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Social Suffering, Gender, and Women's Depression

Jeanne Marecek

There is nothing the matter with one but a temporary nervous depression – a slight hysterical tendency – what is one to do? (p. 10)

I get unreasonably angry with John sometimes. I'm sure I never used to be so sensitive. I think it is due to this nervous condition.

But John says that if I feel so I shall neglect proper self-control; so I take pains to control myself – before him, at least, and that makes me very tired. (p. 11)

But these nervous troubles are dreadfully depressing.

John does not know how much I really suffer. He knows there is no reason to suffer, and that satisfies him. (p. 14)

I don't feel as if it was worth while to turn my hand over for anything, and I'm getting dreadfully fretful and querulous.

I cry at nothing, and cry most of the time. (p. 19)

Charlotte Perkins Gilman, 1899/1973

These lines are from *The Yellow Wallpaper*, a short story composed by Charlotte Perkins Gilman at the turn of the 19th century. Gilman was no stranger to social suffering. The story was, as Elaine Hedges puts it, “wrenched out of her own life” (1973, p. 37). Gilman was an outspoken leader and theorist of the feminist movement of the late 1800s, regarded by some as its leading American intellectual. Gilman's focus was primarily on women's economic dependency in marriage, which she regarded as the linchpin of female subordination (Gilman, 1898). Despite her political convictions, Gilman herself was trapped by the prevailing conventions of marriage and motherhood. Shortly after the birth of her first child, she fell into grinding misery. She described her condition as a “growing melancholia,” consisting of “every painful mental sensation, shame, fear, remorse, a blind oppressive confusion, utter weakness.” (Gilman, 1935, p. 90). She experienced “a constant dragging weariness miles below zero. Absolute incapacity. Absolute misery.” She would often “crawl into closets and under beds to hide from the grinding pressure of that profound distress” (Gilman, 1935, p. 91).

Gilman's words bespeak what we today would recognize as profound depression. She speaks of exhaustion, melancholy, misery, guilt, constant crying, and weakness. Yet, in keeping with the diagnostic conventions of her times, she was diagnosed not with depression but rather with neurasthenia and "nervous prostration" with a "slight hysterical tendency." Dr. Silas Weir Mitchell, a leading psychiatrist of the day, treated her. Mitchell was known throughout North America and Europe as an expert in the treatment of women with ailments like Gilman's. Indeed, Sigmund Freud is said to have expressed a keen interest in Mitchell's treatment methods because he himself sought to help women in similar distress.

Mitchell's prescription was a rest cure that enforced continual bed rest and constant feeding with rich, heavy food such as cream and sweets. It was common for his female patients to gain up to 40 pounds on this regimen and such weight gain was considered curative. Mitchell demanded that patients refrain not only from physical activity but also from intellectual endeavors and social stimulation. Gilman's fictional heroine, for instance, is chastised for jotting brief notes in a small notebook in violation of her doctor's orders. The regimen was both authoritarian and infantilizing, requiring female patients to submit without question to isolation, passivity, and medical control over their lives.

Throughout the novella, the heroine of *The Yellow Wallpaper* voices tentative critiques of bourgeois marriage, of the stifling norms of wifely and motherly behavior by which she must abide, of gendered power relations, and of Dr. Mitchell's rest cure. In the end, however, she is unable to sustain those critiques and plunges into the depths of madness, perhaps succumbing to suicide. Charlotte Perkins Gilman's own story has a better ending, though not a triumphant one. At the end of a month in Mitchell's sanitarium, she fled. Her condition, she proclaimed, was worse than when she had entered. She also fled her marriage because she had come to believe that she could not regain her mental equilibrium unless she lived independently. Although she married a second time, she did not live with her second husband nor depend on him for financial support for herself and her child. Instead she eked out a precarious living through her writing and speaking, sometimes taking in lodgers to make ends meet.

Why begin a discussion of women and depression with a lengthy description of a woman who lived 100 years ago and was never diagnosed as depressed? Charlotte Perkins Gilman's suffering has several lessons for those of us who are interested in the connections between gender and psychosocial suffering, and, more broadly, in psychopathology as an object of scholarly inquiry. I am not concerned to debate whether Gilman was really depressed or not. For sure, she suffered mightily. Gilman's story warns us against the intellectual mistake of reifying diagnostic categories such as depression. Like any psychiatric diagnosis, depression is a cultural category arising in a particular time and place. In Gilman's time,

other categories named her suffering. Moreover, the diagnostic category of depression encompasses just a small fraction of the total field of depressive suffering.

Gilman's situation holds lessons about the gender politics of psychological suffering and of its diagnosis and treatment. *The Yellow Wallpaper* can be read as a meditation on the gap between expert knowledge and lived experience. Dominant discourses of her time, such as that of Dr. Silas Weir Mitchell, put forward an etiology of Gilman's condition that was grounded in neural physiology. (For Mitchell and other psychiatrists of his time, the term *nervous exhaustion* had the literal meaning of a nervous system overtaxed to the point of depletion.) Gilman and her heroine give voice to a different etiology, one grounded in social relations, gendered structures of power, and the confines of conventional domesticity. Gilman lived and wrote at a time (not unlike the latter decades of the 20th century) when some women were asserting new rights and demanding changes in gendered power relations in public and private life. It is hardly surprising that she and several other prominent feminists and female leaders seemed particularly prone to the conditions then called neurasthenia, nervous prostration, nervous exhaustion, and hysteria. Living in a time of social flux, they flouted the norms of proper feminine decorum. Often they were vilified or ridiculed by their social circle or by the press. No doubt they sometimes experienced self-doubts and internal conflict as they found themselves embroiled in situations fraught with contradiction.

The theme of this chapter is that cultural narratives organize, provide significance for, and influence the form, frequency, and social relations of women's depression. My orientation therefore diverges sharply from most of the other contributors, as well as the editors. I take categories of disorder, such as depression, as cultural artifacts shaped in response to prevailing concerns at different periods of history. I do not assume that such categories are universal, fixed natural entities awaiting scientific investigation. Gilman's tale points toward two contrasting narratives of women's suffering. The medical establishment of her day put forward explanatory narratives grounded in physiology and notions of inherent feminine weakness. Such explanations direct our gaze toward the individual in isolation, set apart from culture and social context. In contrast, Gilman put forward a narrative concerned with gendered power dynamics, thwarted self-expression, and culturally imposed limitations. She pointed not to inherent deficiency but to structural inequities of power. Accounts like Gilman's insist that depression and other forms of disorder are *social* suffering; they situate suffering in social, cultural, and political contexts.

The bifurcation between biologically based accounts of psychological distress and social accounts has proven remarkably durable in North American psychology. Biological foundationalism too has persisted in

North American intellectual life, particularly in psychology, in spite of a long line of trenchant critiques (e.g., Haraway, 1981). Even today, discussions of female psychology typically are initiated by first considering bodily difference (such as genes, hormones, brain differences, and neurochemistry). In that way, biology is made to appear as if it were the grounding for social experience.

In North America, the dominant accounts of depression and other categories of suffering have focused on the individual as the locus of pathology, risk, and resilience. Like Gilman, many feminist researchers have endeavored to shift attention to social relations and cultural context. Their accounts of women's suffering have emphasized social structures, cultural institutions, and social relations rather than individual deficiency or pathology. However, such models of suffering typically have been marginalized by psychological and psychiatric researchers and in the psychotherapeutic professions. The research technologies typically espoused by North American psychologists channel inquiry away from societal conditions and into the exploration of individual psyches removed from culture and history (Henriques, Hollway, Urwin, Venn, & Walkerdine, 1984). Even when psychologists set out to study the societal bases of suffering, the constraints of the discipline – its structures of thought, its measurement technologies, its preference for laboratory experiments, and its language practices – often stealthily transform projects into investigations centered on individuals lifted out from culture, society, and history. In the specialty journals in clinical psychology, the individual often appears as a carrier of weakness or deficiency, whether because of biological inheritance, faulty childhood socialization, or a life history of traumatic events. Surveying research on women several years ago, Mary Crawford and I coined the phrase “woman as problem” to describe this mode of producing knowledge (Crawford & Marecek, 1989). It remains a prominent approach to conceptualizing psychopathology (Marecek, 2001).

DEPRESSION: IS IT A “WOMAN’S PROBLEM”?

For at least three decades, therapists and researchers have identified depression as a “woman’s problem.” Depression was one of three high-prevalence diagnoses identified in the Conference on Women and Mental Health jointly convened by the National Institute of Mental Health (NIMH) and the American Psychological Association (APA) in 1979 (Brodsky & Hare-Mustin, 1980). Roughly 10 years later, “women and depression” was the subject of a Task Force sponsored by the Women’s Program Office of the APA (McGrath, Keita, Strickland, & Russo, 1990). Ten years later (in 2000), the APA sponsored a “Summit on Women and Depression” (Mazure, Keita, & Blehar, 2002).

The claim that depression is a woman's problem rests mainly on rates and counts of people with depression. Depression is considered a woman's problem because greater numbers of women than men experience depression and because depression is especially common among women. Throughout the latter part of the 20th century, researchers in several Western European and North American societies noted a preponderance of women among those who experience depression (Weissman & Klerman, 1977). Women in present-day North America and Europe appear to have rates of clinical depression that are between two and three times higher than men's (Bebbington, 1996; Kessler, McGonagle, Swartz, Blazer, & Nelson, 1993; Weissman et al., 1993). Moreover, in community surveys, women usually report more or more severe symptoms of depression than do men. This gender difference appears to emerge sometime in adolescence and to persist thereafter throughout the lifespan (Mirowsky, 1996; Nolen-Hoeksema & Girgus, 1994).

Overall, the risk of depression appears to have expanded to younger and younger age cohorts during the latter part of the 20th century. Prior to World War II, it appears that depression occurred mainly to people beyond the age of 40. By the 1970s, however, experts began to diagnose depression among people in their 20s and 30s. The idea of that children and adolescents too could suffer from depression took hold in the late 1970s and was linked to the rise of cognitive theories of depression. Prior to that, psychoanalytic formulations of childhood ego development held that children lacked the capacity for depression. (As we shall see later, this idea that depression requires a degree of psychic maturity was also applied to so-called primitive peoples by colonial psychiatrists.) By the 1990s, experts began alerting the general public to the problem of widespread depression among teenagers. Today even children between 7 and 11 years of age are said to be at risk for depression. Are the rates of depression actually changing? Or have successive generations of diagnosticians and therapists become more and more astute at uncovering depression? Or have our understandings of depression and its symptom criteria shifted to encompass broader range of emotional experience and thus to envelop more and more people? We need to be careful not to essentialize depression or its symptom criteria as monolithic and unchanging entities that exist in isolation apart from our descriptions of them. Historians of medicine have shown how various diagnoses and diagnostic categories (among them, schizophrenia, depression, psychopathy, nymphomania, chlorosis, posttraumatic stress disorder (PTSD), multiple personality disorder, psychogenic amnesia, and eating disorders) and their symptom criteria have shifted in accord with cultural and political trends and, in some cases, disappeared altogether. We must also avoid the unwarranted assumption that scientific knowledge is necessarily progressive, always arriving at closer approximations of the truth.

Before we declare depression to be a woman's problem, let us step back to consider that claim more closely. A number of issues bear consideration:

Is the Gender Gap Universal?

Evidence that women have higher rates of depression than men is limited to certain locales. The gender gap seems to be specific to Western Europe and North America. Agricultural societies show little or no gender difference in rates of depression (McCarthy, 1990). Data from non-Western countries are skimpy, but reports from India, Thailand, Rhodesia, and Sri Lanka report no excess of depression among women. Thus, we must modify the blanket statement that depression is a women's problem to a more cautious one, that it may be a Western European and North American woman's problem. We should not be surprised that the gender gap is culture specific. The incidence, patterning, and epidemiology of many disorders differs considerably from one cultural setting to another (Demyttenaere et al., 2004; World Health Organization, 2000). As we will see, what we call depression appears to be nearly absent in some parts of the world. Although simple cross-national comparisons of rates of depressive symptoms tell us little about culture, they suggest that the culture gap in depression far exceeds the gender gap. What is surprising is how seldom culture has been a focus of serious inquiry by psychiatrists or clinical psychologists.

Has the Gender Gap Been Constant over Time?

Comparisons across historical eras are tenuous because definitions of depression are not fixed. Nonetheless, it seems unlikely that the current male–female difference found in Euro-American societies has been constant over time. One can find mention of depression-like thoughts, emotions, and somatic complaints in medical and religious writings from Greek and Roman times onward. However, historical writings do not mention a specific female proclivity toward depression. Turning to modern times, Elizabeth Lunbeck's (1992) landmark study of the records of the Boston Psychiatric Hospital in the early 20th century offers a glimpse into the diagnosis and treatment of women and girls in that era. In Lunbeck's analysis, depression and melancholia were not diagnoses of high prevalence for women and girls treated at the Boston Psychiatric Hospital; indeed, these categories were only rarely applied to women. The historical evidence is too scanty and too fragmentary to conclude either that the gender gap has been constant across history or that it is historically contingent. However, in the absence of historical evidence for a gender gap in depression, it seems unwise to presume that such a gap has always prevailed.

Is Depression a Culture-Bound Syndrome?

Brute comparisons of rates of depression across national boundaries are not particularly meaningful. Expressions of suffering and demoralization take different forms in different cultures, within and across national boundaries. The configuration of emotion, thought, and action that we call depression is an enactment of suffering that is specific to contemporary Western societies. It typically involves negative affect, such as sadness and the inability to experience pleasure, a profound loss of interest in activities, and diminished zest for life. It also includes profound pessimism and negative beliefs about the self, as well as bodily symptoms of fatigue, reduced activity, trouble eating and sleeping, and loss of interest in sex (cf. Hollon, Thase, & Markowitz, 2002). These experiences have been codified into symptom criteria in the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV;* American Psychiatric Association, 1994) and the *International Classification of Diseases, Tenth Revision* (World Health Organization, 2002).

The *DSM-IV* criteria of depression include only a small fraction of depressive phenomena. Moreover the affective and cognitive elaboration of suffering that we call depression is particular to present-day, Western, industrialized societies. These societies, of course, comprise only a small fraction of the world's population. In global perspective, it is the Western expression of depression that is atypical (Jadhav, 1996). For most of the world's population, there are other modes of registering and communicating social suffering and demoralization. In South, Southeast, and East Asia, bodily complaints are prominent. In China, for example, suffering individuals report the sensation of chest pains, as if the heart is being squeezed (Kleinman & Good, 1985). A substantial proportion of depressed Sri Lankans describe burning sensations in the body, frequently on the soles of their feet. They do not register core depressive symptoms, either in their spontaneous accounts or when completing symptom inventories such as the General Health Questionnaire (Kuruppuarachchi & Williams, 2001). Indians (both men and women) frequently report semen loss and accompanying malaise. In Nepal, researchers from a psychosocial organization administered a standard inventory of depression (the Center for Epidemiologic Studies Depression Scale [CES-D]) to roughly 100 women whose circumstances placed them at high risk of depression. Only 3% of the women scored in the depressed range on the full scale; however, 18% exceeded the cutoff for depression when only the somatic subscale was considered, a six-fold difference (Eller & Mahat, 2003). In Nigeria, suffering individuals report feeling like ants are crawling inside their heads. "Soul loss" is a culture-specific enactment of depressive suffering among the Hmong people of Laos. In short, depressive suffering takes varied, culture-specific forms. These culture-specific forms are overlooked, even in diagnostic systems designed for international use.

The meanings and moral valuation of depressive suffering and the prescribed channels for managing suffering are also culture specific. Present-day Western accounts of depressive suffering (such as the account embodied in the *DSM-IV*) characterize such suffering as an aberrant experience and as a secular and medical (perhaps even neurochemical) problem. Such characterizations are not universal. Indeed, as Obeyesekere (1985) points out, the idea that such painful affects and cognitions as despair, worthlessness, pessimism, self-abnegation, and withdrawal constitute a problem is far from universal. Among devout Buddhists in Sri Lanka, these painful affects and experiences arise from the recognition of the existential human condition. Theravada Buddhist teachings counsel followers to cultivate willful dysphoria through prescribed meditation exercises. These include ruminating on death, feces, and bodily decay, as well as meditations on the impermanence of material goods, social relationships, and worldly pleasures. Many other spiritual traditions (including Islam and some forms of Christianity) have urged believers to cultivate grief, self-abnegation, and resignation to suffering as part of their spiritual practice. In a number of religious traditions, the embrace of grief and suffering is a mark of maturity, full moral personhood, and wisdom. My point is not that medicalized and secular views of depressive suffering are false or unhelpful. Rather, I only remind the reader that our views of depression are socially fashioned and culturally located. As a framework for theorizing and research, they shape the questions we ask, the phenomena we observe, and the interpretations we offer.

The range of depressive phenomena that we experience, their meanings (including the moral meanings), and the channels for relief are culturally located. We should therefore anticipate that gender differences in depression too will be bound up with culture. From a cultural psychologist's vantage point, the question is not whether more women than men meet the symptom criteria for depression in one country or another. Rather we should ask what strategies for expressing and managing suffering are available to women and men in particular settings.

Does the Diagnostic Category of Depression Have a History?

Whether seen in the long historical view or in a much shorter one, ideas of what constitutes depression are not fixed. An intriguing study by Jackson (1986) describes two idioms of dysphoria in Western history: melancholy and acedia. The genealogy of each of these terms reflects the religious, moral, medical, and psychological meanings that are intertwined in our ideas about depressive suffering. Over the centuries, the meanings of melancholy have shifted, variously emphasizing somatic, psychological, and moral aspects. Acedia also underwent shifts in meaning before disappearing entirely. At one time, the construct acedia referred to a state of

both indolence and sorrow. Thus, *acedia* had overtones of moral failing as well as personal distress.

Focusing more narrowly on the past century, we still observe flux in the diagnosis of depression. You will remember that Charlotte Perkins Gilman described her mental state in terms that closely resemble current symptom criteria for major depressive illness. Yet although Gilman received three diagnoses from leading psychiatrists, none of them alluded to depression. Perhaps clinical depression was understood differently in Gilman's day or perhaps it was eclipsed by other diagnostic categories that were believed to be the special province of women from Gilman's background. Contemporary researchers have expended considerable effort to craft explicit, objective, reliable criteria for diagnosing depression. Nonetheless, the meanings of depressive suffering ebb and flow in response to cultural currents beyond researchers' control. Psychiatric diagnoses depend largely on people's verbal reports of their subjective experiences. Hence, they are always entangled in linguistic practices and cultural meaning systems.

Two current cultural trends seem pertinent to North Americans' subjective experiences of depressive suffering. For the past several years, massive government-supported and commercial campaigns have been explicitly directed toward remaking popular beliefs about depression. The goal of these campaigns has been to inform people how vulnerable to depression they and their loved ones are, to give them tools to self-diagnose depression, and to promote antidepressant drugs. The government-sponsored campaigns have successively targeted younger and younger age groups (high school and college students) and, most recently, men (Kluger, 2003). Pharmaceutical companies that sell antidepressant drugs have sponsored even more insistent marketing campaigns. Whatever benevolent motives they might have, such mass media campaigns are potent cultural interventions. They promulgate a particular vocabulary for communicating one's suffering and for understanding emotional life. They accentuate psychologized discourses of suffering, selfhood, and social life, displacing philosophical, sociopolitical, or spiritual discourses (Rose, 1996). They also direct sufferers to remedies (notably antidepressant medication) aimed exclusively at symptomatic relief. Societal or sociopolitical changes are not mentioned as a means of alleviating depressive suffering.

The second trend pertains to the culture of psychotherapy. Recent decades have seen the rise to prominence of the concept of trauma as a primary explanation for women's suffering. In this context, trauma refers to experiences of gender-linked victimization, such as rape, sexual abuse, and many forms of intimate violence and intimidation. For feminists, the trauma idiom has offered a compelling means of narrating women's suffering. It has become a staple in the booming marketplace of popular psychology and women's self-help. The trauma idiom, along with the diagnostic category of PTSD, is in wide usage among feminist therapists and

others who claim special expertise in helping women. For instance, when Diane Kravetz and I interviewed 100 self-identified feminist therapists in the mid-1990s, several told us that trauma or PTSD was the diagnosis of choice for women. Taking the trauma history was an essential part of a clinical assessment. As many of these therapists understood it, the benefit of the label PTSD was that it had no implication of psychopathology. Instead, it signified to the client that she was having a normal response to a traumatic situation (Marecek, 1999). In contrast to the practitioners' embrace of PTSD, only a handful made mention of depressive disorders. Moreover, not one of these 100 experts on therapy for women identified the treatment of depression as one of her or his specialties. For the time being, the attractiveness of the diagnostic category of PTSD – a portmanteau that embraces a grab bag of symptoms and dysfunctions – may be eclipsing the category of depression, at least among feminist therapists, a group that constitutes an important subset of therapists who work with women. I hope that this volume succeeds in calling attention to depressive suffering and in sparking interest in developing psychotherapies that address the needs of depressed women.

This is not the place to elaborate the pros and cons of the trauma movement and the emergent field of traumatology. (For critical feminist readings of trauma, PTSD, and related issues, see Burstow, 2003; Haaken, 1998; and Lamb, 1999.) The point is that cultural and professional discourses about women's suffering bring forward alternate constructions of suffering, alternate names for it, and alternate enactments of it. In the real world of psychotherapy practice, diagnosing is less a matter of scientific accuracy than a negotiation with clients (and often third-party payers) to find a useful and acceptable way of framing the clients' problems. Such cultural practices and discourses confound researchers' efforts to produce true accounts of women and men who are depressed. In recent years, alternate discourses have often signaled feminist contestation over women's diagnoses. Indeed, feminist therapists' embrace of the categories of trauma and PTSD can be read as an effort to contest the biomedical perspective that has come to dominate the mental health professions. Ironically, however, PTSD has gained credence in the psychiatric mainstream by conforming more and more closely to the biomedical framework. Indeed, a prominent agenda for those who call themselves traumatologists has been to establish its neurobiological basis.

Truth in Tests? Measuring Depression

The discovery of antidepressant medications in the 1960s opened the way to a new kind of research on treatment efficacy. This research paradigm required methods of diagnosing clinical depression that were more reliable than clinical judgment and that yielded finer calibrations of depression.

Thus, rating scales and inventories replaced clinicians' judgments. Such rating scales can be seen as means of narrating depressive suffering. One of the most common measures of depression is the Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961). The BDI emphasizes cognitive and affective features that are germane to Beck's theories about the cognitive antecedents of depression. In fact, the BDI was originally designed to serve as an instrument for charting a client's week-to-week progress in Beck's cognitive behavior therapy, not a means of diagnostic classification. Inactivity, apathy, lassitude, weakness, and the wide variety of somatic complaints (such as burning feet and semen loss) are not assessed in detail.

Questions about how depression is measured bear directly on claims of a gender gap in depression. Is the gender gap a gap in depressive suffering or in the ways we measure it? Do men and boys express, experience, and enact such suffering differently than women and girls? If so, we must ask whether depression inventories index masculine and feminine enactments of depression equally. In our time and place, the emotion practices of men and boys are very different than those of women and girls (Shields, 2002). Stapley and Haviland (1989), for instance, reported that one of the strongest gender differences in self-reports of emotions was boys' tendency to deny experiences of negative emotion. Also, boys were less likely than girls to give elaborated reports of emotion connected to affiliative situations or relationships. Boys elaborated on emotions connected to activity, aggression, and achievement. If these childhood emotion practices persist in adulthood, men's experiences of depressive suffering may not be fully tapped by depression inventories. Depression inventories for adults typically do not include items concerned with disturbances in activities (e.g., sports) or feelings related to aggression (such as contempt and anger). Instead they accentuate disturbances in relationships and feelings related to sadness and despair.

Norms of masculinity in many subgroups of Euro-American societies put pressure on males to be cool, detached, and tough (McLean, Carey, & White, 1996; Oransky, 2002). An extreme example can be seen in an interview that Oransky had with a 15-year-old boy a few months after the World Trade Center attack in New York City. On the day of the attacks, the boy confided, he had concealed his fear that his stockbroker father had died in the attack because he believed his peers would ridicule him if he appeared upset. This boy and his peers, all from affluent white families, ridiculed emotional expression as "girly" and "faggy." Manly men, in these boys' eyes, deal with adverse events by stoically "sucking it up" and maintaining an unperturbed front. Do such norms shape men's enactment of depressive suffering? A study of clinically depressed men suggests that they do (Vrendenburg, Krames, & Flett, 1986). The men's self-descriptions emphasized work-related problems (e.g., inability to perform

adequately; difficulty making decisions) and somatic concerns (e.g., physical complaints; concerns about their general health). The men did not acknowledge crying, sadness, or dejection. Depression inventories may inadvertently accentuate emotion practices that men and boys feel obliged to repudiate because they are culturally coded as feminine. Inventories may also omit emotion practices consonant with norms of masculinity, for example, consuming alcohol or drugs. In settings in which masculine norms of emotional suppression and toughness hold sway, the extent of men's depressive suffering may be underrepresented.

The Epistemology of Epidemiology

The statistical scene setting that epidemiological data entail serves the rhetorical function of implying that unambiguous facts about depression are being provided (Reekie, 1994). Rates and counts transform depressive suffering into a bounded category, although in reality, the set of experiences we call depression is not a fixed entity, but an emergent set of social practices. The reliance on statistical counts also reproduces a binary logic of sorting depressed women from normal women. It leads researchers to focus on searching for psychopathological characteristics or social experiences that distinguish depressed women from their "normal" counterparts. Yet, depression is both an ordinary mood state and a clinical condition; the line between ordinary and pathological is under continual renegotiation.

Whether or not more women than men are depressed, it is important to study depressive suffering as a gendered phenomenon. It arises in the context of gendered social relations and gendered social institutions. The enactment, expression, and management of depressive suffering are necessarily bound up with cultural configurations of masculinity and femininity. Indeed, the characterization of depression as a woman's problem emerged alongside the emergence of the second wave of feminism in the United States. Various ways of figuring women's depression and understanding its origins closely parallel the ways that late 20th century women came to understand themselves. It is to this history that I now turn.

WOMEN'S DEPRESSION AND WOMEN'S LIBERATION

Middle Class Women and the Problem with No Name

Like other progressive movements of the 1960s, the women's liberation movement viewed psychotherapy as a suspect cultural institution. Feminists viewed therapists as complicit in perpetuating women's oppression. Movement members unleashed relentless critique of psychoanalysis, which was the prevailing theoretical framework of the mental health

professions. Psychoanalytic theories of female depression viewed normal femininity as incorporating such qualities as masochism, low self-esteem, dependency, disappointment, and inhibited hostility. These traits inevitably developed once a girl recognized that she lacked a penis. Freud described this realization as a permanent "wound to her narcissism" (1925/1974), one for which she blamed her mother. A "second reproach" directed to her mother followed: "It is that her mother did not give her enough milk, did not suckle her long enough" (Freud, 1931/1974).

For feminists of the 1960s, this kind of theorizing was intolerable. For them, women's depression was not a result of inferior anatomy but a social problem that demanded societal solutions. Naomi Weisstein's *Kinder, Küche, Kirche: Psychology Constructs the Female*, first printed in 1968 and reprinted 30 times thereafter, issued a scathing critique: (1) what is advanced as scientific dogma about women merely recycles cultural stereotypes and (2) psychology's claims about female nature grossly underrate the influence of social context. A few years later, Phyllis Chesler's *Women and Madness* (1972) charged therapists with putting women in a double bind. Norms of femininity required certain behaviors (such as emotional expressiveness and dependence) that were simultaneously regarded as psychiatric symptoms. Femininity was thus rendered pathological. At the same time, nonconformity too was judged pathological.

In keeping with the progressive political ethos of the 1960s and 1970s, women's liberationists put forward social models of women's depression. They sought its causes in the conditions of women's lives under patriarchy: Important among these were subordination in marriage; constricted economic, social, and political roles and opportunities; and adverse life events and circumstances. *The Feminine Mystique*, published in 1963 by Betty Friedan, painted a searing portrait of educated, affluent, suburban wives weeping into the kitchen sink on long, empty afternoons. Although we might suppose these women were depressed, Friedan called their demoralization "the problem with no name." The book launched a wide public discussion about middle-class marriage. Friedan's portrayal of middle class family life as a psychological prison for women resonated with many female readers and served to galvanize middle-class White women's participation in the fledgling women's movement.

Sociological research on the relation between marital status and psychological distress offered support for Friedan's charges. Walter Gove and his colleagues (e.g., Gove & Tudor, 1973) examined the rates of mental illness (not specifically depression) among men and women with various marital statuses. Using data from the 1960s, Gove repeatedly produced evidence that single, divorced, and widowed women had lower rates of mental illness than comparable men; married women, in contrast, had higher rates. In a similar study, Laurie Radloff (1975) focused specifically on depression,

examining symptom inventories gathered in community surveys. Radloff too reported that married women were at elevated risk for depression in comparison to other women.

Other sociologists investigated married life more closely. Lopata (1971) argued that the housewife role was so unstructured and diffuse that women who were housewives could obtain little sense of efficacy or accomplishment. Moreover, caring for small children in the confines of a nuclear household produced social isolation. Others noted that cultural expectations (bolstered by the opinions of mental health professionals) held mothers responsible for their children's lifelong mental health, happiness, and success (Caplan, 1989). Such impossible standards generated guilt, blame, and a sense of failure. Further, some theorists proclaimed that older women suffered a depressive empty nest syndrome when their last child departed from the home, leaving them without a role and sense of purpose.

The 1970s were a time when dramatic changes were initiated in gender arrangements in North America, particular among middle-class individuals. Legislative changes cleared the way for women's participation in higher education, professional occupations, and public life. Women gained a new degree of control over their reproductive choices. They entered the workforce in vast numbers. Progressive couples began to experiment with new childcare arrangements from day care to shared parenting to communal child rearing. Ultimately, few of the reforms went as far as feminists had hoped and many subgroups of women did not benefit from them. Many early claims and reforms pertained mostly to privileged women. For example, the possibility of personal fulfillment through paid work could only be realized by women who had access to rewarding jobs. For less advantaged women, low-wage jobs such as domestic service, assembly-line labor, and service jobs could well be tantamount to drudgery and economic exploitation. Nonetheless, the ethos of the times fostered scientific interest in social models of depression and other psychological difficulties. Popular culture, public institutions, and social researchers were open to the idea that social arrangements, institutional structures, and cultural values were implicated in women's depression.

Adverse Life Experiences

The idea that bouts of depression can be triggered by adversity has a long history in social research and robust support. Freud drew the connection between depression (or melancholia, as he termed it) and bereavement in 1917. The landmark studies of Brown and Harris (1978) identified a number of adverse life circumstances that raised the risk of depression among the women they studied in Camberwell, a working-class district of London. A more recent study found that more than 80% of people with

major depression reported that adverse life events had taken place shortly before they became depressed (Mazure, Keita, and Blehar, 2002).

The connection between adversity and depression (and many other forms of psychological distress) is a robust one. But can it explain the gender gap? Are women subject to a greater number of adverse experiences than men? Are there certain experiences that are unique to women and precursors of depression? Feminist researchers and practitioners have focused on gender-based violence and its effects on women's psychic life. They insisted that it was a common occurrence and often a devastating one for women. They also insisted that it was linked to gendered power relations and cultural sanctions for male dominance, sexual aggression, and physical violence. Some depression researchers argued that sexual violation and intimate violence – adverse experiences that predominantly affect women and girls – might account for the gender gap in depression (e.g., Cutler & Nolen-Hoeksema, 1991). Rape, sexual abuse, and intimate partner violence, however, lead to any of a large array of psychological and behavioral difficulties (Koss, Koss, & Woodruff, 1991). It is difficult to make the case that they are specifically connected to depression. Moreover, the response of any particular woman to such violation depends on a complex of factors. These include the circumstances surrounding the victimization, its subjective meaning to the victimized woman, the aftermath (including experiences with medical personnel, police, and legal system), the victim's psychological resources, and the social supports available to her. Although the connection between adverse events and depressive suffering seems unassailable, it does not seem particularly useful to search for a single objectively defined class of events that will account for women's depression.

THE RISE OF PERSONOLOGICAL THEORIES

Social models of women's depression resonated with feminist critiques of society and the mood of progressive social change that marked the 1970s. The 1980s, however, witnessed a sea change in American public life. The 1980 presidential election marked a dramatic swing to social and political conservatism, which included the rise of the religious right, a cultural backlash against feminism, the remedicalization of psychiatry, and the corporatization of medicine. Following in the culture's footsteps, scientific psychology shifted to the right as well. For example, the focus of attention shifted to genetics, the evolutionary basis of gendered behavior, and the neurochemistry of psychological disorders. Many in the mainstream of psychology and psychiatry saw this shift as a corrective to the misguided and unscientific emphasis on the sociopolitical and societal contributions to psychological disorder.

In a less overt way, the study of gender in psychology shifted in the conservative direction as well. For many psychologists, the focus of interest shifted from social forces to the psychic interior. The theorists who captured the stage were psychotherapists and personality theorists who proposed personological explanations of women's depression. These explanations emphasized such factors as personality traits (e.g., lack of assertion, acquiescence, dependence on others, suppression of anger, and low self-esteem), patterns of thinking, modes of interacting, or self-structures that were presumed to be distinctive to women. Although theorists regarded these qualities as originating in early social conditioning, they conceptualized them as qualities within the person, not as relational practices arising from and maintained by ongoing social life.

One example of a personological theory is response style theory (Nolen-Hoeksema, 1991). According to this theory, when women confront negative emotions, they engage in rumination. That is, they focus passively on their feelings of distress and on the possible causes and consequences of these feelings. Men, in contrast, engage in distraction, pushing away bad feelings by diversionary activities such as sports, drinking, and watching TV. Nolen-Hoeksema argued that rumination intensified depressed affect and hopelessness and thus could precipitate a full-blown clinical depression; distraction was a more effective coping strategy. Nolen-Hoeksema's claim of a global male-female difference in response style mirrored a prevalent gender stereotype. However, the idea that women ruminate and men distract themselves was not substantiated in further studies. People's reports of their coping strategies show more complex patterns and less gender differentiation. Both men and women sometimes ruminate and sometimes distract themselves (Strauss, Muday, McNall, & Wong, 1997). Other studies showed that the choice of strategy is domain specific, that is, it depends on what the negative feeling is about. Nolen-Hoeksema herself eventually abandoned her idea that rumination and distraction were gender-linked traits (Nolen-Hoeksema & Jackson, 2001).

More generally, explanations for women's depression based on presumed gender differences in personality risk oversimplification and overgeneralization. The search for gender difference falsely assumes that women are a homogenous group with uniform experiences; this conceals the considerable diversity among women (Hare-Mustin & Marecek, 1994). The idea that depressive symptoms reflect overconformity to societal norms of femininity does not take into account the multiple forms that depressive suffering takes. Nor does it adequately account for the multiple and sometimes contradictory norms of femininity. It also ignores the substantial numbers of men who are diagnosed with depression, most of whom were presumably not socialized to be feminine.

Personological explanations of women's depression suited the conservative times in which they rose to prominence. Although they view

femininity as a product of social conditioning, they do not develop a close analysis of when, where, and how such conditioning occurs. Nor do they explain how it is that women can be recruited to projects of femininity that exact such a price in emotional pain and dysfunction and why they remain mired in them. They risk portraying women as docile victims of culture, who have no means of resistance. Furthermore, personological explanations place the onus of change on individual women. They advocate individualistic technologies of change (psychotherapy, assertiveness training, and cognitive retraining), while leaving social structures untouched.

CULTURAL FEMINISM AND WOMEN'S DEPRESSION

The especial genius of Woman I believe to be electrical in movement, intuitive in function, spiritual in tendency. [M]ale and female represent the two sides of the great radical dualism. Margaret Fuller, 1845/1976

The 1980s ushered in a revival of the notion of a great radical gender dualism, which caught the fancy of a broad swath of North American women. A subset of feminist thinkers extolled women's gentle heroism, harmony with nature, pacifism, superior morality, and ethic of caring for others. This body of thought became known as cultural feminism. In psychology, writers such as Carol Gilligan and the Stone Center group claimed that women were endowed with a unique psychology that encompassed qualities of intuition, empathy, beneficence, and the capacity to nurture others. From these claims sprung another model of women's depression.

The crux of the model was a radical dualism reminiscent of Margaret Fuller's, but framed within psychodynamic theory. In this model, girls and boys develop distinctively different selves and different capacities for relationships during the earliest months of life. In the mother-infant dyad, girls develop a self that is more permeable, less bounded, and more attuned to others. They develop both a capacity and a need for intimate emotional relationships. Nancy Chodorow (1978), who formulated the original version of this theory, was careful to locate her developmental account in the context of the gender and family arrangements specific to late-20th-century, Euro-American, postindustrial capitalism. However, as psychologists and psychotherapists took up Chodorow's ideas, her meticulous sociological groundwork slipped away. What remained was the idea that "the" mother-daughter relationship (now constituted as universal, not as a contingent social arrangement) produced a specifically feminine developmental trajectory and personality structure. All women were said to be oriented to caring for others and to have a special empathic attunement to others' needs. At the same time, they required emotional intimacy and empathic

connection in their personal relationships. When intimacy and connection were unavailable, women could not develop and grow psychologically (Miller & Stiver, 1997).

Relational theorists have drawn on these ideas to develop accounts of women's depression (e.g., Jack, 1991; Kaplan, 1991; Miller & Stiver, 1997). Dana Jack (1991) has put forward the most substantial account. Jack's model of women's depression involves what she has called "Silencing the Self," which is a constellation of self-abnegating beliefs and practices. For example, some key beliefs are that caring demands self-sacrifice and that one should inhibit one's actions and speech to avoid displeasing others. Some key practices include judging oneself according to standards held by others and presenting a compliant and agreeable facade despite inner feelings of anger and resentment. In Jack's model, women have a special fear of emotional abandonment that emerges from their needs for emotional intimacy. Therefore, they are prone to silencing the self, that is, suppressing their needs and feelings for fear of losing relationships. Silencing the self in this way is ultimately self-defeating, however. It leads to a loss of self and it thwarts any chance for genuine intimacy and connection. This impasse places women at risk for depression.

This is not the place to recount in detail the intricate bodies of writing concerning women's relational identity or the controversies they evoked (Becker, 2005; Bohan, 1993; Hare-Mustin & Marecek, 1990; Westkott, 1997). One of the strengths of this body of theory is its careful attention to the minute details of women's daily lives and especially to what women themselves say. The nuanced accounts of women's sorrows, joys, ambivalences, and frustrations often evoke in female readers a sense of deep familiarity. Nonetheless, efforts to validate systematically the gender dualism on which these theories are grounded have not been successful. For example, a meta-analysis of 113 studies found only a small difference between men and women in the "ethic of care" proposed by Carol Gilligan (Jaffee & Hyde, 2000). Moreover, two studies, both using a scale that Jack herself has designed, have found that, contrary to her claim, men had higher scores than women on a Silencing the Self Scale (Gratch, Bassett, & Attra, 1995; Jack & Dill, 1992).

Claims about the emotional experiences and identity development of infants cannot easily be assessed. We do know, however, that even within the United States, childcare practices vary considerably depending on cultural background, family structure, residence patterns, and economic situations. The idea that the affective relationship between mothers and their baby daughters takes a single universal form seems implausible. Moreover, much of the effort to identify a feminine intrapsychic makeup that puts women at risk for depression rests on observations of women who are already depressed. Kaplan, Miller, and Stiver, for example, drew upon case studies of women in their psychotherapy practices. Jack studied a

group of clinically depressed women. What these theorists described may aptly characterize women once they are already depressed. But that does not suffice as an account of how they *became* depressed (Barnett & Gotlib, 1988).

BEYOND THE MEDICAL MODEL: CULTURAL AND CONSTRUCTIONIST STUDIES OF DEPRESSION

Scientific knowledge is shaped in accord with the social and cultural circumstances of those who produce it. As Ludmilla Jordanova has said,

It is a mistake to separate the knowledge claims of medicine from its practices, institutions, and so on. All are socially fashioned, and so it may ultimately be more helpful to think in terms of mentalities, modes of thought, and medical culture than in terms of "knowledge," which implies the exclusion of what is inadmissible. (1995, p. 362)

Many parts of the knowledge-producing process – deciding what should be construed as significant facts, choosing which ones are relevant and important to the question at hand, and crafting an interpretation – are rooted in a researcher's epistemological commitments and cultural location. Whether implicit or explicit, whether consciously acknowledged or not, researchers hold some vision of how the world works and that vision guides our investigations. At best, we can hope to become conscious of that vision and cognizant of how our place in the world contributes to it.

Depression became identified as a woman's problem in the context of the second wave of the North American women's movement some 35 years ago. Indeed, women's depression became an object of scientific curiosity because a group of early feminist psychologists refused to take women's unhappiness as normative. Their critiques challenged the normal versus pathological distinction. They also challenged the medical model and insisted instead that women's subordination was the soil from which depression sprouted. Later epochs of second-wave feminism put forward different images of depressed women, each with a distinctive moral geography and a distinctive understanding of what constituted *woman* and *femininity*. Today, most researchers on women and depression operate on far less edgy ground than those early feminist critics. They hew to conventional positivist epistemologies and seem to regard canonical research and diagnostic technologies as unproblematic. Among other contributions, their work has made women's health (if not gender and health) a subject of legitimate inquiry. Moreover, their work has served to insinuate some sociocultural issues into traditional views of psychopathology (cf. Marecek, 1993). But all epistemologies and technologies are accompanied by characteristic blind spots, deforming their objects of study in characteristic ways. For example, work on women and depression has seldom looked

beyond the notion of gender as qualities located inside individual men and women. Much of the research remains lodged in a reductive framework in which internal qualities such as low self-esteem and suppressed anger are identified as the vital forces behind depressive suffering.

There are few studies concerned with gender and depression that have looked beyond the medical metaphor of depression, which holds it to be akin to a physical disease. Medicalized constructs of depression reduce a complex and socially embedded experience to a single identity. They discount a depressed woman's account of her experience, no matter how complex, astute, and rich it might be. Her words are meaningful only insofar as they meet or fail to meet some symptom criterion. (See Stoppard & McMullen, 2003, for an alternative approach.) Moreover, medical models of depression seem to obviate the need for investigating the constitutive nature of society, culture, and history. As Szekely has commented, "Once a phenomenon has been constructed as a disease, the sociocultural can only be viewed as a factor that further undermines the weak personality of the individual" (1989, p. 176). In this final section, I consider some areas of inquiry about women and depressive suffering that come to mind once we heed Jordanova's words and think about mentalities and modes of thought, rather than knowledge.

The Cultural Politics of Diagnosis

The demarcation of depression as a category of disorder is not a neutral scientific accomplishment, but an endeavor imbued with cultural values and political interests. Indeed, of all psychiatric categories, depression raises the most questions of cross-cultural validity (Jadhav, Weiss, & Littlewood, 2001). Transforming certain emotions and practices into disorders pathologizes them and those who engage in them.

Psychiatric diagnoses inform cultural notions of normality and abnormality, mental health and illness. Historians of medicine have elucidated many examples of psychiatric diagnoses that were used to control behavior and stigmatize those who did not conform to prevailing standards of conduct. For example, scholars have detailed various diagnoses used for women who violated standards of sexual, maternal, or wifely behavior. Postcolonial theorists have detailed how diagnoses of actors as "mad" and actions as "madness" justified the coercive power of the colonizers (e.g., Mills, 2000).

Suman Fernando (2003) recently recounted the reactions of colonial psychiatrists when they realized that depression was comparatively rare among non-Western colonial subjects in some parts of Africa, South Asia, and Southeast Asia. One might think such apparent immunity from depression would be regarded as a psychological strength. However, the absence of depression among colonial subjects was deemed to result from moral

deficiency (such as "irresponsibility"), psychological immaturity ("psychic underdevelopment"), and primitive and childlike natures. This might lead us to ponder the meanings and morality of depression in present-day North American men and women. Depression seems to carry a certain social stigma, whether the sufferer is a man or a woman. Beyond that, is the lower prevalence of depression among men regarded as a sign of moral or psychological immaturity? Is women's depressive suffering taken as an indicator of advanced development, greater maturity, moral superiority, or psychological strength? This seems unlikely. It seems more likely that a diagnosis of depression may convey connotations of weakness, lack of agency, and perhaps self-pity. An important topic for further investigation is whether a diagnosis of depression changes its meaning and moral value according to the social position of the sufferer.

Antidepressants and the Construction of Subjectivity

At present, in the United States, most people (about 75%) who are treated for depression receive antidepressant medication (Kluger, 2003). Antidepressants account for nearly 8% of retail drug sales in the United States (Pomerantz, 2003). In North America, drugs that modulate other aspects of psychic life are plentiful as well. This everyday presence of psychotropic drugs has been incorporated into ordinary people's folk psychology. For example, some people now explain depression as a chemical imbalance; some even refer to chemical depression. Such simplistic biomedical constructions of self, identity, and disorder may contribute to a mechanistic view of human life. Moreover, by obscuring how the *social* is implicated, they discourage a sociocultural analysis of depressive suffering. The literary critic Jonathan Metzl (2002) has explored a genre of literature that he calls the Prozac novel (e.g., *Black Swans*, *Prozac Highway*, *Prozac Nation*, all written by women). Metzl considers how sufferers understand the transformations of personality and self wrought by antidepressants. This kind of study need not be left to literary critics and it need not be limited to fictional texts.

Producing Gender through Depressive Suffering

Bringing a constructionist viewpoint to the study of women's depression opens some novel questions. For social constructionists, gender is not something people are, but what they do and say to produce themselves as (particular kinds of) men and women (Marecek, Crawford, & Popp, 2004; West & Zimmerman, 1987). Similarly, depression is not something people have, but a set of practices authorized by the culture through which people express to others that they are suffering. How have enactments of depressive suffering changed over historical time? Are different

enactments available to people who occupy different social positions? How do those enactments reproduce and reaffirm those social positions? What does women's depressive suffering accomplish in the social worlds they inhabit? Does the enactment of suffering serve as a means to effect changes in contentious social roles and relationships? Is it a means to renegotiate mutual rights and responsibilities (cf. Hunt, 2000)? Rather than asking if adverse events cause depression, a constructionist inquiry might construe adversity as a problem that prompts a woman to initiate a line of action. Depression in this framework is one of many possible lines of action, not a passive giving up.

Many scientific stories can be told about women's depressive suffering. Each is constructed from a particular theoretical vantage point and each reflects the gender politics of a particular cultural moment. All are partially true. Our task is not to sort through them in search of the single correct one. Nor is it to find a rubric that would bring them all together into a comprehensive master account. That is impossible because the premises behind the stories and the disciplinary commitments they entail are incommensurate. In my view, we serve our scholarly purposes well by stepping back to examine these stories as culture artifacts. We will not only situate women's depressive suffering in social and historical perspective, but situate ourselves in that perspective as well. That way, we can glimpse how psychology and culture – like discourses in a mirrored room – mutually constitute each other.

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