

A FIELD GUIDE

# I'M GOOD.

The two words men say when they're anything but.

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What hides behind the phrase. How to recognise it in yourself. How to say something truer. What to do when someone finally tells you the truth.

READ THIS PAGE FIRST

# If tonight is the bad one, skip the book.

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You do not have to be certain. You do not need a plan, a diagnosis, or a good reason. You do not have to be sure it is “bad enough.” If you are frightened of your own thoughts, or you have started thinking the people around you would be better off, that is enough. Reach one of these now. They are free, they are staffed around the clock, and you do not need insurance.

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## 988 Suicide & Crisis Lifeline

United States

**Call or text 988** · chat at [988lifeline.org](https://988lifeline.org)

Free, confidential, 24/7. For suicidal thoughts, emotional distress, substance use, or simply needing a person on the other end. You do not have to be suicidal to call it.

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## Veterans Crisis Line

**Dial 988, then press 1** · text **838255**

For veterans, service members, Guard and Reserve, and those who support them.

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## Crisis Text Line

Text **HOME** to **741741**

If speaking out loud is more than you can manage right now, type instead.

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## SAMHSA National Helpline

**1-800-662-4357**

Free, confidential, 24/7 referral for substance use and mental health. They will tell you what exists near you.

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## Outside the U.S.

**findahelpline.com** lists verified crisis lines in more than 130 countries. Canada: call or text **988**. UK & Ireland: Samaritans, **116 123**. Australia: Lifeline, **13 11 14**.

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### IF IT IS HAPPENING RIGHT NOW

If you have already done something to hurt yourself, or you believe you are minutes rather than hours from it, call **911** or get to an emergency room. Tell someone in the building with you. Do not wait to see whether the feeling passes on its own tonight.

# How to use this book

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This is not a book you are meant to read cover to cover, in order, on a good day. It was built to be opened at the page you need.

There are five parts. They do different jobs, and most people will need one of them far more than the others.

**Part One** is the argument — what the phrase “I’m good” is doing, why it is so useful to the man who says it, and what the evidence actually shows about men and mental health. If you want to understand the problem before you touch it, start here.

**Part Two** is recognition. It describes what distress actually looks like in men, which is often not sadness. If you have been quietly wondering whether something is wrong with you, or whether something is wrong with someone you love, this is the part that will feel uncomfortably specific.

**Part Three** is for the man himself. How to say something truer than “I’m good.” Who to tell first. What therapy actually is, what it costs, and what happens in the room. What to do if you tried once and it was useless. What to do tonight, if tonight is bad.

**Part Four** is for everyone standing next to him — partners, friends, fathers, sons, coworkers. How to ask a question he can answer honestly. What to do when he actually answers it. And how to carry someone without going under yourself.

**Part Five** is the cause itself: what I’M GOOD believes, how it should speak, what it will refuse to do, and how it gets built.

### WHAT THIS BOOK IS NOT

This is not medical advice and it cannot diagnose anyone. Nothing in these pages replaces an assessment by a qualified professional who can actually see you, ask follow-up questions, and take a history. Where this book describes symptoms, it does so to help you recognise that something deserves attention — not to hand you a conclusion. The distance between “this sounds like me” and “I have this condition” is a real one, and only a clinician can cross it.

It is also not neutral about one thing. It takes the position that a man asking for help is doing something competent, not something shameful. Everything else here is open to argument. That is not.

### A note on who this is for

The book says “men” constantly, because that is the population where the specific pattern it describes — high distress, low disclosure, low treatment, high mortality — shows up most sharply in the data. But nothing here belongs exclusively to men. Women suppress, isolate, overwork, and say “I’m fine” too. If you are not a man and you recognise yourself in these pages, the book is not misfiring. Take what is useful.

It also does not assume one kind of man. The pressures described here land differently depending on your age, your culture, your income, your race, your sexuality, whether you served, whether you are raising children, whether you have insurance, and whether the men who raised you could name a feeling. Where those differences matter, the book tries to say so. Where it fails to, the failure is the book’s, not yours.

**The mission is not to make men less strong. It is to widen the definition of strength until honesty, treatment, recovery and asking for help fit inside it.**

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## PART ONE

# The Two Words

Before anything can be fixed it has to be described accurately. This part is the description: what the phrase does, where it came from, and what the evidence says about the men who use it.

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# The Distance Between Two Words

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Someone asks how you are. The answer arrives before the question finishes landing. “I’m good.”

Sometimes it is true. A great many men are, in fact, good, and it would be an insult to pretend otherwise. This book is not built on the assumption that every man is quietly falling apart.

But sometimes those two words are doing an enormous amount of work. They can mean *I don’t know how to explain this*. They can mean *I don’t want to put this on you*. They can mean *if I start talking I’m not sure I’ll be able to stop*. They can mean *I am ashamed of what I feel*. They can mean *I have been the person who handles things for so long that I genuinely do not know how to form the sentence that says I cannot handle this*.

The whole of this book lives in the distance between those two words and what can be standing behind them.

What makes the phrase so effective is that it is not a lie in any way that can be caught. It is socially complete. It closes the exchange cleanly. Nobody follows up on “I’m good” because there is nothing to follow up on. It is a door that shuts without a sound, and both people walk away believing something has been communicated.

**A man can be hurting badly and still look entirely functional from the outside. He can work. He can joke. He can take care of other people. That tells you nothing about what happens when he is alone.**

## What this book is trying to do

Four things, in order.

**Make hidden struggle visible.** Depression, anxiety, trauma, loneliness, addiction, grief, shame, anger and plain exhaustion can all sit comfortably behind a life that looks like it is working. Mortgages get

paid. Kids get to practice. Nobody notices. The first job is simply to establish that this is a real and common configuration, not an exotic one.

**Change the language around help.** The dominant frame treats reaching out as a concession — something you do when you have run out of road. The frame this book argues for is different: getting help is a practical act of maintenance, taken on behalf of yourself and everyone who depends on you. You service the truck before it fails on the highway. Nobody calls that weakness.

**Create recognition before instruction.** Nobody changes their life because a pamphlet told them to. People change when they read a description of themselves they did not expect anyone else to have written down. Recognition comes first. Information comes second. In the wrong order, the information bounces.

**Keep the door open.** This book does not ask any man to tell the world everything. It asks for one honest step, with one person — a friend, a brother, a partner, a doctor, a stranger on a crisis line, or, at minimum, with himself. One step is the entire ask.

## The question this book is built around

There is a version of this conversation that goes: *why won't men talk?* It is a bad question, because it is really an accusation wearing a question mark. It positions silence as a defect in men and stops there.

The better question, and the one this book keeps returning to, is this:

**What would make it easier for a man to tell the truth when he is not good?**

That version leads somewhere. It puts the burden on conditions rather than character, and conditions can be changed. Stigma can be reduced. Bad first experiences with therapists can be replaced with good ones. Cost barriers can be lowered. A friend can learn to ask a second question instead of accepting the first answer. A workplace can stop treating a mental health day as a confession of unreliability. A father can be the first man in his family to say out loud that he sees someone.

None of that requires a single man to become a different person. It requires the room around him to become different.

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**A distinction worth holding onto.** The goal is not to teach the world that every “I’m good” is a cry for help. That would be false, exhausting, and faintly insulting to every man who actually is fine. The goal is narrower and more defensible: to stop treating two words as a completed mental-health assessment.

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# Why This Exists

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This was not chosen because it polled well. It comes from experience.

I have lived through periods of depression and anxiety. I have lived with trauma and with the aftereffects of experiences that did not politely conclude when the event itself was over. I know what it is to have nightmares, fear, anger, pressure, shame and exhaustion follow you into ordinary daylight and sit in the room while you do ordinary things. I have known addiction, relapse, and recovery. I have been through the collapse of a marriage, the disruption of a family, legal stress, and the specific vertigo of watching parts of a life you built become unstable or simply disappear.

And through most of it, I still had responsibilities. I was still a father. I still had work. I still had people who needed things from me. I still had to answer the phone, solve problems, make decisions, earn money, and get through the day.

That is the part that gets left out of most accounts. There is a version of the mental health story where a man breaks down and everything stops. That happens, and it is real. But there is a far more common version where nothing stops at all. He keeps going. He performs competence with total conviction. He is, by every external measure, handling it.

Work, family and music became ways to keep moving. Music in particular became somewhere for emotion to go when ordinary conversation did not seem capable of holding it. Making something did not erase what happened. It gave the pain somewhere to become something else, which is not the same as healing but is not nothing either.

Rebuilding a life took more than pretending the old one had never broken.

## Why this is not a survivor story

There is a familiar shape to these narratives: everything went wrong, lessons were learned, and now everything is fine. That shape is popular because it is comfortable. It is also a lie, and a specifically harmful one.

Recovery is uneven. Strength coexists with fear. Progress coexists with days that are worse than the ones before them. A man can be genuinely rebuilding and genuinely hurting at the same time, in the same week, in the same hour.

When a recovery story shows only the victory, it does real damage to the man who is still in the middle of it. He reads it, measures himself against a finished product, and concludes that he is failing at something other people apparently completed. The honest version has to include the parts that are still open.

**The purpose of this book is to make room for that. Not the polished ending — the unfinished middle, where most people actually live.**

## Who I picture reading this

The man who has become extremely good at looking normal.

The father who does not want his children to see him fall apart, and so does not fall apart, and pays for it privately.

The worker who keeps showing up because showing up is the one thing he still controls.

The business owner who cannot switch off, and has started to suspect that the inability to switch off is not ambition.

The man sitting alone in his car for ten minutes before he walks into his own house, because that ten minutes is the only part of the day where he is not being someone for someone.

The man who uses work, or substances, or anger, or humour, or the gym, or isolation, or endless scrolling — not because he loves any of it, but because stopping would mean feeling all of it at once.

And the other half of the audience: the wife, husband, brother, sister, friend, child, parent or coworker who heard “I’m good,” did not believe it,

and has been wondering ever since whether it would be intrusive to ask one more question.

It would not be. Part Four of this book is entirely about how.

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#### **THE BOUNDARY THIS BOOK KEEPS**

One man's experience is an entry point into a subject. It is not evidence of what every man goes through. Men's experiences differ enormously by age, culture, race, sexuality, income, disability, family structure, military service, faith, geography, and access to care. This book uses lived experience to open the door and published evidence to furnish the room. Where the two disagree, the evidence wins.

# An Anatomy of “I’m Good”

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The phrase survives because it is useful. Before you can replace it, you have to respect what it does.

“I’m good” is not laziness or emotional illiteracy. It is a precision instrument, and most men have been using it for so long that they have stopped noticing how many different jobs it performs. Here are the main ones.

## It is true

Start here, because it matters. Often the man is fine. Ordinary, unremarkable, no crisis. Any framework that cannot accommodate this is a framework that will eventually start manufacturing problems, and men can smell that from a distance.

## It is a time calculation

The honest answer would take twenty minutes and you are both standing in a hallway. “I’m good” is not evasion here so much as compression — a recognition that the container being offered is smaller than the contents. This is why the setting of a conversation matters enormously, and why almost every honest conversation between men happens in a truck, on a walk, in a garage, or at 1 a.m. Those are the containers with room in them.

## It is protection of the other person

Many men run a constant background calculation about how much weight the people around them can carry. Saying nothing feels like a gift. *She has enough on. He’s dealing with his mother. The kids don’t need this.* The logic is generous and the outcome is isolation.

## It is a lack of vocabulary

Some men genuinely cannot locate the word. Not because they feel nothing, but because nobody ever taught them the difference between annoyed, resentful, ashamed, grieving, frightened and hollowed out. The whole range has to route through a small number of available words,

most of which are “fine,” “tired,” and “pissed off.” If your only tool is a hammer, everything gets described as a nail.

### **It is fear of consequences**

This one is not irrational and should never be treated as though it were. Men have real, specific fears about what disclosure costs: at work, in custody proceedings, in security clearances, in a marriage where the balance of who-is-the-strong-one is load-bearing, among friends who will not know what to do with it. Some of these fears are exaggerated. Some are entirely accurate. Telling a man his fear is baseless when it is not will end the conversation permanently.

### **It is identity maintenance**

If a man’s sense of himself is built on being the one who copes, then admitting he is not coping does not feel like sharing information. It feels like demolition. He is not protecting a secret. He is protecting the load-bearing wall.

### **It is a test**

Sometimes “I’m good” is offered specifically to see what happens next. If you accept it and move on, he learns something. If you pause, he learns something else. Men who have been let down before will often run this test without being conscious that they are running it. The correct response to a test you did not know you were taking is simply to slow down.

**“I’m good” can mean strength, gratitude, dismissal, avoidance, exhaustion, privacy, pride, embarrassment, or survival. The campaign lives inside that ambiguity rather than trying to resolve it.**

### **Why the phrase is the right centre of gravity**

It works because it is ordinary. It does not sound clinical. It requires no diagnosis, no vocabulary, no prior interest in mental health. It belongs at work, at the gym, in a garage, in a text message, between a father and a son, and between two men who have known each other for twenty years and have never once discussed being afraid.

Clinical language, whatever its accuracy, has a threshold problem: to use it you must first accept that you are the kind of person the language applies to. “I’m good” has no threshold. Everyone is already inside it. That is the entire strategic value of starting there.

# The Evidence

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The personal story sits inside a public-health problem with a large and consistent evidence base. Here is what it actually shows — and, just as importantly, what it does not.

None of the following says that every man struggles, that men have it worse than women, or that masculinity is a disease. It says something narrower and harder to dismiss: that there is a persistent, decades-long pattern in how many men experience distress, how they communicate it, and whether they end up in front of anyone who can help.

## Mortality

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4×

In 2024, the suicide rate among males in the United States was roughly four times the rate among females — 23.2 per 100,000 compared with 5.7. Men are about half the population and accounted for close to 80% of the 48,824 suicide deaths recorded that year.

CDC, Suicide Data and Statistics (2024 data); AAS/NCSP, U.S.A. Suicide: 2024 Official Final Data.

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The gap is not new and it is not narrowing much. The male rate has run three to four times the female rate consistently across the last two decades. In 2024 suicide became the tenth leading cause of death in the United States.

This figure deserves careful handling, and this book will return to that. Suicide is the most severe outcome, not the subject itself. The overwhelming majority of men who are struggling will never attempt suicide. Reducing men's mental health to a mortality statistic distorts the picture and, used carelessly, frightens people away from the conversation rather than into it.

## Prevalence

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# 19.7%

of U.S. adult men experienced any mental illness in a single year — roughly one in five.

NIMH / SAMHSA NSDUH

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# 41.6%

of men with any mental illness received any treatment in the past year, versus 56.9% of women.

NIMH / SAMHSA NSDUH

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# ~4%

lifetime prevalence of PTSD among men in a large U.S. population study.

VA National Center for PTSD

That middle number is the one to sit with. Roughly one in five men has a diagnosable condition in any given year, and fewer than half of them get any form of care — not intensive care, *any* care, including simply being prescribed something by a family doctor.

The gap between men and women is not small and it is not explained by men being healthier. It is a gap in arrival.



Share of U.S. adults with any mental illness who received mental-health treatment in the past year. Source: NIMH, drawing on SAMHSA's National Survey on Drug Use and Health.

## Substance use

Overdose deaths in the United States fell sharply in 2024 — the largest single-year decline ever recorded — but the sex gap held. The male overdose death rate was 32.2 per 100,000 against 14.1 for women. Roughly seven in ten preventable opioid overdose deaths were men.

This matters here because substance use and untreated distress are frequently the same story told in different vocabulary. A man who would never describe himself as depressed will describe himself, accurately and without embarrassment, as someone who drinks too much. The second description is often the only door available.

## Presentation

Clinical sources are consistent on this point: depression in men can include the familiar symptoms — hopelessness, fatigue, sleep disruption, loss of interest — but it can also present as irritability, anger, withdrawal,

overwork, risk-taking, physical complaints, or a worsening relationship with alcohol or drugs.

None of these behaviours proves depression. Plenty of irritable men are simply irritable. But when a cluster of them appears together and represents a genuine change from how someone normally is, the underlying condition is easy to miss — by family, by friends, by employers, and by the man himself, who is looking for sadness and does not find any.

## Barriers

A systematic review of 47 studies examining traditional masculinity norms and help-seeking found the same barriers recurring across very different populations: emotional suppression, self-reliance, and fear of appearing weak. A separate systematic review focused on young men's help-seeking and healthcare access found the identical themes — pressure to be strong, stigma, internalised stigma, and the belief that a man should solve his own problems.

The consistency is the finding. This is not a quirk of one cohort or one country. It reproduces.

## Connection

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# 15%

of American men reported having no close friends in 2021 — up from 3% in 1990. Over the same period, the share of men with six or more close friends fell from 55% to 27%.

Survey Center on American Life, American Perspectives Survey.

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The U.S. Surgeon General has identified loneliness and social isolation as significant threats to health, operating through biological, psychological and behavioural pathways. For a men's mental health effort, connection is not sentimental decoration around the edges of the real work. It is part of the clinical picture.

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**On reading statistics honestly.** Every figure above comes from a survey or a death record, and both have limits. Survey estimates depend on who answers the door; national mortality data records what a coroner concluded. Sex is recorded in binary categories in most of these datasets, which does not describe everyone. Numbers this large are useful for establishing that a pattern exists. They are useless for telling you anything about the specific man in front of you.

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# How Men Learned to Say It

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Nobody is born fluent in “I’m good.” It is taught, usually early, usually without anyone intending to teach it.

This chapter tries to explain the training without turning it into an indictment. That balance matters. A great deal of men’s mental health messaging fails at exactly this point — it correctly identifies that something in the culture is producing silence, and then addresses men as though they were the culture rather than its product. Men notice. They stop listening.

## The lessons that arrive early

Most boys learn a short and consistent curriculum, absorbed less from instruction than from observation of what gets rewarded and what gets mocked.

- **Distress is embarrassing.** A boy who cries in a group of boys learns something within about four seconds, and he does not forget it.
- **Value is contingent on function.** What you produce, protect, provide or win. Rarely who you are when you are producing nothing.
- **Needing is a lower status than being needed.** The one who helps outranks the one who is helped, and status among men is not an abstraction.
- **Physical courage is a virtue; emotional exposure is not.** A boy is praised for playing through a broken finger and gets nothing at all for saying he is frightened.
- **Anger is permitted.** Of the whole emotional range, one channel is left open. Everything else eventually learns to route through it.

Each of these has a legitimate origin. Composure under pressure is genuinely valuable. Being reliable for other people is genuinely good. The problem is not the content of the lessons but their rigidity — that they are taught as absolutes with no stated exceptions, and then a man hits forty and discovers there is no clause in the contract covering what he is currently going through.

**The target here is not masculinity. It is the version of masculinity narrow enough that a man cannot fit inside it while he is in pain.**

## **Friendship, and how it gets built**

Men's friendships are disproportionately hosted by institutions — school, teams, the service, the job site, the shift. The institution supplies the repetition, the shared task, and the excuse to be in a room together. This works well, right up until the institution ends.

Graduation, a move, a new job, a discharge, a divorce, retirement: each of these deletes a container, and the friendships inside it often go with it. Women's friendships tend to be maintained through direct contact that survives the loss of the shared setting. Many men have never had to build that skill, because until now the setting always did the work.

This is the mechanism behind the friendship recession numbers in the last chapter. It is not that men stopped wanting friends. It is that the infrastructure that used to generate them quietly disappeared, and nobody was taught to build it manually.

There is a second-order effect worth naming. Many men outsource their entire emotional life to one romantic partner — the only person they talk to properly. That arrangement functions until it does not. Divorce, bereavement or a bad stretch in the relationship then removes the support system and the source of the distress in one move.

## **The provider script**

A large amount of male distress attaches to work, money, and the sense of being the one holding it up — and this is where a lot of men are most reluctant to speak, because the shame is specific rather than diffuse. It is not *I feel bad*. It is *I am failing at the one job I understood myself to have*.

Job loss, business trouble, debt, being outearned, being unable to provide the childhood you promised: these are experienced by many men as identity events rather than financial ones. That is why the standard reassurance — *money isn't everything* — lands so badly. It answers a question he did not ask.

## The paradox in the data

Here is the puzzle that sits underneath this whole subject. Women are diagnosed with depression at considerably higher rates than men. Men die by suicide at three to four times the rate of women. Both things are true simultaneously.

There is no settled explanation, and anyone who offers you one with total confidence is overselling. The candidate factors researchers point to include: differences in the methods used in suicide attempts, which affect lethality; underdiagnosis of depression in men because the presentation does not match what clinicians are trained to look for; lower help-seeking, so fewer men are in the system to be counted; higher rates of alcohol and substance use, which increase impulsivity and risk; and social isolation, which removes the people who might otherwise interrupt.

Probably it is all of them, weighted differently for different men. What the paradox establishes is narrower but useful: **diagnosis rates are not a reliable measure of distress**. A population can be under-diagnosed and over-represented in the mortality data at the same time, and men are.

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### WHAT FOLLOWS FROM ALL THIS

If silence is trained rather than innate, it can be untrained — but not by telling men they were trained wrong. It shifts when a man watches another man he respects do the thing he was told not to do, and observes that nothing bad happens. That is a slower mechanism than a slogan. It is also the only one with a track record.

## PART TWO

# Recognition

What distress actually looks like in men — which is very often not sadness. This part is written to be uncomfortably specific, because vague descriptions let everyone off the hook.

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# Depression Doesn't Always Look Like Sadness

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A lot of men miss it in themselves for years because they are checking for the wrong thing. They are looking for crying. What they have is a low, grinding irritation and a life that has quietly lost its colour.

The textbook picture of depression — persistent low mood, tearfulness, hopelessness, loss of interest — is accurate and does describe many men. But clinical sources have documented for decades that depression in men frequently presents through a different set of doors, and those doors do not have “depression” written on them.

## The alternate presentation

These are the features that clinicians report seeing more often in men, and that families most often mistake for personality:

- **Irritability and a short fuse.** Not rage necessarily. A permanently low tolerance. Everything is an imposition. The dishwasher being open becomes a genuine provocation.
- **Withdrawal that looks like being busy.** He is not avoiding people; he is just always working, always out in the garage, always at the gym, always on a screen.
- **Loss of interest in what used to matter.** Not dramatic. He just does not put the record on anymore. He has not touched the bike in eight months. He watches the game without watching it.
- **Physical complaints with no clear cause.** Back pain, headaches, gut problems, chest tightness, a body that hurts in a way that scans keep failing to explain.
- **Sleep going wrong at either end.** Falling asleep on the couch at nine and waking at three, unable to get back. Or not sleeping at all.
- **Escalating alcohol or drug use.** One more drink than there used to be, every night, without any particular occasion.

- **Risk-taking.** Driving faster. Gambling more. Picking fights that are available to be avoided. A carelessness about outcomes.
- **Overwork with diminishing returns.** More hours, less produced, and a growing panic about stopping.
- **Numbness rather than sadness.** This is the one men most often describe when they finally do describe it. Not pain. Flatness. The volume turned down on everything, good and bad alike.

**Men who would never say “I’m depressed” will readily say “I’m exhausted,” “I’m stressed,” “I’ve got no patience left,” or “I just don’t care about anything anymore.” Those are not different conditions. They are frequently the same condition, described in the only vocabulary available.**

## Why this matters practically

Two consequences follow, and both are expensive.

The first is that **the man himself does not recognise it.** He has a mental image of depression — someone who cannot get out of bed — and he gets out of bed every day, so it cannot be that. He concludes that he is simply becoming a worse person: more impatient, less fun, harder to live with. That conclusion produces shame, and shame produces further silence. The loop closes.

The second is that **the people around him misread it as character.** His wife thinks he has stopped loving her. His kids think he is angry at them. His friends think he has become difficult and slowly stop calling. Every one of those reactions is reasonable given the available information, and every one of them isolates him further at exactly the point where isolation is most dangerous.

## The clue that cuts through

Symptoms alone are noisy. Plenty of men are irritable, tired, and drinking a bit much, and are not depressed. The signal that actually matters is **change and duration.**

Ask: is this different from how he has been for most of his adult life? And has it been going on for weeks rather than days? A man who has been

gruff since 1994 is not showing you a symptom; he is showing you himself. A man who was reliably warm and has been flat and short for two months is showing you something else entirely.

#### WHAT A CLINICIAN IS ACTUALLY LOOKING FOR

Diagnosis of a depressive episode generally requires a cluster of symptoms present most of the day, nearly every day, for at least two weeks, causing meaningful impairment in work, relationships or daily functioning — and not better explained by something else, such as a medical condition, a medication, bereavement, or substance use.

That last clause is why self-diagnosis is unreliable. Thyroid problems, sleep apnoea, low testosterone, chronic pain, certain medications, vitamin deficiencies and heavy drinking can all produce something that looks convincingly like depression. This is a genuine argument for seeing an actual doctor rather than reading more articles: some of the causes are found with a blood test.

## What it is not

Depression is not sadness, and it is not weakness, and it is also not a moral event. It is a condition with biological, psychological and social contributors, it is common, and it is one of the more treatable things in medicine. Most people who get proper treatment improve substantially.

That last sentence is the one worth carrying out of this chapter. Not *you might have this*. Rather: *if you have this, it is fixable, and the fix is not mysterious*.

# Anxiety, and the Body That Keeps Score

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Many men arrive at anxiety through cardiology. They think their heart is failing. The scans come back clean, and nobody explains what actually happened.

Anxiety is the single most common category of mental health condition, and in men it very frequently presents physically first. This is not men “somatising” because they cannot access their feelings. The physical symptoms are real, measurable and produced by an actual physiological cascade — the body preparing, correctly and usefully, for a threat that is not going to arrive.

## What it feels like from the inside

**In the body:** chest tightness or pain, a racing or pounding heart, shortness of breath, a sensation of not being able to get a full breath, sweating, trembling, nausea, a churning gut, dizziness, a jaw that aches from clenching, shoulders permanently up around the ears, tension headaches, and exhaustion that sleep does not touch.

**In the head:** a mind that will not stop generating scenarios. Rehearsing conversations that have not happened. Rehearsing conversations that happened four years ago. Waking at 3 a.m. with total clarity about a problem you cannot do anything about at 3 a.m. An inability to concentrate on anything for long, because attention keeps getting pulled back to scan for what is wrong.

**In behaviour:** avoidance. Not making the call. Not opening the letter. Not going to the thing. Every avoidance provides immediate relief and makes the next instance harder, which is the mechanism by which anxiety expands to fill a life.

## Panic attacks

A panic attack is a sudden surge of intense fear with strong physical symptoms — typically peaking within about ten minutes. Chest pain, pounding heart, breathlessness, shaking, sweating, a feeling of unreality, and very commonly the conviction that you are having a heart attack or about to die.

Men often experience their first one and go to an emergency room, which is entirely the right call the first time. What frequently happens next is that they are told their heart is fine and discharged with no explanation of what did happen, no follow-up, and a private conviction that something is deeply wrong with them that the doctors missed.

Two things are worth knowing. Panic attacks are not dangerous in themselves, however catastrophic they feel. And they are highly responsive to treatment — specific, well-evidenced, relatively short courses of therapy exist for exactly this.

### CHEST PAIN IS NOT A SELF-DIAGNOSIS SITUATION

Nothing in this chapter should be read as a reason to ignore chest pain. Cardiac symptoms and panic symptoms overlap significantly, and men in particular have a documented tendency to talk themselves out of seeking care. Get it checked. Then, if the cardiac work-up is clean and it keeps happening, take the anxiety possibility seriously rather than filing it under “nothing.”

## The specifically male shapes it takes

Anxiety in men often gets a socially acceptable costume, which is why it goes unnamed for years.

**It becomes control.** Rigidity about how things are done.

Disproportionate reactions when plans change. Micromanaging at work. From the outside this reads as difficult; from the inside it is an attempt to reduce the number of unpredictable things in a world that feels like it is producing too many.

**It becomes work.** Anxiety and overwork fit together perfectly, because work supplies both the distraction and a socially applauded reason for

the distraction. Nobody stages an intervention over a man being too dedicated.

**It becomes drinking.** Alcohol is genuinely, immediately effective at reducing anxiety, which is precisely the problem. It works, then it rebounds — and the rebound anxiety on the following day is worse than the baseline you started with. The most reliable way to build a serious alcohol problem is to use it as an anxiety treatment.

**It becomes anger.** Fear and aggression sit close together neurologically and closer still socially. For a man permitted only one visible emotion, fear will regularly emerge wearing anger's clothes.

**Anxiety is not a character flaw and it is not a failure of toughness. It is a threat-detection system that has become miscalibrated — running hot, firing at things that are not threats.**

## **The good news, stated plainly**

Anxiety disorders are among the most treatable conditions in mental health. Cognitive behavioural therapy has a substantial evidence base for anxiety and panic specifically; so does exposure-based work for phobias and avoidance. Medication options exist and work for many people. Most men who get proper treatment for an anxiety disorder improve, often considerably, and often faster than they expected.

The delay is almost never about the treatment failing. It is about the years between the first symptom and the first appointment.

# When the Event Ends and the Alarm Doesn't

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Trauma is not the event. Trauma is what the nervous system does afterwards, sometimes for years, in a body that is no longer in any danger.

There is a widespread and damaging assumption that trauma belongs to combat. It does not. The VA's National Center for PTSD reports a lifetime PTSD prevalence of roughly 4% among men in a large U.S. population study — and that is a diagnosis threshold, which sits well above the far larger number of men carrying trauma responses that never get formally assessed.

The events behind it include military service, but also: assault, serious accidents and crashes, childhood abuse or neglect, sudden bereavement, medical emergencies, witnessing violence, natural disasters, being present at something you could not stop. Men who work in emergency services, medicine, corrections and construction accumulate exposure as an occupational hazard nobody puts on the job description.

## What it does

The core of it is a nervous system stuck in a defensive setting. The threat is over; the machinery has not been told.

**Intrusion.** Memories that arrive uninvited. Nightmares. Flashbacks. A smell, a sound, a particular quality of light, and you are back there in a way that is not remembering so much as reliving.

**Avoidance.** Not going near the place. Not watching that kind of film. Not having that conversation. Changing the subject with a speed that other people notice.

**Hypervigilance.** Sitting where you can see the door. Startling at things that do not warrant startling. Scanning constantly. Sleeping badly because part of you is on watch. Many men describe this as simply “being switched on” and do not realise it is a symptom, because they cannot remember being any other way.

**Change in how you see everything.** Persistent negative beliefs about yourself or the world. Guilt, including the specific and irrational-but-immovable guilt of having survived, or of not having done more. Emotional numbness. Detachment from people you love. Loss of interest in things that used to matter.

## **The parts that get missed**

Three things cause trauma to go undetected in men for long periods.

**Delay.** Symptoms can begin months or years after the event. A man who coped fine at the time concludes that a later collapse must be about something else, or about nothing, or about him being weak now in a way he was not then.

**Anger as the presenting symptom.** Irritability and aggression are recognised features of PTSD. Families experience this as a man who has become frightening or unpredictable. They rarely experience it as a symptom, because it does not look like distress. It looks like a problem he is causing.

**Self-medication.** Alcohol and drugs work on hypervigilance and nightmares in the short term. PTSD and substance use disorders co-occur at high rates, and when both are present the substance use is usually the one that gets addressed — often as though it were the whole problem rather than an attempted solution to a different one.

**“It was a long time ago” is not evidence that something has been processed. The nervous system does not keep a calendar.**

## **Why it is worth treating**

PTSD is one of the areas where the treatment evidence is strongest and most specific. Trauma-focused therapies exist that were built for this exact problem and have been tested extensively — among them cognitive processing therapy, prolonged exposure, and EMDR. These are structured, time-limited courses of work, not open-ended talking.

Two things men consistently want to know before they will go anywhere near it:

**No, you do not have to describe everything to everyone.** Trauma treatment is done at a pace you set, with a clinician trained to keep it tolerable. The fear that treatment means being forced to relive the worst thing in detail on day one is understandable and inaccurate.

**No, this does not mean you are broken.** A nervous system that responded intensely to something genuinely dangerous did exactly what it was built to do. The problem is that it did not stand down afterwards. That is a calibration issue, and calibration issues can be corrected.

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If you served: the Veterans Crisis Line is available by dialling **988** and pressing **1**, or texting **838255**. VA mental health services are available to many veterans regardless of discharge status or whether they are enrolled in VA health care, and eligibility is broader than most veterans assume. It is worth asking rather than assuming you do not qualify.

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# Anger Is Usually the Second Emotion

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Something else almost always arrives first. Anger is what it turns into on the way out, because anger is the one exit that was left unlocked.

This chapter is likely to be the most uncomfortable one in the book for some readers, and it should be. Anger is where men's untreated distress most often becomes other people's problem, and any honest book about this has to hold two things at once: that the anger is frequently a symptom, and that it is never the other person's job to absorb it.

## The mechanism

Consider what actually happens in the four seconds before a man snaps at his kid over something trivial.

He is already at capacity. Underneath sits something with a name he may not have available: fear about money, shame about a failure, grief he has not processed, exhaustion he has not admitted to, humiliation from earlier in the day. None of these has a permitted route to the surface. Anger does. So the whole load converts and exits through the one available channel, and the trigger — the noise, the spilled drink, the question — takes the full weight of it.

Afterwards comes shame, which adds to the load, which lowers the threshold for next time. This is a loop with a direction, and it gets worse rather than better if nothing interrupts it.

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### WHAT IS USUALLY UNDERNEATH

Fear. Shame. Grief. Humiliation. Feeling disrespected or replaceable. Feeling like a failure as a provider. Feeling out of control. Physical exhaustion. Hunger and poor sleep, which are unglamorous but genuinely lower the threshold. And frequently, an untreated depression, anxiety disorder or trauma response sitting underneath all of it.

## Two things that are both true

**One:** if a man is angry all the time, something is wrong, and treating it as a character defect will not fix it. Anger management techniques applied to an untreated depression are a bucket under a leaking roof.

**Two:** an explanation is not a permission slip. Understanding why you shouted at your family does not undo the shouting, and the people on the receiving end are not obligated to be patient while you work it out. If your anger has ever made someone in your house afraid of you — not annoyed, *afraid* — that is the line, and it has already been crossed. That is an urgent reason to get help, not a reason to look for a better explanation.

This book will not soften that. Nothing in these pages is a defence of frightening the people you love.

**Anger is information. Read it as a signal that something underneath needs attention — not as an account of what is actually going on.**

## The practical question

When you notice the heat rising, one question does more work than any technique:

### “What is this actually about?”

Almost never the dishes. Almost never the tone of the question. Ask it honestly and an answer usually surfaces within a few seconds, and the answer is usually something that has nothing to do with whoever is standing in front of you.

The technique that follows is unremarkable and works: leave the room. Say you are going to walk around the block and that you will be back. Do not leave silently, which frightens people, and do not leave for the night. Twenty minutes is generally enough for the physiological surge to drop, and you are a different person on the other side of it.

Then come back and say the thing that was actually true. Not the accusation — the fear underneath it.

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#### IF IT HAS BECOME PHYSICAL

If you have hurt someone, or you are frightened that you might, this stops being a mental health chapter and becomes a safety matter. The people in your home need to be safe first; you can get help second, and you should. In the U.S., the National Domestic Violence Hotline (**1-800-799-7233**, or text START to 88788) provides support to anyone affected, including people who are worried about their own behaviour and want it to stop. Making that call is not an admission that you are irredeemable. It is the first competent thing available.

# The Line You Cross Slowly

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Almost nobody decides to develop a drinking problem. They discover, somewhere around year six, that the thing which was helping has become the thing that requires help.

Substance use belongs in a men's mental health book for a straightforward reason: it is frequently the same problem in a different vocabulary. A man who cannot say he is depressed can often say he drinks too much. Sometimes that is the only door in the building.

The numbers make the case. Even after the largest single-year decline in overdose deaths ever recorded in the United States, the 2024 male overdose death rate ran at 32.2 per 100,000 against 14.1 for women, and men accounted for roughly seven in ten preventable opioid overdose deaths.

## How the slide actually works

It is worth being precise about this, because the caricature — a man who drinks in the morning and loses everything — lets an enormous number of men off the hook.

**Stage one: it works.** A drink genuinely reduces anxiety. It genuinely quiets a loud head. It genuinely makes sleep arrive faster. Nothing about this is imaginary, which is why it is such an effective trap.

**Stage two: tolerance.** The same amount produces less relief. The amount goes up. This happens gradually enough that no single night registers as a change.

**Stage three: rebound.** Alcohol wrecks sleep architecture and raises next-day anxiety. Now you are drinking partly to treat the effects of drinking, and the original problem is still there underneath, untreated and slightly worse.

**Stage four: structural.** It has become load-bearing. Removing it means facing everything it was covering, all at once, which is exactly the thing you were avoiding. This is the point at which people stop being able to stop on their own, and it is not because they lack character.

## The questions worth asking yourself

Below is the AUDIT-C, a three-question screening tool used widely in primary care and by the VA. It is not a diagnosis. It is a rough indicator of whether a longer conversation is warranted.

- |                          |                                                                       |                                                                                                  |
|--------------------------|-----------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | How often do you have a drink containing alcohol?                     | <i>(Never / monthly or less / 2-4 times a month / 2-3 times a week / 4 or more times a week)</i> |
| <hr/>                    |                                                                       |                                                                                                  |
| <input type="checkbox"/> | On a day when you are drinking, how many standard drinks do you have? | <i>(1-2 / 3-4 / 5-6 / 7-9 / 10 or more)</i>                                                      |
| <hr/>                    |                                                                       |                                                                                                  |
| <input type="checkbox"/> | How often do you have six or more drinks on one occasion?             | <i>(Never / less than monthly / monthly / weekly / daily or almost daily)</i>                    |
| <hr/>                    |                                                                       |                                                                                                  |

Score each answer 0 to 4, left to right. For men, a total of 4 or more is generally treated as a positive screen — meaning it is worth discussing with a doctor, not that you are an alcoholic.

These four questions are less formal but often more revealing:

- Have you tried to cut down and found you did not manage it?
- Do you drink or use alone, or hide the amount from people close to you?
- Are you using it specifically to manage a feeling — to sleep, to calm down, to stop thinking — rather than to enjoy it?
- Has anyone who loves you raised it, even once, even lightly, even in a way you dismissed?

That last one carries more weight than people give it. Most men get a warning long before they get a crisis, and most men explain it away.

**The question is not “am I an alcoholic.” That word triggers a defence in most men before they can think. The useful question is: is this costing me more than it is giving me?**

## What treatment actually involves

The picture in most men’s heads is a residential facility for a month and a life sentence of church basements. That is one path. It is not the only one, and for many people it is not the relevant one.

The realistic range includes: a conversation with a family doctor; brief structured counselling; outpatient programmes that fit around a job; medications with genuine evidence behind them for both alcohol and opioid use disorder; peer support in many varieties, both twelve-step and secular alternatives; and, when it is warranted, inpatient care. Treating the depression, anxiety or trauma underneath at the same time is usually essential, because leaving it untreated is leaving the reason in place.

#### **DO NOT DETOX FROM ALCOHOL ALONE**

Withdrawal from heavy, sustained alcohol use can be medically dangerous and, in some cases, fatal. This is one of the few places in this book where the advice is unambiguous: if you have been drinking heavily every day for a long period, talk to a doctor before stopping, rather than deciding on a Sunday night to quit on Monday. The same caution applies to benzodiazepines. Medically supervised withdrawal exists precisely because this is a real risk.

SAMHSA's National Helpline — **1-800-662-4357** — is free, confidential, 24/7, and will tell you what treatment exists near you.

One further thing, said plainly because it saves lives: if anyone in your household uses opioids, including prescribed ones, keep naloxone in the house and make sure someone else knows where it is. It is available without a prescription in U.S. pharmacies. It is the fire extinguisher argument — you are not planning on a fire.

# Still Functioning

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This is the configuration this whole book was built around: the man who is unwell and simultaneously performing at an entirely acceptable standard.

He gets up. He goes to work. He is competent there, sometimes exceptional. He makes the money. He shows up at the game. He answers the messages. By every visible metric he is fine, and this is precisely the problem, because there is no metric anywhere that is measuring the thing that is wrong.

He has usually concluded, on the available evidence, that he does not qualify. Other people are actually suffering. He has a job and a family and a roof. Whatever this is, it does not rise to the level of a problem, and taking it to a professional would be an act of self-indulgence.

**Functioning is not a treatment. It is a cost. The energy required to keep performing normality has to come from somewhere, and it is coming from him.**

## What it costs, specifically

**Everything outside the essential gets cut first.** Work and childcare are non-negotiable, so the budget is balanced by cutting friendship, hobbies, exercise, rest and sex. From the outside this looks like a man who has become boring. From the inside it is triage.

**The presence goes.** He is in the room but not in the room. Physically at dinner, mentally running the loop. His family experiences this as distance and often takes it personally, because it looks exactly like someone who has stopped being interested.

**Recovery time expands and stops working.** He needs more time to recover from ordinary demands, and the recovery no longer recovers anything. Sunday does not fix the week. A holiday does not fix the year. This is one of the more reliable indicators that something structural is wrong.

**The margin disappears.** Running at full capacity means there is nothing left for the unexpected. So an ordinary setback — a flat tyre, a bad email, a sick kid — produces a reaction wildly out of proportion, which everyone including him then reads as him being unreasonable.

## **Burnout is not a synonym for tired**

Burnout has a recognised shape: exhaustion that rest does not resolve; cynicism and detachment from work you used to care about; and a growing sense of ineffectiveness — the feeling that nothing you do makes a difference.

It is worth separating from depression, though the two overlap and frequently co-occur. Burnout is usually anchored to a context, most often work; depression tends to colour everything. A useful diagnostic question: **on a two-week holiday with no work contact at all, does it lift?** If it lifts substantially, you are probably looking at burnout and a job that needs to change. If it follows you to the beach, it is probably not the job.

## **The signals worth taking seriously**

- The car. Sitting in it outside your own house for ten minutes before going in. Almost every man who does this knows exactly what it is and has never once described it to anyone.
- Sunday afternoon dread that has crept back to Saturday.
- Actively hoping for something small and legitimate to go wrong — an illness, a cancellation — so that you get a break you would not otherwise permit yourself.
- Being unable to enjoy things you are objectively enjoying.
- Fantasising about disappearing. Not self-harm — just leaving. Driving and not stopping. This is common, rarely voiced, and worth mentioning to someone.
- Relief at the thought of not waking up. This one is different from the others and belongs in a doctor's office or on a crisis line, today, not eventually.

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#### THE BAR IS LOWER THAN YOU THINK

You do not need to be in crisis to be entitled to help. You do not need to have lost anything yet. “I’m functioning, but it is costing me everything I have, and I’ve been doing it for two years” is a complete and sufficient reason to make an appointment. Waiting until it gets bad enough to be undeniable means waiting for damage that did not need to happen.

# The Friendship Recession

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A large number of men in their forties have friends in the way they have a gym membership. It technically exists.

Loneliness is not a soft topic appended to the end of a mental health discussion. The U.S. Surgeon General has identified loneliness and social isolation as significant threats to health and well-being, operating through biological, psychological and behavioural pathways. Isolation is not just unpleasant. It is a health exposure.

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55 → 27

The percentage of American men reporting at least six close friends fell from 55% in 1990 to 27% in 2021. Over the same period the share of men reporting *no* close friends rose from 3% to 15% — a fivefold increase.

Survey Center on American Life, American Perspectives Survey.

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## How this happened without anyone deciding it

The last chapter of Part One introduced the mechanism; it is worth spelling out here because it explains why the fix is not simply “text your mates more.”

Men’s friendships have historically been **hosted**. The school, the team, the unit, the site, the shift, the bar near the plant. Each supplied three things that friendship requires and that adults almost never generate deliberately: repeated proximity, a shared task, and a reason to be there that is not “I wanted to see you.” That last one matters enormously, because for a great many men, needing to state the desire directly is the barrier.

When the host disappears — you graduate, you move, you change jobs, you get discharged, you get divorced, the plant closes, you get promoted away from the people you actually liked — the friendship usually goes with it. Not through any falling-out. It simply stops having a venue, and

nobody builds a replacement, because nobody was ever taught that friendships require deliberate construction after about age twenty-two.

Add to this the pattern of routing everything through one romantic partner. A man with a wife he talks to and no one else has a support system with a single point of failure. If the marriage ends, or if the marriage is the problem, the support and the crisis are the same object.

## **Why it is hard to fix and how it is fixed anyway**

The obstacle is not desire. Most isolated men want connection. The obstacle is that the first move requires openly wanting something, and that is precisely the move most men were trained out of. Sending “we should catch up sometime” is safe because it commits to nothing. Sending “are you free Thursday” is exposure.

Three things reliably work, and none of them are profound.

**Rebuild the host.** Do not try to schedule intimacy. Schedule a recurring, low-stakes, task-shaped thing: a standing Tuesday five-a-side, a Saturday morning ride, a card night, a run club, a workshop, a class, a volunteer shift. The recurrence does the work. You do not have to organise it every time, which is what kills these things.

**Be the one who sends the message.** Someone has to, and everyone is waiting for someone else. Be specific and offer a date. “Coffee Saturday, 9?” converts. “We should catch up” does not.

**Say one true thing.** Friendships deepen through disclosure, incrementally. You do not have to open with your marriage. “Honestly, this year has been rough” is enough of a step. What usually happens next is that he tells you his year has been rough too, because he was also waiting.

**The most common structural feature of men’s loneliness: two men, half a mile apart, each assuming the other is doing fine and would find it strange to be contacted.**

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**On shoulder-to-shoulder.** There is a real and widely observed pattern that men talk more easily when they are doing something else — driving, walking, fishing, working on an engine, playing something. It reduces eye contact, gives the conversation somewhere to go when it stalls, and means no one has to declare that a conversation is happening. Use it. It is not avoidance; it is a workable format, and a workable format that gets used beats an ideal one that does not.

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# Grief, Shame, and the Things Men Don't Name

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Some of the heaviest things men carry do not have a diagnosis attached, which means there is no obvious place to take them. That does not make them lighter.

## Grief that was never given room

Men are frequently assigned a role at a death: handle the arrangements, drive people, manage the estate, hold it together for everyone else. It is a useful role and many men take it willingly, in part because having a job is easier than not having one. The cost is that the grieving gets deferred, and deferred grief does not evaporate. It surfaces later, often in a form that does not look like grief at all — a depression eighteen months on, a collapse triggered by something apparently unrelated, a drinking problem that started around then and never stopped.

There is also grief that society does not fully recognise as grief, and therefore provides no ritual for: miscarriage and stillbirth, where the father is often treated as support staff rather than a bereaved parent; estrangement from a child; divorce, which is a bereavement with no funeral; the death of a friendship; losing a career or a business you built; a body that no longer does what it did. All of these are losses. All of them can produce a grief response. Very few of them come with a casserole.

## Shame, and why it is different from guilt

The distinction is worth learning because it changes what you do next.

**Guilt** is *I did something bad*. It is about behaviour, it is bounded, and it is actionable — you can repair, apologise, change course, make amends. Guilt is uncomfortable and often useful.

**Shame** is *I am something bad*. It is about the self, it is unbounded, and it offers no action other than hiding. Shame is strongly associated with concealment, and concealment is what makes it dangerous: it is the mechanism by which a man stops telling anyone anything.

Men carry shame about a specific and predictable set of things: money and providing, sexual function, being a failure to their children, addiction, things done in anger, things done while using, jobs lost, businesses failed, marriages ended, and things that happened to them that they believe they should have been able to prevent. That last category — shame about victimisation — is one of the most destructive and least discussed, particularly for men who were abused as children or assaulted as adults.

**Shame requires secrecy to survive. It reliably loses strength the moment it is said out loud to one person who does not recoil. That is the entire mechanism, and it is why the first disclosure matters so much more than the tenth.**

## **The things almost never said out loud**

What follows is a partial list of sentences men think regularly and say almost never. They are included because seeing them written down is often the first evidence a man has that he is not uniquely defective.

- *I don't know who I am outside of what I provide.*
- *I am not sure I love my life, and I built this life.*
- *I am frightened almost all of the time and I have never told anyone.*
- *I think my children would be fine without me and that thought does not upset me the way it should.*
- *I have not felt anything much in about three years.*
- *Something happened to me and I have never told a single person.*
- *I am so tired that I have started to look forward to being ill.*
- *I don't want to die. I want to stop.*

If you found yourself in that list, the appropriate response is not alarm. It is to notice that someone else wrote it down, which means someone else has thought it, which means you are describing a common human experience rather than a private defect.

And if the last two landed hardest, take that seriously today rather than at some point. Not because you are in danger this minute, but because that particular exhaustion responds well to treatment, and men routinely carry it for years under the impression that it is simply what life is.

# A Self-Inventory, Not a Diagnosis

This chapter contains two short screening tools used routinely in primary care. They cannot diagnose you. What they can do is convert a vague sense that something is off into a specific reason to make an appointment.

Read that qualification properly. A screening tool is a smoke detector, not a fire investigator. It tells you whether to look further. It does not tell you what is burning, or whether anything is.

## BEFORE YOU START

Answer for the **last two weeks**, honestly, quickly, without arguing yourself down. Most men score themselves lower than an observer would, because the comparison they are running is against their worst period rather than against a normal one. If you catch yourself thinking “well, not *every* day,” answer for what actually happened rather than what would be reasonable.

## Part 1 — Mood (PHQ-2)

Over the last two weeks, how often have you been bothered by the following?

| QUESTION                                    | NOT<br>AT<br>ALL | SEVERAL<br>DAYS | MORE<br>THAN<br>HALF | NEARLY<br>DAILY |
|---------------------------------------------|------------------|-----------------|----------------------|-----------------|
| Little interest or pleasure in doing things | 0                | 1               | 2                    | 3               |
| Feeling down, depressed, or hopeless        | 0                | 1               | 2                    | 3               |

A **total of 3 or more** is generally treated as a positive screen for depression, meaning further assessment is warranted. It does not mean you have depression. It means a doctor should ask you more questions.

## Part 2 — Anxiety (GAD-2)

| QUESTION                                   | NOT<br>AT<br>ALL | SEVERAL<br>DAYS | MORE<br>THAN<br>HALF | NEARLY<br>DAILY |
|--------------------------------------------|------------------|-----------------|----------------------|-----------------|
| Feeling nervous, anxious, or on edge       | 0                | 1               | 2                    | 3               |
| Not being able to stop or control worrying | 0                | 1               | 2                    | 3               |

**A total of 3 or more** is the usual threshold for further assessment of an anxiety disorder. Same caveat, in full force.

## Part 3 — The questions the forms don't ask

The screeners above are validated and useful, and they were designed for a clinic rather than for a man reading a book in his kitchen. These are not scored. They are simply worth answering honestly.

- ☐ Has someone who loves you told you that you have changed, and did you dismiss it?
- ☐ Are you drinking or using more than you were a year ago?
- ☐ When did you last do something purely because you enjoy it, with no other justification?
- ☐ Are you sleeping? Properly, most nights, without chemical assistance?
- ☐ When did you last have a real conversation with a friend — not logistics, not banter, an actual conversation?
- ☐ Are you angry more often than you used to be, at things that do not deserve it?
- ☐ Is there something you have never told anyone?
- ☐ If a friend described your exact situation to you, would you tell him to get some help?

That final question is the most reliable instrument on the page. Men apply a standard to themselves that they would consider absurd if applied to anyone they cared about. If your honest answer is that you would tell him to talk to someone, then you have already made the assessment. You are just declining to apply it to yourself.

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#### WHAT TO DO WITH A POSITIVE RESULT

Book an appointment with a family doctor. Not a specialist, not a therapist yet — a GP. Say this: *“I’ve been feeling off for a couple of months. I did a PHQ-2 and scored X. I’d like to talk about it and rule out anything physical.”*

That sentence takes eleven seconds, requires no emotional disclosure, and is a completely normal thing for a doctor to hear. It is also the single highest-leverage action in this entire book. A GP can screen properly, run bloods to check for physical causes, discuss treatment options, and refer you onward. It is the widest door in the building and most men walk past it.

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The PHQ-2 and GAD-2 are the short forms of the PHQ-9 and GAD-7, which a clinician may use for a fuller picture. If your score is high or something in this chapter frightened you, do not sit with it alone. The 988 Suicide & Crisis Lifeline (call or text **988**) is available at any hour, and you do not need to be in crisis to use it.

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# Signs in Someone Else

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You will not spot it by looking for sadness. You spot it by noticing change, and by trusting the feeling that something is off before you can justify it.

Everything in this chapter is nonspecific. Every item has innocent explanations. The purpose is not to let you diagnose anyone — you cannot — but to lower the threshold at which you decide it is worth asking a second question.

## Changes in behaviour

- Withdrawal. Declining things he used to say yes to. Slower to reply. Turning up less.
- The opposite: relentless activity, never at home, never still, always with a reason.
- Drinking or using noticeably more, or drinking alone where he did not.
- Sleep gone wrong — up at 3 a.m., or asleep by nine and still exhausted.
- Neglecting things he used to take care of: the house, the truck, his appearance, his health.
- New recklessness. Speed, money, fights, risks that are out of character.
- Giving things away, tying up loose ends, or an unexplained interest in getting his affairs in order.

## Changes in how he speaks

- Talking about being a burden, being replaceable, or things being easier without him.
- Hopelessness about the future — not complaining, but a flat certainty that nothing will improve.
- Harsh self-description that used to be a joke and no longer sounds like one.

- Sudden calm or resolution after a long period of visible distress. This can be a good sign. It can also mean a decision has been reached, and it should never be assumed to be recovery without asking.
- Saying goodbye in a way that has more weight in it than it should.

#### THE ONES THAT MEAN ACT NOW, NOT LATER

Any direct statement about wanting to die, ending things, or not being here. Any indication that he has been making preparations. Giving away things that matter to him. A marked increase in substance use combined with hopelessness. Sudden calm after a bad stretch.

If you see these, do not schedule a conversation for the weekend. Chapter 31 covers what to do. The short version: stay with him, ask directly, and call **988** — you can call it about someone else, and they will talk you through it.

### Trust the signal you cannot articulate

People who have lost someone almost always report the same thing afterwards: they knew something was wrong, could not point to anything concrete, and talked themselves out of it because they had no evidence and did not want to be intrusive.

You do not need evidence. The cost of asking a man how he is really doing when he is genuinely fine is approximately zero — a slightly awkward two minutes, and quite possibly a man who feels unexpectedly cared about. The cost of not asking when he is not fine is not symmetrical.

**You are not going to plant an idea in his head. Asking someone directly about suicide does not create the thought, and the evidence on this is consistent. What it does is give a man permission to stop pretending.**

That myth — that raising it makes it more likely — is one of the most persistent and one of the most costly. It keeps people silent at exactly the moment their voice matters most. Part Four is about what to say instead.

## PART THREE

# The Third Word

There is room for one more word after “I’m.” This part is about how to say it, who to say it to, and what actually happens next — in practical terms, with the costs and the awkwardness left in.

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# Why “I’m Not” Is So Hard to Say

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Before the how, the why. Every barrier below is real, several are rational, and none of them get dissolved by being told to open up.

## The barriers, taken seriously

**“It isn’t bad enough.”** The most common one by a distance. There is always someone worse off, and men use that fact as a permanent disqualification. But medicine does not work on a ranking system. Nobody refuses to set a broken arm because someone else has a broken leg. Treatment thresholds exist so that problems get addressed before they become severe, and the whole point of catching something early is that it is not yet severe.

**“It won’t help.”** Sometimes based on a genuinely bad prior experience — see Chapter 21. More often based on nothing, or on a general conviction that talking does not fix anything. The relevant fact is that these conditions have measurable treatment outcomes and most people improve. Not everyone, and not always fast. But the base rate is good, and it is much better than the base rate for doing nothing.

**“I’ll lose something.”** This one deserves respect rather than reassurance, because for some men it is accurate. Jobs, clearances, custody arrangements, professional licences, immigration status, a marriage where the balance depends on him being the stable one. Some of these risks are overstated; some are real. If this is your barrier, the answer is not to be told you are being paranoid. It is to get specific, find out what the actual rules are in your situation, and find a route that works within them. Confidentiality protections are stronger than most men assume, and a doctor or an employee assistance programme can explain exactly what is and is not reported.

**“I should be able to handle this myself.”** The deepest one, because it is not a belief about therapy. It is a belief about what a man is. Worth noticing: you almost certainly do not apply this standard to anything

else. You do not rewire the house yourself. You do not do your own dental work. Specialisation is not a moral failing anywhere else in your life.

**“I don’t know what I’d even say.”** Practical, common, and entirely solvable. That is the next chapter.

**“I can’t afford it.”** Sometimes a genuine barrier and sometimes an assumption that was never tested. Chapter 19 covers the actual cost landscape, including the free routes.

**Reframe it once and it changes shape entirely: getting treated is not something you do because you failed. It is something you do because other people depend on you and you would like to keep being able to show up for them.**

## **The one that matters most**

Underneath all of it, for many men, sits a single fear: *if I start, I will not be able to stop, and whatever is in there will come out all at once, and I will not be able to put myself back together afterwards.*

This is worth addressing directly, because it is the fear that keeps the most men silent and it is largely unfounded. What men consistently report after a first honest conversation is not collapse. It is deflation — the sense that a thing which had been enormous inside their own head turned out to be a normal size once it was outside of it.

You are also not obligated to say all of it. You can say one sentence and stop. You can say “that’s as far as I can go today” and that is a complete and respectable end to a conversation. Disclosure is not a tap that only has two settings.

# The First Honest Sentence

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You do not need a speech. You need one sentence, and it can be a bad one.

The most common reason men do not start is that they are waiting to know how to finish. They picture a conversation where they explain everything coherently, and since they cannot produce that explanation even to themselves, they postpone indefinitely. The way out is to lower the bar to something you can actually clear tonight.

## Sentences that work

Take one of these. Change the words if you want. Use it exactly if that is easier.

“I’m not doing great, actually.”

“Can I tell you something I haven’t told anyone?”

“I’ve been struggling for a while and I don’t really know what to do about it.”

“I don’t want advice. I just want to say it out loud to someone.”

“This is hard for me to say and I’m probably going to say it badly.”

“I think I need to talk to someone. Can you help me figure out how?”

“I’m not okay and I’ve been pretending I am for months.”

That fifth one is worth noticing. Saying that it is hard to say is itself a complete opening move. It buys time, it signals weight, and it means you do not have to be articulate.

## If speaking is too much

Write it. There is no rule that the first disclosure has to be verbal, and a text removes the two hardest parts: watching the other person's face, and having to keep talking afterwards.

"Not looking for a big conversation, but I've been having a rough time. Wanted someone to know."

"Can we get a coffee this week? I need to talk about something."

"I'm alright but I'm not alright, if that makes sense."

You can also start with a stranger. Crisis lines are not only for people in immediate danger; they take calls from men who simply need to say something out loud to someone who is not in their life. In the U.S., call or text **988**. There is no threshold and no record that follows you around.

## Setting matters more than wording

Almost no man leads with a difficult disclosure across a kitchen table with someone looking directly at him. That is a hard format. Choose an easier one.

- In a car. Side by side, no eye contact, a natural end point.
- On a walk. Same benefits, plus movement, which genuinely helps.
- While working on something together.
- Late at night, which lowers everyone's defences.
- In writing, then discussed later once it is already out.

Avoid: during an argument, when either of you has been drinking heavily, in the ten minutes before he has to leave, or in front of an audience.

#### PREPARE FOR A POOR RESPONSE

It is possible that the first person you tell will handle it badly. He might change the subject. She might get frightened and try to fix it immediately. He might say something clumsy. This is a real risk and you should decide in advance what it will mean.

It means that person was the wrong first choice, or was caught off guard, or has their own reasons for finding this hard. It does not mean the attempt was a mistake, and it does not mean the next person will react the same way. If the first door does not open, use a different door. Do not conclude the building is locked.

### Say what you want from the conversation

Most bad responses come from the other person guessing wrong about what is being asked of them. Men in particular default to problem-solving, because that is the mode they trust. If solutions are not what you want, say so at the start.

“I don’t need you to fix it. I just need you to hear it.”

“I’m not asking you to do anything. I just didn’t want to be the only one who knew.”

“Actually, I do want advice on one specific thing.”

Naming the job you are giving someone dramatically increases the chance they do it well. It also relieves them, because the most common reason people freeze is that they are afraid of getting it wrong.

# Who to Tell First

The wrong first person can set you back a year. It is worth thirty seconds of thought rather than defaulting to whoever is in the room.

There is no universally correct answer, but there are patterns.

## The options, with their trade-offs

| WHO                                  | GOOD WHEN                                                                                                                  | WATCH FOR                                                                                                      |
|--------------------------------------|----------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------|
| <b>A family doctor</b>               | You want it taken seriously, physical causes ruled out, and a route to treatment. Requires almost no emotional disclosure. | Short appointments. Lead with it rather than raising it at the door.                                           |
| <b>A partner</b>                     | They already know something is wrong and the relationship is solid.                                                        | They are inside the situation. If the relationship is part of the problem, this is the hardest place to start. |
| <b>A close friend</b>                | Low stakes, no consequences, and he has known you a long time.                                                             | He may have no idea what to do and may reach for a joke. That is fear, not indifference.                       |
| <b>A brother or father</b>           | Shared history, sometimes shared experience.                                                                               | Family patterns are strong. If the men in your family do not do this, expect friction.                         |
| <b>A crisis line</b>                 | You want to say it out loud with zero consequences, to someone trained.                                                    | Nothing. This is the lowest-risk option available and it is free.                                              |
| <b>A therapist</b>                   | You are ready for structured help.                                                                                         | Access and cost. See the next chapter.                                                                         |
| <b>A peer or support group</b>       | You want people who have been through it rather than trained in it.                                                        | Fit varies. Try more than one before deciding the format is not for you.                                       |
| <b>A chaplain, imam, or minister</b> | Faith is part of your life and you want that context.                                                                      | Varies enormously in training. Good ones refer onward; ask whether they will.                                  |

## A note on the family doctor

If you are stuck, this is usually the answer, and it is under-used by men to a striking degree.

A GP appointment is a normal thing on your calendar that requires no explanation to anyone. It can rule out physical contributors — thyroid function, anaemia, sleep apnoea, vitamin deficiency, medication effects — any of which can produce symptoms that look exactly like a mental health condition and none of which are fixed by therapy. It gives you access to referrals, treatment options, and documentation if you ever need it. And it requires you to say roughly two sentences.

“I’ve been feeling off for a few months. Low mood, not sleeping, no patience with anyone. I’d like to talk about it and check nothing physical is going on.”

Book a longer appointment if the practice offers one, and lead with it. Do not spend eight minutes on your knee and raise this with your hand on the door handle, which is what most men do.

**You do not have to tell everyone. You have to tell one person.  
The number that matters is one.**

## What you owe people

Nothing, is the short answer. You are not obligated to disclose to your employer, your extended family, your children, or the internet. Privacy is not the same as secrecy, and choosing who gets access to your interior life is a reasonable thing to do rather than a failure of openness.

The one exception worth thinking about: if you live with people, and things get bad, someone in the house needs to know enough to act. That is not a demand for full disclosure. It is a single person who knows that things are difficult and knows to take it seriously if you say so.

# What Therapy Actually Is

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Most of what men imagine about therapy comes from film and television, where it exists to deliver exposition. The real thing is more boring, more structured, and considerably more like work.

## What happens in the room

A first session is largely administrative and informational. The clinician asks what brought you in, takes a history, asks about sleep, alcohol, medication, family history, and what you want to be different. You will be asked whether you have had thoughts of harming yourself — this is standard, it is asked of everyone, and answering honestly does not trigger anything dramatic.

You do not lie on a couch. Nobody asks about your mother unless your mother is relevant. It is a conversation with someone whose entire job is to notice patterns you are too close to see.

Sessions typically run 45 to 60 minutes, usually weekly at first. Many of the best-evidenced approaches for depression and anxiety are structured and time-limited — often somewhere in the range of eight to twenty sessions — with a defined focus and, frequently, work to do between appointments. It is not open-ended talking without a destination, unless you choose an approach that is.

## The main approaches, briefly

| APPROACH                                                         | WHAT IT DOES                                                                                                                                                                                                                                   |
|------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>CBT</b><br>Cognitive Behavioural Therapy                      | Targets the loop between thoughts, feelings and behaviour. Structured, practical, homework-based. Strong evidence for depression and anxiety. Often the default first offer, and it suits men who want a mechanism rather than an exploration. |
| <b>Trauma-focused therapies</b><br>CPT, Prolonged Exposure, EMDR | Built specifically for PTSD and tested extensively. Structured courses of work at a pace you help set.                                                                                                                                         |
| <b>ACT</b><br>Acceptance and Commitment Therapy                  | Less about eliminating difficult thoughts, more about reducing their grip and acting according to what you value anyway.                                                                                                                       |
| <b>Psychodynamic therapy</b>                                     | Longer, more exploratory, focused on patterns with roots further back. Suits people who want to understand rather than to fix.                                                                                                                 |
| <b>Couples therapy</b>                                           | When the relationship itself is the field of play. Note that individual and couples work address different problems; needing one does not substitute for the other.                                                                            |
| <b>Group and peer support</b>                                    | Cheaper, sometimes free, and does something individual therapy cannot: puts you in a room with people who have been where you are. Underrated by men who assume it means sitting in a circle sharing feelings.                                 |

## Cost, honestly

Private therapy in the U.S. commonly runs somewhere in the region of \$100–\$250 a session without insurance, which is a genuine barrier and should be named as one rather than waved away. The routes around it:

- **Insurance.** Mental health coverage is required to be comparable to physical health coverage under federal parity law. Call the number on your card and ask for in-network behavioural health providers.
- **Employee Assistance Programme.** Many employers provide a set number of free confidential sessions. Usage is typically not reported to your employer. Most people who have one do not know it exists.
- **Community mental health centres.** Sliding-scale fees based on income.

- **Training clinics.** University psychology programmes offer low-cost sessions with supervised trainees. Quality is often high precisely because of the supervision.
- **Open Path Collective.** A nonprofit network offering reduced-rate sessions.
- **Group therapy.** Substantially cheaper than individual work.
- **Peer support and mutual aid.** Free. Includes twelve-step programmes and secular alternatives.
- **211.** Dial it. It connects you to local health and human services, including low-cost mental health options in your area.

## How to find someone

Ask your doctor for a referral; ask your insurer for the in-network list; use Psychology Today's directory, which lets you filter by insurance, speciality, and location; or use the SAMHSA treatment locator at [findtreatment.gov](https://findtreatment.gov). If trauma is involved, look for someone who explicitly names a trauma-focused modality rather than someone who merely says they are trauma-informed.

### FIT IS NOT A LUXURY

The relationship between you and the therapist is one of the more consistent predictors of whether therapy works. If after three or four sessions you do not feel you can be honest with this person, that is information about the match, not a verdict on therapy or on you.

Most therapists offer a brief free consultation. Use it. Reasonable questions: *Have you worked with men dealing with this? What approach do you use and why? What does progress look like, and how will we know? Roughly how long?* A good clinician will welcome those questions. Anyone who bristles at them has told you something useful.

# The Medication Conversation

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This chapter is not advocacy in either direction. It exists because men make this decision based on rumour, and it is a decision that deserves better inputs.

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## READ THIS FIRST

Nothing here is medical advice, and this book cannot tell you whether medication is right for you. Only a prescriber who can assess you properly can do that. What follows is general information intended to help you have a better conversation with one.

## The objections, addressed

**“It will change who I am.”** The intended effect is the reverse: to reduce symptoms sufficiently that the person underneath becomes accessible again. Blunting can happen as a side effect for some people, and it is a legitimate thing to raise with a prescriber and to change course over. It is not the goal, and it is not inevitable.

**“It’s a crutch.”** A crutch is an appropriate response to a broken leg. More usefully: nobody describes insulin, blood pressure medication or an inhaler this way. The category error is treating the brain as the one organ where pharmacological help indicates a moral failing.

**“I’ll be on it forever.”** Some people take medication long-term, often for good reason. Many take it for a period, get the ground back under them, do therapeutic work, and come off it with medical supervision. That decision is made later, with a doctor, based on how things actually go.

**“It’s just numbing the problem.”** This is a fair concern and worth stating properly. Medication treats symptoms; it does not resolve a marriage, a bereavement, a job, or a trauma. But symptoms that are severe enough can make everything else impossible — you cannot do the work of therapy when you cannot concentrate or get out of bed. For many people the sequence is: medication creates enough stability that the underlying work becomes possible. The evidence generally favours combining

medication with therapy over either alone for moderate to severe depression.

## What to know practically

- **Antidepressants take time.** Typically several weeks before meaningful benefit, sometimes longer. Many men stop at two weeks having concluded it does not work. It is worth knowing this in advance.
- **Side effects are common early and often settle.** They should be reported rather than endured in silence.
- **Sexual side effects are real, common, and consistently the reason men stop taking medication without telling anyone.** Say it to your prescriber. It is an extremely ordinary thing for them to hear, options exist, and stopping silently is the worst available response.
- **Do not stop abruptly.** Discontinuation effects can be unpleasant. Taper with medical guidance.
- **Alcohol interacts with most of this.** Be honest with your prescriber about how much you actually drink. They are not there to judge it; they need the number to prescribe safely.
- **The first one may not be the right one.** Finding an effective medication and dose is often a process of adjustment. That is normal practice, not failure.

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Antidepressants carry a warning about increased suicidal thinking in some people, particularly young adults, in the early weeks of treatment. This is a reason for close monitoring at the start and for telling someone you have started — not a reason to avoid treatment. Discuss it with your prescriber, and make sure someone in your life knows you have begun, so there is a second set of eyes during those first few weeks.

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The practical question is not whether medication is philosophically acceptable. It is whether, for you, in your circumstances, the likely benefit outweighs the likely costs — and that is a question for a conversation with a doctor, not for a position taken in advance.

# If You Tried Before and It Didn't Work

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A large number of men are not resistant to help. They are veterans of a bad experience with it, and nobody ever told them that a bad experience is data about that attempt rather than about the whole enterprise.

This is the single most under-addressed barrier in men's mental health. The man who saw someone once in 2017, found it useless, and quietly filed the entire category under "not for me" is not a man who needs convincing that help exists. He needs a diagnosis of what specifically failed.

## What actually went wrong

**Wrong person.** Fit is a genuine variable with a real effect on outcomes. Some therapists will be wrong for you for reasons that reflect nothing about either of you. Trying one therapist and concluding therapy does not work is like eating at one restaurant and concluding you dislike food.

**Wrong approach.** Open-ended exploratory talking when what you needed was structured, mechanism-focused work — or the reverse. Approaches differ substantially, and being handed the wrong one is common.

**Wrong target.** Treating anxiety while an untreated trauma sat underneath it. Treating depression while heavy drinking made improvement impossible. Treating a mental health condition while undiagnosed sleep apnoea or a thyroid problem generated the symptoms. Interventions aimed at the wrong layer do not work, and that is not a failure of the intervention.

**Wrong dose or wrong medication.** Stopping at three weeks. Or stopping because of a side effect that was never reported and could have been managed.

**Wrong time.** You went because someone made you, during a period when you had no intention of engaging. That is not a fair test.

**It half-worked and you stopped.** Extremely common. Improvement arrives, the crisis recedes, attendance drops off, and the underlying work never gets finished. Then the return of symptoms gets interpreted as proof it did not work, when what actually happened is that it was working and got discontinued.

**“It didn’t work” is a conclusion. “What specifically did I try, for how long, with whom, aimed at what” is a diagnosis. Only the second one tells you what to do next.**

## **How to try again differently**

Be a more demanding customer. That is not rudeness; it is the appropriate posture for someone purchasing a service that matters.

- Tell the new clinician exactly what you tried and why it failed. This is genuinely useful information to them and will change what they offer you.
- Ask directly which approach they propose and why it suits your problem.
- Ask what progress should look like and by when. Agree how you will both know if it is not working.
- Set a review point — six or eight sessions — and actually hold it.
- If the first sessions feel wrong, say so out loud rather than disappearing. A good clinician will either adjust or refer you on, and both outcomes are useful.
- Make sure the physical work has been done: bloods, sleep, alcohol, medications. Rule out the mechanical causes before concluding the psychological treatment failed.

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**IF YOU HAVE BEEN TO A HOSPITAL OR A CRISIS SERVICE AND IT WAS A BAD EXPERIENCE**

Some men have been through emergency mental health care and found it frightening, undignified, or worse. That experience is real and it is a rational reason to be wary. It is also not the whole system. Ongoing outpatient care — a GP, a therapist, a community clinic — is a completely different setting with different rules and a different pace. If the acute system failed you, it is worth knowing that the non-acute system exists and looks nothing like it.

# Building the Floor

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This chapter comes with a warning attached, because it is the chapter most likely to be misused.

## WHAT THIS IS AND IS NOT

The things in this chapter are a **floor**, not a treatment. They make everything else more possible and they are worth doing. They do not treat clinical depression, an anxiety disorder, PTSD, or addiction, and any material suggesting otherwise is doing harm. If you take one thing from this chapter, take this: *“have you tried going for a run”* is the single most demoralising sentence you can say to a man with a serious condition, and this chapter is not an invitation to say it.

## Sleep

If you fix one thing, fix this. Sleep disruption is both a symptom and a driver — it makes mood, anxiety, irritability, concentration and impulse control measurably worse, and poor sleep and poor mental health reinforce each other in a loop that is very hard to break from the mood side alone.

Most adults need somewhere in the range of seven to nine hours. A consistent wake time matters more than a consistent bedtime. Alcohol is not a sleep aid — it shortens the time to fall asleep and then degrades the quality of what follows. And if you snore heavily, wake unrefreshed, or have been told you stop breathing, get assessed for sleep apnoea. It is common in men, it produces symptoms indistinguishable from depression, and it is treatable.

If insomnia is persistent, ask specifically about CBT-I — cognitive behavioural therapy for insomnia. It is the recommended first-line treatment for chronic insomnia and it works better than sleeping tablets over any meaningful timeframe.

## **Movement**

The evidence that regular physical activity benefits mood is substantial. It is not a replacement for treatment, and framing it as one is the mistake described above. But as a component alongside treatment it is well supported, and it does something else useful for men specifically: it is a socially acceptable reason to leave the house and be around other people.

Walking counts. Outside counts more. Whatever you will actually do is better than the optimal thing you will not.

One caution, since this book is honest about traps: exercise can become the avoidance rather than the remedy. Three hours a day in a gym you do not enjoy in order to not be at home is not a mental health intervention. Ask yourself which one you are doing.

## **Alcohol**

Covered in Chapter 10, mentioned again because of how frequently it is the invisible variable. If you are drinking most nights and also wondering why your mood and anxiety are not improving, you have a genuinely useful experiment available: stop for three or four weeks and observe. Many men are startled by the result. If stopping proves difficult, or if you have been drinking heavily every day for a long stretch, read the medical warning in Chapter 10 before doing anything.

## **Structure**

Depression erodes structure and the absence of structure deepens depression. The intervention is small and unglamorous: get up at the same time, leave the house once a day, put one thing in the calendar that involves another person. When you are at your worst, do not aim at optimisation. Aim at three things a day.

## **Sunlight, food, and screens**

Daylight early in the day supports the circadian rhythm that governs sleep. Eating reasonably and regularly matters more for mood than any particular diet does. And the specific pattern of lying in the dark scrolling until 1 a.m. wrecks both sleep and mood, which most men know and almost none act on.



**None of this is a cure. All of it is the difference between fighting on level ground and fighting uphill.**

# If Tonight Is Bad

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If you have turned to this chapter because of where you are right now, then read only the box below and act on it. The rest can wait.

## RIGHT NOW

**Call or text 988.** Free, confidential, 24/7, anywhere in the United States. You do not need to be certain, you do not need a plan, and you do not need to have decided anything. If you served, dial 988 and press 1. If speaking is too much, text HOME to 741741. Outside the U.S., findahelpline.com lists verified lines in over 130 countries.

If you have already hurt yourself, or you believe this is minutes rather than hours, call **911** or get to an emergency department. Tell whoever is in the building with you.

## Three things that are true

**You do not have to trust that it will get better.** That is a large thing to ask of someone who feels the way you do, and you are not required to believe it tonight. All that is being asked is that you delay while somebody helps you. Belief can come later.

**The state you are in is not permanent, even though it presents itself as permanent.** That is a known feature of the condition rather than an accurate perception of your life. Crises have a shape: they build, they peak, and they subside. Getting through the peak with someone else present changes the outcome.

**You are not a burden, and the calculation you are running is being run with faulty numbers.** The belief that people would be better off is a symptom with a name — perceived burdensomeness — and it is one of the most consistent features of suicidal thinking. It feels exactly like a clear-eyed assessment. It is not one. Ask the people involved and you will get a very different answer.

## Tonight, practically

- **Do not be alone.** Call someone and ask them to come, or go to where people are. You do not have to explain much. “I’m having a really bad night, can you come over” is enough.
- **Put distance between yourself and anything you could use to hurt yourself.** Ask someone to hold onto things for you tonight. This single step — putting time and obstacles between an impulse and an action — is one of the most effective protective measures there is, because crisis states pass and irreversible actions do not.
- **Do not drink.** Alcohol lowers inhibition and deepens the state you are already in. It is the worst possible thing available tonight.
- **Aim only at the next hour.** Not tomorrow, not the rest of your life. Get to the next hour, then the one after.

## The safety plan

A safety plan is a written document you make *before* a crisis, ideally with a clinician or a crisis counsellor, so that in the moment you are following instructions rather than making decisions. It typically covers: the warning signs that things are turning; things you can do alone to get through the peak; people and settings that help distract you; the people you will contact; the professionals and crisis numbers you will call; and how you and someone you trust will make your environment safer during a bad period.

Make it with someone. Crisis line counsellors do this routinely and will build one with you over the phone. Keep it somewhere you will actually find it — on your phone, in your wallet. The value of a plan is that it does not require you to think clearly at the exact moment when thinking clearly is hardest.

**Reaching out tonight is not a collapse. It is the most competent decision available to you, and it is the one that keeps every other decision possible.**

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If you are reading this chapter about someone else rather than yourself, go to Chapter 31. And know that you can call 988 about another person — they will talk you through what to do.

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## PART FOUR

# The Second Question

For everyone standing next to him. How to ask something he can answer honestly, what to do when he actually answers it, and how to carry someone without going under yourself.

- 
- 24      How to Ask So He'll Answer
  - 25      When He Actually Tells You
  - 26      If You're His Partner
  - 27      If You're His Friend
  - 28      Fathers and Sons
  - 29      At Work
  - 30      Carrying Someone Without Drowning
  - 31      When It's an Emergency

# How to Ask So He'll Answer

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“You alright?” is not a question. It is a greeting with a question mark on it, and it comes with the expected answer already attached.

Most attempts to check on a man fail at the level of grammar. The question is built in a way that makes “yeah, fine” the path of least resistance, and then everyone concludes he did not want to talk. Frequently he did. He was just handed a question that had no room in it.

## Build a better question

Three properties make a question answerable.

**Specific.** General questions get general answers. Name what you have actually noticed.

**Non-clinical.** The word “depressed” makes many men defend rather than answer. You are not diagnosing; you are asking.

**Give it room.** Signal that you have time and that a real answer is welcome.

“How are you *really* doing?” — the word does the work.

“You’ve seemed off for a few weeks. What’s going on?”

“I noticed you’ve stopped coming to things. Is everything alright?”

“That’s the second time you’ve said you’re tired. Tired how?”

“I’m not going to make it weird. I just want to know if you’re okay.”

“On a scale of properly fine to holding it together — where are you?”

## Ask twice

This is the single most useful technique in the chapter. The first answer is reflex. The second answer is often true.

“I’m good.” → “Yeah? Good good, or just good?”

“I’m fine.” → “Alright. I’m asking properly though.”

“Nothing, I’m alright.” → “Okay. I’m around if that changes.”

The pause after the second question does most of the work. Do not fill it. Men very often need four or five seconds of silence to decide whether the offer is real, and most people cannot tolerate four seconds of silence, which is why so many of these conversations close before they open.

## Where and when

Side by side beats face to face. In a car, on a walk, working on something together, late at night. No audience. Not during an argument. Not when he has been drinking heavily. Not when either of you has somewhere to be in ten minutes.

**You are not trying to extract a confession. You are trying to demonstrate that the door is open, and that walking through it will not cost him anything.**

## If he says no

Take it. Pushing turns concern into pressure, and pressure closes doors.

But leave something behind. The goal of a failed first attempt is to make the second attempt easier, and the sentence that does that is simple:

“Alright. But I’m going to ask you again in a couple of weeks, because I’ve been a bit worried. And if anything changes before then, ring me. Any hour.”

Then actually ask again. The follow-through is the entire point. A man who is asked once can dismiss it as politeness. A man who is asked again

three weeks later learns that someone was paying real attention, and that is often what finally makes it possible to answer.

# When He Actually Tells You

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This is the moment the whole thing turns on. He has done the hardest part. What happens in the next sixty seconds determines whether he ever does it again.

Most people mishandle this, and almost always out of love. They panic, they fix, they reassure, they minimise — all of it well-meant, all of it teaching him that disclosure produces a burden he then has to manage.

## The first sixty seconds

**Do not react to the size of it.** Whatever he says, receive it steadily. If your face registers alarm, he will spend the rest of the conversation managing your reaction instead of describing his own state.

**Say thank you.** Explicitly. “Thank you for telling me. I know that wasn’t easy.” This is a small sentence and it does an enormous amount, because it names the difficulty of the act rather than only the content.

**Do not fix anything yet.** The impulse to produce a solution is strong, particularly among men and particularly among people who love him. Resist it for now. The first job is to make being honest survivable.

**Ask what he needs.** “Do you want to talk it through, or do you just want me to know?” is one of the most useful sentences in this book. It hands him control at the exact moment he feels he has given some up.

**Stay.** The most valuable thing available is your continued, unhurried presence. Do not check your phone. Do not look at the clock.

## What to say, and what not to

### INSTEAD OF

### TRY

“Everything happens for a reason.”

“That sounds like a lot to be carrying.”

“Others have it worse.”

“I’m glad you told me.”

“You’ve got so much to be grateful for.”

“How long has it been like this?”

“Have you tried exercise?”

“What’s the hardest part right now?”

“You don’t seem depressed.”

“I had no idea. Tell me more.”

“Just think positive.”

“You don’t have to have this figured out.”

“Man up.” / “Be strong for them.”

“You don’t have to be strong with me.”

“I know exactly how you feel.”

“I don’t know what that’s like, but I want to.”

“You need to see someone.”

“Would it help if I helped you find someone?”

“Don’t say that.”

“Tell me what you mean by that.”

The pattern in the right-hand column: it keeps the conversation open, it does not evaluate, and it does not require him to defend the legitimacy of what he just said.

## Ask the direct question

If anything he has said touches on hopelessness, being a burden, or not wanting to be here, ask directly and without euphemism.

“Are you thinking about killing yourself?”

“Have you had thoughts of ending your life?”

Asking does not plant the idea. That myth is persistent and wrong, and the evidence does not support it. What asking does is remove ambiguity, and ambiguity is what allows a man to keep the worst part to himself while technically having told you something.

If the answer is yes, go to Chapter 31 and do not leave him alone while you read it.

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#### AFTERWARDS

Two things matter more than anything you said in the moment.

**Keep the confidence.** If he asked you not to tell anyone, honour it — with one exception, which is if he is at risk of harm. In that case tell him you are going to involve someone, and tell him why. Breaking a confidence quietly and behind his back does lasting damage to his willingness to ever speak again.

**Follow up.** Message him in a few days. “Been thinking about our chat. How’s this week?” The follow-up is what converts a single conversation into an actual channel. Most people never send it, and it is the cheapest high-value thing in this entire book.

# If You're His Partner

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You are the person most likely to notice first, and the person least able to be objective about it. Both of those things are true at once, and they make this the hardest position in the book.

## What you are probably experiencing

He has become distant, or short, or absent, or all three. He says nothing is wrong. Conversations that used to be easy now feel like negotiations. He is either always at work or always on the couch. Intimacy has declined and neither of you is discussing it. And underneath your worry there is a second feeling, usually unspoken and often accompanied by guilt: you are angry, and you are lonely inside your own relationship.

That anger is legitimate. Loving someone who is unwell does not obligate you to feel only compassion. You are allowed to be exhausted and resentful and still be entirely committed to him. Pretending otherwise is how partners end up burnt out and silent.

## What to understand

**The withdrawal is very often not about you.** Depression and anxiety reduce capacity for connection, and the person closest by absorbs most of the reduction. It is easy to read as rejection because it is functionally indistinguishable from rejection. Knowing the mechanism does not make it hurt less, but it does change what you do next.

**The stakes are different for him than they look.** Many men are frightened that admitting they are struggling will change how their partner sees them — specifically, that it will cost them the position of being the strong one. That fear may be unfounded in your relationship. It is not unfounded in general, and he probably will not name it.

**You cannot be his therapist.** Not because you are not capable, but because the role conflicts with being his partner. A therapist is neutral, is not affected by the outcome, and goes home. You are none of those things.

## What actually helps

- **Describe rather than diagnose.** “You’ve been sleeping badly and snapping at the kids and you haven’t touched the guitar since March” is harder to deflect than “I think you’re depressed.”
- **Speak from your experience.** “I miss you” opens something. “You never talk to me anymore” closes it.
- **Reduce the friction to getting help.** Offer to find the phone number, sit with him while he calls, take the kids, drive him. The gap between intention and appointment is where most of these efforts die, and it is a logistics problem as much as a psychological one.
- **Keep the ordinary things going.** Routine, meals, small plans. Do not let the relationship become entirely about his condition, because that is corrosive to both of you.
- **Get your own support.** A friend, a therapist, a group. You need somewhere that is not him.

**You can be endlessly supportive and he can still not get better. That is not a failure of your love. There are conditions that require professional treatment, and no amount of devotion substitutes for it.**

## Where the limits are

Two things are worth stating clearly, because partners in this position often need permission to think them.

**His illness does not license his behaviour toward you.** If he is frightening you, being cruel, or being abusive, that is a safety issue first and a mental health issue second. Explanation is not exemption. You are permitted to require that it stop, and to leave if it does not. In the U.S., the National Domestic Violence Hotline is **1-800-799-7233**.

**You are allowed to have limits.** “I love you, I am not going anywhere, and I need you to make an appointment” is a reasonable position. So is naming what you can and cannot continue to carry. That is not an ultimatum in the punitive sense; it is honesty about a real constraint, and honesty is what this whole book is arguing for.

# If You're His Friend

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You occupy a position his partner and his family cannot: you are outside the machine. Nothing he tells you threatens a household. That makes you more useful than you probably think.

## The advantage you have

He can tell you things he cannot tell the people he lives with, because you are not affected by them. He does not have to manage your fear. He does not have to worry that what he says will change the atmosphere at home for a week. For a lot of men, the friend is the only available audience for the worst of it.

The corresponding disadvantage: you see him less, so you notice slowly, and you are more likely to accept “I’m good” because you have no baseline from the last three weeks.

## What men who have been through it consistently say helped

- **Someone who kept turning up.** Not one deep conversation. Repeated, ordinary contact that continued through a period when he was poor company and gave nothing back.
- **Someone who went first.** A friend who volunteered his own difficulty, which made the ground safe. This is the highest-leverage thing you can do and it costs you only exposure.
- **Someone who did something practical.** Turned up with food. Helped move something. Sat in the room. Practical help is a love language most men can receive without embarrassment.
- **Someone who did not make it a project.** He did not want to become a case. He wanted to still be a mate who was also having a hard time.

## Practical moves

**Be specific and be the organiser.** “We should catch up” is noise. “I’m coming round Saturday at ten, is that alright” is a plan. A struggling man will almost never do the organising, and if the plan depends on him it will not happen.

**Keep going after a no.** Depression declines invitations. Take the no gracefully and invite him again next week. Six declined invitations followed by one accepted is a complete success.

**Use the shoulder-to-shoulder format.** A drive, a job, a walk, a round of something. It is easier to talk when you are aimed at the same thing rather than at each other.

**Say the unsentimental version.** Male friendship has its own register and you do not have to abandon it. “You’ve been off. What’s going on with you” works. “I’m worried about you, you idiot” works. Speaking in a voice he recognises matters more than getting the phrasing right.

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### DO NOT LET IT GET FUNNY

Humour is the primary defensive tool in most male friendships and it is genuinely valuable — right up until the moment it becomes the mechanism by which nothing is ever said. If he cracks a joke immediately after saying something real, notice it. You can laugh and then come back: “*Alright, but seriously.*” Those three words have opened more conversations between men than any technique in this book.

**You do not need to know what to say. You need to keep showing up and be someone he does not have to perform for. That is the whole job.**

# Fathers and Sons

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Whatever a boy learns about handling distress, he learns mostly by watching. Not from what he is told.

## If you are the father

The instinct is to protect your children from ever seeing you struggle. It is a good instinct and it is producing the wrong outcome, because what a child actually learns from a father who never visibly struggles is that struggling is not something men do — and therefore that whatever he himself is feeling is a private defect.

The goal is not to hand your children your problems. That is a genuine harm, and children should not be made into confidants for adult distress. The goal is narrower: **let them see that difficulty exists and is handled, rather than that it does not exist.**

The difference is in what you show.

### NOT THIS

Detailed disclosure of your fears, your marriage, or your finances.

Falling apart in front of them with no adult managing it.

Making them responsible for your mood.

### THIS

“I’ve had a rough day. I’m going for a walk and I’ll be better when I’m back.”

“I got that wrong and I’m sorry. I was stressed, and that’s not your fault.”

“I talk to someone about this stuff. It helps.”

That last one may be the most valuable sentence a father can say. A boy who grows up knowing that his father sees someone has a completely different set of options available at nineteen than one who does not.

## Talking to a son

Do it in the car. Do it while doing something. Ask specifically rather than generally. And be prepared to go first — a boy who is asked how he feels

by a father who has never once described a feeling will correctly identify the asymmetry and say nothing.

“I had something like that at your age. It was horrible. Do you want to know what helped?”

“You seem flat lately. Not in trouble — I’m just asking.”

“There’s nothing you could tell me that would change how I feel about you.”

Watch for withdrawal, sleep changes, dropping things he cared about, irritability, and a shrinking world. Adolescent distress looks a lot like adolescence, which is exactly why it gets missed. The test is the same as everywhere else in this book: is this a change, and has it lasted?

## If you are the son

Many men reach forty and realise their father has been struggling for thirty years in complete silence, and that nobody in the family has ever said so out loud.

Approaching an older man about this is difficult. He was raised in a stricter version of the same curriculum, he may have no vocabulary at all, and a direct emotional question may simply not compute. What often works better is the sideways route: ask him about his life. His work, his father, the years when things were hard. Men who cannot answer “how are you feeling” can frequently answer “what was it like when the plant closed.”

And going first works here too, in both directions. “I’ve been having a hard time, Dad, and I’ve started talking to someone” gives an older man information he may have been waiting fifty years to receive: that this is a thing people in his family do.

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**On breaking the chain.** Some men reading this had fathers who could not do any of it, and are carrying the results. You are not obligated to repair him, and you may not be able to. But the pattern stops with whoever decides it stops, and the deciding is available to you regardless of what he does.

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# At Work

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Work is where most men spend most of their waking hours, and where the pressure to appear fine is strongest. It is also where changes are most visible to people paying attention.

## If you manage people

Your role is not clinical and should not become clinical. You are not there to diagnose, counsel, or treat. You are there to notice, to ask, to point toward help, and to remove obstacles.

**What to notice:** a change in performance from someone previously reliable; missed deadlines; withdrawal from the team; irritability that is out of character; absence, or its opposite — the person who is suddenly online at all hours and taking no leave; someone visibly exhausted; deterioration in appearance or self-care.

**How to raise it:** privately, without an audience, and framed around what you have observed rather than what you suspect.

“You’ve seemed under it the last few weeks. I’m not asking as your manager — are you alright?”

“I’ve noticed you’re online at midnight most nights. Is everything manageable?”

“Whatever’s going on, you don’t have to tell me. But I’d like to help if I can.”

**What to do next:** know what your organisation offers before you need it — the employee assistance programme, the insurance mental health benefit, the leave policy, the accommodations process. Say the numbers out loud rather than telling him to look it up. And then adjust something concrete: reduce the load, move a deadline, approve the leave. An expression of concern followed by no change in workload teaches him that speaking up produces sympathy and nothing else.

### CULTURE IS SET BY WHAT YOU DO, NOT WHAT YOU POST

A wellbeing poster in the kitchen means nothing next to a manager who visibly takes leave, who does not send messages at eleven at night, and who has said out loud that he sees a therapist. Men read the behaviour of senior men to work out what is actually permitted. Everything else is decoration.

## If you are the one struggling

You are not required to disclose a diagnosis to your employer, and in most cases you should think carefully before you do. What you can do is ask for what you need without explaining why.

“I’m dealing with a health issue and I need to attend some appointments.”

“I need to reduce my hours for a period for medical reasons.”

Find out whether your employer has an EAP — many men have free confidential counselling sessions available and have never checked. Usage is typically not reported to your employer, though it is worth confirming the terms.

In the U.S., mental health conditions can qualify as disabilities under the Americans with Disabilities Act, which may entitle you to reasonable accommodations, and serious conditions may be covered under the Family and Medical Leave Act. This book is not legal advice and the details depend on your employer, your tenure and your state. But it is worth knowing that the protections exist rather than assuming they do not.

## Trades, shift work, and high-risk industries

Construction, mining, transport, agriculture, emergency services and the military carry a specific combination: heavy physical demand, irregular hours, isolation from family, a strong culture of not complaining, and in several cases direct exposure to traumatic events. Several of these sectors show elevated suicide rates.

What works in these settings is rarely a wellbeing initiative delivered from head office. It is a supervisor who asks. It is a toolbox talk given by someone who has been through it. It is peer support from a man in the same boots. If you work in one of these industries and someone has quietly become the person others talk to, that man is doing more for this than any campaign, and he probably needs someone checking on him too.

# Carrying Someone Without Drowning

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This chapter is for you rather than for him. Supporting someone through a long period of illness is genuinely hard, and there is a version of it that destroys the person doing the supporting.

## What it does to you

Exhaustion that sleep does not fix. Constant low-level vigilance — reading his mood before you have taken your coat off. Guilt about being resentful. Guilt about being relieved when he goes out. Loss of your own friendships and interests, because there has been no capacity for them. Anxiety about leaving him alone. And a slow erosion of your sense of yourself as a person with your own life.

If several of those are true, you are not failing at supporting him. You are describing a well-documented pattern, and the fact that it is common does not make it sustainable.

## Three things to hold onto

**You cannot make someone get help.** You can make it easier, you can say clearly what you see, you can remove obstacles, and you can tell him what it is costing you. You cannot make the decision for an adult. Where there is immediate danger, that changes — see the next chapter. Short of that, the choice is his, and holding yourself responsible for a choice you cannot make will grind you down to nothing.

**Your needs did not become invalid.** Sleep, friendships, work, rest, your own health appointments. These are not luxuries you have earned the right to sacrifice. Supporting someone from an empty tank produces worse support and a second casualty.

**You are allowed to have limits.** Limits are not abandonment. “I can’t talk about this at midnight, but I can at eight tomorrow” is a limit. “I need you to talk to a professional as well as to me” is a limit. “I can’t be your only support” is both a limit and a clinical truth.

Being the only person somebody has is not a compliment. It is a structural weakness in his support system, and correcting it is help rather than withdrawal.

## Practical protection

- **Get your own support.** A therapist of your own, a friend who knows the situation, or a carers' group. You need somewhere to put this that is not him.
- **Widen his circle.** Involve his brother, his friend, his doctor. More people carrying less each is better for everyone including him.
- **Keep one thing that is entirely yours.** One evening, one activity, one relationship that has nothing to do with any of this.
- **Do not become the medication manager, the appointment maker, and the emotional support in perpetuity.** Help him build the systems, then hand them back as he becomes able.
- **Watch your own drinking.** This is a common and quiet casualty of long-term caring.

### IF IT IS YOUR CHILD

Parents of a struggling adult son face a particular difficulty: no authority, full responsibility as they experience it, and the fear of pushing him away by pushing too hard. What tends to work is staying reliably present and reliably non-judgemental, being explicit that the door is open regardless of what he has done, and offering practical help he can accept without losing face — the appointment booked, the fee paid, the lift given. And getting support yourself, because carrying fear about your child alone is one of the heaviest things there is.

# When It's an Emergency

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## IF YOU ARE WORRIED ABOUT SOMEONE RIGHT NOW

**Stay with him. Ask directly. Call 988.**

You can call the 988 Suicide & Crisis Lifeline about another person, and a trained counsellor will talk you through exactly what to do. If he has already harmed himself, or you believe he is in immediate danger, call **911** — and if you can, ask for officers trained in crisis intervention.

## Ask the question properly

Directly, calmly, without softening it into something he can sidestep.

“Are you thinking about killing yourself?”

“Are you thinking about ending your life?”

Not “you’re not thinking of doing anything stupid, are you” — which contains the answer you want and gives him an easy exit. Not “hurting yourself,” which is vaguer than it sounds.

Asking does not put the idea in his head. It does the opposite: it tells him that this can be spoken about, with you, without you falling apart.

## If the answer is yes

**Do not panic, and do not leave.** Your steadiness is doing real work.

Whatever you feel, keep it off your face for now.

**Take it seriously without dramatising it.** “Thank you for telling me. I’m glad you did. We’re going to sort this out together.”

**Do not argue him out of it, and do not moralise.** Telling him what it would do to his children is a common instinct and it usually backfires

badly — a man who already believes he is a burden hears confirmation, not persuasion. Listen instead. Ask how long it has been like this.

**Get a professional involved now.** Call 988 together, or with him in the room. Take him to an emergency department. Call his doctor or therapist. Do not make the plan be that you will handle this yourself over the coming weeks.

**Help make his environment safer.** Ask him what he could use to hurt himself and whether he will let you or someone else hold onto it for now. Putting time and distance between an impulse and the means to act on it is one of the most effective interventions there is, because acute crises pass. This conversation is easier than you think, and a crisis counsellor will help you have it.

**Do not agree to keep it secret.** Say so plainly: “I can’t promise that, because I’m not willing to lose you. But I’ll tell you exactly who I’m talking to and why.” Transparency preserves the relationship; secrecy risks his life.

**Stay until someone else is there.** Do not leave him alone in the acute phase.

## Afterwards

The period after a crisis — particularly the weeks following a hospital discharge — is a high-risk time, and it is exactly when attention tends to drop off because everyone assumes it has been dealt with. Keep checking. Help him get to the follow-up appointments. Ask again in a month.

### AND YOU

Being on the receiving end of this is frightening, and people who have been through it often carry it for a long time afterwards without telling anyone, on the grounds that they were not the one in crisis. Talk to someone about it. If you have lost someone to suicide, support specifically for the bereaved exists — the American Foundation for Suicide Prevention maintains directories of survivor support groups. That grief is its own category and it deserves its own help.

## PART FIVE

# The Cause

What I'M GOOD believes, how it speaks, what it refuses to do, and how it gets built. This part is the operating manual — for the founder, and for anyone who works on it later.

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# The Non-Negotiables

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Every cause drifts. These are the commitments that determine what I'M GOOD will still be after the first viral post, the first sponsor, and the first disagreement about direction.

## **1. Strength and vulnerability are not opposites.**

A man can be disciplined, capable, protective, ambitious and resilient while also admitting fear, depression, anxiety, trauma, or the need for professional help. I'M GOOD never asks a man to give up masculinity. It challenges the version of it that is too narrow to hold him while he is in pain.

## **2. We do not romanticise suffering.**

Pain can produce art, perspective and change. It is not a credential, and mental illness is not an aesthetic. Nothing produced under this name should make depression look beautiful, trauma look heroic, or addiction look mysterious and cool.

## **3. We do not turn every difficult emotion into a diagnosis.**

Men can be sad, angry, grieving, lonely or overwhelmed without having a disorder. The cause encourages recognition and help-seeking. It does not diagnose people through a phone screen, and it does not benefit from a world in which ordinary difficulty gets pathologised.

## **4. Recovery is not a straight line.**

Room is left for setbacks, relapse, shame, repair, and second attempts. A recovery story that shows only the victory makes the man still in the middle feel defective. Publish the middle.

## **5. The message must be useful, not merely inspirational.**

Awareness is the start, not the finish. Every piece should eventually connect to something a person can actually do: credible information, treatment routes, peer support, or a way to start one conversation.

## **6. No one owes the internet their trauma.**

A man does not have to post his diagnosis, film himself crying, or disclose his worst experience to prove he supports this. Private honesty counts. Therapy counts. Calling a friend counts. Telling a doctor counts. Saying “I’m not doing great” counts.

## **7. We do not use suicide statistics as shock marketing.**

The mortality data in this book exists to establish that a problem is real. It is not a hook, a thumbnail, or a way to win an argument. Used carelessly, it frightens people away from the conversation and it hurts the bereaved.

## **8. Evidence outranks the founder’s story.**

Lived experience opens the door. Published evidence furnishes the room. Where they conflict, the evidence wins, and the story gets corrected.

**The campaign should never say “real men talk.” It should communicate: *men deserve somewhere safe enough to talk.***

# Mission, Vision, Pillars

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## Mission

To make it easier for men to recognise distress, speak honestly about it, stay connected to other people, and get appropriate help — without feeling that doing so costs them their identity, strength, dignity or value.

## Vision

A culture in which “I’m good” is allowed to be true — but no man feels forced to say it when it is not.

## The five pillars

Every piece of work should belong to at least one, and should be able to say which.

### Pillar 1 — Recognition

Show the hidden forms distress takes: sleeplessness, irritability, isolation, overwork, numbness, panic, substance misuse, loss of interest, shame, recklessness, and the exhaustion of constantly performing normality. Recognition is the entry point for every man who does not yet believe any of this applies to him.

### Pillar 2 — Conversation

Normalise better questions and better answers. “You good?” becomes “How are you really doing?” “I’m good” becomes “Actually, it’s been rough.” The objective is permission, never forced disclosure.

### Pillar 3 — Connection

Encourage men to build and rebuild real relationships. Friendship, family, peer and recovery communities, faith communities where relevant, sport, creative work, and professional support all reduce the

experience of carrying everything alone. The friendship recession is a mental health issue and should be treated as one.

#### **Pillar 4 — Action**

Point to credible next steps: learning the symptoms, seeing a doctor, finding therapy, joining a group, addressing substance use, making a safety plan with a professional, or checking on someone whose behaviour has changed.

#### **Pillar 5 — Story**

Use music, film, photography, writing and real testimony to reach men who will never click on a clinical article. Art opens the door; evidence and resources wait behind it. This is the pillar that makes the other four reachable.

#### **THE THREE QUESTIONS EVERY PIECE MUST ANSWER**

Before anything is published under this name, it should answer at least one of these:

- What can be hiding behind “I’m good”?
- What helps a man say something more honest?
- What can another person do after he does?

### **Visual identity**

Resist the clichés. Not every struggling man is sitting in the dark with his head in his hands, and that image has been used so heavily that it no longer registers as anything.

Distress mostly happens in daylight. At work. At dinner. In traffic. At the gym. At a child’s game. In a studio. While laughing with friends. Showing ordinary functioning alongside internal strain is far closer to the actual idea, and far more likely to be recognised by the man this is for.

**The most important image in I’M GOOD is not a broken man. It is a man you would never have guessed was struggling.**

# How I'M GOOD Sounds

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The voice is one man talking to another. Intelligent, direct, unsentimental, and warm without being soft. If a post could have been written by a wellness brand, rewrite it.

## Use

- Plain language instead of therapy jargon, wherever plain language does the job.
- Humour where it fits. This subject does not have to be transmitted exclusively through darkness, and men who are struggling still laugh.
- Specific experiences rather than generic motivational statements. “Ten minutes in the car before you go in” beats “it’s okay not to be okay” every time.
- Hope that acknowledges reality instead of denying it.
- Credible research and named professional resources alongside lived experience.
- Second person, sparingly. “You” is powerful and becomes hectoring if overused.

## Avoid

- “Man up” messaging, including ironically. The irony does not survive a screenshot.
- Treating men as emotionally defective, or blaming them for patterns they were taught.
- Making masculinity the enemy. It loses the audience in one line and it is not what the evidence supports.
- Performative trauma, pity-seeking, savior narratives, or using someone’s story as content.
- Suggesting that a song, a campaign, a workout, a friendship, a religion or positive thinking substitutes for professional care when professional care is needed.

- Suicide statistics as a hook.
- Diagnosing anyone, publicly or privately. Ever.
- Toxic positivity. “Everything happens for a reason” has ended more conversations than it has opened.

## The line-level test

Read it back and ask: **would a 47-year-old contractor who has never used the word “mental health” about himself read this without wincing?**

If it makes him feel talked down to, diagnosed, lectured, or sold something, it fails. If it makes him think *how do they know that*, it works.

| WEAK                                  | STRONGER                                                                        |
|---------------------------------------|---------------------------------------------------------------------------------|
| “It’s okay not to be okay.”           | “You can be fine at work and not fine in the car.”                              |
| “Reach out. You are not alone.”       | “Text one person tonight. One. That’s the whole ask.”                           |
| “Real men talk about their feelings.” | “Nobody taught most of us how to do this. It’s a skill, not a character trait.” |
| “Check on your strong friend.”        | “Ask twice. The first answer is a reflex.”                                      |
| “Depression is a silent killer.”      | “Most men aren’t sad. They’re irritable, exhausted, and can’t sleep.”           |

### STANDING RULES FOR LANGUAGE

Say *died by suicide*, not *committed suicide* — the older phrasing carries the language of crime. Never describe methods, in any format, for any reason. Do not describe a suicide as inevitable, romantic, or as a solution to anything. When discussing suicide at all, include a crisis resource in the same piece, every time. These are consistent with international guidance on safe reporting and they are not optional here.

# Duty of Care

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The moment this exists publicly, strangers will send messages at two in the morning telling you things they have never told anyone. This chapter must be written before that happens, not after.

This is the part of running a mental health cause that nobody plans for and everybody encounters. It is the difference between a project that helps people and one that hurts someone by accident.

## What I'M GOOD is not

It is not a crisis service, a treatment provider, a counselling service, or a substitute for care. Nobody working on it should behave as though it were, and this should be stated publicly in the bio and in the pinned post rather than buried.

Say it plainly and where people can see it: *“We’re not a crisis service and we can’t provide counselling. If you need someone right now, call or text 988 (US) or find your local line at findahelpline.com. We read every message but we can’t always reply quickly.”*

## The direct message protocol

Write this now. Keep it saved. Follow it every time, including when you are tired.

| SITUATION                                                         | RESPONSE                                                                                                                                                                                                                |
|-------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Someone shares a difficult story</b>                           | Acknowledge warmly and briefly. Thank them. Do not advise, do not diagnose, do not counsel. Offer one resource. Do not ask follow-up questions that invite deeper disclosure you cannot hold.                           |
| <b>Someone describes symptoms and asks what's wrong with them</b> | Do not answer the question. "I can't tell you that and it wouldn't be right for me to try — but a doctor can, and it's a normal appointment to make."                                                                   |
| <b>Someone indicates thoughts of suicide or self-harm</b>         | Respond immediately with crisis resources. Do not attempt to counsel them through it. "I'm really glad you told someone. Please call or text 988 now — they're trained for exactly this and I'm not. Will you do that?" |
| <b>Someone describes immediate danger</b>                         | Crisis resources, plus emergency services. If you have a location and a genuine belief of imminent danger, contacting emergency services is appropriate.                                                                |
| <b>A minor makes contact</b>                                      | Extra caution. Point to resources appropriate for young people and to a trusted adult. Never move to a private channel.                                                                                                 |
| <b>Anything you are unsure about</b>                              | Under-respond rather than over-respond. A short, kind message plus a resource is never the wrong answer.                                                                                                                |

## Rules for the people running the accounts

- **Never counsel.** You are not qualified, and warmth is not a substitute for training. The most caring available action is a fast handoff to someone who is.
- **Never promise availability you cannot sustain.** "My DMs are always open" sounds generous and becomes a promise you will eventually break at the worst possible moment for someone.
- **Never share someone's story without explicit, specific, written permission** — including anonymised versions, which are frequently identifiable to the people who know them. Ask again before publishing. Let them withdraw at any point.
- **Never screenshot a DM.** Not even to praise it.
- **Do not let one person become the only responder.** That person will burn out, and probably will not say so.
- **Keep a resource list to hand** in every language and region you have an audience in.

- **Moderate the comments.** A cruel reply under a man's first public disclosure does more damage than the post did good. Delete, block, and do it fast.

#### LOOK AFTER THE PERSON RUNNING THIS

Reading distressing messages daily has a cumulative effect. This is documented among moderators, helpline volunteers and community managers, and it applies to founders with lived experience most of all — because much of what arrives will resemble your own worst period. Set hours. Do not read messages last thing at night. Have your own therapist. Bring in help before you need it. A founder who burns out serves nobody, and there is a particular cruelty in a men's mental health cause that quietly destroys the man running it.

## Governance and money

Decide the structure deliberately rather than by accident: an unincorporated cause and creative project, a fiscally sponsored initiative under an existing nonprofit, or an independent 501(c)(3) with its own board and filings. Each has real differences in cost, obligation and credibility, and this is a conversation for an accountant and a lawyer rather than a decision to drift into.

Two rules regardless of structure. **If you take donations, be exact** about who receives the money and what it funds; nothing destroys a cause faster than ambiguity here. And **vet every partner**. The treatment industry contains excellent providers and predatory ones, and lending this name to a bad clinic would cause direct harm to the exact people it is meant to protect. Prefer partnerships with established, credible organisations over whoever offers money first.

# Building the Platforms

Each platform rewards something different. The message stays fixed; the format adapts.

| PLATFORM         | WHAT IT IS FOR                                                                                                                                                      | WATCH FOR                                                                                                                         |
|------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|
| <b>Instagram</b> | Visual recognition and shareable lines. Carousels do genuine educational work. Reels reach beyond the following. Stories are where the audience actually replies.   | Aesthetic drift toward inspiration-poster content. Keep it specific.                                                              |
| <b>TikTok</b>    | The widest reach to younger men, and to men who would never follow a mental health account. Spoken-to-camera and short scenes outperform graphics.                  | Strict rules around suicide and self-harm content. Read the current community guidelines properly before posting on those themes. |
| <b>Facebook</b>  | Older men, fathers, trades, and local community — a demographic other platforms miss entirely. Longer text performs. Groups are the strongest tool on the platform. | Comment sections require active moderation.                                                                                       |
| <b>YouTube</b>   | Depth. Interviews with clinicians, long-form testimony, music, documentary. Also the best search surface: men look things up here privately.                        | Slow to build. Worth it anyway.                                                                                                   |
| <b>A website</b> | The permanent home. Resources, the full guide, the crisis page. Owned rather than rented, and it survives any platform change.                                      | Keep the crisis resources one click from every page.                                                                              |

## Recurring formats worth building

- **“Behind I’m Good.”** First-person accounts, anonymous or attributed, of what was actually happening when a man said it.
- **“Ask Twice.”** Short scenes of the second question being asked and landing.
- **“Signals.”** Educational pieces on the overlooked presentations — irritability, overwork, numbness, physical symptoms. High save

rates, and they teach families what to look for.

- **“The Ten Minutes in the Car.”** Ordinary male moments where the strain shows. Visual, recognisable, no dialogue needed.
- **Clinician conversations.** Short, plain-language interviews. Credibility and reach at once.
- **“What Helped.”** Specific, concrete, unglamorous accounts of what actually worked. Antidote to inspiration content.
- **Music and film.** The pillar that opens doors nothing else opens.

## Content principles

**Recognition first, instruction second.** A man must see himself before he will accept information. Lead with the scene, close with the step.

**Every piece ends somewhere.** One action, one resource, one question. Awareness with no exit is decoration.

**Never post a suicide-related piece without a crisis resource in the same piece.** Not in the comments. In the piece.

**Do not chase every trend.** A trend that requires flattening the message is a trend to skip. The audience being built here is one that has been let down by performative concern before, and they are unusually good at detecting it.

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**On the annual calendar.** Movember (November) and Men's Health Month (June) bring predictable attention to this subject, and there is a case for using them. There is a stronger case for being conspicuously present in the other ten months, since the defining weakness of men's mental health messaging is that it arrives once a year and then disappears. Being the account that was still posting in February is a real differentiator.

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# What Success Actually Means

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Followers, views, press and celebrity attention expand reach. They are not the purpose, and confusing them for it is how causes become brands.

## What would actually count

- A man recognising that his irritability, isolation, drinking, numbness or overwork might be connected to something treatable — and deciding to find out.
- A friend asking a second question instead of accepting the first answer.
- A father talking to his son more honestly than his father talked to him.
- Someone making a first appointment — therapy, medical, recovery, or support.
- Men telling their stories without being mocked, minimised, or turned into content against their wishes.
- Partnerships with credible organisations that measurably increase access to education, support or treatment.
- A body of music and art that men can find themselves in without feeling preached at.

## What to actually measure

Most of the above cannot be counted directly. Some proxies are still worth tracking, and they are more informative than follower growth.

| SIGNAL                                         | WHY IT MATTERS                                                                                                                                                                                |
|------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Saves and shares</b> , over likes           | A save means he intends to return to it. A share to one person means it was useful enough to pass on.                                                                                         |
| <b>Clicks to resources</b>                     | The closest available measure of movement toward help. Track it.                                                                                                                              |
| <b>“I sent this to my brother”</b><br>comments | The mechanism working exactly as designed.                                                                                                                                                    |
| <b>Unsolicited accounts of action taken</b>    | Rare, unmeasurable at scale, and the most meaningful data there is. Keep a private record.                                                                                                    |
| <b>Audience composition</b>                    | If the following is mostly women supporting men, that is worth knowing. It is not failure — they are a legitimate and important audience — but it means the male-facing work needs attention. |
| <b>Partner outcomes</b>                        | Referrals generated, sessions funded, events held. Concrete and defensible.                                                                                                                   |

**The ultimate ambition is cultural: to make honesty less costly for men. Nothing about that is measurable on a quarterly basis, and it is still the point.**

# The First Ninety Days

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A sequence, in the order that protects people. Foundations before reach.

## Days 1–30 — Foundations

- Secure the name across platforms and as a domain, even before launching.
- Write the crisis-resource page. This exists before the first post, not after.
- Write the DM protocol from Chapter 35 and save it where it can be reached quickly.
- Write the disclaimer language for the bio and the pinned post.
- Build the visual identity and a small set of reusable templates.
- Draft twenty pieces of content before publishing any. Launching with a queue prevents the panic-posting that produces the worst material.
- Identify three credible organisations to approach later. Do not approach yet.
- Decide the legal and financial structure, or decide explicitly to defer it and set a date.

## Days 31–60 — Launch quietly

- Publish the founding statement — short, personal, specific. Not the whole story. One honest paragraph.
- Begin the recurring formats. Consistency beats volume; three good pieces a week beats fourteen thin ones.
- Publish the field guide as a free download. It is the credibility anchor and the thing people will share.
- Start the email list. Platforms change their rules; a list belongs to you.
- Now approach the partner organisations, with the guide in hand as evidence of seriousness.

- Watch what actually lands. Let the audience show you the format rather than deciding in advance.

## **Days 61–90 — Build depth**

- Record the first clinician conversation. Credibility compounds.
- Release the first piece of music or film under the name, with resources attached.
- Open a submission route for stories, with a written consent process attached to it.
- Bring in one other person to share the DM load. Do not still be doing this alone at day ninety.
- Review honestly: what worked, what was performative, what to stop.
- Set a sustainable rhythm. This is a decade-long project and the failure mode is a brilliant four months followed by silence.

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### **THE THING TO PROTECT ABOVE ALL**

Everything here can be rebuilt except credibility. One careless post that diagnoses somebody, one shared story used without consent, one partnership with a predatory provider, one week of using grief as a hook — and the men who most need this will correctly conclude it is another thing being sold to them. Move slower than the platforms want you to.

# Where to Get Help

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Verify these before relying on them; services change.  
Everything here was accurate as of publication.

## Crisis — United States

### 988 Suicide & Crisis Lifeline

**Call or text 988** · [988lifeline.org](https://988lifeline.org)

Free, confidential, 24/7. Suicidal thoughts, emotional distress, substance use, or simply needing to talk. You can also call about someone else.

### Veterans Crisis Line

**988, then press 1** · text **838255** · [veteranscrisisline.net](https://veteranscrisisline.net)

### Crisis Text Line

Text **HOME** to **741741** · [crisistextline.org](https://crisistextline.org)

### SAMHSA National Helpline

**1-800-662-4357** · Free 24/7 treatment referral for substance use and mental health.

### National Domestic Violence Hotline

**1-800-799-7233** · text START to **88788** · Support for anyone affected, including people concerned about their own behaviour.

### RAINN

**1-800-656-4673** · Sexual assault support, including for male survivors.

### Trevor Project

**1-866-488-7386** · text START to **678678** · For LGBTQ+ young people.

### 211

Dial **211** · Local health and human services, including low-cost mental health care.

## Crisis — International

### Find A Helpline

[findahelpline.com](https://findahelpline.com) · Verified crisis lines in more than 130 countries.

### Canada

Suicide Crisis Helpline — call or text **988**

|                                     |                                                                                                                      |
|-------------------------------------|----------------------------------------------------------------------------------------------------------------------|
| <b>United Kingdom &amp; Ireland</b> | Samaritans — <b>116 123</b> · CALM (Campaign Against Living Miserably), a men-focused service — <b>0800 58 58 58</b> |
|-------------------------------------|----------------------------------------------------------------------------------------------------------------------|

|                  |                                                                        |
|------------------|------------------------------------------------------------------------|
| <b>Australia</b> | Lifeline — <b>13 11 14</b> · MensLine Australia — <b>1300 78 99 78</b> |
|------------------|------------------------------------------------------------------------|

|                    |                                          |
|--------------------|------------------------------------------|
| <b>New Zealand</b> | Need to talk? — call or text <b>1737</b> |
|--------------------|------------------------------------------|

## Finding treatment

|                          |                                                                 |
|--------------------------|-----------------------------------------------------------------|
| <b>FindTreatment.gov</b> | SAMHSA's locator for mental health and substance use treatment. |
|--------------------------|-----------------------------------------------------------------|

|                                   |                                                                      |
|-----------------------------------|----------------------------------------------------------------------|
| <b>Psychology Today directory</b> | psychologytoday.com · Filter by insurance, speciality, and location. |
|-----------------------------------|----------------------------------------------------------------------|

|                             |                                                                           |
|-----------------------------|---------------------------------------------------------------------------|
| <b>Open Path Collective</b> | openpathcollective.org · Nonprofit network offering reduced-rate therapy. |
|-----------------------------|---------------------------------------------------------------------------|

|                            |                                                                                                                |
|----------------------------|----------------------------------------------------------------------------------------------------------------|
| <b>Your employer's EAP</b> | Many employers provide free confidential counselling sessions. Check — most people do not know they have this. |
|----------------------------|----------------------------------------------------------------------------------------------------------------|

|                                  |                                                                         |
|----------------------------------|-------------------------------------------------------------------------|
| <b>VA mental health services</b> | mentalhealth.va.gov · Eligibility is broader than most veterans assume. |
|----------------------------------|-------------------------------------------------------------------------|

## Information and support organisations

|             |                                                                                           |
|-------------|-------------------------------------------------------------------------------------------|
| <b>NAMI</b> | nami.org · Helpline <b>1-800-950-6264</b> · Education, support groups, family programmes. |
|-------------|-------------------------------------------------------------------------------------------|

|                              |                                                   |
|------------------------------|---------------------------------------------------|
| <b>Mental Health America</b> | mhanational.org · Free anonymous screening tools. |
|------------------------------|---------------------------------------------------|

|             |                                                                                         |
|-------------|-----------------------------------------------------------------------------------------|
| <b>NIMH</b> | nimh.nih.gov · Plain-language, evidence-based information on conditions and treatments. |
|-------------|-----------------------------------------------------------------------------------------|

|                                                   |                                                                            |
|---------------------------------------------------|----------------------------------------------------------------------------|
| <b>American Foundation for Suicide Prevention</b> | afsp.org · Prevention resources and support for those bereaved by suicide. |
|---------------------------------------------------|----------------------------------------------------------------------------|

|                                         |                                                      |
|-----------------------------------------|------------------------------------------------------|
| <b>Face It Foundation / HeadsUpGuys</b> | Men-specific depression support and peer programmes. |
|-----------------------------------------|------------------------------------------------------|

# Sources

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This guide is an original synthesis of public-health, clinical and peer-reviewed sources. It is not medical advice. Statistics reflect the most recent data available at the time of writing; check the primary sources for updates.

**Centers for Disease Control and Prevention.** Suicide Data and Statistics. Reports that the male suicide rate in 2024 was nearly four times the female rate.

[cdc.gov/suicide/data](https://cdc.gov/suicide/data)

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**Drapeau, C. W., & McIntosh, J. L. (2026).** U.S.A. Suicide: 2024 Official Final Data. National Council for Suicide Prevention. 48,824 total deaths; 38,977 male (rate 23.2 per 100,000) and 9,847 female (rate 5.7).

[thencsp.org/suicide-statistics](https://thencsp.org/suicide-statistics)

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**American Foundation for Suicide Prevention.** Suicide Statistics, drawing on CDC WISQARS 2024 data.

[afsp.org/suicide-statistics](https://afsp.org/suicide-statistics)

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**National Institute of Mental Health.** Mental Illness statistics, drawing on SAMHSA's National Survey on Drug Use and Health. Past-year prevalence of any mental illness: 19.7% among males, 26.4% among females. Treatment received among adults with AMI: 41.6% of males, 56.9% of females.

[nimh.nih.gov/health/statistics/mental-illness](https://nimh.nih.gov/health/statistics/mental-illness)

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**National Institute of Mental Health.** Men and Mental Health. Notes lower rates of treatment among men and the importance of symptom recognition.

[nimh.nih.gov/health/topics/men-and-mental-health](https://nimh.nih.gov/health/topics/men-and-mental-health)

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**Garnett, M. F., & Miniño, A. M. (2026).** Drug Overdose Deaths in the United States, 2023–2024. NCHS Data Brief. Male rate fell from 44.3 to 32.2 per 100,000; female rate from 18.3 to 14.1.

[cdc.gov/nchs](https://cdc.gov/nchs)

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**National Center for Health Statistics (2026).** Mortality in the United States: 2024. Overdose deaths 79,384; suicide the tenth leading cause of death.

[cdc.gov/nchs/pressroom](https://cdc.gov/nchs/pressroom)

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**Mayo Clinic.** Male depression: understanding the issues. Discusses under-recognised presentations, unhealthy coping, and barriers created by traditional male roles.

**American Psychological Association.** Coverage of men's depression, treatment stigma, and research into irritability, fatigue and anger as possible expressions of depression.

[apa.org](https://apa.org)

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**Systematic review.** Men's Mental Health Matters: The Impact of Traditional Masculinity Norms on Men's Willingness to Seek Mental Health Support. Review of 47 studies identifying emotional suppression, self-reliance and fear of appearing weak as recurring barriers.

[pmc.ncbi.nlm.nih.gov/articles/PMC12117241/](https://pubmed.ncbi.nlm.nih.gov/articles/PMC12117241/)

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**Systematic review.** The socio-ecological determinants of help-seeking practices and healthcare access among young men. Identifies pressure to be strong, fear of vulnerability, and masculine attitudes as repeated barriers.

[pmc.ncbi.nlm.nih.gov/articles/PMC10957130/](https://pubmed.ncbi.nlm.nih.gov/articles/PMC10957130/)

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**VA National Center for PTSD.** Epidemiology and Impact of PTSD. Reports lifetime PTSD prevalence of approximately 4% among men in a large U.S. population study, and discusses comorbidity and functional impact.

[ptsd.va.gov](https://ptsd.va.gov)

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**U.S. Surgeon General / HHS.** Our Epidemic of Loneliness and Isolation: advisory on the healing effects of social connection and community. Describes social connection as influencing health through biological, psychological and behavioural pathways.

[hhs.gov/surgeongeneral](https://hhs.gov/surgeongeneral)

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**Cox, D. A. (2021).** The State of American Friendship: Change, Challenges, and Loss; and Why Men's Social Circles Are Shrinking. Survey Center on American Life, American Perspectives Survey. Men with six or more close friends fell from 55% (1990) to 27% (2021); men reporting no close friends rose from 3% to 15%.

[americansurveycenter.org](https://americansurveycenter.org)

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**Kroenke, K., Spitzer, R. L., & Williams, J. B. W.** The Patient Health Questionnaire-2 (PHQ-2) and the Generalized Anxiety Disorder-2 (GAD-2). Brief validated screening instruments used in primary care. Screening tools indicate whether further assessment is warranted; they do not diagnose.

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**Bush, K., et al.** The AUDIT Alcohol Consumption Questions (AUDIT-C). Brief screening instrument for hazardous drinking, used widely in primary care and by the VA.

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**Editorial note.** This document is a cause and creative foundation combined with a general-information guide. It is not medical guidance and it cannot diagnose or treat anyone. Future public-facing educational materials produced under this name should be reviewed against current evidence and, where appropriate, developed with qualified mental-health professionals and partner organisations. Where this guide describes symptoms, treatments or screening instruments, it does so in general terms; individual circumstances vary and require individual assessment.

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I'M GOOD.

# A man should be allowed to be strong without being required to be silent.

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The cause begins with two words, because sometimes two words are all a man gives us. The work is to build a world in which he knows there is room for a third —

## “I’m not.”

And room for whatever comes after it.