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“You have to fight to legitimize your existence all the time”: The social context of depression in men with physical disabilities.

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Abstract

Little is known about the common experience of depression in men with physical disabilities. To help address this gap, we present findings from a qualitative study situated in the social determinants of health (SDH). Findings describe the detrimental effects of marginalization, economic precarity, restrictive masculine norms, stigma, and the need to resist ableist messages on men’s health and well-being. It is our intention to raise awareness of the impact of the SDH on depression in men with physical disabilities and encourage clinicians and policy makers to address the social domain as they seek to improve mental health in this population.

Keywords

social determinants of health; male depression; marginalization; economic precarity; stigma

Depression is a common secondary condition in people with physical disabilities who comprise 26% of the U.S. population (CDC, 2019). This is significant because co-occurring physical and mental health conditions are synergistically more impairing than either type alone (Kessler, Ormel, Demler, & Stang, 2003). A seminal study of physical disability and aging found that the onset of clinically significant depressive symptoms in high functioning persons resulted in a spiraling decline in physical and psychological health, with concomitant increases in rates of institutionalization and death (Bruce, Seeman, Merrill & Blazer, 1994). Similarly, the combination of physical disability and depressive symptoms in men is strongly predictive of 10-year mortality (van den Brink, et al. 2011). Although depression as a secondary condition has been discussed in the medical literature for decades, the majority of this literature has paid little attention to the social dimension of mental health (Priebe, 2016). Moreover, very little has been written about the how the social determinants of health (SDH) shape the experience of depression in people with physical disabilities, particularly in men. This is concerning since men with physical disabilities experience clinically significant depressive symptoms at rates 2-6 times higher than their non-disabled

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counterparts (Mitra, Wilbur, & Allen, 2005; Shen, Huang, Kung, Chiu & Tsai, 2017; Walinder & Rutz, 2001). Consistent with recent calls to attend to preventable and modifiable factors that influence mental health (Shim, Kho & Murray-Garcia, 2018) and better understand the lived experience of mental disorders (Stanton, Rosenbaum, & Rebar, 2019), the purpose of this paper is to report findings from a qualitative study of depression in men with physical disabilities situated in the context of the SDH.

Disability and the Social Determinants of Mental Health

Social determinants of health are conditions created by economic, social and environmental policies that impact health and well-being and access to health care. Societal structures manifest in the SDH and include poverty, low educational level, discrimination, unemployment, social exclusion and stigma which are associated with poor mental health; debt is also associated with mental disorders and has a graded effect (Allen, Balfour, Bell & Marmot, 2014). People with disabilities are at particular risk for experiencing such adversities (Nakkeeran & Nakkeeran, 2018). It is also known that economic resources available at the onset of disability predict mental health outcomes over time (McGiffin & Galatzer-Levey, 2019). Reduced income and its negative effects on housing, transportation, and social interactions produce structural disadvantages for people with disabilities (Frier, Barnett, Devine, & Barker, 2018). These structural effects subsequently lead to the development of secondary conditions that synergistically comprise functional ability leading to even greater disadvantage across the lifespan.

Disability, Gender, and Depression

The medical model labels disability as an individual “defect” (Barnes, 2020; Goering, 2015), paying no attention to systemic social structures that produce and sustain disability in daily life. The medical model perpetuates ableism defined as the differential attitudes toward and treatment of individuals based on ability status deemed as “normal” (Wolbring, 2012). In turn, ableism leads to discrimination and social prejudice against people with disabilities. In contrast, the minority model of disability defines disability as the embodiment of both exclusionary societal ideologies and impairments (Seibers, 2008). Common societal ideologies include ableist practices and beliefs that assign inferior value to people with disabilities and their contributions. Although both physical and mental health conditions are disabilities subject to ableism, for the purposes of this paper we distinguish between physical disability and depression because our focus is on their co-occurrence.

Gerschick (2000) theorized that attention to three social processes were necessary to understand experiences of disability: the stigma associated with disability, gendered interactions, and the importance of the body in enacting gender roles (Gerschick, 2000). Successful enactment of dominant gender norms increases one’s social capital (de Visser & McDonnell, 2013); failure invites social devaluation. Bodies are central to realizing this gendered social recognition. As described by Gerschick (2000):

Bodies are central to achieving recognition as appropriately gendered beings.
Bodies operate as social canvases on which gender is displayed and kinesthetically as the mechanisms by which it is physically enacted. Thus, the bodies of people

with disabilities make them vulnerable to being denied recognition as men or women. The type of disability, its severity, and visibility mediate the degree to which the body of a person with a disability is socially compromised (p. 1264).

Although men and women with disabilities are both subject to ableism, their experiences diverge. Whereas women experience sexism and ableism, men's masculine gender privilege conflicts with their stigmatized disability status resulting in status inconsistency (Coston & Kimmel, 2012; Gerschick, 2000). Men with physical disabilities may be feminized by others if they are unable to meet traditional gendered expectations of breadwinner, muscularity, strength, and vigor (Mik-Meyer, 2015; Scott, 2014). Depression, which has been cited in the men's health literature as a perceived weakness or emasculating condition (Seidler, Dawes, Rice, Oliffe & Dhillon, 2016), poses additional challenges to the already compromised social capital many men with physical disabilities possess. Gerschick & Miller's (1994) seminal work on masculinity found that men with physical disabilities respond to dominant masculinities by relying on them for their sense of self, reformulating them to better fit with their limitations, or rejecting them altogether. Subsequent masculinity research with men with physical disabilities has confirmed this pattern (Abbot, et al. 2019; Gibbs, 2005; Nolan, 2013; Shuttleworth, Wedgwood & Wilson, 2012).

Despite the realities of systems of oppression, prior to the last decade, the medical literature commonly focused on disability-related stressors such as pain or fatigue and/or latent biological processes as a primary explanation for the problem of depression in people with physical disabilities (Brown, 1990; Schreurs, de Ridder, & Bensing, 2002; Sullivan, LaCroix, Russo & Walker, 2001; Williamson & Shulz, 1992). This limited focus has begun to shift, with some investigators exploring how social processes, such as stigma and discrimination, also influence mental health in people with physical disabilities (Brown, 2017; Gayman, Brown, & Cui, 2011). This shift has coincided with greater recognition that people lower on the social hierarchy experience more cumulative stressors and may have less access to buffers compared to people with greater social advantage, resulting in the onset of mental disorders (Allen et al. 2014). Despite the important contributions of this emerging work, more information is needed on how social factors intersect with gender, disability, and mental health to change policy and practice and improve outcomes.

Methods

We report here on qualitative findings from a larger community-based participatory research study. The larger study and our prior work have been influenced by Independent Living philosophy which is grounded in the disability rights movement. Independent Living philosophy conceptualizes a person with a disability as someone with one or more impairments whose access to participation in community life is constrained by societal barriers such as architectural, attitudinal barriers and discrimination. Hence, members of the Independent Living movement seek equal access and full community participation for people with disabilities expressed through the values of self-determination, empowerment, choice, and consumer-control (National Council on Independent Living, 2019). Centers for Independent Living, which are also grounded in Independent Living philosophy, have been our primary community partners in this work.

Previously, we developed a program named Healing Pathways to improve depressive symptoms in women with physical disabilities which is implemented by and for members of this population (Hassouneh, Alcalá-Moss, & McNeff, 2011; Hassouneh, Nguyen, Chen, & McNeff, 2013; Mood, Hassouneh, & McNeff, 2015). The overall goal of the ongoing larger study is to adapt Healing Pathways to develop an analogous peer program appropriate for use with men with physical disabilities and to assess the feasibility, acceptability, and effect size of the new program.

We conducted a qualitative investigation guided by a critical hermeneutic approach to inform development of the new program. Critical hermeneutics expands interpretive hermeneutics by placing analyses in larger societal, economic, and historical contexts that explicitly address issues of power and ideology (Harvey, 2012). Qualitative data collection included two sequential periods. First, the authors conducted individual life history interviews to inform development of an initial outline for the new program content. Next, focus groups offered additional data and feedback on these development efforts. We obtained approval from the Oregon Health & Science University Institutional Internal Review Board before conducting our research.

Sample

Participants in this study self-identified as men with physical disabilities and depression. In total, 24 participants consented to join the study including 8 who participated in individual interviews and 16 who participated in two focus groups. Three participants were either born with or acquired their disabilities at a very young age; all others acquired their disabilities as adults. A variety of impairments were represented in the sample including spinal cord injury, multiple sclerosis, visual impairment, and traumatic brain injury. One of the participants was African-American and the remainder of the sample was white; one participant was gay and the remainder were heterosexual. We recruited participants for this study via advertisements in disability newsletters, Craigslist, Centers for Independent Living, personal contacts, and snowball sampling. Participants were sampled from urban and rural areas. All participants were screened for study eligibility based on the following inclusion criteria obtained via self-report: 1) physical disability; 2) depression; 3) male gender; 4) age 18 or older. Participants screened as eligible to join the study with a score of 16 or greater on the Center for Epidemiologic Studies Depression Scale (CES-D). All participants were asked about the type of assistance needed to meet their physical needs when participating in individual and focus group interviews.

Data collection and analysis occurred concurrently beginning with the first individual interview and ending after the second focus group.

Data Collection

All questions about the study were answered prior to initiation of data collection and written informed consent was obtained. Decisional ability was based on self-report. All participants expressed understanding of the contexts of informed consent forms. Academic investigators conducted individual interviews lasting an average of 90 minutes at private locations preferred by participants. Six participants were interviewed face-to-face at a location of their

choice and two were interviewed over the telephone. Using an unstructured interview guide, participants were asked to talk about their experiences of physical disability and depression in the context of their life history beginning in childhood. After individual interviews were completed and the initial analysis completed, two focus groups were conducted by trained men with physical disabilities from collaborating Centers for Independent Living. The focus group interview guide included questions about men's experiences of gender, social class, depression, and physical disability as well as questions about development of a peer program. All interviews were audio-recorded and transcribed verbatim by a professional transcription service.

Analysis

The hermeneutic circle in critical hermeneutics serves as a model for knowledge development through dialectical analysis. The central thesis of critical hermeneutics is that foreknowledge or background meanings shape all textual interpretations. Hence, interpretation cannot be free of the social, historical, and power dynamics that shape lived experience (Harvey, 2012; Smith & Hodkinson, 2005). Dialectical analysis refers to understanding the global meaning of a text by comparing the meaning of the parts in relation to the whole and vice versa (Harvey, 2012).

We conducted a thematic analysis using Independent Living Philosophy as a sensitizing critical framework. Thus, our analysis of the narratives included a lens through which we looked for experiences of discrimination and physical and social barriers as they relate to and impact physical disability and depression. All narratives were imported into MAXQDA and coded using the coding and memoing functions of this software. First, we read the narratives in their entirety to gain a sense of the whole. Next, we used the participants' words to generate codes from the text. As we continued to generate codes, we looked for relationships between them and refined our coding scheme in an iterative fashion looking both within and across cases (Ayres, Kavanaugh, & Knafl, 2003). We asked questions of the data and memoed on emerging themes to document and support the analytic process. Both authors participated in the analysis and differences of opinion were resolved by consensus. In line with the hermeneutic circle, as we attempted to gain insight into participants' experiences, we learned more about ourselves in return (Fontana & Frey, 2005). For this reason and consistent with the analytic approach, the primary investigator kept a journal as a means of practicing reflexivity during the data collection and analysis process. The codebook developed by the authors was also shared and discussed with the community investigators who confirmed the relevance of codes and the associated analytic structure. As the final analytic structure of themes emerged, we engaged in limited member checking to assess our final understanding of the phenomenon.

Results

We present five themes: 1) *marginalization and distress*; 2) *economic precarity and system breakdown*; 3) *performing masculinity*; 4) *secrecy and stigma*; and 5) *resisting ableism*. *Marginalization and distress* describe participants' experiences of pervasive devaluation in the context of a social hierarchy. *Economic precarity and system breakdown* refers to

participants' economic precarity in the context of public and private disinvestment in the welfare of people with disabilities. From this marginal position, most participants also attempted to *perform masculinity* by enacting dominant masculine gender norms to gain social capital, but this ultimately left them unable to disclose depression, even to peers reflecting experiences of *secrecy and stigma*. Finally, *resisting ableism* describes participants' resistance to negative societal messages and the energy and toll these efforts took over time.

Theme 1: Marginalization and distress.

Marginalization refers to the "process through which persons are peripheralized based on their identities, associations, experiences and environment" leading to social exclusion and vulnerability (Hall, Stevens, & Meleis, 1994; p. 25). In an integrative review of marginalization, Baah, Teitelman & Reigel (2019) concluded that social positionality is linked to the SDH through this process. Consistent with this finding in the literature, we found that participants' intersecting social locations were linked to experiences of pervasive devaluation in the context of dominant social hierarchies which in turn caused frequent mental distress; participants who were more socially marginalized and lacked the social capital to compensate were most distressed. Disability was viewed by all participants as a marginal social location in the hierarchy of social and political power:

Phillip: You...discount yourself because you get these kinds of hidden messages...that enter in our society about people with disabilities.

Ted: People with disabilities. They're almost seen as – not only second-class citizens... almost like in a caste system – where like, you know, they're sort of "the undesirables" ...it creates a...hierarchy.

Ted went on to reflect on how his social position as a white male, although one of privilege, was depressing because as a man with a visible physical disability he did not feel privileged, reflecting the problem of status inconsistency for this population:

Dealing with...all the "isms"...you have to take some time to process how your gender identifies you and...when you don't have a strong identity as a man in our society, there's a lot of questions about that...if you're not following the traditional-football...whatever...then you're written off in a lot of ways...not fitting into those cultural stereotypes, and trying to be your own person, and then, being persecuted because of that....And that's created depression... it doesn't allow for anything to feel good. Because, everyone's being oppressed—we live in an oppressive society.

John, an African-American participant from a low socio-economic background who continued to live in poverty, also expressed a deep sense of disillusionment with society based on his experiences with ableism, racism, poverty and violence:

I was born with flat feet...And people talked about me. That's depressing...So, I wore shoes to be able to walk...So—barriers. That's depressing...you may be poor, rich, or whatever...our society has got many different ways of coming at you...

because...I've been discriminated against, I've been treated like I'm not human because I'm black and...because I'm a man. I've been through all those doors... I've seen people lay on the streets all my life since I've been a little kid...It's depressing.

Phillip, Ted and John connected their own experiences of social marginalization with a general societal pathology. Whereas Phillip described covert discrimination related to physical disability, John went a step further, stating that our uncaring treatment of each other as human beings is a naturally depressing phenomenon.

Theme 2: Economic Precarity and System Failure

The link between poverty and mental disorders is well-established (Santiago, Kaltman, & Miranda, 2013) and economic security both in terms of income and housing are key SDH. For participants in this study, frequent inability to perform the traditional breadwinner role coupled with the failure of public and private systems to provide critical and expected supports led to significant mental distress.

Although the traditional breadwinner role prescribed for heterosexual men is often unattainable in the current economic system (Cornwall, 2016), we detected the effects of this outdated expectation in most interviews:

Harry: That's what the heart of it for most men is their ability to be valued...And value directly corresponds to generally work and what I can offer, how I can give, what I can provide. And if you're not providing, then you don't feel like you're a man.

Vince: We go from a person who's a provider, a traditional role as a male to we're not providing. There's a lot with that.

Ted: Men have to be strong, we have to be breadwinners and we have to...fight against a system that for many people disabilities were...not given a fighting chance...We live in, you know, a pretty competitive society.

Juxtaposed against the expectation that men will be breadwinners was the reality that many participants either had difficulty earning a living or anticipated that this could happen to them in the future due to changes in health and functioning:

Jack: I have enough bladder issues of my own relative to infection and...other things that are going to have to be dealt with...surgically. And...having spinal cord injuries for those surgeries complicates matters because I can't sit up. And if I can't sit up, I can't work. And if I can't work, I can't feed my family. And things like that just scare the hell out of me.

Although Jack feared the economic consequences of a loss of functional ability in the future, most participants had already or were in the midst of dealing with this reality. For these unemployed or underemployed participants, support from the social safety net was critically important. It is understandable then that perceived deterioration of the safety net engendered a sense of fear and constant worry in them:

Focus Group Two:

Sam: I'm a train wreck.

Rick: I fight that every day. What can I do to make my part of the bills? What can I hustle? What can I sell?

Stan: I do that all the time – worry, worry, worry about disability. Am I gonna get it? What's the judge gonna say?

Vince: The rumination.

Stan: What's gonna happen if he says no?

Rick: It's like am I gonna lose my house?

Sam: I'm constantly worried financially. I'm constantly worried about what tomorrow holds sort of thing...

Rick: If you even have a future.

The sense of economic precarity described by participants, although most severe among those who were poor and unemployed, was not limited to this group. Disinvestment in disability benefits and services and the threat of having existing supports taken away contributed to mental distress. Phillip was gainfully employed, and his physical impairment was sufficiently stable that he did not express any concerns about his ability to work in the future. However, Phillip still feared cuts to disability services because he relied on home services to live independently:

With...the possibility of services being cut...I use...in-home services now —for 20 hours a month...I know I'm only good through July of this year, so what's gonna happen to me after that? It makes me nervous to think that...what am I gonna do about creating a home care environment for me in the months and years ahead?

In addition to the deterioration of the social safety net, problems accessing services in the private sector were also reported and associated with physical impairment and mental distress:

Len: I've had...a work-related injury and...the employer was like, "Well, we're done with you"...it was a...workman's comp injury, and if that program was working...to provide the healthcare that they are supposed to...I would have been able to rehab...quicker, and been in less pain – and had more functioning much quicker than what I ended up having.

Jack: I have had...hip pain since I got this wheelchair two years ago...almost always. And my legs hurt a lot in this wheelchair... I got an orthopedic cushion to try and fix the problems. They...said it would work, it didn't work. It made it worse. And then, I tried to get another wheelchair like the other one, and the insurance company said, "No." I took that at face value and didn't fight it. And now, I have a new doctor, and he said let's try again. So now, I'm trying to be a self-advocate...I've been on the phone two days this week and will be back on the phone tomorrow to...lobby my case. So you're talking...about some of the

hassles that come with disability because of insurance companies denying claims, and then, you have to get on the phone, and you have to fight with them and go back and forth.

The neglect of what were supposed to be supportive systems, resulted in Len losing his job and having difficulty maintaining employment following his injury and Jack experiencing physical pain and fatigue while battling to continue to meet the demands of his job. This system breakdown further contributed to participants' sense of economic precarity.

Theme 3: Performing Masculinity

Social structures that stigmatize people for asking for and receiving help are an important SDH. The heavy emphasis on individual responsibility for health and well-being in the U.S. and industrialized West (La Grand, 2013; Spark, 2017; Teghtsoonian, 2009) combined with dominant masculine norms that equate help seeking with weakness (Mahalik, Good, & Englar-Carson, 2003; Seidler et al. 2016), are examples of this problem. Regardless of their personal beliefs, all participants in this study were aware of and influenced by restrictive masculine norms. Restricting norms influenced how participants expressed their emotions, how they asked for and received assistance from others, and experienced their bodies. Some participants actively resisted these restrictive norms; most did not. All participants described men as being socialized to avoid vulnerable emotions:

Conway: “Men have been taught to, you know, suck it up and not to cry in public, and that shows weakness.”

Focus Group Two:

Facilitator: what sort of messages are communicated...about having depression, having disability, being a man?

Sam: Suck it up. Suck it up.

Vince: Be a man... You grow up in the lifestyle of suck it up and don't cry. Don't deal with it. You're a man. You're a pussy if you get hurt and you cry or whatever. You just deal with it.

Although avoidance of vulnerable emotions was most important, avoidance of emotional expression generally was also described as a concern because it was perceived to be a form of weakness:

Mark: Man doesn't want to talk about it. What are you feeling right now? None of your business.

John: “I'm a man” men are like, “I don't got feelings.”

These views were rooted in binary perceptions of gender, where femininity was associated with free emotional expression and masculinity with restricted emotion and logic:

Conway: Women are...usually very open to express their emotions. And men are usually more bottled up, most of them...hold that anger. Men feel like...if they share their...

weaknesses or...what's going on in their head, people are gonna judge them, that they're gonna be considered weak...And...then they're gonna feel...even more, vulnerable, you know?...Nobody wants to feel more vulnerable...that's a scary situation, especially if they're already feeling that. Where women...all wanna spit it out.

Sam: Women are emotional creatures and men are logical creatures and that's the two biggest differences is men typically generally think with their brain first in a logical sense.

Mark: Men don't want to express themselves...whereas women, they wanna, they want to just talk and talk and talk about it. Like, a favorite example, some guy might say, "Hey did you hear about Jim breaking up with Jill?" "Yeah man, tough luck." "Yeah, tough luck." Whereas two women, "Did you hear about Jill's breakup?" and they talk about it for hours. So, men aren't going to – men are simple.

Despite the frequent endorsement of this gender binary by many, there was also recognition among participants that bottling up emotions could eventually catch up with men, potentially finding expression in unhealthy ways:

Focus Group One:

Jeff: I've seen at funerals where people are laughing.

Facilitator: But, really, they're crying...their eyes out, and I think... it's a release mechanism. It's a valve to, like – to blow off

Jim: Yeah, blow off the steam.

Ryan: So, you don't blow up and do something really bad. Take a gun and shoot people. Conway: One case that was severe depression. A member of family had been accused of something...he was so depressed, he, found a pistol from a friend and killed himself.

Participants' reports of restricted emotional expression are consistent with what has been widely documented in the literature in samples of non-disabled men, suggesting that dominant masculine norms of the invulnerable man influenced men in this sample in much the same way it has others (Levant, 2011; Levant, Hall, Williams, & Hasan, 2009).

Similarly, we found participants were restricted in their willingness to ask for and receive help from others, a finding that is well-documented in the men's health literature (Galdas, Cheater, & Marhsall, 2005; Johnson, Oliffe, Kelley, Galdas, & Ogradniczuk, 2012; Wasyilki & Clairo, 2018).

Herman: All these things...that I can't do anymore. And I can't fix it. I'm a freaking fixer, man. I want to fix everything. And I can't even come close to fixing what's going on in my head...That's one of the hugest things is that the balance, the asking for help.

Phillip: Men with physical disabilities definitely wanna have that outer mask of, you know, muster up the confidence and outward appearance of not needing help.

Mathew: That's the hardest part as males – who asks for help? "I don't need your help."
Who are you kidding?

While a few participants had reformulated or rejected dominant masculine norms of independence and self-reliance, most, despite sometimes needing assistance from others, had not yet successfully negotiated this terrain. Instead, they continued to experience mental distress when receiving help.

All participants recognized the presence of dominant discourses tying physical ability and strength with masculinity. Since all but three participants acquired their disabilities in adulthood, many expressed a sense of loss and feelings of frustration with their changing abilities:

Focus Group Two:

Ralph: I can't do what I used to do. So, what does that mean for me as a man? That's big...

Rick: When I was young and dumb and stupid, god, I could tear up the world. Now, I'm lucky if I can walk from one end of the house to the other.

Rick: I'm not, you know, limber like I used to. Hit the ground, I can't get up.

Mathew: That one's a big one. That's a huge one for us with disabilities, that I'm not the person I was before the disability.

The link between masculinity and physical ability led some participants to assume more painful bodily postures, resisting the use of assistive devices in public spaces:

Focus Group One:

Jim: It took me a while to actually get into the [wheel]chair because I could act – I mean, to this day, I can get up and I can walk out to my car from here. But I know that every step hurts.

Jeff: And...the back of my leg, knee hurts like hell and my feet hurt, and...my balance is so off because it's just gotten that way. And it took me a while to actually get in the [wheel]chair, but once I started...I can move around now. God, what a difference it made in my life.

Jeff: But...that's part of the masculine thing. Damn it, I can go ahead and walk...

Participants' willingness to endure unnecessary physical pain to avoid using visible assistive devices points to the need for members of this population to reformulate or reject conceptions of masculinity to create something that works for them, enabling healthy and flexible responses to changes in function (Gerschick & Miller, 1994; Shuttleworth, Wedgwood & Wilson, 2012). Although social contexts left participants vulnerable to depression, the cost of admitting this experience was further stigmatization, a well-documented determinant of mental health (Craig, Dattary, Engel, O-Driscoll & Loannaki,

2017; Hatzenbuehler, Phelan, & Link, 2013; Whittle et al. 2017). Therefore, many participants preferred to keep their depression a secret.

Theme 4: Secrecy and stigma of depression.

Research has shown that stigma has a negative impact on individuals and communities, including delays in help seeking and adhering to treatment (House, Marasli, Lister, & Brown, 2017; Knaak, Mantler, & Szeto, 2017). Consistent with this pattern, the subordinate position of participants in this study did not lend itself to disclosure of depression which was uniformly described as a stigmatizing condition. Most participants described a masculine code of secrecy around depression and most did not tell others they experienced it:

Tim: You were considered weak if you had depression.

Jack: Men with physical disabilities don't want to talk about depression...they don't want to talk about another weakness or failing.

Ted: I belong to all sorts of groups and...it's really hard to find advocates that don't have, on some level, depression. But identifying it and acknowledging it...is not seen as something that's valued.

The stigma of depression was so great that several participants recommended we avoid using the word depression in our plan to develop a peer program and instead focus the program on stress reduction:

Harry: Oh, the stigma...a depression support group just – it's so – sounds so heavy.

Focus Group One:

Jeff: I feel like the word “depression” with men a lot of times, because of the stereotype of weakness –

Jim: Downgrading.

Jim: It's a shut-off.

Michael: I think that's something that they should stay away from.

Conway: ...I think that's gonna scare and push men away...

For those men with physical disabilities who struggled to compensate for the detrimental effects that restrictive masculine norms had in their lives, publicly admitting to having depression was out of the question. Mental distress was often seen as a sign of “weakness,” leading men to remain silent. Several participants also reported that even in the context of building relationships with other men with physical disabilities, depression could not be disclosed directly due to the need to maintain social position. The tendency of men to size each other up both psychologically and physically for the purpose of ascertaining one's position in a social dominance hierarchy was pervasive.

Theme 5: Resisting Ableism

Hatzenbuehler et al. (2013) observed that people who are stigmatized:

...Use and deplete self-control to manage a devalued identity, which requires a flexible use of emotion regulation strategies in the short term. Over time, however, the effort required to cope with stigma diminishes individuals' psychological resources and therefore their ability to adaptively regulate their emotions, which can have negative consequences for both mental and physical health" (p. 816).

Hence, while resistance to oppression is commonly viewed as healthy action (Zlolski, 2019), the effort required to resist internalizing negative societal messages and attempt to overcome disadvantage requires enormous energy. In this study all participants struggled to varying degrees to achieve some level of success in the existing social order and while resisting stereotypes. Most described these efforts as cumulatively exhausting. Those who experienced greater marginalization due to their intersecting social locations were most affected. Jack resisted ableism by presenting himself as a positive representative of people with disabilities at his workplace which employed several thousand people:

Because of some of my job duties I am a relatively rare sight up here...And...I have an obligation to practice what I preach...So, when I'm here, somebody says "hi" to me, I always say "hi" back...And...I don't want to put people with obvious disabilities in a bad light...I kind of feel like that since there's only about 10 of us here.

Despite his efforts to represent people with disabilities in a positive light and serve as a role model for others, Jack was feeling discouraged at the time of his follow-up interview:

To me fighting the good fight means being a good role model and doing what I can to help other people with disabilities find jobs. But I am getting discouraged. I have been making an effort to say "hi" to everyone I see here but people just walk right by and act like I am invisible. And accessibility continues to be a major problem here...I am not seeing real progress.

Ted described a similar desire to achieve success and a concomitant struggle to resist marginalizing social discourses. Over time this struggle led to feelings of exhaustion:

I've had...successes, but it's always come at a price...Because starting out with disabilities...you have to fight...to legitimize your existence all the time...I've lost the will to push as vigorously as I once did because I feel like I'm not being accepted and...it takes a little starch out of your, like, experience because...it just gets to be...very exhausting.

The constant battle to resist oppression was echoed by John but in starker terms. John compared his daily life struggles to surviving a war:

When you wake up, you face a war; you never know when somebody's going to push a button...and trying to do the things you want to do as far as taking care of yourself there is always going to be some type of depression...Yeah, it's a constant struggle.

The struggle to resist social hierarchies gave most participants a sense of purpose but was also exhausting. The unrelenting onslaught of social inequity and need to fight for acceptance compounded feelings of depression, perhaps made worse by the inability to disclose these experiences even amongst peers.

Discussion

This study revealed that societal structures play a critical role in shaping the experiences of depression in men with physical disabilities. Although many participants reported common risk factors for depression which in isolation are usually viewed as individual risk factors, when the narratives were examined critically and collectively, their experiences of mental distress were clearly linked to SDH. Key factors included marginalization, economic precarity, restrictive masculine gender norms, and stigma. These findings are consistent with a growing body of literature on the SDH of mental health in marginalized populations generally and people with disabilities specifically which reflect growing mental distress and system breakdown. For example, in a study (N=559) examining how gender and physical disability influence psychological distress, Brown (2014) found that societal devaluation was predictive of depressive symptoms in men and women. Several qualitative studies of people with disabilities have supported this finding by describing the nature and impact of the societal devaluation they experience. A study examining the meaning of community in people with psychiatric disabilities in Canada (N=31) found a large disconnect between neoliberal images of community as a specific geographical place that offers easy access to security and belonging and the pervasive inequity and social exclusion, poverty, discrimination, and stigma actually experienced by participants (Frederick, Tarasoff, Voronka Costa & Kidd, 2017). Similarly, a study of physical disability (N=9) and the SDH conducted by Frier and colleagues (2018) found that disability negatively impacted access to employment, housing, transportation, and social acceptance, with income being the primary driver of all factors. Finally, a study of people with disabilities (N=64) seeking assistance from the social safety net conducted by Whittle and colleagues (2017) reported that pervasive stigma and broken systems described as "...excessive, obstructive, and penalizing bureaucracy from social institutions, leading to destitution and poor mental health" were the norm (p.181). Similar to findings from this body of literature, we found that ableist devaluation of participants in this study intersected with other marginal positions such as class, race, and sexual orientation resulting in marginalization and mental distress.

A unique contribution to this literature offered by our paper was an analysis of the influence of masculine gender on participants' experiences with depression. The effects of gendered power relations were evident in participants' interpretations of masculinity both in terms of how they positioned themselves in the gender binary and their concerns about the pairing of depression and disability. Fear that depression would be perceived by others as a form of weakness ultimately led participants to keep quiet about their depression to avoid further stigmatization. Moreover, participants' efforts to resist internalizing negative stereotypes took emotional energy that they could otherwise have used to help regulate emotional states. The desire to avoid being perceived as weak and vulnerable also shaped how participants expressed themselves and inhabited their physical bodies in public space. Common perceptions that men's social value was directly linked to their earning power, which

ultimately served to reify the traditional masculine role of breadwinner in this group, bolstered the social capital of those participants who fulfilled this role and undermined the capital of those who experienced greater marginalization.

Consistent with the literature cited above, economic precarity and system breakdown were described by participants as a constant stressor. The literature on mental health and neoliberalism is consistent with this finding. Neoliberalism is an ideology, both economic and social in nature, which relies on the market to determine what is valuable and desirable. People are then required to adjust their attitudes, habits, and behaviors to fit market demands and failure to do so for whatever reason is seen as a form of social deviance (Esposito & Perez, 2014). Hence, neoliberalism, through actual and threatened cuts to the social safety net and cultural messaging that places the onus on individuals to manage and control risks to their safety, finances, and health, has brought increased vulnerability and volatility, both material and affective, to people's lives (Adams, Estrada-Villalta, Sullivan & Markus, 2019; Esposito & Perez, 2014; Frederick et al. 2017; Layton, 2014; Teghtsoonian, 2009); the only viable response to precarity is to compete harder for seemingly scarcer resources to guarantee one's own safety and fate which in turn, intensifies mental distress (Wilson, 2018). Likewise, participants in this study who sought help to support their physical and psychological wellbeing from social programs, employers, and health care systems, reported significant barriers to receiving help due to lack of resources in the public sector and a strong emphasis on profit margin in the private sector. These barriers reinforced and contributed to participants' social and economic precarity and created a sense of exhaustion from the constant need to compete for resources, which in turn both created and exacerbated mental distress.

The biomedical approach to depression which focuses on the scientific management of symptoms and heavily emphasizes the development, marketing, and prescribing of psychotropic drugs, has largely failed to address the issue of economic precarity (Dougherty, 2019). Hence, too often, contemporary psychiatric discourses diagnose and locate social problems in individuals (Priebe, 2016). Our account of men with physical disabilities' experiences with depression suggests it is time that we take a larger view and consider the problems of individuals as deeply embedded in the fabric of society and the economy.

Implications for Practice

Knowledge gained from this study about the compounded stigma experienced by men who have co-occurring physical disabilities and depression and lack of available supports to address their mental health needs can be used to inform the development of mental health promotion efforts targeting men with physical disabilities and expand services in the community. In health care settings awareness of the influence that marginalization, economic precarity, restrictive masculine gender norms, and stigma have on men with physical disabilities can improve the quality of clinical encounters by improving the sensitivity of clinical communication and promoting routine evaluation of client resources during the assessment and treatment of depressive symptoms in this population. Moreover, connecting people with physical disabilities with community resources and instituting case management for those with confirmed depression would help address economic and

treatment needs while buffering stress. Such resources may include nonprofit organizations and government agencies that offer services to people in need by providing financial resources for housing and utility support, employment assistance, and food. Partnerships between health care organizations and Centers for Independent Living are also needed to expand the impact and availability of peer programs that promote the development of social networks to buffer stress and offer novel treatment options like Healing Pathways (Author, 2013). At the societal level, the socioeconomic status of men with physical disabilities can be increased by strengthening the capacity of agencies that provide job skills training and coaching and improve access to disability benefits. Finally, the social factors that produce mental distress can be addressed via public and economic policies that improve everyday life by reducing unequal access to wealth and resources.

Strengths and limitations of the Study

The study demonstrates several strengths including a community-based participatory approach, a focus on an underserved and understudied population, and triangulation of individual and group data during the analysis phase. Limitations of this study include a sample that was comprised primarily of men with acquired disabilities who were white and heterosexual. Future research that directly attends to the intersectionality of participants is needed including studies of disability in specific racial and ethnic and gender and sexual minority groups. This study was also limited by the fact that most men participated in a single interview. Given the time and expense associated with multiple interviews, it was not feasible for us to follow-up with each participant a second time.

Recommendations for future research

Future research to develop and test preventative interventions and treatments for existing depression in community settings should be a priority. The use of community-based participatory research designs which attend to the culture, needs, and wisdom of communities is optimal for the conduct of such studies. Nurse researchers who develop interventions aimed at mental health promotion and depression treatment should collaborate with disability communities who are major stakeholders in mental health initiatives at the community and societal levels.

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