Depression: Gender Matters (082)

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Contact hours: 4

Course price: $10

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Course Summary

This course looks at the nature of depression and how it relates to gender. Discusses sex bias in diagnosis and gender differences in suicide rates. Introduces irritable male syndrome and its causes. Presents an instrument for assessing male depression, the Diamond Male Depression Scale, and explains its development and use.

COI Support

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Criteria for Successful Completions

80% or higher on the post test, a completed evaluation form, and payment where required. No partial credit will be awarded.

Course Objectives

When you finish this course you will be able to:

1. Explain why gender matters in regards to depression.
2. Discuss the nature of depression and how it manifested.
3. Distinguish between sex and gender and their roles in depression.
4. Define Irritable Male Syndrome and enumerate its causes.
5. Debate the existence of sex bias in the diagnosis of depression.
6. Show the need for an instrument for assessing male depression.

Why Gender Matters

> Women seek help. Men die.
>
> Ernst and Angst (1992)

This stark conclusion was drawn following a study of suicide prevention by Ernst and Angst (1992). They found that 75% of those who sought professional help in an institution for suicide prevention were female. Conversely, 75% of those who committed suicide in the same year were male. Since depression is a significant risk factor for suicide and men receive less treatment for depression than women, it is vitally important that we have a better understanding of the way depression manifests itself in males. Failure to diagnose and treat depression can lead to significantly increased morbidity and mortality. Considering that depression is the most frequent reason for suicide, early diagnosis of depression in men can save lives.

Case

Morris is a 42-year-old Caucasian male, seen in the hospital following a suicide attempt in which he took an overdose of sleeping pills. In the initial interview he didn't appear to be sad or depressed; rather, he seemed frustrated, irritable, and angry. Morris reported that he had had difficulty finding a job in his chosen profession as a writer and he blamed "the corporate control of publishing companies" for not giving him a chance to demonstrate his talents. He maintained that he wasn't depressed and that, while he had taken too many sleeping pills, he wasn't really trying to kill himself. His wife was distraught.

"I never suspected he might be depressed," she said. "He was just withdrawn and irritable all the time. I always had to walk on eggshells. I never knew when he was going to blow up. I tried to be supportive of his writing career, even when it was difficult to make ends meet. We have a five-year-old son. I haven't told him why his father is in the hospital. I guess, I don't really understand it myself."

Morris refused any kind of counseling, but a better picture emerged when his wife found a journal he had been keeping. At first she thought he was describing a character in a story. Then she realized he was talking about himself.

June 4: Your flesh crawls, your scalp wrinkles when you look around and see good writers, established writers, writers with credits a block long, unable to sell, unable to find work. Yes, it's enough to make anyone turn pale and sicken.

August 15: Faster, faster, faster, I walk. I plug away looking for work, anything to support my family. I try, try, try, try, try. I always try and never stop.

November 8: A hundred failures, an endless number of failures, until now, my confidence, my hope, my belief in myself, has completely run out. Middle aged, I stand and gaze ahead, numb, confused, and desperately worried. All around me I see the young in spirit, the young in heart, with ten times my confidence, twice my youth, ten times my fervor, twice my education.

I see them all, a whole army of them, battering at the same doors I'm battering, trying in the same field I'm trying. Yes, on a Sunday morning in early November, my hope and my life stream are both running desperately low, so low, so stagnant, that I hold my breath in fear, believing that the dark, blank curtain is about to descend.

There are millions of men like Morris whose depression is masked by other signs and symptoms. Those who are on the front line of healthcare need to do a better job of recognizing them. Since there is no blood test for depression, we make our diagnoses based on patient response to our questions; but, if we are not asking the right questions, the answers won't help us prevent future problems.

It is a common assumption that the symptoms of depression are the same for everyone. Now we are learning that symptoms of depression in men may be markedly different from those commonly seen in women.

The Nature of Depression

The experience of depression likely preceded recorded history. Certainly it has been recognized for thousands of years. Aretaeus of Cappadocia (c. 81–138 A.D.) is credited with the first clinical description of depression. Hippocrates, the Greek physician of antiquity, was well aware of depression; he called it "melancholia."

Although it presents with an array of physical symptoms, depression is considered a disorder of mood. It is also called an "affective disorder" to signify that one of its key aspects is a disturbance of emotions or feelings. Almost 20% of adults will have a mood disorder requiring treatment during their lifetime, and about 8% of adults will have a major depressive disorder. Depression is the leading cause of disability and premature death among people aged 18 to 44 years, and it is expected to be the second leading cause of disability for people of all ages by 2020.

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) is the 2013 update to the American Psychiatric Association's (APA) classification and diagnostic tool. The DSM-5 supersedes the DSM-IV-TR, which was published in 2000.

The American Psychiatric Association's DSM-5 (2013) Diagnostic and Statistical Manual of Mental Disorders, states that the diagnosis of depression depends on the presence of two cardinal symptoms: (1) persistent and pervasive low mood, and (2) loss of interest or pleasure in usual activities. Depressive symptoms are judged to be of clinical significance when they interfere with normal activities and persist for at least two weeks, in which case a diagnosis of a depressive illness or disorder may be made (DSM-5, 2013).

The DSM-5 (2013) defines two classes of mood disorders in adults: Bipolar and related disorders and depressive disorders. Bipolar, or manic-depressive, disorder is characterized by both a depressed and a manic component of mood. Some scientists think what we usually consider depression may be better characterized as a syndrome than a discrete disorder. A syndrome may have many causes that result in what appears to be the same constellation of symptoms (Winokur, 1997).

A number of changes occurred between DSM-4 and DSM-5 in understanding depression:

- The bereavement exclusion in DSM-IV was removed from depressive disorders in DSM-5.
- New disruptive mood dysregulation disorder (DMDD) was added for children up to age 18 years.
- Premenstrual dysphoric disorder was moved from an appendix for further study, and became a disorder.
- Specifiers were added for mixed symptoms and for anxiety, along with guidance to clinicians for suicidality.
- The term *dysthymia* would also be called persistent depressive disorder.

The Disability Adjusted Life Years (DALYs) measure lost years of healthy life regardless of whether the years are lost to premature death or disability. Using the DALYs measure, major depression has been ranked second only to ischemic heart disease in magnitude of disease burden in developed countries (Murray and Lopez, 1996). This may be an understatement, however, because people with depression are at greater risk of developing heart disease (Nemeroff et al., 1998).

The cost of depression to society is large. Kessler and colleagues (1999) reported depressed workers had between 1.5 and 3.2 times more short-term work disability days in a 30-day period than nondepressed workers, with a salary-equivalent productivity loss averaging between $182 and $395. The Massachusetts Institute of Technology Sloan School of Management ranks depression among some of the most costly major health concerns—including coronary heart disease, cancer, and AIDS—and says that depression is more widespread than all three (Turner, 1995).

Many people assume that depression is primarily a problem that affects women. Yet men commit suicide at rates 4 to 18 times the rate for women. In order to prevent suicide and offer better treatment options for both men and women, we need a better understanding of depression as it relates to gender.

Gender and Depression

Sex and Gender

The terms *sex* and *gender* are often used interchangeably, though they refer to different concepts (Bem, 1993). **Sex** is the biologic designation as male or female. A person's sex is the result of human reproduction—the coming together of chromosomes from the father and mother. **Gender** is a perception that is shaped by society and culture. In terms of gender, maleness and femaleness are defined by a myriad of determinants including what we wear, our jobs, and our household tasks (Small, 1995).

Wood and Eagly (2002) use the term *sex* to denote the groupings of people into female and male categories; for them, the term *gender* refers to the meanings that societies and individuals ascribe to female and male categories. Deaux (1985) suggested that in research it is appropriate to use the term *sex* when participants are selected based on biologic characteristics.

In 2001 the Institute of Medicine published a report entitled "Exploring the Biological Contributions to Human Health: Does Sex Matter?" which addressed and highlighted the role of biologic sex differences in health and disease. It focused particularly on sex differences in nonreproductive areas of the male and female. The institute drew several conclusions:

1. Sex (being male or female) is an important basic human variable that should be considered when designing and analyzing studies in all areas and at all levels of biomedical and health-related practice.
2. Differences in health and illness are influenced by individual genetic and physiologic constitutions, as well as by an individual's interaction with environmental and experiential factors.
3. The incidence and severity of diseases vary between the sexes and may be related to differences in genetic constitution and individuality, in exposures, the routes of entry, the processing of a foreign agent, and cellular responses.
4. Basic genetic and physiologic differences in combination with environmental and experimental factors result in behavioral and cognitive differences between males and females. (IOM, 2001)

Epidemiology of Depression and Gender

Beginning in the 1970s and continuing today, gender has been an important variable in understanding depression (Bird and Rieker, 1999; Kuehner, 2003). In 1977 Weissman and Klerman reviewed the evidence for differing rates of depression between the sexes, in the United States and elsewhere, during the previous forty years. They found that studies showed women experienced depression at rates much higher than men, and critically analyzed the various explanations offered. These explanations included the possibility that the higher rates found in women may not be accurate as well as the possibility that the higher rate found in women may be the result of biologic susceptibility, psychosocial factors such as social discrimination, or female-learned helplessness.

The World Health Organization (WHO) has been conducting research on the epidemiology of depression since the 1970s. In a 1979 WHO report, Sartorius estimated that 100 million individuals in the world suffer from depression and these people then affect three times as many other people during their illness. Despite WHO's long history of research on depression, gender differences in depression have not become part of WHO's research until recently (Culbertson, 1997).

In 2001 WHO published a report on mental health and illness throughout the world. The research found that the overall prevalence of mental and behavioral disorders does not seem to be different between men and women. Anxiety and depressive disorders are, however, more common among women, while substance use disorders and antisocial personality disorders are more common among men (Gold 1998).

In 1990 Nolen-Hoeksema published *Sex Differences in Depression*, which reviewed studies of depression and gender conducted outside the United States. She found a mean 2:1 female-male ratio of depression in developed nations. However, in studies of depression in some developing countries, she reported no significant findings of female-male depression differences. Her book explored the reasons for the high sex differences and exceptions to the general trend. For instance, she found that among prepubescent children, boys are more likely to be diagnosed as depressed than girls, but by age 14 girls become more prone to depression. She notes that among college students, the Old Order Amish, the widowed, and people 65 and older, no sex differences were found.

More recently, Nolen-Hoeksema, Larson, and Grayson (1999) examined how social conditions and personality characteristics affect each other and contribute to the gender difference in depressive symptoms. In their study, women reported more chronic strain, a greater tendency to ruminate, and a lower sense of mastery than men. But other researchers, such as Cochran and Rabinowitz (2000) and Pollack (1998), believe that men and women may experience comparable levels of depression but express it in different ways. Pollack notes that when the percentages of alcohol abuse, depression, and antisocial personality disorder in men and the percentages for depression and anxiety disorders for women are combined, the results are comparable.

Though there is disagreement about whether women's rate of depression is much higher than men's or whether they are similar but expressed through different symptoms, there is no disagreement about the fact that depression and suicide are closely related and men's suicide rate is much higher than women's (Möller-Leimkühler, 2002). Further, the rates of depression and suicide in males have been increasing since the 1980s (Culbertson, 1997), treatment for depression in men is less effective than it is for women (Möller-Leimkühler et al., 2004), and depression is less likely to be diagnosed in men than it is in women (Möller-Leimkühler, 2002).

Suicide, Depression, and Gender

The following data are derived the National Center for Health Statistics, 2009.

General Information on Suicide

- More than 36,000 people in the United States die by suicide every year.
- In 2009 (latest available data), there were 36,909 reported suicide deaths.
- Suicide is the fourth leading cause of death for adults between the ages of 18 and 65 years in the United States.
- Currently, suicide is the tenth leading cause of death in the United States.
- A person dies by suicide about every 15 minutes in the United States.
- Every day, approximately 101 Americans take their own life.
- Ninety percent of all people who die by suicide have a diagnosable psychiatric disorder at the time of their death.
- There are an estimated 8 to 25 attempted suicides for every suicide death.

Depression and Suicide

- More than 60% of all people who die by suicide suffer from major depression. If we include alcoholics who are depressed, this figure rises to over 75%.

- Depression affects nearly 10% of Americans ages 18 and over in a given year, or more than 24 million people.
- More Americans suffer from depression than coronary heart disease (17 million), cancer (12 million), and HIV/AIDS (1 million).
- About 15% of the population will suffer from clinical depression at some time during their lifetime. Thirty percent of all clinically depressed patients attempt suicide; half of them ultimately die by suicide.
- Depression is among the most treatable of psychiatric illnesses. Between 80% and 90% of people with depression respond positively to treatment, and almost all patients gain some relief from their symptoms. But, first, depression has to be recognized.

Gender and Suicide

- There are four male suicides for every female suicide, but 3 times as many females as males attempt suicide.
- Between the mid-1950s and the late 1970s, the suicide rate among U.S. males aged 15–24 more than tripled. Among females aged 15–24, the rate more than doubled during this period. The youth suicide rate generally leveled off during the 1980s and early 1990s, and since the mid-1990s it has been steadily decreasing.
- Between 1980 and 1996, the suicide rate for African American males aged 15–19 has doubled.
- The suicide rates for men rise with age, most significantly after age 65.
- About 60% of older adults who take their own lives see their primary care physician within a few months of their death.

This latter statistic points out the importance of recognizing symptoms of depression.

Warning Signs of Suicide

Suicide can be prevented. While some suicides occur without any outward warning, most people who are suicidal do give warnings. The American Foundation for Suicide Prevention (AFSP) is exclusively dedicated to understanding and preventing suicide through research, education and advocacy, and to reaching out to people with mental disorders and those impacted by suicide. The AFSP offers the following warning signs.

Observable Signs of Serious Depression

- Unrelenting low mood
- Pessimism

- Hopelessness
- Desperation
- Anxiety, psychic pain, and inner tension
- Withdrawal
- Sleep problems
- Increased alcohol and/or other drug use
- Recent impulsiveness and taking unnecessary risks
- Threatening suicide or expressing a strong wish to die

Making a Plan

- Giving away prized possessions
- Sudden or impulsive purchase of a firearm
- Obtaining other means of killing oneself such as poisons or medications
- Unexpected rage or anger

The emotional crises that usually precede suicide are often recognizable and treatable. Although most depressed people are not suicidal, most suicidal people are depressed. Serious depression can be manifested in obvious sadness, but often it is expressed as a loss of pleasure or withdrawal from activities that had been enjoyable. In men, it can often manifest in increased irritability, anger, and hostility. Suicide can be prevented through early recognition and treatment of depression and other psychiatric illnesses.

Hopelessness (often present in those with severe depressive illness) and previous suicide attempts are significant and independent prospective risk factors for suicide (Brown et al., 2000). Although previous suicide attempts are an important risk factor, two-thirds of suicides occur on the first attempt (Mann, 2002). Other identified risk factors for completed suicide include being widowed or divorced, living alone, having a recent adverse event (such as job loss or death of loved one), having severe anxiety, having a chronic medical illness (especially a central nervous system disorder), and having a family history of suicide attempts or completions (Gaynes et al., 2004).

The assessment of suicidal thoughts or behavior and decisions about possible interventions are extremely important for all clinicians, not just mental health professionals. Up to two-thirds of patients who commit suicide have seen a physician in the month before their death (Matthews et al., 1994). It is rare for a patient to report thoughts of suicide spontaneously to their physician, and this is particularly true for men (Matthews et al., 1994). Thus it is particularly important that clinicians be sensitive to warning signs and be willing to ask the right questions—in ways that are likely to illicit a response that will lead to an accurate assessment of risk.

Suicide Rates for Males and Females

Suicide rates have increased significantly for both young men and older men over the past 25 years (Cochran and Rabinowitz, 2000). Suicide rates in men increase with advancing age (Anderson et al., 1997; Murphy, 1998).

These findings are corroborated in Will Courtenay's (2011) *Dying to be Men: Psychosocial, Environmental, and Biobehavioral Directions in Promoting the Health of Men and Boys.* Courtenay cites the following suicide and death rates from the Centers for Disease Control (CDC).

Suicide and Death Rates for Males and Females (per 100,000 population)			
Age group	Male rate	Female rate	Male/female ratio
15–19	10.9	2.7	4.0
20–24	21.4	4.0	5.4
25–29	19.5	4.7	4.2
30–34	18.3	5.2	3.5
35–44	23.9	6.8	3.5
45–54	25.8	8.8	2.9
55–64	21.4	7.0	3.1
65–74	21.5	3.4	6.3
75–84	27.3	3.9	7.0
85 or older	38.6	2.2	17.5

Source: CDC, 2010.

We see that the suicide rate for males is higher than it is for females at all stages of life; it is always in double digits for males and single digits for females. The lowest rate for males is higher than the highest rate for females. The mid-life years (45–64) are difficult for both males and females, but the years after retirement (65+) show suicide rates dropping significantly for females but increasing dramatically for males. As populations age throughout the world, the issue of suicide in male seniors needs to be addressed seriously.

Do Men Act Out and Women Act In?

One of the most interesting and intriguing experiments on gender differences in depression was conducted by J. Douglas Bremner, director of mental health research at the Atlanta Veterans Administration Medical Center and author of the book *Does Stress Damage the Brain?* (2002). Bremner gathered a group of formerly depressed patients and, with their permission, gave them a beverage that was spiked with an amino acid that blocks the brain's ability to absorb serotonin, the neurotransmitter that allows us to feel upbeat and happy.

Of great interest were the gender-specific differences in the way men and women reacted to the potion that blocked the effects of the serotonin. Typical of the males was John, a middle-aged businessman who had fully recovered from a bout of depression, thanks to a combination of psychotherapy and Prozac.

Within minutes of drinking the brew, however, "He wanted to escape to a bar across the street," recalls Bremner. "He didn't express sadness, he didn't really express anything. He just wanted to go to Larry's Lounge."

Contrast John's response with that of female subjects like Sue, a mother of two who was in her mid-thirties. After taking the cocktail, "She began to cry and express her sadness over the loss of her father two years ago," recalls Bremner. "She was overwhelmed by her emotions."

The implications of this research study can help us better understand how to recognize the different ways men and women experience depression. John didn't "look depressed" or seem sad. He didn't want to talk. He wasn't emotional. He acted out. He just wanted to get a drink. Sue, on the other hand, "looked depressed." She cried and talked about her sadness over the loss of her father. She "acted in" her sense of loss and depression and expressed her emotions freely.

A number of studies have found that men are less likely than women to seek help for depression (Möller-Leimkühler, 2002). Men don't feel depressed so they don't seek help for the problem. Even healthcare professionals fail to see the man as depressed, but as withdrawn, angry, or alcoholic.

Women and Depression

Psychologist Susan Nolen-Hoeksema (1995) interviewed 1,328 people aged 25 to 75. Participants were asked how depressed they felt, and what they found themselves doing when their mood was low. They were given a test to measure their tendency to "ruminate," or brood, about how bad they felt and what they were doing to deserve to feel this bad. Participants were asked about problems they had experienced as a result of alcohol dependence or abuse, including losing a job or an important relationship. In addition, they were asked about the extent to which they drank to cope with negative feelings, to help themselves feel better, and to deal with stress.

"I have found that women's tendency to ruminate more than men is tied to their lack of power and the stresses that come with this lack of power in society," says Nolen-Hoeksema. "In addition, women's stronger emotional ties to others, compared to men's, may contribute to their tendency to ruminate."

Nolen-Hoeksema found that while women tend to over-think when they are depressed, men tend to act out their pain. They often drink to escape their feelings of hopelessness and helplessness. "But some men are ruminators and some women drink to cope," she adds, "and for both men and women, rumination and drinking to cope are related." In other words, people who do one are at increased risk of doing the other.

While alcohol may temporarily dampen rumination for men, Nolen-Hoeksema suggests that it seems to fuel rumination in women. Instead of quelling women's worries, using alcohol to cope with distress just gives them one more thing to worry about, she speculates.

Men and Depression

The National Institute of Mental Health (2001) published a booklet on depression in men. Its introduction declares:

> Both men and women get depression. But men can experience it differently than women. Men may be more likely to feel very tired and irritable, and lose interest in their work, family, or hobbies. They may be more likely to have difficulty sleeping than women who have depression. And, although women with depression are more likely to attempt suicide, men are more likely to die by suicide.

NIMH interviewed a number of men, including Will and Patrick, who describe their experiences with depression

"When I was feeling depressed I was very reckless with my life," says Will, an attorney. "I didn't care about how I drove, I didn't take care walking across the street, I didn't care about dangerous parts of the city. I wasn't affected by any kinds of travel warnings. I didn't care. I didn't care whether I lived or died and so I was going to do whatever I wanted whenever I wanted. And, when you take those kinds of chances, you have a greater likelihood of dying."

"I'd drink and I'd just get numb," says Patrick, a retired first sergeant in the U.S. Air Force. "I'd get numb to try to numb my head. I mean, we're talking many, many beers to get to that state where you could shut your head off, but then you'd wake up the next day and it's still there. Because you have to deal with it, it doesn't just go away. It isn't a two-hour movie and then it goes 'The End' and you press Off. I mean it's a twenty-four hour a day movie and you're thinking there is no end. It's horrible."

Irritable Male Syndrome

> When women are depressed, they . . . eat or go shopping. Men invade another country.
>
> Comedian Elayne Boosler

> Men get irritable. Women get sad.
>
> Ron Kessler, PhD

Ron Kessler, a professor of healthcare policy at Harvard, describes depression in men this way: "When you study depression among children, they don't talk about being sad, they talk about being angry and irritable. Children don't have the cognitive capacity to make sense of all their feelings. There's a great similarity between children and men. Men get irritable; women get sad" (Kessler, 2003).

The Irritable Male Syndrome: Understanding and Managing the Four Key Causes of Depression and Aggression (Diamond, 2004) reports on many men and women who were trying to better understand what was going on in their lives. Here are a typical woman and man.

A Woman's View

For about a year now—it could be even longer, it's hard to know exactly—I have felt my husband of 22 years pulling away from us. He has gradually become sullen, angry, and moody. His life energy is down and his sex drive has really dropped off.

Recently he has begun venting to anyone who will listen about how horrible we all are. He is particularly hard on our 19-year-old son Mark. It's so surprising because our son has always been industrious and competent. My husband has always shared my view that Mark is one of the hardest-working kids we know. But all of a sudden that has changed. Mark still works from 6:30 until 4:30 every day, but now his Dad accuses him of being unmotivated, lazy, and any other negative thing he can think to say.

If the kids aren't living up to his standards it is my fault; when they're good it is because he has been such a positive influence in their lives. If there's a problem, it must be because of the way I've raised them. I know that sounds bizarre, but that's how he is thinking.

He blames me for everything these days. If his socks or underwear are missing, I must have put them somewhere to piss him off. I'm not kidding, that's what he tells me. The thing that bothers me most is how unaffectionate he has become. I don't even get the hugs I did in the past and, when he does touch me I feel grabbed rather than caressed. My husband used to be the most positive, upbeat, funny person I know. Now it's like living with an angry brick!

A Man's View

[Rick is a 52-year-old married man, with children aged 22 and 26. His responses are typical of many men who have spoken out.]

I think my irritability is related to my time of life and to the stresses that seem to be mounting both at work and at home. I'm an electrical engineer and work for a large company in the Midwest. There has been a great deal of "consolidation" over the last few years and many people have been let go or forced into early retirement. Even though I have been here a long time, and I don't think I am vulnerable to losing my job, I still worry.

There is always so much to do and there never seems to be enough time. I have trouble staying on top of it all. I don't have much physical or mental energy these days. All of this is affecting my sleep. My wife keeps asking me what's wrong. I don't know what to tell her. I usually answer that nothing is wrong. When she persists I often snap at her.

Although I love my wife, I feel we have grown apart over the years. We used to be very close, but now we often seem like opposites and that creates its own kind of stress. I can feel unappreciated, unheard, uncared about. She expresses the same feelings. Even though we are aware of it we don't seem to be able to do anything about it. It's very discouraging and depressing.

For me, depression and irritability are closely linked. I don't really lash out that often. I mostly hold the feelings in. I don't want to fight, but sometimes things erupt and I blow up at her. I can tell she's hurt. I feel guilty and that makes me angrier. It seems to be a vicious cycle. She says I am often sarcastic and cutting. I don't think I am, but maybe she's right.

Another thing she complains about is how I drive. You might say that I have a good deal of road rage. When people cut me off or drive in a manner dangerous to others around them, I get furious. I'll yell, pound the steering wheel, and once I even chased someone off the freeway to teach him a lesson. I was clearly out of control. My wife and I generally carpool to work and she hears all my cussing and sees all my gesturing. I know it makes her uncomfortable and she says it makes me look uneducated and low-class.

When we're out having fun, I can go from being happy-go-lucky to being crabby in the blink of an eye. Something small will happen. I take it personally and become irrationally angry. For instance, I'll be at a bar with some friends and if the waitress is slow in getting to the table, it infuriates me. Sometimes I'll say something hurtful, like "It's about time you got around to doing your job." Other times I'll just leave and go home, fuming all the way.

I lack a sense of well-being much of the time. I have come to doubt my ability to be a reliable, dependable, likeable person. My confidence in myself is low. When I feel hateful or annoyed with everyone I just want to isolate myself. That way I don't have to deal with them and I won't do things I'll regret later. As a result, I have become estranged from my wife and children. Even at work, which used to be a place I felt comfortable and where I had a lot of friends, I feel cut off and isolated.

This depression/irritability syndrome affects **everything** in my life. I feel that I have achieved very little of what, as a young man, I had hoped to achieve. I long to be much more confident and competent, much more relaxed, much more self-sufficient, and much more successful. I hope you can help me.

What Is Irritable Male Syndrome?

Irritable male syndrome (IMS) is a state of hypersensitivity, anxiety, frustration, and anger that occurs in males and is associated with biochemical changes, hormonal fluctuations, stress, and loss of male identity. Working with males who are experiencing IMS, and with those who live with them, reveals that there are four core symptoms: hypersensitivity, anxiety, frustration, and anger.

Hypersensitivity: The First Core Symptom

The women who live with these men say things like:

- "I feel as if I have to walk on eggshells when I'm around him."
- "I never know when I'm going to say something that will set him off."
- "He's like a time bomb ready to explode but I never know when."
- "Nothing I do pleases him."
- "When I try to do nice things, he pushes me away."
- "He'll change in an eye-blink. One minute he's warm and friendly. The next he's cold and mean."

Often the men don't recognize their own hypersensitivity. Their perception is that they are fine but everyone else is going out of their way to irritate them.

The men say things like:

- "Quit bothering me."
- "You know I don't like that. Why do you keep doing it?"
- "Leave me alone."
- "No, nothing's wrong. I'm fine. Quit asking questions."
- "Why don't you ever . . . want sex, do what I want to do, do something with your life, think before you open your mouth, do things the right way?"
- Or, they don't say anything. They increasingly withdraw into a numbing silence.

One concept I have found helpful is the notion that many of us are "emotionally sunburned," but others don't know it. Think of a man who is deeply sunburned and gets a loving hug from his wife. He cries out in anger and pain. He assumes she knows he's sunburned, so if she "grabs" him she must be trying to hurt him. She has no idea he is sunburned and can't understand why he reacts angrily to her loving touch. This can lead a couple down a road of escalating confusion.

Anxiety: The Second Core Symptom

Anxiety is a state of apprehension, uncertainty, and fear resulting from the anticipation of a realistic or fantasized threatening event or situation. There are many real threats that men are dealing with in their lives—sexual changes, job insecurities, relationship problems. There are also many uncertainties that lead men to fantasize about future problems.

These kind of worries usually take the form of what-ifs. What if I lose my job? What if I can't find a job? What if she leaves me? What if I can't find someone to love me? What if I have to go to war? What if something happens to my wife or children? What if my parents die? What if I get sick and can't take care of things? The list goes on and on.

Frustration: The Third Core Symptom

Princeton University's WordNet offers two definitions that can help us understand this aspect of IMS.

1. Frustration is the feeling that accompanies an experience of being thwarted in attaining your goals. Synonym is defeat.
2. Frustration is a feeling of annoyance at being hindered or criticized. The dictionary offers an enlightening example to illustrate the use of the word: "Her constant complaints were the main source of his frustration."

Men who have IMS feel blocked in attaining what they want and need in life. They don't even know what they need. When they do know, they believe there's no way they can get it. They feel defeated in trying to improve their lives. These men feel frustrated in their relationships with family, friends, and co-workers. The world is changing and they don't know where, how, or even *if* they fit in.

Author Susan Faludi captures this frustration in her book *Stiffed: The Betrayal of the American Man* (1999).The frustration is expressed in the question that is at the center of her study of American males. "If, as men are so often told, they are the dominant sex, why do so many of them feel dominated, done in by the world?" This frustration, often hidden and unrecognized, is a key element of IMS.

Anger: The Fourth Core Symptom

Anger can be simply defined as a strong feeling of displeasure or hostility. Yet anger is a complex emotion. Outwardly expressed, it can lead to aggression and violence. Turned inward, it can lead to depression and suicide. Anger can be direct and obvious or subtle and covert. Anger can be loud or quiet. It can be expressed as hateful words, hurtful actions, or stony silence.

For many men, anger is the only emotion they have learned to express. Growing up male, we are taught to avoid anything that is seen as the least bit "feminine." We are taught that men "do" while women "feel." As a result men keep all emotions under wrap. We cannot show we are hurt, afraid, worried, or panicked. The only feeling allowed many men is anger. When men begin exhibiting IMS, anger is often its primary manifestation.

Whereas feelings like anger, anxiety, and frustration can occur quickly and end quickly, irritability can develop into a mood state that lasts a long time and may trigger the feelings over and over again. Anger can have a major impact on a person's entire life. "When we're in a mood, it biases and restricts how we think," says Paul Ekman, professor of psychology and director of the Human Interaction Laboratory at the University of California Medical School in San Francisco (UCSF). Ekman is one of the world's experts on emotional expression. In describing these kinds of negative moods, Ekman continues:

> It makes us vulnerable in ways that we are normally not. So the negative moods create a lot of problems for us, because they change how we think. If I wake up in an irritable mood, I'm looking for a chance to be angry. Things that ordinarily would not frustrate me, do. The danger of a mood is not only that it biases thinking but that it increases emotions. When I'm in an irritable mood, my anger comes stronger and faster, lasts longer, and is harder to control than usual. It's a terrible state . . . one I would be glad never to have. (Ekman, 2003)

What Causes Irritable Male Syndrome?

Case

Over the past three years, especially, my relationship with my wife has begun to deteriorate. In the past there were open displays of affection and frequent verbal affirmations. Now, I seem to be irritable all the time. My attitude seems to be "Don't come near me, don't talk to me, I had a hard day, I want the entire world to piss off."

She now rarely tries to hug me, never initiates sex, and talks to me about half as much as she used to. It's gotten to the point where I find out what's going on in her life from my mother or sisters. We're both miserable and its ruining our lives. I don't understand what is causing me to act this way.

Although triggers vary for individual men, there are four key elements at the core of most men's problems:

1. Hormonal fluctuations
2. Biochemical changes in brain chemistry
3. Increasing stress
4. Loss of male identity and purpose

Testosterone and IMS

In order to understand the way in which hormonal fluctuations cause IMS in men, we need to know something about testosterone. Theresa Crenshaw, author of *The Alchemy of Love and Lust* (1996), describes testosterone this way:

> Testosterone is the young Marlon Brando—sexual, sensual, alluring, dark, with a dangerous undertone. . . . [Testosterone] is also our "warmone," triggering aggression, competitiveness, and even violence. "Testy" is a fitting term.

We know that men with testosterone levels that are too high can become angry and aggressive. Recent research shows, however, that most hormonal problems in men are caused by testosterone levels that are too low.

Gerald Lincoln (2001), who coined the term "Irritable male syndrome," found that lowering levels of testosterone in his research animals caused them to become more irritable—biting their cages as well as the researchers who were testing them.

Serotonin and IMS

Most people have heard of the brain neurotransmitter **serotonin**. When we have enough flowing through our brains, we feel good. When there isn't enough, we feel bad. Siegfried Meryn, author of *Men's Health and the Hormone Revolution* (2000), calls serotonin "the male hormone of bliss." Women have the same hormone in their brains and it has an equally positive effect on them. "The more serotonin the body produces," says Meryn, "the happier, more positive and more euphoric we are. Low serotonin can contribute to a man's irritability and aggression."

One of the most common causes of low serotonin levels is diet. Many men believe that eating lots of red meat is "manly." Judith Wurtman and colleagues (2006) at the Massachusetts Institute of Technology found that a high protein, low carbohydrate diet can cause increased irritability in men. They found that men often mistake their cravings for healthy carbohydrates—found in vegetables like potatoes, rice, corn, and squash—with cravings for the protein found in meat.

"Eating protein when we need carbohydrates," says Wurtman, "will make us grumpy, irritable, or restless." Wurtman's team also found that alcohol consumption increases serotonin levels initially. However, chronic use dramatically lowers serotonin, resulting in depression, carbohydrate cravings, sleep disturbances, and being prone to argumentativeness and irritability.

Stress and IMS

We all know the feeling. We've had another one of those days at work. One deadline after another and there isn't enough time to breathe. Someone always seems to be making more demands and no matter how hard we try to stay on top of things, we seem to be getting farther and farther behind. Many of us have lost our jobs. If we have a job we're often working more hours for less money. The economy is in turmoil. Our savings are dwindling and our hopes for retirement seem to be fading away. We all know the feeling of being stressed out. But what exactly is stress and why is stress reduction so important?

In my experience as a psychotherapist, I have found that stress underlies most of the psychological, social, and medical problems (including IMS) that people face in contemporary society. For most of us, stress is synonymous with worry. If it is something that makes us worry, then it is stressful. However, our bodies have a much broader definition of stress.

To the body, stress is synonymous with change. It doesn't matter if it is a "good" change, or a "bad" change, they are both stressful. A divorce is stressful; however, when you find your dream home and get ready to move, that too is stressful. Good or bad, if it is a change in your life it is interpreted as stress by your body.

We can't avoid stress, nor would we want to. Life is change. The problem is what happens when there is too much change in too short a time. We might think of the problem that leads to irritable male syndrome as "dis-stress" or "overstress." Stress is unavoidable, necessary, invigorating, and life-enhancing. Distress and overstress can cause untold problems if not understood and prevented.

So, what can we do to relieve stress? If you think about the kinds of stresses our bodies are designed to meet, they all involve physical activity. When a wild animal came into the camp of our hunter-gatherer ancestors, they either fought or ran away. Either way utilized a lot of physical energy. It's physical activity that allows the body to attend to the stress and return to normal.

In our modern world, we usually don't have wild animals bursting into our living rooms. The stresses are more psychological than physical. Yet the reaction is the same. Our bodies release stress hormones that can only be dissipated through physical activity. So, if you build up stress every day, you must do something physical every day. Walk, run, take an aerobics class. You'll feel better and it's a surefire way to treat IMS.

Loss of Male Identity and Purpose

For most of human history, the male role was clear. Our main job was to "bring home the bacon." We hunted for our food and shared what we killed with family and tribe. Everyone had a role to play. Some were good at tracking animals. Others were good at making bows and arrows or spears. Some men could shoot an arrow with enough strength to kill a buffalo. Others were skilled at singing songs and doing dances that invoked the spirit of the animal and made the hunt more effective.

But now many of us work at jobs that we hate, producing goods or services that have no real value to the community. We've gotten farther and farther away from the basics of bringing home food we've hunted or grown our own. The money we receive is small compensation for doing work that is meaningless. Yet the men with some kind of job, no matter how bad it is, are the lucky ones. More and more men are losing their jobs and are unable to find new ones.

In *Stiffed (*1999), Susan Faludi concludes that male stress, shame, depression, and violence are not just a problem of individual men but a product of the social betrayal men feel as a result of a changing economic situation. One of the men Faludi interviewed at length could be speaking for millions of men:

> There is no way you can feel like a man. You can't. It's a fact that I'm not capable of supporting my family. . . . When you've been very successful in buying a house, a car, and could pay for your daughter to go to college, though she

> didn't want to, you have a sense of success and people see it. I haven't been able to support my daughter. I haven't been able to support my wife. I'll be very frank with you: I. Feel. I've. Been. Castrated.

As Faludi interviewed men across the country, she confirmed something most adults know all too well. Men put a lot of their identity and sense of self-worth into their jobs. If we aren't working or can't support our family, we feel that we're not really men. We need to help men realize there is more to who they are than a paycheck.

Male Depression and the Shifting Economy

> Men in the changing economy will face the same risks for depression that women faced in older economies: trapped in a family role from which they cannot escape because of an inability to find employment.
>
> Boadie W. Dunlop, MD

The factors impacting American men when Susan Faludi wrote *Stiffed* in 1999 are devastating men throughout the world in the current economic climate. An editorial in the *British Journal of Psychiatry* indicates that depression rates in men are on the rise and likely to increase further due to socioeconomic changes around the world. The study's principle author Boadie Dunlop, of Emory University School of Medicine in Atlanta, writes:

Compared to women, many men attach a great importance to their roles as providers and protectors of their families. Failure to fulfill the role of breadwinner is associated with greater depression and marital conflict. (2011)

Research shows that since the beginning of the recession in 2007 roughly 75% of the jobs lost in the United States were held by men. Women are increasingly the primary household earners, with 22% of wives earning more than their husbands in 2007 as compared to only 4% in 1970. There is little reason to believe that traditional male jobs will return in significant numbers even when the economy fully recovers. Dunlop continues:

> The recent recession afflicting Western economies serves as a harbinger of the economic future for men, especially for those with lower levels of education. Dubbed by some the "mancession," the economic downturn has hit men particularly hard because of its disproportionate effect on traditional male industries, such as construction and manufacturing, although, of course, working women have also been affected. (2011)

In my clinical practice, I have seen an increasing number of men who are out of work or are afraid of losing their jobs. The experience is often devastating. They become anxious, irritable, angry, and sometimes suicidal. It not only impacts the men but also their families. Underlying these behaviors are experiences of loss and persistent feelings of hopelessness, helplessness, and worthlessness, the hallmarks of depression. Yet social pressures continue to discourage men from reaching out for help despite the increasing stresses they are experiencing.

Sex Bias in the Diagnosis of Depression

Most clinicians believe that we are treating our male and female clients with equal understanding, care, and concern. But sex bias can influence whether we recognize depression in men, how supportive we are when we recognize it, and how we treat depressed men once they are properly diagnosed.

Sex bias can be defined as "a systematic deviation from an expected value that is associated with the sex of the individual" (Hartung and Widiger, 1998). Some have suggested that deviations from expected values "reflect society's sexism" (Kaplan, 1983) or a "deeply entrenched sexism in the American Psychiatric Association" (Caplan, 1995). Although this kind of sexism may exist, Hartung and Widiger (1998) point out that sex bias can also result from well-intentioned, conscientious efforts to provide accurate estimates of differential sex prevalence rates.

The fact that there are differences in prevalence rates between males and females is not to suggest that bias is always present. There are substantial differences in ratios between many mental disorders (Nolen-Hoeksema, 1995). For example, there appear to be male-female genetic and hormonal differences that contribute to the higher rate of rapid cycling in bipolar disorder in women (Leibenluft, 1996) and various interacting bio-psycho-social factors that result in a substantial preponderance of boys with conduct disorder (Eme and Kavanaugh, 1995).

The larger numbers of disorders more common in boys (17) compared to the number more common in girls (3) may be an instance of sex bias (Hartung and Wittiger, 1998). It may be that boys are referred for treatment and hence diagnosed more often than girls because they are exhibiting behavior that is more troublesome to parents or teachers than because they have more mental health problems (Goodman et al., 1997).

This kind of sex bias may express itself in adulthood in a different way. The source for the initiation of treatment in adulthood is more likely to be the identified patient. Since women are more likely to initiate treatment for mental disorders than men (Möller-Leimkühler, 2002), this may account for a degree of the gender discrepancy seen in clinical settings (Good and Wood, 1995). This may be particularly important in understanding gender and depression (Möller-Leimkühler, 2002).

The diagnostic criteria for major depression found in the DSM-IV-TR (American Psychiatric Association, 1994) include symptoms that represent a feminine-gendered pattern (as defined in mainstream Western culture) of the disorder (Kilmartin, 2005). A number of clinical researchers (Diamond, 2004; Lynch and Kilmartin, 1999; Real, 1997) suggest that women often "act in" as a result of gender-role conditioning that emphasizes both the expression of feelings and focus on internal judgments of their own inadequacies. Men, on the other hand, are conditioned to "act out," and thus men's depression is more likely to be expressed through chronic anger, self-destructiveness, drug use, gambling, womanizing and workaholism (Rutz, 1999). Underlying these behaviors are experiences of loss and persistent feelings of hopelessness, helplessness, and worthlessness, the hallmarks of depression (Kilmartin, 2005).

The "acting-out" depressive pattern is labeled "masculine (a psychological term) rather than "male" (a biological term) because many men are conventionally depressed and many women evidence a masculine style of depression. But because the cultural pressure to conform to gender expectations is so strong, most sufferers of masculine depression are males (Kilmartin, 2005). Cultural conditioning defines masculinity as anti-femininity (Brannon, 1985). For instance, if females cry, males are conditioned that crying is not masculine. From an early age boys learn to avoid any behaviors that are viewed as feminine because they can lead to social punishment. Thus we see that, because women are conditioned to "act in" when they are feeling depressed (cry, worry, ruminate) men are encouraged to do the opposite (remain stoic, disconnect from feelings, and convert vulnerable feelings into anger).

A Better Instrument for Assessing Male Depression

Most patients with symptoms of depression are treated in primary care settings—not by mental health professionals (Sharp and Lipsky, 2002). Depressed patients present with feelings of sadness, loneliness, irritability, worthlessness, hopelessness, agitation, and guilt that may be accompanied by an array of physical symptoms. Recognizing depression in a primary care setting may be particularly challenging because of time constraints and because patients, especially men, rarely report emotional difficulties. To the contrary, patients with depression who present to primary care professionals are more likely to describe somatic symptoms such as fatigue, insomnia, pain, loss of interest in sexual activity, or various vague symptoms (Suh and Gallo, 1997).

There is no laboratory test to establish the diagnosis of clinical depression. Instead, a trained interviewer conducts a clinical interview to determine if the patient meets established criteria. The most commonly used criteria, which are updated periodically, are the DSM-IV-TR or the International Classification of Diseases, Tenth Revision (ICD-10).

A number of questionnaires are available to help clinicians identify and diagnose adult patients with major depression. Based on a review of studies between 1970 and 2000, Williams and colleagues (2002) evaluated eleven questionnaires ranging in length from 1 to 30 questions that were assessed in 28 studies. Six are depression-specific:

- Beck Depression Inventory (BDI)
- Center for Epidemiologic Studies Depression Screen (CES-D)
- Zung Self-Assessment Depression Scale (SDS)
- Depression Scale (DEPS)
- Geriatric Depression Scale (GDS)
- Single Question (SQ)

The BDI, the CES-D, and the SDS were developed specifically to identify depression. They include similar numbers of questions. They use response formats that rely on classifying frequency of symptoms or ranking symptom severity. These three instruments are among the most thoroughly evaluated in primary care and can be used to rate the severity of depression and monitor response to therapy.

Although these instruments are widely used and accepted, a number of researchers believe that the most widely used assessment scales are gender biased (Cole et. al., 2000; Stommel et al., 1993). They tend to include that are generally more true of women than of men. They also leave off questions that depressed men, but not depressed women, might answer positively.

Is There a Male Depressive Syndrome?

Due to increasing suicide rates in the 1980s, the Swedish Committee for the Prevention and Treatment of Depression (PTD) organized a training program on the diagnosis and treatment of depression for all the general practitioners on the island of Gotland (Rutz et al., 1995). The researcher's were surprised to find the rate of depressive suicides in females decreased dramatically after the PTD program, while the proportion of male depressive suicides was almost unchanged after the PTD education (Rutz, 2001a).

Based on the Gotland studies, Rutz (1999) postulated a "male depressive syndrome," with symptoms that differ from common depressive symptoms among females. According to this view, depression in men often seems to be masked by atypical symptoms like irritability, anger attacks, aggression, stress, anxiety, and fatigue. A number of studies (Diamond, 2010; Oquendo et al., 1999; Möller-Leimkühler, 2003) have shown that the high suicide rate in men may result from under-diagnosis of depression. Since symptoms such as irritability and anger are not included in leading international classification systems, depression may be overestimated in females and underestimated in males (Salokangas et al., 2002).

The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR), originally published by the American Psychiatric Association in 1994 and revised most recently in 2000, has become the world's standard. Among its criteria for evaluating a person for major depression are the following:

> A person must have at least one of three abnormal moods that significantly interfered with the person's life:

1. Abnormal depressed mood most of the day, nearly every day, for at least 2 weeks.
2. Abnormal loss of all interest and pleasure most of the day, nearly every day, for at least 2 weeks.
3. If 18 or younger, abnormal irritable mood most of the day, nearly every day, for at least 2 weeks.

Based on these criteria, many clinicians focus on depressed mood and loss of interest and pleasure when evaluating adults, and they don't think of irritability as a symptom of depression, at least in those over the age of 18.

In a review of the literature, Whitfield (2003) found 209 studies published in peer-reviewed journals that linked depression with a history of childhood trauma. Although there have been a number of theories put forth to explain male depression, a theory based on gender-specific vulnerability to trauma has important clinical implications. Pollock (1998) postulates:

> Historical, cultural, and economic forces have affected parenting styles so that, as boys, men will suffer a traumatic disruption of their early holding environment, a premature psychic separation from both maternal and paternal caregivers. This is a normative male, gender-linked loss, a trauma of abandonment for boys which may show itself later as an adult through symptomatic behavior, characterological defense and vulnerability to depression.

Based on his theory of gender-specific vulnerability to trauma, Pollock (1998) suggests a classification he calls "Major Depressive Disorder—Male Type." Pollock posits a number of symptoms, including the following :

- Increased withdrawal from relationships: May be denied by patient.
- Overinvolvement with work activities: May reach a level of obsessional concern, masked by comments about "stress" (burnout).
- Increasingly rigid demands for autonomy.
- Shift in the interest level of sexual encounters: May be either a decrease or an increase (differentiate from mania).
- Increase in intensity or frequency of angry outbursts.
- New or renewed interest in psychoactive substance self-administration.
- Denial of any sadness and an inability to cry.
- Harsh self-criticism: Often focusing on failures in the arenas of provider and/or protector.
- Depleted or impulsive mood.
- Avoiding the help of others: The "I can do it myself" syndrome. (Pollock, 1998)

Other theories seeking to understand the different ways males and females express depression focus on role conditioning (Kilmartin, 2005; Lynch and Kilmartin, 1999; Real, 1997). These theories are based on research showing that masculinity is culturally defined as anti-femininity (Brannon, 1985; Pollack, 1998; Kilmartin, 2005). Men are conditioned to express themselves in opposite ways to those of women. If women "act in" their feelings, men "act out." Thus Kilmartin (2005) suggests that, diagnostically, male symptoms of depression should include the following:

- Bad temper
- Aggression
- Substance abuse
- Physical and sexual risk-taking

- Emotional numbness
- Over-involvement in work or sports or both
- Impoverished friendships

It was because symptoms like those noted above were not included in standard depression scales that I developed the Diamond Male Depression Scale (DMDS) to supplement other scales in common use.

The Diamond Male Depression Scale

The Diamond research study was designed to clarify the theoretical constructs related to depression and to see which symptoms are most predictive of depression and suicide risk as well as which symptoms most distinguish depressed men from depressed women. A summary of the research findings can be seen here. The full research study is available here.

Study Population

A total of 1072 individuals (323 females and 749 males) filled out the Diamond **Male Depression Scale** (DMDS) questionnaire. Ages ranged from 18 to 80 with a mean age of 51. Most respondents were from the United States, but people responded from a total of 45 countries. Previous research indicated that men, particularly depressed men, would be less likely to respond than women, so a specific effort was made to reach out to that group. To see the complete Diamond Male Depression Scale questionnaire, click here and scroll down to Appendix 1.

In addition to the author's website, menalive.com, announcements were sent out through McManweb.com (a site for people interested in depression and bipolar disorder) and maledepression.com (a site focused on depression and men). The sample was predominantly older, male, married, employed, white, educated, and living in the United States. There was considerable reporting of psychiatric illness in the participants and their families.

Data Collection Tools

The Diamond Male Depression Scale questionnaire was administered online to a population of men and women. The questionnaire had seven sections. The first included demographic information on age, sex, marital status, relationship happiness, children, race, employment, income, education, and veteran status. Additional information was sought in this section on whether the subjects had been diagnosed with a depressive illness or other common mental illnesses and whether family members had been so diagnosed.

The second section presented 51 questions that included atypical symptoms thought to be associated with male-type depression. The selection of questions was based on clinical experience of the author over the past forty years as well as previous research focused on atypical symptoms thought to be more common in males than females (Cochran and Rabinowitz, 2000; Kilmartin, 2005; Lynch and Kilmartin, 1999; Real, 1997; Rutz, 1999).

The third section contained the 20-question Center for Epidemiologic Studies Depression Screen (CES-D) mentioned earlier. The fourth section focused on suicidal ideation and intent and included four questions taken from the Beck Hopelessness Scale as well as two questions that asked directly about suicidal ideation and intent.

The fifth section addressed issues surrounding the drinking of alcoholic beverages. It contained the four questions from the CAGE scale assessing alcohol abuse and one question that asked about the quantity of alcohol consumed. The sixth section asked about possible co-morbidities, including a number of physical illnesses and medications thought to be associated with depression. The seventh section included the questions from the Gotland Male Depression Scale.

To see the complete study, including the Diamond Male Depression Scale, click here.

DMDS and Its Subscales

Three subscales were identified and then correlated with the CES-D depression scale.

Sub-Scale 1: Emotional Acting-In Depression

This scale focused on feeling negative, stressed, empty, and other internal expressions of depression and included the following items from the full 51-item questionnaire:

- d28 I feel I'd like to get away from it all.
- d34 I feel that things are stacked against me.
- d35 People I count on disappoint me.
- d36 I feel stressed out.
- d40 I feel emotionally numb and closed down.
- d41 I feel hopeless about the future.
- d42 I feel powerless to improve things in my life.
- d43 I feel my life has little worth or value.
- d44 I have little interest or pleasure in doing things.
- d45 I find I am complaining about things in my life.
- d46 I feel sorry for myself.

- d48 I feel burned out.
- d49 I feel empty inside.
- d50 I feel tired even when there is no reason to be so.
- d51 I have difficulty making everyday decisions.

Sub-Scale 2: Emotional Acting-Out Depression

This scale focused on such things as being difficult, irritable, angry, and other external emotional expressions of depression and included the following items from the full 51-item questionnaire:

- d1 I flare up quickly.
- d2 I have trouble controlling my temper.
- d22 I am easily annoyed, become grumpy, or impatient.
- d27 Other people "drive me up the wall."
- d29 When others disagree with me I get very upset.
- d37 It doesn't take much to set me off.
- d38 I have difficulty maintaining self-control.

Sub-Scale 3: Physical Acting-Out Depression

This scale focused on such things as violence, gambling, alcohol abuse, and other external, physical expressions of depression and included the following items from the full 51-item questionnaire.

- d4 I have hit someone when I was provoked.
- d8 I work longer hours because going home is stressful.
- d10 I gamble with money I have set aside for other things.
- d11 I drive fast or recklessly as a way of letting off steam.
- d12 If I'm feeling low, I'll use sex as a pick me up.
- d23 I have felt I should cut down on my drinking or drug use.
- d30 I feel like picking a fight with someone.
- d31 I get so jealous or possessive I feel like I could explode.

Gender, Depression, and Suicide Risk

All three sub-scales were significantly correlated with the traditional CES-D depression scale, indicating that they are, in fact, measuring aspects of depression:

- Scale 3, Physical Acting-Out, showed significant gender differences between depressed males and depressed females.
- Scale 1, Emotional Acting-In and Scale 2, Emotional Acting-Out, also showed differences between depressed men and women, but not as significantly as with Scale 3.
- Even non-depressed men and women showed significant differences in how they responded to items on Scale 3. This is important since it allows clinicians to assess possible danger for men even before symptoms get serious enough to be labeled as "depression."
- Scale 1, Emotional Acting-In showed a significant positive relationship with suicide risk, showing that it is a useful scale to examine suicide risk potential.
- Increasingly, there was a negative relationship between Scale 2, Emotional Acting-Out, Scale 3, Physical Acting-Out, and suicide risk.

We could argue that "acting out" might be an alternate way of killing oneself so that those who use those methods may be "killing themselves slowly." A number of clinical researchers (Kilmartin, 2005; Lynch and Kilmartin, 1999; Real, 1997; Rutz, 1999) have suggested that "acting out" in behaviors such as drinking too much, anger, and aggression may be ways in which some people express their hopelessness.

The present study suggests that the theoretical construct of a "male depressive syndrome" is valid. Further, it offers an expanded conceptual framework as to what symptoms should be included and includes the development of three subscales to more accurately describe such a syndrome. Future research should be directed at developing studies to validate the scales and to develop scores for levels of risk for depression.

Healer, Heal Thyself

My wife Carlin and I walked tentatively into the nicely restored old building to attend the "family weekend." Our son had been in treatment for a drug problem and we were there to learn and offer support. As part of the weekend experience, all family members were given questionnaires. One was a depression questionnaire. We dutifully filled it out and my wife scored "high" while I scored "low." Carlin talked to a counselor, who suggested that Carlin might want to be evaluated for depression when we returned home.

Driving back, we talked, and it became clear that Carlin had been feeling depressed for some time. Once home, she saw a doctor, was evaluated, and subsequently put on anti-depressants. Her life and mine changed for the better. It was as if she had come out of a fog. Her joy returned and she became much more fun to be around.

A few months into her treatment, Carlin suggested that I might be depressed as well and suggested I see her doctor. I promptly refused.

“I’m not depressed,” I thought out loud. “If I were I’m sure I’d know it. I’m a therapist and I treat depression. I’d certainly recognize it in myself.”

“OK, it was just a suggestion,” she said. She gave me a gentle smile.

“Anyway,” I reminded her, “I took the depression quiz at the treatment center and I scored low.”

As far as I was concerned the case was closed. Nevertheless, disturbing thoughts would pop into my head. My father had suffered from manic-depressive illness all his life and had tried to commit suicide. I knew that the disease ran in families. Though I kept telling myself I was immune—God knows we therapists can be the most pig-headed people when our own mental health is questioned—still there were those doubts. Plus, I found I was often irritable, angry, preoccupied, and withdrawn. But that couldn’t be depression, could it?

I convinced myself that my irritability and anger were justified. “Who wouldn’t be upset with what I have to put up with?” I would argue. “I’m stressed out at work, the kids seem to go out of their way to get on my last remaining nerve, and my wife is going through menopause.”

Carlin received the brunt of my anger, which she fought to deflect. But what did she expect? If she’d just be nicer, more loving, more interested in sex, everything would be okay. It never occurred to me that my constant anger made it nearly impossible for her to be nicer, more loving, or more interested in sex.

More and more often I found I was having fantasies of running away from it all. I’d see myself getting in my car and just driving into the sunset. Other times I saw myself with another woman, someone who was kinder and gentler and who understood me—someone like Carlin used to be. Those thoughts both excited and scared me. I knew we couldn’t go on like this, but I had no idea what to do.

Finally, Carlin made the decision for me. “Look,” she told me directly, “we’re both miserable. If our marriage is going to survive, you’ve got to see someone.” Reluctantly, I made an appointment with the doctor she had seen. He did a complete evaluation and I was sure he would say I was a normal guy who had to deal with a lot of stress in his life. Instead, he told me I was suffering from depression and would benefit from treatment. I was shocked. I thanked him and was about to leave when he said something that hit me between the eyes.

"You need to be aware that men often experience depression differently than women, and highly successful and intellectual men, in particular, often deny that they are depressed."

When I got home Carlin was anxious to hear the results. I told her what the doctor had said and she seemed relieved. I told her I wanted a second opinion. She blew up. "You want a second opinion? I'll give you a second opinion. You're depressed and you need treatment just as I did. It helped me and it will help you." She turned and walked out of the room.

I didn't want to believe I was depressed. It just didn't fit with my view of myself. And it didn't fit with what I knew were the symptoms of depression. My mood wasn't depressed most of the time. I hadn't lost interest in my work or activities I loved. I slept fine and my energy was OK. I didn't feel worthless and I didn't think of killing myself.

I did decide to see another doctor. Even though I liked this one much better than the first, she told me essentially the same thing as doctor number one. She also explained that men who are depressed are often hypersensitive, irritable, and angry. She gave me a book to read by a world-renowned psychologist, Kay Redfield Jamison. In *An Unquiet Mind: A Memoir of Moods and Madness (*1997), Jamison described depression in a way that cut to my core. "You're irritable and paranoid and humorless and lifeless and critical and demanding, and no reassurance is ever enough. You're frightened, and you're frightening, and 'you're not at all like yourself but will be soon,' but you know you won't."

I could no longer deny the truth. I *was* dealing with depression. I agreed to begin therapy as well as to try medications. I found that my life turned around. I wasn't so hypersensitive. Little things didn't bother me as much. I wasn't so reactive and I felt less irritable. As Carlin described it, "You used to look at me in a way that chilled me. Your eyes were narrow and beady. Now when you look at me I feel your love. It's wonderful."

It was partly the result of these experiences, which took place a number of years ago, that I came to see that men generally experience depression differently from women. It also convinced me that the evaluation tools currently used to diagnose depression were inadequate to assess depression in many men. I committed myself to finding out how we could do a better job in evaluating depression in men.

Summary

From my forty years' experience as a clinician, I have found one of the primary reasons male depression often goes unrecognized, undiagnosed, and untreated is that most depressed men act out their depression by becoming irritable, angry, and withdrawn, while women tend to act in their depression and become anxious, sad, and teary. Women's response often brings sympathy and support, while men are often viewed as mean rather than depressed (see table).

Comparing Men's and Women's Responses to Depression	
Women tend to:	Men tend to:
Blame themselves for problems	Blame others for problems
Feel sad and tearful	Feel irritable and unforgiving
Sleep more than usual	Have trouble sleeping or staying asleep
Be vulnerable and easily hurt	Be suspicious and guarded
Try to be nice	Be overtly or covertly hostile
Withdraw when feeling hurt	Attack when feeling hurt
Be more obviously depressed	Hide their depression and act out
Feel they were set up to fail	Feel the world is set up to fail them
Be slowed down and nervous	Be restless and agitated
Maintain control of anger/ May have anxiety attacks	Lose control of anger/ May have sudden attacks of rage
Be overwhelmed by feelings	Have blunted feelings, often numb
Let others violate boundaries	Have rigid boundaries; push others out
Feel guilty for what they do	Feel ashamed for who they are
Be uncomfortable receiving praise	Be frustrated if not praised enough
Accept weaknesses and doubts	Deny weaknesses and doubts
Fear success	Fear failure
"Blend in" to feel safe	Try to be "top dog" to feel safe
Use food, friends, and love to self-medicate	Use alcohol, TV, sports, and sex to self-medicate
Believe their problems could be solved if only they could be a better… (spouse, co-worker, parent, friend)	Believe their problems could be solved if only their… (spouse, co-worker, parent, friend) would treat them better

Comparing Men's and Women's Responses to Depression	
Women tend to:	Men tend to:
Wonder "Am I loveable enough?"	Wonder "Am I being loved enough?"

These are important times for those working in healthcare. As the everyday stresses increase for everyone, we healthcare professionals have to offer guidance and support. We also have to deal with stresses in our own lives and be sure we are taking care of ourselves. Understanding the gender-specific aspects of depression can go a long way in allowing us to help others while helping ourselves.

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Post Test (Depression Gender 082)

Use the answer sheet following the test to record your answers.

1. Depression is:

   a. An effective condition.
   b. A permanent state of discouragement.
   c. A disorder of mood.
   d. A usually temporary bad feeling.

2. Sex is the biologic designation as male or female, while gender is:

   a. A concept used to explain the differences between the sexes.
   b. An ill-defined concept that is not scientifically based.
   c. So broad a term that it defies definition.
   d. A perception shaped by society and culture.

3. When the Institute of Medicine addressed nonreproductive sex differences in males and females, it concluded that:

   a. Sex is more of a distraction than a relevant variable in most scientific studies.
   b. Sex should be considered in all studies that are health-related.
   c. Sex is more influential in psychological than somatic investigations.
   d. Sex is more influential in somatic than psychological investigations.

4. When depression is recognized and treated:

   a. Between 80% and 90% of people respond positively.
   b. More than half of depressed patients improve.
   c. About a third of patients respond positively.
   d. It is difficult to measure improvement in depressed patients.

5. Signs of serious depression include all but which one of the following?:

   a. Having trouble sleeping or sleeping frequently during the day.
   b. Crying frequently following loss of a spouse a month ago.
   c. Giving away prized possessions.
   d. Increased alcohol or other drug use.

6. Serious depression in men is often expressed by:

a. Obsessiveness.
b. Infidelity.
c. Irritability.
d. Furtive behavior.

7. The suicide rate for males is:

a. Lower than it is for females until age 65.
b. Higher than it is for females at all stages of life.
c. About the same as females' rate over the lifespan.
d. Always in single digits despite higher rates at times.

8. Men are less likely than women to seek help for depression because:

a. Their masculine pride gets in the way.
b. They don't want to talk about their emotions.
c. They prefer to withdraw into themselves.
d. They don't "feel depressed" because they don't recognize the symptoms.

9. A research study found that, compared to men, women express depression by:

a. Ruminating, or brooding.
b. Relying on alcohol or drugs.
c. Becoming hostile and sullen.
d. Acting out.

10. The four core symptoms of Irritable Male Syndrome are:

a. Frustration, anger, obsessiveness, and anxiety.
b. Anger, anxiety, frustration, and insomnia.
c. Hypersensitivity, anxiety, frustration, and anger.
d. Hypersensitivity, excessive drinking, hostility, and frustration.

11. Whereas some feelings can occur quickly and end quickly, irritability:

a. Is often internalized and unrecognized.
b. Is a coping mechanism rather than a feeling.

c. Has only fleeting impact on depression itself.

d. Can develop into a mood state that triggers negative emotions over and over.

12. Irritable Male Syndrome has been related to all but one of the following:

a. Vitamin B deficiency.

b. Low levels of testosterone.

c. Serotonin deficiency.

d. Loss of male identity.

13. In the study of depression, sex bias is:

a. The unconscious preference for one sex over the other.

b. Applying different standards to females than to males.

c. A deviation from an expected value associated with the sex of an individual.

d. Identifying males and females with certain attributes from the outset.

14. When depressed women "act in," they:

a. Isolate themselves and refuse to go out into the community.

b. Resort to workaholism.

c. Become self-destructive and drink excessively.

d. Focus on internal judgments of their own inadequacies.

15. For the first time, there are laboratory tests to establish the diagnosis of clinical depression.:

a. True

b. False

16. Pollack's proposed classification called "Major Depressive Disorder—Male Type," includes all but one of the following:

a. Avoiding the help of others.

b. Denial of any sadness and inability to cry.

c. Secret crying episodes and inability to stop.

d. Inability to show any emotions outwardly.

17. Notable differences do exist between the behaviors of depressed men and women. **Men** who are depressed:

a. Are overwhelmed by feelings.

b. Blame themselves for problems.

c. Try to blend in to feel safe.

d. Use alcohol, TV, sports, and sex to self-medicate.

Answer Sheet

Depression: Gender Matters (082)

Name (Please print your name): _____

Date: _____

Passing score is 80%

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____

Course Evaluation (Depression Gender 082)

Please use this scale for your course evaluation. Items with asterisks * are required.

- 5 = Strongly agree
- 4 = Agree
- 3 = Neutral
- 2 = Disagree
- 1 = Strongly disagree

* Upon completion of the course, I was able to:

a. Explain why gender matters in regards to depression.

○ 5 ○ 4 ○ 3 ○ 2 ○ 1

b. Discuss the nature of depression and how it manifests.

○ 5 ○ 4 ○ 3 ○ 2 ○ 1

c. Distinguish between sex and gender and their roles in depression.

○ 5 ○ 4 ○ 3 ○ 2 ○ 1

d. Define Irritable Male Syndrome and enumerate its causes.

○ 5 ○ 4 ○ 3 ○ 2 ○ 1

e. Debate the existence of sex bias in the diagnosis of depression.

○ 5 ○ 4 ○ 3 ○ 2 ○ 1

f. Show the need for an instrument for assessing male depression.

○ 5 ○ 4 ○ 3 ○ 2 ○ 1

* The author(s) are knowledgeable about the subject matter.

○ 5 ○ 4 ○ 3 ○ 2 ○ 1

* The author(s) cited evidence that supported the material presented.

○ 5 ○ 4 ○ 3 ○ 2 ○ 1

* This course contained no discriminatory or prejudicial language.

Yes No

* The course was free of commercial bias and product promotion.

Yes No

* As a result of what you have learned, do you intend to make any changes in your practice?

Yes No

If you answered Yes above, what changes do you intend to make? If you answered No, please explain why.

* Do you intend to return to ATrain for your ongoing CE needs?

- Yes, within the next 30 days.
- Yes, during my next renewal cycle.
- Maybe, not sure.
- No, I only needed this one course.

* Would you recommend ATrain Education to a friend, co-worker, or colleague?

- Yes, definitely.
- Possibly.
- No, not at this time.

* What is your overall satsfaction with this learning activity?

5 4 3 2 1

* Navigating the ATrain Education website was:

- Easy.
- Somewhat easy.

- ○ Not at all easy.

* How long did it take you to complete this course, posttest, and course evaluation?

- ○ 60 minutes (or more) per contact hour
- ○ 50-59 minutes per contact hour
- ○ 40-49 minutes per contact hour
- ○ 30-39 minutes per contact hour
- ○ Less than 30 minutes per contact hour

I heard about ATrain Education from:

- ○ Government or Department of Health website.
- ○ State board or professional association.
- ○ Searching the Internet.
- ○ A friend.
- ○ An advertisement.
- ○ I am a returning customer.
- ○ My employer.
- ○ Other
- ○ Social Media (FB, Twitter, LinkedIn, etc)

Please let us know your age group to help us meet your professional needs.

- ○ 18 to 30
- ○ 31 to 45
- ○ 46+

I completed this course on:

- ○ My own or a friend's computer.
- ○ A computer at work.
- ○ A library computer.
- ○ A tablet.
- ○ A cellphone.
- ○ A paper copy of the course.

Please enter your comments or suggestions here: _____

_____

_____

_____

Registration Form (Depression Gender 082)

Please print and answer all of the following questions (* required).

* Name: _____

* Email: _____

* Address: _____

* City: _____ * State: _____ * Zip: _____

* Country: _____

* Phone: _____

* Professional Credentials/Designations:

_____

* License Number and State: _____

* Please email my certificate:

◯ Yes ◯ No

(If you request an email certificate we will not send a copy of the certificate by US Mail.)

Payment Options

You may pay by credit card or by check.
Fill out this section only if you are **paying by credit card.**
4 contact hours: $10

Credit card information

* Name: _____

Address (if different from above): _____

* City: _____ * State: _____ * Zip: _____

* Card type:

◯ Visa ◯ Master Card ◯ American Express ◯ Discover

* Card number: _____

* CVS#: _____

* Expiration date: _____