Depression care optimization for men:
A modality based on twenty years of evidence

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ABSTRACT

Men are experiencing double jeopardy when it comes to depression, being at high risk but unable to seek help for their problem. To address this we asked (1) "Why do men not use depression-related health services?" and (2) "How can governments better reach, support, and treat depressed men?". We conducted an evidence review using a framework developed by Arskey & O'Malley (2005). Embase, MEDLINE and PsychINFO were used to find articles published from 1st January 1997 to 31st June 2017. We used a systematic search strategy to identify evidence concerning men's engagement with health services in the context of depressive disorder and then employed a thematic analysis framework developed by Braun & Clark (2006), to chart data and summarize results. Eighteen publications were reviewed, including qualitative studies, quantitative studies, and literature reviews. The recommendations from the papers was synthesized into a 'Depression Care Optimization Modality' consisting of three aspects of depression care (literacy, accessibility, and efficacy) and three key stakeholders (men, the general public, and the national healthcare system). It is the first systematic attempt to formulate a gender-sensitive modality to guide efforts to optimize depression care for men. The modality can be used to guide governments' endeavor to close the depression care gap and improve the quality of life for men, as well as a stepping stone to design more rigorous studies in the field.

INTRODUCTION

Depression in men warrants special attention. Although official statistics have consistently shown that depression rates in men are only half of those in women [28], men are three times more likely to commit suicide [16]. They also exhibit higher rates of alcohol and substance use, violence towards others, and self-harm [18].

This paradox suggests that current depression statistics have excluded a large portion of the male population who, hypothetically, did not reveal their condition or seek treatment. Good & Wood argued that men are experiencing double jeopardy, being at high risk but unable to seek help for their problem [12]. The treatment gap is evident even in countries with free healthcare. In Canada, men used mental health services less than women although their suicide rate was four times higher [17]. “Women seek help – men die”, concluded a Swiss study based on findings that 75% of mental health patients were women while 75% of suicides in the same year were committed by men [4]. The unmet need of depression care for men is a critical public health issue.

This report asks how national governments can better serve men who suffer from depression. It employs an evidence review framework to search for an answer. The review consists of two parts. In the first part, it will uncover why men do not use depression-related services by examining the various dimensions of the complex relationship between men, depressive disorder, and depression care. Building on the insights of part one, the second part will explore potential interventions and the roles different stakeholders may play to improve the health outcomes. Health outcomes are defined as changes in help-seeking behavior and depressive symptoms [8].

The final product of the study is a modality to guide national policymaking as well as future research. In contrast to the popular belief that men do not seek help [2], this study offers a more nuanced view that men will seek help if the help channels are appropriate, accessible, and effective.

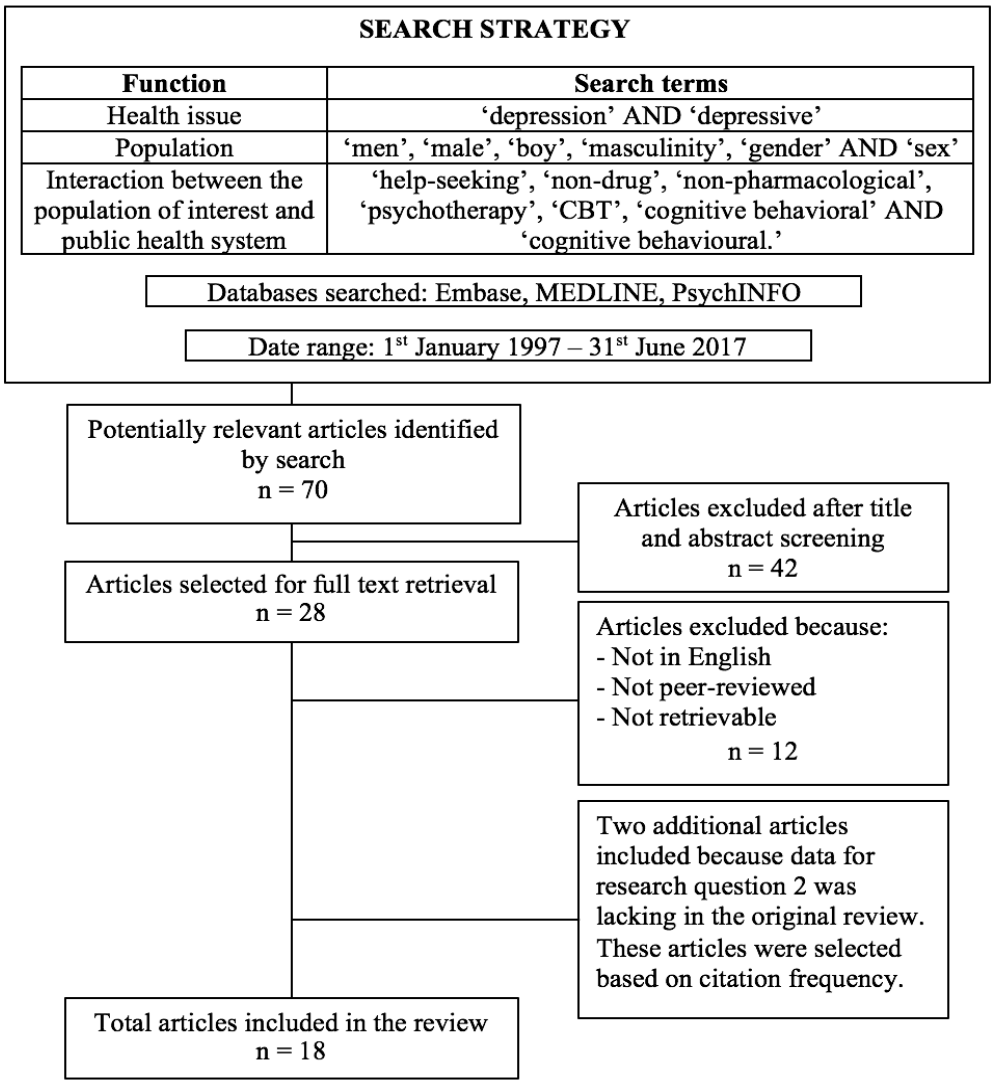
METHODS

Practice in evidence review necessitates an explicit description of the conceptual framework used. As boundary-spanning research, this review uses a framework developed by Arskey & O'Malley (2005) [5], a method suitable for topics with limited evidence. While it makes no attempt to assess the quality of evidence or specific recommendations, it captures the broader principles and practices required to address the complex policy issue of depression care optimization for men.

The methodology involves the following phases:

1. Research Questions – (1) "Why do men not use depression-related health services?"; and (2) "How can governments better reach, support, and treat depressed men?"

Figure 1: Summary of literature selection process



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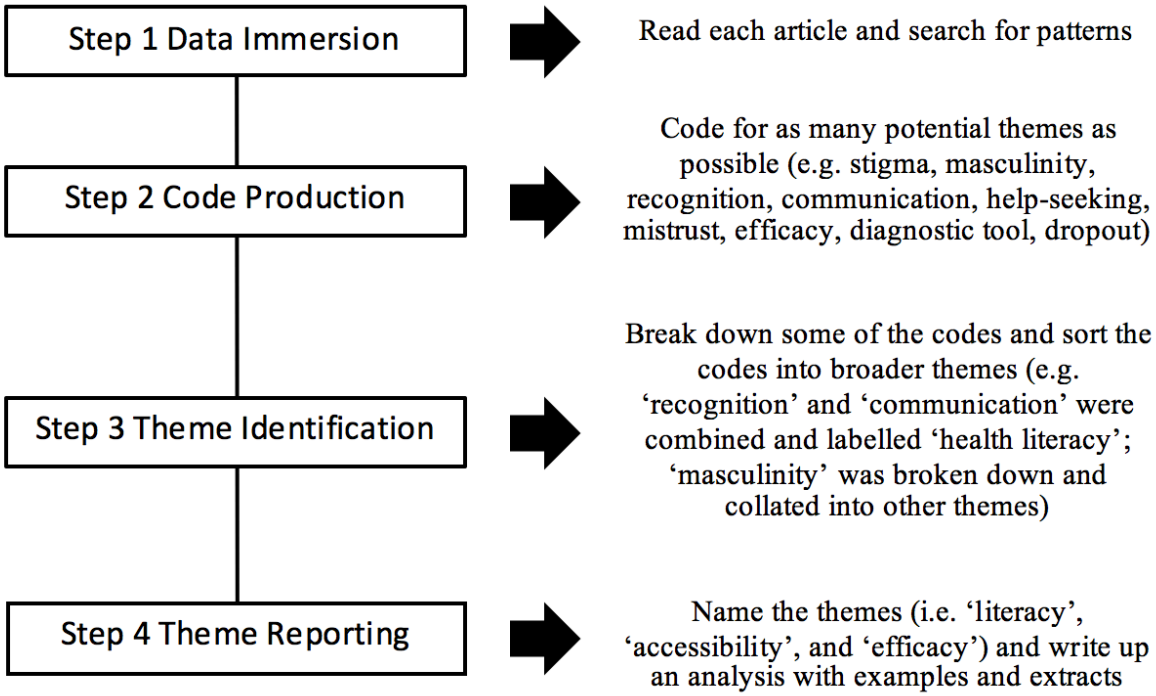
2. Literature Identification – identifying evidence concerning men's engagement with health services in the context of depressive disorder *(Figure 1).*
3. Charting Data and Summarizing Results – employing a framework for thematic analysis developed by Braun & Clark (2006) [6], to identify, analyze, and report themes within the data set. A 'theme' captures something important about the data in relation to the research question and represents a level of patterned meaning *(Figure 2).*

Figure 2: Summary of thematic analysis process



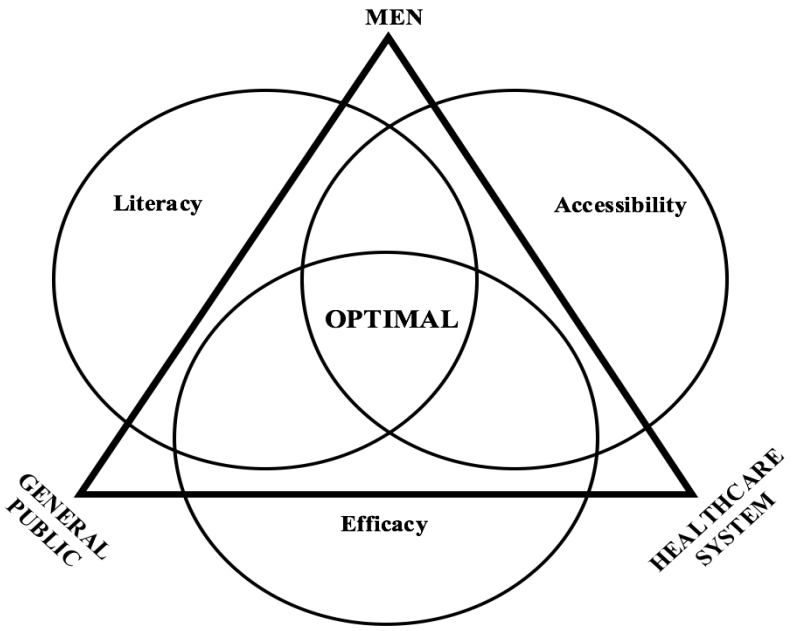
	Literacy	Accessibility	Efficacy
Found in Reference	2, 3, 9, 10, 11, 13, 19, 20, 22	2, 3, 9, 10, 13, 19, 20, 22, 24	1, 3, 7, 11, 14, 19, 21, 22, 23, 25, 26, 28

Source: Author

RESULTS

Eighteen publications were reviewed, including qualitative studies, quantitative studies, and literature reviews. Three themes were identified in relation to Research Question 1: (i) mental health literacy, (ii) accessibility, and (iii) efficacy. For Research Question 2, three stakeholders were identified: (i) men, (ii) the general public, and (iii) national healthcare system. The final product is a 'Depression Care Optimization Modality' consisting of three key aspects of depression care and three key stakeholders *(Figure 3).*

Figure 3: Depression Care Optimization Modality



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Research Question 1 – Why do men not use depression-related health services?

(i) Literacy

Low level of mental health literacy among men is a theme that consistently comes across as important in the literature review. Coined by Jorm et al. (1997), 'Mental Health Literacy' is defined as the "knowledge and beliefs about mental disorders which aid their recognition, management, or prevention" [15]. Mental health literacy has four main components: (a) recognition of risk factors, symptoms, and beliefs associated with mental disorders; (b) knowledge of self-help strategies and the professional help available, as well as how to access them; (c) positive attitudes that facilitate symptom recognition and help-seeking behavior; and (d) first-aid skills to support others who are developing a disorder. Mental health literacy is not simply a matter of possessing knowledge, but having the ability to link that knowledge with actions that benefit one's own health and that of others.

Studies have shown that the depression rates among men are high but many depressed men do not seek help or delay help-seeking for years [e.g. 9, 11, 12]. Even for severe conditions, help-seeking delays lasting months are common [11]. Failure to seek help has serious consequences because the longer the depression is left untreated, the more chronic it becomes and the more difficult it is to treat.

There are several explanations for this dilemma.

1. Recognition: Fourteen studies (82%) included in a systematic review by Seidler et al. (2016) reported that men have difficulties recognizing and understanding depressive symptoms. Other studies supported that men are less adept at recognizing psychological symptoms than women [e.g. 2, 3, 10].
2. Communication: A study of 2,721 participants by Rickwoord et al. (2005) found that men struggle to describe feelings and emotions. They have limited emotional vocabulary and skills required to seek help. As a male participant said, “Sometimes you just can’t find a word to say, even if you do want to talk about it”.
3. Stealth Symptoms: Hammer and Vogel (2010) discussed that depression in men is often masked by externalizing behaviors such as substance abuse, aggression, and withdrawal. These stealth symptoms are common in men but are often not regarded as signs of depression.

(ii) Accessibility

Problems surrounding accessibility were discussed extensively in the studies reviewed [e.g. 2, 9, 13]. Many men were found unable to seek help, even when they recognize depressive

symptoms and have the language to communicate their problem. Two interpretations have been suggested. One is that the stigmas associated with depression discourage men from seeking help. Another is that men are looking for help, but the types of help they are comfortable with are not available.

Fear of stigmas has been cited as a major barrier to men's decision to seek help. According to Möller-Leimkühler (2002), depression is sometimes perceived not as a psychiatric disorder, but as an extension of normal feelings that everyone experiences at some point and can be managed alone. This attitude was argued to be particularly strong among men. Traditional masculine ideals require men to be independent and in control of their emotions. Many men do not seek help because they fear that in doing so, they are less "manly". A more alarming fact is that many men look at help negation as an honorable act. 'Help negation' refers to a decision to not use available help when it is needed. According to Tang et al. (2014), negating help is sometimes seen as a sign of character strength to overcome life's challenges. This pattern has been recorded across cultures and religions [e.g. 3, 9, 22].

Another interpretation is that there is an incompatibility between men's needs and the services being offered – namely that depression-related services are not male-friendly. Seidler et al. (2016) found that men perceived existing psychotherapy options as "feminizing". The process of sharing vulnerabilities and entering paternalistic relationships in psychotherapy made men uneasy. Moreover, it has been argued that the current design of depression care fails to account for the help-negation effect inherent to depression. Chang (2014) cited a study of 9,000 adolescents from various ethnic backgrounds showing that depressive symptoms (e.g. anxiety, fatigue, irritability) induce social withdrawal and loss of

motivation to seek help. As depression becomes severe, men find it increasingly difficult to reach out and articulate their thoughts. Similarly, a large, national study in Canada, cited in Möller-Leimkühler (2002), found that higher levels of depressive disorder are associated with reduced intentions to seek both professional as well as informal help. These social and biological needs may not have been sufficiently factored into the design of depression care.

(iii) Efficacy

The third theme addresses the efficacy of diagnosis and treatment because health outcomes encompass not only the initial act of help-seeking, but also the consultation experience and treatment outcome that take place thereafter. Under-diagnosis of depression in men may be due to ineffective diagnostic methods. Effective diagnosis is dependent on the presentation of symptoms by men. Studies showed that many men express depression in ways that do not correspond to existing diagnostic tests, such as structured interviews based on the APA's Diagnostic and Statistical Manual of Mental Disorder [e.g. 2, 22, 26]. Men tend to limit the disclosure of symptoms, underplay their severity, and understate the magnitude of need. At the same time, male doctors may exhibit gender biases and ignore underlying emotional problems of men's physical symptoms [19]. Symptoms such as alcohol abuse and drug use are not taken as a sign of underlying depression, so the illness is undetected.

Another issue concerning efficacy is treatment adherence. Compared to women, men are more likely to discontinue treatments before receiving an adequate course. In a 12-month study of nine men by Gamero, Vucínovich & Oñate (2010), one-third of the participants left by the fourth month and only one remained for the full period. Compared to women, men were reported to be significantly less satisfied with mental health services [3]. Consequently,

early termination of therapy is common. A systematic review (Seidler et al., 2016) explained that many men dislike therapies because they are 'paternalistic' and involve 'just talking'.

A more fundamental problem is the weak evidence base found in this area. While many treatments have been recommended for use with depressed men, the evidence for adopting a specific option is often poor. For example, Cognitive Behavioral Therapy (CBT), a popular treatment option, has been claimed to be "male-friendly" because it focuses more on behavior and less on emotion [23, 26]. Although this type of claim is relevant, it is essentially an opinion rather than a definitive rationale based on evidence. Few efficacy studies concerning depression care have included gender as a key variable [2, 23]. They also often have small sample size [e.g. 1, 11, 28], suffer from selection bias [e.g. 14, 24, 25], or lack a control group [e.g. 3, 14, 26]. Weak study designs translate into weak claims.

Research Question 2 – How can governments better reach, support, and treat depressed men?

(i) Men

a. Improving mental health literacy

Effective help-seeking behavior requires an awareness of emotional experiences and a language to express them. A low level of emotional competence is a barrier to seeking help, while a high level allows for early detection and timely treatment. Men must be equipped with both the skills to understand their internal worlds and the vocabulary to share their emotional needs with others. This must be done in ways that are culturally acceptable and personally empowering.

Also, men need to be assured that they do not have to abandon masculine values in order to engage in depression care. Spendelow (2015) argued that the concept of masculinity is malleable and can be reframed to allow for integration of depression. Masculinity can be associated with both positive and negative health outcomes. Like other behaviors, depression can be an opportunity for men to demonstrate the healthy aspects of their masculinity. Help-seeking can be framed as a courageous course of action for managing and gaining control over depressive symptoms.

A gender-sensitive brochure is an example of an intervention that can improve men's emotional competence and encourage help-seeking. In a clinical trial by Hammer & Vogel (2010) with a sample of 1,390 depressed men, male-sensitive brochures improved men's understanding of depressive symptoms and the benefit of help-seeking significantly in comparison to gender-neutral brochures. The brochure featured symptoms that characterize depression in men such as aggression, restlessness, and substance use. It used male-friendly language such as "coaching session", "mental health consultant", and "strategy for attacking", as opposed to the conventional clinical language of "therapy session", "psychiatrist", and "treatment". This type of intervention not only demystifies misconceptions around depression but makes the education accessible to the target audience.

b. <u>Raising awareness about help-seeking and help-refusal</u>

Many depressed men engage in unhelpful responses in an attempt to maintain or restore a perceived departure from an idealized model of masculinity; others underestimate their

problem and their need for outside help and attempt to deal with the problem on their own. High rates of suicide attempt and completion in men suggest that help is needed much more than the current frequency of it being sought.

It is important to raise awareness among men that depression is a real illness that can affect any man at any age and, more importantly, is also treatable, especially through early diagnosis and intervention. Help-seeking is wise, whereas avoidance is detrimental. Treating depression through self-medication techniques like alcohol use and social withdrawal is not only unhelpful, but it makes the problem worse.

Plausible interventions are ones that encourage men to challenge distorted or inaccurate beliefs about depression and help-seeking. According to Rickwood et al. (2005), anticipating signs that may lead to help-negation (e.g. optimism bias and self-stigma) can decrease the probability of help-negation. Teaching men about the tangible benefits of early detection and treatments may also be beneficial. Chang (2014) emphasized that the values of help-seeking should be promoted together with the harm of help-negation.

(ii) General Public

a. <u>Improving public attitudes toward depression care for men</u>

Studies showed that men often rely on their families and social network in coping with psychological distress [e.g. 9, 20, 23]. Seidler et al. (2016) found that speaking to doctors is least preferred by men, while discussing symptoms with a mother or female partner is most preferred. Other potential sources of social support are teachers, sports coaches, and youth workers for those who are still in schools. For those no longer in school, the roles of religious

and community leaders are important. These individuals are in a unique position to offer first-aid support and help depressed men to access professional health services. The role of non-health professionals is particularly relevant in certain cultures, such as Chinese culture. It was reported that Chinese people tend to view mental health professionals as an undesirable last resort [9].

Chang cited several studies showing that positive attitudes transmitted by family and peers facilitate men's help-seeking behavior. Additionally, social support in itself can serve as a stress buffer, protecting men from the potential damages of a stressful situation. Cruess (2002) referred to Cohen & Wills (1985) who found that individuals who are integrated socially tend to have reduced stressors and faster recovery from depression.

Ensuring positive attitudes of the public toward depression care (e.g. "seeking help is appropriate for men" and "various help channels are available") is critical. Hammer & Vogel (2010) proposed the use of modern marketing strategies to cultivate accurate and positive public attitudes toward depression care. Rickwood et al. (2005) recommended that mental health education be incorporated into school curriculum.

b. Equipping people with knowledge and skills to support their loved ones

In addition to having positive attitudes, people need to be equipped with the technical knowledge and practical skills required to support their loved ones. Non-health professionals, especially family and friends, play important roles at different stages of a man's life. They can help to promote mental fitness, intervene when depressive symptoms develop, and ensure treatment-adherence in men.

Rickwood et al. (2005) discussed that an intervention may involve training family members and peers to understand and recognize depressive symptoms in men. It may include practicing support strategies, such as how to point out depressive symptoms without being judgmental (e.g. “you always seem to get stomach pains before work” or “you haven’t played golf for months”). Seidler et al. (2016) found that men tend to be less comfortable with verbal forms of emotional expression and prefer physiological means such as writing, facial expression, and body movement. The use of non-verbal tools (e.g. guiding men to write down a list of symptoms) may be another useful form of support.

Importantly, the training must emphasize the rights and empowerment of men, ensuring that all interventions are non-stigmatizing [23]. One tactic is the careful use of language. Men often struggle to accept their depressive symptoms. Helpers may avoid the “depression” label at the onset and allow them to come to the conclusion at their own pace.

(iii) National Healthcare System

a. *Normalization strategies to reduce stigmas surrounding depression care*

Men often underestimate the extent to which their peers are accepting psychological help. Health professionals can help to correct the distorted stereotype that real men do not seek help and normalize depression care when working with male clients. According to Addis & Mahalik (2003), assuring male clients that seeking help is normal can encourage help-acceptance.

Another strategy is to reframe the act of help-seeking to align with traditional masculine values. Spendelow (2015) cited Kilmartin (2005) who argued that the concept of 'courage' can be represented by going against the gender stereotype, 'independence' by not following the crowd, and 'leadership' by taking initiatives to seek help. Similarly, Hammer & Vogel (2010) suggested that health professionals may commend male clients for their courage required to come to a counseling service, or note that by taking care of themselves they retain the strength to help others. An alternative strategy is to clarify the biological basis of depression: depression can be caused by an imbalance of brain chemicals. This can help demystify the misconception that depression is a result of weak personal willpower.

b. Redesigning the therapeutic setting and relationship

The most effective therapeutic settings are ones that are confidential, easy to access, and personally acceptable to men. Compared to specialized mental health care, primary care, as a setting, is associated with less stigma and more accessibility. Male predominance in using primary care has been recorded in a study by Alosaimi et al. (2014). One plausible intervention is to integrate mental health services into primary care. Other studies propose a provision of services through anonymous avenues, such as phone and the internet [e.g. 14, 20, 22]. These settings are believed to be attractive alternatives for those who avoid the conventional healthcare system. Hausner, Hajak & Spießl (2008) demonstrated in their study that a serious, scientifically-oriented website is particularly appealing to men.

Men with greater difficulties of emotional expression often have poorer therapeutic bonds with their therapists, which reduces treatment effectiveness and treatment-adherence. In response, Rickwoord et al. (2015) recommended that health professionals move beyond the

traditional therapeutic approach (eradicating 'the bad') and toward strategies that capitalize on strengths and virtues (promoting 'the good'). That is, a move away from addressing what is wrong with men toward identifying the qualities that empower men to improve themselves and society. Health professionals must recognize existing strengths, capabilities, and skills present in men, and see men for who they are rather than who they are not. To illustrate, when discussing the nature of counseling with male clients, counselors might frame the process as a solution-oriented, cost-effective, and patient-directed team effort. Men favor collaborative interventions involving power-sharing and problem-solving [13]. Instead of describing counseling as a time for sharing vulnerabilities and emotions, counselors might use masculine language, such as "tackle the problem", "defeat depression", and "team up".

CONCLUSION

The emerging policy issue of depression care for men warrants boundary-spanning research to inform national policymaking. This study has considered a range of evidence concerning men's experience with depression and what may work to reach and treat them. The product is a 'Depression Care Optimization Modality'. The modality consists of three aspects of depression care (literacy, accessibility, and efficacy) and three key stakeholders (men, the general public, and the national healthcare system). Improving the mental health literacy of men as well as their social network is essential. Men are more likely to seek help when they realize that their masculine ideals of courage, strength, and autonomy can be affirmed in the process. Families and peers can assist men in various stages of depression care. They can help men recognize symptoms and access help. Aligning health services with men's preferences is also critical. Depression care needs to be male-friendly. In particular, those working with men

need to use the right language and take a ‘positive’ approach that views men as assets, and partner with them at as many levels as possible.

Central to the modality is the partnership between men, the general public, and the healthcare system. These stakeholders have key roles to play in improving the health outcomes for men. Effective partnership requires that all parties coordinate a positive approach that caters toward the needs of men.

This study offers a systematic yet concise account of available evidence over a period of twenty years. The modality can be incorporated within broader national policymaking processes to develop gender-sensitive, evidence-informed interventions. To the author’s knowledge, this is the first systematic attempt to formulate a gender-sensitive modality to guide depression care optimization for men. Gender-sensitive policymaking has mainly focused on women, because women are traditionally believed to be an underserved population. By arguing that men are also underserved, this study attempts to change the paradigm.

Furthermore, this modality can be used as a stepping stone to design more rigorous studies in the field. As evidenced by the literature identified in this study, there are many methodological issues inherent in the existing research in this field: weak study design, small sample size, participant dropout, sampling bias, and reporting bias. Notable problems include studies that had as few as a single participant or high drop-out rates, most participants self-selecting to be in the study, and a heavy reliance on self-reporting as a measure of outcome. Also, economic evaluation was completely absent although cost-effectiveness is a serious

consideration in a policy process. Healthcare is provided within a finite budget. Governments are required to allocate resources to different groups equitably and efficiently, in a way that maximizes health outcomes for the whole population. These issues call for more proactive research. This study serves to guide the endeavor. The goal is to close the depression care gap and improve the quality of life for men.

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