

Depression in Women: Psychological Disorder or Social Problem?

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ABSTRACT

Rates of depression consistently are found to be higher in women than men. Feminist analyses emphasize the disadvantaged position of women in society in accounting for the higher rates of depression among women. Mainstream theories of depression emphasize intra-individual factors. An evaluation of research on depression supports the conclusion that findings are more consistent with feminist than with mainstream formulations. A feminist perspective on depression, however, is unlikely to have much impact on mental health practice and policy, because of the dominant position of the psychiatric profession in legitimating clinical definitions of depression.

RÉSUMÉ

Les taux de dépression et cela d'une manière consistante sont plus élevé chez la femme que chez l'homme. Les analyses des féministes accentuent la position désavantageuse des femmes dans la société en tenant compte des hauts taux de dépression parmi les femmes. Les théories en vigueur sur la dépression accentuent les facteurs biologique et intra-individuel. Une évaluation de recherche faite sur la dépression appui la conclusion que les constatations sont plus consistantes avec les féministes qu'avec les élaborations en vigueur. Toutefois, il est peu probable que la perspective féministe ait un impact significatif sur l'habitude et la ligne de conduite de la santé mentale et cela du à la position dominante de la profession psychiatrique qui tarde à définir légitimement ce qu'est une dépression en terme médical.

Depression is one of the more frequent forms of psychological disorder in people receiving treatment for mental health problems, as well as within the general population (Guttentag, Salasin, & Belle, 1980). One finding from epidemiological research that has attracted attention in recent years is that rates of depression in women exceed those in men by a large margin. The sex ratio for depression is generally placed at around 2:1 or higher (Weissman, Leaf, Holzer, Myers, & Tischler, 1984). Furthermore, among women depression occurs at a higher rate than other disorders, whereas in men depression occurs at a rate similar to that of some other disorders (Guttentag et al., 1980).

Women diagnosed as depressed account for a sizeable proportion of those receiving treatment in psychiatric and mental health facilities. For instance, the 1980-81 statistics for patients discharged from psychiatric units in New Brunswick general hospitals (G. Cormier, Planning and Evaluation Division, N.B. Department of Health, personal communication, February 28, 1985) revealed that almost 50 percent of all women patients received a diagnosis of depression, whereas only 23 percent of men were so diagnosed. Moreover, the N.B. statistics indicated that women with a diagnosis of depression represented 30 per-

cent of *all* patients treated in general hospital psychiatric units in 1980-81. These figures imply that the treatment of depressed women accounts for a substantial portion of clinical services provided by staff in New Brunswick psychiatric facilities.

The sex difference in rates of depression and attempts to offer explanations for this finding are the focus of a growing body of research. I have become interested in exploring this area for several reasons. First, previously accepted findings of higher rates of depression in women are now being disputed, and the existence of a sex difference in depression is the subject of debate in the psychiatric and psychological literature (Angst & Dobler-Mikola, 1984; Hammen, 1982; Newmann, 1984; Parker, 1979). Second, an intriguing feature of this debate is that mainstream researchers generally take the position of arguing against the presence of a sex difference in depression, whereas those who hold a feminist analysis of mental illness accept the sex difference findings. In other areas where sex difference findings have been debated, mainstream researchers have usually accepted evidence of differences between the sexes, whereas feminist researchers have taken the position of critics, pointing to androcentric biases in research (Kimball, 1986). Third, and perhaps of most importance,

the status of findings regarding the existence of a sex difference in rates of depression has implications for mental health policy.

Feminist and mainstream perspectives lead to different strategies for alleviating depression in women. Within psychiatry and psychology, current theories of depression emphasize the causal role of biological and/or psychological factors (Willner, 1985). Emphasis on biological processes is consistent with use of electro-convulsive therapy (ECT) and antidepressant drugs as treatments of choice for depression (Smith & Richman, 1984; Whybrow, Akiskal, & McKinney, 1984). Similarly, in psychotherapy, the goal is usually the modification of psychological deficits presumed to underlie depression (Beck, Rush, Shaw, & Emery, 1979).

In contrast to these mainstream views, feminist writers conceptualize depression in women as a psychological consequence of their disadvantaged social status. In broad terms, feminist analyses point to a link between socially oppressive conditions experienced by women and their high rates of psychological depression (Belle, 1982; Bernard, 1976; Chesler, 1972). Feminist analyses imply that increased public support for social programs, aimed at improving conditions for women, would be an important part of any strategy for decreasing rates of depression in women.

Clearly, research bearing on the issue of sex differences in depression has important implications for mental health policy and for decisions about how public resources are allocated. One approach to explaining sex differences in rates of depression has been in terms of biological factors, such as genetic and hormonal influences. In her recent review of research in this area, however, Nolen-Hoeksema (1987) concluded that biological explanations for depression in women lack consistent empirical support and that the observed sex differences in depression cannot be adequately explained in biological terms. Finding that women have higher rates of depression than men, therefore, implies that social conditions play some role in depression in women and that intervention strategies need to incorporate social factors in addition to (or instead of) the traditional focus on bio-psychological processes. Lack of clear evidence that rates of depression are higher in women than in men, while not necessarily inconsistent with social formulations, fits more closely with psychiatric conceptions that emphasize the role of intra-individual factors.

In the remainder of this paper, first I will provide a brief overview of findings on rates of depression in women and men, and then examine research relevant to explanations for higher rates of depression in women. Next, I will discuss why mainstream researchers are reluctant to accept as valid the findings of sex differences in rates of depression. I will conclude that available evidence is entirely consistent with feminist formulations of depression as a social problem, but that the powerful role played by the mental health professions, particularly that of psychiatry, in legitimizing definitions of depression, serves as a major obstacle to changes in mental health policy that would be beneficial to the well-being of women.

Evaluation of Evidence for Sex Differences in Depression

To understand research on depression, it is necessary to know something about the way depression is defined and assessed. Depression is generally defined as a disorder of mood or, more technically, an "affective disorder" (American Psychiatric Association, 1980). A central feature of depression is that the person's mood is characterized by feelings of sadness and hopelessness about their past accomplishments, present circumstances, and future possibilities (Beck et al., 1979). For depressed mood to be considered indicative of depression, however, it has to be more persistent (usually lasting two weeks or more) than the fairly fleeting "low" moods experienced by most people from time to time (American Psychiatric Association, 1980). In depression, low mood is usually accompanied by other "symptoms" such as feelings of guilt, sleep disturbance, appetite loss, impaired concentration, fatigue, suicidal ideas, and so on (American Psychiatric Association, 1980).

Clinically, the presence of depression is assessed from interviews and behavioural observations. A psychiatric diagnosis of depression is based on the pattern of symptoms shown by the person. If the depression is judged severe enough to warrant a formal diagnosis, treatment generally would be recommended. Several self-report questionnaires have also been developed to assess depression. While such questionnaires are useful for assessing severity of depressed mood and presence of depressive symptoms, in clinical practice and research, a diagnosis of depression would not be made solely on the basis of questionnaire responses.

An issue that is central to interpretation of findings of sex differences in rates of depression concerns the validity of diagnostic procedures used to assess depression. In a widely-cited paper published in 1977, epidemiologists

Myrna Weissman and Gerald Klerman reviewed available research on prevalence of depression in men and women and concluded that a "true" sex difference existed in rates of depression, rates in women being higher than rates in men. However, the conclusion reached by Weissman and Klerman has been challenged on the grounds that many studies included in their review involved use of diagnostic procedures with dubious validity (Hammen, 1982; Parker, 1979).

Fortunately, more recent epidemiological studies have involved use of diagnostic criteria for depression that are officially sanctioned by the psychiatric profession. The findings of these studies, summarized in Table 1, indicate that, in general population samples, women have significantly higher rates of diagnosed depression than men. Findings of studies in which depression was assessed by self-report questionnaire measures, also summarized in Table 1, show a consistent pattern of sex differences, with women reporting higher levels of depression than men.

Table 1
Sex Difference Findings in
Recent Epidemiological Studies

Study	Place	Measure	Rates/Scores	
			Females	Males
<i>Diagnostic Criteria</i>				
Bebbington et al. (1981)	U.K.	ICD-9/PSE (1 mo. prevalence)	9.0%	4.8%
Henderson et al. (1979)	AUST	ICD-9/PSE (point prevalence)	6.7%	2.6%
Myers et al. (1984)	U.S.	DSM-III/DIS (6 mo. prevalence)	3.0-4.6%	1.3-2.2%
<i>Self-Report Measures</i>				
Byrne (1981)	AUST	Zung-SDS	>32 M=23.5	18.6% M=19.6
Frerichs et al. (1981)	U.S.	CES-D	>16 M=10.4	23.5% M= 7.6
Radloff (1975)	U.S.	CES-D	M=9.5	M=6.8

Note: ICD-9 = *The International Classification of Diseases* (9th ed.; World Health Organization, 1980). PSE = Present State Examination (Wing, 1980). DSM-III = *Diagnostic and Statistical Manual of Mental Disorders* (3rd ed.; American Psychiatric Association, 1980). DIS = Diagnostic Interview Schedule (Robbins, Helzer, Croughan, & Ratcliffe, 1981). Zung-SDS = Zung Self-Report Depression Scale. CES-D = Center for Epidemiological Studies Depression Scale.

Findings with self-report measures are viewed as less compelling than those in which depression was assessed in terms of diagnostic criteria; nevertheless, they do provide information about the extent to which depressive symptoms are present in different groups.

Although self-report symptom measures are widely used in psychiatric and psychological research, psychiatric epidemiologists have taken the position that findings with such measures cannot be interpreted as indicative of rates of clinical disorders in the general population (Link & Dohrenwend, 1980). Instead, they argue that self-report measures are best viewed as assessing a non-clinical condition, one which they term "demoralization." As a consequence of this view, findings of sex differences in self-reported depressive symptoms have been dismissed as largely irrelevant to the issue of whether there is a sex difference in depression (Hammen, 1982).

Findings of studies using diagnostic criteria to assess depression, because they are based on procedures considered valid by mainstream psychiatry, would appear to be less easily dismissed. There are signs, however, that such a dismissal of sex difference findings is beginning to occur. In a recently published report of rates of diagnosed depression in young adults in Zurich, Switzerland, rates of depression were found to be higher in women (Angst & Dobler-Mikola, 1984). The investigators also found that women reported more depressive symptoms than men at similar levels of self-reported occupational impairment. Based on this observation, they proposed that diagnostic criteria be modified to require fewer symptoms in men in order to make a diagnosis of depression. When these modified criteria were applied to the original data, the sex difference in rates of depression was considerably reduced.

Essentially, the diagnostic strategy advocated by Angst and Dobler-Mikola (1984) seems to reflect the assumption that women do not have higher rates of depression than men—women just report more depressive symptoms. More generally, this latter study shows that even the procedure considered most valid for assessing depression is not immune from attempts to discount sex difference findings. In a later section, I will explore the reasons for mainstream researchers' reluctance to accept as valid findings that show a sex difference in rates of depression.

Explanations for Sex Differences in Depression

Space does not permit a review of all the explanations offered to account for sex differences in depression. Two of the more frequently proposed explanations will be dis-

cussed in order to illustrate how findings have been interpreted. Research relevant to response bias and social explanations for higher rates of depression in women will be described briefly.

Response Bias Explanations

The suggestion that rates of depression in women are inflated because they tend to report more depressive symptoms than men, is an instance of response bias explanations for sex differences in depression. According to response bias explanations, a true sex difference in depression does not exist. Rather, it is assumed that higher rates of depression in women reflect the influence of various response bias processes that result in underestimation of rates in men and/or overestimation of rates in women.

Warren (1983) has suggested that men avoid expression of depression because such feelings would conflict with their self-image of "masculinity." In a similar vein, Hammen and Peters (1977, 1978) have hypothesized that men are motivated to avoid expression of depression because they are more likely than women to meet with social rejection if they appear to be depressed. Support for Hammen and Peters' hypothesis is quite mixed and, to date, there have been no studies based on real-life interactions. Typically, studies have examined the responses of college students using analog procedures (written descriptions of depressed individuals) or contrived interactions between strangers (Doeffler & Chaplin, 1985).

The hypothesis that sex differences in depression arise because of women's greater willingness to disclose depressive feelings to others, presumably derives from stereotypical beliefs that women are more emotionally expressive than men. However, gender role prescriptions also include the expectation that women are warm, friendly, and supportive in interactions with others, behaviors that are hardly consistent with depression. An equally plausible possibility is that expression of depressive feelings is proscribed for women as well as for men. A desire to avoid negative social sanctions may motivate women as well as men to hide feelings of depression from others. Moreover, the argument could be made that women may have to be *more* depressed than men before they will disclose their feelings. Because expression of depressive feelings conflicts with the expectation that women are available to nurture others, one consequence of such disclosure is that women are especially likely to be rejected by others. Thus, to avoid such rejection women may have to be even more depressed than men before admitting it to others.

Women's greater willingness to report depressive feelings also has been used to account for the finding that there are more women than men with diagnoses of depression among treatment populations (Hammen, 1982). The findings of several recent studies, however, tend to argue against such an interpretation of treatment statistics. For instance, in a sample of people seen at a hospital emergency department, Rosenfield (1982) found that men diagnosed as depressed were more likely than similarly diagnosed women to be recommended for hospital admission. Page (1985) analyzed information contained in civil commitment certificates from two Ontario hospitals and found that symptomatology reported for men included more stereotypically "feminine" symptoms, such as depression, whereas symptomatology attributed to women was more stereotypically "masculine" in content (e.g., assaultive behaviour). Based on U.S. data, Fox (1984) reported that men were more likely than women to have sought outpatient treatment if they had experienced depression. Taken together, these findings suggest that rates of depression derived from official statistics may actually underestimate the extent of sex differences in rates of depression.

Higher rates of depression in women also have been explained as an artifact due to the occurrence of "masked" depression in men. According to this view, in some proportion of men, an underlying depression goes unrecognized because it is masked by other symptoms such as alcoholism. If rates of depression are underestimated in men due to masked depression, then elevated rates of drinking problems and other symptoms of masked depression might be expected in married men, a group that consistently appears to be the least depressed. However, higher rates of problems thought to mask depression have not been found in married men (Klerman & Weissman, 1980; Radloff, 1975). Instead, symptoms considered signs of masked depression occur at increased rates in men having social characteristics, such as being single or divorced, already identified as predictive of higher levels of depression. Moreover, findings of a recent study on intergenerational patterns of alcoholism and depression were inconsistent with the idea that the two disorders are different forms of the same underlying disorder (Merikangas, Leckman, Prusoff, Pauls, & Weissman, 1985).

In conclusion, although response bias explanations for higher rates of depression in women continue to be put forward by mainstream investigators, a review of available research reveals that support for response bias factors is lacking and in some cases findings are contrary to predictions. The possibility that reported rates of depression in women underestimate true rates has not been explored.

Instead, most research has been directed towards attempts to discount findings of higher depression rates in women.

Social Explanations

Findings of higher rates of depression in women have been criticized on the grounds that investigators have failed to control for background social factors that are correlated with both sex and depression. For instance, in her review of research on sex and depression, Hammen (1982) writes:

Whether women show an excess of depression compared with men in similar role situations or whether the sexes are similar under similar circumstances remains unclear at this time (p. 146).

Hammen seems to be suggesting that if men and women are found to be equally depressed under identical social conditions, then additional explanations for sex differences in depression are unnecessary. It is implied that sex differences in rates of depression are methodological artifacts arising from the failure of investigators to control for "extraneous" social variables.

The position taken by Hammen and others, however, sidesteps the issue of systemic discrimination against women and ignores the extensive documentation of women's disadvantaged status on socioeconomic indicators. Feminist analyses (e.g., Belle, 1982) identify inequalities in the status of women as a crucial starting point in accounting for higher rates of depression in women. Thus, the finding that sex differences in depression are eliminated or reduced in size when background social factors are taken into account would be consistent with feminist explanations for higher rates of depression in women.

Evidence from a number of studies involving general population samples indicates that when background social factors are statistically controlled, an existing sex difference in depression is either reduced or eliminated entirely. For instance, Gore and Mangione (1983) found that, after controlling for marital and employment status factors, a sex difference in depression was no longer present. Other investigators have reported that when statistical controls for various socioeconomic and demographic variables were employed, an observed sex difference in depression was reduced (Amenson & Lewinsohn, 1981; Radloff & Rae, 1979) or eliminated (Aneshensel, Frerichs, & Clark, 1981).

Finding that the sexes are comparable in rates of depression when men and women are specifically selected to be similar on background social factors also would be consistent with feminist analyses. Studies of this kind have been cited by mainstream investigators as evidence against the presence of a sex difference in depression. For instance, several studies involving college student samples have failed to find a sex difference in depression (Hammen & Padesky, 1977; Padesky & Hammen, 1981; Parker, 1979). Another recent study found no sex difference in depressive symptoms among young adults selected from those employed in the same job category in the British civil service (Jenkins, 1985). Rather than arguing against a sex difference in depression, studies such as these indicate that in homogeneous samples of young, unmarried adults, levels of depression in women and men tend to be comparable.

Further support for the role of social factors in depression is provided by the results of a recent study by Repetti and Crosby (1984) which involved women and men whose occupations were either high or low in prestige (professional vs. sales/service). Within levels of occupational prestige, there was no sex difference in depression; however, men and women in high prestige occupations were less depressed than those in low prestige occupations. The findings by Repetti and Crosby (1984) are particularly significant because women are more likely than men to be in low prestige (and low paying) jobs.

In conclusion, the findings reviewed above are quite consistent with feminist formulations that link higher rates of depression in women to their disadvantaged social status. Other approaches to explaining sex differences in depression, that focus on biological factors or socialization processes related to gender, cannot satisfactorily account for such findings.

Mainstream Resistance to Sex Difference Findings

Despite the growing body of evidence consistent with social explanations for sex differences in depression, such findings have had little impact on mainstream views about links between sex and depression or on prevailing modes of treatment. Instead, as I have tried to show, evidence of higher rates of depression in women has been discounted on various grounds. Sex difference findings have been downplayed by proposing that criteria for diagnosis of depression in men and women be defined differently (Angst & Dobler-Mikola, 1984). Another recent suggestion is that depression associated with adverse social conditions should not be considered as "true" depression (Bebbington, Sturt, Tennant, & Hurry, 1984). Given these

indicators of trends in the field of depression research, it seems that further research within current paradigms offers little promise of increasing understanding of depression in either sex.

However, it is important to analyze reasons underlying mainstream resistance to findings that link the disadvantaged social status of women to their vulnerability to depression. Identification of sources of this resistance is necessary if effective strategies are to be devised for advocating the development of mental health policy that better serves the needs of women. Sources of mainstream resistance can be located in both the theoretical and applied domains.

At the theoretical level, findings of sex differences in depression represent a threat to the integrity of the medical model of mental illness, because such findings cannot easily be accommodated without acknowledging the role of social factors in psychiatric disorders. Since the medical model informs much of psychiatric practice, theoretical challenges also undermine the dominant position of psychiatry in the mental health field. Thus, part of the resistance to findings of sex differences in depression may lie in the threat posed to the theoretical hegemony of the medical model of mental illness.

Historically, an important function within psychiatry has been the definition of mental illness for diagnostic purposes. The diagnostic role also provides an important means of defending the medical model against contradictory evidence. Through the promulgation of diagnostic manuals (such as DSM-III), psychiatry plays an important gate-keeping role in legitimizing definitions of depression and other clinical disorders for research purposes. Non-psychiatric researchers are required to conform to psychiatric definitions of depression in order to gain credibility for their research. Findings which conflict with prevailing views, such as sex differences found on self-report measures of depression, can be dismissed as irrelevant to psychiatric definitions of depression.

In recent years, within psychiatry there has been a reassertion of the primacy of biological modes of treatment for mental illness (Maxmen, 1986). This retrenchment appears to have occurred at a time when claims to therapeutic expertise by other mental health professions (psychology, social work, nursing, etc.) have increased in scope. One strategy available to psychiatry for retaining its dominant role is through use of biologically-oriented treatments, such as drugs and ECT, which require medical training. Anti-depressant medication or ECT gener-

ally is considered the treatment of choice in many cases of depression, a view that also coincides with medical model formulations of depression. Given that treatment of depression represents a significant part of psychiatric practice, the lack of credence given to evidence which is contrary to prevailing views of depression is hardly surprising. Reluctance to accept alternative formulations of depression, therefore, may stem from fears within psychiatry that other mental health professionals may gain a greater role in the treatment of depression.

My analysis leads me to the conclusion that a feminist position on depression will be strongly rejected within the mental health establishment, given the extent of investment in psychiatric formulations of depression. Nevertheless, many of the findings on depression that emerge from a feminist analysis provide a basis for much needed changes in the direction of mental health policy and research, which would, I believe, contribute to the well-being of women.

The finding that depression occurs in women at a high rate compared to other forms of disorder provides justification for calls for increased funding for research on this problem. In Canada, research on women's mental health problems is underfunded compared to research on mental health problems among men (Stark-Adamec, 1981). Lack of attention to women's mental health problems also is reflected in the perception among clinicians that women's mental health problems are less serious than problems experienced by men (Page, 1987). The sex bias in allocation of research resources and lack of attention to women's mental health problems can be identified as appropriate targets for feminist efforts.

More broadly, the conclusion that research has yielded findings which support social explanations for higher rates of depression in women is also consistent with efforts to achieve greater equality for women in areas such as education, childcare, and employment. Overall, current findings imply that policy and research need to be more consistent with the position that depression in women is a social problem rather than a psychological disorder.

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