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Differential Relationship between Depression Severity and Patients' Perceived Family Functioning in Women Versus Men

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Abstract

Previous research suggests that depression and family functioning are related, and that women and men may differ in how they respond to and cope with depression. Significantly less attention has been paid to whether gender moderates the relationship between family functioning and depression. In the current study, the relationship between depression severity and perceived family functioning, both generally and in specific areas, was examined in women and men ($n = 117$) hospitalized with major depression. Level of depression severity was not significantly different in men versus women. Correlations between depression severity and most domains of family functioning were significant and positive for men only. Further, gender statistically moderated the associations between depression severity and family functioning in the areas of problem solving, communication, affective responsiveness, and behavior control. Implications for the assessment and treatment of family dysfunction in severely depressed patients are discussed.

Keywords

family functioning; Major Depressive Disorder; gender; psychiatric hospitalization

A wealth of theoretical and empirical literature exists linking poor family functioning with depression. Miller, Kabacoff, Keitner, Epstein, and Bishop (1986) examined overall family functioning and found that families of non-comorbid depressed patients had more severe impairment than families of other diagnostic groups. Prognosis also appears to be significantly worse for depressed patients with dysfunctional families compared to depressed patients with better functioning families (Miller et al., 1992). Concerning intimate relationships, compared to those with nonaffective disorders or those without psychiatric disorders, patients with major depression demonstrated fewer positive interactions and more negative interactions with their spouse or live-in-partner (Zlotnick et al., 2000). Likewise, there is evidence for a strong association between overall marital dissatisfaction and depression (Herr et al., 2007; Whisman, 2001).

A separate line of research has explored gender differences in depression. Although there is little empirical evidence to suggest that men and women experience different symptoms of depression (Addis, 2008; Uebelacker et al., 2009), research exists showing that there may be a difference in how men and women respond to and cope with the emotional distress of depression (Boughton and Street, 2007; Mahalik, 2008; Wilhelm et al., 2008). One line of research attributes this variability to differences in gender socialization (Addis, 2008).

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According to Addis (2008), men's responses to depressed mood may be shaped by adherence to masculine norms, which include "antifemininity, competitiveness, homophobia, emotional stoicism, physical toughness, and power over women" (p.157). These norms may lead men to feel uncomfortable with affective experience and to avoid introspective responses, such as sadness, which are commonly associated with women (Addis, 2008; Warren, 1983). Rather than promoting introspection, masculine gender norms encourage action and men may learn that externalizing responses to negative affect, like drinking, taking risks, self-harm, and expressing anger are more masculine and appropriate (Addis, 2008; Wilhelm et al., 2008).

On the other hand, in response to emotional distress, research shows that women are more likely to express their feelings by engaging in such actions as crying, worrying, and talking about sadness (Kilmartin, 2005). Women are also "reinforced for relationship-oriented behavior in childhood" and report more interpersonal awareness than men (Boughton and Street, 2007, p. 188; Wilhelm et al., 2008). As a consequence, women may more readily seek out interpersonal outlets for their depression (i.e. social support) than men. Research shows women may be more likely to have personality styles that place greater value on emotionally close relationships (Boughton and Street, 2007). Evidence for this is indicated in studies examining predictors of recovery from depression in women and men: while the existence of interpersonal relationships was significant for men, the quality of interpersonal relationships was significant for women (Boughton and Street, 2007).

Although previous research suggests that depression and family functioning are related, and that women and men may differ in their attempts to cope with depression, significantly less attention has been paid to whether the relationship between family functioning and depression actually differs between women and men. Some studies have found a stronger association between current depression or depressive symptoms and self-reported marital dissatisfaction for women than men (Herr et al., 2007; Whisman, 2001). For example, Kornstein and colleagues (2000) found that while women reported greater impairment in marital adjustment than men, whereas men reported greater work impairment than women. However, another study found comparable associations between interpersonal dysfunction (e.g. interactions characterized by tension, arguments, and criticism) and depression for men and women (Zlotnick et al., 2000). More importantly, to our knowledge no previous research has examined whether specific dimensions of family functioning are more or less associated with depression severity in women versus men. Furthermore, much of the previous research in this area (e.g., Herr et al., 2007; Whisman, 2001; Zlotnick et al., 2000) has been conducted in outpatient samples and the level of depression severity and acuity of illness may affect associations between depression and family functioning.

Thus, in the current study we sought to examine whether women and men who have been hospitalized with depression differed in the degree to which their depression severity was associated with their perceived family functioning, both in general and across specific areas, such as communication and affective involvement. Whereas past studies employed broad measures of overall interpersonal interactions, as Zlotnick et al. (2000) recommended, we used the Family Assessment Device (FAD), which is a more comprehensive measure that explores several specific aspects of family functioning (Epstein et al., 1983). Compared with the majority of previous studies which have been conducted with less severely depressed individuals, patients in the current study were diagnosed with major depression and hospitalized for depression. This population was selected because there is a paucity of previous research on more severely ill groups.

Increased knowledge about how specific dimensions of family functioning may present in patients with depression and whether those dimensions differ by gender may lead to more

comprehensive assessments of patients' psychosocial functioning, as well as more targeted treatments of any family dysfunction they may be experiencing. A wealth of research shows that positive social support and healthy family functioning are associated with recovery from depressive episodes and overall well-being (Cohen and Willis, 1985; George et al., 1989; Keitner and Miller, 1990). Furthermore, research shows that when specific dimensions of family functioning, as outlined in the FAD, are examined in depressed patients, certain ones are more strongly associated with recovery than others (Keitner et al., 1995). Therefore, improved assessment and treatment of family functioning in patients with depression is important for bolstering patient outcomes.

Based on previous research, we expected that impaired general family functioning would be positively associated with more severe depression in both women and men. However, because no known research has examined whether specific dimensions of family functioning are more or less associated with depression severity in women versus men, we had no a priori hypothesis regarding this issue.

Method

Participants

The sample consisted of 117 inpatients and day hospital patients at a psychiatric hospital who were participating in a larger treatment study investigating the efficacy of individual, family, and pharmacological treatments for severe depression. Inclusion criteria required: 1) a primary diagnosis of Major Depressive Disorder (American Psychiatric Association, 1994) according to the Structured Clinical Interview for DSM-IV (SCID; First et al., 1995); 2) a score of > 20 on the 17-item Modified Hamilton Depression Rating Scale (MHRSD) (Miller et al., 1985a); 3) age over 18 years; 4) ability to speak and read English; and 5) currently having a family member available to participate. Patients were excluded if they: 1) had any of the following based on the SCID: a) manic episode within one year, b) a psychotic disorder such as schizophrenia; 2) another primary diagnosis based on the SCID of: a) any anxiety disorder, b) anorexia or bulimia, or c) PTSD; 3) were pregnant or lactating; 4) required a type of specialized psychiatric treatment not provided by the larger study; or 5) had a significant medical disorder that might either: a) contribute to patients depression or b) would contraindicate pharmacological treatment. Treatment outcome results will be described in a separate report¹.

Of the 117 participants, 73% were women and 27% were men. The mean age was 39.4 years ($SD \pm 10.8$) and the mean years of education was 13.9 ($SD \pm 2.1$). Seventy-five percent of the sample was Caucasian. Forty percent were married for a mean of 12.4 years ($SD \pm 10.8$). The mean number of people in living in the household was 2.7 ($SD \pm 1.3$).

Measures

Psychiatric diagnosis—The presence of lifetime and current diagnoses was determined using the SCID (First et al., 1995) to confirm the inclusion and exclusion criteria.

Depressive symptoms—The Modified Hamilton Rating Scale for Depression (MHRSD) (Miller et al., 1985a) was administered to evaluate depression severity for the week prior to hospital admission. The MHRSD is an adapted form of the original scale that includes standardized questions to increase reliability. We used the 17-item total, which is strongly

¹Miller IW, Beevers C (2011) Combined cognitive therapy and family therapy for severely depressed patients. Manuscript in preparation.

correlated with the original scale and has a high inter-rater reliability (intraclass correlation = .93). Higher scores indicate more severe depression.

Perceived family functioning—The Family Assessment Device (FAD) (Epstein et al., 1983) was completed by the patient and used to assess family functioning across the seven dimensions proposed in the McMaster Model of Family Functioning prior to the patient's hospitalization (Epstein et al., 1978). Families were defined as people living with the patient in his or her home. The 60-item measure includes seven subscales, each composed of 6–12 items. Patients were asked to rate each item with regard to how well it describes his or her own family on a 4-point scale ranging from Strongly Agree to Strongly Disagree. The seven FAD subscales are: Problem Solving (ps), Communication (cm), Roles (rl), Affective Responsiveness (ar), Affective Involvement (ai), Behavior Control (bc), and General Functioning (gf). As described by Miller et al. (1986), Problem Solving reflects the family's ability to resolve problems in a functional way. Communication assesses whether family discussion is clear and direct. Roles refers to family members' established ways of handling tasks. Affective Responsiveness assesses the appropriate expression of a range affect in different situations. Affective Involvement is related to family members' interest and value in each other's activities. Behavior Control is related to the way the family maintains its own standards of behavior. Finally, General Functioning is designed as an overall assessment of family functioning and is comprised of items that are *separate* from the other scales. FAD scores range from 1–4 and are based on the mean of the items within the scale. A higher score on the FAD indicates *poorer* family functioning. The scale has been shown to have good internal consistency (coefficient alpha = .72–.92) and test-retest reliability (.66–.76) (Miller et al., 1985b). FAD subscale scores have been shown to correlate significantly with other measures of family functioning as hypothesized, and discriminate between families rated by experienced clinicians as healthy or unhealthy (Miller et al., 1985b; Miller et al., 1986).

Procedure

The current study was approved by the local Institutional Review Board. Patients who consented to participate were interviewed and completed questionnaires while hospitalized or immediately following their discharge. All assessments were conducted by trained bachelors-and graduate-level interviewers and completed prior to the initiation of study treatments. Interviews were audiotaped and closely supervised by study investigators. Regular supervision of interviews was conducted to maintain reliability.

Data Analysis

First, chi square analyses were performed to determine if there were significant differences between men and women on demographic variables, variables relating to specific aspects of participants' past and present mental health status, and the FAD subscales. Next, correlations between the 17-item MHRSD scores and each of the FAD scale scores were calculated for the entire sample and for men and women separately. Finally, moderation analyses tested whether gender moderated the relationship between depression severity and family functioning. Moderation formally examines whether the strength of a relationship between two variables differs as a function of a third variable. As described by Whisman and McClelland (2005) for cross-sectional data, we conducted partial correlations between the interaction term (gender x depression severity) and each FAD scale controlling for the main effects (gender and depression severity). We also controlled for the type of family relationship (married/cohabitating vs other family relationship). As recommended by Whisman and McClelland (2005), variables were centered and gender was dummy coded ($M = -0.5$ and $F = 0.5$).

Results

Preliminary analyses demonstrated no significant differences between men and women on any demographic variables (see Table 1). Chi square analyses showed no significant differences between men and women on the following: single versus recurrent depressive episodes, $\chi^2 = 1.108$, $df = 1$, $p > .05$; single versus multiple psychiatric hospitalizations, $\chi^2 = 1.43$, $df = 1$, $p > .05$; or the presence of a co-morbid anxiety disorder, $\chi^2 = .786$, $df = 1$, $p > .05$. Men and women in the sample also did not differ in the length (weeks) of the current depressive episode, $t(115) = .25$, $p > .05$. In addition, there was no significant difference between men and women in depression severity as measured by the 17-item MHRSD, $t(115) = .385$, $p > .05$. Results also showed no significant differences on any of the FAD scale scores, except for affective responsiveness. Men had higher affective responsiveness scores than women, indicating poorer functioning in this area, $t(115) = -2.42$, $p < .05$ (see Table 2).

For the full sample, significant positive correlations were found between depression severity and each of the FAD scales (see Table 3). When data were analyzed separately by gender, significant positive correlations were found for both men and women between depression severity and the FAD general functioning scale. However, correlations between depression severity and family functioning were significant and positive for men, but not for women on all other scales, including problem solving, communication, roles, affective responsiveness, behavior control, and affective involvement. Scatterplots were examined for outliers that could skew the results, but none were found.

The above differences in correlations by gender could be confounded by differences in variability on these measures by gender (i.e., restricted range problems). Therefore, we further tested whether gender moderated the relationship between depression severity and family functioning. Results showed that gender significantly moderated the relationship between depression severity and family functioning for FAD problem solving ($r = -.19$, $p = .044$), FAD communication ($r = -.19$, $p = .045$), FAD affective responsiveness ($r = -.20$, $p = .038$), and FAD behavior control ($r = -.22$, $p = .022$); but not for FAD general functioning ($r = -.17$, $p = .076$), FAD roles ($r = -.15$, $p = .120$), or FAD affective involvement ($r = -.16$, $p = .090$) such that men had stronger positive associations between these areas of perceived family dysfunction and depression severity than women.

Discussion

This study extends the research that examines the link between poor family functioning and depression, possible differences between how women and men respond to and cope with depression, and potential gender differences in the relationships between depression and family functioning. Gender differences were not found for demographics or psychiatric severity. As expected, family functioning and depression severity were correlated in the sample in general. However, gender moderated the strength of the associations between depression severity and several dimensions of perceived family functioning as measured by the FAD. For the men in our study, there were significantly stronger positive associations between depression severity and perceived family functioning in the areas of communication, problem solving, behavior control, and affective responsiveness.

Our findings are somewhat different from those reported in previous samples. Using data from the National Comorbidity Survey, Zlotnick et al. (2000) found that while current major depressive disorder was associated with poorer quality of relationships with a spouse, live-in partner, relatives, or friends, but this effect did not differ between women and men. In that study, however, the researchers focused broadly on the extent of positive and negative interpersonal interactions in general. In the current study, while no significant gender

differences were found in the relationship between general family functioning and depression, differences emerged when specific aspects of family functioning were examined, as stated above. . The fact that the FAD measures more specific aspects of family functioning than the questions about interpersonal interactions used in the National Comorbidity Survey could explain the difference in findings between this and Zlotnick et al.'s (2000) study. Further replication is needed in populations with comparable depression severity to verify these findings.

In addition, Herr et al. (2007) found that both currently depressed men and women in a community sample reported poorer marital satisfaction compared to non-depressed participants, and that this difference was stronger for women than men. Likewise, across 26 studies, Whisman (2001) found a stronger association between depressive symptoms and marital dissatisfaction for women than men. Our study did not solely examine satisfaction with and adjustment to marriage and a particular spouse, as is the case with the measures of relationship functioning used in the studies by Herr et al. (2007) and Whisman (2001). These previous studies used the Dyadic Adjustment Scale-Satisfaction Subscale (DAS-S; Spanier, 1976), the Marital Satisfaction Inventory-Global Distress Scale (MSI; Snyder, 1979), the Marital Adjustment Test (MAT; Locke and Wallace, 1959), the Kansas Marital Satisfaction Scale (KMS; Schumm et al., 1986), and the Quality of Marriage Index (QMI; Norton, 1983). Rather, the FAD measures functioning for families as a whole as perceived by the patients, which may have led to our different findings.

Kornstein and colleagues (2000) used the Social Adjustment Scale-Self-Report (SAS-SR; Weissman & Bothwell, 1976) and found that while women reported greater impairment in marital adjustment than men, men reported greater work impairment than women. While the SAS-SR measures "instrumental or expressive role performance" or how one functions in different roles, unlike the FAD, it does not measure specific domains of functioning (e.g., affective responsiveness and behavior control) across those roles. Again, our results likely differ from these findings due to the relative specificity of the FAD..

Some researchers have attempted to explain the differences between men and women related to depression based on gender socialization. For example, it has been suggested that men have less exposure to depression in other men and within themselves because masculine norms discourage reporting depressive symptoms (Kilmartin, 2005; Wang et al., 2007). Consequently, men and their family members may be less familiar with dealing with depression and this may cause more perceived disruption in the family as they try to navigate this new experience. It is also possible that a family may be unwilling to accept the unfamiliar experience and will adhere to gendered social norms dictating appropriate emotional response. For example, Addis (2008) found that, compared to women, men received more negative reactions upon reporting symptoms of depression. As a result, men may perceive their depression as dysfunctional and this may negatively bias their perception of their functioning within the family. Alternatively, because women may be socialized to be more introspective and to seek out interpersonal outlets for their depression, they and their families may have more exposure to depression, which could serve to normalize the effects their depression may have on their family functioning (Kilmartin, 2005). Moreover, men's perception of their functioning within the family may also be negatively biased in part by "sociocultural expectations regarding gender roles" which suppose that while women are to be more attuned to their family, men are to be more attuned to work (Kornstein et al., 2000, p. 8). Therefore, men may have more distorted perceptions of their family functioning when depressed.

Furthermore, Warren (1983) reported that the refusal of men to acknowledge distress, so as not to appear feminine nor to decrease their toughness, confidence, and self-reliance, might

negatively affect genuine interpersonal communication. This problematic communication can negatively impact the family and may lead men to perceive greater deficits in family functioning. The male sex role components of competence and toughness may further encourage men to assume responsibility for problem solving and behavior control in the household. Also, perhaps because masculine norms may make men more uncomfortable with affective experience, when men are depressed they can feel especially inept in the area of affective responsiveness.

Several limitations of the present study warrant further consideration. Whereas our sample consisted of hospitalized patients who agreed to participate, the relationship between gender, depression severity, and family functioning may differ in non-treatment seeking community samples or in outpatient treatment samples, in which depression may be less severe, and where suicidality may not be as present. On the other hand, focusing on a hospital sample enabled us to largely control for gender differences in the severity of depression that could otherwise serve to confound gender differences in family functioning. Furthermore, as little previous research has specifically focused on hospitalized samples, it is important to explore these relationships in various treatment populations (Whisman, 2001). Of course, future research should attempt to replicate the relationship we found between depression and family functioning by gender in other samples.

Additionally, because the evaluation of family functioning was measured using patient self-report, our findings may be more reflective of a perceptual bias rather than actual deficits in family functioning. However, as Whisman (2001) highlights, self-report measures of marital satisfaction have been shown to correlate within couples, with therapist ratings of couple conflict, and with observations of negative couple interactions. This provides some support for the validity of self-reports of family functioning. The next step would be the inclusion of clinician and family ratings to compare and contrast with patient reports. Furthermore, our use of a comprehensive measure of family functioning is an improvement over past studies that were constrained by their more limited scope of assessment. Finally, the low number of non-white participants in our sample also potentially limits our ability to generalize to more diverse populations.

Despite the limitations of this study, implications for effective treatment of depression can be drawn from these findings. Our findings may provide valuable insights regarding the differential relationship between depression severity and perceived family functioning between men and women. Increased attention to family functioning in the treatment of severely depressed patients may be important, especially for men. In addition, our findings suggest that it is advisable to assess various dimensions of family functioning, as they may provide clearer information on how depression is affecting the family. Future research is necessary to replicate these findings and further examine possible explanations for the relationship between depression severity and family impairment.

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Table 1**Sample Demographics and Psychiatric Severity**

	Women	Men	Total
<i>N</i>	85	32	117
Mean age (<i>SD</i>)	38.42 (10.95)	42.03 (10.13)	39.41 (10.81)
Mean years of education (<i>SD</i>) ^a	13.91 (2.18)	14.00 (2.02)	13.93 (2.13)
% White ^b	72.9	81.2	75.2
Mean # of people in household (<i>SD</i>) ^c	2.74 (1.31)	2.47 (1.32)	2.66 (1.31)
% Married	36.5	50.0	40.2
Mean # years married	10.44 (10.98)	16.96 (9.27)	12.44 (10.81)
% Single	23.5	15.6	21.4
% Divorced	17.6	21.9	18.8
% Separated	5.9	6.2	6.0
% Widowed	4.7	6.2	5.1
% Living together	7.2	0	7.7
MDD, single episode	14 (16%)	8 (25%)	85 (73%)
MDD, recurrent	71 (84%)	24 (75%)	32 (27%)
No previous psychiatric hospitalizations ^d	71 (59%)	15 (47%)	65 (56%)
1 or more previous psychiatric hospitalizations	34 (41%)	16 (50%)	50 (43%)
Co-morbid anxiety disorder	40 (47%)	18 (56%)	58 (50%)
No co-morbid anxiety disorder	45 (53%)	14 (44%)	59 (50%)
Age of onset of MDD mean (<i>SD</i>)	22.48 (11.77)	26.66 (15.70)	
17-item MHRSD mean (<i>SD</i>)	24.75 (4.73)	25.09 (4.21)	24.85 (4.58)

Note. No significant differences were found in any of the variables above. MDD = Major Depressive Disorder, MHRSD = Modified Hamilton Rating Scale for Depression.

^aYears of education missing for 3 women and 2 men.

^bRace data was missing for 13 women and 6 men.

^c# in household and marital status missing for 1 woman.

^d# of previous hospitalizations missing for 1 woman and 1 man.

Table 2

Gender Differences on Family Functioning

Measure	Women (<i>n</i> = 85)	Men (<i>n</i> = 32)	<i>t</i>	<i>p</i>
	Mean (<i>SD</i>)	Mean (<i>SD</i>)		
FADgf	2.32 (.563)	2.53 (.715)	-1.67	.097
FADps	2.34 (.516)	2.52 (.511)	-1.69	.095
FADcm	2.49 (.478)	2.65 (.572)	-1.49	.139
FADrl	2.36 (.421)	2.42 (.424)	-.691	.491
FADar	2.21 (.581)	2.57 (.761)	-2.43	.019 ^a
FADbc	1.97 (.435)	1.99 (.540)	-.098	.922
FADai	2.16 (.450)	2.23 (.678)	-.689	.492

Note. FADgf = general functioning; FADps = problem solving; FADcm = communication; FADrl = roles; FADar = affective responsiveness; FADbc = behavior control; FADai = affective involvement

^aMen's FADar scores were significantly higher than women's, indicating poorer functioning in this area of family life.

Table 3

Correlations between depression severity (MHRSD 17-item scale) and family functioning (FAD)

Measure	Full sample (<i>N</i> = 117)	Women (<i>n</i> =85)	Men (<i>n</i> =32)
FADgf	.313**	.293**	.373*
FADps	.218*	.120	.515**
FADcm	.208*	.117	.434*
FADrl	.238*	.183	.406*
FADar	.288**	.210	.485**
FADbc	.186*	.086	.433*
FADai	.218*	.159	.359*

Note. FADgf = general functioning; FADps = problem solving; FADcm = communication; FADrl = roles; FADar = affective responsiveness; FADbc = behavior control; FADai = affective involvement.

*
 $p < .05$

**
 $p < .01$