ABSTRACT

THE LIVED EXPERIENCES OF DEPRESSION AND COPING:
PERSPECTIVES OF DEPRESSED MALES
AND THEIR SPOUSES/SIGNIFICANT OTHERS

By Jili Witte

The purpose of this study was to explore and describe the lived experiences of depression and coping from the perspectives of men and their spouses/significant others. Depression affects over 6% of Americans. More than 80% of patients with depressive disorders are estimated to seek care from primary care providers. Despite numerous studies on depression, effects of depression and treatment issues, there is paucity of research related to males with depression. To enhance the health care provider’s understanding, the following research questions were asked: (a) What is the lived experience of depression in men and their spouses/significant others? (b) How does the family cope with the recurrence of depression? and (c) How can the advanced practice nurse (APN) help with depression?

Parse’s (1998) Human Becoming Theory provided the framework for this study. A phenomenological qualitative design was used to gather narrative data in order to explore and describe their experiences. Open-ended interviews with both the depressed man and his spouse/significant other took place jointly. Data were analyzed according to Giorgi’s (1995) approach.

The sample comprised a convenience sample of six men diagnosed with major depressive disorder (MDD) and their significant other/spouse. The settings for data collection were private psychiatric clinics, depression support groups and community centers. The researcher was the data collection instrument. Interviews were audiotaped and transcribed verbatim. Data were analyzed according to Giorgi’s (1995) approach.

Data analysis of the depressed men’s perspectives indicated three main themes: (a) Diagnosis: What is it? (b) Coping: Pulling Through; and (c) The Treatment: Relief. Data analysis of spouses/significant others indicated three main themes: (a) Disbelief: What now? (b) Continuing On: Wishing for Normalcy; and (c) The Treatment: Relief.

Nurse practitioners can utilize the findings of this study to optimize the care they give to the depressed male and his spouse/significant other. This study showed that a more comprehensive nursing evaluation of the male’s depression and its effects on the spouse/significant other would help identify areas to focus treatment. Through interventions tailored to meet the patient and spouse’s/significant other’s needs, APNs can have a more profound and lasting impact on the outcomes of the patient and spouse/significant other.
THE LIVED EXPERIENCES OF DEPRESSION AND COPING:
PERSPECTIVES OF DEPRESSED MALES
AND THEIR SPOUSES/SIGNIFICANT OTHERS

by

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CHAPTER I
INTRODUCTION

Major depressive disorder (MDD) affects approximately 14.8 million American adults or approximately 6.7% of the U.S. population over age 18 (National Institute for Mental Health [NIMH], 2007). Depression is a common disorder associated with suffering, morbidity, and mortality. Researchers have studied many aspects of depression such as difficulties in relationships (Benazon & Coyne, 2000; Gupta, Coyne, & Beach, 2003; Hickey, Carr, Dooley, Guerin, Butler, & Fitzpatrick, 2005), differences in gender (Angst, Gamma, Gastpar, Lepline, Mendelewicz & Tylee, 2002; Kiviruusu, Huurre, & Aro, 2007; Wilhelm, Roy, Mitchell, Brownhill, & Parker, 2002;), and the onsets and recurrences (Alloy, Abramson, Whitehouse, Hogan, Panzarella, & Rose., 2006).

Alloy et al. (2006) did a 2 ½-year prospective study on the onset and recurrences of depression. The researcher categorized the participants into low and high risk for depression based on their cognitive styles. High-risk participants had odds of major, minor and hopelessness depression from three to almost seven times greater than low-risk individuals. Negative cognitive styles were similarly predictive of first onsets and recurrences of major depression and hopelessness depression but predicted first onsets of minor depression more strongly than recurrences.

Feely, Sines and Long (2007) did a grounded theory study to capture perceptions of living with or caring for individuals with depression, respondents' perceptions of the pre-diagnosis, and depression encounter. The key category that emerged was the pre-diagnosis phase of depression and the now experience. Five key themes surfaced within this category: (a) negative impact of significant life events; (b) self-blame;
(c) personal characteristics; (d) pre-diagnosis, depression unknowingness; and (e) pre-help seeking. The findings suggested that health care providers need to better understand the lived experience of people with depression in order to provide holistic treatment and care.

Benazon and Coyne (2000) studied mood and specific burdens experienced by spouses of patients in treatment for depression. Depressed men and women with their spouses were administered a structured tool to explore the relationship between spouses living with a depressed patient and the frequency the couples reported depressed mood. The researchers found that spouses living with a depressed patient reported significantly more depressed mood and numerous specific burdens such as: the patient's feeling of worthlessness, the possibility that the patient would become seriously depressed again, the emotional strain on the spouse, the patient's constant worrying and the patient's lack of energy. Benazon and Coyne stated that these burdens as well as the gender of the spouse accounted for the spouse's depressed mood.

Angst et al. (2002) found gender differences in depression and coping. These differences persisted across all age groups. They found men reported fewer symptoms than women; as a consequence, men reached the diagnostic threshold of MDD less often. Also, the researchers found men coped by increasing their sports activity and consumption of alcohol, and women through emotional release and religion.

Wilhelm et al. (2002) also studied gender differences related to risk for depression and coping factors. They found few gender differences in the experience of depression in a group with established episodes of major depression; but women reported more emotional arousability when depressed. In regards to coping, women
reported higher rates of dysfunctional parenting and their partners as less caring. Men coped by using recreational drugs.

Many studies have cited a higher prevalence of depressive disorder in women (Angst et al., 2002; NIMH, 2007; Wilhelm et al., 2002). Even though men have a lower incidence of depression than women, Angst et al. concluded that men should be screened and treated for depression with as much frequency as women. Ninety percent of people who commit suicide have a diagnosable mental disorder, most commonly a depressive disorder, and of these, four times as many men as women die by suicide (NIMH).

Despite numerous studies on depression, effects of depression and treatment issues, there is paucity of research related to males with depression. Many studies have been done on women during their life cycle such as postpartum and menopause related to depression (Ancelin, Scali, & Ritchie, 2007; Austin, Tully, & Parker, 2007; Becker, Orr, Weizman, Kotler, & Pines, 2007; Josefsson & Sydsjo, 2007). Also, much research has been done using a quantitative design (Angst et al., 2002; Benazon & Coyne, 2000; Siegel, Bradley, Gallo, & Kasl, 2004). Few studies have been done using a qualitative approach (Ehrenreich, Hilden, & Malterud, 2007; Feely, Sines, & Long, 2007; Pereira, Furegato, & Pereira, 2005) and fewer on the couple’s perspective of depression.

Pereira et al. (2005) investigated the lived experience of long-term psychiatric hospitalization of four women in Brazil. They found that sad events in life, emotional conflicts, different types of abuse causing “negative experiences,” and long-term hospitalization could possibly be minimized through adequate assistance provided by psychiatric nurses in outpatient services.
Ehrenreich et al. (2007) did an analysis of the written life stories of people having depressive or anxiety related disorders. They found themes related to negative expectations of life, the self, or the values and capabilities of others or of the patient. The authors concluded that written life stories reveal knowledge of the patient's dysfunctional thought patterns. They suggested that further research would benefit from studying how these findings could be used in subsequent encounters.

There are studies regarding coping and depression (Burton, Chaneb, & Meeks, 2007; Norton, 2007); however, many of these studies are quantitative in nature, and none address coping and depression in males. Burton et al. (2007) studied mental illness coping versus general life stress coping among older severe mental illness sufferers. Eighty-five adults with severe mental illness completed a coping questionnaire. Participants described significantly more strategies for coping with mental illness related stressors than with other stressors, but used similar types of strategies. Women reported more coping strategies than men.

Norton (2007) studied 895 undergraduate students spanning four cultures by administering the 21-item Depression, Anxiety, and Stress Scales (DASS-21). Norton found significantly higher scores in depression and coping in the Asian culture compared to the African, White and Hispanic/Latino descent.

Very little research has been done related to APNs and depression. The research that is available incorporates other variables into the studies. Fowler (2006) conducted a study to identify alcohol dependence, depression and their co-morbidity as common health problems in the U.S. and to emphasize APNs' interventions including screening, treatment and outcome evaluations for individuals and their families suffering with alcohol dependence and depression. Fowler found that APNs have the opportunity
to successfully intervene with individuals and their family with alcohol dependence, depression and their co-morbidity.

Groh and Hoes (2003) studied the practice methods and beliefs about degree of competence in the assessment, diagnosis and treatment of depressive symptoms in women by nurse practitioners. A survey about the diagnosis and treatment of depressive symptoms in women was given to 3,000 random APNs with membership to the American Academy of Nurse Practitioners. Groh and Hoes found assessment and treatment protocols used by APNs were consistent with the Agency for Health Care Policy and Research guidelines and similar to the protocols used by psychiatrists and non-psychiatric physicians. Yet only 65% believed their education had adequately prepared them to assess and diagnose depression, and only 52% believed they had been adequately prepared to treat depression.

There are numerous studies on hope in different contexts. For example, recent studies include hope in conjunction with medical illnesses (Gum, Snyder & Duncan, 2006) and life meaning (Feldman & Snyder, 2005). However, there is little research on hope and depression.

Feldman and Snyder (2005) conducted a quantitative study on 139 college-age students. Participants received a packet containing the following questionnaires:
(a) Hope Scale to measure dispositional goal-directed hope, (b) Purpose in Life Test, (c) Sense of Coherence Scale, (d) Life Regard Index to measure meaning in life, (e) Beck Depression Inventory, and (f) State Trait Anxiety Inventory to measure relevant mental health variables. The researchers found that hope and depression are stronger among participants with lower levels of life meaning.
Significance to Nursing

Individuals with depression are seeing their primary health care providers rather than psychiatrists, to be treated for depression. Sharp and Lipsky (2002), in their study, found depressed people see their primary care provider on a more regular basis versus their psychiatrists.

In an epidemiological study of women seeking treatment in rural primary care clinics, 25% were found to meet diagnostic criteria for a psychiatric disorder. More than 80% of patients with depressive disorders are estimated to seek care from primary care providers, and only less than 10% of patients are referred to a mental health provider. Only 20% of depressed persons seek treatment from a mental health professional. However, up to 50% of depressed persons visit their primary health care provider at least once during a 6-month period. One group of health professionals that has regular contact with depressed patients is primary care providers, namely, APNs who are in contact with depressed patients on a regular basis. Since APNs will be the first line of contact, they must be proficient and knowledgeable enough to identify, treat and understand the experiences of depression from the patient’s perspective.

Statement of the Problem

Major depression is a public health problem affecting millions of Americans and their families. The majority of studies regarding major depression are quantitative in methodology. Furthermore, these studies have focused on depression from either the spouse's or the individual's perspective, but not both the individual and the spouse.
Purpose of the Study

The purpose of this study was to explore and describe the lived experiences of depression and coping from the perspectives of depressed men and their spouses/significant others, and how APNs can help the family with a recurrence of depression.

Research Questions

The major research question was: What is the lived experience of depression? Related questions were: (a) How does one's family cope with the recurrence of depression? and (b) How can APNs help with depression?

Definitions of Terms

Conceptual Definitions

Lived experience: "The world of everyday life as the total sphere of experiences of an individual which is circumscribed by the objects, person, and events encountered in the pursuit of the pragmatic objectives of living" (Speziale & Carpenter, 2007, p. 77).

Male: Being the sex that produces spermatozoa that perform the fertilizing function in generation (American Heritage Dictionary, 2008).

Depression: Characterized by one or more major depressive episodes (at least 2 weeks of depressed mood or loss of interest). The individual must also experience at least four additional symptoms drawn from a list that includes: change in appetite or weight, sleep and psychomotor activity; decreased energy; feelings of worthlessness or guilt; difficulty thinking, concentrating, or making decisions; or recurrent thought of death or suicide ideation, plans or attempts. The symptoms must persist for most of the day,
nearly every day, for at least 2 consecutive weeks. The episode must be accompanied by clinically significant distress or impairment in social, occupational, or other important areas of function (American Psychiatric Association [APA], 2002).

**Spouse/significant other:** A person who is important to one's well being, especially a spouse or one in a similar relationship (Merriam Webster Online Dictionary, 2007).

**Family:** Depressed patients and their spouses/significant others, who share goals and values, have long-term commitments to one another and reside usually in the same dwelling place (Miller, McDermut, Gordon, Keitner, Ryan & Norman, 2000).

**Cope:** Depressed patient or significant other's way to contend or strive to overcome the everyday stressors that depression produces (Lawrence, Banerjee, Bhugra, Sangha, Turner & Murray, 2006).

**Recurrence of depression:** Episode of depression to happen, come up, or show again repeatedly (Kennedy, Abbott, & Paykel, 2003).

**Advanced practice nurse:** A licensed registered nurse, who has completed graduate training as a clinical nurse specialist, nurse anesthetist, nurse-midwife, or nurse practitioner.

**Operational Definitions**

**Lived experience:** The way a depressed person experiences and understands his or her world as real and meaningful—in this study as reported by the person experiencing depression.

**Male:** Of the male gender, over the age of 18, diagnosed with major depression according to the DSM-IV criteria for 6 months or more.
Depression: Characterized by one or more major depressive episodes (at least 2 weeks of depressed mood or loss of interest). The individual must also experience at least four additional symptoms that includes: change in appetite or weight, sleep and psychomotor activity; decreased energy; feelings of worthlessness or guilt; difficulty thinking, concentrating, or making decisions; or recurrent thought of death or suicide ideation, plans or attempts. The symptoms must persist for most of the day, nearly every day, for at least 2 consecutive weeks. The episode must be accompanied by clinically significant distress or impairment in social, occupational, or other important areas of function (American Psychiatric Association [APA], 1994).

Spouse/significant other: A female person with whom the depressed male cohabits or is married to for at least 1 year.

Family: Depressed patient and his spouse/significant other, who share goals and values, have long-term commitments to one another and reside for at least 1 year, usually in the same dwelling place.

Cope: Depressed patient and significant other’s way to contend or strive to overcome the everyday stressors that depression produces, as reported by the depressed male and spouse/significant other.

Recurrence of depression: Presence of two or more major depressive episodes. To be considered separate episodes, there must be an interval of at least 2 consecutive months in which criteria are not met for a major depressive episode (APA, 2002), as reported by the depressed male and his spouse/significant other.

Advanced practice nurse: A licensed registered nurse, who has received a master’s degree in the science of nursing and is currently working as a nurse practitioner for at least one year with prescriptive authority.
Assumptions

1. All depressed males and their spouses/significant others will be honest in reporting their diagnosis of MDD and lived experiences.

2. Depression in the primary care setting is often underdiagnosed and undertreated.

3. All depressed males and their spouses/significant others are attempting to seek ways to better their quality of life.

Summary

Major depressive disorder is prevalent in the U.S. Males who have been diagnosed with depression tend to see their APNs on a regular basis versus their psychiatrists. Since APNs will be in regular contact with the depressed male, they must be able to understand, identify and treat depression from the patient’s perspective.

The purpose of this study was to describe the lived experience of depression and coping from the perspectives of depressed men and their spouses/significant others. In addition, how the family copes with a recurrence of depression and how APNs can help with depressed were also studied. In this chapter, the background, problem, purpose, significance to nursing, definitions and assumptions of the study were presented.
CHAPTER II
THEORETICAL FRAMEWORK AND LITERATURE REVIEW

Introduction

The purpose of this study was to explore and describe the lived experience of depression and coping from the perspectives of depressed men and their spouses/significant others. In this chapter, a description of the theoretical framework and its application to the study are presented, along with the review of literature.

Theoretical Framework

The theoretical framework that guided this study was Parse's Human Becoming Theory (Parse 1998) (Figure 1). According to Parse, health is a process of being and becoming, which reflects an individual's complex unfolding, and value priorities. Humans are unitary beings that create personal meanings in inter-subjective, mutual process, with the universe, and personal meanings which constitute human lived experiences (Parse, 1998). Human beings create distinguishable patterns of relating. Their patterns reflect the choices individuals make as they progress toward their cherished hopes and dreams in the process of human becoming.
**Principle 1:** Structuring meaning. Meaning multidimensionally is Co-creating reality through the languaging of valuing and Imaging.

**Principle 2:** Co-creating rhythmical patterns of relating is living the paradoxical unity of revealing-concealing and enabling-limiting while connecting-separating.

**Principle 3:** Co-transcending with the possibles is powering unique ways of originating in the process of transforming.

Relationship of the concepts in the squares: 
Relationship of the concepts in the ovals: 
Relationship of the concepts in the triangles:

*Figure 1.* Principles, concepts, and theoretical structures of human becoming (Parse, 1998, p. 56).
Human Becoming Theory

The Human Becoming Theory (Parse, 1998) guides researchers to explore meaning, rhythmicity, and co-transcendence as these phenomena are described in details of what life is like from the person's perspective. There are three major concepts Parse (1998), outlined in her theory:

1. Structuring meaning multidimensionality is co-creating reality through the languaging of valuing and imaging.
2. Co-creating rhythmic patterns of relating is living the paradoxical unity of revealing-concealing and enabling-limiting while connecting-separating.
3. Co-transcending with the process is powering the unique ways of originating in the process of transforming.

Principle one means "that human becoming is the ongoing constructing of reality through assigning significance to experiences at the many realms of the universe that are lived all-at-once" (Parse 1998, p. 35). According to Parse (1981), structured meaning is described in the details of what life is like from the person's perspective.

In principle one there are three concepts: imagery, valuing, and languaging. Imagery is an individual's view of reality. It is "reflective-pre-reflective coming to know the explicit-tacit all-at-once." (Parse, 1998, p. 36). Persons answer questions as they explore the meaning in light of reality and their view of things.

Language, according to Parse (1998), is signifying valued images through speaking-being silent and moving-being still. Language relates to how human beings symbolize and express their imaged realities and their value priorities. This concept is lived multi-dimensionally (Parse, 1998). People disclose things about themselves when they language, even when they are silent and remain still (Parse, 1998).

Principle two states human becoming is an emerging cadence of co-constituting ways of becoming with the universe (Parse, 1998). Patterns of relating are illuminated as people speak about how, who, and what connections constitute day-to-day life and these patterns tell about personal values.

In this principle there are three concepts: revealing-concealing, enabling-limiting and connecting-separating. Revealing-concealing is disclosing-not disclosing all-at-once (Parse, 1998). People at will give and withhold thoughts about themselves and what they know. The rhythmical pattern of revealing-concealing flows in rhythm, human with universe, as a recognizable feature of human becoming.

Enabling-limiting are “the freedoms and opportunities that surface with the restrictions and obstacles of everyday living” (Tomey & Alligood, 2006, p. 526). In choosing, according to Parse (1998), the human moves in one direction, which restricts movement in another, and there are both opportunities and restrictions in what is chosen opportunities and restrictions in what is not chosen.

Connecting-separating is being with and apart from others, ideas, objects, and situations all at once. Both aspects of connecting-separating are a source of human emergence. In everyday life, the human is all at once close to some phenomena and distant from others.
Principle three is co-transcendence and is disclosed when people describe their concerns, hopes and fears (Parse, 1992). Persons are always engaging with and choosing from infinite possibilities about how to be, what attitude or approach to have, whom to relate with, what interests or concerns to be bothered with (Tomey & Alligood, 2006). This principle has three concepts: powering, originating, and transforming.

Powering, according to Parse (1998), is about struggle and life and the will to go on despite hardship and threat. "Pushing-resisting patterns emerge in the human universe process and are present in every human engagement creating tension and sometimes conflict" (Parse, 1998, p. 48). Powering is a process we all change, as one moves from what one is to what one is not yet.

Originating is inventing new ways of conforming-not conforming in the certainty-uncertainty of living. People strive to be like others, and yet they also want to be unique. "It is creating ways of distinguishing personal uniqueness by living in the paradoxical rhythms of conformity-nonconformity and certainty-uncertainty all at once" (Parse, 1998, p. 49).

Transforming is "shifting the view of the familiar-unfamiliar, the changing of change in co-constituting anew in a deliberate way" (Parse, 1998, p. 51). The human-universe process is always ongoing (Tomey & Alligood, 2006). People are struggling to combine the unfamiliar with the familiar in everyday. Humans participate with the universe in a mutual emergence. Within this emergence, the human arising with the universe co-creates becoming. "When new discoveries are made, people change their understanding and, sometimes, life patterns and worldviews can shift with the mystery of an insight that illuminates a familiar situation in a new light" (Tomey & Alligood, p. 527).
The process of relating a lived experience can promote the possibility of allowing the participant to envision a previously unknown significant aspect of his/her lived experience. The principles and concepts of the theory are designed in a way to make the research process explicit in the application of Parse's theory in a formal study.

Case Model

Mr. Taylor, a married man with two children, has stopped doing the things he always has enjoyed. He does not interact with his children, has decreased appetite, sleeps 12 to 15 hours per day, and has stopped having intercourse with his wife. These symptoms have been ongoing for 3 weeks without any sign of improvement. He is informed by his APN that he has clinical depression. Mr. Taylor struggles with himself and with his wife about the diagnosis. His APN presents an opportunity for Mr. Taylor to discuss his feelings and response to the diagnosis. She also spends several hours with the family bearing witness to the changing health patterns, and the changing nature of the relationships between the family members.

Parse's human becoming theory was an appropriate theoretical framework for this study. Within Parse's theory, the patient's own perspective of his predicament, and that of the family is considered to be of vital significance. Nursing from within the Human Becoming Model fundamentally involves coming to understand this, and creating the conditions within which patients and their relatives can come to terms with their situation.

Literature Review

The literature review consists of studies on: living with a depressed patient, qualitative studies that examine the lived experience of the depressed person or a
couple, gender difference in depression and significant other relationships and depression.

*Living With a Depressed Person*

Benazon and Coyne (2000) completed a nonexperimental study examining depressed mood and specific burdens experienced by spouses of patients in treatment for depression. Forty-nine wife depressed couples and 30 husband depressed couples were administered the Structured Clinical Interview for DSM-IV. Spouses completed measures of depressed mood and burden. The measure of burden used in this study was developed and validated by Coyne, Kessler, Margalit and Turnbull (1987). Burden was measured in a two-stage process. The first was a preliminary list of items constructed from a review of previous studies of the burdens experienced by families of schizophrenic, chronically physically ill and aged persons. Next, prospective items were evaluated in a series of focus groups conducted with family members of depressed patients. Thirty-three items were included in the revised list for the use in the survey study. The Multiple Affect Adjective Check List is a 12-item depression subscale of the trait version completed by both patients and spouses measuring depressed mood.

Multiple regression analyses revealed that the sources of burden receiving the highest mean rating by spouses were, in descending order, the patient’s feeling of worthlessness (M = 3.04), the possibility that the patient would become seriously depressed again (M = 2.91), the emotional strain on the spouse (M = 2.69), the patient’s constant worrying (M = 2.66), and the patient’s lack of energy (M = 2.61). These items corresponded with the items that received the highest ratings by the respondents in the Coyne et al. (1987) study.
Benazon and Coyne (2000) also looked at the relation between patient and spouse mood. They found spouse burden and spouse gender could essentially account for the effect of the patient's mood on the spouse's depressed mood. When the patient was male, both patients and spouses had significantly more depressed mood. In analyzing the data, even though the wives of patients had a 10-point higher burden score than husbands of patients, the gender difference in burden was only marginally significant.

*Lived Experiences of Depression*

Robertson, Venter and Botha (2005) completed a qualitative study to explore the life narratives of a group of 10 self-identified depressed individuals. A multiple case study method was used, consisting of interviews in narrative format. The aim of the study was to examine the psychological meaning of depression from the perspective of self-identified depressed people as expressed in their narratives. In gathering the data only one question was used initially: Would you please tell me the story of your life? Some prompting was necessary and seven additional questions were in reserve. The researchers found three common themes: the negative meanings attached to their life experiences; the use of negative language; and political ideology, such as blaming apartheid for one's own racism. The researchers also found themes of how the participants dealt with depression. These included unique outcomes such as ability to make friends, having new interests, externalization and medication.

Harris, Pistrang and Barker (2006) did a phenomenological study that examined how significant others attempted to support a depressed spouse and how each member of the couple experienced the support process. The study consisted of nine people—eight females and one male—who were or had been depressed. Participants were
interviewed jointly with their significant other on two separate occasions. Ten themes emerged and were grouped into two domains. The first domain was the challenges couples faced over the trajectory of a depressive episode, and the second were issues in the support process as experienced by each member of the couple. The researchers chose to limit recruitment to those who had either recently recovered from, or who were in the late stages of depression, since the focus of the study required retrospective reflection about their depression.

Data were categorized into two domains. The first domain was the couple's experience of depression. From this, five themes emerged: bafflement, battling through, coping with the "long, gray periods," starting to "swim again" and the threat of relapse. The second domain was titled "the helping process." It included five themes: "Stumbling along," "walking on eggshells," "communication in depression—a catch 22," "working together" and "managing one's feelings as a helper." The researchers stressed the approach to data collection in conducting conjoint interviews as having strengths and weaknesses. The main weakness of this data collection was each member of the couple tended to elaborate and react to each other's ideas, which meant "that their accounts were not independent, nor was it possible to identify clearly discernible, separate narratives" (Harris et al., 2006, p. 18). The strength of the study was the data collection, which itself provided a comprehensive view of the couples' experience of the support process in depression from the joint perspective of the couple.

Ehrenreich, Hilden and Mallerud (2007) completed a quantitative study to explore how statements drawn from patients' written life stories can help general practitioners understand their patients' maladaptive thought patterns and their negative thoughts.
Twenty-two depressed patients were invited by their primary care providers to participate in cognitive therapy due to depressive disorders.

Three major themes evolved: (a) the world is evil, (b) only the perfect is of value, and (c) emotions are dangerous. In theme one, the life stories shared the common experience of an unpredictable and dangerous world. In theme two, several patients described how they saw themselves worthless as persons and felt they had to be the best, participate in multiple activities or befriend the perfect people in order to deserve the attention of loved ones. In the third theme, the life stories told of lives where the basic assumption was negative feelings were associated with much discomfort. This discomfort arose from arguments, grief or suffering. Results from the written life stories indicated aspects of negative expectations of life, the self or the values and capabilities of others or the patient (Ehrenreich et al., 2007).

Pereira et al. (2005) completed a phenomenological study on four women who were committed to long periods of psychiatric hospitalization in Brazil. Data were collected through open interviews. Analysis showed a process of social exclusion, emotional suffering and inadequate treatment in the hospital, leading to no other option but recurrent hospitalization. The types of treatment available in the psychiatric hospital were inadequate for these participants. According to the four patients, all of these therapeutic modalities induced more mental illness by increasing exclusion. Other forms of treatment, such as group therapy and psychological counseling, were not available. The results indicated the need to encourage family support or social network, which may be more helpful than institutionalization.

Feely, Sines and Long (2007) did a study that was part of a larger grounded theory study designed to capture a sample of people's perceptions of living with or
caring for individuals with depression. The researchers focused on the respondents’ perceptions of pre-diagnosis and depression encounter. The study had a focus group of seven people who had depression. In-depth one-to-one interviews were done further with eight respondents. The researchers found five key themes: (a) negative impact of significant life events; (b) self-blame; (c) personal characteristics; (d) pre-diagnosis, depression unknowingness; and (e) pre-help seeking.

In theme one, the respondents perceived that the experience of depression began before it was actually known to begin. In the second theme, self-blame, people with depression felt they were to blame for the negative impact of significant life events they had experienced (Feely et al., 2007). The third theme included: personal attributes, people pleasing, and the inability to say no (Feely et al.). The respondents stated they believed their personal attributes were to blame for the way they thought and felt. Theme four was the pre-diagnosis depression “unknowingness.” Participants felt that before knowing they had depression, their early life experiences were painful, and lonely thoughts were characterized by a state of “unknowingness” (Feely et al.). In theme five, participants responded to the experience by attempting to deal with it on their own before being diagnosed.

Lee, Kleinman and Kleinman (2007) examined the experiences of depressive disorders among the Chinese. Forty patients who had significant depressive symptoms were recruited using quota sampling from the outpatient department of a regional mental health service. Open-ended, in-depth, ethnographic interviews were taped, transcribed and translated. Six categories of experiences were identified: indigenous affective lexicons, embodied emotional experiences, implicit sadness, preverbal pain, distress of social disharmony, and centrality of sleeplessness.
The indigenous affective lexicons were local expressions that were used to describe depressive experiences that are recognized in psychiatry. The translated terms were loss of enjoyment, confused thinking, poor energy and concentration. The embodied emotional experiences related to emotional distress that was felt "right inside or over the heart" (Lee et al., 2007, p. 4). The third theme of distress of social disharmony was communicated through expressions such as irritable, vexed, shaken, bad tempered and tearful. According to Lee et al., these symptoms are not generally regarded as clinically important. The informants however, regarded these experiences as most distressing since "they disrupt the social harmony within the family, workplace, or other social situations" (Lee et al., p. 4). Preverbal pain referred to depressive experiences that could not be put into words. Participants were extremely distressed but found it hard to articulate their psychological pain. With implicit sadness, the researcher found that sadness and depressed mood were often conveyed implicitly in the interview. Participants expressed deep sadness without using the words for sadness. Finally, regarding centrality of sleeplessness, many of the participants believed that the origin of their symptoms and problems lay in sleeplessness. The informants acknowledged that they were sad or depressed, but they were also adamant that the mood problem was only secondary to their insomnia. For them, insomnia was the disease; depression was only one of the symptoms (Lee et al.).

Oliver and Whiffen (2003) investigated the relationships among men's recollections of childhood rejection by parents, their adult attachment security in current romantic relationships and self-reported depressive symptoms. Seventy-six male participants were recruited for this quantitative study. Participants had to be male and in a current married or cohabitating intimate relationship for at least 2 years. An
association between the childhood and adulthood variables was evaluated in which childhood rejection was linked to depressive symptoms through an impact on adult attachment security. Perceived parental rejection, childhood physical abuse and insecure adult attachment were all correlated with depressive symptoms.

Kennedy, Abbott and Paykel (2003), followed up on a previously studied cohort to ascertain whether the course of depression had improved due to pharmacological and psychological treatments in the last 15 years. Seventy subjects diagnosed with “severe recurrent” depression were followed up using an adaptation of the Longitudinal Interview Follow up Evaluation, after 8 to 11 years. Sixty-five subjects met the criteria for follow up.

High rates of marital breakdown (38%) were seen but most had remarried. Among those in a stable relationship, almost 70% reported a good or moderate relationship with their partner. High levels of antidepressant treatment were reported during follow up with 59% receiving at least 5 years of antidepressant treatment and only 15% receiving less than 1 year of antidepressant treatment. Levels of compliance were reported as being very high with over 85% reporting taking greater than 75% of prescribed dose, and only 5% reporting less than 50% compliance.

High levels of psychological treatment were reported during follow up. Over two-thirds reported routine follow up with their psychiatric care provider. During the last year of follow up almost 60% had been in contact with their primary care provider for psychological assessment or treatment.

Lee and Murray (1988) and Kiloh et al. (1988) conducted 18-year and 15-year longitudinal studies respectively to compare the recurrence of depression. The long-
term outcome of depression showed high recurrence rates and does not appear to have changed in the last 20 years.

**Gender Studies and Coping**

Daughtry and Paulk (2006) did a phenomenological investigation of gender differences in depression related to coping patterns. Participants included 45 women and 32 men who did a written response to an open-ended prompt question. The results revealed seven themes for women and six themes for men. The women used cognitive strategies, self-enhancing strategies, support-seeking activities, self-defeating behaviors, spiritual activities, distraction activities, and professional help seeking to cope.

Males used instrumental-distraction, self-enhancing strategies, self-medication/self-defeating behaviors, support-seeking activities, serenity-seeking, and cognitive strategies to cope. Generally, the researchers found men having more self-defeating behaviors than women.

Angst et al. (2002) did a nonexperimental descriptive study on gender differences related to symptoms, causal attribution, help seeking, coping and the consequences of depression. Angst et al. used a data set covering representative population samples from six European countries. Participants were categorized in “waves” according to when their data were collected. In wave one, the study had 38,434 men and 40,024 women. Wave two had 563 men and 1,321 women treated for depression. Interviewers used the depression section of the Mini International Neuropsychiatric Interview (MINI) screening interview and a specially designed depression questionnaire to interview the subjects.

The results showed marked gender differences in depression. The study reconfirmed the higher female prevalence rates for depression but found no gender
difference for depression. The researchers found that the gender difference in the prevalence of major depression maybe dependent on the total number of depressive symptoms reported. If depressed men report consistently fewer symptoms than depressed women as was studied (Wilhelm et al., 2002), a provider would need to lower the diagnostic criteria for depression by symptoms to accommodate the decreased reporting of symptoms by males.

Miller et al. (2000) did a correlational study on a sample of 86 to identify the correlates of family functioning in couples with a depressed member during the acute phase of the patient’s depression. Eighty-six married couples were included in the study. Patients, their spouses and family members older than 12 years completed the Family Assessment Device that assesses family functioning on six separate dimensions. The McMaster Clinical Rating Scale was used as an observer rating of family functioning. Both tools assess an overall measure of general family functioning plus six sub-dimensions of family functioning: problem solving, communication, affective involvement, affective responsiveness, roles, and behavior control. Both tools significantly correlated with one another. Pearson correlation tests were done for family functioning. The researchers also looked at demographic variables such as sex, age, education, and socioeconomic status to see if any of these correlated with depression. The findings of this study were similar to findings reported in a previous study done on this subject (Miller et al., 1992). The researchers found that no demographic variables were significantly related to impaired family functioning suggesting that these problems cut across all ages, education levels, and social backgrounds. Also, the researchers found that severity of depression was not significantly related to family functioning.
However, the researchers did find that characteristics of the depressive disorder were correlated with level of family functioning.

Brownhill, Wilhelm, Barclay and Parker (2002) investigated the experience of depression, coping and help seeking from men's perspectives. Quantitative methods were used to gather sociodemographic, behavioral data and standard measures of mood and dispositional optimism. Qualitative data were analyzed using a grounded theory approach. The results suggested that men have been socially conditioned to suppress emotional pain, which results in delaying seeking help. When the men did seek help it was because of physical symptoms such as chest pain or drug and alcohol abuse. It was found that these symptoms were masking emotional distress.

Skarsater, Dencker, Haggstrom and Fridlund (2002) investigated how men with major depression cope with daily life with the help of professional and lay support. Twelve men were selected by strategic sampling and analyzed with an approach inspired by phenomenography. Four descriptive categories emerged: being unburdened, restoring one's health, feeling involved, and finding a meaning. The researchers concluded that the men wished to have a stronger social support from the health care professionals than they had received. The men did state they received security and continuous information on an individual basis from their health care provider.

Relationship Distress

Heene, Buysse and Vanoost (2005) did a nonexperimental descriptive study of 415 couples to examine how the degree of self-reported conflict communication, attribution style, and adult attachment style affected the relation between depressive
symptoms and marital satisfaction. In addition, the researchers analyzed gender differences.

The researchers found that self-reported demand withdrawal and avoidance were significant mediators of women's levels of depressive symptoms and marital adjustment, whereas self-reported constructive communication was a significant mediator of men's levels of depressive symptoms and marital adjustment. Furthermore, they found self-reported avoidance served as a significant moderator that affects the direction and strength of the relation between depressive symptoms and marital adjustment in the female sample.

Secondly, the researchers found that causal attributions mediated the association between depressive symptoms and marital adjustment for both women and men, and responsible attributions were also a significant mediator of the association in the male sample.

Lastly, the results documented that self-reported secure, ambivalent, and avoidant attachment mediated the relation between depressive symptoms and marital adjustment in the female sample.

Several gender differences were found. Conflict communication, mediating and moderating effects were especially stronger in the female sample, and women also reported significantly higher levels of constructive communication, demand withdrawal, and avoidance.

Another marital conflict study done by Goldfarb, Trudel, Boyer and Previle (2006) examined the link between marital relationship with depressive and anxiety disorders in adult couples from empirical and descriptive studies from the period of 1984 to 2005. Particular emphasis was placed on the role of different treatment modalities
and methodological approaches for dealing with co-occurring marital discord and psychological distress.

The researchers found there was a well-established relationship between depression and marital discord. The studies that the researchers reviewed suggested different possible causal pathways for this relationship: (a) marital dissatisfaction can precipitate or maintain depression, (b) depression can contribute to marital dissatisfaction, or (c) they can both have a reciprocal causal relationship. Furthermore, personal variables such as self esteem, personality or attachment styles, can also contribute to both marital dissatisfaction and depression and discordant couples with a depressed spouse seem to be characterized by communication difficulties, especially during problem solving activities.

Crowe (2004) discussed problems presented by depression, schizophrenia and substance abuse. Crowe stated there usually is a change in the balance in the relationship, with the partner who is well, retaining their social and psychological equilibrium, while the ill partner in one way or another becomes weaker or more vulnerable. Crowe also stated there was an issue with the stigma of mental illness. Friends and family may become afraid of the patient and their unpredictability and the couple may become isolated as a result.

Crowe (2004) also stated depression has been mentioned as a common cause of disturbance in a couple relationship. The partner will usually be affected by the patient's loss of self-confidence and poor self-esteem. The partner will also feel called on to provide reassurance, and in some cases to take extra precautions if the patient is seen as being in any way a danger to themselves. There may be irritation on the part of the partner and this may lead to further depression in the patient. Crowe concluded that
health care providers need to increase their awareness of this issue, to treat the partner with understanding, and to consider the stability of the relationship as part of their management.

Talbot (2006) wrote an article discussing the psychiatric community's issues involving the severely and chronically mentally ill over the past 50 years and summarized new research that may aid them. Talbot reviewed barriers to better patient care and stated that lack of insight, hope and judgment of patients were part of the problem. Talbot concluded that there is hope for the mentally ill patient if providers implement recent research into their practice.

Support Groups

Collie, Kreska, Ferrier, Parsons, Graddy, Speraza, Manell, Xin-Hua, Perkins and Koopman (2007) conducted a study on women with breast cancer in rural areas. The researchers found feasibility and acceptability of providing support groups to women with breast cancer in a large, rural area using videoconferencing and a workbook journal. Twenty-seven women participated in eight session support groups led by an oncology social worker by going to nearby videoconferencing sites. Older as well as younger women were comfortable using videoconferencing and said the groups were valuable because they promoted information sharing and emotional bonds with other women with breast cancer. They emphasized the importance of a professional facilitator and identified advantages of using videoconferencing for support groups.

Skinner and Latchford (2006) conducted a comparative study on e-therapy (Internet support group) and face-to-face therapy. The researchers investigated self-disclosure style and attitudes toward e-therapy in three groups: current e-therapy clients, current users of Internet mental health support groups, and current face-to-face
counseling clients. Participants completed a measure of self-disclosure and answered questions about the influence of factors thought to be potentially important in influencing a decision to undertake e-therapy. Two versions were used: pencil and paper and web-based. Too few e-therapy clients were recruited for the data to be analyzed. There was no significant difference in self-disclosure style between internet support group users and face-to-face therapy users, although the latter had a higher tendency to self-disclose. Internet support group users were significantly more positive about the influence of using computers to communicate with a therapist. The researchers found that Internet support group users had broadly positive views of the advantages of e-therapy, particularly if they had had some personal experience of therapy. Experience of both using the Internet and therapy appear to be important in determining attitudes toward e-therapy. Self-disclosure was also found to be related to some attitudes toward e-therapy.

Ahlberg and Nordner (2006) conducted a qualitative exploratory study focusing on the experience of participation in support groups for women recently diagnosed with ovarian cancer. Participants were 10 women ages 42 to 76, who recently had been diagnosed with ovarian cancer and had participated in support groups. Data were collected by semi-structured interviews and analyzed using grounded theory. Three categories emerged: (a) sharing experiences and emotions, (b) exchanging information support, and (c) exchanging emotional support. The researchers found that support groups offer an opportunity to share experiences and emotions as well as exchange information. They are also a possible source of emotional support and therefore can contribute to quality of life of patients with ovarian cancer.
Advanced Practice Nurses and Patients With Depression

There was only one study done on APNs and depression. Burman, McCabe and Pepper (2005), did a nonexperimental descriptive study of 52 APN respondents, investigating barriers to treatment and screening related to depression and anxiety, and the diagnostic treatment practices of APNs in the state of Wyoming. The researchers found APNs in primary care routinely identify, evaluate and treat patients with both depression and anxiety, but routine screening practices for depression and anxiety were relatively low. The researchers used self-reports of primary care APNs to document depression screening and treatment practices. The researchers noted that implications for practice included altering the educational preparation of APNs in order to improve clinical outcomes of treatment for depression and anxiety. The low levels of screening and some of the treatment choices of the APNs demonstrate the need for further education in this area.

Summary

In summary, extensive research has been done on depression. More qualitative research is surfacing. Much of the research on depression focused on gender differences (Daughtry & Paulk, 2006), coping (Miller et al., 2000), cross-cultural depression (Lee et al., 2007), and perceptions of pre-diagnosis, depression encounter (Feely et al., 2007). Even less has been studied regarding how APNs can help people with their depression. Only one study, which was done by Burman, McCabe and Pepper (2005), focused on APNs helping people with depression. However, this study only investigated the barriers to treatment and screening related to depression in the state of Wyoming. Ehrenreich et al. (2007) explored how statements drawn from patients'
written life stories can help general practitioners understand their patients' maladaptive thought patterns and their negative thoughts.

In this chapter, the theoretical framework and the review of literature on depression in men were presented. Additional research is needed to understand depression from the patient's perspective. Studies in the area of primary care provider support and treatment for the depressed patient and significant other are sparse. This study provided the participants the opportunity to describe the lived experiences of depression and coping from their perspectives.
CHAPTER III
METHODOLOGY

The purpose of this study was to explore and describe the lived experience of depression and coping from the perspectives of depressed men and their spouses/significant others. The research questions were: (a) What is the lived experience of depression in men and their spouses/significant others? (b) How does the family cope with the recurrence of depression? and (c) How can the APN help with depression?

In this chapter the research design, the population and sample, instruments, procedures for data collection and analysis are presented.

Research Design

A qualitative phenomenological design was used in this study. This design was chosen because of the need to understand the lived experience from the patient through a narrative perspective.

Population, Sample and Setting

The target population for the study was depressed Midwestern males and their spouses/significant others. The criteria for sample selection included:

1. The male participant and his spouse/significant other were able to read, write and speak the English language fluently.

2. The male participant was diagnosed with clinical depression for at least 1 year.
3. The male participant cohabitated with a significant other/spouse for at least 1 year.

4. The significant other/spouse of the participant was willing to participate in this study.

Exclusion criteria included no other diagnosis of psychiatric disorders.

Data Collection Instruments

Data were collected by means of an open-ended interview (Appendix A) and a demographic questionnaire (Appendix B). This researcher was the data collection instrument. To decrease bias during data collection, bracketing was done. Bracketing is a methodological device of phenomenological inquiry that requires deliberate identification and suspension of all judgments or ideas about the phenomenon under investigation or what one already knows about the subject prior to and throughout the phenomenological invesspouse/significant other were:

1. What is your experience of depression?

2. How does your family cope with recurrences of depression?

3. How can APNs help with depression?

Procedures for Data Collection

Prior to data collection, the researcher obtained permission from the UW-Oshkosh Institutional Review Board (IRB) to conduct the study (Appendix C). Permission to distribute an informational flyer (Appendix D) was also obtained through IRBs at two psychiatric outpatient medical facilities, and from a depression support
group leader to recruit potential participants. Fliers were posted at numerous local churches and religious groups, community recreational centers and village halls to solicit participants. It was anticipated that participants would contact the researcher after receiving the informational flyer given to all males who came for outpatient appointments at the clinics. When a potential participant contacted the researcher by the contact information listed on the informational flyer, it was verified that he met the inclusion criteria and given a full explanation of the study. Explanation of the study included the approximate time taken to complete the interview, tape record the interviews, and complete a demographic questionnaire. If the participant indicated willingness to participate in the study, an mutually convenient time was set up for the interview.

Participants were informed that if at any time during the interview, significant psychological distress occurred, the researcher would stay with the participant and transport him to the county's crisis center. If admission to a psychiatric hospital was deemed necessary, the crisis center would follow their protocol for assisting the participant to receive the appropriate treatment. The researcher obtained crisis intervention phone numbers from the county where the data were collected. The phone numbers were readily available to the researcher for any unforeseen circumstances that could not be handled with the preceding plan. After 48 hours, the researcher called the participants to find out if any psychological distress had occurred, and if it did occur, they were referred to the appropriate resource.
Achieving Trustworthiness of the Data

Credibility was established by collecting data over an hour-long interview, thereby initiating trust between the participants and the researcher. After all interviews were completed and data analysis was done, the researcher contacted the participants for member checking. This determined the accuracy of the qualitative findings through taking the final report or specific descriptions or themes back to the participants and determining whether the participants felt that they were accurate. Through this verification process, credibility was achieved.

Dependability was achieved through credibility. Dependability is a criterion met once the researcher has demonstrated the credibility of the findings. "Similar to validity in quantitative research, in which there can be no validity without reliability, the same holds true for dependability: there can be no dependability without credibility" (Speziale & Carpenter, 2007, p. 49).

To establish confirmability, the objective was to illustrate as clearly as possible the evidence and thought processes that led to the conclusions. The researcher kept detailed notes of the processes that led to the overarching themes of: (a) Diagnosis: What Is It? (b) Coping: Pulling Through; and (c) The Treatment: Relief.

Transferability refers to the probability that the study findings have meaning to others in similar situations. According to Speziale & Carpenter (2007), the expectation for determining whether the finding fit or are transferable rests with potential users of the findings and not with the researchers. "It is not the naturalist's task to provide an index of transferability; it is his or her responsibility to provide the database that makes transferability judgment possible on the part of potential appliers" (Lincoln & Guba, 1985, p. 316).
Data Analysis Procedures

According to Speziale & Carpenter (2007), data analysis requires that researchers become immersed in the data. The purpose of data analysis is to preserve the uniqueness of each participant's lived experience while permitting an understanding of the phenomenon that is being studied. During the interviews with the couples, this researcher listened to participants' verbal descriptions. The researcher used Giorgi's (1985) method to analyze the data.

1. Reading and rereading the verbatim transcriptions.
2. As this researcher became immersed in the data, significant statements came to light and were extracted.
3. These statements were transcribed onto index cards for ease of ordering later in the process.
4. The researcher captured the essential relationships among the statements and prepared an exhaustive description of the phenomenon. This constituted the final phase.
5. The researcher made connections between statements obtained in the interview process.
6. It was critical to identify how statements or central themes emerged and were connected to one another for the final description to be comprehensive and exhaustive.
Limitations of Methodology

1. The small sample size may have limited the generalizability of the findings.
2. The small geographic location of data collection may have limited the generalizability of the findings.
3. Participants may have unintentionally responded to questions in a way that they thought they should, versus how they actually felt.

Summary

The purpose of this study was to explore and describe the lived experience of depression and coping from the perspectives of depressed men and their spouses/significant others. In this chapter, the design, sample, setting, procedures for data collection and data analysis, and limitations were presented.
CHAPTER IV

FINDINGS AND DISCUSSION

Introduction

The purpose of this study was to explore and describe the lived experience of depression and coping from the perspectives of depressed men and their spouses/significant others. The research questions were: (a) What is the lived experience of depression in men and their spouse/significant other? (b) How does the family cope with the recurrence of depression? and (c) How can the APN help with depression?

Six men diagnosed with MDD and their spouses/significant others were interviewed. All interviews were audiotaped and transcribed verbatim. Data were then examined for categories and themes that described the experiences of the participants. In this chapter, the results and discussion of the findings are presented. Also, the terms depressed men and participants will be used interchangeably.

Description of Sample

Data were collected by the researcher through face-to-face interviews with study participants from December 2007 through February 2008. Participants for the study were solicited from two psychiatric clinics in northeastern Wisconsin, flyers posted at local libraries, churches and community centers, and a depression support group. A total of 11 depressed men and their spouses/significant others contacted the researcher from the solicitation. Seven who met the criteria were included in the study. One couple
could not be interviewed because they were starting divorce proceedings prior to the scheduled interview and hence declined participation. A total of six depressed men and their spouses/significant others agreed to participate in the study and be interviewed.

Table 1 summarizes the age, years diagnosed with depression, number of depressive episodes and number of hospitalizations of the participants. The average age of the men was 44.6 (SD 10.91). The age range was 33 to 62 years. The mean depressive episodes were four (SD 2.10) over 22 years. The mean length of time diagnosed with MDD was 13.17 years (SD 5.23). The range of time diagnosed with MDD was from 7 to 22 years. The mean number of hospitalizations were 1.50 (SD 1.51). The range for hospitalizations were from zero to four times. Table 2 summarizes marital status, education, family income and number of children and number of children living at home. Fifty percent of the male participants had a high school diploma, 16.7% had some college and 33.3% had graduated from college. About 66.7% were married and 33.4% were cohabitating. Cohabitating was defined as living with the significant other for at least 1 year. The couples had a range of 0 to 3 children living at home. All of the couples had income over $30,000 annually.

The average age of the spouse/significant other interviewed was 42.17 (SD 11.65). The age range was 29 to 59 years of age. With regard to education, 33.3% had graduated from high school, 16.7% had some college or technical school education, and 50% had graduated from college.
Table 1

Age, Years Diagnosed With Depression, Number of Depressive Episodes and Number of Hospitalizations

(N = 6)

<table>
<thead>
<tr>
<th>Demographic Characteristic</th>
<th>Depressed Male Frequency</th>
<th>Percent</th>
<th>Spouse/Significant Other Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depressed male (mean = 44.67)</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spouse/significant other (mean = 42.17)</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>20-29 years</td>
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<td>0.0%</td>
<td>1</td>
<td>16.7%</td>
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<tr>
<td>30-39 years</td>
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<tr>
<td>40-49 years</td>
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<td>0.0%</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>50-59 years</td>
<td>1</td>
<td>16.7%</td>
<td>2</td>
<td>33.3%</td>
</tr>
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<td>60-69 years</td>
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<tr>
<td>Years diagnosed with depression (mean = 13.17 years)</td>
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<td>7-10 years</td>
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<td>Number of depressive episodes (mean = 4)</td>
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<tr>
<td>2</td>
<td>1</td>
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<td>10</td>
<td>1</td>
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<tr>
<td>Number of hospitalizations (mean = 1.5)</td>
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<td>1</td>
<td>16.7%</td>
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<td>2</td>
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<td>33.3%</td>
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<tr>
<td>4</td>
<td>1</td>
<td>16.7%</td>
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</table>
Table 2

*Education, Marital Status, Family Income, Number of Children and Number of Children Living at Home*

*(N = 6)*

<table>
<thead>
<tr>
<th>Demographic Characteristic</th>
<th>Depressed Male Frequency</th>
<th>Percent</th>
<th>Spouse/Significant Other Frequency</th>
<th>Percent</th>
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<td>16.7%</td>
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<td>33.3%</td>
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<td>33.3%</td>
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<td><strong>Marital status</strong></td>
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<td>Cohabiting spouse/significant other</td>
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<tr>
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<td>Over $30,000</td>
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<td><strong>Number of children (mean = 1.67)</strong></td>
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<td>1</td>
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<td>33.3%</td>
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<td>16.7%</td>
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<td>3</td>
<td>2</td>
<td>33.3%</td>
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<tr>
<td><strong>Number of children at home</strong></td>
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<td></td>
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<tr>
<td>0</td>
<td>2</td>
<td>33.3%</td>
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<td>1</td>
<td>3</td>
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<td>3</td>
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<td>16.7%</td>
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The Interview Process

Each interview was conducted over a 20- to 60-minute time period. All of the interviews were conducted in a public place selected by the participants. An alternative location was a quiet conference room at a local library. All participants agreed to be audiotaped. With every couple, the spouse/significant other made the initial contact with the researcher. One male participant was reluctant to discuss his experience with depression during the whole interview and gave short answers. The rest of the participants readily shared their experiences. Prompting questions were used in some interviews. The researcher attempted to promote a caring, empathetic environment through attentive listening, prompting, and presencing during the interviews.

Results and Discussion

Research Question One: What Is the Lived Experience of Depression in Men and Their Spouse/Significant Other?

The depressed male and spouse/significant other were interviewed conjointly. The following pages represent the depressed male responses followed by the spouse/significant other responses. The interviews were audiotaped and transcribed verbatim. Giorgi’s (1995) phenomenological approach to interpretation was used for data analysis.

During data analysis, three main themes emerged from interviews with the depressed male participant: (a) The Diagnosis: What is it? (b) Coping: Pulling Through; and (c) The Treatment: Relief. Each theme included several subcategories. Subcategories in the first theme—The Diagnosis: What is it?—were: (a) knowing something was not right, (b) relief being diagnosed, and (c) not being me. In the second
theme, Coping: Pulling Through, subcategories were: (a) do some physical activity; and (b) communication: talking with significant other/spouse. In the third theme, The Treatment: Relief, subcategories were: (a) medications and (b) talking with the doctor. Themes that emerged from the interviews with the spouse/significant others were: (a) Disbelief: What Now? (b) Continuing on: Wishing for Normalcy, and (c) The Treatment: Relief. In the first theme—Disbeliefs: What Now—subcategories were: (a) unable to believe: what’s going to happen? and (b) panic: what are we going to do?. In the second theme, Continuing On: Wishing for Normalcy, subcategories were: (a) continuing a normal life, (b) hoping for, and (c) keep going: just forge forward. In the third theme, The Treatment: Relief, subcategories were: (a) medications: first line of treatment, (b) talking with the doctor, and (c) support groups versus counseling.

Depressed Male Participants’ Responses

In the first theme—The Diagnosis: What is it?—participants described their experiences before and after diagnosis of MDD. The subcategories were: (a) knowing something was not right, (b) relief being diagnosed, and (c) not being me. Some of these subcategories overlap because of the interrelatedness of the experiences.

Knowing something was not right. Participants reported “knowing something was wrong,” but were unable to recognize the symptoms of depression until their significant other/spouse brought it to their attention or they discussed it with their health care provider. They reported many common symptoms with the feelings of anxiety/worry of not knowing what is wrong, sadness, hopelessness and recognition.

Anxiety of knowing something was different with the participant was reported as: “I knew I had something going on…but then I would worry about it constantly. Worry about getting treated, or actually just diagnosed first to see what the problem was.”
Another participant stated, "I worried constantly about everything; would I be me again? God, I cried all the time because of the worrying."

Sadness and hopelessness were also reported as symptoms. "I was depressed, of course not diagnosed yet, and then I felt hopeless that no one would find what was going on with me, it was like I was double depressed." Another participant stated, "I thought I would feel like this forever, there was no end to this. I wanted to die. I was going to be like this forever."

Recognition of their depression was stated by all participants. One participant stated:

I didn't really know what was wrong, but I knew something was there that just didn't allow me to enjoy stuff that I used to enjoy. And yet when I was depressed there was no way to actually seem like to get yourself out of it. And actually when I went to the doctor, he said that is sounded like I was depressed and once they had actually told me that, then I realized what the problem was; there was an actual problem.

Participants reported that the diagnosis was obvious after being told by the doctor. One participant stated:

You don't realize what's going on around you. Just let me be. I know this is wrong but I can't get out of my cycle. My wife took me to the doctor and it was like turning a light on when he told me what was going on with me. He told me I could be my normal self again. When he told me it was depression, I thought to myself 'I should have known that'. It was so obvious. It was right in front of me but I was so into being in my hole I couldn't look out of it.
In summary, participants experienced symptoms of depression but were unable to recognize it. The results are consistent with the finding of Skarsater et al. (2002) who stated that the men in their study felt “confirmed” when they were seen and confirmed by health care professionals with their MDD diagnosis. The participants in this study also valued confirmation of their diagnosis by their healthcare professionals.

Relief being diagnosed. The second subcategory was Relief Being Diagnosed. After receiving the diagnosis of MDD, all participants stated relief with knowing the diagnosis, because “I could get on with my life now.” One participant stated, “I felt so low, but yet when they found something wrong with me and told me they could help me, it was almost better than my wedding day.”

Another participant reported:

I was glad they told me what I had...or as glad as I could be at that time. I just thought let's start the drugs to make me feel better so I can go hurting with my buddies. They were going on a trip that I wasn't going to be able to go on, but in the end I did make that trip. It was great. I never thought I would do that again, it was really sad how small your world gets with that disease.

One participant mentioned he was:

Relieved that someone would treat a head case. No one wanted to diagnose depression, but if they would realize what they are putting the person through with no diagnosis and keep putting us off. I am really thankful to Dr. B and relieved that he took the time to help me.

Another reported seeing his primary care provider “almost every week” because I would go in one day with a severe headache and then the next week I would have chest pain and then next my back hurt and the next my arm was numb
because I sat on it wrong; you get the idea. It makes sense now with depression; it makes you think so many stupid things.

The somatic complaints reported by the male participants in this study are supported by Robbins’ (2006) study. Robbins found early physical symptoms that may present in MDD are: chest pain, psychomotor changes, gastrointestinal disturbances, appetite changes, headaches, vague aches and pains and sleep disturbance. Robbins also listed possible ways by which men exhibited depression. These included a sense of being unimportant, unproductive at work, sense of personal failure, distractibility, lowered sense of ability, detachment, sense of alienation, loss of sense of optimism and uncertainty. Robbins stated that these signs will first appear at the primary care physician’s office.

In summary, all participants in this study were relieved knowing their diagnosis. The reported symptoms and the length of time without diagnosis negatively impacted their lives by frequent doctor trips for physical complaints, decreasing their social involvement and increasing their worrying.

Not being me. The third subcategory was Not Being Me. Participants reported not being themselves. One stated, “I’m not myself. I sleep all day and then I’m up all night.” Another stated, “I’m not me anymore; I have lost myself and how do I find that person again?” and “I felt like there was basically two of me.” One other expressed his feelings as:

If I looked down at me, I would have thought who are you? What have you become? You used to be so different and now look at you. You make me sick. I think I would have been sick if I saw what I had looked like and acted like before I was diagnosed. Some of the things I did are revolting and disgusting.
Depression is a selfish disease. It is all about you, how will this affect me? You think—actually you don’t think about other people, even your kids. Can you imagine that? Not even your kids. I didn’t care about my kids during that point. It is absolutely revolting. Let’s move on.

In summary, participants reported they sought help. The couples did not specify who initiated seeking help. These results are in contrast with the results of the study by Brownhill, Wilhelm, Barclay and Parker (2002) who found that the spouse/significant other insisted they seek care because of numerous somatic complaints.

Spouse/Significant Other Responses

Three main themes emerged from interviews with the spouses/significant others. These included: (a) Disbelief: What Now? (b) Continuing On: Wishing for Normalcy, and (c) The Treatment: Relief. In the first theme, Disbelief: What Now, subcategories were: (a) unable to believe: what’s going to happen? and (b) panic: what are we going to do?

In the second theme, Continuing On: Wishing for Normalcy, subcategories were (a) continuing a normal life, (b) hoping for, and (c) keep going: just forge forward. In the third theme, The Treatment: Relief, subcategories were: (a) medications, (b) talking with the doctor and (c) support groups versus counseling.

In the first main theme, Disbelief: What Now? participants revealed their thoughts and feelings related to (a) unable to believe: what’s going to happen? and (b) panic: what are we going to do?

Unable to believe: What’s going to happen? One spouse whose husband was diagnosed for 12 years with MDD and had several hospitalizations reported, “You told me that you didn’t feel good, but I denied it because I didn’t want to believe it and I was
thinking more about myself like ‘You can’t be sick. What am I going to do? What’s going to happen to me?’

For some couples, the onset of depression in their spouse had been sudden and dramatic; for others, it was a more insidious experience that was not easily recognized or acknowledged. Particularly during the early stages of a relationship, or during a first depressive episode, spouses/significant others felt baffled by the changes they observed in the mood or behavior of the affected partner. One significant other/spouse explains:

I knew you had some type of depression, but I thought you would get out of it, just like you would a cold. It kept on and one, but I told myself this will get better. You didn’t even know what was going on with you and I didn’t want to tell you because I thought you would use it as an excuse to take some days off of work and we really needed the money. But you never came around and it got worse. I remember you telling me “either take me in or shoot me.” It was awful, of course I took him in. But now everything is better, but then I couldn’t believe he was so sick.

Another spouse stated:

Well I remember when you got sick the first time and it was the fall of ’99 and you told me that you didn’t feel good, but I denied it because I didn’t want to believe it and I was thinking more about myself like ‘You can’t be sick. What am I going to do? What’s going to happen to me?’ And then in January of 2000 that’s when he came home from work one day and we were in the bedroom and he looked at me and said, “I’m really bad and I don’t think I can go on.” And I’m thinking, “What do you mean can’t go on?” And then he said, “You know, I’m suicidal.” And that just—I couldn’t believe it, you know, because I didn’t have any
idea it was that bad. You know, I saw him—he was getting mopey. He was
going to work but, I don't know, I didn't—I was surprised.
That same spouse spoke more of the realization of the diagnosis.
You know 7 years ago when he was first diagnosed it was really hard. In and out
of the hospital, you know. "If he takes his medicine, goes to therapy, he's going
to get better." It was always that thought of it.
A spouse whose husband was diagnosed over with depression 10 years,
expressed her inability to believe. "I still struggle with his diagnosis of depression."
Another spouse talked about the diagnosis and inability to believe as "At first I didn't
think it was depression because I kind of overlooked it. I thought maybe that was just
his personality. I didn't see the symptoms right away. But maybe it was I didn't want to
believe what it really was."
Another spouse stated, "At first it was just kind of let it go—maybe more of a
denial thing." Another statement was "I didn't sign up for this, my life wasn't supposed to
go like this. If I don't recognize it, it could go away. But you know, it didn't."

In summary, participants had difficulty believing their spouses/significant other
diagnosis of depression. The results of this study are similar to the study by Harris,
Pistrang and Barker (2006). In their phenomenological study, Harris et al. categorized
their results into two domains. The first domain was the couple's experience of
depression. From this first domain, five themes emerged: bafflement; battling through;
coping with the "long gray periods," starting to "swim again," and the threat of relapse.
The theme of bafflement is consistent with the theme of disbelief in this study.
Panic: What are we going to do? The second subcategory that emerged was panic: what are we going to do? One spouse who had dealt with the diagnosis for over 5 years first recalled her reaction to the realization of the diagnosis:

This is really no lie, and if I could talk as fast as my head was at that time, I would, but I physically can’t. It was like an auctioneer. Oh my God, what are we going to do for money, how am I going to feed the kids, I need to go full time, if I go full time will he be able take care of the kids, we’re going to lose the house, where will we live, what are my parents going to say, what are the kids friends going to say, are we still going to continue on like usual, when I am away at work and the kids come home from school are they going find him dead. I really don’t want that. How can I be sure that doesn’t happen? I can’t afford a babysitter to prevent that; you know what I am getting at? It was constant thoughts going through. Everything had changed that day in my life and I will never be the same person. Is that all bad? No, but it would be nice for a vacation from it for awhile.

Another spouse expressed concern for her children.

I understood it [depression], but my kids weren’t and I worried all the time that the kids wouldn’t give up on him. I spent a whole lifetime getting us to be a close family and then this fear of this disease could undo everything I did in such a short time.

A third spouse talked about the initial diagnosis and how she felt.

Even though I knew he had the problem, I was worrying all the time about it and I thought that maybe the doctor should be treating me too with some medications because of all my worrying. Of course he didn’t.
In summary, the diagnosis of MDD caused strain on the family, especially the spouse/significant other. They manifested this through worrying and panic symptoms. The results of this study are dissimilar to Robertson, Venter and Botha's (2005) study in that Robertson et al. found families of a depressed person are typically the cause of the depression. The family had taught the depressed individual negative ways of coping and thinking and had negative life experiences.

There were commonalities between the depressed male responses and spouse/significant other responses. The depressed male and his spouse/significant other both knew something had changed in their emotions or personality. The depressed male reported feelings of "not being himself" and "knowing something was not right." The spouse/significant other also reported knowing something was not right with her spouse but also was unable to believe that something was not right.

Research Question Two: How Does the Family Cope

With the Recurrence of Depression?

Depressed Male Participant Responses

The main theme was Coping: Pulling Through. Participants revealed their thoughts, actions and experiences regarding coping with recurrence of depression. Two subcategories evolved from this theme: do some physical activity, and communication: talking with spouse/significant other.

Do some physical activity. The first subcategory in this theme was do some physical activity. All but one participant expressed improving their depressive symptoms by doing some physical activity. They reported that physical activity decreased the severity of the depressive symptoms. "I just do something and try to forget about it [depressive symptoms] and it goes away." One participant stated, "I cope with
everything better if I keep going to the gym to work out, I feel so much better." Other participants reported:

"I go for a walk."

"A lot of times I just go—getting out of the house."

"Once I got more active and doing other things, I think that was much better."

"I lift weights."

One participant expressed his coping by:

I would say one of the ways I cope is to go do something. Get your mind off of it. Your mind's always racing on something and, you know, for me anyways like fishing, I was always trying to figure out the fish versus just sit there and let your mind wander on something all the time that won't do any good. There came a fork in the road where I had to get out and do something physical or else this thing [depression] would snowball out of control.

Another participant described his way of coping before and after the diagnosis.

I self-medicated with drugs and alcohol before my diagnosis; but then with educating myself and trial and error types of things, I found that working out is a much better way of helping myself and my family."

In summary, the results indicated that doing any type of physical activity helped decrease the depressive symptoms. These results are consistent with Daughtry and Paulk's (2006) study in that the authors found men to use more physically active coping strategies than women. The report by one participant about his alcohol and drug abuse prior to diagnosis is consistent with the study by Brownhill et al. (2002) in which men avoided depression by doing "other" things such as using drugs and alcohol. One participant also discussed seeking frequent medical care for somatic complaints.
Barclay and Parker (2002) found when men do seek help, symptom presentations of physical illness such as chest pain, or behavior such as deliberate self-harm or drug and alcohol abuse may mask emotional distress. In turn, this makes it difficult for the provider to make the diagnosis of depression. Barclay and Parker found when the provider initiated discussion of depression, males were willing to be treated, instead of the male initiating the possibility of being depressed.

**Communication: talking with significant other/spouse.** The second subcategory was communication—talking with significant other/spouse. Participants mentioned communication with their significant other as a way of coping. As the depression persisted, many of the men were challenged with family problems resulting from lack of communication. One participant stated:

I knew what was going on with me and where I was, but she didn’t. She was always asking me what was going on or “talk to me”—stuff like that. I always thought she knows what is going on, why is she nagging me. But then when she told me 1 week we went five days without even talking to each other that kind of hit me hard. I actually counted the days and I think she was right. When there was an actual number that I couldn’t deny, I knew there was a problem. When I made an effort to talk to her and tell her what was happening with me it gave me a feeling that someone cared and I’m not in this alone. That helped me a lot.

Others reported “I had my rock [spouse]. I had the thing, that pole in the middle of all the swirling water that I knew would be there at the end. No matter what happened, I knew she would be there when this (depression) would pass—no matter what. We would talk about everything, and she would be there in the end.”
One participant stated, “Talking to her and just having her sit in the same room and not even say anything helped me. After we have been together for so long sometimes you don’t need to say anything.” Another stated, “We would pillow talk. I think it helped you a lot more, but it did help me because it helped you.” Another stated being together in close proximity helped because if I wanted to talk I didn’t have to seek you out. I could just say it. If I would’ve had to go find you I wouldn’t have put forth the effort.

One participant reported that he coped by communicating with his significant other but felt it was a hindrance with his extended family.

It was good to talk to her [spouse], but then my mom would want to know what was going on and call and want to talk and talk and talk—you get the idea. I didn’t want that. I didn’t have the energy for that. S could have taken care of that. You know how moms are, let’s analyze this to death.

Other participants reported:

“I think it’s more of a communication, talk about it, just talk.”

“I had my family; that was the biggest part in dealing with this.”

Other statements made by the male participants in regard to communication:

“I knew I would be okay because she would be there in the end.”

“How could I not make it through this thing without my family?”

“Depression is a selfish disease. It tries to suck your family in and push them away from you. That’s what was so important to me was my family in all of this.”

In summary, participants discussed communication with family especially spouse/significant other as a helpful coping mechanism. Heene, Buysse, and Vanoost, (2005) reported constructive communication was a significant mediator of men’s levels
of depressive symptoms and marital adjustment. However, other research studies indicate a correlation between depression and marital discord due to communication difficulties.

Goldfarb et al. (2006) found a relationship between depression and marital discord. The researchers reviewed different possible causal pathways for this relationship. One of the pathways was discordant couples with a depressed spouse seem to be characterized by communication difficulties.

Oliver and Whiffen (2003) found that the nature of men's attachment to their spouses was linked to their levels of depressive symptoms. For men, avoidance of closeness, lack of trust, and fears about rejection and abandonment are linked to higher levels of depressive symptoms. Oliver and Whiffen found that men's emotional functioning is very much intertwined with the quality of their interpersonal relationships.

In this study, all depressed male participants reported a strong relationship with their spouses/significant others, yet they reported having depressive symptoms such as fatigue, "feeling not myself," as well as a decrease in their social activities.

Spouse/Significant Other Responses

In response to how the family coped with the recurrence of depression, spouses reported themes related to Continuing On: Wishing for Normalcy, which included (a) continuing a normal life, (b) hoping for, and (c) keep going: just go forward.

*Continuing a normal life.* In the first subcategory, a spouse reported reliving back to when the diagnosis was first made. "How are we going to keep everything we have? Like our friends, house, everything. I just can't believe this is happening." Other spouses made similar comments:
I found it very hard living with him. He'd have low lows. I tried to get him to go to work, play with the kids and do all of his stuff that he normally would do, but all I could get was getting him out of bed and onto the couch. I would think can't we just be normal like everyone else?

One spouse talked about having friends coming over.

God, just get going so we can keep on like the normal people we are supposed to be. Our friends are coming over tonight, so don't tell them anything is going on. Just be yourself.

Other comments were made in relation to keeping up appearances in the neighborhood.

What will the neighbors think of him laying around all day? The lawn is unmowed, the house needs repairs, everything looks like crap outside and he is laying down.

Another spouse reflected on her inner thoughts about what is occurring. "What happened to the people we were before this [depression]?” Please God, let him just be his normal self for a little while."

In summary, spouses wanted to continue on with the events in their daily lives as they used to prior to the diagnosis. Crowe (2004) found the problems of depressed people usually lead to a rigidity in their behavior and therefore are not able to continue with the everyday activities. The inability to continue with everyday life often puts pressure on partners to do more of the responsibilities of maintaining a household. Crowe also found that when the depressed male became more rigid in his behavior, the spouse/significant other would take on more of the household tasks to maintain a 'status
quo' in the home. In the current study spouses/significant others wanted to maintain their everyday lives. There was, however, no report of their spouses/rigid behavior.

_Hoping for._ The second subcategory was hoping for. A spouse discussed how she was able to continue on. "It's hope—that's what gets you through. That's the cope." When talking about continuing on, other statements of hope were expressed by the spouses. "You just hope—that's all. Hope he stays with you. Hope he doesn't take the kids. Hope the in-laws don't start to fill his head with stupid ideas. Hope he doesn't end it this time."

Another spouse, who was dealing with her spouse who was in a recurrence at the time of the interview stated:

I hope this will be the last of this [expletive] depression. That is all I have for now. But that hope gets old. But if you don't have that then what do you have? I'll answer that, you have nothing. So it's better to have hope.

Another spouse mentioned hope as things staying the same. "Hoping, hoping; hoping everything will stay the same when you get out of this hole."

One spouse talked about hope of one day not even having to consider this awful diagnosis (MDD):

Not that long ago I had a dream that _ didn't have depression. We didn't have all the doctor bills, or the medicine bills or the lab bills. It was just like before, when we were just hanging out just the two of us. I had such strong feelings of love for him in dream—I still do now, but they are always attached with his illness. The feelings aren't the free feelings of when you were young and first met and have no other cares in the world. When I woke up I found myself hoping this dream was real because that was the reality I was in. After a few minutes I
knew it wasn’t but the feeling I got from that dream was better than a Caribbean vacation—and cheaper than one too. I have to dream and hope, that is how to get a break from it all.

In summary, spouses relied on hope to continue with their routine life. Garnefski, TeeRs, Kraaij, Legerstee, and van den Kommer (2004) found reporting of self-blame, rumination and using positive reappraisal as spouses’ coping methods. Garnefski et al. obtained data on symptoms of 251 depressed males and 379 depressed females’ depression and the use of nine cognitive emotion regulation strategies. Significant differences were found between men and women in the strategies of rumination, catastrophizing and positive refocusing in that women used these strategies more often than men. In both groups, higher extents of reporting self blame, rumination and catastrophizing as strategies were strongly related to higher depression scores, whereas higher extents of using positive reappraisal were related to lower depression scores. In the current study women ruminated about the time when their depressed spouses/significant others did not have depression and what their lives were like.

*Keep going: Just forge forward.* This third subcategory of “keep going” coincides with hope. Almost all participants reported elements of moving forward. One spouse stated, “Where else are you going to go? You just keep going, trudging on, hoping the next day will be better.” One spouse who was happy that her husband did not have a recurrence in 4 years stated, “I just want to continue on like this. I’m hoping this is the way it will continue.”

One spouse whose husband was diagnosed over 10 years ago stated

Yesterday was yesterday. No one can go back to before they were diagnosed.

What are my choices? Either I keep going or I end up having some type of
psychiatric break down. That would not fair well. I guess what I am trying to say is that there is no other option. If you don’t keep going and working at it between the two of you, your other option is divorce.

Another spouse spoke about their relationship in the past and what she came to realize about their future:

We had split up, what was it for? I want to say eight months I couldn’t keep going. It was all about take your meds on time and make doctor appointments and more doctor appointments I had to drive him to them because he couldn’t drive because of the medication he was on. I was really young, like 25. It felt like I had a kid. I didn’t want a child I wanted a husband, so told him I couldn’t handle this and left. In that time I left, even though I wasn’t physically with him, every day I would think about him like did he take his medication, is his sister getting him to all his doctors’ appointments. I missed him so bad. I then came to realize that even though I had all these responsibilities to do, I loved him. I knew we as a couple wouldn’t be the same, but if we could forge forward together we would be okay.

Another spouse who had been married to her husband for over 25 years stated, We said our vows, raised our family and are looking at retirement. This is who we are. I can’t remember a time before he was diagnosed. You get in a mode of just go forward because there is no backward.

In summary, the researcher noted that the spouses are grounded in what is occurring presently in their life and how to achieve what they need to get to keep the family unit going. They also expressed feelings of going forward. Sandberg, Miller and Harper (2002) found that the affected spouse reported greater difficulty communicating
and problem solving during "down" times. The unaffected spouse reported feelings of confusion and frustration towards the affected spouse, but felt a commitment to their family to continue the daily chores of life.

Methods of coping reported by the depressed men and their spouses/significant others were similar. Both established their ways of coping to continue forward when the male spouse/significant other was diagnosed with depression. The depressed male's way of coping was to do some physical activity, talk with his spouse/significant other and feeling secure in his relationship with his family. The spouse/significant other's way of coping was to continue with her normal life and hoping for normalcy in their lives.

Research Question Three: How Can the APN Help With Depression?

Depressed Male Responses

The main theme for this question was The Treatment: Relief. Participants revealed their thoughts and feelings related to medications and talking with the doctor. It should be noted that when the question of how an APN can help with depression was asked, all except one did not know who an APN was. To help explain this question, a related probe was asked: How do you feel your doctor helps you the most?

Medications, along with talking with the doctor. Although medications and talking with the doctor are listed as two separate subcategories, in many responses, medication and talking with the doctor were mentioned in the same comment. Therefore, the two subcategories are listed together. All participants responded that medications were the biggest help to them along with talking with the doctor. Some of the comments were:

Like Dr. M. She prescribes all my meds, but she always counsels me. Just like person to person, as adult to adult. You listen; you treat somebody with respect.
Just to listen like you're doing right now and providing intelligent feedback and having some type of dialogue.

Another participant stated: "No wonder why so many people were committed before—they didn't have all the right kind of meds that we have now. I have no idea what I would have done if I didn't have that. I probably wouldn't be talking to you."

Other comments included:

"[Doctors] help me by giving me medicine, prescribing medicine for me, which really brought me back quite a bit."

"Talking to me like a grown up person. But when it all came down to is the medication that's prescribed."

"I guess being there for him and prescribing the right medications and follow up."

"The medication brought me to a state that he could then participate more in my treatment. The medication is what brought me around first, but discussing the happenings of what is occurring was great too."

"I couldn't have made it without the medication. Talking with the doctor helped too."

"Medications were a Godsend."

"The medication helped, but also talking to your doctor and just talking to him about what was happening to you and to me."

Spouse/Significant Other Responses

Spouses revealed their thoughts and feelings related to medications, talking with the doctor and support groups versus counseling. The main theme that emerged was The Treatment: Relief. Subcategories were: medications: first line of treatment, talking with the doctor, and support groups versus counseling.
Medications: First line of treatment. All spouses reported medications as the first line of treatment for depression. One spouse stated “The medications were what did it. If it weren’t for the meds we would not be here together.” Another spouse stated “Medications and talking to the doctor were the biggest help. But now saying it, the biggest help was the medications. It was like someone turned on a light switch”.

One spouse talked about the advancement of medications.

He didn’t want to take the medications the doctor ordered. He had been taking them for a while and had a problem with weight gain. These new drugs don’t have as much weight gain but still get the job done. So it is a win/win situation for him and me.”

Other comments were “I am thankful for them [medications] every night” and “He couldn’t have gotten better without them.”

Talking with the doctor. Spouses felt that talking with the doctor had helped their husband, and indirectly helped them also. One spouse stated,

I know he just said having the doctor talk to him like a human being. I didn’t go to many visits with him at the doctor, but you could tell that when he had a good doctor and he felt comfortable with him, he would come home from his appointments much more satisfied. This is how I benefited from talking with the doctor.

Another spouse talked about what the doctor would say to her depressed husband.

He would ask you lots of questions, and ask if you wanted to hurt yourself. You always said no to that question, but then he told you how to get help if that would
happen. He would always let you know all possible side effects of any new medications.

One spouse stated,

I started to go to the doctor with him, because he really seemed to like his new doctor. I stopped going with him because it made him feel embarrassed. But I liked it that he liked the doctor enough to go to all his appointments.

In summary, the spouses/significant others had an indirect benefit of talking with the doctors. Listening to her depressed male spouse/significant other's reports of a therapeutic relationship with the doctor had an impact on their relationship.

Support groups versus counseling. The third subcategory under this theme was support groups versus counseling. All except one denied the use of support groups. The spouse who did go to a support group stated,

I went one time, just to try it out. It was okay. I didn't feel comfortable in there. I didn't know anyone in there, which now was a good thing. But, if a friend would've come with me, maybe I would have stuck with it. I should have tried a different group. This group I tried was in someone's house, some of the people frightened me.

This spouse went on to further state:

I went to "one-on-one counseling. That way ____ would have his counseling with the doctor and I would have mine with a therapist. We could each get out what we wanted to say and we wouldn't hurt each other's feelings. After a while of that, we then started to go to a counselor together.

The remaining participants denied going to any type of support groups. The spouses would go to their own counselor, but never seek out a support group for
depression. One spouse said, "No, I never would have even considered a depression support group. What I found from those is that usually you have one person monopolizing everybody's time and all the other sit around supporting that one person. No thanks, I'll go to someone who I know and trust."

Another spouse reported her own counselor helping her.

No, I never did try one of those things (support group), but I keep going to my counselor. It just feels good to air out anything and everything and not have someone who may have more experience in the depression aspect try to one up you. Counseling works best for me and us."

In summary, spouse/significant others listed medication, their husband talking with the doctor, and one-on-one counseling most beneficial for them. Kennedy, Abbott, and Paykel (2003) found high levels of pharmacological and psychological treatment helped in preventing remission. Araya, Komproe, and de Jong (2007) found that social support was correlated positively with coping. Contrary to this belief, Lawrence et al. (2006) found that the responsibility for combating depression was an individual task, and support was considered secondary.

The results of the current study are consistent with the study by Kennedy et al. (2003) in that pharmacological treatment helped with the treatment of depression. In addition, the results are also consistent with the study by Araya et al. (2007) related to spouse/significant other report of social support helping them cope with depression.

With regard to how the APN could help, comments by the depressed men and their spouses/significant others were similar. All felt that medication and talking with the doctor helped with the treatment of depression. The depressed men reported medication as the first line of treatment. They also reported that a therapeutic
relationship with the doctor was a way of helping in the treatment of depression. The spouse/significant other also reported medication as helpful in the treatment of depression. Spouse/significant others also felt that a therapeutic relationship between the doctor and the depressed male individual indirectly helped them.

Summary

The purpose of this study was to explore and describe the lived experience of depression and coping from the perspectives of the depressed men and their spouses/significant others. The research questions were:

1. What is the lived experience of depression?
2. How does your family cope with the recurrence of depression?
3. How can APNs help with depression?

Using a qualitative, phenomenological approach, six couples were jointly interviewed. Data were examined for themes and categories that described the experiences of the depressed male and their spouses/significant others.

Giorgi's approach to methodological interpretation was used to analyze the data. Three main themes emerged from the interviews with the depressed male participants: (a) The Diagnosis: What is it? (b) Coping: Pulling Through, and (c) The Treatment: Relief. Each theme included several subcategories. In the first theme—The Diagnosis: What is it?—subcategories were: (a) knowing something was not right, (b) relief being diagnosis, and (c) not being me. In the second theme, Coping: Pulling Through, subcategories were: (a) do some physical activity; and (b) communication: talking with significant other/spouse. In the third theme, The Treatment: Relief; subcategories were: (a) medications and (b) talking with the doctor. Data analysis of the spouse/significant
other revealed three main themes: (a) Disbelief: What Now? (b) Continuing On: Wishing for Normalcy, and (c) The Treatment: Relief. In the first theme—Disbelief: What Now—subcategories were: (a) unable to believe: what's going to happen? and (b) panic: what are we going to do?. In the second theme, Continuing On: Wishing for Normalcy; subcategories were: (a) continuing a normal life, (b) hoping for, and (c) keep going: just forge forward. In the third theme, The Treatment: Relief, subcategories were: (a) medications, (b) talking with the doctor, and (c) support groups versus counseling.

In Chapter V, the summary of the results, conclusions, implications for nursing practice, and recommendations for further study are discussed.
CHAPTER V
SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Introduction
The purpose of this study was to explore and describe the lived experience of depression and coping from the perspectives of the depressed men and their spouses/significant others. The research questions were: (a) What is the lived experience of depression in men and their spouse/significant other? (b) How does the family cope with the recurrence of depression? and (c) How can the advanced practice nurse help? In this chapter, a summary of the results, conclusions, implications for nursing practice, and recommendations for further study are provided.

Summary of Study Findings
Data were collected by the researcher through face-to-face interviews with study participants from December 2007 through February 2008. Participants for the study were solicited from two psychiatric clinics in northeastern Wisconsin. Flyers were posted at local libraries, churches and community centers, and a depression support group. A total of six depressed men and their spouses/significant others agreed to participate in the study and be interviewed.

All interviews (lasting from 20-60 minutes) were audiotaped and transcribed verbatim. Data were examined for themes and categories that described the experiences of the depressed men and their spouses/significant others.
The three major questions for the depressed men were: (a) Tell me about your experience of living with depression; (b) How does your family cope with the recurrence of depression? and (c) How can the APN help?

The three major questions for the spouse/significant other were: (a) Tell me about your experience of living with your significant other/spouse who has depression; (b) How does your family cope with recurrence of depression? and (c) How can the APN help?

Specific probe questions were asked during the interviews to redirect, clarify, or encourage the participants to reflect further. Three main themes emerged from the interviews with the depressed men: (a) Diagnosis: What is it? (b) Coping: Pulling Through, and (c) The Treatment: Relief.

For the first theme—Diagnosis: What is it?—all six male participants described the experience of knowing something was not right with them. They reported common emotions, such as feelings of confusion, anxiety, and frustration expressed most often. For these participants, the experience of not being diagnosed was often frustrating.

After being diagnosed with depression, these participants expressed relief because they now knew something was not right with them. With being diagnosed, they reported being able to initiate and enjoy their previous activities.

In the second theme, Coping: Pulling Through, participants revealed their thoughts, feeling, and experiences related to how they coped with recurrences of depression. Participants stated that increasing their physical activity by working out, walking outside, and getting out of the house were helpful. One male participant stated that prior to his diagnosis, he was self-medicating with drugs and alcohol; however, he
realized that physical activity was a much more healthy and positive way of coping with the recurrence of depression.

Participants also stated communication with their spouse/significant other as a way of coping. They reported that just talking with their spouse/significant other helped them cope with the depression. They also stated family as being helpful with their coping.

In the third theme, The Treatment: Relief, participants revealed their thoughts about what helped them most with depression. All participants reported medications to be most helpful in treating their depression. Five of the six participants stated that talking with their doctor was also very helpful; however, they reported that they did not value support groups. Although some reported attending support groups, they did not find them beneficial. Others responded negatively when inquired about support groups.

The analysis from the spouse/significant other, demonstrated three main themes: (a) Disbelief: What Now? (b) Continuing On: Wishing for Normalcy, and (c) The Treatment: Relief.

In the first theme—Disbelief: What Now?—they described their experience when they realized that their husbands/significant others needed help. Onset of depression had been sudden and dramatic for some; for others, it was a more insidious experience that was not easily recognized. With the onset, they felt baffled by the changes they observed in the mood or behavior of their husbands/significant others. They also discussed feelings of panic and being worried about themselves, their children, and their finances.

In the second theme, Continuing On: Wishing for Normalcy, the spouses/significant others reported wanting to resume their normal lives they led prior to
their husbands/significant others' diagnosis. They also reported feelings of not wanting their friends to know, wanting to keep up appearances with the house and yard and, in general, yearning for normalcy in their lives.

Hope was listed by the spouses/significant others as a way of continuing with their lives. They expressed frustration with their husbands/significant others' depression and having to deal with it almost on a daily basis.

In the third theme, The Treatment: Relief, reported that medications and a therapeutic relationship with the doctor was helpful in the treatment of depression. While some of them attended support groups, others expressed feelings of discomfort, and some others stated they had no interest in support groups. A few found support in their own counselors.

Relevance of Parse's Human Becoming Theory

Parse's Human Becoming Theory (1998) was used as the theoretical framework for this study. Parse stated that humans are unitary beings that create personal meanings in inter-subjective mutual process with the universe and personal meanings, which constitute human lived experiences (Parse, 1998). Parse's framework was appropriate in this study because it is based on individuals having their own personal meanings and experiences of depression. The Human Becoming Theory guides researchers to explore meaning rhythmicity and co-transcendence, as phenomena are described in detail of what life is like from the depressed person's perspective.

Parse's (1998) first principle interrelates the concepts of imaging, valuing and languaging, showing that human beings structure meaning to reality that is based on lived experiences. The meaning changes or is stretched to different possibilities,
depending on lived experiences. Co-creating in this principle refers to the human
environment—mutual participation in the creation of the pattern of each. Languageing
reflects images and values through speaking and movements. Valuing is the process of
living cherished beliefs while adding to one’s personal world view. Imaging refers to
knowing and includes both explicit and tacit knowledge. Nurses guide individuals and
families to relate the meaning of a situation by making the meaning more explicit.

In the second principle, Parse (1998) likens dwelling to moving with the flow of
the individual/family, leading them to recognize the harmony that exists within the lived
context.

In the third principle, transforming is defined as the changing of change and is
recognized by increasing diversity (Parse, 1998). The practice of dimension is
mobilizing transcendence, which happens in moving beyond the meaning of the moment
to what is not yet. In this, the nurse guides individuals and families to plan for the
changing health patterns.

For this study, the researcher developed an application of the Human Becoming
Theory called the Lived Experience of Depression Framework (Figure 2). In principle
one, imaging is when persons answer questions as they explore the meaning in light of
reality and their view of things. The depressed male individual reported the “knowing
something was wrong.” The depressed male was exploring what was not right in his life.
Principle 1: Structuring meaning. Meaning multidimensionally is Co-creating reality through the languaging of valuing and Imaging.

Principle 2: Co-creating rhythmical patterns of relating is living the paradoxical unity of revealing-concealing and enabling-limiting while connecting-separating.

Principle 3: Co-transcending with the possibilities is powering unique ways of originating in the process of transforming.

Relationship of the concepts in the squares: Powering is a way of revealing and concealing Imaging. Relationship of the concepts in the ovals: Originating is a manifestation of enabling and limiting values. Relationship of the concepts in the triangles: Transforming unfolds in the languaging of connecting and separating.

Figure 2. Principles, concepts, and theoretical structures of lived experience theory of depression based on Parse's theory.
Valuing is about how a person confirms and does not confirm beliefs in light of a personal perspective or worldview (Parse, 1998). In the lived experience of depression, the depressed male individual confirmed his belief of “knowing something was wrong” by the diagnosis of MDD by the doctor.

Languageing relates to how human beings symbolize and express their imaged realities and their value priorities. The depressed male individual had symptoms of depression. Symptoms of fatigue, decrease in social activity, and somatic complaints symbolized the depressed male individual’s reality of depression.

In principle two, the concept of revealing-concealing is when people voluntarily give and withhold thoughts about themselves and what they know. One spouse reported when her depressed husband told her he did not “feel good” and reported he was “suicidal.” The depressed male revealed his thoughts to his wife “at will.”

Enabling-limiting is when the human moves in one direction, which restricts movement in another. The spouse/significant other reported that her depressed husband was doing less around the house, although her husband perceived himself to be doing more toward what he needed to do for himself at that time. This resulted in restricted.

Connecting-separating is being with and apart from others, ideas, objects, and situations all at once. This is illustrated by the depressed male’s way of being with and apart from others, ideas, and situations through coping. Ways of coping were communication and physical activity.

In the third principle, powering is a process we all change, as one moves from what one is to what one is not yet. According to Parse (1998), powering is about struggle and life and the will to go on despite hardship and threat. The depressed male
reported medication as being helpful in empowering and “becoming”—moving from what he is to what he is not.

Originating is inventing new ways to be like others, and yet also wanting to be unique. Medications and communication with health care professionals helped the depressed male transcend the illness, and yet preserve his uniqueness in the process of transformation. Transformation can help the depressed male to develop new life patterns.

Parse (1998) stated that the steps of the nursing process are the steps of the problem-solving method and these are not unique to nursing. However, the assumptions underlying the nursing process—that the nurse is the authority on health and that the person adapts—are not congruent with the Theory of Human Becoming. Parse believes that practice is the empirical life of a theory, and the practice of one theory would be different from the practice of another.

Conclusions

The conclusions from this study were:

1. Depression impacts both the male and his spouse/significant other.
2. The depressed male participants did not recognize the symptoms of MDD.
3. A diagnosis of MDD brought relief when they knew something was not right.
4. Increasing physical activity helps cope in recurrences of depression.
5. Having a strong relationship with their spouse/significant other helps cope with the recurrence of depression.
6. Male participants have many somatic complaints.
7. Medication and a therapeutic relationship with a health care provider are effective treatments for depression.

8. Spouses/significant others are concerned about their family after their husbands are diagnosed with depression.

9. The diagnosis of depression in their husbands causes stress in the spouse/significant other.

10. The spouse/significant other wants to maintain the status quo and normalcy in their lives.

11. The effectiveness of support groups depends on the individual.

12. Both the depressed male and his spouse/significant other are unaware of the role of the APN.

Implications for Nursing Practice

Nursing in general takes a holistic approach to the individual needs of a person. Nursing does not focus solely on the disease process or in finding a cure, but rather examines all aspects of an individual's life. In doing so, nurses must evaluate all aspects of a male's life including the physiological, emotional, cultural and significant relationships.

More than 80% of patients with depressive disorders are estimated to seek care from primary care providers, and less than 10% of patients are referred to a mental health provider. However, up to 50% of depressed persons visit their primary medical care provider at least once during a 6-month period. One group of health professions that has regular contact with depressed patients is primary care providers. Advanced practice nurses are primary care providers and therefore are in contact with depressed
patients on a regular basis. Since they will be the first line of contact, APNs must be able to recognize signs and symptoms of depression.

The depressed men in this study stated that medications helped them with their depression. Advance nurse practitioners have prescriptive authority and therefore can prescribe medications for treatment of depression.

It is also important for APNs to assess the spouse/significant other at office visits. This will allow a determination of any areas that may require physical, emotional, spiritual or social assistance from health care services. Assessment of the spouse/significant other could be done by using a tool with documented reliability and validity.

Advanced practice nurses are essential members of primary care outpatient care, who assist in the referral and treatment of the male patient with depression. The APN should perform a comprehensive evaluation of the male's physical, emotional, spiritual, and social needs in addition to the assessment of the significant other/spouse. Comprehensive evaluation needs to include how each of the individuals is dealing with his depression and helping him identify what he needs. This is an area of further study that can be explored to develop a screening tool to be given to each depressed male individual and the spouse/significant other to help them identify their needs for the primary care provider. Identified areas of weakness, such as emotional distress and social disruption in the significant other/spouse’s support system indicate that additional nursing care, such as evaluating them for signs of depression and giving support, may be necessary to assist the significant other/spouse with programs to help with personal support. Referral to marriage counseling, social support groups or psychological
services may also be needed for the significant other/spouse, as well as her depressed husband/significant other.

In summary, APNs are primary care providers who see 80% of individuals that meet some type of psychiatric diagnosis (NIMH, 2007). Advanced practice nurses can provide a broad array of assessments and therapeutic modalities or interventions. These include depression and coping websites, alternative modalities such as light therapy, and contacts and support group names to both the male patient and the significant other/spouse.

Recommendations for Further Study

1. Administer a marital satisfaction scale, such as the Kansas Marital Satisfaction Scale separately to the depressed male and his spouse/significant other. This information would not be shared with the spouse/significant other and vice versa, but would be used to validate what is said in the interviews in relation to marital satisfaction.

2. Repeat this study with different ethnic populations to determine the influence cultures have on the experiences and perceptions of the depressed male and his significant other/spouse.

3. Conduct studies on specific coping mechanisms, stress management techniques and the concept of hope in order to develop effective nursing interventions for the depressed male and his spouse/significant other.
Summary

In this chapter, the summary of the study findings, conclusions, implications for nursing practice, and recommendations for further study were provided. The purpose of this study was to explore and describe the lived experience of depression from the perspectives of the depressed men and their spouses/significant others. Also, this researcher explored how the family copes with a recurrence of depression and how APNs can help the patient and family with depression. Mental health is necessary for overall well-being, to establish and sustain interpersonal relationships, and to promote individual productivity in the community and society. Many depressed males do not realize they are suffering from a treatable disorder. Advanced practice nurses can help these individuals to recognize their illness and receive appropriate treatment. The goal is to improve the quality of life for individuals with depression through increased screening efforts in primary care, earlier diagnosis, and intervention.
APPENDIX A

Interview Guide
Main questions for male client:

1. Tell me about your experience of living with depression.
2. How does your family cope with recurrence of depression?
3. How can the Advanced Practice Nurse help?

Main questions for significant other/spouse:

1. Tell me about your experience living with your significant other/spouse with depression.
2. How does your family cope with recurrence of depression?
3. How can the Advanced Practice Nurse help?

Prompting questions to be used if necessary:

1a. What symptoms do you have with your depression?
2a. Has your depression affected your relationships and if so how?
2b. Has depression affected your daily life or routines and if so how?
2c. Has the depression caused you physical pain?
3a. What made you decide to seek professional help?
3b. How has your psychiatric provider helped you the most with your depression?
3c. What are some ways that you feel your provider could help you more with your depression?
APPENDIX B
Demographic Questionnaire
1. Age: ________

2. Gender: ________

3. Marital Status:
   a. Single
   b. Married
   c. Divorced
   d. Separated
   e. Widowed

4. Highest level of education:
   a. No formal education
   b. Grade school
   c. Some high school
   d. High school diploma
   e. Some college or technical education
   f. Graduated from college or technical school

5. Your approximate family income from all sources:
   a. Less than 10,000
   b. $10,000-$19,000
   c. $20,000-$29,000
   d. Over $30,000

6. Number of children: ________

7. Number of children living at home: ________

8. Spouse Occupation: ________

9. Number of depressive episodes: ________

10. Length of time diagnosed with depression: ________

11. Number of hospitalizations for depression, if any: ________
APPENDIX C

UW Oshkosh IRB Approval Letter
Ms. Jill Witte  
3080 Jaguar Ln.  
Green Bay, WI 54313

Dear Ms. Witte:

On behalf of the UW Oshkosh Institutional Review Board for Protection of Human Participants (IRB), I am pleased to inform you that your application has been approved for the following research: The Lived Experiences of Depression and Coping: Perspectives of Depressed Males and Their Spouses/Significant Others.

Your research has been categorized as NON-EXEMPT, which means it is subject to compliance with federal regulations and University policy regarding the use of human participants as described in the IRB application material. Your protocol is approved for a period of 12 months from the date of this letter. A new application must be submitted to continue this research beyond the period of approval. In addition, you must retain all records relating to this research for at least three years after the project’s completion.

Please note that it is the principal investigator’s responsibility to promptly report to the IRB Committee any changes in the research project, whether these changes occur prior to undertaking, or during the research. In addition, if harm or discomfort to anyone becomes apparent during the research, the principal investigator must contact the IRB Committee Chairperson. Harm or discomfort includes, but is not limited to, adverse reactions to psychology experiments, biologics, radioisotopes, labeled drugs, or to medical or other devices used. Please contact me if you have any questions (PH# 920/424-7172 or e-mail: rauscher@uwosh.edu).

Sincerely,

[Signature]
Dr. Frances Rauscher  
IRB Chair

cc: Jaya Jamboorathan  
1244

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APPENDIX D

Informational Flyer
University of Wisconsin Oshkosh

Research Study

I am a graduate student from the University of Wisconsin Oshkosh seeking a Masters of Science in Nursing. I am conducting a study to describe the experiences of depression in men and their spouses/significant other.

I am currently seeking participants for my study. The following are criteria for participation in the study:

1. Be of the male gender.

2. Be able to read, write and speak the English language fluently.

3. Diagnosed by a psychiatrist with a DSM-IV diagnosis of major depression for at least one year.

4. Cohabiting with a significant other/spouse for at least one year. Significant other/spouse of participant must be willing to participate in the study.

If you are interested in participating and fulfill these criteria and would like further information, please contact me. At that time, you can decide if you would like to become a participant.

Thank you for your consideration.

Jill Witte RN, BSN

Contact Number: (920) 606-7790

This contact number is completely confidential and only myself, the researcher, has access to any voicemail left.
APPENDIX E

Informed Consent
University of Wisconsin Oshkosh

Informed Consent

I, Jill Witte, graduate nurse practitioner student, in the College of Nursing at the University of Wisconsin Oshkosh, will be conducting a study on the experiences of depression and coping, in males with depression and his significant other. I would appreciate your participation in the study, as it will assist me as a health care provider in understanding about your depression and your coping strategies as well as improving the care for you and your families.

As part of the study, I will be talking with you and your significant other at the place of your choice. I will be conducting one interview and have you fill out a short questionnaire. The interview may last approximately one hour. The questionnaire may take approximately 5-10 minutes.

My study will not interfere with your treatment at any time. Although I could study this topic by just interviewing the male individual with depression, I believe that quality of care and treatment can be improved by understanding the experience of depression and coping from the perspective of the significant other. Also, I do not anticipate that the study will present any medical or social risk to you other than the inconvenience of the time required for the interview and the questionnaire. Participation in the study may not benefit you directly.

The information I gather through interviews and questionnaires will be recorded in anonymous form. I will not release information about you to your doctor or to anyone else in a way that could identify you. If in the future there are any presentations or publications regarding this study, all personal data is removed therefore leaving no identifiers.
If you want to withdraw from the study at anytime, you may do so without penalty. The information collected from you up to that point would be destroyed if you so desire. Once the study is completed, I would be glad to give the results to you. In the meantime, if you have any questions, please ask me.

If you have questions about your treatment as a participant in this study, please call or write:

Chair, IRB for Protection of Human Participants
C/O Grants Office
University Wisconsin Oshkosh
Oshkosh, WI 54901
(414) 424-1415

Although the chairperson may ask for your name, all complaints are kept in confidence. Please sign your name below in the space provided.

I have received an explanation of the study and agree to participate. I understand that participation in this study is strictly voluntary.

__________________________  ________________________
Name                        Date

I agree to be audio taped.

__________________________  ________________________
Name                        Date
REFERENCES


