

# Gender and Depression in Men

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**Four conceptual frameworks are presented for understanding the role of gender in the way men experience, express, and respond to depression. The sex differences framework is often limited by the absence of relevant theory to guide research. The masked depression framework assumes that depression in men can be hidden by substance abuse and other externalizing problems. The masculine depression framework assumes that gender norms affect the presentation of depression and create a phenotypic variant of the disorder. The gendered responding framework assumes that gender norms affect how different men respond to negative affect in general. Each framework is evaluated in light of relevant theory and empirical work, and recommendations are made for future research directions.**

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When one conducts a computerized literature search on the terms “gender” and “depression,” three things quickly become apparent. First, the sheer number of articles published suggests a good deal of interest in the area; depression is one of the few major mental disorders for which gender has played a comparatively central role in research. Second, the term “gender” typically arises in one of two ways. Most commonly, it serves as an implicit, if ill-defined, synonym for differences between women and men in the incidence, prevalence, etiology, or treatment of the disorder. In effect, “gender” has

come to replace “sex differences” in an effort to recognize that many aspects of men’s and women’s experiences are the by-product of social rather than strictly biological processes (Smiler, 2004).

When gender is not used as a synonym for sex differences, it normally emerges as a conceptual framework for understanding social, historical, economic, and psychological processes that shape women’s experience of depression. The third conclusion that one therefore draws is that gender is much less frequently used as a framework for understanding depression in men. In fact, publications on men and depression are outnumbered by those focusing on women by a ratio of over three to one. For example, on March 27, 2007, an unlimited PsycINFO title search for the terms “men,” “men’s,” or “male” combined with “depression” revealed 278 published articles. A similar search for the terms “women,” “women’s,” or “female,” and “depression” revealed 884 published articles. There also appears to be a trend toward greater interest in men’s depression; a search limited to the years 2000–2007 revealed 133 published articles on men and 271 on women, roughly a 2:1 ratio.

The relative lack of research on gender and depression in men is of concern for both sociopolitical and public health reasons. From a sociopolitical standpoint, excluding men from an analysis of gender is analogous to excluding White people from an analysis of race and ethnicity (Frankenberg, 1997); doing so prevents a complete understanding of how gender operates because it treats the behavior and experience of dominant group members as normative and relatively decontextualized from social, political, and historical factors. The behavior and experience of those in the nondominant group are then seen as “different.” Gender becomes “about women,” just as race and ethnicity are often understood as “about people of color.” As a result, the social processes that shape the

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experiences of members of the dominant group (e.g., men) remain obscured by a veil of perceived normativeness.

With regard to depression in particular, the relative paucity of studies focused on men's experience raises several public health concerns. First, although it is well documented that women are twice as likely to be diagnosed with major depression, population-based estimates indicate that there are still a significant number of men who suffer from the disorder, and there is evidence that the gender gap is narrowing (Kessler et al., 1994, 2005; Stoolmiller, Kim, & Capaldi, 2005). Moreover, researchers and practitioners working in the area of men's mental health have increasingly suggested that major depression can be "masked" in men and that this may produce an underestimate of the true rates at which men suffer from the disorder (Cochran & Rabinowitz, 2000; Real, 1997). Second, although women are twice as likely to attempt suicide, men are four times more likely to die from suicide attempts (Moscicki, 1997; Oquendo et al., 2001). Third, studies of help-seeking behavior consistently demonstrate that, on average, men are less likely than women to utilize mental health services for psychiatric disorders (Addis & Mahalik, 2003). Finally, for a variety of reasons, the gendered nature of men's mental health has been relatively invisible in the social scientific and clinical literature. This invisibility has arguably produced longstanding negative consequences not only for men themselves but also for women, children, and communities. For all of these reasons, there is a pressing need to enhance the quality and quantity of research and treatment in the area of men's depression.

I have two goals in this article. The first is to describe four different frameworks for understanding gender and depression in men and to evaluate the degree to which they are supported by existing theory and research. The sex differences framework assumes that depression in men is best understood by comparing men and women on a range of depression-related variables. The masked depression framework assumes that many men who present with problems other than depression are actually experiencing an underlying depression that is transformed into other more externalizing symptoms due to proscriptive gender norms. The masculine depression framework assumes that restrictive masculine gender norms affect how some men express and respond to depression and can create a phenotypic variant of the

disorder characterized primarily by externalizing symptoms. The gendered responding framework assumes that gender plays a role in the way all individuals respond to distressing emotions ranging from basic negative affect to an episode of major depression.

Where empirical research is available for each of the four frameworks, I summarize and critique the major findings. Where research is not available, I make recommendations for needed research and/or theory development. Several themes emerge, including the limitations of focusing on sex differences as a framework for understanding gender and psychopathology, the degree to which theory in clinical practice has far surpassed relevant empirical research, and the need for greater conceptual clarity in our models of the relationship between gender and the experience of, expression of, and response to disorders, such as depression.

My second more implicit goal is to provide a call to action for researchers and practitioners in clinical psychology. What is needed is a serious and sustained effort to empirically, theoretically, and clinically address the role of gender in the way men experience, express, and respond to psychopathology.<sup>1</sup> By "gender" I am referring neither to biological sex nor to personality traits assumed to be essentially masculine or feminine. Rather, I am referring to the network of social, historical, and psychological processes that collectively form ideologies and norms regarding who and how men and women should be. One of the major assumptions I make throughout the article is that different conceptions of gender have a direct effect on how we understand depression in men. For example, if gender is understood as "male versus female," then sex differences research is naturally seen as a logical way to understand depression in men. However, if gender is understood as socially situated response patterns that function to mark individuals as appropriately male or female, then our understanding of the role of gender in men's depression shifts accordingly.

#### **DEPRESSION IN MEN: DEFINING THE TERRITORY**

What exactly does it mean to suggest that depression may be "different" in some men? If research reveals a mean difference in symptom presentation between men and women, does this reflect a difference in the underlying mechanisms generating the symptoms (e.g., a variant at

the level of the underlying disorder)? Or, is the disorder the same but sociocultural pressures to behave in gender-appropriate ways are influencing which symptoms appear publicly? Do some men feel that depression is “unmanly” and, therefore, hide the disorder from others and possibly from themselves? Is there a form of men’s or masculine depression that should be considered a separate disorder unto itself? Or, is there a form of masculine gender-based responding to negative affect in general that constitutes such a different disorder that it should not be labeled depression at all?

The existing clinical and research literature on depression in men has provided widely varying answers to these questions, and it is safe to say that there is currently no unifying conceptual framework guiding clinical research or practice (Addis, 2005). Nor have the assumptions underlying different theoretical frameworks been outlined in detail. For this reason, the following review proceeds more deductively than inductively by elaborating four different frameworks for understanding depression in men and then evaluating the degree to which each is supported by available theory and research. Proceeding this way is preferable for two additional reasons. First, the majority of research on sex differences in depression has been inductive and post hoc. Consequently, it is very difficult to know what to make of the results, because studies are essentially atheoretically driven; the question of sex differences is taken to be inherently interesting without further elaboration on how, why, or under what conditions such differences are useful in understanding depression in men. Second, gender is a construct that can be invoked from a variety of theoretical and methodological standpoints (e.g., McVicker, Clinchy, & Norem, 1998). How we understand it directly affects how we understand its role in disorders, such as depression. To ask any gender-related question is thus to construct gender in a particular way and it is simply not possible to proceed in a purely inductive fashion.<sup>2</sup>

#### **FOUR FRAMEWORKS FOR UNDERSTANDING GENDER, MEN, AND DEPRESSION**

##### **The Sex Differences Framework**

The sex differences framework rests on the assumption that depression exists as the same illness in men and women, although there may be minor phenotypic variations. For example, clinical literature often suggests

that men are more likely to experience anger or somatic symptoms and less likely to experience sadness (e.g., Pollack, 1998; Real, 1997). Gender emerges not as a central theoretical construct but rather as a synonym for sex differences, which are assumed to be inherently meaningful and to have practical implications for diagnosis and treatment. Knowledge about sex differences in areas such as epidemiology, coping, and treatment response has direct practical implications; knowing nothing else about a particular man, except that he is male, we can make some tentative predictions about his depression. At the same time, there are several problems with examining only sex differences. In fact, I will argue that directly comparing men’s and women’s experience as a primary research approach severely constrains the sorts of questions that can be asked and consequently limits our understanding of depression in men.

##### **Evidence**

What evidence is there that men express depression differently than women? First, it has been clear for some time that men are roughly half as likely as women to be diagnosed with major depression. Although it is possible that the ratio is inflated due to sex differences in rates of help-seeking for depression, large-scale epidemiological studies that utilize cold-calling of stratified samples do not rely on prevalence estimates based on treated cases. These studies still yield findings suggesting approximately a 2:1 female-to-male ratio (e.g., Kessler et al., 1994, 2005). It has also been suggested that the prevalence of depression in men has been underestimated due to men’s greater tendency to express depression in ways that do not correspond to the symptoms tapped by structured interviews based on the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*; e.g., Cochran & Rabinowitz, 2000; Leimkühler, Heller, & Paulus, 2007). For example, it is possible that the greater prevalence of substance use disorders in men may reflect, at least partially, the presence of underlying depression. Excluding the possibility that some men may mask depression or express it differently than women, two possibilities that I consider later in this article, the majority of evidence suggests that men are in fact less likely to experience depression as it is currently conceptualized and measured (see Kessler, 2000, for a review). Several theories have been put forth to account for this sex difference, including biological factors, social

learning of gender roles, and coping and response styles<sup>3</sup> (Booth, Johnson, & Granger, 1999; Cyranowski, Frank, Young, & Shear, 2000; Hankin & Abramson, 2001; Nolen-Hoeksema, 1987, 2002).

What evidence is there that men respond to depression differently than women once they experience it? The range of possible differences explored is immense and includes coping, perceived causes, treatment response, comorbidity, etiology, hormonal and neurochemical factors, and a host of other potential differences. Many of the relevant findings come from secondary analyses of existing data sets in epidemiological or treatment outcome studies. For all of these reasons, my analysis of the literature is focused on the broad question of whether there is consistent evidence of differences in the way men and women experience, express, and respond to depression.

It is safe to say that the sheer number of studies devoted to analyzing sex differences in depression far surpasses the reliable findings that these studies have generated. Only two differences have been consistently documented. First, men may be less likely than women to ruminate in response to depressed mood and more likely to distract themselves (Nolen-Hoeksema, 2002). Second, men are less likely than women to seek help for depression (Addis & Mahalik, 2003). There is therefore some evidence that men and women differ *on average* in the frequency with which they experience depression and in how they respond to the disorder. It should be noted that none of these findings pertain to differences in the expression of the disorder *per se* (i.e., symptom differences).

Studies focusing on differences in symptom expression have produced inconsistent findings at best. For example, contrary to existing clinical literature, Winkler, Pjrerik, and Siegried (2005) found no consistent evidence that men experience greater anger or somatic symptoms when they are depressed. In contrast, Vrendenburg, Krames, and Flett (1986) found that within a clinical population of patients receiving treatment, men were characterized by lack of satisfaction, suicidal ideation, work inhibition, somatic problems, and indecisiveness. Women reported more self-dislike, crying, distorted body image, fatigability, and irritability. Khan, Gardner, Prescott, and Kendler (2002) examined symptoms of depression in opposite-sex dizygotic twins where both

members met *DSM-III-R* criteria for major depression. Men were more likely to report insomnia and agitation, while women were more likely to report fatigue, hypersomnia, and psychomotor retardation. In contrast, one large study of 498 patients diagnosed as depressed revealed no sex differences in symptom patterns (Young, Scheftner, Fawcett, & Klerman, 1990).

### Critique

Overall, there appear to be no consistent differences in the specific symptoms men and women endorse. Few of the existing differences documented in specific studies have been replicated. Moreover, the ease of analyzing sex differences in existing data sets, combined with the file drawer problem (Rotton, Foos, Van Meerik, & Levitt, 1995), makes it safe to assume that many more null findings of no difference have gone unpublished. It should be noted, however, that the bulk of published studies were not well designed to detect the sorts of sex differences hypothesized in clinical literature. Some authors have suggested that many men express depression in ways that are not captured by existing interviews and self-report measures (e.g., Real, 1997). In contrast, studies of clinical populations have included patients who have *already been diagnosed as depressed* and have been selected precisely because they reveal typical symptoms of depression. Although this does not rule out the possibility of sex differences in patterns of symptoms, it does preclude studying those men who may be experiencing an episode of depression that, for a variety of reasons, goes unrecognized by themselves and/or healthcare professionals. In support of this possibility, some studies have shown that existing depression measures show less concurrent validity for men than for women and, therefore, may be less accurate in detecting depression in men (Allen-Burge, Storandt, Kinscherf, & Rubin, 1993; Berard, Boermeester, Hartman, & Rust, 1997; Jolly, Wiesner, Wherry, Jolly, & Dykman, 1994).

There are several significant conceptual problems with focusing only on sex differences as a strategy for understanding depression in men. First, such an approach takes an opposition of men's and women's experience as the natural starting point for inquiry; it is as if the idea that women and men may differ on a particular psychological construct is so obvious as to require little conceptual justification. Thus, many studies are essentially fishing expeditions

and do not provide much in the way of a theoretical or pragmatic rationale for examining sex differences.

A second problem is that when we search primarily for ways that men differ from women, we reinforce the implicit assumption that what is useful to know about depression in men is precisely those things that are not true for women. This is a difficult paradox to grasp because the conceptual difference “male versus female” is so pervasively embedded in both everyday and social scientific discourse that we cannot help but see it as natural (Hare-Mustin & Marecek, 1988; Tavris, 1992). Framing research questions in terms of sex differences seems obviously justified because, so the logic goes, if men’s depression is not different from women’s, then why study it as “men’s depression” at all? A literary analogy may help reveal the problem with this logic. No serious scholar of literature would argue, for example, that the best way to understand Portuguese or South African literature is by comparing them to American literature. Instead, each body of work would be explored in its own cultural context, and comparative analyses, if conducted, might emerge at a later point. If, in contrast, one were to proceed initially with an analysis of difference, each body of work would quickly be seen only in how it differs from the other; as a result, its own internal workings would remain obscured.

A final problem is that the sex differences approach necessarily treats members of each gender category as having some uniform essence (i.e., “male” versus “female”) and consequently treats within-group variability as error in the search for mean differences (Roland Martin, 1994). This is obviously necessary whenever between-group variance is the focus for a study, and such studies have the potential to yield useful information. However, when studies of between-group variance are overwhelmingly more common than studies of within-group variance, as they clearly have been in the study of depression in men, several avenues remain unexplored and several questions unanswered. Why are some men willing to seek help for depression and others are not? Why do some men deny that they are depressed even though they clearly fit the symptom profile?

#### **The Masked Depression Framework**

Individual differences in the way men experience, express, and respond to depression can be linked theoretically to

gender socialization practices common in Western countries, such as the United States. Gendered sociocultural symbols and socialization practices are thought to create restrictive norms defining how men should think, feel, and behave (Mahalik et al., 2003; O’Neil, Good, & Holmes, 1995; Pleck, 1981, 1995). Commonly cited components of Western masculine norms include emphases on antifemininity, competitiveness, homophobia, emotional stoicism, self-reliance, physical toughness, financial success, and power over women. These norms are assumed in turn to shape how men respond to problems such as depression (Addis & Cohane, 2005). For example, men who adhere more closely to the norm of emotional stoicism may have difficulty in identifying grief, sadness, or depressed mood (Fischer & Good, 1997; Levant et al., 2003; Pollack, 1998; Real, 1997). Taking this idea one step further, several clinicians and researchers have hypothesized the existence of a form of “masked” or “hidden” depression in some men (Cochran & Rabinowitz, 2000; Pollack, 1998; Real, 1997). For example, in a national bestseller entitled *I Don’t Want to Talk About It: Overcoming the Secret Legacy of Male Depression*, psychotherapist Terrence Real suggested that “hidden depression drives several of the problems we think of as typically male: physical illness, alcohol and drug abuse, domestic violence, failures in intimacy, self-sabotage in careers” (1997, p. 22). A key assumption is that depression can be both exacerbated by restrictive gender norms (masculinity) and made more invisible because of proscriptions against men experiencing or expressing sadness, grief, or depressive affect.

#### **Evidence**

What empirical evidence exists to support the notion of masked depression per se in men? To date, there is no direct evidence documenting the existence of major depression in men where the disorder is definitively present but hidden in some fashion. However, there is a range of indirect evidence (see Cochran & Rabinowitz, 2000). First, men are more likely to express various externalizing disorders, including substance abuse, antisocial personality disorder, and anger. It is possible that many of these men are experiencing an unrecognized episode of depression and coping with it by engaging in behaviors typically seen in these disorders. Second, the sex difference in rates of depression appears smaller in

cultures where antisocial and high-risk behaviors are less tolerated (Egeland & Hostetter, 1983; Lowenthal, Goldblatt, & Gorton, 1995). It is possible that sociocultural factors influence the degree to which depression appears in a masked or more prototypic form (see Cochran & Rabinowitz, 2000). Third, it may be that some men, when they become depressed, have greater difficulty in identifying and communicating their affective experience and it, therefore, remains “masked.” In support of this possibility, both sex (male versus female) and adherence to traditionally masculine norms and ideologies predict higher scores on measures of alexithymia (Carpenter & Addis, 2000; Fischer & Good, 1997; Levant et al., 2003). Finally, the tendency for primary-care physicians to underdiagnose depression in patients presenting with somatic complaints is well documented and appears to be even more likely with male patients (Bertakis et al., 2001; Potts, Burnam, & Wells, 1991; Simon & Von Korff, 1995). The possibility of masked depression in men may contribute to this pattern.

Several authors have suggested that men are both less tolerant of and have more difficulty in recognizing depressed mood than women (Brownhill, Wilhelm, & Barclay, 2005; Levant, 2001). No studies have directly tested whether men who are currently depressed are less able to recognize it or less willing to report it than women. Two studies experimentally manipulated how depression measures were introduced to male and female undergraduates (e.g., as measures of “depression” or “daily hassles”). Page and Bennesch (1993) found that undergraduate men scored higher when the Beck Depression Inventory (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961) was introduced as a measure of hassles than when it was introduced as a measure of depression, whereas no such difference was found for women. In a subsequent study, undergraduate women scored higher when the measure was introduced as “depression” rather than “hassles” (Page, 1999). Two additional studies examined whether the interpersonal conditions under which the Beck Depression Inventory was administered would be associated with self-reported depression for male versus female undergraduates. Presumably, if men felt more stigma about reporting depression, their scores should be lower in a public versus a private administration. Contrary to predictions, no such differences were found (Bryson & Pilon, 1984; King & Buchwald, 1982).

Finally, if men are more likely than women to mask an underlying depression, estimated inheritance rates from family and twin studies should be lower in men; those who are masking an existing depression should be less likely to meet criteria for the disorder and should therefore contribute to lower concordance rates. The available findings are inconsistent with some studies finding lower inheritance rates in men (e.g., Bierut et al., 1999; Kendler, Gatz, Gardner, & Pedersen, 2006) and other studies finding no sex differences in heritability (e.g., Kendler, Pedersen, Neale, & Mathe, 1995; Kendler & Prescott, 1999; McGuffin, Katz, Watkins, & Rutherford, 1996). However, it should be noted that heritability estimates can be affected by several factors other than the presence of masked depression in men.

### Critique

There is no direct evidence of men experiencing an episode of depression that is truly masked in the sense that the illness exists but it shows none of the prototypic signs or symptoms. Such evidence would be extremely difficult, if not impossible, to gather. It simply is not possible to validate the construct of masked depression as it is currently conceptualized because of significant logical and methodological obstacles resulting from our current classification system for psychopathology. The *DSM-IV-TR* (American Psychiatric Association, 2000) defines major mental disorders not by the presence of underlying pathologies or disease entities but by phenotypic presentations (e.g., symptoms). Accordingly, all existing measures for diagnosing depression require the presence of prototypic symptoms that are presumably *not present* in masked forms of depression. This leaves no way to determine the presence of an existing depression independently of its presumably masked presentation. Consequently, there is currently no way to document that depression is present in a particular case, even though the prototypic symptom presentations may be absent or masked.

### The Masculine Depression Framework

Although the construct of masked depression is problematic for all of the reasons described above, it is still possible that masculine gender norms can influence how particular men experience, express, or respond to depression. For example, Joseph Pleck’s gender-role

strain model is guided by the assumption that, for many men, socialization according to restrictive masculine norms creates several forms of developmental and intrapsychic strain, as boys and men struggle to meet unattainable and contradictory standards of masculinity (Pleck, 1981, 1995). Such strains are assumed both to place boys and men at risk for emotional difficulties (e.g., depression) and to create significant barriers to coping adaptively with problems once they exist. Other similar frameworks have also been developed (Eisler & Skidmore, 1987; Mahalik et al., 2003; O'Neil, 1981). Each of them suggests that masculinity can affect how men experience, express, and respond to depression. Because masculine gender norms generally encourage action and discourage introspection, men who are depressed and affected more strongly by such norms are hypothesized to exhibit more externalizing symptoms. As a result, rather than experiencing a truly masked depression, some men may experience a form of "masculine depression" that is a phenotypic variant of prototypic depression.

#### **Evidence**

Over the last two decades, a large body of research has linked individual differences on measures of traditional masculinity to a wide range of physical and mental health outcomes (for reviews, see Cochran & Rabinowitz, 2000; Courtenay, 2000; Levant & Pollack, 1995). With regard to depression, several studies have demonstrated correlations between masculine gender-role conflict and elevated scores on self-report depression measures (Cournoyer & Mahalik, 1995; Good & Wood, 1995; Magovcevic & Addis, 2005; Mahalik & Cournoyer, 2000; Shepard, 2002). Masculine gender-role conflict is defined as psychological distress created by overly rigid adherence to traditional masculine norms (e.g., O'Neil, 1981; O'Neil et al., 1995). These findings are therefore inconsistent with the notion that masculinity leads men to express a masked form of depression. They suggest instead that adherence to traditionally masculine norms may place individuals at risk for experiencing prototypic symptoms of depression. Why this might be is unclear, although one possibility is that norms of emotional restrictiveness lead some men to suppress emotional responding. Suppression has been shown to be associated with increased stress and negative affect (Butler et al., 2003; Gross & Levenson, 1993).

Gender-role conflict in men has been shown to be associated with negative attitudes toward seeking psychological help. It has thus been suggested that men who adhere to traditional masculine norms may be at risk of "double jeopardy"; they are both more likely to experience symptoms of depression and less likely to seek help (Good, Dell, & Mintz, 1989; Good & Wood, 1995). There is also some indirect evidence that masculine gender norms and ideologies create barriers to men communicating symptoms of depression when they are present. Three studies have demonstrated that men who report or are described as suffering from symptoms of depression are reacted to more negatively by peers than are women presenting in a similar fashion (Hammen & Peters, 1977, 1978; Joiner, Alfano, & Metalsky, 1992). Joiner et al. (1992) found that the particular combination of depression, low self-esteem, and reassurance seeking in male undergraduates best predicted interpersonal rejection by roommates. Interestingly, male participants with low self-esteem and low reassurance seeking were less likely to be rejected. In interpreting their findings, Joiner et al. (1992) suggest that,

When men with low self-esteem are depressed, they may be expected to "suffer in silence" and "take it like a man." Excessive reassurance seeking violates this expectancy, as well as stereotypical male behavior in general, and consequently may result in rejection. (p. 171)

#### **Critique**

The vast majority of this research has been conducted with convenience samples of largely Caucasian undergraduate men. Thus, it could be argued that we know very little about the role of masculinity in depression as experienced by men of color. In fact, there is a growing body of literature on variations in the social construction of masculinities along racial, ethnic, and social class dimensions (Connell, 1995; hooks, 2003; Viveros Vigoya, 2001). To date, this work has not been integrated into the literature on men and depression. In addition, regardless of race, ethnicity, or class, there are reasons to question the generalizability of findings based on depressed mood in college student samples to syndromal depression in noncollege samples (e.g., Kendall & Flannery-Schroeder, 1995).

Existing work has not explored the ways that specific gender norms may affect particular aspects of depression in men. For example, norms such as emotional stoicism may make it difficult for some men to recognize sadness, grief, or depressed affect. Others, such as competitiveness, may affect the degree to which different men communicate their depression to others. Still other norms, such as remaining active and distracting oneself from problems, may actually serve a buffering function, at least in the short term. To understand the functions of these norms in shaping different men's experiences will require moving beyond the analysis of simple linear relationships between unitary constructs of masculinity and depression. Greater precision is needed in both theory and method to understand the complexities linking masculine gender socialization to men's depression.

A major shortcoming of existing work is that it has examined only the relationships between masculine gender norms and self-reported symptoms of depression *per se*. This is problematic for two reasons. First, it is clear that traditional masculine norms proscribe expression of emotional distress, such as symptoms of depression. Thus, many men may underreport symptoms in a simple self-report context. No studies have looked at the relationships between masculinity and depression using structured diagnostic interviews where interviewers can probe and clarify the presence or absence of symptoms. Second, although the concept of a fully masked depression is problematic for all of the reasons considered above, it is still possible that masculinity plays a role in the way different men express symptoms of depression. In particular, the possible presence of comorbid externalizing symptoms in men who show clinically significant but subthreshold symptoms of major depression has not been explored. For example, common self-report measures of depression do not include items on substance abuse, although substance abuse can be a form of affect regulation (e.g., self-medication), and this may be particularly likely in men who are avoidant of emotions such as sadness, grief, or depressed mood (Armeli et al., 2003; Isenhart, 1993). In addition, items on irritability and anger are typically given equal weight with other symptoms on self-report depression measures, although they might have greater diagnostic significance for men who adhere more strongly to masculine norms.

A final problem with existing research is that it has focused almost exclusively on symptoms of depression as a final endpoint and not at all on the role of gender in emotional processes that may underlie or precede the development of depression and related disorders. Such work is critical for understanding the role of gender in the etiology of depressive disorders. There is ample evidence that young boys are taught salient lessons about emotion regulation and emotional expression from family members and peers (e.g., Eisenberg, Cumberland, & Spinrad, 1998; Fischer, 2000). These gender-based learning processes may ultimately affect how different men respond to loss, grief, and other forms of negative affect that can precede development of an Axis I disorder, such as major depression.

#### **The Gendered Responding Framework**

The gendered responding framework rests on the assumption that masculinity can play a role not only in how men respond to depression as a disorder ("depression with a big D") but also in how they respond to negative affect in general, including depressed mood, grief, sadness, and so on. This framework shares certain assumptions with the response styles theory originally developed by Nolen-Hoeksema and colleagues<sup>4</sup> (Morrow & Nolen-Hoeksema, 1990; Nolen-Hoeksema, 1987). The latter was developed to account for the increased incidence of depression in women compared to men. A key assumption is that the way individuals respond to depressed mood has a strong influence on the likelihood of developing an episode of major depression and the length and severity of episodes once they begin. Consistent with the theory, nondepressed individuals who ruminate in response to depressed mood are more likely to become depressed and to have longer and more severe episodes of depression (Just & Alloy, 1997; Nolen-Hoeksema, Morrow, & Fredrickson, 1993). In contrast, individuals who distract themselves from depressed mood are thought to have a lesser likelihood of developing an episode of depression. With regard to gender, female adults, adolescents, and children are indeed more likely than males to ruminate in response to depressed mood. Moreover, there is evidence that when shared variance between depressive symptoms and individual differences in rumination is controlled for, sex differences in symptoms of depression disappear (Nolen-Hoeksema,

Parker, & Larson, 1994; Roberts, Gilboa, & Gotlib, 1998; Thayer, Rossy, Ruiz-Padial, & Johnson, 2003).

Although research following from the response styles framework has increased our understanding of depression in girls and women, and to some degree boys and men, it has not led to a corresponding body of theory and research focused specifically on the latter group. There are several reasons why this is the case. First, the theory was designed to account for sex differences in the incidence and prevalence of depression and not for the variety of ways that gender can affect how different men experience, express, and respond to depression. Second, the majority of studies within the response styles framework have examined responses to *depressed mood* as measured by standardized self-report measures of depression. As discussed above, it is likely that masculine gender norms can make it difficult for many men to recognize and/or disclose symptoms of depression when such symptoms exist. Measuring responses only to depressed mood may make it difficult to see the effects of masculine response styles that do not lead to prototypic depression but rather to other dysfunctional outcomes. It is possible that gender socialization may lead some men to avoid experiencing negative affect to such a degree that their mood does not appear sad or depressed. However, these same men may experience significant distress that instead is manifested as somatic pain, stress, substance abuse, or other more externalizing symptoms (Cochran & Rabinowitz, 2000). Other men may be less temperamentally prone to experience negative affect. Still others may experience higher levels of negative affect and not engage in avoidant responses that produce dysfunctional outcomes. In the standard response styles paradigm, these three groups of men would be indistinguishable based on measures of depressive symptoms and response styles.

The response styles framework can be adapted and extended into a more general gendered responding framework that integrates research on positive and negative affect with theory and research on the social construction and social learning of gender. In this framework, positive and negative affectivity are assumed to be both trait and state phenomena and to be risk factors for the development of different psychopathologies (Clark, Watson, & Mineka, 1994; Krueger, Caspi, Moffitt, Silva, & McGee, 1996). Gender should influence how

individuals respond to negative affect because, broadly speaking, recognizing and responding to emotion are contexts in which much gendered learning takes place (Eisenberg et al., 1998; Fischer, 2000). The social learning of masculine gender norms, for example, may lead men to distract, avoid, or get angry in the presence of negative affect. Men and boys also learn that different responses to negative affect, such as drinking large amounts of alcohol or taking unnecessary risks, can function as a means of marking oneself as appropriately masculine in particular social contexts. This type of learning is not limited to responses to depressed mood. The expression of grief, sadness, anxiety, and fear is all generally proscribed by masculine norms.

#### Evidence

Although the gendered responding framework for understanding depression in men has not been directly tested, there are several bodies of existing empirical and theoretical work that support its potential utility. There is consistent evidence that gender socialization plays a role in how men learn to experience, express, and respond to a wide range of emotions (Chaplin, Cole, & Zahn-Waxler, 2005; Eisenberg et al., 1998; Wichstrom, 1999). The effects of such socialization are likely to continue through adolescence into adulthood. For example, findings from studies of child and adolescent coping strategies indicate that boys are more likely than girls to use strategies that involve avoidance of negative affect (Broderick, 1998; Sethi & Nolen-Hoeksema, 1997). The ways in which boys and men respond to negative affect are influenced by culturally prescribed gender norms that discourage expression of “soft” emotions, such as sadness and fear, and encourage expression of “hard” emotions, such as anger. For example, a recent observational and longitudinal study demonstrated a 50% decrease in boys’ expressions of sadness and anxiety from preschool to early school age. Parental responses to emotion, particularly those of fathers, were associated with this decrease over time (Chaplin et al., 2005). Differential emotion socialization has also been linked to the development of externalizing problems, such as substance abuse and aggression (Cole, Michel, & Teti, 1994; Cole, Teti, & Zahn-Waxler, 2003; Eisenberg et al., 2001; Kring & Bachorowski, 1999).

The gendered responding framework is also consistent with research on individual differences in masculinity

and responses to a variety of emotion-related processes. For example, individual differences in masculinity have been found to be associated with problem-solving appraisal (Good, Heppner, DeBord, & Fischer, 2004), alexithymia (Levant et al., 2003), perceptions of stigma associated with alcohol abuse and depression (Magovcevic & Addis, 2005), higher levels of alcohol abuse (Isenhart, 1993; McCreary, Newcomb, & Sadava, 1999), emotional suppression (Wong, Pituch, & Rochlen, 2006), negative attitudes toward help-seeking (Addis & Mahalik, 2003), and lower levels of self-focused attention (Ingram, Cruet, Johnson, & Wisnicki, 1988).

Finally, this framework is consistent with contemporary theoretical and empirical work on emotion that views different emotions, such as depressed mood, not as discrete natural entities but as social phenomena that emerge in the context of more basic core affect. Core affect refers to a physiological state that Barrett (2006a) describes as roughly equivalent to “a neurophysiological barometer of the individual’s relation to an environment at a given point in time” (p. 31). Core affect is thought to be strongly influenced by an ongoing process of valuation that contributes to the perceived positive or negative valence of the affect (Barrett, 2006b). Specific emotions emerge when conceptual knowledge about emotion is brought to bear on core affect. This conceptual knowledge is thought to be learned, highly context-specific, and directed strongly by language (Barrett, 2006a).

A review of the empirical work supporting this paradigm for understanding emotion is beyond the scope of this article (see Barrett, 2006a, 2006c). For the present purposes, it is worth noting that the various meanings that individuals attribute to core affect in different contexts can be understood as aspects of conceptual knowledge about *both gender and emotion*, simply because experiencing, expressing, and responding to emotion is a highly gendered human process (Fischer, 2000; Kelly & Hutson-Comeaux, 1999; Wong & Rochlen, 2005). What it means to a particular man when his core affective state is negatively valenced may be influenced by gendered norms, gender ideologies, and gendered practices relevant to different social contexts. Consider, for example, the differences in gendered conceptual knowledge that might influence how negative core affect is interpreted and responded to following the death of a loved one,

being fired from a high-powered corporate position, or missing one’s children in the context of a painful parental custody dispute. Each of these contexts invokes a variety of masculine norms and practices that may direct what emotions emerge and how they are responded to.

### Critique

The most obvious shortcoming of the gendered responding framework is that it has not been tested directly in relation to depression and associated problems in men. Additional clinical research would need to explore the role of masculinity in the way different men interpret and respond to distressing emotions other than depressed mood *per se*. For example, men who score higher on measures of adherence to traditional masculine norms and ideologies should be more likely to distract themselves from, or avoid, a wide range of soft emotions such as grief, sadness, fear, or anxiety. These same men should be less likely to distract themselves from harder emotions, such as anger or jealousy. Men who adhere more strongly to traditional masculine gender norms should also be more likely to exhibit externalizing responses, such as substance abuse, anger, and unnecessary risk taking following life events that put individuals at risk for increases in negative affect. These might include job loss, divorce, death of a loved one, or other stressful life events.

By focusing on gender and responses to a range of negative affect, the gendered responding framework raises the possibility that masculine norms play a role in the development and maintenance of disorders other than depression. Whether this is a strength or a weakness of the model depends on the particular research questions being asked in a given study. It would be useful, for example, to consider whether there may be a constellation of externalizing symptoms that are functionally related to avoidance of negative affect in “masculine men” and taxonomically distinct from major depression. Alternatively, it could be that such a constellation of symptoms (e.g., substance abuse, irritability, and social withdrawal) falls along a spectrum of depressive disorders and is more likely to present in men who adhere to traditionally masculine norms. Whether such disorders exist is clearly an empirical question. But at this point, it is also a conceptual question; progress in understanding distress in men who adhere strongly to traditional masculine

gender norms is dependent on a curiosity about the degree to which masculinity plays a role in how men experience, express, and respond to negative affect.

### CONCLUSION AND FUTURE DIRECTIONS

In light of the available clinical, theoretical, and empirical literature on depression in men, several conclusions seem warranted. Post hoc comparisons of men and women are limited in what they can reveal about the workings of gender in men's depression. Research should be grounded in conceptual frameworks that integrate different models of gender into our understanding of masculinity and depression. Although frequently suggested in clinical and popular literature, the notion that, on average, depression presents differently in men than in women is not well supported by empirical research. Instead, there appears to be substantial variability between men in both the patterns of symptoms experienced and the way different individuals respond to the disorder. Thus, while it will always be useful to consider potential sex differences in etiology or symptom presentation of any disorder, there is much to be gained by examining differences between men, and within individual men, in how depression is experienced, expressed, and responded to.

At least a portion of this variability can be accounted for by individual differences in adherence to gender norms emphasizing competitiveness, emotional stoicism, antifemininity, homophobia, self-reliance, and other aspects of traditional masculinity. A promising direction for research is to examine the relationships between individual differences in adherence to traditionally masculine norms and various aspects of depression. There is evidence that men who adhere more strongly to these norms may be both at greater risk for developing symptoms of depression and less likely to seek help. It should be noted that the majority of these findings are based on studies of symptoms of depression in nonclinical samples. There is a pressing need to examine the role of masculine norms in populations of men experiencing clinically significant distress. The role of masculinity in the help-seeking process is one important area (Addis & Mahalik, 2003). Studies should examine the gender-based processes that affect how men decide whether or not to seek help for depression and how different men cope with the disorder. Masculinity may also play a role in

whether and how different men disclose depression to family members, friends, and physicians. An understanding of such processes is critical for effective primary prevention and for secondary and tertiary efforts to enhance access to effective care.

There is no direct, but some indirect, evidence that depression may be masked or hidden in some men. Whether men who present with somatic complaints, increased anger, and social withdrawal are experiencing masked depression, some other disorder, or culturally sanctioned responses to negative affect is difficult, if not impossible, to determine given our current research methods and nosological system. To document a masked depression would require an independent marker of the presence of the disorder in the absence of prototypic symptom presentations. There are no known biological markers that have a high enough degree of specificity to serve this function. At the current time, studies of masked depression are therefore unlikely to yield compelling findings one way or the other.

As noted above, there is evidence that adherence to traditionally masculine norms is associated with higher levels of depression on measures that include primarily internalizing symptoms. At the same time, developmental research on emotion socialization and coping suggests that adherence to these norms should be associated with distracting and avoidant responses that lead to externalizing rather than internalizing symptoms (Cole et al., 1994, 2003; Eisenberg et al., 2001; Kring & Bachorowski, 1999). Consistent with the developmental literature, adult men who adhere to traditional gender norms are at greater risk for substance abuse, aggression, and other externalizing symptoms (e.g., Isenhardt, 1993; McCreary et al., 1999). One possibility is that adherence to traditional norms places men at risk both for prototypic symptoms of depression, and for externalizing symptoms that coincide with depression but are not formally part of the disorder. Alternatively, externalizing symptoms in these men may reflect attempts to cope with an existing depression.

Understanding the relationships between masculinity, depression, and both internalizing and externalizing symptoms requires studying a wider range of responses to negative affect in general, in addition to depressed mood. The response styles paradigm could be extended to examine (a) adherence to masculine norms (Mahalik

et al., 2003) as a potential moderator of responses to depressed mood, (b) responses to distressing emotions other than depressed mood, and (c) a wider range of in vivo responses other than distraction and rumination. For example, it would be helpful to study variations in responding to a range of negative affect as a function of individual differences in adherence to restrictive masculine norms. Theoretically, men who adhere more strongly to norms of emotional control and self-reliance should engage in more avoidant responses to a wide range of distressing emotions and should be more likely to keep their distress private. These same men should have a greater likelihood of exhibiting an array of externalizing symptoms. Such hypotheses are central to both the masculine depression and the gendered responding frameworks and have not been evaluated empirically.

#### NOTES

1. Although I focus primarily on depression in this article, many of the empirical and theoretical issues that I consider can be linked to the broader area of gender and men's mental health.

2. Even to instantiate gender as the analysis of sex differences is to invoke the binary conceptual categories of male and female and to assume that such categories are psychologically meaningful.

3. For the purposes of this article, I am not concerned primarily with accounting for why men are less likely than women to be diagnosed with depression, although I do touch on related issues. Rather, the central question that I am considering is whether and how gender plays a role in the way men experience, express, and respond to depression.

4. I refer to this as a "gendered responding" framework rather than a response styles framework for several reasons. First, the idea that particular gendered styles of responding to negative affect are stable dispositions is an assumption that needs to be empirically tested rather than taken for granted. Second, many current approaches to studying gender in the social sciences emphasize the utility of conceptualizing gender as malleable and context-specific processes rather than stable and internal properties of individuals. Approaching gender this way allows for a better account of not only interindividual but also intraindividual variability in the way men respond to positive and negative affect.

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