Haggett A. A History of Male Psychological Disorders in Britain, 1945–1980. Basingstoke (UK): Palgrave Macmillan; 2015.

Introduction

In a scene from an early episode of the popular American drama series *Mad Men*, the character Paul Kinsey warns: 'A modern executive is a busy man. He leads a complicated life. He has family and leisure – and he's supposed to keep *all* that straight.'[1] The show follows the lives of a group of men and women working in the ruthless Madison Avenue advertising world during the 1960s (hence the name *Mad Men*) and is now well-known for its depiction of the merciless and aggressive competitiveness of the industry and its portrayal of heavy drinking and adultery – features which are said to have characterised 1960s corporate culture. Perhaps not so typical of the lives of ordinary men in Britain, the show nonetheless communicates a sense of some of the pressures facing men in a rapidly changing post-war world. The degree to which men actually succeeded in 'keeping *all* that straight' in Britain and the United States (US) during the period has recently become a topic for debate among social commentators, and academic historians.[2] However, the ways in which men coped with professional and personal pressures are less well understood, and we know very little about the degree to which men suffered from emotional and psychological difficulties and how they dealt with them when they did.

Why this history is so poorly recorded is a matter for considerable debate. Many would argue that men are simply much less likely than women to be affected by mood disorders and that women are more naturally predisposed to such conditions.[3] There is a well-versed ancient link between femininity and 'madness', the origins of which are now well known, as are the concerns put forward by feminist commentators from the 1980s who argued that higher cases of psychological illness in women were directly related to the disadvantageous aspects of the female role.[4] Statistically, women do appear to suffer more frequently from depressive and anxiety disorders, featuring more regularly in primary care figures for consultations, diagnoses and prescriptions for psychotropic medication. This has remained consistent throughout the post-war period with current figures suggesting that women are approximately twice more likely to suffer from affective disorders than men.[5] However, this book will argue that the statistical landscape reveals only part of the story. For a start, 75 per cent of suicides are currently among men, and we can trace this trend historically to data that suggests this has been the case since the beginning of the twentieth century.[6] 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.[7] This trend is well-established and is a consistent theme throughout the studies of general practice morbidity that emerged during the late 1950s.[8] Additionally, it has long been acknowledged that men often present with somatic, or 'physical' symptoms which might have an emotional cause. It is therefore highly likely that male cases of depression and anxiety disorders are underdiagnosed.[9] Indeed, 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); however, men were more likely to present with somatic symptoms, including a range of ill-defined disorders affecting the stomach, digestion, sleep and general wellbeing.[10]

Male psychological illness has not been entirely absent from history. In recent years, scholars have written extensively about male presentations of distress in the distant past. Mark Micale has demonstrated how, during the Georgian period, 'nervousness' in males from the upper social strata was commonly accepted and viewed as a sign of 'good breeding'. Advances in scientific and anatomical knowledge from the practice of dissection suggested that the central nervous system was fundamental to understandings of the body. Within Georgian society, the individuals thought to be most seriously affected by nervous distempers were those from the cultured classes who were considered to have more refined nervous systems that were more prone to collapse. The display of emotion in this period was not associated with sexual practice or effeminacy – being 'manly' in Georgian Britain primarily meant being virtuous and wise. Male emotionality, therefore, crossed no inappropriate boundaries, nor brought undue negative attention. Men were therefore quite comfortable looking inwardly and being reflective about their own physical and psychological experiences.[11] The Victorian period that followed ushered in a host of social and cultural changes associated with industrial and imperial pursuit. Bolstered by the evolutionary theories of Charles Darwin and Herbert Spencer, this period witnessed the emergence of new constructions of male and female, in which women were viewed as biologically inferior to men, dominated by their reproductive systems and prone to irrationality. Men, in contrast, were considered to be rational, 'restrained' beings.[12]

Despite the fact that, during the late nineteenth and early twentieth centuries, Charcot and Freud both included accounts of male 'hysteria', and notwithstanding narratives of 'neurasthenia' among intellectual men, it has been [13]

accounts of female insanity that have largely dominated the literature from this period onwards.[13] There is, of course, one important exception: the psychological and somatoform symptoms of trauma in combat. Unexplained and troubling symptoms of trauma have featured in all major combat zones, dating from early accounts of cerebro-spinal shock during the Napoleonic Wars; cardiac exhaustion during the Boer War; shell shock during the First World War, through to more recent experiences of gastric disorders during the Second World War and post traumatic stress disorder in modern times.[14] Male trauma in war has rightly attracted much interest among scholars and culminated in extensive literature on the topic; however, much less attention has focused on the experiences of ordinary men outside the extraordinary sphere of military combat. The aim of this book, therefore, is to gain a more precise understanding of the aetiology and presentation of psychological illness in ordinary men since the mid-twentieth century. I ask a number of questions about the ways in which men presented with symptoms to their doctors and I also consider whether or not we can gauge with any clarity how many cases remained undiagnosed in the community. In particular, the book aims to reveal more about *why* we know so little about male psychological illness, and why such an uncomfortable relationship existed between medicine, culture, masculinity and emotion. It looks in detail at the broad cultural forces that influenced the ways in which men understood their symptoms and coped with their problems. It also examines the gendered cultures that were embedded in medicine and the workplace because, as Judith Butler has argued, gendered behaviour is to some extent 'performative', in that it produces a series of effects that consolidate the impression of being a man or a woman – institutional and structural forces then operate to reinforce such behaviour.[15] However, the book is not only concerned with the cultural; it also examines the 'material' – the limits of medical knowledge and the range of organisational and professional factors that also influenced the understanding and treatment of psychological symptoms. I will argue ultimately that, once these factors are considered, a very different pattern of gendered psychological illness emerges. These insights have important implications, not only for the ways in which we understand gender and mental illness in the past, but also for service providers and policy-makers currently grappling with a somewhat incongruous situation in which 'men are currently half as likely as women to be diagnosed with depression, yet three times more likely to kill themselves because of it'.[16]

The post-war context

The critical social and cultural developments of the post-war decades have provided historians with rich material for analysis. The broad trends are now well known; however, it is important to remember that many of the developments affected men and women in unique ways. Britain's industrial and manufacturing base went into steep decline and mechanisation resulted in a drastic reduction of workers employed in primary and secondary sectors. Women entered the workforce in increasing numbers, energised by an expanding service sector that was well-suited to female employment. Patterns of consumption and leisure shifted markedly after the immediate austerity of the post-war period. By the late twentieth century, almost 12 per cent of consumer expenditure went towards furniture, electrical and other consumer goods; the figure in 1950 was just 4.7 per cent.[17] This trend was undoubtedly stimulated by the growth of popular press and commercial television advertising.[18] The age at which most men and women married began to decline from the 1930s and the demobilisation of men at the end of the war resulted in the post-war baby boom that has, of recent years, become the subject of much demographic debate. Gradually, through the 1960s and 1970s, women gained more control over their fertility following the introduction of the contraceptive pill; however, changes in social 'mores' were of course much slower and less dramatic than the well-versed adage 'the sexual revolution' would suggest. Class and status became a topic for analysis as rising incomes resulted in a blurring of class distinctions and the middle classes lost some of the economic and political advantages they had enjoyed before the war.[19] Inextricably linked to class and social change were the problems of youth and education. The expansion of secondary school education from 1944, the shift from a tripartite system to comprehensive schooling during the 1960s and the gradual expansion of university education resulted in higher numbers of working class children and young adults benefiting from an education previously denied to them.[20] Anxieties about class were duly exacerbated by concerns about race relations and housing shortages due to increasing numbers of immigrants from the West Indies and South Asia who were eager to find work in Britain. While immigrant people brought cultural and religious diversity, Christian Britain simultaneously witnessed a decline in religious practices from the late 1950s – a change that has been described as 'one of the most significant trends of our time'.[21]

The changes to the social, economic and cultural landscape of postwar Britain were ultimately complex and marked by currents and counter-currents that are not easy to explain by grand theories of social change.[22] Contemporary anxieties were nonetheless evident in the proliferation of social studies undertaken from 1945, which, as Chris Harris has remarked, were 'part of a post war mentalité which perceived there to be a sea-change taking place in social life which involved loss as well as gain'.[23] Willmott and Young's influential study of community in Bethnal Green in

London's east end, and Elizabeth Bott's examination of marriage and social networks, attempted to investigate kinship relationships and support systems as families adapted to new economic and environmental circumstances.[24] The anthropologist Raymond Firth, meanwhile, focused his attention on middle-class families, as did Willmott and Young in their later publication on family and class in a London suburb.[25] The overriding message from such work was that fears about kinship networks being under threat were unfounded as familial relationships remained strong despite the on-going social and cultural changes. Preoccupations about class were explored in a number of studies, including Richard Hoggart's *Uses of Literacy* (1957) which examined the unintended consequences of 'mass education' of the working class. The sociologist John Goldthorpe and his colleagues published a series of texts during the 1960s examining the impact of increasing affluence on working class identity in which they argued that workers' class identity remained important to them, despite their increasing prosperity.[26] Concerns about new suburban housing estates and their effects on the mental health of housewives were also evident in research undertaken by clinicians during the 1960s. However, the conclusions were once again somewhat reassuring as findings suggested that psychiatric morbidity was no worse on new estates than it had been found to be in older urban developments.[27] Broadly, the surveys of the period articulated fears about new ways of living, but often unearthed a surprising degree of continuity and cohesion. By the mid-1970s, the sociological study of class identity had become less of a priority as the focus shifted to structural aspects of inequality.[28] Two other major concerns related to the subordination of women put forward by the women's movement, and the problems of youth delinquency – first identified as a problem during the 1950s but increasingly seen as a growing one during the 1960s and 1970s.[29] As numerous authors have chronicled, the 1960s and 1970s were marked by a cluster of liberal reforms on sexuality, abortion and obscenity, although, as Addison rightly points out, the permissive legislation of the period revised rather than abandoned previous boundaries.[30]

The social changes of the period undoubtedly affected the way in which men and women experienced their lives at work, at home and within families; however, contemporary studies focused largely upon 'structures' such as class and labour, and 'institutions' such as marriage and the family. Where they focused on gender, the pressures that were unique to women as wives, mothers and increasingly as workers attracted scrutiny.[31] Men were discussed tangentially as workers within class structures or as youths, but less frequently as husbands, fathers or male individuals. However, in popular culture, literature and film, representations of masculinity emerged more freely – for example in the epic war movies of the 1950s, such as *Bridge on the River Kwai* (1957) and *The Dam Busters* (1955). In romantic literature, the type of ideal man being 'hunted' by young women in Mills and Boon bestsellers was unsurprisingly square-jawed, professional, strong, silent and dominant. Most notably, he was 'inscrutable'.[32] 'Social problem' literature and film became a distinct genre during the 1950s and anxieties about youth and disaffection were reflected in a range of novels, plays and movies depicting the so-called 'angry young men'. As Sutherland notes, the salient features of these young individuals were 'anger, youth and bubbling testosterone'.[33] John Osborne's play *Look Back in Anger* (1956), adapted later for the screen, is among the best known for portraying the class tension and anti-establishment sentiment of the post-war years. Other books and films tackled the themes of ambition and social mobility. John Braine's *Room at the Top* (1957), for example, articulated many of the tensions facing working-class men who sought to achieve higher status and success. Ian Fleming's creation of the character James Bond in 1953 did much over the coming decades to reinforce the stereotypical image of masculinity through the themes of action and sexual prowess.[34]

Reflecting the darker undercurrents of the Cold War and political instability, the 1960s and 1970s were marked by an increase in the popularity of thriller and disaster novels where men, once again, were commonly depicted as valiant and dauntless, able to triumph over adversity.[35] Other works reflected the reform of obscenity laws in 1959 which not only affected the accessibility of literature that had been previously censored, but also ushered in a new wave of 'liberating' sex manuals, such as Alex Comfort's *The Joy of Sex* (1972). The concerns of the women's movement also heavily dominated popular culture during the late 1960s and 1970s and a new generation of writers began to explore 'what it was to be a woman' in fiction and film.[36] The plight of men in this new society did not escape the attention of novelists completely. Joseph Heller's darkly humorous novel *Something Happened* (1974), for example, built upon the concerns put forward earlier by authors such as George Orwell, William H. Whyte, David Riesman and Herbert Marcuse describing the conformity and emptiness faced by men in post-war Britain and the US.[37] The protagonist, Slocum, is restless and dissatisfied; he despises his job and does not care for his family, entering into regular equally unsatisfying adulterous affairs. As will become evident in the following chapters, although these themes emerged with regularity in the popular culture of the time, they were notable by their absence in organised debates about men and psychological illness.

Although the sociological studies in Britain failed to focus directly on men as individuals, in the US during the late 1950s, the sociologist Helen Mayer Hacker raised concerns about the traditional masculine role which 'proscribe[d] admission and expression of psychological problems feelings and general overt introspection, as summed up in the stereotype of the strong, silent man'.[38] Hacker drew attention to the fact that men, increasingly, were expected to show attributes of sensitivity, patience and understanding, yet they had not been relieved of the necessity of achieving economic success – nor were they permitted such catharsis as weeping or obvious displays of emotion. She highlighted a new range of contradictions in the male role at home and work, emphasising the importance of continued research in this area. Although such work would have been considered *avant garde* at this time, Hacker was not entirely alone in highlighting the disadvantages of the male role. In 1959, Ruth Hartley, for example, also criticised the socialisation of young boys into the male sex role, which was ultimately seen as unhealthy and the cause of unhappiness.[39]

In the US, by the 1970s, concerns about the negative aspects of living up to the demands of the male role led to a 'men's liberation' movement. Writers such as Warren Farrell, Herb Goldberg, Joseph Pleck and Jack Sawyer began to explore the 'problems of masculinity'. The Canadian psychologist, Sidney Jourard, writing in an edited collection of essays about masculinity in 1974, noted that although male emotionality was clearly manifest in autobiography, art and literature, in practice, men were still expected to appear tough, objective, unsentimental and emotionally inexpressive. Men who showed 'weakness', he argued, risked being viewed as 'unmanly by others'.[40] The men's movement was undoubtedly more influential in the US; however, during the 1970s a small collective of men in London began producing a magazine named *Achilles Heel*. This publication aimed to challenge traditional forms of masculinity and male power and to support the creation of alternative social structures and personal ways of being. The social theorist Victor Seidler, one of the original founders, noted that men were uncomfortable expressing emotional needs. To register weakness, he argued, brought into question 'the very sense of male identity'.[41] Men, it appeared, had struggled 'to escape an essentialism that for generations had been used to legitimate the oppression of women . . . Masculinity could not be "deconstructed", it could only be disowned'.[42] The *Achilles Heel* magazine published articles on a range of topics that included the family, fathering and work, and it continued until the late 1990s.[43] However, the degree to which their message influenced the lives of ordinary men remains unclear. In the three decades following the Second World War, although a range of intellectuals and social commentators were beginning to question the essential nature of 'maleness', and indeed the desirability of the male role, most men continued to experience their lives within the narrow framework of socially acceptable norms. As Jourard noted perceptively during the 1970s, 'manliness' appeared to carry a chronic burden of stress that was a key factor in health and wellness.[44] The notion that mental illness is rooted in life experience was advanced in much of the sociological literature from the 1970s; however, as will be demonstrated in Chapter 1 of this book, the emphasis on both sides of the Atlantic was routinely placed on the female role and the particular types of stress experienced by women.[45]

Any study of health and sickness must take into account not only the cultural and social landscape of the period, but also the contemporary framework of medical approaches that were formulated and ultimately adopted. The post-war decades were marked by increasing confidence in curative medicine as significant achievements were made in the fields of surgery, pharmacology and bacteriology. The treatment of mental illness was also largely dominated by biological psychiatry and the development of new drugs to treat severe psychological disorders and mild-to-moderate anxiety and depression. One of aims of this book is to explore the ways in which medical approaches that became dominant at that time influenced the kinds of conditions that gained most attention and the likelihood that they would be detected. Most importantly, it will argue that the prevailing medical approach influenced the training of doctors at medical school and consequently the ways in which conditions were understood and treated by general practitioners (GPs). Considered alongside contemporary cultural expectations of male behaviour, these factors are also central to our appreciation of why so many cases of male emotional disorder remained undetected, misinterpreted or diagnosed as somatic disorders.

During the mid-twentieth century, the biomedical model was, of course, not without its critics. Proponents of the social medicine movement such as John Ryle and Thomas McKeown, professors of social medicine at Oxford and Birmingham respectively, argued strongly that constitutional and social factors should be more closely considered and that 'observation' and 'historical analysis' of the patient were important techniques that had been increasingly underplayed.[46] In raising these concerns, the social medicine movement drew upon the views of earlier critics of 'new ways of living': rising consumerism, the breakdown of traditional values and kinship ties, and their possible effects on health.[47] Differing somewhat in their emphasis, other competing movements also emphasised the importance of factors outside the biological sciences. From the late nineteenth century interest in psychosomatic medicine, for

example, led to research on the troublesome relationship between psychological, social and biological factors in disease.[48] Building on the work of such theorists, in his book *Psychosocial Medicine* (1948), Scottish physician James Halliday highlighted the role of social and emotional factors in physical disorders such as peptic ulcers, gastritis, rheumatism and cardiac disease.[49] Additionally, as Mark Jackson has recently shown, the post-war decades marked a period in which increasing concern developed about the negative health consequences of 'stress'.[50] Research developed in a number of broad areas within general medicine, psychiatric epidemiology, psychology, psychosomatic medicine and occupational health and the term 'stress' increasingly began to dominate debates about the negative health consequences of the pressures of modern living.[51]

Nevertheless, as the following chapters will demonstrate, despite the important contributions made by the social medicine movement to aspects of social and psychological causation of sickness, it never fully bridged the divide between prevention and cure, as those such as Ryle had once hoped.[52] As Dorothy Porter has shown, although numerous social medicine departments were established in British universities throughout the 1950s, none of them were ever incorporated into the training of clinicians. Instead, they remained peripheral to the main activities of medical schools.[53] The consequences were manifest in the concerns of H. J. Walton, a psychiatrist from the University of Edinburgh, who, by the late 1960s observed that GPs might be missing psychosomatic symptoms in their patients because of their training at medical school which placed 'great emphasis on basic scientific investigation . . . physical factors or theoretical matters'.[54] Among many medical students, Walton detected a lack of concern about the psychological component to illness, and he argued that some 'physically orientated' graduates actively disliked patients who presented with psychogenic aspects to their illness.[55]

Echoing the aims of the social medicine movement, the aspirations of psychosomatic theorists and stress researchers were aimed at reducing the burden of sickness by pressing for social improvements. However, as other authors have noted, the irony was that the debates increasingly emphasised *personal* rather than collective responsibility for managing stress and coping with life's pressures.[56] Similarly, in the field of occupational health, despite the fact that some studies drew attention to the ways in which conditions at work induced physical and psychological illness, discussions were broadly motivated by concerns about productivity. As such, most researchers employed a ' disease-centred' approach, which underplayed social and emotional factors that might influence sickness patterns.[57] It was ultimately not until the 1980s that studies began to concentrate on the emotional and psychological health of workers and, more broadly, a 'new' public health movement emerged proposing that disease could be prevented by wide-scale changes in personal habits.[58] As is now well known, the criticisms of curative medicine put forward by influential individuals such as Thomas McKeown and Ivan Illich during the late 1970s prompted renewed debates between the proponents of sophisticated medical intervention and those dedicated to the prevention of sickness by social improvements. The irony again was that the work undertaken by social theorists appeared to harmonise neatly with a new political discourse that emphasised the role of the individual in health. McKeown's work was subsequently cited selectively by those looking to 'roll back the state' and buttress claims that government-supported medical services should have a limited role in health.[59] Much of McKeown's thesis was ultimately discredited, but, nonetheless, the notion that social conditions and standards of living ultimately impact on health remains a relevant one. The remit of this book is not to evaluate the relative merits of either approach; indeed, most would now view targeted intervention and social change as complementary to each other.[60] However, the following chapters serve to illustrate how a post-war medical model that emphasised a curative, interventionist approach did much to impede the detection of male psychological and psychosomatic illness. Had the medical model focused additionally upon health issues in political, social and economic terms, it might contrastingly have provided the ideological motivation for explanations of the social causation of disease and consideration of the cultural construction of gendered behaviour that is so intimately connected with mental disorders. A more holistic approach might further have inspired changes in medical education towards the organised study of social pathology which, as Ryle proposed in 1947, might 'give a broader and more humanistic outlook to emerging doctors and fit them better for their important role in a changing society'.[61] As this book will suggest, the longstanding cultural association with women and mental illness further exacerbated clinicians' propensity to diagnose psychological disorders more readily in women than in men.

One of the central arguments presented in this book is that, for a variety of reasons, many of which are not completely understood, men have tended to present with distress in ways that fit less well with the traditional medical models of mental illness. Instead of presenting with classically dysthymic symptoms of low mood, for example, men have been more likely to report physical symptoms affecting the body and musculoskeletal system. I build on this argument throughout the following chapters and contend that it is one of the most fundamental reasons why men do not appear in data for psychological illness as regularly as women. Any discussion of psychosomatic symptoms must necessarily

engage with the growing literature on somatisation – a topic that has been widely debated between psychiatrists and anthropologists since the mid-1950s.[62] In 1977, the American psychiatrist Arthur Kleinman wrote a seminal article criticising psychiatry's 'breathless search' for a universal form of depression across cultures.[63] While acknowledging that there may well be a basic depressive syndrome characterised by depressive affect, insomnia, weight loss and other mood changes, Kleinman argued that this syndrome 'represents a small fraction of the entire field of depressive phenomena' and that it was a 'cultural category constructed by psychiatrists in the west'. By definition, he argued, 'it excludes most depressive phenomena, even in the west'.[64] Kleinman developed these ideas over a long career as a psychiatrist and anthropologist, expounding the notion that 'cultural values and social relations shape how we perceive and monitor our bodies, label and categorise bodily symptoms', and that we therefore 'express our distress through bodily idioms that are both peculiar to distinctive cultural worlds and constrained by our shared human condition'.[65]

Kleinman's ideas were soon well-established and later expanded by a group of other anthropologists and psychiatrists interested in cross-cultural psychiatry. Laurence Kirmayer, whose interest in the subject was rooted in his own family's experience of immigration to Canada, became another key researcher in the field.[66] Kirmayer pointed out the conceptual confusion in the use of the term somatisation, setting out three distinct meanings that could be found in contemporary literature. In western biomedicine, for example, patients were expected to recognise that the roots of their distress lay in psychological or social conflict and articulate them as such to a physician. However, if somatic symptoms presented without organic cause, patients were assumed to be somatising. A second interpretation, and the one promoted by Kleinman, was that somatic symptoms present in place of an emotional problem where the body is a metaphor for social and emotional experience. Finally, psychoanalytically inflected theories of somatisation inferred that emotions could give rise to somatic signs and symptoms.[67] Kirmayer pointed out that, despite the differences in these interpretations, they nonetheless all shared a common core: that 'somatisation always involves a discrepancy between where an observer believes a problem, concern or event is located, or how he expects it to be expressed, and the subject's experience and expression of it in the body'.[68]

There has been criticism of the broad notion of somatisation on a number of levels. Biological psychiatry claims that the concept is relativistic: if our perception and presentation of symptoms is entirely culturally determined, there can be no 'true' psychiatric disorders, proving problematic for clinical practice and treatment. Some also argue that the notion of somatisation somehow buttresses a dualistic concept of medicine, which presumes the physical body is isolated from the mind, proposing instead that emotion is 'embodied' in bodily processes.[69] These matters are still widely debated and are difficult to untangle. Two psychologists from the University of California, Berkeley, John F. Kihlstrom and Lucy Canter Kihlstrom, in an attempt to reconcile opposing camps, have pointed out that the concept of somatisation might be the wrong place to look for a resolution to the mind-body problem, because for many patients, 'problems do not lie anywhere in their bodies. Rather, they are using their bodies, the language and culture of medicine, and the institutions and processes of the health-care system to express and manage their personal and interpersonal difficulties in a way that would be otherwise difficult or impossible'.[70] Thus, understanding somatisation perhaps requires 'not [just] that we look into the patient's body, but rather into the patient's life and the world in which he or she lives'.[71] I situate the accounts that follow from this perspective.

At some basic level, the ideas promoted by the social medicine movement and the concepts put forward by cross-cultural psychiatrists, ascribed to a broadly 'biopsychosocial' model of medicine in which the biological, the psychological and the social are seen as playing an important role in health and illness. The 'biopsychosocial model', as formally articulated by the American psychiatrist George Engel in 1977, criticised the contemporary scientific medical model for its exclusive focus on biological processes, which excluded behavioural and psychological influences. Engel argued that the medical model should take into account the social context in which a person lives. He claimed that:

> By evaluating all the factors contributing to both illness and patienthood, rather than giving primacy to biological factors alone, a biopsychosocial model would make it possible to explain why some individuals experience as 'illness', conditions which others regard merely as 'problems of living'.[72]

The biopsychosocial model was also not without its critics. Although Engel claimed that his model was non-dualistic, some have suggested that by 'reifying the psychosocial components as different from the biological' his ideas were in fact dualistic.[73] It has also been criticised for its eclecticism, broadness and vagueness, because 'if everything causes everything, one cannot fail to be right, while at the same time nothing informative is really being said'.[74] Others have

cautioned that his perspective did not really fit the criteria for a 'model' and could never be more than an idea or a theory.[75] In analysing the material for this project, I accept that many of these criticisms may be valid; however, I contend that a model of medicine in which patients' subjective experiences are considered important, and which accepts that the interactions between the bio-psycho-social domains are complex, offers us (and in particularly me as a historian) the best opportunity to expand our knowledge of psychological and psychosomatic ill-health. The renowned psychiatrist and academic Suman Fernando has observed that symptoms are often experienced as internal and external at the same time; however, western medicine largely considers that illness is experienced as *either* external *or* internal, with one impacting on the other.[76] As the following chapters will demonstrate, when it came to understanding the ways in which men expressed pain and distress, the reductionist model of disease that viewed subjective and objective experiences as 'distinct and separate from each other',[77] provided a barrier between doctor and patient that was in most cases very difficult to overcome.

Structure and design

Writing in the 1950s, Hacker noted that interest and research into the male social role had been 'eclipsed by the voluminous concentration on the more spectacular developments and contradictions in feminine roles'.[78] Part of the problem, she argued perceptively, was that a 'concept' had not emerged for male behaviour, since 'men have stood for mankind, and their problems have been identified with the general human condition'.[79] Hacker's use of the word masculinity was a precursor to the way in which the term has been used in modern times. As Tosh has shown, this is of relatively recent coinage, dating back in common parlance no further back than the 1970s.[80] During the nineteenth century, the term 'manliness' most usually described the gendered lives of men. Manliness implied a single standard of manhood, expressed in certain physical attributes and moral dispositions. Masculinity (often used in the plural 'masculinities') in contrast, fits more comfortably with the post-modern view of the world, with its proliferation of identities and contradictory discourses.[81] Since the work of Joan Scott in the mid-1980s, and following on from the emergence of women's studies, scholars have become increasingly interested in the concept of gender.[82] Key to this concept has been the ways in which male and female identities are socially constructed. Scott argued that 'the story is no longer about the things that have happened to women and men, and how they have reacted to them; instead, it is about how the subjective and collective meanings of women and men, as categories of identity have been constructed'.[83] However, it was not until the 1990s that scholars began to look explicitly at the history of masculinity – a controversial undertaking from the outset because of the risk that it might be colonised by researchers who were concerned with promoting anti-feminist scholarship.[84] Despite obvious tensions, a burgeoning scholarship ensued, with contributions to the debate not only from historians but also from sociologists, and those working in social policy and the health sciences. In line with broader debates about gender, opinion tends to be divided into two camps: one proposes an essentialist notion of manhood and suggests that misguided attempts by women to change the natural order of gender balance have resulted in a 'crisis in masculinity'; the other contends that gender is socially constructed, historically contingent – not 'natural', necessary or ideal, thus exciting the potential for change.[85]

Central to studies of masculinity has been the concept of hegemonic masculinity put forward by the Australian sociologist, R. W. Connell. This is the notion that at any one time there is a normative ideal of masculinity to which men aspire because it is the most honoured way of being a man. It requires all other men to position themselves in relation to it and, ideologically, it has legitimised the global subordination of women to men.[86] It is argued that this model of masculinity has gained ascendancy through culture, institutions and persuasion – although, as Connell points out, it was never assumed to be 'normal' in the statistical sense because only a minority of men might enact it. Most importantly, the concept offered the potential for older forms of masculinity to be displaced by new ones and for less oppressive ways of 'being a man' to become hegemonic.[87] Although the concept is now used widely in scholarship about men and masculinity, it is not without its critics. Margaret Wetherell and Nigel Edley, for example, argue that the term is 'not sufficient for understanding the nitty gritty of negotiating masculine identities and men's identity strategies'.[88] Employing a social psychology perspective, they suggest that a definition of dominant masculinity 'which no man may actually ever embody' might not be appropriate.[89] For a range of reasons, the concept of masculinity itself has also been criticised. It is, for example, often widely used without being precisely defined; it appears to 'essentialise' the character of men and further assumes a false binary or 'dualism' of gender relations.[90] Although it is not the remit of this book to repeat such debates in detail, any scholarship that deals with the lived experience of men must necessarily engage with the discussion. The approach that I take in the following chapters is that the terms masculinity and masculinities remain useful when examining male health and behaviour. As Robertson and Williams recently pointed out, 'masculinities' should not be seen as character types and attributes held by individuals; they can alternatively be recognised as 'processes of arranging and "doing" social practice that operate in

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individual and social settings'.[91] Using this approach, I have been able to understand better the possible links between male behaviour and practice, and men's mental health in a range of settings both within and outside medicine from the 1950s. I thus avoid the notion that there are a range of essential male traits that engender stoic, unemotional and independent behaviour, instead arguing that male customs were (and still are) often constrained by social structures and institutional gendered practices. As a historian, I would also contend that there are still advantages in employing the concept of hegemonic masculinity. The version of masculinity that was most 'honoured' during the post-war period required the projection of strength and control – qualities that did not fit well with a notion of male nervous instability. As Mark Micale has shown in his work on male nervous illness in earlier times, these values were a hangover from the Victorian era when 'the spectrum of emotions deemed appropriate for adult men in Britain greatly diminished' – a point that will be developed more fully throughout this book.[92] This is of course not to say that all men 'achieved' or complied with this version of masculinity. Indeed, as the testimonies from clinicians in this book will illustrate, much of the male psychological and psychosomatic illness that presented in primary care could be correlated with unsuccessful attempts to live up to this ideal.

Of recent years, historians have highlighted a tension that has developed between earlier social histories, which focused primarily upon experience and agency, and more recent cultural histories, which focus upon discourse and representation.[93] As Michael Roper has rightly noted what is often missing from linguistic analyses is an adequate sense of the material: the practices of everyday life and the human experience of emotional relationships.[94] Historians of masculinity have therefore suggested that future studies would benefit from a focus, not only on broad cultural codes, but also upon how men related to these codes.[95] In the words of Roper and Tosh, new histories need to 'explore how cultural representations become part of subjective identity'.[96] This is a challenging task, for we cannot know with any real certainty the subjective processes that operate to mediate between individual men and cultural formations of masculinity. We can only ever hope to 'correlate' certain aspects of male behaviour with the set of cultural codes that predominate at any one time. Roper cautions that earlier social histories which focused on the material practices of daily life tended to make 'untheorised' assumptions about the motivation for certain behaviours, sometimes resulting in accounts that amounted to 'little more than the historian's own unexamined projections onto the past'.[97] To overcome this in his own work, Roper uses a psychoanalytical framework to analyse the unconscious elements of soldiers' behaviour during the First World War, emphasising the importance of 'mothers' and 'maternal support' in the subjective experience of the troops. However, I would question the extent to which it would be possible, or even advantageous to apply any specific theory to explain the associations between discourse, representation and patterns of emotional behaviour among the men under study in this book. A psychoanalytical perspective, for example, would underplay the importance of the historical, medical and social context of the post-war period, resulting in a reductive account of male emotional illness.[98] The approach I take, therefore, is that 'good' history need not necessarily offer certainties, but can nonetheless provide possibilities and insight into the complexities of human experience. As Robertson and Williams recently pointed out, although we need to acknowledge that the 'meaning and language' we attach to bodily experiences changes with culture and through time, this should not lead us to abandon attempts to obtain an 'adequate' understanding of the material.[99] As such, I hope to develop a more nuanced understanding of post-war society, gender and psychological distress, taking into account not only cultural codes, but also the evolution of medical practice and the broader social and economic factors that had such impact on the daily lives of men and women in Britain from the 1950s. I offer convincing suggestions about the connections between discourse and behaviour, but do not claim unproblematically to couple them together.

The chapters that follow by no means provide an exhaustive account of male experience. It has been outside the scope of this project, for example, to consider in any great depth the specific problems faced by black and minority communities or the complexities related to issues of class and geography. I do, however, touch upon these wherever the material allows. The book does not focus directly on the history of psychiatric services, for this subject has been covered fully elsewhere, and, as will become evident, men rarely engaged with services for moderate to minor mental disorders.[100] The history of male psychological illness is somewhat unchartered water and it is hoped that this project will inspire further research to unravel the different mental health challenges that were faced, for example, by ethnic minorities as they moved to Britain following the Second World War.[101] I am also aware that this history has not been written primarily from the perspective of ordinary men themselves. Although some individual narratives are included, it is broadly an account of how medicine and society sought to understand male psychological illness. However, by the end of this book it will become evident that seeking the views of a large group of men about their emotions during the post-war period might prove to be unproductive. As Mark Micale has argued so perceptively in his study of male emotional illness in earlier times, the 'true male malady' has, since the Victorian era, been men's chronic inability to reflect on themselves non-heroically without evasion and self-deception.[102] To be self-aware has been seen as

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'unmasculine' and health has been 'regarded rhetorically as a feminised concern'.[103] Additionally, men's problems have been less visible because historically it has been the male 'gaze' that has undertaken observation and examination, and, as Hacker pointed out over fifty years ago, a male norm by which others have been measured.[104]

I build my arguments about psychological illness in men from the analysis of a wide range of archival material, including the personal papers of clinicians who had a specific interest in mental health. I also examine medical debates about mental illness and the education of doctors at medical school and in general practice. The insights from this material are supported by the oral testimonies of fifteen retired GPs who had experience in practice during the 1950s, 1960s and 1970s and whom I interviewed at length.[105] The study also includes analysis of material from pharmaceutical companies and GP prescribing patterns for anxiety, depression and psychosomatic illness. It draws additionally on debates from industry that can be found in published primary material on the workplace and health – a topic that gained considerable attention in the decades following the war as the nation strived to expand its economic growth and productivity.

Chapter 1 is situated in primary care and explores the ways in which male psychological disorder presented to GPs. It examines the ways in which cultural and social forces influenced medical ideas about gender and mental illness, and illustrates how the biological, interventionist model of medicine in Britain impeded the efforts of those who sought to engage more constructively with debates about the social and emotional dimensions of disease.

The mental health of workers is addressed in Chapter 2, where I argue that debates about sickness absence, absenteeism and stress were dominated by concerns about productivity, resulting in a failure to investigate male psychological illness in the workplace, despite clear evidence of its existence.

The use of alcohol as a coping mechanism among men is the central theme of Chapter 3. I show how inertia within the medical community and the eventual dominance of the disease theory of alcoholism hindered the detection of alcohol abuse among men. I also suggest that the culture of heavy drinking among British men at work and during leisure time did much to obscure damaging levels of alcohol consumption that were very often regarded as normal.

Chapter 4 examines trends in psycho-pharmaceutical prescribing among GPs. The aim of this chapter is to question statistics that suggest unproblematically that women were at least twice as likely to receive a diagnosis and prescription for a psychological disorder. By including categories of drugs that contained 'hidden' tranquillising compounds, often directed at men for gastric disorders, and by examining some of the vagaries of the data, I argue that men in fact feature more obviously in this story.

Chapter 5 addresses what I have termed 'special cases': the mental health of doctors themselves and debates about the psychological health of immigrants who had come to Britain in the decades following the Second World War. By the 1980s, research had begun to uncover a significant problem with alcohol, drugs and mental illness within the medical profession. At the same time anxieties were emerging about the ways in which those with non-British backgrounds were coping with the strains of joining new communities. The two are explored simultaneously, not because their experiences were comparable in any direct way, but because they are together illustrative of many of the broad themes already explored in this book, and serve to advance the core arguments put forward in earlier chapters.

I conclude by suggesting that this history has begun to expose and uncover male psychological distress 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. I argue that because women have 'reported' psychological symptoms with more regularity, this does not necessarily mean that they are more likely to be predisposed to them. This is especially important when, as the book will demonstrate, men have historically been much less likely to identify symptoms in themselves – and far less likely to seek help when they do. Rebalancing our view of the gendered landscape could have far-reaching consequences, not only for historians of mental illness and psychiatry, but for those working currently in the field of mental health where some persist resolutely, and perhaps mistakenly, to focus on the apparent disparity in psychological health between the sexes. If we are to understand more about why so many men commit suicide, we must expend more energy looking at changing cultural practices that have for so long influenced men's ability to recognise, report and manage emotional distress.

Footnotes

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105 GPs were recruited from a range of sources, including the alumni department of Birmingham Medical School and from contacts at the Royal College of General Practitioners. Letters were also sent out inviting response from surgeries in the author's locality. An appendix is provided with details of respondents. All interviews are fully anonymised to protect the identity of the respondents, their colleagues and patients.

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