

## Conclusion

Julian Tudor Hart, a retired GP, widely respected for his contribution to general practice and epidemiological research, recaptured his memories of 'going to the doctor' in a paper published in an edited collection in 2000. Drawing upon a lifetime of experience, he emphasised the importance of the social context of disease. Citing a British study on clinical consultations undertaken in 1975, he reminded readers that this research had indicated '85 per cent of all final diagnoses were reached by simply listening to patients' stories'.<sup>1</sup> Recalling over fifty years of experience of treating patients who presented with ill-defined symptoms with no detectable organic disease, he eloquently articulated much of what has been described throughout this book. Somatic labels, he noted, were often dependent on the current 'fashion'. In his lifetime, hysterical paralysis had become chronic, post-viral fatigue, while ill-defined abdominal pains were consecutively labelled 'grumbling' appendix, spastic colon and irritable bowel syndrome. When it came to psychological illness, Tudor Hart remarked stridently: 'It is hard for later generations to appreciate the hostility of almost all British GPs in the first two thirds of the [twentieth] century to any psychiatric diagnoses other than the gross institutionalised end-stage psychoses they had seen as students.'<sup>2</sup> Drawing on an anecdote from Arthur Watts, who wrote widely about psychological illness in his own general practice, Tudor Hart recounted a story that brutally reflected the realities of psychological illness in primary care. Watts, who described himself at the beginning of his career as having 'a complete blind spot as regards depression', once treated a male patient complaining of constipation. When physical examinations and an X-ray revealed no abnormality, he reassured the patient that there was nothing to worry about and sent him home. Watts recalled: 'He went straight home and put his head in

a gas oven. Even when I heard the news, it never dawned on me that I had missed a classic case of depression; indeed, I felt rather indignant that he hadn't believed me.<sup>3</sup>

Primary care training and practice has undoubtedly been transformed since this time and, since the 1970s, increasing emphasis has been placed on the consultation process and the broader context of disease. *The Future General Practitioner*, a key text published in 1972, indeed stated that general practice comprised a set of 'broad goals'; one of these was to see diagnoses composed 'in physical, psychological and social terms'; another was to understand the ways in which 'interpersonal relationships within the family can cause illness or alter its presentation, course and management'. The book also stated that family doctors should be able 'to demonstrate an understanding of the relationship between health and illness on the one hand, and the social characteristics of patients on the other'.<sup>4</sup> The book *Language and Communication in General Practice*, edited by Bernice Tanner and published in 1976, was another important text which aimed to bridge the separation between the didactic information taught in medical school and the communication skills needed in general practice.<sup>5</sup> Currently, one of the central tenets of general practice postgraduate training is a patient-centred approach in which new doctors are encouraged to 'accept the subjective world of patient health beliefs, the family and cultural influences in the different aspects of intervention'.<sup>6</sup> Another outlined area of competence is 'holistic care', in which GPs are required to show their ability 'to understand and respect the values, culture, family structure and beliefs of [their] patients, and understand the ways in which these will affect the experience and management of illness and health'.<sup>7</sup> The current syllabus explicitly states that there is a requirement for new doctors to understand the concept of the bio-psychosocial model as promoted by Engel, and the notion that 'illnesses have both mental and physical components, and that there is a dynamic relationship between them' – a notion they acknowledge has led to criticisms of the purely biomedical model.<sup>8</sup>

Despite these changes, it is a sobering thought that the current rate of suicide in men in Britain is over three times that of women.<sup>9</sup> In 2012, 4,590 men and 1,391 women ended their own lives. Men are three times more likely than women to become alcohol dependent, and 73 per cent of adults who 'go missing' are men. Men are also more than twice as likely to use Class A drugs, and 79 per cent of drug-related deaths occur in men. These wider indicators therefore suggest that there is something very misleading about the commonly perceived notion that women

are more likely than men to experience mental disorders.<sup>10</sup> The World Health Organization's paper on gender disparities in mental health states explicitly that gender stereotyping compounds difficulties with the identification and treatment of mental illness. The author notes: 'Female gender predicts being prescribed psychotropic drugs. Even when presenting with identical symptoms, women are more likely to be diagnosed as depressed than men and less likely to be diagnosed as having problems with alcohol.'<sup>11</sup> Gender bias, according to this document, has skewed the research agenda: 'The relationship of women's reproductive functioning to their mental health has also received protracted and intense scrutiny'.<sup>12</sup> The author concludes that reducing gender disparities in mental health 'involves looking beyond mental illness as a disease of the brain' and requires clinicians, researchers and policy-makers to 'socially contextualise the mental disorders affecting individuals and the risk factors associated with them'.<sup>13</sup> Recent research does appear to suggest that modern services might be 'inherently feminised' because of the disproportionately low number of men working in frontline mental health service provision.<sup>14</sup> Most services are also difficult to access outside the nine-to-five timeframe, creating a further obstacle for men who have decided to seek help.<sup>15</sup> We might legitimately ask, therefore, despite developments in services, medical education and in psychopharmacology, how far *have* we come since Arthur Watts and Julian Tudor Hart were practising during the 1950s and 1960s?

In no way does this book seek to blame the medical profession or its practitioners for this situation. On the contrary, it has sought to illustrate the complexities involved and to reveal the role of not only medical services, but also that of employers, wider society and individuals. Dame Carol Black's report on the health of Britain's working-age population makes for equally depressing reading. When the report was published in 2008, the economic costs of sickness absence and worklessness associated with ill-health had reached a cost of over £100 billion per year. Echoing many of the problems identified fifty years ago in Chapter 2 of this book, Black set out a number of key challenges recommended for reform. She argued that the importance of the physical and mental health of working people – in relation to personal, family and social attainment – is still 'insufficiently recognised by our society'.<sup>16</sup> Reflecting the sentiments of GPs discussing the issuing of sickness certification in the 1960s, the report also suggested that GPs still feel ill equipped to offer advice to patients about remaining in or returning to work. Explicitly, the report noted that 'their training has to date not

prepared them for this'.<sup>17</sup> Additionally, and perhaps most importantly of all, Black stated that:

Detachment of occupational health from mainstream healthcare undermines holistic patient care. A weak and declining academic base, combined with the absence of any formal accreditation procedures, a lack of good quality data and a focus solely on those in work, impedes the profession's capacity to analyse and address the full needs of the working age population.<sup>18</sup>

Shortly after the release of Black's report, researchers from the men's health charity, Men's Health Forum, warned that these findings had potentially serious consequences for men who spend more of their lives in the workplace and are much less likely than women to make use of almost all other forms of primary health provision. In their policy briefing paper, the authors noted that the NHS should 'begin to find ways of delivering services to men more effectively than has been the case in the past. Acting in partnership with employers to deliver health improvement services in the workplace offers a real opportunity to do this'.<sup>19</sup>

On an individual level, 'engaging with the emotional lives of men' in the twenty-first century appears to be no less problematic than it was fifty years ago.<sup>20</sup> As recent research has shown, 'gender, for males as for females, helps to shape life experience and behaviour, impacting most strikingly upon help-seeking and engagement with health services'.<sup>21</sup> When men do seek help, much distress is routinely unrecognised because many men 'effectively abandon psychological reflection'.<sup>22</sup> Research suggests that socialisation for the male role leads some men to develop fewer emotional skills, leaving them less able to identify and articulate their feelings. Alexithymia (the inability to express emotions) is increasingly considered to be an aspect of normative masculinity and 'as such poses a major barrier to men seeking therapy'.<sup>23</sup> There is also some evidence to suggest that alexithymia is associated with somatisation.<sup>24</sup> Frustratingly, many of these observations are not new. Insights presented over thirty years ago by the men's movement in America suggested that 'men have not been socialised to be comfortable either with affective experience or with the processing of their inner experience'.<sup>25</sup> Consequently, 'depression for many men may be a private experience, unshared with others, that men attempt to alleviate or remove by their own efforts without external help'.<sup>26</sup>

The theoretical position presented in *A History of Male Psychological Illness* is that the post-war model of masculinity widely endorsed since the Victorian period has resulted in men being more likely to somatise in distress. The various chapters, thus, in many ways echo the views of Kleinmann, Kirmayer and others. The research also engages with Mechanic's concept of 'illness behaviour' and the notion that 'illness, as well as illness experience, is shaped by sociocultural and social-psychological factors, irrespective of their genetic, physiological or other biological bases'.<sup>27</sup> Indeed, by the 1980s, Mechanic maintained that 'few seriously doubted that the psychosomatic hypothesis was in some sense valid'.<sup>28</sup> It is striking that if one consults Kleinmann's original paper on somatisation, although his focus was on Chinese culture, many of his insights accord with the experiences of male distress in this book. The biomedical model of depression, argued Kleinmann, excludes a wide range of 'depressive phenomena', even in the west. By definition, therefore, physicians will 'find' what is universal, and not that which does not fit its tight boundaries.<sup>29</sup> Although Kleinmann applied this theory to cross-cultural research, it is also consistent with the accounts of male psychological illness put forward in this book. Medical practitioners have indeed 'found' what is universally defined by, and therefore 'seen' within the western biomedical model.<sup>30</sup> Much of what Kleinman observed in the Chinese study is reflected in the western cultural experience of British men from the 1950s: because male mental illness is associated with weakness and therefore stigmatised, for example, the secondary physical complaints are labelled as medical problems, while the psychological issues remain underplayed.<sup>31</sup> Consequently, in the west, 'empirical data on male depression are quite limited; largely because women have been the focus of concern . . . The overriding concern with female depression has obscured the fact that men are not immune to [it]'.<sup>32</sup>

Among psychologists, social scientists and historians, the debate continues unabated. Are women really more prone than men to mental illness? A recent publication by clinical psychologist Daniel Freeman and writer Jason Freeman claimed unequivocally that women are more vulnerable to mental health problems and that this is therefore a major public health issue. The authors set out their argument in a book entitled *The Stressed Sex: Uncovering the Truth about Men, Women and Mental Health* (2013) and in a range of articles in the psychological and national press.<sup>33</sup> Building their thesis from 'large-scale epidemiological surveys', they claim their conclusion is founded upon a representative sample of international populations. In England, for example, Freeman

and Freeman use the Adult Psychiatry Morbidity Survey (APMS), a questionnaire sent to approximately 2,550 households randomly selected across a wide geographical and socio-economic spread.<sup>34</sup> However, in basing their data analysis upon surveys that rely on self-reporting, the authors at once increase the likelihood that women will feature more commonly than men in the data. As we have established, men are less likely to recognise, express or report symptoms of dysthymia and other classic psychological symptoms. Crucially, and as this book has demonstrated, any balanced analysis of gender and psychological stress must include somatoform symptoms and atypical presentations of distress. Nearly all of the surveys analysed by Freeman and Freeman deliberately excluded somatoform presentations, sleep disorders and sexual dysfunction – all common ways in which men express anguish and distress. Their article, ‘The Stressed Sex?’ published in *The Psychologist* in February 2014, prompted a heated response from a group of professional and academic psychologists, who argued that the unwillingness to report psychological symptoms is an ‘unassailable methodological problem’ when seeking to measure ‘sex differences in something as emotive and self-revealing as mental health’.<sup>35</sup> Additionally, the group re-stated the fact that by adhering only to the ICD and DSM criteria, many of the ways in which men manifest psychological distress will be excluded.<sup>36</sup> Indeed, if we continue to adhere to the tightly defined markers determined by the prevailing biological model of mental illness, we will continue to draw similar conclusions from the data. The parallel statistics for male suicide, addiction, homelessness and prison sentencing must surely speak for themselves.

How then might this history of male psychological illness inform current practice and policy? After all, in most cases, historians are not medical professionals and are not usually trained in psychological medicine. These are fields in which we do not work, and do not therefore face the medical contingencies presented daily to those who apply themselves with dedication to their vocation. We should certainly be careful to avoid unmitigated criticism of the biomedical model of medicine. Pathological, biological and physiological developments have, after all, done much on a global scale to alleviate pain and sickness. By drawing on the insights put forward by those such as Engel, neither have I uncritically accepted the notion of a biopsychosocial model, for others have raised valid questions about such an approach – not least that its boundaries and methodology in practice are unclear.<sup>37</sup> It can never be the place of a historian to settle such debates, but we must nevertheless engage with them. The importance of history lies

in its ability to contextualise health and sickness. Historical research explores the social and the cultural, as well as the medical and the psychological. We seek to view ideas about male behaviour and psychological illness within the context of their time and to illustrate how it might appear that symptoms emerge in 'new' forms and be understood differently in response to prevailing cultural and medical forces. This book has explored a range of medical, cultural, situational and organisational factors that have influenced men and their experiences of distress since the mid-twentieth century. In that sense, it makes no apology for emphasising the important role of wider sociocultural factors in disease and for endorsing a holistic, interactionist model of mental health.

There is much more yet to be done. The experiences of individual men must now be the logical next stage of enquiry if we are to expand our knowledge of male psychological illness. 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. A number of recent initiatives to promote mental wellbeing have drawn on the traditional model of masculinity by raising awareness of mental illness at sports venues, for example. Another enterprise that attracted widespread attention was the 'Men's Sheds' movement that originated in Australia and aimed to engage isolated men in communal activity through furniture restoration.<sup>38</sup> In so-doing, they are perhaps reinforcing and promoting the very 'masculine' ideals from which we aim to move away. However, 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 mind-set of the generations of men who are already adults might be less easy to transform.<sup>39</sup> History does, however, offer the opportunity to expose the ways in which men have coped with distress in the past and to explore many of the social and cultural factors that influence experience. In 1976, Bruce and Barbara Dohrenwend proposed that the debate surrounding which sex was under greater stress, and hence more prone to psychiatric disorder, might be unproductive. Accepting the broad notion that men and women might react differently under psychological stress, they suggested that we would do well to discard unidimensional concepts of psychiatric disorder and 'false questions' about whether women or men were more prone to mental illness. Instead, they recommended we ask instead: 'What is there in the endowments and experiences of men and women that pushes them in these different deviant directions?'<sup>40</sup> Some forty years later, current research still

appears to be constrained by the biological paradigm and the somewhat unhelpful notion that one sex might be more vulnerable to mental illness than the other. It is hoped that *A History of Psychological Illness in Men* has begun to add to our knowledge by providing a historical and sociocultural framework upon which social scientists and clinicians might continue to build.



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