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

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Abstract

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

Keywords

United States; Depression experience; Construction of self; Aging; Masculinity; Older men

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

1. Introduction

We had been driving through the countryside for a while on a road stretching through the distance; a long gray tape woven between neatly rowed fields of almond trees, grape vines, lettuce, and other greens. We met a group of houses set at the edge of town and approached Mr. Capelli's (66 years old) house—a small humble track home bordering railroad tracks with construction fencing surrounding it. As we walked up to his porch, he shyly opened the door as if afraid or uninterested (I could not tell). “I'm sorry but I have tried to clean up but

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there's too much stuff he apologized as he removed clothes, books, food wrappers, medications, and a beer can. A strong, somewhat unpleasant smell scented the room as we sat down on the couch. The rambling of a train startled me. It was so loud I thought it would rip through the house which gradually stopped shaking as the train passed by, its sound dissipating in the distance.

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

2. Depression in older adults

While not highly prevalent in healthy non-institutionalized older adults, it is believed that five to ten percent of older adults in primary care meet criteria for clinical depression (Koenig and Blazer, 1992; Lyness et al., 1999). Untreated depression in late-life is associated with poor quality of life (Unützer et al., 2002), poor adherence to medical care and co-morbid medical disorders such as heart disease and diabetes (Katon, 2003), decreased ability to function (Alexopoulos et al., 1996), increased health care costs (Unützer et al., 1997), and higher mortality (Blazer et al., 2001).

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

3. The social construction of illness

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

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

4. Depression and masculinity

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

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

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

5. Depression and aging

While depression in older adults is better understood from a life course perspective, often medical and public health approaches ignore the illness career and the social and cultural contexts in which emotional suffering is experienced. Moreover, while epidemiological studies document the low prevalence of emotional distress among older adults, Mechanic and McAlpine (2011, 480) note that there is a "persistent belief among clinicians that depression is especially under-recognized and under-treated in elderly populations." However, they point out that this is "hardly surprising" given the variety of co-existing health conditions afflicting older adults (Mechanic and McAlpine, 2011, 480). For some time now, research in the sociology of aging has conceptualized the aging process as a series of ongoing social and biological transitions (Settersten and Angel, 2011) in which shifts in one's social status and roles occur in the context of micro (e.g. family) and macro (e.g. political economy) level dynamics (Saxena, 2006). Factors such as social class and gender (among others) are extremely influential in older adults' mental health "careers," and they

are fundamental forces in shaping conceptions of the self (Matras, 1990; Lynott and Lynott, 1996; Clarke et al., 2011).

Men caught in the vortex of aging and illness such as depression then face more serious challenges to maintaining a credible self. Because aging and depression introduce significant disruptions to social life and identity (Corbin and Strauss, 1985, 1988), (re)con-structing a masculine self is problematic. Specifically, we describe the factors men identify as sources of their depression, the consequences of suffering on their sense of self, and how they respond to a threatened masculine self.

6. Methods

This research is based on interview data from the Men's Health and Aging Study (MeHAS, 2008–2011), a mixed-method, cross-sectional study that recruited white-non-Hispanic (WNH) and Mexican-heritage (MH) men over the age of 60 from California's central valley. MeHAS was approved by the Institutional Review Boards at all participating institutions. Men were asked at the time of their clinic visit if they were interested in participating in a study of depression in older men. If they agreed, they were screened to determine if they met study criteria (i.e. having depression symptoms, taking depression medication, or being diagnosed with depression). Those men who met study criteria were asked to participate in an individual in-depth, semi-structured interview at a different time and location of their preference. Informed consent was obtained twice; at the time of the initial screening for study criteria and at the time of the in-depth individual interview. All participants were compensated $100 (MeHAS methods and sample sociodemographics have been described in detail elsewhere, Hinton et al., 2012, 2014; Dwight Johnson et al., 2013).

6.1. Data collection

Of 80 interviews with older men in their homes or in the clinic, 77 were conducted by a sociologist (first author) and three by a geriatric psychiatrist (study PI). All the Mexican heritage interviews (either in English or Spanish) were conducted by the first author. Interviews ranged from 1.5 to 2.5 h, were conducted in Spanish or English per participant preference, and followed a semi-structured interview guide covering background, depression experience, social responses to depression, suicide, depression help-seeking, and treatment in primary care. All interviews were transcribed verbatim and those in Spanish were first transcribed verbatim by bilingual research staff and then translated into English. Bilingual co-investigators reviewed translations for accuracy and quality. While 80 interviews were completed, only 77 (47 WNH and 30 MH) were usable for qualitative analysis (three were lost to technical issues).

6.2. Data analysis

Data analysis followed a grounded, social constructionist approach to identify main analytical categories and their relationships (Corbin and Strauss, 2007). In an initial open-coding phase, the research team collectively read interviews and achieved consensus regarding thematic categories including psycho-social distress, family, aging, substance use/abuse, suicide, masculinity, coping and self-management and formal help-seeking. Three

researchers then systematically coded all 77 interviews for these eight major topical categories. Once this first “chunking” was completed, the lead author conducted further analyses of interviews to identify subthemes and the patterns presented here regarding how men viewed the onset and trajectory of their depression, its consequences on the self, and their responses to those consequences. The findings presented below result from an extended iterative process in which the study team regularly discussed the results of this coding, and evaluated and resolved discrepancies between team members through a consensus building process. NVivo 9 qualitative software was used for data storage and management.

7. Findings

7.1. The perfect storm: getting sick, getting older, and not working

Older men's accounts of their depression highlight two primary issues: physical decline and economic constraint. Whether due to aging or the toll of chronic conditions over time, most men identified health deterioration as a source of distress that, when coupled with ongoing problems to make ends meet, became the perfect storm characterizing their emotional suffering. Men discussed physical decline in the context of getting older, and they linked their depression to their aging bodies' inability to sustain former activity levels, hold jobs, or engage with others in ways they viewed as productive. Talking about his situation, one man lamented:

> “I don't know, my health's bad, too. That's another reason I ended up not going back to work for an employer because they want you there, usually five, six, seven days a week, sometimes ten hours a day. I can't do it anymore.” (WNH, age 65)

The interplay of physical decline and constrained economic resources was complex primarily because at times they seemed to reinforce each other and other times one seemed to cause the other. A teary-eyed MH man spoke of his depression and economic problems:

> “My wife only works four hours and she also gets paid for taking care of me, a little, just four hours and well it is hard. I can't do anything about it because I can no longer work, but we are getting through, my son helps us a little with the rent and food, to go get bread, but it is hard to pay for rent, water, and electricity and well one also has to eat …”

Men did not talk about their depression as simply endogenous; that is, as having exclusively an internal biological cause or origin. Rather they viewed it as related to social and biological changes that were exacerbated or triggered by aging and leaving the labor market. In attempting to retrace his feelings, another man told us:

> “When you get older, and you lose your job, you ain't got no way to make no more money. You are too old to do anything now. You get depressed because you can't do nothing about it [getting old and not making money]. … None of that ever bothered me [changes in the weather, conflicts with people, getting old, not making money] … That's [not being able to do anything about it] what I think now is at the bottom of it.” (MH, age 78)

Men's suffering conveyed their struggle to make sense of aging bodies in light of their difficulties to remain physically active and productive, mostly in the realm of work. Their accounts contextualized their depression biographically in a narrative that often began by recognizing that they had little awareness of the extent of the changes they were experiencing until their disability and economic constraint became "undeniable" or unmanageable. Tapping his fingers nervously on the table, one man explained:

> "Never gave it much thought. I really didn't know. I didn't even know if I'd get to be 60 to be honest with you. But I also didn't think that for any particular reason that I'd want to leave this life that I'm living. If you can get on the right level, your income's there, and you are getting along with people around you, it's a good place to be. … My body is starting to fall apart … I've got aches and pains in my shoulders, my neck. My sciatic nerve hurts; got arthritis in my big toe. I'm down… I'm not what I used to be." (WNH, age 68)

Trying to hide a slight trembling of his hands, one man played with his cigarette and rubbed his forehead as he spoke about when his pain—certainly physical and perhaps also emotional—became overwhelming:

> "My feeling bad is the pain that I have. … when the pain gets real bad and the physical stuff and I'm aching, and I'm hurting, and I can't do anything hardly anymore. Then I start getting depressed. So this is my problem … I don't know … I'm in pain." (MH, age 70)

In short, older men constructed explanations of their depression as an interlocking dynamic of physical and social factors that lowered their mood in unexpected ways. They had trouble "dating" this series of changes to a specific point in time and only became (painfully) aware of their hitting rock bottom once they were quite disabled physically and emotionally. While it is difficult to pinpoint how the depression evolved through the interaction between physical decline and their inability to earn an income, men clearly spoke of these two factors as mutually reinforcing in a haunting cycle that left them struggling to reconstruct who they were or who they might be.

7.2. The shamed masculine self: losing control and the severing of social bonds

Based on this confusing and paralyzing physical decline and economic unproductivity men described how they realized they could do little to change their situations. "Ah! I don't feel too good today" said a 71-year old MH man squeezing his hands together, "I ain't working now. I feel I should be doing something now. I want to do something, man … but I don't feel good." Staring out into space as if physically present but emotionally absent, a 69-year old WNH man whispered in an apathetic tone, "I'm trying to make things a little bit better, and I feel like sometimes that I'm failing, so then I try to think of, and think, and take it in another direction but I can't …" Men's accounts thus spoke of a lost sense of control and ability to do the things they thought valuable or intrinsic to their role as providers and protectors. This loss of control was typically expressed in feelings of frustration and, above all, uselessness and worthlessness. His voice betraying disappointment, another man spoke of his turmoil:

> "I am older now and I can't do anything anymore, and it hurts me not to be able to do what I had done in the past for people. Another thing that is very important in

> the emotional state of a 60-year-old is their feeling of self-worth and that they still have something to contribute. When you reach a certain age, you feel useless. You feel like well, there's nothing more to do, I just want to die." (WNH, age 61)

Feelings of uselessness and worthlessness pierced the heart of a past masculine self (whether real or imagined) that was predicated on prideful work and productivity; in most instances this meant being the breadwinner in the context of a nuclear family. "Gosh, I wish I could really [describe] it" said one of the WNH men (age 67) breathing deeply, "I think worthlessness. You just don't feel worthy any more. You just don't feel like things are quite turning out right … and [there is] nothing you can do about it." This futility was central to men's sense of shame and their accounts highlighted weakening social bonds, as they detected disapproval all around them given their limited (or lost) ability to embody masculine ideals. Men's inability to fulfill past roles as providers and workers meant biographical disruptions whereby the self teetered on the verge of a credibility crisis. Pointing to his struggle to sustain a sense of dignity in relation to others, one man reflected:

> "[I] feel down, or depressed … I thank God for every year of life that he gives me, but I still think that the older one gets the fewer the things one can do, right? … I am sick right now, sometimes I fall and I can't get up on my own … They [older men] do need to be understood, not for others to argue with them, to contradict them." (MH, age 67)

Thus the shamed masculine self is mirrored in men's deteriorating relationships, especially with kin. Because older men were mostly limited now to the home (either because of health conditions or depressed mood), disruptions to their sense of self became evident by the schisms between what others expected of them as much as what the men themselves believed they should be doing. Another of the men recounted haltingly a conversation with his wife:

> "Five or six days ago my wife told me that I was irresponsible and I told her 'look I am, I am sick and I wish I could work, but I can't … I am sick, it is not that I don't want to, you see that to shower, to eat, to do many things, I can't do them …' Because I have always liked to have money in my pocket and not having money makes me depressed. I need understanding but they [family] should help one because that is the worse, that they [family] don't help one. It is difficult to have a good understanding by the family … [just] because he is old it does not mean that he no longer can." (MH, age 62)

Severed relationships with others plagued the men's struggle for a masculine self that was validated by others. Not only had they seemed to lose control over their own destiny (ability to manage their aging bodies, navigate the care of their chronic conditions, be economically productive), but they had also lost their status visa-vis others. "I knew there was something wrong with me maybe" said a 63-year-old MH man, "but people around me knew that there was really something wrong with me. I was kind of in denial, so to speak." In other words, the shamed masculine self "was out there" for everybody to see and judge; a constant reminder that things had changed (for the worse). In a tone of despair, a man said:

> "But there's nothing to do. You can't do anything, so you don't know what to do. I sit on the bed holding my head all of the time … It's, and for somebody [family/friends] to say 'you are just feeling sorry for yourself,' that even makes things worse because now they ain't going to respect [you] … Deep down, you want to do something so bad you can't do a damned thing, nothing. It's even worse when I didn't have a dime coming in, nothing, nothing." (WNH, age 72)

Mired in frustration about his estranged family, another man shared:

> "If [one] does not have the love of a son, does not have the love of a wife because she has passed or you always have problems with them, one wonders 'what am I doing here? I don't have people's understanding, I don't have anything, absolutely nothing, I don't have money, I can't meet their expectations and this and that. I don't think is the physical pain that hurts the most, but the emotional pain … one can't do anything." (MH, age 64)

The depression experience was hence constituted by social disapproval of some perceived deviant—non masculine-like-—behavior. The shamed self manifested itself in strained or severed meaningful social bonds. A man put it this way:

> "During those bad times, I didn't get along with my family at all. I didn't know if they felt I [was] not doing a good job, like maybe they weren't sympathetic enough, but I think they just didn't know how people can feel when things like this [not working, being sick] happen. … I didn't get along with them for a long time. I had to, but I didn't. Just like that. That was tough." (WNH, age 68)

Men's struggle to exert physical and symbolic power ultimately left them in a mental space of "thinking too much" but "not being able to act on" those thoughts in productive ways. Therefore, their depression accounts reflected a catch-twenty-two in that faced by their losses (i.e. inability to work, economic problems, physical decline), thinking about them further reproduced their inability to "act like a man," to do something decisively and effectively about the problems they confronted. Severed relationships plagued the depression experience not simply because men did not "have the energy" or interest to be with others but because engaging in social interactions invited judgment—and the suffering therein—about their inability to meet masculine expectations. They had lost the audience during the "real men" act by not fully being a man in charge, not being able to control their life in ways that others approved.

7.3. Resisting the shamed masculine self: retracting from and reacting to others

Just as things seemed to reach a stalemate, a set of potential resolutions emerged in men's depression accounts. In attempts to regain what had been vanishing, a handful of men spoke about trying to maintain employment—a sign of a self in control. However, this promise quickly withered away, as one of the men intimated:

> "I have been working like four to six hours a day. That's all I can do. I get tired and useless … But I don't want to take anybody's money and I don't want to be standing around getting paid for nothing." (MH, age 62)

Having a job was not enough to redeem the deeply shamed masculine self. It was not simply about retaining (some) income but also about the perception of whether one as a "man" merited that income. More commonly, older men relied on a "sales pitch" that also proved to be limited. "But those are things that one should control little by little at least, to look for a way" one of the MH men (age 64) stated while thinking about "being stuck" in a vicious cycle of shame, feelings of uselessness and loss of control. A man more adamantly said:

> "You have to take control of your life. You have to run it or manage it in better ways … You have to manage it so that you meet all the required things that people [expect]. [I'm] losing words here. Looking for a 15 cent word and it's not worth a nickel." (WNH, age 70)

However, this narrative of "taking charge" and pulling yourself up by the bootstraps required actions to be a credible manhood act. The most typical forms of resistance the men described involved overacting masculinity through aggressive behavior or retracting altogether from the social world that demanded a masculine performance beyond their reach. One of the men told us in frustration:

> "One begins to get a little angry, but to know how to do it instead of saying 'you don't know, don't talk' because that makes one angry, it makes one feel useless, that one does not know how to do things … I leave, go out, one can't be there." (MH, age 65)

Perhaps the act requiring the least effort to justify was to retract from social interactions fraught with emotional fault lines that could leave the masculine self vulnerable to ridicule. "I just don't want to talk to anybody. Stay away from me … Don't bother me, just leave me alone …" one of the WNH men (age 71) told us in an irritable tone, "then I lock up. I won't talk to anybody" he asserted. The words of another man underscore this:

> "… Get away from people. That's my main thing, just get away from everybody and everything. Forget about anything to do with this … I have to get out by myself and get away from everybody, and stuff like that." (WNH, age 69)

In the end, walking away from interactions with others did not afford men any further edge in resisting the shamed masculine self because it was, ironically, unmanly in the trope of "men do not walk away from conflict or fear but face it directly." Enacting a more proactive strategy, men also resisted the shaming of the masculine self through aggressive behavior and letting others know about their anger. Leaning back on his chair as if tired by the recounting of his experience, one of men spoke in hindsight:

> "I got to be a real bastard, yeah. I became angry, very, very angry, just out of nowhere, from nowhere … It was over two and a half years before anyone could even get through to me, I was so angry." (MH, age 67)

Discussing how his expressions of anger, a man described his morning routine:

> "And I know, because I do know stuff! I know that if I leave the house in a bad [mood], with the depression, feeling sad and not worth anything, just my travel to work causes me problems because I might be honking at somebody, I might flip them off. The road rage kicks in." (WNH, age 70)

Though on the surface aggression was a recognizable manhood act, this strategy was not easily sustained over time either. Enacting control could also threaten men's ability to fulfill masculine expectations rooted in other social roles and identities they had endorsed as they got older. Pointing to this dilemma, a man told us:

> "If I wake up in the morning and I decide to be a bitch, I'll be a bitch all day. I try to control [things] … I don't like being mean. I don't like stomping my foot and giving orders, and acting like I'm head honcho. I don't like that. I don't like to be that way. But sometimes you have to." (MH, age 65)

For example, men's account suggested that their identities as grandfathers or aged men (i.e. wiser, experienced, having hindsight) meant a less "macho" and a more "caring" self. Acting aggressively thus undermined their ability to resist the shaming of the masculine self by further denigrating it. A man recounted his lashing out at his family in a regretful tone:

> "And I was so angry and I used the word 'abusive' earlier but never physical abuse. It was always verbal. … And the people that were the closest to me were the ones I violated the most; my wife, my children, our closest friends. There were times I wouldn't even let them get out of the car and come to the house. I guess one way that I can put it to you is that I used the term "living with the devil" for a long, long time because it was that bad, or worse … But now I see that… and can't do it like that." (WNH, age 66)

Likewise, another man said:

> "I could get up in the morning and just come out of bed in a bad mood. And spend the week that way, making life miserable for everybody. And I had to get out of it. I had to get away from that." (MH, age 63)

As men's accounts of their depression show, older men's selves must be understood in the larger context of masculinity challenged through aging and a moral imperative to remain productive. These men felt betrayed by eroding bodies and minds as chronic and age-related physical illness stalked a hard lived life, like barnacles on an aging vessel. Perhaps triggered by memories of who he used to be, one of the men described a turning point in his life:

> "Only thing I can recall is I picked up the ashtray and I threw that ashtray and it just shattered against the wall. I just went off, you know. The next thing I can recall is I that I just took the coffee table and just flipped it up in the air and it, you know. I can recall that it landed on its legs. It landed upright. I can never do that again" (MH, age 68)

As dominant masculine ideals collide full force with aging and depression in ways they least anticipated, these are men who struggled to salvage dignity amidst shards of sorrow. Their woeful acts of aggression toward, or retraction from, others expressed a wounded masculine self as the final arbiter of their defeat. Facing this realization, one man echoing his peers' words said:

> "I just think of it as me being what I am, and what I've been through, and all the other stuff. It's just the loss of what you use to have, to what you don't have today, is why I am the way I am. That's how I look at it, I guess." (WNH, age 72)

Hopes of re-enacting a new self which neither surrendered to nor escaped from the abyss they confronted came with a constrained, maybe resigned, acceptance about the lives they have led and who they could be now. But this reluctant redefinition of their situation could barely amend a profound loss of manhood in order to save (some) face.

8. Conclusion

The experience of depression was layered as men wove into their accounts a complex narrative of the trajectories of their emotional suffering and deteriorating manhood. Our findings contextualize older men's depression illness experience in relation to this shamed masculine self; a self based upon notions of masculinity that emphasized being productive (typically through work) and being in control (of themselves and their world). Masculine expectations around material accomplishments and social status meant remaining productive and independent. Men's depression experience extended beyond an isolated pathology into a complex and dynamic social disruption of the gendered—masculine—self that was signaled to and recognized by others as a receding ability to perform credible manhood acts. The line between volition—the ability to enact one's intents purposively—and not having control over one's life was definitive of men's depression experience. Thus our analysis suggests that masculinity and aging intersect powerfully in how men deal with the confounding impact of physical, biographical, and social forces that shape their sense of self (for a related review of the literature on depressed individuals' ability to self-manage and maintain quality of life, see Houle et al., 2013). In the context of depression and aging, the loss of productivity crippled their ability to perform expected manhood acts convincingly. These are narratives of men who seem to have lost control of their bodies, their emotions, and their place in the social world.

For these older men, depression was something they had to fix in order to rescue the only self they and their world valued. Grasping to their role as workers, seeking isolation to avoid ill-fated interactions, and acting in overtly aggressive ways to demonstrate their control, all failed them. Attempts to reframe the depression experience were relinquished as men objectified depression as an autonomous entity above and beyond their control; as if depression existed outside of them perhaps similarly to how physical disease is believed to attack the body but is not intrinsically part of it. This led men to a stalemate where resignation or acceptance of their condition allowed some reflection on their life course. What is clear in the men's narratives is that none of them seemed (yet) to have a convincing alternative to the masculine self easily at hand, a self that might have meaningfully substituted for the one they were losing. The *narrowness of the self* inflicted as much pain now as the status it once conferred. With nowhere else to turn, these men could only turn inwards to discover a shrinking set of symbolic resources for dealing with their condition. Many questions remain as to what, if any, this resolution will look like as men move forward toward the eclipse of their lives (for a more optimistic account of the interaction between aging and depression among men, see Roy et al., 2014).

Our analysis also raises questions regarding the role of ethnicity in relation to masculinity, depression, and the self. As our findings show, there are significant overarching similarities between the white and Mexican-heritage men. While our data do not clearly support ethnic

differences, consistent with other literature we speculate that ethnicity may still influence the experience of depression vis-a-vis the masculine self. For instance, we found some evidence suggesting that the Mexican-heritage men spoke of threats to the masculine self in terms of productivity more closely tied to the economic welfare of their family, whereas the white-non-Hispanic men did so in more individualistic terms such as their inability to live their dreamed and longed "golden years." Future analyses may focus on how these different orientations imbued with ethnic undertones inform the reworking of an older self.

Our study may involve a degree of researcher bias that does not necessarily refute our findings and still points to important lessons and future research. First, most interviews were conducted by a (younger) woman interviewer and this may have influenced how (older) men responded to inquiry about their depression experience. It is possible that these men were more comfortable expressing their distress to a non-familial woman associated with a research institute than they might have been with a male interviewer precisely because they did not fear, nor were they defensive about, not fulfilling their traditional male role (a feeling which wives—who rely on that role—or other men—who currently fill that role—might evoke in them). Indeed, because the interviewer was non-threatening to the self that was receding from these men, their accounts convey their suffering in ways that more aptly express their sadness. Second, our sample size, while adequate for a qualitative study, does not allow for definitive generalizations to a larger group of older men. Further, the Mexican-heritage sample was not diverse in terms of socio-demographics factors (the majority were selected from a rural, poor, farm labor region), which limits any analysis of intra-group differences based on degree of social incorporation (for a related analysis of rural older men, see Cambell et al., 2006; Garnham and Bryant, 2014; Roy et al., 2014). Another important limitation relates to analyzing translated material. While our translations were performed by fully bilingual non-U.S. born Latinos, translations are always subject to individual and socio-cultural idiosyncrasies, especially given the heterogeneity among Latinos.

Is it possible that older men with depression who have more successfully reformulated a masculine self might better negotiate their suffering and maintain improved quality of life? How would new selves help these men? What would it do for them to rearticulate their roles as husbands, partners, fathers, grandfathers, and friends? Though it would not eliminate the physical characteristics of depression, an alternative self might help them insofar as they would develop relationships of support, relationships which validate them as men. Encouraging depressed men adopt this narrative could help "cut the edge" of their depression and provide them with the symbolic resources to "fight the good fight" that our interviews found them to be losing. Health care practitioners as well as family and friends may find that focusing their efforts on establishing this counter-narrative renders more benefits to all involved. It is the least these men deserve.

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