Depression in men

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Although fewer men than women experience depression, it has more serious consequences for men, who are particularly likely to commit suicide.

Depression is an important and often overlooked aspect of men’s health. It is very common, with about one in 25 of the UK population having depression at any one time. While women are about twice as likely overall to develop depression as men, the serious impact of depression on men is highlighted by the fact that 17.5 men per 100,000 of the population died by suicide in 2009 compared with 5.2 per 100,000 women. Depression is a significant cause of morbidity in both sexes and, according to the World Health Organization, is the fourth largest cause of disability as measured by disability-adjusted life years. It is clear that no consideration of men’s health would be complete without a focus on depression.

WHAT IS DEPRESSION?
Not all sadness is depression. Although normal human experience should not be medicalised, it is important to recognise, and seek help, when low mood has become persistent, is associated with additional symptoms and causes impaired function. The key features of clinically important depression (major depression) are illustrated in Box 1.

Low mood and anhedonia (an inability to get pleasure or enjoyment from activities previously enjoyed) are the key psychological features of depression. The low mood of depression is often described by sufferers as being a distinct and separate feeling from ordinary sadness,

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Over the past two weeks, five of the following features should be present most of the day, or nearly every day (must include 1 or 2):

1. depressed mood
2. loss of interest or pleasure in almost all activities
3. significant weight loss or gain (more than 5 per cent change in one month) or an increase or decrease in appetite nearly every day
4. insomnia or hypersomnia
5. psychomotor agitation or retardation (observable by others)
6. fatigue or loss of energy
7. feelings of worthlessness or excessive or inappropriate guilt (not merely self-reproach about being sick)
8. diminished ability to think or concentrate, or indecisiveness (either by subjective account or observation of others)
9. recurrent thoughts of death (not just fear of dying), or suicidal ideation, or a suicide attempt, or a specific plan for committing suicide

The symptoms cause clinically significant distress or impairment in functioning

The symptoms are not caused by a physical illness or bereavement

The causes of depression are multifactorial and current thinking emphasises an interaction between a person's vulnerability (such as genetic factors, childhood adversity or trauma and personality) and stresses that can trigger depression or make it difficult to recover (such as adverse life events and social circumstances). Although individual episodes of depression are often self-limiting, usually lasting from a few weeks to months, most people with clinically significant depression have repeated episodes in their lifetime. For a significant proportion of people, depression becomes chronic or recovery is only partial with persisting symptoms and disability. While the most serious outcome is death by suicide (up to 9 per cent in those most severely ill), it is now recognised that depression also significantly increases the risk of dying from other physical illnesses, especially cardiovascular disease.

ARE THERE DIFFERENT TYPES OF DEPRESSION?
Depression is best viewed as an umbrella term for what are probably different underlying conditions or processes, and different patterns are described. Depression can occur as part of bipolar disorder (manic depression), in which periods of extremely elevated mood (mania) occur as well as depression. About 10 per cent of patients with depression go on to experience elevated mood and there is also a current debate, highlighted by celebrity exposure, about how much depression is really a form of mild bipolar disorder.

Sometimes people with depression have variable low mood depending on circumstances, accompanied by sleeping more, an increase in appetite, weight gain, and extreme fatigue with a sense of leaden feeling in the arms and legs. This is termed 'atypical' depression and it is three times as prevalent in women as in men and is also more common in people with depression that mainly occurs in the winter (seasonal affective disorder).

At the other extreme are people with 'melancholia', where there is low mood unreactive to events, typically worse in the morning, with loss of weight and decreased sleep with waking very early in the morning. This is equally prevalent in men as in women.

Although there is no clinical subtype of depression unique to men, compared with women they tend to have a later onset of their first episode, have fewer crying spells and are less likely to have anxiety, helplessness, suicidal ideas, increased appetite and bodily pains, but more likely to be physically slowed up, have greater hostility and to be dependent on, or abuse, alcohol and drugs.

TREATING DEPRESSION
The management of depression begins with a thorough assessment and history taking, including asking about substance misuse and mood elevation. The guidelines produced by the National Institute for Health and Clinical Excellence (NICE) encourage the use of depression rating scales (eg the Patient Health Questionnaire...
PHQ-9, but there are many others).\textsuperscript{1} These, in conjunction with the clinical impression, help the clinician to gauge the severity of a patient’s depression and, more importantly, track the patient’s progress over time.

The main principles of treatment are that it should be monitored, tailored to a patient’s individual needs and circumstances, and evidence based. The most important treatment guidelines in the UK are those produced by NICE\textsuperscript{1} and the British Association for Psychopharmacology.\textsuperscript{6} NICE recommend a ‘stepped-care’ approach to treating depression, ranging from support, monitoring and education for the mildest depression to specialist care and intensive interventions for severe depression (Figure 1). NICE has also recently produced guidance on identification and pathways to care for common mental disorders in primary care in order to improve recognition, and access to services, for patients with depression and anxiety disorders.\textsuperscript{9}

For mild depression, low-intensity psychosocial interventions are recommended, which include exercise, self-help groups and computerised cognitive behavioural therapy (CBT).\textsuperscript{1} Although counselling (sympathetic listening) is frequently requested and provided, it is important to realise that there is no evidence that it works for depression and it is not recommended by NICE.\textsuperscript{1} In recognition that it is difficult to access psychological treatment, the government has instituted the ‘Improving access to psychological therapies’ programme, aimed at addressing this.\textsuperscript{10}

For moderate to severe depression, higher intensity psychological treatment such as CBT, antidepressant medication, or their combination, is recommended. CBT involves helping the depressed individual to recognise and correct their negative distortions in thinking and to reverse the social withdrawal and lack of activities this has caused.

Where medication is indicated, guidelines such as NICE recommend one of the selective serotonin reuptake inhibitors (SSRIs), such as citalopram or sertraline, as first-line treatment in most people because they provide the best balance of benefits and unwanted effects.\textsuperscript{1} It is important to recognise that a trial of antidepressants must be of adequate length at a therapeutic dose, as full clinical benefit can take some weeks to become established. Equally important is the need to continue antidepressants for at least six months after full resolution of the depression to prevent the high risk of relapse in the first few months; this can be difficult if side-effects are troublesome.

People with repeated episodes of depression or incomplete recovery may be advised to stay on antidepressants for much longer or even indefinitely to prevent relapse.\textsuperscript{1,6} Unfortunately, our current treatments for depression are often ineffective and specialist psychiatric care and other treatments not discussed here might be needed.

\textbf{Does male sex influence choice or outcome of treatment?}

The short answer to this is probably not. Because depression in men is more likely to be associated with alcohol or drug abuse, it is especially important to rule this out or to treat it in its own right. Beyond this we do not have good evidence that depression in men and women responds differentially to treatment. Although men find it more difficult to talk about their feelings than women and are more likely than women to be alexithymic (have difficulty experiencing or verbalising emotions),\textsuperscript{11} there is little evidence that sex influences response to
psychological treatment. The results for antidepressants are more controversial and some studies, including the largest naturalistic study to date, suggest that men might respond slightly less well than women to SSRIs, and men may tolerate the older tricyclic antidepressants better than women.

SIDE-EFFECTS OF ANTIDEPRESSANTS
Side-effects of antidepressants can cause patients a great deal of distress and lead to stopping treatment early. The common side-effects of antidepressants are shown in Figure 2. When choosing an antidepressant, it is important to consider the likely side-effects and their importance for the person receiving the drug. Many side-effects are worst at the start of treatment and improve with time (e.g., nausea with SSRIs), whereas others may persist (e.g., sexual side-effects).

Sexual aspects of depression and its treatment
Of particular relevance to the treatment of depression in men, many antidepressants cause sexual dysfunction and a third to a half of both men and women treated with antidepressants have antidepressant-associated sexual dysfunction. Both men and women experience antidepressant-associated loss of sexual desire, arousal and anorgasmia, and in men this often presents as erectile and ejaculatory problems. Given that about 50 per cent of patients have sexual problems associated with depression itself, most frequently loss of sexual desire, sexual side-effects from antidepressants often become apparent only later in treatment as depressive symptoms resolve. Sexual dysfunction is frequently overlooked for reasons that include lack of awareness that antidepressants can cause sexual dysfunction as well as embarrassment about discussing the subject.

Antidepressants vary in their tendency to cause sexual side-effects, with antidepressants that block the reuptake of serotonin (SSRIs, venlafaxine and some tricyclic antidepressants such as clomipramine) particularly likely to cause disorders of ejaculation. However, other mechanisms are clearly important, as even serotonin reuptake inhibitors vary considerably in their tendency to cause sexual side-effects, with paroxetine particularly likely to do so, whereas duloxetine, milnacipran (licensed in France), escitalopram and fluvoxamine appear relatively less likely to do so. There is less evidence about the frequency of sexual side-effects with the older tricyclic antidepressants and monoamine oxidase inhibitors, but phenelzine in particular has been associated with a high rate. Of the newer antidepressants, the drugs that have been shown to have low rates of sexual dysfunction are bupropion (licensed for depression in North America), reboxetine, moclobemide, agomelatine and probably mirtazapine. As antidepressant-associated sexual dysfunction does not usually improve over time, treatment includes switching to a drug less likely to cause sexual side-effects (but this may risk a relapse of depression), and using sildenafil or other phosphodiesterase type 5 inhibitors for erectile dysfunction.

CONCLUSIONS
Although fewer men than women suffer from depression, it is nevertheless a common and distressing disorder with serious consequences, with impairment in wellbeing, relationships and occupation, and men are particularly likely to commit suicide.

Effective treatments work equally well for both men and women, and these need to be tailored to individual needs. Antidepressant drugs are not a short-term
Depression is a common and serious problem in men. Treatment includes switching to an antidepressant less likely to cause sexual side-effects. Sexual dysfunction as a side-effect of antidepressant treatment is common but frequently overlooked, and can lead to impaired quality of life or premature stopping of treatment. Treatment includes switching to an antidepressant less likely to cause sexual side-effects or, if it is important to continue the current drug, consider the use of a phosphodiesterase type 5 inhibitor such as sildenafil for erectile dysfunction.

**KEY POINTS**

- Depression is a common and serious problem in men
- A thorough assessment and stepped-care approach to treatment is important
- Antidepressant treatment needs to be continued beyond initial recovery to prevent relapse
- Sexual dysfunction as a side-effect of antidepressant treatment is common but frequently overlooked, and can lead to impaired quality of life or premature stopping of treatment.
- Treatment includes switching to an antidepressant less likely to cause sexual side-effects or, if it is important to continue the current drug, consider the use of a phosphodiesterase type 5 inhibitor such as sildenafil for erectile dysfunction.