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MALE VIEWS ON HELP-SEEKING FOR DEPRESSION:

A Q METHODOLOGY STUDY

ABSTRACT

OBJECTIVES*:* To identify viewpoints among men with depression about depression and its treatment, consider how these might influence help-seeking behaviour, and generate ideas for interventions and future research. **DESIGN*:*** Q methodology. **METHODS*:*** Twenty-nine men with depression completed a Q sort by ranking a set of statements about depression and help-seeking according to their relative agreement with each statement. Factor analysis was used to identify viewpoints, which were interpreted in the context of participant characteristics and additional information from post-sorting interviews. **RESULTS*:*** A two-factor solution was considered the best fit for the data, and accounted for 45% of study variance. Participants who were significantly associated with both factors described a sense of shame, relating to their own or others' views that being depressed and help-seeking are in conflict with socially constructed "masculine" values, such as strength and self-sufficiency. In the viewpoint represented by Factor 1, however, the benefits of help-seeking outweigh the negatives. In contrast, the viewpoint represented in Factor 2 holds that depression should remain a private struggle and that help-seeking is too risky a move to make. **CONCLUSIONS*:*** In order to access treatment, men must first recognise depression, then overcome considerable perceived and internalised stigma to ask for help. Information about the nature of depression; positive messages about the act of help-seeking, types of treatment available, and effectiveness of treatments; and work

to overcome the challenges posed by long waiting times and other service constraints may increase rates of help-seeking, and represent areas for future research.

PRACTITIONER POINTS

- Interventions to improve recognition of depression symptoms, particularly in the absence of recent negative life events or suicidal ideation, might help to improve help-seeking rates among men
- Media campaigns should consider focusing on the positive elements of help-seeking and potential for recovery, and the impact of such campaigns should be evaluated
- Improving public knowledge of the types of non-medical intervention that are available for depression may help to increase help-seeking rates
- Clinical services and commissioners should be aware of the impact of long waiting times and strict discharge policies on service users, especially those who have difficulty asking for help

INTRODUCTION

DEPRESSION AND HELP-SEEKING

Major depression is one of the most common and disabling mental health disorders in the UK (NICE, 2011). While it can have a brief course, in approximately 50% of cases symptoms last for a year or more, and relapse is relatively common (NCCfMH, 2010). Despite the existence of effective treatments (NICE, 2009), many people do not seek professional help (e.g., Bland, Newman, & Orn, 1997; Lin & Parikh, 1999; Narrow, Regier, Rae, Manderscheid, & Locke, 1993; Newman et al., 1996; Regier, Farmer, et al.,

1993; Regier, Narrow, et al., 1993), or only do so years after the onset of their symptoms (Bruffaerts, Bonnewyn, & Demyttenaere, 2007; Wang et al., 2005). There is robust evidence from clinical and epidemiological research that major depression is more prevalent among females than males (Angst et al., 2010; Angst et al., 2002; Aromaa, Tolvanen, Tuulari, & Wahlbeck, 2011; Chartrand, Robinson, & Bolton, 2012; Hämäläinen et al., 2009; Jorm et al., 2000; Mackenzie, Reynolds, Cairney, Streiner, & Sareen, 2012; Mojtabai & Olfson, 2006), and that the proportion of depressed females who seek help is greater than the proportion of depressed males (59% v. 48%, respectively, in one large European study) (Angst et al., 2002). Lower rates of help-seeking for depression among men are of concern, as depression can have significant personal, social and economic costs, including occupational impairment, increased risk of substance misuse, and increased risk of suicide attempts (e.g., Angst et al., 2002; Kessler, Borges, & Walters, 1999; Simon, 2003).

BELIEFS ABOUT DEPRESSION AND TREATMENT

A large number of studies have investigated factors that might influence the help-seeking behaviour of men, some of which have explored the role of beliefs about depression and compared these between males and females. A systematic review of 71 quantitative and qualitative studies found that females were more likely than males to attribute depression to medical or biological causes, as opposed to non-biological, psychological or environmental causes (Prins, Verhaak, Bensing, & van der Meer, 2008). Research findings also suggest that men might not believe depression or anxiety to be as serious as women do, in terms of length or severity (Edwards, Tinning, Brown, Boardman, & Weinman, 2007). It might therefore be hypothesised that men perceive

less need for treatment in health services. However, this hypothesis has not been formally tested.

There is some evidence that females have more positive attitudes towards mental health care than males (Kessler, Brown, & Broman, 1981). In the above mentioned systematic review, when compared with women, men expressed less confidence in mental health professionals, were more likely to think that antidepressant medication is addictive, and appeared more concerned with the costs and side effects of treatment (Prins et al., 2008). Interestingly, however, more barriers to treatment were reported by females than males. Again, associations between these views and help-seeking behaviour were not formally tested.

A small number of studies have investigated health-related beliefs as possible correlates of help-seeking behaviour in people with depression. There is some evidence that help-seekers tend to have less desire for social distance from people with mental health problems, more favourable attitudes towards help-seeking and consulting professionals, and more positive attitudes towards antidepressants (Aromaa et al., 2011; Lin & Parikh, 1999). Expected satisfaction with treatment has been shown to correlate with the likelihood of having a depression-related outpatient visit over a six-month follow-up period (Fortney, Rost, & Zhang, 1998), while findings relating to the relationship between perceived need for treatment and help-seeking behaviour have been inconsistent (Fortney et al., 1998; Lin & Parikh, 1999). Interactions between beliefs, perceived need, gender and help-seeking behaviour were not reported in these studies.

In-depth qualitative studies with people with depression have highlighted significant levels of self-stigmatisation. In particular, depression seems to contradict

gender-related values and beliefs about what constitutes strength, such as not expressing emotion or feeling vulnerable or dependent on others, and it has been suggested that men expect to be ridiculed by other men for "weakness" if they open up about emotional difficulties (e.g., Emslie, Ridge, Ziebland, & Hunt, 2006).

The existing literature does not provide definitive answers about specific beliefs that predict differences in help-seeking behaviour between males and females, and research is needed to test the hypotheses that beliefs about depression and treatment are related to gender, and account for at least some of the observed variation in help-seeking behaviour. The findings of such research could then inform the development of appropriate help-seeking interventions. Given that the number of beliefs with the potential to influence behaviour is large, and the potential for conceptual overlap is great, a method that allows exploration of wider viewpoints and consolidates information from a number of sources will be useful. The aim of this study is to achieve this, using Q methodology, and to address the question, *"How do men who are currently depressed understand depression, treatment and help-seeking?"*

METHOD

DESIGN: Q METHODOLOGY

Q methodology identifies patterns of thought – or viewpoints – on a topic (Valenta & Wigger, 1997), using a form of factor analysis that highlights patterns of association between *people's views*, rather than *variables* (the focus of traditional factor analysis, or *"R methodology"*) (Watts & Stenner, 2012). Homogeneity of measurement is achieved through a specially-designed form of data collection, called a Q sort, which involves the ranking, or sorting, of a sample of items according to the *"psychological*

significance" (Burt & Stephenson, 1939, p. 276) to the sorter of each item relative to the others (Watts & Stenner, 2012). This data collection method involves the use of a pre-determined frequency distribution, an example of which is shown in Figure 1.

<FIGURE 1>

The sample of items used for a Q sort is known as a Q set, and is drawn from a population of items, known as the concourse. As explained by Watts & Stenner (2012), *"concourse is to Q set what population is to person sample (or P set)*" (p. 34). The concourse consists of views or accounts that exist within society, from any source, about the matter under investigation, and can include established facts and opinions, so long as these are *"made subject to the feelings of a participant"* (Watts & Stenner, 2012, p. 33). Each of the rows in the data matrix that results from a Q sort contains the perspective of an individual. Conducting a factor analysis based on these rows results in the identification of groups of people with shared viewpoints, and explanatory factors can then be sought and interpreted to aid understanding of these (Watts & Stenner, 2012).

PROCEDURE

Ethical approval was obtained from an NHS research ethics committee. The study had four distinct phases: (1) sampling the concourse and developing the Q set; (2) piloting; (3) participant recruitment and data collection; and (4) data analysis.

(1) SAMPLING THE CONCOURSE AND DEVELOPING THE Q SET

This phase followed the established procedure for Q methodology, which was to identify written and verbal opinions about depression, help-seeking and gender that could be argued and debated (Bryant, Green, & Hewison, 2006). Statements were identified from journal articles, questionnaires, web articles, online comments sections, blogs, Tweets, magazines, newspaper articles, and conversations. Statements were grouped into themes, and searching continued until new themes ceased to emerge. A selection of statements was chosen from each theme, and the wording was modified to ensure they were concise and clear. This procedure is a robust qualitative practice, which results in a pool of statements that represent the field of enquiry (Stainton Rogers, 1995).

(2) PILOTING

Phase 1 resulted in 66 statements. Five male acquaintances of the first author completed a Q sort of these, gave feedback on the language, wording and experience of completing the task, and suggested anything they thought was missing. Based on their feedback, the Q set was modified, resulting in 57 final items, shown in Box 1.

<BOX 1>

(3) PARTICIPANT RECRUITMENT AND DATA COLLECTION

Sampling strategy and recruitment

One application of single Q methodology studies is to explore the perspectives of members of a specific group (Watts & Stenner, 2012), and participants can be theoretically sampled on the basis of characteristics of interest. In this study, the group

of interest was males with current depression. Advertising materials were distributed through an Improving Access to Psychological Therapies (IAPT) service, door-to-door leafleting, and advertising in a newspaper/community services local to the IAPT service. Participants were invited to respond by post, phone or email. Those that did were screened for eligibility and, if appropriate, invited to a research appointment.

Inclusion/exclusion criteria and sample size

Inclusion criteria were: (1) male; (2) aged ≥18 years; (3) score of ≥10 on the 9-item Patient Health Questionnaire (PHQ-9; Kroenke, Spitzer, & Williams, 2001), which indicates moderate to severe depression requiring treatment. The exclusion criteria were: (1) unable to read study materials due to insufficient English or visual impairment; (2) current symptoms of mania or psychosis. Studies using Q methodology do not need large participant samples and, as a general rule, the number of participants should be less than the number of Q set items (Watts & Stenner, 2012).

Data collection and measures

Informed consent was obtained from all participants. Demographic data were collected, and depression was measured using the PHQ-9 (Kroenke et al., 2001). Comorbid anxiety was measured using the seven-item Generalised Anxiety Disorder Assessment (GAD-7; Spitzer, Kroenke, Williams, & Lowe, 2006). Participants' understandings of depression, treatment and help-seeking were measured with the Q sort. They were asked to read through 57 cards, each containing an item from the Q set. They split the statements into three piles to facilitate sorting: (1) broadly agree; (2) broadly disagree; (3) neither agree nor disagree, or unsure. They were then presented

with a frequency distribution (see Figure 2) and asked to place the cards according to how much they agreed with each statement relative to the others. Each participant also completed a post-sorting interview, during which they were asked to comment on the personal meaning of statements they placed at each end of the distribution, any others they felt were important, and any chosen by the researcher (e.g., based on participants' comments or apparent contradictions in the sort). They were asked about their experience of completing the task, and whether they felt anything was missing from the Q set.

<FIGURE 2>

(4) DATA ANALYSIS

Data were entered into and analysed using PQMethod (Schmolck, 2014). The first stage of analysis involved calculation of correlations between each possible pair of whole Q sorts, resulting in a correlation matrix. The second stage took the form of a centroid factor analysis, to identify patterns of association in the data – or factors – to explain the maximum possible amount of study variance. Factors were then selected for varimax rotation on the basis of the Kaiser-Guttman criterion, meaning that they needed eigenvalues of ≥1. Finally, to aid factor interpretation, a factor array, or *"single Q sort configured to represent the viewpoint of a particular factor"* (Watts & Stenner, 2012, p. 140), was derived for each factor in the accepted solution. Interpretation of the factors involved careful consideration of the items that distinguished the factors from each other, and the entire configuration of items exemplified by the factor arrays.

RESULTS

PARTICIPANTS

Figure 3 shows the number of responses received and number recruited into the study. Thirty participants were recruited in total, 29 of whom completed the Q sort successfully. One became very distressed due to his depressive symptoms, and did not feel able to complete the task. Details of the sample are given in Table 1.

<FIGURE 3>

FACTOR EXTRACTION, ROTATION AND DEVELOPMENT OF FACTOR ARRAYS

Initially, five factors were selected for extraction, which explained 54% of the study variance. Using the Kaiser-Guttman criterion, three factors were retained for orthogonal rotation using the varimax method, and accounted for 50% of the study variance. Inspection of correlations between factors revealed a significant correlation between two factors, so factor extraction and rotation were repeated to produce a two-factor solution. These two factors accounted for 45% of study variance, and were not significantly correlated with one another. This solution was therefore accepted as the best fit for the data. Factor arrays were derived, and are shown in Table 2 and in the form of Q sort distributions in Figures 4 and 5.

<TABLE 2>

<FIGURES 4 AND 5>

FACTOR INTERPRETATION

The different viewpoints are described below, and each is exemplified by selected factor-defining statements and comments of participants who were significantly associated with the factor. Factor-defining statements are those which were significantly endorsed in each viewpoint. Using these, we can analyse relationships between and possible meanings of statements, in order to create a description of the shared meaning of the viewpoint.

Viewpoint 1: Help is available if you can get to the point of asking for it

Factor 1 had an eigenvalue of 9.86 and explained 34% of the study variance. Fourteen participants (to be known as Factor 1 participants) were significantly associated with this factor ($p<0.01$). Their details are presented In Table 1, alongside those of participants who were significantly associated with Factor 2 (to be known as Factor 2 participants), and participants who weren't significantly associated with either factor.

<TABLE 1>

This viewpoint represents a relatively optimistic view of the availability and accessibility of healthcare, and the importance of accessing care to minimise the impact of depression on relationships, career and everyday functioning. As with Factor 2 (described later), many Factor 1 participants expressed a desire to be able to cope with depression alone, felt that this was the "masculine" thing to do, and feared negative judgement from other men for not being able to manage this. What differentiated the factors was that Factor 1 participants agreed more strongly that

positive aspects of help-seeking make it worthwhile, despite concerns about its meaning. Some attributed this viewpoint to their positive personal experience of help-seeking, and described how this had shifted their views over time.

"A lot of things there, before … would have applied to me … I would have been ashamed to tell anybody … I felt that I should have been man enough to deal with it." [ID1]

In this viewpoint, help-seeking is understood to be consistent with traits that are commonly perceived to be masculine, including courage and taking action to control a situation. While this viewpoint holds that there is no shame in seeking help, comments from participants suggested that this belief was arrived at only after overcoming the sense of shame for long enough to ask for help:

(12) By seeking help, people with depression are taking control of their lives +6

(55) There's no shame in asking for help +5

"It would be good if someone could come up with a way to make men realise asking for help is not weak, you know, that it's being strong" [ID1]

"I don't actually think it is [shameful to be depressed], but at the time … it's more a shame in not being able to do all the things that other people are doing or coping with … I suppose I felt inadequate really." [ID28]

Help-seeking is viewed as a duty that is owed to one's self and others, and the risks of remaining depressed outweigh the risks of help-seeking, meaning it is a

responsible action to take. The risks of remaining depressed include damage to career and important personal relationships, and increased risk of suicide:

(8) If someone is depressed, they have a duty to seek help +1

(11) Seeking help for depression has a positive impact on personal relationships +4

"I think … the consequence of these issues that men struggle with, they end up becoming huge things … [they] affect negatively, in so many ways, culture and society and the lives of other people." [ID6]

"Before I spoke to anyone I got more suicidal thoughts going through my head, so I always think now if I hadn't [spoken to someone] I might have actually acted on it." [ID28]

Available treatments are viewed as accessible and effective and generally it is understood that, if you ask for help, you will receive support, both from friends and from professionals:

(2) With the right treatment, most people can make a full recovery from depression +5

(25) Given the chance, most people would want to help someone with depression +3

(57) Men's requests for help are taken seriously by health professionals +4

After telling friends about problems: "[My friend] said, 'I didn't want to tell any of you but I've been suffering from depression recently' … and then … we were having a really important conversation. And we all felt relief." [ID6]

Viewpoint 2: Depression should be dealt with in private; help-seeking makes you vulnerable

Factor 2 had an eigenvalue of 3.19 and explained 11% of the study variance. According to this viewpoint, people – and particularly men – with depression should be able to overcome this largely or entirely on their own. Failure to do this is understood as personal weakness. There is also a sense of self-blame for the development of depression in the first place. The belief that you should be able to control your emotions and manage your problems alone appears to intensify with age, and is associated with a belief that you should be "sorted" by a certain point in life. There appear to be messages within certain generations or cultures about the role of men in society and in the family, which increase the sense of failure if help is required to deal with emotional difficulties:

(7) The only person who can help you is you +2

(29) Men should be able to handle their problems on their own -1

(33) It's harder to ask for help as you get older +4

"You're supposed to be better at dealing with this … if you handle those situations better and not let them affect you so badly and [not let them] get you to crumble then I suppose you're a better person." [ID8]

This viewpoint holds that by telling other people about depression, and requesting support to manage it, men are exposing unacceptable weakness, which contradicts societal views about what a man should be or how he should act. Through this exposure, men become vulnerable, and open themselves up to negative judgement – particularly by other men – and a loss of personal and professional status:

(51) Men with depression lose their status in society +4

(50) Seeking help for depression is likely to be career damaging +5

(56) Asking for help makes a person vulnerable and dependent on others +3

"I think women would be slightly more understanding … as opposed to men, who more look down on guys who, yeah, can't handle themselves." [ID21]

There is a sense here that people generally do not know how to cope with male distress. By showing such distress to others, men therefore become a burden, which is incompatible with hegemonic masculine values of capability and power:

(36) People get frustrated and lose patience with those who talk about how they feel +6

"I know from what's around me that tears in a man's eye look a lot different than in a woman's … You see a man crying and then you get flustered and you don't know what to do … That's me as well – I look at myself in the mirror and go 'Don't be silly, get on with it' … Men do cry but … I think their tears are more difficult that women's." [ID8]

Rather than help-seeking being viewed as a method of taking control of a situation, it is understood to be a risky move that has the potential to reduce personal control:

(14) If you see a professional for depression, they'll give you a label you don't want 0

(30) People who ask for help with depression are pressured into taking medication -1

(52) People who ask for help are pressured to talk about things they don't want to share +1

Consequently, in order to justify help-seeking, a clear understanding of and explanation for depressive symptoms is required. In the absence of an objectively distressing life event, it can be difficult to recognise depression or distinguish it from normal moods, and symptoms can be difficult to understand. This uncertainty acts as a deterrent to help-seeking:

(47) It's hard to know the difference between normal moods and depression +4

(38) You must have an obvious reason to be depressed to justify seeking help +4

"Until you speak to somebody, you don't know how bad you've got it." [ID15]

"If you can explain why you feel the way you feel then it's easier to talk to someone about it … For me, it's lack of achieving anything of substance … as far as I'm concerned, that's a pathetic reason to be depressed, so it's just something that I'll have to deal with." [ID21]

Waiting lists have an important role to play in this viewpoint. If there is a significant delay between the first attempt at accessing help and being offered a therapy appointment, it can become increasingly difficult to attend, perhaps due to changes in life circumstances or due to a perceived need to justify why low mood has persisted long after an adverse life event. Long waits can feel like the problem is not taken seriously, adding an additional layer of hopelessness and lack of faith in the system:

(15) Waiting lists for treatment are so long, help isn't available when it's needed +6

"I mean … you don't book the operating table because you've cut your finger, do you? So, if I want the operating table it's because I've got a big operation to do here. It's the same thing … if I'm asking for your help, it's because I need it now. Most of all now." [ID15]

There was a sense among participants that some elements of this viewpoint were problematic, as they would actually advise a friend to seek help. The difference appeared to be partly explained by the perspective that seeking help was the appropriate thing to do, but that it's hard to overcome the feeling that you should be able to cope alone:

(22) The advice I'd give a friend who was depressed is different to the advice I'd follow myself +1

"I would tell you to do it [get professional help]." [ID15]

Consensus statements

Factor extraction identified a number of consensus statements – i.e., those that did not distinguish between the factors (see Table 2). Some of those placed towards the "most agree" end of the sorting distribution are listed below. It was generally agreed that certain cultures place more pressure on men to be "strong" and stoic than others, and in doing so discourage help-seeking. Depression was generally understood as a medical condition, and there was a view that people with depression deserve support, which on the surface may appear to be at odds with the view in Factor 2 that one should deal with depression alone. Participants described a difference between *knowing* it is reasonable for people with depression to expect support and *feeling* that this is a sign of weakness when it's you.

(46) It's easier for people from some cultures to ask for help than others_ +3/+5

(45) People with depression deserve support from others +4/+3

(23) Depression is a medical condition that requires medical treatment +3/+3

The following statements were placed around the middle of the sorting distribution. A number of participants commented on the types of help that were available, and said that medication is easier to access and more widely promoted as a solution to depression than talking therapies, which can put some people off seeking help. While lifestyle changes were not viewed as the *best* way to beat depression, they were generally believed to be an important part of recovery.

(44) More men would seek help for depression if different types of help were available +1/0

(37) The best way to beat depression is to make lifestyles changes (e.g., exercise/diet) +1/0

Finally, the statements below were placed towards the "most disagree" end of the scale. Experience had shown participants that depression was unlikely to remit spontaneously, and most agreed that action was required. While this wasn't necessarily formal help-seeking, participants did not strongly endorse talking to friends or family about depression. While very few people recommended use of drugs or alcohol as a helpful coping strategy in the long-term, many had used substances as a way to temporarily escape their depression. As one participant said, *"These are the things I know rather than the things I do"*.

(21) Depressed people should talk to a person they're close to rather than a professional -2/-3

(26) It's better to get drunk or high than see a health professional -5/-6

(6) Depression goes away on its own sooner or later, it's better to wait than ask for help -6/-6

What was missing from the Q set?

Participants were asked whether they felt anything was missing from the Q set. Box 2 contains a set of statements based on the suggestions they made (statements they would agree with).

<BOX 2>

DISCUSSION

This study identified two viewpoints relating to male understandings of depression and help-seeking. There were some differences between the participants who were significantly associated with each factor. The majority of Factor 1 participants were in ongoing contact with IAPT services, and approximately half had previous experience of talking therapies (including counselling, cognitive-behavioural therapy and psychotherapy), which they had found helpful. Two-thirds had previous experience of medication, and nearly all had found this helpful. In contrast, a smaller proportion of Factor 2 participants were in contact with services, only one had previous experience of any talking therapy (counselling, which was described as unhelpful), and a higher proportion of those who had previously tried medication had found this unhelpful.

Participants who had helpful treatment reflected on ways their experiences differed from their expectations, which had been partly based on information in the media. Two messages stood out: (1) prior to experiencing talking therapies,

understanding of the nature and availability of these was limited, and medication was generally understood to be the main treatment option; and (2) there are few messages in the media about the positive elements of help-seeking and potential for recovery. Instead, help-seeking was felt to be related almost exclusively to the potential risks of depression, such as suicide.

Factor 1 participants initially viewed depression and help-seeking as shameful, and described attempts to cope alone prior to making contact with services. Most subsequently experienced some form of treatment and came to view help-seeking as a courageous act, involving taking control of one's life and taking positive action to improve job performance and the ability to provide for oneself or one's family – values in keeping with social constructions of masculinity. This tendency to reconstruct help-seeking as a masculine act has been identified in qualitative studies with men with depression (Emslie et al., 2006). Emphasising positive elements of the help-seeking process that are at odds with the view that this is a sign of failure, weakness or vulnerability, may therefore help to encourage help-seeking among men with depression.

A key element of Factor 2 is that uncertainty about the nature of depression and difficulty justifying being depressed tend to act as barriers to help-seeking, and that overcoming these is made even more difficult when waiting lists are long. Difficulties recognising and communicating the experience of depression have been found among men in previous research. For example, Kessler et al. (1981) found that men were less likely than women to recognise emotional distress and report serious life problems to others. Participants also noted the tendency of the media to highlight suicide as the main risk of depression – the absence of suicidal feelings then led some

to question whether what they were experiencing was depression and, if so, whether it was severe enough to justify help-seeking. This may reflect a finding of Edwards et al. (2007), who reported that men perceived anxiety and depression to be less serious than did women, although the present study did not include any male-female comparison.

Factor 2 participants were from a wider variety of ethnic groups than Factor 1 participants. Of only four people in this study who did not identify as white British, three were Factor 2 participants. Cultural values were identified by these participants as adding increased pressure to be perceived in a certain way as a man, which might be incompatible with help-seeking for depression, and most participants generally agreed that help-seeking was easier in some cultures than others. It is important to also consider the organisation of health services here, and the possibility this might favour people from some cultures over others.

Nine participants were not significantly associated with either viewpoint. In comparison with those who were associated with one of the factors, a higher proportion of these had severe depression and/or severe anxiety. This is an important consideration for future research, as severity of depression and comorbid anxiety have both been shown to be positively correlated with the likelihood of help-seeking for depression (Aromaa et al., 2001; Carragher, Adamson, Bunting, & McCann, 2010; Chartrand et al., 2012; Fortney et al., 1998; Hämäläinen et al., 2004; Hämäläinen et al., 2009; Kleinberg, Aluoja, & Vasar, 2013; Schomerus et al., 2013; Spijker, Bijl, de Graaf, & Nolen, 2001; ten Have, de Graaf, Vollebergh, & Beekman, 2004; Wang et al., 2005).

Based on the findings discussed above, the following are hypothesised to increase help-seeking for depression among men:

1. Interventions to improve recognition of depressive symptoms among men and those close to them, particularly in the absence of recent negative life events or suicidality
2. Media campaigns focusing on the positive and "masculine" elements of help-seeking, such as it being an act of taking control, and the potential for recovery
3. Improving public knowledge of the types of non-medical intervention that are available, such as psychological interventions that are designed to help individuals live according to their own personal goals and values, rather than deprive them of control.

CLINICAL IMPLICATIONS

Waiting lists were identified by participants (especially Factor 2 participants) as a barrier to taking up treatment once they had felt able to approach services. Clinical services should be aware of the impact of long waiting times on all service users, but especially those who have particular difficulty asking for help. If reduction of waiting times is not achievable, efforts could be made to offer alternative forms of support while people wait, to demonstrate that their problem is serious enough to warrant clinical attention.

During recruitment for this study, a number of men made appointments to complete the Q sort, and then cancelled on the day. Some who participated did so only after a number of rescheduled appointments, and attended somewhat reluctantly as they were anxious about the process. They usually volunteered this information at the end of the research session, while saying they were glad they had attended in the end. This may reflect the process some people go through with clinical appointments, and

highlights the importance of active engagement to minimise drop out. Clinical services face a difficult task of balancing the needs of individuals with the overall performance of the service in terms of spending, throughput of service users and minimising waiting lists.

METHODOLOGICAL CONSIDERATIONS

Q methodology is effective at identifying viewpoints about topics of interest, and so was appropriate for this study. There are, however, some limitations of the methodology. The process can be time-consuming for participants, as they are asked to think carefully about and sort a considerable number of statements (Du Plessis, 2005). Despite this, participants in this study gave positive feedback on the experience of completing the Q sort, generally describing it as interesting, enlightening and thought-provoking, even if a little daunting initially. The fixed distribution system can also cause some frustration for participants, as they may feel constricted by the set number of items that can be placed in each column.

Written Q sorts rely on participants having adequate literacy to understand the statements. If understanding is limited and this is not identified by the researcher, the validity of the sort may be compromised (Du Plessis, 2005). In this study, participants' literacy was assessed initially during the consent process, and understanding of Q set items was explored during the post-sort interview. The reliability of the Q sort procedure has at times been called into question by the finding of different results when the same participants complete Q sorts at different times. However, this is only a problem if one expects people to hold and express the same viewpoint at different times (Cross, 2005), which is unlikely. In terms of bias, as with qualitative data analysis

methods, factor interpretation and interpretation of post-sort interview data are associated with some risk of bias based on the researcher's perspective.

A key element of Q methodology is ensuring that a representative sample of the concourse is achieved. As participants can only express themselves using the statements provided, these must be as wide-ranging as possible. Lack of service user involvement during development of the Q set was a limitation of this study. In particular, the procedure would have been enhanced by the inclusion of men with depression – for example, as pilot participants. However, sources used to develop the Q set did include reported views of men with depression, and one strength of this study was that participants were asked to identify opinions that they felt were missing from the Q set, so that these can be considered in future research. Another strength of the study is that it included men with current depression, to capture viewpoints that are likely to influence help-seeking decisions at the time of need.

The participant sample was not intended to be representative of the whole population of men with depression, but was intended to include a range of men of different ages, different ethnicities and with different help-seeking histories. The majority of those who took part in the study identified as white British, were over 40 years of age, and had some experience of help-seeking. People who did not speak English or who had sensory impairments (such as blindness) were excluded from the study. This means the study potentially did not capture alternative viewpoints that might be prevalent among younger people; those from black, Asian and minority ethnic groups; those with no experience of help-seeking for depression; those who speak languages other than English; and those with particular disabilities.

AREAS FOR FUTURE RESEARCH

The findings of this study can be used to test hypotheses about viewpoints that might be associated with gender and the likelihood of help-seeking, and interventions that might help to increase rates of help-seeking among people who are at particular risk of remaining untreated. Future research based on the present findings might focus on strategies to increase awareness of depression symptoms, reduce waiting times, and increase engagement in groups that might be somewhat ambivalent about help-seeking. While this study was not designed to compare groups formally, multiple Q studies can be used to do so, and so studies using this Q set (with additional items incorporated) could be completed with groups with different help-seeking histories, or with a group of women as well as men, so that planned comparisons of viewpoints can be undertaken.

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Box 1: The Q set

(1) People who are depressed should sort out any issues in their lives, rather than seek professional help

(2) With the right treatment, most people can make a full recovery from depression

(3) It'd be easier for men to seek help for depression if there were more positive examples of this in the media

(4) If someone is depressed, they should hide how they feel to protect themselves

(5) People find it too hard to cope with listening to other people's feelings

(6) Depression goes away on its own sooner or later, it's better to wait it out than ask for help

(7) The only person who can help you is you

(8) If someone is depressed, they have a duty to seek help

(9) Professional help should be a last resort

(10) It's more risky to remain depressed than to seek help

(11) Seeking help for depression has a positive impact on personal relationships

(12) By seeking help, people with depression are taking control of their lives

(13) Therapy is just too hard to go through

(14) If you see a health professional for depression, they will give you a label you don't want

(15) Waiting lists for treatment are so long, help isn't available when it's needed

(16) Health professionals are paid to listen, they aren't interested in getting to know people as individuals

(17) If you want to access professional help, it's easy to find out how

(18) There's no point asking for help if you're depressed

(19) Treatments for depression are more suited to women than men

(20) It's better to talk to a male health professional than a female health professional

(21) If someone's depressed, they should talk to a person they're close to rather than a health professional

(22) The advice I would give to a friend who was depressed is different to the advice I would follow myself

(23) Depression is a medical condition that requires medical treatment

(24) Men should be able to control their emotions and not let things get to them

(25) Given the chance, most people would want to help someone with depression

(26) It's better to get drunk or high than see a health professional

(27) People who seek professional help are probably alone

(28) Men who seek help for depression are judged negatively by other men

(29) Men should be able to handle their problems on their own

(30) People who ask for help with depression are pressured into taking medication

(31) Talking therapy can help people with depression

(32) Men and women are treated differently by health professionals

(33) It's harder to ask for help as you get older

(34) Seeking professional help for depression is an overreaction

(35) It's possible to be an alpha male and seek professional help for depression

(36) People get frustrated and lose patience with those who talk about how they feel

(37) The best way to beat depression is to make lifestyles changes, like doing more exercise/improving your diet

(38) You must have an obvious reason to be depressed to justify seeking help

(39) Men who seek help for depression are judged negatively by women

(40) The NHS is up to the job of helping people with depression

(41) Getting information and advice from the internet is better than getting it from the GP

(42) It's too hard to attend treatment due to time, travel or other commitments

(43) People who seek professional help for depression risk losing their freedom

(44) More men would seek help for depression if different types of help were available

(45) People with depression deserve support from others

(46) It's easier for people from some cultures to ask for help than others

(47) It's hard to know the difference between normal moods and depression

(48) Asking for help is a sign of strength and courage, not weakness

(49) Health professionals have a good understanding of the challenges that are faced by men

(50) Seeking help for depression is likely to be career-damaging

(51) People with depression lose their status in society

(52) People who ask for help with depression are pressured into talking about things they don't want to share

(53) Health professionals understand and respect different cultural experiences and needs

(54) It's possible for someone to snap themselves out of depression

(55) There's no shame in asking for help

(56) Asking for help makes a person vulnerable and dependent on others

(57) Men's requests for help are taken seriously by health professionals

Table 1: Details of the sample by association with factors

	Factor 1 (n = 14)	**Factor 2 (n = 6)**	**No factor (n = 9)**
Age range (years)	30-75	37-80	38-61
Mean age (years)	55	52	49
Self-defined ethnicity:			
White British	13 (93%)	3 (50%)	9 (100%)
African	1 (7%)	1 (17%)	-
African mix Arab	-	1 (17%)	-
British Egyptian	-	1 (17%)	-
Currently employed	5 (36%)	2 (33%)	5 (56%)
Post-school education	7 (50%)	4 (67%)	5 (56%)
Depression (PHQ-9):			
Moderate	5 (36%)	2 (33%)	2 (22%)
Moderately severe	7 (50%)	3 (50%)	5 (56%)
Severe	2 (14%)	1 (17%)	2 (22%)
Anxiety (GAD-7):			
None/mild	7 (50%)	2 (33%)	2 (22%)
Moderate	6 (43%)	2 (33%)	-
Severe	1 (7%)	2 (33%)	7 (78%)
Current contact with services:			
None	3 (21%)	3 (50%)	1 (11%)
Ongoing contact with IAPT	11 (79%)	3 (50%)	8 (89%)
Previous treatment (helpful?):			
Medication	9 (64%), 8 helpful	4 (67%), 2 helpful	5 (56%), 4 helpful

Talking therapy	6 (43%), 6 helpful	1 (17%), 0 helpful	9 (100%), 8 helpful
Other/self-help	5 (36%)	1 (17%)	4 (44%)

Table 2: Factor arrays for Factors 1 and 2 (consensus statements in grey)

Item no.	Statement (with some abbreviations)	Factor arrays	
		F1	F2
1	People who are depressed should sort out issues in their lives, rather than seek help	-4	-2
2	With the right treatment, most people can make a full recovery from depression	5	-4
3	It'd be easier for men to seek help if there were more positive examples in the media	3	2
4	If someone is depressed, they should hide how they feel to protect themselves	-5	-5
5	People find it too hard to cope with listening to other people's feelings	1	0
6	Depression goes away sooner or later, it's better to wait it out than ask for help	-6	-6
7	The only person who can help you is you	-3	2
8	If someone is depressed, they have a duty to seek help	1	-2
9	Professional help should be a last resort	-5	-3
10	It's more risky to remain depressed than to seek help	5	1
11	Seeking help for depression has a positive impact on personal relationships	4	1
12	By seeking help, people with depression are taking control of their lives	6	-1
13	Therapy is just too hard to go through	-1	0
14	If you see a health professional for depression, they will give you a label you don't want	-3	0
15	Waiting lists for treatment are so long, help isn't available when it's needed	0	6
16	Health professionals are paid to listen, they aren't interested in getting to know people	-1	3
17	If you want to access professional help, it's easy to find out how	3	-5
18	There's no point asking for help if you're depressed	-6	-4
19	Treatments for depression are more suited to women than men	0	0
20	It's better to talk to a male health professional than a female health professional	-3	-4
21	If someone's depressed, they should talk to a person they're close to, not a professional	-2	-3
22	The advice I would give a friend is different to the advice I would follow myself	-1	1
23	Depression is a medical condition that requires medical treatment	3	3
24	Men should be able to control their emotions and not let things get to them	-4	-2
25	Given the chance, most people would want to help someone with depression	3	-1
26	It's better to get drunk or high than see a health professional	-5	-6
27	People who seek professional help are probably alone	-1	2

28	Men who seek help for depression are judged negatively by other men	0	5
29	Men should be able to handle their problems on their own	-3	-1
30	People who ask for help with depression are pressured into taking medication	-3	-1
31	Talking therapy can help people with depression	4	2
32	Men and women are treated differently by health professionals	0	1
33	It's harder to ask for help as you get older	0	4
34	Seeking professional help for depression is an overreaction	-4	-4
35	It's possible to be an alpha male and seek professional help for depression	2	-3
36	People get frustrated and lose patience with those who talk about how they feel	1	6
37	The best way to beat depression is lifestyles changes, like more exercise/improving diet	1	0
38	You must have an obvious reason to be depressed to justify seeking help	-1	4
39	Men who seek help for depression are judged negatively by women	1	1
40	The NHS is up to the job of helping people with depression	2	-5
41	Getting information and advice from the internet is better than getting it from the GP	-2	-1
42	It's too hard to attend treatment due to time, travel or other commitments	-1	0
43	People who seek professional help for depression risk losing their freedom	-2	-1
44	More men would seek help for depression if different types of help were available	1	0
45	People with depression deserve support from others	4	3
46	It's easier for people from some cultures to ask for help than others	3	5
47	It's hard to know the difference between normal moods and depression	2	4
48	Asking for help is a sign of strength and courage, not weakness	6	3
49	Health professionals have a good understanding of the challenges that are faced by men	2	-3
50	Seeking help for depression is likely to be career-damaging	0	5
51	People with depression lose their status in society	0	4
52	People who ask for help are pressured into talking about things they don't want to share	-2	1
53	Health professionals understand and respect different cultural experiences and needs	2	-2
54	It's possible for someone to snap themselves out of depression	-4	-2
55	There's no shame in asking for help	5	2
56	Asking for help makes a person vulnerable and dependent on others	-2	3
57	Men's requests for help are taken seriously by health professionals	4	-3

Box 2: Statements missing from the Q set, according to participants

- Treatment should be available for as long as it takes to get better
- Healthcare professionals need to be more loving and accepting
- If you had a male idol who came out as having treatment for depression, it would make it easier
- The media should present positive stories of recovery, not just use scare tactics about suicide
- People with depression can carry on with life if they identify it and do something about it
- Schools should allow boys opportunities to talk about their worries in front of other boys and men
- The attitudes of those in authority (e.g., your boss) affect your decisions about help-seeking
- Having had depression is something you would worry about telling a potential girlfriend
- The symptoms of depression make help-seeking too hard
- People may have positive beliefs about depression that influence help-seeking (e.g., it increases creativity)

Figure 1: Example of a Q sorting distribution for 40 sample items, where psychological significance is measured on an 11-point scale of relative importance

-5	**-4**	**-3**	**-2**	**-1**	**0**	**+1**	**+2**	**+3**	**+4**	**+5**

MOST UNIMPORTANT **MOST IMPORTANT**

Figure 2: The Q sort board and instructions

What are your views on seeking help for depression?

Please sort the cards in order to best describe your views.

-6	-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5	+6

MOST DISAGREE **MOST AGREE**

Figure 3: Recruitment flow chart

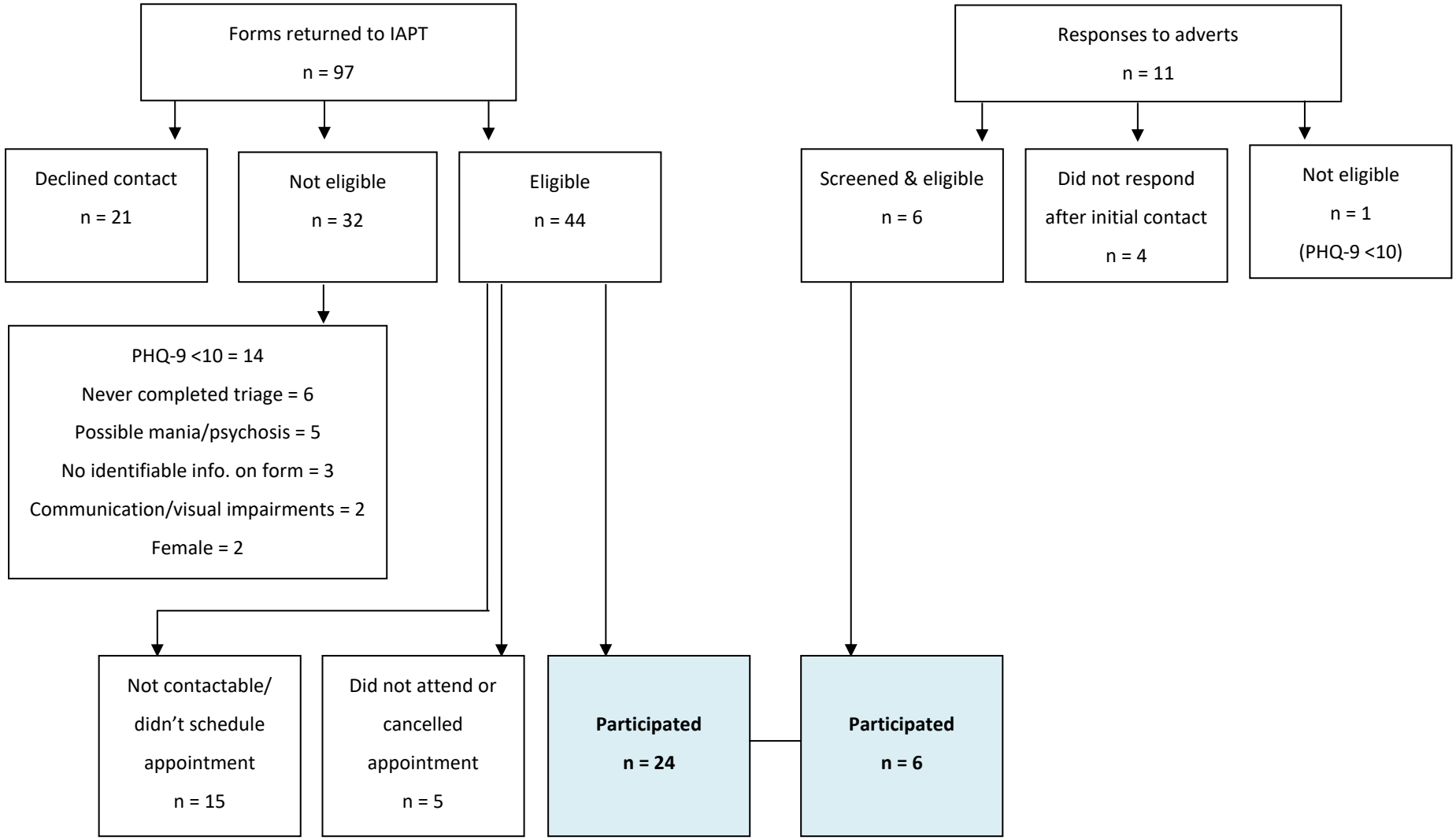

Figure 4: Factor array for Factor 1

-6	-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5	+6
						51 People with depression lose their status in society						
					42 It's too hard to attend treatment due to time, travel or other commitments	**50** Seeking help for depression is likely to be career-damaging	**44** More men would seek help for depression if different types of help were available					
			30 People who ask for help with depression are pressured into taking medication	**56** Asking for help makes a person vulnerable and dependent on others	**38** You must have an obvious reason to be depressed to justify seeking help	**33** It's harder to ask for help as you get older	**39** Men who seek help for depression are judged negatively by women	**53** Health professionals understand and respect different cultural experiences and needs	**46** It's easier for people from some cultures to ask for help than others			
		54 It's possible for someone to snap themselves out of depression	**29** Men should be able to handle their problems on their own	**52** People who ask for help with depression are pressured into talking about things they don't want to share	**27** People who seek professional help are probably alone	**32** Men and women are treated differently by health professionals	**37** The best way to beat depression is to make lifestyles changes, like exercise/diet	**49** Health professionals have a good understanding of the challenges that are faced by men	**25** Given the chance, most people would want to help someone with depression	**57** Men's requests for help are taken seriously by health professionals		
	26 It's better to get drunk or high than see a health professional	**34** Seeking professional help for depression is an overreaction	**20** It's better to talk to a male health professional than a female health professional	**43** People who seek professional help for depression risk losing their freedom	**22** The advice I would give to a friend who was depressed is different to the advice I would follow myself	**28** Men who seek help for depression are judged negatively by other men	**36** People get frustrated and lose patience with those who talk about how they feel	**47** It's hard know the difference between normal moods and depression	**23** Depression is a medical condition that requires medical treatment	**45** People with depression deserve support from others	**55** There's no shame in asking for help	
18 There's no point asking for help if you're depressed	**9** Professional help should be a last resort	**24** Men should be able to control their emotions and not let things get to them	**14** If you see a health professional for depression, they will give you a label you don't want	**41** Getting information and advice from the internet is better than getting it from the GP	**16** Health professionals are paid to listen, they aren't interested in getting to know people	**19** Treatments for depression are more suited to women than men	**8** If someone is depressed, they have a duty to seek help	**40** The NHS is up to the job of helping people with depression	**17** If you want to access professional help, it's easy to find out how	**31** Talking therapy can help people with depression	**10** It's more risky to remain depressed than to seek help	**48** Asking for help is a sign of strength and courage, not weakness
6 Depression goes away on its own sooner or later, it's better to wait it out than ask for help	**4** If someone is depressed, they should hide how they feel to protect themselves	**1** People who are depressed should sort out any issues in their lives, rather than seek professional help	**7** The only person who can help you is you	**21** If someone's depressed, they should talk to a person they're close to rather than a health professional	**13** Therapy is just too hard to go through	**15** Waiting lists for treatment are so long, help isn't available when it's needed	**5** People find it too hard to cope with listening to other people's feelings	**35** It's possible to be an alpha male and seek professional help for depression	**3** It would be easier for men to seek help for depression if there were positive examples in the media	**11** Seeking help for depression has a positive impact on personal relationships	**2** With the right treatment, most people can make a full recovery from depression	**12** By seeking help, people with depression are taking control of their lives

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Figure 5: Factor array for Factor 2

						44 More men would seek help for depression if different types of help were available						
					43 People who seek professional help for depression risk losing their freedom	**42** It's too hard to attend treatment due to time, travel or other commitments	**52** People who ask for help with depression are pressured into talking about things they don't want to share					
			57 Men's requests for help are taken seriously by health professionals	**54** It's possible for someone to snap themselves out of depression	**41** Getting information and advice from the internet is better than getting it from the GP	**37** The best way to beat depression is to make lifestyles changes, like exercise/diet	**39** Men who seek help for depression are judged negatively by women	**55** There's no shame in asking for help	**56** Asking for help makes a person vulnerable and dependent on others			
		34 Seeking professional help for depression is an overreaction	**49** Health professionals have a good understanding of the challenges that are faced by men	**53** Health professionals understand and respect different cultural experiences and needs	**30** People who ask for help with depression are pressured into taking medication	**19** Treatments for depression are more suited to women than men	**32** Men and women are treated differently by health professionals	**31** Talking therapy can help people with depression	**48** Asking for help is a sign of strength and courage, not weakness	**51** People with depression lose their status in society		
	40 The NHS is up to the job of helping people with depression	**20** It's better to talk to a male health professional than a female health professional	**35** It's possible to be an alpha male and seek professional help for depression	**24** Men should be able to control their emotions and not let things get to them	**29** Men should be able to handle their problems on their own	**14** If you see a health professional for depression, they will give you a label you don't want	**22** The advice I would give to a friend who was depressed is different to the advice I would follow myself	**27** People who seek professional help are probably alone	**45** People with depression deserve support from others	**47** It's hard know the difference between normal moods and depression	**50** Seeking help for depression is likely to be career-damaging	
26 It's better to get drunk or high than see a health professional	**17** If you want to access professional help, it's easy to find out how	**18** There's no point asking for help if you're depressed	**21** If someone's depressed, they should talk to a person they're close to rather than a health professional	**8** If someone is depressed, they have a duty to seek help	**25** Given the chance, most people would want to help someone with depression	**13** Therapy is just too hard to go through	**11** Seeking help for depression has a positive impact on personal relationships	**7** The only person who can help you is you	**23** Depression is a medical condition that requires medical treatment	**38** You must have an obvious reason to be depressed to justify seeking help	**46** It's easier for people from some cultures to ask for help than others	**36** People get frustrated and lose patience with those who talk about how they feel
6 Depression goes away on its own sooner or later, it's better to wait it out than ask for help	**4** If someone is depressed, they should hide how they feel to protect themselves	**2** With the right treatment, most people can make a full recovery from depression	**9** Professional help should be a last resort	**1** People who are depressed should sort out any issues in their lives, rather than seek professional help	**12** By seeking help, people with depression are taking control of their lives	**5** People find it too hard to cope with listening to other people's feelings	**10** It's more risky to remain depressed than to seek help	**3** It would be easier for men to seek help for depression if there were positive examples in the media	**16** Health professionals are paid to listen, they aren't interested in getting to know people	**33** It's harder to ask for help as you get older	**28** Men who seek help for depression are judged negatively by other men	**15** Waiting lists for treatment are so long, help isn't available when it's needed
-6	**-5**	**-4**	**-3**	**-2**	**-1**	**0**	**+1**	**+2**	**+3**	**+4**	**+5**	**+6**

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