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Big boys don't cry: depression and men

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[150 word unstructured abstract]

As a minority group receiving a diagnosis of, and treatment for, depression, men require effective interventions. However, community surveys and mental health issues in men, such as suicide and alcoholism, suggest that many more men have depression than are currently seen in healthcare services. This paper explores current approaches to men and depression, which draw upon theories of sex differences, gender roles, and hegemonic masculinity. The sex differences approach has the potential to provide diagnostic tools for (male) depression, gender role theory could be used to redesign health services so that they target masculine problem-focused individuals, and hegemonic masculinity highlights how gender is enacted through depression and that men's depression may be visible in abusive, aggressive, and

violent practices. Depression in men is receiving growing recognition and recent policy changes in the UK may mean that health services are obliged to incorporate services that meet the needs of men with depression.

Introduction

Despite excess depression in women, there are three important reasons for exploring depression and men. First, even if men represent a minority of patients with depression they still require effective interventions. Second, while healthcare services find that they are diagnosing and treating many more women with depression than men (ISD Scotland, 2004; Office of National Statistics, 2000), community surveys (Wilhelm et al., 2002; Bland et al., 1988; Blazer et al., 1994; Meltzer et al., 1995; Singleton et al., 2000; Wells et al., 1989) suggest that this disparity is disproportionate. Excess female depression could, for example, be an artefact of how depression is recognised and treated or of how men self-diagnose and seek help. Third, mental health issues, such as alcohol dependency (Alcohol Concern, 2005) or being subject to compulsory detainment and treatment (Healthcare Commission, 2007), where men predominate could be related to emotional distress and depression. Men's rate of suicide mortality has been found to be four times greater than women's (White & Holmes, 2006) with China as the only country where women's suicide mortality is greater than men's (Hawton, 2000), which seems to suggest underlying issues with depression (Möller-Leimkühler, 2003). Current approaches to men and depression draw upon theories of sex differences, sex roles, and hegemonic masculinity, which will be explored in this paper.

Sex Differences – 'Male Depression'

Broadly, 'gender' is the sexual distinction between male and female that is an amalgamation of biological, cultural, historical, psychological, and social factors but gender can often be used to exclude biological factors. In terms of gender, 'sex' refers to just those biological factors that distinguish male and female and 'sex differences' are factors (biological, cultural, etc.) related to sex. It is important to emphasise that a sex difference is not necessarily biological but it does rest on an assumed common understanding of a biological distinction between men and women. Establishing sex difference in research is simple and powerful (perhaps because of its simplicity), particularly in depression. As with epidemiological studies on depression, more specific studies on symptoms have found that women have more symptoms of depression than men but that there are no sex differences in the quality of symptoms. In a fifteen year prospective community study, there were no sex differences in the number or duration of depressive episodes but, importantly, women

reported more symptoms per episode (Wilhelm et al., 2002). Whereas in clinical samples, sex differences in the number of symptoms are less marked with similar functional impairment and global severity (Young et al., 1990) but women are more likely to have a prior history of treatment for depression (Kornstein et al., 2000). The reduction in sex differences from community to clinical samples seems to suggest that diagnostic procedures or self care practices are resulting in a heterogeneous population of clinical depression. It is interesting to note that where studies have found a symptom to occur more frequently in one sex, the symptoms for women appear in diagnostic criteria (see Box 1). In depressed women, symptoms that have been found to occur more frequently are worry, crying spells, helplessness, loneliness, suicidal ideas (Kivelä & Pakkala, 1988), and augmented appetite and weight gain (Young et al., 1990). Non-diagnostic symptoms found more frequently in depressed women are bodily pains and stooping posture (Kivelä & Pakkala, 1988). However, symptoms that have been shown to occur more frequently in depressed men are slow movements, scarcity of gestures, and slow speech (ibid.), non-verbal hostility (Katz et al., 1993), trait hostility (Fava et al., 1995), and alcohol dependence during difficult times (Angst et al., 2002), which are not common to diagnostic criteria for (adult) depression. Increased hostility could be indicative of a conduct disorder mixed with depression (ICD-10 F92.0) but is limited to onset in early childhood.

INSERT BOX 1 AROUND HERE

It could be that there exists a form of depression that has hitherto remained absent from international diagnostic criteria. Some have theorised a ‘male depressive syndrome’ (van Pragg, 1996; Rutz et al., 1995) that is characterised by sudden and periodic irritability, anger attacks, hostile-aggressive behaviour, and alexithymia (ibid.). The Gotland Scale of Male Depression (Zierau et al., 2002) has been developed with such a syndrome in mind. In an outpatient clinic for alcohol dependency, major depression was found in 17% of male patients while the Gotland Scale found depression in 39%. In a clinical sample, the Gotland scale could not differentiate depression in men and women (Möller-Leimkühler et al., 2004). However, the Gotland Scale looks for signs that are not usually understood as symptomatic of depression so it is not surprising that there is little difference between men and women diagnosed with depression. Nevertheless, in the clinical sample there was a greater intercorrelation of symptoms of male depression in men, which is

something that could be explored in community samples. This scale, when utilised in a study of 607 new fathers, identified a prevalence of 6.5% suffering what could be classed as post natal depression and of these 20.6% were not identified by the use of the Edinburgh Post Natal Depression Scale alone (Madsen & Juhl 2007).

The sex differences approach to depression and men has the potential to provide the diagnostic tools to allow psychiatric services and clinicians to recognise and treat a new form of (male) depression. Nevertheless, it is unclear as to how such an approach translates into treatment such as whether anti-depressants will be appropriate or effective. In addition, focusing on sex differences can mean that differences within men, such as socio-economic status, are ignored.

4.0 Gender Roles – ‘Masked Depression’

Gender role theory understands gender as the cultural and historical ways in which biological sex differences are played out at the individual and social level. As cultural constructs, gender roles are rarely evidenced in an individual but are rather lenses (Bem, 1993) through which men and women perceive themselves and each other. Roles are learnt through processes of socialisation – such as modelling parents – which means that gender roles self-perpetuate and come to constitute material reality. For example, family law often deals with, for example, cases of child abuse and domestic violence and requires its legal professionals and their clients to deal unemotionally with the facts of the case (Pond & Morgan, 2005). As such, successful professionals are those that can negotiate the system by the use of reason while keeping any sentiment private, which proliferates a particular way of being a professional. Epidemiological sex differences in the symptoms of depression may be evidence of, rather than a different type of depression, gender role appropriate ways of expressing or coping with depression.

INSERT BOX 2 AROUND HERE

The male and female roles are understood as norms, which individuals aspire to and enact differently. An individual can adhere strictly to one role (masculine or feminine), weakly to both roles (androgynous), strongly to both (undifferentiated) or to neither (ambiguous). Box 2 provides a short list of adjectives to illustrate the characteristics of the masculine and feminine sex roles. While the definition of a particular role may be culturally dependent we can presume that because gender roles

are self-perpetuating through processes of socialisation they are rarely subject to substantial change. For issues of mental health and illness the copying style of each gender role is particularly apt. In gender role theory, the feminine style of coping is to deal with the emotion associated with the stressor (emotion focused), whereas the masculine style is to deal directly with the stressor (problem focused) (Li et al., 2006). Feminine emotion-focused coping is associated with higher levels of depression than masculine problem-focused coping (Compas et al., 1988; Ebata & Moos, 1991). However, the research on sex differences above suggests that diagnostic criteria fail to include a male depressive syndrome, which may mean that depressive symptoms in masculine problem-focused individuals have remained hidden. Indeed, Good and Wood (1995) point out that the masculine role is antithetical to recognising and expressing depression, and to utilising emotion-focused interventions such as psychotherapy. For example, seeking help could be interpreted as incompetence and dependence (Möller-Leimkühler, 2002) and research has shown that individuals who adhere to the masculine role have negative attitudes towards using counselling services (Good & Wood, 1995). This has led some to theorise a disorder of masked depression, where the reduced affect is, for example, manifest in physical symptoms (Kielholz, 1973). Interestingly, associating masculinity with mental ill health has been important for the anti-sexist men's movement (e.g. the male role leads men to be violent to women) and for an antifeminist backlash (e.g. the male role damages men and privileges women) and this has been taken up in gender role theory with little recourse to empirical evidence. Regardless of whether a masculine individual is more likely to suffer depression it is important to note that if they do it seems they will be less likely to recognise it as depression and to seek help.

The gender role theory approach to men and depression suggests that services could be redesigned to target masculine problem-focused individuals. In addition, services could adopt practices to help men with depression challenge gender role norms, which would theoretically leave them better able to recognise and accept help for their own depression. While gender role theory does acknowledge possible differences within men it relies on a fundamental opposition between male and female, which risks overemphasising gender when other factors, such as class and ethnicity, may be more important. In particular, gender role theory largely focuses on women or, when focusing on men, is based on affluent white US college students who

are unlikely to reflect the diversity of men with depression (consider the sex-role characteristics in Box 2). Indeed, gender-role characteristics can seem rather dated (see Box 2) and a review (Choi & Faqua, 2003) of factor analytic studies validating the definitive sex-role psychometric measure – the Bem Sex-Role Inventory (BSSI; Bem, 1974) – suggest that the understanding of masculinity and femininity in gender-role theory is insufficiently complex. Another difficulty with gender role theory is that it seems to conceptually confuse gender norms with an individual's behaviour, which could result in potentially unhealthy male role norms being seen as 'normal' things for men to do.

Hegemonic Masculinity – 'Depression Enacting Gender'

Connell's (1987) concept of hegemonic masculinity is perhaps the most popular approach to gender in the academe at present. Like gender role theory, hegemonic masculinity focuses on the social, rather than biological, aspects of gender. Gender is understood as something that is actually done by people and a regularity in these actions – such as waking early, being last to leave work, working at home - around a particular way for men to be would be a masculinity. Gender is multiple, as practices may construct many ways of being a man, and historical, as these ways of being a man change. Power is particularly important as 'hegemony' refers to insidious processes of domination where the majority of people come to believe particular ideas are not only natural but are for their benefit. As such, different masculinities compete to define what it is to be a man and the dominant masculinity in any particular context is not simply the one that forces itself upon people but the one that is so socially ingrained it is almost impossible to imagine anything else. Hegemonic masculinity will also have to compete with other identities, such as femininity, class, age, or ethnicity, which means that it is possible that masculinities fail to become the hegemon and are instead subordinated to an other identity. As hegemonic masculinity is defined in particular contexts, it can never be fixed and instead has to be continually reworked as people move through their lives. Sex differences in the symptoms of depression may be evidence of underlying and common gendered practices.

Practices around depression could be part of doing gender. Indeed, being depressed would seem to be unmasculine. In an interview-based study with men who had been diagnosed with depression but were well enough to partake in the research,

Emslie et al. (2005) found that the recovery process was talked about as successfully renegotiating a masculinity. As such, actually being depressed would constitute a failure to be masculine. For a few of the men Emslie et al interviewed, the isolation and loneliness of depression were incorporated as signs of their difference (as more sensitive and intelligent) from others, which seems to suggest that actually being depressed would reaffirm their own masculinity. Although, as so few men are diagnosed with depression it is important to look at practices around depression in non-clinical samples. A focus group study that sought a diverse sample of men, including non-clinical and clinical men, looked at how they talked about seeking help for physical and mental health problems (O'Brien et al., 2005). O'Brien et al found considerable resistance to talk about mental ill health; particularly in the focus groups with young men where masculinity appeared to be being strong and silent about emotions. As a practice, masculinity is something that can be done by both men and women, which means that women need to be included when considering depression in men. Brownhill et al. (2005) conducted focus groups with a non-clinical sample of men and women and found that the important difference was not how depression was experienced but how it was expressed. This study seems to suggest that depression is part of an inner emotional world that is contained, constrained, or set free by gendered practices. The 'big build' (see Box 3) is the descriptive model Brownhill et al (ibid.) developed to explain how masculine practices to depression result in a debilitating trajectory of destructive behaviour and emotional distress. These practices start as avoidance and numbing, and escaping behaviours before leading to violence and suicide. The point seems to be that there is no difference in the depression men and women experience but there are important differences in how depression is done to enact masculinities or femininities.

INSERT BOX 3 AROUND HERE

From the research on depression and hegemonic masculinities, it could be suggested that the destructive behaviours, such as violence in intimate relationships, substance abuse, and suicide, are ways of doing depression that enact particular masculinities. Further, current mental health practices around diagnosing and treating depression could be seen as enacting femininities. From the concept of hegemonic masculinity, depression in men is not masked but often visible in abusive, aggressive, and violent practices nor is it a sign of a male form of depression because women can

do masculinity and may be coping with their depression in similar ways. The point for service provision is that depression may be underlying wider issues of mental health (such as substance abuse) and criminal behaviour. While, hegemonic masculinity may offer clinicians a more nuanced view of their own clinical practices and how their clients act out their difficulties, it fails to offer any specific treatment possibilities. To date, the research on hegemonic masculinity and depression has utilised focus group and interview methods. As masculinity is understood as constantly recurring practices, research needs to adopt methods that get at practices around depression in situ. There are already studies that have looked at how masculinities are achieved through destructive behaviours, such as crime (Messerschmidt, 1993) and hooliganism (Newburn & Stanko, 1994), and it would be interesting to explore these in terms of depression.

The Socialisation of Developing Boys

The introduction of this paper started with three main reasons for the importance of men and depression; men are a minority patient group requiring effective interventions, there seems to be more depressed men in community samples than are receiving treatment, and issues of emotional distress in men indicate depression. Sex differences, gender-role theory, and hegemonic masculinity are approaches that can be combined to start to explain why men are a minority patient group when so many seem to have depression. While Kraemer (2000) argues that men may be biologically disadvantaged by a 'fragile X' chromosome, he also points out that this disadvantage is immediately mediated once an infant's sex is known. The point is that boys are subject to their own biological and psychological development, which cannot be separated from the cultural and historical context where developing boys are socialised. The advantage of such an approach is that it should force us to consider the individual and social together.

In a pioneering study of school boys, Frosh, Phoenix and Pattman (2002) found that masculinity seemed to be lived through attempts to avoid being seen as feminine or homosexual. In particular, femininity and homosexuality seemed to be associated with displays of emotions and the schools reported that if they displayed such emotions they were subject to, and would subject others to, insidious bullying. While usually associated with younger children, the term 'big boys don't cry' is an example of how a young boy may be denied a masculine identity because he has

displayed emotion. It is important to consider what this means for men and depression in practice as the suggestion seems to be that developing boys are socialised into depressed emotionally inarticulate men. If adolescent girls hold the monopoly on discussions relating to emotions then by implication boys are restricted from entering into these domains. This rather stark bi-polarisation of emotional-feminine and unemotional-masculine must influence men's ability to recognise their own emotional difficulties, how they are expressed, and how they seek help to cope with them. A further suggestion is that 'health' more generally is also seen as a feminine issue, which means that these issues are not limited to emotional health (White, 2006).

Future: Gender Equality Policy

The "Real Men. Real Depression" campaign by the US National Institute for Mental Health (Rochlen et al., 2005) and the publication of the leaflet "Men Behaving Sadly" by the UK Royal College of Psychiatrists (2006) demonstrate the growing recognition of depression in men. However, recent changes towards proactive gender equality may mean that health services have to adapt and incorporate an explicit focus on men and depression. The UK Equality Act 2006 - which came into force April 2007 - places a statutory duty (termed the Gender Duty) upon public bodies to ensure that where men and women have different needs services are planned and developed in ways that successfully meet them. If, for example, a local area's Coronary Office reported that the rate of suicide was greater in men than women then we would presume that under the Gender Duty the local health services would need to do something to reduce male suicide. Nevertheless, health services currently lack the expertise required for providing solutions targeted specifically at men (Men's Health Forum, 2006), which means that that they may fail to meet their obligations under the gender duty. There are health service projects that have been designed to meet men's health needs (see Box 4) and it is important we learn from these as services are developed around the different needs of men and women.

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