as a *sign of weakness* inhibited their acceptance of the diagnosis and also their own ability to detect the beginnings of depression.

Little has been written in the professional literature about the process of the onset of depression, particularly from the perspective of the depressed individual. The few sources that were located are presented along with possible links to other areas of research.

A study of women's rates of self-recognition of depression in a women's clinic setting has showed that less than half of women meeting criteria for depression recognized their own depression (Alvidrez, & Azocar, 1999). Disappointing as this percentage might be, men have typically fared worse. Men have been shown to be less adept than women at noticing the occurrence of depression. The research group of Kessler, Brown and Broman (1981) found that "women are more ready than men to translate nonspecific feelings of psychiatric symptoms into conscious problem recognition" (p. 60).

One research group has described how the simultaneous forces of emerging depression are limited by men's few available gender sanctioned outlets for its expression. They chose the term *big build* to represent both men's mounting emotional pressure and their often outward physical characteristics. The researchers argue that men and women are similar in rates of experiencing depression, but vary widely in their processes of identifying and expressing the disorder (Brownhill, Wilhelm, Barclay, & Schmied, 2005).

A four-stage identity process through which depressed persons move in understanding their experience of depression has been identified as well (Karp, 1996). The first stage identified is "a period of *inchoate feelings*" that involves

difficulty labeling and expressing one's experience (Karp, 1996, p. 57). In the second stage, individuals come to believe that a problem exists. During the third step, individuals enter a "*crisis stage*" where problems become increasingly prominent and the individuals enter the world of mental health treatment (Karp, 1996, p. 57). In the fourth and final stage outlined by Karp (1996), individuals describe "*coming to grips with an illness identity*" (p. 57).

A study of teen-agers experiences with depression found that a growth of a distress period preceded the recognition of depression (Wisdom & Green, 2004). The teens in that study reported feeling depressive symptoms building over a period of months and years before finally being able to name their experiences. Primary-care patients have also reported similar difficulties recognizing and phrasing depression. The "lack of a vocabulary and uncertainty about the nature of the problem and distress from uncontrollable behavior" led to confusion and distress (Rogers, May, & Oliver, 2001).

The difficulty noticing the onset of depressive episodes noted in this study is similar to the period of inchoate feelings noted by Karp (1996). Karp does not describe the possibility of recycling through the four stages, but the men in this study have described themselves as having continued difficulties noticing recurrent depressive episodes. The data from this study suggest that the men may become marginally more adept at recognizing recurrent episodes, but still have some difficulty noticing the initial onset of further episodes.

For the men in this study, depression was often conceived in negative terms and commonly described as a *sign of weakness*. Viewing an illness in such pejorative terms likely influences men to avoid accepting that identity. Men may feel social pressure to follow certain scripts, such as being the tough guy, or the strong and silent type, and those scripts have been shown to be associated with decreased help-seeking, and negative attitudes toward therapy (Addis & Mahalik, 2003; Mahalik, Good, & Englar-Carlson, 2003). As one researcher has described, depression also creates its own complications:

> Seeking care for depression is complicated by the disorder itself. Depression creates global negativity and dangerously deflates self-esteem. Because of stigma, admitting that the problem could be depression may cause further damage to feelings of self-worth-"Only weak people get depressed. If I am depressed, I am weak" (Halter, 2004, p. 178).

Additionally, individual's attributions about whether or not depression can be controlled by willpower or strength tend to predict their responses when depression is encountered. People who think depression is a matter of personal control are more likely to hold negative attitudes toward depressed persons. If they encounter depression themselves personally, they are less likely to seek help (Halter, 2004).

The current study describes men's difficulties in recognizing the onset of depressive episodes. Depression begins gradually, and often is interpreted as a variation of normal life problems. Once the problem situation presents, negative associations with the role of the depressed person further inhibit the acknowledging of the disease that must precede receiving help for the problem.

Theme Four: Course

The course of depression is *pervasive, chronic* and *progressive.* Throughout the interviews, an important theme that emerged from the experience of depression were the expectations about the future *course* of the illness. The men in this study described their beliefs that depression was a recurring, *chronic* illness they would likely face over the rest of their lives. Depression was also described as *progressive* in seriousness over time. Finally, as the men reflected on the effects of depression in their lives and futures, they commented on its *pervasiveness* of effect.

The belief that one's struggles will continue and likely intensify could be attributed to cognitive distortions and increased negativity (Beck, 1967; Beck, 1995). Many of the men in this study expressed this point of view. Their awareness of likely continued struggles and deterioration over time does not merely represent a manifestation of pessimistic thinking. The notion that depression is a *chronic*, recurrent, and *progressive* major illness is gaining much research support.

Efforts to understand the course of depression and its gender-related variations are currently underway. Persons receiving outpatient treatment for depression took part in a national survey, and the gender differences present between the first 1500 men and women enrolled in the study were summarized in a recent article (Marcus et al., 2005). Of the first 1500 individuals, roughly one third were male (37.2%). Women's average first onset occurred earlier than

men's (24.3 versus 26.5 years old), and women's comorbid complaints contained more references to anxiety while men's comorbid complaints were more consistent with alcohol and drug use (Marcus et al., 2005).

This study reported that depression seemed to be a *chronic* and *progressive* illness that broadly affected men's functioning. These notions are validated by a team led by Demyttenaere, who reported that "nowadays it is becoming more and more clear that MDD should be seen as a disorder that is *chronic*, *progressive*, and recurrent in nature" (Demyttenaere, Van Oudenhove, & De Fruyt, 2005, p. 17).

Longitudinal studies offer excellent opportunities to view courses of illnesses. In one such study of 12 years duration, the symptom course was found to be variable and fluctuating. Depressed individuals had symptoms most of the time, though not at all observation points. During the 12-year span, 59% of the weeks were described as symptomatic. Also during that time, the levels of severity varied as well (Judd et al., 1998). Citing a "growing confluence of scientific evidence" Judd et al. went on to support the notion that "unipolar MDD (major depressive disorder) is a clinically homogenous illness in which major, minor, and subsyndromal depressive symptoms commonly alternate as different manifestations and levels of illness activity" (1998, p. 700).

As the distinctions between different types of depression are being revised, so too is the view that depression represents a single reaction to a stressor that lasts for one episode. Surveys show that the median duration of a

major depressive episode is usually reported at around 20 weeks long (Solomon et al., 2000). The first episode is often followed by further episodes and there exists significant risk of relapse, or return to experiencing depressive symptoms. As the time horizon for defining relapse is extended outward, the relapse rates rise. At a relapse period of 15 years, the percentage of persons experiencing the return of depression is an astounding 85% (Mueller et al., 1999).

The men in this study reported that depression seemed to pick up momentum and return more frequently over time. Again, the literature supports this claim. The risk of having an additional depressive episode varies directly with the number of episodes a person has already experienced, and the time spent free from symptoms lessens with each returning episode (Bos et al., 2005; Solomon, et al., 1997).

One theory has been advanced to explain why the cycles of depression accelerate with each recurring episode, even when no such triggering event can be identified. The *kindling hypothesis* represents the idea that early episodes are more likely than later episodes to be triggered by psychological stressors. Later episodes appear to spontaneously recur, and may be unrelated to any identifiable current stressor (Post, 1992).

There is evidence that the *kindling hypothesis* may be accounted for by structural brain changes both caused and exacerbated by the experiencing of the depressive episode. Current research is showing how it is possible for “potentially distinct environmental and genetic pathways to a ‘kindled’ or ‘sensitized’ state in

which the mind/brain is predisposed to spontaneous depressive episodes" (Demyttenaere, Van Oudenhove, & Fruyt, 2005, p.28). Recurrent depressive episodes may be ignited by progressively less- negative situations, or eventually even without any external cause at all.

Structural brain changes have been noted in studies of hippocampal volume loss and with fewer observed Serotonin receptors viewable with positron emission tomography (PET) (Sheline, Mittler, & Mintun, 2002). Such changes in the brain structures have been summarized and compared to neurological diseases such as Alzheimer's disease and epilepsy (Kanner, 2004).

Current research on depression shows it to be a *chronic*, *progressive* and recurrent illness (Demyttenaere, Van Oudenhove, & De Fruyt, 2005). Armed with this information, researchers' attention has now shifted to prevention of future and management of current illness. Searching for "effective and efficacious strategies of continuation or maintenance treatments for affective disorders is one of the most important challenges of contemporary psychiatry" (Demyttenaere, Van Oudenhove, & De Fruyt, 2005, p. 24). Perhaps now equipped with the knowledge that men have expressed intuitively in this study, researchers can proceed with the business of searching for ways to ameliorate the suffering faced daily by these men.

Theme Five: Reactions

Men's personal reactions included *feelings about having depression, coping with depression* by way of medicine and therapy, and *financial pressures.*

Men interviewed for this research project expressed their personal *feelings about having depression*, *coping with depression* with medicines and psychotherapy, and *financial pressures*. Predictably there is very little professional literature existing about men's personal *reactions* to having depression. There is minimal information was men's feelings about antidepressant use, and on the *financial pressures* associated with depression. Major themes from the literature are reviewed and discussed with respect to the current study.

Men's personal *reactions* to living with depression are conspicuously absent from the professional literature. Prior to this current study, no systematic investigation of men's own perspectives on living with depression has been presented. The lack of such information was a fundamental reason for this project's inception and completion. Information about men's lives is available however in alternate formats. The section presents information from autobiographies of depressed men as one such source (see Review of Literature).

Now a half-century old, the writings of Talcot Parsons on the sick role concept are still important guides for understanding the personal reactions of depressed men. According to Parsons, a person accepting the sick role is granted two major rights, and must implicitly agree to fill two major duties (Parsons, 1951). The two major rights serve to absolve the sick person "from responsibility for the incapacity, as it is beyond his control, and he is also exempt from normal social role obligations" (Segall, 1976, p. 162). The two major duties call for the

sick role occupant to try to recover from the sick role, and to cooperate with technically competent treatment professionals (Parsons, 1951; Segall, 1976).

Perhaps Parsons' sick role concept explains why the men in this study described their strong desires to recover from depression, even while acknowledging their struggles were likely to be lifelong. The men in this study found the issue of control quite salient to their understanding of depression, and reported that depression was akin to feeling *out of control*. Getting help for depression then, whether with medications, therapy, or other methods, served to reduce the discomfort of feeling *out of control*. Perhaps the act of researching depression also strikes a blow against feeling *out of control*.

More information is available regarding views on medications and therapy. Depressive patients in general have been shown to hold factually inaccurate views about dosing and effects of antidepressants (Kessing, Hansen, & Demyttenaere, 2005). Although the clinical wisdom is that bipolar patients have notoriously negative attitudes toward medication compliance, one study found that "patients with depressive disorder had a view of antidepressants more negative than patients with bipolar disorder" (Kessing, Hansen, & Demyttenaere, 2005, p. 1210).

Men are no more negative about the potential benefits of medications than women, and do not vary significantly in terms of knowledge or attitude toward medications. It has been found that persons who take antidepressants dislike 1) the perceived control they lose by taking the medications, 2) their lack

of certainty knowledge that the medicines are helping, and 3) the antidepressant's side-effects (Kessing, Hansen, & Demyttenaere, 2005).

Knudsen, Hansen, Traulsen, and Eskildsen (2002) studied how taking antidepressants affected women's self-concept. Women described their process of coming to accept their views of themselves as having an illness that required medication, and about the various conflicts they faced. Similar to the findings in the current study, the women described dealing with their own views of depression as a *sign of weakness*, and not wanting to feel dependent upon a medication (Knudsen, Hansen, Traulsen, & Eskildsen, 2002). Appropriate antidepressant use has been shown to be effective and to enhance psychotherapy efficacy rates from 55% to 85% when therapy is combined with medications. Still, much hesitancy to embrace psychopharmacology exists in the hearts and minds of men and women with depression (Keller et al., 2005).

Research on men and therapy has focused mainly on attendance rates, in terms of how likely men would be to seek help for a problem compared to women. From that line of research, it has been shown that men consult physicians at rates half to those of women (Moller-Leimkuhler, 2001).

Men tend to avoid therapy because the demands of therapy are at odds with the traditional male gender role (Brooks, 1998). Traditional male gender role socialization impacts men's hesitancy to seek psychotherapeutic services for problems such as depression, and also influences how the few who do appear in consulting rooms present. One must not underestimate the effects of culture in

men's lives as it pertains to the development of restrictive emotionality and hesitancy to seek assistance through psychotherapy (Good, Thomson, & Brathwaite, 2005)

A variety of perspectives for understanding men's mental health issues are emerging. Implications for men's mental health treatment are being drawn from such divergent areas as social learning, psychodynamic, feminist, and social construction approaches (Addis & Cohane, 2005). As research on men's experiences in therapy broadens and matures, therapists may learn strategies to respond to men's special needs. Men's conformity to traditional masculine stereotypes adds an extra layer of complexity when assessing need for mental health services such as therapy for depression (Mahalik et al., 2005). Cochran (2005) has advocated for guidelines when conducting assessments that may help to develop a respectful and collaborative environment for change among male consumers of mental health services.

Financial pressures figured prominently in the transcripts of men's depressive experiences both as a cause of depressed mood and as a consequence of depression's debilitation. Volumes of research verify these men's experiences. Quite simply, depression does appear to be related to financial strain, job loss, and socioeconomic status. Underlying all three of the above mentioned potential causes is feeling *out of control* of one's own life.

Financial strain is a difficult burden to bear. The professional literature shows that depression, hostility, education level, and psychological stress all are

inversely related to socioeconomic status. Across most human populations, rates of morbidity and mortality are consistently highest among persons in the lowest socioeconomic status groups (Adler, et al., 1994; Everson, Maty, Lynch, & Kaplan, 2002; Kessler, Turner, & House, 1989). Having a negative outlook worsens the effects of financial strain on well-being (Creed, & Klisch, 2005). Negative outlook is often considered one of the core symptoms of depression (Beck, 1967).

Underemployment and unemployment both are contributing factors to depression. Depression can result from unemployment, and worsens the ramifications of job loss by reducing the likelihood of reemployment. If one can't find another job to replace the one that was lost, then *financial pressures* are sure to mount (Price, Choi, & Vinokur, 2002). It is not only the unemployed that are hurt by poverty, however. The working poor are at risk as well. People who earn even twice the federal poverty guideline are 2.5 times more likely to have depression. Persons living in poverty report 4 times higher rates of cynicism and pessimism compared to people who had never experienced poverty even when rates are controlled for age, gender, and health status (Everson, Maty, Lynch, & Kaplan, 2002, p. 894).

The men in this study were emphatic that their financial difficulties exacerbated their experiences of depression, and contributed to feeling *out of control*. The positive-focused term *mastery* is generally used to refer to feelings of being in control instead of the more negative sounding *out of control*. *Mastery*

refers to a person's perception of how much control they have to impact their own environment (Turner, Lloyd, and Russell, 1999). *Mastery* has been found to encourage problem-solving and activity, and therefore reduce depression (Ross, & Mirowsky, 1989). Poverty reduces access to reinforcing experiences and limits the availability of feelings of *mastery*. Depressive symptoms tend to vary inversely with socioeconomic status (Turner & Lloyd, 1999).

Men's personal *reactions* emerged as a major theme in this study. Although the men were hesitant to view themselves as authorities as described in earlier themes, their feelings and thoughts about depression match closely some of the most current research in the field.

Significance of the Current Study

The current study represents a significant contribution to the accumulated understanding of depression among men. Until now, no systematic investigation from the point of view of the men experiencing depression was available. The present study is a strong contribution because the words and experiences of depressed men are presented directly. The group of men participating in this study is a dramatically under-researched population. The men who volunteered for this study were active therapy clients who both self-identified and were objectively verified as seriously depressed, and were screened to avoid possible confounding issues like bipolar disorder and psychotic symptoms.

The current study contributes to the understanding of depression by locating the lived experience of depression within the context of lost personal

control. As such, motivational interviewing techniques and sensitivities to making therapy more welcoming for male clients are necessary skills for therapists to develop. Patience with men attempting to describe experiences they are only vaguely aware of should be exercised, and extra tolerance should be shown to men who present with seemingly vague or somatic complaints. Quite possibly, a fair amount of training in how to use therapy productively might need to precede the beginnings of therapy.

Findings from this study highlight important considerations that professionals working with depressed men should be sensitive to as possibilities. Each professional should investigate with his client individually to see if the themes are appropriate for that particular client.

Recommendations for Future Study

Future studies hopefully will build on the contributions of this study by continuing to seek out depressed male clients for inclusion in projects. Additional qualitative projects as well as other research methodologies that allow for a generalization of findings should be employed.

Additional information should be gathered regarding the process by which psychologists come to understand men who are depressed. Increased recognition of depression could result in earlier treatment and could potentially avoid disastrous outcomes.

Another area for future research should also include reviewing the relationship between depression, coping skills, and the development of *mastery*.

Interventions to build men's esteem upon other than financial and physical means could contribute positively as well. Additionally, research conducted in the future should begin to investigate further the treatment ramifications of considering depression to be a *chronic*, recurrent, and *progressive* illness. Prophylactic use of antidepressants during recovery periods, and prescription of maintenance medications beyond resolution of first depressive episodes offer intriguing possibilities for research. Additionally, new competencies for therapists in treating male depression may be developed based on this study's new understanding of how men view their depression.

Certain information and anti-stigma campaigns have begun recently to provide accurate and appropriate information to the public about men's depression. The current campaign by the National Institute for Mental Health (NIMH) is titled *Real Men. Real depression.* (NIMH, 2003). In that campaign, brief snippets of men's descriptions of depression are presented in print and on Web site formats (NIMH, 2003). The *Real Men. Real Depression*. campaign is described in more detail in a current article (Rochlen, Whilde, & Hoyer, 2005).

Equally as encouraging is the recent Federal Action Agenda released by the U.S. Department of Health and Human Services (DHHS). The DHHS has included as an immediate action priority the need to provide public education about men's depression (SAMHSA, 2005). These efforts are much needed, and should be continued. Hopefully the increased, understanding of men's

experiences with depression facilitated by the current study will contribute in a positive way.

Chapter Summary

The present study represents a description of the life experiences of ten men who volunteered their time and efforts to describe depression. A literature review was conducted on the experience of depression among men to assist in developing an appropriate research question and methodology. The summary of that review is presented in the Review of Literature chapter.

Each participant described his personal experiences with depression in an unstructured interview lasting approximately an hour in length. Interviews were transcribed by the primary researcher and returned to the participants for comments, and to insure validity. Data was analyzed using phenomenological methods developed by Colaizzi (1978). Research methods used for this study are described in the Methodology chapter.

During the analysis, five major themes and one ground emerged from the interviews. The themes were: *describing*, *symptoms*, *recognizing*, *course*, and *reactions*. The ground that provided the context for those five themes was the notion that depression was an experience of being *out of control*. The Results chapter presented the five themes in the words of the participants using direct quotes taken from the interviews. In the Discussion chapter, the themes were discussed along with relevant professional literature from the fields of

Psychology, Sociology, and Medicine. Comments about the significance of the current study and suggestions for future study completed the discussion chapter.

REFERENCES

References

Addis, M. E., & Cohane, G. H. (2005). Social scientific paradigms of masculinity and their implication for research and practice in men's mental health. *Journal of Clinical Psychology, 61* (6), 633-647.

Addis, M. E., & Mahalik, J. R. (2003). Men, masculinity, and the contexts of help seeking. *American Psychologist, 58* (1), 5-14.

Adkins, D. (2001, May 7). What the world didn't know about me, *Newsweek, 37*, 12.

Adkins, D. (2002, August) My greatest hurdle: Depression. *Essence, 33,* 4.

Adler, N. E., Boyce, T., Chesney, M. A., Cohen, S., Folkman, S., Kahn, R. L., & Syme, S. L. (1994). Socioeconomic status and health: The challenge of the gradient. *American Psychologist, 1*, 15-24.

Aldrin, B. (1973). *Return to Earth*. Random House: New York.

Alvidrez, J., & Azocar, F. (1999). Self-recognition of depression in public care women's clinic patients. *Journal of Women's Health and Gender-Based Medicine*, 8, 1063-1071.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.

Aronson, J. (1994). A pragmatic view of thematic analysis. *The Qualitative Report, 2* (1), 1-4.

Austin, M., Mitchell, P., & Goodwin, G. (2001). Cognitive deficits in depression: Possible implications for functional neuropathology. *British Journal of*

Psychiatry, 178, 200-206.

Barbee, M. (1996). Men's roles and their experience of depression. *Art Therapy, 13*, 31-36.

Beck, A. T. (1967). *Depression: Causes and treatment.* Philadelphia: University of Pennsylvania.

Beck, A. T., & Steer, R. A., & Brown, G. K. (1996). *Beck Depression Inventory* (2nd ed. Manual). San Antonio, TX: Psychological Corporation.

Beck, J. (1995). Cognitive therapy: Basics and beyond. New York: Guilford.

Blasi, A. (1991). The self as subject in the study of personality. In D. Ozer, & J. M. Healy, Jr. (Eds.) *Perspectives in personality, Vol. 3: Part A: Self and emotion; Part B: Approaches to understanding lives.* (pp. 161-181). Bristol, PA: Jessica Kingsley.

Bohart, A. C., & Greenberg, L. S. (1997). Empathy: Where do we go from here? In A. C. Bohart & L. S. Greenberg (Eds.) *Empathy reconsidered: New directions in psychotherapy* (pp. 419-449). Washington, DC: American Psychological Association.

Bos, E. H., Bouhuys, A. L., Geerts, E., Titus, W. D. P., Van Os, I. D., Van der Spoel, W. H., & Brouwer, J. O. (2005). Cognitive, physiological, and personality correlates of recurrence of depression. *Journal of Affective Disorders, 87*, 221-229.

Bradshaw, T., & Miller, M. C. (2003, June 16). Stop pretending nothing's wrong. *Newsweek, 141*, 71-72.

Brooks, G. (1998). *A new psychotherapy for traditional men.* Jossey-Bass: San Francisco.

Brown, F. (1976). Self-report inventories. In *Principles of educational and psychological testing* (2nd ed.). Atlanta, GA: Holt, Rinehart, & Winston.

Brownhill, S., Wilhem, K., Barclay, L., & Schmied, V. (2005). 'Big build': Hidden depression in men. *Australian and New Zealand Journal of Psychiatry, 39*, 921-931.

Campbell, J. (1996). Traditional men in therapy: Obstacles and recommendations. *Journal of Psychological Practice, 2*, 40-45.

Carver, C. S., & Scheier, M. F. (2005). Engagement, disengagement, coping, and catastrophe. In A. J. Elliott & C. S. Dweck (Eds.), *Handbook of competence and motivation* (pp. 527-547). New York: Guilford.

Cochran, S. V. (2005). Evidence-based assessment with men. *Journal of Clinical Psychology, 61* (6), 649-660.

Cochran, S. V., & Rabinowitz, F. E. (2000). *Men and depression: Clinical and empirical perspectives.* NY: Academic.

Cohn, H. W. (1997). *Existential thought and therapeutic practice: An introduction to existential psychotherapy.* Thousand Oaks, CA: Sage.

Colaizzi, P. F. (1978). Psychological research as the phenomenologist views it. In R. S. Valle & M. King, (Eds.). *Existential phenomenological alternatives for psychology.* (pp. 48-71). New York: Oxford University.

Coyne, J. C., & Calarco, M. M. (1995). Effects of the experience of depression:

Application of focus group and survey methodologies. *Psychiatry: Interpersonal and Biological Processes, 58,* 149-163.

Creed, P. A., & Klisch, J. (2005). Future outlook and financial strain: Testing the personal agency and latent deprivation models of unemployment and well-being. Journal of Occupational Health Psychology, *10* (3), 251-260.

Dahlberg, K., & Halling, S. (2001). Human science research as the embodiment of openness: Swimming upstream in a technological culture. *Journal of Phenomenological Psychology, 32* (1), 12-21.

David, D., & Brannon, R. (1976). *The forty-nine percent majority.* Reading, MA: Addison-Wesley.

Davidson, L, Staeheil, M., Stayner, D., & Sells, D. (2004). Language, suffering, and the question of immanence: Toward a respectful phenomenological psychopathology. J*ournal of Phenomenological Psychology, 35* (2), 197-232.

Demyttenaere, K., Van Oudenhove, L., & De Fruyt, J. (2005). The lifecycle of depression. In P. Luyten, S. Blatt, and J. Corveleyn (Eds.), The theory and treatment of depression: Towards a dynamic interactionism model, (pp. 17-41). Mahwah, NJ: Lawrence Erlbaum.

Douglas, D. (2004). The lived experience of loss: A phenomenological study. *Journal of the American Psychiatric Nurse Association, 10* (1), 24-32.

Doyle, J. A. (1983), *The male experience.* Brown: Dubuque, Iowa.

Endler, N. S. (1982). *Holiday of darkness: A psychologist's personal journey out*

of his depression. New York: John Wiley & Sons.

Everson, S. A., Maty, S. C., Lynch, J. W., & Kaplan, G. A. (2002). Epidemiologic evidence for the relation between socioeconomic status and depression, obesity, and diabetes. *Journal of Psychosomatic Research, 53*, 891-895.

Finlay, L. (2003). The intertwining of body, self, and world: A phenomenological study of living with recently-diagnosed multiple sclerosis. *Journal of Phenomenological Psychology, 34* (2), 157-178.

Frankl, V. (1963). *Man's search for meaning.* New York: Pocket Books.

Giorgi, A. (1985). Sketch of a phenomenological method. In A. Giorgi (Ed.), *Phenomenology and psychological research* (pp. 8-22). Pittsburgh, PA: Duquesne University Press.

Giorgi, A. (2004). A way to overcome the methodological vicissitudes involved in researching subjectivity. *Journal of Phenomenological Psychology, 35* (1), 1-25.

Good, G. E., & Wood, P. E. (1995). Male gender role conflict, depression, and help seeking: Do college men face double jeopardy? *Journal of Counseling and Development, 74,* 70-74.

Good, G. E., Thomson, D. A., & Brathwaite, A. D. (2005). Men and therapy: Critical concepts, theoretical frameworks, and research recommendations. *Journal of Clinical Psychology, 61* (6), 699-711.

Goodwin, G. M. (1997). Neuropsychological and neuroimaging evidence for the involvement of the frontal lobes in depression. *Journal of Psychopharmacology, 11,* 115-122.

Groth-Marnat, G. (1997). *Handbook of psychological assessment* (3rd ed.). New York: John Wiley & Sons.

Halling, S., & Leifer, M. (1991). The theory and practice of dialogal research. *Journal of Phenomenological Psychology, 22* (1), 1-15.

Halling, S., Kunz, G., & Rowe, J. (1994). The contributions of dialogal psychology to phenomenological research. *Journal of Humanistic Psychology, 34* (1), 109-131.

Halter, M. J. (2004). The stigma of seeking care and depression. *Archives of Psychiatric Nursing, 18* (5), 178-184.

Hedelin, B., & Strandmark, M. (2001). The meaning of depression from the life-world perspective of elderly women. *Issues in Mental Health Nursing, 22,* 401-420.

Heesacker, M., Wester, S. R., Vogel, D. L, Wentzel, J. T., Mejia-Millan, C. M., & Goodholm, C. R. (1999). Gender- based emotional stereotyping. *Journal of Counseling Psychology, 46* (4), 483-495.

Heidegger, M. (1962). *Being and time.* (Translated by J. Macquarrie & E. Robinson). New York: Harper and Row (Original work published 1927).

Heifner. C. (1997). The male experience of depression. *Perspectives in Psychiatric Care, 33,* 10-18.

Hein, S. F., & Austin, W. J. (2001). Empirical and hermeneutical approaches to phenomenological research in psychology: A comparison. *Psychological Methods, 6,* 3-17.

Hopko, D. R., Lejuez, C. W., Ruggiero, K. J., & Eifert, G. H. (2003). Contemporary behavioral activation treatments for depression: Procedures, principles, and progress. *Clinical Psychology Review, 23*, 699-717.

Husserl, E. (1931). *Ideas: General introduction to pure phenomenology.* (Translated by W. R. Boyce Gibson). New York: Macmillan.

Husserl, E. (1970). *Logical investigations*. NY: Humanities (Original work published 1913).

Jambunathan, J. (1996). Depression: Dealing with the darkness. *Perspectives in Psychiatric Care, 32*, 26-29.

James, W. (1890). *Principles of psychology* (2 Vols.). New York: Holt.

Judd, L. L., Akiskal, H. S., Maser, J. D., Zeller, P. J., Endicott, J., Coryell, W., Paulus, M. P., Kunovac, J. L., Leon, A. C., Mueller, T. I., Rice, J. A., & Keller, M. A. (1998). A prospective 12-year study of subsyndromal and syndromal depressive symptoms in unipolar major depressive disorders. *Archives of General Psychiatry, 55*, 694- 700.

Kanner, A. M. (2004). Is major depression a neurologic disorder with psychiatric symptoms? *Epilepsy and Behavior, 5*, 636-644.

Karp, D. (1996) *Speaking of sadness: Depression, disconnection, and the meaning of the illness.* New York: Oxford University Press.

Keen, S. (1991). *Fire in the belly: On being a man.* Bantam: New York.

Keller, M. B., McCullough, J. P., Klein, D. N., Arnow, B., Dunner, D. L., Kessing, L. V., Hansen, H. V., & Demyttenaere, K. (2005). Depressive and bipolar disorders: Patient's attitudes and beliefs toward depression and antidepressants. *Psychological Medicine, 35*, 1205-1213.

Kessler, R. C. (2002). Epidemiology of depression. In I. H. Gotlib & C. L. Hammen (Eds.), *Handbook of depression* (pp. 23-42). Guilford: New York.

Kessler, R.C., Avenevoli, S., & Merikangas, S. K. (2001). Mood disorders in children and adolescents: An epidemiological perspective. *Biological Psychiatry, 49,* 1002-1014.

Kessler, R. C., Brown, R. L., & Broman, C. L. (1981). Sex differences in psychiatric help-seeking: Evidence from four large-scale surveys. *Journal of Health and Social Behavior, 22*, 49-64.

Kessler, R. C., McGonagle, K.A., Zhao, S., Nelson, C. B., Hughes, M., Eshelman, et al. (1994). Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States: Results from the National Comorbidity Survey. *Archives of General Psychiatry*, *51*, 8-19.

Kessler, R. C., Turner, J. B., & House, J. S. (1989). Unemployment, reemployment, and emotional functioning in a community sample. *American Sociological Review, 54*, 648-657.

Knauth, P. (1975). *A season in hell.* New York: Harper & Row.

Knudsen, P., Hansen, E. H., Traulsen, J. M., & Eskildsen, K. (2002). Changes in self-concept while using SSRI antidepressants. *Qualitative Health Research, 12* (7), 932-944.

Kohut, H. (1984). *How does analysis cure?* University of Chicago Press: Chicago, IL.

Kroenke, K., & Spitzer, R. L. (2002). The PHQ-9: A new depression diagnostic and severity measure. *Psychiatric Annals, 32,* 509-515.

Kruger, J., & Dunning, D. (1999). Unskilled and unaware of it: How difficulties in recognizing one's own incompetence lead to inflated self-assessments. *Journal of Personality and Social Psychology, 77,* 1121-1135.

Kvale, S. (1983). The qualitative research interview: A phenomenological and hermeneutical mode of understanding. *Journal of Phenomenological Psychology, 14,* 171-196.

Landro, N., Stiles, T., & Sletvoid, H. (2001). Neuropsychological function in nonpsychotic unipolar major depression. *Neuropsychiatry, Neuropsychology, and Behavioral Neurology, 14* (4), 233-240.

Lejuez, C. W., Hopko, D. R., & Hopko, S. D. (2001). A brief behavioral activation treatment for depression: Treatment manual. *Behavior Modification, 25* (2), 255-286.

Levant, R. (1995). *Masculinity reconsidered*. New York: PLUME.

Levant, R. F. (1998). Desperately seeking language: Understanding, assessing, and treating Normative Male Alexithymia. In W. S. Pollack & R. F. Levant (Eds.) New Psychotherapy for Men, New York: John Wiley. pp 35-56.

Lewinsohn, P. M., Mischel, W., Chaplin, W., & Barton, R. (1980). Social competence and depression: The role of illusory self-perceptions? *Journal of Abnormal Psychology, 89*, 203-212.

Mahalik, J. R., Good, G. E., & Englar-Carlson, M. (2003). Masculinity scripts, presenting concerns, and help seeking: Implications for practice and training. *Professional Psychology: Research and Practice, 34,* 123-131.

Mahalik, J. R., & Cournoyer, R. J. (2000). Identifying gender role conflict messages that distinguish mildly depressed from nondepressed men. *Psychology of Men and Masculinity, 1* (2), 109-115.

Mahalik, J. R., Talmadge, W. T., Locke, B. D., & Scott, R. P. J. (2005). Using the Conformity to Masculine Norms Inventory in work with men in a clinical setting. *Journal of Clinical Psychology,* 61 (6), 661-674.

Marcus, S. M., Young, E. A., Kerber, K. B., Kornstein, S., Farabaugh, A. H., Mitchell, J., Wisniewski, S. R., Balasubramani, G. K., Trivedi, M. H., & Rush, A. J. (2005). Gender differences in depression: Findings from the STAR*D study. Journal of Affective Disorders, 87, 141-150.

Mays, J. B. (1995). *In the jaws of the black dogs: A memoir of depression.* Viking: Canada.

Mensch, J. (1997). What is a self? In B. Hopkins (Ed.). *Husserl in contemporary context.* (pp. 61-77). Netherlands: Kluwer.

Mischel, W. (1968). *Personality and assessment.* New York: John Wiley & Sons.

Moller-Leimkuhler, A. M. (2001). Barriers to help-seeking by men: A review of sociocultural and clinical literature with particular reference to depression. *Journal of Affective Disorders, 71*, 1-9.

Moran, D. (2000*). Introduction to Phenomenology.* New York: Routledge.

Mowrer, O. H. (1983). *Leaves from many seasons: Selected papers.* Praeger: NY.

Msetfi, R., Murphy, R., Simpson, J., Kornbrot, D. (2005). Depressive realism and outcome density bias in contingency judgments: The effect of the context and intertribal interval. *Journal of Experimental Psychology, 134* (1), 10-22.

Mueller, T. I., Leon, A. C., Keller, M. B., Solomon, D. A., Endicott, J. Coryell, W., Warshaw, M., & Maser, J. D. (1999). Recurrence after recovery from major depressive disorder during 15 years of observational follow-up. *American Journal of Psychiatry, 156,* 1000-1006.

National Institute of Mental Health (2000). NIMH suicide facts. Retrieved March 6, 2004, from http://www.nimh.nih.gov/research/suifact.cfm

National Institute of Mental Health. (2003). *Real men. Real depression*. Washington, DC: Author.

Neimeyer, R. A. (1995). Client-generated narratives in psychotherapy. In R. A. Neimeyer & M. J. Mahoney (Eds.), *Constructivism in psychotherapy* (pp. 231-246). APA: Washington, DC.

O'Connor, R. (1997). *Undoing depression: What therapy doesn't teach you and medication can't give.* New York: Berkley.

O'Neil, J. M., Helms, B., Gable, R., David, L., & Wrightsman, L. (1986). Gender Role Conflict Scale: College men's fears of femininity. *Sex Roles, 14*, 335-350.

Owen, I. (1994). Introducing an existential-phenomenological approach: Basic phenomenological theory and research -- Part 1. *Counselling Psychology Quarterly, 7,* 261-273.

Parsons, T. (1951). *The social system.* New York: Free Press.

Polkinghorne, D. (1989). Phenomenological research methods. In R. Valle & S. Halling (Eds.), *Existential-phenomenological perspectives in psychology* (pp. 41-60). New York: Plenum.

Polkinghorne, D. (2005). Language and meaning: Data collection in qualitative research. *Journal of Counseling Psychology, 52* (2), 137-145.

Pollack, W. (1998). Mourning, melancholia, and masculinity: recognizing and treating depression in men. In W. Pollack & R. Levant (Eds.), *New psychotherapy for men* (pp. 147-66). New York: Wiley.

Pollio, H., Henley, T., & Thompson, C. (1997). *The phenomenology of everyday life.* New York: Cambridge University Press.

Post, R. M. (1992). Transduction of psychosocial stress into the neurobiology of recurrent affective disorder. *American Journal of Psychiatry, 149*, 999-1010.

Price, R. H., Choi, J. N., & Vinokur, A. D. (2002). Links in the chain of adversity following job loss: How financial strain and loss of personal control lead to depression, impaired functioning, and poor health. *Journal of Occupational Health Psychology, 7* (4), 302-312.

Real, T. (1997). *I don't want to talk about it: Overcoming the secret legacy of male depression.* New York: Scribner.

Rochlen, A. B., Whilde, M. R., & Hoyer, W. D. (2005). The real men. Real depression campaign: Overview, theoretical implications, and research considerations. *Psychology of Men and Masculinity, 6* (3), 186-194.

Rogers, A., May, C., & Oliver, D. (2001). Experiencing depression, experiencing the depressed: The separate worlds of patients and doctors. *Journal of Mental Health, 10* (3), 317-333.

Rosen, D. H. (1993). *Transforming depression: Healing the soul through creativity*. New York: Penguin.

Ross, C. E., & Mirowsky, J. (1989). Explaining the social patterns of depression: Control and problem solving – or support and talking? *Journal of Health and Social Behavior, 30*, 206-219.

Rutz, W. (2001). Preventing suicide and premature death by education and treatment. *Journal of Affective Disorders, 62,* 123-129.

Schreiber, R. (1996). (Re)defining my self: Women's process of recovery from depression. *Qualitative Health Research, 6*, 469-491.

Schreiber, R. (2001). Wandering in the dark: Women's experiences with depression. *Health Care for Women International*, *22*, 85-98.

Segall, A. (1976). The sick role concept: Understanding illness behavior. *Journal of Health and Social Behavior, 17*, 163-170.

Seligman, M. E. P. (1990). *Learned optimism: How to change your mind and your life.* New York: Pocket Books.

Sheline, Y. I., Mittler, B. L., & Mintun, M. A. (2002). The hippocampus and depression. *European Psychiatry, 17* (Supplement 3), 300-305.

Shepard, D. S. (2002). A negative state of mind: Patterns of depressive symptoms among men with high gender role conflict. *Psychology of Men and Masculinity, 3,* 3-8.

Skarsater, I., Dencker, K., Bergborn, I., Haeggstroem, L., & Fridlund, B. (2003). Women's conceptions of coping with major depression in daily life: A qualitative, salutogenic approach. *Issues in Mental Health Nursing*, *24*, 419-439.

Smith, J. (1999). *Where the roots reach for water: A personal and natural history of melancholia.* New York: North Point Press.

Solomon, A. (2001). *The noonday demon: An atlas of depression.* New York: Touchstone.

Solomon, D. A., Keller, M. B., Leon, A. C., Mueller, T. I., Lavori, P. W., Shea, M. T., Coryell, W., Warshaw, M., Turvey, C., Maser, J. D., & Endicott, J. (2000). Multiple recurrences of major depressive disorder. *American Journal of Psychiatry, 157,* 229-233.

Spinelli, E. (1996). The existential-phenomenological paradigm. In Ray Wolfe & Windy Dryden (Eds.) *Handbook of Counselling Psychology* (pp. 180-200). Thousand Oaks, CA: Sage.

Steen, M. (1996). Essential structure and meaning of recovery from clinical depression for middle-adult women: A phenomenological study. *Issues in Mental Health Nursing*, *17*, 73-92.

Steinberg, W. (1993). *Masculinity: Identity conflict and transformation.* Shambhala: Boston.

Styron, W. (1990). *Darkness visible: A memoir of madness.* New York: Random House.

Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services. (2005). *Transforming mental health care in America. Federal action agenda: First steps* (DHHS Publication No. SMA-05-4060). Rockville, MD: U.S. Department of Health and Human Services.

Tharyan, P., & Raghuthaman, G. (1999). Definitions of depression. *British Journal of Psychiatry*, *174*, 559-560.

Thompson, S. (2002). The role of personal control in adaptive functioning. In C. R. Snyder & S. J. Lopez (Eds.) *Handbook of Positive Psychology* (pp. 202-213). New York: Oxford University.

Tolstoy, L. (1940). *A confession, the Gospel in brief, and what I believe.* New York: Oxford University Press.

Turner, R. J., & Lloyd, D. A. (1999). Personal resources and the social distribution of depression. *American Journal of Community Psychology, 27* (5), 1999.

Valle, R. S., & King, M. (1978). An introduction to existential-phenomenological thought in psychology. In R. S. Valle, & M. King, (Eds.). *Existential phenomenological alternatives for psychology.* (pp. 6-17). New York: Oxford University.

Wahl, O. F. (1995). *Media madness: Public images of mental illness.* Piscataway, NJ: Rutgers University Press.

Wertz, F. (2005). Phenomenological research methods for Counseling Psychology. *Journal of Counseling Psychology, 52* (2), 167-177.

Whisman, M., Perez, J., & Ramel, W. (2000). Factor structure of the Beck Depression Inventory- Second Edition (BDI-II) in a student sample. *Journal of Clinical Psychology, 56* (4), 545-551.

White, M. & Epston, D. (1990). *Narrative means to therapeutic ends.* New York: Norton.

Wisdom, J. P., & Green, C. A. (2004). “Being in a funk”: Teens’ efforts to understand their depressive experiences. *Qualitative Health Research, 14* (9), 227-1238.

Yalom, I. D. (1980). *Existential Psychotherapy*. New York: Basic Books.

Zierau, F., Bille, A., Rutz, W., & Bech, P. (2002). The Gotland Male Depression Scale: A validity study in patients with alcohol use disorder. *Nordic Journal of Psychiatry, 56* (4), 265-271.

APPENDICES

APPENDIX A

DESCRIPTION OF PARTICIPANTS

Description of Participants

Ben is Caucasian, 61 years old, and works as a telemarketer. He has one-year sobriety in his recovery from Alcohol Dependence. Ben is divorced, and sees his adult son and daughter only occasionally. He lives in a shelter for homeless men but hopes to find his own apartment soon. He is an accomplished musician who has written symphonies and had his musical creations performed by entire orchestras. He has been taking antidepressants for over twenty years.

Gene is Caucasian, 38 years old, and works part-time in a factory. He is married and has two middle-school aged daughters. His family lives in a home owned by his mother. He has been taking medications for depression for two years.

Thomas is 37 years old, African-American, and works in a nursing home. He is divorced, and has three daughters with whom he is currently working to regain contact. He is in a residential treatment program, recovering from Cocaine and Alcohol Dependence. He hasn't used in over a year, and has been taking antidepressants off and on for four years.

Ricky is 58 years old, Caucasian, and currently looking for work. He has previously been very successful in security sales, but lost his position with the market response to the Sept 11th attacks. He has been taking antidepressants for the last three years. He is divorced, and does not see his two adult children.

Dennis is 45 years old, Caucasian, and currently unemployed. He lives between the homes of several relatives. He has never been married, and has no children. He said that he was like his father, in that he was “good at getting women, but not good at keeping them.” Dennis has been taking medications for depression for his whole life.

Mike is 43 years old, Caucasian, and currently applying for disability status due to an injury sustained while working in a factory. He is single and has no children. Mike has been taking antidepressant medications for the last five years. His favorite thing to do is to visit a girlfriend’s house, “cook a pizza”, and watch her kids play.

Evan is 56 years old, Caucasian, and currently unemployed. He was previously very successful in automobile sales and indicated that he once “made more money than the President of the USA.” He is divorced and has two adult children. Evan has been prescribed antidepressants for two years.

Jeremy is 46 years old, Caucasian, and self-employed. He asked that the study not describe any factors relating to his job out of fear that “maybe no one would hire me if they knew I was depressed.” He is married, with two young children. Jeremy is one of only two participants from this sample not taking

antidepressants. He says they are just a way to “cover up” problems, and fears they would interfere with his ability to work.

Tony is 48 years old, Caucasian, and recently unemployed due to mounting physical problems. He is currently appealing his denial for disability payments from the government. He has been taking antidepressants for the last three years. Tony is divorced, and does not often speak with his children.

Aldron, is 30 years old, African-American, and dually employed in the management and music industries. Aldron is gay though not currently in a relationship. He is not taking medications for depression at this time.

APPENDIX B

APPROVED IRB APPLICATIONS

- University IRB Application
- Cherokee Health Systems IRB Application

THE UNIVERSITY OF TENNESSEE, KNOXVILLE

Application for Review of Research Involving Human Subjects

I. IDENTIFICATION OF PROJECT

Principal Investigator
Brian Spillman, MA
107 Colonial Drive
Knoxville, TN 37920
Cell: 865-719-0630
Brian.Spillman@gmail.com

Faculty Advisor
Mark Hector, Ph.D.
416C Austin Peay
University of Tennessee
Knoxville, TN 37996
Office: 865-974-1984
mhector@utk.edu

Department/ Unit: Psychology Department

Project Classification: Dissertation

Project Title: A Phenomenological Analysis of Men's Experiences of Depression

Starting Date: Upon IRB Approval

Estimated Completion Date: Summer 2005

External Funding: N/A

II. PROJECT OBJECTIVES

The purpose of this study is to understand the experience of depression among a clinical sample of men receiving counseling for depression. With IRB approval, a series of fifteen audio-recorded interviews will be analyzed using phenomenological methods. Participants will be asked to recount their experience of living with depression. The information obtained from the interviews will be analyzed using phenomenological methods of analysis to find the consistent themes underlying the experience of depression.

III. Description and Source of Research Participants

Selection and Exclusion Criteria

Approximately 15 males will be recruited for this study. These males will qualify by 1) being in outpatient counseling for depression at Cherokee Health Systems mental health center, 2) being diagnosed with depression by their psychologist, 3) self-identifying as having depression, and 4) being willing to participate in this study.

Certain exclusionary criteria exist for this study. No male who is diagnosed with Bipolar Disorder, or is currently suicidal or homicidal, or does not possess sufficient understanding to allow for informed consent will be accepted into this study.

Additionally, men taking OTC or prescription medications are not automatically excluded from the study. No coexisting medical disease disqualifies a potential subject.

Method of Gaining Access to Participants

Possible participants will be identified by psychologists working for Cherokee Health Systems from among active client caseloads. Those psychologists who identify patients for possible participation in this study will be instructed to prescreen participants to insure that participants are neither currently suicidal nor experiencing psychotic symptoms, and that the participation in this study is unlikely to harm the individual. Additionally, psychologists will only consider including patients who possess sufficient understanding to allow for informed consent. In order to make sure that psychologists have enough information about the participant to make that decision, psychologists will be instructed to only consider referring men who have been in therapy for at least three sessions. Individuals who are suicidal or homicidal, psychotic, or diagnosed with Bipolar Disorder will not be eligible for participation in this study.

The psychologists responsible for identifying potential participants will provide a brochure describing the study and detailing how to contact the principal investigator. That brochure is appended to this Form B document and is entitled “Invitation to Participate in a Research Study.” After being contacted by a potential participant, the principal investigator will describe the study and the requirements for a participant. The primary investigator will request that the

potential participant consent to take part in two interviews. The first interview should last around one hour in length. The second interview would last around half an hour and would be scheduled about one week after the first interview. If the potential participant meets the criterion outlined above and is willing to be interviewed, an initial interview will be scheduled at a mutually convenient time and location. The second interview would be scheduled at the conclusion of the first interview. The site of the meetings will most probably be in the private offices of Cherokee Health Systems.

At the beginning of both interviews the participant will be asked to sign the Informed Consent form. At the first interview the participant will be asked to complete a basic quantitative assessment of depression (Beck Depression Inventory 2nd Edition), and describe in as specific terms as possible his own experience of living with depression. At the beginning of the second interview, the participant will be provided with a tentative summary of the first interview and be offered the opportunity to make any corrections or comments. During both interviews no inducements will be provided to encourage participation. Participants will be informed that they will be participating on a voluntary basis and will be told that their identity will remain confidential and they may withdraw at any time. Additionally, the Principal Investigator will reiterate that participation is voluntary and will in no way affect the participant's ability to receive services at Cherokee Health Systems.

Disclosure of Principal Investigator's Relationship with Cherokee Health Systems

The Principal Investigator is employed full-time by Cherokee Health Systems as a counselor. No patient whom the Principal Investigator has ever held a professional counseling relationship with will be approached for inclusion in this study.

IV. Methods and Procedures

Participants will be asked to meet at a mutually agreed upon location that would ensure confidentiality for a tape-recorded interview. The interviews will be unstructured, and the participants will be asked to tell about their experiences of depression. The participant will complete the Beck Depression Inventory (2nd edition) (BDI-2). A copy of the BDI-2 is attached to this document. The principal investigator will conduct the interviews. The interviews will start with the following request: "Please tell me about your experience of depression." The remainder of each interview will be spent following up and clarifying the central

theme. The principal investigator will ask follow up questions regarding themes and topics introduced by the participants. The principal investigator will not introduce themes or topics that have not already been introduced by the participant. It is important to emphasize here that the principal investigator will rigorously attempt not to introduce any of his own ideas or preconceptions regarding the experience of their own depression. The whole focus of this project is on what the participants say about their own experience of depression. The principal investigator has no definition of the experience of depression and no hypotheses to test. Data collection will be conducted with no deception and no manipulation.

At the close of the first interview with the participant, a second meeting will be arranged during which a summary of the results from the first meeting will be presented. The second meeting will be around one week later than the first meeting to allow the principal investigator time to process the material. During the second interview participants will be offered a chance to review the results and make comments or corrections of the summary presented at the second meeting. Participants who do not desire to return for the second meeting will not be required to meet that additional time.

The first interviews with each participant will be tape-recorded and transcripts will be prepared by the principal investigator. The tapes and transcripts will be numerically coded in order to maintain participants' confidentiality. The second interviews with each participant will not be tape-recorded.

The principal investigator will analyze the transcripts using established phenomenological methodology, and may consult with his Faculty Advisor regarding the interpretation of the transcripts. No "interpretive group" will be used to analyze the transcripts. Once the individual transcript is analyzed and themes are found, the principal investigator will share his findings in the second interview with the participant to check for reliability and validity. The second meeting will not be tape-recorded and will be at a time and location mutually convenient and around one week from the first interview.

The primary purpose of the analysis will be to identify common themes across the transcripts. No identifying information will be included in the transcripts, and after transcription, the tapes will be erased. Participants providing self-identifying information during the interviews will have that information edited from the transcripts by the principal investigator. Transcripts will be kept in a locked file cabinet in Dr. Hector's office for three years after completion of this study.

V. Specific Risks and Protection Measures

A. SPECIFIC RISKS AND PROTECTION MEASURES

There is some risk for participants. Specific protection measures have been implemented to minimize the potential of harm from participation. During the interviews participants may recall personal experiences of a possibly sad, embarrassing, or emotionally painful manner. Accordingly, participants may wish to discuss personal issues as a result of completing the interview or may feel unsettled after disclosing personal information.

The primary investigator will remain sensitive to the participant's needs and offer breaks as needed. The participant will determine the interview length, and the interview will end when the participant has completed his comments. Interviews ordinarily last 45 minutes long. Upon completion of the interview, the participant will be given a list of contacts that he may use to discuss personal issues if he desires. That listing will include the phone numbers used to access the office of their psychologist, an after-hours emergency contact number staffed by doctoral-level psychologists, the number for Mobile Crisis evaluation service, the CONTACT 24-hour help line number, and the locations of area hospital Emergency Rooms.

Participants might feel pressure to participate because of being invited to take part in the study by their own psychologists. The perception of feeling pressured to participate is not completely preventable because it could be influenced by factors other than the behavior of the psychologist. However, psychologists are expertly trained to communicate clearly and use their clinical skills in appropriately presenting this feature of optional participation to the research participants. Participants will be reminded that their participation is voluntary on the consents forms, and by the primary investigator before commencing the interview.

B. ADDITIONAL PROTECTION MEASURES

Voluntary participation: Before agreeing to participate, each participant will be provided with a verbal description of the study by the primary investigator as well as a written description of the study (Informed Consent Form). Each participant will volunteer to be interviewed on tape and will be informed that they can terminate participation at any time.

Informed Consent: All participants will read, sign and receive an Informed Consent Form describing their participation in the study. This form includes a description of the study, expectations of participants, and permission to audio-

tape the interview. The Informed Consent Form will also include the name, address, and phone number of the researcher in case any participant wishes to contact him. The phone number provided will be a cell phone number and not the principal investigator's home phone number (Informed Consent Form).

Confidentiality: Both the principal investigator and the Faculty Advisor of the project are aware of and will abide by the American Psychological Association's (APA) Ethical Principles and Code of Conduct of Psychologists. No identifying information will be assigned to transcripts or final reports. Participants will be requested to not use names in the audiotapes. No reports on the study will contain information identifying any participant. Participants will select pseudonyms to be used in lieu of their actual name. The principal investigator will edit from the transcript any self-identifying information provided during the interview by the participant.

Use of audiotapes: In the Informed Consent Form all participants will give permission to audiotape the interview. Audiotapes will be used by the principal investigator and will be used for the purpose of transcribing the interview. The principal investigator will transcribe the audio tapes himself, and no paid or volunteer transcribers will be used. Audio tapes will be stored in a locked filing cabinet in 416 C Austin Peay. When all data have been analyzed and transcribed, the researcher will erase audiotapes.

If a participant has some question about the research project, he can contact either the principal investigator or the faculty advisor. Contact numbers and email addresses for both the principal investigator and the faculty advisor are provided in the Informed Consent Form.

VI. BENEFITS

Potential benefits to participating in this project are probably only incidental. One possible benefit of participating in this study could include participants' heightened awareness of their own life experiences. In addition, this study could be informative for understanding the relatively under-researched area of male depression. The participants will not be paid for their participation in the study.

VII. METHODS FOR OBTAINING "INFORMED CONSENT" FROM PARTICIPANTS

Informed consent will be obtained from all participants prior to taking part in the study. Each participant will sign an Informed Consent Form that will be retained by the faculty advisor. A copy of the Informed Consent Form will be given to all participants for their information.

VIII. QUALIFICATIONS OF THE INVESTIGATOR(S) TO CONDUCT RESEARCH

The Principal Investigator is a doctoral student in the Counseling Psychology program in the Department of Psychology. Brian Spillman has been working on various phenomenological studies for five years and has participated in 10 phenomenological studies. He has conducted research with human participants previously. Brian Spillman has been providing counseling and psychotherapy services since 1997. Prior to attending the University of Tennessee, Brian Spillman received a Master's Degree in Counseling, provided therapy for two years, and earned a license as a Professional Counselor in North Carolina. The student's faculty advisor Dr. Mark A. Hector is a professor in the Counseling Psychology program in the Psychology department. Dr. Hector has taught Counseling Psychology courses for over 30 years. He has also been the primary advisor for over 45 phenomenological research projects.

IX. FACILITIES AND EQUIPMENT TO BE USED IN THE RESEARCH

For this method of research an audio recorder, audiotapes, copies of the Beck Depression Inventory (2^{nd} edition) and a transcription machine are needed. All materials are readily available to the primary investigator. Additionally, a letter of permission from Cherokee Health Systems to contact their patients and use their resources is attached (Letter of Permission).

X. RESPONSIBILITY OF THE PRINCIPAL/CO-PRINCIPAL INVESTIGATOR(S)

By compliance with the policies established by the Institutional Review Board of The University of Tennessee, Knoxville, the principal investigator(s) subscribe to the principles stated in "The Belmont Report" and standards of professional ethics in all research, development, and related activities involving human subjects under the auspices of The University of Tennessee, Knoxville. The principal investigator(s) further agree that:

A. Approval will be obtained from the Institutional Review Board prior to instituting any change in this research project.

B. Development of any unexpected risks will be immediately reported to the Compliances Section.

C. An annual review and progress report (Form R) will be completed and submitted when requested by the Institutional Review Board.

D. Signed informed consent documents will be kept for the duration of the project and for at least three years thereafter at a location approved by the Institutional Review Board.

XI. SIGNATURES

Principal Investigator ____Brian Spillman, MA_____

Signature _____ Date _____

Student Advisor _____Mark A. Hector, Ph.D._____

Signature_____ Date_____

XII. DEPARTMENT REVIEW AND APPROVAL

The application described above has been reviewed by the IRB departmental review committee and has been approved. The DRC further recommends that this application be reviewed as:

[ ] Expedited Review -- Category(ies): _____

OR

[X] Full IRB Review

Chair, DRC

Signature _____ Date

Department Head

Signature_____ Date

Protocol sent to Compliance Section for final approval on (Date) _____

Approved: Compliance Section
Office of Research
404 Andy Holt Tower

Signature _____ Date _____

Invitation to Participate in a Research Study

A Phenomenological Analysis of the Experience of Depression in Men

You are invited to participate in a study of the experience of depression. Your part in this research would involve meeting with the researcher two times.

At the first meeting you would participate in a tape-recorded question-and-answer interview in which you would describe your personal experiences with depression. You will also be asked to complete a short depression assessment form during the interview. The interview lasts approximately one hour.

The second meeting would be approximately one week after the first meeting, and would last about 30 minutes. During this meeting the researcher will present a brief summary of the results from the first meeting, and you will have the opportunity to make corrections and offer comments.

Participating in this study could involve some risk or discomfort on your part. Since the topic of the interview is your experience of depression, you may recall information of a potentially sad, embarrassing, or emotionally painful manner nature. If you participate in this study you will be provided a list of contact resources for dealing with those feelings should they arise.

Your participation in this study would be completely voluntary, and you would be permitted to withdraw from the study at any time without penalty. The information you share will help provide the foundation for further research on the psychological experience of depression. The location the interviews will be arranged to be a site convenient for you.

If you decide not to participate, you may continue to receive services from your psychologist and Cherokee Health Systems. Choosing not to participate in this study will in no way impact your services at Cherokee Health Systems. You do not need to participate in this study to have your depression treated. The researcher will provide you with an explanation of the findings of this study if you desire.

If you would be willing to participate in this study, please contact Brian Spillman at 865-719-0630 (cell), or by e-mail at Brian.Spillman@gmail.com.

Thank you very much!

INFORMED CONSENT FORM

A Phenomenological Analysis of the Experience of Depression in Men

I have been invited to participate in a study of the experience of depression. I was offered to participate in this study because I met study requirements. My part in this research will involve participating in two meetings with the researcher. At the first meeting I will describe my experience of my own depression. I will also be asked to complete a short depression assessment form during the interview. The interview lasts approximately one hour. The second meeting will be scheduled approximately a week later than the first interview, and at that second meeting I will be provided with a summary of the results from the first interview. I will be given the opportunity to make corrections or additional comments during the second interview.

Participating in this study could involve some risk or discomfort. Since the topic of the interview is my experience of depression, I understand that I may recall information of a potentially sad, embarrassing, or emotionally painful manner nature. I will be provided a list of contact resources for dealing with those feelings should they arise. My participation in this study is completely voluntary, and I may withdraw from the study at any time without penalty.

The information I share about my experience will help provide the foundation for further research on the psychological experience of depression. My identity will in no way be revealed to anyone other than the primary investigator at any time. The audio tapes will be numerically coded before they are transcribed in order to maintain my confidentiality. I understand that any information identifying me will be deleted from transcripts and written reports. I understand that I will be offered the opportunity to review the transcript that is prepared from the audio taped interview. I understand that portions of what I say in the interview may be reproduced in written reports. All original tapes will be erased after they have been transcribed. Signed consent forms will be kept for three years after completion of the study. The forms will be stored in a locked file box at a University of Tennessee facility. Tapes and any other identifying information will also be stored at the same location until they are erased at the completion of the study.

Upon completion of this study, the researcher will provide me with an explanation of the findings, if I so desire. Any questions I may have about this study may be answered by contacting the principal investigator Brian Spillman, MA (865) 719-0630 or e-mail Brian.Spillman@gmail.com. (Address: Counseling Psychology program, Psychology Department; Austin Peay Building, 3rd Floor; Knoxville, TN 37996-3400). I may also contact the primary researcher's supervisor Dr. Mark A. Hector at (865) 974-1984 or e-mail mhector@utk.edu. (Address: Counseling Psychology; 416 C Austin Peay; Knoxville, TN 37996-3400) If as a result of participating in this study, I want to discuss personal issues I will contact my psychologist.

I have read and understand this explanation of the research project and have had my questions regarding this study and/or my participation in it answered to my satisfaction. I have been given appropriate time to consider the possible ramifications of my participation. I understand that I do not need to participate in this study to continue to receive services at Cherokee Health Systems. I voluntarily agree to participate.

Name _____ Date _____

(Signature)_____

Address_____

Post Interview Debriefing

Thank you for completing the interview. Your participation has been helpful in contributing to existing knowledge about how men experience depression.

For the Research Participant

I am not currently planning on harming myself or anyone else. I promise to use the following phone list if I do later feel the need to talk to someone.

_____	_____
Research Participant	DATE
_____	_____
Principal Investigator (witness)	DATE

Resource List

My Psychologist's Office:	423-623-5301
24-hour Emergency contact number (CHS):	1-800-826-6881
CONTACT 24-hour helpline:	1-800-784-2433 (toll free)
	865-523-9108 (Knoxville)
Mobile Crisis (24 hours):	865-539-2409

I understand that I may also call 911 or visit local hospital Emergency Rooms.

CHEROKEE HEALTH SYSTEMS APPLICATION FOR IRB REVIEW

Project Title: Men's Experiences of Depression

Principal investigator(s):
Brian Spillman, MA

Submitted for Review

Brief description of Study

The purpose of this study is to understand the experience of depression among a clinical sample of men receiving counseling for depression. With IRB approval, a series of 10 to 15 unstructured, audio-recorded interviews will be conducted with men currently receiving counseling for depression at CHS. Participants will be asked to recount their experience of depression. The information obtained from the interviews will be analyzed using qualitative phenomenological methods of analysis to find the consistent themes underlying the experience of depression.

Men currently receiving counseling for depression at CHS will be recruited to participate in the proposed study. Participants will be 10 to 15 adult males who both self-identify as having depression and have been diagnosed with depression by their doctoral-level psychologists. Possible participants will be identified by doctoral-level psychologists working for Cherokee Health Systems from among active client caseloads. The referring psychologist will be instructed to prescreen participants to insure that referred subjects are neither currently suicidal nor experiencing psychotic symptoms, and that the participation in this study is unlikely to harm the individual. In addition, persons diagnosed with Bipolar disorder are not eligible to participate. In order to make sure that psychologists have enough information about the participant to make that decision, psychologists will be instructed to only consider referring men who have been in therapy for at least three sessions.

After being contacted by a potential participant, the principal interviewer will describe the study and the requirements for a participant. The interviewer will request the volunteer's consent to participate in an interview of no longer than one hour in length. If the volunteer meets the criterion outlined above and is willing to be interviewed, an interview will be scheduled at a mutually convenient time and location.

In the interview the volunteer will be asked to complete a brief measure of depression (Beck Depression Inventory 2nd Edition) and verbally describe in as specific terms as possible their own experience of living with depression. No inducements will be provided to encourage participation. Subjects will be informed that they will be participating on a voluntary basis and will be told that

their identity will remain confidential and they may withdraw at any time. Additionally, the interviewer will reiterate that participation is totally voluntary and will in no way affect the participant's ability to receive counseling services at Cherokee Health Systems.

Subjects will be asked to meet at a mutually agreed upon location that would ensure confidentiality for a tape-recorded interview. The interviews will be unstructured, and the subjects will be asked to tell about their experiences of depression. The principal investigator will conduct the interviews. The interviews will start with the following request: "Please tell me about your experience of depression." The remainder of each interview will be spent following up and clarifying the central theme. The interviewer will ask follow up questions regarding themes and topics introduced by the subjects. Under no circumstances will the interviewer introduce themes or topics that have not already been introduced by the subject. It is important to emphasize here that the investigator will rigorously attempt not to introduce any of his own ideas or preconceptions regarding the experience of their own depression. The whole focus of this project is on what the participants say about their own experience of depression. The investigator has no definition of the experience of depression and no hypotheses to test. Data collection will be conducted with no deception and no manipulation.

The interviews will be tape-recorded and transcripts will be prepared. The tapes and transcripts will be numerically coded in order to maintain interviewees' confidentiality. The transcripts will be analyzed by the primary researcher. The primary purpose of the analysis will be to identify common themes across the transcripts. Once the interviews are transcribed and themes are found, the interviewer will provide a copy of the findings to the research participant to check for accuracy.

No identifying information will be included in the transcripts, and after transcription, the tapes will be erased. Transcripts will be kept in a locked file cabinet for three years after completion of this study.

Anticipated Duration of Study

I anticipate the data collection portion of the study to last no longer than two months. I plan to complete the entire study by December 2005.

Estimated number of subjects

I will interview 10 to 15 subjects; more than ten will be approached in order to secure enough participants. Usually only around half of the participants invited to participate end up actually participating; therefore a total of 30 patients is a reasonable guess as to how many would be asked to participate. The actual number could be as low as only 10.

Collaborating Agencies/Institutions

No other agencies will be collaborating. My major professor and doctoral committee at the University of Tennessee will be monitoring my progress toward completion of this project, however.

Utilization of Cherokee personnel/resources

Doctoral psychologists employed by CHS will be asked to identify men appropriate for the study. Those psychologists willing to participate will refer from among their active caseloads those men diagnosed with non-psychotic major depression. The principal investigator will provide copies of the BDI-2, and will not use copies that were purchased by CHS.

Extra Costs to subjects

There will be no cost to subjects for participation in this study.

Advertising or other recruitment of Subjects

No advertising will be posted regarding this project. The principal investigator will approach individual doctoral level psychologists to solicit their participation in referring patients.

Subject Compensation

Subjects will not be paid for participation in this study. No financial rewards are offered.

Plans for data analysis – Staff and timeline

No CHS staff will be involved in data analysis during business hours. I will conduct the analysis with my research group during my own private time after hours. No other members of the research group assisting me are employed by CHS.

What information to provide to potential participants, both in writing and in discussions;

Possible participants will be identified by doctoral-level psychologists working for Cherokee Health Systems from among active client caseloads. The referring psychologist will be instructed to prescreen participants to insure that referred subjects are neither currently suicidal nor experiencing psychotic symptoms, and

that the participation in this study is unlikely to harm the individual. In order to make sure that psychologists have enough information about the participant to make that decision, psychologists will be instructed to only consider referring men who have been in therapy for at least three sessions. Referring psychologists will distribute brochures detailing how interested subjects may contact the primary researcher.

After receiving the name and telephone number of a potential participant, the principal interviewer will contact the volunteer to describe the study and the requirements for a participant. The interviewer will request the volunteer's consent to participate in an interview of around one hour in length. If the volunteer meets the criterion outlined above and is willing to be interviewed, an interview will be scheduled at a mutually convenient time and location.

In the interview the volunteer will be asked to describe in as specific terms as possible their own experience of living with depression. No inducements will be provided to encourage participation. Subjects will be informed that they will be participating on a voluntary basis and will be told that their identity will remain confidential and they may withdraw at any time. Additionally, the interviewer will reiterate that participation is totally voluntary and will in no way affect the participant's ability to receive counseling services at Cherokee Health Systems.

Deciding who is going to present the information and at what point in your interactions with participants;

Possible participants will be identified by referring psychologists. CHS employees will distribute brochures detailing how to contact the primary researcher. Upon being contacted by potential research participants, the primary researcher will describe the study and ask for participation. If the subject agrees to participate, the primary researcher will gather subjects' signatures on informed consent documents.

How the participants' understanding will be assessed

Doctoral psychologists will refer only patients whom they judge can understand informed consent. In briefly describing the study, the referring psychologist will reiterate the voluntary nature of participation. Once the primary researcher contacts the subject for participating in the study, he will again reiterate the voluntary nature of participation. An informed consent form will be reviewed with the research subject and signed by both interviewer and research subject prior to beginning the study.

Who will obtain the participants' signature or agreement

Informed consent will be obtained from all subjects prior to their participation in the study by the primary researcher. Each subject will be asked to sign an Informed Consent Form that will be stored in a locked file cabinet. A copy of the Informed Consent Form will be given to all subjects for their information.

Consents will be stored in a locked file cabinet in the professional office of the primary investigator for a minimum of three years.

Plans for review and termination of study including:

Estimated completion date of study: Data collection is expected to last for six months. The entire project will be completed as soon as possible, probably near the end of December 2005.

Date of proposed review of study by IRB

At earliest opportunity, this project will be reviewed by CHS IRB. Upon receiving CHS IRB approval, the project will be submitted to UT IRB for approval.

Addendum: Specific Risks and Protection Measures

A. SPECIFIC RISKS AND PROTECTION MEASURES

There is minimal risk for participants. Specific protection measures have been implemented to minimize the potential of harm from participation. Participating subjects will be asked to recount personal experience of a possibly sad, embarrassing, or emotionally painful manner. Accordingly, participants may wish to discuss personal issues as a result of completing the interview or may feel unsettled after disclosing personal information.

The interviewer will remain sensitive to the participant's needs and offer breaks as needed. The participant will determine the interview length, and we will end the interview when he has exhausted his comments. Upon completion of the interview, the participant will be given a list of contacts that he may use to discuss personal issues if he desires. That listing will include the phone numbers used to access the office of their psychologist, an after-hours emergency contact number staffed by doctoral-level psychologists, the number for Mobile Crisis evaluation service, the CONTACT 24-hour help line number, and the locations of area hospital Emergency Rooms. The research participant will be asked to sign a no harm contract stating that he promises to utilize the provided emergency numbers if needed. A copy of the no harm contract will be returned to his referring psychologist.

Subjects might feel pressure to participate because of being invited to participate in the study by their own psychologists. The perception of feeling pressured to participate is not completely preventable because it could be influenced by factors other than the behavior of the psychologist. However, psychologists are expertly trained to communicate clearly and use their clinical skills in appropriately presenting this optional participation to the research subjects. Participants will be reminded that their participation is voluntary on the consents forms, and by the interviewer before commencing the interview.

B. ADDITIONAL PROTECTION MEASURES

Voluntary participation: Before agreeing to participate, each subject will be provided with a verbal description of the study by the primary investigator as well as a written description of the study (Informed Consent Form). Each subject will volunteer to be interviewed on tape and will be informed that they can terminate participation at any time.

Informed Consent: All subjects will read, sign and receive an Informed Consent Form describing their participation in the study. This form includes a description of the study, expectations of participants, and permission to audio-tape the interview. The Informed Consent Form will also include the name, address, and phone number of the researcher in case any subject wishes to contact him (An Informed Consent Form is attached.).

Confidentiality: Both the principal investigator and the co-principal investigator of the project are aware of and will abide by the American Psychological Association's (APA) Ethical Principles and Code of Conduct of Psychologists. No identifying information will be assigned to transcripts or final reports.

Anonymity: Full names of subjects are not announced on the audiotapes or the transcripts. No reports on the study will contain information identifying any subject. Subjects will select pseudonyms to be used in lieu of their actual name.

Use of audiotapes: In the Informed Consent Form all participants will give permission to audiotape the interview. Audiotapes will be used by the principal investigator and will be used solely for the purpose of transcribing the interview (Please see the attached Transcriber's Pledge of Confidentiality). When all data have been analyzed and transcribed, the researcher will erase audiotapes.

If a subject has some question about the research project, he can contact either the primary investigator or the primary investigator's advisor (Dr. Hector). Both the primary investigator and Dr. Hector's phone numbers are provided in the Informed Consent Form.

APPENDIX C

Results of the Bracketing Interview

Results of the Bracketing Interview

Introduction

An advanced doctoral student experienced with phenomenological research conducted the bracketing interview. Care was taken to choose an interviewer that the researcher personally knew and trusted in order to facilitate the discussion of sensitive data. The interview lasted approximately one hour, and was transcribed by the researcher himself.

Personal Experiences

During the bracketing interview, the researcher was asked about his experiences with depression and his thoughts about the current study. In this section, the themes emerging from his personal experiences are presented. Three individual sub-themes from this section include: *how it affects me*, *difficult to notice, difficult to describe*, and *learning to understand and be okay*.

How it Affects Me

The researcher acknowledged having the experience of depression, and described its effects on his life. Depression was described as filtering one's emotions and thinking, and initiating a cycle of existential questions.

> I'd describe myself as a quiet, reflective, contemplative guy. I like to be by myself. I think I just see life through a depressed filter. I'm probably in depressed mode about 75% of the time.
>
> I know depression by how it affects me. I think depression makes me more likely to be sensitive, moody, and self-critical. Depression makes me procrastinate, make excuses, and feel anxious around other people.

> I am aware that being depressed influences me to ask myself questions. I ask myself all sorts of questions like: What's the purpose of life? Am I making good use of my life? Why do I have depression?

Furthermore, the experience of depression was likened to being bound by an invisible rope that constricts both mentally and physically.

> Depression leaves me feeling frustrated and blocked up mentally and even physically sometimes. I feel that depression is an invisible rope binding me up sometimes, in some ways that I've come to know and understand and in some ways that I probably haven't yet understood.

Difficult to Notice, Difficult to Describe

Depression was characterized as an experience that was *difficult to notice* and *difficult to describe*. The realization of the presence of depression happened in retrospect, and living with depression contributed to feeling isolated.

> Looking back I can see that my early experiences were colored by depression but I didn't notice it right away. It was difficult to notice. It wasn't until I was in my mid-twenties that I was ready to acknowledge the problem.

> My personal experiences have been very hard to understand. It's also difficult to describe. I have not known men who talked about having this problem. I have wondered if I'm the only one that feels this way.

Depression was also experienced as an aspect of the self to be hidden from others' view, even though depression affects work, family, and academic pursuits.

> I'm really aware of depression in myself when I'm around others. I wonder if folks see me and see the depression. In most every context of my life, I have to be aware not to let the depression show. It's just not conducive to working in mental health, having a wife and family, or even getting things done around the house. It's definitely not the way to write a dissertation for God's sake.

Learning to Understand and be Okay

Another key part of managing depression was *understanding* how to use the experience in a positive way to benefit others.

> In my work as a therapist I've really focused on learning to understand and to be okay with my own and other's problems. By extending lessons I've learned, I am able sometimes to teach my clients how to live with life on life's terms. Anyhow, once I learned about depression and learned about tolerating distress better I felt that I finally had an understanding of what was going on inside of me, and a way to try and manage that too.

Increased activity was also seen as helpful in personally managing the problem of depression.

> I've found that talking about depression does seem to help, but the best so far has been managing with increased activity. If I have a day that is largely unscheduled, and I stay awake for a couple of hours without getting a shower or moving toward something productive I know that I'm at an increased risk for feeling really depressed that day; its like I can bring the episode on by dragging my feet and lying around, and once the episode is there in full force I have to really struggle to get out of it.

Using accumulated knowledge and expertise while working with depressed men is a challenge, but is made easier by understanding more about one's self.

> Working with depressed men is a real challenge. I used to not like working with this population, but as I've grown and embraced my own struggles I've enjoyed the work more. It seems as though I'm not trying so desperately to hide myself anymore.

In his work as a therapist the researcher described depression as a struggle that has benefited his ability to connect with other depressed men.

> I think I have a better understanding of this problem because of my experiences. I don't share my history with my clients, but I do share the lessons I've learned without telling them the details. It's a road I've been down, a road I'm going down and it helps to know the terrain.

In summary, the researcher described his personal experiences with depression, including the topics of *how it affects me*, an awareness that depression is *difficult to notice, difficult to describe*, and his achievements in *learning to understand and be okay.*

Thoughts about the Current Study

In this section, themes concerning the researcher's thoughts about the current study are presented. A significant goal of the bracketing interview is to uncover possible biases and unconscious hypotheses that may influence the outcomes.

Possible areas of bias for the researcher were uncovered. These areas included theories about how a gendered perspective might be present in the results, a desire to find new symptoms associated with male depression, and a focus on the concept of how masculinity is at odds with depression. Quotations describing these themes are presented below.

Gendered Perspective

The researcher had completed a thorough literature review on depression and masculinity prior to conducting the bracketing interview. One of the areas of focus was the interrelation of gender and depression. The researcher found that he had accepted that perspective and even incorporated the gendered perspective into his expectations about this study.

> I think men could talk about depression from their gendered perspective, however I'm not sure that they will be able to do that. Men may be

> uncomfortable speaking from their perspective of masculinity for any number of reasons.

New Symptoms

The researcher also mentioned that he expected to hear about symptoms of depression, including "hopefully some new symptoms." The particular notion that symptoms were impediments to daily life also was noticed.

> I think we will hear about how depression affects their lives physically, mentally, spiritually, and financially. I think men will describe some of the common symptoms of depression from the DSM-IV, and hopefully some new symptoms may emerge. I'm not all that clear on what may emerge as a new symptom, but I've read about how anger and frustration are often keys to hidden depression in men.
>
> I expect the men in this study to describe their depression, in particular in terms of symptoms that seem to block or inhibit their daily lives.

Masculinity

Finally, the researcher expressed how he expected that the topic of masculinity would be intertwined with the men's narratives of depression. The researcher expected to find a potential conflict between the social messages men receive about their masculinity, and the powerlessness that usually accompanies depression.

> I expect that men may describe the particular problems of masculinity and depression and areas of contradiction between the two experiences. In some ways, masculinity as it is typically constructed seems to exclude the open experiencing of depression.

Summary

In summary, the bracketing interview contained two main themes; each with sub-themes that further described the main themes. First, the main theme of *Personal Experiences* was presented, including the sub-themes of *how it affects me*, *difficult to notice, difficult to describe*, and *learning to understand and be okay*. Next, the main theme of *Thoughts about the Current Study* was described, including the sub-themes of *Gendered Perspective, New Themes*, and *Masculinity*.

The researcher held the information obtained from the bracketing interview as critically important while analyzing transcripts. The researcher frequently compared the bracketing interview with the evolving list of transcripts to ensure that the themes represented the experiences of the participants and not the expectations of the researcher.

Relationship of Bracketing Interview to Study's Themes

The themes from the bracketing interview match the themes from this research project in several ways. From the main theme of *Personal Experiences*, the sub-themes of *how it affects me*, and *difficult to notice, difficult to describe* all roughly correspond to the study's themes of *symptoms*, *recognizing*, and *describing* respectively.

One important difference in the researcher's transcript was that his theme of *learning to understand and be okay* combines and replaces the study themes of *course*, and *reactions*. After much meditation on this difference, the

researcher made the profound realization that his desire for *learning to understand* had began this experiment, and his desire to *be okay* represents his own personal reactions to managing the course of depression. Looking back, the researcher acknowledges that the project was, in the parlance of a beloved advisor, as much *me-search* as research. For in the desire to help put words to a poorly understood experience and bring assistance to those who suffer so silently, the researcher is as much helping himself as anyone else. As the Chinese proverb states," the hand that gives a rose retains some of the scent."

APPENDIX D:

SAMPLE TRANSCRIPT

Sample Transcript

Okay well thanks for coming. In as much detail as possible, please tell me about your experience of depression"

I have never really been able to describe it very well. I knew that when I was 13, one day something hit me that I just felt bad, uh I felt unhappy. And, I realized that I always felt unhappy. I could never really describe it though.
Well, just that times of happiness were really fleeting. Looking back on happiness, happiness just seemed so far away when I look back on it. It wasn't something I would carry with me. You know, I realized then that something was wrong. This is not what I saw in all the people around me or most of the people around me. There was just some sort of energy that I didn't seem to have, some force, some faith that I didn't have. I didn't look forward to anything. I ran across a great description a couple of days ago in reading; it's by this guy that is an alcoholic in recovery. He's a novelist. His descriptions manage to put his insights on paper pretty well from time to time. One of them is that depression or recovery or management of depression is like, uh, let me just read it, like "a gray neutral area like people have clipped all the sharp edges off their souls until they seem to be operating on the spiritual energies of a moth.

The spiritual energies of a moth?

Yeah, and this is kind of the way I see management of depression. Depression itself is just a dark and I can't get up in the beginning of the day and motivate myself to do something, to change attire, to go to work, to feed myself and in managing that I have found that counseling and therapy never seemed to really help much, except that I guess the catharsis but cognitive therapy never seemed to do anything for me. I'd go through the motions and jump through the hoops, but I just felt like I was going through motions and jumping through hoops.

Right.

Cognitive behavior modification, that's all it really was for me. And managing it when I tried, up until the mid 1980s or so I tried all the tricyclic and antianxiety stuff and benzodiazepines and all those things. Just at times I would spiral farther down. The benzos did that to me, right away and kept me down there. But Prozac, beginning with the SSRIs turned around and it was really the only thing that got me going, and then is when I realized I think that, it seemed chemical. It seemed obvious to me that it was chemical but in managing it the

best I ever experienced was just a gray area, where I could climb out of the darkness into this gray area, where it was brighter, but it was still gray.

It was still a gray area.

Yes, and the only time I ever experienced a real period of being up was when I think, I can just think of one or two times. One was when for a period of weeks I was in charge of a musical project that needed to be rebuilt and refitted to a different situation. I did that all the way from orchestration to recording to producing and directing the recording sessions, and it was very near mania I suppose but boy was it fun. Just one or two examples like that but other than that its just gray gray gray gray gray.

One of the first things you mentioned was that its very difficult for you to describe depression well, and then you explained to me how basically depression has been the mode of operation for your life for the bulk of time. There have been a few periods where it seemed less black, and maybe even gray. I wonder how the fact that there haven't been very many periods when depression wasn't there contributes to making it hard to describe and identify the depression?

Absolutely, because it's all I've known and I grew up in a depressive family. My parents were clinically depressed, it was my model and, well the family was fragment in that way. Nobody was very close. It's all we had to look to each other for and about, and even outside the family I don't know why but I just never connected with a much more positive energy outside the family. And I find that a little curious, I don't know why I didn't make those positive connections to go somewhere or at least seize a more positive opportunity and try and make that a part of my environment.

Do you have any theories about why you didn't do those things?

No I don't, and I'm really curious about that because a couple of my kids seem to have succeeded in doing just that.

Having a parent that was depressed but yet seeking out a life that was not depressed?

Yeah, and like my oldest who really had a hard way growing up in his first and formative years somehow he just latched on to positive people and he's just an incredibly positive person. I just, he's just an amazement to me.

Uh hmm.

He's a great father, a great husband, just a positive force. He's not competitive really, not all feet and elbows its c'mon I want to do this, I want to do it well, lets' do this, let's do this dad.

And it's hard for you when you think about it to understand where that came from?

He sure didn't get it from me. I always thought when I do stuff I want to do it well, and I do, you know that's my goal in life is to justify myself I guess in the end. I do that successfully with most anything I undertake, but it's a long long hard struggle where as it takes somebody maybe a couple of months to come up to speed it might take me a year.

Can you think of a time where depression, or having depression seemed to really impact your life?

Hmm. I never really was able to look out and compare myself to other people I think. I would just see all this positivity happening on the outside, but I never really made that comparison.

Okay that's helpful. Was there ever a time that you struggled and felt that I'm struggling because of depression?

It always seemed more basic, more basic yeah. I only seized on that explanation as an intellectual label. It's the only way I can describe to somebody else, "oh I'm depressed, I'm clinically, and chronically depressed. I'm on medication." It's just a piece of language to me.

Can you say some more about how depression is an intellectual piece of language?

Oh it's just in explaining it to others. Uh, it doesn't really explain what's going on with me, I really I've never been able to verbalize that very much very successfully it seems to me. It's just kind of a label as far as I'm concerned.

(A label?) Yes, a very big one, a large one that covers a lot of territory.

It does. One of the other things that I wanted to ask you more about that you said was I think you were telling me you were 13 years old when you said that you realized that something was different about you, and you said 'it hit me' that there was something different.

Umhmm. I can almost visualize the very moment.

Well I'd love to hear about that moment now.

What I remember was I was just feeling crappy, I was in my bedroom by myself, maybe I was younger it seemed to have something to do with naptime, maybe it was younger. But I was by myself, in my room and it was summer and it was hot and uncomfortable. We didn't have air-conditioning. I didn't look forward to going out to play with my neighborhood mates. I had things the things that I wanted, I had food and shelter and a bicycle.. stuff, but I just realized that I just felt crappy, and I realized I'm feeling crappy for some reason, that I just identified that at that moment. And I stepped farther and realized that I always feel crappy, not just sad but just crappy, just unmotivated, just I don't want to do anything, I don't see anything in the future, I'm not real happy about my past, my situation doesn't feel good I don't know what it would take to make me feel better, you know I just had that realization that here I am and I've always felt this way, and I'm not happy with the way I'm feeling. There must be something wrong, and I went on like that for several years I think, and then I talked about it with my mom she didn't, well she said "yeaaah well I don't have much to say because people are just depressed, and some people are more depressed than others."

Your mother said "people are just depressed" and ..

She said, "Some people are more depressed than others"

But everybody has a little bit of depression?

Yeah, it's kind of like 'shit happens ."

Wow. And sometimes more shit happens to some people?

Um hmm.

How did you understand what she said to you at the time?

Well it was a pretty bleak outlook, I wasn't happy with that answer. She said if you need to talk to someone there are people you can talk to, you can talk to me, you can talk to a friend, you can talk to a pastor, uh there was a couple of psychologists in the area, by that time I think psychology was coming to (CITY). I was aware, or had been aware of the fact for years that my mother and father were in "marriage counseling." It didn't seem to be doing much for a fragmented marriage and fragmented family. I didn't put much stock in that. Then psychiatry

came into it, with phenobarb and things like that. You know that wasn't very attractive either with shock treatments.

And you were talking earlier about your experiences with various medication classes and you were describing your reactions to some of the earlier meds, and more current meds. Meds like Prozac, and different classes of medications like tricyclics, SSRIs, and benzodiazepines, and a general feeling that most of medication didn't help. Prozac helped a little more than the others, and then there's an awareness that therapy and cognitive therapy. You made a distinction between therapy was effective in the sense of catharsis, but not as effective in the sense of the cognitive changes that would occur.

Right, exactly.

Well let me just see if I can catch up a bit with some of the things so far. We started out talking about depression, and how it's really difficult to describe and you explained to me some of the reasons why it's been really hard to describe. In some ways depression was there before you had an awareness that it was possible NOT to be depressed, so it was just kind of a basic thing about you. When you interacted with people in the world you describe those people as having depression also, and even when you tried to speak about it having realized you have it yourself, you got very little in the way of information or support, it was just more of a 'shit happens' kind of a, its there, so what?

Right. Not much can be done.

Not much can be done. And a lot of comments like its something that you have to live with.

Yeah it is my lot in life. It's where I am, but I'm not happy with it. I'm not. It seems to me there must be some other direction some way to achieve that other direction. Spirituality is an out, but I've never been religious. I have faith in nothing. Living at the mission is driving me batty, going to church twice a day. Halleluiah and amen. It's not any solace for me. I admire a Christian or person who does get comfort from his religion, but I wish I could do it but I can't.

Religion hasn't been a source of comfort for you.

No, absolutely not.

Okay, as we think about depression and about some of the things that you've said already, is there anything that stands out to you as being really important

that you'd want to underline so far that you've already said about depression, anything you'd want to be sure that I really heard in your description?

So far I think that the most I've experienced in managing depression is working on the spiritual level of a moth. Now that has made it easier, it has been easier I can't deny that, and I'm grateful for it. Now I'm getting pretty frustrated with entering senior citizenship and being frustrated with not being able to get employed as easily as I had, and aspects like that of being older and realized 'wow I really am older now ." I'm not a kid anymore in my late 40s early 50s and feeling 33 and getting away with it. I really am 61, and I just really am getting bummed out about the prospect of this might be as good as it gets. Now I look back at memories and they're just kind of like a photograph that's being consumed by flame around the edges, just kind of going away. Is this really as good as it's going to get? It's discouraging, and depressing.

So a part of living with depression and being aware of getting older for you is being concerned about the way that you may not get any better, that this may be it.

It may be terminal, not in the sense that I'm going to jump off a bridge, but just that this is as good as it gets and it's not going to get any better, and if anything it might get worse.

You're thinking that depression for you is going to be chronic and progressive.

Progressive yeah, that's a scary concept but I think that's what frightens me more than anything. That it's chronic I sort of accept, and hope that it can be managed or positively chemically influenced, but if it's progressive then boy howdy, that's scary.

What the scary side of the progressive nature for you?

Just that it not only does not get better that it might get worse. I might get more debilitated, I've not been this debilitated ... I feel really debilitated now. If it gets any worse, I don't know I guess the hospital's next. I sure don't like being helpless, its not as if I'm unmotivated in that respect, but this being homeless is just a drag.

Uh hmm.

If I could only, only get my own space and take care of myself, I think I could take care of myself, I know how to eat, I know how to eat better than what the feed me down there for God's sakes, on food stamps if need be. That's all I'm

trying to do right now is get some regular income so I can move out. I'd be happy as a clam if I could be living in (PUBLIC HOUSING FOR DISABLED), or some place convenient to downtown.

Tell me some more about being 'happy as a clam', or what do you think that would be like to be happy as a clam?

Haha. Being happy as a clam, I would have my own space and nothing fancy just my own space privacy, the choice of whether or not I had to leave, and being able to eat the way I'd like to eat which is basically healthy. I'm physically healthier than most people my age, or a lot of people my age anyway and I tend to eat a more healthful diet. I'd have a keyboard, a radio, a small sound system I know how to achieve good sound from minimal equipment, I could satisfy myself even with my audiophile tastes, that would be easy enough to achieve. It's just a few basic things.

So those things sound like situations, or items in the outside world that could help you. I'm aware that you've used the word depression a couple of different ways and this is related to that idea that items in the outside world could help you. You've described situations as depressing, the depressing impact of situations, and you've also described depression as an internal state that was independent of situations.

Right I agree.

I'm interested in how you make sense of that world that word, depression first of all.

Internally? Well internally I just don't feel hmm, I can't get out of my shell. It feels like I'm in a shell that I can't get out of it. I'm not a party animal, I'm really very quiet and I have learned over the years and acquired enough tools to not be very uncomfortable in crowds or with other people. For a long time it was a big big problem.

It was?

Yeah, huge problem. I was even agoraphobic at one point. It was really just so bad that walking out to a car was a big big deal from my apartment. I think just, running around with a bunch of crazy narcissistic actors and dancers and stuff from my show business period I acquired social skills. It was either do or die, I guess because it was on a tour and we've got this little prophylactic society running around the country and your right there with no where to go, you can't close off very successfully for long periods of time, you've gotta get some tools

somewhere. I got a lot that way. But given my druthers, I'd rather just stay away, you know leave me alone. Give me my classical radio station and a keyboard, and access to the Internet, if I can walk down to the library then that's all okey-dokey.

So I think I understand, depression is an internal state that is hard to be aware of because there's not very much to contrast it with. Over the course of life you find ways to help you manage the depression.

Yeah, even taking certain kinds of medicine. I learned a lot about anxiety from taking Valium. Here what, twenty or twenty five years ago.

And those tools that help you manage the depression and the anxiety work in varying strengths or potencies over the course of life, and part of what you're experience has been is that you've had to try to set up situations so that you have those tools around you. It's been hard especially now at the mission because you don't have access to tools that you know could help you.

Right, the physical tools or objects.

Yeah the physical objects like the keyboard, the radios and not having those you describe as depress-ing.

Right, depress-ing. It just makes it more depressing, and even what makes that even more depressing on top of that is like well, I don't talk very much to people around the (SHELTER). I avoid people who have conversations with themselves for example. Well that covers a large percentage of people down there.

Yes it does.

I avoid drunks that covers another large percentage. I avoid dopeheads or crackheads, and that list, and there are very few licit people down there, two or there that I really talk with on a continuous basis.

Sounds like an isolated existence?

Not only is it isolated, but it is isolate-ing. Because I'm there and get away from me, stay away from me, don't breathe on me. Go have your shakes somewhere else, and there are the ethnic mindsets most irritating for me is one that dictates that you have to yell to be heard by somebody four feet away.

Well this is a lot of really good information; I really appreciate what you've told me.

I guess what really concerns me is the people who start out depressed and know nothing about depression. That concerns me because its where I came from, where I come from. What are you going to do? I don't know, it's baffling to me.

That part seems hardest to understand, huh.

Yeah I don't know, I really don't know. Sometimes it surprises me, I'm reasonably intelligent and I'm sure of that, but I can't verbalize it. I can't talk about it the way some people do. With some people it just comes out and you're like "wow, how'd you do that? Can I quote you on that?" And I just can't figure out a way to express it, other than "leave me alone." I don't know.

That seems very well said to me. Anything else that you would like for me to be sure to know about depression, about how depression has influenced you, about what you want me to know about depression?

No, no it's just that it's confusing to me. I don't know how to lay it out. I feel debilitated but on the other hand I know that I can do some things as well or better than anybody else. But, getting started is a bitch. I don't know.

Well thank you very much.

You're welcome.

APPENDIX E

INTERPRETIVE GROUPS AND PHENOMENOLOGY

Interpretive Groups and Phenomenology

Although some qualitative researchers do use research groups for assistance with interpreting transcripts, their use has not been demonstrated to be essential. In conferring with the doctoral committee to plan and direct this current study, the primary researcher decided against the use of such an interpretive group.

This decision was made after considering three domains of information. First, previously published information on data analysis was reviewed, and secondly current published studies were examined to ascertain what methods were being used currently and which were deemed worthy of publication. Finally, renowned and highly esteemed phenomenological researchers were personally contacted for their opinions and suggestions regarding this project.

In reviewing the previously published studies describing qualitative and phenomenological data analysis procedures, a host of articles, chapters, and books was found. Sources for articles were located by reviewing recently completed dissertations, and reviewing sources traditionally associated with phenomenological psychology. The original articles and chapters were retrieved and reviewed. Not surprisingly, a local university professor's book was among the most frequently cited (Pollio, Henley, & Thompson, 1997). The work by Pollio's team strongly supports the use of interpretive groups of students to read entire transcripts aloud and confer about their meaning (1997). In fact, these group meetings serve as laboratory experiences for students-in-training; during

coursework the primary researcher participated in another faculty member's research group for three years. The primary researcher also has previously taken a course with Dr. Pollio and thematized transcripts as a part of that class. Clearly, interpretive groups can be helpful for learning data analysis; the question as to whether they are necessary however, remains.

In reviewing various other chapters cited frequently in dissertations that describe phenomenological research methods, writers such as Polkinghorne, Giorgi, and Colaizzi make no mention of the necessity of interpretive groups (Polkinghorne, 1989; Giorgi, 1985; Colaizzi, 1978; Aronson, 1994). More recent writings by Giorgi have emphasized that phenomenology differs from groups striving for consensus. Phenomenology "liberates us from judging our experiences on the basis of what we know to be real" and allows us to "concentrate our attention exclusively to what is being presented to us and on how the given presents itself to us" (2004, p. 20).

Additionally, a recent issue of the reputable *Journal of Counseling Psychology* contains two articles that serve as effective position papers on the future qualitative and phenomenological writings that may begin to appear in the journal (Polkinghorne, 2005; Wertz, 2005). In an article titled *Phenomenological Research Methods for Counseling Psychology*, Professor Frederick Wertz described concepts basic to the methodology. No mention of interpretive groups was made. Similarly, Donald Polkinghorne's article on data collection, language,

and meaning did not refer to interpretive groups as necessary components (2005).

Steen Halling, however has consistently called for the use of interpretive groups in his phenomenological projects (Halling, Kunz, & Rowe, 1994). He describes his method of dialogal research and calls for the use of groups, but also acknowledges that

> there may well be situations in which the individual researcher will do better than a group working collaboratively. For example, we wonder what would happen if researchers were looking at a topic that most people are embarrassed to discuss? (Halling, & Leifer, 1991)

Certainly depression in men would qualify as a potentially stigma-bound and embarrassing topic.

The next step in choosing a method of data analysis involved reviewing current articles published in professional journals. Very few articles using qualitative methodology were located, and the articles found did not reflect existential phenomenological methodologies. Only three recent articles were located that made use of phenomenological research methods in major journals among those reviewed. In all three of the articles published, data was analyzed without the benefit of an interpretive group (Davidson, Staeheil, Stayner, & Sells, 2004; Douglas, 2004; Finlay, 2003). Douglas' study of the lived experience of bereavement draws on methodologies developed by Colaizzi (1978) and closely matches the methodology of the current study. Two other articles from the *Journal of Phenomenological Psychology* also used methodologies that did not

include interpretive groups. Finlay's (2003) study of one woman's experience of being recently-diagnosed with multiple sclerosis is an engrossing account of multiple meetings with one research participant to verify themes and establish validity. Davidson et al. (2004) describe their continuing work and extensive research into detailing the experience of schizophrenia and psychosis using phenomenological research methods, completed without interpretive groups.

The final step in the process of choosing a method of data analysis was to personally contact a selection of prominent writers in the field of phenomenological psychology. The first researcher contacted was Diana Douglas, a recently published author (Douglas, 2004). Douglas explained her choice to "go back to the respondents and verify the exhaustive descriptions" in lieu of using a research group (D. Douglas, personal communication, December 8, 2004).

Next contacted by the primary researcher was Frederick Wertz, recent author of the article *"Phenomenological Research Methods for Counseling Psychology"* published in the *Journal of Counseling Psychology*. The researcher also corresponded several times each with Amedeo Giorgi and Steen Halling, and spoke by phone with Donald Polkinghorne (F. Wertz, personal communication, April 28, 2005 through May 2, 2005; A. Giorgi, personal communication, May 1, 2005 through May 2, 2005; D. Polkinghorne, personal communication, May 13, 2005).

Throughout the contacts with these esteemed professionals, points of view certainly varied. Halling was the only advocate for using groups, and Giorgi was the most vocal critic of using groups. However it was Polkinghorne, who suggested the researcher consider the costs and benefits of using a group, and proceed according to the nature of the study. Correspondence with Wertz also deepened the researchers understanding of phenomenological methodological issues. As Wertz relayed, "it's the relation of the knowledge statements to *the things themselves* that makes them right or wrong, good or bad, useful or not useful rather than consensus in groups." Ultimately, the final decision was made to proceed with Colaizzi's (1978) methodology and return the interview transcripts to the research participants for verification of the emergent themes instead of utilizing an interpretive group.

The primary researcher did not operate completely independently however, and was able to discuss the transcripts from this project as needed with persons possessing invaluable expertise. However, no identifying information was shared about any research participant within this process. Throughout the months the researcher discussed the project with colleagues, read broadly about the topics under consideration, and processed passages with advanced doctoral students and clinical supervisors from psychodynamic and cognitive orientations. The primary researcher acknowledges that by choosing to work without a research group, the data-analysis process was likely lengthened. One benefit of working independent of a research group, however, was the

relative freedom of the researcher to be honest about his own reactions, and thereby limit their intrusiveness into the analysis by taking considerable time with the project, and entering into conference with trusted colleagues. Although this was an academic project, the subject matter and experience under consideration is deeply personal to the researcher. Regardless of the methodology used, as Giorgi explained, the ultimate judge of a methodology is in the product produced (A. Giorgi, personal communication, May 2, 2005).

APPENDIX F

SUMMARY OF BDI-2 SCORES

RESULTS FROM THE BECK DEPRESSION INVENTORY (2ND EDITION)

Analysis of the participants' scores on the BDI-2 yielded a mean score of 29.8, with scores ranging from 12 to 41. The standard deviation from the sample was observed to be 8.9 units. On this instrument, a score of zero to 13 is considered "minimal range", 14 to 19 is considered "mild range", 20 to 28 is considered "moderate range, and 29 to 63 is considered "severe range."

Range	Number of Participants	Individual Scores
Minimal	1	(12)
Mild	0	(none)
Moderate	2	(22, 25)
Severe	7	(30, 31, 32, 33, 34, 38, 41)

VITA

Brian Spillman was born in Winston-Salem, North Carolina on July 2, 1970. He grew up in East Bend, North Carolina and enjoyed roaming the hills and creeks of the foothills in Western North Carolina. He attended North Carolina State University in Raleigh, North Carolina and graduated with degrees in Economics and Management in May, 1993.

Unsatisfied with the business world, he returned to graduate school in the mountains of North Carolina and graduated from Appalachian State University (Boone, NC) in 1997 with a Master's Degree in Community Counseling. He was married to the former Beverly Hight in October, 1997. For two years he worked with adolescents and teen-agers providing individual and family therapy in High Point, North Carolina. In 1999 he enrolled at the University of Tennessee, Knoxville in the doctoral program in Counseling Psychology. He completed coursework and predoctoral internship in August, 2004. Of all accomplishments past and pending, Brian lists obtaining his Ph.D. a distant second to finally earning his *DAD* status. He and wife Beverly welcomed their daughter Carter Elizabeth into the world on August 12, 2004.

Brian continues to press forward in his acquisition of knowledge and its application to assist himself and others. He has worked for the past five years providing psychotherapy and crisis intervention services to the indigent and homeless. Brian still spends as much time as practical roaming the local hills and creeks of Knoxville's neighboring Great Smoky Mountains.