

AN ANALYSIS OF SEX DIFFERENCES IN DEPRESSION: THE SEARCH CONTINUES

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"If we knew more about the reasons why men and women differed in their psychopathology, then we would be well on the way to understanding the causes of many mental disorders." (Mayo, 1976, p. 26) Stoppard has attempted to shed light on the conundrum of sex differences in depression. Her point of departure is a brief review of the basic tenets of several cognitive and behavioural models of depression. She subsequently tallies up the number of studies showing male/female differences in measures that, according to each theoretical perspective, indicate vulnerability to depression. Stoppard's analysis clearly reinforces the need to consider sex differences in depression and underscores the inadequacy of a simplistic "deficit" or "vulnerability" model in explaining such a complex disorder as depression. She also reminds us of our need to consider the differential stressors that men and women experience and the implications they have for any formulation of psychopathology. Finally, Stoppard's review sensitizes researchers and clinicians to implicit sexist biases that may inadvertently be conveyed in clinical theory and practice. For these efforts, Stoppard deserves kudos!

While Stoppard's review perks the interest of researchers and clinicians in these issues, there are several problems inherent in her approach. These include: the failure to adequately consider general methodological issues that need to be addressed by researchers interested in investigating sex differences in psychopathology; and problems related to Stoppard's interpretation and evaluation of cognitive / behavioural models of depression.

Methodological Issues

Sample.

Stoppard fails to consider the heterogeneity of the depression disorder and she ignores epidemiological variations in depression across groups (e.g., studies showing limited sex differences in depression among the Amish [Egeland & Hosteter, 1983]). For the most part, the studies reviewed by Stoppard assess sex differences in college students. As Stoppard notes this is "a group in which sex differences on vulnerability factors typically are not found." Only two studies cited by Stoppard assessed sex differences in clinical populations. Clearly, we cannot begin to understand depression in women by reviewing research that is almost exclusively based on college students. The need to investigate vulnerability factors in clinical populations is particularly important when we consider that sex differences for depression are most apparent when we examine *lifetime prevalence* for depression rather than incidence or point prevalence (Amenson & Lewinsohn, 1981; Eastwood & Kramer, 1981; Weissman & Myers, 1978). This research suggests that sex differences in vulnerability to depression are most clearly noted with respect to the recurrence rather than the first episode of depression. Hence, research examining sex differences in vulnerability factors related to relapse may provide a better avenue for understanding the greater rate of depression in women than research examining sex differences in vulnerability factors in college students, many of whom have not yet experienced a depressive episode.

Changes over the Life Span.

Stoppard fails to consider the changing incidence of depression over the life span. The higher incidence of depression in women occurs most often in the younger age groups (20 to 44). The incidence of depression in women decreases with age and by 65 depression appears to occur equally often in both sexes (Nolen & Hoeksema, 1987). What happens to Stoppard's social stress hypothesis at age 65? Are the differential stressors women experience less likely to occur after age 65? Initial attempts to address these questions have been offered by Kessler and McLeod (1984), Murphy (1986) and Solomon and Rothblum (1986).

Measures of Vulnerability.

Stoppard equates the respective cognitive/behavioural models with only one or two self-report measures that are often of limited reliability and validity. The measures reviewed often have questionable status as vulnerability markers of depression (Segal, 1988). The author fails to critically evaluate the literature that has questioned, and often challenged, the measures that are reviewed (e.g., Sutton-Simon's [1981] critique of the Irrational Beliefs Scales; Dweck and Wortman's [1982] critique of attributional measures; Butler and Meichenbaum's [1981] critique of problem-solving measures). Given the often questionable validity of these measures we should not interpret the absence of sex differences on such questionnaires as a test of the respective theories.

Evaluating Vulnerability Models.

Stoppard has also failed to recognize the methodological limitations that characterize much of the research investigating vulnerability to depression. For example, Abramson, Alloy and Metalsky (1988) note that few depression vulnerability studies adequately test the diathesis/stress model of depression. These studies do not examine the *interaction* between relevant social stressors (negative life events) and attributions for that event. Perhaps it is not the mere exposure to social stressors but rather a special matching between particular vulnerability and social stressors that contribute to depression. For example, as suggested by Hammen and her colleagues (1988), unipolar (but not bipolar) depressives who are overly concerned about social acceptance (sociotropic) are more likely to become depressed when experiencing negative interpersonal events that imply rejection and abandonment. Although Stoppard notes the importance of a diathesis/stress notion in depression research, she fails to take this into consideration as a criterion in selecting studies for her review. Since the majority of studies reviewed by Stoppard do not assess the diathesis/stress notion, this research is of limited value in providing a clear assessment of sex differences in vulnerability to depression. We need to realize that the research to date is marked by numerous flaws and generally does not provide an adequate test of vulnerability factors in depression onset or maintenance. Any review of vulnerability markers for depression that is based on the existing literature, regardless of the target concern, will suffer from the same inadequacies.

Cognitive/Behavioural Models of Depression: Theoretical Issues

Stoppard portrays the cognitive/behavioural models as having a stagnant simplistic view of psychopathology - that a specific deficit causes depression. We believe this is a misreading of many of the theorists. Moreover, Stoppard's presentation does not reflect the more recent attempts by cognitive/behavioural advocates to be sensitive to the transactional, reciprocally deterministic, nature of behaviour (e.g., see Bandura, 1985; Hollon & Kriss, 1984; Mahoney, 1985; Meichenbaum & Gilmore, 1984; Turk & Salovey, 1985). A number of these cognitive/behavioural theorists have highlighted the highly complex interdependent ways that cognition (cognitive events, processes, structures), emotion, interpersonal behaviour, and their resultant consequences, social conditions, and physiological processes, interact. Cognition and behaviour are viewed as only two of several components in understanding psychopathology. Furthermore, the causal role of cognition is viewed as complex and bidirectional rather than unidirectional. Attempts to identify a specific deficit or diathesis as underlying depression will likely prove as inadequate as similar attempts by researchers to find specific deficits for other forms of psychopathology. Researchers might find greater value in viewing disorders as a function of a configuration of several processes that influence different aspects of functioning.

We do concur with Stoppard that models that suggest or even imply that an individual's depression is due to a specific deficit (e.g., cognitive distortions, inadequate problem-solving skills) have the potential of being pernicious. For instance, if a therapist focuses exclusively on one type of deficit in depression (e.g., negative interpretations of events; negative evaluation of the self) at the exclusion of other deficits that may be present (e.g., inadequate interpersonal skills; low social support), this may increase the probability of relapse for the client. Moreover, a patient may mistakenly interpret a failure to maintain therapeutic gains as an indication of further inadequacy ("If I could only think right, behave right, then I wouldn't be depressed).

Are Cognitive/Behavioural Theories "Male-Biased"?

We do not concur with Stoppard's conclusion that "cognitive theories are male-biased in their assumptions about the features that increase the vulnerability to depression." From our perspective, cognitive/behavioural

theories are neither "male-biased" nor "female-biased." Cognitive/behavioural approaches attempt to work collaboratively with clients to understand, articulate and evaluate treatment goals, and then to help clients achieve those goals. Quite often, individuals face very real stressors and societal obstacles that get in their way of achieving their goals. Often these events lead to dysfunctional beliefs and feelings about the self in relation to the world — individuals feel incapacitated and unable to cope effectively with stressors. The goal of cognitive therapy is to help patients to identify stressors and their reactions to stress that are maladaptive. Therapy is designed to empower clients -to help them to regain control and a feeling of efficacy in coping with problems in their lives. In this way a cognitive/behavioural approach is committed to humanistic objectives that reflect great respect for people's circumstances and their values and goals. Out of this perspective emerges both research and theory that is well in line with the humanizing and equalizing objectives of the feminist movement.

While we strongly believe that the perspective that is adopted by cognitive/behavioural theorist is neither male-biased nor female-biased, we also believe that theorists and clinicians interested in understanding and treating disorders that are more likely to occur in a particular segment of the population need to consider the unique social conditions of that group. Any discussion of sex differences in psychopathology should begin with a recognition of the relatively powerless position of women that results from the legal, social, and economic discrimination they face. As the U.S. President's Commission on Mental Health (1978, p. 17) concluded: "The poverty, dependency, and powerlessness associated with women's roles and the devaluation of women's status have destructive effects on women's mental health." Weissman and Klerman (1977, p. 106) drew a similar conclusion: "Sex discrimination results in legal and economic helplessness, dependency on others, chronically low self-esteem, low aspirations, and ultimately, clinical depression. A combination of economic discrimination (women earn approximately 60% of men's salaries for the same work) and social expectations (for women to be submissive, dependent, and passive) contributes to feelings of helplessness and can foster vulnerability to mental disorders such as depression. We believe the existence of these social stressors does not preclude the value of cognitive/behavioural therapies for treating depressed women. In fact, because cognitive/behavioural therapies offer individuals the opportunity to examine the impact of such stressors on their view of themselves and on their beliefs about their self-efficacy, it may be particularly well-suited for the treatment of women suffering from depress