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1
Men, Depression and Discourse Analysis

... where no man can go at all

We, men, are under constant pressure to prove our masculinity. The exploits of the heroes of the popular TV or cinema, together with their divine six-packs, bulging biceps, square jaws and hair in all the right places are quite enough to make you feel green with envy and inadequate. If this were not enough, the good guys, just like us, really, always succeed in whatever they put their minds to. They never crack under pressure, always find this last-minute solution to save the day and are able to get on the high horse and ride into the sunset with a woman of their dreams, who could not only win the Miss Universe competition hands down but has, if need be, an IQ of 250. But the charge *to boldly go where no man has gone before* sometimes appears so very very difficult. For in 'real life' men do crack under pressure, life hurts them, they do feel sad, powerless, helpless. They come up nowhere near to the ideal set by the society of what it is to be a man.

This book is about such men. It is about men who feel and are unable to satisfy the Western requirement that men be active, enterprising, always tough and powerful. I want to write about experiences of men who are powerless and weak, men who somehow cannot 'get a grip' despite just about everybody around expecting them to. This is a book about men in depression. I am interested in exploring what it means for them to have an illness which undermines the very core of what it means to be a man. The overarching argument I shall develop is that the experience of what psychiatry calls depression is intrinsically linked to gender and thus masculinity. There is no depression outside being a man (or woman for that matter). I shall argue that this might have profound consequences both for the psychopathology of depression and its therapy.

Proposing that the experience of depression is gendered, I shall focus on two lines of argument. First, I am interested in how men position themselves in relation to their illness. What does it mean to be depressed, how does depression relate to their selves, their biography, their life? Thus, I am interested in the lived version of depression and its experience. Second, I shall explore the relationship between illness experience and masculinity. I am interested in men's positioning with regard to depression, the dominant model of masculinity and their families. What does it mean to be a depressed man, what does depression do to masculinity?

Beforehand, however, I need to clarify my 'starting points', the assumptions I shall be making with reference to four major research issues. Thus in what follows, I shall briefly review the current psychiatric thinking on depression and its experience, and I shall position my considerations in relation to debates on gender and masculinity. I shall then discuss literature on masculinity, health and depression in particular. I shall finish by laying down my approach to discourse analysis, and suggest how it might be useful in the exploration of mental illness.

Depression

As one might expect, there is vast literature on diagnosis, course, prognosis, therapy and aetiology of depression, or, as psychiatry would have it, the depressive episode (coded by the World Health Organisation as F32 for a single episode and F33 for a recurring one), and impossible to review here. A summary of psychiatric thinking on depression is offered by the National Institute of Clinical Excellence (NICE), the United Kingdom's watchdog of clinical practice. NICE (2004) says that depression is a wide spectrum of mental health problems characterised by lack of positive affect, such as lack of enjoyment or interest in ordinary things or experiences. Although the institute does acknowledge that distinguishing between 'normal' sadness and depression remains problematic, it is the additional symptoms that help make the distinction. Importantly, however, the low mood is typically unreactive to circumstance.

This is a narrative summary of the diagnostic criteria offered by the World Health Organisation's International Classification of Diseases (ICD) (WHO, 1993). The ICD constructs depression in terms of three diagnostic criteria, two of which must be present:

1 depressed mood to a degree that is definitely abnormal for the individual, present for most of the day and almost every day, largely uninfluenced by circumstance, and sustained for at least 2 weeks;

2 loss of interest or pleasure in activities that are normally pleasurable;
3 decreased energy or increased fatigability.

Depression is classified into three degrees of intensity. In the mild episode there 'should' be one or more symptoms present from the additional ones, giving a total number of symptoms of at least four; in the moderate episode, at least six; in the severe one, at least eight. Those additional symptoms include loss of confidence, unreasonable feelings of self-reproach, recurrent thoughts of suicide, excessive or inappropriate guilt, indecisiveness.

The World Health Organisation states that depression affects 121 million people worldwide, is the fourth leading contributor to the global burden of disease in 2000 (second for people between the ages of 15 and 44) and is projected to be second by the year 2020 for all ages and both sexes.[1] Papakostas and associates (2004) add that depression was shown to account for a 23-fold increase in social disability and 5-fold increase in short-term work-disability. In 1994, about 51 million Americans aged 18 years and older were diagnosed with some form of mental illness of which just under half were 'mood disorders' (especially depression) (LeDoux, 1998). A survey of six European countries reported that 17 per cent of the population had experienced depression in the previous six months (Lepine *et al.*, 1997); yet, Paykel and associates (2005) give an even higher estimate of 32 per cent for women and 17 per cent for men. Over a longer duration, 10 per cent of the US population had experienced major depression in the past year and between 20 and 25 per cent of women and 7 and 12 per cent of men will suffer from clinical depression in a lifetime (Segal *et al.*, 2002).

Depression as cultural

However, within psychiatry itself there is a significant opposition both to the psychopathological nosology (see Chapter 2) and to the notions of depression as a mental disorder. It is quite uncontroversial to say that psychiatric categories are not natural kinds (e.g. Kirmayer, 2005; Zachar, 2000; also Cooper, 2004). In other words, they do not refer to diseases that naturally occur in the world, but they are practical categories which help describe and deal with distress. In this sense the two main psychiatric diagnostic manuals are public policies (Sadler, 2005b). Moreover, given the perennial problems with what constitutes normality, the decision whether a condition is a mental disorder is partly a value judgement (Barilan and Weintraub, 2001; Cooper, 2004; Fulford, 1989), underpinned by the personal values and expectations of the individual

clinician (Corin, 1996). In addition, the currently dominant biological thinking of depression (i.e. suggesting that depression is caused by a chemical imbalance in the brain, and particularly decreased levels of serotonin) is just one of the options, and, as history of the disease and its various types coming into or out fashion (McPherson and Armstrong, 2006) shows, there is no reason to believe that it is the 'ultimate' in understanding depression.

Yet, the diagnostic criteria which are to capture mental distress in all people in all situations are challenged much further. Much criticism has been made of the progressive loss of lay conceptualisations of distress in favour of biological models (e.g. Fabrega, 1996; Kleinman, 1995, 1988b; Miller, 2005) and lack of inclusion of the patient's perspective (e.g. Mezzich, 1999; Schmolke, 1999), normally coupled with postulates for inclusion of the social sciences in nosological considerations (e.g. Fabrega, 2005; Lewis, 2000).

Jenkins and Kleinman (1991) stress that all psychopathological considerations, including those of threshold and duration of what counts as a disorder, are ultimately grounded in culturally specific and locally defined judgements about what constitutes abnormal behaviour. Pilgrim and Bentall (1999) second this, pointing out that dominant discourses of psychopathology assume mental illness to be trans-historical and trans-cultural, while the clinician operates in an atypical social setting, having a superior epistemological status, as he/she is equipped with the 'warranting voice' (Gergen, 1989) of the dominant discourse. And yet, this clinician must refer to the lay account of distress in order to make his/her judgement, an account which is inherently indeterminate (Jenkins and Kleinman, 1991)!

There are also critiques which challenge the notion of depression itself. This line of criticism is associated particularly with Kleinman (1986; also Kleinman and Good, 1985), whose research undermined depression as a biological condition showing its social origins. Lutz (1985) points out that judgements referring to it are grounded in the wider beliefs, knowledges and attitudes towards emotions which themselves are cultural constructs (on social constructionist approach to emotions; e.g. Harré, 1986; Harré and Parrot, 1996; Harré and Stearns, 1995; Lupton, 1998). It is the insistence that normality involves positive affect which is at the core of the notion of depression, and the lack of the 'pursuit of happiness' is deemed particularly deviant (Lutz, 1985). Moreover, Kleinman (1996) points out that most research on depression is carried out on those in psychiatric treatment – a self-selected minority of people who decided to seek professional help, not necessarily because of sadness.

As cultural and social expectations place different emphases upon different emotional states and their intensities (Manson, 1996; also Falicov, 2003; Schieffelin, 1985), depression, whatever it might be, happens in the social context in which the distressed person is submerged. This might be the macro-context of not only, say, social class (Blair, 1993) or gender roles (Crowe, 2002), but also the particular situation in which he/she is in. People's decisions as to whether they are ill or not are socially situated and based both on considerations of the local context in which they operate and on their expectations of themselves and those that others are perceived to have of them (Radley, 1994; Radley and Billig, 1996). In this view, depression is nowhere near a 'medical condition', but a social condition underpinned by a variety of discourses outside psychiatry (Fee, 2000b) and resulting from complex decision processes happening well before a formal diagnosis can be made (see also Keys, 1985), during which, incidentally, most of this 'personal' aspect of depression will have disappeared (Casey and Long, 2003; Rowe, 1978).

Such debates are an important context in which depression should be seen. Whether biological or not, depression is also social. And even though the men I interviewed were all psychiatrically diagnosed to have a depressive episode, this in fact does not guarantee consistency or even similarity of their experience (see e.g. Kirk and Hsieh, 2004; Kirk and Kutchins, 1988). Yet, I am interested in those experiences that made them seek psychiatric help and which psychiatry calls the depressive episode. Moreover, they all shared the need to seek psychiatric help and had to deal with the problems and stigmas associated with a (particular) psychiatric diagnosis and psychiatric treatment. More importantly, I am going to juxtapose my informants' experiences with the diagnostic pronouncements. I shall show their 'lived translation' into narratives of depression. In this way I shall attempt to juxtapose the discourses of psychiatry with those of lived experience of mental distress.

Gender and masculinity

I have discussed the issues of gender and masculinity in my earlier work (Galasiński, 2004), and here I would like to offer a summary of where I stand with regard to issues of gender and masculinity. Most importantly, I take an anti-essentialist view of gender identity, thinking of it not so much as a fixed state, but, rather, a process of becoming.

Connell (2002, also 2000) proposes that gender is a social structure within which the society handles the human body and it is within such a social structure that people construct themselves as men or women.

Starting from the act of gender endowment – 'It's a boy' – a human subject is put into a regulatory frame within which he performs masculinity (Butler, 1990), or it is performed for him, especially at the beginning of his life (McIlvenny, 2002a). Masculinity is achieved in situated conduct (West and Zimmerman, 1987; see also Cameron, 1997; McIlvenny, 2002b). Changing perspective, Morgan (1992) proposes that masculinity is something that is done (see also Whitehead, 2002); Brittan (1989) adds that masculinities are always local and subject to change (for a review of definitions of masculinity, see Connell, 1995; also Clatterbaugh, 1997).

This is the first understanding of masculinity I subscribe to. It is an accomplishment in the local situation, a gender identity, always provisional, always subject to change (e.g. Barker and Galasiński, 2001; Kerfoot, 2001). The other is related to social representation. Ochs (1992) proposes that masculinity refers to patterns of behaviour that become associated with being male or female (also Edley, 2001; Tannen, 1999). They are social constructs reducing masculinity to biology, or some non-negotiable identity core, underpinned by perceptions of biologically based 'sex categories' (West and Zimmerman, 1987). In other words, these are ideologies of men and masculinity, idealisations which can be aspired to as much by men as by women (Bordo, 1997). In this understanding, masculinity has little to do with the locally constructed masculine identities, even though it might, of course, act as a regulatory frame in which social actors construct themselves. Such ideologies are constructed by both individual and public discourses, with various social and communicative purposes, with various audiences. They are unlikely to be homogenous and without contradictions (e.g. Chapman, 1988; Edwards, 1997; Rutherford, 1988). In this sense, of course, one can speak of a number of masculinities coming into interaction with such social factors as historical location, age and physique, sexual orientation, education, status and lifestyle, geography, ethnicity, religion and beliefs, class and occupation, culture and subculture (Beynon, 2002: 10). But one could also add disability, illness, military service, imprisonment, trauma, political system and probably a number of other, more micro-scale, contexts (Galasiński, 2004).

In my earlier work (Galasiński, 2004), I rejected the notion of masculinity as a set of practices, social (Barrett, 2001; Pujolar, 2000; Walker, 1994; Whitehead and Barrett, 2001a) or linguistic (Coates, 1997, 1999; Lakoff, 1973; Mulac *et al.*, 2001; Tannen, 1998; for critique, see Talbot *et al.*, 2003). There is no need to repeat the argument here, so let me just say that as analysts, we shall be able to observe certain patterns in social or linguistic behaviour, constructions of identities and the like.

Men do make use of such discourses, practices which they associate with masculinity – this is indeed why we normally would expect men to be dressed in particular clothes, in a particular way. My argument, however, is that while people speak 'the way one speaks', that people dress 'the way one dresses', it does not mean that such practices are linked to masculinity in some sort of essential way.

To sum up, I view masculinity in two dimensions. On the one hand, it is to do with the locally negotiated identities, always provisional, always in a state of flux. It is men's performance of being a man, always done anew, always in a particular local context. Unless they are playing, I think women cannot perform masculinity in this sense, inasmuch as men cannot perform femininity. On the other hand, masculinity is a social construct, a gender ideology, a society's way of associating certain practices with gender. Here masculinity can be seen as a configuration of social practices, but these practices are not there to be read off what men say or do, they are mediated by the society's ideological constructs.

Men and health

There is a consensus in the literature on health and gender that in the developed world men do not fare very well with regard to their health. They not only die significantly younger than women, but more men die of the leading causes of death than women; they also commit considerably more suicides (Cochran and Rabinowitz, 2000). Men are considerably more likely to engage in risk-taking behaviours (Bennett and Bauman, 2000; Fong *et al.*, 2001) and are less likely to report illness (Addis and Mahalik, 2003; Galdas *et al.*, 2005), both facts having significant impact upon their health outcomes. Verbrugge (1989) points out that while women's morbidity tends to be limited to less serious conditions, men have higher prevalence of such fatal conditions as heart disease or arteriosclerosis. Needless to say, men perceive their health as good also more frequently than women (Hearn and Kolga, 2006).

The statistics offered in the literature are quite frightening, if you are a man. A few facts given by Courtenay (2000) make the point forcefully. He states that men in the United States not only suffer from more severe chronic conditions, but they have higher death rates for all 15 leading causes of death. Men's age-adjusted death rate for heart disease is twice higher than women's, with 75 per cent of those dying of the disease before the age of 65 being men. Men account for higher incidence of seven out of ten most common infectious diseases. In addition, men receive significantly less time from their doctors than women and are provided with briefer explanations (Weisman and Teitelbaum, 1989); they also receive

less advice (Friedman *et al.*, 1994). Roter and Hall (1997) have stated that it has never been found that women receive less information from their doctors than men. This can be juxtaposed with findings that men's use of health services is perceived within the dominant discourses of masculinity, with women constructed as responsible for men's health (Lyons and Willott, 1999; Seymour-Smith *et al.*, 2002).

The Gender Equity Project report (Men's Health Forum, 2006) in the United Kingdom says that men are significantly more likely to be overweight and consequently suffer from co-morbidities of overweight and obesity. They are also twice as likely as women to die from the ten most common cancers affecting both sexes. Also in childhood boys do not fare very well (with some evidence that higher men's mortality starts prenatally, Bräher and Maier, 2001). Sixty per cent of all sudden deaths in the United Kingdom occur in boys. Boys are twice as likely to be killed in pedestrian accidents (Men's Health Forum, 2006).

Although the Social Focus on Men report (Mill *et al.*, 2001) proposes that British men's mental health is better than women's, the United Kingdom's Commission for Healthcare Audit and Inspection report, *Count Me In* (2007), shows that significantly more men are admitted to hospitals than women (5:4 ratio), with the ratio rising to approximately 4:1 when referrals via criminal justice routes are considered. About twice as many men as women were noted with learning disabilities (ibid.). While it is frequently recognised that men's health is under-researched (e.g. Hearn and Kolga, 2006), especially in its social aspect (Lee and Owens, 2002), men's mental health is lagging even further behind (Robbins, 2004). Indeed, notably, a recent overview of men's health (Sabo, 2005; see also Connell, 2000) does not discuss men's mental health problems. Still, Singleton and her associates (2000) show that although more women in the United Kingdom suffer from neurotic disorders (including anxiety, depressive, obsessive-compulsive and panic disorders), more men are diagnosed with personality disorders, substance abuse and psychotic disorders. It must be noted, however, that men are regarded as consistently underreporting psychosocial problems (Möller-Leimkühler, 2002; O'Brien *et al.*, 2005). Almost twice as many mentally ill men as women (28 per cent compared with 15 per cent women) were classified as enduring severe lack of social support (O'Brien *et al.*, 2002).

More generally, Pilgrim and Rogers (1999) comment that while female mental health problems are likely to be treated by 'soft' psychiatry, those of men are treated by its 'harsh' end. They also point out (Rogers and Pilgrim, 2003) that there are very few discussions focusing specifically

upon men's mental health, while the focus upon female mental health results in underestimating both the content and prevalence of psychiatric problems in men.

Even though this state of affairs is recognised as in need of much more research (Galdas *et al.*, 2005), mostly it is explained by the dominant ideology of masculinity in which males are socialised. As New (2001) argues persuasively, men can be victims of the very gender order that gives them privilege (see also Emslie, 2005; Sabo and Gordon, 1995). The stereotype of the tough male who does not succumb to difficulties, including those of his health, is thought to prevent men from accessing health services (White, 2001). Indeed, there is consensus in the literature on masculinity that it is socially linked to action and particularly to employment (Willis, 2000; Willott and Griffin, 1996, 1997; also Hood, 1993; Mattinson, 1988). Illness cannot and does not feature in such a model and a healthy male identity equals a strong one (Riska, 2004). Indeed, Pollack (1998) reports that men are more likely to deny depression as they fear it would jeopardise their self-image. In a nutshell, there is some consensus that at least part of men's price for their more powerful position in the society is their poor health (also Courtenay, 2000; Rosenfeld and Faircloth, 2006), with medical services reinforcing the model and demedicalising male behaviour (Riska, 2002, 2004). Evidence from research into men's experiences of illness suggests that at least some illnesses are seen as challenging masculinity. And while it might be expected in the case of impotence (Oliffe, 2005), testicular cancer (Gurevich *et al.*, 2004) or prostate cancer (Chapple and Ziebland, 2002; Oliffe, 2006), it is perhaps less obvious in the case of depression, which is often experienced as unmasculine (e.g. Brownhill *et al.*, 2005; Warren, 1983; see also below). Indeed, Levant (1996) proposes that a new framework for a psychological approach to men should question the traditional norms of the male role (also Miller and Bell, 1996; White, 2002).

Both research and medical practice still face the problem of men's invisibility. There is of course significant literature recognising men as gendered subjects with regard to health (e.g. Courtenay and Keeling, 2001; Hearn and Pringle, 2006b); yet, recognising men as partaking of gender structures is still more a postulate rather than a fact taken for granted (e.g. Gutmann, 1997; Schofield *et al.*, 2000). Moreover, Annandale and Clark (1996) argue that by subscribing to the cultural notions of men's strength, researchers and other health professionals contributed to the 'invisibility' of men's poor health. Nicholson and associates (1999) showed that clinicians felt more confident in their information about mothers rather than fathers; men's emotional distress after pregnancy

loss was reported to be ignored (McCreight, 2004). Szymczak and Conrad (2006) demonstrate how age and disengagement from traditional masculine roles contributed to older men's concerns being ignored. This view of men and masculinity is exacerbated by the common (but questionable, see Galasiński, 2004) assumption that men are unable to speak of their experiences (Pinnock *et al.*, 1998) and particularly their emotions (Grossman and Wood, 1993; Heesacker *et al.*, 1999). Indeed, there is a sizeable literature which takes the alleged men's lack of emotionality at the level of mere assumption (e.g. Clare, 2001; Horrocks, 1994; Middleton, 1992; Seidler, 1994). Some researchers choose to medicalise the alleged male inability to be in touch with their emotions and talk about men in terms of 'alexithymia' (e.g. Honkalampi *et al.*, 2000; Levant, 1998).

Men and depression

Although it is commonly stated that incidence of depression in women is up to twice as high as in men (for British data, see Mill *et al.*, 2001; for discussion of US and international data, see Cochran and Rabinowitz, 2000; see also Singleton *et al.*, 2001), Rogers and Pilgrim (2003) remind us that the picture is different when gender categories are unpicked. Unmarried men, for example, are over-represented in the prevalence of depression (ibid.). There is also consensus that depression in men is often undiagnosed and untreated (although some researchers point out that it might concern depression in general, Higgs, 1999). Pollack (1998) states that 65 per cent of verified depression in men was undetected and undiagnosed (also Aneshensel *et al.*, 1987; Angst and Dobler-Mikola, 1984; Potts *et al.*, 1991). Moreover, while Real (1998) says that the rise in depression rates is greater amongst men, it is accepted that male drug and alcohol abuse, gambling, sex addiction and so forth can be understood as forms of behaviour that act as a defence against overt depression (Busfield, 1996; Giddens, 1991; Real, 1998).

Finally, if depression underlies more than half of suicides (Möller-Leimkühler, 2003), men's significantly higher suicide rate might also be a factor in the lower prevalence of depression among men (e.g. Johnstone, 2000; Rogers and Pilgrim, 2003). Thus in the United States, three out of every four suicides are committed by white men (Moscicki, 1997), with older men (over 75) committing 15 times more suicides than women of the same age (Kennedy *et al.*, 1995). Although, at various rates (in the United Kingdom 'only' three times as many men commit suicides than women; ONS, 2007), men commit more suicides in practically all countries (Hawton, 2000). In view of such data, one must see claims that

the lower prevalence of depression in men has something to do with men having fewer 'real-life problems' with astonishment (for a critical discussion, see Prior, 1999).

Despite that, calls for gender-sensitive assessment of depression (Cochran, 2006; Cochran and Rabinowitz, 2003; Kilmartin, 2005) are largely unheeded. For the most part, the existing literature takes up men's depression in studies of gender differences in which gender is mostly associated with biological sex, one of the demographics which informants are asked to provide. Depending on one's stance, one can find both literature arguing that men's and women's depression does differ from each other (e.g. Hänninen and Aro, 1996; Möller-Leimkühler *et al*., 2004; Rutz *et al*., 1997; Winkler *et al*., 2004; also Pollack, 1988; for review, see Winkler *et al*., 2005) or that it does not (e.g. Klose and Jacobi, 2004; Nolen-Hoeksema, 2001; Vedel Keesing, 2005). It must be said, however, that the studies do not necessarily have to be mutually exclusive, as researchers focus on core or other symptoms, or simply focus on gender differences in filling out particular instruments (e.g. Hammen and Padesky, 1977; Steer *et al*., 1989).

More generally, there is a tendency within social and critical approaches to psychiatry and mental illness (e.g. Busfield, 1996; Johnstone, 2000) and depression in particular (e.g. Stoppard, 2000; Stoppard and McMullen, 2003), as well as in more mainstream psychological and psychiatric work on depression (e.g. Brown and Harris, 1978; Kennedy *et al*., 2004), to focus (explicitly or implicitly) upon women's mental health problems. In fact, I am aware of only one academic book-length monograph devoted to men's depression (Cochran and Rabinowitz, 2000).

Experience of depression

When I was reviewing the literature on depression, I was struck by its vastness, yet I was even more surprised by how minuscule within it is the literature on the experience of the illness. It is quite notable that a series of *Handbooks of Depression*, edited by various scholars, do not take up the issue of the patient perspective or their experience (see e.g. Beckham and Leber, 1995; Gotlib and Hammen, 2002; Kasper *et al*., 2003; Paykel, 1992; Power, 2004). Depression in such literature is represented as sets of features attributed to people, as if they were their more or less inherent faculties which can be measured by a myriad of psychiatric instruments. So, depressed people are characterised by a number of social and emotional dysfunctions (Rottenberg and Gotlib, 2004); vulnerability (Teasdale and Dent, 1987; Zuroff *et al*., 2004); antithetical interpersonal

scripts (Demorest *et al.*, 1999); low physical, role and emotional functioning (Stewart *et al.*, 1989); and long-lasting deficits in psychosocial functioning (Hays *et al.*, 1995). Even lay theories of depression can be measured (Furnham and Kuyken, 1991), while various scales can be compared and assessed (Faravelli *et al.*, 1986).

To put it radically, I do not think psychiatric instruments offer much more than insight into how people fill them in. They offer very little, if any at all, insight into the illness and its experience (also Galasiński, 2008; Nicolson, 1995; Stoppard, 2000). Indeed, Coyne and Gotlib (1983) point out that there is little evidence that what depressed people think has anything to do with how they are portrayed to think on standardised instruments. Such research also ignores the fact that it is the diagnosis itself which can cause significant emotional disturbance which can, in fact, be of greater importance than the symptoms which the instruments are claimed to measure (Kilian and Angermeyer, 1999; Lester and Tritter, 2005; Sayre, 2000).

Indeed, Karp (1996) criticises the existing research on depression for silencing the voices of those in depression, even though, as Stoppard (2000) posits, the knowledge about depression is ultimately held by the people suffering from it. Burr and Chapman (2004) also make this point by showing that South Asian women negotiated their symptoms of depression in ways which allowed them better access to health care. Pollock (2007), on the other hand, demonstrates how accounts of depression were negotiated with the need to maintain face and privacy.

Now, such arguments demonstrate an acute need for research offering in-depth insight into experiences of depression as part of a larger narrative of life experiences, situating depression in its lived context with the foci and relevancies as they appear to those who tell the story, rather than driven by a diagnostic schedule or criteria. Thus, McMullen and Stoppard (2003) show that social and economic circumstances were a significant aspect of how women in depression experienced their illness. Depression could not be seen outside everyday life – financial difficulties, unemployment, relationships and lots of other considerations people in depression, just like the rest of us, face on a daily basis (also McMullen and Stoppard, 2006; Sundquist *et al.*, 2004). The two researchers add that focusing on the socio-economic conditions of women's lives has the potential of preventing depression (McMullen and Stoppard, 2003). I shall demonstrate in this book that the argument could easily be extended onto men's lives.

Incidentally, if doctors are reported to medicalise depression (Thomas-McLean and Stoppard, 2004), and, on the other hand, patients attribute

quality of care to doctor–patient communication (Gask *et al.*, 2003), it seems that exploring the 'stories of depression' with their own relevancies can be seen as directly relevant to improving the care depressed patients receive. Similarly, a study by Rogers and her associates (2001), showing that depression is experienced (both by patients and doctors) as too large and complex to square into the primary health care system, demonstrates the need to account for the experience of depression outside the medical and medicalising model.

The largest number of studies in what little has been written on experiences of depression concerns women. In addition to feelings of aloneness and isolation (Scattolon, 2003) and the discourses of the flawed self (McMullen, 2003), researchers report attempts to 'normalise' depression. Depressed women prefer not to see themselves as mentally ill, likening depression to physical illness (Stoppard and Gammell, 2003), or see it as a result of 'normal' life stress (Scattolon, 2003; also Kangas, 2001). Yet, Stoppard (1997) writes that women's accounts are also ridden with uncertainty as to what is happening to them and why, adding that they reflect experts' medicalised formulations of depression and thus raising questions as to the status of such narratives. The important aspect of such research is that depression is shown as narrated in the social context of its experiences by women who are afforded certain subject positions from which they can offer their narratives (Crowe, 2002).

In his study, Karp (1996) shows, among others, constructions of depression as having a life on its own (see also Chapter 3) as well its impact upon the identities of those suffering, forcing redefinitions of the self, as the illness progresses from what he calls 'inchoate feelings', through acceptance of a problem and a crisis, to the stage of coming to grips with the illness.

I have found three studies explicitly exploring men's experiences of depression (Brownhill *et al.*, 2005; Emslie *et al.*, 2006; Heifner, 1987; but see Smith's (1999) account his own experience of depression). The researchers agree that depression is seen by depressed men in terms of the dominant model of masculinity and the men's non-conformance with it. Strength, control and independence were all values which the interviewed men strived for. Depression is not so much seen in medicalised terms, but, rather, at the backdrop of what Connell (1995) called 'hegemonic masculinity'. This book takes this research further. While I shall confirm this overall finding, I shall also argue for a more nuanced understanding of men's experiences of depression, offering at times alternative interpretations, arguing that it might not always be useful to see the speaking subject in terms of gender.

Moreover, the major shortcoming of this research is that it focuses predominantly upon the content of what is said by the informants. Although I have no doubt that it provides useful and interesting insights into men's experiences of depression, the research overlooks an important aspect of depression narratives: its lexico-grammatical form. This book aims to redress it. The discourse analytic approach I am taking here offers insight both into *what* my informants said and crucially, into *how* they said it. Discourse analysis is a powerful tool in understanding how people engage with and construct reality, including their own experiences. It also provides insight into how they construct their identities in relation to both the social environment in which they find themselves and how they experience it and themselves in it.

Discourse analysis

This book is about how people talk and the discursive resources they avail themselves of. I am interested in how they narrate their illness, themselves in their illness, their lives and those close to them. I assume that all those experiences are predominantly discursive. Following Bauman (1986), it is not the world which is the material of the narrative; rather, it is the narrative from which the world is abstracted. In what follows, I am going to offer a brief account of a model of discourse analysis with which I have sympathy (for a much more comprehensive discussion, see Barker and Galasiński, 2001). The review I offer here is based upon the earlier one, although some accents have changed.

I situate my analyses in a constructionist approach to discourse, and within its critical strand. Thus I draw upon a tradition in discourse analysis which is an amalgamation of a number of approaches, including critical linguistics (Fowler, 1991; Fowler *et al.*, 1979; Hodge and Kress, 1993), social semiotics (Hodge and Kress, 1988; Kress and van Leeuwen, 1996), sociocultural change and change in discourse (Fairclough, 1989, 1992, 1995, 2003) and socio-cognitive studies (e.g. van Dijk, 1993, 1998). Linguistically, it is anchored within systemic-functional linguistics (e.g. Halliday, 1994, 1978; Halliday and Hasan, 1985), which complements the analyst's self-reflexivity (Wodak, 1999) and can help reduce the arbitrariness of interpretation by anchoring it in the linguistic form itself.

I take a textually oriented approach (Fairclough, 1992). Thus, I focus upon the content and the form of stretches of discourse, with an interest in both the semantics and syntax of an utterance, as well as the functions of what is said within the local context, and the social actions thus accomplished. I understand discourse as a form of social practice

within a sociocultural context. Language users are not isolated individuals, but they are engaged in communicative activities as members of social groups, organisations, institutions and cultures. To a considerable extent they speak the way one speaks, the way it is appropriate (in many senses of this word) to speak. I am therefore interested in discovering the 'discourses of depression', the ways in which the experience of a particular disease is made social through the process of narrating it.

The following assumptions I make about discourse are relevant here.

1. Discourse is socially constitutive. It enters into a 'dialectical' relationship with the contexts in which it occurs; so, as much as it depends on its context, it also creates social and political 'realities' (Fairclough and Wodak, 1997; van Leeuwen and Wodak, 1999). One does not have to refer to the notorious case of homosexuality as a former mental disease (Kutchins and Kirk [1999] tell an extraordinary story of how it was demedicalised) in order to argue that such 'traditional' diseases as schizophrenia or anorexia came to existence only after they were created by the dominant discourses of modern psychiatry. Although it has a much longer history (Radden, 2000), the modern understanding of depression does not exist outside discourse. For if the next editions of, say, the International Classification of Diseases contain a different set of criteria for diagnosing the disease, it will simply change. This kind of analysis I shall employ predominantly in Chapter 2, where I shall be analysing dominant psychiatric discourses of depression.

2. Discourse is a system of options from which language users make their choices. The construction of any representation of 'reality' is necessarily selective, entailing decisions as to which aspects of that reality to include and how to arrange them. Each selection carries its share of socially ingrained values so that representation is socially constructed (Hall, 1997; Hodge and Kress, 1993) and alternative representations are not only always possible, but they carry divergent significance and consequences (Fowler, 1996). Nevertheless, texts seek to impose a 'preferred reading' (Hall, 1981) or a 'structure of faith' (Menz, 1989) upon the addressee.

What is important to note is that optionality of discourse refers both to the linguistic form (the notorious 'terrorist' vs. 'freedom fighter' opposition), and also to the content of what is being communicated. As more and more social scientists claim to analyse 'discourse', linguistic discourse analysis tends to focus more upon the form of discourse. Yet, content is an important aspect of our analyses and it should not be thought of

as marginal. Thus, in addition to the analysis of the form of what my informants said, I shall also be using a hermeneutic-like interpretation of discourses in terms of the context in which they were submerged (see Titscher *et al.*, 2000). It is particularly in this perspective that I shall discuss how my informants constructed, more or less explicitly, their masculinity or their relationships.

3. Discourse is ideological. The selective character of representation leads to the view that it is through discourse and other semiotic practices that ideologies are formulated, reproduced and reinforced. I understand the term ideology as social (general and abstract) representations shared by members of a group and used by them to accomplish everyday social practices: acting and communicating (Billig *et al.*, 1988; Fowler, 1985; van Dijk, 1998). These representations are organised into systems which are deployed by social classes and other groups 'in order to make sense of, figure out and render intelligible the way society works' (Hall, 1996: 26), while at the same time they are capable of 'ironing out' the contradictions, dilemmas and antagonisms of practices in ways which accord with the interests and projects of power (Chouliaraki and Fairclough, 1999). And it is with the ideological nature of discourse in mind that I shall be particularly interested in how my informants constructed both depression itself and their selves in relation to the illness. The argument of the dominant model of masculinity which underpins what my informants said will be made within this perspective.

4. Finally, I assume that text – the product of what one says or writes – is intertextual. Texts are full of other texts, accessing them for stylistic, ironic effect or for ideological message. Intertextuality can be intentional, but it also can be unwitting, which suggests that certain texts have a dominant role in how certain contents or experiences are constructed. Here I shall be looking for evidence that the narratives of my informants draw upon certain texts or formulations, particularly in their accounts of illness. Particularly then, I shall be interested in evidence of medicalisation, the dominance of the medical view of reality over a lay one (e.g. Ballard and Elston, 2005).

What I shall not be interested to find, however, is a 'language of depression' in the sense of trying to find some linguistic or discursive markers of the illness. I reject the analyses such as that of Fine (2006), who claims to find characteristics of depression in language. It is practically impossible to make an assessment as to, say, how much or how fast people should speak in order to make a claim that in depression these faculties are decreased. It is also quite difficult to make definitive claims as to what

affect in language is supposed to look like in depression or outside it, with negative thoughts in language being just about unassessable.

Discourse, mental illness and qualitative research

The final element of the background I am laying out here is my view of the relationship between mental illness and discourse analysis. In her Foucauldian analysis of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association (APA), Crowe (2000) suggests that the *Manual* is not so much based on the concept of mental disorder, but, rather, on the implicit assumptions of what constitutes normal behaviour. This 'normality' underpinning the DSM is not only very much Western, but in some cases underpinned by the neo-liberal ideology. Parker and his associates (1995) in turn point out the non-transparency of psychiatric terminology introduced by the DSM as a vehicle of not only constructing disorders, but also providing an emotional and evaluative frame which is imposed upon the person who is labelled with it. In the same vein, Hepworth (1999) challenges the assumptions made by women in psychiatric discourses of anorexia nervosa, while Heinimaa (2000) unpicks the notions of 'self' and 'person' in psychiatric discourses, showing the ambiguities in their use.

Such general critiques are complemented by a number of discourse analytic studies taking up issues of psychotherapeutic and psychiatric practices, such as interviews, diagnosis, note taking. In one of the fullest studies of psychiatric practices, Barrett (1996), a psychiatrist and anthropologist, reports on his ethnographic study of a hospital ward caring for patients diagnosed with schizophrenia. Barrett shows, among other things, how the patient's experience is made irrelevant within the medical frame imposed upon it by such events as the diagnostic interview or the patient's notes (see also Mohr, 1999). Guilfoyle (2001) shows the relationship of power in the psychotherapeutic situation as imposing subjectivities on patients diagnosed with bulimia. Finally, such analyses lead to more positive studies of psychiatric discourses, showing the potential usefulness of discourse analysis in mental health research and practice. Harper (1995, 1998) posits that discourse analysis opens opportunities of negotiability of positions in psychiatric contexts, sensitising clinicians to the possibility of imposing 'illness identities' (also Coyle and Pugh, 1998), while Crowe and Alavi (1999) argue that accepting a patient's account of illness re-establishes his/her participation in the community of others (see also Speed, 2006).

It is the analysis of illness experiences with which I shall be mostly concerned in my argument here. As a thorough discussion of the nature of experience is well outside the scope of this book, I assume here that discourse is a primary platform on which experiences are structured, and expressed. Discourse analysis is therefore a primary and main probe into people's experiences. It is even more so in the case of mental illness.

Focusing upon patients' experience of illness is a response to repeated calls from researchers, both within medicine and in the social sciences, for the inclusion of the subjective into psychopathology (e.g. Haidet and Paterniti, 2003; Kleinman, 1988a; Shaw, 2002) as well as its validity as source of knowledge about illness (Beresford, 2005; Prior, 2003). Moreover, discourse analysis and its focus upon lived experiences of (mental) illness brings the recognition of the fact that there is no one rigid illness narrative, but that they fluctuate depending on the context in which they are told (Hardin, 2003), the aim with which they are told, varying from, say, constructing an illness experience and making it understandable to reconstructing life history (Hyden, 1997; also Frank, 1995; Skultans, 2000). Discourse analysis attempts to gain insight into the experience of mental illness in its high complexity.

Furthermore, if health can be seen as a narrative register (Roberts, 2004), it is precisely through the focus upon individual accounts that one can trace the process of creation of health identities (Fox and Ward, 2006; Frank, 2006), understand illness as suffering (Monks, 2000; Morse, 2001) and, more generally, understand the process of giving shape to the experience of illness (Good, 1994; Mattingly, 1998). As Bury (2001) suggests, an illness narrative offers a lived link between the body, the self and the society in which it is anchored, making only certain worlds more plausible than others (Plummer, 1995). Indeed, Fredriksson and Lindström (2002) report that allowing psychiatric patients to narrate freely results in different plot structures, ones which not only reveal but also might hide suffering. Finally, it is people's accounts that enable researchers to see how mental health patients make sense not only of their madness (Casey and Long, 2002, 2003) but also of the therapy and the healing process (Burr and Butt, 2000). Launer (1999) goes further, suggesting that a narrative-based practice enables both sides to agree on a story that makes sense both to the patient and to the doctor. Greenlagh and Hurwitz (1998) add that narratives not only set a patient-centred agenda, but they are also likely to challenge the institutionally valid knowledge (also Gwyn, 2002). Ingleby (2006) makes the point that the qualitative focus upon illness experience has the advantage of looking at people as active actors who actively interpret their experiences.

Indeed, Crowe (2002) and Stoppard (2000), referring to women's depression, and Hepworth (1999), commenting on anorexia nervosa, show discourse analysis as a powerful instrument in examining experiences of illness and psychiatric services. According to the studies by Van Staden (2002), as well as by Crowe and Luty (2005), Levitt *et al.* (2000) or Ridge and Ziebland (2006), on depression, and by Rudge and Morse (2001) on schizophrenia, discourse analysis can also be useful in the assessment of patients' recovery. And while Lysaker and his associates (2003) propose that it is narrative transformation which can be seen as an outcome in schizophrenia (see also an interesting transformulation of cognitive-behavioural therapy in discourse analytic terms done by Drew *et al.*, 1999), Davidson (2003) argues not only that recovery should not be seen in terms of reduction of symptoms (also Kirmayer, 2005), but, rather, that it should be negotiated by the patient's life narrative (also Svenaeus, 2000).

That does not mean of course that narrative research is the panacea to all problems of mental health research. Patients are not transparent actors who simply tell it like it is, whether to the doctor or the researcher. Chatwin (2006) points out that patients can self-censor, limiting themselves to elements directly relevant to their complaints; Charmaz (2002) notes that a narrative can be used to mask suffering. Moreover, Pilgrim and Rogers (1997) remind that mental health problems are not merely constructions and do have physiological aspects. Yet, my aim here is to shed some light on a crucial aspect of what it means to be mentally ill, the subjective experience of the illness, an aspect which is still significantly under-researched, yet one which constitutes the ultimate context for whatever psychopathological research claims of mental disorders.

Finally, throughout this book I predominantly use the word 'illness', rather than 'disease' (on the distinction, see Kleinman, 1988b). This is because I am mostly concerned with men's experiences of depression, rather than with how depression is described and conceptualised within the discourses of psychiatry or psychology.

The interviewees

This book is based upon a convenience sample of 27 semi-structured interviews I carried out with men diagnosed with the recurring depressive episode of mild or moderate severity (ICD F33.1-2; although two were diagnosed with bipolar affective disorder F31, both in the depressive phase at the time of the interview). At the time of the interview, all interviewees were undergoing voluntary psychiatric treatment for

depression either in an out-patient clinic or in day-care centres (spending only mornings and early afternoons on the ward) where they were interviewed. I carried out my research in two university hospitals in Poland; all interviews were in Polish.

As it happened, all my interviewees were white, Polish, heterosexual, between the ages of 30 and 60. All were or had been (three were divorced) in stable relationships with female partners (usually, wives). There is no doubt that these characteristics of the sample have had an impact upon the kind of data I collected. Two points can be made, though. First, logistic, the practicalities of my research were such that I collected my interviews over the period of over one year (with six weeks of actually working as an intern in one of the hospitals). Although only two men declined to be interviewed, I managed to collect only 27 interviews. During my internship, coming to work every day and passing through an out-patient affective disorders clinic, I realised very quickly that the vast majority of patients are women and there are simply extremely few men who seek psychiatric help for depression. Given such conditions, it is extremely difficult to diversify the sample. Second is an academic one. With hindsight I am pleased with a very coherent sample of interviewees, which translated into the data which were very amenable to analysis. My informants offered insights into how men who espouse the dominant model of masculinity do actually relate to it. The tightness of the sample might also suggest that I have been able to talk to those men who most frequently seek help. But I do realise that I am not focusing upon gay men, single men or perhaps those who do not seek help and struggle with their depressions at home. The experiences of these groups of men still require researchers' attention.

The interviews I carried out concerned mostly experiences of depression, but also the men's relationships as well as their views on the illness, masculinity and recovery. Apart from two interviews (they were with the two least-educated men of the sample) which were shorter, all interviews lasted for about an hour. After recording them, all were transcribed, while the extracts I analyse here were translated into English.

The book's projects

Writing about men and mental illness is political. Inevitably, it raises issues of power, patriarchy or gender relations. This is why I want to make my political projects in the book explicit. The need to do so struck me when I was reading Cochran and Rabinowitz's *Men and Depression.* Towards the end of the preface, they express hope that their book would

not be seen as politically provocative, noting their debt to researchers and clinicians exploring women's depression and insisting that men's depression is worth our attention. I found this statement extraordinary, yet I recalled my own experience of presenting a paper on men's emotionality a few years ago. The discussion was quite brief and consisted of one statement. A well-known scholar declared that men's emotionality might be important, but what is really important is to explore women's emotionality.

The first aspect of my political project is to restate the importance of research into men and masculinity, even those white, heterosexual and middle-aged. It is as important as that exploring women and femininity. I do accept that such men used to be the 'human universal' in research, yet, thankfully, we do know better now, also because it worked against the men themselves. There are plenty of issues relating to us white, heterosexual, middle-aged men (incidentally there are plenty of other adjectives that could be added here) that are not only interesting, but also important both to us and to the society. Our depression is one of them.

The second part of my political project is to reinforce Johnson's (1997) rejection of man as the all-purpose universal oppressor. Although many are, not all men are oppressors. There are also considerable numbers of men who are oppressed and vulnerable (also New, 2001; Taylor, 2006). Some are both, some are only oppressed. This book is about men who are oppressed, vulnerable, who are at their most powerless. They are also mentally ill, which in itself puts them on the margins of the society, and I hope to give them voice, or at least some voice. I want to reinforce the message that inequality, strife, vulnerability, marginality or powerlessness applies also to men. And given the dominant model of masculinity, it might be even more difficult for them to accept that.

Finally, even though this book is critical of psychiatry, I want to be taken as its critical friend. This book is not intended as yet another attack on psychiatry and its nosology. My argument is not meant to be anti-psychiatric. I believe that psychiatry is the most useful discourse of mental illness, useful also for those in distress. This does not mean that it cannot improve and learn from those who would like to enter into a dialogue with it. This dialogue, even though occasionally already in existence, on a larger scale is long overdue (Fee, 2000a).

The book is also a personal project. When I embarked on the research underpinning this book, I took up an internship in a psychiatric hospital. I wanted to see psychiatry from inside. Daily, I met people who were willing to share their misery, suffering, pain with me. The conversations

and the interviews were sometimes more difficult for me than for them, yet I appreciate their willingness to help me write my book very much. All who agreed to be interviewed expressly hoped that what they had to say would help understand depression better and help others like them in coping with it. I do hope I shall do justice to their expectations.

Overview of the book

This book consists of three parts. Part 1 (Chapters 2 and 3) takes up the issue of depression. While in Chapter 2 it is explored as a construct of dominant psychiatric discourses, in Chapter 3 I discuss how my informants constructed it in their narratives. In Part 2, I am interested in how the self partakes of the experience of depression. Thus, in Chapter 4, I focus on how depression is attributed to the self, demonstrating that the relationship is never easy. The self is never explicitly constructed in terms of depression, but, rather, a number of distancing strategies are used. In Chapter 5 I look at the accounts of everyday life in my corpus. Contrary to my expectations, the informants' narratives focused on actions, rather than on their psychological states. In Chapter 6 I explore my informants' biographies. Once again, contrary to what I expected, depression is not a 'disruption' in the biographies of the men I interviewed; rather, it is a milestone, on a par with others. Chapter 7, the final in Part 2, takes up the constructions of the 'timeless self' my informants used to account for their depression, showing it as inevitable, rather incidental in their lives.

Part 3 of the book is concerned with issues of masculinity in the narratives I collected. Chapter 8 explores the relationship between depression and masculinity and discusses the challenge the illness poses for my informants' gender identity. In Chapter 9, in turn, I take up depression's relationship to work, a crucial aspect of the dominant gender ideology, demonstrating that work is seen as a crucial aspect of recovery. Chapter 10, finally, shows the difficult relationships my interviewees have with their families, for the most part feeling rejected by them. The concluding chapter both takes stock and shows the significance of discourse analytic research into the experience of mental illness for psychiatry. I also suggest extensions of the argument onto issues of insight as well as suffering.

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