



Research paper

The gender difference in depressive prevalence is due to high prevalence of somatic depression among women who do not have depressed relatives



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ABSTRACT

Background: Given that several studies have found the gender difference in depression to be rooted in psychosocial forces and others have shown the difference to be due to a gender difference in somatic depression, we compared the gender difference in somatic depression among respondents who reported no relative depressed with that of all other depressed respondents.

Methods: Respondents in a representative sample from the Zurich study who met criteria for somatic depression and reported no relatives (first-degree, or parents, or mothers, or fathers in separate analyses) with depression were compared to other depressed respondents as to gender.

Results: The gender difference in the prevalence of depression among respondents with somatic depression who reported no relatives with depression (whether the relatives were all first-degree, or any parent, or mothers only or fathers only) was significantly greater than the gender difference in depression among other respondents.

Limitations: The measure of depression among relatives was based upon reports of the respondents.

Conclusion: All or almost all of the gender difference in depression in this representative sample is due to a gender difference in somatic depression among respondents who reported no depressed relative. Somatic depression may be a disorder distinct from depression without significant additional somatic symptomatology. If so, it is likely that it should be treated differently.

1. Introduction

A higher prevalence of depression among females compared to males has long been recognized (Kessler et al., 1994). One line of research suggests that the gender difference is due to a higher prevalence among women of specific subtypes of depression such as atypical or somatic depression (Halbreich and Kahn, 2007). Several studies have supported this hypothesis and one demonstrated that the higher female prevalence of depression was due to a gender difference in somatic depression while the gender difference in atypical depression was almost completely due to its overlap with somatic depression (Silverstein et al., 2013).

Another line of research involves several studies that suggest that the gender difference in depression is due to a higher prevalence among women of depression rooted in psychosocial processes (Ge, Conger and Elder, 2001; Hankin, 2009), in particular psychosocial issues related to gender roles (Cespedes and Huey, 2008; Kuehner, 2003).

Bringing together these two lines of research, studies that relied on a self-report measure of depressive symptoms (CES-D) demonstrated that the gender difference in depression was due to a high prevalence of somatic depression among women who have been exposed to attitudes and treatment from parents suggesting that women are at a disadvantage compared to men (see Silverstein and Lynch, 1998). Some of these studies used respondents' reports of the attitudes of their parents but some related respondents' self-reports of depression to reports of attitudes suggestive of gender limitations made by their parents.

One study of female high school students found reports of feeling disadvantaged by being female made by their mothers to be related to daughters' reports of somatic depression but not to their reports of depression that did not meet criteria for somatic depression. In contrast, mothers' self-reported depression was related to daughters' reports of non-somatic depression but, when mothers' reports of gender disadvantage were held constant, not to daughters' reports of somatic depression (Silverstein and Blumenthal, 1997).

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It is important to make clear that, as noted by Rutter et al. (2003) and many others, no disorders are completely psychosocial or completely endogenous and, as discussed below, there is no reason to believe that women who develop depression related to psychosocial issues never have parents who are depressed. Nonetheless, the studies cited above suggest the hypothesis that the gender difference in the prevalence of depression may be largely due to the higher prevalence among women compared to men of somatic depression that is not related to the depression of their mothers and, by extension, possibly their fathers and other relatives. That hypothesis is tested here on data from a representative sample.

2. Methods

All procedures contributing to this work comply with the ethical standards of the relevant national and institutional committees on human experimentation and with the Helsinki Declaration of 1975, as revised in 2008. The project received prior approval (1978) from the Ethical Committee of the Zurich University Psychiatric Hospital. The Zurich Cohort Study comprises a cohort of 4547 people (2201 men; 2346 women) representative of the canton of Zurich in Switzerland in 1978. At that time, the male participants were 19 years old (at mandatory conscription) and the female participants were 20 years old (complete electoral register). The response rate for men was 99.7%. Women were identified at the age of 20 by the complete electoral register; half of the women chosen randomly received mailed questionnaires, and 75% of them responded.

A screening scale for physical and emotional symptoms, the Symptom Checklist 90-R (Derogatis, 1977) was administered to prospective study participants. To enrich the probability of psychiatric syndromes, a stratification procedure based on over-sampling of those whose score exceeded the 85th centile of the Symptom Checklist 90-R global severity index score was applied. In total, 591 participants (292 men, 299 women) were selected for interview. Two thirds of the interview sample comprised high scorers and one third were randomly selected from the remainder of the initial sample (global severity index scores below the 85th centile). The prevalence estimates reported at each wave of the study were weighted to yield unbiased population estimates, as described by Eich et al. (2003).

The interview sample had face to face interviews at ages 21 (1979), 23 (1981), 28 (1986), 30 (1988), 35 (1993), 41 (1999), and 50 years (2008) for women; men were one year younger at all interviews. The entire cohort was contacted at each wave irrespective of participation at the previous interview wave. Over 30 years, 43% of the cohort participated in all seven interviews, 55% in six interviews, 66% in five interviews, 75% in four interviews, 83% in three interviews, and 91% in at least two interviews. On average, about 10% of the participants dropped out at each interview wave. Previous analyses showed that those who dropped out did not differ significantly from those who continued to participate with respect to psychiatrically relevant demographic characteristics (Eich et al., 2003).

Medical residents and clinical psychologists with extensive clinical training administered the Structured Psychopathological Interview and Rating of the Social Consequences for Epidemiology (SPIKE), with modules for 13 psychiatric and 12 somatic syndromes, in the participants' homes. The interviews took 1–4 h. (Angst et al., 2005). Screening probes based solely on the major phenomenological features of each syndrome (such as depressed, irritable, sad mood) were administered for each of the 25 syndromes. Separate modules covered the descriptive phenomenology of psychiatric syndromes including depression, fears/phobias, panic attacks, generalised anxiety, hypomania, obsessive-compulsive disorder, eating behaviours, post-traumatic stress, behaviour problems, suicidality, and alcohol, tobacco, and drug use. The successive versions of SPIKE have enabled application of the diagnostic criteria for DSM-III (*Diagnostic and Statistical Manual of Mental Disorders*, third edition), DSM-III-R, and DSM-IV (American

Psychiatric Association, 1980; 1987; 1994).

The interview on depression concentrated on the past twelve months. The diagnoses, on which the statistics rely, were all maximised over 7 interviews covering one year (ever yes/no). The critical symptoms had to present in the same year. Each respondent was only included one time in the analysis even if the respondent met criteria for depression/somatic depression in multiple interviews.

As in the earliest studies of somatic depression, respondents with somatic depression met criteria for depression and reported three of: headaches, breathing difficulty, fatigue, body image problems (want to be thinner or unhappy with body shape), eating problems (regular fasting, bingeing, or intentional vomiting), and sleep problems (trouble falling or staying asleep). The findings that led to all of the above symptoms being included in the criteria for somatic depression are described elsewhere (Silverstein, 2013; Silverstein and Perlick, 1995). Respondents with non-somatic depression met criteria for DSM major depression but did not report at least three of the somatic symptoms listed above. Depression among the parents and siblings of respondents was measured by asking respondents whether their parents (1981), parents or siblings (1986) or children (2008) suffered from depression.

2.1. Statistical methods

The analyses reported here of the Zurich data were weighted to be representative of the general population. Respondents were divided into four groups, non-somatic respondents who reported at least one parent, sibling, or child with depression, non-somatic respondents who had no first-degree relative with depression, somatic respondents who had at least one relative with depression, and somatic respondents who had no relative with depression. In order to disaggregate the findings, these analyses were repeated substituting for respondents' reports of depression among all first-degree relatives, their reports of depression of either parent, of mothers only and of fathers only. To specifically investigate the role played by somatic depression among respondents who reported no relatives (in different categories of relative in different analyses) with depression in leading to a gender difference in the prevalence of depression, the respondents in this group (somatic with no depressed relatives) were compared statistically the other three groups combined into one using χ^2 with Yates correction (but the data for all groups separately are presented in the tables). No non-depressed respondents were included in the analysis so the statistical significance of the results was not influenced by the widely reported gender difference in overall depression. Furthermore, by combining into one group all respondents with non-somatic depression and the respondents with somatic depression who reported depressed relatives, the results of the statistical analyses were not influenced by the gender differences between these groups but only by the difference between the somatic depression with no depressed relatives group and all other depressed respondents.

3. Results

The number of depressed female and male respondents in the four somatic/nonsomatic depression X first-degree relatives with/without depression groups is shown in Table 1A. Of these depressed respondents, almost one quarter (23.2%) of the females exhibited somatic depression and reported no parents, siblings or children with depression. This is many times more than the fewer than one out of 30 (3.1%) depressed males in that group. The 2 (male vs. female) X 2 (somatic depression with no depressed relatives vs. the other three groups combined) comparison was significant, $\chi^2(1, n=582)=42.5, p < .0001$. Also informative is the proportion of depressed male and female respondents in each of the groups. The proportion of males in the non-somatic group who reported relatives with depression (54.3%) is much higher than the proportion of females (33.6%), the proportion of males in the non-somatic group who did not report relatives with

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