

Masculinity and mental health – the long view

Ali Hagggett gives a historical perspective

As a medical historian engaged in research on the history of men's mental health, it is striking how little research exists on the ways in which men have coped with professional and personal pressures. The literature on male psychological and emotional disorders is equally sparse. Why this history has been so poorly recorded is a matter for considerable debate.

As the authors of the introduction to this special feature have noted, scholars of gender studies have broadly tended to assume a male norm and focus consequently on 'femaleness' and differences from the norm, while academic historians (and feminist historians in particular) have focused repeatedly on deconstructing the well-versed ancient association between women and 'madness'. Some continue to argue that men are simply much less likely to be affected by mood disorders and that women are more naturally predisposed to such conditions (Freeman & Freeman, 2013). Statistically, women do appear to suffer more frequently from depressive and anxiety disorders, featuring more regularly in figures for consultations, diagnoses and prescriptions for psychotropic medication. This has been consistently so since the 1950s, with current figures suggesting that women are approximately twice more likely to suffer from mood disorders than men (WHO, n.d.).

However, my research suggests that the statistical landscape reveals only part of the story. We know that 75 per cent of suicides are currently among men, and we can trace this trend back historically to data that suggests this has been the case since the beginning of the 20th century (Watts, 1966; Wilkins, 2009). Alcohol abuse, a factor often related to suicide, is also significantly more common in men, who are more than twice as likely to become alcohol dependent than women (Wilkins, 2009). This trend too is well-established and is a consistent theme throughout the studies of general practice

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morbidity that emerged during the late 1950s (Bancroft & Watts, 1959). The subject of help-seeking for psychological disorders certainly seems to be an area that presents particular challenges to masculinity, complicated by the fact that when men do seek help from medical practitioners they often present with somatic or psychosomatic symptoms that may have an underlying emotional cause. It is therefore highly likely that male cases of depression and anxiety disorders are under-diagnosed (O'Brien et al., 2005; Wilkins, 2009). Family doctors practising in the 1950s noted that women tended to present with symptoms of low-mood, anxiety, lack of motivation and sadness

(which, for the most part were easy to recognise), whereas men were more likely to present with somatic symptoms, including a range of ill-defined disorders affecting the stomach, digestion, sleep and general well-being (Royal College of General Practitioners, 1956–1958).

So it appears that the reluctance of men to speak about their own illness and the broader collective silence that surrounds the emotional world of men has a long history. However, interestingly, it is by no means a 'continuous' one. I will suggest that alternative constructions of masculinity observable in earlier times resulted in very different approaches to nervous disorders and symptoms of depressive illness. History can indeed tell us much about the origins of dominant forms of masculinity, and perhaps we might look to earlier periods and alternative constructions of masculinity to cultivate healthier ways of expressing emotional distress.

Georgian sensibility and the Victorian 'stiff upper lip'

Although there is now widespread acceptance among social scientists and historians that masculine traits are not essential attributes, but that they are in large part socially and culturally constructed, it is the familiar image of the tough, stoic male that remains the dominant or 'hegemonic' masculinity in the developed Western world.

However, historically, the inhibition of emotionality is by no means a constant or immutable male trait. During the Georgian period (1714–1830), for example, advances in scientific and anatomical knowledge from the practice of dissection suggested that the central nervous system was fundamental to understandings of the body. There was widespread discussion about how it worked, and physicians thought that many diseases and afflictions were connected in some way to it. This resulted in a new interest in nervous disorders, which were thought to affect

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men and women alike. Among Georgian society, the individuals thought to be most seriously affected by 'nervous distempers' were those from the cultured, well-to-do classes, who were considered to have a more refined nervous system, which was more prone to collapse. Nervousness among the higher social strata was commonly accepted and seen as a sign of 'good breeding'.

The display of emotion among men in this period was not associated with sexual practice or effeminacy. Being 'manly' meant different things in Georgian Britain; primarily being virtuous and wise. Male emotionality therefore crossed no inappropriate boundaries nor brought undue negative attention. As a consequence, men were quite comfortable looking inwardly and being reflective about their own physical and psychological experiences.

During this period, an explosion of nerve doctors and medical treatises emerged providing advice on remedies and lifestyle. The physician George Cheyne, for example, published a text entitled *The English Malady* in 1733, in which he described symptoms of melancholy, lowness of spirits, insomnia and agitation. These, he argued, were common in wealthy people and had several causes, most notably the pace of new modern life, luxurious living and immoderate lifestyle. In the book, he urged people to take up what he called a 'low regimen', meaning a temperate lifestyle. Cheyne's own experience informed his writing, for he suffered himself from many of these symptoms, including headaches, lowness of spirit and disturbance of appetite. Many of his case studies focused upon men. By demarcating nervous distempers as unique to the cultured classes, physicians were able to

disassociate themselves from the lower social orders. That 'good blood and bad nerves went hand in hand' was broadly manifest in the attitudes and associations of society and shaped the ways in which people viewed themselves in sickness and in health (Micale, 2008).

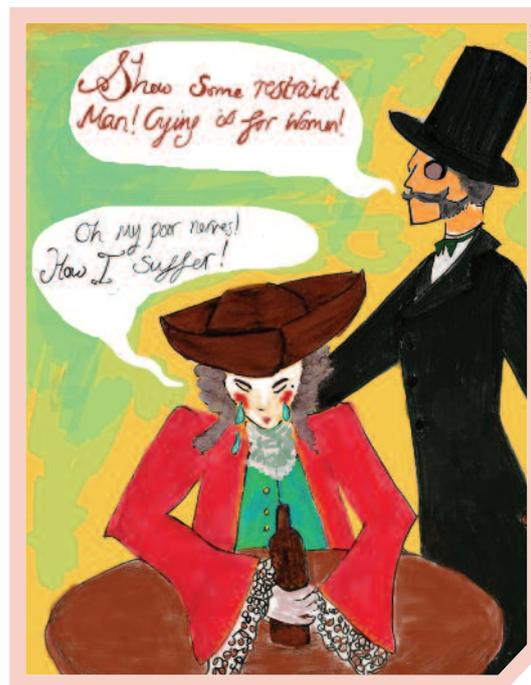
Scholars have long shown how the huge social and cultural changes of the Victorian period (1837–1901) that followed resulted in new gender constructions and ideas about what it was to be a man or a woman. However, it is only more recently that historians have begun to explore the ways in which these changes, and the consequent stigmatisation of male emotionality, impacted upon male mental health (Micale, 2008).

By the mid-19th century, Britain had become the world's leading industrial nation, and it is hard to overstate the scale of changes wrought by industrialisation and imperialist pursuit. British ascendancy in the world required

the projection of 'power' and 'control'; qualities that did not fit well with a notion of male nervous instability. More generally, the preceding intellectual movement – the Enlightenment – had espoused a range of values that were increasingly seen as excessively liberal and egalitarian. Women, for example, had begun to fight for equal rights in suffrage, divorce and inheritance. The 19th century was in many ways a backlash to this liberal Enlightenment thinking, and on a range of levels a period of social and cultural conservatism emerged. Industrialisation itself promoted the division of labour by sex and heavy factory work, mining and construction became distinctively 'male' environments, while symbolically, women became 'angels in the house'. This term was coined in 1854, by Coventry Patmore, in a poem of the same title. It was used increasingly to describe women who embodied the perfect Victorian ideal of the dutiful wife and mother.

At the same time, these social changes were bolstered by the evolutionary theories of Charles Darwin and Herbert Spencer that emphasised core differences between men and women (Darwin, 1859; Spencer, 1864). Women were thought to be biologically inferior to men, dominated by their reproductive systems and prone to irrationality. Men, in contrast, were considered to be rational, 'restrained' beings.

Other factors duly reinforced these developments. The rise in Protestant religious enthusiasm, for example, favoured personal values of will-power, obedience and fidelity. Christian 'manliness' meant being a good husband and father, leaving little room for emotional self-expression. Within European medicine and psychiatry, the study of human sexuality emerged, promoted by individuals such as Iwan Bloch, Richard von Krafft-Ebing, Maunus Hirschfeld and Havelock Ellis (Hall, 2000). This new 'science' of sexology began to investigate and regulate sexual practices, and attempts were made to



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define 'normal' and 'abnormal' sexual behaviour. Consequently, the notion that homosexuality was deviant behaviour resulted in anxieties about homo-social affection and its potential association with effeminacy. The values put forward by the British military and the public school system also notoriously fostered strict morality, stoicism and the 'stiff upper lip'.

The 20th century and beyond

In Edwardian Britain (the reign of King Edward VII 1901–1910), the rigid social hierarchy continued to be held together by the shared values of national pride and imperialism. 'Authority' was everywhere and cultivated in the military, in schools, the Church and other organisation (such as the Boy Scouts, Mothers' Union, the Territorial Army and the Temperance League). Within the military, discipline was an absolute requirement. Desertion and cowardice were punishable by death, serving as a deterrent to other soldiers.

The emphasis on courage and strength was intimately connected to Victorian and Edwardian notions of 'manliness'. The symptoms of mental illness were heavily stigmatised and frequently confused and conflated with a range of social problems, such as crime, alcoholism and vagrancy. Most psychiatric patients were managed within asylums. Freud's theories were underdeveloped and carried less influence in Britain where a biological view of mental illness predominated. Psychological approaches were treated with suspicion because they encouraged introspection and egoism which might aggravate an existing deficiency of 'willpower' (Jones & Wessley, 2005).

Soldiers exhibiting strange somatic and psychological symptoms presented very quickly after the onset of the First World War, 100 years ago. Symptoms were initially thought to have been the result of damage to the central nervous system from heavy artillery explosions. The term 'shell shock' was first used by the physician Charles Myers (1873–1946) in his 1915 article in the *Lancet*, although he did not invent the term. Symptoms included blindness, deafness, palpitations, paralysis, muscle tremor and anxiety. The condition caused alarm because it challenged Victorian notions of stoicism and moral will. Fundamentally, the weak, degenerate and effeminate had traditionally been associated with

neurosis, yet men of all ranks appeared to succumb to the condition. It prompted physicians to consider the possibility of a psychological cause and caused division and debate between physicians who supported organic causes and those who believed in the psychological origins of trauma. Although the report of the War Office Committee of Enquiry into Shell-Shock that took place in 1922 after the war suggested that there was measured acceptance of the psychological origins of war trauma, and of some psychological therapies, considerable cultural ambivalence and antagonism to new ideas remained. 'Misfits' and poor recruits, for example, were still thought to break down more easily under stress and neurosis continued to be associated implicitly with weakness and lack of will.

The radical social and cultural changes that took place during the Victorian period continued to influence ideas about masculinity and the emotions well into the 20th century and provided the precursors to the current situation in

psychological and psychosomatic ill health in men during the decades following the Second World War. General practitioners noted increasingly during the 1950s, for example, that somatic symptoms were 'a mask' and an excuse with which to come to the doctor (Hopkins, 1955). A physical symptom was viewed as 'more acceptable' to the patient, his family and his friends than the underlying emotional cause (Hopkins, 1955).

John Fry, a post-war pioneer of general practice-based research, kept meticulous personal notes about his patients, which were also regularly interspersed with references to male patients with dyspepsia and 'epigastric pain', a term used to describe pain in the gastric region (often aggravated by alcohol), for which no organic cause could be found. Such patients were often additionally described as 'agitated', sometimes 'depressed', but seldom 'neurotic', a term that was largely still reserved for anxious women (Fry, ca.1950–ca.1980, Personal papers).

It seems that most GPs had great difficulty relating causal or precipitating factors to psychogenic symptoms, and there was acceptance that much male psychological illness remained undiagnosed in the community. Recent research continues to suggest that men still present with somatic conditions that might have a psychological dimension. Symptoms not only include gastric disorders, but also erectile dysfunction and obesity, suggesting that symptoms might acquire different significance in different cultures, contexts and times. It would certainly seem that the number of men experiencing common mental disorders is still underestimated, a problem exacerbated when practitioners rely on their male patients' ability to volunteer information about mental health concerns (Wilkins & Kemple, 2011).

Physicians treating patients in the three decades following the inauguration of the National Health Service admitted that they were poorly trained in psychological medicine and that they often unwittingly colluded with stereotypical views about femininity and masculinity, providing psychiatric diagnoses for women and somatic



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which men appear less likely to experience depression and anxiety, in part because they are less comfortable expressing their feelings and less willing to seek help for their problems. It is indeed perhaps instructive that the research from my current project has uncovered evidence of widespread

diagnoses for men. A number noted that, within medicine, a strong association persisted between women, 'hysteria' and menstrual or menopausal mood changes. Until the late 1970s, most GPs were male themselves and thus often affected by the same difficulties when challenged to be reflective or emotionally expressive during the patient consultation process (Haggett, in press). Although health services have developed greatly since this time, there is nonetheless still evidence that society's narrow view of 'how men should behave' impacts upon health professionals' ability to understand and cater for men's needs (Wilkins & Kemple, 2011).

A longer narrative also illustrates how notions of 'weakness' that became tied to mental breakdown influenced men's willingness to recognise symptoms of depression and anxiety. Michael Roper (1995), for example, has shown how a 'cult of toughness' existed among men working in British organisations during the 1950s and that this was heavily influenced by the experience of compulsory national service, which did not end until 1960. Until the 1980s, studies on stress in industry tended to focus on physical and chemical hazards to health and on absenteeism, while mental illness was of subsidiary interest (Cooper & Marshall, 1976). This one-sided picture was further confused by medical sickness certificates that rarely confirmed a psychiatric diagnosis owing to the stigma it might bring the worker.

That male neurosis did exist is nonetheless undisputed, due to evidence that emerged in a handful of publications in response to concerns about nervous illness and absence from work following the stress of war (Fraser, 1947). However, no formal discussion developed about neurotic and depressive illness in men, despite evidence that it occurred. In contrast, a gendered landscape that assumed women were more likely to experience mental illness duly provided fertile ground for academics, clinicians and social commentators alike (Haggett, 2012). It is clear that elements of stoic, Victorian masculinity still survive because the common view remains that men often interpret symptoms of emotional distress as 'weakness', and that this provides a barrier to seeking help.

Historical parallels can also be drawn between earlier debates on alcohol abuse and current concerns about binge-drinking. Alcohol consumption has long been widely accepted as one of the most common ways in which men self-medicate for emotional distress; however, it is consumption among young females

that has tended to attract negative attention. From Hogarth's desperate 18th-century depiction of a syphilitic, drunken woman in *Gin Lane* to the current media depictions of intoxicated, scantily clad, young women outside nightclubs, it is long-established moralistic overtones about women and alcohol that are most often reflected. The focus on women carries with it familiar historical connotations of 'women's classic role within public health as both "innocent victim" and vector of infection' (Berridge et al., 2009, p.600).

During the 1960s, concerns about alcohol abuse and a renewed focus on the disease theory of alcoholism led to a developing interest among some in the medical community. However, the focus was largely upon the recognition, diagnosis and treatment of alcoholism and upon the social problems caused by drunken offenders. Although men were significantly overrepresented in statistics for alcohol abuse, few enquired further about the reasons for the onset of drinking. In contrast, discussion about women who drank tended to explore the ways in which aspects of the female role (their conditioning, upbringing and life-expectations) might cause them to drink (e.g. Camberwell Council on Alcoholism, 1973–1975). Debates about alcohol say much about the wider tensions and contradictions that have existed in postwar Britain about masculinity, male emotional health and gendered 'ways of coping' (Haggett, in press).

Without undermining the importance of health concerns about women and binge-drinking, the fact remains that older men remain the group with the highest alcohol-related mortality. It is certainly the case that throughout the second half of the 20th century, social drinking increasingly became a primary cultural symbol of 'manliness' (Lemle & Mishkind, 1989). Heavy drinking symbolised greater masculinity than lighter drinking, and the more a man tolerated his alcohol, the more manly he was deemed (Lemle & Mishkind, 1989). However, the British media's focus on young women indicates that social and cultural factors continue to influence ideas about masculinity, femininity and vulnerability to stress and mental disorders.

Reflections

So, how might history inform current knowledge and practice? Historians look at the social and the cultural as well as the medical and psychological. We seek to view ideas about male behaviour and

psychological illness within the context of their time and illustrate how symptoms might appear in new forms and be understood differently through time in response to prevailing cultural and medical forces. In practice, history offers novel public engagement opportunities in schools, sports venues and doctors' surgeries, to educate young males about alternative masculinities, such as the 'nervous male' of the 18th century. As Mark Micale reminds us, during the Georgian 'cult of sensibility', Britons of both sexes 'monitored their transient psychological aches and pains as never before', and the expression of male emotion in literature included 'copious shedding of tears' (Micale, 2008, pp.27, 25). One challenge might be whether we confront or exploit familiar notions of stoic masculinity in order to persuade men to think about their mental health. As recent researchers have noted, behaviours and attitudes take a long time to change, and while early intervention might allow young boys to foster healthier ways of expressing emotion, the mindset of the generations of men who are already adults might be less easy to transform (Wilkins & Kemple, 2011).

History does, however, offer the opportunity to expose, uncover and perhaps 'normalise' male mental illness, where it seemed previously hidden, but was in fact prevalent – either existing undiagnosed in the community, or presenting in complex psychological and psychosomatic forms in primary care. It might also be worth reminding current generations of men that many of the most famous male figures in history were challenged by a host of psychological and psychosomatic symptoms; Charles Darwin, John Stuart Mill and Winston Churchill, despite firmly inhabiting the age of the 'stiff upper lip', were among the most notable. Historians are well placed to work alongside psychologists, health scientists and policy makers to facilitate change and provide advocacy supported by evidence from the longer view. Based on past experiences, historians are also appropriately positioned to help inform policy makers where a change in direction might seem politically unpalatable. An allegiance to one discipline does not, after all, exclude openness to other perspectives. A sense of the whole can most usefully inform the part.

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