Journal of Affective Disorders 188 (2015) 179–187

Contents lists available at ScienceDirect

Journal of Affective Disorders

journal homepage: www.elsevier.com/locate/jad

Research report

Men's use of positive strategies for preventing and managing depression: A qualitative investigation

Andrea S. Fogarty [a,*], Judy Proudfoot [a,b,c], Erin L. Whittle [a], Michael J. Player [a,c], Helen Christensen [a,b,c], Dusan Hadzi-Pavlovic [a,c], Kay Wilhelm [a,d]

[a] Black Dog Institute, Hospital Road, Randwick, NSW 2031, Australia
[b] NHMRC Centre for Research Excellence in Suicide Prevention, Sydney, Australia
[c] Faculty of Medicine, University of New South Wales, Sydney, Australia
[d] Faces in the Street, Urban Mental Health and Wellbeing Institute, Level 6, O'Brien Building, Victoria Street, Darlinghurst, NSW 2010, Australia

ARTICLE INFO

Article history:
Received 15 June 2015
Received in revised form
30 July 2015
Accepted 29 August 2015

Keywords:
Men
Depression
Coping strategies
Prevention
Management

ABSTRACT

Background: One in eight men experience depression and men account for 75% of suicides. Previous research has focused on men's reluctance to seek help and use of unhelpful coping strategies.
Method: Thematic analysis was used on transcripts from 21 focus groups and 24 in-depth interviews focused on positive strategies men use to prevent and manage depression.
Results: In total, 168 men were recruited and the majority (63%) reported no current depression. Four major themes were identified, where men: (1) used a broad variety of positive strategies and made clear distinctions between prevention and management, (2) used strategies that were "typically masculine", as well as challenged expectations of manliness, (3) felt powerless in the face of suicide, and (4) had accumulated wisdom they felt was beneficial for others. Men specifically advised others to talk about problems. Prevention relied upon regular routines for "balance", while management relied upon "having a plan".
Limitations: The majority of the men were aged over 55 years and highly educated. Younger men or those without tertiary education may favour different strategies.
Conclusions: In contrast to using only unhelpful strategies, the men used a broad range of positive strategies and adapted their use depending on mood, symptom or problem severity. Use of positive strategies was sophisticated, nuanced, and often underlined by a guiding philosophy. Rather than simply reacting to problems, men actively engaged in preventing the development of depressed moods, and made conscious choices about when or how to take action. Clinical and public health implications are discussed.

1. Introduction

Worldwide, mental health and substance disorders are leading contributors to non-fatal disease, accounting for 183.9 million disability adjusted life years (Whiteford et al., 2013). Women are more likely than men to experience depression (Angst et al., 2002), while men are more likely to report substance use and externalising disorders (Addis, 2008). Mirroring global patterns, Australian women report higher rates of distress, but men report more than twice the rate of substance use problems (Australian Bureau of Statistics, 2012), and account for 75% of suicides (Australian Bureau of Statistics, 2014).

While debate continues about specific contributing factors to these gender differences (Nolen-Hoeksema, 2001; Parker and Brotchie, 2010; Piccinelli and Wilkinson, 2000), it is clear that men are at greater risk of suicide, men's depression can be "hidden" (Brownhill et al., 2005), or under-diagnosed by traditional measures (Danielsson and Johansson, 2005; Kilmartin, 2005), and men are less likely than women to seek help (Addis and Mahalik, 2003; Angst et al., 2002). Barriers to help-seeking include pervasive effects of personal shame and perceived stigma (Danielsson and Johansson, 2005; Hall and Partners, 2012; Heifner, 1997; Ritchie, 1999), apprehension about health professionals or what treatment "means" (Hoy, 2012; Mansfield et al., 2003), and the influence of masculine norms, which can limit emotional expression while emphasising self-sufficiency (Addis, 2008; Addis et al., 2010; Magovcevic and Addis, 2005). For some men, help-seeking is associated with a loss of personal identity (Hall and Partners, 2012) and may only be sought once they are "desperate" (Johnson et al., 2012).

* Corresponding author: Fax: +61 2 9382 8207.
E-mail address: a.fogarty@unsw.edu.au (A.S. Fogarty).

http://dx.doi.org/10.1016/j.jad.2015.08.070
0165-0327/

Furthermore, men use fewer coping strategies than women (Tamres et al., 2002), with recent research emphasising that men often cope with distress and depression using unhelpful strategies (Nolen-Hoeksema, 2012). A recent meta-ethnographic approach found that men expressed feelings of anger, hostility and aggression and subsequently employed strategies such as using drugs, alcohol, over-work or taking sexual risks, as ways to numb, avoid, or distract from depression (Addis, 2008; Brownhill et al., 2005; Hoy, 2012). Using ineffective coping strategies thus contributes to prolonged depression, lower detection, and treatment delays (Brownhill et al., 2005; Hausmann et al., 2008).

Some research has identified positive strategies men use to cope with depression, including taking time out, reframing negative events, problem solving, physical activities, meditation, and stronger social connections (Brownhill et al., 2005; Ramirez and Badger, 2014). However, men's maladaptive responses are a more predominant theme in the literature (Whittle et al., 2015), where more articles feature men's use of negative coping strategies than adaptive (Hoy, 2012). Where positive strategies are reported, their use is often acknowledged as occurring after a period of worsening symptoms, reluctance to seek help, and failure of strategies that only provided temporary relief (Chuick et al., 2009; Ramirez and Badger, 2014; Whittle et al., 2015).

Given this context, it is essential to consider how men manage depression naturally, or cope in the absence of clinical intervention. The present study therefore examined positive strategies identified by men as effective for preventing and managing depression.

2. Method

Data was collected using in-depth interviews and focus groups with men in New South Wales and Victoria, Australia with reporting informed by the Consolidated Criteria for Reporting Qualitative Research (COREQ) (Tong et al., 2007). Focus groups were chosen owing to their strengths in exploring how and why people think about particular issues (Kitzinger, 1995), as well as their ability to stimulate interactions or increase participation of people who become engaged by group discussion (Kitzinger, 1994; Willis et al., 2009). Interviews were also offered in recognition that some participants may feel more comfortable discussing sensitive topics alone (Biddle et al., 2013). At each location, we aimed to recruit two interview participants and 12 focus group participants.

The research was led by two senior academics (JP, KW), with extensive experience and qualifications in psychiatric research, who provided training in risk management. All interviews and focus groups were conducted by one of three facilitators (EW, MP, AF), with previous research experience and academic qualifications in mental health.

2.1. Recruitment

Men were recruited from twelve metropolitan and non-metropolitan locations. The study was promoted via partner organisations, including Men's Sheds, community-based men's organisations and the lead institution's professional and digital networks. A local facilitator was employed at nine locations to publicise the study, recruit participants, arrange a venue, and identify local mental health services.

The recruitment flyer asked “What do you do when things get tough?” and avoided the words “depression” or “suicide” in order to attract men both with and without previous experience with depression. This approach was taken so as to identify as broad a range of positive strategies as possible, including: strategies used by men not in contact with health services, strategies particularly relevant to prevention among men who had not been depressed and strategies specific to management among those who had. Men were eligible if they were aged 18 years or more and could attend the specified time.

2.2. Procedures

Men participated in face-to-face interviews or focus group discussions with between six and eight participants and each location was attended by two facilitators. Participants were given an information sheet and gave signed consent. A questionnaire collected demographic information, assessed current depression via the Patient Health Questionnaire-9 (PHQ-9) (Kroenke et al., 2001), and asked about lifestyle and history of depression.

As recommended for discussions involving sensitive topics (Biddle et al., 2013), participant wellbeing was monitored. Men indicated on a visual analogue scale of 1 (*“as unhappy as I can be”*) to 10 (*“as happy as I can be”*) how they were feeling before the discussion/interview and again afterwards. All focus groups and interviews lasted between 45 and 90 min. The introduction emphasised confidentiality and that there were no right or wrong answers. Participants gave written feedback and were reimbursed AU$50 for their time and travel. All discussions were digitally recorded and transcribed.

A semi-structured interview schedule included “ice-breaker” questions to help participants talk generally about mental health, before moving to personalised questions about how they prevent, intervene early, and/or manage feeling down. Questions were open-ended, with specified prompts (Table 1). It was expected that men without previous depression experience may find questions about suicide confronting. As such, questions about suicide were asked in the third person with men able to disclose personal experiences if they chose.

2.3. Risk management

“At-risk” participants were identified by: (i) indicating current suicidal thinking (score higher than 0 on item ix of the PHQ-9); (ii) indicating current depression (PHQ-9 score of 19 or more); (iii) indicating worsening mood after participation (lower score on the visual analogue scale); or (iv) exhibiting distress and/or disclosing suicidal thinking during the discussion/interview. At-risk participants were followed up by a researcher at the close of discussion, who remained until their distress eased. For those requiring further follow-up, permission was sought to contact a family member and/or their GP. In rare cases of severe distress, the researcher contacted local services and the lead clinician (KW). All incidents were logged and reviewed.

All participants received a resources sheet for further information, referral or services and were able to choose three wallet-sized “coping cards” to keep. The cards contained short coping tips, or brief exercises (e.g. mindful breathing). Participants were contacted the following week, querying whether any concerns had arisen.

2.4. Data analysis

Thematic analysis was chosen to interrogate the data, owing to its flexibility (Aronson, 1995), rigour (Fereday and Muir-Cochrane, 2006) and common use in psychology research (Healey et al., 2009; Joffe and Yardley, 2004; Wright et al., 2012). Thematic analysis allows for the identification, analysis, interpretation and reporting of patterns within qualitative data (Tuckett, 2005), as well as recognises the reflexive role of the researcher in presenting the data (Mays and Pope, 2000).

For these analyses, a primarily inductive approach was

Table 1
Focus group and interview schedule.

Ice-breaking	
Q1	What are some of the words men use to describe feeling down?
Q2	How can you tell if a man is feeling down *[or use participant's words]?*
Q3	Can you tell if a woman is feeling down *[or use participant's words]*?
Prevention	
Q4	On a day-to-day to weekly basis, what sort of things do men do to stay feeling positive?
Q5	Do you have any particular things that work well for you?
Early intervention	
Q6	Most people have been through a rough patch or felt down *[or participants' words]*. How do you know when you are getting down or starting to feel blue?
Q7	What types of things do you to nip it in the bud and make yourself feel better?
Management	
Q8	Can you think about a particular time that you, or someone you know, has actually been very down *[or use participants' words]* or had a rough patch?
Q9	How did *[they/you]* deal with it?
Q10	What are some of the more unhelpful things you have seen or heard others do when they're feeling down *[or use participants' words]*?
Q11	What are some of the positive or helpful things you or other men you know have done during these times?
Suicide	
Q12	So now I want to talk about some stronger feelings that some people have when they are feeling down. If a man is really down *[or use participants' words]*, how can he stop himself thinking that that life is not worth living?
Advice	
Q13	What advice would you give to other men who might be going through something similar?
Q14	Turning now to a time when you have been through a rough patch – either a big one or a small one. What aspect of how you dealt with this situation are you most proud of?

adopted, rather than imposing a pre-existing framework. All coders (AF, EW, MP) had pre-existing familiarity with the data, having conducted the data collection. To ensure immersion, each coder listened to multiple recordings while editing transcripts for errors and re-reading each transcript. Transcripts were de-identified and imported into a project file in NVivo10 (QSR International, 2014).

Initial line-by-line coding was undertaken independently by three coders on the same two transcripts, to generate first-stage coding. These codes were discussed and refined until all three coders agreed upon a resultant framework to apply to a further three transcripts. A second discussion included refinement of codes and generation of tentative thematic groupings in the data. All coders used coding memos to record ideas about possible interpretations. Primary coding and analysis of the remaining transcripts was then completed by EW and AF, following five (non-linear) phases of thematic analysis (Braun and Clarke, 2006). This included identification of similarities and differences across the transcripts, sorting codes into themes and collating data extracts within themes. Themes were confirmed, named and defined via a process of constant comparison across individual transcripts and emergent themes were tested against coded transcripts. Regular meetings were held with the study team to discuss the analysis and refine the results. Transcripts from interviews and focus groups were analysed concurrently, using the same methodological approach. Only one interview transcript from each location was coded line-by-line, with remaining interview transcripts read for consistency with the findings.

The study was approved by the UNSW Human Research Ethics Committee.

3. Results

3.1. Demographic and clinical profile

In total, 168 men participated (Table 2) ranging in age from 19 to 92 years (mean 55.7; SD 18.5). Half were retired, and more than half (56.5%) were married or in de-facto relationships. Two-thirds (69.1%) were tertiary educated (Table 3).

The majority (62.7%) reported no current depression symptoms; a third (33.0%) reported mild-to-moderate depression, with only 4.4% experiencing moderate-to-severe depression (Table 2). Over half (52.4%) had ever been depressed, 25.9% had taken anti-depressants and 36.5% had sought help from a GP or health professional (29.4%).

3.2. Thematic analysis results

A principal finding was that the positive strategies identified by men did not vary according to previous experience with depression. There were some exceptions, for example, men without a history of depression were unlikely to report using anti-depressant medications as strategy. But on the whole, the positive strategies were used by men to prevent and manage depressed moods in similar way. As such, reporting of themes applies to the group as a whole. In the majority of groups, there were broad levels of agreement among the participants, with no notable contested discussions. Where points of view differed, most participants appeared to both acknowledge and support that differences result from individual preferences, with many providing feedback that they had learned useful and new strategies from listening to others. Only one discussion appeared to be negatively affected by the opinions of a dominant participant, with group members reducing their level of engagement in the discussion. Data analyses identified four major themes and nine related sub-themes. Where possible, participants with different points of view are reported in each theme.

3.3. Theme 1: A range of positive strategies on standby

Men reported using of a broad variety of adaptive coping strategies and choosing a particular strategy depended on what they were feeling and/or perceiving that action was needed. They described taking steps to ensure overall health through the use of

Table 2
Location of interviews and focus groups.

State	Interview participants (*n*)	Focus group participants (*n*)	Number of focus groups (*n*)
New South Wales			
Metropolitan	6	36	6
Non-metro	7	37	5
Victoria			
Metropolitan	4	31	4
Non-metro	7	40	6
TOTAL	**24**	**144**	**21**

Table 3
Demographic and clinical characteristics of the sample.

Demographic profile			Clinical profile		
	n	%		*n*	%
Age			**PHQ-9 severity**		
18–24 years	14	8.4	None – minimal depression (0–4)	101	62.7
25–34 years	16	9.6	Mild depression (5–9)	41	25.5
35–44 years	17	10.2	Moderate depression (10–14)	12	7.5
45–54 years	19	11.4	Moderately severe depression (15–19)	4	2.5
55–64 years	33	19.9	Severe depression (20+)	3	1.9
65–74 years	44	26.5			
75 or more years	23	13.9			
Employment			**Fantastic lifestyle questionnaire**		
Full- or part-time or self-employed	55	32.3	None-minimal changes needed (42–50)	51	37.8
Retired, full-time home duties	85	50.0	Good work, on the right track (35–41)	57	42.2
Unemployed, unemployed due to illness or injury	17	10.1	Fair (30–34)	16	11.9
Student	13	7.6	Somewhat low, you could take more control (20–29)	11	8.1
Marital status			**Ever been depressed**	88	52.4
Never married	43	25.6	(Self-reported)		
Married, de facto	95	56.5			
Separated, divorced, widowed	30	17.9			
Education			**Help seeking**		
Primary, secondary	52	31.0	Ever seen a GP for mental health problems	62	36.5
Trade, apprenticeship, certificate, diploma	64	38.1	Ever seen another health professional for mental health problems	50	29.4
Bachelor degree	27	16.1	Ever taken medication for depression	44	25.9
Post-graduate degree	25	14.9			

preventative strategies, noticing warning signs, and taking action when they were feeling down or depressed. A clear distinction arose between two stages: preventing feeling down and managing depression. Though men were asked about early-intervention, this resonated only with a minority of men who had generally previously received professional help.

3.3.1. "Prevention": the importance of investing in self-care

Taking preventative steps for mental health was a key concern for many of the men, who conceptualised prevention as investing time and energy into behaviours that directly benefited overall health. Self-care was easily articulated, with a particular emphasis on physical health as a gateway to better mental health. Men described a variety of physical activities (e.g. running) which were viewed as inextricably intertwined with mental health.

While nearly all agreed that maintaining good physical health was essential for mental health, there was considerable diversity in how they approached this. Many described individual approaches, while acknowledging that it may not have the same effect for all men. Nevertheless, where practising these behaviours was halted, or interfered with, men perceived immediate flow-on effects for how they were feeling:

> "*I think along with activity, but eating well and getting plenty of sleep. I find if I don't sleep well then all hell breaks loose pretty quickly.*" (FG56yrs)

Men also acknowledged that while some activities had clear physical health benefits, their motivation was often in pursuit of mental health "side benefits", for example socialising and connecting with friends through regular contact:

> "*…you are taking the focus off your negative feelings and you are also interacting with other people. So it mixes things together and helps a lot.*" (FG19yrs)

Enjoyable activities were also important to preventing worsening moods, or depression. Pleasurable activities took a variety of forms, with some emphasising that having time to one's self was important, while others focused on social connections as crucial factors in not having "too much" time alone. Not having the time or space to pursue enjoyable activities was perceived as a threat to their mood and many emphasised the importance of incorporating such activity into a daily routine with real protective benefits:

> "*I watch the sunrise over the park every morning and listen to the birds, and then I get up and I go for a run or a ride on my bike, and it sets me up for the day.*" (FG50yrs)

Men also articulated guiding principles underpinning self-care, for example a conception of "balance" representing ideal prevention. Where balance was maintained, it represented a smoothly running system, while having the incorrect balance could only be sustained for a short time before having negative effects. For some, balance was a concrete concept, such as avoiding an over-crowded schedule, while for others it involved balancing their own needs with the perceived needs of others:

> "*I was just giving too much of myself to too many people… there was not enough left for me. So I have said no to a lot of things, and I have narrowed my focus and so now life is a lot more abundant…*" (FG30yrs)

Of key importance is that generally men described a process of conscious engagement with a variety of activities as a way of maintaining mental wellbeing. However, one participant conceived of this differently, arguing that is was a "chicken and egg" scenario and denied he specifically engaged with prevention:

> "*I do them because I like to keep active and interested. I donot do them to avoid having a bad mood…*" (I68yrs)

3.3.2. "Management": tools to use, as required

Men acknowledged times when they began to feel down, or experienced adversity that interrupted prevention. They described the processes they used to respond to such times, often articulating management in both proactive and reactive terms. On the whole, the men conceived of management as using additional resources and recognising the need to solve or mitigate problems that contributed to feeling down or depressed:

> "*I call it clutter removal. All the things that clutter up my life that are unnecessary, I will remove. I will simplify my life.*" (FG69yrs)

For many, mood management was characterised by a sense of perspective – of having tried other approaches and arriving at realisations through maturity or experience. In particular, for one man, management shifted from being a reactive process to a proactive attempt to change his mind-set and understand his circumstances differently:

> "*Am I going to keep choosing to stay in this vicious circle or am I going to choose something different and get out of this hole one step at a time?*" (I49yrs)

Management was constantly underlined by the importance of

having a "structure" to rely upon, which helped men to retain a sense of control and was often voiced in terms of prioritising tasks or devising a plan to tackle stress. An essential element of this "structure" was the need to persevere, even if they did not feel like it:

> "*… you feel like you are walking through wet cement… even though it is tough if you keep going, it is actually the path back out.*" (FG56yrs)

Others highlighted the importance of choosing to focus on certain things in order to cope. This included practicing gratitude exercises, where men described actively assessing their day for positive moments. Men stressed that persistence and practice were key elements to creating habitual behaviour, which they associated with lasting changes in mood management. Notably, management was sometimes described as something that they could only skilfully practice after learning things "the hard way" or after a "close call". A few described a stage before management, where they were able to detect warning signs (e.g. tiredness, losing interest in music) and intervene to take action early. However, this was not a commonly held understanding.

3.3.3. Strategies as flexible and adaptive

The flexible use of the same strategy for different scenarios was a key sub-theme, with men emphasising that their favoured strategies adapted across prevention and management (e.g. exercise). Some described how a disciplined approach to exercise helped prevent depression, but explained that they might exercise more intensively, or with a friend, when they were experiencing feelings of frustration. Others described responding to warning signs by getting out for a run, while for others the early warning sign itself was not wanting to exercise. In short, the use of a particular activity was adapted to specific needs or moods at specific times.

> "*If I don't [exercise] for a couple of days and I start getting a bit ratty, I think. It is also good for prevention, but it is also good for unwinding, so after a really tough day at work it is cool. And the tougher the day it is the harder I will ride…*" (FG30yrs)

Similarly, another described how initially, starting anti-depressant medication was necessary in managing a particularly depressed period. However, he now viewed it as a form of prevention, since incorporating it into a daily routine:

> "*I think [medication] is an invisible suit of armour that makes bullets bounce off…*" (FG47yrs)

3.4. Theme 2: Recurrent ideas about "manliness"

A central theme was the influence of what constituted "manly" behaviours. Men described a shared societal understanding of a "typical" man, which directly affected how they handle problems.

> "*Men are supposed to be strong when…things get tough, the tough get going. It is put into our psyche. And I think men are expected to perform, and I think this is probably why we have trouble admitting when things are bad.*" (FG50yrs)

However, not all men identified with this ideal, even while describing its potential to affect others. In particular, the men moved fluidly between discussing their use of "typically masculine" strategies and those strategies characterised in the literature, or by the men themselves, as "feminine". Some differences did emerge in that some positive strategies "instinctively" felt right, or came naturally to the men (i.e. typically masculine behaviours), while other, more feminine strategies may not have come "naturally" to begin with, but were useful now.

3.4.1. Recurring influence of "typical masculinity"

The men referenced prevailing ideas of self-sufficiency and problem solving. Relief from stress was sought through examining the causes of problems and approaching a solution "logically", with the added benefit that solving problems improved self-worth and could boost motivation. Likewise, having a plan helped buoy confidence, in that finding a solution allowed them to move on.

> "*Isn't that such a typical man way of doing? We look for a reason; how do we fix that reason.*" (FG35yrs)

Goal-setting was also strongly tied to manly pride. While this varied considerably in terms of whether goals were short-term (e.g. daily to-do list) or long-term (e.g. train for a marathon), they all related to feeling accomplished, seen as essential to wellbeing. They also described using an analytical thought process to "reframe" the way they looked at problems, in order to gain a new and potentially useful perspective. For some this occurred naturally, while others described learning the process:

> "*…the thing for me that is the most effective is classic [Cognitive Behaviour Therapy]… I think of it as challenging a negative reaction…it had to really be shown to me that you can do that, that you can actually change your opinion about something… that your reactions don't have to be fixed and that they are quite often wrong, and as soon as that was shown to me, it was like a light coming on.*" (FG47yrs)

Thought reframing was common, even among those who had not received CBT. Men described asking a series of questions, with the goal of changing their thoughts (e.g. was there was another way to look at it, were they were overreacting). Asking questions allowed men to consciously choose a different approach, or an optimistic view, rather than be at the mercy of feelings.

Goal-setting, thought reframing and accomplishment were tied to typically masculine domains and pressures to be successful, often felt in the work place. The common factor to these strategies was an attempt to take a new perspective, which helped to change how problems were interpreted.

3.4.2. Challenging expectations of manliness

Discussion consistently highlighted how conforming to stereotypically male behaviours could be detrimental to mental health. They considered an inability to talk about emotions as a problem and openly spoke about challenging these expectations. These positive strategies were characterised by a broad "acceptance" which could take the form of accepting their current situation, their feelings (both good and bad), being vulnerable, or that mistakes can happen.

> "*This might be the wrong thing to say… but I just accept that I am going to feel shit sometimes… and it's not going to kill you.*" (FG30yrs)

Some spoke positively about the beneficial effects of crying. One man described it as a cathartic and cleansing process, which to him *"feels wonderful, this feels amazing"* (FG23yrs). Likewise, nearly all men spoke positively about opening up, talking about their problems and asking for help as particularly useful strategies. For some, this had not always been the case. However, the men emphasised the value of connecting with others, even if this was confronting or difficult.

Others described openness to using strategies not viewed as typically masculine, including practising meditation and mindfulness, dedication to helping others, finding their life purpose and consciously building relationships. Men also perceived that the situation was slowly changing and that men might not always be expected to live up to detrimental stereotypes. Some put this

down to greater community awareness of depression in men:

"*So it is changed… and I think that is probably cultural things… Depression in men is out there. It wasn't 50 years ago…*" (FG44yrs)

3.5. Theme 3: Silence around suicide

A key finding was that the men struggled with talking about suicide and were markedly less forthcoming with ideas about how to prevent or manage suicide risk. Only a minority disclosed personal experiences with suicide and among those with no personal experience, ideas were often couched with caveats that they were not sure about what could truly help.

3.5.1. Clueless and powerless

Many men described being clueless about what led to suicide and how this precluded them from offering suggestions, preferring to leave that to experienced people. This was particularly evident when men described knowing about another person's suicide or attempt. Often they had not perceived warning signs, and were left shocked and surprised:

"I actually had a friend that committed suicide last year… He actually never mentioned he had a problem, to nobody. He wasn't going to the doctor or whatever. So when I actually heard the news, it was very shocking." (FG22yrs)

Some described continuing bewilderment and wondered what they should have noticed. Even where they knew a person was struggling with their mood, men still described a lack of awareness of what this possibly signified.

"*…I had no impression that this sort of person was going to take their own life, no inkling that he might, no idea that he was that much down*." *(I24yrs)*

Cluelessness was often coupled with feelings of being powerless to act, having no idea how to recognise or address the seriousness of the situation. This prompted one man to wonder about the potential for other people to be at-risk:

"*… it did make me think that there are probably lots of people who are having problems with things that they don't let you know about. And it is difficult for you to recognise and therefore know how to handle it…*" *(I68yrs)*

Some worried that intervening had the potential worsen things, while others discussed the difficulty of addressing suicide prevention in existing contexts, for example, an already-crowded school curriculum. Some mentioned the lack of funding available to do real work, while others stressed a desire to "do something" and the need for society to take responsibility for the problem. However, nearly all emphasised not knowing what to say, where to start or what could work.

3.5.2. Suggested strategies

In this context, some proposed strategies when asked, but emphasised they were speaking without fully understanding the perspectives of suicidal men. Family ties were mentioned often:

"*Just thinking about who'd look after my wife…*" (I67yrs)

A few men had disclosed having made a previous attempt and they strongly agreed, describing how thinking about the aftereffects of suicide on their family, particularly children, was a motivating factor during difficult times. One man spoke about trying to find the humour in life, particularly avoiding becoming too cynical, while another described being inspired by a biography to find something to live for, no matter how difficult the circumstances:

"*…whenever I am feeling particularly shithouse, I look at the photos of my kids on my phone. And that is the thing. I think it's that one thing that you want to see the next day, and that helps.*" (FG50yrs)

3.6. Theme 4: Accumulated wisdom

Finally, a broad theme concerned wisdom that men accumulated through experience, which might be useful to others. This emerged as a retrospective examination of things they wished they had known earlier, or in the form of current advice to other men who might be struggling.

3.6.1. Talk about it

By far, the most common piece of advice concerned talking to others about problems, whether with a professional, or with a trusted friend, mentor or family member. Men emphasised the importance of choosing the right person, who was both trustworthy and understanding for talking to be beneficial:

"Developing a network, a group of people, especially a couple I can trust with… how I'm actually feeling, and people I feel safe with so I can just unpack what I'm feeling…" (FG64yrs)

For some, finding peers was essential – through joining a Men's Shed, for example – while for others, it was as simple as thinking about who cares about them. Still others stressed the importance of talking with a professional, even when they acknowledged men might have reservations. While not everybody agreed with the need to talk to a professional (one man stressed this was a measure of last resort), nearly all agreed with the need to talk to somebody:

"Find a good doctor…You know, there are an ocean of things that you can do that can better manage the mood or the depression, but in the end they can't surpass the stability of seeing someone who is looking for the warning signs and knows them…" (I38yrs)

3.6.2. This too shall pass

In keeping with some of the strategies already described, they urged other men to remember that tough times are temporary. They emphasised the importance of taking a long perspective, not reacting too quickly, and learning from experience.

"…as you get older I've found that you get better at dealing with problems, you start seeing things in better perspectives, you get a bit smarter as to how you deal with things and you learn that this too will pass. No matter what comes up, you'll deal with it. Now I wish I'd known that in my 20 s…" (FG47yrs).

To do so, they advised using strategies to ride out rough patches and revisited ideas such as: distracting themselves through hobbies, activities, helping others, doing pleasurable things, finding joy or purpose. An essential component was learning through experience that *"it's all manageable"* (I38yrs). In short, the men advised doing things that helped to shift focus from their problems to gain perspective.

3.6.3. Develop a plan

Another key piece of advice was to "have a plan". They were not prescriptive about the form a plan should take, just argued that it was useful to have an idea of how they planned to respond to problems in future. This echoes aforementioned ideas about having structure to rely upon, or guiding principles that help to prevent being down or depressed. For one man, this meant having a

plan for his life, while for others it was more concrete, with predefined steps:

> *"I really think that's a good thing. To have a flow-chart, these are the steps you can take. Have you tried this? Yes. All right. Did it work? No. Go to this one. Did that work? No. And then ultimately it's down to professional help."* (FG52yrs)

Having a plan was seen as positive self-care, in that it helped men to feel in charge of solutions. Others agreed, especially in light of a reluctance to seek outside help. They advised that having a plan of attack for future problems helped them to feel prepared and to retain a sense of self-sufficiency.

4. Discussion

The key finding was that far from using only unhelpful or ineffective coping strategies to deal with psychological distress and depression, men reported the successful use of a broad range of positive strategies and adapted their use at different times depending on mood, symptom or problem severity. The results show that men's use of these strategies was sophisticated and nuanced, and often underlined by a guiding philosophy or approach. That is, rather than simply reacting to problems as they arose, the men in this study actively engaged in attempts to prevent depressed moods, and made conscious choices about when or how to take action. Effective self-help strategies for prevention were characterised by having routines to keep things balanced, while self-management was characterised by having a structure or plan to rely on, which helped to relieve symptoms and support perseverance.

Consistent with previous work, we found that men took an active role in monitoring their overall health (Smith et al., 2008) and favoured some strategies previously identified as adaptive responses to feeling down, depressed or suicidal. This includes, maintaining good physical health (Watkins and Neighbours, 2007), having strong social connections (Emslie et al., 2006), gaining support or sense of belonging from a community (Pringle, 2004), and seeking professional help (Skärsäter et al., 2003), including taking medication (Chuick et al., 2009). As with other research, we found that strategies which emphasised problem solving (Brownhill et al., 2005; Nolen-Hoeksema, 2012; Tamres et al., 2002), or reframing depression in helpful ways (Addis et al., 2010; Cleary, 2012; Hall and Partners, 2012) were particularly important, in that men described comfort with using these strategies, which helped them to feel in control of their problems, and these did not conflict with social expectations concerning manliness (Addis et al., 2010; Cleary, 2012). Similarly, the current results agree with previous research, which found that men felt helpless and shocked in the face of others' suicides (Brownhill et al., 2005), and stressed that connections with family were important in preventing attempts (Oliffe et al., 2012).

Previous research has often focused on men's maladaptive responses to depression (Whittle et al., 2015), or on barriers to seeking professional help (Addis and Mahalik, 2003; Moller-Leimkuhler, 2002). In contrast, the present study focused on positive coping strategies used naturally as a form of self-help. The results demonstrate that not only do men actively engage with their mental health, they also make clear delineations between preventing and managing the development of depressed moods. While men's active engagement with monitoring their health has been reported before (Smith et al., 2008), this study adds important information on how men monitor their mental health in particular, even in the absence of being depressed, and how men view links between optimum physical and mental health. Key factors in successful self-help involved openness to using different strategies, even those that were not typically masculine, and being flexible in adapting their use according to need. Thus, prevention and management were seen as distinct, with an ebb and flow between them that helped men to make choices and take action.

In addition, in contrast to some studies (Brownhill et al., 2005; Chuick et al., 2009; Emslie et al., 2006; Johnson et al., 2012; Ramirez and Badger, 2014), this study incorporates insights from men with and without experiences of depression, suicidal behaviours or accessing health services. Just under half of the sample reported no previous depressive episodes and around a third had sought professional help. Thus, the positive coping strategies reported here have the benefit of being endorsed and used by men who currently self-monitor and effectively manage their mental health, rather than only representing strategies that men may have learned through accessing treatment for depression. The strategies reported exemplify genuinely effective strategies that have utility and acceptability among a range of men. Taken together, these strategies thus may be more acceptable to men who are currently depressed or developing symptoms, and who are unlikely to seek professional help. Likewise, the study identified a willingness to use strategies that might be seen as traditionally "feminine" with men openly discussing how conforming to masculine norms could be detrimental to their mental health.

4.1. Limitations

The study is potentially limited in that a majority of the sample were aged 55 years or more and were highly educated relative to the general population (Australian Bureau of Statistics, 2008). It may be that younger age groups, which bear a disproportionate mental health burden, or men without tertiary education, would conceive of prevention and management differently, or may use different strategies. However, given that many men described accumulating wisdom through life experience, or gaining perspective with age, it may be that their insights provide useful information for early intervention among younger people. Future research should confirm whether the strategies reported here are used and endorsed in a broader population of men, and should also examine whether there are any important differences in use of particular strategies according to age or level of education.

4.2. Implications

The results have several implications for clinical and public health in suggesting viable targets for the development of (1) health promotion and education campaigns in a wider community context or (2) individual skills development or treatment plans for men with and without depression.

Firstly, men appear to acknowledge both the seriousness of depression and the negative aspects of conforming to masculine stereotypes. Future public health messaging could capitalise on these sentiments by emphasising how men themselves report finding relief in talking to others, being vulnerable with their problems, accepting the experience of a wide range of emotions and using a variety of different positive strategies as both prevention and management. Public health messaging should also incorporate and emphasise the widely endorsed advice that has been volunteered by men with different experiences: talking to others is essential, distress and depression pass and having a plan in place to respond to tough times is invaluable.

Secondly, men benefit from trying a variety of strategies and over time can develop a suite of personalised options to be reliably used to prevent or manage symptoms. Professionals with male clients who are not currently depressed but are interested in maintaining positive health or who are involved in supporting

depressed men to self-manage their mood could focus on building skills that resonate with other men. That is, support men to: try out new strategies, assess their usefulness, adjust use of a particular strategy according to mood, create (and maintain) a routine, plan or structure that both prevents and manages distress and depression, self-monitor warning signs of a worsening mood, practice using new techniques regularly, and practice perseverance.

Lastly, the results showed that there is still considerable room for improvement in educating men about suicide, in terms of understanding what can lead to, or prevent, suicide. Future public health messages would do well to emphasise the importance of intervention, that men at-risk would like others to notice (Player et al., 2015), and that there are resources available. Similarly, while family connections were cited as important to preventing suicide, future campaigns would need to consider that alternative strategies are particularly needed for isolated men without many family or social connections.

Funding

This research project was funded by *beyondblue*, Australia with donations from the Movember Foundation (Grant SBcb6725).

Competing interests

The authors declare that there is no conflict of interest.

Acknowledgements

We would like to acknowledge the contributions made by the 168 research participants. We are grateful to Mr Roy Powell of Mensheds Australia and Ms Sally Nathan at UNSW who facilitated our engagement with community-based organisations.

References

Addis, M.E., 2008. Gender and depression in men. Clin. Psychol. Sci. Pract. 15, 153–168. http://dx.doi.org/10.1111/j.1468-2850.2008.00125.x.

Addis, M.E., Mahalik, J.R., 2003. Men, masculinity, and the contexts of help seeking. Am. Psychol. 58, 5–14.

Addis, M.E., Mansfield, A.K., Syzdek, M.R., 2010. Is "masculinity" a problem?: Framing the effects of gendered social learning in men. Psychol. Men Masculinity 11, 77–90. http://dx.doi.org/10.1037/a0018602.

Angst, J., Gamma, A., Gastpar, M., Lépine, J.P., Mendlewicz, J., Tylee, A., 2002. Gender differences in depression. Eur. Arch. Psychiatry Clin. Neurosci 252, 201–209. http://dx.doi.org/10.1007/s00406-002-0381-6.

Aronson, J., 1995. A pragmatic view of thematic analysis. Qual. Rep. 2, 1–3.

Australian Bureau of Statistics, (2008). 4102.0-Australian Social Trends. ⟨http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4102.0Chapter6002008⟩ (retrieved from 27.07.15).

Australian Bureau of Statistics, (2012). 4338.0-Profiles of Health, Australia, 2011–13. ⟨http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/4338.0main+features12011-13⟩ (retrieved from 24.11.14).

Australian Bureau of Statistics, (2014). 3303.0-Causes of Death, Australia, 2012. ⟨http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/3303.0main+features100042012⟩ (retrieved from 24.11.14).

Biddle, L., Cooper, J., Owen-Smith, A., Klineberg, E., Bennewith, O., Hawton, K., Gunnell, D., 2013. Qualitative interviewing with vulnerable populations: individuals' experiences of participating in suicide and self-harm based research. J. Affect. Disord. 145, 356–362. http://dx.doi.org/10.1016/j.jad.2012.08.024.

Braun, V., Clarke, V., 2006. Using thematic analysis in psychology. Qual. Res. Psychol. 3, 77–101.

Brownhill, S., Wilhelm, K., Barclay, L., Schmied, V., 2005. 'Big build': hidden depression in men. Aust. N. Z. J. Psychiatry 39, 921–931. http://dx.doi.org/10.1111/j.1440-1614.2005.01665.x.

Chuick, C.D., Greenfeld, J.M., Greenberg, S.T., Shepard, S.J., Cochran, S.V., Haley, J.T., 2009. A qualitative investigation of depression in men. Psychol. Men Masculinity 10, 302–313. http://dx.doi.org/10.1037/a0016672.

Cleary, A., 2012. Suicidal action, emotional expression, and the performance of masculinities. Soc. Sci. Med. 74, 498–505. http://dx.doi.org/10.1016/j.socscimed.2011.08.002.

Danielsson, U., Johansson, E.E., 2005. Beyond weeping and crying: a gender analysis of expressions of depression. Scand. J. Prim. Health 23, 171–177. http://dx.doi.org/10.1080/02813430510031315.

Emslie, C., Ridge, D., Ziebland, S., Hunt, K., 2006. Men's accounts of depression: reconstructing or resisting hegemonic masculinity? Soc. Sci. Med. 62, 2246–2257. http://dx.doi.org/10.1016/j.socscimed.2005.10.017.

Fereday, J., Muir-Cochrane, E., 2006. Demonstrating rigor using thematic analysis: a hybrid approach of inductive and deductive coding and theme development. Int. J. Qual. Methods 5, 80–92.

Hall and Partners, 2012. Men's Help Seeking Behaviour: Report of Research Findings.

Hausmann, A., Rutz, W., Meise, U., 2008. Women seek for help-Men die! Is depression really a female disease? Neuropsychiatrie 22, 43–48.

Healey, C., Peters, S., Kinderman, P., McCracken, C., Morriss, R., 2009. Reasons for substance use in dual diagnosis bipolar disorder and substance use disorders: a qualitative study. J Affect Disorders 113, 118–126. http://dx.doi.org/10.1016/j.jad.2008.05.010.

Heifner, C., 1997. The male experience of depression. Perspect. Psychiatr. C 33, 10–18.

Hoy, S., 2012. Beyond men behaving badly: a meta-ethnography of men's perspectives on psychological distress and help seeking. Int. J. Men's Health 11, 202.

Joffe, H., Yardley, L., 2004. Content and thematic analysis. In: Marks, D.F., Yardley, L. (Eds.), Research Methods for Clinical and Health Psychology. SAGE Publications, London.

Johnson, J.L., Oliffe, J.L., Kelly, M.T., Galdas, P., Ogrodniczuk, J.S., 2012. Men's discourses of help-seeking in the context of depression. Sociol. Health Illn. 34, 345–361. http://dx.doi.org/10.1111/j.1467-9566.2011.01372.x.

Kilmartin, C., 2005. Depression in men: communication, diagnosis and therapy. J. Men's Health 2, 95–99. http://dx.doi.org/10.1016/j.jmhg.2004.10.010.

Kitzinger, J., 1994. The methodology of Focus Groups: the importance of interaction between research participants. Sociol. Health & Illn. 16, 103–121. http://dx.doi.org/10.1111/1467-9566.ep11347023.

Kitzinger, J., 1995. Qualitative Research: Introducing focus groups. vol. 311.

Kroenke, K., Spitzer, R.L., Williams, J.B., 2001. The PHQ-9: validity of a brief depression severity measure. J. Gen. Intern. Med. 16, 606–613.

Magovcevic, M., Addis, M.E., 2005. Linking gender-role conflict to nonnormative and self-stigmatizing perceptions of alcohol abuse and depression. Psychol. Men Masculinity 6, 127–136. http://dx.doi.org/10.1037/1524-9220.6.2.127.

Mansfield, A., Addis, M., Mahalik, J., 2003. "Why won't he go to the doctor?": the psychology of men's help seeking. Int. J. Men's Health 2, 93–109. http://dx.doi.org/10.3149/jmh.0202.93.

Mays, N., Pope, C., 2000. Qualitative research in health care. Assessing quality in qualitative research. BMJ 320, 50–52.

Moller-Leimkuhler, A.M., 2002. Barriers to help-seeking by men: a review of sociocultural and clinical literature with particular reference to depression. J. Affect. Disord. 71, 1–9.

Nolen-Hoeksema, S., 2001. Gender differences in depression. Curr. Dir. Psychol. Sci. 10, 173–176. http://dx.doi.org/10.1111/1467-8721.00142.

Nolen-Hoeksema, S., 2012. Emotion regulation and psychopathology: the role of gender. Annu. Rev. Clin. Psychol. 8, 161–187. http://dx.doi.org/10.1146/annurev-clinpsy-032511-143109.

Oliffe, J.L., Ogrodniczuk, J.S., Bottorff, J.L., Johnson, J.L., Hoyak, K., 2012. "You feel like you can't live anymore": Suicide from the perspectives of Canadian men who experience depression. Soc. Sci. Med. 74, 506–514. http://dx.doi.org/10.1016/j.socscimed.2010.03.057.

Parker, G., Brotchie, H., 2010. Gender differences in depression. Int. Rev. Psychiatr. 22, 429–436.

Piccinelli, M., Wilkinson, G., 2000. Gender differences in depression: Critical review. Br. J. Psychiatry 177, 486–492. http://dx.doi.org/10.1192/bjp.177.6.486.

Player, M.J., Proudfoot, J., Fogarty, A., Whittle, E., Spurrier, M., Shand, F., Wilhelm, K., 2015. What interrupts suicide attempts in men: A qualitative study. PLoS One 10, e0128180. http://dx.doi.org/10.1371/journal.pone.0128180.

Pringle, A., 2004. Can watching football be a component of developing a state of mental health for men? J. R. Soc. Promo Health 124, 122–128.

QSR International. (2014). NVivo 10 for Windows. ⟨http://www.qsrinternational.com/products_nvivo.aspx⟩ (retrieved from 21.11.14).

Ramirez, J.L., Badger, T.A., 2014. Men navigating inward and outward through depression. Arch. Psychiat. Nurs. 28, 21–28. http://dx.doi.org/10.1016/j.apnu.2013.10.001.

Ritchie, D., 1999. Young men's perceptions of emotional health: research to practice. Health Educ. J. 99, 70–75. http://dx.doi.org/10.1108/09654289910256932.

Skärsäter, I., Dencker, K., Häggström, L., Fridlund, B., 2003. A salutogenetic perspective on how men cope with major depression in daily life, with the help of professional and lay support. Int. J. Nurs. Stud. 40, 153–162. http://dx.doi.org/10.1016/S0020-7489(02)00044-5.

Smith, J.A., Braunack-Mayer, A., Wittert, G., Warin, M., 2008. "It's sort of like being a detective": understanding how Australian men self-monitor their health prior to seeking help. BMC Health Serv. Res. 8, 56. http://dx.doi.org/10.1186/1472-6963-8-56.

Tamres, L.K., Janicki, D., Helgeson, V.S., 2002. Sex differences in coping behavior: a meta-analytic review and an examination of relative coping. Person. Soc. Psychol. Rev. 6, 2–30. http://dx.doi.org/10.1207/s15327957pspr0601_1.

Tong, A., Sainsbury, P., Craig, J., 2007. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. Int. J.

Qual. Health C 19, 349–357. http://dx.doi.org/10.1093/intqhc/mzm042.
Tuckett, A.G., 2005. Applying thematic analysis theory to practice: a researcher's experience. Contemp. Nurse. 19, 75–87. http://dx.doi.org/10.5172/conu.19.1-2.75.
Watkins, D.C., Neighbors, H.W., 2007. An initial exploration of what 'mental health' means to young black men. J. Men's Health 4, 271–282. http://dx.doi.org/10.1016/j.jmhg.2007.06.006.
Whiteford, H.A., Degenhardt, L., Rehm, J., Baxter, A.J., Ferrari, A.J., Erskine, H.E., Vos, T., 2013. Global burden of disease attributable to mental and substance use disorders: findings from the Global Burden of Disease Study 2010. Lancet 382, 1575–1586. http://dx.doi.org/10.1016/S0140-6736(13)61611-6.
Whittle, E.L., Fogarty, A.S., Tugendrajch, S., Player, M.J., Christensen, H., Wilhelm, K. Proudfoot, J., 2015. Men, depression, and coping: are we on the right path? Psychology of Men & Masculinity. No Pagination Specified. doi: 10.1037/a0039024.
Willis, K., Green, J., Daly, J., Williamson, L., Bandyopadhyay, M., 2009. Perils and possibilities: achieving best evidence from focus groups in public health research. Aust. N. Z. J. Public Health 33, 131–136. http://dx.doi.org/10.1111/j.1753-6405.2009.00358.x.
Wright, K., Armstrong, T., Taylor, A., Dean, S., 2012. 'It's a double edged sword': a qualitative analysis of the experiences of exercise amongst people with Bipolar Disorder. J. Affect. Disord. 136, 634–642. http://dx.doi.org/10.1016/j.jad.2011.10.017.