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ORIGINAL RESEARCH

Understanding major depressive disorder among middle-aged African American men

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Abstract

Aim. This paper is a report of a study of how a cohort of African American men recognized and expressed symptoms of depression, and how depression affected their lives.

Background. Major depressive disorder has had global financial consequences in the form of healthcare visits, lost work hours, and disruption of family lives. Early recognition of depression and engagement of depressed individuals to promote management and treatment of this disorder is crucial in controlling its impact. African American men are often not included in research exploring factors that limit their engagement in mental health care.

Method. A descriptive qualitative study using semi-structured interviews was conducted in 2008 with ten African American men between the ages of 40 and 59 years. All participants self-reported a history of depression.

Findings. Three central themes were identified: life events, the funk, and the breakdown. Life events were identified as stressors which led the men to experience what they described as the funk, which was later identified as depression. Due to lack of resolution of the funk, a breakdown was experienced. Over time study participants became informed about their condition, and their responses to managing depression varied depending on individual and contextual factors.

Conclusion. It is important to approach depression diagnoses from a broad perspective rather than as a limited list of symptoms. Healthcare providers would benefit from taking into account cultural factors, gender and age, examining them carefully in relation to the development of depressive symptoms.

Keywords: African Americans, major depressive disorder, middle-aged men, nursing

Introduction

Major depression disorder (MDD) is projected to become the leading cause of disability and the second leading contributor to the global burden of disease in approximately 10 years (Kerr & Kerr 2001). It is estimated that by 2020 the number of years lost to death and disability from depression will be surpassed only by those due to heart disease (Kerr & Kerr 2001). According to the National Institute of Mental Health (2001), approximately 18·8 million American adults have a

depressive disorder. Undiagnosed and untreated depression contributes to suicide which has important implications for men, who are four times more likely to die of suicide in the United States of America (USA) as women (Porche 2005). These statistics are evidence of why depression is a major health concern in the USA and throughout the world. They support the need for early detection and culturally sensitive approaches to intervention for depression, which is critical to mitigating the adverse effects of MDD, particularly for men.

There is limited research focusing on men with depression, specifically for African American men (Watkins *et al.* 2006). Given that research literature has linked higher levels of depression to psychosocial stressors and negative life events, African American men in the USA may well have a greater propensity for depression than the majority population. Rich and Ro (2002) state that the term 'crisis' has been used to characterize the markedly elevated rates of morbidity, disability and mortality of ethnic minority men compared with their majority counterparts. These disparities are especially marked for African American men (Watkins *et al.* 2006).

Background

Multiple theories have been developed to explain the aetiology of depression; however, the actual diagnosis of depression is not linked to any particular theory (Barron 1998). The American Psychiatric Association (APA) developed the *Diagnostic and Statistical Manual-IV-TR* (*DSM*) (APA 2000) to provide criteria for the diagnosis of mental illnesses, including MDD, based on symptomatology. This was formulated to minimize confusion among healthcare professionals about criteria and provide a common language to determine if an individual meets diagnostic criteria for depression. The cultural formulation, as outlined in the DSM-IV-TR, has been found to be a valuable tool that, however, has not been systematically tested. Fábrega (2001) reports that the DSM-IV's cultural formulation has the advantage of being (i) an already known instrument and (ii) usable by both mental health specialists and non-specialists. It also enhances the value of ethnography as a clinical data-gathering method, covering the patient-owned perspective and including data on the patient's identity, explanatory models, psychosocial environment and functioning, relationship with the diagnostician, and an overall cultural assessment for diagnosis and care. Imprecision and subsequent heterogeneity of the narrative data are disadvantages of the current cultural formulation (Fábrega 2001).

Alarcon (2009) reports that a quantitative approach, such as a scale, needs to be devised to convey objectively the qualitative nature of the information gained from the cultural formation. The DSM-IV-TR would also benefit from added empirical data that captures the depressive symptoms of wider population groups which are influenced by gender, ethnicity and culture (Campinha-Bacote 1994, National Mental Health Association, 2004). For example, Cochran (2001) and Pollack (2001) report that the DSM-IV-TR ignores expressions of depression characteristic of the traditionally masculine male such as: (i) self-medication with alcohol or drugs to dissociate from pain; (ii) intense denial of psychological pain; (iii) irritability and expressions of anger in place of ruminative guilt, sadness or despair; (iv) withdrawal from personal relationships, perhaps in place of anhedonia; and (v) distracting behaviours, such as overfocusing on one's career and/or sexual hyperactivity. Recently, there has been a call for better understanding about the roles that gender, culture and social differences play with regard to understanding mental health disorders, including MDD (Rochlen *et al.* 2009). However, this effort has yet to have a major influence on the *DSM*'s description of diagnostic criteria for MDD. One particular group that has received limited attention related to expression and outcomes of MDD are African American men (Watkins *et al.* 2006). Attention to cultural barriers is required to mitigate adverse health outcomes that can be encountered by this specific group.

The study

Aims

The aims of the study were to identify how this cohort of African American men (i) recognized and expressed symptoms of depression and (ii) how depression impacts their lives.

Design

A qualitative descriptive design was used (Sandelowski 2000). Although less interpretive than phenomenological or grounded theory approaches, this design, results in a comprehensive summary of the data and the meaning given to the data by the participants (Sandelowski 2000). Typical of all qualitative research, it offers the possibility of exploring human experience in a unique sociocultural context from the perspective of the individual, and offers an opportunity to gain insight into the participants' values and experiences with regard to the phenomena of interest (Wiart & Burwash 2007). A conceptual culture model described by Cuellar and Paniagua (2000) provides understanding of how most mental illnesses are diagnosed based on an individual sharing their personal or subjective feelings and experiences.

Participants

A convenience sample was sought through the Internet, and flyers posted in clinics and other public locations. Advertisement in local newspapers targeting African Americans was the primary source of potential participants. Inclusion criteria for participation specified men who: (i) self-identified as African American, were born in the USA; (ii) were between 35 and 65 years of age; and (iii) self-reported they had been diagnosed with MDD by a healthcare provider at some time during their lives Men were excluded if they self-reported that they: (i) had been diagnosed with schizophrenia, anxiety, history of psychosis, mania or hypomania; (ii) had a probable medical or organic cause for depression; (iii) had a severe, chronic, or life threatening medical illness; (iv) had current substance abuse; and/or (v) had a learning disability.

Data collection

Data collection began in August, 2008 and concluded in October, 2008. Semi-structured interviews were the primary data source. Audio-taped, in-depth interview sessions were conducted by a single interviewer, an Advanced Practice Registered Nurse, and lasted approximately 60–90 minutes. To provide a sense of comfort and control, interview locations were established at the discretion of the participant and agreed upon by the researcher. Interview core questions included: (i) How were you diagnosed with depression? (ii) Describe what your life was like before you were affected by depression? and (iii) How did your life change after you were diagnosed with depression? The questions were modified with each subsequent interview to verify concepts and categories. At the conclusion of interviews participants were thanked for their time and 30 US dollars as a token of appreciation.

The interviewer then took time to recall and reflect on what was learned from the interview, including interpersonal interaction, followed by written field notes (Kvale 1996). The audiotapes were transcribed in Microsoft Word and reviewed for accuracy by both researchers prior to hand coding for common themes and concepts.

Ethical considerations

Institutional review board approval was obtained for the study. Participants received written confirmation that responses were to be protected with the strictest confidence and that the data would be securely stored and later destroyed. Prior to signing the informed consent, participants had the opportunity to ask questions, and were then given a copy of the consent.

Data analysis

The analytic process was guided by Corbin and Strauss's (2008) approach. In this method, the phenomenon is examined to discover what it is and how it works. The process includes generating, developing and verifying concepts that build over time (Corbin & Strauss 2008). The analytic process began following transcription of the initial interview. In this method the researcher does not collect all data before beginning the analysis phase. The data were analysed following each interview to give insight for data collection in subsequent interviews and adjustment to questions. The initial phase of the analytical process included reviewing the data for categories. We used conceptual ordering to organize the data or concepts according to their properties and dimensions. Categories (i.e. higher-level concepts) were seen across multiple interviews; these categories included a cluster of lower-level concepts which provided a description of the category. A core category was established to represent the main theme or phenomenon. When new concepts were discovered during subsequent participant interviews, we returned to previous interviews to verify whether or not the lower-level concepts were present. The process continued until saturation occurred.

Rigour

Morse *et al.* (2002) proposed that rigour in qualitative research includes investigator responsiveness, methodological consistency, sampling adequacy, an active analytic stance and saturation. Before data collection began, we identified our prior assumptions through critical self-analysis. Critical self-awareness as to the nature and impact of personal beliefs, attitudes and assumptions about depression was ensured through ongoing discussion between us. Thus, bracketing (e.g. holding our preconceived beliefs and opinions about depression among African American men in abeyance) our feelings prior to the study and agreement on coding between us also helped with establishing rigour. Analysis occurred concurrently with data collection, driving increasing refinement of interviewing foci as data were crosschecked with the appearance of developing patterns. Rigour was also established through the interviews being conducted by a lead researcher who was a doctoral student, supervised by a psychologist. Having one interviewer helped to avoid differences in interviewing styles and techniques. Also, transcripts were reviewed by both researchers, the more senior with demonstrated knowledge of qualitative research for verification of concepts and categories. Convenience sampling enabled us to discover the concepts that were relevant to the phenomenon and

population, and allowed us to explore the concepts in depth (Corbin & Strauss 2008). This was done by verifying concepts identified in subsequent interviews.

Findings

Ten interviews were completed and included in the analysis. The mean age of the participants was 49 years, with a range of 40–59 years. Most (60%) of the men had never been married. Some (30%) had had college or trade school education, and most (70%) had an annual household income of less than US $20,000. Half (50%) of the men identified themselves as Christian/Protestant, while others stated that they were Catholic, Muslim, spiritual or nonreligious (See Table 1).

Themes indentified in the data were: (i) life events, (ii) the funk and (iii) the breakdown (Figure 1). These themes are described below, along with significant concepts that were captured in each.

Table 1 Participant demographics

Variable	*N* = 10
Age	
35–45	3
46–55	6
56–65	1
Marital status	
Never married	6
Married	1
Divorced	1
Separated	1
Widow	1
Education	
High school diploma	1
Some college/trade school	6
Associate degree	1
Bachelor's degree (BS, BA, etc.)	2
Employment	
Employed full-time	2
Employed part-time	3
Unemployed	1
Disabled	4
Income	
Less than US $20,000/year	7
US $20,000–50,000/year	3
Religion	
Catholic	1
Christian/Protestant	5
Muslim	1
Not religious	1
Other: spiritual	2
Current treatment	
None	5
Medications	2
Therapy	1
Medication/therapy	1
Other: exercise and group work	1
Past treatment	
None	3
Medications	2
Therapy	1
Medication/therapy	4

Theme 1: life events

Each participant encountered his own unique stressors through life events, including physical, social and psychological stressors. The stressors identified were past use of drugs and alcohol, dysfunctional family, child abuse, divorce/break-up, the economy, unemployment, homelessness, the Iraq war, death in the family and chronic illness. The men believed that one or more of these stressors had led them down the path to depression:

> Many of my symptoms came from past substance abuse.

> My family kind of imploded... it was very dysfunctional. Everybody except my mother drank or did drugs. My parents got divorced. So it was really crazy. My father was stressful.

> She wanted the divorce because she didn't want me. I was in the way.

One participant explained how parking tickets, credit card debt and lack of a bank account had caused him stress: 'I've been depressed behind that. I'm a say mild [depression] but I know how to shake it off'. He felt that he had come to a place where he could remove the blanket of depression whenever it crept back into his life.

Some of the men still battled with the stress of not living up to their own expectations and/or potential. For one, the perception that his peers were more successful and accomplished deeply troubled him: 'I really feel like I'm behind my college friends. I really feel like I'm light years behind. So, it's like, God, I got to catch up'.

In addition to their personal stressors, some men identified external life stressors from racism, sexism and cultural differences as variables that increased their duress. Whether it was one stressor or many, they inevitably led participants to another phase, the funk, the second central theme identified.

Theme 2: the funk

The funk is a state of depression in which the man is either unaware of the existence of depression or aware that what he is experiencing is indeed depression. At other times

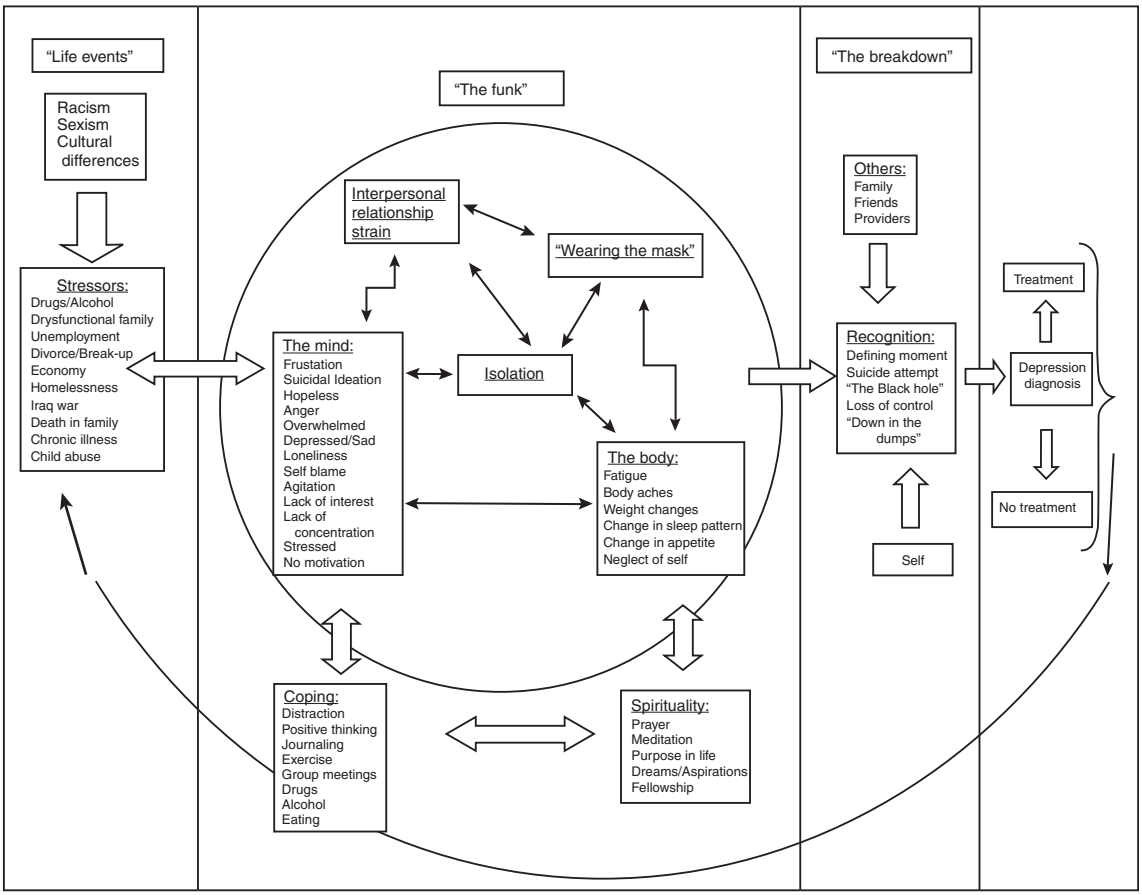

Figure 1 Conceptual model of African American men and depression.

participants endured a level of depression they felt they could control. During the funk they experienced several noticeable changes including: (i) isolation; (ii) interpersonal relationship strain; (iii) wearing the mask to hide emotional stress or turmoil; (iv) feelings and emotional fluctuations that men identified as the mind; and (v) physical changes/neglect of self-care.

During the first episode of the funk, participants typically did not recognize what was happening to them, although they could sense that something was 'off', 'not right', or that they felt unlike themselves. Most kept uneasy feelings to themselves, thinking that they would eventually run their course or that they could control the situation. Even after experiencing the funk and later realizing that it was actually depression, the men continued to think that they needed to 'shake it off' or to control their emotions.

Others had their own way of describing the experience:

> Kind of depressed; kind of in a funk; couldn't get out of it.

> I think that I am more hyper aware of when I'm getting into a funk and can work through it a lot faster. I call those years the dark years. I remember feeling like I was in a black hole spinning down. And I couldn't bring myself out of it…Just weird.

Isolation, whether self-motivated or not, was another important concept that was integral to what participants referred to as the funk. They continually spoke about not wanting to be around others, which was due either to their mood or to the generally negative way in which they interacted with family or friends:

> I just found myself isolated and just down in the dumps basically. So I didn't really understand what was going on. I just considered it bad days, you know, and I'd get through it. But I didn't. It just got worse.

> I noticed that I wasn't joyful, I didn't want to deal with nobody, I had a negative attitude and I thought the whole world was against me. And I just got through it day by day.

Isolation typically caused strain in interpersonal relationships. Close relationships with significant others, immediate family members and friends often suffered most. Some of the men wished to express their feelings to loved ones and desired companionship, but did not know how to express themselves

or felt embarrassed to admit to these feelings. The strain often occurred as a result of the isolation they experienced or the change in personality that some underwent:

I get harsh... people say I get mean, abrupt or, you know, just on the edge… I get snappy. Now I notice that and take advice. I must be having a bad day.

As far as going out and spending time with family... that's not on my mind, you know. Even though that would be good for me. I'm thinking about all my problems. I don't want to go have a celebration when I'm feeling depressed.

In a one-on-one intimate relationship I acted out… It's just verbal…. I start calling them things I never should have called them.

Many participants acknowledged that isolation was an attempt to keep their depression a secret. This secrecy allowed them to hide feelings or experiences from others through wearing 'the mask'.

The desire to keep everyone at a distance allowed participants time to figure out what they were experiencing or to manage the depression – that is, to seek an understanding of their experience:

He [referring to his psychologist] really thinks that it's a little hard to read me because I put on a good face and I sort of play the role.

I think most people see me as pretty upbeat...most of my friends have never seen that side of me. I don't tell them that I take antidepressants.

At work I had to switch gears to put that smile on my face to sell something or talk about someone's home, which is the biggest thing in their life – it is really a challenge and a tightrope to have to act and switch gears.

They wore the mask before a variety of people, including friends, family, healthcare providers and clients. The stigma of depression may also have played a role in wearing the mask, due to the potential embarrassment it could have caused. However, wearing the mask was a burden and almost seemed like work, as it was often easier to isolate oneself rather than pretend that everything was all right.

The thoughts, emotions, and feelings the men experienced varied considerably; however, all felt unlike themselves, whether feeling down and depressed or feeling agitated and angry:

I saw signs. I had begun to get more agitated than I had been… I'm not as trusted, I don't have a sense of humour, I feel that I get agitated, annoyed, or impatient.

Usually a feeling of listlessness, not wanting to do anything, wanting to sleep and not wanting to get out of bed; not being motivated, letting daily to-do things pile up.

I started changing my behaviour, started wanting control, wanted dominance.

Some men also experienced frustration with themselves and their inability to get out of the funk they experienced. They believed that they should be able to control their minds and the behaviours stemming from depression. These internal feelings were often expressed outwardly.

Other physical manifestations of depression affected them in a variety of ways, including eating habits, energy levels, sleeping patterns and physical pain. Some ate more, whereas others ate less; as a result, these eating habits had an impact on body weight and affected their sense of self. Lack of energy and fatigue also had an impact, linking with their lack of motivation and desire. Yet other men experienced bodily aches and headaches during their depressive episodes:

I've gained weight, lost weight and gained weight. I'm at the point where I'd just like to maintain and not go back and forth with that and having to start all over.

Would want to sleep at work; energy was probably low.

I get very tense...and in here it just knots up…I call it my gut. I get some headaches at times... that come from worry and thinking too much. Situations I can't change.

Along with the physical symptoms, they also neglected themselves, either through poor eating habits, lack of hygiene, or other activities of daily living:

I wasn't cutting my hair, shaving, nothing. I said, 'Naw, this ain't you, man. You better get back together.' Yeah, 'cause I like to keep my appearance up.

Sometimes it would be day-to-day basics like taking care of hygiene…My physical health, you know vitamins…really basic living skills that are neglected when depression hits.

During the funk stage, these men attempted to use various coping mechanisms. The impact of spirituality on their lives was also evident. Unfortunately, most did not know about effective coping mechanisms until they had already experienced a defining moment in their depression. Through that experience and time, they actively learned to cope with the depression. There was a fear of experiencing another defining moment.

Fundamental concepts that emerged in managing depression among these participants were coping and spirituality. Spirituality (e.g. prayer, meditation, reading the bible) and other nonreligious practices (e.g. journaling, exercise, overeating) seemed to have an impact on the funk and vice versa. Some may consider spirituality as a form of coping with the depression and giving a purpose in life. But more

importantly, for some of these men it was critical as their belief system restrained them from acts of suicide:

I'm more into the church, that helps a lot…..I'm part of fellowships and different men's groups that I can bring those things to the table and discuss and that helps.

In the sense that God must have had a reason for me to still be here…that's where you got to be a strong person to stand up and be that person that God want you to be and I just don't know if I can do it. I want to but I don't want to make any claims or promises.

Self-awareness and acknowledgement or previous episodes of the funk influenced the way participants coped with the funk. Some mentioned religious activities and their relationship with God, while others had more universal experiences. This path included finding a purpose in life, a reason for living, or pursuing one's passion in life.

Participants also called upon a variety of coping mechanisms during bouts of depression. In retrospect, most were able to identify positive vs. negative coping mechanisms. Positive coping mechanisms provided a means to improve symptoms and helped to gain a sense of control. Negative coping mechanisms, such as overeating or not eating, past drug and alcohol use and smoking cigarettes, were also identified:

Usually I'll do things like journaling, exercising, attend group meetings and talk to different people.

I don't turn to drugs and alcohol anymore. I don't turn to food too often. I still smoke. I guess it's a trade off.

Thinking positively and taking each day at a time are ways that some of the men described how they coped with the depression:

The only thing mentally that I can think to do is to just try to keep swimming and keep my head above water…just thinking that somehow this is going to work out.

Some reverted to distractions as a means of coping with depression and life situations. This included focusing on jobs, helping others, and indulging in televised entertainment:

So the economy fears and woes definitely are causing some problems. For the most part I'm just trying to take everything day by day. Stay involved with volunteering and doing things to take the concentration off of myself. And think about somebody else.

I smoke. I watch TV – sports, you know. I don't drink anymore. That's basically it besides getting involved with my job. When I'm not working I like sports and I smoke cigarettes. I don't drink. That's it.

The funk experienced by the participants included five concepts which had an interactive relationship with their methods of coping and spirituality. However, inability to recognize the funk as depression led most of the men to a breakdown.

Theme 3: recognition of depression: the breakdown

Rather than seeking help from professionals, many participants devised their own methods of dealing with depression, including personal management and self-control. Many stated that they felt unlike themselves or that they were in a funk and just wanted to shake it off. Some received advice from family and friends to seek help or to simply get over what they were experiencing; however, in most cases the men were either in denial about their depression or thought they could handle it on their own:

…all the advice I got was from friends, neighbours, and relatives that 'You'll get over it,' you know, or 'Oh well, you know, live with it,' so that's been my experience.

…and I was encouraged by a friend to go seek mental health. I said, 'Ain't nothing wrong with me'.

Everybody was asking what was wrong with me and I was telling them nothing was wrong with me.

The breakdown eventually led to that defining moment when they realized that the funk had taken control of them. They were given a diagnosis of depression through a variety of sources. These included marriage/couple counselling, mandated evaluation, healthcare through incarceration, drug/alcohol abuse treatment, primary care providers and other therapists. A sense of enlightenment occurred during this time, even if it was not the first breakdown these men had experienced:

I would be at work and just all of sudden break down and start crying…I mean I never cried at work. I couldn't help it.

It's like I really should have caught that earlier. I had no idea it was getting to me as much as it was until it acted out the way that it did.

While I was at work I think I had a nervous breakdown…I was crying.

Some of the breakdowns led to suicidal ideation, suicide attempts, and accidental overdoses:

Took the trash can liner out of the trash can and wrapped it around my head and they came in the room and had saved me because I had stopped breathing.

I have stopped in front of police and told them to shoot me. I had standoffs with police with a rifle.

At one time I did take a 0·45 and I played Russian roulette with myself.

Participants described the act of breaking down in a number of ways, including hitting rock bottom and spinning out of control. Breakdowns manifested as uncontrollable crying in unusual locations (such as the workplace), suicide attempts and sometimes incarceration. Embarrassment typically followed these episodes. Some of the men admitted to intentionally acting out in order to hide deeper emotions; the behaviours took place in order to avoid others witnessing what they were feeling inside because of the belief that it would not have been manly to express those feelings and emotions. However, having hit rock bottom, they disclosed that they did not wish ever to return to that place; they did not want to experience that type of suffering again.

After the breakdown or realizing that the funk was actually depression, participants chose different routes to manage their diagnoses. Some pursued or continued counselling while others tried medications or both. Others bypassed typical treatments, but continued with personal coping mechanisms. Some tried focusing on the positive:

> I came back out of it and started feeling like myself again…My spirit was coming back. My energy was coming back, my going out making new friends and going on with my life.

> I came out of that hailing the Prozac. I love some Prozac. It brought me out of it.

> I still haven't gotten to the point where I feel like I want to take psychiatric meds, because I just felt like I was even more crazier. I didn't do very well on them.

> Eventually, I did seek help. And that's when I found out they actually had a term called depression for what I was experiencing.

After experiencing the breakdown, one participant observed: 'It doesn't have to get worse before it gets better'. Participants' rationales for treatment and how long they used treatment varied, but lack of access to healthcare was a problem:

> I mean, being low income, medical attention wasn't readily available. So a lot of that should've been treated early, which wasn't.

> I don't have insurance, so I don't go to see a doctor regularly or any of that.

Finally, the process the men experienced often did not end with the diagnosis and/or treatment of the depression. Many experienced additional stressors that led them through the process all over again. It is not uncommon for a person with a diagnosis of MDD to experience subsequent episodes of depression; however, our participants felt better equipped to handle the episodes and were often in fear of heading towards another breakdown. Unfortunately, some were not prepared to handle more episodes of depression and experienced additional breakdowns that included suicide attempts.

Discussion

Study limitations

Limitations of the study included the recruitment of participants from a single geographical location. Medical records were not reviewed; therefore, it was assumed participants were honest about their diagnosis of depression and lack of recent substance or alcohol abuse and other mental illness diagnoses. Men in this study were initially diagnosed with depression, on average, 9·5 years ago. It might have been difficult for them to recollect their experiences; however, many of them did experience recurrent episodes. Although not the focus of this study, it might have been helpful to include a diverse sample of men to examine similarities and differences in how depression was described and experienced within their cultural contexts. This would be useful since research on depression among men as a group is limited.

Experiences of depression

African American men's experiences of depression lie in the complex relationships between their masculinity and social structures (Sean 2005). Moreover, how depression is recognized and diagnosed needs to be examined from a contextual view. According to the *DSM-IV*-TR (APA 2000), culture can influence experience and communication of symptoms of depression; thus, it is very important for healthcare providers to identify and understand the terminology that patients use to describe their experiences with depression. In a study by Kendrick *et al.* (2007), participants referred to depression as 'stress'. Although participants in our study did not use the word stress to describe depression, they communicated understanding of the connection. The term depression was not used until the men began talking to a healthcare professional; however, they could identify being in a funk. Therefore, healthcare professionals need to consider cultural nuances (i.e. colloquialisms) among populations groups, as a central part of their assessment. Feeling comfortable about enquiring about a colloquial word or expression and knowing the cultural context of the individuals being served helps to give clues about what patients are experiencing, thereby reducing misinterpretation or gaps in understanding patient needs. Furthermore, this adds to providing cultural competent care, which will also help to mitigate mental health disparities among diverse population groups.

What is already known about this topic

- Gender is an important factor when examining symptoms of depression and how they coincide with the diagnostic criteria of major depressive disorder.
- Depression is projected to be the leading cause of disability worldwide in about 10 years.

What this paper adds

- Life events were identified as stressors which led the men to experience what they described as the funk, which was later identified as depression.
- Due to lack of resolution of the funk, a breakdown was experienced.
- Over time the men became informed about their condition, and their responses to managing depression varied depending on individual and contextual factors.

Implications for practice and/or policy

- Additional research is necessary to understand how age, gender and ethnicity affect the language patients use to describe depressive symptoms.
- Healthcare providers should treat patients as individuals to set the tone during consultations that promotes positive engagement and encourage patients to voice their unique experiences with depression.

Most of the signs and symptoms included in the *DSM* criteria for MDD were mentioned by at least one of our participants at some point. However, the DSM criteria have limitations and provide a narrow view of the complex phenomenon of depression, and social and cultural mental health specialists have consistently condemned the hidden ethnocentrism (White-oriented) of the DSM and its 'benign neglect' of issues that can hinder effective recognition of disorders among more diverse populations (Alarcon 2009, p. 133). Rochlen *et al.* (2009) reports that men present atypically at times, and healthcare providers need to maintain a high index of suspicion for depression among men suffering from psychosocial or economic stress, abuse of alcohol or other substances, or unexplained somatic symptoms, particularly chronic pain. They also assert that depression should be considered when men (or their wives or partners) report more difficulty coping with anger.

Major depression is a heterogeneous disorder, with different individuals exhibiting different symptom profiles. Therefore, without listening to a patient's story and authentically 'hearing' their words, it would be challenging to identify depression based on the nine non-contextual symptoms listed in the *DSM*. The following are not prominent in the *DSM* related to depression: (i) isolation, interpersonal relationship strain, and wearing the mask and (ii) social problems such as racism, discrimination, patriarchy and poverty. These all affect human experience, yet can become lost when using the *DSM* (APA 2000), which focuses on disorders as rooted in the individual. Clear absence of culture-specific or culture-bound syndromes related to larger contextual issues can reduce adverse experiences to invisibility when healthcare providers adhere only to the *DSM* system of assessment. Because of culturally different ways of reporting symptoms and complaints, professionals should interpret clients' communication as psychopathology cautiously (Rochlen *et al.* 2009). Instead, they should consider clients' reports within that person's cultural context and use this information as an indicator of how clients present concerns and solve problems. Cauce *et al.* (2002) found that cultural experiences not only affect diagnostic assessment criteria, but also influence help-seeking behaviours that could increase or decrease use of mental health services for prevention or treatment of mental health conditions and suicidal behaviours.

Our findings show that it is important not to take signs and symptoms out of context when addressing depression. Listening to a patient's story may very well lead to a diagnosis through assessment of their life experiences. Kendrick *et al.* (2007) noted that young African American men wanted the opportunity to share their stories, not the symptoms they were experiencing. Understanding this and responding to these men in a culturally competent manner is critical for effective patient engagement. Practitioners must continue to synthesize what is known about depression among African American men, and to use this information to help educate and partner with them to implement coping strategies that can have a positive influence on their life course.

There is a need for research focused on African American men's high rates of MDD and suicide. These high rates raise concerns about why there is not more of a moral and social mandate to address this issue to reduce mortality from suicide. There is also a need for intervention research examining the quality of engagement strategies to increase African American men's trust of mental health and physical health services and address their mental health condition pre-breakdown (Cheatham *et al.* 2008).

Conclusion

Given the increased recognition of depression and its negative effects on men's health, it seems critical that proactive

assessments of depression and other mental health disorders are conducted by all nurses, not solely those who specialize in psychiatric/mental health nursing. The value of just listening can have significant effects on understanding a patient's experience by hearing the words used to describe depression (e.g. the funk), thereby facilitating a connection that generates exploration of ideas, concerns and expectations. This can lead to shared decision-making about addressing concerns related to depression. Listening is not only helpful in terms of uncovering diverse perspectives, but is also valued by patients for its therapeutic benefits.

It is important for healthcare providers to educate the public about the risk factors, signs and symptoms of depression, and where help may be sought. This includes reaching out to men in non-traditional locations, such as barbershops, places of employment, recreational facilities, churches and other religious settings. Approaches to reducing stigma (e.g. perception of weakness) can also be supported by nurses through strategies of effective engagement. It is critical to promote mental wellness by exploring therapeutic approaches to engaging African American men with depression, to discuss their emotional concerns and to work with them to seek resolution to these concerns.

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Conflict of interest

No conflict of interest has been declared by the authors.

Author contributions

KB was responsible for the study conception and design. KB performed the data collection. KB performed the data analysis. KB and RW were responsible for the drafting of the manuscript. KB and RW made critical revisions to the paper for important intellectual content. KB provided statistical expertise. KB obtained funding. KB provided administrative, technical or material support. KB supervised the study.

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