Selected factors contributing to major depression in women

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Abstract
An estimated 10 million Americans suffer from depression of one sort or another at a cost of some $27 billion a year in loss of work productivity, permanent disability, depression related alcohol and drug abuse, and the actual costs of treatment (Rovner, 1992). But Americans are ill at ease, ill-prepared and ill-informed about how to deal with depression. According to Rovner, a survey by the National Institute of Mental Health found that more than half of those polled believe depression may be linked to personal or emotional weakness.

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SELECTED FACTORS CONTRIBUTING TO
MAJOR DEPRESSION IN WOMEN

A Research Paper
Presented to
The Department of Educational Administration
and Counseling
University of Northern Iowa

In Partial Fulfillment
of the Requirements for the Degree
Master of Arts

by
Jewel E. Cooper
May 1994
This Research Paper by: Jewel E. Cooper

Entitled: SELECTED FACTORS CONTRIBUTING TO
MAJOR DEPRESSION IN WOMEN

has been approved as meeting the research paper requirements for
the Degree of Master of Arts.

March 17, 1994
Date Approved

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March 28, 1994
Date Approved

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Introduction

An estimated 10 million Americans suffer from depression of one sort or another at a cost of some $27 billion a year in loss of work productivity, permanent disability, depression related alcohol and drug abuse, and the actual costs of treatment (Rovner, 1992). But Americans are ill at ease, ill-prepared and ill-informed about how to deal with depression. According to Rovner, a survey by the National Institute of Mental Health found that more than half of those polled believe depression may be linked to personal or emotional weakness.

According to The Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R) (American Psychiatric Association, 1987), major depression is manifested by the presence of at least five of the following symptoms (including one or both of the first two) nearly every day for at least two weeks: (a) depressed mood, (b) markedly reduced interest or pleasure in almost everything, (c) significant weight or appetite change, (d) insomnia or hypersomnia, (e) psychomotor retardation or agitation, (f) fatigue or loss of energy, (g) feelings of guilt or worthlessness, (h) reduced ability to think or concentrate, and (i) recurrent thoughts of death or suicide. In order to meet DSM-III-R criteria, these symptoms must not be caused by an organic condition, and they will not represent a normal reaction to a bereavement.
Many people who exhibit symptoms of depression meet fewer than five of the DSM-III-R criteria for a major depressive syndrome and/or do not seek help from a mental health professional and receive a psychiatric diagnosis (Ritter, 1993). Thomas (1993) contends that some of the reasons many do not seek help are: cost of treatment, lack of access to clinical services, stigma associated with receiving help, unavailability of social support, or immobilization caused by the depression. Depression has been referred to as the "common cold" of psychological problems (Seligman, 1975).

The prevalence of depression seems to be increasing, and its onset seems to be occurring at an earlier age (Klerman, Lavori, Rice, Reich, Endicott, Andreasen, Keller, & Hirschfield, 1985). Approximately one in fifty depressed clients is hospitalized, and depression accounts for 75 percent of psychiatric hospitalizations (Seligman, 1990). One in one hundred people suffering from depression commits suicide, while 15 percent of those with chronic, recurrent depression commit suicide (Klerman, Weissman, Rounsaville, & Chevron, 1984).

Depression seems to overwhelmingly be a women's disorder (McGrath, Keita, Strickland, & Russo, 1990). There are currently at least 7 million women in the United States with diagnosable depression. Also, the number of depressed women exceeds that
of men by an average of two to one in over 30 countries and in all Western cultures (Abramson & Andrews, 1982; Nolen-Hoeksema, 1990). This sex difference in the incidence rate of depression "is one of the most consistent findings in the literature and holds for White, Black, and Hispanic women and persists when income level, education, and occupation are controlled" (McGrath et al., 1990, p. 1).

Given its prevalence and rate of incidence, it is likely that many clients who will seek help from a mental health counselor will be women complaining of depression. Understanding the causes and pervasiveness of this disorder in women can help the mental health counselor in providing a therapeutic relationship with depressed clients. Cook (1993) stated that a depressed woman can start to move out of her depression and into recovery in a therapeutic relationship that enhances her self-confidence, self-direction, autonomy and sense of personal power.

The purpose of this paper is to study selected factors which contribute to major depression in women. A review of the literature will explore these major factors: relationships, employment, cultural stereotypes, learned helplessness, economic factors, victimization, lesbianism, and ethnicity. The cognitive aspect of depression will be briefly addressed.
Seligman (1990) noted that most people with depression are able to struggle on with their lives, perhaps even succeeding in concealing their symptoms from others. In some, depression may be present at a subclinical level for many years, actually becoming ingrained in their personality. Those with severe depression, however, typically manifest significantly impaired functioning. Woodruff (1975) asserted that depression is the most frequent complaint prompting outpatient psychiatric visits.

According to the DSM-III-R, depression, in varying degrees of intensity, duration, and pattern of onset, is the prominent feature in major depression, dysthymia, depressive disorder not otherwise specified, bipolar disorder, bipolar disorder not otherwise specified, and cyclothymia. Seligman (1975), who studied the relationship between helplessness and depression in a person's development, found that as many as 30 percent of the population will experience some form of depression during their lives. Approximately 18-23 percent of women and 8-11 percent of men experience a major depressive episode during their lifetimes. Seligman added that approximately 3 percent of men and 6 percent of women have a major depressive episode of sufficient severity to require hospitalization. Women not only are more prone to depression but also tend
to have an earlier onset. Kaplan and Sadock (1985) found that incidence peaks in women between ages thirty-five and forty-five and in men over age fifty-five.

Depression often has a genetic component (Boyd and Weissman, 1982). There is a tendency for major depression to be associated with a family history of depression and/or alcohol abuse, particularly if the family environment was a negative one. This relationship seems to hold true for women more than for men.

Seligman (1990) posited that the onset of depression often follows one or more negative and stressful life events, frequently involving a real or threatened loss of a relationship. The anticipation of loss may trigger a return of unresolved feelings about an earlier loss. This pattern is particularly likely to occur in a person with few social supports, no intimate confidants, and generally negative social relationships. A vicious cycle is likely to develop in which depression is exacerbated by a person's lack of friends, while at the same time the person cannot readily make friends because he or she is depressed.

DePaulo and Ablow (1989) defined major depression as being more than the low feeling that accompanies disappointment or loss. It is an illness with specific signs and symptoms. The difference between feeling "blue" or sad from time to
time and depression is that a person's ability to function is significantly affected by depression. Nolen-Hoeksema (1990) stated that it is generally accepted that even moderate levels of depression appear to significantly impair functioning in work, school and social situations.

Rathus and Nevid (1991) described the most prominent feature of depression as a downcast mood. Other common features of depression include changes in emotional states, such as persistent periods of feeling down, sad or blue, tearfulness or crying, feeling guilty or remorseful about past misdeeds, increased irritability, jumpiness, or loss of temper. Seligman (1990) noted that the primary symptoms of depression are feelings of discouragement and hopelessness, a dysphoric mood, a loss of energy, and a sense of worthlessness.

A person who is depressed may feel unmotivated or have difficulty getting out of bed in the morning. According to Formanek and Gurian (1987), a depressed person may experience a reduced level of social participation or interest in social activities, a loss of enjoyment or interest in pleasurable activities, reduced interest in sex, or a failure to respond to praise or rewards. Depression can also cause a person to move or talk more slowly than usual. A person who experiences depression may also have difficulty concentrating or thinking
clearly, may think negatively about himself or herself and their future, may lack self-esteem, have feelings of inadequacy, and may even think about death or suicide.

Gotlib and Colby (1987) studied selected clients in their private practice to determine the most effective treatments for depression and found that suicidal ideation is a pervasive secondary or underlying symptom in depression. People suffering from depression may be in such severe emotional pain that they feel as though their symptoms will never end. Suicide may seem to be their only escape. Gotlib and Colby's study revealed that there are approximately 200,000 suicide attempts and 25,000 suicides annually in the United States; 80 percent of these seem linked to depression.

Depression is a mood disorder that can be seriously incapacitating and can consist of a broad range of symptoms. Thomas (1993) asserted that in the United States depression in women is one of the most pressing health problems of the 1990s and will most likely continue into the 21st century. One fourth of all women will have a depressive disorder during their lifetime.

Factors Contributing to Depression in Women

Kaplan (1991) believed that the frequency of depression in women suggests that depression may not be an "illness" superimposed on an alien or indifferent personality structure,
but rather may be an exaggeration of the normative state of being female in Western society. In her study of sex differences and depression, Nolen-Hoeksema (1990) concluded that although there is considerable research showing a relationship between hormonal abnormalities and some depressions during the premenstrual phase, very few women who are depressed at this time show symptoms only at this phase in their cycles. They also have symptoms at other stages, and many who have severe premenstrual depression have a personal or family history of depressions unrelated to the menstrual cycle. Similarly, most mood changes during pregnancy or resulting from the lack of a desired pregnancy seem to occur in women who are predisposed to affective disorders. McGrath and his colleagues (1990) studied certain risk factors that predispose women to depression and deduced that because pregnancy and infertility both occur in a social context, when women are depressed at these times, it is important to examine their prior mental health history as well as their attitudes and feelings about their situation.

Cook (1993) found that developmental, psychological, and sociocultural conditions of a woman's life has a greater impact than does biology on her emotional state. A woman's relationships is one of these sociocultural conditions.

Gilligan (1982) contended that girls, whose primary caretaker is generally female, tend to have a prolonged
attachment to their mothers. This early relationship becomes a prototype for later relationships. Boys, on the other hand, tend to be pushed toward early separation. "Male gender identity is threatened by intimacy while female gender identity is threatened by separation" (p. 8). Internalization of the caretaker's empathetic attitude (or the lack of it) as well as the quality of their mutuality contribute to the capacity for later mutuality (Jordan, 1991). In the reproduction of this "mothering" in later life, if a woman's need for mutuality is not met or if her relational capacity is impaired, she may be at a greater risk of becoming depressed.

Kaplan (1991) also studied the effects of a woman's relationships and purported that when a woman is severely constricted in the full development of her relational capacities, and when she is strongly discouraged or punished for self-expression, the conditions are established that can lead to depression. Jack (1991) seemed to agree with Kaplan by stating that a woman experiences a continuous sense of loss when opportunities for mutual empathy and mutual empowerment are limited. The culture of inequity makes it difficult for a woman to maintain a positive sense of self or to keep her "self" in a relationship. Further, the feminine assets of empathy and flexible ego boundaries, as well as concern for others, are strengths valued by society, but they carry with them a vulnerability to depression.
Marriage seems to "protect" men more than it does women, since husbands more often than wives report being affirmed and understood by their partners (McGrath et al., 1990). In their study of risk factors and treatment issues relating to depression in women, McGrath and his colleagues found that unhappily married women will typically experience more depressive symptoms than either happily married or unmarried women. Women's feelings of powerlessness or inequality in a marriage relative to decision making on household chores, as well as feeling frustrated, isolated, and lonely within their relationships, seems to increase women's propensity to depression. According to Klerman and Weissman (1985), being unable to communicate with spouses and have their relational needs met by that person can be depressing for most women. It can be especially depressing for those who have endowed their marital partners with some magical ability or strength to protect and take care of them.

An unhappy marriage is "a grave risk to a woman's mental health" (McGrath et al., 1990). A man tends to become more depressed when single, widowed, or separated; a woman tends to become more depressed when married and unable to make the kinds of connections with her family members that she wants. A woman's vulnerability to depression is compounded when she is the mother of young children, increases with the number
of children living at home, and is greatly affected when she is the caretaker for aging parents or in-laws, whether or not she is still caring for her own children at the time. McGrath and his research partners believed this "role overload" could often be offset by a low level of marital strain, an affirming job, or both. The quality of a woman's relationship with her partner appears to mediate her experience of painful events or chronic conditions.

Tallmer (1983) studied depression in older women, and found that older widows generally have an easier time adjusting to their role loss than do widowers, probably because of the ongoing nature of their support systems. Although there are some true stresses in later life such as poverty, poor health, and the losses of a partner, friends, and home, first-onset of major depression is rare after age 65. Formanek (1987) speculated that most long-term depressed older women were also depressed as young women. In other words, some women carry into their later years a vulnerability that, when combined with stressors in the social environment, can frequently lead to depression.

Women provide nurturance and support to others more frequently than do men and are disproportionately sought as confidants and companions by both men and women (Rubin, 1985). Women's "range of caring" exposes them to a greater risk of
depression than is the risk for men. In addition, women are expected to respond to the pain and needs of others, whether or not their own needs for support and validation are met (Bernard, 1982). Women suffer from a "contagion of stress" when people they care about are distressed and women bear the heavy weight of the social system, which can "literally grind down the spirit" (p. 8).

A sociocultural factor that is becoming increasingly important in women's lives is employment. On the basis of her studies of sex differences in depression, Nolen-Hoeksema (1990) asserted that satisfying employment can help women deal with marital stress, and women with marital problems who work outside the home seem to be less depressed than those who do not work outside the home. Multiple roles can compensate for one another in times of difficulty, which places full-time homemakers at a disadvantage in terms of relying entirely on their spouse and children as their primary sources of gratification. If the marital relationship is poor or unsupportive, depression is often a result.

Aneshensel (1986) studied marital and employment role-strain, social support, and depression among adult women and found that the most depressed group among nine categories of women was composed of nonemployed wives with high marital strain. These "most depressed" women were five times more
depressed than were the members of the least depressed group, which was composed of employed wives who experienced a combination of low marital strain and low employment strain. Other studies have found that "housewives" are the most depressed group of women (Young-Eisendrath and Wiedemann, 1987). These women are more depressed than their employed husbands, particularly if they do not feel affirmed in their marriages or if they feel as though they lack intimacy in their primary relationship.

Higher income housewives are less prone to experience depression. They can afford to hire others to perform some of the worst tasks of homemaking, and therefore have more outlets for alternative sources of affirmation than low-income housewives (Nolen-Hoeksema, 1990).

Helplessness is a characteristic of depression, and when women adopt stereotyped images of femininity in addition to an accompanying cognitive set against assertion, they are especially predisposed to depression (Weissman, 1980). The concept of learned helplessness, taken from the work of Seligman (1975), describes the conditioning of women to passivity and waiting to be fulfilled rather than to the traditionally masculine attitudes of independence and action. This lack of instrumentality or mastery is considered an indicator of reduced mental health. Without a sense of efficacy in their
lives, women frequently feel at the mercy of others and to situations that befall them. Young-Eisendrath and Wiedemann (1987) studied how women were empowered through psychotherapy and found that more frequently than is true for men, women's locus of control is external. Women tend to believe that forces "out there" have more determining effects on their lives than do their own efforts. They expect to be taken care of and are dependent upon the feedback of others when judging themselves or their abilities.

Belle (1982), in discussing learned helplessness, stated that depression is "an almost unavoidable response to an environment that allows women little control over most of the important things in life and little hope that life will improve" (p. 241). Learned helplessness leaves women with a limited response (or problem-solving repertoire) when under stress and, therefore, they become extremely vulnerable to depression.

Cultural stereotypes and expectations contribute to depression in women. A woman is raised with a "model of goodness", in which goodness is equated with self-sacrifice (Jack, 1991, p. 139). In order to be kept safe from anxiety about abandonment, many women adopt the rigid cultural stereotypes of "ought," "should," "good," and "bad" that define a good woman. If a woman acts according to masculine or societal
definitions of "goodness" and becomes independent, assertive, and competent, she often does so at the cost of her "womanhood" (Heriot, 1985). Being a good woman (i.e., submissive, passive, and dependent) places her in a double bind because "to be a healthy woman by society's standards is to be a sick adult" (p. 12).

Women are raised to be "nice ladies" and not express their anger (Kaplan, Brooks, McComb, Shapiro, and Sodano, 1985). Jack (1991) noted "there is a basis to women's fears of negative consequences to the marital relationship if they express either anger and dissatisfaction or fear to their partners" (p. 43). To keep from expressing anger, many women carefully monitor and judge their thoughts and silence their voices. If they do express anger, they are sometimes labeled immature or neurotic. Sometimes their inner rage and growing resentment explodes at partners or children. Then, feeling guilty about violating a cultural value, or fearful at the potential loss of the relationship, they often alternate between being overly nice and "good" or angry and withholding. But they are depressed in either case.

Kaplan (1991) observed that the pattern of women severely inhibiting their own strivings and actions so as to preserve relational ties seems to emerge over and over in clinical work with depressed women. Lebe (1983) seemed to agree by
pointing out that fear of loss of love or attachments keeps women fearing the success that may bring about differentness or separation from loved ones.

The potential for loss of relational ties can affect women from childhood on, beginning when female aspirations strain the maternal bond (Miller, 1976). Women may learn from an early age that their strivings for achievement often do threaten their relationships with other family members as well as with their spouse or partner. This only reinforces their fears of success and may cause women to inhibit actions that will further their own goals. Kaplan (1991) noted that being viewed by self or others as selfish or being threatened with loss of love or abandonment may keep some women's goals and hopes for themselves contained.

The loss of a "life dream," something they especially wanted to do in life, causes deep regret and often mourning (Ween Olsen, 1988). The loss of the competent self they could have become and the accompanying loss of positive feedback for their achievements can lead to a hopelessness and helplessness that is depressing for many women.

The life situations of many women can be depressing because "real social discriminations make it difficult for them to achieve mastery by direct action and self-assertion, which only further contributes to their psychological distress"
(Kleman and Weissman, 1985, pp. 502-503). These inequities can lead to legal and economic helplessness, dependency on others, chronically low self-esteem, low aspirations, and ultimately, major depression. Compared with men, some women lack the power necessary to attain goals they might set for themselves, and the kind of work they do is evaluated more negatively and taken far less seriously (Nolen-Hoeksema, 1990). As a group, many women are segregated into low-paying jobs where subtle discrimination and sexual harassment are prevalent. Yet, women often learn to ignore or accept injustices as a way of surviving because they often cannot afford to quit their jobs or leave relationships.

According to the U.S. Department of Labor (1992), women, on average, earn 74 cents for every dollar a man earns, an inequality which has persisted for as long as statistics have been kept, and most likely since the beginning of time. According to Cook (1993), far more women than men are the single custodial parents and sole supporters of minor children. Fewer than half of the 60 percent of fathers who are required by divorce decrees to pay child support payments do so on a regular basis. Further, the standard of living of divorced women and their children drops about 70 percent in the first year after a divorce, whereas the standard rises 42 percent for men during the same time period.
Poverty is a "pathway to depression," and 75 percent of the U.S. poverty population is composed of women and children (McGrath et al., 1990, p. xii). Belle (1990) posited that poverty has been found to be highly correlated with psychological distress. Additionally, high levels of depression are common "among women without confidants, child-rearing assistance or employment and among women experiencing chronic stressful conditions, particularly those reflecting economic problems" (p. 385).

Belle (1990) suggested that income level is predictive of depression because it predicts financial, parenting, and child care problems. After studying several hundred low-income mothers, Belle concluded that unaltered stressful life conditions often take a toll not only in the form of depression, but also in the form of attempted suicides, mental breakdowns, health problems, and children's adjustment problems. "The long-term problems of poverty, burdensome responsibilities, and foreclosed opportunity contribute more heavily to the depression of low-income mothers than a single crisis or tragic event" (Belle, 1982, p. 241).

"Victimization in interpersonal relationships is a significant risk factor in the development of depressive symptomatology in women" (McGrath et al., 1990, p. 28). Nolen-Hoeksema (1990) estimated that from 21.7 to 37 percent
of women have experienced childhood sexual assault, from 25 to 50 percent have experienced partner battering, and between 12 and 46 percent have been raped. As many as 71 percent of working women may experience sexual harassment. Being physically violated in a personal relationship sets up a vulnerability for depression. Estimates of the rate of suicide attempts in battered women range from 25 to 42 percent.

Being of lesbian orientation places many women at high risk for depression (McGrath et al., 1990). In their study of factors that contribute to depression in women, these researchers found that depression is the most common reason that lesbians give for seeking counseling. The high rate of suicide attempts they found among lesbians (41 percent) is 2 1/2 times that of the 26 percent of white heterosexual women who have either seriously considered or attempted suicide. Even though lesbian women carry with them a reduced societal and socioeconomic status in comparison with men, as do their heterosexual sisters, the double burden of being a lesbian in this society may increase rates of depression.

McGrath and his colleagues (1990) found that fear of rejection and misunderstanding led only 28.4 percent of lesbians to "come out", that is, let their sexual orientation be known, to their mothers and only 19.3 percent come out to their fathers. For many lesbians, parents are not included among their support
network, while the reverse is true for most heterosexual women. McGrath and his colleagues further reported that fear of stigmatization and job loss keeps many lesbian women and their partners closeted or isolated. For women not affiliated with a lesbian network, their lover may be their only confidante. Depression "may be a greater risk factor for rural lesbians or lesbians who are not out to many people outside of their partner" (Rothblum, 1990, p. 71).

The coming-out process is stressful for many lesbians, but once women are out, it can be both psychologically and socially advantageous (Rothblum, 1990). As is true for nonlesbian women, being in a supportive relationship is related to positive mental health for lesbians. Conversely, disruption in a primary relationship is a risk factor for depression. Other factors which are precursors of depression include being mothers of young children in a society that treats their offspring homophobically, coming out to children, fear of their children's rejection, and ongoing custody battles (which 80 percent of lesbians lose in lower courts).

Satisfying work helps to alleviate some of the burden of depression in heterosexual women, but discrimination and job insecurity are common for lesbians. Cook (1993) believed that most occupations are closed to people who are openly lesbian or gay. Leading a double life at work, in the family,
and in society often takes its toll on mental health. About 80 percent of all lesbians consult a mental health professional at some point in their lives. However, they often receive inadequate treatment, due in part to the fact that the goals of counseling frequently are to cure them of their "affliction" or to convert or reorient them to heterosexuality. Ritter and O'Neill (1989) reported that women may find a lesbian-affirming counselor or at least one who sees her orientation as somewhat normative, but many women leave counseling more hopeless and depressed than before.

Lesbians who are nonwhite, older, adolescent, or working-class may feel particularly isolated (Rothblum, 1990). Their sisters who are more educated, white, urban, and have some job security or self-employment have more access to lesbian-affirming information and to positive role models within the lesbian community. Members of ethnic minority groups may not be aware of lesbianism within the history of their own culture or may not see lesbian women of color to emulate. Rothblum further posited that as if being a stigmatized subgroup within an already oppressed population were not sufficient to render them vulnerable to depression, it is estimated that half of all black and Latina lesbians have been physically abused.
Just as any form of oppression is associated with depression in women, so is race or ethnicity. McGrath and his research partners (1990) established that ethnic minority women are more likely than Anglo women to share a number of socioeconomic risk factors for depression. Some of these factors include racial/ethnic discrimination, lower educational and income levels, segregation into low-status and high-stress jobs, unemployment, poor health, larger family sizes, marital dissolution, and single parenthood.

Discrimination-provoked violence is a risk factor for depression in any low-status or stigmatized group of women, with lesbian and ethnic minority women being the most common examples (Rofes, 1983). Additionally, black and Hispanic women are particularly likely to be poor.

The Cognitive Aspect of Depression

A tendency to see everything in the most negative light is typical of the depressive's way of thinking (Beck, Rush, Shaw, and Emery, 1979). Although depression has traditionally been viewed as an affective disorder with resultant thinking abnormalities, Beck and Burns (1976) published recent evidence that indicates there is a thinking disorder in depression and that this thinking disorder may be more central than was previously believed.
There appear to be gender-related differences in this thinking disorder, so that even mild depression in women can induce the production of further negative cognitions (Joseph, 1987). Abramson and Andrews (1982) suggested that because of their conditioning to passivity and helplessness, women often develop pessimistic explanatory styles in which they come to expect that they cannot control outcomes. From their perspectives, they believe they do not have the ability, or that it is not within their power, to attain highly valued outcomes or to avoid adverse ones. Further, they engage in a ruminative response set when depressed that serves to amplify symptoms and extend depressive episodes.

Men, in contrast to women, are socialized to distract themselves from depression by engaging in physical activity. The tendency of males toward distraction when distressed may lead some to maladaptive extremes such as excessive consumption of alcohol, aggressive behavior, or a dampening of emotions altogether (McGrath et al., 1990). Women tend to ruminate and to "hold on" to depression, which only interferes with instrumental behavior and may increase feelings of helplessness and depressive explanations for their behavior. "Women and girls exhibit attributional styles commonly observed in depressed and/or helpless people, whereas men and boys exhibit attributional styles commonly observed in nondepressed and/or mastery-oriented people" (Abramson and Andrews, 1982, p. 90).
Women have a tendency to blame themselves for negative events and to attribute the results to some defect of theirs (Abramson and Andrews, 1982). For many, it is a great relief to learn that the depression is not their fault, but rather a natural response to such factors as gender role conditioning, devaluing or violent relationships, abuse, poverty, a stigmatized sexual orientation, racism, discrimination, role strain, or oppression.

Summary and Conclusion

This paper examined the major sociocultural factors which contribute to major depression in women. The rate of major depression in women exceeds the rate in men by an average of two to one. There are currently seven million women in the United States with a diagnosable depression. Whether married or unmarried, mothers or nonmothers, young or old, many women experience depressive symptomatology. A literature review revealed that women are predisposed to depression as a result of hormonal abnormalities, relationship orientation, unsatisfying employment, and cultural stereotypes of "womanhood" such as being submissive, passive and dependent. Additional factors that contribute to depression in women include learned helplessness, women's tendency toward external locus of control, social and economic discrimination, and being victims of sexual assault, partner battering and rape. The stigma of lesbianism
and the oppression of ethnicity were also explored as contributing factors to depression. Rumination and faulty or irrational thinking was found to be prevalent in women suffering from depression.

Because of the prevalence of depression, it is important for mental health counselors to be knowledgeable about the foremost sociocultural factors which contribute to the incidence of major depression in women. Major depression is not a weakness for which to feel guilt or self-condemnation. Depression is treatable and its prognosis is favorable. As mental health counselors increase their awareness and knowledge of this illness, they are better able to pass these insights on to their depressed women clients, who, in turn, can feel more empowered to move through depression and into recovery.
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