NAVIGATING INWARD AND OUTWARD THROUGH DEPRESSION

By
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As members of the Dissertation Committee, we certify that we have read the dissertation
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ABSTRACT

The phenomena of men and depression is poorly understood. Men continue to be under diagnosed with depression but commit suicide four times the rate of women. This grounded theory study explored the psychosocial processes that occurred in men who suffered from depression. There were a total of nine men who participated in this study who ranged in age, educational level, and marital status. Eleven interviews were conducted with nine men.

The theory that emerged from this study was *Navigating Inward and Outward Through Depression*. The process of navigating was the core concept and defined as a process of moving through depression and having to steer one’s life in different directions in order to move in and out of the stages of depression. The first stage was: *Being Different*. In this stage the men attempted to share their feelings, but were constantly rejected by society came to believe that nobody cared or nobody would understand their feelings. The second stage, *Concealing Feelings*, refers to how the men learned to navigate out of stage one and into stage two of learning to hide their internal feelings and thoughts. The third stage, *Disconnecting*, was defined as the way the men would numb their emotional pain. As their emotional pain became more intense, the concealing no longer worked. The men used external behaviors to physically numb their pain. The fourth stage, *Hitting Bottom*, refers to the men losing hope for their future and wanting to give up on life. The men had thoughts of suicide or thoughts that death would be an option to relieve the emotional pain. The fifth stage, *Acknowledging and Confronting*, refers to the ability to acknowledge they were depressed and understand
how depression was affecting their lives.
CHAPTER 1
INTRODUCTION
The National Institute of Mental Health (NIMH) reports that over 16 million people are affected by depression and over 6 million are men. Depression is one of the most complex mental illnesses that affects overall well being, including the emotional, physical, intellectual, social and spiritual dimensions of the person (Kessler, 2003; Moore, McLaughlin, 2003; NIMH, 2002). The World Health Organization (WHO, 2001) ranked mental illness as the number one cause of disabilities. The WHO reports mental illness is a serious public health challenge and a burden to the health care system across the world. Funding for mental health care is supported by state and federal governments at 57% compared to 46% of overall health care expenditures (Coffey, King, Mckusick, Genuardi, 2000). Badger, McNiece, Gagan, (2000) reported that people who suffer from depression use twice the services and health care funds than people without depression. The economic cost of untreated or inadequately treated depression is significant to the U.S. economy (Stewart, Ricci, Chee, Hahn, & Morganestein, 2003).

Depression has one of the highest mortality and morbidity rates of all health conditions. It has been estimated that 25% to 30% of adults with depression attempt suicide and about 30,000 lives are lost in the United States annually as a result (Goldney, 2002; WHO, 2001). Suicide has a greater impact on society, families, and individuals than any other acts of violent deaths. Suicide claims more lives than homicide or war-related deaths. Suicide was ranked as the 11th leading cause of death among Americans in the year 2000 (WHO, 2001).

Despite advances in research, our understanding of depression among men remains limited. Further study of male depression is necessary because to date, there is a lack of understanding of how depression manifests among men, and there is no consistent
grouping of male depressive symptoms that have been clearly identified (Grant & Potenza, 2005). Therefore, a grounded theory study is necessary to advance understanding of male depression within a social and nursing context (Angst, Gamma, Gastpar, Lepine, Mendlewicz, & Tylee, 2002; Winkler, Pjrek, Heiden, Wiesegger, Klein, Konstantinidis, & Kasper, 2004; Winkler & Courtmary in Good and Brooks, 2005).

Statement of Purpose

The purpose of this study was to discover the basic social and psychological processes of men who are living with depression. The outcome will be to develop a substantive theory of depression in men.

Research Question

The research questions that guided this study were:

1) What are the basic social processes that can be uncovered in depressed men?
2) What beliefs do men have regarding being a man and depressed?

Background and Significance

The purpose of this section is to present a brief overview of what is currently known about men and depression and the significance to further study this topic.

Studies that have examined men’s health suggest that men experience serious emotional, physical, and social problems throughout their life span, yet health issues among men remain understudied. Men die at the rate of seven to nine years earlier than women and have higher death rates for all fifteen leading causes of death including suicide. Men suffer from depression at half the rate of women, but commit suicide four times more frequently than women (Cochran & Rabinowitz, 2000; Davidson & Lloyd, 2001; Glicken, 2005; Good & Brooks, 2001; Harrison & Dignan, 1999).

Although women experience depression at higher rates than men, researchers are becoming more interested in trying to understand the reason men commit suicide four
times more often than women (Brooks, 2001; Cochran & Rabinowitz, 2001). Levant (1996) reports that men are disproportionately represented among many vulnerable populations because men abuse alcohol and other drugs twice as often as women, have higher rates of homelessness, and are responsible for 86% of all violent crimes. These data may reflect the social and personal responses men may have to depression because research has suggested that men often are under diagnosed and under treated for depression as currently understood (Brooks, 2001; Cochran & Rabinowitz, 2000).

Over the last twenty years scientists have devoted further study to the psychology of men. They have concluded that the male gender role in the US society is problematic because men learn and are rewarded from an early age to constrict and not express their emotional pain. This leads men to hide or adopt maladaptive behaviors such as self medicating with alcohol or drugs, use violence to avoid emotional pain, or to become workaholics (Cochran & Rabinowitz, 2000). These symptoms may manifest as guilt, negative attitude to self, poor concentration, impaired memory, or tearfulness. However, men ignore and suppress these feelings which leads to the impairment of their health and psychological well being. The complexity of socializing men has led researchers to examine how adopting an ideology of masculinity can impact men’s mental health, which will be discussed next.

Masculinity Ideology

The concept of masculinity ideology has relevance to this study because the behaviors and attitudes men adopt are socially constructed and necessary to be accepted by other males. According to Brandon (1976 as cited in Levant, 1995) and Levant (1995) masculinity ideology is when a male endorses and internalizes social beliefs about masculinity and the male gender role within the structure of gender. Masculinity
ideology is assumed to be learned behavior since there are no biological data to support this concept (Davidson & Lloyd, 2001; Levant, Richmond, Inclan, Heesacker, Majors, Rossello, Real, 1997). Therefore, it can be assumed that this concept will be passed from one generation to the next. Societal norms condition boys into being men by cultural codes, visual images and observations of masculine men (Davidson & Lloyd, 2001; Gilmore 1990). The masculine gender role socialization promotes stoicism and suppression of emotions. These social norms influence the behaviors, thoughts, and feelings in men and prevent healthy expression of emotions (Cochran & Rabinowitz, 2003; Zamarripa, Wampold, & Gregory, 2003).

The definition of masculinity ideology for this study is: a socially constructed concept that explains how men interact with their environment, developing a sense of self and psychological well-being.

Masculinity ideology contributes to men feeling conflicted between being comfortable with the self and societal norms. This conflict will cause feelings of sadness, loneliness, nervousness, and lower self-esteem. These feelings may lead to depression; suicide; violence; anxiety; substance use, and impaired cognitive, physical, and social functioning (Cochran & Rabinowitz, 2003; Zamarripa, Wampold, & Gregory, 2003).

Cultural norms are clear that men must fit into a masculine role to be accepted as men. These attributes include avoiding anything that is feminine, being the provider of the family, while the wife’s role is to be home and raising the children (Davidson & Lloyd, 2001; Fisser & Good, 1998; Fragoso & Kashubeck, 2000; Gutmann, 1997; Hart, 2001; Levant et al 2003; Long, 1989; Mahalik, Locke, Ludlow, Diemer, Gottfried, Scott, Freitas, 2003; Moller-Leimkuhler, 2002; Newell, 1996; Real, 1997; Zamarripa, Wampold, & Gregory, 2003).
Gender roles are embedded into males and females at birth. This can be observed by the color of blankets and clothes and the toys received; boys receive cars, and girls receive dolls. Even though males and females start with similar psychological profiles, these change very rapidly with culture and societal norms. Developmental psychology and biological science researchers have concluded that males and females have the same emotional needs, and are equally expressive, dependent, and have the need for physical affection (Real, 1997). Until about the age of four or five, boys and girls adapt to the masculine and feminine norms. Males or females do not have the capacity to integrate these differences, but societal norms help shape their identity of maleness and femaleness (Real, 1997).

Access to health care is problematic for men because seeking care is perceived as un-masculine behavior for most men, making it difficult to openly admit they need help or to willingly expose the vulnerabilities they are experiencing (Cochran & Rabinowitz, 2000, Davidson & Lloyd, 2001; Hart, 2001; Harrison & Dignan, 1999; Lynch & Kilmartin, 1999, Moller-Leimkuhler, 2002; NIMH, 2003; Verrinder & Denner, 2000;). In addition, seeking care or treatment is not socially accepted by other males because it is a sign of weakness (Harrison & Dignan, 1999). This impact of masculine gender role socialization is one of the factors that obscure the expression of depressed mood or emotional trouble by many men (Cochran & Rabinowitz, 2003). Although males experience unpleasant emotions just as often as females, males do not seek care or treatment for their emotional issues (Maris, Berman, & Silverman, 2000). Researchers have concluded that men are more willing to suffer the consequences of poor health conditions than to admit that they are in need of health care services, especially for mental and emotional health (Cochran & Rabinowitz, 2000; Harrison & Dignam, 1999; Gutman, 1997; Long, 1999).
Summary

The studies of men and masculinity have been important to advancing our understanding of the impact of socializing men. Men learn that a person is either masculine or feminine. Men learn from an early age that it is not acceptable nor will they be accepted if they have feminine traits. Expression of emotions is viewed by many men as feminine and seeking help is seen as a sign of weakness. This ideology has significant implications for the health of men living with depression. However, these theories do not fully explain why men express depressive symptoms differently than women and why men are diagnosed less often than women.

Theories that have focused on masculinity ideology have not fully described the impact on depressed men. Studying depressed men in the context of a vulnerable population will begin to give this population a voice and decrease the disparities of mental health care based on gender. Depressed men are marginalized because they are alienated from others based on how men should act and behave in society.

Vulnerability and Men

The nursing profession has made an effort to decrease health disparities among groups who have been identified as marginalized or vulnerable. However, research has focused on people of color, the poor, immigrants, the mentally ill, sexual minorities, children, and victims of violence in the United States (Hall, 1999). Men have not been extensively studied within the framework of vulnerable populations or marginality. Utilizing this framework will provide a deeper understanding and address the health needs of men.

Current nursing paradigms do not view men as a vulnerable population unless they are gay, living with AIDS/HIV, poor, or homeless. However, being depressed and male in our society places them at risk for poor health outcomes. In addition, depressed
men are marginalized because they have been socially excluded from being appropriately diagnosed with depression based on their gender and society’s view that does not recognize that men express symptoms of depression differently than women. Depression in men is not recognized by our current screening tools which places men at higher risk for negative health consequences (Piccinelli & Wilkinson; Potts, 1991).

Marginalization is a concept that is being used by nurse scholars for knowledge development regarding vulnerable populations who are often hidden, stigmatized, and denied access to health care services (Hall, Stevens, & Meleis, 1994). Hall et al. define marginalization as “the process through which persons are peripheralized on the basis of their identities, associations, experiences, and environments” (p.25). The elements of marginalization described by Hall et al. (1994) are intermediacy, differentiation, power, secrecy, reflectiveness, voice, and liminality.

Wills and Porche (2006) have begun to identify men who are marginalized. They view marginalized men based on ethnicity, race, class, socioeconomic status, disability, sexual orientation, political ideology, religion, and age. Men who are marginalized have not had a voice in the current health system. These men are in need of specialized health services and innovative strategies to meet their health care needs (Wills & Porche).

Flaskerud and Winslow (1998) consider people vulnerable when they lack social connectedness. They consider social connectedness as a way people are integrated into society and free from marginalization, stigma, or discrimination. Socialization of men in Western culture emphasizes that men do not express their feelings or emotions. These norms have been socially constructed and place depressed men in the margins of society because they are stigmatized as being weak or feminine, which is the ultimate taboo among male social norms (Albizu-Garcia, Alegria, Freeman, & Vera, 2001; Brook, 2003; Cochran & Rabinowitz, 2000; Piccininelli & Wilkinson, 2000; Williams, 2003;
Zamarripa, Wampold, & Gregory, 2003). This increases the risk for depression and the associated complications such as disability, interpersonal conflict, abuse of alcohol and drugs, decreased quality of life, and suicide (Cochran & Rabinowitz, 2000; Harrison & Dignan, 1999; Moller-Leimkuhler, 2000; Williams, 2003;). Depressed men feel a sense of alienation because they cannot turn to their peer group due to the fear of being ridiculed. These men suffer from tremendous guilt and feel like failures for and not measuring up to the society’s expectation of “being a man.” This leads to high risk behaviors such as increased use of alcohol or drugs, male violence, and suicide (Brooks, 2003; Robbins, 2006; Williams, 2003).

Significance to Nursing

There is a growing need for knowledge development in the area of men’s health in nursing. This initiative is on the national level to help address the needs of men. Issues surrounding the impact of masculinity and manhood are important areas to address in the men’s health nursing movement (Porche & Willis, 2004).

Nursing research contributes to the body of knowledge that addresses health disparities, improves health outcomes, and advocates for vulnerable and marginalized populations. The knowledge generated from this study will address issues regarding men’s mental health that will contribute to the improvement of health outcomes, decrease the disparity among men, and identify further areas of study.

There is no substantial body of knowledge that addresses the health disparities experienced by men. Many men who experience health disparities are often among the populations who are socially isolated, stigmatized, have limited access to healthcare services, and unhealthy coping strategies. In addition, the goal of addressing health disparities among men is the improvement of health outcomes through community-based
screening, nursing interventions, and high quality mental health services that address men’s health needs (Wills & Porche, 2006). Reduction in poor health outcomes will be achieved by identifying men at high risk for depression. This will require better screening tools that are gender specific and lead to the development of programs to support men who are depressed; assist men in seeking early and preventative care and treatment, ultimately reduce health services costs, and promote mental health and well being among men.

Nurses interact with men who present with various health care needs. The knowledge gained from this study will help guide nursing care and provide a theory to predict and describe men who may be vulnerable to depression. Nurses must understand that men may have different responses to depression and must be able to recognize presenting behaviors or reactions to depression that will prompt the nurse to investigate further. Psychiatric Mental Health nurses are in need of a deeper understanding of men’s poor help seeking behaviors, coping responses, increased use of drugs and alcohol, and poor mental health outcomes (Porche & Willis 2004).

An examination of depression in men will help advance nursing science by describing and explaining the underlying basic social and psychological processes of depression in men. In addition, the knowledge about these aspects of depression will help to develop of substantive nursing theory and identify areas for further research.

Nursing Perspective of Human Beings

Advancing nursing knowledge requires nurse scholars to study phenomena of interest within the context of the nursing discipline. Building theoretical knowledge in nursing may be informed by various perspectives and scholars must identify their perspective so that the boundaries are clear and the study of nursing phenomena is
distinct from other human sciences.

Meleis (1997) explains that a perspective is a way a group within a discipline views a phenomenon of interest that contributes to scientific knowledge that is distinct from other disciplines. Nursing as a human science is focused on how human beings experience health and illness and the responses they have to these experiences. These experiences are influenced and shaped by many variables such as social structures, gender, and culture. Nursing science also seeks to explain the actions and reactions of human beings as they experience various aspects of health and illness (Meleis, 1997).

Nursing is a human science that has focused on the study of human beings and how they interact and respond to their internal and external environments. Nursing is an interactive process and is invested in assisting human beings develop a sense of wellness and fulfillment in life so their human existence is valued and protected. As a discipline, nursing contributes to scientific knowledge from a unique perspective when studying phenomena.

This uniqueness is distinct from other disciplines by the identification of the metapardigm of nursing. The four concepts that are central interest to nursing are person, environment, health, and nursing (Fawcett, 2000). One of the relational propositions nursing is concerned with is the interactions between the person and his or her environment and the effects on the health status of individuals and communities (Fawcett, 2000).

Kim (2000) defines environment as “the entity that exists external to a person or to humanity, conceived either as a whole or as that containing many distinct elements” (p.13). Males learn how to interact with their environment from a masculine perspective. Men learn from an early age that there are many rewards to being a masculine male and many negative consequences from society if they have feminine traits.
One ontological assumption in nursing philosophy is concerned with the person-environment interactions and the impact on perception, thought, and feelings during health and illness states (Meleis, 1997).

Theoretical Perspective

The researcher’s epistemology is important to scientific inquiry because it expresses beliefs about how one comes to know the world and makes sense of reality (Crotty, 1998; Powers & Knapp, 2006). Therefore, the philosophical foundation for this study is social constructionism and the theoretical perspective is symbolic interactionism. The theoretical perspective helps identify the orienting philosophical assumptions that will inform the chosen methodology.

Social Constructionism

The epistemology that informed this study is social constructionism. The assumption of social constructionism is meaning that is constructed through social interaction among a group and common social norms that are adopted and accepted. A key argument of social constructionism claims that knowledge is the result of social practices and the behaviors, attitudes, and norms are all constructed. Furthermore, a social constructivist view is that the individual makes sense of social realities through internalizing (learned behavior) the accepted norms of the group. Therefore, the construction of knowledge is not a personal endeavor but a process that involves the social interactions with their environment (Audi, 1999; Cheung, 2000; Crotty, 1998).

Social constructionism lends itself to the study of gender issues. Social
constructionism has the assumption that gender is socially formed (Addis & Cohane, 2005). This view highlights the ways gender itself is constructed through the process of individuals’ interaction with their environment and adopting social norms. Social constructionism clarifies that masculinity is a process that is constantly being constructed and challenges men to become masculine (Addis & Cohane, 2005). There can be many interpretations of masculinity depending on the context in which it is being studied, such as ethnicity and socioeconomic class. In addition, it is clear that gender is socially formed, but it is biology that separates men and women.

Social constructionism provides the perspective to understand how we make sense of gender roles. It is through the socialization process and interactions that creates the meaning in our social environment and our interpretations. Therefore, through the interactional process people use symbols, language, gestures, and behaviors that have certain meanings that are only understood among the people within the group.

**Symbolic Interactionism**

Some knowledge that focuses on interaction is borrowed from the discipline of sociology, with symbolic interactionism as a useful perspective. According to the assumptions of symbolic interactionism human beings: (a) must be understood as a social person, (b) must be understood as thinking beings, (c) are constantly interacting with their environment, (d) are influenced to act based on social interactions, and (e) are active beings in relation to their environment and possess free will to make choices (Charon, 2007). These assumptions are congruent with the chosen methodology for this study, which is Grounded Theory.
Symbolic interactionism was first conceptualized by Herbert Mead and later further developed by one of his students, Herbert Blumer. Blumer is credited for coining the term symbolic interactionism, but Mead is credited with developing and refining the idea and the early tenets. Blumer continued to develop a deeper understanding of symbolic interactionism and refined some of the tenets that Mead originally taught. Blumer believed that the interpretive process in the construction of meaning is central to the understanding of social experience and how it was lived. Blumer relied on Mead’s notes, interviews, and journals he left behind after his death. Blumer continued to analyze these materials and was able to produce theories grounded in the empirical data (Benzies & Allen, 2001; Jeon, 2004).

Blumer’s work set the foundation for grounded theory and provided the philosophical underpinnings of the method. In addition, these underpinnings will help guide the research in identifying the problem, formulating the questions, selecting data analysis strategies, and conceptualizing the themes that emerge from the data (Munhall, 2001).

Blumer identified four assumptions of symbolic interactionism: (a) People individually and collectively act on the basis of the meanings that events have for them, (b) meaning arises in the process of interactions among individuals, (c) meaning for individuals emerges out of the ways in which other individuals act to define things, and (d) meanings are assigned and modified through an interpretive process that is ever changing, subject to redefinition, relocation, and realignment (Blumer, 1969 cited in Benzies & Allen, 2001).
In addition to these assumptions, Blumer believed that the symbolic interactionism view has a nondeterministic perspective of the individual and makes the assumption that there is freedom of choice in human behavior within societal and cultural norms. People have the ability to interact with others in the context of the environment and communicate with symbolic use of language, gestures, and behaviors that make some type of meaning and sense to each other (Benzies & Allen, 2001).

An important tenet of symbolic interactionism is that truth is tentative and never absolute because meanings change within the individual. In other words, truth is dependent on the context for the individual and their social interactions with others, environment, and self (Benzies & Allen, 2001).

Society is external to the human being, but through the socialization process, society eventually becomes internalized and part of our existence. Society is constructed by historical ideas, meanings, and behaviors that are passed on from one generation to the next. Therefore, these ideas and meanings were socially constructed, but it is through the interpretive process that we make sense of these realities (Charon, 2007).

The goal of using grounded theory was to produce an explanatory theory regarding social interactions and patterns among the group being studied. This method has emerged from symbolic interactionism which is embedded in social psychology and sociology (Annels, 1996; Munhall, 2001; Schreiber & Stern, 2001). Symbolic interactionism theory is concerned with human behavior and how social interactions define human actions, societies, social interactions and the influence these interactions have on the person (Blumer, 1969). Symbolic interactionism assumes that people are
constantly interacting and interpreting their actions and interactions. These interactions with others and their environment give meaning to who they are and what they do (Eaves, 2001).

Symbolic interactionism acknowledges that human beings must have a role that fits the nature of social interactions (Blumer, 1969; Jeon, 2004). In other words, people will have to be part of a group that understands, defines, and adapts to the objects and symbols that have meaning to them. When they are embedded in these interactions they will not be able to see what meaning these interactions have on the “self.” Therefore, the “self” needs to be situated in interactions within the social world because the person and the external world cannot be understood independently of each other. The “self” is developed and defined through a process on a continuum as the person interacts with other human beings (Jeon, 2004).

In summary, symbolic interactionism provides the theoretical perspective that guided this study to explicate the social processes of uncovering meaning and the nature of meaning that is represented in depressed men, their interactions with others, and their environment. These meanings will only be understood from their perspective and through the interpretation of the researcher (Jeon, 2004). Symbolic interactionism lends itself to explore how men define their role in society and the process of how their roles change and are shaped as they became depressed.

This theoretical perspective fits well with the study of nursing phenomena because nursing is not concerned with individual parts of the human being but the whole
person which includes the biological, psychological, and social domains (Benzies & Allen, 2001).

Chapter One Summary

This chapter presented an overview of depression and explained the seriousness and complexity of this condition. Depression among men is poorly understood and under studied. The statement of purpose, research question, background and significance of problem were presented. In addition, the vulnerability of men was described as was the need to decrease health disparities among this population. The significance of this study for the advancement of nursing knowledge and the nursing perspective held by this researcher were addressed. The chapter concluded with the theoretical perspectives that will inform this study. Social constructionism guides the epistemology and symbolic interactionism is the theoretical perspective which informs the chosen methodology. The following chapter will present theories of depression and review related literature regarding men and depression.
This chapter will present relevant theories and literature on depression and depression in men. The chapter will be organized into three sections. The first section will define terms that will be used throughout the study to provide the context in how these terms will be interpreted. The second section will present some of the most clearly documented theories which describe the etiology of depression from a biological and psychological perspective. The final section will present the relevant literature that has contributed to explaining depression in men. This literature review will include studies on gender, gender role conflict, and help-seeking behaviors among men.

Definitions

*Depression*

Depression is a multidimensional construct that must be clearly defined in the context it will be used to differentiate pathological sadness from normal responses to stress and injuries (Andreessen & Black, 2001; Bennett & Badger, 2005). For the purpose of this study, depression will be defined according to the Diagnostic Statistical Manual IV-TR (2000) and will include major depression and dysthymia disorder. Both major depression and dysthymia are disorders of mood (sometimes called affective disorder) characterized by pervasive feelings of sadness, guilt, anger, inadequacy, despondency, pessimism, diminished interest or pleasure, and other associated symptoms that interfere with everyday activities that are distinctly different than the person’s “normal” mood (Cochran & Rabinowitz, 2000; Ebert, Loosen, Frauman, 2002).
Major Depression

Major Depression describes the symptoms of a person who is experiencing a dysphoric mood or a loss of interest or pleasure in all or most of the activities that once provided joy and pleasure (Schwartz & Petersen, 2006). Other pervasive symptoms included appetite disturbances, change in weight, disrupted sleep pattern, psychomotor agitation or retardation, decreased energy, feelings of worthlessness, hopelessness, and difficulty in concentration or thinking that occur every day for at least two weeks in duration.

Dysthmia

Dysthemia is a disorder that has the same symptoms of depression, but is less severe, and the person experiences the symptoms most of the day for two years. The person must have a minimum of two out of the six symptoms: appetite disturbance, sleep disturbance, low energy, low self-esteem, poor concentration, and feelings of hopelessness (Schwartz & Petersen, 2006). This form of a mood disorder can be severe enough to interfere with work, social, and family life as well as other activities of daily living and functioning.

Men’s Health

The definition that will be used for men’s health is the definition by Porche and Willis (2004). Their definition is “a holistic, comprehensive approach that addresses the physical, mental emotional, social, and spiritual life experiences and health needs of men throughout their lifespan.” (p. 254).
Theories of Depression

The purpose of reviewing the current biological and psychological theories of depression is to provide an overview of common dominant theories that explain and describe this disorder. In addition, these theories explain the different responses that people have to depression. There is not one theory that sufficiently explains the variations in this disorder.

Biological Theories

Over the last decade there have been biological discoveries that have given researchers a better understanding of depression. There are multiple theories in the literature regarding the pathophysiology of depression (Dunlop & Nihalani cited in Schwartz & Petersen, 2006). The monoamine theory, hippocampal-pituitary-axis theory, and the cellular plasticity and neurogenesis hypotheses are among the most clearly documented biological theories which describe the etiology of depression. Researchers have discovered that the pathophysiology of depression is more complex that once thought and goes beyond the receptor and neurotransmitter theories. Depression is associated with neuronal pathology that involves structures and neurochemical changes in regions of the brain, specifically, the hippocampus and prefrontal cortex (Insel & Charney, 2003).

Monoamine Theory

The monoamine hypothesis has been well documented in the literature explaining the pathophysiology of depression. Over 40 years ago the discovery of the monoamine
oxidase inhibitors (MAOI) provided scientists the information needed to link depression to a biological etiology (Hindmarch, 2001; Stahl, 1997). The hypothesis proposes that there is a deficit in one or more of the three biogenic monoamines, which include serotonin, norepinephrine, or dopamine (Carlson, 2004; Ressler & Nemeroff, 2000; Stahl, 1997).

Serotonin (5HT) is a critical neurotransmitter in the brain that affects a person’s mood and behavior (Delgado, 2000). Serotonergic neurons are found in the raphe nuclei, midbrain, neocortex, basal ganglia, temporolimbic regions, hypothalamus, cerebellum, and the brain stem (Andreasen, 2001; Carlson, 2004; Hedaya, 1996; Keltner, 1998).

Serotonin is derived from complex enzymatic activities that is converted starting from the precursor tryptophan hydroxylase, then to tryptophan, and finally to serotonin (Stahl, 2000). Serotonin plays a role in the regulation of sleep, aggression, libido, memory, cognition, impulsivity, stress response, and pain (Stahl, 2000). When levels are depleted a person may experience irritability, hostility, loss of appetite, and decreased libido. When serotonergic receptors are over stimulated a person may experience increased agitation, aggression, and hallucinations (Carlson, 2004; Ressler & Nemeroff, 2000; Stahl, 2000;).

Norepinephrine (NE) is a neurotransmitter that has been associated with depressive symptoms. The brain is rich with NE receptor sites (Ressler & Nemeroff, 2000). The prime areas in the brain rich in NE are the locus coeruleus, frontal cortex, parietal cortex, occipital cortex, cerebellum, temporal lobe, and hypothalamus (Andreasen, 2001; Delgado, & Moreno, 2000; Ressler & Nemeroff, 2000).
Norepinephrine originates from complex enzymatic activities beginning with the precursor tyrosine which interacts with tyrosine hydroxylase, dihydroxphenlalanie, (DOPA) and finally decarboxylase (Stahl, 2000). NE is a post synaptic terminal stimulator at the alpha1 and 2, and Beta1 receptor sites. The presynaptic adrenoceptors are autoreceptors that facilitate the release of NE (Stahl, 2000). When these sites are under stimulated or there is a lack of norepinephrine, individuals experience problems with concentration, impaired attention, fatigue, psychomotor retardation, and dysregulation of stress (Ressler & Nemeroff, 2000; Stahl, 2000). Excessive amounts of NE result in anxiety, hyperalertness, paranoia, and loss of appetite. (Ressler & Nemeroff, 2000; Stahl, 2000).

Researchers have identified that there is a dysfunction with the dopamine neurotransmission in mood disorders (Leon, Croes, Sayed-Tabatabaei, Claes, Broeckhoven, vanDuijn, 2005). The dopamine circuitry has pathways throughout the brain (Andreasen, 2001). The prime areas of these pathways associated with depression are in the mesolimbic, nigrostriatal, prefrontal cortex, temporolimbic, and specifically the amygdala and hippocampus (Andresen, 2002; Carlson, 2004; Stahl, 2000),

The dopamine hypothesis has been around since 1975 but the interest in the functions of serotonin and NE has been the priority over the last decade (D’haenen & Bossuyt, 1994). Researchers have become more curious about the specific functions of dopamine and the causal relationship to the symptoms of depression. Dopamine, like the other neurotransmitters, is produced by a complex enzymatic activity (Stahl, 2000). The precursor to dopamine is tyrosine (Carlson, 2004; Stahl, 2000). Tyrosine hydroxylase
converts to L-Dopa which is broken down by DOPA decarboxylase, then finally the neurotransmitter, dopamine (Carlson, 2004). When the dopamine transmission is interrupted due to low stimulation of dopamine receptors, a person may experience anhedonia, psychomotor retardation, lack of motivation, and affective and emotional dysregulation (Stahl, 2000). Over stimulation of dopamine produces symptoms such as hallucinations, creativity, disorganized thinking, loose associations, and mania (Carlson, 2004; D’haenen & Bossuyt, 1994; Leon et al, 2005).

Researchers have concluded that an increase in neurotransmitters has a role in the pathophysiology of depression but the clinical benefits are not observed until a few days or weeks after the administration of an antidepressant (Delgado, 2000; Hurtley & Szuromi, 2003). The monoamine theory does not provide an explanation for the delay, therefore, this theory can only partially explain the pathophysiology of depression.

Hypothalamic-Pituitary-Adrenal (HPA) Axis Theory

Researchers have linked stressful life events to the predisposition of depression (Young, Abelson, & Cameron, 2004). The theory postulates that early childhood trauma such as abuse or loss of a parent causes biological scars (Heim, Plotsky, & Nemeroff, 2004). These “scars” create neurons containing corticotrophin-releasing factor (CRF) which increases a person’s vulnerability to be sensitive to stress. Exposure to chronic stress has been a consistent theme in people who suffer from depression as reported in the literature (Charney & Manji, 2004; Fuchs, Czeh, & Flugge, 2004; Hindmarch, 2001; Lee, Ogle, & Sapolsky, 2002).

The cascade of events to activate the HPA axis begins with a real or perceived
threat (stressor) (Heim, et al, 2004). The central nervous system releases higher levels of CRF from the hypothalamus into the portal vasculature which then acts on the anterior pituitary CRF receptors (Hindmarch, 2001). Adrenocorticotropin (ACTH) is then released from the anterior pituitary gland which releases glucocorticoids from the adrenal cortex. Arginine vasopressin has been identified as a co-secretagogue of CRF during a stress response (Hindmarch, 2003; Nestler et al., 2000). It is hypothesized that these high levels of CRF causes damage to the hippocampus (Nestler, et al, 2002).

CRF is important for stress mediation. This hormone also provides increased energy, increased arousal, focused attention, and fear formation when necessary (Stahl, 2000). The brain regions that are stimulated by CRF are the prefrontal cortex, hippocampus, amygdala, and hypothalamus (Bale, 2005). These brain regions are also vulnerable to damage with high levels of CRF with the hippocampus being at the highest risk (Lee et al., 2002; Nestler et al., 2002).

Researchers have identified that reduced hippocampal volumes are associated with depression which may explain the symptoms of cognitive impairment and difficulty with concentration experienced by some individuals with a diagnosis of depression (Bale, 2005; Barden, 2004; Roy, 1992)). However, this theory does not fully explain all the symptoms of depression. In fact, Young, Abelson, and Cameron (2004) concluded that people with pure depression did not have a dysfunctional HPA axis system; rather a dysfunctional HPA axis system is only seen with individuals who experience co-morbid anxiety. Lee et al. (2002) emphasized that there is no concrete evidence that depression causes hippocampal neuron loss. This theory needs further
Neuronal Plasticity and Neurogenesis

Researchers have gained an understanding of the function and relationship of cyclic adenosine monophosphate (AMP), element binding protein (CREB), and brain derived neurotrophic factor (BDNF) to the symptoms of depression (Duman, 2002). It is clear that cyclic AMP, CREB, and BDNF play a major role in neural plasticity, which gives the neuron the ability to change and adapt (Duman, 2002). Neural plasticity is essential to allow the brain to adapt when aversive stimuli occurs because without plasticity the gene expression is altered by influencing the function of neurotransmitters, receptors, channels, intracellular processes, growth factors and structural proteins, synaptic strength and neuronal activity, and the survival of neurons (Manji et al. 2003; Vaidya & Duman, 2001). Any disruption in these cellular processes may cause the change in affect and anhedonia symptoms of depression (Duman, 2002). The cascades of intracellular events that occur have profound influence on cellular resiliency. This is critical to prevent cellular atrophy, death, and endangerment of hippocampal neurons (Manji et al., 2003).

Researchers have concluded that neurotrophins help regulate and mediate neuron death or survival, modulate synaptic transmission, and synaptic plasticity (Manji et al 2003). There are many proteins that belong to the neurotrophin family which bind to specific receptor sites and activate tyrosine kinase receptors which help regulate BDNF (Manji et al,2003; Duman, 2002). BDNF has other key functions besides neuronal viability such as playing a major role on synaptic plasticity and the release of
neurotransmitters such as GABA, dopamine, and serotonin (Duman, 2002; Manji et al., 2003).

The neuroplasticity hypothesis has significant implications for understanding depression. Research has demonstrated that prolonged depression leads to morphological changes in the neurons of the brain, specifically in the hippocampus (Lee et al., 2002).

Mackowiak (2004) defines neurogenesis as “the process that involves cell proliferation, migration and differentiation” (p. 673). The neurogenesis theory explains that depressive symptoms are caused by impairment of neuron development. Researchers have observed this process in animal studies of other mammalian species, such as a rabbit, rat, mouse, cat, and primates, as well in the human brain (Makowiak, 2004).

The neurogenesis theory is an area of interest because researchers have discovered that both physical and psychosocial stressors impair hippocampal cell proliferation (Makowiak, 2004; Sapolsky, 2004). The process of neurogenesis gives a logical explanation for the reason it takes several weeks for an antidepressant to work (Henn & Vollmayr, 2004). There is not a clear understanding how antidepressants stimulate or facilitate neurogenesis. However, it is speculated that antidepressants have a role in regulating proliferation of newly born cells, including BDNF (Sapolsky, 2004). In addition, many of the processes that involve neurogenesis stimulate proliferation and influence the survival of newly born neurons (Eisch & Nestler, 2002; Sapolsky, 2004).

Brain Regions and Depression

Pizzagalli et al. (2004) conducted a study to test the hypothesis that melancholia, a subtype of depression, is a dysfunction of the pathophysiology in the prefrontal cortex.
Nestler et al. (2002) reported in a review that many researchers have focused on the
dysfunction of the prefrontal cortex that causes the symptoms of depression. They
concluded that the symptoms of depression emerge from multiple areas of the brain and
involve several processes, not just one region or one process. Nestler et al (2002)
reported that the neurocortex and hippocampus are responsible for the cognitive aspects
of depression that result in memory impairments, feelings of worthlessness, hopelessness,
guilt, and suicidal thoughts. The symptoms of anhedonia and decreased motivation may
result in the dysfunction of the nucleus accumbens and amygdala (Pizzagalli et al, 2004).
The hypothalamus plays a role in the symptoms that are involved in the disruption in
sleep, appetite, decreased libido, and other activities that used to be pleasurable to the
person (Stahl, 2000).

The neuroplasticity and neurogenesis theories have provided logical explanations
regarding the association with depression, but further research is warranted to clearly
understand the cellular processes. Most of these studies have involved animal models
and postmortem studies which both pose issues of their own. The problem with
postmortem studies is there is no way to understand the brain morphopathology that
occurs immediately after death (Rajkowska, 2000).

Psychological Theories

Depression is not only a physical or biological disorder, but a psychological one
as well. The emotional or mood symptoms of depression include lack of pleasure,
sadness, hopelessness, impaired cognition, and increased preoccupation with death or
suicide (Hedaya, 1996). Analysis of the psychological theories provide insight into the
etiology of depression from a nonbiological perspective, one that is of relevance to psychiatric mental health nurses as well as other health care professionals.

*Psychodynamic*

The earliest psychological theory of depression was described by Sigmund Freud in 1917 when he developed the psychodynamic theory (Caldecott-Hazard & Schneider, 1992; Street, Sheeran, & Orbell, 1999). The psychodynamic theory explains that depression is caused by an early negative life event that leads to maladaptive behaviors later in life. The assumption is the past becomes locked away in the unconscious mind (Furman & Bender, 2003). Psychodynamic theorists view human beings as deterministic (Fall, Holden, & Marquis, 2004). Freud believed that human behavior is a result of irrational forces, unconscious motives, and biological and instinctual drives that are expressed through sexuality (Corey, 2001).

Freud conceptualized depression as “mourning and melancholia” (as cited by Karasu, 1990, p. 134). This was an attempt to describe the difference between normal grief and pathological depression. Normal grief would be due to a loss of an important person such as a mother, father or sibling. Melancholia was an external loss such as a break up of a romantic relationship. These losses resulted in an intrapsychic conflict resulting in psychological distress.

Melancholia was a key concept in Freud’s explanation of depression (Cochran & Rabinowitz, 2000). He wanted to make the clear distinction between grief and pathological depression and this was a way he was able to articulate the difference (Karasu, 1990). Melancholia had three preconditions according to Freud which are: “1)
ambivalence, 2) loss of the object, and 3) regression of libido into the ego” (as cited by Karasu, 1990, p. 134). Psychodynamic theory makes the assumption that when individuals become angry and disappointed, they turn these emotions inward towards the self instead of toward the real object. These emotions are expressed later in life as rage, aggression, low self-esteem, and depression (Karasu, 1990).

The basic assumption is any early childhood experience predisposes the person to depression as one enters adulthood. The after effects of the experience lead to difficulty with relationships, feelings of being unloved, need to punish self, and a sense of helplessness and hopelessness (Fall et al, 2004). These assumptions of the theory have remained consistent over the years as the theory has evolved (Cory, 2001; Karasu, 1990). There is no doubt that Freud contributed a great deal to the scientific community. However, psychodynamic theory is still controversial and not well studied (Fall et al, 2004). The use of psychodynamics takes specialized training and is a labor intensive approach to treat people with this modality (Corey, 2001; Fall et al, 2004). Other studies have taken on a different direction such as cognitive behavioral models.

Cognitive Theory

One of the most widely accepted theory of depression is clustered under the label of cognitive theory (Fall, 2004). This theory emerged from Rational Emotive Behavior Therapy (REBT), developed by Albert Ellis in 1955 (Corey, 2001). Therapists adopting a REBT approach believe that human beings are born with the capacity to think rationally or irrationally. Human beings have the choice to live in happiness, love, and share with other human beings. Human beings can also make the choice to self destruct, avoid
certain thoughts, and self blame (Corey, 2001). The primary assumption of cognitive theory is that people are at higher risk of developing depression when they experience stress because they develop maladaptive beliefs, incorrect interpretations and perception of life events, therefore, information is distorted (Alloy, 2001).

Modern cognitive theory has been further developed and Aaron Beck was one of the first researchers to explore this theory. Beck’s cognitive theory posits that negative thoughts lead to maladaptive emotions and behaviors (Kovacs & Beck, 1978). He believes that human behavior is an expression of how people perceive their life experiences and the world. Beck’s theoretical assumptions of cognitive theory are: “1) people’s internal communication is accessible to introspection, 2) people’s beliefs have highly personal meanings, and 3) meanings can be discovered by the person rather than being taught or interpreted by the therapist” (as cited by Corey, 2001 p. 309).

Researchers who adopt the cognitive behavioral model in psychology believe that cognitions are the cause of emotional distress and maladaptive behaviors (Beichel & Turner, 1986). However, Beck has made it very clear that his belief of cognitive theory describes the aspects and characteristics of depression and not the etiology (Kovacs & Beck, 1978). When Beck was working with depressed patients, he observed a constant theme of negative thinking. The characteristics he observed were “automatic thoughts (i.e. repetitive, unintended, and not easily controllable), thoughts reflecting themes of loss and revealing negative views of the self, the world, and the future” (Haaga, Dyck, & Ernst, 1991, p. 215).

Additional assumptions of this theory are that behaviors, cognitions, and
biochemistry all play a role in the disorder of depression (Haaga et al., 1991). The cognitive theory asserts that the negative cognitions typify depression and are the core elements of a depressive schema that are stimulated by stressors in life. Haaga et al. (1991) found that all depressed people show similar negative cognitions, but causal pathology involving moods and dysfunctional beliefs only applies to some. The cognitive theory also predicts that people with a high need to receive approval from others or the need to strive for perfection are at high risk for developing depression (Hankin, Abramson, Miller, & Haeffell, 2004).

Cognitive theories view depression as the result of internally determined thoughts and how the person constructs their reality from these thoughts (Street et al., 1999). Researchers are aware that early negative life events have an influence on how people react and adapt to their environment. The events are not the primary focus because cognitive therapists believe that it is the cognitions that keep people in a depressed state (Street et al, 1999).

Existentialism

Victor Frankl (1986) was an existential psychiatrist who contributed to the development of the existential thought related to a theory of depression. Frankl tested this theory of existentialism when he was placed in a concentration camp during World War II (Furman & Bender, 2003). At the time he was already a psychiatrist and questioned how some people were able to survive the horrible treatment and experience while others would give into the despair, became depressed and died (Furman & Bender, 2003). Frankl concluded that Freud’s theory was not accurate in making the assumption that
people were driven for pleasure (sexual drives and motives). Instead, Frankl, purported that people are driven for meaning, an underlying assumption of this approach. In other words, people are driven to make sense of their suffering and to find the meaning in their despair (Frankl, 1986; Lukas, 2000). Existential theory assumes that “recognition of suffering is a necessary part of the human experience” (Blair, 2004 pg. 334). Frankl’s theory is just one of many existentialist interpretations. Other well known existentialist theorists are Rollo May and Irvin Yalom (Corey, 2001).

Existentialism is deeply rooted in philosophy that has emerged as a school of psychology (Corey, 2001; Fall et al, 2004). The main focus of existentialism is the quest a person has for life and how one finds meaning and purpose. Existentialists assume that people are born into a state of nothingness and it is up to the individual to create meaning (Frankl, 1986; Furman & Bender, 2003). The focus of existentialism is to gain the understanding of what it means to be human (Corey, 2001).

The underlying assumptions of this theory believes that human beings are in a constant state of transition. Part of being human is the drive to discover and make sense of their existence and purpose in life (Cory, 2001; Furman, & Bender, 2003; Lukas, 2000). Existentialists believe that human beings have the ability to achieve these basic conditions:“1) the capacity for self-awareness, 2) freedom and responsibility, 3) creating one’s identity and establishing meaningful relationships with others, 4) the search for meaning, purpose, values, and goals, 5) anxiety as a condition of living, and 6) awareness of death and nonbeing” (Corey, 2001, pg. 145).

The existential theory assumes that meaning is critical to the existential
conception of depression. Yalom (1980) frames depression as the individual’s lack of responsibility in life. He assumes that all human beings have a sense of locus of control. It is up to the person to take responsibility to create meaning. The people who are able to find a meaningful life develop a high degree of locus of control (Furman & Bender, 2003).

When people lose meaning or direction in life, it leads to despair and depression (Frankl, 1986). The world seems meaningless therefore, they are filled with negative thoughts, question their own mortality, and wonder what is the purpose to continue living (Corey, 2001). A meaningless life leads to emptiness (Frankl, 1986). Frankl (1986) conceptualized this as the existential vacuum. People who experience the existential vacuum have a sense of frustration in life which leads to the lack of purpose, lack of enthusiasm, and boredom. Frankl believed this triad leads to depression, aggression (suicide and homicide), and addiction (abuse of alcohol and drugs) (Frankl, 1986).

In summary, psychodynamic theories are based on Freudian’s concepts suggesting that depression is a result of an early life trauma or a major loss. The assumption is when a person in adulthood experiences a loss, they are re-traumatized from the earlier loss and this causes the person to experience depression. Cognitive theory is based on Beck’s concepts that people who are depressed have negative thoughts about the world, self, and their future. This theory makes the assumptions that people with depression have distorted thoughts and perceptions.

Existential theory is focused on finding meaning in life. If individuals lose
meaning they experience the existential vacuum and have a sense of emptiness. This theory explains that when people are depressed they do not have meaning in their lives.

Summary

Depression is a multifactorial disorder and cannot be explained or described from only the biological, psychological, or sociological perspective. The theories presented in this section do not provide an adequate explanation regarding the phenomena of male depression. These theories have provided evidence to guide psychotherapy and psychopharmacological interventions to those men who have sought out help, been properly diagnosed, and open to treatment. However, these theories have not helped in preventing the consequences of untreated depression (i.e., suicide) or early detection because of the lack of knowledge that describes how depression is manifested in men and properly diagnosed in this population. A theory specific to men and depression is long overdue and necessary to understand the issues regarding male depression to prevent health consequences, decrease the long term disability associated with untreated depression, and provide an explanation to men and nurses so they understand male depression. Generating a theory specific to depressed men and their social experiences will uncover the social and psychological processes among this population.

The conclusions of this review suggest that there is a need for psychiatric mental health nursing to have knowledge of both biological and psychological theories of depression. These theories have direct implications for practice and research of psychiatric mental health nursing and help shape our beliefs, values and knowledge of the person suffering with depression. It is important from a nursing perspective that we do
not reduce the person to their disease.

I believe that the biological theories are not superior to psychological theories and both have very distinct differences. Both theories serve different purposes but the practice of psychiatric mental health nursing benefits by blending both types of theories to understand the behavioral and emotional responses people have when suffering from depression. Therefore, it is my belief that depression is a complex syndrome that is caused by one or more factors associated with biological, psychological, sociological, and environmental interactions with the person.

Depression and Men

The remainder of this chapter will present research focusing on social theories. These theories include gender differences, gender role, and help seeking behaviors among men.

*Gender Differences and Depression*

Studies that have focused on gender differences in depression have concluded that men present to their health care provider with other co-morbid conditions such as alcohol or substance abuse (Aday, 2001; Cochran & Rabinowitz, 2003). These co-morbid conditions tend to mask depressive symptoms and lead to undiagnosed, untreated, and unidentified depression (Cochran et al, 2003; Potts, Burnam, & Wells, 1991). Men tend to conceal, mask, or deny their feelings of depression which leads to other destructive behaviors (Cochran et al, 2003; Zamarripa, Wampold, & Gregory, 2003). Alcohol and other substance abuse continues rise among men (Epperly & Moore, 2000). Men abuse alcohol at greater numbers than women, the highest rates of alcohol abuse
among men occur between the ages of 25 and 39 and alcohol is abused by 14% of men over the age of 65 (Epperly et al, 2000). These facts have led researchers to conclude that the high incidences of alcohol and drug use are a maladaptive coping mechanism for men to manage their depressive symptoms.

Men often present with interpersonal conflicts when they are depressed. Men tend to become aggressive and abusive towards others when they are depressed including their spouses, families, or significant others (Cochran et al, 2003). This leads to higher rates of domestic violence and dysfunctional families. Men with depression project blame onto others, use physical intimidation and force whenever they perceive threats to their masculinity from others, and use physical aggression to cover up their psychological pain (Cochran et al, 2003).

Men who suffer from depression experience feelings of hopelessness and helplessness, but externalize coping and do not seek help (Cochran & Rabinowitz, 2000). In contrast, females seek support from family, friends, and health care providers. Females tend to report physical and psychological symptoms and seek medical help at higher rates than men (Piccinelli et al, 2000). Females discuss their thoughts, feelings, and emotions openly with friends and family members (Alexander, 2001; Piccinelli & Wilkson, 2000). Women are open and honest with their health care provider whereas men minimize their complaints and mask their emotions (Piccinelli et al., 2000). Often, the health care providers do not recognize the need to explore these superficial complaints with the male patient (Alexander 2001; Lynch & Kilmartin, 1999; Piccinelli & Wilkson, 2000).
Studies have been able to support some of the early speculations that men manifest depressive symptoms differently than women. Cariney (2002) did a large descriptive study in Canada that focused on gender differences and how they may change as men and women pass the menopausal age. They concluded that women do suffer from depression at greater rates than men but that there are not changes after age 55.

Goodwin and Gotlib (2004) conducted a study to identify if depression had a relationship to personality factors and a gender difference. They concluded that neuroticism was higher in women than men. It was not clear if culture or society’s norms were taken into consideration. Goodwin (2004) encourage other researchers to replicate this study because they believe this may be the beginning of explaining the gender differences in depression.

Studies have been able to support the finding that men manifest depression differently than women. Men report atypical symptoms like irritability, aggression, and antisocial behaviors (Moller-Leimkhler, Bottlender, Strub, & Ruts, 2004). Women have higher rates of crying and weeping episodes, men present with blunted affects and irritability (Winikler 2003). Interestingly, both genders had similar reports of sadness.

Marcus et al. (2005) found a difference in how men and women present symptoms of depression. They concluded that men have higher rates of obsessive-compulsive behaviors, and alcohol and drug use than women. Men also report more thoughts of suicide but women acted on their thoughts more frequently with attempts. In addition, women have higher rates of somatic complaints, bulimia, and crying than their male counterparts(Marcus, et al., 2005).
These studies are providing some empirical data that is necessary for clinicians to use when assessing and screening men for depression. Hart (2001) is a clinical psychologist who treats depressed men and is the author of *Unmasking Male Depression*. This book illustrates his clinical observations with working with men and depression. Cochran and Rabinowitz (2000) are two leading researchers in the study of men and depression who have published extensively on this topic. Their publications are geared toward practicing clinicians in the assessment and evidence based practice for working with men and depression.

People who commit suicide have been found to have had a past history of a mood disorder, primarily depression (Chioqueta & Stiles, 2003). Review of the antecedents that led up to the suicide found that over 90% of people that commit suicide suffer from a psychiatric illness (Goldney, 2002). In these cases approximately 60-70% suffered from major depression.

Men have preconceived assumptions regarding suicide. Men not only become self destructive by abusing alcohol and drugs, but decide to engage in any high risk behavior such as reckless driving. These can be viewed as socially accepted behaviors among males, but in fact, the intent of suicide is evident (Diego et al 2002; Stanistreet et al., 2003).

Males also become more impulsive because they have difficulty experiencing and expressing their emotions and feelings. They are taught that men should not experience despair, but it is more acceptable for them to become impulsive, angry, and act out their emotions in a negative manner (Diego et al., 2002). These behaviors among men led
researchers to examine gender roles more closely.

**Gender Role**

Gender role conflict is defined as “a psychological state that stems from negative consequences of masculine role socialization and can be understood as a marker of individual differences in role adherence that result in the process of social gendering” (Magovcevic & Addis, 2005, p.127). Mahlik (1999) defines gender role strain as “societal norms around gender ideals often contradictory, inconsistent, and unattainable’ (p.33). From a cognitive therapy perspective, this can be viewed as unrealistic gender roles schema that cause cognitive distortions. This leads to low self esteem, feelings of worthlessness, or hopelessness. These lead to men trying to live up to unrealistic expectations that have been socially constructed, and when violated, they experience negative psychological consequences (Mahalik, 1999). Several studies have attempted to assess how gender role conflict and gender role strain affect the mental health of men.

Franchina, Eisler, and Moore, (2001) conducted a study that involved 107 undergraduate male students to assess which men were susceptible to stress when their masculinity was threatened. They concluded that men with higher masculinity ideology endorsement will exert power and control over others. These men could be at risk for aggressive behavior towards others. Another conclusion from their study would also indicate that these men feel a sense of insecurity and low self esteem. A study completed by Jakupcak, Lisak, and Roehr (2002) found similar results. They concluded that masculine ideology does impact the self schema of men. The results also indicated that when the male gender norms are violated, autonomic arousal is caused. These
findings indicated that physically aggressive men report higher levels of internal arousal while arguing with their female partners than did nonviolent men.

Fragoso and Kashubeck (2000) examined the relationship of gender role conflict and mental health among Mexican American men. They concluded that Mexican American men are likely to report high levels of stress and depression when they experience gender conflict. There was a strong correlation between the endorsement of masculine ideology and depression.

Levant et al. (2001) conducted a similar study as Fragos et al. but the focus was on Russian men. Their study did include United States (US) men with different ethnic backgrounds. Their aim was to further investigate the social constructionist perspective on gender roles. They discovered that ethnicity has a greater effect on masculinity ideology than gender. The conclusion was that both Russian men and women endorsed masculinity ideology at higher rates than US men and women.

Mahalik and Cournoyer (2000) compared depressed with non depressed men to examine the difference in how they internalize their emotions and how gender role socialization affects their moods. They concluded that depressed men scored higher on the gender role conflict scale. In addition, they also found that depressed men scored higher on the items that indicated emotional restrictions. Depressed men reported more conflict at work and with their family.

Similar results have been found in other studies that examined gender role and the relationship to depression. Men with high gender role conflict had more restricted emotions, abused alcohol, and had higher rates of depression. In addition, Shepard (200)
found that men in their study endorsed dysphoria, self dislike, feelings of failure, and guilt. These men reported that these emotions were a sign of weakness and felt unmasculine but would not report these feelings to anybody (Magovcevic & Addis, 2005; Sheppard; 2005; Zamarripa, Wampold, Gregory, 2003).

Alexander (2001) and Brownhill, Wihelm, Barclay, and Schmied (2004) had similar findings in their studies. They found that most men do not have close relationships with other people. This makes it impossible for them to have someone they can trust and feel comfortable to express their feelings or have someone to go to when they are in need of help. Men conceal and hide their feelings. These results were supported in both studies. Alexander further reports that men do not want to burden others with their issues. It was evident that men develop strategies to self manage their depression such as risk taking behaviors, drugs, alcohol, self harm, aggression, and violence. Heifner’s (1997) grounded theory reported similar findings. However, her study was poorly designed and she did not develop a theory based on her findings.

Good, Heppner, DeBord, and Fisher, (2004) study concluded that there was not a relationship between masculine role conflict and men’s experience of psychological distress. This study challenged numerous studies that have concluded there is a relationship and men who have a high masculine role conflict experience higher levels of psychological distress (e.g. Addis & Mahalik, 2003). In other words, they concluded that men did not experience any psychological distress due to conflicts with social norms. This is the only study found in this literature search that had these conflicting results.
The problem with these studies is the majority used college age participants, and some of these participants were given college credit for participating in the studies. The other issues are these studies had samples primarily of white men attending college. This does not reflect the disadvantage populations nor can we get a good assessment of how these populations are affected with depression.

*Help Seeking Behaviors*

Blazina and Marks (2001) examined how gender role conflict affects men in seeking help for mental or emotional issues. They discovered that men with high gender role conflict experience negative moods and do not seek help. These men viewed seeking help negatively and also reported uncomfortable feelings when sharing feelings with other men, especially in a group setting. Mansfield and Courtenay (2005) had similar findings in their study. Masculine gender roles are defined as, men should be strong, stoic, and in control. Men view asking for help as violating all of these norms that are defined by society. In addition, these study results also concluded that that men were concerned about being viewed by others as being vulnerable. These studies also found that in general, men believed they could not trust and be open with healthcare providers.

Albizu-Garcia, Alegria, Freeman, and Vera (2001) studied health seeking behaviors among Puerto Rican men. They concluded that men wait longer to seek any help for mental or emotional issues. The longer they wait, their risk of suicide increases.

A study examining the beliefs of men regarding people seeking help for depression concluded that men believe the person in need of help were weak and associated with feelings of pity. They also concluded that men blamed the person for
having depression (Halter 2004). However, study results concluded that logically, the men in the study had an understanding that depression is caused from biology, social, and environmental factors.

**Preliminary Study**

The purpose of this preliminary study was to enable the researcher to develop the skills necessary to conduct scientific research. These skills included interviewing, transcribing from audio taped recordings, doing comparative analysis, and working with the researcher’s advisor to restructure the interviews and data analysis. The grand tour question was asked “Tell me about a time you can recall when you were depressed?” This question appeared to be sufficient because each participant provided rich thick descriptive data. The interview then continued with probing questions. An application for approval to the Internal Review Board was submitted with an informed consent form; approval was granted prior to collecting data for the preliminary study.

There were a total of 2 men who participated in this preliminary study. The first participant was a married 44 year old White male. He had 2 children and a 2 year college degree. His age of onset of depression was at 18 years. The second participant was a 40 year old White single male with no children. He had a 4 year college degree and his first onset of depression was at the age of 21.

Both men provided rich thick data through their responses to the open ended questions and probes. From this preliminary study the findings identified three stages of depression.

The first stage was *Acting Out*. During this stage the men externally reacted, used
physical aggression, anger, and used high risk behaviors such as reckless driving or starting fights to express their feelings. One man responded “I was destroying myself.”

The second stage was *Numbing*. In this stage each man took on behaviors that would help avoid their feelings of depression. These included excessive alcohol use and illicit drugs. One man responded “I just kind of felt numb….I just didn’t care.”

The third stage was *Acceptance*. This stage was identified as the time when the men began to accept the depression and that this would be part of their lives. They reported that they had to take a different direction in life, take responsibility and accept their feelings so they could function in their daily lives. The most concerning in this stage was both men decided to ignore the issue of depression and did not seek help. One man responded “I was in my twenties and I started to feel somewhat better, and I became less acutely depressed then I became more of this functionally depressed.”

This preliminary study served two purposes; 1) to obtain preliminary data and 2) to conduct preliminary interviews to assist the researcher in developing the skills necessary to conduct qualitative research. An application for approval to the Internal Review Board was submitted with an informed consent form and approval was granted prior to collecting any data for this preliminary study. This preliminary study helped the researcher develop research skills in the areas of interviewing, transcribing from audio taped recordings, auditing the transcripts for accuracy, doing comparative analysis, and working with his dissertation chairwomen on restructuring the interviews and data analysis from a distance.
Synthesis

Based on the literature that was reviewed, the state of the science on men and depression remains underdeveloped. Most research studies have relied on quantitative methods to examine men and depression and the most studied areas of research have focused on gender differences, gender role, and men’s health seeking behaviors.

Studies focused on gender differences lack an explanation regarding what contributes to the increased or decreased risk of developing depression among men (Cochran & Rabinowitz, 2003). Studies concluded that depressed men experience emotional pain similar to women but there is no explanation for the reasons men wait so long to seek treatment, are diagnosed less often, and have higher incidents of co-morbid disorders such as alcoholism, drug addiction, and interpersonal conflicts. Previous studies have not identified any patterns to explain why this is occurring among men.

Gender role conflict has been studied extensively for the last 20 years (Levant & Pollack, 1995). However, there have not been sufficient studies that specifically focus on the relationship between gender roles and men with depression (Levant & Pollack, 1995). The studies that specifically examine the relationship of depression and gender role have found that depressed men have high gender role definitions (Magovcevic & Addis, 2005; Robertson, 2001; Sheppard; 2005; Zamarripa, Wampold, Gregory, 2003). However, this was not the case with Good et al. (2004) because they found no relationship between gender role and depression in their study. Therefore, this single theory is inadequate because it does not fully explain or describe depressed men nor does it predict who is vulnerable to depression.
Many studies have concluded that further studies are necessary to fully understand the complexity of the interaction between psychological and psychosocial influences (Cochran & Rabinowitz, 2003). Many studies also indicated that a better understanding is necessary before interventions can be developed in the treatment and detection of depression in men. It is evident that the current available research has gaps in explaining and describing the realities of male depression. These studies have not provided enough detailed evidence to gain a full understanding of the etiologies and manifestations of depression specifically to address the mental health needs of men.

There are few qualitative studies that have been conducted to explore the processes that occur in men who are depressed. Qualitative research may provide the perspective and give a voice to these men suffering from depression and add to the quantitative research studies as well as providing researchers with the information necessary to move the science forward. Cochran and Rabinowitz (2000) support well-designed qualitative studies because they believe that qualitative inquiry will help move the science beyond the superficial aspects of the traditional male gender role to gain a deeper understanding of the male experience with mental and emotional issues. The results from the preliminary study supported that qualitative inquiry will produce thick rich data that will be useful in generating new knowledge.

Therefore, a grounded theory is appropriate to identify the patterns and process that are occurring in depressed men. A grounded theory design can discover areas that have not been identified to fully understand depressed men.
Chapter Two Summary

This chapter defined terms that will be used for in this study. A review of the biological and psychological theories and their importance were discussed. This chapter also presented relevant literature on depression and gender differences, gender role, and help seeking behaviors. A preliminary study with preliminary findings was also presented.
CHAPTER THREE
METHODOLOGY

This chapter will discuss the methodology chosen for this study. A brief overview of the usefulness of qualitative inquiry and the background, purpose, and advantages of using grounded theory will be discussed. The procedures of the data collection and analysis will be explained. In addition, how nursing knowledge will be advanced using grounded theory to study men and depression will be explained.

Qualitative Inquiry

Qualitative research involves broadly stated questions about human experiences and realities extrapolated from the persons or groups being studied while they are embedded in their natural environments. Qualitative methods produce rich and descriptive data that provide researchers the ability to conceptualize the human experiences, realities, and meanings to describe or explain the phenomena under study (Munhall, 2001). In addition, qualitative research is based on the assumption that truth is dynamic and can be discovered only by studying persons as they interact within their natural environments (Norwood, 2000). The research methodology being proposed for this study is grounded theory.

Purpose of Grounded Theory

Grounded theory was chosen because this approach emphasizes discovery of meaning and social processes among the population being studied. Specifically, this
approach allows the researcher to uncover meanings that have not been identified in previous research because meaning and process will emerge as the data are being analyzed. In addition, grounded theory is the methodology that will identify the health challenges that depressed men are confronted with, and how they respond and cope with depression. The goal of this study was not to test or validate an existing theory but to generate a theory through discovery that explained and described the social psychological processes of depressed men.

Glaser (1967) explains that the purpose of grounded theory is to discover what is going on in any given social situation. Grounded theory is aimed at understanding how people or a group (i.e., men with depression) defines their reality through the social processes. Process is defined as “something which occurs over time and involves change over time” (Glaser, 1992, p.89). Strauss and Corbin (1998) further define process as “a series of evolving sequences of action/interaction that occur over time and space, changing, or sometimes remaining the same in response to the situation or context” (p.163). The social context will identify how men interact with other men, women, and their environment and how these interactions influence the way they behave, think, and react (Glaser & Strauss, 1967; Ramirez, 2005).

Since the discovery of grounded theory, nurse researchers have embraced this method over the last 30 years to advance nursing knowledge. Grounded theory has helped develop nursing theory by using a systematic, rigorous, legitimate method to describe and explain various human experiences, interactions, and meanings in a social context (Munhall, 2001).
Through the use of grounded theory nurses researchers are able to identify concepts related to nursing. These concepts are then developed into categories, themes, and eventually generate nursing theory. A high value is placed on evidence-based practice which is driven by quasi-experimental studies. Well developed grounded theory studies can and have contributed to evidence-based practice by providing a better understanding of how people or groups make sense of their realities.

According to Hall and May (as cited in Schreiber and Stern, 2001), grounded theory is underutilized in nursing theory development. They argued grounded theory is useful and should be applied more frequently in nursing practice. They state “a) the theory can help us to think about extant knowledge and about practice in new and presumable better ways; b) based on these new and better ways of thinking, practice may be improved in some often, unspecified, way; and c) the theory can help to guide future research, which then will generate new knowledge that eventually may improve practice” (p. 213). The theory development not only formulates theoretical knowledge regarding human experiences and associated meaning but will lead to nursing interventions (Wilson, Hutchinson, & Lindell, as cited in Fitzpatrick & Wallace, 2006).

Background of Grounded Theory

Barney Glaser and Anselm Strauss (1967) discovered grounded theory when they became interested in studying the process of dying among terminally ill patients. They were recruited in the 1960s by the Dean at the University of California San Francisco to help strengthen the doctoral program in nursing. Both Glaser and Strauss were educated
in sociology. Strauss received his education and training at the Chicago School of Sociology. He was a student of George Herbert Mead which gave him a strong grounding in symbolic interactionism. Glaser was well educated in quantitative social research methods at Columbia University (Baker, Wuest, & Stern, 1992; Jeon, 2004). Soon after they joined the school of nursing, they introduced the students to grounded theory in order to study nursing phenomena. Examples of these phenomena are *The Nurse and Dying Patient* by Quint, 1967; *The Politics of Pain Management* by Fagerhaugh and Strauss, 1977; *Affiliation in Step-Father Families* by Stern, 1978, and *The Management of Chronic Illness* by Corbin and Strauss, 1988 (Baker, Wuest, & Stern, 1992).

**Advantage of Grounded Theory**

The aim of using grounded theory methodology was to discover the basic social processes of depression among men. The philosophical underpinning theoretical perspective of symbolic interactionism is a way to move the concrete reality to an abstract level to gain an understanding of the processes that are occurring among depressed men (Jeon, 2004). This was essential for theory development and the philosophical foundation gives creditability and strength to the study design. The study of nursing science cannot always rely on quantitative research to explain, predict, or describe phenomena of interests because the nature of nursing science is focused on human beings and their interactions with others, society and their environment.

The theoretical perspective of grounded theory guides the researcher to gain an understanding of how people make sense of reality through social processes. This leads to the identification of concepts that are developed into a grounded theory. In addition,
grounded theory was aimed at understanding how a group (i.e., men with depression) defines their reality through social interactions. People who share common situations or illnesses do experience some common meanings that will be discovered by using a grounded theory approach (Munhall, 2001; Schreiber & Stern, 2001).

The link between symbolic interactionism and grounded theory is that meaning of events to people will be constructed through social processes. Human behavior can be explained through an interpretative process by identifying their definitions of their objects, gestures, events, and situations they encounter (Schreiber & Stern, 2001).

Grounded theory is a method that has advantages over other qualitative methods when there is little known about a problem. The assumption when using this method is that people or groups being studied share common social psychological problems that have not been identified or understood in previous studies. Therefore, using grounded theory helps to identify and define the health problems so they could be explained and understood by others as well as identify areas for further study (McCann & Clark a, 2003).

There is little known about men and depression from a nursing perspective and the goal of this study was not to test or validate an existing theory but to develop a theory. It is not uncommon for a grounded theory to be further developed into a middle range theory that can be useful to the practice of nursing (Schreiber & Stern, 2001). Because this study was not interested in culture or philosophical inquiry, grounded theory was chosen.
The epistemology of grounded theory is to acquire knowledge about social realities and to discover the knowledge that exists. The assumption of grounded theory is that there is a process that occurs through interactions among people and their social roles, behaviors, and symbols (McCann & Clark, 2003a). The social roles of men were examined to generate knowledge about how men related to their environment and construct meaning from social processes and how their health and psychological well-being was affected.

Glaser (1967) explains that the purpose of grounded theory is to discover what is going on in any given situation. The intent of this study was to explain the social situation by identifying the core and subsidiary processes occurring with depressed men. Therefore, using grounded theory in this study was appropriate because the issue of men and depression is a social process. In other words, the social context identified how men interact with other men, women and their environment, and how this interaction influenced their thoughts, behaviors and reactions. Grounded theory lends itself to study processes in a psychological and social context (Baker, Wuest, & Stern, 1992).

Justification for Straussian Method of Grounded Theory

Since *Discovery of Grounded Theory* (1967), Glaser and Strauss have refined the methods to develop grounded theory in their own different ways. Researchers who decide to use grounded theory need to be aware of these differing perspectives and philosophies because classic grounded theory (Glaser) has a different epistemology than Strauss’s and Corbin’s version (Annells, 1996; McCann & Clark, 2003). The following paragraphs make the argument for choosing Strauss’s methodology.
Glaser’s epistemology of grounded theory remains embedded in an interpretative approach to research that is influenced by the critical realist ontology and postpositivist paradigm. The assumption of this view is that reality can be found, but only partially measured in research. This approach has more of a positivistic influence than that of Strauss and Corbin (Lomborg & Kirkevold, 2003; McCann & Clark, 2003).

Conversely, Strauss and Corbin’s epistemology is influenced by the social constructivism paradigm. Social constructivism is based on the assumption that truth is constructed both individually and collectively (Lomberg & Kirkevold, 2003). The assumption of this view is that reality cannot be known, but can be interpreted. This paradigm is influenced by symbolic interactionism. This perspective guided the researcher in this study because the study of the concept of masculinity is heavily influenced by social realities as well as socially constructing how the role of men is developed and perceived in society.

This researcher agreed with the axial coding procedure and it made logical sense that a researcher needed to use this method to formulate a more precise explanation about the phenomena of interest (Strauss & Corbin, 1998). This stage of analysis helped the researcher develop a more rigorous theory by validation. This method by Strauss and Corbin helped the novice researcher develop the complex thinking skills that were necessary for grounded theory. In contrast, Glaser assumes that these skills are natural and the researcher should be able to generate the theory through the analysis of the data.

In addition, Strauss’s and Corbin’s framework relies on analyzing both the structural and contextual interaction influences. It seems logical to use a paradigm model
to further develop categories. It was necessary for the researcher to be conscious of the risk of forcing the data (McCann & Clark, 2003).

The remainder of this chapter will explain the procedures that will guide this study.

Sampling

*Sampling Approach*

Theoretical sampling was used throughout the sampling process. Theoretical sampling was necessary for grounded theory so that the researcher could simultaneously collect, code, and analyze data, thus generating theory (Glaser, 2001; Schreiber & Stern, 2001). The purpose of theoretical sampling was to change the process that shifts as the codes develop and a theory emerges. The sampling process was completely controlled by the emerging theory. As the theory emerged, the researcher interviewed another participant to test and refine the emerging theory and then continue until saturation was reached. The goal was to continue to collect data until the point of saturation of the theoretical codes. Saturation of a code was accomplished when the researcher was able to identify the completeness and use the data to answer questions regarding the cause, context and consequences of the particular theoretical code (Munhall, 2001; Schreiber & Stern, 2001). Theoretical saturation was achieved when there were no new data emerging relevant to a particular code and all variations of the codes were able to be explained (McCann & Clark, 2003).

The sampling decision was made purposefully to advance the theory during the entire research process. Participants were chosen purposively because they were the
experts in the area of the research content. Meaningful information continued to be gathered from participants until saturation of theoretical codes and hypothesis were formulated and tested.

Inclusion Criteria

Participants were English-speaking adult males over the age of 21 years old who had a diagnosis of major depression or dysthymic disorder according to Diagnostic Statistical Manual IV-TR (2000). Dysthymic disorder is a form of depression and is differentiated by the length of time the person experiences the symptoms. Usually dysthymia symptoms last over one year and are not an acute episode of depression. Participants continued to be solicited until the point of saturation. There were nine participants in this study; the portraits of these participants are presented in chapter four.

Gender and Minority Inclusion

The study was restricted to the male gender. Every attempt was made to include ethnic minorities into the study to gain further understanding of how ethnicity may affect men from other cultures and races that are suffering from depression. Participants were not excluded based on ethnicity, socioeconomic status, education, sexual orientation, or religious beliefs.

Exclusion Criteria

Participants were excluded if they had any cognitive impairment, were unable to answer the questions without the assistance of a care provider, or were actively experiencing suicidal thoughts or gestures.
Recruitment

Participants were recruited from private practice therapist outpatient offices. The term therapist was used to include qualified mental health care providers who were licensed to diagnose and treat individuals with mental and emotional issues. Providers included psychiatric nurse practitioners, psychologists, psychiatrists, social workers, and mental health counselors. The research was publicized to men at various private practice therapist offices through flyers and informational brochures. The therapist provided the men with the brochure if they expressed interest and the men contacted the researcher. The participants were provided with a 24-hour confidential cellular phone number with voice mail capabilities to call for more information. The researcher returned their call and explained the research study and answered any questions from the potential participant. During this screening process, the researcher evaluated the participant based on the inclusion and exclusion criteria. Prior to beginning the interview, the researcher explained the potential risks and benefits and obtained a written consent from the participants.

Setting

The setting and time of the interview by the participant occurred at a location that was conducive to grounded theory interviewing. There was a professional office available for use if the participant wished to meet at this location. The researcher made arrangements to meet at an agreed time, date, and location. Seven of the participants were interviewed in the private office; one participant was interviewed in his home and one chose to be interviewed at his private office at his work site. The sites were selected
as comfortable environments, ensured privacy and confidentiality.

**Interviews**

The researcher completed one interview with each of the nine participants with two men having two interviews. As the study progressed, two men were interviewed a second time for member checks and confirmation of the theory. The interviews lasted one to one-in-half hours. The interviewer asked the over arching question “Tell me about your experience with depression?” The interview were followed by probing questions such as “When did you become aware you were depressed?” and “What changes have you noticed over time?”

Consistent with grounded theory, the interviews were open and flexible. Glaser (2001) recommends that researchers become familiar with as many types of interview styles as possible because grounded theory will require a variety of styles dependent on the participants and the stage of the study. For example, at the beginning stages of the study the researcher did not know what he was looking for so the interviews were open and the researcher asked few questions, listened, and took notes (memo). As the study progressed the questions for the next interview was revised so the interviews took on a more structured style to saturate the categories. For example, as the category *Being Differet*, was emerging the researcher asked “other men that have been interviewed reported they felt different, can you tell me your experience with this?”

**Transcription of Audio Tapes**

All eleven interviews were recorded on audio tapes. Each tape was coded by using one letter (p=preliminary or c=case) and an eight digit number that was assigned by
their interview number (i.e. interview number 1=case 01) followed by the date of the interview (mm/day/year).

Each audio tape was reviewed by the researcher for content and accuracy. The researcher made memos as ideas and questions as they emerged during the analysis and data collection process. The audio tapes were transcribed by a professional typist who met the IRB standards. When the transcriptions were completed, the researcher listened to the audio tapes while following the transcriptions to check for accuracy. The researcher corrected any errors that were necessary to ensure accuracy of the data. A second level of accuracy was completed by the researcher’s dissertation chair listening and comparing selected audio tapes with the transcriptions. This process was completed with four of the tapes and transcriptions; the researcher’s chair concluded that the transcriptions were 95% accurate.

Observations

Observations were made throughout the interviewing process. Observations such as use of language, gestures, type of dress, jewelry, hair style, physical expression, and mannerisms were recorded in the researcher’s field notes. The notes became part of the data to analyze to guide the researcher in discovering the emerging theory. The notes contained additional information such as questions, ideas, and hypothesis, and the researcher gathered additional data. The notes became part of the comparative analysis to add information for further inquiry or confirmation of theoretical codes (Glaser, 1978).
Data Analysis

Consistent with grounded theory, the data analysis began with the very first interview that was conducted. The key principles of grounded theory are the researcher must simultaneously collect, code, and analyze the data as he proceeded with data collection (Munhall, 2001). The objective of theoretical sampling was to have the data guide the researcher to the next step in the data collection to confirm or disconfirm the emerging categories (Glaser, 1998). Glaser believes that memos, interviews, and observations become part of the data, therefore, these were analyzed for the development of the theory.

The data analysis began with the constant comparative method, which is the analytic method used throughout the grounded theory study. During this process the generation of theoretical constructs, along with substantive codes and categories and their properties, were identified to formulate hypotheses. The researcher was comparing incidents with incidents, incidents with categories, and categories with categories or constructs with constructs (Munhall, 2001). The data were then coded by using open, axial, selective coding.

The theoretical data analysis began with open coding. This was the beginning step in the discovery of categories and their characteristics. During this step the data were broken down into incidents and were closely analyzed and compared for the similarities and differences that led to further investigation (Glaser, 1998). Open coding consisted of reading and examining the transcribed interviews line by line to obtain select phrases,
words, or stories that contained single unit of meaning. This level of coding elicited a list of concepts from the data. Open coding was followed by axial coding.

Axial coding was the process of identifying the relationships between the categories and subcategories along the lines of their properties and dimensions (Strauss & Corbin, 1998). Axial coding was accomplished by organizing and structuring the data using a paradigm. Straus and Corbin (1998) stated that a paradigm “is nothing more than a perspective taken toward the data” (p. 128). This was a strategy used to gather and order the data so both structure and process were integrated. The researcher constantly analyzed the day by asking who, when, where, why, how and what consequences occurred. It was through this process that the research was able to define the concepts, categories, and subcategories to give them greater explanatory power. Axial coding was followed by selective coding.

Selective coding was the process that further defined the core categories. It was through this coding process that the concept *Navigating* was identified as the core category. *Navigating* explains the process that is occurring with the other categories explain only part of the story. *Navigating* is the conceptual idea that all of the other categories were subsumed under and their relationships were linked.

Quality Control

The researcher worked closely with his dissertation chair for quality control purposes and to ensure the creditability of the study. The following steps were followed 1) the researcher’s dissertation chair reviewed one third of the transcripts and audio tapes to check for accuracy and creditability, 2) the researcher discussed with his dissertation
chair his observations, ideas, hypothesis, the emerging theory, approximately every two weeks and 3) the researcher had regular conference calls with his dissertation chair to discuss progress, emerging themes and the concepts that were identified. In addition, hypotheses were identified; emerging theory discussed, and received assistance, guidance, and mentoring for conducting scientific research.

Protection of Human Subjects from Research Risk

Every attempt was be made to protect the participants from any psychological and unforeseen risks. The participants were of legal age and competent to give appropriate consent. For the purposes of this study, competency was defined as the individual’s ability to give legal and informed consent to participate in the study. In addition, the participant had full autonomy in their decision making capacity.

Respect for the person was incorporated by treating each participant as an autonomous person and respecting their human dignity. The respect for persons was accomplished by approaching and treating them with respect and dignity and explicitly stating this during the consent process (Dunn & Chadwick 2002).

The principle of beneficence was applied by treating the participant in an ethical manner not only by respecting every individual’s decisions and protecting them from any unforeseen harm, but also by making every attempt to promote their well being. The principle of beneficence was explicitly stated in the risk and benefit section of the informed consent (Dunn & Chadwick 2002).

The principle of justice was incorporated in the inclusion and exclusion criteria. Every attempt was made to include the participants who meet the inclusion criteria
regardless of religion, ethnicity, or sexual orientation. No participant was excluded from the study and all data, transcripts, and memos were used during the data analysis. The principle of justice was applied when selecting the participants for the study based on the inclusion and exclusion criteria and not based on their religion, ethnicity, or sexual orientation (Dunn & Chadwick 2002).

Risk to the Participant

There were nine participants who were screened for the study and all nine participated. These men were over 21 years of age with a diagnosis of major depression, dysthymia or had experience with being depressed. This study focused on men who had a depressive disorder and how they have experienced the process of living with depression and seeking mental health services. There was minimal risk to persons participating in this study. The researcher was an experienced psychiatric nurse practitioner and he assessed each participant for signs of distress during the interviews and none of the interviews had to be stopped because all the participants tolerated the procedure without any distress or reactions.

Prior to being referred for the study, the participants were screened by their therapist for stability of their symptoms and suicidal ideation. Any potential participants would have been excluded if the therapist thought that talking about their symptoms of depression or their history of living with depression would be harmful to their mental or emotional health. Participants were able to cease the interview at any point of the study without any consequences.

The participants were advised that the researcher must follow the mandatory
reporting laws in cases of abuse, suicide, or homicidal ideation. In these cases the researchers followed the procedure for the state of Washington mandatory reporting and would report this information to the therapist and county designated mental health professional if it were necessary, however this was not necessary for any of the participants. If the participant revealed any thoughts of suicide to the researcher, the researcher would remain with the participant contacting the therapist and the county designated mental health professional so the participant can obtain the service deemed necessary, however, this was not necessary for any of the participants because the participants were stable with their depression.

Trustworthiness

Chiovitti and Piran (2002) emphasizes that grounded theory research must clearly illustrate rigor in order for grounded theory to be appropriate for clinical nursing practice. They stress that grounded theory research must assure credibility, audibility and fittingness to establish rigor. Chiovitti and Piran adopted Beck's definition of creditability which states “how vivid and faithful the description of the phenomenon is” and “credibility relates to the trustworthiness of the findings” (Chiovitti & Piran, 2002, p.430). Auditability is achieved when other readers can clearly follow the decision path concerning the study from the beginning to the end. Fittingness refers to the transferability and pertains to the applicability of the research findings to others in similar situations (Chiovitti & Piran, 2002).

Credibility

Credibility of the research was be achieved by having the researcher’s dissertation
chair review the descriptions and interpretations of the human experiences that the researcher discovered. There were follow up interview with two participants to review and confirm the findings to ensure the credibility of the data.

It was imperative that the researcher was able to define truth as subject-oriented rather than research-defined. In other words, the researcher must remain neutral and unbiased as the data are collected and interpreted. Data that are both confirming and disconfirming to the research questions must be revealed. Participants will be excluded if the researcher had any prior clinical knowledge about the participant’s history.

Audibility

Audibility is essential to maintain the rigor of grounded theory. Audibility is accomplished when another researcher is able to follow the audit trail of decisions made by the researcher. Audibility was validated when the researcher’s dissertation chair was able to arrive at the same conclusion given the same data set (Chiovitti & Piran, 2002; Sandelowski, 1986). The audit trail was composed primarily from memoing, coding, and diagramming. According to Glaser (1998) memos are the beginnings of writing the theoretical codes and their relationships as they emerge from the data. Memos provided an avenue to capture and keep track of the theory as it emerged and provided for the systematic tracking necessary for an audit trail. Memos were written from interview to interview and during the data analysis asking the questions of the data. The memos demonstrated how the researcher derived the codes and the progression and evolution of the theoretical codes.

The researcher adopted the same criteria that Chiovitti (2003) recommended when
approaching the transcribed interview data. The following questions were asked of the data: 1) What is happening to the data? 2) What does the action in the data represent? 3) Is the conceptual label or code part of the participants vocabulary? 4) In what context is the code/action used? 5) Is the code related to another code? 6) Is the code encompassing by a broader code? and 7) Are there codes that reflect similar patterns? (These questions were developed by Glaser (1978), Strauss (1987), and Strauss and Corbin, (1990)). Using these standardized questions provided an audit trail for another researcher to follow. In addition, the researcher provided an overview of each participant (chapter four) to illustrate the reason the particular participant was chosen.

Chapter Three Summary

This chapter presented the rationale for using qualitative inquiry for this study. The chosen methodology for this study was grounded theory. Grounded theory was discussed starting with the purpose and the background methodology. This chapter also discussed the advantages of using grounded theory and a summary of choosing Straussian methods for this study. The procedures including sampling, inclusion, exclusion, interviewing, data analysis, and protection of human subjects were discussed. Trustworthiness of grounded theory was also discussed.
The purpose of this chapter is to present the findings from the data analysis after a total of eleven interviews from men who described the process of navigating though depression. The first section of this chapter presents a portrait of each of the participants. The portrait is a brief description about the lives of the men who participated. The second section of this chapter will provide the explanation of the theory, *Navigating Inward and Outward of Depression*. The chapter will conclude with a summary.

**Portrait of the Participants**

Nine men who suffered from depression participated in this study. The ethnicities of the participants were primarily White with one participant who was of Puerto Rican descent. The ages ranged from 28 to 64 years; educational levels ranged from General Equivalence Diploma to Doctor of Philosophy. Two of the participants were single, two were separated, two were divorced, and three were married. Five of the participants had at least one or more children and four had no children.

Three of the participants reported the onset of their depression started during their pre-teen years. Five of the participants reported their onset of depression started during their teen years and one participant reported the onset of his depression was in his early twenties. The next section will describe each participant separately using their chosen pseudonym.
Earl

Earl was a man in his mid-40s who worked in the healthcare field. Earl grew up in a home with both his parents and continues to have a close relationship with them. Earl enlisted in the Marine Corps in his late teens. He described himself as an angry and aggressive young man that frequently engaged in fights. He also reported that he had used alcohol and drugs during this period in his life to escape the emotional pain of loneliness. He was one who did not like to be told what, when, and how to do something and therefore this caused him to be dishonorably discharged from the Marine Corps.

He had several years of college and was separated from his second wife at the time of this study. He had two children with his first wife and a step child with his second wife. Earl reported that he is able to reflect on his life and accepted that he had depression in his during his teens and twenties. He believes that many of his destructive behaviors as a young man were to his depression. He reported that he had thoughts of suicide but never acted on them. He acknowledged the behaviors were slowly destroying his life but at his lowest point did he “not care if he lived or died” and believed that “nobody else cared about him.” He thinks having the responsibility to raise his children helped him focus his life in a different direction and that his children gave him a sense of purpose.

Clark

Clark was a man in his early 40s who worked in the health care industry, and had a bachelor’s degree. Clark was in a relationship at the time of the interview but has never
been married or had any children.

Clark was adopted and continues to have a close relationship with his adopted parents. He did meet his biological mother and had a close relationship with her prior to her death. He stays in close contact with his biological uncles and goes hunting with them.

Clark described his depression as a “functional depression.” He defines this as being able to get up, go to work, and hide his struggles with his depressed mood because he feels no purpose in life and lacks enjoyment most days. His depression started around the age of twenty one and continues to struggle with depression most days. During this period in his life, he reported that he would excessively drink alcohol. He would have other high risk behaviors such as driving his car fast and did not care if he crashed and he felt that he knew the risks and described this as “passive suicide.”

*Warren*

Warren was an unemployed man in his mid 50s who completed his GED. Warren described himself as growing up feeling worthless, helpless and continues to proceed with life struggling with these feelings on a daily basis. He reported that he has no friends and has difficulty establishing relationships with people because he believes he does not “fit in.” He reported that he grew up in a chaotic home that included frequent fighting, arguing and alcohol use. He did not feel close to his parents and he believed he was a burden to them. He became an alcoholic and lived on the streets for several years before he joined Alcoholic Anonymous and stopped drinking. Warren reported he has not been able to be successful in sustaining employment because of his “anger and
picking fights.”

Warren has two grown children who now have their own families. Warren makes an effort to be part of their lives, especially his grandchildren but feels unwanted at times and has difficulty relating to his son who Warren visits with the most lives in the same city, whereas his other son that he feels closer too lives in another state and Warren is unable to be with him.

Warren describes his depression as feeling “unhappy, miserable and blue.” He reported his depression started in his early childhood and thinks he has suffered with it all of his life. He denies that he had suicide thoughts because of his belief in a higher power but reported that he would “pray for God to take me.” His fear of death prevented him from committing suicide and he reported “I’ll fail at it [suicide] and end up in a wheelchair or burden on people.”

Warren continues to struggle with depression and remains continues to received psychotherapy and use medications. He reported that every day is different and his depression is better on some days and worse on others.

Hector

Hector was Puerto Rican man in his late thirties. At the time of the interview he was a doctoral student and teaching at a university. He was in a long distant relationship with another man and has no children.

Hector grew up in a two parent home. As a teenager he was active in school, was a high academic achiever, and had many friends. He described his family as loving and remains close to his family and visits with them frequently. He recalls feeling depressed
at the age of 18 while he was going to college. He lost interest in his academic studies and had difficulty achieving passing grades. He decided to seek treatment and started seeing a psychiatrist in high school.

Hector describes himself as an emotional man who cries easily. He believes that crying is a healthy way to release emotions. He used alcohol and shopping sprees as a way to escape his emotional pain. Hector speaks openly about his depression and is able to recognize and accept it. He continues to struggle with his depression and continues to see mental health providers for psychotherapy and medication management.

David

David was an unemployed White man in his late forties and completed several years of college at the time of his interview. David grew up in a two parent home. He has a close relationship with his parents but stated his dad was not the “warm fuzzy type.” His parents had frequent arguments and constantly threatened to divorce. As a result, David has a fear of people leaving him or dying and being left behind. He believes that this has contributed to his depression.

David reported that his depression started around the age of nine. He described this time as being unhappy with life, lack of joy, and fear of people or pets dying. As he entered his teenage years he became active in high school and does not recall being depressed during these years. After high school he joined the army and subsequently became a police officer.

David used aggression, alcohol, and promiscuity as a way to escape his emotional pain during his twenties and thirties. As the depression intensified David decided to seek
treatment but that was not until he was 34 years old, divorced for the second time, had multiple failed romantic relationships, and had a failed career in law enforcement.

David remains engaged in treatment and continues to struggle with depression. He has difficulty getting through a conversation because he cannot control his crying. David has frequent thoughts of suicide and he continues to live because he does not want to die, hurt his parents or girlfriend but would like to emotional pain to go away.

*DD*

DD was a White unemployed man in his late twenties. He was separated from his wife and living on state assistance and subside housing. He had a history of living on the streets or in his car.

DD grew up in a two parent home. His dad was in the Air Force so they moved frequently. His parents had frequent arguments and DD never understood their relationship. His parents finally divorced when DD was a young boy and was frequently left with his dad and felt like his mother abandoned him. He describes this period of his life as being extremely lonely and terribly missed his mother.

DD recalls his depression started at the age of 6. This was the age that DD attempted to hang himself on the playground swing set. He was saved and was forced to engage in treatment. DD was able to complete high school and then he joined the Army.

DD used alcohol, aggression, and physical exercise as a way to escape his emotional pain. DD can now talk about the sexual and physical abuse he suffered as a child and believes this has contributed to his depression.

DD acknowledges his depression and continues to receive counseling to help
manage the symptoms. He continues to struggle with the symptoms of being hopeless and feelings of worthlessness because he has not been able to find gainful employment. He is unsure about his future but is working with various state agencies to access the services he needs to move his life forward.

**Joe**

Joe was an Italian man in his early fifties who was married to his third wife. He had three biological children with his first wife and four step children with his second and third wife. Joe has completed several years of college and works in the health care industry.

Joe grew up in a two parent home. He describes his childhood as a “good one” and had a close relationship with his parents and siblings.

Joe recalls his depression starting in his teen years. He recalls that he ignored the feelings until they became unbearable and decided to seek treatment and was prescribed medications. He did not enter into counseling until his late forties.

Joe describes his depression as “dysthmia” meaning there is always a sense of sadness, negative thoughts, and lack of enjoyment most days. He becomes more sensentative to his environment which leads to feeling overwhelmed, exhausted, irritable, and loss of motivation. Joe thinks one of the lowest times in his life was when he lost his second wife to a chronic illness. The intense emotional pain he experienced was unbearable and this led him into seek counseling for his depression.

Joe continues to struggle with his depression on a daily basis. He has a good supporting family and occupation but at times he feels like a burden to those around him.
because of the way he is affected by depression.

Tom

Tom was a White man in his early sixties, who was married with two grown children. Tom completed college and earned a masters degree in a social science. He works in the social and healthcare services. Tom grew up in a divorced family and both parents abused alcohol.

Tom made a suicide attempt at the age of 18 by overdosing on several medications. His parents found Tom and tried to keep him awake by making him walk around and drink coffee. His parents hesitated to take him to the hospital because of the stigma associated with depression and suicide attempts. It wasn’t until Tom was critically ill and having seizures that his parents called for help. Tom recovered from this suicide attempt after being in a coma for ten days.

Tom believes he denied his depression for several years and used work as a way to compensate. It wasn’t until his wife validated that there was something wrong and encouraged Tom seek treatment. Tom recalls that his heart was broken when his children told him that they don’t even look forward to him coming home from work. It was this situation that helped Tom acknowledge that he was depressed.

Tom decided to seek treatment and now he believes he has suffered from depression for several years. Tom continues to take medications for his depression and will seek counseling when needed.

BG

BG was a White man in his early sixties and a retired professor. BG grew up in
New York and was from a broken home. His dad was a compulsive gambler and an alcoholic. BG frequently witnessed his father physically abusing his mother and then he later became a victim of the physical abuse. BG’s father eventually left the family and BG never heard from him again and speculates he was murdered because of the debts he owed to various people. BGs mother worked and raised him alone.

BG completed high school and attended college. He completed his doctorate and worked as a college professor most of his life. BG recalls that his had intermittent episodes of depression in high school and college and had counseling in college when he was struggling.

BG married in 1970 and has one grown child. BG and his wife had a history of having marital problems and they sought marriage counseling to help resolve their problems. During this time BG never identified himself as depressed and did not recognize that something was wrong even though he felt lonely, “gloomy,” and had thoughts of death. It was until BG read an article in Newsweek about men and depression that he came to realize he was suffering from depression. He made the decision to seek treatment at the age of 64 and now can reflect that he was suffering from this disorder most of his life.

Summary

The age ranges of these men were between 28 to 64 years, they were primarily White, employed with some college education. The majority of the men were single and had one or more children. The next section will explain the grounded theory that was discovered from men who were able to describe their process they endure from being
Overview: Basic Social Psychological Process of Navigating Inward and Outward Through Depression

The basic social psychological process that emerged from the data analysis was *Navigating Inward and Outward Through Depression* (Figure 4.1). The process of navigating was the core concept and defined as a process of moving through depression and having to steer one’s life in different directions in order to move in and out of the stages of depression. The men learned to navigate their lives to manage and survive their depression. The men would navigate inward with each stage and then navigate out of the stage when they could manage the emotional pain associated with the stage. This is not a step-by-step linear process but one based on men moving through each of these stages with the initial stage of *Being Different* and eventually reaching the sixth stage of *Health with Others*.

Figure 4.1 Grounded Theory: Navigating Inward and Outward Through Depression
The first stage, *Being Different*, refers to the basic social structural process (BSSP). Three subcategories were identified in this BSSP as these men were navigating through this stage. These were *Rejection*, *Loneliness*, and *Being an Outcast*. In this first stage, these men attempted to share their feelings but were constantly rejected and coming to believe that nobody cared or nobody would understand which led to loneliness. This rejection reinforced that they were different, intensified the loneliness, and therefore lived their lives feeling like outcast.

The second stage, *Concealing Feelings*, refers to the BSSP of how these men learn to navigate out of stage one and into stage two and learned how to hide their internal feelings and thoughts. Because of the rejection they experienced this led to concealing the intense internal feelings. Three subcategories emerged in this stage; *Being Lost*, *Disguising*, and *Feeling Vulnerable*. The men learned to hide their internal feelings by acting confident or aggressive when feeling intense self doubt and uneasiness with themselves.

The third stage, *Disconnecting* was the BSSP that refers to the way the men would numb their emotional pain. During this third stage, the pain was becoming more intense and the concealing no longer workeds so they would use external behaviors (e.g. alcohol and drugs) to physically numb their pain. Three subcategories that emerged in this BSSP were *Being Destructive*, *Being physical* and *Suffering Alone*. Many men abused alcohol, money, work, or food. Some men used aggression and physically and verbally attacked others. The men were not only destructive to themselves, but their behaviors affected others around them. They learned to suffer alone and concealed their
pain from themselves and disconnecting from others. They learned to navigate through this stage by using external behaviors to numb their pain.

The fourth stage, *Hitting Bottom*, was the BSSP that refers to these men losing hope for their future and wanting to give up on life. Two subcategories emerged in this stage; *Losing Hope and Death As An Option*. In this stage the men lost meaning and began to realize the emotional pain was so unbearable that they needed to navigate their life in a direction that would relieve the pain. The men had thoughts of suicide or thoughts that death would be an option to relieve the emotional pain.

The fifth stage, *Acknowledging and Confronting*, refers to the BSSP when the men were able to acknowledge they were depressed and how this was affecting their lives. Two subcategories emerged in this stage that helped the men navigate through this stage; *Labeling Their Emotions* and *Seeking Help*. They came to realize they had to confront the pain so they could navigate outward toward *Health with Others*. The men experienced the emotions learning to heal with others so there were not suffering alone in the journey of navigating out of their depression.

The sixth stage, *Healing With Others* refers to the BSSP when the men were able to share their thoughts and feelings with others and began the healing and recovery process. They came to realize they were not in this alone and by sharing their thoughts and feelings promoted healing.

The next section will present each category and subcategories of the grounded theory *Navigating Inward and Outward Through Depression* in more detail. Data will be presented to illustrate the categories and subcategories of the theory.
Stage One: Being Different

Being Different was the initial stage of Navigating Inward and Outward Through Depression. Being Different was defined as being separate, unusual or not alike. Each man had a different way of experiencing this, but all believed that there was something wrong with them and therefore they did not fit in or was separate from something. Many of the men attempted to express their innermost thoughts and feelings, but these men were subsequently rejected by their parents, friends and colleagues. This rejecting reinforced their feelings of being different and they internalized the feelings of Being Rejected, Feeling Alone, and Being an Outcast (Figure 4.2). Three subcategories will be presented with the data from the participants.

Figure 4.2

BEING DIFFERENT

Being Rejected
Feeling Alone
Being an Outcast

Being Rejected, was the first subcategory of stage one and was defined as not being heard or listened to. Many of these men were in need of help but the people closest to them rejected their cry for help. For example Earl described this as:

“I did try and talk to my master sergeant about it [depression] before…. besides that they [military] didn’t care anyway, the way things are ran in the military” (p. 5, line 202-205)
Clark had the same experience when he tried to talk with his parents about being depressed but he felt rejected by them. He describes this as:

I don't talk a lot to my parents about my feelings and stuff like that you know I'm kind of like way…. I don't talk a lot about this kind of thing specifically and…. you know my parents sometimes don't show a lot of empathy you might say with my situation sometimes so I probably grown not to talk to them too much about that kind of thing (p. 3, line 128-132).

……like I said with my parents not being real empathetic toward my situation……they were kind of clueless you know my grieving process way back then and you know they would kind of blow me off like it was nothing when in fact it was I was in pretty dire straits at the time……like I said they were pretty much well fairly pretty much clueless about that (p. 4, line 143-148). Oh, I’d remember my dad one time at the table eating he just pretty much exploded he just pretty much said get over this, I am tired of you moping around…. Ah, it was like a kick in the gut  (p. 11, line 472-474; line 476).

Warren described this as:

…..maybe, if there was somebody to talk to. but I’ve never…I’ve tried a lot of therapists and a lot of churches and I’ve never really been able to talk to anybody because nobody really wanted to ever stop and take time to pay attention because I think I’m a man and so therefore I’m just supposed to just buck up and say I’ll just, you know, power my way through this (p. 6, line 237-241).

David described his experience as

…..she [ex-girlfriend] referred to my crying as childlike. That shows the kind of compassion she had. Which us brings us back to the point that for some weird-ass reason I still love her but I just can’t be with her (p. 8, line 356-358).

DD experienced being rejected by not having people around him that he could talk to.

He felt rejected because he believed that people did not want to hear about his depression. He reported:

To struggle with depression and be a male um the first thing is acknowledging that I’m depressed and that’s something that’s very unmanly in society’s view and so nobody wants to hear about it and yet I not only have to accept it I have to deal with it which isn’t an easy thing and in a world where everybody’s a stranger it’s hard to learn how to deal with it off of someone else so you have to somehow be
manipulated in how you go about things and sometimes when you’re manipulated in order to learn something you piss a couple people off and so you make enemies along the way because they don’t understand what you’re doing (p. 13, line 557-563).

Um and that’s just a for instance uh but I guess uh as far as being a man and being depressed I guess nobody wants to hear about it. Everybody expects you to be one of the gears of society that is essential to turn in order for society to work properly. Being disabled is unheard of especially at the age of 28. Understanding that you’re depressed means that you admit to it and that’s not right because that’s just not how things are done so you, I alienate myself even more from other men and I astound women when I talk to them because I can talk emotional (p.14, lined 576-581).

Joe described his rejection as not being able to talk about what he was feeling to his parents or others because he perceived them as ignoring him. He explained:

“you really could not talk about sensitive or intimate issues with them because it was much easier for people to ignore or look the other way” (p. 3, p127-128).

Joe also believed that when he decided to seek counseling his symptoms were minimized and he felt the therapist did not understand the seriousness of his depression.

…. The person I somehow got referred to um she’s a nurse practitioner probably about mid sixties, kind of a very grandmotherly-like and I thought oh no, this is not gonna work. This is not going to do it for me, but she started getting me to talk and bringing things out and I started liking her and my trust in her developed more, but I don’t think she realized the seriousness of it when I first came in because I said you know, I…I’ve got a spouse that I think I’m gonna lose within the next couple months and uh I said…..my spouse has already made the determination to wean herself off of her meds and I says I think it’s gonna be sooner than later and I think she felt because I was so depressed and maybe traumatized that I was over-exaggerating (p. 7-8, line 308-316).

Tom experienced rejection from multiple people, the first being his parents. He described how he was treated when he attempted suicide. Tom had attempted suicide at the age of eighteen. His parents found him after he overdosed on medications but his parents still rejected him because they delayed treatment due to the stigma associated with a drug overdose. Tom described this experience:
Um you know how they treated me after they found out I took the pills I mean immediately I mean the stigma at least from their point of view was so great that um they didn’t take me to the hospital until I went into convulsions. That was probably why I was in a coma for ten days. So I had a little bit of anger about that. I don’t remember that. I don’t remember the convulsions, I don’t remember apparently they stuck a tooth or a spoon in my mouth uh and I bit down and cracked a tooth. I don’t remember any of that. They told me they walked me around the backyard, pumped me full of coffee and uh so after I woke up I mean everybody was very, very cautious. I could feel that you know they were weighing every word before they said it uh that the thing I remember the most is obviously when you wake up after ten days in a coma even though you’re probably being fed with the I.V. or some kind of tube(p. 5, line 206-215).

Tom felt some rejection from his family and reported:

Um sometimes the kids thought that I was being either very sarcastic or ridiculing them and it was because my voice tends to drop when I get pretty tired the it flattens out too and I don’t know what there is about that quality but they were reading it as I was kind of belittling them and during that discussion my wife said you know sometimes when you’re kind of in that mood – she didn’t call it depression – the kids and I don’t look forward to you coming home. That just kind of broke my heart. I thought jiminy Christmas you know what happened here? (p.2, line 74-80).

Tom also felt rejected when he tried to seek treatment with antidepressants from his physician but the physician did not believe Tom was depressed. Tom recalls:

I recognized it during a physical and decided to ask my doctor for a trial of antidepressants and so he asked me the typical kind of vegetative sign and I’d compensated so well that he asked how are you sleeping. I said for the most part fine, my appetite’s fine, you know I don’t dwell on things and all of the vegetative sign question, pleasure and suicidal thinking and we got to the end of the interview and he said is there anything else. I said yeah, I’d like a trial of antidepressants so he said Tom, I don’t have anything clinical to base it on. So he’s a kind of by-the-book doc (p. 1, line 28-36).

When Tom would express his emotions by crying he was rejected by his kids.

Tom described this time as:

I’ve cried several times…. I tend not to really express emotion unless I’m in the extreme – either low or high. Um the last time I cried was when [wife] woke up one morning and said I think I want a divorce. I’m going huh? I thought she was
kidding. And I said well can we talk about that? She said I can’t tell you anything. So we kind of worked together but I was very tearful and every time I looked at her I would begin crying and my kids got tired of me crying and I got tired of me crying; I’m sure Cathy did too.” (p. 9, line 302; line 377-382).

BG also had a similar experience with being rejected. He described:

It’s hard to say. Uh…just fear maybe of not knowing what not knowing how events, certain things have shape maybe shaped you and and being reluctant to uh…being reluctant to uh uh open up. Uh certainly difficult to open up to well my mother. She wouldn’t have understood……..she would not have understood it (p. 7, line 289-292).

Um but at the same time you know it’s something that you can’t in today’s America no matter how common the condition is there is a certain portion of the population that sees you as stigmatized or unreliable or some damn thing (p. 8, line 379-381).

*Feeling Alone* was second subcategory in stage one that reinforced *Being Different*. *Feeling Alone* was defined as the internal feelings of being by themselves with no support from family or other support systems, even though the men had people surrounding them they felt alone. The common belief was that they did not fit in or belong to anything and that no body cared. This left these men feeling alone and they had to navigate through their emotional pain by themselves. Earl was able to describe this process as:

OK, I think depression and what it means to me, it was about the timing or a time when I was in the Marine Corps and basically I felt I was depressed because I guess like I I didn't feel I was in the that I belonged to anything at that time like I really belonged where I was or doing what I was doing that kind of thing OK, it was out of place (p. 1, line 4-7).

I didn't think because and felt to me like no one cared no one I mean I could something like I should've thought about it at the time and it's I didn't belong with the people I was around I didn't feel that anyone really cared about me I guess at the time (p. 1, line 18-21).
Warren was able to describe his *loneliness* as:

Oh, man, that started way back when I was just a little kid. I grew up in a real—we call it dysfunctional today—family and so there were all kinds of problems. Alcoholism and fighting and all that sort of stuff so as a little kid I didn’t fit into school because I didn’t have any social upbringing so therefore um being alone was a common, everyday thing. Not being accepted was a common, everyday thing and so my…I don’t remember if it was my mom or dad used to say was just blue and what that meant was I guess kind of um, unhappy, I guess. And later on I learned that that was the beginning of depression (p. 1, 43-50). Um I think I should be able to accept things as they come at me. For example, the sarcasm and the criticisms, the scrutiny, I get that a lot because I’m not able, I just don’t somehow fit in and people find me an easy target and if I could just tell somebody to screw off, you know, without…or before I get into a pissing contest, you know. Things would be better and I’d be a better person and I’d be able to move forward on a daily basis. The way it is, I don’t move forward. I just kind of stay in this same place where it’s always been, where I’ve been unable to make friends and keep friends and which goes to show that right now I don’t have anybody that ever calls me and says he come on over, let’s do this or I need to borrow something, can I come over and it get it, or something. I don’t have any friends……. Nobody calls me and says ‘you want to go flying?’ or ‘let’s go do this’ or ‘I need help with something’ or ‘hey, how are you doing?’ . I wish I could be one of those people that somebody would call once in a while. Or that I could call somebody and say ‘hey, let’s go do this to do, can you come over and help?’ or something. I can’t even call my son because he ignores me and pushes me away, so its do I want to be different and better and fit in better? Yeah. How do I do that? I don’t know….I don’t know. I get along okay when I go to those functions but I don’t have anybody that I can just sit down next to or get close to or anything. It’s always just kind of ‘hey, how’re you doing? (p.6, line 258-276).

David believes that the *loneliness* worsens his depression and tries to avoid being lonely. He described:

Loneliness brings on depression for me because the more alone I am the more time I have to think about the things that make me sad, so I try not to I try to keep busy constantly and if that means going someplace where there’s some people that’s one thing that’s really been a problem for me. One of my biggest issues is the fact that I’m not working so I don’t have a lot of interaction. I’m somewhat of an introvert and I’ve heard it explained that introverts exhaust energy during a workday and extroverts gain energy during a workday. They get all jazzed up from all the interaction and stuff (p. 13, line 597-603).
DD had similar experiences with *loneliness*:

I was very lonely. I remember a feeling of where’s Mom? I remember uh feeling so lonely because I was like what’s wrong here? I mean I guess that it wasn’t really what’s wrong here but there’s something wrong here at least was the feeling (p. 5, line 211-213).

BG had a wife and son, but still there was a feeling of aloneness in the world. He described his *loneliness* as feeling isolated:

Well if can bear to be alone much of the time you know, take care of yourself, my mother was proud of that, that I could do that at the same time you know it it…..you on your own resources and maybe excessively and makes it uh a little more difficult to associate…. (p. 6, line 250-252) I um after it happened I kept and I began to get some perspective on it I figured it was you know there was lots of background issues stemming from childhood but the actual onset of it is uh you know January through March when my wife was away uh during winter which was bleak and um a feeling of isolation (p. 1, line 39-42).

*Being an Outcast* was the third subcategory in stage one. Because of being rejected and feeling lonely, the men believed they were separate from the overall society. They believed that what they were feeling was a defect and that something was wrong with them; therefore this led to the feelings of *being an outcast* of society. *Being an outcast* was defined as being refused or acceptance by society and was the third subcategory in *Being Different*. Therefore, each man believed that they did not belong and therefore did not fit in or were part of a group, community or society as a whole.

Warren was able to define this as:

Less than. Unable to cope. Afraid. Misfit. Um…for the most part just a lot of fear. Not being able to get along, not being able to respond, not having the ability to just get along in life like some others do (p. 5, line, 229-231).

Joe explained his experience of feeling like an *outcast*:

as a teenager I have no recollection of discussing this with anyone because of self-esteem issues or whatever it felt like that maybe I at least internally I was very
abnormal and I was very different when in fact now I probably wasn’t but back then I just didn’t know enough (p. 3, line 107-110).

BG described his account of feeling different as like an outcast:

(sigh) Feeling that there was something wrong with me. It was some, something dark, something something that I couldn’t quite put my finger on uh and that uh you know that that it (sigh) well it wasn’t it wasn’t dominant on my personality. It was something that sort of shackled or shadowed me that I had to repeatedly encounter uh it it as I said when I was in professional life that stuff is pushed to the margins but now you’re quote retired, you have time to ruminate excessively upon such things.

Summary of Stage One

**Being Different** is the first stage of *Navigating Inward and Outward Through Depression*. During this stage the men believed like they were separate from the group and believed that there was something wrong with them. Three subcategories emerged in this stage, **Being Rejected, Feeling Alone and Being an Outcast**.

**Being rejected** was illustrated by the men as they attempted to express their feelings, but they believed they were not heard. This led to **Feeling alone** because they felt that nobody cared and they were in this world alone. The third subcategory was **being an outcast**. This was described as not being accepted, as they were made to believe as if they had a flaw in their character or being.

The next section will describe **Concealing Feelings**, the second stage of *Navigating Inward and Outward Through Depression*.
Stage Two: Concealing Feelings

Concealing Feelings was the second state of Navigating Inward and Outward Through Depression. Concealing Feelings was defined as hiding the experiences one is having with internal feelings and thoughts. When the men felt rejected by society in stage one because of the overwhelming feelings of being different they moved into a stage of concealing as a way to compensate for their depression and the feelings they were experiencing. Most of these men reported that they felt they had to wear a mask and hide their struggles or having to portray a certain appearance in public. Each of the men who participated in this study leaned to hide their internal feelings and thoughts. Concealing became a way of life and these men learned to pretend as if they were confident, although internally, these men were experiencing intense emotional pain and could not express or show it to the external world. Three subcategories emerged in this stage; Being Lost, Disguising, and Feeling Vulnerable (Figure 4.3). These three categories will be described next.

Figure 4.3

CONCEALING OF FEELINGS

Being Lost
Disguising
Feeling Vulnerable
Being Lost was the first subcategory in stage two and was defined not having a sense of direction about how to move through life. Some of these men were not sure how to proceed to become part of society. Earl was able to recall when he felt lost and feeling that he had no direction in life:

Umm, well I was completing high school and trying to figure out my life and where I was headed with it and that kind of thing……I felt like I had no control ……..I joined the Marine Corps to try and help me out I thought maybe I could get schooling money and advance the my education um, maybe find a goal in life um, at that point in my life when I joined the Marine Corps my parents really couldn't afford to put me through college or anything like that, um and basically I turned 18 years old and I was out the door that's the way I felt. I got a suitcase from my parents for my graduation present so I think I could that probably had something to do with it you know with and their ideas basically your 18 you're out……your old enough to to fend for yourself and that kind of saying (p. 1, 33-42).

Clark described a similar experience when he recalled how he felt lost when he was depressed. He recalled:

Ah, pretty much yea, I mean that you know I was aware of what I was doing and you know it was kind of like a time when you were a lost soul you might say you are just trying to you know make best the best you can do at the time (p. 2, line 47-50).

Clark explained further:

well ultimately it is kind of like being stuck in the pit or spinning my wheels I'm not going anywhere….. kind of……..not quite sure exactly where I am going and in those aspects you know family job religion, mortality, are there other ones? [laughs] those all are pretty much the ones that get me p. 5, line 200-201; 204-207).

DD described his feeling of being lost as going in a different direction in life then he imagined because of his depression the experience of being rejected. He stated:

Well it kind of ties in to uh Standing on the Shore because it seems like if in my
life my ship I’ve headed out to sea. I’m going in a complete different direction and I’m leaving people behind because I’m done being left behind (p. 12, line 483-487)

Joe connected his experience of being lost to his career. His depression causes negative thoughts and he looses confidence in moving his career in a different direction.

He stated:

So that’s part of the thing I think that depresses me too is I think I’ve gone as far as I can go short of going someplace else and doing something different as far as I can go here in the hospital. A lot of people see me as being successful, a lot of subordinate people because I’ve come up through the ranks and I did it without much of a real formal education, but you know others who were my peers or superiors may view me and say he could have gone a lot further. It’s a shame. I don’t know (p. 10, line 446-451).

Tom felt this feeling of being lost when he was asked for a divorce by his wife. He was not sure what direction his life should go and was not sure how he could survive without the relationship. He recalled:

I’m not able to track very well because emotionally I’m not there. Um but during other times where it’s relatively normal I don’t express how I’m feeling. I think I feel things um but very disportionate to maybe how I should…um unless I’m in crisis and then maybe it’s disportionate the other way. And I, like a lot of I think men kind of to work through, can I survive in this relationship or can I survive in this world without this relationship. Uh and so I had to get to that point before I could actually stop crying and stop you know just tearing up every time I thought about it (p. 9, line 385-391).

Disguising was the second subcategory in stage two. Because these men were feeling strong internal feelings of being rejected and feeling lost they lacked confidence in themselves and leaned to disguise. Disguising was defined as putting on a mask or disguising the true feelings one is experience. These men learned to keep their feelings turned inward. Earl learned to keep his emotions and feelings to himself. He recalls not letting anyone see his emotions and putting on a different persona in public. He
described this as:

it’s not the manly thing to do. You know it is not, especially in a situation like that in the marine corps you don’t feel weak it not something you do….. You would be scrutinized and humiliated um, you can’t show weakness it not something especially worrying, it is beat in to you that basically you don’t give up. …..it when I was in the Marine Corps I knew I probably cried at night but I would never show them…My grandfather was a marine, an ex-marine. Yea, I guess I grew up with toughness and he would karate chop me when I was just nine years old and basically he would say you want to see a karate chop and karate chop me and I almost suffocated from it but I was not going to let him see that I was going to cry so I turned away and I went to my room so I can try and catch my breath and I remember and I hated him. I hated my grandfather (p. 6-7, line 235-236; 240-241; 255-260; 280-281).

Clark described how he was *disguising* when he chose not to seek help:

I don't know if that was pride or been embarrassed or what specifically I choose, I didn’t chose that at the time…..I’ve always been slightly depressed……..my own definitions to things there is acute depression when every thing really bad and there is you know very functional depression and you know when you can function in life very well from the outside you know you go to work and ultimately you do have some nagging problems (p. 7-8, 312-313; 329-334).

Another way these men were able to *disguise* their depression was to keep conversations on a superficial level and not revealing their true thoughts and feelings with those around them. Hector described his *disguising* as not sharing too much about himself. He also put on mask as if he was the one with advice for others so other people would seek him out to share their inner most thoughts and feelings because he put on a positive personality. On the inside Hector was experiencing his own struggles with depression. He explained:

I did but as far as sharing everything that we share today um with friends sometimes with some friends but I wasn’t about sharing too much what I feel, how I feel, etcetera with friends. I’m really private. I actually feel uncomfortable when I tell something to someone when its personal and that I know the other person knew about it even if it was someone I trusted or someone I care for and they care for me……I will feel like how do you know. Then you feel like
everybody knows. So yes, I talked…mainly I was the one who people come to talk to. You know, my friends come talk to me about all their problems. Life is always beautiful for me……. It depends who I’m sure who you are talking to. I mean if you sit down with a group of men who are let’s say professionals, all with a good family and uh…and uh it’s different when you share I think when you share your sensitivities with other men……and there are many men may not have the sensitivity that I have and there are men that understand uh human behavior and human conduct and I guess those are men that I might get closer with, become friends with them (p. 13, line 585-595; p. 15-16; line 687-692).

David also kept his feelings to himself and hid from his mother. His mother recognized that he was depressed, but David was having obsessive thoughts that he may have AIDS because of his promiscuous sexual activities in his past. He learned to not to reveal personal information and therefore disguised. He stated:

…..like I said, my mom had been through it. She recognized it and I certainly didn’t tell my mom that I thought I had AIDS or even that I was obsessing but she picked up and coincidentally it was during Christmas time, or maybe not so coincidentally because that’s you know that’s when a lot of that obsessing would happen during the holidays. She picked up on the depression part of it and she figured I just had the family curse if you will and so she knew I was coming down for Christmas so she made me an appointment with her uh psychiatrist….. when I pulled up here for the meeting I was crying all the way down the hill and I pulled in here and I’d stopped crying and a friend of mine, a good friend of mine, a gal works on third floor here and she’s walking to her car and she’s pulling out and she see’s me. Hi Dave, how ya’ doing? Fine. What’s wrong? Nothing? No, come on. There’s something… Anyways, we end up talking for a few minutes and she kind of cheered me up a little bit and uh but I cry because I’m happy, I cry when I’m sad, I cry when I get pissed off sometimes. I just cry and it just drives me nuts. (p. 4, line 142-148; p. 9, line 382-388).

DD described his disguising as putting on a mask to protect his family from his troubles. His dad was in the Air Force and DD explained that their “dark secrets” were not out. He described as:

You’ve got to make-believe everything’s alright. Even if it isn’t… the family counseling kept on but it seemed like I learned how to wear a more variety of masks. Instead of telling the absolute truth, what you have to do is come up with something colorful so that way you try to get your way and what you want and
controlling the other members of the family through counseling and you know there is problems but you have to address it not as it is but as you want it to be. (p. 3, line 13; p. 4, line 151-154).

Joe described his *disguising* as:

so I knew how to talk the talk and I knew how to portray myself in a certain manner and you learn how to survive..... You know you start having the self-doubts, self-esteem issues more, things like that and you start thinking if people really knew who I am or what I really think or what I really feel because on the surface I don’t think people see that even unless if I am really struggling and I’m really depressed and I call in ill for a day or a couple days to really pull myself together I…I’m…I function fairly well at work. Some days it’s more of a struggle than others but for the most part people don’t see it except for those who are closer to me.... Well I was calm on the exterior but I was…I was shaking on the inside. You know, having a lot of self-doubt but I think when you get to that you rely on your judgment and you do a lot of self-talk and just common sense, judgment, you know, don’t over-react, think things through….I can portray. I got good at learning how to present myself in public I think. I think it became a skill over the years. I’m not bragging about it. I think it’s just how I evolved you know to survive, because the antidepressants certainly weren’t always doing it. (p. 3, 123-124; p.8, line 346-352; 359-365).

The third category in the second stage of *Concealing Feelings* was *Feeling Vulnerability*. *Feeling Vulnerability* was defined as feeling exposed as weak, primarily not being able to live up to expectations set by society, themselves or others. Many of these men experienced feelings of vulnerability as they moved through their depression. Because of these feelings they would continue to *disguise* and protect themselves from *Feeling Vulnerable*.

Clark explained that he has become callous with others in order to protect himself from pain. He describes this as:

I have a little callous and numbness, it is difficult to explain but I think I have become hardened and callous to a lot of things and so specifically it is hardened not to get hurt and harder to get you know as depressed as I use to be, now this is really not a conscious effort it is something that your body or mind does to protect itself from severe pain and depression that is just my own diagnosis you might say
I am just a bit callous…. Outside of work I would say I am a very angry person. There is frustration to me leads to a little bit of anger and specifically at work (p. 12, line 526-532; p. 13 line, 566-567).

Warren experienced vulnerabilities when he felt inadequate and other men would point these out. He described:

if my inabilities to accept or to be able to recognize the crap that men are throwing at me, if I was to recognize it would be a neat deal because then I could probably shrug it off or fight back in a way that would level the playing field. But I’ve never been able to do that (p. 6, line 244-248).

Joe had similar descriptions of feeling vulnerability. He reported:

When I’m my most vulnerable and I’m not that numb you almost feel like part of your manhood is taken away a little bit or that we live in this macho world that you know a man is supposed to be portrayed as this. I never really got caught up in that but when I got down to being real vulnerable I think I would buy into that a little bit more and you know on the exterior I…I could do things or say things and say well I’m superior in my manhood, I can give you a hug or something like that, but deep down at the core of your being I think that’s how it impacted me some. You know you start having the self-doubts, self-esteem issues more, things like that and you start thinking if people really knew who I am (p. 8, line 341-352).

BG stated:

(sigh) It’s hard to say. Uh…just fear maybe of not knowing what not knowing how events, certain things have shape maybe shaped you and and being reluctant to uh…being reluctant to uh uh open up. Uh certainly difficult to open up….. Well you’re supposed to be self-reliant, ah strong personality, you’re supposed especially if you’re an educator you have a couple degrees you’re supposed to have a handle on rationality. You’re supposed to be able to more or less shape your own life. Uh depression is concession. Uh you don’t know you you’re not sure of yourself as a man, as a professional too….......those are not so positive things in our society (p. 7, line 281-291; p. 14, line629-633 ).

Summary of Stage Two

Concealing Feelings was the second stage of Navigating Inward and Outward Through Depression. During this stage, the men learned to deal with being different by
concealing their internal thoughts and feelings. There were three subcategories that emerged in this stage, *Being Lost, Disguising, and Feeling Vulnerable.*

*Being Lost* was described as not having a sense of direction about how to move their life forward and out of depression. This left the men feeling at dis-ease so they learned to *disguise* their feelings and thoughts from others. They did this by putting on a “mask” in public and hiding the struggles they were experiencing. This led to feelings of *feeling vulnerable.* *Feeling Vulnerable* was defined as having their thoughts, feelings, and struggles exposed and feeling that they could not live up to the expectations by society, themselves or others.

As these men continued to navigate through these first two stages of depression, this led them to the third stage of *Disconnecting* which is discussed in the next section.
Stage Three: *Disconnecting*

Disconnecting was the third stage of *Navigating Inward and Outward of Depression*. Three subcategories emerged in this stage; *Being Destructive*, *Being Aggressive*, and *Suffering Alone* (Figure 4.4). As the men progress through this process and learned to navigate through their emotional pain of *being different* and *concealing*, they discovered that the pain was becoming increasingly intense. It became more difficult to deal with *being different* and *concealing their feelings* and they moved into the third stage of *disconnecting*. Disconnecting was defined as using high risk behaviors such as, aggression, or other behaviors that allowed them to numb their emotional pain. The goals of this stage were to numb the pain so that they were able to continue to function in their daily lives. In this stage, these men withdrew from themselves, their families, and society.

Figure 4.4

**DISCONNECTING**

- Being Destructive
- Being Aggressive
- Suffering Alone
These subcategories will be discussed next.

*Being Destructive*, the first subcategory in stage three, was defined as engaging in behaviors that were high risk and that had negative consequences to them. These behaviors included abusing alcohol, drugs, and gambling. These behaviors had significant health risks associated with them, but they also put others at risk such as families or society.

Earl talked about his use of alcohol and drugs as a way to escape the emotional pain he was experiencing while he was in the Marines. He reported:

I think it was a gradual thing that came on gets a little um, I guess that's when I realized when I was in the marine corps that I was in a place and I needed to get out of that situation but I was doing too many drugs alcohol, uh, and not really caring about my life whether either lived or died or more what happened it didn't matter… Well it started out with alcohol and then marijuana and then and I did, um, mushrooms and LSD and Quaaludes and cocaine, meth, just basically if I could take a pill or snort it up my nose… after that I ended up in Florida high on Quaaludes and drinking and the worse thing drove my car from California to Florida and ended up over there UL (unauthorized leave) from the Marine Corps and it was too late by the time I sobered up to figure out where I was and suppose to be back…. I guess I knew I was out of control like I knew I was destroying myself I figure it out making things worse I just things weren't working but I had something to do with it but it was too late when I figured out I had to get out ….. and it really didn't matter (p. 2, line 58-61; p. 4 176-179; p.8, line 352-355).

Clark also used alcohol to disconnect from his emotional pain. He said:

…..at the time probably I was feeling pretty bad and it's something that happened it wouldn't have mattered that time. Um I kind of joked one-time this kind of like passive suicide where you know you just kind of risk taking a little bit and you know what happens just happens um you know another thing is like the club scene drinking a little bit too much sometimes in being as a rule driving intoxicated and stuff like that and I didn't try to do that many drugs and that did come up once in awhile risk-taking things such as unprotected sex when in fact you know you were maybe with people that were a little bit higher risk people you shouldn't be with you might say (p. 2, line 76-85).
Warren started drinking around the age of 13. He considers himself as a recovered alcoholic but recognized that alcohol was how he numbed his pain and disconnected from others. He also explained that he engaged in other high risk behaviors:

Yeah, that started real young. I was about 13 I guess and my parents of course drank every day, every night and so there was different times the neighbors would come over and they’d be drinking or we’d go over to the neighbors’ or to someplace and of course there’s always be drinking and so us kids would learn to steal beer you know. If somebody left their mixed drink sitting somewhere we’d drink that down you know. And so we learned early and so I drank from time I figure it was 13 until I was 28 and I ended up getting divorced twice and ended up on the streets of L.A. homeless when I was 28 so quite a drinking career. Lost everything I had. I’d gain things, I’d get things, I’d steal things and lose things and always in trouble…in jail a lot – 62 times I think it was (p. 3, line 114-123).

Hector describes:

For someone who don’t drink, I drink a lot……I’m another social drinker. I drink; I have to have a cup of wine every day because of my cholesterol (laughter). No, I don’t drink it every day but sometimes I drink one or two glasses of wine during the week. Um here now since I’m just starting only um I don’t drink every weekend, I don’t drink all the time but sometimes I might sit down and drink, go through half a bottle of vodka or the whole bottle (p. 12, 407-412).

David had similar experiences in using alcohol to disconnect from his depression. He said:

…the only way I could do anything about that [depression] was to drink and that would relax me and it was a constant thought. And um until they put me on… I don’t remember what they put me on initially…anyway that took care of that and I’ve been pretty much on all the antidepressants at one point or another… Yeah. I um I drank a lot as a cop and we had a saying that we like to drink to much to have to quit and so that’s how we monitored our intake if you will. We tried to go partying not more than one night in a row, you know, or two nights in a row, or whatever. And it wasn’t an issue… …I drank throughout the whole eighties but it was under control and then we went into the nineties and I was no longer a cop. I
was working for an insurance company and um I uh started drinking after work and so I started drinking – I don’t even remember this. I know that’s how I combated the obsessive thoughts about AIDS was by having a drink. When it got too much to handle I’d have a drink and that would relax me a little bit. And then my really hard-core drinking probably didn’t start until um late…well mid-nineties until about 2000 maybe and then I just quit. I was drinking pretty much all night long after work and that was it. I wouldn’t go out for drinks, I wouldn’t you know I’d just sit at home and drink hard liquor (p. 3, line 135-139; 173-188).

Joe used gambling as a way to escape his pain and disconnect from the emotional pain he was experiencing from the depression. He explained:

I…I…I dealt with it [depression] with gambling. My gambling got a lot more excessive until one day I just woke up and said hey, I’ve got to stop this and I…I quit gambling for three or four months. I mean I did not go at all which was really good for me because I was going a number of times a week and could do all-nighters and get lost in the casino by myself just being by myself and not have to deal with people and just look at a machine and uh it really hasn’t been a big issue since because then I met …….and even though she likes to go she’s nowhere near the gambler that ……was and so she doesn’t feed my addiction like …….did and plus out of respect for …….I made certain commitments because I know that that could be uh…uh…a real um ….. It can be real destructive for us, so I never go alone anymore. If I do go she goes with me and in that area I kind of need an external conscience, you know? (p. 3, line 258-268; p. 4. line 270-271).

*Being Aggressive*, was the second subcategory in stage three, and defined as doing something physical. Some men used physical and verbal aggression toward others, occasionally engaging in fights. Earl was one who used physical aggression toward others. He described this as:

It was anger well, I know I directed my anger towards other people and I guess that was a way to try and get rid of it… Anybody I guess it was [silent] I guess innocent people. You know I would go to bars get drunk and want to fight…. Yeah somebody looking at me or something you get angry…. I think it's stupid you know inflicting pain on somebody else it was uncalled for I guess that kind of escalated it it just made it worse and I felt worse about myself…..You know just drunken stuff and hanging out and doing too many drugs and stuff and I got court-martialed and thought it was pretty much the end of my career. Anyway, yea fighting and I busted up a staff sergeants jaw he was being a jerk started pushing people around he was drinking and was on duty and I just decided to step
in and fight with him. And I ended up being court-martialed and I just lost pay and rank and then I went UL it hurt I didn’t like that but beating somebody kind of gives you a thrill and rush to beat somebody down…. (p. 2, line 87-88; p. 3, line 92-93, 97, 111-112, 367-172; p. 7, line 297-298 ).

Warren also used physical aggression as a way to numb his pain and turn the aggression outward. He explained:

When I was younger I’d get in fights all the time, you know, physical fights, and then when I was married or dating or in bars or wherever I was I was always kind of looking for a fight or argument, always trying to have my way because I never got along and so trying to push my way into other people’s lives would always create problems and so then I’d drink and get in trouble and go to jail and had a hell of a time in my first 30 years and then I got sober. I got sober at 28 actually and the anger subsided for a while. I was going to a lot of AA meetings and but then the inability to get along returned and the anger started up again and so I was just about no better off sober than when I was drinking. So the anger continued and continued and continued and the difference between being drunk and sober was that I wasn’t in any physical fights anymore and so I was always in an argument with somebody or disagreement or something. It was just my nature to just react (p. 2-3, line 86-97).

David described his experience as turning the aggression on his wife and other. He described this as:

I think I was frustrated at something and I felt, I started feeling this inclination to focus on my wife and that scared the hell out of me because I didn’t want to…I didn’t want to hit her. I mean lord knows she was the sweetest person in the world you know and I didn’t and so I went to [therapist] and I don’t remember how it was resolved and I certainly never….., I got busted a couple of times for excessive force….. I was being scrutinized and I grabbed some kid by the hair and dragged him out of some bushes where he was hiding and they busted me for…for excessive force. But quite frankly you know a year earlier that kind of contact was pretty much encouraged so it’s just…you know what I mean? It was…I’ve had this happen before where when I get scrutinized some bosses I can work for really well, other bosses um I don’t work with so well and so what they do is they scrutinize me until they can get me fired. This is why I’m currently unemployed. And when that scrutiny happens I normally have a pretty good self-esteem and a pretty good, I feel pretty strongly about how I do my work and doing it right in my decisions and so all that goes out the window when you’re getting scrutinized and um I start making mistakes which is to the glee of my bosses and then it goes downhill from there. So that’s kind of what was going on with that situation. As a
police officer however I quit before they fired me (p. 4, 208-212; 219; p. 5-6, line 227-237).

The third subcategory in stage three is *Suffering Alone*. *Suffering Alone* was defined as the men managing their depression independently and shutting out others from their lives. Because the men were disconnected from others, they lived with their depression alone and did not share their pain with anyone.

An example this was illustrated by Joe:

I can recall this as a teenager, as a young man and even now uh when I withdraw I can literally withdraw into myself and shut myself out from the world. Uh I haven’t been that way since my first divorce because I think the relationships keep me from doing that because I value my relationships so much so that I just don’t completely withdraw into myself and shut myself out um because I know it hurts those around me if I do that um plus the fact that I think I um I had two individuals who not only loved me but were skilled much more from a professional sense that they can recognize things and draw things out of me more (p. 6, line 226-232).

Tom used his inflexibility to shut his family out. When he became more depressed he would become more rigid and yell at his family until they would leave him alone when in fact he was experiencing a depressed mood. He described this as:

I’ll go home and start cleaning and I’ll um get very sensitive, almost inflexible to if the counters aren’t clean I’ll clean them so that’s a cue to everybody in my family if I start cleaning that I might be mildly depressed. Also I’m very inflexible in terms of if …. says well we’re going to a reception um and it’s at four o’clock and then she [wife] calls me or tells me at three-thirty when we’re ready to leave that no we’re not going until five I just throw a fit and I’m not going and why is everybody changing plans and so another symptom I see looking kind of……anecdotally is that um I tend to be very inflexible and uh I get very upset when plans change suddenly. Um fortunately my kids and my wife have learned to deal with that by uh they when they tell me something that changes suddenly they just leave the room and I chat with myself and you know throw a pitch fit but it’s not much fun doing it all by yourself (p. 1, 2, line 41-52).
Summary of Stage Three

Disconnecting is the third stage of *Navigating Inward and Outward Through Depression*. *Disconnecting* was defined as using high risk behaviors, aggression or other behaviors that would allow the men to numb their emotional pain. The three subcategories discussed and defined were *Being Destructive, Being Aggressive, and Suffering Alone*.

*Being destructive* was defined as behaviors that were high risk and had negative consequences associated with them. These behaviors include abusing alcohol, drugs, and self focused gambling. These behaviors had significant risks to them, but also to others such as their families and society. *Being aggressive* was defined as using physical and verbal aggression toward another person. *Suffering alone* was defined as managing their depression independently and shutting out others from their lives. They did not share the intense emotional pain with anybody, driving others away and left them to *suffer alone*.

As these men continue to navigate through this third stage of *disconnecting*, they progressed to the fourth stage of *Hitting Bottom*. *Hitting Bottom* will be discussed next.
Stage Four: *Hitting Bottom*

*Hitting Bottom* was the fourth stage of *Navigating Inward and Outward of Depression*. *Losing Hope* and *Death As An Option* were the two subcategories that emerged in this stage (Figure 4.5). *Hitting Bottom* was defined as when the men lost hope and meaning and began to think of death or suicide as a viable option to end the pain. The men did not care if they lived or died during this stage. They discovered that they could no longer numb their emotional pain because every day was a struggle and effort to get through life. These men began to *lose hope* and think that *death was an option*.

![Figure 4.5](image)

*Losing hope* was defined by these men as losing purpose and meaning in life. Warren illustrated this as:

You know, the grief of in one way it was weird because the grief was not necessarily so much the death of the son but just another…pardon my language, but another god damn episode of the wrong happening again. More of the bad part of life. More tough stuff, you know. You’ve got to keep fighting and fighting and fighting. Most of my adult life has basically been “what’s the use?” It’s like what the hell, pour it on. Bring it on. It’s just been…it’s just been a lot of tough stuff that maybe other people can walk through easier than me but it’s been just debilitating to me for the most part for my whole life. I think the real problem with most of my life is that I want to be more of a social creature but I’m not and
that bothers me that I don’t have people that I can call or talk to or B.S. with or nobody ever asks me to come over and help pull a motor or roof their house or anything and so nobody ever wants to just go have coffee and B.S., nobody wants to go to a movie. I can’t pick up women anymore. I just don’t know how anymore, so it’s just one of those things that it just accumulates and it’s a daily thing. It doesn’t go away (p. 7-8, line 328-342).

DD described losing meaning and purpose as:

Well those that I saw as friends because my friends could also be the greatest source of pain because I was different. My feelings were always getting hurt… Um…well yeah. That’s life as a kid and it became kind of life as an adult as well. It carried over. Very unexpectedly. Uh there was a period where it just didn’t matter….It’s like a rock falling from a crane. You were just moving and all of a sudden you tumble, tumble and all of a sudden stand still. It is the most uh nerve-wracking experience I’ve ever experienced…. And I had to hit rock bottom with the depression. I knew that I had depression but I figured I could fight it. I just didn’t know how until I hit rock bottom (p. 10, line 427-428; 431-438; p. 16 line 698-699).

BG described his experience with this as:

(unintelligible) just repetitive kind of gloomy thoughts and uh uh feelings of of uh I don’t know, guilt or or uh unease, discomfort with yourself uh (sigh) a feeling of somehow that you you you disliked yourself as you were, you didn’t know how to get out of the box that you were in uh you actually I’ve had to struggle for many things in my life and I have. It it it was but it never left me with a kind of comfortable secure feeling uh about it and and maybe these things come snowball like at you at that time…. Um, gloom, uh feeling of uh almost hopelessness, uh did it matter that you’re getting up today. I always got up. Uh did other people care? Uh well my son and my wife did. (p. 4, line 157-162; p. 9, line 409-410).

It was during this stage of Hitting Bottom, that these men started thinking about death as an option. This was illustrated by Earl “I really didn’t care if I lived or died; whether I lived or died the next day it didn’t matter (p. 1 line 17-18; p. 2, line 76-77).

Clark had similar statement such as:

at the time probably I was feeling pretty bad and it's something that happened it wouldn’t have mattered that time. Um I kind of joked to one-time this kind of like passive suicide where you know you just kind of risk taking a little bit and you
know what happens just happens (p. 2, line 76-80).

Other men thought of death by wishing they would die from another cause. Warren said:

Never had suicidal thoughts. I used to pray for God to take me because I didn’t want to commit suicide because I was just too scared, just too scary. My thought was is probably like anything else I’ll fail at it and I’ll end up in a wheelchair or a burden on people which of course that goes back to when I was a kid I used to think I was a burden to my parents and so that was another part of my life. It was like oh, yeah, I’m just a pain in the ass, you know. But suicide has never really been a thought. Never been a thought. I used to pray that for a heart attack, do something, car accident, something, drowning, something fast. Let’s get it over with because I can’t do this anymore. But never had a thought of suicide. So I even have a pistol, but it’s just for protection. There is not thought of putting a clip in the pistol. That’s not something I’m ever gonna do. It’s just too ugly. I’m not very bright or something but the point is that that’s just wrong. There’s got to be another way, you know. So that’s what I think about suicide (p. 13, line 593-604).

When Joe is depressed his thoughts become “dark” and he thinks of death but not in the sense of suicide. He stated:

to be honest with you, I don’t think and I don’t know if this has anything to do with it, I don’t really recall ever really truly being suicidal. I do recall often enough struggling with I get more of a preoccupation with death and my thinking gets much more darker, but I’ve never been to a point that I ever thought you know that I’ve got to end this, you know? I guess it’s just a way too I’ve learned to cope but sometimes it’s been a real effort over the years and so (p. 9, line 386-391).

Summary of Stage Four

The fourth stage, Hitting Bottom, of Navigating Inward and Outward Through Depression was discussed. The two subcategories, Losing Hope and Death as An Option were defined and discussed.

Losing Hope was defined as losing purpose and meaning in life. The predominant belief these men had is they did not care if they lived or died. This led to the second
subcategory of this stage, *Death as An Option*. *Death as an Option* was defined as these men began to have thoughts of suicide or thoughts of death. They believed that dying was an option to relieve the emotional pain they were experiencing because the pain was unbearable. As the men continued to navigate, they proceeded to the fifth stage of *Acknowledging and Confronting*. This stage will be described and discussed in the next section.
Stage Five: Acknowledging and Confronting

Acknowledging and Confronting was the fifth state of Navigating Inward and Outward of Depression. Acknowledging and confronting was defined as recognizing being depressed and becoming ready to face the challenges. Two subcategories emerged during this stage, Labeling Their Emotions and Seeking Help (Figure 4.6). The men discovered that they were vulnerable and in need of help because they no longer could manage their emotional pain alone. Once they were able to accept that they were suffering from depression, they began to acknowledge what they were experiencing and how their lives were being affected. The men confronted the stigma associated with being a man and being depressed. However, stigma was not a major concern to them, because they discovered they had to confront the pain and seek treatment to navigate out of their depression.

Labeling their Emotions was defined as the ability to recognize and label the feeling and emotional pain experienced. Once the men were able to label their
experiences they were able to describe what they were feeling and able to self and others to accept they were experiencing depression. Earl labeled his experience as:

I guess during that time I was frustrated [long pause and silence]. I guess there was some sadness of course….. Sadness, I guess it really means it kind of just runs and together there's as hopelessness I guess there's you know there's nothing I can do about it…..: [silence] it all depended, now I know but I don't think I knew back then. That the sadness was there (p. 3-4, lines 132-133, 142-143, 147-148).

Clark labeled his experience differently but the theme was that he began to acknowledge what he was experiencing. He described this as:

Hmm, kind of sense of hopelessness you might say and again it is pretty much the opposite of like I said when your exercising you feel good you greet the day with excitement and stuff whereas when you are depressed you wake up and you know you're not looking forward to the day you might say and I am getting to the point with this job and it is starting to really affect me and dread having to go to work…. Um, you can, that is partially true I look forward to my days off going out to do the things that I like to do specifically now again when I am severely depressed I don't even like to go out and do the things like many me, like my hunting, fishing, yard sales working with wood and things like that but there are points when there again, ah yes can I get up and it is difficult for me to even to get myself to do that like I said building things with wood and going out and doing some hunting and things like that….kind of driving around…mopping around (p. 10. lines, 425-431, 436-443).

Hector talked about accepting his depression as being part of him:

I have to admit to myself I have a condition, I don’t fight it where it comes from and move forward and I have to first forgive myself for one of the things I have not been able to achieve or to do since depression you can’t see it well you forget about yourself because you look in the mirror and you look perfectly healthy so you say well I’m healthy, why I can’t do this or that and so accepting that I have a condition has helped me to move. This has been, this I said this last six month or year when I started therapy again then I’ve come to realize if I had a cancer ….I wouldn’t be able to do anything so I have to admit to myself that I am ill. I am sick so I can’t and my sickness means that maybe I will not wake up in the morning at the time I have to like for example today I just did my schedule from today to tomorrow at five, six, whatever I’m gonna study for this class, I’m gonna finish this work and then I’ve put my other classes, I was starting to do my time to move forward and turned back and fell asleep. Three and a half hours. Then you
start to feel bad because I was doing my schedule to move forward and then boom, something held me back. Well now that time I may feel bad is very short and each time it keeps getting shorter. It’s like then I compare it – not that I’m dying of cancer, thanks God, but that I have an illness and it is depression and that means that things will happen. Now where before I will probably feel bad about it but now I know well that’s how it reflects the illness and I have to move on. Sitting down and crying is not gonna help me…Um as I mentioned at the beginning, I’m starting to, I have to accept even illness. Um it’s harder sometimes, sometimes it’s difficult because you still who you are. You still are a thinking human being (p. 3-4, lines 129-147; p. 15, lines, 661-663).

David was able to label his experiences as symptoms such as:

Well there’s basically two components to my depression. One of them is of course sadness. I cry a lot and um the other component is obsessive thoughts and um they interact. Sometimes my obsessive thoughts are about something that’s sad and um so um when it gets, when my depression gets really bad then I lose interest in my hobbies and become somewhat lethargic and um…um and that’s kind of how I know when I’m becoming depressed is because if I start losing interest in my hobbies then I know well that’s an advanced stage of depression for me but part of my obsessive behavior is to keep my mind straight and keep focused I’ll in my mind um run through projects (p. 1, lines 31-38).

Well the three things I do is I feel what I call sad or low, I feel anxiety and I feel and then I cry and in combination with either of the two and um occasionally rarely, but occasionally, I’ll feel dread and um that’s kind of reminiscence of when I thought I had AIDS you know? Like something bad is gonna happen but that’s usually just momentarily because I look around and I think nothing bad is going to happen you know. But as far as sadness goes, I just…I just feel sad then I start crying and I cry for a while and then I’m usually okay for a while and it’s hard to get through a conversation with anybody (p. 7, lines 336-342).

DD described his experience as he went through the process of accepting and also described the emotional pain he was suffering. DD described this as:

To struggle with depression and be a male um the first thing is acknowledging that I’m depressed and that’s something that’s very unmanly in society’s view and so nobody wants to hear about it and yet I not only have to accept it I have to deal with it which isn’t an easy thing and in a world where everybody’s a stranger it’s hard to learn how to deal with it (p. 13-14, lines 557-560). There was a lot of pain in me. There was a lot of pain around me as well (p. 13, lines 539-542). Well I didn’t want to acknowledge it because I figured that acknowledging it would be to give it power over me because I saw my life was crazy. I only got to
acknowledge it within the last year to year-and-a-half because I was fighting
acknowledging it like as soon as I got together with my wife but I was so busy
running around doing other things trying to be uh Ricky Ricardo and take care of
my Lucy um that I didn’t have time to think about it. I was just a mess and I
blocked something out completely and I didn’t know exactly what was eating me,
all I just knew is that I was lonely, I was hurting, I didn’t know I was depressed
but I just felt…to me it wasn’t depression because that word was like a no-no or
something. I just knew that I felt empty and I didn’t care whether I lived or died
and all of a sudden she ran into me and uh despite my best efforts I fell in love
and it was the greatest feeling next to dangling from that jump rope. And then
when things started going awkward because of her mental conditions and mine uh
I couldn’t face reality until finally we started our periods of separation since I’ve
been here in Spokane and on my own living in my car in the cold of the night
thinking what is wrong. I had to face reality. What is this? I just knew that
something was consuming me and then after talking to a few people I discovered
that it is depression and then after evaluating my life for the past 24 – no I was 26
at that time – 26 years everything that I could remember had been touched by
depression. So I had to admit (p. 15, lines 650-671).

DD labeled his depression as:

I have a very, very deep sadness and loneliness as well that that has to battle. A
desire to feel peace um so I guess you could say desire keeps me going to battle
my rage and my hate and my anger. Um…those are pretty much the predominant
ones (p. 18, lines 768-771).

BG labeled his depression as:

I just uh began to really feel uh gloomy and uh uh I uh I never I was never a
case of just lying in bed all day. I was trying to do things. I always try to push
myself to do tasks around the house and fix up stuff uh but it began to it began to
wear on me. I was having trouble sleeping uh I had gloomy thoughts and uh ah
the theme of death came up uh I never attempted suicide or thought of it but just a
theme of kind of uh you know this is the end somehow of your life and then you
note that you’re in a cul-de-sac and uh it it just my wife wasn’t there and too in
the sense of which she’s always planning your day for you. Um so I had more
time I guess to brood and think and then it became kind of uh hard to bear and
what really triggered the idea to get counseling was an article in in uh
Newsweek magazine. They just devoted the whole issue to men and depression
and uh I said well I have I think I I have some of these issues and uh then I started
to try to get help (p. 2, lines 53-63).
BG further described what he was experiencing by saying:

Kind of a flash of self-recognition and feeling I better do something about it. Because I felt rotten, it wasn’t gonna go away uh a shame element was not gonna play a role in this. I felt I ought to when you have a toothache you go to a dentist. You know when you have a problem that requires some kind of intervention - when we had marital problems before I sought, I sought because….. my wife, wasn’t about to do that I I I pushed it and we we got some help – that you take action (p. 12, lines 555-560).

The second subcategory that emerged in this stage was Seeking Help. Seeking Help was defined as making the decision to seek help from others. Most men had to seek validation from others or other external sources such as literature to acknowledge and confront the depression. BG reported that he read an article in Newsweek and related to the experiences of other men. This “triggered” him to seek help. He stated:

….what really triggered the idea to get counseling was an article in in in uh ………Newsweek magazine. They just devoted the whole issue to men and depression and uh I said well I have I think I I have some of these issues and uh then I started to try to get help (p. 2, lines 61-64).

Joe also relied on others to seek validation that his symptoms were becoming more obvious and he needed to consider seeking professional help. He reported that his co-workers encouraged him to seek help. He stated:

But I think when you experience a traumatic event that I had experienced and you tap into all your resources and you realize you don’t have a whole lot left and you know that you’re not in trouble yet but you’re heading down that road and people say are you seeing someone or whatever and [co-worker] had mentioned to me a couple times and the one time I remember [co-worker] mentioned that to me I was working…I was working night shift at the time but I came in to work a swing shift so I was there at three o’clock and [co-worker] were getting off within the next hour and we crossed paths in the staffing room and [co-worker] mentioned it to me and I really thought about it that night and through the weekend because it was a Friday and that provided me I think the impetus to go ahead and to do so. So when I first went in I was real nervous, I was real like boy I don’t know if I really want to do this (p. 7 lines 299-308).
Some men would wait till they were hitting bottom before they would seek help. The men continued to try and ignore the emotional pain but the external behaviors were no longer working for them so they had to seek help to navigate out of the fourth stage. David described this by saying:

Well yeah, it’s emotional pain because it never ever stops. You have this horrible, you have this horrible um feeling that is there 24/7. I woke up this morning at six o’clock in the morning and the very first thought I had in my head was of my old girlfriend and I started crying. The very first thought I had in my head and you know and so it to be unable to shake that is all day it’s exhausting and you just want it to stop. Well I was miserable at the time. Really miserable and so I was up for anything. (p. 13, lines648-652; p.14, 676).

Summary of Stage Five

Acknowledging and Confronting was the fifth stage of Navigating Inward and Outward of Depression that was discussed. Acknowledging and Confronting was defined as the men recognizing and becoming aware of being depressed resulting in a readiness to face the challenges of seeking help. They also became aware of how the depression was affecting their lives. The two subcategories in this stage, Labeling Their Emotions and Seeking Help were discussed.

Labeling Their Emotions was defined as the ability to recognize and label the feelings and emotional pain experienced. This helped them accept feelings that what they were experiencing were feelings of depression.

Once the men were able to acknowledge and confront the pain, they were able to labeling their emotions. This led them to Seek Help from others so that they would be able to navigate out of this stage and begin to Healing with Others which will be discussed next.
Stage Six: Health with Others

*Healing with Others* was the sixth stage of *Navigating Inward and Outward Through Depression*. *Healing with Others* was defined as making the decision to share their thoughts, feelings, and challenges with others. The predominant form this took was seeking help from a professional, but others began to share their experiences with friends and family to seek validation. The progression through this stage moved them through the process from stage three *Disconnecting and Healing Alone* to reconnecting with others and themselves and *Healing with Others*. Earl described this as:

> It took me awhile to figure out that I actually get something by helping other people and I guess that makes me feel like belonging….I felt some [pause] satisfaction in life…. having my children uh, I think having my children helped bring me out of it [depression] and that was probably the first thing that when I decided I had to something for them now that I am thinking about it. They got me away from the drugs and alcohol and just existing there, I knew somebody had to take care of them and be responsible (p. 9, lines 373-375; 382-386).

Warren talked about being able to find a therapist with whom that he was able to connect and felt he was being heard. He reported:

> Well I’d seen therapists different times on and off all through my sober life. This August will be 27 years sober and different churches and my goal is always to find out why are people the way they are. Why don’t they leave me alone? That’s what I thought was the problem. What’s the matter with everybody? And I didn’t find out anything until I started seeing [therapist] and she was able to bring it around to where it was like okay, this is what is and what you’re seeing isn’t exactly right. So I came in to see her with the attitude like I came in to AA was like well, this has got to be better than what is. Ironically she was the only one that really gives me the honest and proper feedback. All the other therapists have just basically sat back in their chairs and said “uh-huh”, “uh-huh”, “yeah.” (p. 10, lines 452-460).

Hector talks about connecting with friends and breaking the cycle of isolation and withdrawal. He said:
Um get out there I used to go out and have a drink when I’d go dance. I love to dance so I have my night dancing and have my drinks and share with friends but mainly go out and do my exercise. I will use herbal medication like St. John’s Wort and I will make sure that I eat well, control…if I know I was feeling depressed and I was feeling bad then I will control what I was drinking or how much I was drinking. Um I will try to read something positive, something that will bring me a good idea or a good feeling about life and about what I have. Um, um just go out and talk to a friend probably, accept that I was not feeling good and well today is the day for a drink, dance, and jump in the beach. So I try to do something that will make me happy that I will enjoy. Sometimes I will just go on my own to a move if I don’t feel like staying and being home and doing nothing here so I will go on my own, jump in my car, go to the movie and come out with a…(p. 9, lines, 386-399).

Some of the men had validation from their families that they needed to seek help because their families noticed there was something wrong and suspected depression.

David said:

Well it was a no-brainer because like I said, my mom had been through it. She recognized it ….she picked up and coincidently it was during Christmas time, or maybe not so coincidently because that’s you know that’s when a lot of that obsessing would happen during the holidays. She picked up on the depression part of it and she figured I just had the family curse if you will and so she knew I was coming down for Christmas so she made me an appointment with her uh psychiatrist or whatever and uh he kind of let me know what was happening and wrote me a prescription for something – I can’t remember – and he got me set up here with [psychiatrist]…. Yeah, I had no idea what was going on…. no clue whatsoever (p. 4, lines 142-150; 155; 159).

Joe took advice from others around him. He stated:

Well, a number of people I think were concerned about me. I had never gone to counseling before in my life. I mean never, ever. I always considered myself very self-sufficient and maybe that’s part of putting on that mask over the years thinking oh, I can do it within myself. I have enough knowledge in this. But I think when you experience a traumatic event that I had experienced and you tap into all your resources and you realize you don’t have a whole lot left and you know that you’re not in trouble yet but you’re heading down that road and people say are you seeing someone (p. 7, lines, 296-302).

Tom had validation from his wife. He stated:

I casually asked my wife as we were kind of cleaning do you think I’d
benefit from antidepressant medication and I was on a ladder – not very far off the ground, thank goodness – because she said well yes, I do and I almost fell off the ladder uh because I’d compensated so well to the point where I was really kind of in denial and then she spelled out what they see, what my kids see and what she sees….I was compensating so well that by the time I was strong enough to look at antidepressants that I really didn’t have a clinical justification to do so and it was only my family urging me that kept me on track (p. 2, lines 62-66; p. 14, lines 608-609).

BG connected with friends around him to help validate what he was feeling. This helped him feel like there was other men have similar struggles and this helped him Heal with Others. BG described this stage as:

Uh (sigh) coming here I talked to a guy across the street, Ron, I talked to Tom finally Price next door who told me to my shock that he had the same condition and that he uh you know he wouldn’t get up in the morning this or that and that sort of you know……. This kind of confirmed that you know you’re obviously uh not alone. Other people right around you who you know of this condition or even have it. (p. 7-8, lines 343-346; 350-351).

Summary of Stage Six

*Healing with Others* was the sixth stage of *Navigating Inward and Outward Through Depression*. *Healing with Others* was defined as these men made the decision to share their thoughts, feelings, and challenges with others. The predominate form this took was seeking help from a professional but others shared their experiences with family and friends to seek acceptance and validation

Chapter Summary

This chapter presented the findings from this research study.

The first part of this chapter presented the portraits of each participant. The second part of the chapter explained and described the grounded theory.
The grounded theory *Navigating Inward and Outward Through Depression* was explained. The five stages, *Being Different, Concealing Feelings, Disconnecting, Hitting Bottom, and Acknowledging and Confronting* were defined and data bits were provided to illustrate the categories and subcategories in detail.

**Figure 4.7 Grounded Theory: Navigating Inward and Outward Through Depression**

- **Stage 1** Being Different
- **Stage 2** Concealing Feelings
- **Stage 3** Disconnecting
- **Stage 4** Hitting Bottom
- **Stage 5** Acknowledging and Confronting
- **Stage 6** Healing with Others

*Being Different* was the first stage in the process. In this stage men felt rejected, alone and outcast from society. The second stage was *Concealing Feelings*. In this stage men felt lost, vulnerable and as if they were putting on a disguise in order to conceal their feelings and thoughts from others. The third stage was *Disconnecting*. This was the stage that men used high risk behaviors and were being destructive, physical or verbal aggression, and suffering alone. The fourth stage was *Hitting Bottom*. The men in this
study described this stage as losing hope for their future and thinking that death was an option to end their emotional pain. The fifth stage was *Acknowledging and Confronting*. This was the stage that the men began to *acknowledge* what they were experiencing and confront the challenges of depression. *Healing with Others* was the sixth stage. In this stage the men began to reconnect to themselves, family, society, and continued the healing process with others.

The fifth and final chapter will be presented next. This chapter will included the grounded theory developed through this research will be examined and compared to previous literature, theories, and other studies. This final chapter will also include the implications for nursing theory, practice and research.
CHAPTER FIVE
DISCUSSION AND RECOMMENDATIONS

This fifth and final chapter presents the interpretation of this study. The chapter will begin with the integration of the findings with the literature. This will be followed by presenting the implications for nursing theory, nursing research and nursing practice. The chapter will be end with the limitations of the study and concluding remarks and comments.

Integrating the Literature

The basic social processes that emerged from this study described a series of stages that occur as men navigated through depression. In this next section, the findings from this study will be compared with the literature review that was presented in Chapter Two. The comparisons of the literature review and findings will be presented within the biological and psychological theories discussed in chapter two as well as three additional categories of, 1) Men and Depression, 2) Help Seeking Behaviors and 3) Gender Role.

Biological Theories

My study findings are consistent with the biological theories that describe the etiology of depression being a result from an interaction within the neurotransmitter systems. Most men in the study confirmed that their symptoms improved or were better controlled with the use of an antidepressant.

Psychological Theories

Similarly, my study findings provided further validation of the psychological
theories of depression discussed in chapter two. These men defined their depression that was consistent with psychodynamic, cognitive, and existential theories. For example, DD suffered an early childhood loss providing additional validity for the psychodynamic perspective about how depression develops. David had negative thoughts that contributed to his depressive symptoms which were consistent with cognitive theories. Additional validity about the existential perspective was provided by Earl who described how finding meaning changed his depression from an existential perspective when he chose to take responsibility and make changes in his choices so he could focus on his children.

**Men and Depression**

My study findings are consistent with previous studies such as Cochran & Rabinowitz, (2003) that focused on gender differences and concluded that men manifest depression differently than women (Cochran et al, 2003; Zamarripa, Wampold, & Gregory, 2003). Studies that have focused on gender differences of depression have concluded that men present to their health care provider with other co-morbid conditions such as alcohol or substance abuse (Aday, 2001; Cochran & Rabinowitz, 2003). These co-morbid conditions tend to mask depressive symptoms and lead to undiagnosed, untreated, and unidentified depression (Cochran et al, 2003; Potts, Burnam, & Wells, 1991). Men tend to conceal, mask, or deny their feelings of depression which leads to other destructive behaviors (Cochran et al, 2003; Zamarripa, Wampold, & Gregory, 2003). These findings have led researchers to conclude that the high use of alcohol and drugs are coping mechanisms for men to manage their depressive symptoms. On the contrary, findings from my study concluded that men manifest depression differently than
we previously understood and the current diagnostic tools are not adequate to screen men for depression. These differences will be discussed next.

Findings from my study extended our understanding of the behaviors men chose to navigate through their depression. My study identified two processes that occurred regarding masking and the use of alcohol. In Stage Two: Concealing Feelings, the men felt the need to disguise by presenting differently in public so their feelings and thoughts would not be exposed. The men in this study would present as if they were confident in themselves and what they were doing but internally they had emotional pain. The concealing process was used prior to the use of alcohol or drugs. Stage Three: Disconnecting was the stage that these men used alcohol and drugs as a way to disconnect from themselves, family and society due to the intense emotional pain and they found ways to numb and disconnect from the pain. In contrast, to previous studies that merely described the use of alcohol and drugs were as a way that men masked their depression (Cochran et al, 2003; Zamarripa, Wampold, & Gregory, 2003; Epperly & Moore, 2000) whereas as my study provides a deeper explanation by providing the meanings of these behaviors and actions.

The findings from my study had similar findings to Cochran et al (2003). Cochran and his colleagues concluded that men often present with interpersonal conflicts when they are depressed (Cochran et al, 2003). Men tend to become aggressive and abusive towards others when they are depressed including their spouses, families, or significant others (Cochran et al, 2003). Men with depression project blame onto others, use physical intimidation and force whenever they perceive threats to their masculinity from
others, and use physical aggression to cover up their psychological pain (Cochran et al., 2003). Finding from my study were consistent with Cochran et al (2003), but further uncovered a deeper understanding of these actions the men used to disconnect. Three processes were identified in stage three, *Disconnecting, Being Destructive, Being Aggressive, and Suffering Alone*. *Being Destructive* included behaviors such as the use of alcohol, drugs or gambling to disconnect from others. *Being Aggressive* were actions that were used such as physical or verbal aggression towards other people around them such as strangers, family, or friends. *Suffering Alone* were the actions that men used to shut others out from their lives and were trying to navigate through their depression alone without the involving of others.

My study had similar results as Moller-Leimkhihler et al (2004) in that men were able to describe what they were experiencing; however, my study revealed that men had to navigate through several stages before reaching the fifth stage of *Acknowledging and Confronting*. It was in this stage that men were able to identify and label their feelings and acknowledge how the depression was affecting their lives. Most of the men did not realize their irritability or other behaviors were related to their depressed mood. Studies have been able to support the finding that men manifest depression differently by reports of atypical symptoms like irritability, aggression, and antisocial behaviors (Moller-Leimkhihler, Bottlender, Strub, & Ruts, 2004).

*Help Seeking Behaviors*

Similar findings were identified in my study about how men who suffer from depression experience feelings of hopelessness and helplessness, but externalize coping
and do not seek help (Cochran & Rabinowitz, 2000). In contrast, women seek support from family, friends, and health care providers. Females tend to report physical and psychological symptoms and seek medical help at higher rates than men (Piccinelli et al., 2000). Women discuss their thoughts, feelings, and emotions openly with friends and family members (Alexander, 2001; Piccinelli & Wilkson, 2000). Similar findings were identified in my study but conceptualized as *Suffering Alone* which provides a deeper understanding than previous studies (Alexander, 2001; Piccinelli & Wilkson, 2000) have been able to describe. *Suffering alone* was a subcategory in stage three in my study and defined as managing depression independently and shutting out others from their lives. The men discovered they had to acknowledge and confront the depression themselves before they were able to heal with others such as their family, friends, or therapist. Reconnecting with themselves and others helped them through the healing process and face the challenges of their illness.

My study had similar findings to previous studies (Albizu-Garcia, Alegria, Freeman, and Vera, 2001; Blazina and Marks 2001; Mansfield and Courtenay 2005) in regards to seeking help, but being a man did not prevent most from seeking treatment. The key point from my study is the men *Hit Bottom* before they sought help from others. Most of these men reported that being a male did not matter because once they recognized they were experiencing depression they became hopeful and realized there was a way to relieve the emotional pain by seeking treatment. My findings are more consistent with Albizu-Garcia et al (2001) in that these men delayed treatment, only sought help when their pain was unbearable, were considering suicide, and/or losing hope.
Some men in my study had similar findings to the study conducted by Halter (2004) in that men did not want to be a burden or bother to others and this was one of the reasons for them to conceal and disconnect as they navigated through their depression. Halter’s (2004) study examined the stigma associated with seeking care for depressive symptoms found that men seeking treatment believed they would be cared for out of pity and people with depression were viewed as weak (Halter 2004).

Findings from my study were consistent with previous studies regarding men having thoughts of suicide and death but rarely acted on their thoughts (Diego et al 2002; Marcus et al, 2005; Stanistreet et al., 2003). In addition, some men in my study reported they experienced obsessive thoughts about death and when their depression symptoms increased their anxiety and obsessing increased as well.

**Gender Role**

Gender Role Conflict is defined as “a psychological state that stems from negative consequences of masculine role socialization and can be understood as a marker of individual differences in role adherence that result in the process of social gendering” (Franchina, Eisler, and Moore, 2001; Magovcevic & Addis, 2005, p.127). In my study, the men did not relate their depression to their gender role however; they did report that they felt different. This was illustrated in stage one: *Being Different*. This was based on the men trying to express their feelings but they were rejected by others and felt as if something was wrong with their character. It was not until they acknowledged and
confronted the depression and that they were able to accept they had no control over their illness. The rejection made them feel like an outcast.

My study findings had similar results from previous studies (Mahalik and Cournoyer, 2000; Magovcevic & Addis, 2005, p.127; Mahlik, 1999) that described how men respond to depression; however my findings provided deeper descriptions of how the men make meanings of their actions. For example, my findings identified that men would navigate through a process that began with restricting their emotions (stage two, concealing), abusing alcohol and conflicts at work and with family (stage three, disconnecting), and experience negative thoughts, feelings of inadequacies that led to hopelessness (stage four, hitting bottom), whereas these other studies related their finding to male socialization.

My study findings extended the findings from Alexander (2001) and Brwonhill, Wihelm, Barclay, and Schmied (2004) in that most men do not have close relationships with other people. This makes it impossible for them to have someone they can trust and feel comfortable to express their feelings or have someone to go to when they are in need of help. Men conceal and hide their feelings. Findings from my study found that men develop strategies to compensate for their depression by high risk behaviors, drugs, alcohol, self harm, aggression, and violence.

The next section will present the theoretical perspective that informed this study.
Theoretical Perspectives

The two theoretical perspectives that informed this study were Social Constructionism and Symbolic Interactionism. The following section will present how this study stayed congruent with these perspectives.

The assumption of social constructionism is that meaning is constructed through social interaction among a group and common social norms that are adopted and accepted. A key argument of social constructionism claims that knowledge is the result of social practices and the behaviors, attitudes, and norms are all constructed. Furthermore, a social constructivist view is that the individual makes sense of social realities through internalizing (learned behavior) the accepted norms of the group. Therefore, the construction of knowledge is not a personal endeavor but a process that involves the social interactions with their environment (Audi, 1999; Cheung, 2000; Crotty, 1998). This study illustrated the beliefs of men were constructed through their interaction with others and their environment. This was illustrated in stage one Being Different. These men were rejected and made to feel like an outcast of society and they accepted this as reality. They learned to internalize their thoughts and feelings by concealing them and they learned to behave a certain way to hide these feelings and thoughts as identified in stage two Concealing Feelings.

Symbolic interactionism was the theoretical perspective of this grounded theory study. The goal of using grounded theory was to produce an explanatory theory regarding social interactions and patterns among the group being studied. This method
has emerged from symbolic interactionism which is embedded in social psychology and sociology (Annels, 1996; Munhall, 2001; Schreiber & Stern, 2001). Symbolic interactionism theory is concerned with human behavior and how social interactions define human actions, societies, social interactions and the influence these interactions have on the person (Blumer, 1969). Symbolic interactionism assumes that people are constantly interacting and interpreting their actions and interactions. These interactions with others and their environment give meaning to who they are and what they do (Eaves, 2001).

Symbolic interactionism acknowledges that human beings must have a role that fits the nature of social interactions (Blumer, 1969; Jeon, 2004). In other words, people will have to be part of a group that understands, defines, and adapts to the objects and symbols that have meaning to them. When they are embedded in these interactions they will not be able to see what meaning these interactions have on the “self.” Therefore, the “self” needs to be situated in interactions within the social world because the person and the external world cannot be understood independently of each other. The “self” is developed and defined through a process on a continuum as the person interacts with other human beings (Jeon, 2004).

The men in this study found meaning through their actions and interactions with others. They constantly navigated through their depression based on what they were feeling and the responses of others. This was clearly illustrated in the patterns of behaviors that emerged. For example, in stage three Disconnecting from themselves and
others became a way to survive and function in their daily lives because of the rejections from society and concealing their feelings were becoming more difficulty.

Implications for Nursing Theory

“Theory is the goal of all scientific work; theorizing is a central process in all scientific endeavors; and theoretical thinking is essential to all professional undertakings” (Meleis, 1994, p. 8). The knowledge generated from this study has contributed to a better understanding of the phenomena of men and depression. The substantive theory generated was *Navigating Inward and Outward Through Depression*. This theory explains and describes the basic social processes that occurred as these men navigated through their depression. This theory provides a new and unique perspective on the phenomena concerned with men and depression and conceptualized the behaviors men chose to survive their depression. This theory has moved our knowledge beyond the studies that only focused on male gender and provided a deeper understanding of the reasons men chose certain behaviors to compensate for depression. These behaviors symbolized and had meaning for the thoughts and feelings the men experienced with depression.

The hypothesis generated in this study provides the basis for further testing of the theory in practice, which will lead to the development of interventions for men suffering from depression. In addition, further development of the theory can predict men who are at high risk for depression and the negative consequences related to depression based on the stages identified in *Navigating Inward and Outward Through Depression*. 
Implications for Nursing Research

This study has significant implications for nursing research. Through this grounded theory study there were six stages that were uncovered that will lead to further investigation to gain a better understanding of depressed men. This study is timely because there is a growing need for knowledge development in men’s health nursing. Men continue to be under diagnosed of depression but commit suicide at greater rates than women. This research has provided the basis for further studies to focus on prevention, interventions and screening tools for early detection and diagnosing of depressed men. Each of these areas will be discussed further.

This theory identified a six stage process that men navigated through. Further research in each stage can be further developed and preventative interventions could be developed specific for the first four stages to prevent the progression through these stages. Each of these stages has negative health risks and consequence associated with them and as the men progress through these stages the health risks increase in severity. In addition, this study provided enough evidence that indicated there are specific antecedents (e.g. Being Different, Concealing Feelings, and Disconnecting) that occur prior to Hitting Bottom which indicated a time when the men are the most vulnerable to suicide.

This theory provides the foundation for further development of interventions focused specifically on men. These interventions need to be focused on how providers relate to men and build a trusting relationship, helping men engage in early treatment,
assisting men in understanding their behaviors and the meaning of these behaviors. The meaning of these behaviors will not only be useful to health care providers but also to the men and their families.

In addition, this study has provided further evidence that the current screening tools available are not adequate to diagnosis depression in men because they do not relate to the six stages of depression men go through. This study provided very specific stages that men progress through when they are depressed and provided the foundation for further research so such tools can be developed and tested within the six stages of *Navigating Inward and Outward Through Depression*.

**Implications for Nursing Practice**

This theory has provided useful clinical knowledge not only to nurses, but other health care professional that care for and treat men with depression. The six stage process men progress through provides the clinical knowledge necessary for early detection of depression among men who are vulnerable to health risks associated with depression (e.g. alcohol abuse, suicide). When men present to the emergencies rooms, clinics, or triage centers with the behaviors identified in this theory, clinicians must investigate further with the men to rule in or rule out depression.

The first four stages have predictable health consequences that are associated with each stage and increase in the severity and risk. It is clear in this theory that the emotional pain intensifies with each stage of the process until it becomes unbearable and the man discovers he can no longer navigate out of the depression alone and makes the decision to seek help. However, nurses can assess when men are in the early stages of
depression using this theory, helping men understand they are in need of professional treatment.

The theory of *Navigating Inward and Outward Through Depression* provides nurses the conceptualization to assess and develop interventions for depressed men. The six stages clearly provide nurses the guidance to be able to interpret and predict the behaviors of depressed men.

In additions, this theory can guide nurses in educating other nurses and health care professionals, men, and women about how depression manifest in men. This theory provided the evidence necessary to explain how men present differently and also provided the meaning of their behaviors and other high risk behaviors the men used to compensate for their depression. The goal of this theory was to advance our knowledge and understanding of depression in men so we can decrease the incidents of suicide among men by using this new knowledge for early detection, better interventions, through public education efforts.

Summary

This section presented an overview of the basic social processes that emerged from this grounded theory study. In addition, this section presented the integration of the literature, linkages to the theoretical perspectives, and the implications for nursing theory, research, and practice. The next and final section will present the limitations of the study and concluding remarks.
Limitations of the Study

This study was based on a total of eleven interviews. One of the primary limitations of the study was the lack of experience of the researcher. The techniques and skill conducting qualitative research were practiced and developed with a preliminary study but having more experience would have strengthened the researcher skills.

Conclusion

This study used a grounded theory method to inquire further about men and depression. The theory that was discovered is *Navigating Inward and Outward Through Depression*. This theory is descriptive and explanatory of this phenomena of concern. In addition, this theory will make significant contributions to advance science and our current understanding of men and depression. This theory gives a unique and different perspective into this phenomena that has not been described using the voice of men who suffer from this terrible and debilitating disorder called depression.
APPENDIX A: LETTER TO PROVIDERS
05.29.07

Dear Mental Health Therapist:

My name is Jeff Ramirez and I am currently a nursing doctoral candidate at the University of Arizona working on my dissertation research. My area of research is focusing on men and depression.

The topic of men and depression remains under studied and we know little about this phenomenon. I am conducting a grounded theory study to help describe and explain the underlying basic social and psychological processes of depressed men. In addition, the knowledge about these aspects of depression will generate a formal theory and identify areas for further research.

I am asking for your assistance in recruiting men into my study. Potential participants should be free to make their own independent decision to participate without any coercion or influence. The inclusion criteria are English-speaking men over the age of 21 who meet the DSM IV-TR diagnostic criteria for major depression or dysthmia. Potential participants need to be able to give consent independently. The only exclusion criteria is if you or another qualified mental health provider has given the potential participant a co-morbid diagnosis of a cognitive disorder such as Alzheimers, dementia, or other neurological diseases that interfere with their ability to accurately answer or recall their experiences with depression.

This is a qualitative study that will involve an interview with me. The interview will last approximately one hour and it will be recorded on an audio tape recorder. The audio tape will be transcribed by a professional transcriptionist. The participant’s identity will be protected by coding the transcripts and I will be the only person who would be able to identify the person and their transcript from the interview.

I have enclosed copies of a brochure that explain the study for potential participants and a flyer to be posted in your office to help recruit men into the study. If you have a man that is interested in the study and you think they meet the inclusion criteria please give them a copy of the enclosed brochure with my contact information. If you have any questions or need more brochures you can contact me on this confidential cellular phone, 509-280-4960.

Please feel free to contact me with any questions.
Thank you for you assistance.
Sincerely

Jeff Ramirez
509-280-4960
APPENDIX B: HUMAN SUBJECT APPROVAL LETTER
22 May 2007

Jeff Ramirez, Doctoral Candidate
Terry Badger, Advisor
College of Nursing
PO Box 210203

BSC: B07.173  SOCIAL PROCESSES OF BEING A MAN AND BEING DEPRESSED

Dear Mr. Ramirez:

We received your research proposal as cited above. The procedures to be followed in this study pose no more than minimal risk to participating subjects and have been reviewed by the Institutional Review Board (IRB) through an Expedited Review procedure as cited in the regulations issued by the U.S. Department of Health and Human Services [45 CFR Part 46.110(b)(1)] based on their inclusion under research category 7.

Although full Committee review is not required, a brief summary of the project procedures is submitted to the Committee for their endorsement and/or comment, if any, after administrative approval is granted. This project is approved with an expiration date of 22 May 2008.

The Institutional Review Board (IRB) of the University of Arizona has a current Federalwide Assurance of compliance, FWA00004218, which is on file with the Department of Health and Human Services and covers this activity.

Approval is granted with the understanding that no further changes or additions will be made to the procedures followed without the knowledge and approval of the Human Subjects Committee (IRB) and your College or Departmental Review Committee. Any research related physical or psychological harm to any subject must also be reported to each committee.

A university policy requires that all signed subject consent forms be kept in a permanent file in an area designated for that purpose by the Department Head or comparable authority. This will assure their accessibility in the event that university officials require the information and the principal investigator is unavailable for some reason.

Sincerely yours,

Theodore J. Glattke, Ph.D.
Chair, Social and Behavioral Sciences Human Subjects Committee

TJG/mm
Cc: Departmental/College Review Committee
APPENDIX C: CONSENT TO PARTICIPATE
Informed Consent

SOCIAL PROCESSES OF BEING A MAN AND BEING DEPRESSED

Introduction

You are being invited to take part in a research study. The information in this form is provided to help you decide whether or not to take part. Study personnel will be available to answer your questions and provide additional information. If you decide to take part in the study, you will be asked to sign this consent form. A copy of this form will be given to you.

What is the purpose of this research study?

You are being invited to participate voluntarily in the above-titled research project. The purpose of this project is to gain an understanding of how depression has affected your life and how you have managed living with depression.

Why are you being asked to participate?

You are being invited because you can provide information about being a man and being depressed. The criteria for this study are men who are at least 21 years old and suffering from depression.

How many people will be asked to participate in this study?

Approximately 15 persons will be asked to participate in this study.

What will happen during this study?

The following information describes your participation in this study. You are being asked to participate in an interview with Jeff Ramirez, researcher that will take about one hour. The interview will consist of the researcher asking you questions. The interview will be recorded on an audiotape and then transcribed by a trained transcriptionist and typed into a Microsoft word document. All information will be confidential, and all identifying information will be removed. You may ask any questions during the interview, decline to answer any questions, or withdraw and end the interview at any time.
How long will I be in this study?

About 1 hour will be needed to complete this study. Some participants will be asked for a second interview to verify the accuracy of the data and findings. Please indicate if you would be willing to be contacted for a second interview: ☐ Yes  ☐ No

Are there any risks to me?

The risks of this study are minimal. Sometimes individuals may experience temporary discomfort when discussing their feelings or their situations. If you experience any discomfort and want assistance in contacting your mental health provider and you will be provided with the phone number of the local mental health crisis center which has 24 hour operations.

Are there any benefits to me?

You will not receive any benefit from taking part in this study.

Will there be any costs to me?

Aside from your time, there are no costs for taking part in the study.

Will I be paid to participate in the study?

Your participation is completely voluntary and you will not be paid or compensated for your participation.

Will video or audio recordings be made of me during the study?

We will make an audio recording during the study so that we can be certain that your responses are recorded accurately only if you check the box below:

☐ I give my permission for audio recordings to be made of me during my participation in this research study.

Will the information that is obtained from me be kept confidential?

The only persons who will know that you participated in this study will be the research team
members: Jeff Ramirez, Principal Investigator and Deanna Cunha, transcriptionist.

Your records will be confidential. You will not be identified in any reports or publications resulting from the study. It is possible that representatives of the Federal Government, Human Subjects Protection Program, or representatives of other regulatory agencies that supports the research study will want to come to the University of Arizona to review your information. If that occurs, a copy of the information may be provided to them but your name will be removed before the information is released.

May I change my mind about participating?

Your participation in this study is voluntary. You may decide to not begin or to stop the study at any time. Your refusing to participate will have no effect on you. You can discontinue your participation with no effect on you. Also any new information discovered about the research will be provided to you. This information could affect your willingness to continue your participation.

Whom can I contact for additional information?

You can obtain further information about the research or voice concerns or complaints about the research by calling the Principal Investigator Jeff Ramirez, Ph.D. Candidate, at (509) 280-4960. If you have questions concerning your rights as a research participant, have general questions, concerns or complaints or would like to give input about the research and can’t reach the researcher, or want to talk to someone other than the research team, you may call the University of Arizona Human Subjects Protection Program office at (520) 626-6721. (If out of state use the toll-free number 1-866-278-1455.) If you would like to contact the Human Subjects Protection Program by email, please use the following email address http://www.irb.arizona.edu/suggestions.php.

Your Signature

By signing this form, I affirm that I have read the information contained in the form, that the study has been explained to me, that my questions have been answered and that I agree to take part in this study. I do not give up any of my legal rights by signing this form.

__________________________________
Name (Printed)
Participant’s Signature                     Date signed

**Statement by person obtaining consent**

I certify that I have explained the research study to the person who has agreed to participate, and that he or she has been informed of the purpose, the procedures, the possible risks and potential benefits associated with participation in this study. Any questions raised have been answered to the participant’s satisfaction.

__________________________________
Name of study personnel

__________________________________   _______________
Study personnel Signature                     Date signed
APPENDIX C: INTERVIEW QUESTION GUIDE
Interviewing Guide

Grand tour questions to begin interview:
1. Tell me what it is like living with depression and being male?

Additional probing and clarifying questions.
Tell me about the first time you knew you were experiencing depression?
   a. What was that experience like for you?
   b. Can you give some examples?

Tell me about what it is like being a male and living with depression?
   a. What expectations did you have of yourself as a male?
   b. What expectations do you think other have of you?
   c. How do you handle these expectations?

Can you tell me about the experience you had when you decided to seek professional help and/or treatment for the first time?
   a. What symptoms did you experience?
   b. How did those symptoms affect you?
   c. Can you give some examples?

Can you explain your decision process that led you to seek treatment?
   a. Is there anything else you would like to tell me?

Let me see if I understand……..
What does that mean to you……
What led you to that decision……..
What led to that conclusion……..
What was most significant to you about that…………..
Tell me more about…………..
How do view……..
Can you explain further…………..
Reference


Epperly, T., D. & Moore, K., E. Health issues in me: part II common psychosocial disorders. *American Family Physician, 6* (1),117-1124


Gender differences in depression: Findings from the STAR*D study. *Journal of Affective Disorders, 2005*(87), 141-150.


