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Factors Associated with Depression among Women

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Abstract

The study intended to formulate a conceptual model for understanding factors associated with depression among women from the perspective of the gender and power and Cognitive-behavioral theories. The authors reviewed empirical literature related to foundational explanations of two theories of gender power and cognitive-behavioral approaches as they relate to depression amongst women. Empirical data were reviewed, leading to the development of an integrated model for understanding and addressing depression amongst women. The model acknowledges the dominant role played by bio-chemical factors in predisposing one to depression, and contends that other intervening factors, in this case, mediator, should also be considered. It is recommended that academicians, social work practitioners, and health professional test the presented model within their respective localities.

Keywords: Depression, women, conceptual framework.

Introduction

Depression is a psychiatric disorder characterized by an inability to concentrate, insomnia, loss of appetite, anhedonia, feelings of extreme sadness, guilt, helplessness and hopelessness, and thoughts of death[1.] Depression is a disorder that has been medically and socially identified as a very serious condition that can influence every aspect of life of the individual experiencing it[2]. Depression is also associated with a high rate of mortality. According to the World Health Organization (WHO),[3] depression is one of the leading causes of the global burden among all diseases worldwide. It is projected that it will be the second leading cause of health disability by 2020[4.] WHO[5] estimates that depression affects an estimated 121 million people worldwide, and that 73 million of them are women. In Africa, HIV and AIDS has been identified as a leading cause of depression amongst women. Case studies in Zambia, South Africa and Uganda reported depression levels amongst women living with HIV at 85%, 40% and 534.3% respectively[6]. In Botswana, health statistics list depression as the second largest leading cause of psychiatric morbidity among outpatients, with women having more depression as compared to men[7].

Despite this, very little is known about depression as a mental health problem in developing countries like Botswana. However, the government has put health care in place systems and policies that are used to assist people with depression. There is a dual care system being informal (traditional) health care and formal (western) health care systems. People choose their preferred system based on their beliefs and experiences. Some utilize one while others utilize both. Mental health care is provided through the Ministry of Health, via the mainstream health care system and through mental health hospitals. Currently there are two mental hospitals and one outpatient psychiatric unit. In the mainstream health care system, there are health wards in hospitals and community mental health nurses in the clinics. Provision of services is mainly guided by the *National Health Policy on Mental Health*[8].

Statement of the Problem: Women who are depressed are likely to be less productive leading to low or no outputs at work and within their families. For depressed women with children, depression can also contribute to deviant behavior amongst children as a result of poor parenting. Studies have also shown that high levels of stress, which is a precursor to frustration and depression, compromises women's immune system making them susceptible to other opportunistic immune deficiency morbidities[9]. At community level, women continue to be caregivers taking care of the sick and elderly and most of the family husbandry is the responsibility of women including parenting from birth to adulthood. For women to play this role they need to be healthy and depression free. It is therefore of paramount importance for the health sector to identify the critical factors associated with depression among women in order to address the problem comprehensively. Hence, factors associated with depression amongst women should be known and a conceptual model developed so that those factors could be better understood and addressed.

Purpose of the review: Though the imbalance in depression cases among men and women has been identified, the imbalance has not been interrogated conceptually. The purpose of this paper therefore, is to suggest a conceptual model for understanding factors associated with depression among women from the perspective of the gender power and cognitive-behavioral theories.

Significance of the review: The systematically analyzed factors associated with depression provide social workers and other health workers with an empirically-based framework that could inform their practice. The outcomes of the study also contribute empirically-based information for the Social Work profession which could lead to curriculum review in relation to the subject of factors associated with depression among women.

Research Methodology

The authors reviewed literature related to foundational explanations of two theoretical models of gender power and cognitive-behavioral approaches as they relate to depression amongst women. Data from studies done worldwide was used to develop an integrated model for understanding depression among women. The interrelationships between associated factors were interrogated leading to the development of an integrated model for addressing depression amongst women.

Literature Review: The theory of gender and power: Coined by Robert Connell, this theory seeks to explain the dynamics of relationships between men and women in the society. The theory states that relationships between men and women can be explained using social and environmental factors. Societal expectations, parenting roles, and multiple gender differences that are influenced by environment might lead to depression. This study borrows from Wingood and DiClemente's theory of gender and power which argues that relationships between men and women can be better explained through four associations: Labor and socioeconomic status, power, structure of cathexis and biological explanations. Wingood and DiClemente used this theory to explain the prevalence of HIV among women. The theory states that in society, there are three structures that denote men and women's lives. These are the sexual division of labor, the sexual division of power and the structure of cathexis. The theory offers an empirical way to assess the effects of socially-defined gender roles of the structural dimensions involved with them in daily life. The theory provides a way to assess not only at the overall content but also at the general quality of women's lives as compared with that of men. Women are overburdened by the multiple and complicated roles of primary parent, wife, and paid worker[10].

The structure of sexual division of labour refers to the culturally and socially assigned roles and responsibilities of both men and women. One notes that society assigns women a lot of responsibilities and conflicting roles. Women are therefore overburdened with multiple roles and responsibilities and culturally expected to maintain their own, as well as their sons', husbands' and boyfriends' health[10]. Moreover, most of the roles given to women are those that are not paying and are physically and emotionally demanding and engaging. Nazroo, Edwards and Brown[11], report that women are more likely to have depression as a result of their roles which then lead to differences in the experience of life events. Sub- associations of labour and depression in women include socio economic status, caregiving and orphanhood.

The structure of sexual division and power relates to power differentials that exist between men and women. Depression is associated with loss of power among women and feelings of helplessness and hopelessness. Women are not likely to be given positions of power in society, thus rendering them powerless to change their life circumstances. In the sexual divisions of power, men are given positions of responsibility in the personal and political arena. This helps them to have power to make decisions that favor them. By virtue of women not being in those positions, their voices are not heard and their needs less likely to be met. Low paying and unchallenging jobs are also said to lead to decreased psychological well-being and subsequently depression[12]. Sub associations of power and depression include gender based violence and decision making.

Structure of cathexis relates to the sexist cultural norms, beliefs, stereotypes that define and confine men and women's behaviour. The structure of cathexis is also known as the structure of social norms and effective attachments. In this structure, certain expectations on how women's sexuality should be, are held by the society. This is also characterized by emotional and sexual attachments women have with men and the importance thereof. Acceptance of gender roles by women has negative health outcomes[13]. Gender role internalization exacerbates and mitigates psychological distress and ultimately mental ill health[14].

For purposes of the study, biological factors have been adapted to mean bio-chemical factors. Several studies have linked biochemical factors to depression among women. Central nervous system neurotransmitter abnormalities are linked to depression. Neurotransmitters are chemical messengers within the brain that makes possible communication between the nerve cells. Specifically, depression is linked to chemical imbalances of serotonin, norepinephrine (noradrenaline), glutamate, cortisol, dopamine Acetylcholine and GABA systems in the brain[15.]

Serotonin is responsible for a lot of functions in the brain, such as mood regulation, pain tolerance, sleep patterns, and appetite. Low levels of Serotonin prompt a drop in norepinephrine levels thus leading to depression. Norepinephrine helps our bodies to identify and react to stress. People with low norepinephrine levels tend not to handle stress well- leading to depression. Dopamine regulates one's ability to have a sense of pleasure hence low levels of dopamine lead to depression[16]. Sub associations of the bio chemical explanation and depression in women include genetics, hormone and reproductive events and health status.

Cognitive-behavioural Approaches: Cognitive-behavioral approaches focus on mental events such as thinking and feeling and how they influence behaviour. The theory holds that people

are influenced by the interactions between their behaviour, thoughts, and environmental events. Proponents of this theory are Albert Bandura, Aaron Beck, Abert Ellis and Martin Seligman. They argue that faulty information processing, irrational thinking and distorted judgments affect behaviour negatively[17]. Beck's Negative Cognitive Triad further explains that depressed people experience a range of negative thoughts about themselves, the world, and the future.

Contributing to the theory, Nolen-Hoeskema et al[18]**,** states that women tend to ruminate about issues. For example if one had a negative experience, instead of just viewing it as one of those things and moving on, they over analyze the issue, find reasons for it, rehearse it over and over and thus re-live the negative emotions associated with such an event and other past painful events. This then hinders one's healing process. In a nutshell, the theory suggests that the way women view and interpret stressful life events determine whether they will be depressed or not.

Coping mechanisms in women might also contribute to depression, especially that when women are depressed, they worry and ruminate, which worsens the issue. Women are also said to develop depression under relatively low stress levels as they have the tendency to blow the issues out of proportion. Piccinelli and Wilkinson[16] stated that psychological attributes and individual differences in coping skills play a role in depression in women.

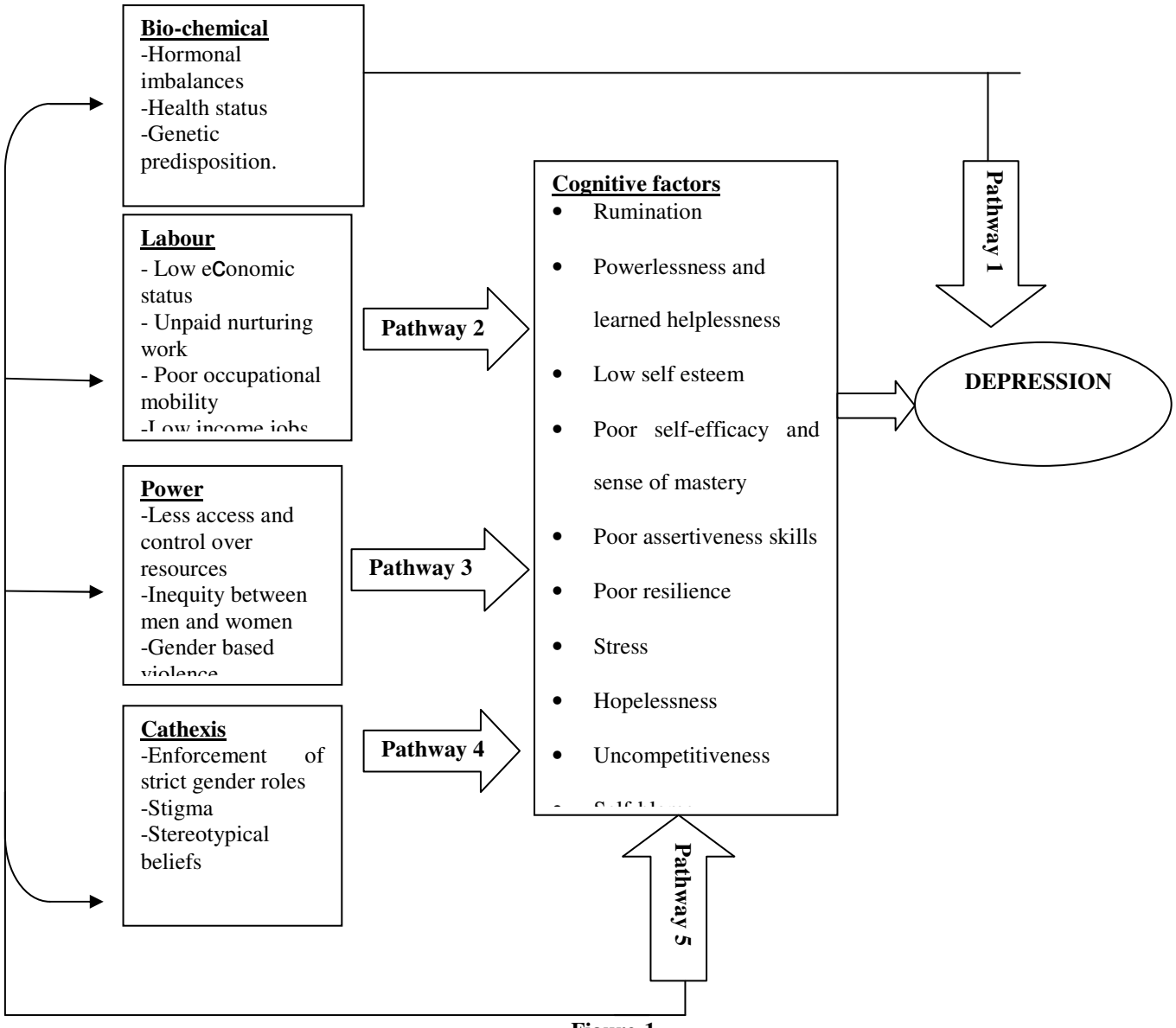

Figure-1
A Proposed Conceptual Model for Understanding Depression among Women

Results and Discussion

The Proposed Model: This paper proposes a conceptual model of depression which links two integrated theories, being the structured theory of gender and power (structures of labour, power, cathexis, and bio chemical properties) and Cognitive-behavioral approaches. The model argues that even though biological predisposition can directly lead to depression, the broad socio-economic structural factors may not directly lead to depression; hence some mediating factors have to be considered. Cognitive-behavioral factors are mediators between the broad socio-economic structural factors and depression. Thus the model proposes five pathways to depression as stated below:

Pathway 1: Bio-chemical Properties: In this pathway, the bio-chemical properties are directly associated with depression. The bio chemical function of the reproductive and central nervous system such as hormonal imbalances and chemical balances are directly associated with bio-chemical depression even without interacting with other factors. Nazroo and Edwards[11] speculate that there is evidence from twin and family studies to the effect that genetic factors are operating in the genesis of depression and affective disorders[19]. The link between depression and hormonal and chemical imbalances is also supported by Afifi[15], who urges that depression is linked to chemical imbalances of serotonin, norepinephrine (noradrenaline), glutamate, cortisol, dopamine Acetylcholine and GABA systems in the brain.

Pathway 2: Sexual division of labour, SES and cognitive factors: Factors related to sexual division of labour, socio economic status, low income jobs, unpaid nurturing work and poor occupational mobility lead to negative cognitive interpretations to lead to depression. Karasek and Theorell[20], argue that many recent studies demonstrate that workers in jobs with high demands and low control tend to report greater depression and anxiety. When women constantly find themselves in disempowering positions as characterized by low socio-economic status, they appraise themselves negatively, develop low self-esteem and feel they have no control over their situations. This then leads to depression.

Pathway 3: Sexual division of power, Gender based violence, caregiving and cognitive factors: Factors linked to sexual division of power, gender based violence, caregiving combine with cognitive factors to lead to depression[21]. In the social strata women appear to have less power and access to resources. They tend to stay in undesirable conditions to acquire the basic necessities of life. These undesirable conditions entail situations such as keeping an abusive partner and working under undesirable conditions. They become powerless and helpless in these situations. Moreover, these conditions instigate severe emotional, physical and psychosocial factors and serious consequences such as poor resilience, self-blame and disempowerment that bring about depression. McGrath, Keita, Stickland, et-al[22], elucidate that both greater exposure to stressful life events and lack of coping resources (personal, social and economic) have been found to contribute to depression in women.

Pathway 4: Structure of cathexis and cognitive factors: Factors related to how women perceive their relationships with men and significant others, interplay with cognitive factors to lead to depression. Furthermore, strict cultural norms and stereotypical beliefs influence women's gender identity. Internalizing such beliefs and norms can lead to poor assertiveness skills, low self-esteem and poor self-efficacy, hopelessness and depression. In addition, women who tend to disregard such norms and roles are stigmatized and isolated, compounding the issue further.

Pathway 5: Bio-chemical, sexual division of labour, sexual division of power, structure of cathexis and cognitive factors: In this pathway, all the factors interact to lead to depression. All the four structures of the theory of gender and power interact together with cognitive factors and initiate depression. Genetic predisposition, hormonal imbalances, health status, low income jobs, unemployment, abusive relationships, strict cultural beliefs, inadequate opportunities in decision making and cognitive factors intermingle to lead to depression. Women experience emotion focused coping, external locus of control and learned helplessness that in turn brings about depression.

Recommendations: Governments should ensure that they develop health policies with are responsive to women. Such policies might ensure: i. Training of enough professionals on mental health and line Ministries. ii. Availability of responsive, integrated, comprehensive and linked social services. iii. Support for initiatives that aim to eradicate poverty. iv. Early identification and treatment of mental ill health, especially depression.

A multi-disciplinary approach to mental ill health has to be at play in designing treatment plans for consumers in all mental health centres. Treatment should include social based intervention (psychotherapy) as well as biological based intervention (medication). The treatment program should address the individual and family needs and the community and government should take responsibility for the treatment program.

The approach to addressing issues and support for people with mental ill health should reflect complexity, circular nature of causal variable and interconnectedness nature of factors contributing to depression. The issue should also be addressed from a multi sectorial perspective with families, NGOs, faith based organisations and different government ministries working together.

Programmes should be gender sensitive and gender specific as most factors disadvantaging women like poverty, low economic status, lack of involvement in decision making, gender in equality, gender based violence, teenage pregnancy and other related issues addressed by various policies are associated with depression among women. The paper also recommends that

academicians, social work practitioners, and health professional should test the presented model in their respective localities.

Conclusion

The paper argues that there is no one theory that can fully explain the relationship between depression and women. The current debates in mental health are of the view that, generally mental health cannot be fully explained by any one theory. Rather a buffet of theories should be considered, especially that there are circular interactions and confounding variables in terms of contributing determinants, risk factors and buffers. The same applies to factors contributing to depression among women. Though authors argue that no one theory can explain depression, they do not suggest with an alternative theory. Hence this paper concluded with a conceptual model of depression which links two integrated theories, i.e. gender and power and cognitive behavioral approaches. The model argues that even though bio-chemical predisposition can lead to depression, other factors on their own cannot do so, as there are some mediating factors to be considered. For example the loss of a loved one does not necessarily lead to depression, but may depend on how one appraises the situation, and on whether one has social support or not. That is to say cognitive behaviour factors are used as a mediator between the broad socio-structural factors.

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