GENDER DIFFERENCES IN YOUTH DEPRESSION AND SUICIDAL BEHAVIOUR

DEPRESSION

Epidemiology

- Lifetime risk for male depression is about 25%.
- Preadolescent boys are more likely to be depressed than preadolescent girls.
- However, by adolescence, the prevalence of depression in females rises to more than twice that of males (Hankin, Abramson et al., 1998; Kessler, McGonagle et al., 1994).
- Fergusson and colleagues found that by age 18, 9.7% of males, and 26.5% of females met criteria for DSM-IV mood disorders (Fergusson & Horwood, 2001).
- Various models have been proposed to explain the emergence of gender differences. These will be discussed later.
- However, "we still do not know if depression is truly less common among men, or if men are just less likely than women to recognize, acknowledge, and seek help for depression" (National Institute of Mental Health, 2005, p2).

Aetiology

- Young people exposed to rape and sexual abuse are at increased risk for depression, both in the short and long term (Nolen-Hoeksema & Girgus, 1994).
- In a sample of 588 adolescents aged 11-20 who were incarcerated in juvenile correctional facilities in the U.S., Gover (2004) examined whether sexual abuse was related to higher levels of depression, and whether there were gender differences in these effects. Gover found that childhood sexual abuse was related to both depression and to increased risk of criminal offending. Results:
  - Sexually abused incarcerated boys report higher levels of depression than non-abused incarcerated boys.
  - The depressive effects of childhood sexual abuse were similar for males and females.

- "Gender differences in depressive symptoms appear to emerge in early adolescence and then remain throughout the adult life span" (Nolen-Hoeksema, Larson, & Grayson, 1999).

Symptomatology

- Depression in youth may predict more severe depression in adulthood (Weissman, Wolk et al., 1999).
- Craighead (1991, cited by, Hankin et al., 1998) notes that there are gender differences in the disorders that are co-morbid with depression; males tend to be conduct disordered-depressed and females tend to be anxious-depressed.

"Males Externalise, Females Internalise"

- Depressed adolescent boys may sulk, get into trouble at school, be negative and grouchy and feel misunderstood (National Institute of Mental Health, 2005).
- Males are over-represented in the externalising disorders, such as conduct disorder, aggressive disorders (Canetto, 1997), antisocial personality disorder and substance abuse (Piccinelli & Wilkinson, 2000).
- There is some debate as to whether or not substance abuse is a symptom of depression (National Institute of Mental Health, 2005). "*I drink and I'd just get numb. I'd get numb to try to numb my head.*"
- Fergusson and Woodward (2002) found that depressed young males (aged 14-16 years) were more likely than non-depressed young males and depressed young females to report alcohol abuse or dependence, leaving school without educational qualifications, and multiple periods of prolonged unemployment between the ages of 16 and 21.
- Adolescent males report fewer symptoms of depression than adolescent females (Hankin et al., 1998), but depressed males and females experience similar social and occupational impairment (Piccinelli & Wilkinson, 2000).

Factors Explaining Gender Differences in Depression

There are relatively few studies that investigate depression only in males. However, there are a number of studies that have investigated gender differences in the causes and correlates of depression. These studies include:

- Nolen-Hoeksema and Girgus (1994) suggest three models to explain gender differences in depression:
  1. the same risk factors (e.g. biological changes, sexual abuse) cause depression in males and females, but these factors become more prevalent in girls during adolescence
  2. the risk factors leading to depression are different for males (e.g. athletic failure) and females (e.g. interpersonal conflicts), and these factors become more common for girls during adolescence
  3. females are more likely to carry risk factors for depression even before adolescence, but challenges during adolescence must interact with these risk factors to cause depression.

  The authors conclude that the most likely explanation is the third model, which is best supported by the available data.
- The emergence of gender differences in depression during adolescence may be explained by the increased risk for sexual abuse among females during this time, and the effects are greater for girls who have more passive ways of coping with this experience (Nolen-Hoeksema & Girgus, 1994).
- It appears that social factors and stressful life events (such as sexual abuse, relationship problems, and academic failure) also play a significant role in the development of depression in adolescence (Brooks-Gunn & Warren, 1989; Cyranowski, Frank et al., 2000; Ge, Lorenz et al., 1994).

- Differences in the trajectories of stressful life events may influence gender differences in depression (Ge et al., 1994). Ge and colleagues reported that:
  - Girls and boys are exposed to an increasing array of stressful life events during adolescence (including death or illness of a loved one, family changes, family financial problems), however girls react more negatively to stressful life events.
  - Increases in girls' depressed mood are clearly associated with stressful life events.
- A number of authors have investigated biological risk factors for depression.
  - In a New Zealand longitudinal study of young adults Caspi and colleagues (Caspi, Sugden et al., 2003) found that the individual's genetic make-up moderates the relationship between stressful life events and diagnosis of depression (in other words, the effect of stressful life events on depression was stronger for those individuals who carried a certain gene).
  - Silberg and colleagues (Silberg, Pickles et al., 1999) found that: 1) for boys, depression appeared to be solely attributable to negative life events; 2) in girls, increases in depression were found even amongst those who had not experienced a stressful life event, implying other risk factors were involved; 3) a significant effect of genetic heritability (using twin samples) in girls may explain the significant increase in depression at adolescence.
- Other authors have speculated that the under-representation of depressive illness in males may be the result of under-reporting (due to the lingering stereotype of depression being a female condition), recall bias (Piccinelli & Wilkinson, 2000), and/or "inadequate diagnostic and therapeutic concepts concerning depression and suicide in the male population" (Walinder & Rutz, 2001, pS23).

- It is also possible that the standard definition of depression and the diagnostic tests that are based on this definition "do not adequately capture the condition as it occurs in men" (National Institute of Mental Health, 2005, p8).
- Walinder and Rutz (2001) have proposed a "male depressive syndrome" to explain the difference between male and female depression and suicidality. It is characterised by:
  - low stress tolerance
  - acting-out behaviour
  - low impulse control
  - irritability, restlessness, dissatisfaction
  - substance abuse
  - antisocial behaviour
  - depressive thought content
  - heredity loading, depressive illness, alcoholism, suicide.
- Some men may believe that it isn't manly to be depressed, emotional problems are seen as "feminine." They can accept physical disability, but mental disability makes them feel helpless and out of control.
- It has also been postulated that males cope with their depression by engaging in physical activity, they may throw themselves compulsively into their work, turn to alcohol or drugs, become frustrated, angry, irritable or violently abusive, or start engaging in reckless risk-taking behaviour (National Institute of Mental Health, 2005; Piccinelli & Wilkinson, 2000).
- Women, on the other hand, may cope with their depression by thinking and talking about their depression, seeking professional help, praying and seeking religious help. They may also self-harm, develop eating disorders, and women are more likely than men to smoke to cope with their depression.

SUICIDAL BEHAVIOUR

Epidemiology

- Completed suicide is more common in males than females, but attempted suicide and suicidal ideation are more common in females than in males (Gould, 2003).
- This is often referred to as the "gender paradox" of suicidal behaviour.
- Isometsa and Lonnqvist (1998) found that although 62% of women who committed suicide had made previous suicide attempts, 62% of men who committed suicide had not made a previous suicide attempt.
- In New Zealand in 2002, the suicide rate among 15-24 year old males was twice that of females (Ministry of Health, 2005).
- In 2002 in New Zealand, suicide was the second leading cause of death, after road traffic accidents, among both young males and females aged 15-24.
- For both males and females, higher levels of depression are associated with the increased probability of suicidal ideation (Allison, Roeger et al., 2001) and suicide attempt.

Aetiology

- Martin and colleagues (Martin, Bergen et al., 2004) found that self-reported sexual abuse was strongly and independently associated with:
  - suicidal thoughts, plans, and threats
  - deliberate self-injury
  - suicide attempts
  - hopelessness
  - family dysfunction

Boys who reported current high distress about sexual abuse had "10-fold increased risk for suicidal plans and threats, and 15-fold increased risk for suicide attempts, compared to non-abused boys" (Martin et al., 2004).

- Fergusson and colleagues (Fergusson, Horwood et al., 1999; Fergusson, Horwood et al., 2005) examined the extent to which gay, lesbian and bisexual (GLB) young people were at increased risk of suicidal behaviours. They found that predominantly homosexual young people were at increased risk of suicidal ideation and suicide attempts compared to their heterosexual peers. This effect was stronger for males than for females.
  - 71.4% of predominantly homosexual males met criteria for major depression at age 25
  - 71.4% of predominantly homosexual males reported suicidal ideation at age 25
  - 28.6% of predominantly homosexual males reported at least one suicide attempt by age 25
  - 10% of predominantly homosexual females reported at least one suicide attempt by age 25
- "In men, low income and smoking were associated with attempted suicide, while attempted suicide in women was associated with poor self-evaluated health, low educational attainment, and drug use" (Zhang, McKeown et al., 2005).

Factors Explaining Gender Differences in Suicidal Behaviour

While there are a number of theories to explain the gender difference in suicide rates, research studies, including those from New Zealand, suggest that:

- <u>Gender-related method preferences</u> almost completely explain the gender differences seen in suicide rates:
  - males prefer more lethal methods (e.g. hanging)
  - methods favoured by females tend to be less lethal (e.g. overdose)

  Therefore, males are more likely to complete suicide and females are more likely to attempt suicide (Beautrais, 2002). *Please see the attached PDF of this paper.*

- A series of other explanations for gender differences in suicidal behaviour have been offered, but there is generally poor evidence to support these. These explanations include differences arising from:
  - Suicidal intent: women may intentionally use less lethal suicide methods to draw attention to their situation, and do not intend to die.
  - Ascertainment: it is possible that there may be gender biases in the reporting and classifying of suicide deaths.
  - Differences in psychopathology: because males are more prone to aggressive, antisocial and externalising behaviours, they are likely to make more impulsive, lethal, active and determined suicide attempts.
  - Psychosocial differences: 1) having children may protect females against suicide; 2) females are more willing to seek help and discuss their problems than males (Beautrais, 2002).
- In addition, Canetto (1997) suggests that, during adolescence, cultural meanings have the potential to account for gender differences in suicidal behaviour.
  - Nonfatal suicidal behaviour (e.g. suicidal ideation and nonfatal suicide attempts) is associated with "femininity" and that killing oneself is considered "masculine" and "powerful" – as a rational response to adversity.

  Therefore, she argues that due to social pressures, males may be protected against nonfatal suicidal behaviour, but are more likely to resort to more lethal means of suicide to reduce the likelihood of surviving.

TREATMENT OF DEPRESSION AND SUICIDAL BEHAVIOURS

- More than 80% of people with depression (both men and women) can be treated successfully. For youth with depression, both psychotherapy and pharmacotherapy have been shown to be beneficial. However, there is clear evidence that adolescent males are unlikely to seek treatment for their problems.
- Horwood and Fergusson (1998) reported that a great majority (76.5%) of young people (aged 18) who met criteria for psychiatric disorder failed to seek treatment. Those young people with mood disorders (predominantly females) were most likely to seek treatment (35.4% sought treatment), while those with substance use disorders (predominantly males) were least likely to seek treatment (7.3% sought treatment). 30% of females with any psychiatric disorder sought treatment, while only 16% of males sought treatment.
- There is some evidence to suggest that the "risk of suicide following depressive illness is highest where the rates of diagnosis and professional treatment are lowest" (Walinder & Rutz, 2001, pS21). Further, Walinder and Rutz believe that male depressive illness may manifest itself in ways that are "unrecognized by current diagnostic systems and/or rejected by the present health care system" (pS22).
- Given that young males have such a high suicide rate, and that males in general are less likely to seek treatment for their depression, particular emphasis needs to be placed on identifying depression and suicidality in young adolescent males and engaging them in treatment.
- The design of screening, clinical assessment, and interventions needs to take into account differences between males and females in the aetiological factors related to psychiatric disorders and suicidal behaviours (Lewinsohn, Rohde et al., 2001).

- We have provided you with two important papers that reflect the current state of knowledge and expertise in the areas of depression and suicidal behaviour and provide guidelines for assessing, treating and managing children and adolescents with depression and suicidal behaviour. These papers are the: *Practice Parameters for the Assessment and Treatment of Children and Adolescents with Depressive Disorders* (Anonymous, 1998); and *the Practice Parameter for the Assessment and Treatment of Children and Adolescents with Suicidal Behaviour* (Shaffer, Pfeffer et al., 2001). Please see the attached PDFs of these papers.
- See also the review on treatment (CASA ejournal, September 2005) for a summary of specific treatments for adolescents with depression.

TREATMENT AND MANAGEMENT OF EXTERNALISING BEHAVIOURS

- It has been previously noted that ***"Males Externalise, Females Internalise."*** Therefore, assessment and intervention approaches may need to be tailored to meet the specific needs of depressed and suicidal males. The expression of externalising behaviours such as conduct disorder and substance use disorders may reflect underlying depression in some males.
- However, treating externalising behaviours, particularly conduct disorder, is complex.
- We have provided you with a copy of the *Practice Parameters for the Assessment and Treatment of Children and Adolescents with Conduct Disorder* (Steiner, 1997) (see attached PDF) to accompany the Practice Parameters for Depression and Suicidal Behaviours.
- Because anxiety disorders are highly comorbid with depression, particularly in women, we have also provided you with a copy of the *Practice Parameters for the Assessment and Treatment of Children and Adolescents with Anxiety Disorder* (Bernstein & Shaw, 1997).

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