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WOMEN AND DEPRESSION

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Synopsis—Neurotic depression is twice as common among women. This is a puzzle to medical and social science. In this article, genetic and hormonal explanations are considered as well as the problem of distinguishing body from mind. Environmental causes are considered from the viewpoint of epidemiology, psychoanalysis and sociology. Neurotic depression is viewed as the outcome of an excess of stresses over supports and related to a woman's marital status, class and occupation.

In the doctor-patient relationship, the doctor has a privileged role in interpreting what is said, an interpretation which appears as scientific to some and as individual to others. For, in order for it to be meaningful in a personal exchange, language constantly refers back to symbols which have been historically and culturally generated and, in doing so, incorporates particular historical and cultural values. By subjecting doctors and their patients to invoking a particular ideology, language binds us and blinds us in an allusive search for reality.

Neurotic depression is diagnosed twice as commonly among women. Why is this? Are women constitutionally predisposed to depression? Is it genetic or hormonal? Does their socialization in childhood make them more likely to become depressed as adults? Or are their adult social roles intrinsically more depressing? These questions puzzle doctors, social scientists and women. But, how objective is the diagnosis of depression?

CONSTITUTIONAL DETERMINANTS

Debates around sex differences frequently offer an either/or choice: either biology or sociology, either essentialism or constructivism. However many behavioural and medical problems involve both constitutional and environmental factors. In studies of twins, schizophrenia has been shown to have a genetic component. At the other end of the spectrum an organic problem like duodenal ulcer is related to social influences like stress, smoking and the ingestion of alcohol. Holistic doctors therefore tend to reject a dualistic approach.

So how can one analyse the possible contribution of constitutional factors in neurotic depression? There are two possible biological factors which could affect behaviour, genes and hormones. A genetic hypothesis might be that the X gene is linked with neurosis. Torgersen (1983) tested this in a nationwide study of Norway. He compared the incidence of neurosis among identical and non-identical twins. If there is a genetic component,

when one twin develops the disease an identical twin is more likely to be affected than is a non-identical twin. Torgersen did find a greater concordance rate among identical than among non-identical twins. But he found this greater concordance occurred among male identical twins. Identical female twins showed little difference from non-identical female twins in their incidence of neurosis. This suggests a higher hereditary contribution to neurosis in males. These interesting results do not provide evidence for a greater genetic contribution to neurosis among women.

A theory which included hormonal influences on behaviour might be adduced from the observation that some women complain of mood changes premenstrually, postpartum and at the menopause. Katharina Dalton (1964) has popularized the theory that premenstrual tension is associated with progesterone deficiency. Antony Clare (1979) saw women complaining of premenstrual symptoms at St Thomas' Hospital and measured their blood progesterone levels. He found no association between premenstrual symptoms and progesterone levels. No other objective evidence has been produced of hormonal imbalance being associated with mood disorder.

It may be that researchers have looked at the wrong hormonal regulators or that they have looked in the wrong places. It is easier to measure levels of a particular chemical in the blood stream, than it is to measure the level in the brain. In 1817 a general practitioner James Parkinson described 'the shaking

palsy'. After this it took over a century of research to find L-dopa which can treat the particular chemical deficiency in a particular part of the brain.

This may seem like an apology for biologists. But the inaccessible nature of the brain really does make research difficult and slow. Some of the cases which Charcot labelled as hysteria in the nineteenth century have since been found to be organic disorders.

The problem of not knowing when behaviour is determined by organic or psychological factors, by body or mind, constitutes a continuing dilemma for doctors. It especially puzzles those who specialize in either neurological (body) or psychiatric (mind) disorders. Every doctor sooner or later finds she or he has labelled someone's complaint inappropriately. This is a constant source of uncertainty and confusion.

The medical profession may present united and definite views to outsiders. However, within the profession there are many uncertainties over boundaries and lack of knowledge. This is nowhere more acutely felt than between neurologists who regard themselves as physicians par excellence, and psychiatrists who are quite anxious about overlooking a physical disease. When psychiatrists suspect their patient has a physical 'rat' they quickly summon a physician with the pithy request 'rule out organic brain' or simply '?organicity'.

ENVIRONMENTAL FACTORS

Confusion among the purveyors of therapies is depressing to us as consumers. Let us return to the enigma of depression. Epidemiologists study the distribution of disease. They have associated factors such as mosquitoes or contaminated water with the spread of infectious diseases like malaria and cholera. The factors associated with the distribution of depression are much more complex and yet epidemiologists have found some interesting associations. Hirschfeld and Cross (1982) show that, statistically, depression occurs more commonly among married women than married men. It occurs less commonly among single women than single men and less commonly among widows than widowers. The distribution of depression between gender groups conflates all individuals regardless of civil status. Most people are married. The overall incidence best represents the distribution of depression among people who are married and tends to misrepresent the distribution among people who are not.

These statistical findings run counter to constitutional theories and favour environmental factors. Bernard (1972) and others would go on to implicate marriage in the genesis of depression. However it is not so easy to disentangle cause and effect. Constitutional or childhood environmental factors may determine the propensity to marry. Gender

specific factors may select some individuals for and exclude others from the married state. And these factors may work in different directions for each gender group. Srole *et al.* (1962) suggested that:

'Males in their active courting role tend to choose a wife who enhances their culturally conditioned self-image of masculine dominance' (p. 80).

Assuming this to be so Knupfer and her co-workers (1966) went on to hypothesize that:

'If a man wants to be superior to his wife, it would follow that given a range of talents in both sexes those left over after the pairing would be inferior men and superior women' (p. 895).

They assessed the qualities of single and married men and women and particularly asked them about their childhood stresses. The investigators found that single women report they had a more favourable childhood environment than did single men, but also they found single women reported fewer childhood stresses than any other group including married men and women.

Psychoanalysts since Freud (1931) and Deutsch (1947) have emphasized the effect of childhood influences in the epigenesis of adult personality and the predisposition to neurosis. These authors have suggested that girls tend to learn to be passive, dependant and masochistic in childhood. It is suggested that these characteristics predispose an individual to depression in adult life. From the histories of private patients the psychoanalysts tended to induce universal theories. These theories do not easily lend themselves to scientific testing or falsification.

However, empirical studies on depression are being undertaken. Brown and Harris (1978) studied the social origins of depression in the community. They related depression to severe events like death of a parent, loss of employment or housing and to ongoing difficulties like an alcoholic spouse. Their study emphasizes how much depression is related to poor material circumstances. These economic determinants had been ignored by therapists working in the private sector. The psychoanalysts saw patients who were mostly in Social Class I. From experience with these private patients the analysts formed theoretical models.

These models subsequently informed psychiatric thinking on the aetiology of depression. It remained for social scientists to show how inapposite analytic paradigms are for doctors working in the National Health Service. Brown found that 23 per cent of working-class women in his survey had a psychiatric disorder and depression in particular, compared to 6 per cent of middle-class women. Many of these women did not seek help from doctors surmising, perhaps correctly, that medical advice could not help them.

Brown has contributed to a growing view among psychiatrists that depression is one outcome of an equation between stresses and supports. Stresses make a woman more vulnerable to depression. Supports protect her in the face of stress. Vulnerability factors include having three children or more under 14 and lack of employment outside the home.

A cardinal protective factor is having a close, intimate and confiding relationship. This relationship can be with a domiciled man or woman partner. When women say they have such a relationship they can withstand major stresses to a greater extent without developing depression. However, despite being married, some women do not have a close, intimate and confiding relationship. When these women face major stresses, they are *more* likely to develop depression.

The higher incidence of depression among working-class women particularly reflects their exposure to more stress. But Brown and Harris note a decrease in intimacy between the man and woman once the working-class wife had children. These couples may polarize their work roles and communicate less well, a pattern of behaviour which is unsupportive and may partially account for the higher incidence of depression among working-class women.

What is the relationship between marriage and mental illness? Does depression cause poor marriage? Or does poor marriage lead to depression? It is difficult to establish cause and effect. Probably both situations occur. Birtchnell and Kennard (1983) examined the relationship between quality of marriage and mental illness. They found that the mental health of women in bad marriages was significantly worse than that of those in good marriages. In some cases, the woman's mental health improved after leaving a poor quality marriage; in such cases, they concluded, the depressive symptoms were the result, rather than the cause, of the bad marriages.

Birtchnell and Kennard (1983) also found class to be an important factor. They found that marital maladjustment was related to mental illness in the wife only when the husband was in Social Class III-V. They state:

'Significantly more patients received less affection than they gave and had dominant husbands' (p. 79).

So far marriage and class have been related to depressive illness. However, it is not yet clear that these are independent variables. It may be that the most important determining variable is a woman's occupation. Work outside the home has a protective effect on the mental health of women. The psychiatrist, Rachel Jenkins (1985a) studied men and women in comparable jobs in the Home Office.

The men and women were similar with regard to age, marital status, class, stresses and supports. In this homogeneous occupational group there was no difference in the prevalence of mental disorder. One cannot infer from one study a simple relationship between depression and such factors as occupation, marriage, gender and class. The relationship is a complex one. But in studying sex differences in psychological well-being Briscoe (1982) has suggested one conclusion may be that 'perhaps women need jobs in the same way as men need wives' (p. 32).

LANGUAGE AND DEPRESSION

So far it has been assumed that depression is an unambiguous term. How is the label given or acquired? What does it really mean? Are women really more depressed? Let us first examine how people come to be diagnosed.

(1) An individual may experience a change in mood but may or may not recognize this as a problem.

(2) Assuming the individual problematizes a mood change, she may or may not seek help from a general practitioner.

(3) When an individual visits her GP the doctor will decide whether the help seeker and his/her problem should be labelled psychiatric.

(4) If the person/problem is labelled psychiatric, the GP may or may not refer the patient to a specialist.

(5) If the patient is referred to a psychiatrist he or she is assumed to be 'a case'. What is wrong is then a matter of specialist opinion.

First there is the question of individual problem recognition and help seeking. To some extent the two are intertwined. There is no point in defining a problem for which there is no remedy. To some extent this may account for the fact that working-class women often do not problematize real depressive symptoms. They may intuit that their mood is secondary to economic and social problems. They know there is no medical solution for these harsh material realities.

When stresses exceed supports, men may be less likely either to problematize themselves or seek help from a GP. Adjustment problems in men are more likely to be expressed by excess alcohol intake or antisocial behaviour. This behaviour may cause distress to others, but the individual may not recognize he has problems or seek help for them. A person with this cluster of symptoms is labelled by psychiatrists as having a personality disorder. Although women are more often diagnosed as depressed, men are more often diagnosed as having personality disorders. Dohrenwend and Dohren-

wend (1976) have suggested that men and women express problems differently. Their contention is that depression in women and personality disorders in men are in a sense functional (or dysfunctional) alternatives.

The Dohrenwends' theory assumes men and women potentially have equal stresses in adulthood. But, they propose constitutional or childhood influences cause adults to express adjustment problems differently. Men's behaviour more often causes them to be diagnosed as having a personality disorder. Women more often problematize themselves, seek help, and are diagnosed as neurotic. Walter Gove (1978) has opposed this view vehemently. He maintains that married women working in the home with children really do have more stresses and less support than their male counterparts.

Having described the first stage of problem recognition and help seeking by the patient, we can go on to the relationship created when a patient engages the help of a professional. Birtchnell (1974) states:

'There is no observable or measurable representation of mental illness, so its presence is largely a matter of the psychiatrists' opinion' (p. 347).

Part of the training in a speciality involves learning to report observations in an agreed way. However, without physical landmarks it is very difficult for psychiatrists to reach a consensus on what their perceptions are. In one study Kreitman and co-workers (1961) found psychiatrists agreed in making a generic diagnosis of neurosis 52 per cent of the time. But they agreed on the specific category of neurosis, for example depressive neurosis, only 28 per cent of the time!

Rachel Jenkins (1985b) has studied the agreement between general practitioners on diagnostic terms. Without post-graduate training in psychiatry, it is not surprising that GP's agree on terminology even less often than psychiatrists. A GP, Dr John Fry (1960) acknowledged this dilemma when he said that without a consensus on nomenclature and criteria for diagnosis, we rely 'on the personal outlook of the individual doctor' (p. 89). Szasz (1961) took this subjectivist view to its extreme when he discussed the proposition that mental illness exists in the minds of doctors.

Perhaps mental illness does exist in the mind of doctors, but also in the minds of patients. It comes into being in the dialectical relationship between them. Michel Foucault (1976) has suggested that doctors inherited the priests' confessional role. The one who listened took on a hermeneutic function. He interpreted what was said and in doing so became master of truth.

Religious imperatives were replaced by medical norms. Some of these were based on new values.

Priests had valorized the celibate man. Doctors valorized the family man. But in other respects priests and doctors shared common cultural values. Freud transformed Judeo-Christian doctrine into scientific discourse. This is particularly true when he posits the conceptual relationship between man and other beings. Man's anatomy and psycho-physiology are constructed as simultaneously normal and ideal. By comparison, Freud (1925) states:

'I cannot evade the notion (though I hesitate to give it expression) that for women the level of what is ethically normal is different from what it is in men. Their superego is never so inexorable, so impersonal, so independent of its emotional origins as it is in men' (p. 342).

Foucault (1976) argues that the medical profession cast itself in a new role to support the family. New personages began to appear in the discourse:

'The nervous woman, the frigid wife, the indifferent mother' (p. 101)

Under the scrutiny of the doctor he says:

'The feminine body was analysed, qualified and disqualified, as being thoroughly saturated with sexuality whereby it was integrated into medical practice, by reason of a pathology intrinsic to it' (*ibid*: 81, 104).

Are doctors and patients still labouring to divest themselves of these cultural stereotypes dressed up as science? Is that why more women problematize themselves and incur the label of neurosis? Freud popularized the word hysteria in describing women. It literally means wandering uterus and figuratively the uterus symbolized emotionality. It was inserted into a series of contrasting pairs: mind/body, reason/emotion, scientific doctor/hysterical patient, man/woman. We are so attuned to these linguistic chains that they seem to contain some intrinsic truth. Saussure (1915) has suggested that it is almost as if word-images determine our perceptions of reality, locking us in a circular chain. Doctors no less than patients perpetuate these cultural stereotypes. A dualistic approach has meant that doctors have labelled their patients as either having an organic or emotional condition. If an organic diagnosis could not be made, then a diagnosis of hysteria might be. The psychiatrist, Eliot Slater (1965) followed up a group of patients labelled hysterical by neurologists. He found that in the course of time 60 per cent developed clear signs of an organic disease.

A binary linguistic system links mind, reason, scientific doctor and man. On the other side are the characters: body, emotion, hysterical patient and woman. Exceptions in this dichotomizing system must learn to live across a linguistic structure and parley images that do not take account of their own experience. The male identified medical woman or

'honorary chap', is often satirized. But little is spoken of the depressed male. A study by Hammen and Peters (1978) found that a man who talks as if he were depressed is likely to be rejected socially. Such a person is already more likely to be single, divorced or widowed and so unsupported. Is he less likely to seek help? And when he does so are his symptoms minimized? Is he unwittingly normalized? Although men are diagnosed as depressed half as often as women, they more often commit suicide. This empirical fact has not conceptually been accounted for. What happens when phenomena fail to fit ideological norms? Foucault says that they are subject to the logic of censorship. This is a triple injunction of silence, nonmanifestation and non-existence. Is this what happens to the depressed man, literally?

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