Chapter 5

Mood Disturbance across the Lifespan

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As the most frequently reported form of mood disturbance, depression is said to be the "common cold" of emotional distress. Sadness is a common, human response to loss, failure, rejection, or disappointment. This sadness can be profound, as it may be after the death of a loved one. However, sadness is not depression unless it becomes complicated by negative feelings about our futures and our selves. Depressed people feel badly about themselves, they blame themselves for things going wrong in their lives, and they have trouble imagining a better future. Depression that is clinically meaningful involves physical symptoms as well, including changes in appetite, energy levels, and sleeping patterns. Depression is usually preceded by one or more highly stressful life events, which typically involve loss or devaluation, such as the break up of a relationship, or failure at school or work (Brown & Harris, 1978). Even positive life events can entail an element of loss and so risk depressed mood. For instance, when women first become mothers, they may be overjoyed by the baby's birth but at the same time feel that they have lost freedom and control over their lives.

An important contextual factor that is related to depressive symptoms is poverty. Children who live in poverty endure a number of other conditions that may account for the link with depressive symptoms. For instance, poor children are more likely to live in neighborhoods with social problems, less likely to participate in activities outside of school and more likely to have a mother who is depressed and who uses physical punishment to discipline them; these intervening variables appear to account for the association between child poverty and depressive symptoms (Eamon, 2002). Among adults, poverty is associated with being unmarried and living

in a rundown, unsafe environment, both of which appear to account for the association with depressive symptoms (Ross, 2000).

One of the most robust yet mystifying facts about depression is that girls and women are twice as likely as boys and men to experience it. The lifetime rate of clinical depression is 20-25% for females and 7-12% for males (Nolen-Hoeksema, 1987). The rates are equal only before the age of 10 and after the age of 80 (Jorm, 1987). Thus, girls and women are more vulnerable than boys and men across most of the lifespan. In this chapter, we attempt to understand what it is about the lives of girls and women that make them vulnerable to depressed mood.

<1>Biological Explanations: Hormones and Genes

The fact that the gender gap first emerges in early adolescence has suggested hormonal origins to many researchers. Recent research confirmed that the gender difference emerges at puberty, regardless of the age at which that occurs (Angold, Costello & Worthman, 1998). Girls experience a sharp increase in depression at this time, while boys experience a sudden decrease. However, the fact that puberty increases girls' risk for depression does not mean that hormones cause depression. The hormonal changes associated with puberty coincide with significant social and emotional changes in children's lives. Thus, pubertal girls may be at risk for depression because of hormonal or social factors, or a combination of both. For instance, negative life events seem to be more depressing for pubertal than pre-pubertal girls (Silberg et al., 1998).

Although researchers have long speculated that women's depression is caused by such hormonal events as puberty, menstruation, childbirth, and menopause, no specific hormonal mechanisms have been identified. There is no evidence that menopausal women are at special risk for developing depression (Ballinger, 1990), which makes a hormonal explanation for those depressions that do occur unlikely. The picture for premenstrual syndrome (PMS) and

postpartum depression (PPD) is more complex but not yet clear. For instance, consistent with a hormonal explanation, there is a subgroup of women who are at high risk for depression after childbirth (Cooper & Murray, 1995). However, only thyroid dysfunction has been consistently associated with some cases of PPD (Hendrink, Altshuler & Suri, 1998). Additionally, women who suffer with PMS (Graze, Nee & Endicott, 1990) and PPD (Whiffen, 1992) are at risk for depression at other times in their lives, which indicates that their periods of depression coincide both with times of hormonal change and with times of stability.

It is possible that reproductive hormones have an impact on the neurotransmitters implicated in depression. Neurotransmitters are chemicals in the brain and nervous system that influence moods. Female hormones have an impact on how neurotransmitters are made and used by the nervous system. However, there is no evidence directly linking depression to hormones. In addition, the hormones that are most clearly linked to depression, such as cortisol, do not differ between the sexes in a way that explains the gender difference.

In contrast, depression clearly has a genetic basis. While the genetic contribution to adult depression is equal in men and women (Kendler & Prescott, 1999), studies of adolescents show that genetic factors appear to play no role at all in adolescent boys' depressive symptoms (Jacobson & Rowe, 1999; Silberg et al., 1999). The meaning of this finding is not clear. Some researchers argue that the genes responsible for depression are "turned on" in girls during puberty (Silberg et al, 1999), while others argue that depression genes simply are more strongly expressed in girls than in boys (Jacobson & Rowe, 1999).

<2>Psychological and Social Factors

Depression is associated with a variety of psychological and social risk factors, including dysfunctional beliefs (Beck, Rush, Shaw & Emery, 1979), ruminative coping (Nolen-Hoeksema,

1987), a tendency to feel hopeless (Abramson, Alloy & Metalsky, 1989), and personality traits such as dependency and self-criticism (Coyne & Whiffen, 1995). All models of depression are "diathesis-stress" models, that is, they assume that the underlying risk, whether biological or psychosocial, must be triggered by life stress in order for depressed mood to develop. In this chapter, we focus on two classes of risk factors that have been implicated in female depression throughout the lifespan: gender role and problematic relationships.

<1>Gender Role

The term gender role is broad, and can refer to the socialization of gender-typed personality traits, to social conditions that typically are associated with one gender more than the other, or to the enactment of gender-typed behaviors such as care giving.

<2>Personality Traits.

The socialization of boys encourages the development of instrumental personality traits such as independence and decisiveness, while girls' socialization encourages the development of interpersonal and expressive traits such as empathy and caring for others. By early adolescence, girls possess fewer instrumental traits than boys do. Susan Nolen-Hoeksema and Joan Girgus (1994) argued that this relative lack of instrumental traits impedes girls' ability to cope with the biological and social challenges of adolescence. Consistent with this hypothesis, adolescents who self-report high levels of instrumental traits are more confident about their ability to solve problems, which protects them from feeling depressed (Marcotte, Alain & Gosselin, 1999). In addition, some researchers argue that depression is linked to the socialization of negative feminine traits, such as passivity and over-involvement with others to the exclusion of self (Helgeson & Fritz, 1998).

<2>Body Dissatisfaction

The normal changes associated with puberty mean that girls gain fat, especially in their breasts and buttocks, while boys become taller and more muscular. Thus, girls move away from societal ideals about thinness, while boys move closer to the ideal for men. As a result, body dissatisfaction is normative among adolescent girls, but rare among boys. This is problematic for girls because physical attractiveness is a central component of adolescents' self-esteem. Attractiveness determines popularity with both sexes and in girls may over-shadow other characteristics such as intelligence and ability. Not surprisingly, body dissatisfaction is associated with depressive symptoms in both sexes. Girls who feel dissatisfied about normal physical changes have lower self-esteem and are more likely to be depressed than girls whose attitude toward their bodies is more positive (Wichstrom, 1999).

<2>Interpersonal Violence

Girls and women are more likely than boys and men to be victims of violence, especially in intimate relationships. All forms of interpersonal violence, including sexual assault and physical abuse, are associated with depression, especially in girls and women (Weaver & Clum, 1995). In particular, researchers have focused on a history of childhood sexual abuse (CSA), which is strongly associated with adult women's depression. When a history of CSA is controlled for statistically, the gender difference in adult depressive symptoms disappears (Whiffen & Clark, 1997), which suggests that CSA may explain why girls and women experience more depressed mood than do boys and men.

A history of CSA may make it difficult for girls to cope with some of the challenges of adolescence, such as changes in their bodies and dating. Girls who were sexually abused as children may be ambivalent about normal, physical changes that make them attractive because sexual activity was a source of shame in the past. In addition, CSA may lead to the development

of specific cognitive biases that are associated with depression. For example, when children are sexually abused, the assailant typically blames them for the abuse. The tendency to blame oneself for uncontrollable, negative events may become a stable part of the abused child's personality, such that even life events that are clearly out of one's control are perceived to be one's fault (Wenninger & Ehlers, 1998). CSA also may cause permanent changes to the nervous system that increase reactivity to stress (Weiss, Longhurst & Mazure, 1999), which may make CSA survivors biologically prone to experience depression in the face of life stress.

CSA also has an indirect impact on adult depression through its influence on relationships. Close relationships, particularly with romantic partners, protect women from becoming depressed when they experience life stress (Brown and Harris, 1978). However, women with a history of CSA have more interpersonal problems than do women without this history (Rumstein-McKean & Hunsley, 2001). They report difficulties getting close to and trusting other people, and many report that they avoid having close relationships altogether. In addition, the quality of their romantic relationships may be poor. For instance, CSA survivors are more likely to be physically victimized by their romantic partners or to be sexually assaulted. Re-victimization is directly associated with episodes of depression during adulthood.

<2>Work Outside the Home

Bebbington (1995) reviewed the role of gender role enactment in adult women's depression. He pointed out that married women with young children are at the greatest risk for depression, except in countries and cultures where homemaking is highly valued. Conversely, being employed outside the home is protective for women, despite the fact that the vast majority of working mothers report high levels of stress as a result of work-family conflict. Compared to stay-at-home mothers, working mothers have higher self-esteem and they feel more competent,

even about their parenting. It may be useful to think of employment specifically and of gender roles generally, as factors that have a positive impact on the development of instrumental traits and behaviors. For instance, women who work outside their homes may have the opportunity to develop traits such as independence and self-confidence, as well as problem-solving skills that help them to cope with life stress.

<1>Problematic Relationships

While boys are socialized to value independence and competition, girls are socialized to value interpersonal relationships, particularly with their families and spouses. As a result, girls and women derive much of their self-esteem from their ability to establish and maintain positive connections with significant others (Josephs, Markus, & Tafarodi, 1992). There is substantial evidence that difficult interpersonal relations are linked to the onset of depression; once depressed, girls and women stay depressed in part by generating interpersonal conflicts (Hammen, 2003). In this section, we summarize the evidence that depression is related to two sources of interpersonal strain: family relationships for adolescent girls and relationships with romantic partners throughout the lifespan.

<2>Family Relationships

Depression in adolescents is strongly linked to dysfunctional family relationships (Cummings & Davies, 1999). Compared to nondepressed youth, depressed youth report lower levels of family cohesion and closeness, fewer social resources, lower levels of support and approval from their parents, more family conflict and poorer communication with parents, more parental control, and a negative family climate (Sheeber, Hops &Davis, 2001). As girls make the transition into adolescence, they begin to place more importance on interpersonal relationships than do boys. Thus, difficult family relationships can have a significant impact on adolescent

girls' mood even when they are not directly involved (i.e. parents' marital problems). One longitudinal study showed that girls were more vulnerable than boys to family problems such as marital conflict and low levels of family intimacy, which accounted for their social and emotional adjustment (Davies & Windle, 1997). Although adolescents typically spend less time with their parents than do younger children, they continue to identify their parents as their most significant sources of support. For girls, family relations are a better predictor of adolescent depressive symptoms than are peer relations, particularly when they are highly stressed (McFarlane, Bellissimo, Norman, & Lange, 1994).

Secure attachment bonds with parents allow girls to create positive cognitive models of the self and the self-in-relation. These models are important sources of information about girls' intrinsic worth, and about the emotional responsiveness of significant others. When researchers studied adolescents in an inpatient psychiatric setting, strong gender differences were found in attachment (Rosenstein & Horowitz, 1996). Adolescent girls were more likely than boys to be depressed and to be intensely worried that they would be abandoned by attachment figures. In contrast, boys were more likely than girls to have a dismissing attachment style characterized by self-sufficiency. This research suggests that adolescent girls who suffer from depression place a high importance on interpersonal bonds, but also that they have little confidence that people will be consistently available and responsive to their emotional needs. An insecure attachment relationship with one's primary attachment figure, usually the mother, appears to decrease girls' self-esteem, and increase the likelihood of depressed mood (Roberts & Monroe, 1999).

Mothers also are an important source of support for adolescent girls. Adolescent girls tend to experience more stressful life events and to be more reactive than boys are in response to these events. However, a warm, supportive relationship with one's mother attenuates the impact

of stress on girls' but not boys' depressive symptoms (Ge, Lorenz, Conger, Elder, & Simons, 1994). Maternal support also may be implicated in the normal developmental process of individuation. Girls tend to feel depressed when they perceive discrepancies between who they are and who their parents wish them to be, which may reflect the relational basis of their self-esteem. However, these discrepancies are only problematic for girls who also perceive their mothers as unsupportive of their autonomy. Girls who see themselves as discrepant from what their mothers want for them, but see their mothers as supportive of their autonomy have high levels of self-esteem and low levels of depression (Moretti & Wiebe, 1999).

A discussion of family functioning and depression would not be complete unless it included mention of the impact of parental depression on adolescents. In interactions with their children, depressed parents show more negative mood and make more negative attributions, they communicate with vague, inconsistent and often confusing messages, they express more rejection and hostility, and they show less warmth and positive mood than nondepressed parents do (Chiariello & Orvaschel, 1995). Thus, depression makes it difficult for parents to meet their children's emotional needs on a consistent and reliable basis. Not surprisingly, the children of depressed parents are six times more likely to suffer from depression than are the children of nondepressed parents. Given that adolescent girls are already more likely than boys to become depressed, this risk becomes alarmingly high in adolescent girls with a depressed parent.

Parental depression may have a direct negative impact on adolescent girls through poor parenting (Hammen, 2003). In addition, the children of depressed parents may feel guilty and be overly focused on the depressed parent (Cole-Detke & Kobak, 1996). Depressed parents may turn to their children to meet their own emotional needs and to alleviate their distress, which may cause the adolescent to neglect her own needs and assume the role of caregiver (Rosenstein &

Horowitz, 1996). Because of their interpersonal focus, girls may be more likely than boys to take on a caregiver role with a depressed parent. Statistically, a depressed parent also is more likely to be a mother than a father, with additional consequences for daughters in the form of reduced maternal support. Thus, parental depression, particularly in mothers, may be another source of adolescent girls' risk for depressed mood.

<2>Dating Relationships

Non-depressed adolescent girls believe that depression occurs when girls feel disconnected in their important relationships, particularly with boyfriends, or when they do not have a romantic partner (Hetherington & Stoppard, 2002). Consistent with this perception, adolescent girls are at risk for depression when romantic relationships end (Silberg et al., 1999). In late adolescence, girls may increasingly turn to romantic partners for the emotional support that earlier in their lives was provided by their parents. Lack of this form of intimacy may increase their vulnerability to depression. The acceptance and validation that is provided by an intimate romantic relationship may enable adolescent girls to regulate their negative moods. For instance, one study showed that girls who lacked intimacy in a romantic relationship were more likely to endorse dysfunctional beliefs about themselves when induced to have a negative mood (Williams, Connolly, & Segal, 2001).

However, romantic relationships are a double-edged sword. The results from a large-scale longitudinal study indicate that becoming involved in a romantic relationship also increases adolescent girls' depressed mood, in part because having a boyfriend can have a negative impact on girls' relationships with their parents (Joyner & Udry, 2000). Young women who are prone to depression may unwittingly select romantic partners who increase their risk of depression. Another study, which followed young women for up to 5 years after graduation from high

school, found that young women who initially were unhappy went on to become involved with young men who tended to be aloof, guarded, unemotional, and unempathic, and hence emotionally unsupportive (Daley & Hammen, 2002). This constellation of traits also increases depression levels in married women (Whiffen, Kallos-Lilly, & MacDonald, 2001). Thus, women who are prone to depression appear to choose romantic partners who are likely to exacerbate and maintain their depressive tendencies.

<2>Marital Relations

Depression is associated with attachment insecurity in romantic relationships (Whiffen et al., 2001), and with marital distress (Whisman, 2001). There also is evidence that marital distress increases the risk of an episode of depression and predicts relapse after recovery. For instance, Whisman and Bruce (1999) showed that spouses who were maritally distressed but not depressed at baseline were nearly three times more likely to become clinically depressed over the subsequent year than were individuals who were neither maritally distressed nor depressed. Marital distress and depression are even more strongly associated among individuals who have a history of poor interpersonal relations. For example, women who were sexually abused during childhood are both better protected by good marital relations and more vulnerable to depressive symptoms when their relationships are of poor quality than are women without this history (Whiffen, Judd, & Aube, 1999).

Marital distress has an impact both on the level of conflict that a couple experiences and on the level of support they provide to one another. Both aspects heighten vulnerability to depression. Women who experience life stress are protected from becoming depressed by having someone in whom they can confide (Brown & Harris, 1978). Similarly, once a woman becomes depressed, having a warm and supportive spouse facilitates her recovery (McLeod, Kessler &

Landis, 1992). Husbands who denigrate the importance of relationships or who are indifferent to their wives are especially likely to maintain and exacerbate their wives' depression (Whiffen et al., 2001).

Women may be more sensitive than men to conflict and lack of support. When one partner is depressed, the couple tends to have hostile and conflicted interactions, regardless of whether the depressed person is the husband or the wife. However, when the wife is depressed, their interactions are measurably more negative. In addition, depressed women feel even more depressed after a hostile interaction with their spouses than do depressed men (Gotlib & Whiffen, 1989). Marital distress lowers women's self-esteem, which increases their vulnerability to depression (Culp & Beach, 1998). Unlike depressed men, once women become depressed, they tend to interact with their spouses in ways that perpetuate depression, for instance, by expecting their partners to be critical and by behaving unsupportively in marital interactions (Davila, Bradbury, Cohan, & Tochluk, 1997). Thus, marital distress and depression may form a unique negative feedback loop in women. Women also may need more support than men do to maintain their well being. On average, men and women do not differ in the levels of support that they receive. However, if women require more support and if they are more adversely affected by conflict with their spouses, then together these findings may explain why marital distress is more likely to induce depression in women than in men (Bebbington, 1995).

Women may be at risk for depression when their beliefs about the importance of relationships are taken to an extreme, that is, when they feel that harmony in their relationships must be maintained at all costs. Women who hold this view may "silence" themselves to preserve the illusion of harmony (Jack, 1991). "Self-silencing" involves suppressing negative thoughts or feelings that might threaten the relationship. This self-censorship alienates the

woman from her own thoughts and feelings, which ultimately results in her becoming depressed. Self-silencing may be an interpersonal coping strategy that is particularly likely to develop when the romantic partner or spouse is critical and intolerant (Thompson, Whiffen, & Aube, 2001).

Finally, there is evidence that depressed mood is contagious (Joiner & Katz, 1999). Contagion effects are likely to be pronounced among women, who appear to be especially sensitive to their spouses' marital distress and depressed mood (Whiffen & Gotlib, 1989). Thus, women's risk for depression may come not only from their own marital distress, but also from their husbands' distress.

<1>Summary and Integration of the Research

We identified two linked themes, gender role and problematic relationships, that appear to place girls and women at risk for depressed mood. Girls are socialized to value interpersonal relationships and to value themselves for their skill in maintaining close and harmonious relations. Relationships can have a protective effect if they are healthy and secure or a detrimental effect in the context of discord and insecurity. Because of the emphasis girls and women place on relationships, they may ruminate about negative family events, they may feel caught or trapped in family problems, and they may become enmeshed in the problems of family members (Davies & Windle, 1997). In taking on gender socialized responsibilities for maintaining relationships, girls and women may put their own emotional needs aside, which ultimately may result in mood disturbance. Thus, the comparatively high rate of depressed mood in girls and women appears to be closely associated with the importance that girls and women place on harmony in their relationships, particularly those with their families and spouses. Unfortunately, girls and women who experience depression often grow up in families where relationships are distressed and where they are rejected, only to enter romantic relationships and

marriages where they feel unsupported and criticized. In addition, they may perpetuate their emotional distress through the generation of interpersonal conflict. Thus, for many women, disturbed relationships are both the cause and consequence of depression (Hammen, 2003).

<1>Treatment Implications

Psychological treatments need to take into account the interpersonal and social context in which women's depression occurs. Three standardized psychological treatments for depression have been shown to be effective: Cognitive-Behavioral Therapy (CBT; Beck et al., 1979), Interpersonal Therapy (IPT; Frank & Spanier, 1995) and Process-Experiential Therapy (PET; Watson, Gordon, Stermac, Kalogerakos, & Steckley, 2003). CBT is aimed at reducing dysfunctional beliefs about the self, world, and future that accompany depression. This treatment may help women change dysfunctional beliefs about relationships. IPT is focused directly on changing the disturbed interpersonal relations that give rise to depression. PET assists clients to process painful emotions and past experiences. After treatment, clients who received PET tend to report fewer interpersonal problems. Marital therapy also is an effective treatment for women's depression when it co-occurs with marital distress (Jacobson, Dobson, Fruzzetti, & Schmaling, 1991). Finally, attachment-based family therapy appears to be an effective treatment for adolescent depression (Diamond, Reis, Diamond, Siqueland, & Issacs, 2002). Depression tends to be co-morbid with other problems, most commonly anxiety and personality disorders (Melartin & Isometsae, 2000); the existence of co-occurring disorders usually complicates treatment.

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