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THE MALE GENDER ROLE AND DEPRESSION

by

Thomas Liljegren

A plan B paper submitted in partial fulfillment  
of the requirements for the degree

of

EDUCATIONAL SPECIALIST

in

Psychology

Approved:

UTAH STATE UNIVERSITY

Logan, Utah

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## ABSTRACT

## The Male Gender Role and Depression

by

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Although depression is a common mental health disorder, less research has been devoted to men's experience with depression compared to women's experiences. Although men may exhibit similar patterns of depression as women, men often have unique pattern of exhibiting depression characterized by substance abuse, irritability, aggression, and interpersonal conflict. The paper presents a review of the relevant literature on male depression and, in particular, how it is potentially affected by male gender role factors. Biological, psychological, social, and artifact theories have been proposed to explain gender differences in how depression is expressed. It is hypothesized that the male gender role and gender role strain contribute to men's unique presentation of depression. Gender role strain has been found to relate to depression and help-seeking behavior. Men may be reluctant to discuss depressive feelings and less aware of depressive symptoms or exhibit symptoms of alexithymia. Men are more likely to employ externalizing coping responses to depressive feelings. Different cultures have some differences and some similarities compared with Western culture in responses to depression. Among multiple cultures, cultures where alcohol or aggression is actively discouraged, males exhibit more depression. Several male gender specific therapies have been developed for male depression. However, there has been little research on the effectiveness of these treatments.

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In an important sense there is only one complete unblushing male in America: a young, married, white, urban, northern, heterosexual Protestant father of college education, fully employed, of good complexion, weight, and height, and a recent record in sports. Every American male tends to look out upon the world from this perspective, this constituting one sense in which one can speak of a common value system in America. Any male who fails to qualify in any one of these ways is likely to view himself (during moments at least) as unworthy, incomplete, and inferior (Goffman, 1963, p. 128).

Although Erving Goffman's quote is from the 1960s, it nevertheless accurately describes the complexity and difficulty of developing a healthy male ego in today's society. "Becoming and being a man in today's world is as hard as it has ever been," said Pollack and Levant (1998, p. 1). However, despite the problems that many men face, psychology rarely focuses exclusively on men's issues. Women generally outnumber men in psychotherapy by a ratio of two to one (Brooks, 1998; Cochran, 2005). Many diagnostic and treatment concerns have focused primarily on women to the exclusion of unique diagnostic and treatment issues that men face (Cochran & Rabinowitz, 2003). The diagnosis and treatment of depression is a prime example of where male gender differences are rarely discussed in the context of diagnosis and treatment.

Pollack (1998) suggests that society has less understanding and empathy for male emotion and depression. However, some researchers suggest that depression may be more common in men than previously thought but is manifested as dysregulation or abandonment depression that is masculine-specific (Pollack, 1998). In other words, different aspects of the male gender role may lead men to develop, experience, and act out their depression in unique ways.

In the Diagnostic and Statistical Manual of Mental Disorders—Forth Edition, Text Revision (DSM—IV-TR) a Major Depressive Episode is defined as the change in an individual

with the presence of 5 of the following symptoms for at least a two week period (American Psychiatric Association, 2000, pg. 356):

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by other (e.g., appears tearful).
2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)
3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day.
4. Insomnia or hypersomnia nearly every day.
5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restless or being slowed down).
6. Fatigue or loss of energy nearly every day.
7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)
9. Recurrent thoughts of death (not just the fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

Additionally, the DSM—IV-TR specifies that must cause significant impairment in and an individual's functioning; does not meet the criteria for a Mixed Episode; is not due to another psychological or medical condition or the physiological effects of a substance. These criteria represent the primary criteria for diagnosing depression in male and female clients in the United States.

Some authors suggest that the typical symptoms associated with depression (such as a depressed mood, fatigue, and loss of energy and pleasure in activities) may be too narrow to reflect how depression manifests in men (Cochran, 2005; Pollack, 1998; Pollack and Levant, 1998). Whereas women more often manifest the typical, internalized depressive symptoms, men may manifest their depression through externalizing behavior such as substance abuse or anger

(Pollack, 1998). One study suggested that healthcare professionals fail to diagnose depression in males with depressive disorders over 60% of the time when symptoms that warrant a diagnosis are present (Potts, Burnam, & Wells, 1991). Men are more likely receive a substance abuse disorder, antisocial personality disorder, or another externalizing disorder diagnosis instead of a valid depressive disorder diagnosis (Pollack, & Levant, 1998; Cochran, 2005).

The possible underdiagnosis of men with depression may be due to three primary factors (Pollack, 1998). First, males are less likely to admit depression because it is seen as unacceptable to their masculine self-image. Second, men are less likely to experience overt mood shifts than women. Third, clinicians may be more reticent to ask about depression in men (or diagnose it) because of the acceptance of societal attitudes about depression in men (Pollack, 1998). When alternative criteria such as antisocial behavior and alcohol or drug use symptoms are included that might be more sensitive to male depression, rates of male and female depression were equal (Cochran, 2005).

Gjerde, Block, and Block (1988) developed four empirically based styles of male-based depression, only one of which, "discontent with self" approximates how depression is typically conceptualized. The other three models are: interpersonal antagonism (such as blaming), unrestraint (impulsivity and compulsions), and unconventionality (or rebelliousness). These other three models suggest that male depression often manifests through actions that are more in tune with more expected or acceptable male emotions such as anger, violence, hostility, and dangerous behavior.

Other studies have suggested that while men may present with depressive symptoms that are similar to women's symptoms and have a similar course of the disorder, they express their symptoms in different ways than women (Cochran & Rabinowitz, 2003). Men often report

similar symptoms as women (such as dysphoria, thoughts of death, or sleep and appetite disturbances), but these are often expressed and experienced through work-related problems and interpersonal conflicts, perceived threats to self-esteem, gender-role conflict, antisocial and narcissistic traits, and alcohol and drug abuse or dependence (Cochran & Rabinowitz, 2003). Women, in contrast, are more likely to have more internalized expression of depression and comorbid anxiety (Pollack, 1998).

### Purpose of Paper

Although depression is one of the most researched and treated psychological disorders, its diagnosis, characteristic symptoms, and treatment is typically based on the presentation of the disorder that is more common in females (Cochran, 2005). While these symptoms often apply to men as well, there are other criteria that may also be seen in many men such as increased substance use and externalizing behavior, which are not typically characteristic of a depression diagnosis. Some of these depressive symptoms are hypothesized to develop largely from difficulties with the male gender role (Oliver & Toner, 1990). These unique gender factors create a different picture of male depression that may change its presentation, diagnosis, and treatment.

The consequences of male depression can often be very serious. For example, men have about 4 completed suicides for every one female completion (Center for Disease Control and Prevention, 2009). Additionally, men often lack emotional awareness of some of their depressive symptoms (Levant, 1998) and generally have a greater reluctance to receive any treatment (Pollack, 1998). Many of the symptoms and correlates of male depression, such as substance abuse and aggressive behavior, often place men at a greater risk for the worst

consequences of depression such as suicide, drug addiction, or overdose. Taken together, this suggests that the consequences for male depression (i.e. violent behavior, substance use and abuse, and suicide) can be extreme, but that men are less aware of their own depression and less likely to seek help.

This paper will examine the empirical literature on gender differences in the presentation of depression symptoms. In particular, it will discuss different male gender role characteristics that may play a role in male depression, and examine how that role is affected by sociocultural factors. This will be examined by looking at studies on male depression from mainstream Western cultures as well as traditional and non-Western cultures.

First, the differences noted in male depression, including differences in prevalence, symptomatology, and comorbidity will be discussed. The research about what factors may lead to gender differences in depression and how these gender factors may affect the estimated prevalence of depression will be introduced. Additionally, opposing views and conflicting evidence of differences in males' presentation of depression will be covered.

Second, the paper will discuss the social and gender-role issues that are hypothesized to contribute to the differences in male depression. Empirically based theories of male gender-role conflict will be briefly reviewed and how these gender-role conflicts can lead to male depressive symptomatology will be explained. Factors characteristic of the male gender role have been found both to serve as a protection against depression for men in some instances (such as coping style and attribution of negative incidences) and as factors that can lead men to express their depression in other negative ways (such as substance abuse or violence). The different effects of the male gender role on how men experience and express depression will be discussed.

Third, the paper will examine studies based on traditional cultures (i.e. non-Western cultures and cultures that are more communal and less individualistic) and examine the difference that more traditional values have on the gender differences in depression. Traditional cultures (such as Amish and Jewish cultures) within large Western countries will be examined as well as some cultures in non-Western countries. Whether traditional values have an effect on the prevalence or presentation of male depression will be examined.

Finally, the clinical implications of male depression will be discussed. The paper will look at how effective typical depression treatments (such as medication or cognitive therapy) have been in treating male depression as well as review several therapies designed specifically to address male gender-issues in therapy.

#### Inclusion and Exclusion Criteria for Paper

Literature was searched for using the PsychInfo database. Articles were searched for that addressed any gender issues either in the prevalence, symptomatology, diagnosis, or treatment of depression. Search terms such as “male depression,” “men,” “treatment,” and “gender differences” were used to identify articles. Relevant articles were selected if they were either 1) empirical studies about some aspect of male depression or its treatment or 2) a meta-analysis of multiple empirical studies. Other articles were found using the reference sections of articles about depression. Additionally, studies were looked for that used some standard form of diagnosis or assessment of depressive symptomatology (i.e. the DSM-IV—TR diagnostic criteria, or Beck Depression Inventory, or another psychometrically sound assessment tool such as the Center for Epidemiologic Studies Depression Scale).

#### Gender Differences in Depression

##### *Rates of Depression*

The prevalence of major depressive disorder in men is approximately half the rate of depression in females (Kessler et al., 1993; Sloan & Kornstein, 2003). Overall, the lifetime prevalence of Major Depressive Disorder in women is 21.3%, and 12.7% in men (Kessler et al. 1993). Differing studies estimate that women are 1.7 to 2.7 times as likely to exhibit major depressive disorder during their lifetime as males (Kessler, 2003; Kessler et al., 1993; and Weissman et al. 1993). The gender difference in Major Depressive Disorder has been found across a number of different countries and ethnic groups (Weissman, 1996). However, other studies suggest that gender differences in rates of Major Depressive Disorder are not universal to all ages and ethnic groups (Brodaty et al., 2005).

The rate of depression in men and women is similar throughout childhood, but diverges between 11 and 13 years of age at the time that puberty and adolescence begin (Kessler et al., 1993). The divergence between the rates of male and female depression continues during the “childbearing years” before converging again at approximately 55 years or the age of menopause for women (Bebbington et al., 1998; Brodaty et al., 2005). During adolescence, girls’ depression rates become approximately double that of boys (Broughton & Street, 2007).

#### *Severity of Depression*

It has been hypothesized that in addition to exhibiting a greater likelihood of developing depression, women may also exhibit more severe depression. In their meta-analysis of studies of gender differences in depression, Hildebrandt, Stage, and Kragh-Soerensen (2003) found that women reported more depressive symptoms than men in all four studies that collected data on number of depressive symptoms. However, evidence that women reported higher overall total scores on depression ratings was equivocal, with four studies finding no difference between genders and three finding significant differences with women reporting higher levels of

depression (Hildebrandt, Stage, & Kragh-Soerensen, 2003). These results are consistent with other past studies as well. Contrary to the common hypothesis, severity of depression is relatively similar for men and women (Frank et al., 1988; Hammen and Padesky, 1977). Men and women report experiencing individual symptoms similarly (Frank et al., 1988; Young et al., 1990), however men tend to report significantly fewer symptoms than women (Angst and Dobler-Mikola, 1984; Ernst and Angst, 1992, Young et al., 1990).

### *Symptomatology*

Although men and women appear to have similar severity of depression, they may have different constellations of depressive symptoms. It has been hypothesized that women display more classical depressive symptoms, whereas men are less likely to display many typical depressive symptoms.

In Hammen and Padesky's (1977) study of male and female responses on the Beck Depression Inventory among a sample of unmarried college students, men demonstrated a specific pattern of responses. Men were distinguished by showing an inability to cry, loss of interest in other people, a sense of failure, and somatic responses. Men responded in the most extreme pattern on the "crying spells" item, suggesting that they may not feel they are able to cry, even when they wanted (Hammen & Padesky, 1977). Steer et al. (1989) replicated this study and found similar results. They suggested that women have a more affective and cognitive pattern of depressive symptoms while men exhibit more performance symptoms, such as irritability, somatic symptoms, and lower libido.

Similarly, Gjerde, Block, and Block (1988) found that female and male adolescents demonstrated several different patterns of symptoms on the California Adult Q-Sort, which they summarized in four male factors and three female factors. Females' responses were summarized

in three factors: Ego-Brittleness, Unconventionality, and Rumination. Ego-Brittleness was characterized by a combination of low self-expectations, feeling a lack of meaning in life, self-defeating behavior, and brittle ego defense system. Unconventionality is characterized by rebelliousness and having unusual values and thought processes. Finally, using rumination as a defense mechanism and feeling anxiety in somatic symptoms characterized the Rumination factor. For women, Unconventionality and Rumination factors both showed a linear relationship with Scores on the Center for Epidemiological Studies-Depression measure (CES-D) with higher scores on these factors (indicating greater unconventionality and rumination) associated with higher depression scores. However, the Ego-Brittleness factor was high for individuals who scored very high or very low on the CES-D measure.

Male subjects in the Gjerde, et al. study (1988) study demonstrated four factors: Interpersonal Antagonism, Unrestraint, Discontent with Self, and Unconventionality. Interpersonal Antagonism was characterized by deceitful and exploitive interpersonal behavior and hostility, as well as a lack of guilt, sympathy for others, and submissiveness. The Unrestraint was related to symptoms such as impulsiveness, having low self-expectations, withdrawing from adversity, and being unproductive. The Discontent with Self factor was characterized by a lack of meaning in life, being self-defeating, and overreacting to frustration. Finally, the Unconventionality measured the same symptoms as the female factor. Among adolescents who had the highest scores on the CES-D measure for depression, the Interpersonal Antagonism factor was even higher than would be expected by a simple linear positive relationship between the two variables, suggesting that the presence of depression may intensify interpersonal conflict among male adolescents. All four male factors individually showed a positive linear relationship with scores on the CES-D measure. Ratings indicated that the

presence of beliefs related any of the four factors increased (as measured by higher ratings in those domains)—Antagonism, Unrestraint, Discontent with Self, or Unconventionality—so did scores on the depression measure.

This study (Gjerde et al., 1988) suggested that only one of the male depression factors, Discontent with Self, corresponds with how depression is usually conceptualized. Instead, “acting out” symptoms such as Antagonism, Unrestraint, and Unconventionality were characteristic of males with depression. On the other hand, two of the three female depressive factors, Ego Brittleness and Rumination, correspond with more classic symptoms of depression. In general, the Gjerde et al. (1988) study found that male adolescents were more likely to act out with aggressive, externalizing behaviors, whereas adolescent females were more likely to be introspective and have a dislike for self. Additionally, it is notable that among 18-year old females, depression was related to low self-esteem, but not in 18-year-old depressed males.

In Hildebrandt, Stage, and Kragh-Soersen’s (2003) meta-analysis of gender differences in depression across ten different studies, they found that women with depression reported more appetite disturbances, sleep disturbance, and weight changes than did men with depression. Additionally, males were found to be more likely to have melancholic depression--characterized by inability to find pleasure, insomnia, and lack of appetite – than were women

Similarly, Winkler et al. (2004) found in their study of hospitalized depressed patients that women displayed more affective lability and dysphoria than male patients. Conversely, male patients more often displayed affective rigidity and blunted affect in addition to increased somatic symptoms. At discharge, male patients were likely to exhibit compulsive behaviors. The different symptoms found in Winkler et al. study is consistent with the general pattern found in most studies of women exhibiting more internalizing symptoms (such as rumination, crying,

low self-esteem, etc.), while men more often had externalizing symptoms (such as interpersonal conflict, substance use, and impulsive behaviors).

### *Psychopathology and Comorbidity*

About two-thirds of individuals with major depressive disorder have at least one co-occurring Axis I disorder, most commonly anxiety or substance abuse disorders. Males and females with depression often demonstrate differential patterns of comorbidity that correspond with their different patterns of symptoms.

Fava, Abraham, Alpert, and Nierenberg (1996) found among patients seeking treatment for major depressive disorders that men were more likely to have a history of alcohol or substance abuse or dependence, whereas women more often had a history of simple phobia and bulimia. No difference was found between men and women in any other anxiety disorder, somatization disorders, or dysthymia. However, it was hypothesized that the uniqueness of the sample may have led to the equality in comorbid anxiety disorders in the sample. Among men with depression, men who seek treatment may be more likely to have comorbid anxiety (Fava et al., 1996).

Rapaport et al. (1994) also found that among depressed outpatient clients, men being treated for depression were less likely to have a comorbid mental health disorder than women. However, unlike Fava et al. (1996) they did find that men were less likely to have comorbid anxiety disorders. Additionally, Rapaport et al. also found that men were more likely to have substance abuse disorders (although not alcoholism) than women.

### *Male Depressive Syndrome*

The gender differences in how men and women experience depression, their different symptoms, and their different co-morbidity has led some researchers to hypothesize that there exists a separate “male depressive syndrome.” This syndrome is characterized by anger, irritability, interpersonal conflict and hostility, and impulsivity (Winkler et al., 2004). Winkler, Pjrek, and Kasper (2005) found that in a sample of outpatient clients with depression, men were twice as likely as women to exhibit anger attacks. Additionally, their hypothesis of male depressive syndrome was supported by results of lower impulse control, more substance use, more impulsive behavior in men as compared to women. Moller-Leimkuhler et al. (2004) found similar results among inpatient male clients with depression, who developed a unique pattern of symptoms characterized by significantly more antisocial behavior, irritability, and aggressiveness than female inpatient clients.

### Explanations of Gender Differences in Depression

There are multiples explanations that have been proposed to contribute to the gender differences in depression. Biological factors are hypothesized to be a contributing factor, however psychological and cultural factors also appear to play a large role in creating gender differences in the expression of depression. Explanations for gender differences in depression will be divided into four categories: biological, psychological, social, and artifact theories.

#### *Biological Explanations*

No direct genetic factors have been found that affect the gender difference in depression (Piccinelli & Wilkinson, 2000). Genetic risk factors for depression appear to be similar for both sexes. However, other biological factors may be mediating variables in the development of depression. A relationship has been found between gonadal hormones and negative affect,

which coincides with the increase in female depression in early puberty (Piccinelli & Wilkinson, 2000). Additionally, some neurotransmitter differences between genders at different ages (among noradrenaline and serotonin) may also contribute, but how is unclear (Piccinelli & Wilkinson, 2000).

### *Psychological Explanations*

Several separate psychological variables are hypothesized to contribute to the development of depression, including personality variables, cognitive thinking styles, and differential coping styles. Differences in self-esteem, self-worth, and feelings of competence have been incorporated into multiple theoretical orientations (Broughton & Street, 2007). Some studies have suggested that beginning in adolescence, females are more prone to a negative view of self that is associated with depression (Sakamoto, 2000). However, rate of maturity and the importance placed on appearance appears to be a mitigating factor. Girls who mature early or associate physical appearance with self-worth report lower self-esteem and higher rates of depression (Hankin & Abramson, 2001; Broughton & Street, 2007).

The presence of neuroticism (involving worrying tendencies and increased negative emotion) has been linked to increased likelihood of first depression episode (Hirschfeld et al., 1989). Because this trait has been found to be more common in women it may be predictor of gender difference in depression (Parker & Brotchie, 2004; Widiger & Anderson, 2003). An overall, feminine gender-role orientation (as measured by the Bem Sex Role Inventory) has also been associated with higher levels of depression (Allgood-Merton, Lewinsohn, & Hops, 1990).

Taken together, these studies suggest that there are multiple personality factors that may place women at greater risk for depression, including neuroticism, feminine gender orientation, and the association between self-worth and physical appearance. However, there is less known

about what personality factors may protect men from develop depression or how a masculine gender-role orientation may lead to lower rates of depression.

Cognitive attribution and coping styles also play a role in creating gender differences. Women are more likely to adopt a ruminative coping style, characterized by intense focus on depressive symptoms and their causes (Broughton & Street, 2007), which has been linked to longer and more severe episodes of depression (Nolen-Hoeksema, Morrow, & Frederickson, 1993). Men more often employ a more solution-focused coping techniques and distraction in response to depressive symptoms.

Several cognitive attribution styles more common in women also may make women more likely to develop depression. An internal, as opposed to external, attributional style has been linked to vulnerability to depression (Broughton & Street, 2007). In particular, people who attribute negative events to internal, global states are more likely to exhibit depressive symptoms. This style has been found to be more common in women than in men (Abramson & Andrews, 1982). Additionally, learned helplessness, closely related to depression, is also more common in women than men (Nolen-Hoeksema, 1987).

### *Social Explanations*

A variety of social explanations have also been proposed to explain gender differences in depression. It has been suggested that men place less importance on interpersonal relationships than women. This may lead interpersonal problems to have less of a depressogenic effect on men than on women (Broughton & Street, 2007). This has led multiple authors to create a “cost of caring hypothesis” which states that because women place greater emphasis on interpersonal relationships, they are more vulnerable to experiencing depression due to negative life experience of others people (Turner & Avison, 1989; Kendler, Thornton, & Prescott, 2001).

Additionally, the quality of social support (or lack thereof) also has differential effects on the development of depression. While social support seems to act as a buffer to developing depression after experiencing negative events, it does not otherwise appear to affect the development of depression in men (Barnett & Gotlib, 1990). However, low social support may be depressogenic for women regardless of life events (Barnett & Gotlib, 1990).

Taken together, it appears males place less importance on interpersonal relationships and social support than women, and that it has less of an effect on the development of depression in men. Other social factors such as different social roles for men and women and more negative life events for women have also been hypothesized to explain the differences in depression between genders, but research has been equivocal in support of these ideas (Broughton & Street, 2007).

#### *Artifact Theories*

Some researchers have hypothesized that the way in which depression is conceptualized and assessed may also directly contribute to the gender differences in depression. For example, depressive questionnaires may reflect too narrow a definition of depression, failing to assess acting-out and antisocial symptoms of depression that are common in men (Broughton & Street, 2007; Winker et al., 2004).

Additionally, men's greater reluctance to report depressive symptoms, even when they are judged to have equal levels of depression, may lead men to be less diagnosed on both self-report questionnaires and diagnostic interviews for depression (Broughton & Street, 2007). In comparing diagnoses made by using the standardized Diagnostic Interview Schedule compared by diagnosis made by professionals, Potts et al. (1991) found that men were significantly more likely than women to be underdiagnosed with depression (although men were underdiagnosed

more often than women only by medical practitioners, not mental health practitioners). Additionally, women were significantly more likely to be overdiagnosed with depression than men. This suggested that some professionals might be less likely to diagnose depression in men than in women.

### The Male Gender Role

It is hypothesized that many of the differences in male depression are related to gender role development and the norms and expectation that accompany the male gender role. The research suggests that many aspects of the male gender role leads male depression to be unique and helps to explain the concept of the Male Depressive Syndrome. Male gender role norms help to explain men's differential expression of depressive symptoms, different self-reported experience of depression, different coping mechanisms, and different ideas about treatment.

Pleck's Male Gender Role Strain Theory (Pleck, 1981, 1995) is a research based theoretical framework for understanding male gender role development. Additionally, it provides a theoretical background for understanding how male gender role development affects the development of depression. This theory provides a basis for understanding how gender role factors effect male depression.

#### *Male Gender Role Strain*

Pleck's revised Gender Role Strain Theory (1995) is based on ten research-based propositions about gender role development:

1. Gender roles are operationally defined by gender role stereotypes and norms.
2. Gender role norms are contradictory and inconsistent.
3. The proportion of people who violate gender role norms is high.
4. Violating gender role norms leads to social condemnation.
5. Violating gender role norms leads to negative psychological consequences.
6. Actual or imagined violation of gender role norms leads individuals to

- overconform to them.
7. Violating gender role norms has more severe consequences for males than females.
  8. Certain characteristics prescribed by gender role norms are psychologically dysfunctional.
  9. Each gender experiences gender role strain in its paid work and family roles.
  10. Historical change causes gender role strain (Pleck, 1981).

The theory is based around the idea that individuals hold stereotypes, “widely shared beliefs about what the sexes actually are like” (Pleck, 1981, pg. 135), and norms, or “widely shared beliefs about what the sexes should be like” (Pleck, 1981, pg. 135). Brannon (1976) defined four primary factors of male social norms and stereotypes: No Sissy Stuff (defined by the avoidance of anything feminine); the Big Wheel (desiring success, status, and admiration from others); the Sturdy Oak (having toughness, confidence, and self-reliance), and Give 'Em Hell (defined by adventure, aggression, and violence). Gender Role Strain theory hypothesizes that these values form the ideal that males attempt to reach and compare themselves to.

Pleck (1995) summarized these ten propositions into three broad ideas about difficulties often present in gender development. First, a significant proportion of males fail to fulfill male-role expectations. For example, an individual who may choose a more traditionally feminine profession may feel that he does not conform with masculinity expectations professionally. This may lead men to feel a “gender role discrepancy” between their own masculinity and their masculine ideals, which may result in low self-esteem or other adverse psychological consequences, possibly including depression.

Second, the male socialization process can itself be traumatic for some men, even if male gender expectations are successfully fulfilled. For example, some psychodynamic theory suggests that while women are able to maintain a close relationship with their mothers throughout development, boys are asked to increasingly detach themselves from their mothers in

order to develop independence and distance themselves from femininity (Levant, 1995). This “gender role trauma” may also lead to negative psychological outcomes.

Third, successfully fulfilling gender role expectations may itself create many negative characteristics in men and may have negative psychological effects. This “gender role dysfunction” suggests that there are inherent negative side effects to the masculine gender role. For example, some studies have suggested that scoring high in masculinity on the Bem Sex Roles Inventory is correlated with increased delinquency (Horwitz & White, 1987) and psychological violence towards dating partners (Thompson, 1990).

### *Masculinity Ideology*

“Masculinity ideology” is another factor that is hypothesized to affect male gender role strain. This concept “refers to beliefs about the importance of men adhering to culturally defined standards for male behavior” (Pleck, 1995, pg. 19). It reflects the level to which an individual internalizes and personally endorses cultural norms and stereotypes about the male gender role (Thompson & Pleck, 1995).

Masculinity ideology is hypothesized to play a mediating role in gender role discrepancy, gender role trauma, and gender role dysfunction. The degree to which an individual endorses and internalizes cultural gender norms affects how much an individual may compare his own behavior to gender expectations. How intensely he may seek to develop some of the characteristics that may lead to gender role dysfunction is affected by how much an individual invests in those gender role norms.

Additionally, masculinity ideology can be affected by the culture in which an individual exists. Different cultures vary in the importance they place on behaving according to expected gender role norms (Pleck, 1995). For example, an individual who is a professional athlete is

likely to be exposed to different cultural ideologies than a male who is in the field of nursing or another traditionally feminine field.

### *Measurement and Research*

Support for Gender Role Strain Theory is provided by the growing research for the Gender Role Conflict Scale (O'Neil, 1986), a measure that is theoretically based on Pleck's theory (1981). The measure was devised around the concept that gender role conflict is "a psychological state in which socialized gender roles have negative consequences for the person or others" (O'Neil, 2008, pg. 362). In developing the Gender Role Conflict Scale multiple psychological domains (cognitive, affective, behavioral, and unconscious domains), situational contexts (such as transitions in gender role and gender role conflict experienced from other), and personal variables (such as the negative experiences an individual may have experienced do to deviating from, violating, or conforming to gender role norms) were considered in defining the construct of gender role conflict and developing assessment items.

The Gender Role Conflict Scale is broken down into four factors: Restrictive Emotionality; Success, Power, and Competition Issues; Restrictive and Affectionate Behavior Between Men; and Conflicts Between Work and Family Relations (O'Neill, 1986). The Restrictive and Affectionate Behavior Between Men, Restrictive Emotionality, and Conflicts Between Work and Family Relations areas are all considered to have direct relationship with how gender role conflict is defined, whereas Success, Power, and Competition Issues are considered to be a broader masculinity norm that indirectly assesses gender role conflict (O'Neill, 2008).

Since its initial development, 22 studies have been conducted that have supported its factorial validity (O'Neil, 2008). Factor intercorrelations are moderate, ranging from .35 to .68

(Moradi et al., 2000), suggesting that the factors are related to each other, but still separate entities. The validation and wide use in research of the Gender Role Conflict Scale provides support for the theoretical basis of the scale—Pleck's Gender Role Strain Theory. Additionally, eight studies have used confirmatory factor analysis to validate the four-factor structure of the GRCS (Englar-Carlson & Vandiver, 2002; Faria, 2000; Good et al., 1995; Hernandez, Sanches, & Liu, 2006; Kratzner, 2003; Moradi et al., 2000; Rogers et al., 1997; Wester, Pionke, & Vogel, 2005).

### Depression and the Male Gender Role

Pleck's Gender Role Strain paradigm explains how the male gender role can lead to various adverse consequences. In particular, the male gender role can affect the development and expression of depression. This happens in multiple ways according to Pleck's theory: first, it affects how men respond to feelings of depression; second, it affects how men express depression and what symptoms they develop; third, it affects the coping strategies that men use to deal with depression; and fourth, it affects the way that men seek help for depression as well as other related mental health issues.

#### *Responding to Feelings of Depression*

The male gender role is hypothesized to affect both men's awareness of depressive symptoms and how they may respond to feelings of depression. The male gender role often suggests that many men, particularly those who have a very strong masculine ideology, feel and express feelings of sadness in a very different ways. This may offer a possible explanation for why men exhibit depression less than women.

Research suggests that many men have a difficult time experiencing, recognizing, and putting feelings into words, referred to as alexythymia (Potash, 1998). While extreme

alexithymia is often found in men with a history of trauma or PTSD, it is believed that milder forms of alexithymia are experienced by many men (Potash, 1998). Levant (1998) refers to this as “normative male alexithymia.” It is suggested that each of the three types of gender role strain (gender role discrepancy, gender role trauma, and gender role dysfunction) may lead men to distance themselves from expression of emotion.

The presence of alexithymia may lead to many negative consequences. “It blocks men who suffer from it from utilizing the most effective means known for dealing with life’s stresses and traumas” such as identifying and discussing emotions with other individuals (Levant, 1998). Theoretically, this may lead men to deal with stress in ways that may lead to negative consequences such as substance abuse, violence, sexual compulsions, or other risky behavior (Levant, 1995).

The presence of alexithymia may help to explain the lower prevalence of depression in males. Many men with alexithymia fail to identify and verbalize many emotions (Levant, 1995). Levant suggested (1995) this failure may make some men less likely to verbalize an experience of depression (which will be discussed in greater detail later in this paper) and, instead, more likely to use coping strategies of escape and distraction that may make them more likely to develop substance abuse disorders and anti-social behaviors. Emotions may be misunderstood or mislabeled and addressed in externalizing ways that have negative consequences for the individual. In this way, alexithymia provides an example of the Gender Role Strain Theory (Pleck, 1995) proposition that “certain characteristics prescribed by gender role norms are psychologically dysfunctional.”

For men who feel depressive symptoms, masculinity norms may guide their response to these symptoms. In their qualitative study of men’s response to depression and other illnesses,

O'Brien, Hart, and Hunt (2007) cite the negative association between femininity and expressing emotion as a reason that many men attempt to hide depression. Many men stated that exhibiting emotional distress or talking about their sadness "flouted the conventional practice of masculinity" (pg. 190).

In O'Brien, et al.'s (2007) study, three separate groups of men suffering from depression, prostate cancer, and heart disease were created and asked to discuss their experience with their illness. In contrast with other illnesses (prostate cancer and heart disease) where men typically provided details about the symptoms and course of their illness, men with depression were hesitant to describe their illness and provided less detail. This was true even though depression was the most common disorder discussed in groups, often mentioned in prostate cancer and heart disease groups as well as the depression group. This indicated that although feelings of depression were much more common than any other illness discussed, depression was treated in discussion with much more stigma than other illnesses. Other forms of loss, such as physical losses or loss of employment due to illness, were much more openly discussed than negative emotions related to depression.

O'Brien et al. (2007) found that some men indicated that there were unwritten "rules" that guided what is and is not appropriate for men for discuss—many body injuries and illnesses were considered okay to discuss, but anything regarding mental health had a stigma attached to it. Participants stated that if they were able to express their experiences of depression, they expected to receive very little understanding or sympathy from others, particularly other men. They often stated that it was an invisible illness, and men were expected to keep it hidden.

Emslie et al.'s (2006) study of men's accounts of their own depression produced more elaborative responses from many men about their own experiences with depression. In this study, 16 men from Oxford, England who had existing diagnosis of depression were selected to participate in an open-ended interview about their experience with depression. Ages of participants ranged from 31 to 75 years old and 5 of the 16 men were classified as having bipolar disorder. Most men's primary emotional response to feelings of depression was that of "isolation and 'difference'" where they felt separate from others and struggled to fit in socially (Emslie, 2006). Men often expressed a need to reconcile their negative emotions with their sense of masculinity and regain a sense of self-control over their own health care. For example, some men conceptualized their "battle" with depression in more masculine terms, such as viewing depression as an "opponent" who needed "defeating." However, other men viewed seeking any help as taking away from their sense of self-control and against their masculine sense of self (Emslie, 2006).

Men's difficulty with acknowledging their depressive symptoms is consistent with Pleck's Gender Role Strain Theory (1995), in particular the proposition that "violating gender role norms leads to social condemnation." In O'Brien et al. (2007) study, the threat and expectation of social condemnation from others, especially other men, was a consistently reason men expressed for why they kept their depression hidden. Additionally, this provides another example of the Gender Role Strain Theory proposition that some gender role norms are psychologically dysfunctional. In this case, even when depression is recognized, it may prevent many men from admitting and discussing their depression and, ultimately, in developing effective and healthy coping mechanisms.

*Gender Role Conflict as a Cause of Depression*

Difficulties in successfully conforming to male gender role and upholding gender role norms may also play a causal role in some men's depression or exacerbate symptoms. Gender Role Strain Theory offers some explanations of how this may happen. The three specific types of gender role strain that are often felt by men—gender role discrepancy, gender role trauma, and gender role dysfunction—each may play a role in some men developing depression (Pleck, 1998).

The men in Emslie et al.'s (2006) qualitative study each stated that their negative thoughts and emotions stemmed from their teenage years. Many said that they were called "weak" or "sensitive" and began to feel they were not masculine enough. Other men, both gay and straight, were called homophobic insults. These men reported feeling that they began to feel "culturally subordinate" (pg. 2250) because they were judged as not being part of the "circle of legitimacy" that conforming to masculine gender role norms and stereotypes. This provides an example of Pleck's (1981) proposition that violating gender role norms and stereotypes leads to negative social and psychological consequences.

Conversely, many men reported feeling depressive symptoms following a loss of their masculine identity in O'Brien et al.'s (2005) study of men coping with illness. All men in their heart disease groups reported not being physically able to work as being of central importance as being a major stressor. The sudden termination of their working situation was perceived as being a major stressor and a loss of masculinity. Interestingly, men who were closer to their age of retirement reported less stress and feeling of loss of masculinity than other men. This suggests that because not working was a more acceptable behavior for them as they neared retirement that it was not as much of a threat to their masculinity. Men in their prostate cancer groups also reported a loss of masculinity due to physical changes due to their illness and its treatment

(O'Brien et al., 2005). In each case, men became very aware of a gender role discrepancy and often felt a sense of loss and mourning due to the effects of their illness and its treatment.

These prominent and consistent experiences of depressed men in Emslie et al.'s (2006) and O'Brien et al.'s (2005) studies provide examples of gender roles discrepancy (Pleck, 1995) where each of these men indicated that they felt that they did not measure up to masculinity ideals. While the origins of their feelings of discrepancy differed—from teenage failure to meet gender ideals to removal of elements central to subjects' masculinity later in life due to illness—all subjects expressed feeling gender role discrepancy compared to gender role norms.

Several studies have also examined the relationship between gender role conflict as measured by the Gender Role Conflict Scale, and depression. Good and Mintz (1990) and Good et al. (1996) found that gender role conflict was significantly correlated with scores on measures of depression, with correlations between .26 and .31 ( $p < .001$ ). In a male college-age population, Good and Mintz (1990) found that all four components of gender conflict (success, power and competition; restrictive emotionality; restrictive affectionate behavior between men; and conflicts between work and family relations) showed small to moderate correlations with depression (with correlations ranging from .12 to .31;  $p < .05$  to  $p < .001$ ).

Good and Wood (1995) found similar associations as Good et al. (1996) and Good and Mintz (1990) between all male gender role conflict and depression domains (correlations between .11 and .33;  $p < .05$  to  $p < .001$ ) with the strongest correlations on the restrictive emotionality (.18;  $p < .001$ ) and conflict between work and family domains (.33;  $p < .001$ ).

Additionally, Good and Wood (1995) examined what gender role factors may affect depression. They divided gender role conflict into two underlying factors: restriction-related gender role conflict (which consists of limiting male friendships and emotional experiences) and

achievement-related gender role conflict (which consists mostly of driving for success and comparative degree of success). In other words, restriction-related gender role conflict is what men *should not* do, while achievement-related gender role conflict is what men *should do* to fit in with gender role norms and stereotypes. Good and Wood (1995) found that restriction-related and achievement-related gender role conflict each affected depression in different ways. While restriction-related gender role conflict was significantly related to men's attitudes about seeking help for their depression (accounting for 24.9% of the variance in help-seeking attitudes), it was not significantly correlated with the experience of depression. Conversely, achievement-related gender role conflict was not significantly related to help-seeking attitudes, but was significantly related to depression (accounting for about 21.4% of the variance in depression). This suggests that the gender-role norms related to the drive for success and the conflicts that this often creates between family and work roles may play a larger role in the development of depression. Additionally, this suggests that gender role-discrepancy may play a role in depression as men compare themselves to other's success and gender-role based achievement ideals.

Good et al. (1996) conducted a study on a similar population (university counseling center clients), but obtained slightly different results than Good and Wood (1995). On the Gender Role Conflict Scale, they found the restricted emotion and conflict between work and family relations scales to be the strongest predictors of depression (correlations of .30 and .37 respectively,  $p < .001$ ). Additionally, restrictive personality was also significantly related ( $p < .001$ ) to paranoia (along with the drive for success and drive for achievement;  $p = .38$ ), interpersonal sensitivity difficulties ( $p = .40$ ), and psychoticism ( $p = .37$ ). Conflict between work and family was also significantly related to obsessive-compulsivity (correlation of .37,  $p <$

.001) (Good et al., 1996). This study suggests that gender role conflict is related to a number of adverse psychological consequences including, but not limited to, depression.

Taken together, these studies suggest that gender-role discrepancy plays a role in the development of depression as men sense a failure to meet up with gender norms and expectations. Additionally, multiple gender-based norms seem to play a role in depression. Achievement-based gender conflict may play a particularly important role in the development of depression. However, family and work conflict; restrictive emotion; and restrictive affection between men may also play a role in creating or maintaining depression.

#### *Coping Responses to Depression*

As reviewed previously, men exhibit a unique pattern of coping with depression. Men more often use active distraction and instrumental or action-oriented coping styles to deal with negative emotion (Nolen-Hoeksema, 1987). Additionally, men are more likely to make simple, external attributions for negative emotion (Abramson, Matalsky, & Alloy, 1989; Abramson & Andrews, 1982). These coping and attribution styles are less associated with depression than internal-based attribution and ruminative coping styles (Nolen-Hoeksema, 1987; Abramson & Andrews, 1982). While this coping style can serve as a protective factor against depression, it may also have some negative effects and may provide an example of gender role strain.

Men's coping methods are consistent with gender role norms and may be an attempt to avoid gender role conflict. In a study in which 153 college undergraduate males were interviewed, Mahalik and Rochlan (2006) found that the most likely coping responses for depression were: talk to best friend or family member (not wife or partner) (mean rating score of 2.39 where 3 was very likely and 0 was very unlikely), wait to see if it goes away (mean rating of 2.15), distract self through activities (2.14 mean rating), or exercise and workout (mean rating

score of 2.10). Most of these coping strategies are examples of active coping actions and distraction.

While talking to others (other than their wife or partner) may indicate a willingness to discuss depression as a coping mechanism, it appears that discussion directly related to seeking outside professional help is potentially more discouraged. The least likely actions to do to cope with depression were all those that involved help-seeking such as talking to an expert or clergy member (mean rating of from 0.96 to 1.13), or learning on how to help themselves or about depression (mean score of 0.71) (Mahalik & Rochlan, 2006). Similarly, male respondents in O'Brien et al.'s (2007) and Brownhill et al.'s (2004) studies spoke of denial and avoidance as a primary method of coping—multiple men expressed that “denial of depression is one of the means used to demonstrate masculinities” (O'Brien et al., 2007, pg. 196).

Masculinity in Mahalik and Rochlan's (2006) study was also a predictor of coping methods used in response to depression. Men who rated themselves as having high conformity to masculinity norms based on the Conformity to Masculinity Norms Inventory were less likely to talk to their wife or a professional about depression. Also, they were more likely to work out or “have a few drinks” to cope with depression (Mahalik & Rochlan, 2006). This suggested that in coping with depression, men who strongly conform with masculinity norms, strive to avoid breaking any gender role norms by talking about their depression, seeking help from others, or potentially showing weakness.

While these normative methods of coping may be effective in coping with negative emotions, Brownhill et al. (2004) propose that there is a progression of methods of coping with depression that leads increasingly to more negative outcomes—a “big build” of managing depression. Based on qualitative analysis from multiple focus groups with men about

depression, they propose that men progress in coping with depression from internal, “acting in” coping styles and progresses into more abnormal and maladaptive “acting out” coping behavior (Brownhill et al., 2004).

The “big build” model suggests that methods of avoiding and ignoring depression are the initial stage (Brownhill et al., 2004). The next progression is numbing coping behavior, such as drug and alcohol use, designed to relieve emotional stress. When numbing depression is ineffective, more extreme escaping behaviors are often used as the next coping strategy. This can include activities such as increasing time spent at work or developing extramarital affairs. All of these behaviors are considered the “acting in” coping behaviors where the individual is primarily acting on himself, although some escape behaviors (such as sexual affairs) may involve acting out.

Theoretically, if these coping strategies are ineffective, there is a continuing “build up” of unreleased negative emotion (Brownhill et al., 2004). Eventually, this build up is often released using externalizing, acting out coping methods that may involve violence, aggression, and lashing out at others. Ultimately, the final externalizing form of coping with negative emotion, some men turned to deliberate self-harm or suicide.

The big build theory is supported by Angst and Ernst’s (1990, as cited in Moller-Leimkuhler, 2003) study of suicide among males in Switzerland, who found that although 75% of suicides were among men, 75% of those who accepted treatment for suicide prevention were women. Studies have shown that suicide was considered less wrong, less foolish, and less weak for males than for females (Deluty, 1988) and men who committed suicide were considered to be more well-adjusted than females who committed suicide (Lewis & Shepherd, 1992). This suggests that suicide is perceived to be a more acceptable behavior for males than for females.

This is compounded by the perception that failing at committing suicide is perceived as culturally inappropriate for males (Canetto, 1997). Similarly, Dahlen and Canetto (2002) found that respondents with androgynous gender role identities rated depression as being more “wrong” than respondents with masculine gender role identities [ $F(387) = 3.20, p < .05$ ].

Taken together, these studies suggest that men’s coping strategies to manage depression and negative emotions may have a multiple effects. First, it may make them less likely to develop depression because some of the commonly used “action-oriented” coping strategies, such as exercise or conscious distraction, may effectively reduce negative emotion and be less likely to increase depression and anxiety than other coping methods such as rumination. Secondly, male gender role may make men less likely to use other effective coping methods such as discussing negative emotions and depression with other individual, particularly a spouse, and they may expect negative consequences if they were to share these feelings.

Finally, when depression is not coped with effectively it may build up and lead to progressively more deleterious coping mechanisms being used. This “big build” of negative coping mechanisms range from avoidance and numbing of depressive symptoms to more externalizing coping strategies such as substance abuse, aggression, violence, and possibly suicide.

### *Depressive Symptomatology*

The symptoms displayed by males with depression may be largely affected by gender role norms and gender role ideation. Gender role norms affect the depressive symptoms males exhibit. Meanwhile, gender role ideation likely affects the degree to which men exhibit symptoms that match gender role norms.

As discussed previously, men with depression often have a different constellation of depressive symptoms than women with depression. They have often exhibited more externalizing symptoms such as irritability and interpersonal conflict. They are also more likely to exhibit withdrawal and emotional rigidity. In other words, men with depression are more likely to “act out” their depression and less likely to report internalizing symptoms. In fact, they are defined by a *lack* of internalizing depressive symptoms at times as they exhibit withdrawal. Additionally, males more often have comorbid substance abuse and antisocial behavior. (Hammen & Padesky, 1979; Steer, 1989).

Additionally, some research suggests that masculinity ideology of an individual, the importance they place on following gender role norms, may also affect the expression of depressive symptoms. In a study of gender role typing and depressive symptomatology, Oliver and Toner (1990) found that the level of depression (as measured by the Beck Depression Inventory) did not differ for men that were rated more masculine or more feminine on the Short Bem Sex Role Inventory (BSRI). However, withdrawal symptoms were reported to be much more severe for the masculine depressed males ( $M = 4.16$ ,  $SD = 2.51$ ,  $n = 19$ ) than for feminine depressed males ( $M = 2.08$ ,  $SD = 3.14$ ,  $n = 12$ ). This suggested that the masculinity ideation—the amount that men conformed and placed importance on masculine gender role norms and behaviors—significantly influenced the degree to which they exhibited the withdrawal depressive symptom (Oliver & Toner, 1990). Additionally, the withdrawal symptom corresponds with the most common male coping methods of managing depression of avoidance and distraction.

Overall, the symptoms that characterize male depression are consistent with gender role norms and expectations. For example, the strong presence of the withdrawal symptom is

consistent with the male gender role norm of not expressing emotion and inability to cry is consistent with the avoidance of behavior that is perceived as feminine. Instead, symptoms that involve substance abuse, irritability, and interpersonal aggression more easily fit within male gender role stereotypes.

### *Attitudes Towards Help-Seeking*

Gender role norms and gender role conflict have a large effect on the development and presentation of depression in men. However, gender role also have a large effect on male depression by its effect on men's help-seeking behavior. Male gender role norms may affect help seeking for men with depression in two main ways: 1) by affecting their likelihood to seek treatment and 2) effecting how they discuss their behavior during treatment.

Good, Dell, and Mintz (1989) analyzed the relationship between male gender role variables, as measured by the Gender Role Conflict Scale and the Attitudes Toward Men Scale (which measures endorsement of male stereotypes), the Attitudes Towards Seeking Professional Psychological Help Scale (which measures general attitude toward psychological help), the attitude and behavioral sections of the Help-Seeking Attitudes and Behaviors Scale (which assesses clients anticipated help-seeking attitudes and behaviors in response to specific stressors). Gender role variables were predictive of all three help-seeking variables. On the Help-Seeking Attitudes and Behavior Scale (HABS), gender role variables explained 3.3% of the variance on the attitude scale ( $p < .05$ ) and 8.9% of the variance on the behavior scale ( $p < .001$ ) (Good, Dell, & Mintz, 1989). Additionally, the restrictive emotionality gender norm contributed 1.9% and 6.3% of the variability on the HABS attitude and behavior scales, respectively. Higher endorsement of traditional male gender role stereotypes and restrictive emotionality were associated with a more negative attitude towards help-seeking and less help-seeking behavior.

Gender role variables also had an effect on specific professional help-seeking attitudes in Good, Dell, and Mintz' study (1989). The  $R^2$  of 0.176 indicated that gender role variables explained 17.6% of the variability in Attitudes Toward Seeking Profession Psychological Help (ASPPH) that assessed general attitude toward seeking professional psychological help ( $p < .001$ ) with high scores on masculinity related to negative views of help-seeking. Similarly, among a college-based sample, Good and Wood (1995) found that restriction based male gender role conflict—defined by limiting male friendships and emotional expressiveness—explained almost 25% of variability in psychological help-seeking attitudes on the ASPPH, with higher restriction-based gender role conflict related to negative help-seeking attitudes.

In summary, these studies found that male gender role variables explained variability in overall attitude toward professional help-seeking, attitude toward help-seeking in general, and reported past help-seeking behavior. In particular, gender role norms that restricted affection between men and expressing emotion led men to be less likely to have a positive attitude towards seeking help for depression.

Finally, when seeking help men may discuss and report depressive symptomatology and depressive episodes differently than women. It has been hypothesized that in an ambiguous retrospective situation, such as when an individual may be asked to explain depressive experiences, individuals are likely to respond in a manner consistent with their gender stereotypes (Sigmon, et al., 2005). Sigmon et al. (2005) hypothesized that this response bias may become heightened the more likely the subjects were to have after-study follow-up interviewers and if the subjects expected a continued helping relationship to be formed. In their study, men responded in increasingly stereotypical ways as the follow-up became more intrusive. Men gave less-stereotypical answers when they believed they would have no further contact with

researchers, whereas they gave more stereotypical answers if they were told they would be contacted multiple times for follow-up interviews. Men increasingly responded with more masculine or instrumental traits related to depression such as action-oriented coping responses. This suggested that when men are seeking help, gender role norms may lead them to report fewer expressive or emotional symptoms, particularly when they expect the helping relationship to be lasting.

### Male Gender Role and Depression in Other Cultures

While there has been substantial research on gender role conflict and depression, the vast majority of the research has been conducted on white, male participants. Additionally, many of the participants have been from university populations. There has been little research on the affect of gender role conflict on depression among populations with more diverse ages and cultural backgrounds.

Almost all of the research on gender conflict and depression has been conducted on participants from modern, Western, predominantly European cultures. Eastern cultures such as those found throughout Asia have some different cultural expectations for men and different ways of coping with depression. Additionally, some Western societies such as the Amish and Orthodox Jewish populations may also have different cultural expectations for men and different coping styles. Analyzing how other cultures with different values than that of typical white, Protestant, culture experience depression may provide a greater understanding of how cultural gender role expectations affect men as well as how it affects how they manage their depression.

*Orthodox Jewish*

There are a number of factors that led some authors to believe that Jewish males may have different responses to depression than other many white, Western males. The population has its own behavioral and social norms as well as different patterns of employment (Loewenthal et al., 1995). Multiple studies of the Orthodox Jewish population in England suggest there are some specific cultural differences, such as a possible greater acceptance of men expressing negative emotion, that led them to believe they may have different patterns of depression (Loewenthal et al., 1995; Yeung & Greenwald, 1992; Loewenthal et al., 2002; Levav et al., 1997).

It has been found that Jews have significantly higher rates of depression than Protestants (Yeung & Greenwald, 1992). This increase is due largely to an increase in the rate of depression among Jewish males as compared to Protestant males (Loewenthal et al., 1995; Levav et al., 1997). Loewenthal et al. (1995) found that 14% of strictly Orthodox Jewish men ( $n = 79$ ) had depression, compared to 15% of Jewish women in the sample ( $n = 100$ ). Interestingly, the less strict traditional-orthodox Jewish population in their study reported less depression (6% in men compared to 11% for traditional-orthodox women). This suggested that there might be cultural factors in the Orthodox (particularly strict-orthodox) Jewish population that produces different reported rates of male depression.

One hypothesis is that depressed mood is more culturally acceptable among Jewish men. Loewenthal et al. (2002) found that Jewish individuals demonstrated more tolerance for depression ( $F_{1,157} = 4.54$ ;  $p = 0.03$ ) than white, Western, Protestant individuals. Jewish women and men demonstrated similar tolerance for depression. This greater tolerance for depression may make men feel less stigma towards feeling depression and coping with negative feelings.

It has also been hypothesized that cultural factors may also influence how Jewish men cope with depression. While many Western men often employ avoidance and acting-out coping methods such as violence or substance use or abuse, Jewish culture is hypothesized to discourage these coping methods. In general, alcohol use is significantly lower in Jews than Protestants and Jewish men and women have more negative attitudes toward alcohol use (Loewenthal et al., 2003). Loewenthal et al. (2003) suggested that Jewish males may not “mask” their depression through some numbing and acting out styles of coping. In turn, this may make them more likely to exhibit symptoms typical of depression.

The different cultural expectations for men may lead Jewish males to experience depression differently than many other Western males. Because expression of negative emotion is not discouraged in Jewish males, there is likely not the same feeling of violating gender role norms by exhibiting depressive symptoms. Additionally, if there is less stigma attached to discussing depression and negative emotions with others, they may be more likely to use this as a coping mechanism and less inclined to use other acting out forms of depression that are often employed as means to avoid, numb, or distract an individual from negative emotion.

### *Asian*

There are a number of cultural gender role factors that may affect how Asian men experience and express depression. Though different Asian cultures have unique values, emotional regulation and conformity to cultural norms are both highly valued in many Asian cultures (Gonzalez et al., 2006). Greater adherence to Asian cultural values corresponds with greater emphasis on adherence to male gender role norms (Gonzalez et al., 2006). The different Asian gender role expectation may be hypothesized to produce different experiences of depression than in many Western cultures. For example, in Chinese culture instead of exhibiting

negative emotion it has been hypothesized that many Chinese men express their depression primarily in somatic symptoms (Chang, 2007).

In a study with 971 Taiwanese college population, Chang (2007) found that they were significantly more likely to report somatic symptoms of depression than cognitive symptoms on the Beck Depression Inventory [ $t(970) = 54.01, p < .001$ ]. For example, "heartache" may mean sadness or "tiredness" may mean despair (Chang, 2007). Somatization of depressive symptoms may be viewed as a way to "save face" and avoid the stigmatization that is associated with mental health in Taiwanese culture (and potentially other Asian cultures as well) (Chang, 2007). Additionally, scores on the BDI were statistically significantly negatively correlated with scores on the Attitudes Towards Professional Help: a Shortened Form, a measure of willingness to approach psychological help for depression (correlation of  $-.09$ ). However, although the correlation is significant due to the large sample size, it is not a large correlation. Females and less-depressed males rated themselves as more open to visiting a psychological profession than males who rated themselves highly on depression scales. Although the statistically significant correlations are low, this study suggested some similarities between Taiwanese males and U.S., predominantly white males in the stigma attached to male depression and towards seeking mental health. However, it appears that many Taiwanese men may experience depression in the culturally unique manner of somatizing negative emotions.

While Taiwanese men may share some of the stigmas about depression, some other Asian male samples may still exhibit different prevalence rates of depression and dysthymia than males from Western cultures. Takeuchi et al. (1998) found very little difference in prevalence of depression and dysthymia among 1,747 Chinese-American males and females in the Los Angeles area (1.07:1 female to male ratio) taken from a census sample. Differences in

prevalence of depression and dysthymia between men and women appeared as Chinese-Americans became more acculturated, suggesting that as more typical white, Western cultural attitudes are adopted, then Western patterns of gender differences in depression also appear. Conflicting results were found among a study of gender difference among Filipino-Americans. Among a professional, community, and campus sample of 59 men in California Filipino-Americans exhibited more depression as they became more acculturated (Gonzales et al., 2006).

There is little research to offer much explanation for these different prevalence rates for depression between Asian men and women. However, it is hypothesized that the low rate of alcohol use may be related to the increased report of depressive symptoms in some Asian male samples (Takeuchi, 1998). As in Jewish males, it is suggested that the lack of using avoidance with alcohol as a coping method may make some Asian males more likely to exhibit depression instead of masking it with substance use. However, any conclusions must be very tentative due to the scarcity of research on Asian male populations.

### *Amish*

The Amish choose to live a life full of strenuous work and devotion to conservative Christian religious ideals. Additionally, any form of aggression, violence, and hostility is taboo and very discouraged. These cultural differences led some to believe that there would be different patterns of depression in the Amish community, particularly among men (Jakubasch, Wurmlie, & Genner, 1994).

In a sample of 25 men and 18 women from an Indiana Amish community (ranging in age from 16 to 83, average age of 36.6) Jakubaschk, et al. (1994) found no difference in the prevalence of depression between Amish men and women based on scores on the Beck Depression Inventory [ $t(41) = -0.23$ ;  $p = 0.82$ ]. There were also no gender differences in

hostility on the Buss-Durkee Hostility Scale [ $t(41) = 0.10$ ;  $p = 0.92$ ]. Additionally, there were no differences in depression or hostility depending on the age of the respondents.

Jakubaschk et al.'s study (1994) suggested that, as with the Jewish and Chinese males, Amish men are unlikely to use some of the typical avoidance and acting out ways of managing negative emotion such as hostility, violence, and alcohol (also discouraged in Amish cultures). This may have led them to 'hide' their depression less and instead to exhibit depressive symptoms in a similar manner as Amish females.

### *Latin-American Populations*

Mexican culture has a very specific cultural ideal for the male gender role and its related behaviors, often referred to as machismo (Fragoso and Kashubeck, 2000). Machismo has been characterized negatively as 1) callous sexuality towards women, 2) a perception of violence as masculine, 3) and a view of danger as being exciting. It has also been associated with the positive characteristics of physical strength and attractiveness, virtue, dignity in personal conduct, and defense of others (Fragoso & Kashubeck, 2000). Similar to men in other Western cultures, Mexican males are less likely to seek professional care for depression and other mental illness (Cabassa, 2007). However, the trend to not seek treatment for mental health problems is even more pronounced in the Mexican-American population compared to other racial and ethnic minority groups (Cabassa, 2007).

Fragoso and Kashubeck (2000) studied the relationship between machismo, gender role conflict, stress, and depression in 113 Mexican-American college students ( $n = 18$ ), community members ( $n = 54$ ), and associates of the primary researcher ( $n = 41$ ) ranging from 18 to 79 years old (mean age = 38.4). Study participants had higher machismo scores than previous studies on Hispanic samples using the the Multiphasic Assessment of Cultural Constructs. However, the

participants also scored lower on overall gender role conflict than previous samples that were primarily white, non-Hispanic college students (Good et al., 1995). Additionally, machismo was not related to gender role conflict (as measured by the Gender Role Conflict Scale). This suggested that high machismo or high masculinity ideation in this sample of Mexican males did not show the same relationship with gender role conflict and masculinity ideation as seen in other Western cultures.

Although, the measure of machismo and gender role conflict were not related, each were related to scores of depression as measured by the Center for Epidemiological Studies Depression Scale (CES-D) (Fragoso & Kashubeck, 2000). Machismo explained 14% of the variance on the depression scale as higher levels of machismo were related to higher scores on the CES-D [ $t(98) = 4.12, p < .0001$ ]. Similarly, higher scores on gender role conflict were related to higher scores of depression. Additionally, Restrictive Emotionality (RE) and Restrictive Affectionate Behavior Between Men (RABBM) were related to depression individually as factors as well [ $t(95) = 3.09; p < .003$  in RE;  $t(95) = -2.75; p < .007$  for RABBM]. These indicated that greater restrictive emotionality and less restrictive affectionate behavior between men were related to higher depression scores.

The limited evidence from this study on male depression in Mexican-Americans is equivocal in its support for other Western research on the male gender role and depression. The study of Mexican-Americans differed from other Western samples in that high conformance to masculine gender role ideologies, machismo, did not lead to increased gender role conflict. There are no clear explanations for this difference. However, Mexican-Americans demonstrated a similar relationship as other Western cultures between machismo values and depression as well as gender role conflict and depression. This suggested that the Mexican cultural role for men

and the effect of male gender role conflict might be very similar for Mexican-Americans and the Mexican culture as for other Western cultures.

Samples from Costa Rica also exhibited similar patterns of gender role conflict and help seeking as other Western culture samples. In a comparison between a sample of 60 male participants from a Massachusetts university and 45 male participants from a Costa Rican university, Lane and Addis (2005) examined the correlation between gender role conflict and the likelihood of men seeking help from a variety of potential help-seeking sources (such as their mother, father, partner, friends, a professional, or from the internet. They found the Costa Rican sample exhibited greater conflict between work and family [ $F(97) = 8.43$ ;  $p < .01$ ] and greater restriction of emotion between men [ $F(97) = 9.05$ ,  $p < .01$ ] on the Gender Role Conflict Scale compared to the Massachusetts sample. Although the Costa Rican sample had higher ratings on the same areas of gender role conflict compared to the U.S. sample (such as Restrictive Affectionate Behavior Between Men) indicating greater gender role conflict in these domains, overall there were fewer significant associations between gender role conflict and help-seeking behavior in the Costa Rican sample than in the U.S. sample. In the U.S. sample, 6 significant negative correlations between gender role conflict and potential help-seeking relationships were found (ranging from  $-.25$  to  $-.47$ ) compared to only 2 in the Costa Rican sample ( $-.30$  and  $-.36$ ). In both samples, these negative correlations indicate that as gender role conflict increases, help seeking behavior decreases, as measured by lower scores on help-seeking behavior. In other words, men in the U.S. sample had many more correlations between high scores on gender conflict domains and low scores on likelihood of seeking out help from different potential help-seeking relationships.

### *Conclusion*

Each of these different cultures had a different set of expectations for male behavior and emotional expression. Additionally, they had different accepted ways of managing negative emotion and depression. The different male gender roles and coping patterns employed by individuals in the different cultures were correlated with both differences in the prevalence of depression in men and differences in how men express and experience depression.

The only group that did not discourage the expression of depression in men was the traditional, Orthodox Jewish population. In the Orthodox Jewish population, depression was much more prevalent in males than in predominantly white, Protestant samples. Additionally, since it has been suggested that Orthodox Jewish males also often hold positive views towards seeking professional help for depression, they may be more likely to seek help than other men. The lack of stigma around depression in the Orthodox Jewish culture may have made men more likely to both express and seek help for depression.

Along with the Orthodox Jewish population, the Amish and some Asian populations studied also showed similar rates of depression between men and women. In all of these populations, some or many of the "masking" or "acting out" ways of coping with depression such as substance abuse (much less common in Orthodox Jewish, Amish, and Asian populations) or interpersonal hostility and violence (much less common in Amish and Orthodox Jewish populations) were behaviors that were culturally discouraged. This suggested that when men were not able to mask, avoid, or numb their negative emotions, they might be more likely to express symptoms of depression.

That the two cultures most similar to white, U.S. culture studied (Mexican-American and Costa Rican cultures) produced the most similar results to other samples from other Western cultures adds some generalizability to the other findings on male gender role and depression.

The studies on Mexican-Americans, machismo, and depression and the studies on Costa Rican university students follow a similar pattern of depression and its relationship to male gender role factors as studies using participants who were predominantly white and college-aged.

Conformity to gender role norms and gender role conflict were both related to depression in white, college aged samples and Mexican-American samples.

### Clinical Implications of Gender Role Conflict and Depression

While the body of research on other areas of male gender role conflict and depression continues to grow, there is a lack of research about the treatment of depression in men, particularly with consideration of male gender role factors. Most of the research on men with depression is conducted on male and female clients validating existing treatments for depression. However, some male-specific therapies have been developed for male gender role factors and depression, although there is currently very little research on the effectiveness of these treatments.

#### *Empirically Supported Treatments*

Several empirical evaluations of mental health treatments for depression have found positive responses to treatment in men. The National Institute of Mental Health Treatment of Depression Collaborative Research Program (Elkin, 1989) found that cognitive-behavioral and interpersonal therapy were both as effective as proven drug treatment (with imipramine) for most patients, both male and female. Subsequent studies specifically on male samples found similar results, with men responding positively to both cognitive-behavioral and interpersonal therapy (Thase et al., 1994, 1997). Additionally, group treatments have also shown positive results with men experiencing depression (Kelly et al., 1993). Kelly et al. (1993) found that among a sample

of 68 HIV infected males, both cognitive-behavioral and social support groups produced reductions in depression, hostility, and somatization as measured by lower ratings reported on the Center for Epidemiologic Studies Depression Scale (CES-D) and the Symptom Checklist-90-Revised (SCL-90-R) when compared to a control group that received no treatment which showed very few treatment gains.

Taken together, these studies indicate that men benefit from the same empirically supported treatments for depression that have demonstrated effectiveness with women. Generally, gender of the subject has not been a significant predictor of outcome with any of these different therapies (Cochran, 2005). While these therapies are not designed to address male gender role issues, they still managed to treat men with depression with similar effectiveness as with females with depression (Cochran, 2005).

#### *Gender Role Specific Treatments*

While the majority of the research on treating depression in men has used generalized therapies designed for females and males with depression (and often other mental health issues as well), there have been some gender-specific therapies that have also been developed. These therapies are designed to address the aspects of male depression that are gender-specific as well as the gender role factors that effect depression in men.

While not designed specifically to treat depression, Good, Gilbert, and Scher's (1990) Gender Aware Therapy (GAT) provides a framework for integrating gender-roles into the treatment of various disorders, regardless of therapeutic theoretical orientation. GAT is based on five principles. First, gender is conceptualized as an integral aspect of counseling and mental health; clients' difficulties must be understood within a gender perspective. Second, problems should be considered within their social context. In other words, a systems perspective that

considers other systems such as employment, family role, and laws and policies that affect the client. Third, therapists should actively seek to change gender injustices by examining how gender stereotypes affect the client and actively counteracting gender bias. Forth, the development of collaborative therapeutic relationships should be emphasized by de-emphasizing the “expert” role of the therapist in favor of a more collaborative and egalitarian relationship. Finally, the client should be free to choose feelings, views, and behavior without feeling constricted by gender roles and stereotypes.

The principles of GAT are intended to be integrated throughout therapy by seeking to understand how clients’ gender-role has affected their concerns, raise awareness of gender-role stereotypes with the client, and strive to understand how the intervention may affect the clients’ conception of their gender-roles (Good, Gilber, and Scher, 1990). For men, GAT may involve being aware of their resistance to enter into a help-seeking relationship in therapy. It also may involve making the client aware of gender role stereotypes and discussing ways in which they affect the client. At times, GAT may even involve challenging men’s beliefs about independence, intimacy, and vulnerability. While GAT is designed as a set of principles to aid in the therapy of both male and female clients with any mental health disorder, it also provides a framework for discussing gender role issues that affect males with depression (Good, Gilber, & Scher, 1990; Good & Mintz, 2001).

Pollack (2001) uses many of these same principles in his psychodynamic therapy for men. However, this specific psychodynamic therapy is specifically designed to work with men with depression and men’s gender role trauma, particularly the “premature push for separation in boys” from their caregivers (pg. 529). Although it does not currently have any research on its effectiveness, it is hypothesized that this gender-role encouraged separation from caregivers and

discouragement from expressing tears and sorrow combines to create lasting trauma in many males with mental illness and depression (Pollack, 2001). Gender-role trauma may result in disruptions to interpersonal relationships, restricted emotionality, difficulty tolerating feelings of vulnerability, and a tendency to block the expression of emotion.

Pollack advocated for a change in how men are treated initially in therapy, particularly psychodynamic therapy. He states that many men are “most afraid of the very fact that they are afraid” (Pollack, 2001, pg. 535) and are strongly resistant to admitting any dependence on the therapist for help. It is suggested that instead of prematurely pushing the client into further recognition of the problem that brings him into therapy, that the therapist should offer the client understanding, support, and help the client “save face.” This allows the client to feel a sense of implementing and developing change on their own accord. Essentially, Pollack suggested that by changing how the therapist approaches the initial stage of therapy—viewing it as an “extended consultation” with the client where disappointments, conflicts, and expectations are discussed without interpretation or confrontation—would allow men to open up to deeper issues of depression and vulnerability on their own timeframe and would make them more open to change.

Similar to how Pollack’s psychodynamic therapy for men adds the discussion of gender sensitive elements such as gender role strain into traditional psychoanalytic therapy, Mahalik’s gender-related cognitive therapy (2001) adds an awareness of male gender roles to current cognitive therapy. However, like Pollack’s psychodynamic therapy for men, it does not currently have any empirical validation. Through the perspective of gender role development, cognitive structures are built around the process of gender role socialization. Mahalik states that many aspects of male gender role socialization may lead to men developing unhealthy cognitive

distortions. For example, the gender role value of the importance of winning may lead a male to become distraught over losing an important contest. Or, an individual may feel a strong sense of shame at discussing his feelings in therapy because he believes strongly in the emotional control gender role value.

Mahalik (2001) suggested that when a client has cognitive distortions related to gender role socialization, the first task of the therapist working with a male client is to help the client connect the gender role belief with his depressed feelings. Next, clients need to become aware of the behaviors that result from their distortions. For example, a client who feels he does not want to discuss his depressed emotions with others for fear he will seem weak may resort to drinking instead to numb his emotions. The therapist can help the client become aware of how his actions are tied to these cognitive distortions. Finally, therapists may challenge clients to test the accuracy of their gender role stereotypes. The individual with the belief that men should not share their emotions may be challenged to try this multiple times and report back on what negative consequences occurred. In this way, they may discover the inaccuracy, or at least exaggeration, of their gender-role based cognitive distortions.

However, Mahalik (2001) cautions against viewing even male gender role values as maladaptive. "Therapists need to walk a fine line between how these messages have been helpful and good for clients on one level while exploring with them how these rigidly held messages may also be costing them" (Mahalik, 2001, pg. 560). In other words, the therapist must collaborate with the client to figure out how to manage the benefits and costs of various gender role values.

Each of the above programs for gender-sensitive therapy offers a series of suggestions and ideas for integrating gender-sensitive ideas of how to work with males within the context of

existing treatment ideology. Other theorists, notably Brooks (1998) and Rabinowitz (2001) have created similar sets of gender sensitive techniques to be employed in group treatment and family treatment, respectively. However, they do not offer specific steps or a novel treatment program that can be employed by a therapist. Nor do they have any research on clinical outcomes.

Levant's (1998) treatment for normative male alexithymia represents a different type of male-specific treatment in that it provides several specific and sequential steps for the therapist to implement in treating male alexithymia. While this is not designed to treat depression, specifically, because restricted emotionality is a common feature of male depression this treatment may also provide a sample of a treatment plan that may be used for men with depression and restrictive emotionality. Levant (2001) defines five key steps in treating male alexithymia. First, the therapist uses psychoeducation about alexithymia where the client learns about his limitations in his ability to name and express emotions. This is meant to help the client make more sense of their experience and begin to tolerate negative emotions. Second, the therapist helps the client develop a greater emotional vocabulary, particularly emotions that may be related to emotional connections with others or emotional vulnerability.

After the client gains an education about their alexithymia and develops a greater emotional vocabulary, then he is encouraged to begin to put use this knowledge. In Levent's (2001) third step—learning to read the emotions of others—the client begins to observe others' facial gestures, tone of voice, and body language in order to try to recognize their emotions. It is suggested that recognizing and naming emotions begins by observing others because it is often less threatening initially for many clients to attempt to observe and name emotions in others than in themselves.

Forth, the client applies his emotional vocabulary to his own experience and maintains and emotional response log (Levant, 1998). The client is directed to record his bodily sensation, the social or relational context, and the emotions that are connected with them. Finally, the fifth step involves continued practice with applying emotional awareness to the client's own experience. This can be done in multiple ways, including working in a group therapy context or using video playback. The emotional response log is maintained throughout this stage.

While Levant's therapy for alexithymia does not directly address depression, it provides a step-by-step system for treating the symptom of alexithymia and restricted emotion in men. Additionally, instead adding therapeutic suggestions to be used within other existing therapeutic frameworks, it provides its own framework for treating this specific concern. However, currently no outcome studies have been completed on Levent's therapy for alexithymia.

#### Limitations of Current Research

Good and Sherrod (2001) stated that "gender aware research investigating effective treatments for men's problems is just beginning. Virtually all problems that have been associated with masculinity could be further delineated and corresponding treatments developed and assessed" (pg. 33). While this quote is directed towards male gender-role research in general, it is equally applicable to research on male depression and the male gender role.

Some areas of male depression—such as gender differences in prevalence, symptomatology, coping styles, and comorbidity—have been extensively researched. However, most areas of research on male depression and the male gender role have significant limitations. Three particular limitations are prevalent in much of the research. First, the majority of research on the male gender role and on gender role conflict has been done on predominantly white,

middle class males. In particular, college populations are vastly over-represented in studies. This likely impacts how generalizable the results and theories are to other populations.

Second, there is a lack of research to back up many of the hypotheses and theories about how the male gender role affects depression. Brownhill et al.'s (2004) "big build" theory of the progression of men's coping with depression from more internal forms of coping to more harmful, "acting out" forms of coping is one such example of this problem. While this theory is consistent with many men's descriptions of coping with depression and has qualitative support from their research, there is no quantitative research to support their conceptualization of stages or the progression from stage to stage.

The lack of outcome research to support theory is particularly problematic in the clinical application of treating male depression. Even the most elaborate theories that have clear steps or principles, such as Good et al.'s (1990) Gender Aware Therapy and Levant's (1998) treatment for alexithymia, have no outcome research to support their use. While each have anecdotal support and seemingly sound theoretical underpinnings, it is not known if they actually improve men's success in therapy for depression and its related symptoms.

Third, there is a lack of theory derived from quantitative research. There is some quantitative research on depression and the male gender role in various non-Western or traditional cultures such as the Amish, British Orthodox Jews, and various Asian cultures. However, these quantitative findings have not been incorporated into theories on gender role conflict and depression. This lack of incorporation of other multi-cultural data raises questions to the generalizability of theories such as Brownhill's (2004) "big build" theory of coping with depression and the various studies linking gender role conflict with higher scores on depressive measures.

However, some developments in the field of psychology seem to signal an increased attention to research on men. The development of the Society for the Psychological Study of Men and Masculinity, Division 51 of the American Psychological Association, and their official journal (*Psychology of Men and Masculinity*) have given a larger forum for men's issues and the publishing of research on masculinity.

### Clinical Conclusions and Recommendations

If men with depressive symptoms are open to discussing their depression or negative emotion, then empirically supported therapies (such as cognitive-behavioral therapy or interpersonal therapy) are likely to be efficacious for both male and female clients (Elkin, 1989; Thase et al., 1994, 1997). However, getting men to that point where they may be able to be treated for depression may, in fact, be the challenge in treating some male clients. Many depressed clients may either be reluctant to discuss negative emotion and depression or they may be coming to the therapist for other concerns. Clinicians can help men with "masked" depression in several key ways.

First, clinicians' awareness of the different ways that many men may cope with negative emotion may help them recognize depression in some men who may not express typical symptoms of depression such as negative affect or dissatisfaction with self. Recognition that symptoms such as substance use or abuse, interpersonal antagonism, irritability, and aggression may all be ways that clients "act out" negative emotion can help clinicians address possible depression in some male clients. It should be noted that although these symptoms may be alternative coping strategies for dealing with negative, they also exist independent of negative emotion.

Second, gender role sensitive questioning may make men more likely to discuss negative emotion. This may help the clinician 1) determine the client's emotional vocabulary and 2) help the client to "save face" while discussing negative emotion. There are several things that may help the clinician to do this:

1. Not pushing the client to discuss depression or negative emotions directly, but instead seeking understanding of presenting issues without confrontation and allowing emotional issues to emerge as the therapeutic relationship develops.
2. Allow clients to develop and implement changes of their own accord—make them true collaborators in the therapeutic process. This may help some men overcome reluctance to enter a therapeutic relationship or depend on the therapist.
3. Evaluating clients' emotional vocabulary and, when needed, helping to educate clients on recognizing and communicating negative emotion.
4. Discussing cognitive distortions related to gender role values held by clients that may affect them negatively.
5. Recognize the ways in which gender role values may serve as defenses for an individual and may, at times, be very functional for the individual as well.

#### Conclusion and Suggestions for Future Research

Men in most white, Western, cultures are much less likely to demonstrate depression than women. Despite this, it remains an important area of psychology in need of further research and greater clinical understanding. While fewer men are affected by depression, the consequences of

depression for males may be particularly severe—with substance abuse, violence, and suicide all being significantly more common among males with depression.

An awareness of the significant differences in how men experience depression may improve initial recognition and treatment of depression in men. As seen in Potts, Burnham, and Wells (1991) and Broughton and Street (1997), men are likely to be underdiagnosed with depression. Greater recognition by practitioners, lay professionals, and men themselves of the different symptoms that men may experience as part of depression (such as interpersonal aggression, substance use, loss of interest in other people, or a sense of failure) may allow more men to recognize it and seek appropriate treatment.

Regardless of the limitations of the research, there still appears to be a link between many masculine gender role factors and depression. Pleck's (1995) three types of gender role strain—gender role discrepancy, gender role trauma, and gender role dysfunction—suggest that the development and maintenance of the male gender role identity can be problematic for many men. Both restriction-related gender role factors (such as restrictive emotionality) and achievement-related gender role stress (such as driving for success) have been tied to depression in men (Good & Wood, 1995). Taken together, these findings indicate that gender role factors affect depression in men in multiple ways.

Because gender-role factors can play a role in the development and willingness of men to seek help for their depression, the development and empirical validation of gender-specific techniques in dealing with males with depression is an area that would benefit from future research. While some treatments seem to have good suggestions and principles for aiding male clients, their effectiveness is unknown at this time. Finally, greater research and acknowledgement of multi-cultural factors would 1) provide a greater understanding of how

different gender role socialization affects male depression and 2) would increase the generalizability of current research and theories.

Improvement in the knowledge base about depression in men as well as further research into effective treatments for men may help men seek treatment more often, receive appropriate diagnosis, and receive more effective treatment that addresses their needs with consideration of their gender role socialization. As becoming a man continues to be “as hard as it’s ever been” (Pollack & Levant, 1998, pg. 1) this research may help many men manage their negative emotions and gender role socialization.

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