

# Gender Differences in Depression and Male Depression: A Social Psychological Review

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### **Abstract**

This paper presents a review of the literature on gender differences in depression in general and male depression in particular. Literature and research on the definition and nature of depression are presented first. Gender differences in depression are discussed under two major categories: social and psychological. The discussion on gender differences in depression is used to reflect on the nature of male depression. A critical discussion of the literature presented is provided.

## **Introduction**

If someone enters a library or browses through the internet for books and articles on depression they will very quickly realize that there is a vast amount of work on this widespread human experience. According to Leader (2008), depression today can be found everywhere, on films and television, in GP's referral letters, in magazine articles and celebrities' interviews. It is of no surprise then that depression is considered by some as "the common cold of mental health" (Harvard Mental Health Letter, 2006, p. 1).

Depression then, seems to be as old as the human race, and is an experience that more or less everyone has felt at times (Rowe, 2003). We can all recall times when we confessed being 'down in the dumps', having 'low mood', being 'fed up', feeling 'down' or 'having the blues'. We have heard our friends and family use these terms, and read about them in magazines and books. In this review, views on the nature and definition of depression, gender differences in depression, and the unique nature of male depression are presented. A critical discussion of the literature is also provided at the end.

## **What is Depression?**

Although depression seems to be quite a common human experience, and could be as old as the human race, the first written description we know of depression, presented at the time as melancholia, is by the Greek physician Hippocrates in the fourth century B. C. (Becker, 1974; Gilbert, 1992; Wolpert, 1999). Since then, melancholia and later depression (Meyer, 1905 as cited in Becker, 1974) have been occupying many writers and researchers' minds and many people were and still are, struggling to find the lost joy. According to Mathers and Loncar (2006, p. 2022) "By 2030, the three leading causes of burden of disease will be HIV/AIDS, depression, and ischaemic heart disease in the baseline and pessimistic scenarios" and according to the World Health

Organization, by 2020 depression is estimated to climb to the second place in the Global Burden of Disease for men and women of all ages (World Health Organization, 2009).

But does feeling low mean that we are depressed? According to Rowe (2003) the difference is that when someone is depressed, support and compassion cannot bring any comfort and on the contrary, lead to self-punishing and self-reproach. The author describes depression as a self constructed prison made of a complicated network of opinions, that we have of our self, others and life in general. Rowe argues that the depressed holds as "real, absolute and immutable truths" (p. 17), six opinions according to which, s/he considers her/himself as evil and valueless and should never forgive others nor her/himself, that other people should be feared and envied, that life is unbearable but death is worse, that things were bad in the past and can only get worse in the future and that it is unacceptable to get angry. Gilbert (1992), also describing depression, classifies the symptoms in four different areas of human functioning: motivation, emotion, cognition and biology.

Opposing the above views, Leader (2008) argues that depression as a biological disease is clinically and culturally constructed and mourning and melancholia are the actual states or experiences that 'depressed' people go through. It has to do with loss which is not restricted only to death or separation, but might involve circumstances, ideas, objects and in general, a certain way of being. Describing the difference between mourning and melancholia Leader (2008, p. 8) writes: "In mourning, we grieve the dead; in melancholia, we die with them". He argues that there is a need to understand depression as an outcome of social procedures and changes where social support networks sustained by a sense of community, have been weakened within the market driven economies.

Similarly, Stoppard (2000) describes two main ways that depression can be understood. Depression can be a category of a mood disorder or could be understood as a continuum or a

dimension, which is linked with the severity of the depressive state. The former seems to be supported by mental health professionals, at least in Northern America, and the latter is considered to measure "dysphoria" (a subjective experience characterized by a sense of psychological distress or discomfort), rather than depression (Stoppard, 2000). What is remarkable though and therefore in need of being highlighted, is that at the end of the day what we know about depression lies on the peoples' personal experiences and on the way they describe it (Stoppard, 2000).

Thus, defining depression might just mean to gather subjective human experiences, organize them into clusters and then finding a way to measure them. This would be a very positivistic approach to studying depression and, arguably, a sure way to lose the actual subjective experience of the individual. According to Winokur (1997) depression could be seen as a syndrome rather as a disease due to the plurality of different causes, leading to the same group of symptoms.

A clearer view on defining depression is given in the work of McPherson and Armstrong (2006) on the role of social determinants of diagnostic labels in depression. Following the term and its many different sub-type labels, for example major/minor, atypical, reactive, refractory, endogenous/exogenous depression, they were able to identify possible reasons for the vast amount of sub-types in depression, their appearance and dismissiveness at certain times and the dominance of others throughout the years. They agreed with Armstrong's (1980) view that depression is a twentieth century phenomenon and concluded that depression and its sub-types, as a diagnostic label, is constructed according to historical and cultural, social procedures.

What can be concluded from the plethora of different views on the definition and nature of depression is that there is no actual agreement. Different approaches, different models, produce different knowledge. Basic epistemological and philosophical perspectives seemed to have overtaking attempts to define depression. Is it an illness, a social construct or a different experiential

experience for everyone depending on the meaning each person attributes to it? As fruitful as this dialogue between approaches and views seem, it is of great importance to acknowledge the role research plays on studying depression and how this can be used towards the clients' interest. This will be more clearly seen in the discussion below on the research on gender differences.

### **Gender differences in depression**

Among these different ways to define depression within the plurality of approaches, research has also been devoted to gender differences in depression. The results so far, seem to favour the view that women are more inclined to suffer from depression or report depressive symptoms (Weissman and Klerman 1977). Even though there are researchers who support the artefactual nature of the gender differences in depression (e.g. Newmann, 1984; Vrendenburg et al., 1986; Bromet et al., 1986; Coryell et al., 1992), female pervasiveness in depression is well known (e.g. Radloff and Rae, 1979; Weissman, 1985; Billings and Moos, 1985; Nazroo et al., 1997 ; Piccinelli and Wilkinson, 2000 ). Further, according to Weissman and Klerman (1977) the prevalence of depression in women has been evident in all countries and over all time periods with very few exceptions. Cochran and Rabinowitz (2000) argue that there is an approximate two to one ratio between women and men in major depressive episode, major depression and dysthymia . According to Magovcevic and Addis (2008) there are qualitative gender differences in specific depressive symptoms. However, Hilbrandt et al (2003) argue that when it comes to general characteristics of depression like mean number and presentation of symptoms, severity, and duration or prevalence of a single episode, there are no observed differences between men and women.

With women's prevalence in depression well documented, it seems interesting to point out that men outnumber women in substance-related use and disorders, antisocial personality and any psychiatric condition (Cochran and Rabinowitz, 2000). This can be linked with the way depression

is manifested in males and females and Cohran and Rabinowitz (2000, p. 13) raise the question "how many men who might be 'depressed' are manifesting their depression in these categories or through other undocumented syndromes?".

Questions like this are thus driving a shift towards more complex, multifactorial approaches to investigating depression (Mc Grath et al., 1990). Commenting on this, Stoppard (2000 p. 10) argues that "ultimately depression is likely to be explained as arising from some combination of individual biological make-up (genes, biochemistry), psychological characteristics (personality traits), and social conditions (circumstances of everyday life)". Interestingly, in a review of the aetiology of depression Goldberg (2006) identifies genetic, hormonal and social factors that could explain women's prevalence in depression. However, and even though they acknowledge the female preponderance in rates of depression, Piccinelli and Wilkinson (2000) question the role that genetic, biological and certain social factors play and present adverse experiences in childhood, mood disorders in childhood and adolescence, coping skills, vulnerability to adverse life events and sociocultural roles as likely relevant to gender differences in depression.

Arguably what should be acknowledged is the plurality of factors identified to play a role on gender differences in depression and it is the aim of this paper to focus on the social and social psychological factors. It is our view that a focused paper will provide an in depth understanding of the issues on gender and depression from a specific stand point. For further reading on how additional factors may influence gender differences in depression see: Mendlewicz and Fleiss, 1974; Goldin and Gershon, 1983; Ehrhardt, 1985; Sevy et al., 1995; Seeman 1997; Winokur, 1997; Cyranowski et al. 2000; Perry et al. 2002 Seidman 2006; Staley et al. 2006; Kanayama, 2007; Gooren, 2007; Vermeersch et al. 2008.

### Social factors

According to Piccinelli and Wilkinson (2000), multicultural research has shown that women's prevalence in depression rates can be linked with social roles and cultural influences. They argue that even though biological sex is a useful starting point to understand gender differences in depression, social context, identities and norms should be taken into consideration. Being quite valiant, Nazroo et al. (1997) argue that the specificity of the effect that gender-based division of domestic labour has on depression, renders biology unable to explain gender differences in depression.

The connection between stressful life events and gender is one of the several social factors that have emerged from the research on gender differences in depression. On the one hand, girls seem to suffer sexual abuse more often than boys and this makes them more sensitive to later stressful life events (Goldberg, 2006), and according to Bond et al. (2001) victimization and bullying is strongly related to later depression only in girls. On the other hand, it could be argued that , bullying and victimization especially during childhood and adolescence, can lead to depressive outcomes in men as well (e.g. Real, 1997; Cochran and Rabinowitz, 2000, Leary et al., 2003). Discussing the impact of life events on gender differences in depression, Piccinelli and Wilkinson (2000) question the clarity of the evidence in favour of women's higher vulnerability towards stressful life events but they acknowledge a possible gender difference on the "quality of experience associated with life events" (p. 488). Overall, according to Bebbington (1996) although adversities were more common in women, such experiences have not been found to account entirely for their higher frequency of minor affective disorders.

At a rather descriptive level it seems that young girls form closer relationships with peers, they are encouraged to share their feelings more and generally display a more affiliative style of relating in comparison with boys (Gilligan, 1982; Real, 1997; Taylor et al., 1997; Goldberg, 2006) . Even though theorists agree on the more affiliative style of women's relating, there seems to be a



plethora of different views and explanations on its aetiology. Real (1997) believes that this is a part of women's gender role learning from parents, teachers and society, while Stoppard (2000) supports that gender as an individual characteristic has symbolic aspects within the discursive domain and points out that cultural discourses construct the nature of femininity in such a way that a 'good' woman is the one that is focused on relationships and caring. Nolen-Hoeksema (1987, 1991) in accordance with feminist theories, focuses on women's lack of social power to explain women's tendency to ruminate when distressed, passively and repetitively focusing on one's symptoms of distress. It can be concluded, therefore, that what seems as affiliative, caring, emotional way of women's relating can be a try for controlling a patriarchal context where women have lower social and economic status. Miller (1988) supports that women's focus on the relationship is due to the unique nature of the mother-infant bond and the subsequent identification with the mother that encourages the relationship as central to experience, and not due to society's expectation. Furthermore, and connecting depression with the role of stressful life events, Coldberg (2006 ) argues that women tend to develop more close one-to-one relationships in comparison with boys throughout their childhood and adolescence. This leads girls to experience more disappointments within their relationships which, Colberg argues, results to an increase of the risk of developing emotional disorders.

Nolen-Hoeksema et al. (1999) point out that women's lower social status, lower occupational and financial status and their 'silencing' of opinions and desires in order not to endanger their relationships (Jack, 1991; Helgenson, 1994) results in losing control over their environment; a state similar to Seligman's (1975) learned helplessness theory. But women seem not only to hide their opinions but to have or believe they have, fewer choices as well. Piccinelli and Wilkinson (2000 p. 488) argue that "Individuals with few overvalued goals and/or lacking an intimate sense of perceived choice are at high risk since they are left with few alternatives for self-

definition and self-evaluation when their main goals are threatened. Both of these situations are more likely for females".

Along these lines, other theorists (e.g. Crosby, 1982; Barnett, Brennan and Marshall, 1994; Stoppard, 2000) have addressed the issue of the double role women are called to play as full time workers and full time housewives which raises the risk for depression, general distress or burnout (Gove and Tudor, 1973; Hobfoll, 1991; McIntosh et al., 1994). Women also seem to be underpaid in comparison with men and in western societies they either rely on men to be the "family breadwinners", or the state (Stoppard, 2000). Moreover, childbearing is mostly a woman's responsibility (Stoppard, 2000) and according to the Office for National Statistics Social Trends report (as cited in Barnett, 2007) nine out of ten single parent families are headed by mothers. According to Piccinelli and Wilkinson (2000) marriage imposes gender-specific demands on women and limits the number of social roles that women can acquire. They argue that women, after marriage, rely their self-esteem on the meaning they attribute to the role of the housewife, which by itself is demanding, while at work women are dealing with economic discrimination and job inequality. Both work and house obligations seem to create mixed and sometimes conflicting roles. Nazroo et al. (1997) argue that gender differences in social roles and the cost of caring which results from the nurturing role females acquire (Kesler and McLeod, 1984), are responsible for the gender differences in depression rates. These authors have found that problems with children, housing and reproduction were more salient for women and depressive episodes were higher in women when faced with a crisis on these domains. Thus, and on the one hand, it is the social role that women seem to hold that explains their vulnerability and their sensitivity about household and family issues which lead to higher risk of depression. On the other hand, males seem to be more occupied with issues about work and finances and seem to under-report crises about children, housing and reproduction (Nazroo et al., 1997). Interestingly, in a research on alcohol use and depression symptoms among employed men and women, Parker et al. (1987) have found that lower

family income is a variable related to depression only in men while family disruption and prior marriage have the same impact on both genders. Fincham et al. (1997) have found that even though marital satisfaction and depressive symptoms is highly correlated for both genders, women are more vulnerable to develop depressive symptoms when their marital satisfaction is declining.

In favour of the great impact that the above mentioned social constrains against women have in gender differences in depression, it has been found that in certain societies or cultures where social gender discrimination is unlikely, like among orthodox Jews in London (Loewenthal et al., 1995) or the Old Order Amish (Egeland and Hostetter, 1983) gender differences in depression are not evident (Piccinelli and Wilkinson, 2000). But other studies have produced contradictory results. According to Weich et al. (1998) gender differences in depression are not explained by gender differences on the type or number of social roles occupied.

The important role that culture plays on the onset of depression and on gender differences in depression is evident in research by Takeuchi et al. (1998). Examining 1747 Chinese American adults living in Los Angeles, they have found that acculturation is an important factor that influences the depressive outcome between men and women. In particular, when the levels of acculturation (to the American culture) were low there were no gender differences but high acculturation resulted in higher depression rates among the women.

Social support seems to appear as another factor that plays a role on gender differences in depression. There are scholars that seem to consider friendship and family networks as important and in general it can be said that social support does enhance mental health. Sinokki et al. (2009) argue that mental health is connected with low levels of social support and depression seems to be connected with low social support in the workplace. In terms of gender differences, women's affiliative style of relating seems to increase women's need for support networks and the importance

they play as a recovery predictor or even on the onset of a depressive episode. In a twin study, Kendler et al. (2005) have found that women report higher levels of social support and are more affected by low levels of social support than their twin brothers. In a study on sex differences in depression after widowhood van Grootheest et al. (1999) have found that widows maintain or find sources of social support more easily than widowers. Commenting on the possible reasons, they claim women's different style of relating and forming close meaningful relationships, men's social inhibition to admit feelings of weakness or loneliness and Wortman's et al. (1993) view that within a marriage, social relationships are maintained by the wives. However, Piccinelli and Wilkinson (2000) argue against the role of social support in the depressive outcome between men and women and claim that social support is equally important for both genders. Zlotnick et al. (1996) have found that social support is related to the severity of depressive symptoms equally for both genders.

### Social Psychological factors

Connected with social and genetic factors and the style of relating, are coping styles men and women apply when dealing with distress and stressful life events. Some researchers attribute differences in coping styles between men and women in personality traits, cognitive functions and attributional style (Seligman, 1975; Beck, 1976; Hanninen and Aro, 1996; Brewin and Chris, 1996). Nolen-Hoeksema (1990, 1987) has introduced the response style model of depression according to which there are two response styles in dealing with mood states: the ruminative response style and the distracting response style. Women seem to use the ruminative response style while men employ the distraction response style when dealing with depressive mood. What is interesting is that the description of the ruminative style fits well with the traditional description of a depressive disorder; withdrawal from social support and instrumental coping, focus on individual shortcomings, individual beliefs and a discriminative focus on dysphoric mood and an attempt to explain (Cochran and Rabinowitz, 2000). The distraction response style, on the other hand, includes acting out sometimes in a dangerous self destructive way such as reckless driving or alcohol abuse. This is

highly connected with the way men manifest their depressive mood and seems to be one of the main features of male depression.

Culture does influence coping patterns and it seems that women's tendency to focus attention on self-blame, which leads to lower self esteem and higher depression (Kaplan, 1977), is up to a point culturally induced (Cochran and Rabinowitz, 2000). Accordingly, men who culturally 'prefer' more action orientated coping styles might benefit from externalizing blame, holding on to higher levels of self esteem and being able to utilize problem-solving techniques. But opinions seem controversial. On the one hand, Real (1997) points out that men's instrumental coping patterns are defenses against depression. On the other hand Clare (2000) argues that changes in gender issues brought by the work of feminists and social researchers are in men's favour since it provides the cultural approval to focus more on relationship and less on power and possessions. Nevertheless, it could be argued that western capitalistic political system drives women towards a more competitive style of living rather than men towards an affiliate style of relating. What seems more possible though, is that both the former and the latter are evident and co-exist.

Following the response style model of depression (Nolen-Hoeksema, 1990, 1987) researchers have found that the rate of suicide is higher in men even though unipolar depression in females is more common (Moscicki, 1997; Ottar Bjerkeset et al., 2008). For example, in 2004 American men were four times more likely to die from suicide than women (National Center for Health Statistics, 2004). In a sample of college students, Langhinrichsen-Rohling et al. (1998) found that men reported more life threatening and potentially suicidal behaviour even though both men and women reported similar depressive symptoms. Exploring the additional factors that are associated with the increased suicide in men, Cochran and Rabinowitz (2000 p. 146) list various parameters: family history of suicide (Moscicki, 1997), isolation from others (Canetto, 1994), poor

health (Motto and Bostrom, 1997), disruptions in the family environment, like violence, incest, alcohol or substance abuse (Brown and Anderson, 1991; Maris, 1997; Moscicki, 1997).

Piccinelli and Wilkinson (2000 p. 489) describe three main characteristics that have been attributed to people at risk of depression; "globality (that is, failure is related to factors applying across a variety of situations), stability (namely, factors responsible for failure is related to factors applying across a variety of situations) and internality (where the individual regards himself or herself as relatively incompetent)". And even though, according to what has been discussed so far, it seems that many scholars argue that females display these factors more than men, e.g. rumination, self blame (Nolen-Hoeksema, 1990, 1999), Piccinelli and Wilkinson (2000) support that there is no sufficient evidence that women display more cognitive characteristics that result to depression. Overall, it can be said that conclusions on the role of psychological differences in depression between men and women should be carefully drawn since the research seems contradicting.

### **Male depression**

To date, and as has been seen, research on gender differences in depression is that most researchers have focused on women and their depressive symptoms. For example, and as it is evident above, it could be argued that the research on the social factors that are connected with depression mostly discusses women's socialization, while men's socialization is usually presented as a separate section under the title 'male depression'. It could be argued therefore that in trying to explain women's depression, researches have in a way feminized depression producing great amounts of articles and books on women's mood disorders. This by no means implies that there is no research on male depression, but it can be argued, and adopting here a discursive perspective, that research might have played a part on the construction of the 'female characteristics' of depression only. This argument can be a useful starting point for exploring depression in men as the same mood disorder women suffer from, but is often manifested and expressed differently.

To begin with, it is necessary to note that if views on depressive symptoms are broadened, women's preponderance in depression rates stops (Smith et al., 2007). Interestingly, percentages for alcohol abuse, depression and antisocial personality for men are comparable with percentages for depression and anxiety disorders for women (Pollack, 1998a).

The depressive spectrum disease conceptualization (Winokur, 1972, 1979, 1997; Winokur et al., 1978) is trying to explain the difference in severity of depressive states (e.g. major depression and dysthymia) and is in accordance with the various ways depression might be manifested. Winokur and colleagues have found that women had a genetic link to depression and men to alcoholism. According to spectrum disease classification, depression can be separated in two categories; endogenous/psychotic for example familial pure depressive disease, and those that emerge due to emotional instability for example, depressive spectrum disease (Winokur, 1997). The latter seems more associated with anxiety disorders, alcoholism, substance abuse, and personality disorder in relatives (Cochran and Rabinowitz, 2000). According to Real (1997) Winokur's research data are consistent with what is evident from clinical practice. Moving a step further, Real challenges the notion that addictions and depression are separate disorders and raises the question whether they refer to different manifestations of the same disorder between men and women. This conceptualization seems to explain adequately women's preponderance in depression and men's prevalence in alcoholism and antisocial personality disorder.

The depressive spectrum disease seems to elucidate a minor depressive state in men with addictive or antisocial behaviour but according to Real (1997) this consists of a covert depressive state in men which by no means is minor. Men display two different types of depression, overt and covert (Real, 1997). Overt depression is what would be characterized as major depression and it is described by the 'usual' depressive symptoms evident in uni-polar depression. However, covert

depression refers to an underlying, hidden, depressive state that mostly men suffer from. Other authors, refer to it as 'male type' depression (Pollack, 1999), 'masked depression' or label risk-taking behaviours as 'depressive equivalents' (Brownhill et al., 2005).

Men's gender role is about being strong, being able to stand the pain and move on without expressing any weaknesses. For example, the rock band Jethro Tull describe men as the ones "who every day can turn another page" and countless are the examples in literature and in cinema that portray this stereotypical view of masculinity. In the film 'Cinderella Man' the main character, a boxer, saying goodbye to his family before a crucial match, hugs and kisses his daughter and younger son, while he shakes hands with his oldest son. Watching the scene, the younger son reaches out for a hand shake. According to Cochran and Rabinowitz (2000) being masculine is about not acquiring a victim stance. In his writings Jung (1956) supports that the masculine is symbolized by the sun and the hero. In fairy tales women are weak and needy while men are the strong determined heroes who are willing to sacrifice themselves for the greater good or to rescue a woman in need (Real, 1997). In neonatal units, girls are spoken to in softer tones than boys, they are seen as 'so well-behaved', 'a real flirt', 'waits her turn so nicely', while boys are labeled as 'naughty', 'mischievous', 'greedy' (Real, 1997; Barden, 2001). In a research with newborns, Condry and Condry (1976) found that adults would see a crying 'girl' as frightened and a crying 'boy' as angry. In both circumstances the baby girl or baby boy, was the same child. In a different study, Fivush (1989) found that mothers attribute only positive emotions to their daughters while they attribute both positive and negative emotions to their sons.

From the literature it can be seen that the way parents treat their boys and girls is influenced by the expectations and speculations about his or her needs and state. An angry boy would of course be treated differently from a frightened girl. Gender identity seems to be attributed to children from the first seconds they come into the world and this is continued throughout childhood and



adolescence. Real (1997) remarks that behind covert depression lies trauma, either active or passive. Boys have a relational side as much as girls have an assertive side. Becoming masculine is quite often about depriving boys from their relational capacity. Hanson et al. (2008) have found that boys report exposure to some type of violence in their lifetimes more than girls and Real (1997) argues that boys learn how to be masculine both through passive and active trauma, by diminishing connection to the mother, aspects of the self and others.

According to trauma expert Mellody (1987) there is a distinction between 'disempowering abuse' and 'falsely empowering abuse'. The former refers to shaming, putting the other into a helpless position while the latter refers to an exaggerated boost of someone's self-esteem. Both types of abuses in childhood lead to disorders of self-esteem (Mellody, 1987) and Real (1997) argues that boys are usually not subjected to one or the other abuse type but interchangeably to both. A useful example can be drawn from sports. First is first and second is nothing. According to Real (1997 p. 166) "we raise boys to live in a world in which they are either winners or losers, grandiose or shame filled".

When men are not 'allowed' to express weakness or pain, not only they are reluctant to seek help, but the shame is so intense that they might hide their pain even from themselves. This leads to a state where they become emotionally numbed, a state which is called alexithymia (Real, 1997). According to Parker et al. (1999) alexithymia is more common in boys. Kraemer (2000) on cultural expectations of masculinity, argues that shy boys become "ashamed of being ashamed" (Krugman, 1995) and try to stop feeling anything, creating an invulnerable image of themselves. In some circumstances, covertly depressed men seem not just unable to express their feelings but to identify them in the first place. This seems to explain men's externalizing behaviours like violence, substance abuse, gambling e.t.c. Further, it has been argued that through these behaviours men actually try to bring back the lost feeling rather than trying to 'ease the pain' (Khantzian, 1990).

Moreover, Real supports that covertly depressed men display addictive behaviours as defence mechanisms against the underlying pain. In particular, men use two different ways of "addictive intoxication" called "merging" and "elevation"(Real, 1997). When men apply merging, the boundaries of the self become more loose or even vanish. This is evident in substance addictions, bingeing and love addiction where the love object becomes a way to soothe hidden, unacknowledged pain. Elevation refers to what would be mania in its purest form. In the elevating state, the person has feelings of grandiosity and power. While in mania someone needs an external object to trigger the grandiose feeling, in elevation the covertly depressed man consumes or does something to increase his self-esteem in order to fight depression. Examples of elevation would be addiction to gambling and violence, aggressive or dangerous driving. According to Real (1997 p. 65) "These two forms of addictive intoxication differ in that merger gives the illusion of fusion with a force that is larger than life, while elevation gives the illusion of becoming such a force oneself". In many circumstances, when 'merging' does not work against the repressed pain, men switch to 'elevation'. Interestingly, Cochran and Rabinowitz (2000) argue that an experienced narcissistic wound in a man's life as a precipitating factor for homicidal and suicidal violence.

According to Brownhil et al. (2005) men feel depression in the same way as women, but the difference lies on what men 'do' when they are depressed. They argue that through risk-taking behaviours, violence, substance abuse, aggression, depressed men are employing five coping mechanisms against the hidden pain. They try to "avoid it", men tend to forget or not think about problems; "numb it", for example through substance abuse; "escape it", maybe spending many hours at work; "hating me, hurting you" through either self-abuse or/and anger related behaviours and violence; "stepping over the line" for example, committing suicide.

Apparently, it can be concluded that there is respectable evidence that depressed men may manifest depression differently and quite often they fight against it by any means, in order to keep it hidden. This raises serious issues on assessing depression in men and providing appropriate help. Do men need different or more sensitive assessing approaches? Research on gender differences in the depressive symptoms profile seems controversial. While Young et al. (1990) support that there are no significant differences on the depressive symptoms profile between men and women, Smith et al. (2007) have produced opposite findings and conclude that gender differences in the presentation and course of depression are evident. The picture becomes more blurred when we include covert or masked depression. In addition, measuring and assessing depression seems problematic. Gumbiner and Flowers (1997) question the way men and women respond in the structured measures of depression and in a way challenge their validity across genders since they argue, that men and women score differently. Reviewing the literature on the matter Cochran and Rabinowitz (2000 p. 85) have identified several clinical features associated with depression in men, extremely useful for identifying and assessing underlying depressive state: "strain between gender-role expectations and performance (Good and Wood, 1995; Heifner, 1997); assertions of autonomy and interpersonal distance, increased conflict and anger in relationships (Williamson, 1987; Frank et al., 1988); withdrawal from and decreases in social contacts (Oliver and Toner, 1990); perceived threats to self-esteem and self-respect (narcissistic wounding), disappointment in self (Ahlund and Frodi, 1996); alcohol and other drug abuse and dependence (Grant, 1995); inability to cry (Hammen and Padesky, 1977); antisocial, narcissistic, and compulsive personality traits (Black et al., 1995; Frank et al., 1988); decreases in sexual interest but not sexual activity (Nofziger et al., 1993); somatic complaints (Hammen and Padesky, 1977); work-related problems and conflicts (Vredenburg et al., 1986); difficulties with concentration and motivation (Maffeo et al., 1990)". All the above features seem to be in accordance with the literature on male depression and provide an overall description. Nevertheless, health professionals should not stop here. Being aware of the gender issues in depression and according to what has been mentioned above, someone who is

assessing a man should look for any behaviours, beliefs or coping strategies, that could serve as a defense against hidden pain or hidden trauma.

Identifying depression in men is extremely important for their well being. An offender might be punished for his crimes but will not be considered as possibly depressed. A man that works too much will not be referred for psychological assessment but he is often going to be rewarded by employers for his hard work (Brownhill et al., 2005). Further more, in addition to men's unidentifiable psychological difficulties, men display a reluctance to seek help in the first place. Men tend not to express their pain and might not share or ignore health concerns in order not to seem weak or needy (Kraemer, 2000). Good and Wood (1995) have found that college students are ashamed to seek psychological help. Finding ways to bring men closer to available help and creating a safe and male friendly way of providing psychological support is one of the major challenges in male psychology and in male depression particularly.

## **Discussion**

Discussing the different views on the nature and definition of depression and the literature on gender differences in depression has provided a solid base to discuss and understand the unique nature of male depression. With women's prevalence in depression rates evident it seems that research has been striving to understand the aetiology behind it and have in a way reproduced the 'feminine' characteristics of this mood disorder. At the same time and for over the past twenty years, feminist theorists and researchers have brought to the surface the nature of the difficulties and challenges women face nowadays. This may have led traditional notions of masculinity and men's self-positioning in society being questioned and re-evaluated.

Men were expected to be tough, not to express feelings or any kind of weakness and this was probably one of the main reasons for their preponderance in acting out behaviours, anger,

violence or substance abuse. Nowadays, many would argue that men have more choices. And even if this sounds as a step forward, it might consist of a problem. Men are facing a transition in their traditional status. They are 'loosing' their identity but they do not seem to have something solid, defined to replace it with. In this case it seems that men have two choices, struggling to keep the traditional masculine identity alive or facing the changes and try to move on. But this implies that they have to admit weakness and mourn what is lost. Men nowadays might be torn between their old, tough traditional masculine identity and the new, undefined, blurred and multifaceted one. Moreover, given that men might move to different directions it deprives them from a strong consensus, which was evident in the traditional views of masculinity that could support them through the crisis. But what we seem to miss is that changes in society do not happen rapidly. Indeed, men's gender identity has developed and changed in the past years, but traditional masculinity is still evident; in the media, in films, in the way we raise our children. Psychologists and researchers might be forgetting that 'out there' the stereotypes are still strong and now, under threat, they might be becoming even stronger. This is where the importance of counselling and psychotherapy lies. The psychologist is in connection with the client's views, meanings and fears and can work on this level in connection with what the client experiences as depression, as masculinity, as 'identity crisis'.

So what is masculinity nowadays? What does it mean for a depressed man to be masculine? Does it consist of some kind of a trauma? These questions seem a good starting point to understand the uniqueness of male depression and the role that masculine identity plays. Qualitative research focusing on the idiosyncratic phenomenology of the experience is an extremely helpful tool to get as close as possible to understanding how being a man and suffering from depression co-exist and whether they co-influence each other.

Furthermore, addressing the subject from a wider view, there is a need to explore the role research and the discourse around gender differences in depression plays. Is it possible that the actual divide between males and females in depression actually feeds the differences and strengthens the gap? According to Real (1997) boys are boys and girls are girls, they don't have to 'become' boys and girls. Does research play a role on the construction of the differences? Does it construct the way men and women 'should' feel when depressed? Conducting research on such a meta-analytical level would provide a great opportunity for researchers to self-reflect on the role they play on the construction of 'scientific truth' in depression and gender.

Gender differences and gender identity issues are extremely complicated. The situation becomes worse when they are combined with mental health. In terms of understanding male depression maybe a good starting point would be Tori Amos's lyrics "sometimes I think, I think I understand, the fear in a boy, the fire in a man".

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