Men's accounts of depression: reconstructing or resisting hegemonic masculinity?

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Men's accounts of depression: Reconstructing or resisting hegemonic masculinity?

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ABSTRACT *(292 words)*

There is evidence that depressive symptoms in men are often undiagnosed and untreated. It has been suggested that men may find it difficult to seek help because culturally dominant (or hegemonic) forms of masculinity are characterised by emotional control and a lack of vulnerability, while depression is often associated with powerlessness and the uncontrolled expression of emotion. However, very little research exists which examines men's experiences of depression. We analysed 16 in-depth interviews with a wide range of men with depression. Our analysis explored associations between depression and men's gender identities. We found that, as part of recovery from depression, it was important for men to reconstruct a valued sense of themselves and their own masculinity. The most common strategy was to incorporate values associated with hegemonic masculinity into narratives (being 'one of the boys', re-establishing control, and responsibility to others). While this strategy could aid recovery, there was also evidence that the pressures of conforming to the standards of hegemonic masculinity could contribute to suicidal behaviour. In contrast, a minority of men had found ways of being masculine which were outside hegemonic discourses. They emphasised their creativity, sensitivity and intelligence, explicitly reflected on different models of masculinity and redefined their 'difference' as a positive feature. Our research demonstrates that it is possible to locate men who can, and will, talk about depression and their feelings; thus generalisations about depressed men always being silent are misleading. While some men will have the resources to construct identities that resist culturally dominant definitions of masculinity, many others will find it more useful (and perhaps less threatening) to re-interpret potentially feminising experiences as 'masculine'. Health professionals need to be aware of the issues raised by men's narratives which emphasise control, strength and responsibility to others.

INTRODUCTION

Gender differences in mental health have long been noted. Almost 30 years ago, Weissman & Klerman (1977) observed that the rate of depression amongst women was around twice that for men. More recent figures confirm this finding; the prevalence of treated depression in general practice in Britain is around 3% for men and 7% for women (ISD Scotland, 2004; ONS, 2000). However, it has been suggested that depressive symptoms in men are often undiagnosed and untreated (Royal College of Psychiatrists, 1998), and that men may express emotional distress in other ways (Lennon, 1987). Suicide rates in the UK are currently three times higher for men than women, and are higher for men than women in every country except for China (Hawton, 2000; ONS, 2005). While suicide is not classified as a mental disorder, major depression underlies more than half of suicides (Moller-Leimkuhler, 2003). In addition, community surveys indicate that gender differences in depression in the general population may be smaller than expected; a survey conducted in 2000 in Britain found that 10% of men and 12% of women reported depressive symptoms of moderate to high severity and that 2.6% of men and 3.0% of women were classed as having had a 'depressive episode' in the week before interview (Singleton, Bumpstead, O'Brien, Lee, & Meltzer, 2001).

In order to better understand men's mental health, we draw upon work which has focused on the relationship between the social construction of 'masculinity' and health beliefs and behaviours (Chapple & Ziebland, 2002; Charmaz, 1995; Moynihan, 1998; Robertson, 2003; White, 1999). Over the last twenty years, theorists have started to conceptualise "a multiplicity of masculinities.. inhabited and enacted variously by different people and by the same people at different times" (Paechter, 2003, p.69). Connell's influential work contrasts a culturally authoritative, or hegemonic, pattern of masculinity with less powerful configurations of gender practice such as subordinated masculinities (e.g. homosexual men) and marginalized masculinities (e.g. working-class men, black men) (Connell, 1995, 1996). Hegemony is about the "winning and holding of power" and having the ability to dictate the terms in which events are understood so that they appear 'natural' and 'normal' (Donaldson, 1993, p.643). White, middle-class, heterosexual men set the standard for other men, but whatever the variation in status, "being a man means 'not being like women'" (Kimmel, 1994, p.126).

This work suggests that men may find recognising and seeking help for depressive symptoms problematic; indeed, Warren (1983) has argued that depression is 'incompatible' with masculinity. She lists three main reasons. First, expressing emotion and crying - common experiences in depression - are linked to femininity; thus a "man may find depression an intolerable condition because it makes him feel like a woman" (Warren, 1983, p.151). Secondly, masculinity is linked with competence and achievement, while depression is often accompanied by feelings of powerlessness and lack of control. Thirdly, masculinity requires men to be tough and self-reliant, whereas the experience of depression often leaves people feeling weak and vulnerable. Similarly, Courtenay (2000) agrees that emotional control and the denial of vulnerability are important parts of hegemonic masculinity and argues that the "denial of depression is one of the means men use to demonstrate masculinities and to avoid assignment to a lower-status position relative to women and other men" (p.1397).

Men with mental health problems have received relatively little attention in the social science literature. Men with depression have been particularly under-researched, probably because anxiety disorders and depression are conditions associated with women (Prior, 1999). The few qualitative studies which have included men have been limited by a lack of attention to men's gendered experiences; in other words, men have not been treated as "engendered and engendering persons" (Gutmann, 1997). Karp (1994; 1996) and Kangas (2001) found that both their male and female respondents emphasised feelings of isolation as they sought to integrate illness into their identities. Karp describes the 'depression career' (from initial feelings of distress, through reaching crisis point, to the possibility of feeling that it is possible to 'get past' depression) and the decisions that respondents had to make about keeping problems to themselves or 'going public', while Kangas argues that "stories of depression are stories of marginalization" (p.90). However, neither author examines the complex relationship between gender and illness in their analysis.

Smith (1999) is unusual in providing an explicitly gendered analysis of his experience as a man with severe clinical depression. His account emphasises the importance of maintaining control, ignoring pain and suppressing emotion. The description of his

internal monologue illustrates the power of hegemonic masculinity: “Pull yourself together, Brett. You shouldn’t be here. Men don’t go and see anyone about these ‘soft’ and ‘wimpy’ things… Real men don’t moan. They don’t hurt. They just don’t do emotions. They get on with life” (p.274). O’Brien and colleagues (2005) also found that many men in their study emphasised the importance of remaining ‘strong and silent’ about emotional difficulties. They conducted 14 focus groups with a diverse sample of men in order to explore help-seeking behaviour. The authors experienced resistance, and even hostility from some younger men, when respondents were asked to discuss mental health issues. However, men in two groups who shared some common experiences of mental health problems talked more freely about their experiences, which they often labelled as ‘stress’ rather than ‘depression’. They believed that other men would be unsympathetic if they discussed emotional problems, viewing them as weak, unable to cope and as a potential subject of ridicule. Interestingly, the authors identified a small minority of men who had chosen, or had been forced, to reject the health practices associated with hegemonic masculinity. They did not appear to find help-seeking as challenging to their male identity as other respondents, perhaps because their longstanding depression made them feel ‘different’ (both from other men and from their former selves) and so distanced them from hegemonic masculinity.

In this paper, we present data from in-depth interviews with 16 men who identified themselves as having depression. We explore respondents’ accounts of depression and examine the connections between their narratives and social constructions of masculinity. In our analysis, we are interested in the extent to which men draw on, or contest, discourses associated with hegemonic masculinity when they have an illness commonly constructed as incompatible with masculinity.

METHODS

This paper uses a relatively new methodology: qualitative secondary analysis (Heaton, 2004). The primary study investigated the experiences of 38 men and women who had been diagnosed with depression. The secondary analysis – reported here – draws on 16 interviews with men and consists of an in-depth investigation of an emergent issue not addressed in the primary study: (how) does depression influence men's gender identities?

The study

This paper draws on qualitative data collected for the depression module of the DIPEx (personal experiences of health and illness) website. The website contains analysis of interviews with people about their experiences of health and illness illustrated with video, audio and written clips, questions and answers, health information, links to resources and a section where visitors to the site can post messages (Herxheimer & Ziebland, 2004). The website is run by the DIPEx charity based in Oxford, UK. Between 2003 and 2004, 38 people were interviewed for the DIPEx depression module– usually in their own homes - by DR, a male researcher with extensive experience of interviewing on sensitive topics. Considerable effort was invested in finding male participants and 16 men were interviewed. The study was approved by the Multi Centre Research Ethics Committee in the UK, and the interviews were copyrighted for inclusion on www.dipex.org . Only seven men were prepared to be seen on video via the Internet; the others allowed written extracts from their interviews to be placed on the website or allowed actors to speak their words (see table 1). The issue of stigma frequently played a role in decisions to remain anonymous on the website.

To be eligible for the DIPEx study, participants had to be over the age of 18, identify as having had depression, and be feeling sufficiently well to undertake the interview. People were invited to take part through GPs, psychiatrists, patient support groups and newsletters. Qualitative studies of depression to date have relied upon convenience samples, been based on women, and/or relied on auto-ethnographies, so one of the aims of this study was to recruit a broad range of participants so that a variety of perspectives and experiences could be analysed. Participants were recruited to

include men and women from various age groups, ethnic and social class backgrounds, and locations in the UK. Respondents also varied according to when they were diagnosed, the type of depression they were diagnosed with and the treatment they considered most useful. The final sample included 16 men, of whom 5 identified as gay, 3 were from ethnic minority backgrounds and 5 had bipolar depression.

Open-ended, in-depth interviews were conducted in which respondents were given as much time as required to talk about their lives in their own words, and to focus on issues about depression that were important to them. A topic list was used in the second part of the interview to ensure consistency. Topics included: life before depression; the period of time when things seemed 'not quite right'; the depression experience(s); social consequences of depression; help seeking and personal coping strategies. Interviews ranged from 90 minutes to 180 minutes, and were recorded by audio and/or video with the consent of each participant. Audio recordings were professionally transcribed and transcripts were returned to respondents for checking. The analysis here is based on the full interview transcripts for those 16 men; only short extracts from the interviews appear on the website.

Analysis

Analysis took place in two phases. Initially, DR identified emerging themes based on a 'modified grounded theory' approach and multiple levels of analysis as described elsewhere in the literature (Glaser & Strauss, 1967; Ridge, Minichiello, & Plummer, 1997). The software NUD*IST 6 was used to aid the coding, organization and searching of narrative sections from each interview. The initial analysis was cyclical and continually moved between reviewing the literature, data collection and coding, linking codes and revising and reshaping the analysis. From the first phase of analysis, DR wrote up thematic topic summaries (which feature on the DIPEx website), produced summary tables of the key features of interviews, and developed further thematic discussion papers on the overall analysis (Ridge, in preparation; Ridge & Ziebland, in preparation). The initial analysis was clarified and scrutinised by SZ and DR through regular meetings and electronic exchanges.

In the second phase of analysis, CE undertook secondary analysis of a subset of the data (men) in order to explore a new research question: (how) does depression influence men's gender identities? Respondents were not asked in the interviews to comment on how 'being a man' influenced their identity or their experience of depression. Therefore, any explicit references to masculinity were made spontaneously by respondents.

There has been some debate about secondary analysis of qualitative data; on one hand, it has been suggested that the researcher who collects the data is the person best placed to undertake analysis, whilst on the other, it has been argued that the 'distance' an independent researcher has from the data can be helpful (Heaton, 2004). In this case, the 'gap' between primary and secondary researchers was bridged through extensive discussion about the context of the study and the data collection process (Heaton, 2004). This process was aided through the authors' similar views about the analysis of qualitative data and a shared theoretical framework (Connell's (1995) work on multiple masculinities). In order to aid familiarization, all the transcripts were read repeatedly and the raw data were recoded in accordance with the new research question. QSR Nvivo 2.0 was used to facilitate the analysis of themes and explore the underlying reasoning of respondents. Following McCracken (1988), analysis moved from the particular (a detailed analysis of language in each transcript) to the general (a comparison of patterns and themes across of all the transcripts). Hypotheses were formulated, tested against the transcripts, and where necessary re-formulated in a cyclical process. All authors were involved in debating and refining the final analysis and commenting on a number of drafts of the paper.

FINDINGS

Overview

As part of recovery from depression, it was important for men to reconstruct a valued sense of themselves and their own masculinity. The most common strategy was to incorporate values associated with hegemonic masculinity into narratives (being 'one of the boys', re-establishing control, and responsibility to others). However, a minority of men consciously distanced themselves from culturally dominant forms of masculinity. They emphasised their creativity, sensitivity and intelligence, explicitly

reflected on different models of masculinity and redefined their 'difference' as a positive feature.

EXPERIENCING DEPRESSION

Darkness and difference

In comparison to other studies (e.g. O'Brien, Hunt, & Hart, 2005), the men who came forward for the DIPEx study were willing to talk about their feelings and experiences of depression. Respondents discussed a range of emotions they had experienced during depression, most commonly sadness, guilt, detachment, anger and fear. Many referred to the tears they had shed and the "uncontrollable misery" of depression. They used vivid imagery to communicate feelings of isolation ("like being in a glass tube where you could see everybody but you couldn't reach them"), darkness and torment ("like rotting in the depths of hell") and imprisonment ("down in that hole and there's no light"). Conversely, coming out of depression was described in terms of brightness and escape (e.g. "the sun seems to shine better, the colours of nature are much sharper"; see also Kangas, 2001; Karp, 1996; Schreiber, 1996; Smith, 1999).

Respondents described feelings of isolation and 'difference' (e.g. feeling alone, being anxious, not fitting into social situations, having trouble articulating their experiences) and many identified their negative thoughts and emotional turmoil as stemming from their childhood or teenage years. The men's depression journey also involved the potential for multiple insults to their sense of masculinity. Some men described being labelled as weak or sensitive children by their families. Others had been bullied at school and derided as 'sissies', 'poofs' or 'gays'. Plummer (1999) argues that these powerful homophobic insults are used to delineate acceptable and unacceptable male identities amongst boys from their early years, and so are important in shaping masculine identities for both gay and straight men. Similarly, Connell (1995) proposes that this sort of abuse signals the expulsion of some men from the "circle of legitimacy", marking them as culturally subordinate (p.79). Our study provides further evidence for these theories. Both heterosexual and homosexual respondents discussed their experiences of homophobic insults and some referred to the 'macho' school environment. For example, DP23 (a gay man) referred to the insults he was subjected to at school, while DP04 (a straight man) discussed how his school

environment did not encourage boys to express emotions. DP04's account also shows how the depression experience itself could be described as a negation of valued masculinity ('you feel weedy'):-

> *.. suddenly there were these bigger boys and they called me a sissy. I didn't know for years what that meant .. but they obviously had it in for me (DP23)*

> *… at that age, 17, school kid, pretty macho, tough environment I think, not a place you could really talk about feeling bad and not really possessed of a vocabulary. ... you feel really alone, you feel weedy, you feel cack, you just think that you're no good (DP04)*

The continuous process of identity construction

At the time of interview, most respondents had established helpful recovery narratives. However, a few seemed to be floundering. Their lack of positive future plans suggested that, at the time of interview at least, they had resigned themselves to certain limitations in their lives or were even 'past caring':-

> *I feel with myself and the way things have gone, it's almost like certain aspects I'm past caring anyway (DP33)*

> *I find living at the moment.. quite tricky.. You know I often think. .although it sounds rather dark, what am I doing in the world?.. What shall I do, how shall I fill the time?.. It's (life) not really how I'd like it to be of course. (DP17)*

It is important to bear in mind that many people cycle in and out of depression. Respondents who seemed despondent at interview could well move to a more positive stage in the depression cycle; similarly, those who seemed to be doing well at interview might struggle at other times. Although respondents were not directly asked to talk about suicide, 3 men revealed they had experienced serious suicidal thoughts and a further 6 discussed their suicide attempts, yet these men were all well enough to be eligible for interview and had, in almost all cases, established helpful recovery narratives. As Karp suggests, "for many, depression involves a life centred on a nearly continuous process of construction, destruction, and reconstruction of selves in the face of repeated problems" (1994, p.26).

This continuous construction of selves is inextricably linked with the construction of gender identities. The remainder of this paper will examine the narratives respondents used in order to maintain a valued sense of their selves as men. The most

common strategy was to incorporate values associated with hegemonic masculinity into recovery narratives.

(RE)CONSTRUCTING IDENTITY AROUND HEGEMONIC MASCULINITY

Being 'one of the boys'

Most of the time, gender identity is so taken-for-granted that men do not consciously think about what it means to 'be a man'. As Paechter suggests, "it is only when we find ourselves performing, or attempting a masculinity.. that for some reason fails to 'fit' a particular social situation .. that (the) performative aspect is brought home to us as we subtly, or not so subtly, change our behaviour" (2003, p.69).

A number of men in our study referred explicitly to their gender identity when they discussed the importance of being 'one of the boys' (also see Plummer, 1999). For example, DP14 described how joining a bowling club had been helpful to his recovery because he finally felt he belonged to a group of men after a lifetime of feeling an outsider:-

> *I sort of blossomed .. in amongst new people, an interest and all the rest of it, and being one of a bunch. And that seemed to be important to me, to be one of the boys. (DP14)*

Not all respondents felt secure that they were 'one of the boys'. DP03's narrative suggests that he was acutely aware that public tears could compromise his male identity and make him stand out from other men:-

> *It was quite embarrassing if somebody, you were talking in a group and you found yourself suddenly bursting into tears. We're not very good at that sort of thing (laughs) particularly men aren't. (DP03)*

Worryingly, there was some evidence that the pressure of conforming to the standards of hegemonic masculinity could play a part in suicidal behaviour. DP36 recalled how he forced himself to jump off a multi-storey car-park by deriding himself as a coward. His narrative refers to the tension between discourses about suicide: is it courageous or is it cowardly? Others reported they had not gone through with suicide attempts because they were too scared or did not have the courage to endure the physical pain, suggesting that at some level they subscribed to the belief that suicide took courage.

DP36 alluded to trouble between himself and other men when recovering from his injuries in hospital after his suicide attempt. His narrative suggests that he was painfully aware of the gap between his gender identity and the dominant masculinity of the 'macho' men on his ward:-

> *I started to climb over... and I climbed back and then I sort of ridiculed myself that I was a coward and wouldn't do it. And now I think it would have been a lot braver not to do it. ..I did have trouble early on (recovering) in the orthopaedic ward as you've got like all these young guys who've come off motor-bikes and, and sporting things, it's quite macho, which I'm not particularly like (DP36)*

Re-establishing control

Respondents' narratives emphasised the importance of moving from dependence to independence and re-establishing control in order to recover from depression. For example, establishing a degree of control over health care was seen as an important part of recovery. DP31 believed that reducing dependency on drugs and health professionals facilitated recovery:-

> *The vital thing, I think, to recovery is that you have to become independent and yet everything around you is geared towards forcing you to become more and more dependent - dependent on drugs, dependent on other people like professionals to make decisions for you. Your whole autonomy is being taken away and gradually eroded, so everything's conspiring against you to become.. effective again. (DP31)*

The relationship between establishing control and taking medication could be conceptualised in different ways. Like DP31, DP07 emphasised his reluctance to become dependent on medication (and, indeed, on anything else):-

> *I think one can go to a psychoanalyst for years and years and even be dependent. In fact, I have a problem with this possibility of being dependent on anything, so that's why my resistance until now to have medication, or with taking Viagra, or with the sleeping pill .. So I want to be able to feel that I'm more independent and more in control of my own feelings (DP07)*

Decisions about <u>taking</u> medication – as well as <u>resisting</u> medication – could also be justified by referring to the concept of control. For example, DP13 suggested that taking lithium had helped him to regain control over depression.

> *I found myself going into a depression, so I got back on the Lithium ...… it gave me a feeling that I've got some control now of this thing. (DP13)*

Other men drew on imagery associated with heroes and battles in their narratives. DP10 described conceptualising his illness as an entity that could be fought in order to 'pull' himself out of depression. His description of depression as an opponent and the emphasis on strength, anger and control draw on qualities associated with traditional masculinity:-

> *.. you've ..got to sort of reach down and.. somehow find the strength deep down to start putting it into motion. It's really weird. I got really, really angry at the depression. … it was as if I was treating it as a person now.. I just thought to myself 'No, you are just not going to do this to me. You know, you are not going to have this control that you've had over me for the last two years. .. I'm going to, you know, pull myself out of this'. (DP10)*

DP07 used similar imagery when he conceptualised depression as an ordeal from which the hero emerges a stronger man: 'no pain, no gain'. This construction is important because of the way that a potentially feminising condition is reinterpreted in a way that is consistent with hegemonic masculinity:-

> *I don't think depression is at all, or fully, a bad thing or a bad process to go through because, as I say, I come out very strong … I think it's through suffering.. no pain, no gain (DP07)*

Some men saw suicide as a potential means of establishing control. DP38 suggested that contemplating suicide as a teenager had given him a feeling of power when the relationship with his violent father spiralled 'out of control':-

> *I realised that.. something was out of control. Having had a difficult relationship with my, my father which, you know was managed at a certain level of discomfort…I found myself standing at the top of a tower block thinking 'this doesn't work, I've had enough, I want to stop'.. and there was no language to describe it… it was just really clear. Enough. It was very extreme. I don't know why I didn't actually jump off, I just didn't. And came home with just a different level of seething resentment and hatred which actually made me feel very powerful because I realised I'd gone through something. (DP38)*

Similarly, DP05 described the strength and comfort he derived from an internet discussion group for depressed people contemplating suicide. His powerful account concluded with the realisation that having the option of suicide gave him a sense of control:-

I must admit a lot of depression is about .. lack of control of yourself, and lack of control of, of your thoughts. But at least to have control over whether you kill yourself or not, it's sort of the last thing that you've got control over, and to take away that feeling of control.. really it's the last crutch which is holding you up. . I hear people talking about suicide, it was a cry for help, it was, you know, it was cowardice or whatever. No - it was a positive step. It's the best thing that you feel that you can possibly do at the time. (DP05)

Responsibility to others

A number of men referred to the important role that their family had played when they had been feeling suicidal. All of the men who had experienced serious suicidal thoughts (but had not gone on to make suicide attempts) discussed how thoughts of their relatives' grief, or responsibility to their family, had acted as a deterrent. As a teenager DP23 felt he could not commit suicide because of feelings of responsibility for his widowed mother, while DP10's thoughts of his family and friends at his funeral deterred him:-

I had this life which was at home quite happy, but which at school was really a nightmare….. We had a gas cooker in those days and I used to think it would be so easy to stick my head in it.. I thought 'well I can't do that to my mother, you know, because my mother needs me. I can't do that to her'. So I felt this sort of feeling of responsibility. (DP23)

I actually had this image of my best friend and of my folks actually at my funeral crying. And I just thought, you know, 'I can't do it because of them'. (DP10)

In contrast, thoughts about their family had played a part in decision-making for two men who had attempted suicide. Like the men quoted above, their over-riding concern was the happiness of their families. However, in the depths of their depression, these men believed that their families would be better off without them:-

I was convinced that .. my wife, and sons would be far, far happier without me. I remember writing notes to each of them.. and it was perfectly lucid in my mind… that I was doing the best thing. (DP01)

It started becoming more and more frequent thoughts of suicide ..active thoughts of suicide .. you know, the reason why.. I was unhappy was that my family was unhappy. And the reason they were unhappy was me. And if I wasn't there.. they would be happy. (DP05)

DP05 also expressed some ambivalence about whether his roles as a husband, father and provider helped, or hindered, his recovery from depression. At first, he suggested

that these social roles were positive as they provided some structure in this life at a time when this had been all but disrupted by his depression. However, later in the interview he suggested that these responsibilities also delayed his recovery:-

> *I think. what I needed was for the worry and the responsibilities to be taken away. .. when I'd started getting seriously depressed, if I could have taken out six months to go and lie on a beach and not have any worries, and not have any responsibilities, and for the bills to be taken care of, and for the children to be fed, I think I would have got a lot better a lot quicker. (DP05)*

While the support of partners and feelings of responsibility to relatives could help respondents recover from depression and resist suicidal urges, pressures associated with gendered social roles could work in the opposite manner to complicate, delay or prevent recovery.

WHO WANTS TO BE NORMAL ANYWAY? CONSTRUCTING 'DIFFERENCE' AS ADVANTAGEOUS

A minority of respondents redefined their 'difference' from others as a positive rather than as a negative feature of their identity. These men emphasised the value of their difference from, and sometimes even their superiority to, others. While they sometimes drew on the narratives associated with re-establishing control and responsibilities to others described above, they did not want to be like everybody else. Indeed, the strategy of viewing oneself as set apart from others is diametrically opposed to aspiring to be 'one of the boys'.

Depression as increased sensitivity and intelligence

One way in which these respondents emphasised their difference from others was to compare themselves to real or fictional characters with varying claims to hegemonic masculinity. DP01 compared himself to two strong men who suffered from depression: Churchill (Britain's prime minister during World War II) and Hemingway (an American author renowned for his drinking and womanising who eventually committed suicide). DP09 used Marvin the Paranoid Android as a role model (a depressed robot from Douglas Adams' novel 'The Hitchhiker's Guide to the Galaxy' who despises everyone and has 'a brain the size of a planet'). These comparisons draw on the notion that men who suffer from depression have other qualities, such as more intelligence or emotional sensitivity, than those who do not. DP09's rather

subversive statement - “I didn’t really want to be normal, in many ways” - was a theme taken up by other men in this group:-

> *But this (depression) is sort of imponderable… I learned to use it to my benefit .. and then I flattered myself I wasn’t the only clever one. Churchill had it, Ernest Hemingway had it. (DP01)*

> *I had a few Marvin the Paranoid Android routines worked out.. it was the closest thing to a role model I had really. .. I was compensating for lack of social skills by being eccentric deliberately. I didn’t really want to be normal, in many ways… I went to a (self-help) group in ’95, and it was quite nice realising that these people did suffer from depression and yet they were very intelligent and sensitive people. (DP09)*

Depression as heightened masculinity

Even male sexual problems could be incorporated into narratives which emphasised difference in a way that was compatible with masculinity. Gurevich et al (2004) reported similar findings in their study of testicular cancer. Some of their respondents constructed their masculinity as accentuated rather than threatened by cancer, arguing that their sex life had improved in some ways and that they felt “more of a man” because of the experiences they had been through. In our study, two married men in their thirties discussed delayed ejaculation - a side effect from their anti-depressant medication - and compared themselves jokingly to ‘porn stars’ because of their ability to ‘keep going for hours’:-

> *I believe the technical terms is delayed ejaculation ..Well I could (ejaculate) but it took me, you know, I’d be a hell of a porn star because I’d keep going for hours (laughs) yeah . (DP05)*

> *With Seroxat the first thing I noticed was, (laughs) this is a bit embarrassing, but I couldn't ejaculate… And it's kind of a weird… you feel like a sort of porn star, you can go for hours you know (laughs) (DP04)*

Resisting hegemonic masculinity

DP07 and DP38 were particularly adroit at constructing difference as advantage. Both men were gay and from ethnic minority groups. They drew on their sense of being ‘other’ in order to incorporate depression as just another ‘difference’ in their identities. Their distance from majority culture allowed them both to reflect and comment on different styles of communication and attitudes to mental health. DP07 believed that Brazilian culture dealt with emotions and mental illness more openly than English culture. His reference to the alleged mental health concerns surrounding

the footballer David Beckham at the time of interview was used to reject the notion that depression "is an illness for women or ..for weaker people":-

> *I think mental illness in England you still have the kind of stigma, but I deal with this much better I think, because in Brazilian culture I grew up with people seeing psychoanalysts and having nervous breakdowns . I think even Beckham.. it was in the newspaper that he had or was about to have a nervous breakdown last year.. and I said, "oh good," ...because it breaks this assumption that depression is an illness for women or illness for weaker people. (DP07)*

DP38 was highly articulate about his sense of difference and described himself as 'culturally bilingual'. His strategy to cope with being a working class black child in a white middle class school in England had been to over-achieve. However, at the age of 30 he decided he was "not prepared to play the game" of assimilation to make others feel comfortable. At over 6 feet tall, he was well aware of the way black men can be constructed as hyper-masculine, over-sexed and a physical threat. His defiant statement – "I don't move with the pack at all' –points to an identity constructed on the margins, specifically around his differences as a black male interested in art and other men:-

> *I really fashion myself as not belonging anywhere.. I don't move with the pack at all. My way of being out there is more to do with being gay than being black really … some people have asked me do I feel doubly burdened by being a member of two .. from time to time despised minorities and I don't actually feel, see it as double burden. By the time I was really getting conscious of being gay a lot of my experiences around being black had worked like some kind of rough dress rehearsal… I'd got a lot of experience of being different and learning how to survive in spaces where you are not supposed to be (DP38)*

This emphasis on difference allowed some respondents to discuss changes in themselves that many men would perhaps find uncomfortable within the constraints of traditional masculine discourse. Some discussed how they had become more creative through writing, crafts and art, and perceived themselves to be more understanding and compassionate towards themselves and others as a result of depression. For example, DP01 discussed how the strength he gained from depression helped him to care for his wife through her terminal illness:-

> *When my wife was ill, she wanted to die at home. And that was difficult to say the very least… But this experience of mental illness seemed to give me a great deal of strength. I would cry, and I would go off into the kitchen, and cry. And then my*

wife would say, "You've been crying, if you're going to cry, you come in here, we'll both cry in here together." So it brought us very close ..(DP01)

Finally, DP04 explicitly referred to different models of masculinity in his thoughtful description of how his gender identity had changed through depression and therapy. He was able to acknowledge his vulnerability while also retaining a valued sense of masculinity through his search for 'a kind of middle ground' between being macho and a 'wet bugger':-

I think it sort of depends on what your models of masculinity are. I mean I think one of the problems is that you sort of lack a kind of middle ground between being kind of really macho and emotionless and kind of tough… And then the other thing you don't want to be is a kind of wet bugger.. I went to a boys' school it was pretty rough (laughs).. it wasn't the kind of place you admitted vulnerability, and I suppose that's what going to therapy is about. (DP04)

DISCUSSION

It is perhaps not surprising that so few studies have set out to explore men's experiences of depression and that even fewer have conducted an explicitly gendered analysis of their data. Even qualitative studies on conditions such as coronary heart disease, still considered by many to be a 'male disease', rarely consider the influence of masculinities on men's illness and recovery (Emslie, 2005; Emslie, Hunt, & Watt, 2001). Our study is thus unusual. Our results suggest that it is important for men with depression to reconstruct a valued sense of themselves and their own masculinity as part of their recovery. Respondents used varied and creative strategies to try to rebuild this valued sense of masculinity. Many drew on values associated with hegemonic masculinity. For example, rather than seeing depression as making one powerless, some men conceptualised it as an heroic struggle from which they emerged a stronger person. While this could be a positive way of reaffirming masculinity, some aspects of hegemonic masculinity could be health-damaging, and even push men towards contemplating suicidal behaviour. In contrast, a minority of men constructed a narrative based around 'difference'. These men explicitly reflected on different models of masculinity and ways of being masculine which were outside hegemonic discourses. These different strategies were part of a constantly changing life-long project. It is impossible to separate out whether feelings of 'difference'

(often influenced by practices associated with dominant masculinity such as name calling and ridiculing of behaviours perceived as feminine) are a consequence of, or a contributing factor in, depression.

Our research demonstrates that (some) men (at some times) can and will talk about depression; thus, generalisations about depressed men demonstrating strength through silence can be misleading. Oliffe (2005) found similar results when interviewing men about another potentially emasculating condition: impotence after prostate cancer. They found that, in the right circumstances, men were willing to talk about their emotional and physical experiences and so questioned the "much cited stoicism" that is assumed to stop men from talking, or being talked to, about sensitive subjects (p.9). It is also important not to assume that all of the strategies described here are unique to men. Some women with depression also see taking anti-depressant medication as a loss of control and perceive themselves as gaining strength through depression (Karp, 1996; Maxwell, 2005; Schreiber, 1996). However, the meanings of aligning oneself with, or distancing oneself from, culturally dominant forms of gender are likely to be very different for women and men. Werner et al (2004) found that women with chronic pain distanced themselves from "the stereotypical medical discourse of the crazy, lazy, illness-fixed or weak women" in order to convince others about the credibility of their pain (p.1035). This calculated separation from (devalued) norms of femininity is very different from the way in which some men distanced themselves from norms of hegemonic masculinity in our study.

It could be argued that our sample consisted of an unusual group of men with depression who were willing (and well enough) to volunteer to be audio-recorded or filmed for a website and so make their story public. However, respondents were given the option to safeguard their identity, and around half chose to do this. It is not the case that these men were at the 'mild' end of the spectrum of depression, given the numbers which had experienced hospitalisation, serious suicidal thoughts or had attempted to commit suicide. Finally, it is true that we are likely to have missed the truly 'strong and silent' depressed men (O'Brien et al, 2005) but it is difficult to see how we could have accessed and interviewed this group. Indeed, 'strong and silent' men (and women) are likely to be under-represented in qualitative studies of illness.

Although suicide was not an original focus of our study, more than half of the sample had experienced serious suicidal thoughts or had attempted to commit suicide. Our research shows the complex nature of some 'masculine' attributes. For example, while responsibility to others had stopped some men with serious suicidal thoughts from acting on these feelings, beliefs that family members would be 'better off without them' had contributed to suicidal thinking. Canetto (1997) argues that nonfatal suicidal behaviour is associated with femininity whereas suicide is associated with masculinity. Thus, surviving a suicide attempt is perceived as particularly inappropriate behaviour for males. She suggests that suicide prevention programme should explicitly address beliefs about gender and suicidal behaviour and reduce the stigma of surviving a suicidal act.

Similarly, Kilmartin (2005) argues that health professionals should teach men with depression about the importance of gender in order to help them "resist the cultural pressure to be masculine when it conflicts with life goals" (p.97). He suggests building on positive masculine qualities such as courage (emphasising that it is brave to take risks by expressing feelings and challenging culturally dominant definitions of masculinity) and leadership (through showing other men more effective ways of dealing with emotional lives). This is a useful suggestion and our empirical research suggests some men will have the resources (and the desire) to construct identities that not only resist culturally dominant definitions of masculinity, but also point to other ways of being male. However, the power of hegemonic masculinity means that many men are likely to re-interpret potentially feminising experiences as 'masculine' and health professionals need to be aware of the problems, as well of the benefits, of narratives which emphasise control, strength and responsibility to others.

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Table 1 Characteristics of respondents

ID number	Age	Website representation[1]	Type of depression	Occupation	Relationship status	Children
DP01	75	Video	Bipolar	Retired brewer	Widower	2 (>18)
DP03	66	Actor	Unipolar	Retired civil servant	Married	2 (>18)
DP04	31	Actor	Unipolar	Teacher	Married	No
DP05	33	Actor	Bipolar	IT	Married	2 (< 18)
DP07	45	Written	Unipolar	Planner	Partner (male)	No
DP09	35	Actor	Unipolar	IT	Single	No
DP10	30	Written	Unipolar	Tourism	Single	No
DP13	69	Video	Bipolar	Retired gardener	Single	No
DP14	73	Video	Unipolar	Retired electrician	Married	2 (>18)
DP16	40	Video	Unipolar	Higher Education	Partner (male)	No
DP17	35	Video	Unipolar	Unemployed	Single	No
DP23	50	Video	Unipolar	Higher Education	Single	No
DP31	55	Video	Bipolar	Higher Education	Partner (female)	2 (>18)
DP33	39	Written	Unipolar	Admin assistant	Single	No
DP36	37	Actor	Bipolar	Piano teacher	Single	No
DP38	45	Written	Unipolar	Artist	Partner (male)	No

1. Respondents chose whether to let visitors to the website see extracts from their video interview, see actors speaking their words, or access text extracts from their interview.