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Barriers in Diagnosing and Treating Men With Depression: A Focus Group Report

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Abstract

This study reports on the experiences of 45 male focus group participants with a history of depression. Men responded to questions addressing the interaction between the male role, masculinity, depression, and experiences with treatment for depression. Using a qualitative, thematic-based coding strategy, three primary themes emerged. First, participants described aspects of the male gender as being in conflict or incongruent with their experiences of depression and beliefs about appropriate help-seeking behaviors. Second, men outlined alternative symptom profiles that could interfere with the recognition of depression and willingness to seek help. Finally, men expressed a range of positive and negative reactions toward depression treatment and treatment providers. Implications for health care providers are provided.

Keywords

men and depression; masked depression; focus group; qualitative

Rates of clinically diagnosed depression differ sharply between men and women. Estimates in the United States suggest that adult women are diagnosed two to four times as often as men (Cochran & Rabinowitz, 2000; Kessler et al., 1994; Kornstein et al., 2000). In the United Kingdom, depression rates have been estimated at 7% and 3% for women and men, respectively (Emslie, Ridge, Zeibland, & Hunt, 2006). These figures stand in contrast with suicide rates. Men complete suicide at a rate of four to five times more often than women (Cochran & Rabinowitz, 2003; Moscicki, 1997). In 2004, 26,000 men died by suicide, approximately 70 men each day (National Institute of Mental Health, 2004).

In addressing the reasons underlying these gender differences, some have suggested an inherent gender bias in the criteria used to diagnose depression (Kilmartin, 2005; Pollack, 1998). This argument suggests that many of the symptoms of depression, as outlined in the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (American Psychiatric

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Association, 2000) may be difficult for men to recognize or acknowledge, because of socially reinforced masculinity norms, including self-reliance, restriction of emotion, and toughness (Addis, 2008; Cochran & Rabinowitz, 2000; Magovcevic & Addis, 2008; Mahalik, Locke, et al., 2003). Furthermore, some men may manifest depression in ways not represented in the diagnostic criteria. Examples include overinvolvement in work, anger, isolation, help-seeking avoidance, and physical pains (Cochran & Rabinowitz, 2000; Magovcevic & Addis, 2008; Pollack, 1998). Also, research has demonstrated that men who subscribe to traditional male gender role norms tend to endorse negative help-seeking attitudes and yet frequently have depressive symptoms (Good & Mintz, 1990; Good & Wood, 1995). Collectively, these factors may account for significant under-diagnosis of depression in men (Connell & Messerschmidt, 2005; Kilmartin, 2005).

The argument that men may either not endorse traditional symptoms of depression or cover up their depression with other behaviors has been referred to in various contexts as “masked” or “male-type” depression (Kilmartin, 2005; Rabinowitz & Cochran, 2008). This designation is increasingly visible in both the academic and popular literature (Addis, 2008; Cochran & Rabinowitz, 2000; Hart, 2001; Real, 1997; Wexler, 2005). Assumptions underlying this framework have influenced the development of several mental health initiatives, most recently the “Real Men. Real Depression” campaign (Rochlen, Whilde, & Hoyer, 2005) sponsored by the National Institute of Health, the largest funding agency for health care research in the United States.

Importantly, research to support these frameworks has been relatively limited. Moller-Leimkuhler, Bottlender, Straub, and Rutz (2004) found stronger relationships emerging between depression and symptoms of irritability, aggressiveness, and antisocial behavior among men diagnosed with depression than women. More broadly, women have been described as tending to “act in” their depression in ways more consistent with the diagnostic criteria, whereas men tend to “act out” through problematic behaviors and aggression (Kilmartin, 2005).

In one interview study, 16 men diagnosed with depression in the United Kingdom noted that recovery from depression involved the reestablishment of hegemonic masculinity through the use of narratives such as “being one of the boys,” “reestablishing control,” and “responsibility to others” (Emslie et al., 2006). Another study on 217 inpatients (113 men) found differences in the core symptoms of depression between men and women but not in symptom severity. Men had more pronounced decreases in libido, greater rigidity of affect, higher rates of hypchondriasis, and compulsive impulses (Winkler et al., 2004). Finally, in an instrument development study, Magovcevic and Addis (2008) found that men conforming to traditional masculinity norms tended to display a more externalizing, somatic pattern of depression than men endorsing more nontraditional gender role norms.

In summary, there is a shortage of studies addressing how men describe their experiences of depression and how aspects of the male role may limit recognition of a depressive disorder and exacerbate treatment barriers. The current study intended to contribute to this understudied area of research. Our primary goal was to increase our understanding of the influence of masculine role expectations on the recognition of depression symptoms, appropriate help-seeing behaviors, reactions to male-type/masked depression, and reactions to depression treatment. In initiating this study, we aimed to provide implications for a broad range of health care providers in regular contact with men, including primary care physicians, counselors, or clinical psychologists. In discussing the results, we use the term *health care providers* except in cases where participants identified specific types of providers.

Method

Procedures and Participants

To ensure inclusion of diversity in race/ethnicity and income, participants were targeted by neighborhood and zip code in Rochester, NY; Austin, TX; and Sacramento, CA. Interested participants responded to craigslist.com or flyers claiming that researchers were "looking for men and women to participate in a study about why people might or might not seek treatment for depression." Flyers were posted at county clinics, physician offices, and neighborhood recruiting hubs (e.g., shopping centers, apartment complexes, churches, bus stops). To target specific neighborhoods, city (Sacramento and Austin), or county (Rochester), zip codes were ranked from highest to lowest median income level. Zip codes closest to the 15th percentile (lowest income) and those near the 50th percentile (lower middle income) were identified for neighborhood recruitment. In addition, postcards were mailed to a sample of addresses in targeted zip codes. We targeted a working-age sample who had a personal and/or family history of depression, spoke and understood English, and could participate in a group discussion. Potential participants were screened for inclusion by one of three research assistants. To determine if the individual had a personal and/or family history of depression, each participant was asked the following question: "Has a physician ever told you and/or a family member that you were depressed?" Participants who met the criteria were assigned by gender to the neighborhood and income group (low income or mid-income) that most closely matched their zip code.

This article examines only the data from the 6 men's focus groups comprising 45 men. Participants ranged in age from 24 to 64, with a mean age of 48 years. Fourteen (28%) men were married or a member of an unmarried couple; 13 (28%) were either divorced, widowed, or separated; and 19 (42%) reported never marrying. Most (n = 28, 62%) were Caucasian, 7 (16%) were African American, 4 (9%) were Latino, and 6 (13%) described themselves as mixed race/ethnicity. Four (9%) participants did not graduate from high school; 9 (20%) had a high school diploma or equivalent; and 32 (71%) had some college or college degree. More than half were unemployed (53%) and reported their household income to be <$30,000 annually (62%). One participant had not been treated for depression; he discussed his experience with his wife's depression. Thirty-four (76%) participants described their health as good to excellent and 28 (80%) had sought treatment within the past 12 months for emotional or mental health concerns.

Data Collection

All study procedures were approved by institutional review boards at each of the three study sites. Before the focus groups, participants completed a questionnaire that included demographic information, general health status, health care, and access. Guiding questions were developed based on a review of the literature and the expertise of study investigators from various disciplines (sociology, psychology, communication, internal medicine, family and community medicine) and tested in pilot focus groups (one at each study site). Following the pilot focus groups, modifications were made to the interview guide to simplify and decrease the number of questions.

Questions asked to the entire set of focus group participants addressed optimal messages for educating the public about depression and reducing help-seeking barriers (full list of focus group questions available on request). In addition, male participants were also asked about (a) unique obstacles that may interfere with depression recognition and help-seeking behaviors, (b) messages they received that may contribute to these barriers, and (c) participants thoughts, reactions, and experiences to the concepts of masked or male-type depression (after having these ideas overviewed by the facilitator).

Focus groups at each site were led by trained group leaders who conducted all the groups held at their site. All focus groups were digitally recorded and lasted 75 to 110 minutes. Study participants provided informed consent prior to focus group participation and received a $35 stipend after completing the group discussion for their time.

Data Analysis

Digital recordings were transcribed verbatim and reviewed for accuracy in transcription. Codes were applied to each of the transcripts in a line-by-line coding process. Coders paid specific attention to the role of masculinity and men's characterizations of depression, help seeking, and treatment. Half of the data (three transcripts) were independently reviewed by two of the authors (ABR and LW) and subcategories of larger codes were noted. Coders discussed these categories and came to a consensus on recurrent themes, conceptual descriptions, and illustrative examples from focus group responses and compiled a codebook for assessing the remaining three transcripts. To be considered a salient aspect of men's discussions, a theme had to appear in two or more focus groups. An outside auditor, not familiar with the methods or goals of the study, further reviewed the preliminary codes, including the first half of the data. The remaining transcripts were then reviewed to test for data saturation.

Results

Table 1 provides a summary of the themes, subthemes, and representative quotes extracted from focus group transcripts.

Incongruence Between Male Role, Depression, and Treatment

Participants described multiple aspects of the male role as interfering with the experiences and symptoms of depression, help-seeking patterns, and successful treatment. This perceived incongruence was attributed to how the male role is perceived by the men themselves, their understandings of others' perceptions, and men's socialization process more broadly. For example, men tended to equate depression with strong emotions, weakness, deficits, and vulnerability. Yet participants described men's socialization in opposing terms, with an emphasis on avoiding feelings, appearing strong, and never crying. This contrast was succinctly captured by one man who noted, "My role (as a man) is to be strong. It's weak to be depressed and sad and cry."

Furthermore, several participants noted how discussions about depression with a friend, family member, or health care provider would be particularly challenging. Not surprisingly, these types of intimate and unstructured discussions were described as atypical for men who instead preferred directive, short-term, and goal-oriented dialogue. One man described men's communication patterns as follows:

> Well, it's an unfortunate thing that we as men don't talk about our lives with people. You know, you—you said you work with a guy for 20 years—do you have kids? You know, you don't talk about your life. And so why would you ever talk about depression if you can't talk about your own kids? As men, I think that hinders a lot of what could be healing.

Similarly, another participant described the lack of vocabulary men have for emotion-oriented conversations. He added,

> "*We tend to talk about things when there is a clear purpose, not just to share experiences. I think that we tend to have a more limited vocabulary when it comes to emotion and so on.*"

In follow-up questions, participants generally agreed that aspects of the male role could potentially interfere with a man's ability to recognize depressive symptoms, accept a depression diagnosis, and engage in dialogue with treatment providers.

Another commonly expressed theme relevant to the incongruence of the male role pertained to how happiness was perceived by men. Several men commented that happiness was not necessarily equated with masculinity or being a man. One respondent described this theme as follows:

> The definition of what it takes to be male doesn't include necessarily happy. It's productive, self-reliant, tough, strong, stoic. Happy is not really part of it. And so to not feel happy doesn't necessarily seem like a problem.

Finally, the theme of incongruence was identified through men's discussions of their family roles as providers. Participants frequently noted that being a man meant providing for and protecting the family. From their perspective, depression threatened this role, a core part of their identity. Men recognized their need to guard against threats to this role. Yet men also recognized how depression was affecting their role in their family, frequently noting a growing impatience for handling conflict or problems in the family. One participant illustrated the impact of the reaction that his family had to his depression as follows:

> That tore my family up, because I was the rock, I was always the one that just did everything right, and handled everything. Then all of a sudden, I just started to shut down, and everybody just told me to snap out of it and this and that.

Male-Type and Masked Depression

Several participants emphasized their belief that men may experience depression in a qualitatively different way than women. Furthermore, many participants seemed to agree that the traditional criteria for depression might not capture some men's accounts of depression. However, other participants seemed uncertain of whether depression differs between men and women or did not comment on this question.

Among participants who did respond, three subthemes emerged. We identified the first subtheme as "looking good at all costs." This profile endorsed men's tendency toward covering up painful feelings with a façade of stability and normalcy. To this point, participants emphasized the importance of maintaining the illusion of control, despite feelings of intense, inner pain. The importance of this theme was well represented by one participant who said,

> I'll feel really bad sometimes, and I don't want to shave. And I don't want to do, and it's like, but I do it anyway, 'cause I don't want anybody to know. So I clean up and I shave and I get tight and I go out in the world, and no one knows.

A second subtheme emerging from this discussion was men's tendency to cover up depressed feelings with substances or other activities, most notably work. In this pattern, participants emphasized that feelings of depression became particularly acute when the drinking, drugs, or overinvolvement in work ceased. Men offered different perspectives in regard to whether men were consciously aware of this "cover-up" pattern. Some men noted that they were aware of masking or covering up, whereas others felt this was beyond their conscious level of awareness. Below, a participant responds to his strategy for engaging in other activities to avoid depressive feelings:

> I work 60 hours a week. You drink, smoke pot, and get into reading, you know, novel after novel. And all kinds of behaviors to keep the mind away from it, you know, and I see people, men, do that all the time, especially workaholics, alcoholics, um, you know, blowing $120 at the strip club every week.

A final subtheme pertained to what identified as a "self-mask." Essentially, this represented men's refusal to recognize the possibility of depression. However, there was heterogeneity in this pattern: Some men described a lack of awareness of the legitimacy of depression, whereas others described an overall refusal to accept depression as the source of their emotional state. One man reflected the self-mask by noting,

> In my mind, the question presupposes a recognition of depression, and then, a conscious response of that awareness, that I'm not sure—I'm not sure I ever did. I don't think I was trying to hide it. I think I was trying to ignore it or pretend it didn't exist.

Reactions to Treatment and Treatment Providers

Participants expressed a range of reactions to depression treatment and treatment providers. Overall, six subthemes were identified, reflecting three treatment barriers and three benefits or recommendations to health care providers. Regarding barriers, participants appeared to have little faith in providers who are slow to take action and express uncertainty. One participant expressed his negative reactions toward psychotherapists with the following comment:

> I have problems with therapists. They're just getting paid a lot of money and, uh, putting their time in and they're taking notes but they're not really taking action.

Frequently, participants' concerns regarding treatment providers manifested in the form of a more generalized ambivalence, as reflected by one respondent who noted,

> And if you have this sense of "I don't know if there's anything that can change this," or "I don't know if there's anything that can be done," then why talk to anybody about it if it's not really going to make any kind of change?

Second, even though the prescription of medications may be viewed as an action-oriented attempt on the part of the provider to treat depression with alacrity and confidence, participants expressed feelings of frustrations regarding drug treatment. These included the difficulty of finding the "right drug" and the overall lack of efficacy of different medications. One participant summarized his experiences by saying,

> I haven't been involved in any kind of treatment for, for a long time now. But in the past I just haven't ever had any good result. People were pushing drugs on me basically.

Third, participants noted that men's overall preference to solve their problems without the help of others exacerbated their skepticism about treatment. Participants often described seeking professional care as a last resort. This perspective was seen in the following participant's response:

> It's easier to stay in a state of denial than to have to admit something, because when I admit if I'm depressed then I have to take action.

There was also notable support for the promise of treatment and the appropriate handling of treatment options by physicians. These viewpoints often promoted the perspective that men can live healthy, satisfying lives with successful treatment. One participant noted,

> Since you know, I think I was 27 was the first time I was hospitalized and I can say that it's not a death sentence. It's not something that's unmanageable. There's treatment for it. You just have to be willing to show up for treatment, and chances are better than not that you'll be able to live with it.

In discussing what makes depression treatment helpful for men, participants emphasized the utility of having a focused time and space to address the problem. This was represented by one participant discussing therapy for his partner's depression:

> The therapist … allowed him to be angry and express his anger and it gave him some place to be angry without being angry at me and that worked well for him.

Finally, participants often noted the helpfulness of a physician's role in reframing depression as a medical condition. Focus group members consistently emphasized this as one of the most helpful approaches for physicians who worked with male patients to adopt; a convincing biologically based explanation allowed men to increase their acceptance of depression as a legitimate disorder and increase openness to treatment. This viewpoint was well illustrated by one participant:

> But I think … the public ought to get educated about it, and just treat it like diabetes or hypertension. Because I have hypertension and I have to take this pill for the rest of my life … if the public knows that it's just another illness, maybe there wouldn't be so much bias or so much a stigma.

Discussion

Compared with women, men are diagnosed with depression less often (Kornstein et al., 2000) and have higher suicide rates (Moscicki, 1997), and less positive attitudes toward help-seeking options (medical and psychological; Mahalik, Locke, et al., 2003). Men who adopt traditional and restrictive masculinity norms tend to have high rates of depression and negative perceptions of available help-seeking options (Pederson & Vogel, 2007; Shepard, 2002). Good and Wood (1995) succinctly captured the importance of this point by emphasizing the double bind for depressed men, namely, men most in need of seeking help appear to be the most resistant and avoidant of available help-seeking options.

The themes identified herein can help explain this double bind in a manner that has important potential implications for health care providers in regular contact with men. The first theme suggests that aspects of the male role may consciously or unconsciously interfere with the recognition of depression and related treatment. This finding seemed to parallel Warren's (1983) description of an intolerance of depression that men endorse. Warren argued that the male norms of self-reliance, control, toughness, and competence as being incompatible with depression, which may include the experience of vulnerability, powerlessness, and weakness. Furthermore, as noted by Brownhill, Wilhem, Barclay, and Parker (2002), the incompatibility of depression with masculinity may contribute to lack of recognition of depressive symptoms and help-seeking behaviors.

Interestingly, the state of happiness, described by several participants as an opposing feeling to depression, was not considered a natural, or logical, masculine trait. Again, this might reflect somewhat of a passive acceptance of a depressed mood by some men who may not see depressed feelings as unusual, atypical, or unmasculine. Alternatively, the perception of happiness as being an opposing feeling to depressed state may reflect one of many misperceptions the general public seems to have about depression (Heim, Smallwood, & Davies, 2005). In other words, men may see depression as simply "not being happy" when the disorder is far more complex and can manifest itself in many different ways in a person's life or lifestyle. Finally, men described discussions about depression to be difficult, atypical, unfamiliar, and threatening.

Collectively, these themes suggest that some men may perceive the experience of depression as normative and may believe that the associated symptoms, therefore, do not need to be addressed. The lack of congruence between the male role, depression, and the depression-

related treatment parallels literature addressing men's avoidance of counseling services in general. In this area, the culture of therapy and its emphasis on vulnerability and verbal expression of feelings contrasts sharply with men's stoicism and avoidance of emotions (Addis & Mahalik, 2003; Mahalik, Good, & Englar-Carlson, 2003; Rochlen, 2005; Rochlen, Blazina, & Raghunathan, 2002).

The second broad theme pertained to the diverse reactions toward male-type and masked depression. A significant number of men endorsed the concept of male-type and masked depression, which have been largely limited to theoretical and academic discussions. For example, men shared vivid stories of their typical depression symptoms being covered up by other problematic behaviors or compulsions. Furthermore, men emphasized the normative male role of never exposing weaknesses, looking good to others, and hiding inner (and often acute) emotional pain. Finally, participants described their own "self-masks," indicating their tendency to not allow themselves to acknowledge or see their own struggles with depression.

Although more research is needed, the descriptions provided in this study are consistent with Pollack's (1998) original formulations of masked depression. Combined with anecdotal or case-study accounts of masked depression (Hart, 2001; Kilmartin, 2005; Lynch & Kilmartin, 1999; Rabinowitz & Cochran, 2008), these data call for a reexamination of the appropriate applications of the traditional diagnostic criteria for some types of men. Furthermore, these data support the high degree of comorbidity with other disorders that men with depression often experience (Lowe et al., 2008; Penick et al., 1994).

Our third set of themes pertained to men's reactions to treatment and treatment providers, including potential treatment barriers and promising strategies for health care providers to consider for male patients. One frequently mentioned barrier was perceptions of incompetence among health care providers (including counselors and physicians). Furthermore, men expressed skepticism and shared their stories of frustration regarding both antidepressants and psychotherapy treatment. In addition, participants described treatment as a last resort with a strong preference toward resolving their concerns without the help of others, a reference to the well-documented male role norm of self-reliance (Mahalik & Rochlen, 2006; Mansfield, Addis, & Courtenay, 2005). Still, men maintained positive reactions toward depression treatment with many commenting on their significant progress as a result of their treatment. Men noted that treatment offered a structured place to address their depression, including symptoms of masked depression such as anger, and convincing explanations from physicians of depression as a biological problem.

Although based on a small sample of focus group participants, the above findings suggest several implications for health care providers to consider. First, as men may not spontaneously report feeling sad or even blue or distressed, and may not recognize anything "abnormal" about their mood, health care providers should focus on functioning: "Have you had any difficulties getting things done around the house?", "What about at work?", and, on positive functioning, "What do you do for fun?" Other open-ended questions should also be considered, such as "How are things going at home?" Health care providers also need to educate men that low-grade unhappiness and difficulty functioning are not necessarily normal and can be treated.

Second, it may be helpful for health care providers to consider the importance of certain male role norms, including self-reliance, courage, and being the family "breadwinner," in discussions with male patients. This approach of drawing on male-norm strengths was adapted by the "Real Men. Real Depression" campaign with their primary slogan, "It takes courage to ask for help. These men did." Furthermore, because men view care seeking for

depression as threatening and may express distress in other ways (e.g., somatically), health care providers, particularly primary care providers, need to ask explicitly about mood and functioning and carefully assess alternative presentations of depression (Moller-Leimkuhler, Heller, & Paulus, 2007) or depression profiles (Kilmartin, 2005), besides those outlined in the *DSM-IV-TR*. Men present atypically at times, and health care providers need to maintain a high index of suspicion for depression among men suffering from psychosocial or economic stress, abuse of alcohol or other substances, or unexplained somatic symptoms, particularly chronic pain (Bair, Robinson, Katon, & Kroenke, 2003). Depression should also be considered when men (or their wives or partners) report more difficulty with anger.

Finally, health care providers should recognize the relational and potentially threatening nature of depression-related discussions with male patients. Health care providers may need to be particularly aware of the importance of developing rapport with male patients who may be resistant to open dialogue with them about depression. In doing so, normalizing depression as well as emphasizing the generally favorable outcomes of depression treatment may be particularly helpful. By emphasizing that treatment has been found to be equally effective for men, when men are actively engaged in treatment with their health care provider. Furthermore, our findings underscore the importance for health care providers to explain depression as a medical illness that has a biological and social component.

Importantly, there are a number of limitations to the current study that should be considered in further research. First, in discussions among focus group facilitators it was noted that many participants in our samples revealed serious and long-standing depression, with some having been hospitalized and others having attempted suicide. Furthermore, many men acknowledged being diagnosed with bipolar disorder and substance abuse, indicating a considerable range in the types of depression that participants experienced. Hence, the results should be generalized with caution to men with shorter bouts of major depression or dysthymia. Second, all the men in the sample, with the exception of one, self-identified as depressed. At some level, these are men who accepted this label. Therefore, the sample had characteristics that might not well represent men who refuse to acknowledge a depression diagnosis and who avoid seeking help. Nevertheless, their stories are helpful as illustrations of the struggles that occur on the road to acknowledgement of depression.

Third, “group think” can occur in focus group settings, resulting in themes that might not emerge as commonly if interviews were conducted on an individual basis (Seal, Bogart, & Ehrhardt, 1998). Fourth, all the group facilitators were Caucasian academic health professionals, which may have affected the process of the group and type of information disclosed. Finally, the exclusive focus on men in this study is not intended to imply that the themes identified do not have relevance for women or other populations. Although researchers have emphasized the usefulness of addressing barriers to help-seeking from a within-group perspective (Addis & Mahalik, 2003), these considerations may be equally prominent for other groups.

In closing, our findings underscore the importance of further research on depression recognition and treatment barriers for men. Themes identified in our study generally suggest characteristics of the male role as interfering with the recognition of depression and willingness to engage in treatment. Health care providers may benefit by recognizing the gender-based themes that may interfere with treatment, evaluate alternative presentations of depression symptoms, and explain the causes of the disorder in ways that may facilitate symptom recognition and treatment acceptance.

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Table 1

Summary of Themes, Subthemes, and Representative Quotations

Themes	Subthemes	Representative Quotations
Incongruence between male role, depression, and treatment: Aspects of the male role may interfere with men's experience of depression and help-seeking patterns	Depression as normative to male role	"Part of the problem is our whole socialization process. It's always been okay for girls— women—to cry when they feel bad … but for—for boys, you know, boys don't cry."
	Happiness not linked to masculinity	"You could still feel like a successful man and not be happy, because who cares if you're happy or not?"
	Depression dialogue atypical for men	"Not only is it difficult for a man to talk about feelings, it's also unexpected."
Male-type or masked depression: Endorsement of men's alternative or unrecognized experience of depression	Looking good and remaining in control	"I'm thinking the way he's overcompensated by appearing to be happy all the time and everybody thinking he was the happiest guy in the world when that was his way of masking his very severe depression."
	Covering up depression with substances or other problematic, compulsive behaviors	"I think I throw myself into some sort of particular task. And I know a lot of men, maybe that's all we really ever do—just get to work on something."
	Self-mask/refusal to recognize depression	"For me it's easier to stay in a state of denial than to have to admit something, because when I admit if I'm depressed then I have to take actions on it."
Reactions to treatment and treatment providers: Positive and negative reactions toward treatment	*Barriers*	
	Perceived incompetence or ambivalence	"Maybe we're just a society of people wanting some gratification. But I'd like to have a reason or confidence that something is going to make a difference."
	Frustration toward drug treatment	"So, it wasn't until I'd taken maybe three, four, or five medications that I decided, well, I didn't like any of those so I'm not going to get anymore."
	Preference to solve problems on own	"I'm my primary caretaker, you know. It's my responsibility to look up on the Internet if I know what my conditions are and how it affects me."
	Benefits	
	Efficacy of treatment	"And, and so, uh, I think that's the positive side of, of psychotherapy is, is having breakthroughs and—I think that being in therapy allows you the opportunity to have those kind of breakthroughs."
	Focused time to address problems	"It gives you a time and place to focus on that problem."
	Reframing depression as medical condition	"A medical problem just like if you had a stomach ache or heart disease and that you could treat it with …"