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Men and Depression
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Depression affects approximately 13% of men during their lifetime, with rates increasing with age to 40% of men between 40-60 years of age. This age worsening is reflected in suicide rates that triple in midlife and reaches 4-10 times the rate of females in geriatric men. These extremely high suicide rates are independent of culture as the World Health Organization has reported very high suicide rates in men over 75 years of age in all reporting countries but one.

Depression appears to present differently in men than women. Men tend to have more irritability, anger and insomnia. Men are more likely to deny their depression and consequently act it out with aggressive behavior or alcohol abuse. Shame and stigma issues are overrepresented in male depression. Men tend to withdraw socially and emotionally. It would be fair to suspect depression in men with the three A's – anger, alcohol abuse and anhedonia. As one of my patients so eloquently summed it up, “I don't get depressed – I get drunk and then I get even !”.

The risk factors for male depression includes a positive family or personal past history of depression, drug/alcohol abuse, presence of chronic illness, decreased sexual potency, work stress and marital problems. Men are more difficult to recruit to active treatment because of the denial of symptoms or minimization of impact of the illness. However men are often motivated to comply with treatment when they realize the positive effects that treating depression can have on the chronic illnesses like diabetes and hypertension. Improved earning ability and improved sexual functioning can be motivating factors for treatment.

Emerging research has focused on the role of male hormones in depression. We know that women can have depressive challenges that are associated with perimenopause/menopause. However men can go through similar testosterone declines that have been referred to as andropause, male climacteric states or low testosterone syndrome. This usually begins in middle aged men and continues with aging into elderly years. It can be associated psychologically with depressed mood, low self-confidence, fearfulness, irritability, low libido and impaired sexual functioning. The irritability is especially expressed as poor tolerance to stressful life events that were previously handled more effectively. Some have speculated that this is a major cause of depressions that do not respond appropriately to medications.

Andropause can cause physical symptoms such as loss of body hair, thinning/drying of skin, anemia, obesity, headaches, decreased muscle strength and increased fatigue. Balding and hair loss does not predict andropause. It is over-represented in men with diabetes and asthma. It can start in the forties but definitely should be suspected in the mid fifties and beyond. It should always be ruled out in men with depression who do not respond appropriately to antidepressants.

Laboratory evaluation of testosterone can simplify the diagnostic process. Total serum testosterone levels follow a diurnal variation that is higher in the early morning (7-8AM) and lower in the evening (7-8PM). Total testosterone levels includes a component that is freely circulating in the blood stream and another predominant component that is bound to plasma proteins called Sex Hormone Binding Globulin (SHBG). The free component is the biologically active component, but increases in the amount of SHBG decreases free testosterone levels by capturing it from circulating freely in the bloodstream. SHBG increases with age and the free testosterone does not. Thus percentage of biologically active free testosterone decreases with age and the bound version increases. The early morning total testosterone level is used as a screening test for andropause, with the normal range on most assays being 325-1000 ng/dl.

Andropause can be caused by other causes such as zinc deficiency, elevated prolactin hormone levels from antipsychotics or pituitary disorders, lipid lowering medications and alternative treatments such as saw palmetto and flaxseed oil. Testosterone can be replaced in the form of patches, gels, pills, injections and oral adhesives. DHEA is used as a precursor to testosterone. It usually takes four weeks to see an antidepressant effect from hormone replacement. However hormone replacement should not be used in mania/hypomania, prostatic cancer, pedophilia or any antisocial or aggressive states.