The question of gender differences and depression

Learning outcome: Discuss cultural and gender variations in prevalence of disorders

Women are diagnosed as having a depressive disorder significantly more frequently than are men and, with a few exceptions, report more depressive symptoms than do men in most geographical areas of the world.

There are several different arguments as to why there is this difference in prevalence of Major depressive disorder in women. Here is some evidence for and against those arguments.

**Argument 1: It is an income effect, not a gender effect.**

By most indicators, women's economic status is lower than men's. It could be that the differences observed in rates of depression in men and women are the result of differences in socioeconomic status instead of gender differences. Ensel (1982) tested for this possibility by comparing men's and women's mean scores on a depression scale, controlling for income level, education level, and occupation. In both of these studies, women still had more depressed mean scores than men after all these socioeconomic indicators were taken into account. These results suggest that observed sex differences in depression are not simply the result of differences in income.

McGrath et al (1990) argue that women are more likely to encounter such stressful life factors as physical and sexual abuse, poverty, single parenthood, and sexual discrimination.

**Argument 2: The difference is the result of reporting bias.**

Some researchers have argued that the sex differences in depression result from men's unwillingness to admit to and seek help for depressive symptoms. This hypothesis holds that men and women experience depressive symptoms equally frequently, and to the same degree, but because depressive symptoms are perceived as feminine, men are less likely to admit to them.

A number of studies have failed to support this hypothesis. King & Buchwald (1986) found men no less willing to disclose symptoms than women. The study, however, used college students for participants. However, Barsky, Peekna & Borus (2001) found that women and men seem to differ in their thresholds for judging and considering a given sensation to be unpleasant or
bothersome — i.e., for labeling and describing the sensation as a symptom. This reporting bias may well result from powerful socialization forces which begin in childhood. Men are supposed to try to deal with symptoms and not give in until it is a threat to themselves. Women also report more intense, more numerous, and more frequent bodily symptoms than men. They conclude that women and men experience somatic symptoms, bodily distress, and physical health differently.

The findings of Barsky, Peekna & Borus regarding somatic symptoms has also been supported in the study of depression. Padesky & Hammen (1977) carried out a study of college students in which the level of depressive symptoms at which women said they would seek psychotherapy was lower than the level at which men said they would seek help. However, it is important to note that the students were not currently suffering from those symptoms, so the situation was only hypothetical.

Amenson & Lewinsohn’s (1981) study of actual help-seeking behavior found that men and women with similar levels of self-reported depressive symptoms were equally likely to seek psychiatric help or go to a general practitioner. In addition, the researchers found that men and women with equal levels of self-reported symptoms were equally likely to be diagnosed as depressed in a clinical interview.

**Argument 3: It is difficult to diagnose depression because men and women have different kinds of symptoms.**

According to this hypothesis, men and women are equally susceptible to depression, but depression in men often takes the form of "acting out" behaviors instead of sadness, passivity, and crying, which are symptoms commonly included in self-report inventories. In particular, it has been suggested that the male equivalent of depression is alcoholism. Proponents of this argument point to statistics showing that twice as many men as women are diagnosed as alcoholics, and suggest that the rates of alcoholism in men make up for the absence of depression in men. This argument is boosted by evidence that in cultures in which alcohol consumption is strictly prohibited, such as among the Amish, no sex differences in depression are found (Egeland & Hostetter, 1983).

Yet there is evidence that depression is as likely a consequence as a cause of alcoholism in men. Cadoret & Winnower (1974) report that in patients suffering from both depression and alcoholism, most of the men reported becoming depressed at least 10 years after the onset of alcoholism.

Alcoholism and depression can be considered two different maladaptive responses to difficult life circumstances. Societal restrictions against women drinking excessively may protect women who are vulnerable to alcoholism from developing the disorder. In summary, there apparently is little justification for dismissing the observed sex differences in depression as simply due to differences in men's and women's willingness to show the common symptoms of depression.
Argument 4: There are biological reasons for the higher prevalence among women.

It is widely believed that hormonal fluctuations strongly affect moods in women. Women are believed to be more prone to depression during the premenstrual period, the postpartum period, and menopause, each of which is characterized by changes in the levels of a number of hormones.

In a meta-analysis by Kessler (2001) it was found that although the gender difference first emerges in puberty, other experiences related to changes in sex hormones (pregnancy, menopause, use of oral contraceptives, and use of hormone replacement therapy) do not significantly influence major depression. These observations suggest that the key to understanding the higher rates of depression among women than men lies in an investigation of the joint effects of biological vulnerabilities and environmental provoking experiences - for example, how the early onset of puberty in women is addressed by a culture.

The biological explanations of sex differences in depression, as a class of explanations, do not explain the absence of sex differences in certain subgroups, such as the Amish, university students, and bereaved persons. Sociocultural and psychological factors, such as the supportiveness of the Amish culture or the greater impact of a spouse's death on men than on women, more convincingly explain the variations across groups in sex differences in depression.

Argument 5: The origin of depression is rooted in gender roles.

Psychologists have argued that a central element of women's roles in society is the nurturance of relationships. These theorists suggest that women's concern with relationships makes them more vulnerable to despair and depression. They argue that women's self-assessment and sense of self-worth is based on the success of their loving relationships. When a love relationship fails, a woman loses her self-definition.

What is the evidence that women are more concerned with relationships than are men? Gilligan (1982) presents largely anecdotal evidence indicating that when presented with a moral dilemma, women are more likely to worry about how the problem presented to them would affect relationships between the persons involved, whereas men are more likely to invoke rules of justice in solving problems. Gilligan's work has been criticized for the conclusions she makes on the basis of data from unstructured interviews conducted with small samples.

In an extensive review of studies of sex differences in social behaviors and self-concept, Maccoby & Jacklin (1974) found that, although women and girls describe themselves as more socially oriented than men, their actual behaviors do not show more concern with social relationships than men's behaviors do.
In addition, it is not clear why investing one's self-worth in interpersonal relationships should be more likely to lead to depression than investing it in material and professional success, as men are said to do. Are failed love relationships more frequent events over the life span than failures at work? Why would not men’s lack of investment in interpersonal relationships make them more vulnerable to feelings of loneliness and loss? Even if we could find conclusive evidence that women are more concerned about relationships than men are, this is only correlational evidence - and does not lead to a cause and effect understanding of depression.

Theorists suggest that, because the desire for relationships is an inherent aspect of female personality, women who attempt to succeed in jobs will be continually faced with disturbing conflicts between their natural propensity toward relationships and demands to be independent and competitive in the job. A number of sex role theorists have been concerned with the incompatible expectations put on a woman when she enters the marketplace. Deviance from sex role expectations may result in social rejection.

For example, Costrich, Feinstein, Kidder, Marecek & Pascale (1975) found that assertive women were rated as more unattractive and in need of psychotherapy than were assertive men. Some support for the role conflict hypothesis comes from epidemiological studies of depressive symptoms in the general population. Aneshensel, Frerichs & Clark (1981) administered the CES-D to 1,000 residents of Los Angeles County. They found that among persons who were married and employed, women reported significantly more depressive symptoms than men; this was not true among unmarried, employed persons. This pattern of results is in line with the assertion that having dual roles can be a risk factor for depression in women.

You may notice, however, that a significant amount of the research on role conflict is from the 1970s and 80’s as more women were entering the workforce. In addition, a significant number of the studies are based on the US where child care services are private and expensive, putting an added financial strain on working mothers, sometimes countering the financial gain that results from employment.

**Argument 6: The difference is rooted in levels of rumination**

Nolen-Hoeksema has proposed that differences in coping styles may underlie the gender differences in depression. She has found that men are more likely to distract themselves when they feel depressed, whereas women are more likely to amplify depression by ruminating about their feelings and their possible causes - that is, they think a lot about how they feel and try to understand the reasons they feel the way they do. Rumination is not, of course, limited to women. In one study, Nolen-Hoeksema (2000) found that both men and women who ruminate more following the loss of loved ones or when feeling sad are more likely to become depressed and to suffer longer and more severe depression than those who ruminate less.
Nolen-Hoeksema & Girgs (1994) have outlined three risk factors for depression in adolescence. They argue that girls are more likely than boys to have these risk factors for depression. The risk factors are:

1. Girls are less assertive than boys and score lower than boys on questionnaires that assess leadership ability.
2. Girls are more likely than boys to engage in ruminative coping. An eighteen month longitudinal study has shown that this coping style predicts onset of depression and is associated with more severe symptoms (Just & Alloy, 1997).
3. Girls are less likely than boys to be physically and verbally aggressive and are less dominant in group interactions. Research by Sapolsky has shown the effects of power hierarchies on stress levels and health.

Recent brain research seems to support Nolen-Hoeksema’s theory. In a study carried out by the University of Toronto (Farb et al, 2011), they found that brain responses can predict onset of depression. Farb and his team showed 16 formerly depressed patients sad movie clips and tracked their brain activity using an fMRI. Sixteen months later, nine of the 16 patients had relapsed into depression. The researchers compared the brain activity of relapsing patients against those who remained healthy and against another group of people who had never been depressed.

Faced with sadness, the relapsing patients showed more activity in a frontal region of the brain, known as the medial prefrontal gyrus. These responses were also linked to higher rumination: the tendency to think obsessively about negative events and occurrences. The patients who did not relapse showed more activity in the rear part of the brain, which is responsible for processing visual information and is linked to greater feelings of acceptance and non-judgement of experience.

This study suggests that there are important differences in how formerly depressed people respond to emotional challenges that predict future well-being. Ruminating in order to analyze and interpret sadness may actually be an unhealthy reaction that can perpetuate the chronic cycle of depression.

**Conclusions**

By examining the theories above, it is clear that there is no one clear reason for the gender differences in the prevalence of depression and other disorders. The reason for gender differences must be based on an integrated approach - that is, one that looks at biological (genetic vulnerability, pubertal hormones, pubertal timing), cognitive (emotional reactivity, rumination, body consciousness) and socio-cultural (interaction with negative life events, poverty, societal gender roles) factors.
Exploring further

1. Create a graphic organizer which illustrates the complex nature of gender differences in the prevalence of depression.

2. This document focuses primarily on the reasons that women may be diagnosed more often with depression. However, the World Health Organization has identified other disorders which display similar gender gaps. The lifetime prevalence rate for alcohol dependence is more than twice as high in men than women. In developed countries, approximately 1 in 5 men and 1 in 12 women develop alcohol dependence during their lives. Men are also more than three times more likely to be diagnosed with antisocial personality disorder than women. In addition, women are the largest single group of people affected by Post-Traumatic Stress Disorder (PTSD). Go online and see if you can find arguments for why these differences exist. How do those arguments compare to the ones in this document?