Social Science & Medicine 124 (2015) 1–8

Contents lists available at ScienceDirect

Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

Shards of sorrow: Older men's accounts of their depression experience

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ARTICLE INFO

Article history:
Received 27 August 2013
Received in revised form
27 October 2014
Accepted 28 October 2014
Available online 29 October 2014

Keywords:
United States
Depression experience
Construction of self
Aging
Masculinity
Older men

ABSTRACT

The experience of depression is diverse based on social locations and context. A sociological perspective building on masculinity, illness work, and the self provides a useful theoretical framework to understand how older men negotiate emotional suffering. This article examines older men's accounts of their depression experience from a social constructionist approach. This analysis is based on data from 77 in-depth interviews with depressed older men who participated in a larger mixed-method study, the Men's Health and Aging Study (MeHAS). We show how older men construct depression accounts in which they integrate biological and social factors associated with feeling a loss of control. This is experienced as a shamed masculine self given their inability to perform manhood acts, which leads them to severe social bonds. Men's accounts also shed light on how they resist the shaming of the masculine self by deploying two primary strategies: acting overtly masculine through aggressive behavior and by retracting from social interactions that may lead to feelings of shame. These strategies appear futile and they are only partially able to embrace alternative masculine values in line with roles as grandparents and older, wiser men. Depression in older men is characterized by an ongoing negotiation of limited statuses and roles given dominant conceptions of masculinity.

"All I can do is [to] tell you I feel like shit…" (Depressed man, aged 62)

1. Introduction

We had been driving through the countryside for a while on a road stretching through the distance; a long gray tape woven between neatly rowed fields of almond trees, grape vines, lettuce, and other greens. We met a group of houses set at the edge of town and approached Mr. Capelli's (66 years old) house—a small humble track home bordering railroad tracks with construction fencing surrounding it. As we walked up to his porch, he shyly opened the door as if afraid or uninterested (I could not tell). "I'm sorry but I have tried to clean up but there's too much stuff" he apologized as he removed clothes, books, food wrappers, medications, and a beer can. A strong, somewhat unpleasant smell scented the room as we sat down on the couch. The rambling of a train startled me. It was so loud I thought it would rip through the house which gradually stopped shaking as the train passed by, its sound dissipating in the distance.

We talked with Mr. Capelli for nearly three hours during which he hardly made eye contact but often cried (at times inconsolably, at other times struggling to restrain himself). He answered our questions about his childhood, work, family, physical and mental health, and relationship with doctors, retirement and what the future held for him. His answers conveyed a profound suffering; his life had never been good but it had turned out worse than he expected. In his later years, he became sicker, stopped working, lost his wife, struggled to pay bills, and had a cursory relationship with his sons. He often sought medical help for his various ills, including depression for which he was taking medications that did not seem to help. "It's just horrible, horrible" he said, "I don't wish this on anybody … everything is piling up on me, and there's nothing I can do about it, except for just sit there, and just say, 'okay, you want it, come and get it.' I don't want any of it. I just want to get it over with because I'm tired of fighting it." How do we make sense of Mr. Capelli's despair? Why do Mr. Capelli and other older men like him view the world in this way? How does he deal with this emotional distress and what does that mean to a man who is now older? This article examines the illness experience of older men with depression in the context of masculinity and aging, as it implicates what sociologists call the "self."

2. Depression in older adults

While not highly prevalent in healthy non-institutionalized older adults, it is believed that five to ten percent of older

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http://dx.doi.org/10.1016/j.socscimed.2014.10.054
0277-9536/

adults in primary care meet criteria for clinical depression (Koenig and Blazer, 1992; Lyness et al., 1999). Untreated depression in late-life is associated with poor quality of life (Unützer et al., 2002), poor adherence to medical care and co-morbid medical disorders such as heart disease and diabetes (Katon, 2003), decreased ability to function (Alexopoulos et al., 1996), increased health care costs (Unützer et al., 1997), and higher mortality (Blazer et al., 2001).

Epidemiological research also documents gender differences in depression prevalence and treatment rates among older adults. While older women are two to three times more likely to suffer from depression (Kessler et al., 2005), older men have higher rates of completed suicide (Conwell et al., 2011), and depression is considered a modifiable risk factor for completed suicide (Unützer et al., 2002). Older men are less likely than older women to receive depression treatment (Klap et al., 2003), and they are less likely than women to have their depression recognized by a primary care physician (Crawford et al., 1998). Finally, men have lower rates of health service utilization and are less likely to seek mental health services (Husaini et al., 1994).

3. The social construction of illness

A sociological approach to depression reframes this epidemiological landscape by critically examining depression in the context of medicalization and as a contested psychiatric diagnosis (Blazer, 2005; Conrad et al., 2010; Horwitz and Wakefield, 2007; Pilgrim and Rogers, 2005; Bentall and Pilgrim, 1999). In *Asylums*, Erving Goffman (1961) established how mental illness was socially constructed in total institutions such as mental hospitals. Since then scholars have examined how experiences of illnesses (and concomitant narratives) reflect meaning making in the context of suffering and how the self is transformed through this process (Corbin and Strauss, 1985; Goffman, 1963; Karp, 1992, 1994, 1997, 2009; Scheff, 2000, 2001; Smith, 1999; Ridge and Ziebland, 2006; Ridge et al., 2011).

While not specifically focusing on depression, Charmaz (1983, 1991) argued that chronic illnesses (and arguably depression) in women and men create a fundamental type of suffering that leads to the loss of valued self-concepts. Chronic illnesses impose disruptions that when not producing new valued social identities result in "diminished self-concepts" over time in the context of everyday life (Charmaz, 1983, 168). She argues that illness engenders disruptions in social engagement by fostering isolation and feelings of becoming a burden. Individuals experience a loss of self that requires re-crafting one's social identity to fit a life with illness. The debilitating effects and the impaired control people experience due to serious chronic illness must be understood in relation to a medical system that is ill-prepared to respond to alternative forms of care for the chronically ill (Charmaz, 1983; see also Corbin and Strauss, 1985, 1988; Bury, 1982, 1991, 2001) due to the organization of healthcare delivery and norms about the meaning of illness within a culture that promotes individual responsibility, independence, privacy, and hard work (Charmaz, 1983, 170–171). The depression experience is a form of intense suffering that demands much illness work by the afflicted and those around them. However, questions emerge about how older men who face additional physical and social burdens negotiate these changes in the context of (perhaps) diminished emotional resources due to depression.

4. Depression and masculinity

The health sciences literature has focused on the undertreatment of depression in men which is thought to result from psychological or cognitive dissonance; that is, the mental discomfort experienced by individuals who are confronted with new information that conflicts with their strongly held beliefs, values, and ideas (Addis and Cohane, 2005). Researchers have also noted that men are less likely than women to express overt affect and/or report depression symptoms (O'Connor et al., 2000) that might trigger further physician inquiry into the possibility of (pathological) psychological distress. This has led to hypotheses regarding "male depression," "masked depression" (Moller-Leimkuhler et al., 2004) or "depression without sadness" (Gallo et al., 1999), which may also include symptoms such as substance abuse and anti-social behavior (Pollack, 1999). Though health sciences research on depression has focused on testing differences between men and women, such studies have produced inconclusive results (Zierau et al., 2002).

A sociological perspective of masculinity—not as an individual attribute or characteristic but as derived from "cultural practices that construct women and men as different …" (Schrock and Schwalbe, 2009, 278)—offers a more nuanced theoretical framework to understand men's health in general and depression in particular. The construction of masculinity involves the exertion of control over others and the environment—"manhood acts" (Schrock and Schwalbe, 2009, 280)—that ultimately (whether men intend it or not) reproduce gender inequality (Martin, 2003; Lorber, 1994). A masculine self must be successfully validated by others (Goffman, 1959), and this identity work is always a socio-political act through which men must effectively adjust their "doing" of masculinity (West and Zimmerman, 1987) in relation to a specific audience and situation. When manhood acts are performed, men may emphasize different aspects of these dominant ideals (i.e. being the breadwinner, being in control, emotionally detached, independent and/or self-reliant) based on social context (Kimmel, 1996; Kimmel et al., 2005; Connell and Messerschmidt, 2005; Garnham and Bryant, 2014).

More recently an emerging body of empirical work examining the intersection of depression and masculinity sheds light on men's experiences. For example, Emslie et al. (2006) argue that some men can construct accounts of depression that reproduce hegemonic masculine ideals, while others produce accounts that reframe or resist these constraining set of expectations (Roy et al., 2014). Even though these latter men constituted a small group, Emslie et al. (2006, 2255) posit that established assumptions about depressed men's inability to express emotions, sensitivity, and articulate their feelings of sadness can be misguided because some men have different resources to reconstruct, resist or reinterpret "feelings of difference," which are typically associated with feminizing or emasculating conditions (see also Johnson et al., 2012; O'Brien et al., 2005; Oliffe et al., 2012). For older men these resources may have changed or eroded altogether, thus this poses interesting questions about how they make sense of emotional suffering in light of dominant conceptions of manhood. Might older men with deeply rooted perceptions of masculinity be able to reformulate alternative masculine selves? If so, how do they deploy agency in the context of extant emotional suffering and normative expectations?

5. Depression and aging

While depression in older adults is better understood from a life course perspective, often medical and public health approaches ignore the illness career and the social and cultural contexts in which emotional suffering is experienced. Moreover, while epidemiological studies document the low prevalence of emotional distress among older adults, Mechanic and McAlpine (2011, 480) note that there is a "persistent belief among clinicians that