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Do depressed and anxious men do groups? What works and what are the barriers to help seeking?

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Aim: To map the availability and types of depression and anxiety groups, to examine men's experiences and perception of this support as well as the role of health professionals in accessing support. **Background:** The best ways to support men with depression and anxiety in primary care are not well understood. Group-based interventions are sometimes offered but it is unknown whether this type of support is acceptable to men. **Methods:** Interviews with 17 men experiencing depression or anxiety. A further 12 interviews were conducted with staff who worked with depressed men (half of whom also experienced depression or anxiety themselves). There were detailed observations of four mental health groups and a mapping exercise of groups in a single English city (Bristol). **Findings:** Some men attend groups for support with depression and anxiety. There was a strong theme of isolated men, some reluctant to discuss problems with their close family and friends but attending groups. Peer support, reduced stigma and opportunities for leadership were some of the identified benefits of groups. The different types of groups may relate to different potential member audiences. For example, unemployed men with greater mental health and support needs attended a professionally led group whereas men with milder mental health problems attended peer-led groups. Barriers to help seeking were commonly reported, many of which related to cultural norms about how men should behave. General practitioners played a key role in helping men to acknowledge their experiences of depression and anxiety, listening and providing information on the range of support options, including groups. Men with depression and anxiety do go to groups and appear to be well supported by them. Groups may potentially be low cost and offer additional advantages for some men. Health professionals could do more to identify and promote local groups.

Key words: anxiety; depression; groups; men; primary care; qualitative

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Introduction

The assumption that men are less vulnerable to depression and anxiety than women is increasingly being questioned. Men are less likely to be

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diagnosed with depression (Piccinelli and Wilkinson, 2000; Van de Velde *et al.*, 2010) and anxiety (Kroenke *et al.*, 2007; Walters *et al.*, 2012). Importantly, higher rates of male suicide in most countries (Payne *et al.*, 2008; ONS, 2009) as well as much higher rates of drug and alcohol abuse (Nolen-Hoeksema, 2008; Oliffe and Philips, 2008; Ridge *et al.*, 2010) suggest that men may deal with mental health issues and distress differently to women.

Compared to women, men consistently demonstrate a greater reluctance to seek help for their health (Galdas *et al.*, 2004; Addis, 2008; Men's Health Forum, 2008) and especially for mental health problems such as depression (Hunt *et al.*, 1999). Stigma linked to societal ideals and expectations of men's behaviour is thought to be one of the main reasons that men avoid seeking help for depression. Depression may challenge masculine ideals of physical and emotional toughness (Emslie *et al.*, 2006). Emotional displays can be seen by men as self-indulgent and are linked to femininity; providing further motivation to deny and hide depression (Warren, 1983). One study found that some older men who did admit to experiencing depression described feeling isolated and different (O'Brien *et al.*, 2005). Younger men in the same study who tried to talk about mental health problems were quickly silenced through mockery. Alternatively, activities such as drinking alcohol is a more culturally acceptable way for men to relieve their stress, especially working class men (Dolan, 2011).

If men do acknowledge and seek help for depression and anxiety, general practitioners (GP) treatment options are generally limited to medication and referral to counselling or cognitive behavioural therapy (Gilbody *et al.*, 2003; McPherson and Armstrong, 2012). Such talking therapies are popular (Lam, 2001; van Schaik *et al.*, 2004) but usually offered on an individual basis (Bower and Gilbody, 2005). However, in many areas of the United Kingdom patients are increasingly being offered groups rather than individual therapy, in an effort to increase access to care. Group formats can potentially reach more patients, more cost-effectively and address social isolation (Morrison, 2001; Araya *et al.*, 2006) although their evidence base is yet to be fully established (Cuijpers *et al.*, 2008; Cramer *et al.*, 2011).

Given the stigma of depression for men, their lower rates of help seeking and some evidence that talking in groups about mental health may expose men to mockery, we sought to explore group support for men in more detail. This study therefore aimed to establish if men do attend therapeutic/support groups for depression, the types of group they attend, the reasons why they attend them and the advantages and disadvantages of groups.

Method

Recruitment, sampling and data collection

Mapping group availability

An initial mapping exercise sought to identify all free or low cost, statutory and voluntary sector groups for men with depression or anxiety in an English city health authority (Bristol Primary Care Trust, September 2010–January 2011). Groups were identified by talking to key mental health community organisations such as MIND and snowballing techniques, as well as internet searching. This process was carried out until we had exhausted all lines of enquiry and no new groups were being identified. The mapping exercise aimed to identify as many groups as possible that might be attended by men with depression. From the outset, however, we were interested in the more structured groups for mild to moderate depression or anxiety and less interested in groups for physical health problems or addictions. The team wanted to explore further the assumption that men would be harder to recruit into more structured groups. Anger groups were actively looked for and included (albeit from an adjacent health authority), based on the understanding that anger is thought to be a more typical male response to depression (Winkler *et al.*, 2006). A template was developed to help gather comparative details on the aims and structure of each of the community groups such as where and how frequently the group met, who led the group and who could join. In addition to examining the types of services available, this mapping exercise served as a sampling framework to select a subsample of groups to observe in detail.

Box 1 Details of the groups identified by the mapping exercise and study involvement

Group description	Stated aims and objectives of the group	Structure	Funder and host organisation	Mixed sex or men only?	Who can join?	Recruitment to study
Professionally led support group	To provide general support and build confidence	Weekly drop in. Meet in community kitchen in healthy living centre. Open support. Share activities, for example cooking. Free to group members. Led by (paid) men's health worker	Statutory sector	Men only	Open to men in local area. Referral by GP or other health professional referral initially to one to one support	Selected for observation. Observed this group once. Interviewed the facilitator and three group members
Peer-led depression group	To help support anyone with mental distress. Run by users for users	Twelve steps model loosely followed. Weekly drop in. Facilitator also group member. Six groups around the city hold weekly drop ins. Small weekly fee (eg, £1.50) to cover refreshments	Voluntary sector	Mixed	Anyone with depression. Advertise group on the internet and through local organisations such as MIND	Selected for observation. Observed one of these groups for three sessions. Interviewed seven group members, two of whom also worked as facilitators
Peer-led social anxiety group	Provide support and social opportunities in safe environment	Twice weekly self help groups. Two groups running in Bristol and a monthly women-only group. Some structured discussions, social activities and practice public speaking once a month. Small weekly fee to cover refreshments	Voluntary sector	Mixed	Anyone experiencing social anxieties that impact on quality of life Advertise group on the internet and through local organisations such as MIND	Selected for observation. Observed one of these groups once. Interviewed three group members, one of whom worked as a facilitator
Professionally led anger management group	The services aim to help you cope with your problems, to begin to help you understand how you feel and to help you start dealing with the problems in practical ways	Rolling programme of six to eight week long psycho-educational groups: depression management, anger management, assertiveness, anxiety management, stress management, relaxation skills mindful living. Free to attendees	Statutory sector	Mixed	Adults living in South Gloucestershire suffering from mild to moderate symptoms of common mental health problems such as anxiety, stress and depression. Self referral or referral by GP	Selected for observation. Observed anger group twice. Twice tried to arrange observation of depression group, one member in group did not want to take part in study so did not observe. The other group we tried to observe had no men attending. Interviewed one facilitator

Box 1 Continued

Group description	Stated aims and objectives of the group	Structure	Funder and host organisation	Mixed sex or men only?	Who can join?	Recruitment to study
Professionally led depression/anxiety group	Aimed to help male students feel more confident, less isolated and 'find their voices'	Short course run for four weeks – one off course in 2011. Free to attendees	University funded	Men only	Any male student at university X	Could not select for observation as group no longer running. Interviewed one facilitator
Professionally led depression/anxiety group	Psychological therapy aimed at improving well-being and recovery for people experiencing anxiety and depression	Psycho-educational groups of four to six weekly sessions on mood management and stress control. Cognitive behavioural therapy groups of 12 sessions. Free to attendees	Statutory sector	Mixed	People in Bristol who are experiencing depression, anxiety or stress. An initial assessment decides which level/type of support is needed (including groups and individual support). People already using secondary mental health services not eligible. GP referral	Approached for study inclusion but manager declined. Reason given that it would be too intrusive for participants. Interviewed one facilitator/manager
Peer-led depression support group	To provide a safe place for people using, or who have used, mental health services	Weekly drop in and support group, not structured. Peer led	Voluntary sector	Mixed	Anyone using or have used mental health services but excluding those with severe mental health illness	Did not approach for observation. Interviewed one group member
Peer-led mental health group	To provide a social space for mental health service users to interact and share common interests and experiences	Weekly drop in. Open agenda including watching DVD discussions, etc. User run. Ran for limited period	Voluntary sector	Mixed	Black African or Caribbean service users and carers	Approached for study inclusion both observation and interview but facilitator declined. No reasons given. Information for mapping exercise was provided
Professionally led depression/anxiety support group	Opportunity for students to meet others and share experiences	Weekly drop in during university term time	University funded	Mixed	Open to any student at university X but aimed at students who are feeling low or anxious	Did not approach for observation

Box 1 Continued	Group description	Stated aims and objectives of the group	Structure	Funder and host organisation	Mixed sex or men only?	Who can join?	Recruitment to study
Peer-led mental health support group	To promote self-advocacy, good practice and meaningful service user involvement. Act as an informal network of support	Monthly informal support, self-advocacy and social opportunities	Voluntary sector	Mixed	Anyone using secondary mental health services and/or anyone having been prescribed drugs for emotional or mental distress	Did not approach for observation. Interviewed one group member	
Peer-led mental health campaign group	Campaign and support group for secondary mental health service users past or present	Meet every six weeks	Voluntary sector	Mixed	Any user or ex user of mental health services	Did not approach for observation	
Peer-led mental health walking group	Self help user support group to help people get out of their homes and meet others	Meet twice weekly. Informal social group. Not structured. Run by volunteers	Voluntary sector	Mixed	Anyone suffering from mental illness who lives or works in local area	Did not approach for observation	

Group observations

The groups selected for observation were purposively sampled to represent maximum variation of: participants (men-only, mixed-gender); types of mental health issue (depression, anxiety, anger); and group structures (professionally led, peer-led, structured format). Four out of seven groups approached for observation agreed (see also Box 1). All participants in both the observations and the interviews received both written and verbal information about the research and provided informed consent before data collection. Where group consent by all members was given, sessions were observed between one and three times. Observations of the sessions were captured either by note taking alone (two groups) or by both note taking and audio-recording (two groups) and later transcribed. To distinguish between the different types of data collection technique and data recording method the following conventions are used: data collected by Interview are [I]; data collected by Observation are [O]; by audio-Recording are [R] and by Notes are [N]. The observations looked at attendee characteristics, group interaction and facilitation style. All interviews and observations were carried out by a female researcher (H.C.). Ethics approval was given by the South West 4 committee (10/H0102/47).

Individual interviews

For participant interviews we aimed for a broad representation of men including some who had: (a) attended mental health groups; (b) not attended mental health groups but had spoken to their GP about depression or anxiety; (c) not attended groups nor spoken to their GP about depression or anxiety (see also Table 1). In order to meet these overall aims three recruitment methods were employed. First, all men attending groups that were observed were invited for interview. However, it was not possible to invite men for interviews in the anger group due to time limitations. Second, the electronic records of two primary care practices were searched to generate a list of male patients suffering from depression. The list was checked by GPs and letters sent out including study information and a screening questionnaire asking about use of mental health services. A total of 108 letters were sent out to male patients and 12 positive responses were received. The patients invited for interview out of

Table 1 Overview of participant numbers and recruitment method

Data collection method	Details	<i>n</i>
Interviews with men with depression and anxiety	Attendees of groups	9
	Medical notes search	5
	Media advert	3
	Total	17
Interviews with staff	Facilitators of groups	12 ^a
	Total	12
Observations	Groups observed	4
	Group attendees	30 ^b

^a Out of a total of 12 staff interviewed, six of these were men who also talked about their own feelings of anxiety or depression and who had all attended group services as group members. All interviewees have been counted only once and are described either as 'staff' or 'men with depression and anxiety' even though the boundary between staff and non-staff in this study is fairly fluid.

^b Includes men who were also interviewed individually.

these 12 responders ($n = 5$) were purposefully selected according to the type of support they used (eg, group support or individual therapy) to maximise representation of different types of support used in the sample. A secondary selection criteria of ethnicity was used to increase ethnic diversity in the sample. The third recruitment strategy, which aimed to recruit men who neither accessed groups nor spoke with their GP about depression and anxiety, was to place adverts in local papers and community newsletters.

Where possible, participants with depression or anxiety invited for group observation or interview completed a demographic questionnaire and an assessment of depression, the Patient Health Questionnaire (PHQ-9). The PHQ-9 was used because it is short and provided some comparison and continuity with a previous study on groups and depressed women (see Cramer *et al.*, 2011). Although the PHQ-9 is generally well validated and commonly used in primary care (Wittkamp *et al.*, 2007) some critics point to a gender bias in diagnostic criteria and screening tools (Courtenay, 2000; Addis, 2008) and which would include the PHQ-9, and omitting anger as a key dimension is one example (Winkler *et al.*, 2006).

Staff who facilitated groups from each of the groups observed were interviewed. In addition interviews were conducted with a range of staff, all of whom ran groups for people with anxiety or

depression. Some of these staff were facilitating some of the 12 groups identified and included in the mapping exercise (see Box 1), while other staff who were interviewed ran groups which were considered outside the remit of the mapping exercise (eg, they ran men's groups in secondary care or with specific target populations such as men living in hostel accommodation). All interviews were semi-structured, used a topic guide and were conducted at locations convenient to interviewees such as community health centres. All interviews with staff (S) and participants (P) were audio-recorded and transcribed.

Data analysis

Thematic analysis using the constant comparison technique was used to scrutinise both the group observations and interviews (Strauss and Corbin, 1998). The software 'ATLAS.ti' aided data management. An initial coding framework was developed from observation and interview transcripts. This framework was added to, refined and codes built into broader categories and themes. In order to ensure robust analysis another member of the team (J.H.) concurrently and independently coded a portion of the transcripts. H.C. led the analysis and discussed the preliminary coding framework and themes with S.P. and J.H. initially and then with the wider authorship group.

Results

Types of groups available to depressed and anxious men

The mapping exercise identified 12 groups that men with depression or anxiety could potentially attend (see Box 1). Some of the groups followed a particular structure or therapeutic model while many provided more informal support. Some groups ran on a regular basis throughout the year, while others ran for shorter periods. Most groups were either free to attendees or asked for a small contributory fee to cover refreshment costs. The groups that ran in the statutory sector were all professionally led and tended to be accessed through GP referral. Most groups had some form of target population or restricted membership but very few groups were only open to men. Further details of the four groups that were observed can

Box 2 Details of the groups observed and group attendees

	Peer-led depression group	Peer-led social anxiety group	Professionally led support group	Professionally led anger management course
Attendance criteria	Open to men and women	Open to men and women	Open to men only	Open to men and women
Structure	Structured group based on turn taking for half the session. Also follow a 12 steps model, 1.5 h long, once a week, day time	Fairly structured group based around different weekly topics (eg, symptoms, relationships, workplace issues, public speaking). 1.5 h long, once a week, evening. Monthly socials in pub. Women only group once a month	Unstructured men's <i>space</i> with activities regularly available (eg, cooking sessions, guest speakers, Wii fit, craft projects or outings). Venue: community kitchen. Food provided (eg, pizzas, fruit). 1.5 h long, once a week, day time	Structured course based around written material. 1.5 h long, once a week for six weeks, evenings. GP or self referral
Facilitator	Male facilitator in 60s with experience of depression	Male facilitator in his 30s with experience of social anxiety	A professional male mental health worker in his 40s who saw most men on a one-to-one basis before they attended the group. Referral for one-to-one from GP or other community worker	Two professional female trainers in their 40–50s
Typical session	Notices and reminder of group rules. Twelve steps to recovery read aloud. Individual turns taken to talk ending turn with personal goal. Second half discussion relevant to mental health issues. Brief group feedback and serenity prayer read	Reminder of the rules, notices, structured method for introducing each member to the group. Small group discussion on the week's topic or in whole group if a public speaking session. Closing feedback. Extensive written information and support also provided or available on the groups' website	Informal and loosely structured sessions. Men arrive, chatting, teas and food laid out. Cooking session and craft projects started. Some men smoke on the balcony, some do the Wii fit	Facilitators talk through a topic based using on a written hand-out (eg, unhelpful thinking patterns, expressing anger safely). Attendees not encouraged to share too much personal information during the course but to seek individual counselling for this
Number and gender of attendees on week(s) observed	Week 1: 5 men; 0 women, Week 2: 3 men; 0 women, Week 3: 7 men; 1 woman. (as these were peer-led groups attendee numbers includes male facilitator/ group member)	Week 1: 8 men; 2 women (as these were peer-led groups attendee numbers includes male facilitator/ group member)	Week 1: 6 men; 0 women. (plus additional male facilitator)	Week 1: 3 men; 0 women, Week 2: 3 men; 0 women, Week 3: 3 men; 0 women. (plus two additional female facilitators)

Box 2 Continued

	Peer-led depression group	Peer-led social anxiety group	Professionally led support group	Professionally led anger management course
Ages of attendees	40–70s age group	20–50s age group	18–50s age group	20–40s age group
Depression scores (PHQ-9) of attendees ^a	1, 3, 6, 6, 8	3, 9 ^b	20, 23, 10 ^c	8, 0, 12
Age attendees left full time education	16, 17, 19, 21, 21 ^d	21, 23	15, 16, 18	16, 16, 18
Employment status of attendees	Range of employed, in part-time education and retired	Of those asked, both employed	All unemployed	All employed

^a PHQ-9 scores: Up to 14 may indicate mild depression, 15–19 indicates moderate to severe depression, over 20 indicates severe depression. (Please note not all attendees of groups filled in a depression score as generally only those people who agreed to do an interview did this.)
^b Please note the assessment tool was for depression not anxiety.
^c This group member only completed four questions of the PHQ-9 but scored 10 out of a possible top score of 12 of these four questions.
^d Although one group member left school at 16, he now teaches adult education.

be found in Box 2. From the demographic data and depression scores from attendees as well as detailed observations of the four groups, it was possible to see that the various groups may have appealed to different target populations, although these data must be seen as preliminary ideas only. For example, the peer-led groups generally had members with a higher school leaving age and milder depression scores. By contrast men attending the professionally led men-only group generally had lower school-leaving ages, they all had high depression scores and some had more serious mental health issues such as schizophrenia and addictions such as alcoholism.

Having established the range and type of mental health groups available to men in a single city, this paper draws further on the observational data with four groups (*n* = 30 attendees), interview data with staff who run groups (*n* = 12) and interview data with men with depression or anxiety (*n* = 17), see also Table 1. From this data set three key themes emerged: isolation and the social benefits of groups; the value of groups and strategies for attracting men; accessing support and the role of health professionals.

Isolation and the social benefits of groups

Feeling lonely, isolated or bored were frequently mentioned reasons for going to a group by attendees, as well as practical considerations like affordability. The social attractions of groups were talked of as both an initial pull and something that sustained their on-going attendance:

I like the cooking, someone to talk to, connect, make friends.

P18 [I,R, aged 35, attendee at men-only group]

I was struggling at University so I didn't know too many people, so I suppose it was a sort of social aspect. ... [] I just saw this poster on the library wall ... [] obviously it's a cheap option...you don't have to think quite so much about getting involved... [And] if the group works well then it adds a social dimension.

SP2 [I,R, facilitator and attendee of depression groups]

Men's isolated situations were often described as resulting from difficult life events such as a

relationship breakdown. Groups were not necessarily the first choice in an immediate crisis, but more of an on-going social option. While relationship breakdown is not uniquely experienced by men, what the accounts revealed was a particular pattern of isolation, responses and coping. For example, one man talked about how he tried to connect with people through his work, recognition of his own dependence on female partners for support and his suicide attempt:

I've had [] shops for the last 35 years ... [] That was the kind of a way to track people in so that I had a source of human contact, because I tend to isolate quite a lot. ... [] people that I've met as well as myself who are very cut off and very lonely, and if they go to their GP and have a little five minute chat, it might be a lifeline for them... [] And when the break up took place, because I was so dependent you know, in relationships I kind of go, I like to kind of close my eyes and dive in... [] I took an overdose.

P6 [I,R, aged 77, attendee at peer-led depression group and peer-led anxiety group]

Another theme on the attractions of groups was the importance of support outside family or friends. Some men emphasised the difficulties of explaining or discussing personal feelings with family members:

I definitely think it helps you manage your own mental health, whether it would stop you getting down into a huge depression I don't know but in terms of like just sharing with people on a weekly basis [with people] who say aren't members of your family and aren't close friends and cos it's entirely in confidence I just think that can be you know sort of quite healthy.

P7 [I,R, aged 45 attendee at peer-led depression group]

One man contrasted his own delay and reluctance in talking to his family and friends with that of his sister:

Participant: Oh her and mum talk about it [depression] all the time. [] my sister was actually receiving medication for I think it

was a good year before I was [] she spoke to my mother about it, she spoke to her GP, her friends [] I'm completely the polar opposite of my sister [] I didn't want to burden them [friends or family] I didn't want cos you know I don't wanna drag everyone down with my problems so, I don't wanna sit there and be the miserable one. []

Interviewer: Mhm and you didn't have any friends that you could talk about that sort of personal stuff at the time?

Participant: No, I have some amazingly good friends but I just didn't want to. [] I don't talk about it with my friends now... [] They're aware of what happened but we don't talk about it.

P24 [I,R, aged 44, had attended a cognitive behavioural therapy group and counselling]

Socio-economic data given continues the theme of depressed, lonely, isolated men. For example, in the overall sample of men in the study (groups attendees and non groups attendees) and where we had data, only seven men out of 32 respondents reported living with partners/wives. One man who did not attend any groups seemed to live a particularly lonely, unconnected existence. He was unemployed and described a life with virtually no ties or support:

Interviewer: What about [] your support networks? Have you got some good friends or family around?

Participant: Absolute zero, absolute zero... I got family [] I was brought up in a children's home... [family members] certainly wouldn't listen. [] I see a mate now and again [] I even said to my, well kind of an ex-girlfriend, I phone her and that's all I do, I don't see her, 'I can't support you, I can't support myself [] there's nothing there for us to be together'... even when I was in the children's home [] the people that look after you, that's all they do [] and then you leave and then 'bye bye' you don't see them again.

P29 [I,R, aged 54, did not attend groups or counselling and was not registered with a GP]

Responding to an advert, an older man gave an interview with a strong narrative thread about attempting to live up to masculine ideals of self-sufficiency and control as exemplified by his father. An unspecified tragedy had occurred in his early adult life and he explained that he had coped with his grief and depression by isolating himself and sailing. This man's account suggests an explanatory connection between isolation, not seeking help and masculine ideals of self-sufficiency:

I took some drastic action and sailed away. [] For about thirteen years.... [] the one man whom I respect more than or respected more than any other person I have ever met is my father.... [] he tried to bring me up with his standards and I always tried to live by those standards [] He used to say things like "anyone can be born male but if you wish to be a man in the true sense of the word you have to be two things: You have to be invincible and indestructible". [] I never saw him worried or upset or at a loss for anything. He was always very calm, very sure and always in control.

P27 [I,R, aged 77, not registered with a GP but did attend a depression support group]

A discernible pattern of isolation emerged from the data. Some men explicitly linked a value of self-sufficiency to non-help seeking, while others stated a preference for support outside their immediate family and friends. Some of the men attended groups partly out of recognition of their own isolation. Many community peer-led groups ran on a weekly basis all year round and so provided some men with a regular way to access on-going support.

The value of groups and strategies for attracting men

A general observation gathered from most of the staff interviews was that getting men to come and continue to come to groups required particular strategies, effort and attention. The groups observed attracted men in by various methods, partly related to the different models of group facilitation and potential or actual attendees. For example, the facilitator of the men-only group initially worked with most group members on a one-to-one basis and trusting relationships with him had been clearly established. Working

with men with high support and mental health needs, this facilitator always provided food and explained that it was important to address men's mental health needs indirectly:

Generally we have a couple of pizzas, erm, bits of fruit, fruit juice... [] some men just come for the food. Especially some of the clientele that do come along because they are quite poor, they are trying to get off drugs, erm, struggling to make ends meet, money-wise. So giving them some food or something just to make them feel it's worthwhile ... [] There has to be some enticement to get them there...and the first thing they say is 'what's the point in me going there, what's in it for me?' ...[] the emotional stuff comes out once they are there.

S1 [I,R, facilitator of men-only group]

The two peer-led groups provided opportunities for leadership, increased self worth and reduced stigma through sharing. For example, one man who started as a group member went on to facilitate a group and said:

I think it takes the attention off yourself which I think is a good thing and I, I do think that's one of the strengths in it, thinking about other people ...[] there is a sense of erm achievement and you know, giving back.

SP2 [I,R, facilitator and attendee of peer-led depression groups]

Another man touched on the issue of stigma and sharing in terms of the status equality that is available in peer-led groups between facilitators and members. During one group session he told a joke and directly linked it to the ethos of the group:

A man who falls down a hole and can't get out...[]the doctor just drops a, a prescription down the hole... [] the priest drops a prayer down the hole. And then a friend goes past ...[] And he jumps down into the hole. He said, 'Well, what did you do that for? Now we're both stuck down the hole?' And he said, 'Yeah, but I've been here before and I know the way out.' And I thought that really related to how I feel about [peer-led] groups as opposed to professionals.

P33 [O,R,N, week 3 of the peer-led depression group]

A (female) facilitator of groups for homeless men similarly reinforced the idea that groups are attractive and powerful because by coming together stigma is reduced. She also pointed to the structural barriers that continue to exist between most therapists and clients:

I am a great believer in groups ... [people are] ashamed of having some kind of mental health problem ... [] your therapists are likely to be middle-class... [] You know if other people in the group are saying you know I've tried this, that or the other and it works, that is going to be much easier to hear and much more useful to people ...[] that shared experience that you get in a group, that witnessing of each other's problems and that learning from each other is very powerful.

S21 [I,R, facilitator of homeless men's groups]

While in this study the peer-led community groups appeared to be attended by better educated men with milder depression scores, the broader attractions of status equality and reduced stigma may widely appeal to many men and can be provided to various degrees by different types of group.

Excluding women from groups did not seem to be an initial appeal for men to attend. The majority of men in this study, when asked directly, stated a preference for mixed gender groups. While acknowledging that the informants who preferred mixed sex groups were also largely attending mixed-sex groups, rather than having tried both, the general perception projected onto men-only groups was that they might inhibit sharing and talking openly about feelings. By contrast facilitators who had run both mixed and men-only groups pointed out that in their experience, men could explore difficulties with (heterosexual) relationships and emotional feelings more easily in a men-only group. For example, one (male) facilitator recalled a successful older men's group and contrasted this to a mixed-sex group where one man had taken on a restrictive role:

In this [men-only] group it felt okay, people were able to kind of share that um vulnerability and express the difficulties they had.... [] there was a unifying thing as well that a lot

of the men in that group were able to recall the war [] In another group the male who suffered with depression but would not admit it, became a jovial character [] a jack-the-lad almost type character with these women around him that he would joke and banter... [] males in a male-only group showed a more genuine openness to themselves and each other.

S13 [I,R, facilitator of groups]

Accessing support and the role of health professionals

A proportion of men who experience depression or anxiety may not approach a health professional directly to talk about this. In this study we managed to interview some men who said they had not sought help for their depression. In common with most men in this study these men spoke about the difficulty of seeking help and in particular talking about their feelings of depression and anxiety. For example, one man spoke about how he had to overcome pride before he could approach his GP to talk about depression. This man said that his depression was recognised at school but he then had a long period of alcoholism, which he now saw as covering an underlying depression:

The alcoholism probably kicked in around 18/19 and carried on till ...yes about 30/31... [] ...and realise the, over the years... I hadn't actually combat or even beaten, I haven't beaten depression, I just masked it with alcohol ... [] I swallowed me pride and getting to see my GP, this is how I am feeling, the depression has kicked in again and I need something to do.

P22 [I,R, aged 35, attendee of Alcoholics Anonymous groups]

Another man with an alcohol problem said he had been embarrassed when he once tried talking to his GP. This man said that the onus to make changes was placed on himself by the GP and implied that the idea of trying to talk again to a GP, especially a male GP, would be challenging:

I think I've got a bit of a drinking problem... [] all the old crew split up. Mrs, kids, with her. Lost me job. But that was years ago... [The GP] Just told me to pull me socks up

basically....So basically yeah, here's the number, if you wanna help yourself, go and help yourself... [] I've even apologised for going up there and saying sorry and ... for wasting her breath....Yeah, it was quite embarrassing actually....especially to a bloke GP....You know, it's easier to talk to a woman. Or I find it easier to talk to a woman and anyway....I wouldn't even go anywhere near it [if it was a male GP] no.

P23 [I,R, aged 46, did not attend groups or counselling and was not registered with a GP]

This man said that he thought by doing a research interview it might help to clarify his feelings and uncertainty around stress and depression. In the following excerpt, he links his reluctance to talk openly to masculine ideals of emotional self-sufficiency:

I don't even know whether I'm depressed or whether I'm just a lazy twat who's feeling sorry for himself [] I can't really explain it to me-self how I feel. [] I don't think it's in our nature to open up. [] sometimes you look at a woman and you think oh I wish I could have a good old ball like they, like women do ... [] We just gotta tell ourselves to shut up and stop being a dick head. [] I don't, you know, wanna tell anybody that I'm having a bit of a concern about anything.

P23 [I,R, aged 46]

Another man felt that he could not talk openly with his GP about his mental health problems, because his life insurance would be invalid if he subsequently killed himself. As a British Sikh, he described a burden of expectations as an eldest son in an arranged marriage and this excerpt highlights some of the additional difficulties and cultural constraints to help seeking for some men:

My mum and dad are old and the other problem, if anything happened to them my brothers blame me for it. [] If I was to divorce my wife at the beginning it could be a big impact for the rest of my brothers for getting married.... [] somebody had to be the oldest son and unfortunately it was me.

P28 [I,R, aged 42, had once tried counselling]

Some men who managed to overcome their pride or embarrassment highlighted a number of ways where health professionals were helpful and facilitated good support. For example, one older man said he had relied on his GP to give him information:

I don't like them [computers], I don't have one. He [GP] gave me a list of support groups available, individual therapists, expensive ones, cheap ones and various other support groups. That was very helpful, he printed it out for me.

P6 [I,R aged 77, attendee at peer-led depression group and peer-led anxiety group]

The way health professionals explain and describe options for local support may affect whether men take up that support. For example, several men mentioned that they disliked the idea of counselling because they did not see the point of talking about things that happened in the past and could not be changed. Group options might therefore be attractive to some men who hold these views:

I found [counselling] difficult because we started going into more stuff in terms of my background with my family relationships [] So delving into family issues that hadn't gone right. I am not getting any solutions here, I am not getting anywhere with this [counselling] and it's just driving me insane.

P10 [I,R, aged 28, attendee at peer-led anxiety group]

It just didn't seem to challenge anything, it was erm, or analyse anything, it was just erm a commiseration sort of thing ... [] the counselling just seemed a little bit more [pause] yeah just gave me an opportunity to talk []but it didn't seem to be enough.

P11 [I,R, aged 37, attendee at peer-led anxiety group]

There were several positive accounts of men being listened to by GPs at a critical time. Despite a previous poor encounter with a GP, one man, described a more recent significant encounter with his GP. This account is interesting in that the respondent says he initially presented with physical symptoms and chest pain, as well as

illustrating a wider and recurring theme in the accounts of other men of trying and failing to get help from their GP at a younger age:

I think it's about fifteen years ago since I first went to the doctor. And I had trouble sleeping, I couldn't stop thinking about things ... [I] was pretty much fobbed off ... [] I had considered chucking myself under a train at one point... [] Which is why two years ago when I went to the doctor I wasn't expecting a lot for it. [] So I went and I saw doctor, who actually listened to what I had to say, it was great, he saved my life I think. Cos the fact that he responded to what I'd said and the way he was helpful rather than just you know buck your ideas up [] I sort of broke down in front of the doctor ... [] It's inbred into you, it's a manly thing you don't go to the doctor ... [] I initially spoke about how I was physically feeling ill ... [] and then he got me to speak at length about everything else that had happened.

P24 [I,R, aged 44, attendee at depression groups and had tried counselling]

Barriers to help seeking was a common theme in most of the interviews, including those who also attended groups. For some men the barriers continued to prevent them from seeking help while for others it just delayed them. GPs could represent both barriers and enablers to help seeking.

Discussion

This study has shown that men do attend groups for support with depression and anxiety. Social isolation was a key feature of many men's accounts, especially after a relationship breakdown. Some men recognised their own isolation and explicitly sought groups for social reasons. Other men who attended groups stated a preference for ongoing mental health support outside their immediate family and friends. The different types of groups identified seemed to relate to different member audiences. For example, a professionally led group was mostly attended by men with higher mental health and support needs and their mental health issues were addressed indirectly. The equality of members was valued in the peer-led groups as were

opportunities for leadership. While men-only groups allowed men to talk in different ways and about relationships, mixed gender groups were generally preferred. Barriers to accessing support centred around men's perceptions that, as men, they should deal with their personal issues themselves. GPs and other health professionals may be able to play a key role in helping men to acknowledge their experiences of depression and anxiety, or they may be perceived as unhelpful and obstructive.

The accounts in this study are consistent with previous work that has suggested that men are less likely to be diagnosed with depression and anxiety than women (Van de Velde *et al.*, 2010), more likely to delay help seeking (Galdas *et al.*, 2004), use alcohol to deal with their distress (Dolan, 2011) and more likely to attempt suicide (ONS, 2009). However, while much of the literature demonstrates how cultural ideals of masculinity create barriers and attach stigma to men seeking help for depression and anxiety (O'Brien *et al.*, 2005), the findings of this study also show how men do seek and receive help, especially in group settings. Emslie *et al.* (2006), found that some men recovered from depression when they joined activities that made them feel 'one-of-the-boys' or when they had the opportunity to act as leaders for other men. Following Emslie *et al.*, peer-led groups and men-only groups may therefore provide structures towards recovery. Groups have other advantages that may be attractive to men such as providing a structured way to make social contact, providing opportunities to tackle sensitive issues sideways on and alcohol issues not necessarily being a reason for exclusion. The observations and socio-economic data collected on attendees of the groups suggest how different types of groups may be attractive to different groups of men. The more educated men seemed to be more attracted to the peer-led groups where issues of depression and anxiety were directly addressed and discussed and this is consistent with studies that suggest middle class men find it easier to talk and display a range of emotions (Seale and Charteris-Black, 2008). While this study found a preference for mixed gender groups, it should not be uncritically accepted that women should participate in mixed gender groups to support men, unless their (women's) support needs are also being met.

Strengths and limitations of the study

The main strengths of this study are that it explored a little known topic area, with a strong combined interview and observational methodology that managed to recruit and include the views of some men not in contact with other services. In terms of limitations, this study used the PHQ-9 as a descriptive tool and measure of respondent depression but which does not measure anxiety levels so well or include all dimensions of men's depression (Winkler *et al.*, 2006). Additionally this study draws on a relatively small sample of men and groups, although the aims of the study were exploratory in nature. We were not able to gain access to an existing black and minority ethnic group or a younger men's group that would have helped to explore in more detail some of the important findings only so far touched on. However, generalisability of the results arises not from representativeness or size of the sample but from concepts that are likely to be relevant in other settings (Green, 1999).

Conclusions

This study highlights the role that groups can play in supporting men with depression and anxiety. National Institute for Clinical Excellence guidelines recommend that depressed patients should be treated with brief individual psychological interventions as first-line treatment, with group therapies being an option for people who prefer this (NICE, 2009). Unlike individual therapies which are usually only available free for short periods of time, peer-led community groups can offer men year round, low cost, social and mental health support that may help to de-stigmatise and de-medicalise their experiences and their advantages could be more widely appreciated. Most members of peer-led community groups, however, might also, at times, need one-to-one support from other health professionals. Groups may be a good starting point to engage some men and may combine well with one-to-one talking therapies. Any one type of group is unlikely to suit all men but factors such as the group style, how they advertise and who they have as a facilitator can help to attract and target certain subgroups of men. Because men with depression and anxiety may find it hard to admit to having depression, providing 'face-saving' excuses for attending groups (such as

providing food) are worthwhile. Men's mental health workers may provide an important model for successful group support for hard-to-reach men with more severe social and mental health problems. The delay in many men's accounts of help seeking points to the greater need to identify and support men in distress especially at younger ages.

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Competing Interests

There are no competing interests except that Helen Lester was also the secretary of the Royal College of GPs Scientific Foundation Board.

Ethical Approval

The study was approved by the South West 4 committee (10/H0102/47)

Contributors

H.C. designed this study with help and support from C.S. and R.A. H.C. undertook the interviews, observations, analysed and interpreted the data, and J.H. and S.P. supported the analysis. H.C. wrote the first draft. The whole team revised the article for important intellectual content and all members of the team gave final approval of the version published. H.C. is the guarantor. All contributors had full access to all of the data in the study and can take responsibility for the integrity of the data and the accuracy of the data analysis.

Data Sharing

There is no additional data available.

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