Gender and Depression

By Marwan M. Kazimi

One of the most reliable and oft-cited findings in the epidemiology of depression is that adult women are about twice as likely to be depressed as adult men (Nolen-Hoeksema, 1987). The term depression itself has been defined differently throughout the history of the study of this illness; since feelings of sadness and disappointment are part of the human condition experienced by everyone at some point of their lives, whether or not they are depressed, "depression" must be defined. The boundary between normal mood and abnormal symptoms remains undefined, however. Usually, symptoms which are intensive, pervasive, and persistent, and which interfere which normal functioning, are considered pathological. In the interests of examining the effect of sex and gender differences, the term depression will be defined according to the symptoms delineated by psychiatric professional associations.

As recognized in the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R, American Psychiatric Association, 1987), symptoms of depression in adults are: depressed mood, lessened interest in one's usual activities, significant weight change, sleep problems, psychomotor agitation or retardation, fatigue and loss of energy, feelings of worthlessness, indecisiveness, problems in concentrating, and suicidal thoughts and attempts. Any concentrated combination of these symptoms in an individual may provoke a diagnosis of depression. Furthermore, while depression is classified into several broad categories, this paper attempts to deal strictly with nonbipolar depression, most obviously because the disparity in rates of affliction according to gender applies only to this type of depression. For bipolar disorder, characterized by symptoms of depression along with manic episodes, the rates of affliction are nearly equal for both genders (Pariser, 1989). Since bipolar disorder has been found to correlate to biological and genetic function much more so than other depressive mood disorders, this is an early indication that the causes of depression will be found among more social and personal characteristics, and that any gender related differences will often follow from gender differences constructed by culture and, even more so, society.

Approaches to the study of depression have evolved over time, and thus so have hypotheses as to why the overall prevalence of depression is significantly higher for women (6.0%) than for men (2.6%). While such hypotheses include genetic, psychosocial, and neuroendocrine functions related to the most obvious difference between men and women, the reproductive cycle, recent studies have shed much doubt on the existence of clearly defined biological and neurological difference as direct causes of depression. For instance, while some believe that menopause is associated with higher rates of depression, literature on the topic does not support the assumption (Schmidt and Rubinow, 1991). While this does not exclude the possibility that more subtle forms of such"physical" differences between males and females and differing societal views of men and women as possible factors contributing to gender variance in depression. More specifically, research has examined the period of adolescence as providing possible explanations, arguing that it is during adolescence that clear gender differences that might contribute to the varying rates of depression arise. Even more recently, however, this notion has been challenged on the basis that differential treatment according to gender begins well before adolescence.

While it seems logical that during adolescence, and even before, personal and societal pressures act to produce differential reactions to male and female maturation, and that gender stereotypes contribute to such reactions in such a way that may lead to risk factors for depression during adolescence, and later on in adulthood, most literature on the topic fails to consider the potentially important differences between constructions of sex difference and"real" or natural differences, and how they might contribute to depressive behavior. Hence, following a description of recent thinking on the topic of formative development of depressive factors and traits, the role of culture and society will be considered, despite the fact that there still exists no consensus as to the causes of gender as it relates to depression.

Three models exist for the basis of the emergence of gender differences in depression in early adolescence (Nolen-Hoeksema and Girgus, 1994). The first proposes that the same factors cause depression in boys and

girls and that these factors become more prevalent in girls than in boys in early adolescence, leading to the emergence of gender differences in depression. The second model holds that the factors leading to depression are different for girls and boys and that the factors leading to depression in girls become more prevalent in early adolescence than those factors leading to depression in boys. In the third model, certain gender differences in personality or behavioral style present before adolescence for females to make adolescent girls and adult women more prone to depression than males. Thus, models one and three both hold that the factors that cause depression are the same in girls and boys; in model three, though, the risk factors for depression are inherently more common in females than in males in childhood, but later, during adolescence, are coupled with new challenges that all children face to create the gender difference in depression. While model three does not require that new challenges of early adolescence be greater for girls than boys to explain gender differences in depression, many of the new biological and social challenges that girls face during that growth period are, in fact, greater than for boys.

Of the above models, model one has failed to win support, due to research showing that gender differences in characteristics such as assertiveness, coping, and interaction styles, whether through"nature or nurture," are established in childhood, and thus do not emerge in adolescence (Nolen-Hoeksema and Girgus, 1987). The second model is supported by little evidence, although for a different reason--it is difficult to test, as testing would require a clear understanding of mental and psychological differences between females and males, e.g. how stress affects them differently, and no such understanding has yet been achieved. Thus, the third model is most often accepted as closest to reality. This hypothesis of pre-determined gender-related differences in risk factors for depression interacting with the greater number of social and biological challenges for females proves logical upon examination through three different lenses--biological, personal, and societal.

Although clear gender-differentiated biological changes do occur in early adolescence, there is little evidence that these biological changes contribute directly to the emergence of the gender difference in depression. The most popular biological theory of females' greater vulnerability to depression is that disregulation of the hormones produced by the ovaries (e.g. estrogen and progesterone) causes depression in females (Nolen-Hoeksema, 1990). This thinking originally emerged through observations that at least some women tended to become depressed during periods of rapid shifts in the levels of these hormones, such as during the premenstrual period. However, most studies of the link between hormones and depressed mood in women have been found to be seriously flawed in methodology, while and equal number found no relationship between women's hormones and moods (Sanfilipo, 1994). On the other hand, society's reaction to the gender-differentiated biological changes of adolescence may play a role in the differing rates of depression for males and females. These society-driven reactions relate to differences in biological changes, social conditions, and societal expectations.

While the significance of the biological changes brought about through hormonal level variation during the adolescence have not been shown to correlate with gender-related differences in depression, the development of secondary sex characteristics may have a greater influence on the emotional development of girls and boys than hormonal development (Brooks-Gunn, 1988). Girls value the physical changes that accompany puberty much less than boys do. Whiles girls undergo bodily changes of increased fat content, an undesirable trait in today's muscle-tone-conscious West, and outward feminization that may be subject to ridicule, boys develop more muscle and other body traits that are considered"desirable." Furthermore, menstruation can produce feelings of uneasiness in adolescent girls, who, as it is, go through more chronic dieting and hold more negative images of their own bodies than do boys. When the relationship between body image and depressive symptoms is controlled for, however, the significance of gender remains (Girgus et al., 1989), indicating that there are further causes of the gender differences in depression.

Personality attributes of girls and boys have been linked to the gender differences in depression, especially with respect to the different responses to stress, or differing"coping styles." Studies have shown that females are more likely to ruminate over their distress and males more likely to distract themselves (Ruble et al., 1993). This difference is important, because the former style may amplify and prolong depressive symptoms, thus leaving females more vulnerable to a depressive state. Furthermore, stereotypes that have been constructed over time and applied to females, such as passivity, helplessness, and dependence, are

attributes consistence with a depressive image. Thus, construction of gender differences coincides, at least at some point, with the development of ideas concerning depression, and thus leads to speculation that societal factors play perhaps the most important roles in the differentiation of depression according to gender.

Obvious social challenges more often confront females than males in adolescence. Females are two to three times more likely to be victims of sexual abuse (Trickett and Putnam, 1993), and being a victim of such abuse can lead to a sense of helplessness, chronic fear, and social stigma, clear stressors for depressive behavior. Also, parental and even peer expectations and attitudes contribute to confusion of female adolescents and children. For instance, the cultural stereotype that girls are less adept at mathematical and technical activities, and even, in many cases, that girls are less intelligent than boys, may cause examination by intelligent girls of their position and achievement and thus may lead to depressive conditions. In a study of females, a significant correlation was found between intelligence and depressive systems, although it is not known to what extent this is caused by rejection by peers (Block, Gjerde, and Block, 1991).

Thus, it seems important to examine the factors that might lead girls to have different coping styles and to be more reactive to life changes than boys. The construction of gender stereotypes, or gender socialization, plays a central role in such sex differences. As noted above, many typical female characteristics, such as helplessness, passivity, and emotionality, are associated with depression. In stark contrast, several studies have suggested that"masculine" characteristics are associated with higher self-esteem and less depression (McGrath et al., 1991). The construction of gender identity that incorporates gender stereotypes begins even before adolescence, but may exert its greatest effect at that time, when myriad changes and social stresses converge on females. Even the sex difference in ruminative versus distractive coping styles mentioned above as a possible precursor of gender difference in depression, may emerge from the stereotypes that males are active and ignore their moods, while females are emotional and inactive (Nolen-Hoeksema, 1987).

The ideas concerning the emergence of gender difference in depression in early adolescence and even in childhood assume continuity between the adolescent and adult states for well-defined reasons. Many of the challenges that are more prevalent in the lives of adolescent girls continue to be more prevalent in the lives of adult women as well. Further, since depression interferes with performance, adolescent depression may undermine opportunities for accomplishing goals; not attaining goals or performing as one wises may then carry over into possibilities for depression in adulthood because of unfulfilled expectations or desires. Finally, depressed mood may influence thinking such that negative memories and interpretations of events are more prevalent and can influence decision-making, leading to a sort of downward spiral.

Research on gender-related differences up until this point has advanced from blind belief that hormones were solely responsible to the point where the lack of knowledge and insight is accepted. The various theories, specifically the one concerning different pre-adolescent risk factors for women and subsequent exposure to stress and challenge during adolescence, are just beginning to integrate the many variables that most likely contribute to this modern phenomenon. This is important because it is unlikely that there is is only one factor, or even a small set of factors, that accounts for the emergence of gender differences in depression in early adolescence. There do appear to be many pathways to depression, and a number of biological, psychological, and social theories of depression recognize this.

However, the findings up until now have focused on Western culture, when a comparison of cultures may help to ascertain the extent to which cultural and social construction has created this clear difference in rates of depression. If it can be shown that cultures around the world do not experiences such a difference in rates of depression, the Western model can be reexamined through a cultural lens. Such an analysis of gender-related depression in other cultures would, of course, entail the further difficulty of sorting out how Western analysis necessarily alters non-Western practice simply through examination. Another important topic for future research if whether the accepted model can help to explain both the emergence of the gender difference in depression and the emergence of gender differences in other types of"internalizing"

disorders, such as anxiety and eating disorders. It seems logical that depression and these other disorders would be linked through the common cultural construction of stereotypes that is gender socialization.

In all, the lack of fundamental understanding of the nature of this difference in rates of depression for men and women poses major questions concerning the ambivalence of researchers to more fully explore the anthropological and sociological nature of these gender differences in depression. Especially since there is such an overlap between the stereotypical views of women and their personalities and the definition and criteria for depression, it would seem that more thoroughly examining the constructed or natural barriers for females in our society might lead to a better understanding of the causes and, more to the point, the real symptoms of depression. This latter point stems from the possibility that the categorization of depression and its application to both men and women is inherently wrong, that, just as there are probably more types of depression than are currently defines, there may be an intrinsic difference in what constitutes depression in women and men.