

# Big boys *do* cry

INVITED COMMENTARY ON ... BIG BOYS DON'T CRY<sup>†</sup>

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**Abstract** Do men comprise a minority group whose distress would be better understood by positing a new 'male depressive syndrome'? Or have gender differences been overemphasised for political reasons that are clinically unhelpful? An unifying list of mistaken categories of depression advocates caution.

Branney & White (2008, this issue) invite us to consider the possibility that there could be 'a form of depression that has hitherto remained absent from international diagnostic criteria'. Such a 'male depressive syndrome' might arise from the way social and cultural forces shape male responses to distress. In other words, if 'big boys don't cry' this may be because, as Branney & White express it, 'developing boys are socialised into emotionally inarticulate young men, unable to express depression'.

The possibility that men might experience depression differently from women seems plausible. It would certainly be important: for example, the authors point out that the 'gender duty' of the UK Equality Act 2006 would require services to ensure that men's needs are being met.

## Arguing for 'male depression'

There are therefore compelling reasons to investigate further. Branney & White present three arguments in favour of a new form of male depression:

- political/ethical: that men are a 'numerical minority group' requiring effective interventions
- epidemiological: that there are more men with depression in community samples than are receiving treatment, indicating unmet need
- psychological: indicators of emotional distress in men (e.g. greater substance misuse, hostility,

violence and suicide) differ from those in women, but are none the less caused by depression.

The political argument is unconvincing and probably unhelpful. Minority groups are defined in social and political terms not by their numbers, but by the disadvantage and disempowerment they encounter within mainstream society. Although fewer men than women may experience depressive symptoms, we should not infer that they are consequently neglected or disenfranchised.

Epidemiological studies have consistently found that more women than men experience depression. Branney & White compare Office for National Statistics data from community surveys with data about general practitioner consultations. The male:female ratio for 'neurotic' conditions in the community is 0.8, whereas the male:female ratio for depression in primary care is 0.4. Since these ratios measure different parameters in different populations, comparisons of this kind are probably not very meaningful.

Furthermore, sex differences (using Branney & White's definition) in the prevalence of depression disappear in the over-55s, are not evident in people who are out of work and are diminished for parents with child care responsibilities. They also tend to disappear in studies in which social differences are minimised (Bebbington *et al.*, 2003). Influences on the prevalence of depression in men and women are a complex mix of biological, social and economic factors. Gender clearly permeates this network of interactions, but there is no evidence to suggest it is a primary cause.

<sup>†</sup>See pp. 256–262, this issue.

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## Keep it simple

Is it appropriate to conceptualise aggression as part of a 'behavioural pattern of depression'? Attributing such behaviours to a putative male depressive syndrome and then counting them as 'symptoms' (as in the Gotland Scale) leads – unsurprisingly – to an increase in the prevalence of such 'depression'.

What men and women say and do when distressed is so varied and poorly understood that it seems unnecessarily limiting to categorise this as 'depressed'. Just because women's problems seem to be more readily medicalised does not mean that men should be trying to catch up!

Branney & White bravely waded into a complex interface between sociological, developmental, psychodynamic, neurobiological and epidemiological perspectives on psychological distress. Where these approaches overlap – for example in gender biases regarding defence mechanisms, or behaviour influenced by social context – the ideas presented here are refreshing and potentially useful. But pseudoscientific myth-making about gender is arguably just as prevalent today as it was in the past (Cameron, 2007). We should beware of creating a contemporary version of the kind of laughably archaic gender stereotypes cited by the authors: men who are 'ambitious, independent leaders' and 'gullible, child-like, yielding' women.

Psychiatric nosology is littered with diagnostic terms (e.g. 'masked', 'hysteroid', 'involuntal' and 'hypochondriacal' depression) that once seemed sensible, but are now obsolete. The dangerous absurdity of unfounded diagnosis-mongering is exemplified by the defunct Italian diagnosis of *depressio sine depressione* – depression without depression.

Since the evidence suggests that depressive symptoms are distributed dimensionally in the population rather than in discrete categories (Melzer *et al*, 2002), it seems wise to remember Occam's razor: 'All other things being equal, the simplest solution is the best.' In summary, big boys do cry – but that doesn't make them depressed.

## Declaration of interest

None.

## References

- Bebbington, P., Dunn, G., Jenkins, R., *et al* (2003) The influence of age and sex on the prevalence of depressive conditions: report from the National Survey of Psychiatric Morbidity. *International Review of Psychiatry*, **15**, 74–83.
- Branney, P. & White, A. (2008) Big boys don't cry: depression and men. *Advances in Psychiatric Treatment*, **14**, 256–262.
- Cameron, D. (2007) *The Myth of Mars and Venus: Do Men and Women Really Speak Different Languages?* Oxford University Press.
- Melzer, D., Tom, B. D., Brugha, T. S., *et al* (2002) Common mental disorder symptom counts in populations: are there distinct case groups above epidemiological cut-offs? *Psychological Medicine*, **32**, 1195–1201.

### *The Dying Child*

He could not die when trees were green,  
For he loved the time too well.  
His little hands, when flowers were seen,  
Were held for the bluebell,  
As he was carried o'er the green.

His eye glanced at the white-nosed bee;  
He knew those children of the spring:  
When he was well and on the lea  
He held one in his hands to sing,  
Which filled his heart with glee.

Infants, the children of the spring!  
How can an infant die  
When butterflies are on the wing,  
Green grass, and such a sky?  
How can they die at spring?

He held his hands for daisies white,  
And then for violets blue,  
And took them all to bed at night  
That in the green fields grew,  
As childhood's sweet delight.

And then he shut his little eyes,  
And flowers would notice not;  
Birds' nests and eggs caused no surprise,  
He now no blossoms got;  
They met with plaintive sighs.

When winter came and blasts did sigh,  
And bare were plain and tree,  
As he for ease in bed did lie  
His soul seemed with the free,  
He died so quietly.

*John Clare (1793–1864) was born in Helpston to an agricultural labouring family. He came to prominence in 1820 after Poems, Descriptive of Rural Life and Scenery was published. Between 1833 and 1837 he became increasingly depressed. He was certified insane in 1837 and treated at Dr Allen's private asylum at High Beach in Epping Forest until 1841, when he escaped. He was certified insane for a second time in December 1841 and spent the rest of his life at Northampton General Lunatic Asylum. It was here that he wrote 'The Dying Child'. He continued to write until close to his death. Many of the poems written in the asylum years were transcribed and preserved by William Knight, an asylum steward.*

Poem selected by Professor Femi Oyebode

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