
Male Midlife Depression: Multidimensional Contributing Factors and Renewed Practice Approaches La dépression d'âge mûr chez l'homme : facteurs contributifs multidimensionnels et approches pratiques renouvelées

Debbie L. Grove
University of Calgary

ABSTRACT

Based on original doctoral research conducted with midlife women and men who completed counselling for depression, this article presents research findings of male participant perspectives and experiences in managing midlife depression and the role of counselling. Hermeneutic inquiry using conversational semistructured interviews generated multiple discoveries. Individual differences in sociocultural, relational, and environmental dimensions shaped the course of depression. Stress, low self-awareness, lack of strategies, and regrets negatively impacted depression management. Self-directedness, collaborative therapy, and use of multiple resources facilitated management. Findings suggest an integrated practice approach to address individual differences in midlife issues, role strain, stress, and past adversity.

RÉSUMÉ

Se fondant sur une recherche originale de niveau doctoral auprès de femmes et d'hommes d'âge mûr ayant suivi des séances de counseling pour cause de dépression, cet article présente les résultats de recherches concernant les perspectives et expériences des participants masculins dans leur gestion de la dépression d'âge mûr, ainsi que le rôle du counseling. Le recours à une approche d'enquête herméneutique faisant appel à des entrevues conversationnelles semi-structurées a permis de faire plusieurs découvertes. Des différences individuelles dans les dimensions socioculturelles, relationnelles, et environnementales ont influencé la trajectoire de la dépression. La gestion de la dépression a subi des influences négatives liées au stress, à une faible conscience de soi, au manque de stratégies, et aux regrets. L'autonomie, la thérapie collaborative, et l'utilisation de multiples ressources ont facilité la gestion. Les résultats suggèrent une approche de pratique intégrée pour la prise en compte des différences individuelles dans le cas des problématiques de l'âge mûr, de la tension de rôle, du stress, et de l'adversité antérieure.

Depression has been viewed as a key indicator of mental health in midlife (Deeg, 2005). According to Gilmour and Patten (2007), 4% of employed Canadians between the ages of 25 to 64 experienced depression during the preceding year, while only 3% of working Canadians experiencing depression sought counselling (Ipsos Reid, 2007). In their research regarding depression literacy in Alberta, Wang et al. (2007) concluded, among other findings, that mental health promotion geared to men was needed. Another Canadian-based research study conducted by Wang et al. (2005) reported the need for enhanced national initiatives target-

ing mood disorders. Women are twice as likely as their male counterparts to seek help for depression (Cyranowski, Frank, Young, & Shear, 2000; Good & Wood, 1995; Heifner, 1997; Robbins, 2006), but men outnumber women two to four times in suicide attempts resulting in death (Cochran, 2001; Möller-Leimkühler, 2003; Murphy, 1998). The World Health Organization reported that depression will be the second leading cause of disability worldwide, behind heart disease, by 2020 (Murray & Lopez, 1997). By 2030, it is predicted that depression will be the largest contributor (World Health Organization, 2008). More recently, on Mental Health Day, October 10, 2012, the World Federation of Mental Health published *Depression: A Global Crisis*.

“One of the most consistently documented sex differences in incidence of psychological problems is depression” (Cook, 1990, p. 372). Because men seek help less often than women, their depression tends to be underdiagnosed (Cochran & Rabinowitz, 2003; Kilmartin, 2005). Researchers have suggested that although men and women have similar depression symptom profiles, they differ in how they present symptoms and how they cope with depression (e.g., Cochran & Rabinowitz, 2003; Pollack, 1998). Rochlen, Whilde, and Hoyer (2005), however, posited that depression for the sexes is stereotyped. Gendered conceptualizations of depression could constrict the broader context of depression. Nevertheless, the unique aspects of male depression have important considerations for counselling and counsellor training and development.

Confronted by this picture of depression in Canada, I focused my doctoral research on investigating counselling efficacy for midlife depression with an emphasis on questions related to depression self-management, therapy outcome research, and adult learning. I was particularly curious about individuals’ experiences of managing depression once counselling had ended. My hermeneutic inquiry involved 15 conversational semistructured interviews with midlife women and men who had completed counselling for depression. This article presents the perspectives and narratives of the 6 men who participated in the study. Their experiences further our understanding of male midlife depression, stretch traditional practice paradigms beyond standardized treatment, and invite us to discuss renewed practice approaches.

MAPPING THE COURSE OF MIDLIFE DEPRESSION: BRIEF SURVEY OF THE LITERATURE

Midlife, as a life stage construct, has been associated with a range of ideologies including crisis (Erikson, 1963), decline (Frenkel-Brunswick, 1968), and expressivity and individuation (Jung, 1933). Stereotypes have developed around this stage of life that depict men as being in pursuit of youth and depict women as being concerned about aging (Stoppard, 2000). Midlife has been conceptualized as a time of generativity (McAdams, de St. Aubin, & Logan, 1993), adapting to life transitions (Hudson, 1999), and taking stock of life’s gains and losses (Goldstein, 2005; Heckhausen, 2001; Lachman, 2004). Midlife is generally between the ages

of 35 and 65 years (Staudinger & Bluck, 2001; Willis & Martin, 2005). Life-work stressors and long work hours (Galambos & Walters, 1992), care for elders, finances, household and family responsibilities, occupational issues, and health risk factors are prevalent during midlife. The course of depression has also been linked to the effects of early exposure to stress, adversity, and family functioning (Cummings & Davies, 1999; Rahman, Iqbal, Bunn, Lovel, & Harrington, 2004; Weissman et al., 2005). Health risk factors are associated with exposure to prolonged periods of stress (e.g., Sharpley, 2009). Poor responsivity to stress negatively impacts problem-solving, coping, flexibility, adaptability, and sense of control (Pettit & Joiner, 2006).

Multiple Roles During Midlife

“Exposure to stressors can affect people in innumerable ways. These effects can be physical, psychological, and social, they may be subtle or dramatic, and they may occur immediately or manifest themselves over the course of a lifetime” (Cleary, 1987, p. 39). Some researchers (e.g., Peterson & Wilson, 2004) have pointed to North American cultural values such as individualism, competition, capitalism, and a demanding work ethic as factors contributing to depression and health issues. Stress in one life domain spills over into other areas (Goldstein, 2005; Lachman & James, 1997). Buffers for stress include level of support and the quality of relationships (Greenberger & O’Neil, 1993). People respond differently to stress, including differences in their physiological threshold for stress (Sapolsky, 2004). Too many roles can deplete energy and well-being (Skaff, 2006), whereas too few roles can be isolating.

Gender role conflict contributes to stress and depression when a life role is overly defined by gender and restricts how one would prefer to navigate daily life (O’Neil, 1990; Robinson, 1999). The impact of multiple roles and the demands inherent in midlife have predominantly been discussed in the depression literature related to women’s health. If we are to better understand and work with male depression, a more in-depth analysis of contributing factors is essential. Mahalik and Cournoyer (2000) linked internalization of restrictive gender roles to limited emotionality and increased work-family conflict for depressed men. “Men’s conflicts and stresses related to male gender roles also have been theoretically and empirically associated with increased depression and psychological distress” (Good & Wood, 1995, p. 70). The pressure to attain traditional forms of success defined by male gender roles impacts well-being (Good, Dell, & Mintz, 1989; O’Neil, 1990). In light of this previous research, an examination of the impact of gender role conflicts and the impact of multiple-role stress would be helpful in attaining a deeper understanding of how men experience and manage depression.

How Does Change Happen for Depression?

“As the public becomes increasingly psychologically sophisticated and aware of multiple treatment options, the fit between a client’s preferred approach and the therapist’s provision of a specific treatment rationale will become all the more

important” (Addis & Jacobson, 2000, p. 324). Anderson (1996) referred to being in sync with clients. Because clients are the ones who make change happen (Bohart, 2000; Bohart & Tallman, 1996, 1999; Duncan, Miller, & Sparks, 2004; Maione & Chenail, 1999; Tallman & Bohart, 1999), what works for them in counselling is privileged over a preferred counsellor modality. Further supporting this notion is research evidence that there is no one best approach for treating depression (e.g., Shapiro et al., 1994). The National Institute of Mental Health (NIMH) Treatment of Depression Collaborative Research Program (TDCRP) study reported that various treatment approaches obtained similar outcomes (Asay & Lambert, 1999; Elkin et al., 1989).

APPROACH TO INQUIRY: GADAMERIAN PHILOSOPHICAL HERMENEUTICS

When I embarked on finding a best fit, Gadamerian philosophical hermeneutics, an interpretive mode of inquiry, addressed how I wanted to explore midlife depression and counselling. I preferred to honour participants’ experiences in a way that captured both in-depth and broad considerations. I also knew that my interpretive lens as a counsellor could not be bracketed. I imagined that findings would somehow contribute to renewed practice approaches. Given that verbatim transcripts were my data, I needed a qualitative method that would address the dynamics of conversation and language and the role they play toward understanding. To learn more about this method, a few suggested sources include Gadamer (1960/2004, 1976, 1988, 2001, 2006); Johnson (2000); McKnight (1973); and Schwandt (2000).

Participant Recruitment: Seeking Experts on the Topic

Following ethics approval from the Conjoint Research Ethics Board of the University of Calgary, participant recruitment began. Purposive (Byrne, 2001) recruitment of individuals (between 35 and 55 years of age) who had completed (or were close to completing) counselling for the primary presenting concern of depression was conducted. Invitation letters were mailed to 24 counselling centre executive directors in western Canada. The five centres that participated were mailed a thank-you letter and recruitment poster sheets; these sheets were also given to those individuals interested in participating. In order to broaden recruitment, ads were placed in health and wellness magazines, in online newspapers, on university and college campuses, and on counselling association websites. Participants who volunteered for the study were mailed a Written Consent Form and a Demographic Information Form and were requested to complete and return these prior to the research interviews.

The Hermeneutic Conversation: Gathering Data

Six semi-structured conversational interviews were conducted with midlife male participants (age range = 35–55 years). At the time of the study, 3 of the men were single, 2 were married, and 1 was divorced. Three of the participants

completed individual counselling for depression, and 3 completed both group and individual counselling.

Interviews ranged in length from 1 hour to 2.5 hours. Some participants stated a preference for a telephone interview or an online synchronous interview, and these preferences were honoured. A Sony digital voice recorder was used. An interview guide was employed; however, depending on the direction in which participants took the conversation, new and follow-up questions were added in order to enhance understanding (Cohen, Zahn, & Steeves, 2000). Kvale (1996) described conversational interviewing as a way to achieve multiple perspectives because it is inviting, open, exploratory, dialectical, and not overly directive and structured. The hermeneutic interviewer (van Manen, 2002) remains open to where conversations go (Geanellos, 1999). This style does not mean a less rigorous focus on the topic; rather, it calls for staying mindful of addressing the research questions and fostering conversational dialogue.

Data Analysis and Synthesis: Surveying Individual Parts and Horizons

I tracked emerging ideas, discoveries, and new questions during, following, and between interviews and personally transcribed all interviews. This time-consuming task was an invaluable part of data analysis and provided a re-experiencing of my conversations with participants. Transcription provided an opportunity to attentively listen for meaning communicated through diction, tone, affect, attitude, and language use (Love, 1994). I used the hermeneutic circle to analyze and synthesize emerging findings. This meant exploring the interconnectedness of parts and wholes, a continual movement among horizons, and allowing a deepening of understanding to take place (Cohen et al., 2000). For example, parts include participants' use of language within the whole of an interview and within a specific life event against the backdrop of a life narrative. According to Gadamer, we make sense of the world through certain fusions or points of view (Lang, 1999). Breadth and depth of understanding arise from multiple perspectives and sources. Horizons are influences in the background such as assumptions, ideas, meanings, and experiences that intersect to create meaning. Each participant and I brought our unique horizons to our conversations. My role as researcher was to honour their original horizons, not modify or validate them.

Prolonged Engagement with the Topic: Rigour and Trustworthiness

A strength of hermeneutic inquiry is its rigorous engagement with the topic. The trustworthiness or rigour of qualitative research includes its credibility, transferability, and dependability (Koch, 1994; Kvale, 1995; Lincoln & Guba, 1985). Data synthesis entailed prolonged engagement (Byrne, 2001) at various points with the literature review, in-depth interviews, and intense analysis of the verbatim transcripts. I reviewed all transcripts multiple times while keeping the extant research literature and research questions close at hand. Each verbatim transcript was an individual Word file, stored in a secure computer file. The initial survey generated a rough diagram of circles of emerging ideas based on all sources of data.

As the process unfolded, electronic transcripts were transformed into an array of highlighted colours depicting discoveries (e.g., emerging metaphors, chapter title ideas, global and specific responses to research questions).

DISCOVERIES: MULTIDIMENSIONAL PATHWAYS TO DEPRESSION
AND WINDING ROADS TO SELF-MANAGING IT

My research findings generated new discoveries and continued the discussions of past research in such areas as the effects of childhood adversity on lifetime depression. Participants brought to life Grams' (2001) concept of continuity and Gadamer's (1960/2004) metaphor of life histories as a continuing chain. Their life narratives depicted a rich tapestry of sociocultural, familial, relational, and environmental aspects contributing to depression. Adolescence was presented as a pivotal age for the onset of depression. Childhood adversity included alcoholism in the parental home, discrimination and prejudice, and family conflict. Mono-cultural communities were discussed by one participant as an oppressive force in the formation of his depression. The men highlighted the absence of intervention and supports growing up, partly due to their silence about depression. They communicated their experiences of loss including divorce, employment, income, self-esteem, career direction, meaning, and sense of purpose. Participants brought to light areas in which counselling fell short and the self-directed strategies that were helpful. The diversity of approaches that participants used to help manage depression speaks to the individual nature of depression. For the purpose of this article, the verbatim transcript excerpts have been shortened. Because most participants preferred a pseudonym not be used, the term "participant" was chosen.

Continuity of Earlier Life Experiences and the Effects at Midlife

In the passages that follow, participants connected childhood and adolescence to the onset of depression. Distal experiences of low self-esteem, learning disabilities, prejudice, and household conflict were depicted as impacting depression management in midlife:

Everybody was saying I have low self-esteem over the years ... I don't know how to get out of it, how to bring yourself up, especially when you're brought up like that, you just carry on. If your parents are always down and negative on you, you just keep going like that.

This participant shared the effects of alcoholism in his home growing up:

My depression started in my 20s, and when I turned 40 is actually when I was diagnosed and went on antidepressants ... For me, I know a factor was growing up in an alcoholic family.... I remember throughout my 20s and 30s kind of always searching outside of myself for meaning and purpose.... My dad was the alcoholic in our family.... I thought maybe he was coping with depression or his own unhappiness through alcohol.... So, within my home life, I could

have control and that's probably why I live alone and I'm not married and I haven't had a family. It was the need to maintain some control.

Beesley and Stoltenberg (2002) reported that conflict and alcoholism in the family generates a need for environmental monitoring and control seeking. The next participant depicted how a confluence of challenges such as poor school supports, low self-esteem, and living in a monocultural neighbourhood shaped the depression he has experienced across his life:

If I had teachers that were trained to detect learning disabilities rather than just shove me off in a corner.... There's so many things that could have been prevented that would have just benefited me.... I was between the age of 12 and 15 with an inability to express myself.... no one was helping me.... I just knew that I was angry.... the subculture in the community that I grew up in, it's like what Orange County is to the city of Los Angeles; you either belong or you don't belong.... If you're not the perfect jock, not the perfect academic at the same time and you have a disability or something that you're lacking, you are automatically put in a different category.

Research has shown that neighbourhood characteristics affect well-being and mental health (O'Campo, Salmon, & Burke, 2009). Educational encounters influence how learning is perceived later in life (Michie, Glachan, & Bray, 2001). The above participant discussed how returning to school as a mature student triggered low self-esteem and confidence and reminded him of earlier negative educational experiences. Similarly, in the following excerpt, another participant connected difficulties that began during early adolescence and continued into adulthood:

I'm going through a pretty key point of my life here, this hasn't just started; this is not something that started even five years ago.... I think this [depression] has been going on since I was 12 or something. These thought patterns that I have where I really minimize myself and minimize what I do.... Then I lived a lot of my adult life drinking and doing some drugs.... I remember being back in engineering school and I was an older student because it was my second stint at university. I flunked out the first time.

Growing up with family conflict (Gilman, Kawachi, Fitzmaurice, & Buka, 2003; Ross & Mirowsky, 1999) and alcoholism in the home can contribute to low self-esteem (Anda et al., 2002; Steinhausen, 1995). Landerman, George, and Blazer (1991) suggested that prolonged adversity during early life decreases ability to manage stress.

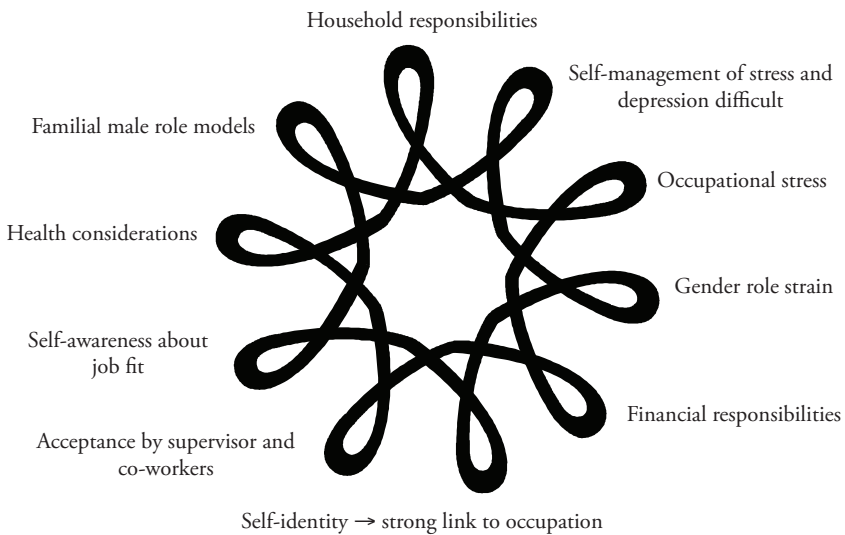
Confluence of Gender Strain, Stress, and Depression

When men internalize representations of "success," they can experience gender role strain (Mahalik & Cournoyer, 2000). Male identity is often strongly connected to performance expectations and career (Heifner, 1997). Depression has been connected to restrictive gender norms and pressure to conform (Cook, 1990;

Good et al., 1989; Good & Mintz, 2005; Good & Wood, 1995; Heifner, 1997; O’Neil, 1990). Figure 1 conceptualizes my conversation with one participant and helps communicate the competing demands some men experience during midlife. Below is part of our conversation as he discussed a challenging time in his life:

I’m a professional engineer.... then I’ve got like some real world issues with the house to deal with like we need a new roof, I may or may not be going back to work in a month.... I’m saying I’m a bad person.... It’s been like that for so long and it’s like a wheel caught in a rut, so hard to get up out of that rut.... Do I put myself back in that position and do the best I can to manage it [job] and accept it and fully inform my workmates and my supervisors about my mental health position.... Or, do I just forego that professional career and look for a job as a manual labourer somewhere.... why put yourself under so much stress, stop trying to put a round peg in a square hole.... Yes, you can live on a little less money, you don’t have to worry about it every night.

Figure 1. Midlife Transition, Stress, and Role Strain Interactions (adapted from original, Grove, 2011)



During our conversation, the following participant compared himself to family members and male role models, concerned that he had not achieved the same successes. As his experience of burnout and depression highlights, “purpose and identity” that come solely from one’s occupation can lead to burnout when the job is overly demanding:

Work's always given me my purpose and identity and so what I did was a big part of my identity.... I had a fairly demanding job... quite often by the end of the week, if I put in excess hours, I would be pretty exhausted and would want to be alone and do nothing. I've learned I have a different perspective and a different balance now.... I ended up leaving.... I just burnt out and I had a hospital admission for depression and suicide and I just had a breakdown and was totally burnt out and saw no way out, I was very unhappy.... I had about a year off work.

Burnout and depression in the context of work (Bakker, Demerouti, & Euwema, 2005; Demerouti, Bakker, Nachreiner, & Schaufeli, 2001) is often exacerbated by having too many roles. At the same time, however, work identity can foster a sense of purpose and meaning. Next, when too many roles and responsibilities are combined with a demanding job and concern for a loved one, stress and depression can be the result:

It was the stress that caused a lot of this stuff that ended up in depression. It was bad, there was just chaos and I didn't realize it. I knew home was busy, but I never realized how much I do.... how much I do outside of work and at home.... And then my wife went through depression, but she made it through, but I picked up all the slack in the home.... I think I would have made it through, but work was just so overwhelming.

It appeared that life-work balance was very difficult for participants, with career a key contributor to stress and depression. In some instances this was a breaking point, leading to burnout, hospitalization, divorce, suicidality, and financial loss. This suggests insufficient resources to meet the demands of life. For some participants, this meant a "wake up call" to find ways to reduce stress, change jobs, and consider alternatives.

When the Bubble Bursts: How Men Learn to Manage Stress and Depression

Participants shared their insights and perspectives about counselling efficacy and specifics about how they came to reduce and manage depression. Counselling was presented as less helpful than other forms of help (e.g., personal development workshop). In most cases, a single form of intervention was not effective; instead, participants discovered what worked through experimenting with different resources (e.g., counselling, self-help materials, group therapy, and the Internet). The therapeutic relationship influenced whether or not counselling was helpful; in turn, poor alliances tended to sway participants toward self-directed activities.

SELF-DIRECTED AND EXPERIENTIAL LEARNING TO MANAGE DEPRESSION

Interestingly, learning about depression triggers was predominantly accomplished through learning by experience, reading self-help materials, and accessing the Internet. Participants did not report learning this in counselling. Below are two examples:

What I've learned is that although I had that perseverance and drive when I was younger, I didn't realize how depressed I was and I didn't recognize those symptoms in myself, and what I'm learning now is that anger ... recognize that it is a symptom of depression.

Yesterday I didn't have a good day. I spent the whole day on the computer on the Internet. That's the classic thing and my mood gets terrible, I feel worthless, and yesterday was just a case in point and then I find it so hard to intervene on myself and stop that behaviour.

Implications for counselling include the importance of helping men gain and maintain increased self-awareness. For example, Zuroff, Blatt, Krupnick, and Sotsky (2003) reported that "self-identification" increased clients' "adaptive capacities" to manage stress. In my study, participants able to discuss specific steps also tended to more effectively manage depression. Again, they tended to learn these strategies on their own:

To just snap out of it if I'm thinking about something that happened yesterday that was bad. Just get out of that and move into what you're doing now, what you're experiencing now. I drive a lot with the kids and I just enjoy what we're seeing, so many beautiful things in life.

I can't handle too much emotional stress ... I have learned a lot about myself and as well to pick and choose who to let in your life. People can really drain you ... I learned to say no, get enough sleep, exercise. Also, it's okay to feel down because I am human, and to not let others judge me or get the best of me.

I went through some lessons around boundaries and again it was learning to set my own boundaries.... I guess what was acceptable to me and what wasn't.

The main things for me that trigger depression is when I think too much about my mistakes and dwell on them without allowing myself to move on by finding out how to correct those mistakes so I don't do them again and to move forward after I find the solution. I've also learned that I have to surround myself with people that think alike and look for positive solutions no matter what the situation is so they can move forward.

You take whatever curve ball that life is throwing at you or if you've twisted yourself in that you can always untie the knot. And I can take yesterday and I can lament missed opportunities. I was moody so I didn't go out for a bike ride with my kids.... [missed] opportunity to bond with them ... but today it's clear to me, it was one of those days, and today will be a lot better, and tomorrow you're doing the best that you can.

One participant referred to "life lessons" and "pearls of wisdom" that he acquired by trying different strategies. At the same time, he indicated that he was regretful that it took so long to discover ways to help him manage depression.

SELF-AWARENESS KEY TO MIDLIFE DEPRESSION MANAGEMENT

It seemed as though midlife presented a time of increased self-awareness and a willingness to seek out what was needed to manage depression and enhance the quality of life:

I think getting to understand a little bit about myself. One of the things I realized is that the primary part of my being has the need for solitude and the need for time to be alone and quiet time and time to reflect, and learning what it is about me that nourishes my being. Time alone, time in nature, I'm not a corporate person. The other thing is I have a very giving, compassionate side to myself that needs to be nourished and I need to be doing something that is rewarding in that way.

I think that there is an improvement because of learning more about yourself, but also figuring out how to manage situations, how to get rid of toxic relationships in your life, how to deal with other people better and stand up for yourself, and I think that those things definitely are skills that you acquire that help you maintain mental health ... I think you're pretty naive about these things when you're 20. Something that counselling can't teach.... I mean you have to go through enough awkward situations to figure out the good strategies of getting yourself out of them. I don't think that's something that you read about or learn through counselling. It's not to say that you couldn't, but I mean that's not usually how it happens.

I've never really been happy with the kind of normal expectations, supposed to have a good job, make lots of money, have a big house, go on trips, and that's the meaning of life. That's never really been my path. Society puts expectations on us in terms of what's success, and our parents maybe want us to be certain things.

Learn to appreciate that the small mundane moments in life are at least as valuable or more valuable and more numerous than the peak experiences. Learning to reconceptualize what is an "experience." Every living moment can be an experience, but people seem to be focused or distracted by thinking of experiences as something that will happen to them in the future, or has happened in the past.

Self-awareness of personal needs, resources, depression triggers, and lifestyle preferences were fostered through combined interventions. These included individual counselling, group therapy, personal development workshops, self-reflection, journal writing, support groups, and videos on topics such as self-esteem.

Debunking Stereotypes About What Men Find Helpful

A variety of resources were discussed, and it was rare that one intervention was found to be effective. In contrast, multiple types of information, supports, and resources were used. These findings were beneficial to understanding what is helpful and emphasized the need to develop personally relevant strategies when

working with clients. Below are a few examples of what participants used to help manage depression. For most, they characterized depression as something requiring ongoing maintenance:

I watch these positive motivational segments on TV. I go to this reaching-out group and they meet every couple weeks and they had this one segment on the gifts of self-esteem. It was a series of DVDs, seven hours' worth. I just went through that and there were so many good things in there, and then I always tell my therapist who can use it with different patients.

And I did a men's retreat, I guess that's not officially group counselling... but I know that for the rest of my life, I'm going to have to be invested in some kind of group interaction like this therapy I'm doing now because I need somewhere to spill all this out.

Walking to clear one's mind is very helpful, deep breathing to let go of anxiety, swimming. I recommend *Self Matters* by Dr. Phil and online resources by Alberta Mental Health and CMHA [Canadian Mental Health Association], also the monthly drop-in at CMHA. I subscribe to their newsletters to keep me updated on different activities and courses... I find in today's society, we all have to be responsible for our health to a great degree in getting better. It's a very individualized society, which is even harder on the depressed person because of isolation. And, if one does not seek help, it's not going to arrive automatically on the doorstep.... One needs to almost make a promise to themselves to fight this by doing all the things I discussed.

Although outreach campaigns for men (e.g., *Real Men. Real Depression*; National Institute of Mental Health, 2003) often report men's lack of help-seeking, I would suggest this is not universal, based on my conversations with participants. At the same time, however, the self-directedness that many of the participants characterized seems to suggest autonomous approaches to depression management. "[I]t is important for therapists to assist clients in becoming aware of and using extratherapeutic resources, including support networks, self-help materials, and community programs that are available to them" (Asay & Lambert, 1999, p. 47). Post-therapy factors are rarely discussed in the literature, and yet research has indicated that client and extratherapeutic factors are highly influential for successful therapy outcomes (e.g., Asay & Lambert, 1999; Duncan et al., 2004; Maione & Chenail, 1999). When I asked participants if their counsellors discussed ways to manage depression once counselling was finished, none of them reported that this was discussed.

Non-Collaborative Counselling Impacts Depression Management

Collaborative counsellor competencies include, for example, creating a trusting learning climate to explore goals and preferred approaches, being flexible, and listening for client-constructed meaning and discourse (Anderson, 1996; Bohart, 2000; Bohart & Tallman, 1999; Strong, 2002, 2009). Participants discussed how their counsellors' preferred approaches were poor fits for them:

She seemed to have a very specific form of therapy to recommend and she focused almost exclusively on that. Now, I know that there are various alternative forms, and I knew about this particular form she was recommending ... I did practice the particular form of therapy she seemed to be familiar with, but, overall, I felt that the technique did not directly address the cause of the problem. It addressed symptoms ... I did not come away with increased insight into the initial problem.

The treatment has to be tailored specifically to the knowledge level of the patient. If the patient is curious, intellectually, and already has some knowledge or insight about human behaviour, then engaging him or her in that area would be very helpful because that might cause the patient to initiate insights on their own into themselves. Self-insight is what I am referring to, rather than imposing a specific technique that the counsellor might be familiar with.

Being in sync with clients also means adapting to a conversational and therapeutic style facilitative of working through problems and brainstorming solutions, checking-in to determine what is helpful, and adjusting the pace of counselling, if necessary (Anderson, 1996; Bohart & Tallman, 1999). Discussion of treatment rationale empowers clients with information to decide if a suggestion is right for them (Ilardi & Craighead, 1994). Below are examples from participants of sessions that were not in sync. Feedback was such that individual counselling was more out-of-sync than collaborative and synchronized:

If she'd just lighten it up a bit, it would have been a lot better ... She [new therapist] was really pleasant to talk to and had a good sense of humour to bounce stuff off her.

The technique she relied upon is called, I think, cognitive reorientation, or something similar, and I am somewhat familiar with the idea behind it. Also, I think that the counsellor did not adequately take into consideration that cultural differences might make a particular technique less or more effective. She seemed to rely heavily on this particular favourite. In my case, cultural differences in relating to the world and to elements in the environment did make a difference ... being from a collectivist culture.

You've got to train yourself. Therapy is good. Overall it's excellent, but I just think I was trying too many things all at once and I got down on that if it didn't work in a couple days.

If I had six different problems that happened in the previous month, then maybe they'd give you six different things to work on. If you bring in too many problems, then that's not good for therapy, maybe just bring in a couple, but it's hard for people who are depressed, maybe just stick with one thing. I had too many little things that were bothering me and would be given too many things to work on.

Research investigating therapy outcomes for depression (Blatt, Zuroff, Quinlan, & Pilkonis, 1996; Kim, Wampold, & Bolt, 2006; Krupnick et al., 1996; Zuroff & Blatt, 2006) found that therapists played a key role in therapy outcomes more than did type of treatment. Moreover, adult learners seek out information, prefer consultation and collaboration, and benefit from autonomous and experiential learning opportunities (Knowles, Holton, & Swanson, 2005). When clients are actively engaged and attribute gains to their own efforts, they are more likely to experience change and maintain it (Kelly, Roberts, & Ciesla, 2005; Meyer et al., 2002; Watson, Gordon, Stermac, Kalogerakos, & Steckley, 2003). This is an especially important consideration for depression when it requires ongoing management. The risk for non-collaborative counselling is that clients could prematurely leave counselling without the needed skills, resources, and confidence to manage depression. This could have contributed to participant autonomy and self-directed strategies. If successful, however, their efforts could bolster self-management of depression and well-being.

DISCUSSION: CONTRIBUTIONS, LIMITATIONS, AND FUTURE DIRECTIONS

So I think that aspect is getting a lot better and people like myself are opening up our minds to it and saying you can use it as a tool just like you would use a hammer at work to be successful at your job, and, that's what it is, it's a tool that you need to use once in a while and there's nothing to be ashamed of. (Research Participant, 2009)

While, collectively, we have much work ahead, such as demystifying counselling for men, the above participant gives us hope that counselling conceptualized as a helpful life tool may help us improve how we make counselling a good fit, how we market counselling, and how we pay careful attention to not pathologize depression and counselling. Hermeneutics continually invites us to project forward to the future, not to predict it, but to engage with curiosity and action. Critical examination of participant feedback helps us consider new directions for depression counselling and therapy, counsellor training and development, and consolidating our efforts as a profession to—perhaps—more creatively think about how we work with depression. We can get stuck in traditional paradigms shaped by powerful narratives about gender, culture, and popular North American ideologies—all of which influence counsellor prejudices (in the Gadamerian sense) and practice approaches, but these are not indelibly etched realities. Continued feedback from clients at various junctures is vital. This includes avenues for feedback throughout a counselling session or via research endeavours and service evaluations.

Participant Feedback Summary

The range of interventions and resources that participants discussed suggests that working with depression extends well beyond standardized approaches and assessment based, for example, on a two-week snapshot of symptomatology. Personalized strategies for managing depression were predominantly learned based

on life experience and more akin to trial-and-error rather than collaborative planning with a counsellor. Dialogue about post-counselling supports did not take place, leaving participants in some instances to fend for themselves on how they would continue to manage depression. In contrast, though, one participant knew he had a support group to fall back on to help with ongoing maintenance. Those individuals who discussed specific strategies they actively use tended to be proactively managing depression. They presented awareness of triggers for mood, thoughts, and energy. When self-awareness was low, participants indicated difficulties in knowing what to do.

Implications for Counselling and Counsellor Training

As participants highlighted, depression was not linked to an isolated event. This finding suggests the need for counsellors to explore with clients the course and onset of depression. Life courses may include loss, relational ruptures, adversity, abuse, alcoholism, and discrimination, among other challenges. As a result, counsellor competencies for midlife depression include working in areas such as grief, abuse and trauma, interpersonal therapy, and multicultural counselling. Therapy for male depression often includes exploration and expressivity related to the accumulation of loss and regrets (Cochran, 2005; Cochran & Rabinowitz, 2003; Hart, 2001). “Uncovering and identifying loss experiences, recognition of cultural and familial norms regarding resolution of loss, and expression of grief are important tasks for the gender-sensitive therapist when working with depressed men” (Cochran & Rabinowitz, 2003, p. 136).

Asking clients about their understanding of depression and use of resources not only honours their life experiences and knowledge, but also provides an opportunity to explore what was helpful, what was less helpful, and why. In turn, counsellors can learn how their clients prefer to work, can identify gaps in resources and needed referrals, and can build upon existing resourcefulness and strengths in managing depression. This collaborative conversation is especially important when new clients have already completed individual and/or group therapy, workshops, and self-help resources. Not reinventing the wheel for midlife clients respects their prior learning and facilitates being in sync with them (Anderson, 1996). Kilmartin (2005) emphasized that therapy for men should include skill-building exercises (e.g., framing emotional expression as a valuable skill). Kilmartin stated that early engagement with male clients is key to increasing their comfort with counselling and prevention of early termination. In fact, participants commented that what they found most helpful from their work in counselling was learning specific skills (e.g., stress management, relaxation, and breathing exercises).

Based on participant feedback, a preferred working style seems to echo some of the principles found in adult learning, such as collaboration, honouring life experience, and generating learner-defined objectives. Given the multiplicity of midlife roles and responsibilities, exploring barriers to learning and change (e.g., time restrictions, finances, and health; Ohsako, 2000) would likely help create an appropriate treatment plan, one that is not focused on too many topics

and exercises (as one participant pointed out). In these ways, counselling might bolster client active engagement in-session and generate motivation to continue efforts outside counselling. I particularly like Bohart's (2000) suggested approach to invoke client involvement in change and learning through a combination of empathy, interpersonal learning, problem-solving, co-constructive dialogue, exercises and skills training, and guided learning. These various components could be customized to meet the individual goals and preferences of clients. In the end, it would appear that counsellors have to be equipped with a broad range of tools (e.g., working styles, interventions for depression, psycho-educational materials, knowledge about community resources, and integration of appropriate referrals) to work effectively with male midlife depression.

Limitations and Contributions

Six interviews would not be the quantity and breadth needed for generalizability, predictability, theory building, and verifiability. Instead, I purposefully sought those individuals who could address the topic as experts of their own lives. Their narratives were honoured, as the use of extensive verbatim transcripts illustrates. Heterogeneity was narrowed given that participants were recruited based on an age range and completion of counselling for depression; however, diverse life experiences, occupations, ethnic backgrounds, family configurations, interventions and counselling modalities, and resources were reported. It is possible that those individuals who volunteered for the study are self-directed and conversational and thus more apt to access resources on their own.

Rigorously attuning to the research questions and participants' experiences augmented the study's trustworthiness and generated in-depth discoveries about midlife depression. Replication would certainly be a challenge, but, a new researcher and participants would also bring different perspectives to the topic. As the primary researcher, my interpretive lens and prejudices (Gadamer, 1988) analyzed and synthesized the data, limiting the scope of interpretation. Participants interpreted their experiences of depression and counselling, extending my single voice to many. Findings could contribute to the development of a practice resource for working with male midlife depression.

A strength of this hermeneutic project was the weaving together of various perspectives (e.g., extant research literature, participants' narratives, sociocultural influences, and my work as a counsellor). Some of the research findings (e.g., collaborative therapeutic relationship) are relevant to counselling overall, not only working with depression.

Future Directions

When we consider the World Health Organization's prediction about the increased prevalence of depression by 2020, teenage depression and suicide, and midlife depression linked to occupational stress, our focus becomes clearer about the need for earlier intervention, effective stress management for all sexes, and continued awareness and dialogue about contributing sociocultural factors. The

bubble needs to burst with respect to dominant ideologies about depression based on sex and gender. The need for stress management is prevalent during midlife. Although we may automatically think of female role strain during midlife, it is important to remain mindful of role strain and role conflict for men, too, particularly as family configurations and responsibilities continue to change. For all participants, adolescence marked the course of their experiences with depression. Implications of this finding are far-reaching and include working with parents and teachers to recognize the signs of depression, school-based programs to mentor male students (especially those who may be facing adversity at home and/or in their neighbourhoods), and encouraging dialogue and exploration of anger and life circumstances. Findings by researchers such as Wälinder and Rutz (2000) that men tend to first discuss symptoms with a physician affirms the need for collaboration among health and mental health care professionals.

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About the Author

Debbie L. Grove completed her doctoral studies in counselling psychology at the University of Calgary. Her clinical work involves psychotherapy with individuals and couples. She specializes in depression, anxiety, relationships, trauma, grief, and occupational issues. Areas of research and writing focus on midlife health and well-being, practice approaches, and adult learning. Debbie is an associate faculty member at City University of Seattle, Graduate Program in Counselling Psychology.

Address correspondence to Dr. Debbie Grove, Learning to Live Psychological Services, 10339-106 Street, Edmonton, Alberta, Canada, T5J 1H8; e-mail <drgrove@learningtolive.ca>