Depression in men: communication, diagnosis and therapy

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Abstract

Women are diagnosed with depressive disorders twice as frequently as men, and yet evidence from differential rates of substance abuse, incarceration, and especially suicide calls into question the assumption that men are less susceptible than women to depression. It is possible that there is a ''masculine'' form of depression that is under-diagnosed and under-treated. Health professionals should work toward a greater understanding of cultural masculinity in the service of conceptualizing, diagnosing and treating male clients/patients who may be suffering from a disguised form of this common mental illness. Therapists who treat conventionally gendered male clients/patients should educate these men about masculinity as an important context of their problem, and should attend closely to issues of emotional expression, premature termination of therapy, and grief.

Although twice as many women as men are diagnosed with major depression [1], men commit suicide four times more often than women [2], abuse alcohol and other drugs at least twice as often [3], and commit 86% of all violent crimes [4]. These social and personal problems may reflect underlying depressive symptoms that are undiagnosed and untreated [5–7]. This problem is illustrated by the following excerpts from Dr. Spencer's intake interview of 21-year-old Paul, who comes to the Psychological Services Center at his university.

Intake interview between Dr Spencer and Paul

Dr Spencer: ''What brings you to the Center?''
Paul: ''Well, I've been having trouble concentrating in my classes and sleeping at night. I don't get to sleep until very late at night, and then I oversleep and miss my morning classes, which gets me farther behind in my work. I'm doing poorly in all of my classes and can't seem to get motivated.''
Dr. Spencer: ''How long has this been going on?''
Paul: ''About 6 weeks or so.''
Dr. Spencer: ''Is there anything in particular that happened at that time.''
Paul: ''Well, it was midterm time, and there was a lot of pressure because of that, and I was having trouble getting along with the boss at my part time job, and also this woman broke up with me . . .''
Dr. Spencer: ''And how do you feel about that?''
Paul: ''I feel she shouldn't have done it.''
Dr. Spencer: ''Do you feel sad?''
Paul: ''No – like I told you, I'm having trouble concentrating and sleeping. I guess the whole thing pisses me off a little, but that's not what I need help for.''
(The session continues. Toward the end):
Dr. Spencer: ''How do you think that counseling might be helpful to you?''
Paul: ''I want you to help me not think about it.''

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Dr Spencer might treat Paul's distractibility and sleep problems and ignore the grief issues created by the breakup, taking at face value Paul's assertion that he has no subjective feelings of sadness. A physician might prescribe sleep aids or antianxiety medication rather than refer the patient to psychotherapy.

The diagnostic criteria for major depression found in the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV) [8] include symptoms that represent a feminine-gendered pattern (as defined in mainstream Western culture) of the disorder. Women often ''act in'' because of a gender role that emphasizes both the expression of feeling and a focus on internal judgments of their own inadequacies. In contrast, men are socialized to ''act out'', and thus men's depression is more likely to be expressed through chronic anger, self-destructiveness, drug use, gambling, womanizing, and workaholism [5]. Underlying these behaviors are experiences of loss and persistent feelings of hopelessness, helplessness, and worthlessness, the hallmarks of depression. Because they are socialized to avoid introspection and the awareness of disempowering feelings, many men fail to recognize that they have a mental health problem in need of attention. Moreover, health professionals who come into contact with men who display masculine patterns of depression may fail to refer the client/patient to appropriate treatment. Paul's symptoms do not meet the DSM-IV criteria for any depressive disorder, yet they are very similar to patients whose symptoms do fit the diagnosis.

This article is an attempt to describe a masculine style of depression and provide recommendations for health professionals in communication, diagnosis and treatment of male clients/patients who display this pattern. The approach consists of motivating men to seek treatment and helping them to acknowledge vulnerable emotions, develop supportive relationships with other men and with women, take responsibility for their problems and the destructive interactions that often accompany, and build the skills necessary for more effective management of their lives and relationships.

Cultural masculinity and its effects on symptom patterns

Cultural masculinity is the pressure to behave and experience the self in ways that the culture defines as sex-appropriate [6]. However, an individuals' reactions to this pressure are widely variable. There are many men who do not like sports and many women who do. Likewise, there are many men who are emotionally expressive and many women who are not. The ''acting-out'' depressive pattern described above is labeled 'masculine' (a psychological term) rather than 'male' (a biological term) because many men are conventionally depressed and many women may evidence a masculine style of depression. But because the cultural pressure to conform to gender expectations is so powerful, most sufferers of masculine depression are males.

Masculinity is culturally defined as antifeminity [9]. In most of the mainstream culture, the worst insult for a boy is to say that he runs, throws, looks, or acts like a girl [10]. Thus boys learn from an early age to avoid any behaviors that are culturally defined as feminine because displaying such behaviors can lead to social punishment from male peers, parents and other adults, siblings, and even from female peers. Avoidance of the feminine is also reinforced by media images that often portray socially attractive men as being unemotional, hyper-independent, and violent. These same images portray feminine-acting men as weak, neurotic, and deserving of punishment.

Because women stereotypically ''act in'' in response to psychological conflict (e.g., by crying, worrying, and talking about sad feelings), men are encouraged to do the opposite: remain stoic, banish thoughts about their problem from their consciousness, dissociate themselves from their emotions or convert vulnerable emotions to anger, and take action in response to their feelings.

The DSM-IV criteria for depression describe a feminine, acting in, mode, including: consciously depressed mood, fatigue, loss of energy, and diminished pleasure in activities. It is not surprising that women are diagnosed with depressive disorders twice as often as men. Some theorists believe that this sex difference is due to institutional sexism, which certainly provides a great deal of stress, or to a ruminative style of depression that is a product of gender socialization, or to both [1]. However, in some men, patterns of substance abuse and criminal behavior may reflect a dissociative and action-oriented approach to dealing with depressive symptoms.

Diagnostically, I believe that masculine symptoms of depression should include: bad temper, aggression (anger is the ''masculine emotional funnel system'', one of the few emotions for which male expression is culturally sanctioned; thus vulnerable emotion is often converted into anger [11,12]), substance abuse, physical and sexual risk taking, emotional numbness, over-involvement in work or sports or both, and impoverished friendships.

Why, then, should we label these symptoms as depressive if the behavioral manifestations are so different from the pattern that the mainstream psychiatric establishment describes as depressive? One of the most successful non-medical models of depression conceptualizes it as a cognitive problem. That is, depressed people hold beliefs about themselves, their world, and their futures that maintain their symptoms. More specifically, depression can be thought of as a triad of beliefs: that one is fundamentally flawed, that his/her flaw is in a highly valued area, and that it will never change. In other words, whatever is negative in one's life is viewed as internal (''it's me''), stable (''it's forever''), and global (''it affects everything I do''). These cognitions lead to chronic feelings of being helpless, hopeless, and worthless [13,14]. As these are feminine-defined cognitions and emotions, conventionally gendered men who are depressed are likely to defend against these thoughts and feelings through the behavioral pattern described above. The client presented at the beginning of this article experiences these cognitions but, through masculine socialization, he has become adept at erecting psychological defenses against them and distorting the emotional experience they induce.

Treatment considerations

Given the proclivity of men to disguise their depressive symptoms (sometimes even from themselves), health professionals can expect that the average man will have to be in considerably more pain than the average woman to enter treatment. If, as the stereotype predicts, it is difficult enough to ask for directions when one is lost in the car, it would be inordinately problematic to have to say: ''I am helpless and clueless, and I need help in managing my emotional life.'' Moreover, if we are able to convince him to accept psychotherapy, we will be asking him to express his feelings, cooperate, and introspect, all feminine-defined behaviors. Sensitivity to ''men's issues'' will result in improved delivery of service. Following are some general guidelines for treating men who display a masculine style of depression.

Teach about gender

Gender is an important context of men's responses to health care. For example, conventionally gendered men may be less likely than others to comply with physician's orders, report their pain accurately to a chiropractor, or take time off from work to attend physical therapy. Because the psychotherapy situation is likely to address topics that are especially gender salient (e.g., self-esteem, emotions, relationships, and self-concept), it is important to introduce the topic of masculinity early in the relationship. Many men have never considered the effects of gender on their behavior, yet it is an important context for their lives. I would argue that one of the goals of treatment should be to help the client/patient move into the position to resist the cultural pressure to be masculine when it conflicts with his life goals. It is very difficult to resist a pressure that one cannot name, and so professionals can do great service by teaching about masculinity. As a result, the male client/patient achieves a better language for symbolizing his experience.

Inoculate against premature termination

Most people who experience any non-acute disorder have suffered with the problem for a long time before they seek treatment. This reluctance to engage services may be especially likely for mental health problems, which continue to carry a degree of social stigma. Nearly all clients/patients have mixed feelings about requesting services, but men may be especially so, due to the masculine dictates for self-sufficiency and emotional control. In the early sessions, or even in the first session, clients/patients often begin

to feel better. They feel relieved at having told their stories, and the professional has listened empathically and instilled some hope for the future. When symptoms improve to a barely tolerable level, the man might be tempted to drop out of treatment. Doing so prematurely will usually result in a return to the previous symptom level. Therefore, a health professional should inoculate the client/patient against premature termination by predicting his ambivalence toward treatment, offering support, and strongly recommending that he continue to attend therapy despite feeling slightly better.

Emotional expression as skill

Revealing one's feelings can feel threatening and awkward for a conventionally gendered man, yet doing so is critical to the psychotherapeutic process. Some men may think of affective self-disclosure as something that they cannot possibly do. The treatment professional can frame talking about the emotional life as a skill that will improve with practice: ''Remember the first time you tried to swing a golf club or play a chord on the guitar? It felt awkward, and you weren't very good at it, but if you stuck with it, it became second nature. It is the same way with talking about how you feel.''

Build an emotional vocabulary

When asked, ''How do you feel?'' Many men respond, ''About what?'' It is important to discuss emotions in situational contexts to provide a structure for introspection. Referring to body sensations can also be helpful. A therapist might talk about anxiety in terms of physical gut reactions or talk about sadness in terms of facial expressions. It is critical to help the conventionally gendered man build an awareness of his feelings by insisting that he use an emotional vocabulary. Some may even need a list of emotion terms. And it is not infrequent for clients/patients to speak of their experience in the second person (or, worse, in the third person). Therapists should require the client/patient to restate a comment like, ''Well, when you don't get the job you want, you tend to get disappointed'' to ''I didn't get the job that I wanted and I felt disappointed'' and then point out the different feelings that arise from the two statements. Another entry into the man's emotional world may come from the use of the masculine mode of story telling. Many men are adept at recounting incidents from their lives. Therapists can help them to access their feelings by listening for emotional themes in their stories and exploring these themes with them.

Access the vulnerable feelings underneath the anger

Because it is socially acceptable for men to express anger, they may often convert less socially sanctioned emotions into anger. In the scenario that opens this article, Paul only acknowledges anger even though he may be sad, self-doubting, disappointed, and vulnerable. Therapists should help clients to access these feelings, a process that is especially important to grieving. If anger is a response to threat, it is helpful to identify the threat to deal with the anger.

Deal with your own gender issues

It is critical that health professionals become aware of their own views of masculine mental health and resist the urge to join their service recipients in the unhealthy aspects of gender conformity. They must resist the urge to avoid feelings, offer less emotional support, or expect more hyper-independence from men than they would with women.

Expanding masculinity

Men sometimes fear that the counseling process will ''feminize'' them. Therapists should address men's fear of femininity, but therapeutic work can also be framed as an expansion of positive masculine qualities rather than as a feminization process.

Expansion of positive masculine qualities

- *Courage* is masculine. It is courageous to take a psychological risk by expressing your feelings, asking for what you want, and talking about masculinity in the face of the cultural pressure to deny your feelings, get what you want through domination, and uncritically accept the culturally dominant definition of masculinity.
- *Independence* is masculine. Men can be independent by not always doing what other men do when there is good reason to resist.
- *Leadership* is masculine. Men can be leaders by showing other men healthier visions of masculinity and more effective ways of dealing with their emotional lives.
- *Assertiveness* is masculine. Men can be assertive by claiming their rights as dignified human beings. Men can assert their rights to have feelings, to express those feelings, to behave outside of dominant definitions of gender, and to ask for what they want in relationships.
- *Facing a challenge* is masculine. Men can see a challenge as getting something done despite difficulty. The challenge can be faced by building the skills that they have not acquired because cultural masculinity conspires against them. They can accept the challenge to learn how to better relate to others, respect women, take care of their health, and deal effectively with their emotions.

In summary, a better understanding of cultural masculinity and the application of this knowledge to the health setting will result in increased sensitivity to problems associated with a disguised form of depression. This article has summarized several suggestions for communicating and dealing with men who present for psychological treatment. However, an additional challenge for health professionals is to develop alternatives to traditional psychotherapy for men who are not a good fit for the counseling setting. It is also important to point out that this model of masculine depression has received only indirect empirical validation, and investigators need to develop research and diagnostic measures of masculine depression along with treatment protocols.

This article is the third in a series of articles on patient-physician communication. Further articles in the series will be published in future issues of the journal.

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