

## Men's Hidden Depression

In the middle of the journey of our lives,  
I found myself upon a dark path.

—DANTE

When I stand beside troubled fathers and sons I am often flooded with a sense of recognition. All men are sons and, whether they know it or not, most sons are loyal. To me, my father presented a confusing jumble of brutality and pathos. As a boy, I drank into my character a dark, jagged emptiness that haunted me for close to thirty years. As other fathers have done to their sons, my father—through the look in his eyes, the tone of his voice, the quality of his touch—passed the depression he did not know he had on to me just as surely as his father had passed it on to him—a chain of pain, linking parent to child across generations, a toxic legacy.

In hindsight, it is clear to me that, among other reasons, I became a therapist so I could cultivate the skills I needed to heal my own father—to heal him at least sufficiently to get him to talk to me. I needed to know about his life to help understand his brutality and lay my hatred of him to rest. At first I did this unconsciously, not out of any great love for him, but out of an instinct to save myself. I wanted the legacy to stop.

One might think that I would have brought to my work a particular sensitivity to issues of depression in men, but at first I did not. Despite my hard-won personal knowledge, years passed before I found the courage to invite my patients to embark upon the same

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journey I had taken. I was not prepared, by training or experience, to reach so deep into a man's inner pain—to hold and confront him there. Faced with men's hidden fragility, I had been tacitly like most therapists—indeed, like most people in our culture—to protect them. I had also been taught that depression was predominantly a woman's disease, that the rate of depression was somewhere between two to four times higher for women than it was for men. When I first began my clinical practice, I had faith in the simplicity of such figures, but twenty years of work with men and their families has lead me to believe that the real story concerning this disorder is far more complex.

There is a terrible collusion in our society, a cultural cover-up about depression in men.

One of the ironies about men's depression is that the very forces that help create it keep us from seeing it. Men are not supposed to be vulnerable. Pain is something we are to rise above. He who has been brought down by it will most likely see himself as shameful, and so, too, may his family and friends, even the mental health profession. Yet I believe it is this secret pain that lies at the heart of many of the difficulties in men's lives. Hidden depression drives several of the problems we think of as typically male: physical illness, alcohol and drug abuse, domestic violence, failures in intimacy, self-sabotage in careers.

We tend not to recognize depression in men because the disorder itself is seen as unmanly. Depression carries, to many, a double stain—the stigma of mental illness and also the stigma of “feminine” emotionality. Those in a relationship with a depressed man are themselves often faced with a painful dilemma. They can either confront his condition—which may further shame him—or else collude with him in minimizing it, a course that offers no hope for relief. Depression in men—a condition experienced as both shame-filled and shameful—goes largely unacknowledged and unrecognized both by the men who suffer and by those who surround them. And yet, the impact of this hidden condition is enormous.

Eleven million people are estimated as struggling with depression each year. The combined effect of lost productivity and med-

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ical expense due to depression costs the United States over 47 billion dollars per year—a toll on a par with heart disease. And yet the condition goes mostly undiagnosed. Somewhere between 60 and 80 percent of people with depression never get help. The silence about depression is all the more heartbreaking since its treatment has a high success rate. Current estimates are that, with a combination of psychotherapy and medication, between 80 and 90 percent of depressed patients can get relief—if they ask for it. My work with men and their families has taught me that, along with a reluctance to acknowledge depression, we also often fail to identify this disorder because *men tend to manifest depression differently than women*.

Few things about men and women seem more dissimilar than the way we tend to handle our feelings. Why should depression, a disorder of feeling—in psychiatric language, an *affective disorder*—be handled in the same way by both sexes when most other emotional issues are not? While many men are depressed in ways that are similar to women, there are even more men who express depression in less well-recognized ways, ways that are most often overlooked and misunderstood but nevertheless do great harm. What are these particularly male forms of depression? What are their causes? Is the etiology of the disorder the same for both sexes? I think not. Just as men and women often express depression differently, their pathways toward depression seem distinct as well.

Traditional gender socialization in our culture asks both boys and girls to “halve themselves.” Girls are allowed to maintain emotional expressiveness and cultivate connection. But they are systematically discouraged from fully developing and exercising their public, assertive selves—their “voice,” as it is often called. Boys, by contrast, are greatly encouraged to develop their public, assertive selves, but they are systematically pushed away from the full exercise of emotional expressiveness and the skills for making and appreciating deep connection. For decades, feminist researchers and scholars have detailed the degree of coercion brought to bear against girls’ full development, and the sometimes devastating effects of the loss of their most complete, authentic selves. It is time

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to understand the reciprocal process as it occurs in the lives of boys and men:

Current research makes it clear that a vulnerability to depression is most probably an inherited biological condition. Any boy or girl, given the right mix of chromosomes, will have a susceptibility to this disease. But in the majority of cases, biological vulnerability alone is not enough to bring about the disorder. It is the collision of inherited vulnerability with psychological injury that produces depression. And it is here that issues of gender come into play. The traditional socialization of boys and girls hurts them both, each in particular, complementary ways. Girls, and later women, tend to internalize pain. They blame themselves and draw distress into themselves. Boys, and later men, tend to externalize pain; they are more likely to feel victimized by others and to discharge distress through action. Hospitalized male psychiatric patients far outnumber female patients in their rate of violent incidents; women outnumber men in self-mutilation. In mild and severe forms, externalizing in men and internalizing in women represent troubling tendencies in both sexes, inhibiting the capacity of each for true relatedness. A depressed woman's internalization of pain weakens her and hampers her capacity for direct communication. A depressed man's tendency to extrude pain often does more than simply impede his capacity for intimacy. It may render him psychologically dangerous. Too often, the wounded boy grows up to become a wounding man, inflicting upon those closest to him the very distress he refuses to acknowledge within himself. Depression in men, unless it is dealt with, tends to be passed along. That was the case with my father and me. And that was the situation facing David Ingles and his family when we first met.

"So, what do you get when you cross a lawyer, a dyslexic, and a virus?" David, himself a lawyer, eases into his accustomed chair in my office.

His wife, Elaine, also a lawyer in her mid-forties, and their seventeen-year-old son, Chad, show no signs of curiosity. Elaine levels

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a gaze a few inches above her husband's left ear. Without looking at him, she says simply, "No, David." And we all sit for awhile in ponderous, uncomfortable silence. David stares at me amiably, a tall man grown pudgy in middle age, with an open, dark face and thinning black hair. Sitting across from her husband, Elaine angles her small, muscular body as far from him as possible. Chad, a beanpole in baggy pants and a T-shirt, puts on a pair of wire-rimmed John Lennon sunglasses and rotates his chair toward the wall.

"Take off the glasses," David mutters to Chad, who ignores him.

While David glares at Chad, Elaine informs me, once again, that David is really quite a good father, involved, caring.

"Take them off!" David repeats.

Chad grunts and slumps further away.

I had been treating David and Elaine for close to six months. Elaine first wanted me to see the two of them, not for Chad's sake but for the sake of their marriage. After twenty years she had to admit that she felt—and had felt for some time now—miserably alone. David was good-natured, helpful, cooperative. The problem was that she felt like he just wasn't there. For a while, she had wondered if he was having an affair, but David seemed too *vague* to pull off an affair. More and more, he moved through his life savoring nothing, not her, not his son, not even his own success. For years he had been working too hard. Now he had also begun drinking too much and, on too many occasions, blowing up. Elaine worried about David's anger; she worried about his health. Although she had not yet said it out loud, Elaine already knew by the time she called me that she was on the verge of leaving her husband.

David had weathered his wife's complaints before. His strategy had always been to batten down the hatches and wait until it all blew over. "Sort of an extended PMS" was how he had described her dissatisfactions. As their therapist, I informed him that this time he might have to do some changing himself. But when David showed signs of responding, Chad began acting up, so I asked them to bring in their son, "as my consultant." I was interested to hear

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what this boy—who was in the middle of their marriage from the day he had been born—would have to say about his parents. But Elaine had another agenda.

"David," Elaine says evenly. "You need to tell Terry about hitting Chad."

"I didn't hit him," David says sullenly.

"Whatever." Elaine shrugs this off. "It needs to be addressed."

David hovers for a moment between fighting and giving in. Then he sighs, leans back in his chair, and tells me the story.

"Chad was walking out the back door last night," he begins, "with the keys to the car in hand. Elaine and I were in the kitchen, and I asked him a few questions—Where was he going?—that sort of thing."

"Yeah right," snorts Chad.

His father's pointed finger shoots up at him. "Was I unreasonable?" David asks. "Was I?"

"All right," I calm David. "Tell me what happened."

"So, he doesn't answer. And Elaine and I follow him into the garage"—he glances reproachfully at his son—"where he starts to give me a lot of back talk. Right?" he turns to Chad.

"Go on," I say softly.

"Well, I tell him, 'Fine. If you want to keep up the back talk, then I keep the car.' You know, 'Hey, it's your choice, okay?' And he throws the keys against the car . . ."

"On the ground," says Chad.

"Against the car," repeats his father, "and then I hear, 'Fuck you' under his breath." David falls silent.

I try catching his eye. "At which point you . . ." I prompt.

"I pushed him," he allows.

"You pushed him," I repeat.

"Yes. You know, I shoved him. Whatever. I pushed him." David stares intently at the spot of rug between his feet.

"Hard?" I ask.

David shrugs.

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"Hard enough," says Elaine.

I look for a moment at Chad. Behind his glasses, I cannot tell his expression, or even if he is crying. I am suddenly aware of how thin he is, how young.

I stand up, motioning David to stand beside me. "Show me how it went," I say.

In conventional individual therapy, people tell their therapist about the things that have happened to them out in the world. In family therapy, the major players in such events are often sitting together in the therapist's office. It is a tradition in family therapy to shift from reporting about tough events to having the family reenact them. Bringing the scene palpably into the room adds an emotional charge that the therapist can use to advantage.

Reluctantly, with many safeguards and assurances, David and his family let me set up the scene. Chad still wears his sunglasses. When they get to the part where Chad throws down the keys and mutters "Fuck you" under his breath, David, with alarming speed, throws his son against the wall of my office so hard that he knocks a picture off one of its hooks, leaving Chad winded. David has pinned his forearm against his son's throat. His muscles are taut and his breathing is hard. "Say it again!" he threatens. "Go ahead. Say it again!"

Chad is gasping for breath. He is scared. Elaine is scared. My heart is pounding as well.

"David." I touch his shoulder gently while looking at Chad. "It's okay." I can feel his muscles relax under my touch. "I get it," I say. "Really clearly. Good job."

Everyone takes a deep breath and after a while our hearts stop hammering. I ask Elaine if she would role-play David, and she agrees. Now I mold her into position as David, with her forearm against Chad's throat. Then I walk with David to the far end of the room, and I ask him to take a good look at this tableau. We stand for a long time together, our shoulders almost touching. Whether it is my imagination or not, I can feel sadness radiating from him, like heat, as we stand side by side.

"What do you see, when you look at this?" I ask him. "What do you feel?"

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David drops his head. After a long while he speaks. "I guess it's not right," he offers, ever so meekly.

"Pretty grim," I agree. After a pause, he nods. "Tell *bim*," I say, nodding toward Elaine, who is role-playing David, still with an arm pressed against Chad's throat. "Tell him what he needs to hear."

David shuffles about uncomfortably. "You're a jerk," he cracks, halfheartedly.

"No, I mean it." I say, standing close. "Tell him."

David pauses for a long time, then he lifts his head and addresses his role-played self. All traces of self-mockery or humor have left him. "Don't do it," he says quietly.

"Don't do what?" I push him.

"Don't treat him that way." His voice is small, flat.

"Is that enough force to stop this guy?" I ask.

"No," he agrees.

"It's going to take some conviction," I tell him. "Some *oomph*, you know what I mean?"

David nods.

"You want to try it again?" I ask.

Without answering in words, David obediently squares off. This time he reaches deeper in and his voice carries some weight. "Don't treat him this way," he says.

"More," I say. "Louder."

"Don't treat him this way," David repeats.

"Good!" I say. "Do it again. Tell him why."

"Don't fuck with him," David begins. "Just don't . . ." and then the dam breaks. "He's your *son*, for Christ's sake!" David yells, thoroughly enrolled. "For Christ's sake! He's your *son*."

David suddenly deflates, crestfallen and profoundly sad. I have not seen him look this way in the months we have worked together. This is an opening.

As his sadness grows in the space between us, I ask, "Tell me, who else are you talking to, right now? Is there anyone else standing beside this guy as you say this? Friend? Teacher? Mother? Father?"

David looks absolutely defeated. "I guess," he allows.

"So, who is it?" I ask softly.

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Embarrassed and angry, he says, "My father."

"Tell me about him," I ask.

David sketches the portrait of a responsible, taciturn, working-class man who put in long hours to provide for his family, who loved them all—though he rarely spoke it—whose sudden temper sometimes got the better of him.

"I guess the apple hasn't fallen too far from the tree," David says with a sheepish smile.

"We're working on it," I assure him. We look together at the frozen tableau facing us across the room, both of us thinking.

"Don't treat *bim* this way," I repeat, musing. "David, can you give me a particular memory, a scene, a vignette that would capture that feeling with your dad?"

At first David does not remember any, but then he begins to tell me:

David recalls himself as a boy of seven or eight handing his father a report card with a bad grade. He is nervous because of the D he got in some subject or other.

"We don't get D's in this family," his father intones, in David's memory. And then, in a sudden, raw temper, his father reaches out, grabs the report card, and rips it to pieces.

"Take that back to your teacher," his father says.

Frightened and angry, young David grabs at his father's hands. "What did you do that for!!!" he screams. Without a word his father draws back his huge fist and lands it squarely on the boy's chest, knocking him to the ground.

"I haven't thought about that for years," says David.

Again, I get up. "Show me," I ask him.

David and I act out the scene first. And then Chad and Elaine agree to reenact it. David and I step to one side, as we watch Chad playing the young David, with Elaine playing David's dad.

"We don't get D's in our family!"—once, twice, three times the fist goes out until the scene feels real enough that violence is palpable in the air.

"Okay, David," I say. "Fix this scene. Make it right."

David looks down at me for a moment, quizzically, and then,

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without a word, signals the players to begin. Again, the frightened boy offers the offending report card. The father destroys it. The boy protests. The father leans into his swing—but at just that moment David steps forward, catching the fist in his own large hand and enveloping it.

David looks his "father" in the eye and says very quietly but with full conviction, "Don't do it, Dad. Don't touch the boy." I notice he is shaking as I step in behind him.

"Don't hurt him, Dad," I prompt.

"Don't hurt him," David repeats. He has begun to tear up.

"He's just a little boy," I prompt.

"He's just a little boy." David bends over and cries. It is a strangled cry without sound that lifts his shoulders.

"Don't hold it back, David," I say. "You'll just give yourself a headache."

David sits down, still crying, his face hidden in his hands. Elaine pulls her chair next to him, rests her palm on his thigh. I ask Chad to pass his father the tissues. As he does, for just a moment, briefly, almost furtively, David grasps his son's hand. Chad takes off his sunglasses and folds them into the pocket of his shirt.

David did not know it, but he was depressed. Along with whatever biological vulnerabilities he may have carried, David's depression was born from the pain of that little boy—not just from this one incident with his father, but from hundreds, perhaps even thousands of similar moments, small instances of betrayal or abandonment, perhaps more subtle than this one but just as damaging. For those with a biological vulnerability to the disorder, such moments can become the building blocks of depression, a condition which, conceived in the boy, erupts later on in the man. David's unrecognized pain ticked inside like a bomb, waiting for its appointed time. The force of that ticking pushed him from his family. It sped him toward mood buffers and self-esteem enhancers like work, alcohol, and occasional violence. By the time I first met him, his son was on the edge of school failure and his wife was on the verge of filing for

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divorce. The bomb inside was due to release itself and his life was about to explode. And neither he nor anyone close to him would have understood why. But I knew why.

I knew what it felt like to have the breath knocked out of you by your own father, what it meant to be thrown against a wall and dared to fight back. Intimacy with the sticky threads of loving violence that bind parents to sons across generations helped me recognize David's secret. Deep inside his bullying and drinking, his preoccupations and flight, lay that little boy. The depressed part of David, his unacknowledged child, waited in darkness, resentfully, for its moment in the light, wreaking havoc upon anyone near. Showing great courage, David allowed, on that afternoon in my office, the pain he had carried within for decades to break through to the surface. His vulnerability drew the people he loved back toward him. The appearance of his hidden depression permitted him to touch and to be touched after a long, bristling time behind armor. In his struggle, David Ingles is not alone.

In order to treat a man like David, I must first "get at" him, "crack him open." The patient needs help bringing his depression up to the surface. Depressed women have obvious pain; depressed men often have "troubles." It is frequently not they who are in conscious distress so much as the people who live with them.

If you had asked David what was bothering him, before that session, it is uncertain what he would have answered, or even if he would have given an answer at all. Like a lot of the successful men I treat, David was unpracticed in, even wary of, introspection.

What David might have told you was that he was unhappy at work, where he had a new senior partner to deal with, whom he neither liked as well as his old mentor nor felt particularly favored by. He might have told you that over the last several years he had grown increasingly restless—to the point where it had become difficult for him to sleep at night without pills and hard to get through a dinner at a friend's house without a few cocktails. David knew—though he would not have bored anyone other than Elaine with the

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details—that he was bothered more and more by stomachaches and by backaches, which his internist chalked up to “stress,” a medical opinion that David dismissed as “the great twentieth-century catchall.”

David’s physician was right, however, although his diagnosis did not go nearly far enough. David was “stressed.” At forty-seven, he had begun to feel old. He did not like the spare tire that no amount of racquetball seemed to touch. He did not like the receding hairline. And he did not like looking at the kind of women he had always admired only to have them now look away with disinterest or sometimes with outright disdain. If asked, David would gladly have unloaded his feelings of disappointment about his difficult son, Chad. He might even have voiced his sense of betrayal by Chad’s “overprotective mother,” who, from the day of Chad’s birth, had undercut his attempts to be firm with the boy. Toward the end of an evening, after a sufficient number of drinks, David might have confessed his unhappiness in his marriage—how unsupported he felt, how much like a stranger in his own home. Not once would it have occurred to him that he might be suffering from a clinical condition. But the depression David neither felt nor recognized was close to fracturing his family. It was eating away at his relationship with his son and eroding his marriage. In his efforts to escape his own depression, David had let himself sink into behaviors—like irritability, dominance, drinking, and emotional unavailability—that pushed away the very people whom he most loved and needed. As Elaine described it, he was no longer himself. Like Shakespeare’s Lear, David, without realizing it, had lost his estate. “What do you see when you look at me?” demanded the broken king of his fool. And the fool replied, “Lear’s shadow.” Depression was whittling David, fading him to a shadow state as surely and inexorably as a physical disease like cancer or AIDS. As one of my clients put it, depression was “disappearing” him.

We do not generally think of driven men like David as being depressed. We tend to reserve the concept of depression for a state of

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profound impairment, utter despair, thorough debilitation. A truly depressed man would lie in bed in the morning, staring up at the ceiling, too apathetic to drag himself off to another meaningless day. By comparison, what David faced seemed barely to qualify as midlife malaise. As Thoreau once wrote: “The mass of men lead lives of quiet desperation.” Others, not so quiet. When we think of depression, it is to those “others, not so quiet” that our thoughts usually turn.

For close to twenty years, I have treated those others—men with the kind of depression most of us easily discern. I call this state *overt depression*. Acute and dramatic, the pain inflicted by overt depression is writ large. In contrast, David’s type of depression was mild, elusive, and chronic. The kind of depression from which David suffers is not even referenced in most of the literature about the disorder. The guidebook for diagnosis used by most clinicians throughout the country is the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders* (DSM IV) which labels a person as having a clinical depression only if he or she shows, for a duration of at least two weeks, signs either of feeling sad, “down,” and “blue,” or having a decreased interest in pleasurable activities, including sex: In addition, the person must exhibit at least four of any of the following symptoms: weight loss or gain, too little or too much sleep, fatigue, feelings of worthlessness or guilt, difficulty making decisions or forgetfulness, and preoccupation with death or suicide.

The condition described in the DSM IV is the classic form of depression most of us think of. Although many men may be reluctant to admit that they are suffering from overt depression, the disorder itself has been recognized since ancient times. As early as the fourth century, B.C., Hippocrates, “the father of medicine,” reported a condition whose symptoms included “sleeplessness, irritability, despondency, restlessness, and aversion to food”—a description of overt depression easily recognizable today. Hippocrates saw the malady as caused by an imbalance of black bile, one of the four humors, and he therefore named the disease simply “black bile,” which in Greek reads *melanae cbole*, or *melancholia*.

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Overt depression preys upon men, women, and sometimes children from all walks of life, all classes, all cultures. Epidemiologists have found descriptions resembling overt depression throughout the world—both in developed and in developing societies. And the number of overtly depressed people seems to be on the rise. Researcher Myrna Weissman and her colleagues checked medical records going back to the beginning of the century. They calculated that, even allowing for increased reporting, each successive generation has doubled its susceptibility to depression. Such trends were corroborated worldwide in a random sampling of 39,000 subjects from such diverse countries as New Zealand, Lebanon, Italy, Germany, Canada, and France. Researchers have found depression in greater numbers and at earlier ages than ever before throughout the world.

The National Institute for Mental Health reports that in the United States somewhere between 6 and 10 percent of our population—close to one out of every ten people—are battling some form of this disease. And yet, as sobering as these figures may be, I believe they greatly underestimate the full impact of depression in men's lives. A man like David Ingles, whose condition manifests itself in ways more subtle than those described by the DSM IV, would not have been included in these figures, even while the effects of his less obvious disorder are powerful enough to threaten his health and break up his family. Why is it that not only the general public but even the medical and psychiatric community give credence to depression in only its most obvious and most severe form? In a recent national survey, over half of the people questioned did not see depression as a major health issue. In another survey, in which 25 percent of the respondents had themselves experienced depression, and another 26 percent had observed it in family members, close to half of the respondents still viewed the disorder not as a disease or a psychological problem deserving of help, but rather as a sign of personal weakness.

Our current patterns of judgment and denial about depression are reminiscent of the older moralistic attitudes toward the disease of alcoholism, and the source of our minimization is much the same now

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as it was then. The issue is shame. While depression may carry some sense of stigma for all people, the disapprobation attached to this disease is particularly acute for men. The very definition of manhood lies in "standing up" to discomfort and pain. It is sadly predictable that David would be more likely to react to depression by redoubling his efforts at work than by sitting still long enough to feel his own feelings. Until therapy, "giving in" to his pain would have been experienced by David not as a path toward relief, but as a humiliating defeat. In the calculus of male pride, stoicism prevails. All too often, denial is equated with tenacity—"Under the bludgeonings of chance / My head is bloody, but unbowed."

When David Ingles runs from his own internal distress, he plays out our culture's values about masculinity. As a society, we have more respect for the walking wounded—those who deny their difficulties—than we have for those who "let" their conditions "get to them." Traditionally, we have not liked men to be very emotional or very vulnerable. An overtly depressed man is both—someone who not only has feelings but who has allowed those feelings to swamp his competence. A man brought down in life is bad enough. But a man brought down by his own unmanageable feelings—for many, that is unseemly.

This attitude often compounds a depressed man's condition, so that he gets depressed about being depressed, ashamed about feeling ashamed. Because of the stigma attached to depression, men often allow their pain to burrow deeper and further from view. Physician John Rush spoke in an interview about the stain of "unmanliness" attached to the condition and its possible consequences:

[Depression] doesn't mean I'm weak, it doesn't mean I'm incurable, it doesn't mean I'm insane. It means I've got a disease and somebody better treat it. One of my friends says, "Depression? Hell, boy, that's wimp disease." Wimp disease? Oh, yeah, it's wimp disease. And I guess the ultimate wimp kills himself.

What John Rush implies is correct. For many men—ashamed of their feelings and refusing help—"wimp disease" can kill. Men are four times more likely than women to take their own lives.

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Over the last twenty years, researchers have investigated the relationship between traditional masculinity and physical illness, alcohol abuse, and risk-taking behaviors—and have demonstrated what most of us already know from common experience: many men would rather place themselves at risk than acknowledge distress, either physical or emotional. In *The Things They Carried*, Tim O'Brien gives a clear example of the force of men's shame, when he remembers his fellow "grunts" in Vietnam:

They carried their reputations. They carried the soldier's greatest fear, which was the fear of blushing. Men killed, and died, because they were embarrassed not to. It was what brought them to the war in the first place, nothing positive, no dreams of glory or honor, just to avoid the blush of dishonor. They crawled into tunnels and walked point and advanced under fire. They were too frightened to be cowards.

Preferring death to the threat of embarrassment, the men O'Brien describes remind me of Harry, the old-fashioned Irish father of one of my clients, who was too ashamed to see a doctor until cancer had eaten away half of a testicle.

The theme of the "manly" denial of vulnerability was epitomized by my patient Stan, a twenty-one-year-old undergraduate whom I saw for a short time. One hot night in Fort Lauderdale during spring break, Stan let himself be drawn into a Hollywood-style barroom brawl with some locals. After "too many brews" and "with a bunch of sweaty pals" to show off to, Stan started swinging just like they do in the movies. Stan bragged to me that he "did a lot of damage that night." Evidently someone did some damage to him as well. One punch was enough to sever a nerve in his cheek and cause paralysis in almost half of Stan's face. The skin hangs like leather. Stan, having seen so many celluloid heroes take a drubbing only to stand up and dust themselves off again, never considered that another man's punch could do such a thing to his face.

Men's willingness to downplay weakness and pain is so great that it has been named as a factor in their shorter life span. The ten

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years of difference in longevity between men and women turns out to have little to do with genes. Men die early because they do not take care of themselves. Men wait longer to acknowledge that they are sick, take longer to get help, and once they get treatment do not comply with it as well as women do.

For generations, we have chosen male heroes who literally are not made of vulnerable flesh—Superman, "the man of steel," Robocop, Terminators I and II. And our love of invulnerability shows little sign of abating. Both celebrities and ordinary men across the country have developed a new fascination with muscle. Every one of 256 nonmuscular adolescent boys studied by psychologist Barry Glassner demonstrated either mood or behavioral disruptions related to feelings of inadequacy. And a national survey of 62,000 readers conducted by *Psychology Today* showed a direct correlation between self-ratings of high self-esteem in men and self-ratings of muscular physiques. Men's preoccupation with "hard bodies" is fast encroaching upon traditionally female domains such as anorexia and bulimia. For the first time, a significant number of men have begun to join women in developing obsessive concerns about the size and shape of their physiques. In America, it seems, a woman cannot be too thin and a man cannot be too hard.

Trends like these underscore that, despite current talk about the "new man," and the "sensitive man," any slippage in the strict code of masculine invulnerability may be little more than window dressing. While some aspects of traditional masculinity may be changing, the code of invulnerability remains much as it was twenty years ago when Pat Conroy wrote his autobiographical novel *The Great Santini*. Colonel Frank Santini, after emotionally brutalizing his son, goes on to give the boy a critical piece of advice.

"Above all else," Santini tells him, "you must guard your six. Remember, *always protect your six*."

Your "six," in the pilot's jargon Dad spoke, was a fighter plane's vulnerable back engine—its rectum, its Achilles heel. As a family therapist, I read such a scene between father and son with mixed emotion. Santini's code of invulnerability perpetuates pain. And

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yet, until that code changes, we cannot dismiss his advice as altogether stupid. The world of men and boys can be a tough one. It turns out, for example, that depressed men are not being altogether paranoid when they fear the reaction of others to their admission of turmoil.

Researchers Hammen and Peters tested hundreds of college roommates on exactly this issue. They found that when female college students reached out to their roommates for support about being depressed, they met with nurturing and caring reactions. In contrast, when male students disclosed depression to their roommates, they met with social isolation and often with outright hostility. The "roommate study" was later repeated on campuses all over the country with much the same results. It is true that men do not easily disclose their depression. But it also seems true that many may have good reason to hide.

"My first therapist told me to reach out to people," said Steven, a patient of mine in his thirties. "I was in medical school at the time—which, by the way, my shrink had been through himself, so you'd think he might have known better. 'Reach out,' he says. So good old Stevie—who always does as he's told—began reaching out. Boy, was I naive! Reach out and get crushed by someone. I think my friends would have stayed closer to me if I'd said I had AIDS. My brother decided he was too busy to talk to me for the next seven months. You know those depressed guys you read about who have this delusion that they put out a stink—you know, that they smell? Well, I think I get how they feel."

The stigma surrounding depression often affects both the distressed man and his family. For family members, there may be an impulse to "protect the male ego" by colluding in the man's obfuscation. In one session, Elaine spoke to me of not wanting to "show David up" by addressing the pain she felt radiating from him. Partners of depressed men often express fear that naming the man's condition will only make matters worse. It is better just to "get on with it" and "not dwell on the negatives." But when we minimize a

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man's depression, for fear of shaming him, we collude with the cultural expectations of masculinity in a terrible way. We send a message that the man who is struggling should not expect help. He must be "self-reliant." He must resolve his distress on his own.

In the same way that family members and friends may feel awkward or even cruel in confronting a depressed man's condition, so too may medical care providers, who are not immune to our culture's prejudices. John Rush put it this way:

Doctors are still reluctant to make the diagnosis [of depression] because they, too, feel like, "Oh, you must have done something wrong. How did you get yourself into this pickle?" which sort of means the patient is to blame. It's okay if you have a neurological disease—Parkinson's, Huntington's, urinary incontinence, a busted spine because you got into an auto accident—but once you move up to the higher cortical areas, now you don't have a disease anymore; now you have "trouble coping"; now you have a "bad attitude."

In one session Elaine reported that, worried about her husband, she had insisted that David "check in" with their family doctor, a man who over the years had become a friend. David described the visit to me as a case of "the reluctant leading the awkward."

"I'm very fond of Bob," David said, "but let's face it. He's a lot more comfortable talking over test results than asking about the state of my mind."

"Or your drinking," Elaine piped in.

"Or my drinking," David allowed.

Mental health professionals, who presumably are trained to see beyond a man's report of unease or bodily complaints, are not much more successful than general practitioners with this issue. Many psychotherapists, particularly in the current, managed care environment, would treat the manifestations of David's depression—his drinking, marital tensions, or troubles at work—in short-term, focused therapy without identifying these symptoms' underlying cause.

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One factor mitigating against the recognition of David's condition is that mental health professionals, no less than anyone else, tend to look for what they expect to find. The conventional wisdom that women are depressed while men are not leads some therapists away from an accurate diagnostic assessment.

A number of studies looking at who gets labeled as being depressed have been carried out nationwide. Some, like the Potts study involving no less than 23,000 volunteer subjects, have been conducted on a massive scale. The results of most of them show a tendency for mental health professionals to overdiagnose women's depression and underdiagnose the disorder in men.

In a study of a different nature, psychologists were given hypothetical psychiatric "case histories" of patients with a variety of complaints. Only one variable was changed, the sex of the client. Consistently, psychologists diagnosed the depressed "male" clients as more severely disturbed than depressed "female" clients. On the other hand, women alcoholics were viewed as being more severely disturbed than their male counterparts. These conflicting results show that an overlay of gender expectations complicates the judgment of clinicians. It seems that they are punishing clients of both sexes with a more severe diagnosis for crossing gender lines. If it is unmanly to be depressed and unwomanly to drink, then a depressed man must be *really* disturbed, just like an alcoholic woman.

While a great many men conceal their condition from the outside world, and while those close to them—loved ones, doctors, even psychotherapists—may miss a diagnosis of overt depression, a man like David Ingles goes even further with the deception. David not only managed to camouflage his condition from those around him; he managed to hide it even from himself. A great many men never make it into the official roll call of the depressed because their overt depression remains undiagnosed. But other men, like David, fail to get help because their expression of the disease does not fit the classic model as described in the DSM IV. David suffers

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from what I call *covert depression*. It is hidden from those around him, and it is largely hidden from his own conscious awareness. Yet it nevertheless drives many of his actions. David Ingles buries himself in work; he wraps his disquiet in anger and numbs his discontent with alcohol. Everywhere in his life, the prohibition against bringing his vulnerable feelings into the open fosters behaviors that leave him and the people around him ever more disconnected. An unrecognized swell of abandonment washes over David when Elaine does not respond to him and causes him to wall her off in subtle retaliation—throwing the couple into an escalating cycle of alienation. David's unacknowledged desperation to be involved with Chad—to be the kind of father his father was not—leads him, paradoxically, to bully his son, to reenact the very drama he wishes to avoid. My work with families like the Ingleses has convinced me that many of the difficult behaviors one sees in men's relationships are depression driven.

Under the names of "masked depression," "underlying characterological depression," and "depression equivalents," the kind of disguised condition David suffers from has been written about sporadically for years. But it has rarely been systematically studied. Researcher Martin Opler observed as far back as 1974: "Masked depression is one of the most prevalent disorders in modern American society, yet it is perhaps the most neglected category in psychiatric literature." That neglect continues. If *overt depression* in men tends to be overlooked, *covert depression* has been rendered all but invisible.