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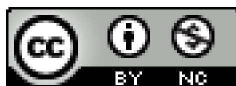

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Manifestations of Male Depression:

Theories of (Under) Diagnosis

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Abstract

Depression is a serious and often debilitating disorder that affects approximately 16 million Americans per year. Because women are diagnosed with depression 2 to 3 times more often than men, depression in women has been more thoroughly researched; however, depression in men is a relatively understudied topic. In this paper I highlight how depression is manifested in men specifically via somatic symptoms, addictive outlets, externalizing behaviors, and other manifestations. I investigate potential causal factors for these manifestations. Additionally, opposing theories about whether depression is under-diagnosed are explored.

Manifestations of Male Depression: Theories of (Under) Diagnosis

Depression is a mood disorder that affects approximately 5.4% of Americans in any given two week period (Pratt & Brody, 2008), which translates to approximately 16 million Americans. Akhtar-Danesh and Landeen (2007) estimate the lifetime prevalence of major depression at 12.2% of the population in the United States; however these rates are higher for women than men. The risk of developing depression is between 10-25% for women and only 5-12% for men (American Psychiatric Association, DSM-IV-TR, 2000). Mezzasalma (2010) explains that, when the cost of medication and lost productivity are taken into account, depression costs the United States approximately $81.5 billion per year.

There is a difference between a depressed mood and the diagnosis of depression. Like other mood disorders, the mood itself is not necessarily problematic and can actually be an appropriate reaction to different stressors in one's life. For example, feeling depressed after the death of a loved one is a normal part of grief; however, depression that is not sparked by a specific, recent life event may be problematic and considered to be a disorder. Pollack (1998) refers to these differences as mourning versus melancholia, where mourning is a natural reaction to loss and is considered to be normal, whereas melancholia (depression) is associated with severe chronic self-reproach. "Freud felt that the inner attacks upon the self were actually unconscious criticisms aimed against another loved one, who either disappointed or left that person. They took the disappointing other and turned the feeling inward" (Pollack, 1998, p. 158).

In modern diagnostic terms, severe melancholia is referred to as major depression (DSM-IV-TR, 2000), which is characterized by either depressed mood or loss of interest or pleasure in nearly all activities (anhedonia) for a period of at least two weeks. Children and teens may

present with irritability rather than sadness. At least four additional symptoms must accompany this persistent negative mood. These symptoms include changes in appetite or weight, sleep, and psychomotor activity; decreased energy; feelings of worthlessness or guilt; difficulty thinking, concentrating, or making decisions; or recurrent thoughts of death or suicidal ideation, plans, or attempts. These symptoms must occur for the majority of nearly every day, be different or more severe than the person's previous status, and must be significant enough to interfere with this person's daily functioning (DSM-IV-TR).

Correlated Factors

There are several factors that have been shown to contribute to depression in men and women. These factors affect men and women differently and are often correlated with more severe symptoms in one gender than another. Because these factors are correlated, it is difficult to determine whether they are causal or the result of depression.

Socioeconomic status. Akhtar-Danesh and Landeen (2007) found that, in a sample of Canadian individuals, regardless of sex, those who made less than $30,000 per year were subject to higher rates of depression than the general population and that 18.4% of individuals who made $10,000 or less per year had depression. This was 6.2% higher than the national average (Akhtar-Danesh & Landeen). This study demonstrates that low socioeconomic status (SES) is associated with elevated rates of depression; however earning an income greater than $30,000 per year was not predictive of reduced rates of depression. Similarly, Simon and Nath (2004) suggest that people with low SES experience more negative emotions and those with higher SES experience more positive emotions. Though most women are working outside the home (Taylor, Kochhar, Morin, Wang, Dockterman, & Medina, 2009), they often have a dual role between work and

home (Stone & Lovejoy, 2004). This may be an incentive for many women to pursue part-time rather than full-time work, though it reduces their overall income. Because women generally are of lower SES, this could contribute to an increase in the experience of negative emotions and depression in women compared to men; however, there are many potential correlating factors.

Age. Age is also a factor in depression. Male and female pre-pubescent children experience similar rates of depression (Nolen-Hoeksema, 2001), and some (Wade, Cairney, & Pevalin, 2002) even argue that, before the age of 12, boys experience depression at higher rates than girls. Additionally, Wade et al. note that pre-pubescent boys often demonstrate higher levels of depressive symptomatology than girls at this age. It is well documented that by age 13 or 14 (Nolen-Hoeksema; Wade et al.) there is a schism in these rates of depression. In fact, between the ages of 16 and 17, girls are 2.5 times more likely to be diagnosed with depression than their male peers (Wade et al.). Nolen-Hoeksema explains that the smallest difference between male and female rates of depression exists in college-age students. However, Akhtar-Danesh and Landeen (2007) posit that, compared to other age groups, men and women at this age (20-24 years) also suffer from the highest rates of depression, whereas Pratt and Brody (2008) argue that the highest rates of depression are seen among individuals (especially women), ages 40 – 59. There are virtually no gender differences in rates of depression in individuals over the age of 75, and this age group also experiences the lowest rates of depression. It appears that as adults age, rates increase for men and begin to stabilize and decrease for women.

There are differences in rates of depression based on age, but age also influences symptomatology and comorbid conditions that often accompany depression. For example, children of different ages process emotion in different ways. Older children internalize more and

have higher comorbid anxiety, whereas younger children usually experience more conduct disorders and externalizing problems. Similarly, children with depression are usually more irritable and aggressive than adults with depression (Ginicola, 2007). Male children and adolescents are more likely than their female counterparts to exhibit symptoms of depression via delinquency, school problems, and oppositional defiance (Fleming & Englar-Carlson, 2008).

Minority status. In comparison to rates of depression among heterosexual individuals, being a sexual minority is correlated with the development of depression (Hatzenbuehler, McLauhlin, & Nolen-Hoeksema, 2008). Sexual minority teens exhibit higher levels of anxiety and depression symptoms. They also tend to ruminate or dwell on these symptoms, which is shown to prolong and worsen dysphoric states (Hatzenbuehler et al.). Clark, Anderson, Clark, and Williams (1999) suggest that perceived prejudice can increase stress and stress-related problems. Stress often associated with being a minority-status individual may explain increased rates of depression in this sample of sexual minority teens. In comparison to heterosexuals, the tendency of these sexual minority students to ruminate when feeling sad can also contribute to depression in this population, because depression is correlated with this coping style. Additionally, Hatzenbuehler et al. found that poor emotional awareness was correlated with being a sexual minority teen. Poor emotional awareness can contribute to the development of depression because, like rumination, poor emotional awareness mediates the relationship between minority status and internalizing symptoms (Hatzenbuehler et al.).

Although it seems logical to assume that if the stress of being a sexual minority can potentially increase depression rates, being an ethnic minority could similarly contribute to elevated rates of depression. This logic, however, is not supported in a study conducted in the

United States by Oquendo, Ellis, Greenwald, Malone, Weissman, and Mann (2001). Conversely, these results indicate that Cuban Americans have the lowest rates of depression (2.5%), followed by Mexican Americans (2.8%), African Americans (3.5%), European Americans (3.6%), and lastly, Puerto Ricans (6.9%). It appears that most ethnic minorities in the United States actually endorse lower rates of depression than European Americans. The National Health and Nutrition Examination Study (NHANES) estimated rates of major depression at 10.4% in European Americans, 8.0% in Mexican Americans, and 7.5% in African Americans (Beidel, Bulik, & Stanley, 2010). Jackson-Tricke, Greer Sullivan, Wells, Rogers, Camp, and Mazel (2000) note that only 0.8% of Asian Americans report experiencing major depression. This association between depression rates and ethnicity is likely a factor of cultural differences across different ethnicities. For example, ethnic minorities with a collectivist paradigm may experience greater social support, which is a protective factor against depression, than European Americans.

Marital status. The prevalence of depression is correlated with marital status, which has also been shown to interact with gender. Generally rates of depression are similar in married and single individuals, who experience less depression than cohabiting heterosexuals, who are subsequently less susceptible to depression than those who are separated or divorced (Akhtar-Danesh & Landeen, 2007). Interestingly, single women report lower rates of depression with increased age, whereas single men report *increased* rates of depression as they age. Though Akhtar-Danesh and Landeen say that the lowest rates of depression are seen in married individuals, Piccinelli and Wilkinson (2000) argue that protective effects of marriage may only exist for men and marriage may actually have a negative effect on women, increasing their rates of depression. There are several possible explanations for this correlation between marriage and depression in women. For example, it has been shown that the number of children under age 18

in a household is negatively related to positive emotions in mothers. Thus, getting married and having children can influence the frequency of positive and negative emotions (Simon & Nath, 2004), especially for women who are usually more affected by interpersonal stressors than men (Ginicola, 2007).

Coping styles. Internalizing is a coping style which is implicated with both depression and gender. Internalizers are usually highly empathetic and show prosocial behaviors, such as spontaneously helping others, and are less aggressive than externalizers (Perren & Alsaker, 2009). Lack of prosocial behavior is correlated with externalizing problems, which men demonstrate more often than women (Perren & Alsaker). Internalizing is more common among women and is positively correlated with depression; externalizing, on the other hand, is negatively correlated with depression and is more common among men. Externalizing negative feelings can distract an individual, serving as an effective coping style for dealing with dysphoric moods (Lyubomirsky & Nolen-Hoeksema, 1995).

The way in which one copes with a dysphoric or depressed mood can influence the progression of this negative mood. Individuals who have researched the effects of ruminating on dysphoric moods (Lyubomirsky, Caldwell, and Nolen-Hoeksema, 1998; Lyubomirsky & Nolen-Hoeksema, 1995; Nolen-Hoeksema, 2001) argue that ruminating can actually prolong and exacerbate feelings of sadness that can develop into a depressive disorder. Rumination, which is more common among women, is an internalizing coping response to depression. This coping style involves the passive and repetitive focus on one's symptoms of distress, while trying to understand the meaning and consequences of these negative feelings (Nolen-Hoeksema & Larson, 1999). It is possible that rumination relates to the development of depression because

rumination decreases problem-solving abilities, making it difficult for ruminating individuals to escape their cycle of helplessness, rumination, and depression. A vicious cycle exists between dysphoria and ruminative problem solving because each affects and increases the other (Lyubomirsky & Nolen-Hoeksema). Nolen-Hoeksema and Larson argue that the cycle of chronic strain (stress), low mastery (low self-esteem), and rumination leads to depression. They state that individuals who ruminate are more negative about their past, present, and future.

Treynon, Gonzalez, and Nolen-Hoeksema (2003) explain that not all aspects of rumination contribute to the development of depression. However, the brooding aspect of rumination could solely account for this association between ruminating and depression. Brooding is defined as "a passive contemplation of what's wrong in your life and how you wish it were better" (Treynon et al., p. 257). Women are more likely than men to use a ruminative coping method when feeling dysphoric or depressed, whereas men tend to distract themselves. Nolen-Hoeksema (2001) argues that this difference in coping style between men and women could at least partially account for the gender differences seen in rates of depression.

Genetic components. There are many correlates and potential causal factors of depression that deal with environmental factors or coping mechanisms. However, there is also a genetic component to the development of depression. Piccinelli and Wilkinson (2000) argue that genetic factors may influence stable personality characteristics involved in both vulnerability to depression and exposure to high-risk environments. This means that our genetics play a role in inheritance of internal characteristics associated with depression as well as what environments we will inherit. Even though there are many environmental or personal predictors of depression, Real (1997) argues that vulnerability to depression is an inherited trait.

Negative life events. Having a vulnerability to depression can interact with negative life events to make an individual even more likely to develop depression. Adverse experiences in childhood have been shown to increase the risk of later depression through biological mechanisms; personal vulnerability such as low self-esteem, helplessness, and external locus of control; and environmental factors such as low social support/status, single parenthood, or chronic stress (Piccinelli & Wilkinson, 2000). Factors involved in depression include adverse childhood experiences, depression and anxiety in childhood and adolescence, negative sociocultural roles, and psychological attributes related to adverse life events and coping skills (Piccinelli & Wilkinson). It seems logical to assume that negative life events, especially during childhood, could increase the risk of developing depression. Abuse, neglect, and other forms of trauma are extremely stressful for children and can contribute to increased rates of depression (Piccinelli & Wilkinson). Similarly, stressful life events are correlated with increased risk of attempting and completing suicide (Moschichi, 1997), as unemployment is highly correlated with depression. One type of stressful life event is losing one's job, which is correlated with financial hardship, anxiety, and depression in men (Montgomery et al., 1999).

Employment and unemployment. Employment is related to both depression and gender. It interacts in complicated ways with many aspects of one's life, including competing family responsibilities and self-esteem. Some of these interactions may be particularly relevant to women, as homemaking and childcare reduce the potential to pursue full-time employment, often resulting in lower income. As demonstrated above, low SES individuals are at higher risk of having depression. Although women are more represented in the work force than they use to be (43.3% in 1970 vs. 59% in 2009), Taylor et al. (2009) note that women are usually predominately responsible for childcare and housework, even if they are working full time

outside the home. Employment usually has a positive effect on well-being, thus women who do not have outside employment may rely on their role as a housewife for their source of identity and self-esteem (Piccinelli & Wilkinson, 2000).

In addition to financial reasons, Lips (2008) notes that employment can also be beneficial because it gives individuals a sense of control over their lives, positive self-esteem, and can reduce stress. Taylor et al. (2009) report that nonworking women are nine times more likely than nonworking men to cite interpersonal ties as their reason for not working. Comparably, 61% of working women with young children would prefer to work part time rather than full time, whereas less than 20% of working fathers would prefer to stop working full time. Although some men are shifting into this role of homemaker, women still greatly outnumber men in this role, whereas men still over represent women in the labor force by about 13 percentage points (Taylor et al.).

Though employment can be beneficial and protective against poor mental health, unemployment can lead to negative health consequences. Bjorklund (1985) argues that unemployment can have serious negative effects on mental health and he views unemployment as a form of suffering. Bjorklund explains that loss of income and negative stigmas associated with unemployment may contribute to the interaction between unemployment and poor mental health. Hintikka, Lehto, Niskanen, Huotari, Herzig, Koivumaa-Honkanen et al. (2009) argue that unemployment may be related to poor physical and mental health through the effects of stress. Certain stress hormones are shown to be higher among unemployed individuals. Because stress is correlated with increased rates of depression, unemployment may be related to depression via stress. According to Montgomery et al. (1999), unemployment appears to be causal of mental

health problems such as anxiety and depression in men, although they note that individuals of disadvantaged demographic group (e.g., low SES) are more likely to experience both depression and unemployment. Additionally, it should be noted that severely depressed individuals may not be coded as unemployed if they are too impaired to even seek employment. Thus the relationship between unemployment and depression may not necessarily be causal.

Unemployment may be particularly difficult for men who often feel they are responsible to care for their family. Both losing one's job and showing signs of depression can threaten part of a man's identity as the rock, protector, and provider for his family, as these characteristics are incongruent with the masculine standard of always being in control (Rochlen, Paterniti, Epstein, Duberstein, Willeford, and Kravitz, 2009). Employment is closely related to social support, as most individuals spend the majority of the day at work. Just as social support is protective against depression, employment can offer similar benefits. Piccinelli and Wilkinson (2000) argue that individuals with undervalued jobs lack a sense of perceived choice and are at high risk of developing depression. Individuals with rewarding employment, on the other hand, have the opportunity to define themselves through their work and develop a sense of achievement and positive self-esteem.

Social support. There are many ways in which people deal with negative life events to minimize adverse impact on their life. One such strategy is utilizing social support from friends, family, or professionals. Poor social support is related to the onset and relapse of depression in both men and women, but social-skills training can reduce depression symptoms (Piccinelli & Wilkinson, 2000). The quality of social support is often based on the amount of self-disclosure exchanged between individuals. By this definition, women appear to have higher quality or more

social support. Women often have stronger affiliative styles and are more vulnerable to events affecting interpersonal ties than men (Piccinelli & Wilkinson). However, social support can also take the form of doing an activity with someone else, which is how men traditionally show social support.

Pessimistic explanatory style. When people are faced with negative life events, poor environments, undervalued employment, and unemployment, they can develop a feeling of helplessness. People who experience a chronic lack of control over their environments often respond to a negative life stressor with helplessness because they have learned that their behaviors have no effect on the outcome of a situation (Nolen-Hoeksema & Larson, 1999). Once referred to as learned helplessness, this reaction to negative life events is now termed "pessimistic explanatory style" (Lin & Peterson, 1990). A pessimistic explanatory style is linked to poor health, as individuals who interpret negative events using internal, stable, and global rationale, are less likely to problem-solve and seek treatment (Lin & Peterson). Instead, these individuals feel helpless to change their negative situations and are at an increased risk of developing problems such as depression, passivity, poor motivation, and low self-esteem (Nolen-Hoeksema & Larson). Nolen-Hoeksema and Larson explain that this type of explanatory style leads women to engage in rumination more than men when distressed, increasing the likelihood of developing depression. Similarly, once an individual becomes depressed, the expectation of negative outcomes and of hopelessness may worsen the existing depression (Piccinelli & Wilkinson, 2000).

Other comorbid conditions. Just as certain personality characteristics, demographics, and experiences correlate with rates of depression, several psychological conditions and

disorders often accompany depression as well. Common comorbid conditions of depression include anxiety, bipolar disorder, eating disorders, disruptive behaviors, delinquency, perceived physical ailments, lower functioning, lower self-esteem, interpersonal problems, and substance abuse (Wade et al., 2002). It is important to be aware of these often co-occurring conditions, because (especially in men) symptoms of *these* conditions may be present before symptoms of an underlying mood disorder (Rabinowitz & Cochran, 2008). The presence of these conditions can serve as a clue to clinicians to probe for possible depression in these patients as well. There are, however, many symptoms that clinicians must be aware of when diagnosing a patient with depression. Throughout this paper, I outline several lesser-known symptoms and co-occurring behaviors that are often a sign of depression in men.

Because women are diagnosed with depression approximately twice as often as men, studies on gender differences in depression have often focused on what makes depression in women different, special, and thus more common. In this paper I explain that men are the minority group in the population of depressed individuals. Because of this, I argue men are the group that should be examined, and researchers should attempt to learn what makes depression in *men* different. Too often, men are viewed as the norm and their problems are overlooked because they are seen as standard, normal, and healthy (Addis, 2008). This type of view implies that men are non-gendered individuals, just as in examinations for race differences, European Americans are often viewed as non-raced. This sort of normative comparison is very androcentric and does a disservice to women who are, by comparison, labeled as the minority or experimental group. This also hinders men who are overlooked and under-examined because they are viewed as the normative or control group (Addis, 2008). Similarly, this androcentric view encourages clinicians to overlook what makes men unique, and instead bolsters the

assumption that men are the norm and that variation from this standard shows "abnormality." This means that problems such as violence, restrictive emotionality, and risk-taking are considered relatively normal because they are standards of the male gender norm and are not usually examined and treated as problematic.

Research Topics

Social constructs play an integral role in shaping how men manifest depression symptoms and in how these symptoms are read by peers, family members, and psychological/medical professionals. In this paper I investigate three research topics: First, I identify different manifestations of depression that are more commonly seen in men. These expressions of depression are grouped into categories of somatization, addictive outlets, externalizing symptoms, suicide, and other manifestations. Second, I explore potential causes for men's manifestation of depression in ways that are considered to be deviant from traditional depression symptoms. The organization of this section mirrors that of the first, providing insight into the potential causes or manifestations of these behaviors. Furthermore, I outline different theories of male depression that also help to explain these manifestations. In the third section, I explore theories about why women are diagnosed with depression two to three times more often than men. Some argue that these differences are due to under-diagnosis, but others believe these differing rates are an accurate depiction of genuine gender differences in depression.

Manifestations of Depression in Men

In the United States there is a belief that women are more emotional than men (Simon & Nath, 2004). Kring and Gordon (1998) demonstrate that women are more expressive of most emotions compared to men. However, though women exhibit more sadness, disgust, fear,

surprise, happiness, and anger, they did not differ from men in their *experience* of these emotions. This means that men and women generally experience emotions at the same intensity, but women tend to externalize emotions whereas men internalize them. Externalizing emotions is characterized by high expression of emotion and comparatively low experience of emotion. Internalizing, in contrast, is associated with experience of high emotional arousal with low emotional expression (Kring & Gordon).

Kring and Gordon argue that these differences in expression of emotion are the result of display rules which dictate what behaviors are appropriate for one gender and shameful for another. In the United States, it is viewed as more acceptable for women to express emotions (besides anger), however men are expected to be stoic and restrict (internalize) their emotionality. Although men tend to internalize whereas women externalize the expression of emotion, the way in which men and women show their depression symptoms is often reversed. That is, men usually externalize symptoms of depression via behaviors such as aggression and substance abuse, whereas women are more likely to internalize their depression symptoms by ruminating and looking inward to examine the cause of their depression. Again, this is likely the result of gender role expectations for men and women.

There are differences in how often and with what intensity women and men express emotions, but there are also differences in how these emotions are expressed. For example, Simon and Nath (2004) argue that women usually express anger verbally whereas men more often express this emotion behaviorally. More frequent emotions are reported among individuals who are younger and have lower SES; however the effect of low SES on increased emotions is greater in men than women (Simon & Nath). Simon and Nath state that men report feelings of

calm and excitement more frequently than do women, and women report feeling anxious more often than do men. However, when the individual's SES is taken into account, results are no longer significant. That is, women are often of lower SES than men, which could increase their rates of negative emotions compared to men. This implies that negative emotions may be a factor of SES rather than gender. However, even when participants' SES was taken into account, women still tended to report more feelings of sadness than men did. In general, however, women's experience of more negative emotions can be explained by their lower household incomes (Simon & Nath). This is because, on average, women make less money than men, even though they usually work more hours than men, when household work is taken into account (Nolen-Hoeksema, 2001).

If men and women report experiencing negative emotions at a similar frequency, when SES is taken into account (Simon & Nath, 2004), why are women diagnosed with depression twice as often as men? There is no simple answer to that question; however there are several possible theories. It could be that men and women actually *experience* depression at similar rates, but men usually internalize and women externalize negative emotions, making it difficult for clinicians to identify these emotions in men. If men are internalizing and not showing negative emotions, but are externalizing symptoms of depression behaviorally, it leaves little relevant material for a clinical diagnosis of depression. Similarly, clinicians are not immune to cultural stereotypes and may expect to find depression in a woman, but are not looking for it in a man; this may lead to artificial differences in rates of depression in men and women. Thus it is important to research how depression symptoms are traditionally endorsed in men. Below, the manifestations of depression which men typically exhibit are separated into four major categories: somatization, addictive outlets, externalizing symptoms, and suicide. It is important

to note that these manifestations of depression are not always consistent with traditional diagnostic criteria of clinical depression, even though men often manifest depression symptoms in these ways.

Somatization

Although men and women with depression tend to report similar levels of functional impairment, men often report fewer and/or less severe depressive symptoms (Khan, Gardner, Prescott, & Kendler, 2002). Depression in men may look slightly different than the stereotype of a moping, crying, sad individual. Instead, men with depression may be characterized by an inability to cry, general withdrawal from social activities, anhedonia, suicidal wishes, work inhibition, somatic preoccupation, and indecisiveness (Vredenburg, Krames, & Flett, 1986). Instead of endorsing feelings of sadness and hopelessness, men with depression are more likely to report an inability to perform adequately at work, marked difficulty in making decisions, general lack of enjoyment and satisfaction, increased concern or preoccupation with general physical health, and thoughts of suicide (Vredenburg et al.). Few of these symptoms are characteristic of classical depression and may be overlooked by clinicians, family members, and friends.

The symptoms men tend to endorse often include somatic preoccupation, perhaps because physical ailments rather than mental distress are traditionally considered more appropriate for men. Women with depression often cry, showing obvious pain, whereas men with depression are thought to have troubles that need to be examined to get to the underlying depression (Real, 1997). Cochran and Rabinowitz (2000) explain that somatizing one's internal pain allows men to project these feelings outward instead of internalizing these negative feelings

and blaming oneself. Similarly, by externalizing these troubles, men are able to avoid shame and ridicule from peers while appearing in control and emotionally stoic.

Depression in men is often characterized by seemingly innocuous symptoms such as over-involvement in work, an increased demand for authority or power, or a shift in their level of interest in sexual encounters (Pollack, 1998). However, symptoms such as increased anger, greater use of psychoactive substances (self-numbing), self-criticism, withdrawal from relationships, impulsive plans to have loved ones planned for in case of his death, depleted or impulsive mood, and/or disorders of concentration, sleep, or weight may be more obviously harmful (Pollack). Often symptoms of depression in men include feelings of failure, loss of social contact, an inability to cry, and increased somatic complaints such as headaches, insomnia, and agitation (Hammen & Padesky, 1977; Khan et al., 2002). S.W. Tolle (personal communication, March 28, 2010) notes that, in addition to these somatic symptoms, gastro-intestinal distress can also be a common manifestation of underlying depression and anhedonia in men. Similarly, men are much less likely to cry than women (Lombardo, Crester, & Roesch, 2001), which is one of the most obvious symptoms of depression listed in the DSM-IV (Khan et al., 2002).

Women report more help-seeking behaviors when depressed, whereas men with depression are less likely to seek social support, which may keep their depression undetected. Instead of seeking social support, men tend to cope with depression by ignoring their mood change, taking drugs, or drinking alcohol (Vredenburg et al., 1986). Because men do not cry as often as women when depressed, often deny pain or sadness (Pollack, 1998), and only seek

treatment as a last resort (Rochlen et al., 2009), it may be less obvious to clinicians that these men are experiencing depression.

Addictive Outlets

Just as men tend to express more somatic symptoms of depression than women do, they are also more likely to express depression through the use of addictive substances or behaviors (Cochran & Rabinowitz, 2000). These addictive outlets can be a manifestation of depression as well as a coping mechanism for the emotional pain that accompanies this mood disorder. Hallfors, Waller, Bauer, Ford, and Halpern (2005) note that teenage sex and drug behaviors may be predictive of future depression. Specifically, binge drinking and excessive marijuana use appear to contribute to a fourfold risk of developing depression in teenage boys. Even though coping mechanisms are not the same for every man, there are some general trends in how men often cope with feelings of depression.

Real (1997) notes that almost any coping habit can become an addictive outlet, rather than a healthy way to relieve stress. Examples of such addictive outlets include applause from an audience, stock market winnings, gambling, spending, sexual conquest, love addiction, substances abuse, violence, and work or success (Real). Many of these activities or behaviors can be adaptive for the average person; however they can become an addiction when used as a coping method for dealing with or hiding from depression. Real argues that, as the (masked) depression worsens, the need for the addictive outlet increases, while it simultaneously becomes less and less effective. Rochlen et al. (2009) explain that when addictive outlets (e.g., drinking, drug use, or over-involvement in work) are removed, the depression which these behaviors were concealing becomes especially acute and difficult to deal with. With the addiction to sexual

conquest, for example, a man's feelings of depression may initially abate when he has sex. However, as the disorder progresses, he feels the need to have sex more often, but gets less and less relief from his depression. It is easy to see how this cycle can quickly lead to an addictive pattern, where the need for the addictive outlet increases as it progressively becomes less effective.

Rabinowitz and Cochran (2008) argue that many men have masked depression and that addiction, in its various forms, can be an indicator of this hidden mood disorder. It is important to be inquisitive about addictive behaviors to determine what is driving these compulsions. Real (1997) asserts that addiction can often conceal underlying depression, and depression may be masking hidden trauma. The only way to access this trauma is to uncover the depression; however, the only way to uncover this depression is to work through the presenting addiction (Real). He further emphasizes the importance of examining men's hidden depression by pointing out the severity of this pain. Pain which is internal and able to be spoken about is seen as less disturbed than pain that is externalized and acted out unconsciously. Similarly, Cochran and Rabinowitz (2000) note that hidden depression may lead to several of the problems clinicians think of as typically male, such as physical illness, substance dependence, aggression, anger, and violence.

Externalizing Symptoms

Although depression is considered to be an internalizing disorder, symptoms of this disorder can often be externalized. Though men are more likely to internalize emotions (not expressing an emotion they are feeling), they are more likely than women to externalize symptoms of depression. For example, instead of internalizing feelings of sadness, as many

individuals with depression do, men may externalize these feeling through aggressive behaviors or substance abuse (Rabinowitz & Cochran, 2008). When individuals externalize symptoms of depression, they may also be using addictive outlets as a way to externalize their pain. Thus there is some overlap between externalizing symptoms and addictive outlets. The category in which a particular behavior belongs also depends on the researcher's perspective. Some (e.g., Rochlen et al., 2009; Cochran & Rabinowitz, 2000) are more inclined to identify many of these externalizing symptoms as addictive outlets, however others (e.g., Pollack, 2006) are more apt to refer to them as typical, although problematic, behaviors of the male gender role. Because some addictive outlets such as aggression and sexual conquest are consistent with traditional male gender norms, it may be difficult to identify them as signs of underlying depression. Women tend to internalize their feelings of depression through depressed moods and feelings of worthlessness or hopelessness (Ginicola, 2007); though Pollack (1998) argues there are four types of *male-based* depression, only one of which can be coded by an observer as a symptom of depression as it is currently defined.

The first form of male-based depression, discontent with the self, is an internalizing method of experiencing depression, and fits the current model of depression (DSM-IV-TR, 2000). The second form of depression is interpersonal antagonism, which involves blaming others for one's negative feelings. By blaming others for their internal pain, men externalize their pain, shifting the blame away from themselves. The third form is unrestraint, which is characterized by impetuous and rash behavior. Last, unconventionality and rebelliousness are seen as evidence of male-based depression which, along with interpersonal antagonism and unrestraint, are exemplified through men's anger, rage, and risky behaviors (Pollack, 1998). Rabinowitz and Cochran (2008) also support the assertion that male depression can be

manifested and masked via externalizing behaviors such as anger management issues, irritation or agitation, substance abuse, withdrawal from interpersonal relationships, and obsession or preoccupation with work or hobbies.

Suicide

In accordance with this pattern of externalizing depression in men and internalizing in women, men are more than four times more likely than women to complete suicide, but women are approximately two times more likely to contemplate suicide (Oquendo et al., 2001). Suicide rates also differ according to age, SES, and marital status, but appear to differ most along gender lines, as male completed suicide exceeds female suicide in all countries besides China (Piccinelli & Wilkinson, 2000). Although suicide and suicidal ideation are important concerns, it appears that fewer than 1 in 200 people who have suicidal thoughts actually complete suicide (Piccinelli & Wilkinson). However some claim that suicide is substantially underestimated (e.g., death by cop and planned car crashes) (Moschichi, 1997). The population at the highest risk of completing suicide is men with depression who are more than 65 years old. Among men over age 65, reported rates of completed suicide compared to women are 10:1 (Pollack, 1998). Because men (especially those over age 65) are at an increased risk of completing suicide, it is important to identify and investigate the causes of these striking statistics about men's high suicide rates. Since depression is strongly correlated with suicide, high rates of suicide in men may be a sign of underlying and undiagnosed depression.

Other Manifestations

There are many different manifestations of depression, however, there are also many theories about why men often manifest their feelings in ways that are not entirely consistent with

traditional diagnostic criteria for depression. Four theories of male depression, which will be covered later in this paper, include the theories of sex differences, masculine depression, masked depression, and gendered responding (Addis, 2008). Pollack (1998) hypothesizes that, just as men may manifest symptoms of depression differently than women, the causes of their depression may also be different. For example, Pollack explains that the socialization of men to become independent at a young age is viewed as abandonment, which is associated with vulnerability to depression. Pollack claims that boys and men attempt to keep their independence from their mothers by rejecting feminine identification as they strive to maintain their masculine self. Many men fear that expressing feelings of depression will make them appear less manly. A study by Hammen & Peters (1978) demonstrates that these fears may be substantiated because of the way society conceptualizes depression as a sign of personal weakness, rather than a legitimate disorder. In this study, depressed men are rated more harshly than depressed women, which implies that men are shaped by societal expectations which dictate that they should be strong, both physically and emotionally. Unfortunately, many of these frameworks stem from information presented in the media, which frequently portrays men as unemotional and invincible.

Reasons for Alternative Manifestations of Depression in Men

The expectations of the masculine gender role can be difficult for men to live up to and violations of these norms can cause men a great deal of ridicule (Pollack 2006). Thus, men with depression who wish to avoid harassment and social rejection are motivated to manipulate the expression of their depression symptoms to better fit the traditional male gender role. Below, I

outline different conjectures about *why* men manifest depression via somatic complaints, addictive behaviors, externalizing symptoms, suicide, and other means.

Somatization

Many men experiencing depression endorse somatic symptoms rather than more traditionally diagnosed symptoms of depression, such as sadness. There is a social stigma related to depression in men and many aspects of depressive behavior are directly opposed to stereotypically appropriate masculine behavior (Vredenburg et. al, 1986). Men are likely to be punished or rejected for expressing feelings of depression and men with depression are attributed with significantly more feminine traits than non-depressed men. Vredenburg et al. argue that men encounter negative reactions when they express the more emotional aspects of their depressive symptomatology. It is seen as more socially acceptable for men to have physical rather than emotional problems, which are often interpreted as feminine. Thus, many men with depression focus on their somatic symptoms and withdraw from social contact, rather than expressing their emotions and risk being labeled as feminine. Many men with depression explain that discussions with friends, family, and even physicians or therapists can be uncomfortable because this sort of interaction is not common for men (Rochlen et al., 2009). Therefore, men who wish to get treated, but want to avoid social rejection, generally present with depressive symptoms that are clinically significant and also consistent with the male gender role. This may explain why there is a higher prevalence of men presenting with specific types of depressive symptoms such as day-to-day stress and problems at work (Vredenburg et al.).

As adults age, the gender differences in symptomatology increase. This suggests that women and especially men tend to express a gender-specific pattern of symptoms as they are

exposed to punishment from peers for "inappropriate" symptom patterns (Vredenburg et al., 1986). The presentation of specific, somatic symptoms is considered more appropriate for men and is associated with less peer victimization and ridicule (Vredenburg et al.). Additionally, because men are not usually very good at introspection (because it is not a skill they are often taught), many men with depression first notice symptoms of depression through somatic concerns rather than negative emotional experiences (S.W. Tolle, personal communication, March 28, 2010; Real, 1997). Because of this, it is especially important for clinicians to be cognizant of the male tendency to present with somatic concerns when they are experiencing depression.

Addictive Outlets

Men are more likely to express their feelings of depression via addictive outlets such as substance abuse than are women (Cochran & Rabinowitz, 2000). These outlets can be distracting coping methods, but they can also be signs of underlying depression that may not have any other observable symptoms. There are several theories about why men are more likely to cope with depressive symptoms through addictive outlets. Lyubomirsky and Nolen-Hoeksema (1995) argue that men often try to distract themselves from their negative and dysphoric moods. Examples of distracting coping styles include exercise, playing basketball with friends, or drinking. Men often hide behind a façade of normal male behavior (especially work). This masks depression, giving the impression that these men are in control, even if they are in a great deal of pain (Rochlen et al., 2009). Real (1997) proposes that any outlet can become an addictive coping style for depression, though using drugs such as alcohol can quickly lead to dependence. Real explains that non-depressed men use mood-altering behaviors such as sex, gambling, and drinking to

relax, be intimate, or have fun. Covertly depressed men, on the other hand, use these behaviors to gain relief from distress and can become addicted to them as a form of self-medication. This idea of depression being hidden beneath addiction will be explored more fully later in this paper in the discussion of covert depression.

There appears to be a bidirectional relationship between depression and alcohol use: Alcohol both provides temporary relief from and increases depression. Similarly, compared to non-depressed individuals, substance users who are depressed have been shown to experience effects of substances more strongly and have higher expectations that the substance will make them feel better (Real, 1997). This increase in biological dependence coupled with the expectation that the substance will alleviate depression symptoms, is a formula for addiction and could partially explain why men with depression often have comorbid addiction. Jackson, Manning, and Wells (1995) explain that another negative consequence of alcohol for depressed individuals is that patients who abuse alcohol are less likely to utilize mental health services, which could hinder their recovery. Additionally, Real suggests that the addictive outlet a depressed man uses can become less and less effective over time. Diminishing effectiveness, as well as an increasing perceived need for an addictive defense, leads to a continuing cycle of addictive behavior.

Levant, Richmond, Majors, Inclan, Rossello, Heesacker, and Rowan (2003) argue that, although there are biological differences between men and women, constructs of masculinity and femininity are social rather than biological constructs. Consequently, society has shaped the perception that drinking is a masculine, rather than feminine, behavior. Thus, gender roles could contribute to the association of depression and alcohol use in men.

Addiction, however, does not always come in the form of a substance, as many men with depression can become addicted to activities such as sex, gambling, and work. When a man is addicted to work, he may struggle to continue achieving success as his depression worsens, because it becomes more difficult to do well while his attitude progressively deteriorates. Addiction to work can be a difficult outlet to spot because success and extreme devotion to work are culturally accepted behaviors for men that may be overlooked as potential signs of underlying depression. Similarly, love addictions (especially to a spouse) can be misunderstood as devotion to one's partner rather than a means of compensating for feelings of depression (Real, 1997).

Addictive outlets such as these can be masking a deeper problem of male depression (Rabinowitz & Cochran, 2008). For example, some men with depression say they try to deny their depression by distracting themselves. Some of these man said they were aware of masking their depression, whereas others said they had been unaware (Rochlen et al., 2009). Mechanisms used to either distract oneself or cope with depression may develop into an addictive escape rather than a simple coping or distracting behavior. Real (1997) believes that one must first address the addiction, which often masks co-occurring depression. Clinicians should be watchful for signs of addiction, especially in their male patients, as these may be indicative of underlying depression.

Externalizing Symptoms

There is often shame associated with male depression (Hammen & Peters, 1978) and men often feel that the expression of depressive symptoms, as well as help-seeking behaviors, are incongruent with masculine norms (Rochlen et al., 2009). This could account for the greater

tendency of men to externalize symptoms of depression. Simon and Nath (2004) explain that although women are more likely to talk about their feelings and pray, men are more likely to use mood-altering substances, an externalizing coping mechanism for dealing with depression. There are differences in the ways men and women deal with emotional distress: women are more likely to seek social support, whereas it appears many men have learned to conceal their feelings instead of expressing their emotions (Simon & Nath). Levant et al. (2003) present a similar point of view, arguing that traditional gender-role socialization leads men to adopt dominant and aggressive behaviors, but requires women to adopt nurturing and gentle behaviors. Levant et al. point out that in cultures where gender roles are less sharply defined men are no more aggressive than women, and women do not seem softer or more maternal than men. Thus these differences in emotional expression appear to be social rather than inherent biological constructions. This could explain why women tend to express negative emotions verbally, whereas men tend to express these emotions behaviorally (Simon & Nath).

Male behaviors like drinking, dominance, and emotional unavailability are behaviors which men have been taught; however they are maladaptive for men seeking help, as they push away the people who want to help them the most (e.g., their wife, family, and friends) (Real, 1997). Levant et al. (2003) highlight the fact that not all men are equally likely to endorse traditional masculinity, which emphasizes emotional restrictiveness and contributes to differences in how men and women deal with feelings of depression. Other factors which are significantly associated with the endorsement of traditional masculinity include being younger, being single, having low expectations of educational attainment, greater church participation, being sexually active, being African American, and not living in the North, Midwest, or West (versus the South) (Levant et al.). Additionally, this study demonstrates that the effect size of

gender is larger than the effect size of culture. This either means there are similarities in how different cultures shape men and women or there is a biological component that contributes to these gender differences.

It appears that there is a relationship between endorsement of traditional masculinity and alexithymia, which is a mild, subclinical form of depression (Levant et al., 2003). Thus, traditional male socialization may be associated with normative male alexithymia. Pollack (1998) argues that male gender-linked trauma is becoming normative, as there is a push for men to be emotionally independent from a young age. That is, many men do not identify with their emotions and instead displace them, pushing these feelings outward and externalizing them, which is viewed as normal for men to do. According to male gender norms, men are expected to look good and in control, hide emotional pain, and hide any signs of weakness (Rochlen et al., 2009). Viewing these potentially harmful behaviors as a normal part of the traditional masculine gender role can be harmful to men. Socialization to the male gender role has damaging effects in the emotional socialization process, which encourages boys to suppress and channel their self-awareness, empathy, and expressivity (Levant et al.). In addition, teaching boys and men to ignore, suppress, and project their emotions hinders their ability to introspect and identify or work through negative emotions. This is not to say these characteristics of the male gender role contribute to inflated rates of depression in men. Rather, if men and women experience similar rates of depression, these standards of male socialization may make it difficult for men to respond to negative emotions. This means that men who develop feelings of depression may not be equipped to identify and deal with these negative emotions.

Violating male gender norms may lead to psychological distress because men who deviate from these norms may feel they have failed to live up to internalized notions of what it means to be a man (Pleck, 1995). Not adhering to male gender norms leads to uncomfortable feelings of distress. Also, men are rewarded for following traditional male roles such as emotional restrictiveness; they are punished by peers as well as their own negative physiological reactions, for expressing emotions that are incongruent with traditional masculinity.

The issue of strong adherence to traditional male gender roles appears to be more of a concern among men than women across cultures. Levant et al. (2003) show that men score more traditionally on gender-role adherence than women. In this study men generally score traditionally masculine on gender-role behaviors, whereas women have a wider range of scores which include both feminine and masculine gender-role behaviors. This shows that women have more flexibility in which behaviors they can present, while still behaving in accordance with culturally accepted norms for women. Men, on the other hand, have a truncated range of behaviors that are acceptable and consistent with agreed-upon standards of male behavior.

One hallmark of the male gender role is emotional stoicism; this is evident in the pattern of poor emotional disclosure in men. However, Hammen and Peters (1978) explain that men have reason to hide their emotions because of how they are teased and ostracized when they do disclose to peers. Although women who report depression to peers are often met with nurturance and support, men who say they are depressed are isolated and met with hostility by others, especially women (Hammen & Peters). Men who endorse traditional symptoms of depression are rated as more feminine and are not typically accepted by their male peers (Hammen and Peters). Thus, men are often forced by the constraints of acceptable masculine behavior to present their

feelings of depression in distorted, externalizing fashions. Pushing their negative feelings outward and placing the blame of their pain on external factors allows men to maintain their network of social support as they experience feelings of depression. These externalizing tactics can, however, mask depression these men are experiencing and make it difficult for them to receive treatment.

Suicide

Because there are many barriers for depressed men to receive treatment, some may feel desperate to find release from their untreated pain. For many depressed men, this can result in suicidal thoughts and completion. Suicide is a serious concern, especially among those with depression, as the two are highly correlated. In the United States, suicide is the 9th leading cause of death in the general population and the 3rd leading cause of death among those ages 15 – 24 (Moschichi, 1997). Oquendo et al. (2001) point out that, even though women are twice as likely as men to attempt suicide, men are about four times more likely to complete suicide than women. Reasons completed suicide is so high in men might be because men tend to choose more lethal methods, may be less resilient in the face of major stressors, have more psychopathologies, have a higher propensity to violence, have greater substance abuse, are reluctant to seek help, and are less able to articulate emotional distress (Hunt, Sweeting, Keoghan, & Platt, 2006). These factors also make it difficult for men to identify and deal with their own symptoms of depression.

Men with depression may feel they have few options for dealing with their emotional pain because of male gender role restrictions. If they are unable to manifest their depression symptoms in an "appropriate" way, men may feel that suicide is their final face-saving defense against the shame of failing to live up to perfectionistic masculine ideals (Pollack, 1998).

Similarly, attempted suicide is viewed by peers as less acceptable for men than completed suicide (Hunt et al., 2006). However, this finding is not consistent in women, where completed suicide is perceived as less acceptable than attempted suicide. All suicidal persons were perceived as relatively feminine, but nonfatal suicidal behavior is viewed as particularly feminine; killing oneself is not as permissible for women just as surviving a suicide attempt is not as permissible for men (Hunt et al.). This means that men who attempt suicide are more motivated to complete the act as they will often be shunned and labeled feminine if they survive a suicide attempt. This could explain why, of all firearm suicides, nearly 80% are by men (Moschichi, 1997). Use of a firearm is the most common method to complete suicide for men and women, and accounts for about 60% of all suicide deaths in the U.S. The second most common method for completing suicide is different for men and women. Women are more likely to use drugs and prescription medications, whereas men are more likely to hang themselves (Moschichi).

Although men in every ethnic group are at a higher risk of completing suicide than women, it is interesting to note that aspects of masculinity are protective against suicide completion and that higher masculinity scores are negatively correlated with rates of suicide completion (Hobbs & McLaren, 2009). Agency, which reflects characteristics of independence, competitiveness, self-assertion, and self-control, seems to be particularly protective. Higher levels of agency are associated with lower levels of suicidality in both men and women (Hobbs & McLaren). Both agency and masculinity have been shown to be protective factors in the mental health of adults, especially men, so it makes sense that these characteristics could also be protective against suicidal thoughts and actions.

Agency may be of particular importance to older men who are at a significantly higher risk for completing suicide than any other demographic group. In a sample of Australians, older men ages 65-74 and 75 and over complete suicide at a rate of 20.2 and 24.8 per 100,000 respectively. The general population of men complete suicide at a rate of 16.8 per 100,000 (Hobbs & McLaren, 2009). Women in this study have much lower rates of suicide compared to men: older women ages 65-74 and 75 and over complete suicide at a rate of 4.1 and 5.3 per 100,000 respectively. This is similar to the average rate of suicide among this population of women in general (4.3 per 100,000). Thus, not only do men demonstrate much higher rates of suicide, this trend increases dramatically with age (Hobbs & McLaren).

Just as depression is highly correlated with suicidality, it also appears to interact with levels of agency. Hobbs and McLaren (2009) explain that the rate of increase in suicidal ideation with increased levels of depression is greater for older men with low levels of agency compared to older men who have high levels of agency. This shows that agency may be related to suicide via depression and that both suicide and depression are affected by rates of agency. Hunt et al. (2006) argue that, even though high masculinity scores are associated with fewer suicidal thoughts, people with more traditional gender scores are more likely to have suicidal thoughts. The association between traditional gender attitudes and suicidal thoughts is particularly apparent at older ages. It is interesting to note that masculinity and agency are negatively correlated with suicide rates, yet men are four to five times more likely to commit suicide than women (Oquendo et al., 2001; Pollack, 1998). This suggests that aspects of masculinity are protective against both depression and suicide; however other aspects of adherence to traditional male gender norms are associated with higher rates of depression and suicide.

Besides gender and low levels of agency, other variables which are linked to suicide include unemployment, marital isolation, low socioeconomic status, and substance abuse (Pollack, 1998). Most of these factors are also implicated in the prevalence of depression. Substance abuse may have a causal relationship with suicide, but it can also be associated with undiagnosed depression in men. Pollack shows that 60% of those who die from suicide have mood disorders at the time; thus rates of depression are related to death by suicide. However, it is possible that this co-occurrence of depression and suicide is even higher, as many depressed individuals (especially men) are undiagnosed.

Rates of suicide also vary not only by gender, but by ethnic group as well. Pollack (1998) identifies different ratios of depression and suicide between ethnic groups. For example, a study conducted by the NHANES shows that European American men and women, as well as African American men, have the highest suicide rates relative to rates of depression, whereas Puerto Rican and Mexican Americans have lower rates of suicide relative to their rates of depression. Similarly, reported suicide rates are lower in Cuba, Puerto Rico, and Mexico than in the Unites States. The NHANES also shows that rates of depression among ethnic minorities in the U.S. are lower than rates of depression in European Americans (Beidel et al., 2010). Though it is difficult to pinpoint what causes these differences, Pollack argues that protective factors against suicidality may vary across ethnic groups and cultures. For example, ideas of familialism and fatalism may be more common among Hispanic Americans than other ethnic groups. Familialism, an emphasis on close relationships, may also protect against stress, which can be associated with both depression and suicide. Fatalism, the expectation of adversity, may be an adaptive stance in the setting of chronic strain (Pollack). This could explain, in part, why rates of

suicide in Hispanic Americans are about half that of European Americans, as Hispanics tend to endorse these protective attitudes of familialism and fatalism.

Other Manifestations

Although cultural and individual differences provide some insight, it is difficult to explain why rates of suicide are so high in men relative to their rates of diagnosed depression; however, it is equally challenging to identify the source, manifestation, and true prevalence of male depression. Addis (2008) outlines four well-established theories of male depression that may provide insight into the potentially under-diagnosed issue of male depression.

Sex differences theory. Addis (2008) summarizes Pollack's sex differences theory (1998), which essentially says that depression exists as the same disorder in both men and women, although the phenotypic displays may differ slightly. Men are more likely to endorse specific symptoms of the disorder such as anger and somatic symptoms, whereas women express more feelings of sadness. This theory postulates that depression is underestimated in men because they often express depression in ways that are not consistent with symptoms listed in the DSM-IV-TR (2000). Instead men who have depression often present with issues of substance abuse or somatic concerns, which are not official symptoms of depression. According to the sex differences theory, male depression is characterized by lack of satisfaction, suicidal ideation, work inhibition, somatic problems, indecisiveness (Khan et al., 2002), insomnia, and agitation; whereas women often experience hypersomnia and psychomotor retardation (Addis).

Proponents of the sex differences theory argue that there are differences in how men and women express symptoms of the same illness. However, there are also differences in the ways men and women cope with or respond to their feelings of depression. These coping styles can

also influence the severity and course of the illness. When men are depressed they tend to distract themselves from their negative feelings by thinking about something different or doing an activity to get their mind off of their negative mood. Women, on the other hand, tend to ruminate on their feelings of depression, which has been shown to worsen depression symptoms and increase the duration of depressive episodes (Lyubomirsky et al., 1998; Lyubomirsky & Nolen-Hoeksema, 1995; Nolen-Hoeksema, 2001). However, these are general findings about gender differences and there are individual differences and variations which should be taken into account as well.

Addis (2008) highlights many important aspects of the sex differences theory, though he also points out that there are problems with examining only sex differences. For example, social constructs are ignored when one examines only biological sex differences. This is an issue because gender interacts with other variables such as social interactions and environments. This issue is addressed via the masculine depression theory, which emphasizes the importance and impact of gender norms on the expression of depression.

Masculine depression theory. According to the masculine depression theory, masculine gender norms influence how men often experience, express, and/or respond to depression. In accordance with masculine gender norms, men exhibit more externalizing symptoms of depression than women and often act out their emotions rather than introspecting. Though men's tendency to distract themselves when depressed may be an adaptive coping mechanism for dealing with depression (Lyubomirsky & Nolen-Hoeksema, 1995; Lyubomirsky et al., 1998), the masculine depression theory argues that male gender norms can lead to emotional restrictiveness, which is associated with increased stress and negative emotion. Thus, it appears that there are

both positive and negative aspects of adherence to male gender norms in terms of depression symptomatology.

A man's interpretation of his adherence to the masculine gender role can influence his self-concept and his likelihood of developing depression. The masculine depression theory highlights a correlation between masculine gender-role conflict and depression, emphasizing that gender-role strain can increase stress and negative feelings associated with depression. This theory supports the notion that adherence to traditional male gender norms leads to an increased likelihood of experiencing symptoms of depression. Similarly, men who endorse traditional gender roles are less likely to seek help. The tendency of men to avoid depression treatment or even diagnosis is central to the theory of masked depression, which argues that depression in men may be hidden from both clinicians and the affected individuals.

Masked depression. Cochran & Rabinowitz (2000) explain that men often have masked or covert depression. These men may be expressing their depression through outlets such as alcohol abuse, delinquency, reckless and aggressive behaviors, and somatic complaints, because these manifestations of depression are more consistent with the male gender role. Addis (2008) notes that hidden depression can also lead to physical illness, domestic violence, failures in intimacy, and self-sabotage in careers. Many of these manifestations of masked depression result from restrictions of Western masculine norms. Through cultural conditioning, men learn to suppress emotional pain such as sadness and guilt and often mask these feelings though other behaviors (Cochran & Rabinowitz), such as aggression. These norms emphasize anti-femininity, competitiveness, homophobia, stoicism, self-reliance, physical toughness, financial success, and power over women. These standards may shape how men respond to depression (Addis).

Similarly, some men mask their depression through externalizing manifestations in an attempt to distract themselves from their symptoms (Rochlen et al., 2009).

Strict adherence to restrictive gender norms can exacerbate covert depression, making symptoms of depression (which are usually viewed as feminine) less obvious. Cochran and Rabinowitz (2000) explain that masked depression is a form of "face-saving" for men who wish to act in accordance with male gender norms that emphasize emotionally stoicism and strength. Covertly depressed men often hide behind addictive outlets such as substance abuse or overindulgence in work. However, Real (1997) argues that at its core, covert depression is a disorder of self-esteem, where poor self-esteem is manifested in covert depression. Similarly, Pollack (2006) notes that self-esteem and depression are related and negatively correlated.

The main problem with the theory of covert depression is that all existing measures of diagnosing depression require the presence of symptoms that cannot be seen in masked depression (Addis, 2008). Because covertly depressed men have hidden symptoms, it is challenging to assess and treat these men. It is also difficult to support the theory of covert depression, because researchers struggle to prove that hidden depression exists at all. Although it is challenging to identify covert depression, Real argues that the only cure for covert depression is overt depression. Thus, men with covert depression must be able to identify their emotional pain before they can begin to heal it.

Gendered responding. Proponents of the gender responding theory argue that the process of experiencing, expressing, and responding to emotion is highly gendered. Female gender norms encourage emotional recognition and disclosure, whereas male gender norm make it difficult for men to recognize and disclose negative feelings and symptoms of depression

(Addis, 2008). According to this theory, men who endorse traditional male gender norms are more likely to develop depression and are less likely to seek help. These men are also at higher risk of developing externalizing problems.

Just as men manifest depression symptoms in specific ways that are different from women, masculinity also plays a role in how men respond to depression and associated symptoms, such as grief and sadness. For example, men are less likely than women to brood and ruminate about their feelings of dysphoria. Instead, they are more likely to use strategies that involve avoidance of negative affect, which can lead to externalizing problems such as substance abuse and aggression (Addis, 2008). Although individuals who ruminate in response to depression have longer, more severe episodes than those who distract (Nolen-Hoeksema, 2001), there is a fine line between efficacious distracting and avoidance of depression that can result in addictive and/or suicidal behavior.

Theories of (Under) Diagnosis

There are many theories about why women are diagnosed with depression much more frequently than men, however there is no general consensus about whether these incongruent frequencies are the result of actual differences in the rates of depression, or if there is an issue of under-diagnosis of depression in men. Individuals who argue there is an artificial schism in rates of depression often feel that socialization encourages men to manifest depression symptoms in ways that are not recognized and diagnosed by clinicians. Others believe these different rates may be authentic, because of the ways men and women usually respond to negative feelings and because of environmental factors that may affect men and women differently.

Artificial Differences in Rates of Depression by Gender

Some researchers argue that, although there are differences in the rates at which men and women are *diagnosed* with depression, there are no differences in the rates of *experienced* depression. Lyubomirsky and Nolen-Hoeksema (1995) point out that, when rumination is controlled for, there are no gender differences in depression. Additionally, Pollack (1998) notes that there are no gender differences in prevalence when chronic or recurrent depression is measured. This shows that, even though women are initially diagnosed with depression more often, men experience equally frequent rates of recurrent or chronic depression as women. This could be because severe depression is often recurrent; however women are more often diagnosed with mild depression. Another argument in support of the idea that there is an artificial difference in depression rates between genders is that, before puberty, boys and girls are diagnosed with depression at similar rates. In actuality, boys are diagnosed with depression more often than girls before the age of about 14 years (Piccinelli & Wilkinson, 2000). This leads credence to the argument that social versus biological factors contribute to the inflated rates of depression in women, compared to men.

People who feel there is an artificial division in rates of depression often believe that men are under-diagnosed with depression. Men with depression can be overlooked because they often endorse symptoms that are not traditionally associated with depression (e.g., somatic complaints, substance abuse, and other externalizing problems). Additionally, the way in which men are socialized to be stoic and emotionally restrictive may contribute to their inability to identify the source of their negative emotions. This means that many men are unaware of their depression and do not seek help for their unidentified pain (Cochran and Rabinowitz, 2000). Real (1997)

argues that men are poor at emotional disclosure and have trouble identifying and explaining their negative emotion, making it difficult for them to identify their experience of depression.

Boys and girls are shaped to endorse behaviors which are congruent with appropriate display rules and are taught which activities and beliefs are appropriate for male versus female gender roles. These rules dictate that depression is feminizing, which means it is inconsistent with the male gender roles (Vredenburg et al., 1986). Consequently, boys and men are taught not to disclose symptoms of depression because they are likely to be punished or rejected for expressing these "feminine" feelings of depression (Hammen & Peters, 1978). Allen-Burge, Storandt, Kinscherf, and Rubin (1994) argue that men may be unwilling to admit feelings of depression because of long-term gender- socialization that does not permit this sort of emotional disclosure. Therefore, men who experience and identify feelings of depression may be reluctant to disclose these emotions because they fear the negative reactions of their peers. Vredenburg et al. (1986) explain that there is a social stigma about depressed men and people usually rate depressed men more negatively than they rate depressed women. This is most likely because many aspects of depressive behavior, such as crying, are in direct opposition to behaviors that are considered to be masculine (Vredenburg et al.).

Although there are social obstacles preventing men with depression from being diagnosed with this disorder, there are also barriers with the criteria they must fit to be diagnosed. Piccinelli and Wilkinson (2000) argue that the definition of depression may be based on female symptoms because women report more depression symptoms than men. That is, if men and women experience different *types* of depression the male type may not be as identifiable as the female type. Extreme aggression, substance abuse, and addiction to work are

symptoms that often accompany male depression. But these symptoms are not classically considered to be signs of depression since they are not often seen in depressed *women.* Simon and Nath (2004) point out that women often express emotions verbally, whereas men usually express emotions behaviorally. Thus, externalizing problems may be a sign of depression in men, but because women rarely display these symptoms when depressed, they are not classified by the DSM-IV-TR (2000) as signs of depression.

Clinicians are not exempt from the effects of gender socialization and may be less apt to identify and treat depression in a man than in a woman, which may contribute to a rift in the rate of depression diagnosed in men versus women. Cochran and Rabinowitz (2000) explain that symptoms of depression in men may be difficult to diagnose as signs or manifestations of depression. Thus, covertly depressed men often remain undiagnosed. Real (1997) also supports the argument about under-diagnoses of depression in men, explaining that if *overt* depression is overlooked in men, then *covert* depression does not stand a chance of being diagnosed by the average professional.

Authentic Differences in Rates of Depression by Gender

Although theories about masked depression and gender-role socialization support the argument that men with depression are often under-diagnosed, this argument is not unequivocally supported. In fact, many researchers believe that the difference between male and female rates of depression is authentic. Supporters of an authentic difference often argue that negative life events that happen to women more than men may be partially responsible for these differences in the frequency of depression in women and men. Coping styles such as rumination may influence increased rates of depression in women compared to men.

Gender-specific stressors. Differences in rates of diagnosed depression may exist because women experience certain negative life events, which are shown to contribute to depression, more than men. Nolen-Hoeksema (2001) argues that as much as 35% of gender differences in adult depression could be accounted for by the higher incidence of assault experienced by women. Similarly, women are more likely to experience higher rates of chronic strain than men because of work and family stressors. The types of jobs many women occupy often involve more emotion work and repetitive tasks, which is associated with increased stress. In addition, women are usually predominantly responsible for housework and childcare that involve similar stressors as typically female-dominated jobs (Taylor et al., 2009). Nolen-Hoeksema claims that women respond more poorly to stressors and have greater reactivity to stress than men; this could be because of differences in biological responses, self-concept, and coping styles.

Khan et al. (2002) identify possible explanations for differences in depression such as social roles, cultural norms, and adverse life events. The influence of social roles and cultural norms, which shape women to be more passive and submissive (Nolen-Hoeksema, 1995), may be partially responsible for increased rates of depression in women. In cultures where gender roles are less sharply defined, men are no more aggressive than women, and women do not seem softer or more maternal than men, showing that these behaviors are the result of social constructs rather than inherent biological differences between men and women (Levant et al., 2003). Following this argument, if men were socialized to be passive, emotional, and submissive they would be at an increased risk for developing depression as well. Rosenfield (1980) elucidates this concept, explaining that in non-traditional relationship with reversed gender roles, men experience more depression than women. This suggests that feminine gender roles are associated

with increased rates of depression (although issues such as lower SES often associated with this role may confound the results). Similarly, the construction of gender roles may be at least partially responsible for women's increased risk of sexual abuse and other negative life events that are associated with increased risk for developing depression.

Lyubomirsky and Nolen-Hoeksema (1995) argue that, because women are socialized to be submissive, unassertive, and passive, they are more susceptible to depression than men, as men are often encouraged to be agentic, independent, physically and emotionally strong, and in control (Rochlen et al., 2009). In addition to personality characteristics that may leave women more susceptible to depression than men, women may be more affected by certain situational factors than men as well. For example, women who get married experience higher rates of depression as they age compared to women who remain single. For men, on the other hand, marriage appears to be protective against depression and married men experience lower rates of depression as they age, whereas single men experience higher rates of depression with age. That is, marriage is associated with increased rates of depression in women and decreased depression in men, contributing to gender difference in rates of experienced depression. It is possible that this association between marriage and increased rates of depression in women is influenced and moderated by the effects of parenthood, which may be more stressful for women than men (Simon & Nath, 2004). Just as women may be more affected than men by the number of children in the home, they may also be affected more strongly by interpersonal stressors than men. Ginicola (2007) argues that women are more likely than men to develop depression because of interpersonal stressors.

Nolen-Hoeksema and Larson (1999) argue that, on average, women experience more negative events and have less control over important areas of their life than men; this can lead to learned helplessness and a pessimistic explanatory style (Nolen-Hoeksema & Larson; Lin & Peterson, 1990). This sense of low mastery and learned helplessness, along with the experience of negative and stressful events, increases the likelihood of developing depression. Nolen-Hoeksema (2001) argues that women may be particularly vulnerable to depression because they have less power and status than men and experience traumas, such as sexual abuse and chronic strain, more often than men. Sexual abuse, which is highly correlated with depression, and other early traumatic experiences that happen to girls more than boys, may explain higher levels of depression in women (Piccinelli & Wilkinson, 2000). Thus, if women are experiencing these causal factors more often than men, it makes sense that they would also be more susceptible to depression than men.

Being in an environment where the consequences of one's behavior do not correspond to the behavior itself can lead someone to develop low mastery and a pessimistic explanatory style. Similarly, women average more hours per week of work but earn less money than men, which can lead to a sense of burnout, distress, and depression (Nolen-Hoeksema & Larson, 1999). Because women are more likely to be in situations like this, Nolen-Hoeksema & Larson argue that women may experience more depression than men because they have more chronic strain, more rumination when depressed, and a lower sense of mastery over their lives.

Rumination. It appears that rumination is both a symptom and response style of depression. However, this response style may actually prolong and worsen depression (Lyubomirsky & Nolen-Hoeksema, 1995). In a study by Nolen-Hoeksema and Larson (1999),

dysphoric college students were induced to either distract themselves or to ruminate. The results show that dysphoric individuals induced to ruminate experience longer and more severe negative affect than both the control groups (non-dysphoric ruminators and distracters) and dysphoric distracters. Lyubomirsky and Nolen-Hoeksema (1995) explain that ruminating while in a dysphoric mood can actually turn stressful events into prolonged depression. This response style affects current, past, and future thoughts (Lyubomirsky et al., 1998). That is, dysphoric individuals who ruminate are likely to rate past and present experiences as more negative and are more likely to express negative expectations about future events than individuals who distract themselves.

Depression and rumination can fuel each other because an individual with depression is likely to feel helpless and to ruminate. Ruminating while in a dysphoric or depressed mood enhances the feelings of depression and prolongs these symptoms. Additionally, rumination affects recall of autobiographical memories and increases the number of negative memories recalled, while making it more difficult to remember positive memories. Lyubomirsky et al. (1998) argue that these individuals, because they more easily access negative memories or more easily imagine themselves in negative situations, believe that negative events have happened to them more often than they really have. This response to depression likely draws one's attention to the network of negative memories associated with that mood, making them more accessible and easier to retrieve. This could account for increased recall of negative autobiographical memories among dysphoric ruminators; and because dysphoric women are more likely to ruminate than dysphoric men, this could also account for different rates of depression in men and women.

The increased ease of recalling negative memories in dysphoric ruminators can also affect their expectations about future events. Expectations of negative future events can lead to a self-fulfilling prophesy. Additionally, those who ruminate when depressed are worse at problem-solving (especially about interpersonal issues) than dysphoric individuals who distract themselves (Lyubomirsky & Nolen-Hoeksema, 1995; Lyubomirsky et al., 1998). This can lead to a vicious cycle of depression and rumination, because the depression causes an individual to ruminate, which then leads to worse problem-solving abilities. This makes it difficult for people to remedy the cause of their depression and identify more appropriate coping methods.

A more adaptive coping technique than ruminating when depressed, is distracting oneself from a negative mood. Men are much more likely than women to respond to negative moods using this distracting coping method, which could account, in part, for extreme differences in rates of diagnosed depression between men and women (Nolen-Hoeksema, 2001). Because dysphoric ruminators use their negative mood and other depressive symptoms as information in generating and interpreting memories and events, they continue the self-feeding cycle of depression and rumination. Lyubomirsky et al. (1998) argue that distracting can temporarily relieve a dysphoric mood and may reduce the accessibility of negative thoughts. Thus, the distracting coping style that men are more likely to use, may help dysphoric individuals problem-solve and reduce their negative and depressive feelings.

Even though the distracting coping style may be more beneficial for dysphoric and depressed individuals, it may be difficult for ruminators to change their way of dealing with negative emotions. Lyubomirsky et al. (1998) point out that when depressed people are left on their own they know they should think positive thoughts to lift their mood, but they still tend to

generate negative thoughts. Women, who are more likely to introspect, may dwell on these negative thoughts more than men often do. Because their thoughts are so negative when they are depressed and ruminating, comparatively positive thoughts are still negative thoughts—they just appear to be positive in comparison. Dysphoric individuals often have highly elaborate negative self-schemas that are not altered easily (Nolen-Hoeksema & Morrow, 1991). Similarly, Lyubomirsky et al. point out that rumination appears to be a relatively stable, yet maladaptive coping style rather than a personality trait.

Piccinelli and Wilkinson (2000) similarly argue that rumination is a coping style rather than a personality trait. They propose that higher vulnerability to depression in women is related to gender differences in coping because women are more likely to endorse ruminative coping styles than men when in dysphoric moods. It appears that gender differences in depression rates are at least partially accounted for by differences in rumination (Nolen-Hoeksema, 2001). This is likely due to gender socialization that encourages women to introspect and examine their emotions rather than ignoring or suppressing them. Women are more likely to internalize depression symptoms, using less effective ruminative coping strategies such as verbal and self-consolatory strategies, as well as negative self-talk (Piccinelli & Wilkinson). Ruminating is much more common in women than men, as men tend to distract themselves from their negative mood rather than ruminating and brooding over their dysphoric feelings (Lyubomirsky & Nolen-Hoeksema, 1995; Lyubomirsky et al., 1998).

Evidence that rumination causes a dysphoric mood to develop into a full depressive disorder implies that men's tendency to distract themselves from negative moods may be protective against depression. Because women are far more likely to ruminate when feeling sad

or down, this finding may account for much of the gender differences in rates of diagnosed depression between men and women (Piccinelli & Wilkinson, 2000). In fact Nolen-Hoeksema and Larson (1999) suggests that there are no differences in rates of depression based on gender and these differences seem to be solely based on one's tendency to ruminate. Thus, genetic factors do not seem to lead to higher rates of depression in women directly, but increased rates of depression in women may be moderated via rumination. In fact, social factors may be responsible for this greater tendency of women to ruminate since rumination increases with higher rates of chronic strain and feelings of helplessness.

Although distracting oneself appears to be a more effective coping style for dealing with depression, it is not healthy for men to ignore their feelings completely by employing distracting coping methods. Additionally, some distracting coping styles are dysfunctional and maladaptive. The aspect of rumination which is associated with depression is the brooding component, that involves a passive contemplation of what is wrong in an individual's life and wishes for these negative events to improve (Treynon et al., 2003). Thus, not all aspects of rumination are shown to increase dysphoria and depression. However, the passive, brooding type of rumination is shown to be maladaptive and is associated with increased and prolonged depression. Similarly, by distracting themselves via substance abuse and other addictive outlets, men may simply be masking their depression and trauma (Real, 1997), leaving it undiagnosed and untreated.

Conclusion

Issues of male depression can be elusive and convoluted because signs of depression are often manifested in peculiar ways among men. It is important for clinicians to understand that men are likely to express indications of depression through somatic symptoms, externalizing

behaviors, and addictive outlets. Although all of these symptoms are not included in the DSM-IV-TR (2000) as diagnostic criteria for depression, they are important indicators that men exhibiting these characteristics may also be experiencing depression. Another issue of particular importance to the population of depressed men is the risk of suicide, which is substantially higher in men than women. It is likely that high rates of suicide in men are an indicator of undiagnosed depression in these men as well (Pollack, 1998).

Just as depression may explain high rates of suicide in men, it may also be driving some behaviors which are considered to be staples of the male gender role. For example, aggression and substance abuse are relatively common and socially acceptable in men, but they are behaviors that are sometimes manifestations of underlying feelings of depression. Similarly, complaints of somatic ailments, such as trouble sleeping, headaches, and other concerns about physical health can be signs of emotional, rather than physical distress. Addiction and suicidality may also be signs of depression in men who present for treatment, but do not wish to endorse the more feminine characteristics of depression.

Because men with depression often endorse behaviors which are not characteristic of depression, it becomes difficult to determine how many men truly suffer from depression. Some researchers argue that depression is under-diagnosed in men because their symptoms are hidden and because clinicians are not expecting to find depression in men as often as they do in women. However, others argue that the dissimilar frequency of depression in men and women is authentic. This argument states that women have often experienced life events and environments which are correlated with increased depression rates, whereas men experience these factors less frequently. Additionally, the tendency of women to cope with negative emotions by ruminating

may increase their likelihood of developing depression. Men, on the other hand, tend to distract themselves from their negative mood, which decreases their likelihood of developing depression.

Limitations

In this paper I outline many manifestations of depression in men and potential causes for these manifestations. I believe that knowledge about these specific male behaviors and symptoms may help clinicians more accurately assess men for depression. However, there are many limitations to this research as well and symptoms listed here are generalizations that are not representative of every man with depression. The first limitation involves restraints of the covert depression model. It is complicated for clinicians to diagnose a disorder when no symptoms of that disorder are overtly present. Similarly, if the symptoms of depression are unknown, not only to the clinician, but to the patient as well, it seems speculative and unreasonable to diagnose for depression under these circumstances. The second limitation is the notion that many of these manifestations of depression exist because of the way in which men are socialized to present certain behaviors and ailments while limiting their expression of feminine characteristics. Although understanding the reasons for these manifestations of depression may be helpful to clinicians, this pattern of convoluted depression symptomatology will likely continue until there are changes in the social constraints of typical gender traits, which is unlikely to happen quickly.

The criteria for diagnosis of depression are also unlikely to swiftly change in response to men's unique symptom profile. If current diagnostic criteria and social contexts continue, it is unlikely that there will be large changes in the rates, expression, or treatment of depression in men. The transition toward understanding men's unique expression and experience of depression

will likely be a slow process with many barriers along the way. It is important for clinicians to be cognizant of the symptoms men often endorse in order to reverse this trend of ignoring depression in men.

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