Women and depression essay

All human beings feel temporarily sad and blue at various times in their lives; most people bounce back quickly and resume their usual demeanor.

An intermittent, temporary sadness is not a description of clinical depression. However, an alarming trend has been surfacing over the last two generations. Growing numbers of people in the United States and indeed around the world are increasingly becoming depressed, and the rates of depression are much higher in women Studies using case records as well as community surveys have found women to be at higher risk, and the difference in risk holds true for white, black, and Hispanic women and across occupations, income, and education levels.

Depression in women is a complex phenomenon. A task force of the American Psychological Association in 1990 depicted increased depression in women over men linked to several social factors including: . Avoidant, unreceptive, dependent behavior patterns; distrustful, negative cognitive styles; and focusing too much on depressed feelings instead of action and mastery strategies 2. High rates of sexual abuse in childhood so that depressive symptoms might be long-lasting symptoms of " post- traumatic stress syndrome" for many women 3. The burdens of marriage and childrearing, which fall much more greatly on women 4. Poverty, in which women and children are vastly over-represented (Breggin, 1991, pp. 319-320).

In the United States depression in women is one of the most pressing health problems of the 1990s and is projected to continue into the 21st century. One fourth of all women have a depressive disorder during their lifetime.

There are currently 7 million U. S. women with a diagnosable depression, but many will not receive help for the following reasons: cost of treatment, lack of access to clinical services, stigma associated with receiving help, unavailability of social support, or immobilization caused by the depression, which reinforces helplessness. There are great numbers of women whose depressions go undiagnosed. Community surveys have provided evidence that untreated depression is prevalent among women of all ages. Depression in women is misdiagnosed 30% to 50% of the time (Christine Ann Heifner, 1996).

Depression is a mood disorder that can be seriously incapacitating. The experience is one of sadness and lethargy. Classic symptoms include weight loss or gain, insomnia or hypersomnia, low self-esteem, difficulty concentrating, and slowed physical movement or increased agitation. Clients may complain of aches and pains throughout the body. Lack of interest in activities that formerly gave them pleasure (anhedonia) is evident; in fact, a general “ I don’t care anymore” attitude may prevail. Women have told us that they feel worthless and guilty, and they often reproach themselves.

Thoughts of death or plans to attempt suicide may result from the pervasive hopelessness. Depression is not solely an either/or phenomenon but is rather a continuous variable consisting of a broad range of symptoms. Although many readers may be familiar with the descriptions of depressive disorders that follow, we include them for the benefit of students and others who do not regularly use Diagnostic and Statistical Manual of Mental Disorders (DSM III-R). The DSM III-R (American Psychiatric Association, 1994) categorizes depressive disorders as major depression and dysthymia; the two disorders

share similar symptoms, differing only in duration and severity. For a client to be diagnosed with major depression, at least five of the following symptoms must be present during the same 2-week period and represent a change from previous functioning; further, at least one of these symptoms must be depressed mood or anhedonia.

1. Depressed mood most of the day, nearly every day. In children and adolescents, can be irritable mood. 2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day; 3. Significant weight loss when not dieting or weight gain (e.

g. , a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. In children, consider failure to make expected weight gains. 4. Having trouble sleeping or sleeping too much; 5. Feelings of restlessness, or fatigue; 6. Feelings of worthlessness or excessive or inappropriate guilt; 7.

Diminished ability to think or concentrate, or indecisiveness; 8. Recurrent thoughts of death, recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide. http://www. bphope. com/symptoms. html Major depression can occur in mild, moderate, or severe forms, with and without psychotic features such as visions or hallucinations. Psychotic depression is less common.

Recurrences occur in a high percentage of cases. Dysthymia is a chronic, milder disturbance of mood (formerly called depressive neurosis); it is diagnosed when a client reports depressed mood for most of the day, more days than not, for at least 2 years. At least two of the following symptoms

must accompany the depression: (a) poor appetite or overeating, (b) insomnia or hypersomnia, (c) low energy or fatigue, (d) low self-esteem, (e) poor concentration or difficulty making decisions, and (f) feelings of hopelessness. Depression is a whole-body illness involving interacting biological, psychological, and socio-cultural factors. There has been a phenomenal increase in knowledge about the role of neurotransmitters over the past couple of decades, with the preponderance of research focusing on no-repinephrine and serotonin (although other neurotransmitters are also involved).

Alterations in neuroendocrine function have also been implicated in depression (i. e. , hypersecretion of cortisol). Space does not permit review of the literature on biological factors; our focus will be on the psychological and socio-cultural. Descriptions of depression have been around since antiquity.

In the 5th century B. C. , Hippocrates first classified depression as melancholia. There have been descriptions of depression in ancient Greek, Egyptian, and biblical texts, as well as in the distinguished literature of many countries. Although there have been numerous theories proposed over the years, we will summarize only a few that have either historical importance or current application. There is no one single theory that addresses all aspects of this complex phenomenon at this point in time.

Sigmund Freud wrote a book in 1917 titled Mourning and Melancholia. The central theme is one of loss, loss of either a significant person or of an attraction to a person. According to Freud, melancholia and grief symptoms

are similar. In both conditions the sorrowful person feels sad and lonely, has a lack of motivation, and is lethargic. The difference is that the “ mourner” has a reason to be so unhappy, having really lost someone, whereas the loss experienced by the melancholy person is likely to be in the mind. Freud believed melancholics were angry and punished themselves by repressing their anger. Many subsequent psychoanalytic theorists have defined depression as anger turned inward or against oneself, and this view has prevailed for many years. Anger was viewed as the internal force behind thoughts of self criticism, doubt, and feelings of worthlessness.

It was long thought beneficial for depressed persons to express their anger. However, expression of anger does not prevent individuals from becoming depressed, nor does it necessarily produce relief from depressive symptoms. Frameworks proposing loss of significant attachments and suppression of anger as the two factors most involved in depression prevailed during the 20th century, but other theoretical formulations were spawned. Behavioral example, Lewinsohn (1974) described it in terms of positive and negative reinforces (i. . , depression was the result of too few positive reinforces and the treatment for depression would be to increase the same). Martin Seligman’s (1975) theory of learned helplessness proposed that a person became depressed because of inability to control the outcomes in his or her environment.

These theories could not account for the fact that not everyone responds to situations in the same way. In other words, why do some and not others become depressed given the same set of circumstances? Perhaps cognitions and perceptions of events play a role. Aaron Beck’s (1976) cognitive theory

of depression evolved from his clinical practice. He noticed that depressed clients tended to exaggerate or over generalize their failures. They also personalized circumstances in inappropriate ways.

Beck concluded that depressed people look at themselves and their world negatively, and as a result ultimately internalize a dim view of the present and the future. Seligman has reconstructed his “ learned helplessness theory” with more emphasis on thinking. Seligman’s premise was that illogical attributions about events can influence a person’s “ helplessness deficits,” and can place him or her at risk for depression.

In a new theory Abramson has replaced the word helplessness with “ hopelessness,” a condition that results from not being able to control or to attain valued outcomes. Hopelessness combined with negative life events leads to depression. Another set of theories has to do with women’s status and their work and family roles.

Gilligan (1982) and Miller (1976) have argued that “ nurturing,” “ caring,” and an over abiding interest in interpersonal relationships place women at depression risk. Socialization of female children may be a crucial influence on future depression development. Women learn early that their needs are not important. They learn that they are destined to be care givers and may spend a lifetime sacrificing and giving of them, often without feeling appreciated.

Understandably this situation may lead to anger in women which may accumulate and fester; women may find themselves in a no-win situation.

Research on gender differences in depression has been meager. According to Nolen-Hoeksema, “ There is much we do not know.

… Often the crucial studies for testing these explanations have yet to be carried out, and the studies that exist have often been inconclusive.

In fact it is remarkable how little attention empiricists have given to such an important phenomenon” (1990, p. 2). Some research has been done on preschool children and adolescents, generally showing no gender differences in depressive symptoms before the adolescent years; when there are differences, the greater incidence is in boys, not girls (Nolen-Hoeksema, 1990). From about age 14 onward, more symptoms are reported by girls than boys (Albert & Beck, 1975) and from age 19 onward women twice as often as men report and demonstrate depressive symptoms. The highest rates of depressive symptoms occur between the ages of 18 and 24 (Nolen-Hoeksema, 1990). Kaschak identified women’s depression as linked to their ordinary, daily life issues: 1. The importance on relationship as significant success or failure as a woman 2.

Loss of possible choices, such as admittance to careers and mastery-related tasks 3. Equating self-esteem with appearance 4. Self-denial entrenched in self-esteem 5. Lack of access to emotional and financial resources 6. Invisibility of connection to children and grandchildren 7.

Waiting and feeling being valued more than acting 8. Having responsibility for what one cannot control (p. 173). In his book From Paralysis to Fatigue: A History of Psychosomatic Illness in the Modern Era, Shorter (1992) describes patriarchal societies’ and their physicians’ attempts to describe

psychosomatic illnesses in ways that hold their own views of reality. Women, responding to socio cultural-restrictive conditions and seeking help for distress, persist to be viewed as having traits less pleasing than those of men and, therefore, pathological and needing treatment to fit into the culture's or society's view of the definite norm (Breggin, 1991; Shorter). Depression has been depicted as a feminine experience (Chesler, 1972).

" What women do when they are depressed comprises the norm on which the criterion for depression are based" (Tavris, 1992, p. 259). Though depression has been depicted as being a feminine experience, the APA Diagnostic & Statistical Manual IV (4th ea. 1994) classifies the illness and its diagnostic criteria from a patriarchal view (Kirk & Kutchins, 1992). The biological diagnosing and treatment of depressed individuals, mostly females, is carried out in most part by male psychiatrists. Recovery from the depression can be an assumed goal of treatment, though it is both socially and culturally suitable for women to widen careers as psychiatric patients (Breggin, 1991; Chesler). Dunlap also supports the fact that women become depressed at twice the rate of men. Dunlap's central perspective is on the lack of power, both the realism of cultural powerlessness and the resulting psychological belief system.

After discussing the concept of power, she explores five themes intimately associated with women's depression. (1) The social position of women in our patriarchal culture puts in to the powerlessness so evident in depression. 2) Loss of self, the silencing of self, or what Dunlap calls the " eclipsed self," resultant from the multiple discounts that focus to women's socialization, also puts women at risk. (3) What happens to women in intimate

relationships is another sole factor that makes them more vulnerable to depression, not as women's pathological dependency, but because of the complexity of establishing meaningful connections in our culture, particularly with men. (4) The objectification of women's bodies is another contributor to loss of self, anger, and, of course, depression. (5) Women lean to fear the powerful emotion of anger. This fear and the lack of power to effect change consequences in frustration and the ineffective use of anger, which puts in to women's depression (1997 xi).

It is found that psychological aspects put in the basic reason of higher rate of depression in women that is the real realities linked with the power inconsistencies between men and women. This aspect is a matter of disparity in access to social goods, such as significant work, safety on the streets and in the home, supporting voice, and child-care assistance. Miriam Greenspan simply states that " oppression is depressing" (Greenspan, 1983, 193). Though this is not an often-heard phrase, it makes sense that social injustice would have deleterious psychological effects such as depression. Again, Greenspan claims: " As long as men as a group have power over women as a group, the authority to institutionalize the ways in which women are distinct, treated, and mistreated as persons, large numbers of women will be depressed". (Greenspan, 1983, 193-194) Biological events that occur in women's lives such as initiation of menses, pregnancy, childbirth, and menopause may have some role in the etiology of depression. Feminist writers have sought to minimize negative discussions of the impact of reproductive events on women's lives in light of all the cliches that smack of irrationality, helplessness, and lack of control.

However, these events are realities for women, and even when viewing them from a positive perspective, some events emerge as possible contributing factors for depression. Hormonal changes may make some contribution to depression in both adolescents and older women, and the events surrounding pregnancy and childbirth enhance depressive vulnerability, especially when social support is lacking. Although there are some studies showing correlations between hormone levels and moods, no causal effects have been demonstrated (Nolen-Hoeksema, 1990). One theory that has been offered in an effort to explain gender differences in depression is that women are more likely to seek psychological help than men that in fact men are as frequently as depressed but that women more often report their symptoms.

It is probably true that women seek help for their depression more frequently and that women are more likely to self-disclose or discuss their troubles. Also, men may handle their depression differently (e. g. , by abusing drugs and alcohol). However, these explanations are not sufficient.

In an effort to outline the factors that contribute to depression in women, we were struck by how vulnerable women seem to be. There are many women who are at risk, the most obvious being the poor, the undereducated, and those who have been psychologically, physically, and sexually abused. Life stress was a central determinant of depression in a study of London working class women by Brown and Harris (1978). Caring for young children (Radloff, 1975) or adolescents (McBride, 1987), caring for aging parents (Jarvik & Small, 1988), and being in an unhappy marriage (Weissman, 1987) increase depression risk. In unhappy marriages, women are 3 times as likely as men to be depressed (Weissman, 1987).

Ross and Mirowsky (1988) found that unemployed mothers of children were more depressed than employed mothers. But if employed mothers had sole responsibility for arranging child care, they also had extremely high depression levels. It makes sense that as the demands on their care giving increased, the mothers had even less time to meet their own needs. Such women may become angry about virtually losing themselves in caring for others. Because anger is not a socially sanctioned emotion for women, they may become depressed or physically ill. This is sometimes a signal to their significant others that something is not right, therefore saying " I need help.

" Even " baby boomers" (Seligman, 1988) and high-achieving women (Braiker, 1987) may be at risk. Vicarious stress that is taking on the stressors of close affiliates is also a likely contribution. Arieti and Bemporad (1978) pointed out the heavy emphasis in psychiatric literature on " pathologic dependency" in depressives. Based on the male oriented cultural valuing of autonomy and self-sufficiency, women have been construed as overly dependent on others (thus more likely to become depressed because of relationship failures). In a recent book Jack (1991) argues that the concept of " dependency" requires reexamination; women in her study described their need for intimate closeness, a need that, when unmet, led to depression.

According to Jack, this need for intimacy and connection is not dependency and is not pathological. Although Jack's argument is persuasive, the research presented in her book has received some criticism because of the small sample of depressed women (12 white women from rural communities) and the severe abuse many had received, limiting generalizability of the findings.

Arthur Schopenhauer (1883) wrote a treatise “ On Women” in which he depicted women as being sex objects, devious, vain, and generally having arrested development. This misogynistic vision of women unfortunately has been perpetuated by other influential writers during the past 100 years, and we contend that such disparaging views have been internalized by women, greatly affecting their self-esteem. Almost sixty years later Clara Thompson (1942) wrote, “ The official attitude of the culture toward women has been and still is to the effect that woman is not equal to man .

.. the assumption of woman’s inferiority was a part of the prevalent attitude of society and until recently was accepted by both sexes as a biological fact” (1942, pp.

31 -335). Annie Dillard, in describing her growing-up in a privileged American family in the 1950s, wrote about how little she and her friends thought about their own futures or their development separate from men. Ah, the boys …

How little I understood them! How little I even glimpsed who they were … all along the boys had been in the process of becoming responsible members of an actual and moral world, we, small minded, and fast talking girls had never heard of.

They had been learning self-control. We had failed to develop any selves worth controlling. We were enforcers of a code we never questioned; we were vigilantes of the trivial. The boys must have shared our view that we were, as girls, in the long run, negligible (1987, p. 90).

Social discrimination of women has occurred at all levels of society and has been a generally accepted condition. It is easy to see why women might become frustrated, feel impotent and psychologically distressed; and, indeed, experience depression as a result. We did not ask questions in our study related to victimization experiences such as sexual assault, battering, or sexual harassment on the job, but such experiences are quite common.

Approximately one of every four girls is molested sexually during childhood or adolescence. Acquaintance rape is in the news and seems to be much more prevalent than formerly thought. Kaschak (1992) surveyed working women and found that as many as 71% may experience sexual harassment. These figures make sense in the context of women coming forth with their stories following the “ Hill-Thomas” hearings in which Anita Hill, a former aide to Clarence Thomas, a Supreme Court nominee, claimed sexual harassment. Obviously women experiencing victimization of any kind should be considered at high risk for a depressive disorder.

Other populations reported to be at increased risk include ethnic minority women, lesbians, women living in poverty, adolescents, older women, professional women, substance abusers, and women with eating disorders; the reader is referred to the report of the APA’s National Task Force on Women and Depression for further discussion about the risk factors in each of these groups (McGrath et al. , 1990). Clearly, more research is needed for understanding women’s greater propensity for depression. The APA task force has outlined specific detailed recommendations (McGrath et al. , 1990, pp. 36-39), as primary foci for future research endeavors.

Several theorists have hypothesized that anger plays a significant role in depression. Abraham’s (1927) postulation that manic depressive patients have repressed violence and Freud’s depiction of depression as anger turned inward provided the beginning of this causal linking. Supporting these theories, some studies have found greater inwardly expressed hostility among depressed individuals. Biaggio and Godwin (1987) conducted discriminant analyses to see which of nine indices of anger and hostility best discriminated between college students in the upper and lower third of scores on a depression scale; intropunitiveness scores were the strongest discriminator (i.

e. , inwardly directed hostility). Depressives reported less verbal hostility but significantly more resentment than nondepressed controls in a 1970 study by Friedman. Weissman (1987), in a study of 80 women (40 depressed and 40 control), found that depressed women expressed more anger in interpersonal relationships than did the control subjects. In a study of women hospitalized for depression, Gershon, Cromer, and Klerman (1968) reported that women who ventilated their anger were more depressed than those women who did not ventilate their anger.

In a study comparing depressed patients with posttraumatic stress disorder (PTSD) patients and normals, Riley, Treiber, and Woods (1989) found within the depressed group a positive relationship between severity of depression and levels of anger and hostility, but severity of depression was not related to measures of anger expression. Both clinical groups showed higher levels of general anger than the normal group. Vigorously disagreeing with the

notion that depression is anger turned inward, Tavris (1989) proposed that “ If anything, anger is depression turned outward.

Follow the trail of anger inward, and there you find the small, still voice of pain” (p. 14). Menopause is a time in women’s lives when their estrogen and progesterone cycles start to fluctuate randomly until ovarian production of those hormones mainly ceases. Physicians and women have leaned to relate depressive disorders that occur throughout menopause to hormonal irregularities or deficiencies (Beeber, L. 996). An involvement between the decreasing ovarian hormone production and start of depression has not yet been systematically confirmed. Though estrogen supplementation throughout and after menopause may help prevent mild forms of depression, estrogen alone is not an efficient treatment for moderate-to-severe depression.

Paradoxically, the progesterone often set along with estrogen to menopausal women in an effort to “ normalize” their hormonal status might be associated with worsening of mood. Clinicians who study people and their relationships note that women lean to place greater value on personal relationships than do men. It is considered that the greater need for emotional connectedness demonstrated by women might place them in a more vulnerable position with regard to mood stability, as the success of relationships cannot be determined by one person alone (Lego, S. 1996). Since the time of Freud, the power status of women comparative to men has been discussed as a contributor to emotional symptoms in women. Many women do experience feelings of low self-esteem and self-worth resultant partly from cultural factors. As a rule, girls are less probable to receive

encouragement to be active in team sports where productive competitiveness and self-sufficiency are learned. Women whose cultures lean to value “ masculine” traits over “ feminine” traits and to limit educational and employment opportunities for women outside the home are thought by several experts to be at greater risk for undiagnosed and therefore untreated depression.

Other experts differ, charging that this conclusion is a mistaken product of Western values and biased against those cultures that “ shelter” their women. There is proof that in Western culture marriage seems to offer a protective effect for men but is a stressor for women. Differing to popular opinion, studies tend to show that married women experience more depression than do single women. The National Mental Health Association reports that depression is more common among women who stay home full-time with their small children than among women in the general population. Though depressed women benefit from antidepressant medications, they lean to receive fairly less benefit than do men and to experience greater levels of side effects. That can be due to physical differences in the way men’s and women’s bodies handle medications.

Hormone shifts are an obvious example. Another considerable difference is women’s relatively greater fat deposits, which take up and store antidepressants, making less medication originally available in the bloodstream for delivery to the brain. Gastrointestinal differences between men and women also influence the way in which the stomach and intestines absorb medications.