CONSULTATION WITH MEN: A MATTER OF GUESSWORK

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Abstract

To investigate men's experience of depression, coping styles and help-seeking behaviour, we recruited a non-clinical sample of male teachers and students from sites of a tertiary education institution, to a series of focus groups. Quantitative methods were used to gather sociodemographic and behavioural data, and two standard measures of mood and dispositional optimism. Qualitative data were analysed using a grounded theory approach. Women were recruited from the same context, as a comparative group. The findings suggest that men have a tendency to suppress their problems and emotions, which is translated into delayed help-seeking. When men eventually do (or are forced to) seek help for physical symptoms, any depressive symptoms can be overlooked because of men's reticence to disclose, coupled with their view that doctors should be 'smart enough' to read the signs. The doctor-male patient relationship appears to be a subtle, yet complex, dynamic process. The challenge for doctors is to employ new methods of non-threatening questioning within a safe environment in order to facilitate self-disclosure in men.

Keywords: Depression; men; focus groups.

Introduction

Depression in primary care is common but detection rates are low (Blacker & Clare, 1993). Of concern, patients who present with depression in primary care are thought to be roughly equal to those who go undetected or unrecognised (Paykel, 1989; Simon et al. 1999a; Arthur et al. 1999; Kessler et al. 1999). Of interest, Good et al. (1987) and Brody et al. (1997) found most patients considered it appropriate to turn to their doctor for help with emotional distress, but only a minority did so (Good et al. 1987).

We hypothesise that more men than women fall into the 'undetected' group of primary care patients because some symptoms and coping styles are less likely to be detected in men under the commonly accepted rubric of depression. We sought to investigate men's experience of depression, coping styles and help-seeking behaviour through the language used by men. While the emphasis is men's experience, groups of women were also included to identify common experience for both sexes, and to determine what issues seemed more confined to men.

METHODS

Sample

Male teachers and students were recruited from campuses of the Institute of Technical and Further Education (TAFE). Female teachers and students were recruited as a comparative group.
Quantitative method
The pre-focus group questionnaire measured sociodemographic information including age, marital status, teacher/student status, full-time/part-time teaching or studying, dependents, whether from a non-English speaking background, behavioural variables including alcohol and cigarette use, and participants’ self-rated health out of 10. Two short standard measures were used to measure mood, (the Positive and Negative Affect Schedule [PANAS]: Watson et al. 1988a; Kercher, 1992), and dispositional optimism, (the Life Orientation Test [LOT]: Scheier & Carver, 1988b).

Qualitative method
Focus groups were used to generate discussion and provide "new" information (Kreuger, 1988; Morgan, 1993) about men's experience of depression. Ten focus groups were conducted with men across four sites. Four focus groups were conducted with women at two of those sites, to provide comparative data. The discussion schedule related to the physical and emotional effects of depression, coping styles, and help-seeking. The data was analysed using a Grounded Theory approach (Strauss & Corben, 1990).

RESULTS
Seventy-seven males participated in this study. The average age of male teachers and students was 48.4 (SD 5.5) and 20.4 (SD 3.8) years, respectively. Twenty-five females participated in this study. The average age of female teachers and students was 46.1 (SD 6.1) and 37.6 (SD 14.2) years, respectively.

DISCUSSION
What happens to men who are depressed, and how do they cope?
These men identified symptoms (in themselves and observed in other men) commonly accepted in the rubric of major depression, such as lethargy, loss of concentration, changed sleeping and eating patterns (American Psychiatric Association, 1995). However, they also identified additional signs of a 'build up' or escalation of affect in men triggered by an external negative event.

Men's tendency to discharge distress through action is precipitated by feelings of being out of control and may result in risk-taking behaviour such as road rage, violence, aggression, attempted or completed suicide. This risk-taking, destructive behaviour had more salience for the younger men.

These men also identified an 'escape' coping style, common in men, of avoiding or numbing problems with alcohol or drugs, such strategies also known as "depressive equivalents" (Beck, 1967; Real, 1997; Cochran & Rabinowitz, 2000). The older men, either by a maturing effect, having direct negative experience of risk-taking, or having family responsibilities, tended to curtail their behaviour, adopt other 'escape' behaviours, such as increased hours spent at work (under the guise of conscientiousness), or act out of character, for example, reverting to adolescent behaviour, or engaging in extramarital affairs.

In coping with depression, men's tendency to escape from, avoid or defer dealing with emotional problems is translated into delayed help-seeking. These men say they have been conditioned to think that seeking help is a sign of weakness (Heifner, 1997; Levang, 1998), but they also admit they should seek help earlier than they would normally do.
What can doctors do to detect depressive symptoms in men?
Male patients may be reticent to self-disclose to male doctors unless a trusting relationship has been established either over time, or by sensitively asking the 'right' questions (related to work and family/relationships) in the 'right' way (using an indirect questioning route) in a non-threatening manner. The presentation of somatic symptoms or change in lifestyle behaviour provides the signal for doctors to employ this type of questioning. The patient needs to open up otherwise he will depart the consultation with the physical symptoms 'fixed' but still suffering in emotional isolation.

What can men do to facilitate the consultation process?
Social conditioning of 'boys don't cry' has dissuaded, discouraged or prevented men from seeking help and relief from the symptoms of depression. Men need to tackle (rather than avoid) emotional problems by acknowledging and reporting them (Warren, 1983), and then 'working on them' with others before they 'build up' and become serious. Locating the cause will also help to take the guesswork out of the assessment process for busy doctors.

What can we learn from women about men who are depressed?
A noteworthy insight from women in this study was that they perceive men drink alcohol to conceal or mask their feelings. Women see men as using alcohol as an excuse to express themselves, or because it makes them feel 'less stupid' to talk about their experience and what they are 'feeling'. They agree that social conditioning (perpetuated by men) has contributed to the stereotypical behaviour of the suppression of emotion (Miller, 1976) resulting in a negative effect on men, and those closest to them.

An unexpected observation in this study was that both men and women focussed on the limitations of coping styles in the other gender. However, men and women have a complementary role to play in helping each other to cope with depression by appreciating and maximising the other's strengths, that is, as men 'think', and women 'feel', emotions (Gilligan, 1982). In other words, men have the capacity to modulate women's emotional expression while women have the capacity to draw out men's thoughts on their feelings.

CONCLUSION
The proposition that women suffer from depression at twice the rate of men may prove misleading because men's coping styles may be different to women's. We are proposing that men have some expressions of depression that are overlooked or not presented in the clinical context. The narrow "window of opportunity" that exists for detecting depression in men in primary care leaves little room for guesswork.
REFERENCES


