Women and Depression

Lorraine Hathaway
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University of British Columbia
School of Social Work
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Depression is one of the most prevalent and least understood emotional problems which afflicts individuals in North American society. Along with feelings of alienation and anomie, it leads the list of the modern individual's emotional complaints. It has been recognized as a problem since antiquity and descriptions of the symptoms of depression have been remarkably similar over time. Despite the general agreement in descriptions of the disorder, modern researchers, like their ancient counterparts, have consistently complained about their slow progress in understanding and treating the problem. Depression has been described as paradoxical, elusive and perplexing. (Beck, 1967)

One of the most striking and perplexing aspects of depression in North America is the well-established fact that women experience and are treated for depression in far greater numbers than men. (Weissmand and Klerman, 1977) Many social workers in the field are well aware of the higher incidence of depression among women as they are frequently confronted by female clients who report that they feel sad, hopeless, and unable to cope with their lives. These complaints may range from mild but pervasive feelings of apathy, fatigue, boredom and gloom (frequently called the housewife's complaint) to intense and overwhelming feelings of despair which too often lead the woman to a desperate suicide attempt.

Both the prevalence and the seriousness of depression in women is a cause for concern among mental health practitioners. Yet, except for research exploring forms of depression which only affect women (i.e. post partum depression), there has been little systematic research into the causes and treatment of depression, specifically in women. However,
there have been indications of greater interest in this area within the past ten years. Renewed interest has, in part, been sparked by the advent of modern feminism and feminist critiques of the mental health system's understanding of female psychology and its treatment of troubled women.

Feminists have focused their attention on analyzing women's role in modern society and on explicating the effects which the feminine role has on the emotional difficulties which many women experience. Feminists have challenged many commonly accepted assumptions about the nature of femininity and have attacked the mental health community's acceptance of this traditional view of women. They have criticized treatment programs which are based on what they consider to be a distorted view of women and have proposed alternate ways of helping emotionally troubled women.

The feminist challenge to the mental health system has special relevance for the field of depression, the most common of all of women's psychiatric complaints. The challenge has raised many important issues for mental health practitioners. It has focussed attention on the links between women and depression and has raised questions about the ways in which practitioners analyze and treat depressed women.

This paper is an attempt to examine the links between depression and women, and to look at the issues involved in understanding and treating the problem. The first section examines the problem from the clinician and clinical researchers point of view. It looks at depression as a psychiatric problem. How prevalent is it? How is it defined?
What causes it? How can it be treated? The issues which are dealt with in this section are: (a) findings in the research on prevalence of depression, with particular emphasis on findings of female preponderance; (b) the definition of clinical depression, the assumptions on which the definition rests, and the problems involved in defining depression; and (c) an examination of the 4 dominant explanatory and therapeutic schemes related to depression (organic, psychoanalytic, cognitive, and behaviorist theories). The emphasis in section C is on critically analyzing the major underlying assumptions which each theory makes in constructing and treating the depressed woman. The research evidence on which each theory rest is examined. Feminist and other critiques of the major theories of treatment approaches are presented.

Section II looks at the feminist view of depression and women. Issues which are examined in this section are: a) feminist analysis and critique of the mental health community's treatment of emotionally troubled women; b) the feminist analysis of women's role in society and the relationship between women's role and depression; c) feminist approaches to working with depressed women. The focus in this section is on explicating the underlying assumptions of the feminist approach. Relevant research findings are presented as well as critiques of the feminist position.

The final section summarizes those aspects of theory and practice which the author sees as significant to social workers who are working with depressed women. This section includes a discussion of some of the conclusions which the author has reached about working with depressed
women in this society, and suggestions for what the author hopes is a more integrated approach to the problem.

To work with depressed women, a case example is presented in Section I and used throughout this paper. The case study is based on Sylvia Plath's novel *The Bell Jar* which chronicles the life of Ester Greenwood, a 20-year-old college student who becomes seriously depressed as she attempts to define her own identity as a woman and artist in 20th-century North American society. This semiautobiographical novel can be taken as a document of Plath's understanding and explication of what it means to be a depressed woman. As it was written by a woman, who both endured and ultimately succumbed to that experience, it seems an appropriate choice for a case example and one which provides some insight into the desparate struggle which depressed women so often endure.

The problem of depression and women is complex, and there is considerable disagreement among theoreticians, researchers, and practitioners about how it can best understood and treated. The lack of clarity in the field and the conflicting approaches to the problem have implications for the women who seek help from the mental health community. As social workers, we are intimately involved in the problem of depression and women. As a profession, we often stand at the interface between the woman within her social world and the psychiatric treatment world. Frequently, it is we social workers who help a woman embark on her career as a mental patient. It is often our job to make an initial assessment of the woman's mental state, and to extract relevant details of her life for
presentation to the treatment community. In some settings, we may be engaged in the treatment process itself. We are often involved in the social ramifications of depression for the woman and her family. We may be asked to provide practical or emotional support for her, and on some occasions, we are responsible for placing her children in foster care. In view of our extensive professional involvement with depressed women, it is important for us to be sensitive to the many issues in the field, and as a profession, to approach this problem with as broad and comprehensive an understanding of it as possible. It is hoped that this paper will be helpful in adding some clarity to this complex and difficult problem.
I. The Clinicians and Clinical Researcher's View
Issues and Problems
A. Prevalence

We begin an exploration of the clinician's view of depression by examining findings in the research on prevalence of depression. Questions of prevalence have been addressed by epidemiologists in their attempt to isolate the numerous factors that determine the frequency and distribution of this psychiatric disorder within the general population. Evidence of the prevalence of depression generally comes from 4 sources. The primary source is clinical observation of patients who come for treatment. Prevalence is also determined from community surveys of individuals not in treatment; from studies of suicides and attempted suicides; and from grief and bereavement studies. (Weissman and Klerman, 1977) Data from patients in treatment is always considered an underestimate of general prevalence in that treatment is contingent on availability of resources, financial, motivational and other health care factors.

General findings in the epidemiology of depression can be summarized as follows: 1) it is estimated that the overall incidence of depression in the North American population is approximately 3 to 4%; 2) of the general depressed population, it is estimated that 1 in 5 are treated by a doctor; 1 in 50 are hospitalized; and 1 in 200 commit suicide; 3) averaging various estimates, the lifetime expectancy for anyone in the population of becoming clinically depressed is about 10%; 4) the risk of becoming depressed is about 10 times greater than of becoming schizophrenic; 5) an individual who suffers from recurrent manic-depressive episodes can expect to spend about 5 to 6 years of her life in a hospital if she experiences her first clinical depression at 25 and lives until
she is 70 years old; 6) finally, the death rate for depressed women is twice the normal rate, and the death rate for depressed males is three times the normal rate. (Lehmann, 1971)

In examining the demographic variables which are significant in depression, we find that the singular most striking characteristic is that women preponderate at a ratio of about 2:1. (Silverman, 1968, Lehmann, 1971, Gove and Tudor, 1973, Weissman and Klerman, 1977) This finding is remarkably consistent throughout the literature. Female preponderance is established in clinical observation and treatment and in community surveys. This finding is generally supported in cross cultural comparisons, although it is reversed in India where depressed males preponderate. (Lehmann, 1971, Katz, 1971, Weissman and Klerman, 1977)

Within the overall statistics of women in treatment for mental illness, it has been found that nearly 60% are classified as having either affective psychosis or neurosis. (Smith, 1975, Chesler, 1973, Gove and Tudor, 1973) Gove has reported a higher overall rate of mental illness in married women when compared to single, divorced and widowed women and men. In a recent study, Brown found that working class, married women with young children had the highest rates of depression. (Weissman and Klerman, 1977)

These findings would all suggest that a North American's risk of becoming depressed increases simply by virtue of being born female. Her risk of becoming depressed becomes even higher if she is married and caring for young children.

Another demographic finding of epidemiologists is that the likelihood
of becoming depressed increases with age. (Lehmann, 1971) Weissman and Klerman, however, note a recent international trend towards increased depression among younger women. (Weissman and Klerman, 1977) Depression has also been found to be more common in industrialized societies than primitive cultures, more common in whites than blacks, and more common in the United Kingdom than in North America. (Lehman, 1971, Katz, 1971, Zubin, 1971)

All of the findings cited above appear to be quite straightforward and factual. However, beneath this objective facade lie a number of major issues in the field. The major question with which epidemiologists struggle is whether the differences or trends which they have discovered reflect real differences within the population or are artifacts as a result of methods of gathering or interpreting data. As Dorothy Smith points out, all statistical information is produced by a variety of individuals interacting in different settings, and each number which is reported, in reality, represents a series of abstraction and judgments about an individual and her problems. (Smith, 1971) To put it more concisely, individual's lives do not simply fit into the categories which the statistics represent; they must be fitted into those categories. As a result, there are a variety of disagreements within the field about the meaning of statistical findings in depression.

These disagreements can reflect differences in how the categories of depression are defined or disagreements about how to interpret certain behavior as fitting into one category or another. More specifically, clinicians may disagree about what kind of behavior to accept as part of
depression and about how to evaluate the subjective reports of their patients.

In examining the issues in the statistics of female preponderance, it is clear that each issue reflects a concern about the effect which difficulties in the definition and diagnosis of depression have on the production of mental health statistics. Weissman and Klerman's article "Sex Differences and the Epidemiology of Depression" summarizes the issues and evidence in the field.

Certain investigators are concerned that female preponderance does not reflect real differences in the rates of depression but rather is the result of the fact that: (1) women weigh events as more stressful than men which leads them to report more symptoms; (2) women report more symptoms than men because it is socially more acceptable to them to do so; (3) women go to the doctor more often than men and engage in more help seeking behavior. What is being called into question is the reliability of using patient's subjective reports in the diagnosis of depression. An alternate explanation for female preponderance would be that women complain more than men and that their complaints are, therefore, more frequently heard, diagnosed and counted in the statistics of depression. Weissman and Klerman point to studies by Paykel et al. (1971) and Cannon and Redick (1973) which indicate that there is no difference in the way women and men weigh stress, not are there differences in their perceptions of the social acceptability of psychiatric problems. As community surveys also report a female preponderance, Weissman and Klerman conclude that there is no evidence to support a questioning of the reliability of the statistics supporting female preponderance.

Whether issue in the statistics of female preponderance is the idea
that men use alcohol to mask depression and are, therefore, seen and statistically counted as alcoholic and not depressed. This theory is based on findings that men in treatment for alcoholism have symptoms of depression. However, studies in this area have been unable to determine whether the symptoms of depression preceded the use of alcohol or were a consequence of alcohol use. Weissman and Klerman, therefore, conclude that the links between alcoholism and depression have not yet been established and must await further proof.

It must be noted, however, that the issue raised above is related to how depression is seen or defined, and that modifications in the instructions of how clinicians are to diagnose depression would alter even the most well established 'fact' that females preponderate. Thus a set of instructions which told clinicians to view alcoholism as masked depression would virtually eliminate the sex differences found in the disorder.

One finding that does not seem to be alterable is that women are seen, diagnosed and treated for depression by the North American health care system twice as often as men and that when women do come in contact with the mental health system, they are fitted into affective and neurotic disorder categories 60% of the time.

As we have seen in the above, the major issues in the epidemiology of depression revolve around problems in the definition and diagnosis of the disorder. All questions of prevalence ultimately hinge on the question of how clinical depression is defined. The criteria which are used to determine what kind of behavior will be taken to indicate that an individual is clinically depressed will greatly effect the prevalence
of depression within the general population. All researchers agree that the definition and diagnosis of depression is one of the most troublesome issues in the field. We must, therefore, turn to this issue in order to gain a better understanding of the sources of the difficulties.
B. Issues in the Clinical Definition and Diagnosis of Depression

There is no other issue in the field of depression which is more difficult for the researcher and clinician than the question of the definition and diagnosis of the disorder. In opening a symposium on depression in the 70's, Ronald Fieve stated, "It might be said that the principal reason for our lack of understanding about depression has been the lack of agreement in diagnosing it. Furthermore, our lack of agreement in diagnosing it may be based on conflicting sets of instructions that have been handed down to us by psychiatrists." (Fieve, 1971, p.1)

Similar sentiments have been echoed by many others in the field. Indeed, Silverman states that, "It appears that the clinical diagnosis of manic-depressive psychosis and other depressive conditions is made no more consistently than would occur by chance and that observer variability is the principal element in diagnostic discordance." (Silverman, 1968, p. 24)

In approaching this thorny area, issues in the definition and diagnosis of depression will be examined as representing disagreements about how to construct the person as depressed and what meaning to give to her problem. Furthermore, it will be shown that many of the issues in the definition of depression as a clinical syndrome and mental illness are actually embedded in issues in the field of psychiatric classification and that the disputes can be taken to represent difficulties in the way psychiatric classification is organized to deal with depression.

A basic problem in the definition of clinical depression is the fact
that feeling depressed, sad or gloomy is a very common human experience. We have all probably experienced times in our lives when we felt hopeless, apathetic, dejected and questioned whether the struggle was really worth it. These feelings may have emerged in us after some loss, disappointment or during a period of uncertainty and agonizing self evaluation. As these feelings are common and considered a normal part of the human experience, it is relatively easy for us to empathize with some who tells us that she feels depressed. We feel that we intuitively know what she means when she uses the term and usually don’t require an elaborate definition.

Psychiatry also recognizes that depressed feelings are common, normal and appropriate feelings in humans and as such do not constitute a problem which falls within the scope of its expertise. What it seeks to address itself to are those feelings which fall outside of the boundary of normal feelings and constitute a psychiatric disorder or mental illness. As a result, in defining depression, psychiatry attempts to identify those features which distinguish depression as a psychiatric disorder from its normal counterpart. However, in trying to define clinical depression as distinct from a normal mood state, clinicians arrive at their first set of definitional dilemmas. Is clinical depression best viewed as an intensification of a normal mood or a qualitatively different experience? Does it represent a biological derangement within the woman, an illness of psychogenic origin or a response to stress? Should it be defined as part of a continuum of affective responses which spans from normal mood to a complete withdrawal from reality,
or is it best understood as a number of discrete illnesses or syndromes each of which reflects a qualitatively different state? Despite the many efforts to resolve these definitional problems, the problem today is essentially unresolved and "continue(s) to defy our most energetic attempts at resolutions." (Zubin, 1971, p. 7)

Zubin notes that part of the difficulty in resolving the problem of definition lies in the nature of depression itself. He states,

"The reason for this slow progress is not a lack of methods and techniques but rather that the basic feature of depression is an inner feeling of sadness and dejection; the rest is epiphenomena. As we have been unable to determine the cause for this inner sadness..., we are left with a subjective intuitive feeling which manifests itself, if at all, by verbal report and indirectly by such different types of behaviors as fearfulness, diminished appetite, psychomotor retardation and a host of others. Added to this basic problem, we have such additional problems as deciding whether depression is a transient mood state, a symptom, a syndrome, an illness or a combination of all or some of these." (Zubin, 1971, p. 7-8)

Zubin also points out that efforts to resolve and answer these definitional questions will depend on the vantage point which is taken in approaching the question. Thus, the researcher may approach the question by looking at those aspects of depression which he finds amenable to measurement or objective assessment, adopting a speculative approach which allows him to test a wide variety of hypotheses. The clinician who is charged with alleviating the individual's actual suffering, will probably want to decide which definition will be most helpful in treating the patient and relieving her distress. His role may not afford him the opportunity to speculate on definitional issues, as he, in practice, must act. While he may recognize the whole definition of depression presents serious problems, his role as helper will force him to make a series
of decisions about how depression will be seen and treated. This role must lead him to act on the basis of vague and incomplete knowledge as he decides to prescribe medication, to undertake psychoanalysis, to administer electroconvulsive shock therapy. In part, his role calls on him to act as if he understands the nature of clinical depression as it expresses itself in the individual patient. His task is to fit what she presents as her problem with what he understands about depression, and to treat her on the basis of that understanding.

As the clinician is faced with the task of diagnosing depression within an individual patient, the issue which must be addressed is how he arrives at that diagnosis. In order to gain some understanding of this process, it is important first to look at how psychiatry defines and classifies clinical depression for those engaged in the practical task of diagnosis. While it should be noted that psychiatry is not the only discipline which deals with and treats the depressed woman, it is important to focus on psychiatric definition and diagnostic process because psychiatry, more than any other discipline is authorized by North American society to deal with and treat depression as an abnormal behavior, and it accepts major responsibility in this area.

As we examine the ways in which psychiatry diagnoses and classifies clinical depression, the focus will be on the underlying assumptions upon which the diagnostic process rests.

There is agreement among psychiatrists that "disturbed feelings are generally a striking feature of depression." (Beck, 1967, p.6) Hence, depression is classified in psychiatry as a primary mood disorder or an
affective disorder. Clinical depression is believed to manifest itself through a variety of affective, vegetative and cognitive symptoms. Beck summarizes these as follows:

1) specific alteration in mood: sadness, loneliness, apathy;
2) a negative self concept associated with self reproaches and with self blame;
3) regressive and self punitive wishes: desires to escape, hide or die;
4) vegetative changes: anorexia, insomnia, loss of libido;
5) change in activity level, retardation or agitation.

(Beck, 1967, p.6)

These traits taken together are believed to constitute the symptom complex or syndrome of clinical depression.

Within this broad description, clinical psychiatry makes a number of sub classifications. The first is to estimate the intensity of the affective state (mild to severe). Clinicians may also classify the depression as either a reaction to psychological stress or conflict (reactive) or arising from some internal or biological state (endogenous). Tied to this question is the idea that a depression may represent a neurotic condition (one which implies that the individual maintains contact with ordinary reality) or a psychotic condition (one which implies that the individual has lost contact with reality). It must also be decided whether the depression is marked by mood swings (bipolar) or a singular depressed mood (unipolar). An estimate must be made of whether the depression constitutes the woman's main problem (primary) or whether it is secondary to some other major problem. Finally, an attempt will be made to pinpoint the depression as one of a series of discrete clinical entities i.e. manic depressive psychosis, psychotic reactive depression, neurotic reactive depression, etc. Such classification assumes that each type of
depression can be distinguished from all other types by a number of discrete signs or symptoms which are consistent throughout the population. Furthermore, these types of depression are thought to have a specifiable onset, duration, and outcome and to be amenable to certain forms of treatment. (Beck, 1957)

In its most ideal and simple form the process of psychiatric assessment, diagnosis and treatment of the depressed woman should proceed along the following lines. The depressed woman is interviewed by the clinician and in the process of the interview responds to a series of questions about her emotional and physical state and her thought processes. On the basis of her responses, the clinician makes a series of judgements which seek to match her symptoms with known clinical syndromes. The discrete clinical entity which best fits her condition will determine her diagnosis and treatment will be selected on the basis of the diagnosis.

This entire process rests on the medical model of assessment, diagnosis and treatment. The medical model itself rests on a number of assumptions. A key assumption which the model makes is that symptoms are manifestations of an underlying unitary disease process which occurs within the individual. Symptoms are assumed to provide clues to the nature of that underlying process. The healer's job is to correctly interpret those clues on the basis of known facts and diagnose and treat the underlying problem. If he has correctly assessed and diagnosed the problem and an effective treatment is known, the patient will be cured and their symptoms will vanish. Therefore, accurate assessment and diagnosis are essential for proper treatment.
As the medical model presumes that the disease rests within the individual, the symptoms of the disease will not be greatly affected by environmental or cultural variables. Hence, smallpox is assumed to present the same clinical picture regardless of differences in sex, race or culture.

This model has, of course, served medical science well where the assumption of an underlying unitary disease is more readily verified by observable evidence. It is, however, open to more serious criticism when it is applied to emotional problems and problems which are considered to be psychogenic in origin. Thomas Szasz is one of the most outspoken critics of the use of the medical model in psychiatry. He points out that the analogy between physical and mental illness is tenuous. Underlying psychopathology must be assumed as it cannot be proven by direct evidence. Symptoms must be taken to represent clues to an underlying illness process and that illness must be assumed to rest within the individual. Once these assumptions are made, the search for clues is turned inward to the intrapsychic life of the mentally ill or depressed woman. In addition, the model places the clinician in the role of arbitrator or judge of what is healthy and normal behavior and what is sick behavior. His views of normalcy and proper adjustment to life thus become very important in the diagnostic process. Furthermore, the model implies a deterministic and universal view of the nature of an individual's psychological development, and therefore, is not sensitive to the role which the individual's interpersonal relationships and culture can have on the problem. (Szasz, 1961)
If we consider the problems involved in the diagnosis of depression, it is clear that the diagnostic process may be affected by a variety of clinical expectations. The diagnosis may be affected by whether the woman who is interviewed fits into the dominant psychiatric model ( stereotype) of the depressed patient (a white, middle-aged, middle class, married female). This stereotype which was determined to be important as a result of clinical findings can also be seen to influence those same findings if the stereotype influences the clinician’s expectations and subsequent diagnosis. The clinician’s diagnosis may also be affected by past psychiatric diagnoses of the patient. In addition, the clinician’s assumptions about what he believes is normal and healthy behavior for a woman in this culture will also influence how he evaluates the patient.

As the clinician has no back up system with which to objectively test his diagnosis and has no physical evidence with which to confirm it, his diagnosis will be highly subjective. Again, as Smith has pointed out, patients do not just fit into categories; they must be fitted into them. All of the above would lead to the wide differences in the diagnosis of depression which are reported in the literature.

If we agree that what the clinician diagnoses in the patient will, in part, be determined by his expectations, then we can also assume that his ideas about what causes depression will influence the signs he looks for in the patient and what he finds.

To illustrate this point, we turn to the case example of Ester Greenwood, the main character in Sylvia Plath’s novel The Bell Jar. To briefly summarize the known facts in Easter’s background, we find that at
the onset of her depression, Ester was a 20 year old college student who was attending a private girls college on a scholarship. She was an excellent student, bright, creative and well liked by her peers. She had an active social life and was involved in student affairs. She wanted to become a writer and poet and had several poems published in a woman's magazine.

Ester was an only child, raised by her widowed mother. Her father died when she was 8 and her mother, with whom it appeared she got along well, taught in a community college in order to maintain the family's middle class life style. Ester had no prior history of depression and had no contact with psychiatry prior to this depression.

Immediately preceding her depression, Ester had won a literary prize and spent a month in the summer as a guest editor for a leading magazine. She returned to her New England home to prepare for a summer school course, but found that she had not been accepted into the course. She remained at home for the rest of the summer. Quite rapidly, she began to feel sad, gloomy, apathetic and lethargic. She was unable to sleep, eat or read and had little hope for the future.

How would Ester's condition be defined and diagnosed? If we examine the question of whether her depression represents an endogeneous or a reactive depression, we find that a clinician who assumes that depression is primarily an organic disorder caused by chemical imbalance could find ample evidence to support his view in Ester's case. He would point to a successful and well adjusted young girl, with no prior mental history who became suddenly and rapidly depressed for no apparent
reason. While it was true that she had suffered an academic setback in being rejected for the summer course, this minor event would not account for a major depression. As a result, from this point of view, the depression would be clearly classified as endogeneous, and the case would be seen as providing evidence for the validity of that construct. However, in reviewing the facts of the case, a clinician, who assumes psychogenic causes for depression, would also find ample evidence to support his theory. He would point to the psychic shock which the rejection from summer school had on Ester, the blow to her self esteem which she suffered, and the childhood loss of her father as prime indicators that the depression was reactive. Thus the diagnosis of reactive depression would be made and again, the case could be seen as providing evidence for the validity of that construct.

My point in citing this example is not to decide which causal theory best explains Ester's condition, but rather to show that both the organic and the psychogenic theory are plausible and the facts of Ester's case can be fitted into either theory. The way in which the actual fit is made (how her depression would be defined and diagnosed) would at last partially depend on the position which the clinician adopted about the etiology of the disorder.

To sum up, we can see that the definition and diagnosis of depression as a psychiatric disorder depends on a number of major assumptions. The fundamental assumption is that depression represents an underlying unitary psychopathology which rests within the patient and expresses itself through a complex of symptoms. This central assumption has been
questioned by Szasz and others, who point out the tenuous nature of the analogy between physical and mental illnesses. The process of diagnosis rests on the assumption that the underlying psychopathology can be discovered through the symptoms and classified as one of a number of discrete clinical entities, by matching symptoms with categories. However, it has been argued that such a classification system fails to recognize the complexities of the diagnostic process, which relies on a tremendous amount of interpretation by the clinician. Clinical interpretations may be influenced by many factors including: the clinician's assumptions about normal and abnormal behavior, his clinical stereotype of the depressed patient, his exposure to previous psychiatric diagnoses of the patient. Finally, it has been argued that the clinicians assumptions about the etiology of the depression would also have impact on his definition and diagnosis of the disorder.
C. Assumptions and Issues in the Etiology of Depression

As we have seen, the way in which depression is defined and diagnosed is influenced by the clinician's understandings of the causes of clinical depression; for his explanatory theory will provide him with instructions or guidelines about what to look for in the depressed woman, how to interpret what he sees, and how to treat the problem. As with all other issues in depression, there is no consensus within the field as to which theory of depression best explains the problem, nor is there agreement about the most effective method of treating the depressed individual. (Zubin, 1971, Beck, 1967, Silverman, 1968, Weissman and Klerman, 1977) The question of causation has been approached from many points of view and reflects the wide array of opinions and controversies in the field.

In approaching the question of causation or etiology, four dominant explanatory theories of depression will be examined. They are the organic, psychoanalytic, cognitive and behavioral theories of depression. Each of these theories will be briefly outlined and analyzed. The analysis will explicate the major assumptions on which each theory rests; the degree to which the theory accepts the underlying assumptions of the medical model; what position, if any, each theory takes about the nature of femininity and the relationship of women and depression; the evidence which is cited to support each explanation; the treatment of depression which each theory can be taken to support; and the role which each theory assumes the therapist should take vis-à-vis the woman. Finally, major criticisms of each theory will be reviewed and discussed in relationship to the treatment of depressed women.
i. Organic Theories of Depression

As we have already seen, a clinician who assumes an organic cause for depression would see in Ester Greenwood's situation some of the indicators of that disorder. He would note the lack of stress factors or trauma which preceded the depressive episode and would probably conclude that the depression was endogeneous. His theoretical position would make the assumption that the cause of clinical depression can be found in the biochemical or genetic makeup of the depressed woman. An organic theory of clinical depression assumes that the depression is caused by a biochemical imbalance within the individual or is the result of an inherited, genetic predisposition to the disorder.

Organic theorists work within the medical model and more than any other group fit most appropriately within that model. This is because organic theorists and researchers, unlike their psychoanalytic colleagues, do not rely on the assumption that illnesses of the mind and emotions are analogous to illnesses of the body. They attempt to find the causes of the emotional state of depression within the actual biological substrate of the depressed individual. Like the physical sciences, their work relies heavily on the scientific method of inquiry, as theorists attempt to find objective, verifiable evidence for their causal hypotheses.

Organic theorists address the issue of female preponderance in depression and suggest two main hypotheses to explain it. The first hypothesis is that depression can be linked to changes in female endocrine physiology. They note a greater prevalence of depression in women...
following pregnancy, menopause and during the premenstrual period, and hypothesize that a specific female hormone may be implicated in mediating the depression. The second main theory to explain the link between women and depression is the hypothesis that there is a genetic factor operating in depression and that that factor is sex-linked to the X chromosome. (Weissman and Klerman, 1977, Winokur, 1971)

As stated above, organic theorists seek objective, verifiable evidence for their theories and there have literally been many hundreds of studies investigating organic factors in depression. Among the biological factors which have been explored are the effects of: blood glucose, acidity and alkaline reserve, serum calcium and phosphorous nitrogenous substances, lipiodal substance, chorides, steroid metabolism, thyroid function, blood pressure reactivity, salivary secretion and levels of brain activity (EEG) in sleep and state of arousal. (Beck, 1967) No attempt has been made to review all the findings on organic factors. Instead, summaries of available evidence presented by Beck (1967), Weissman and Klerman (1977), Cole (1971), Marshall (1971), and Shepard (1971) have been relied on in reviewing the evidence.

Beck finds that experimental tests of organic hypotheses suffer from a wide number of methodological problems. Among the sources of error which Beck cites are: diagnostic methods of dubious reliability and validity; inadequate, heterogeneous samples; inadequate control for variables such as sex, diet, age, state of nutrition and activity level. Beck finds a consistent pattern in depression research in which early positive findings are not confirmed by later, more careful studies. He reports that there is some consistency in positive findings associating depression with
changes in sleep EEG patterns, sodium retention, and excessive levels of steroids. However, the results on steroid levels are not specific to depression but rather appear to be associated with many different states of emotional arousal. Sodium retention studies are limited in number. In sum, Beck finds the evidence for organic causation of depression to be inconclusive and in need of further and more tightly controlled research. (Beck, 1967)

Within the organic theory of depression, considerable interest has been shown in the catecholamine hypotheses of affective disorders and in the efficacy of antidepressant medication. The catecholamine hypothesis makes the supposition that depression results from a depletion of the active supply of norepinephrine within the depressed individual. The two major antidepressant medications, the MAO inhibitors and tricyclic antidepressants, are both thought to act to increase the availability of norepinephrine. (Beck, 1967) Therefore, experimenters, attempting to validate this hypothesis have directed their attention to studies of the effects of MAO inhibitors and tricyclics on experimental animals and studies of the efficacy of these antidepressants in humans. Results from studies of the efficacy of antidepressants in humans have found their effectiveness to be limited when compared to the use of placebos. (Cole, 1971, Raskin, 1971, Marshall, 1971, Shepard, 1971) In reviewing the findings on the antidepressant medications, Cole finds that, "on the average, the superiority of these drugs over placebos is not impressive, particularly in the case of hospitalized patients with depressive illnesses." (Cole, 1971, p. 82) Evidence supporting the catecholamine hypothesis which is
derived from animal studies must be viewed with some skepticism as the results may not be comparable with human subjects. (Beck, 1967) While tests continue to be made, it must be concluded that at present this hypothesis has not been validated.

A review of the available evidence to support organic hypotheses explaining female preponderance finds that the evidence is also inconclusive. Weissman and Klerman conclude that the evidence shows that "the pattern of the relationship of endocrine to clinical states is inconsistent" (Weissman and Klerman, 1977, p. 106) and that supportive evidence is not sufficient to account for the differences in prevalence which have been found. The evidence which is reported on the possibility of X-linkage and depression in women is conflicting, and based on small samples. Weissman and Klerman conclude that "evidence from genetic studies is insufficient to draw conclusions about the mode of transmission or to explain the sex differences. (Weissman and Klerman, 1977)

From all of the above, it can be concluded that the available evidence in support of a biochemical or genetic theory of the cause of depression is inconclusive and that further proof would be needed to confirm such theories.

Theories of organic causation are generally taken to support therapeutic intervention which acts on the biological substrate of the depressed individual. Available chemical treatments of depression include the use of tricyclic antidepressants, MAO inhibitors and lithium carbonate. The other major physical treatment in use is electroconvulsive shock therapy, which has been found to offer rapid symptomatic relief in some cases.
of severe, retarded, endogenous depressions. (Cole, 1971) Physicians who prescribe antidepressant medications generally use them to treat individuals with endogeneous depression, where the cause for the sad feelings is not readily understood by the clinician. While this may be taken to be a rule of thumb, it is not universally accepted. (Shepard, 1971) Lithium is used in the treatment of manic depressive disorders and is considered the medication of choice for that disorder. (Cole, 1971) Thus, the clinician who adopts an organic causal model for at least some forms of depression attempts to differentially use the available treatments to maximize their effectiveness. Of course, all these efforts will be subject to the inconsistency of diagnosis that plagues the field. As we have seen, one man's endogenous depression is another man's reactive disorder is another man's manic depressive psychosis.

Beyond this diagnostic problem in the organic treatment of depression, is the question which some researchers raise about the efficacy of antidepressant medications. Cole believes that if the antidepressants were all taken off the market they would not really be missed. (Cole, 1971) Shepard questions the widespread use of these drugs in view of findings of limited efficacy, and the belief among practicing physicians that antidepressants have established that depression is a physical illness which is treatable by physical means. (Shepard, 1971) In view of the limited success of antidepressants which the literature reports, one must question why they are in such widespread use. Shepard suggests that the reason for their popularity rests in the physician's role, his expectations and his interaction with the patient. He cites the
following remark by an eminent contemporary physician:

"If you admit to yourself that the treatment you are giving is frankly inactive, you will inspire little confidence in your patients (unless you happen to be a remarkably gifted actor), and the results of your treatment will be negligible. But if you believe fervently in your treatment, even though controlled tests show that it is useless, then your results are much better, your patients are much better and your income is much better too ... (Shepard, 1971, p. 107)

So again, we can see that the physician, in his role as therapist, is expected to act as if he understands the nature of clinical depression as it expresses itself in the client, and that his assumptions will influence the therapeutic process. Researchers engaged in clinical drug trials also recognize the importance of expectation on the effectiveness of antidepressants, and find that placebos can be seen as effective in relieving depression. A study by Schapira showed that yellow placebos were found to be more effective than red or green ones in treating depression. (Shepard, 1971) Of course, organic theories of depression cannot explain this effect, they must simply acknowledge it as one of the many confounding variables with which their experimental studies must contend.

In evaluating the organic position on depressive disorders, it is important to look at both organic theories and the supporting evidence as explanations of the etiology of depression and at the application of an organic model to the treatment of the depressed woman.

Organic theories of depression rest on an assumption of a biological cause for the disorder. As we have seen, the evidence upon which they rest is largely inconclusive. There is some support for the notion of increased biological susceptibility but no clear understanding of the mode
of transmission. The organic theories do not deal with nor explain many findings in the area of depression. Among these findings are: cultural differences in the incidence and symptomatology of depression; higher rates of depression in industrialized society; age factors in the incidence of depression; higher rates of depression among married women; the effect of life stress on depressive disorders. What these explanations omit is an understanding of the depressed person in her social world.

Shepard and others acknowledge the importance of social factors and most researchers expect that a comprehensive understanding of depression will have to address social factors. There is also an acknowledgement that current biological theories are undoubtedly overly simplistic. (Beck, 1967) "In a sense, what organic researchers aim at is not a complete understanding of depression but rather a more comprehensive understanding of biological factors in its etiology. While they do make the fundamental assumption that depression will have a biological component, they seek validation of this assumption in experimental studies. As such, their work falls within the more demanding framework which scientific inquiry requires. However, it must be concluded that despite a considerable amount of research, "there is still very little basic knowledge of the biological substrate of depression." (Beck, 1967, p. 125)

In critically evaluating the application of the organic model to the treatment of depressed women, it seems clear that many of the uncertainties which are acknowledged by theoreticians and researchers cannot find expression in the actual treatment situation. In his interaction with the woman, a clinician who prescribes drugs or ECT is called
upon to act on the presumption that these treatments will be effective. It is a presumption that both he and the patient have a vested interest in believing. (Shepard, 1971) 

In assuming an organic cause for the problem of depression, the clinician leads the patient to see her depression as caused by something in her physical nature rather than by her life situation. To the extent that the treatment is seen as and experienced as helpful by the patient, both she and the clinician will be satisfied. Drug therapies and ECT are clearly the most simple of the available treatments for depression, and there is much in North American culture which encourages the use of drugs to cure all manner of ailments. Drug companies spend millions of dollars annually promoting and advertising chemical cures for depression, and encouraging the widespread use of antidepressants. However, as we have seen, research on the efficacy of drugs and ECT indicates that while such treatments produce dramatic improvement in some patients, they are largely ineffective in treating many others. 

The widespread use of antidepressant medication has the interactional consequence of encouraging many women who feel depressed to see themselves as sick and to look for the causes of their illness within their internal makeup. Given the lack of evidence to support such a simplistic notion, such treatment is open to criticism on the basis that it diverts the woman from examining other possibilities which might better explain her sad and hopeless feelings.
Clinicians, who adopt a psychoanalytic model to understand depression, make the assumption that depression is caused by intrapsychic conflicts within the depressed woman. Psychoanalytic theories of depression have evolved from the basic Freudian theory of human behavior and development, and they cannot be understood without some understanding of the assumptions which the Freudian view of humanity entails. Therefore, this review will briefly outline some of the basic assumptions of Freudian psychology, with special emphasis on the Freudian theory of normal female development. It will also outline some of the basic assumptions upon which psychoanalytic theories of depression rest.

Freudian psychology rests on an assumption of psychic determinism, in that it views human behavior as determined by lawful universal psychological processes. Freud viewed the human organism as a complex energy system and saw psychic energy as derived from metabolic processes, with body energy and energy of the personality converging in the id and its instincts. He assumed that instinctual energy is quantitative, displacable and, like all other energy forms, is governed by the laws of conservation. Freud also viewed instinctual energy as subject to transformation and use in a variety of activities. Freudian psychology attempts to discover the many ways in which this basic and limited source of psychic energy can be transformed in the course of human development and tries to outline the lawful process by which these transformations occur.

Freud postulated a tension reduction model of personality. He believed that the aim of an instinct is to achieve satisfaction by reducing
sources of tension or need. He theorized that the tension reduction drive is guided by the pleasure principal but that drive directed activity is determined by the object of the instinct, which may change many times as psychic energy is displaced from one object to another. Freud recognized that there are times when a drive cannot find gratification in an appropriate object. He assumed that, in these situations, defensive structures are erected to block attempts at immediate gratification. The dynamics of personality for Freud become the "interplay of these reciprocally urging and checking forces." (Hall and Lindzey, 1957, p. 44) In this view, human intrapsychic life emerges as an ongoing battle between overwhelming and insatiable hedonistic drives and the defensive structures which operate to tame those drives. (Deutsch and Krauss, 1965)

Freud hypothesized that personality consists of a dynamic tension between 3 main structures: the id, the source of psychic energy; the ego, the mediator between the id and the external environment and the superego, the internalization of social norms and expectations. His theory of personality is developmental and assumes that the individual must progress through a number of stages to achieve a mature, fully developed personality. Stages of development are assumed to be universal and unaffected by differences in language, culture and race. Freud postulated 4 stages of development (oral, anal, phallic genital). Each stage is associated with a different body zone which becomes invested with sexual energy. The Oedipal stage of development (phallic) is considered crucial in both male and female development for its resolution is believed to result in the integration of the superego. In males, the oedipal situation can be briefly
e summarized in the following way. The infant male forms a love bond with his mother and is angry and resentful of his father. He notices that females do not have penises and assumes that they are castrated males. He fears that he will be castrated by his powerful father for his desire for his mother. He, therefore, identifies with his father to protect himself from castration and gives up his mother but eventually seeks other women as love objects. The oedipal situation is thus resolved and the super-ego is formed. This relatively direct and simple theory is used to explain both male sexual identification and the development of the superego.

Unfortunately, such a simple and direct theory will not work for females. Like her brother, the infant girl also takes her mother as the primary love object. The problem, therefore, becomes one of constructing a series of events which will lead her to give up her mother and form an attraction for her father, so that she, like her brother, can progress through the oedipal situation. As a result, Freud and his disciples were particularly interested in the pre-oedipal period in female development. The theory which was constructed to deal with the complications in normal female development can be summarized in the following way. The young girl has a primary love attachment to her mother. She becomes aware of the fact that her brother has a penis and she does not. She believes that she once possessed a penis but was castrated. She regards herself as inferior and is envious of the male for his possession of a penis. She recognizes that her mother also lacks a penis and blames her mother for her castration. She turns away from her mother and towards her father in hopes of regaining the lost object and enters the
She gives up her wish for a penis and puts in its place a wish for a child and "with that purpose in view she takes her father as a love object." (Freud, 1974, p.23) Eventually, her love for her father must come to grief but she abandons her father reluctantly and incompletely. Thus in women, the oedipal situation is never completely resolved. As a result of this series of events, the normal woman fails to acquire a highly developed superego, and is more narcissistic, dependent, has lower self esteem, and more inhibited hostility than her male counterpart, for she can never really get over her loss of a penis except by bearing a male child. Such is the Freudian view of the normal woman's personality and development. (Horney, 1974)

Freudian theory asserts that the normal progression through the stages of development may be distorted by excessive frustration or gratification at a particular stage with a large amount of libidinal energy fixed at that stage, leaving an insufficient supply for further development. Under extreme frustration, libido may be taken from a pain zone and regress to an earlier one. Psychopathological symptoms are determined by the developmental stage to which a particular individual is fixated or regresses.

Psychoanalysts generally agree that depression is a symptom or indication of a psychopathological process in the development of the personality. However, there is a wide spread of opinions about the proper theory to explain this type of symptomatic distress, and the psychoanalytic position on depression is not a unified one. (Mendelson, 1974) While all the theories rest on the general framework which has been
described above, theorists differ in their descriptions of the exact mechanisms of depression. Therefore, some of the central ideas and assumptions which Freudians and neo-Freudians make about depression will be summarized.

Freud viewed depression as a reaction to an imaginary and vaguely perceived loss which deprives the ego. The lost object is introjected or incorporated into the individual's psyche and the anger over the loss is, therefore, directed inward. This incorporation of the object represents a regression to the oral stage of development. (Freud, 1917)

Abraham also believed that the depressed individual is fixated at the oral stage and associated it with both dependent personalities and with the primitive hostility of oral expulsive fixations. He saw it origins in childhood disappointments in the pregenital stage of development compounded by disappointments in later life. Eado saw the depressed person as having intense narcissistic needs and poor self esteem, reacting to the loss of his love object with anger and self punishment. Melanie Klein believed that the origins of depression are in the first year of life and felt that depression is rooted in the lack of mother's love during infancy. Bibering identified the fall of self esteem as central to depression. There are, of course, many other views; however, the picture which appears to emerge from all of the above is that the depressed individual's personality is marked by dependency, narcissism, hostility, low self esteem, deprivation of love and a highly punishing superego.

(Mendelson, 1974, Beck, 1967) One cannot help but note the striking parallels between the psychoanalytic understanding of the normal female and
Psychoanalytic view of depression, as Weissman points out. (Weissman and Klerman, 1977) The great difference between the two profiles might well be that one individual is supposed to be happy while the other is supposed to be unhappy.

Psychoanalytic theorists work within the medical model but apply that model by analogy to psychological processes. The individual is seen as psychologically ill and her symptoms are manifestation of an underlying psychopathology. The task of the clinician is to correctly interpret these signs, diagnose the underlying personality disorder and treat it. Once the personality has been restructured (treated), the symptoms will spontaneously remit.

Evidence to support the psychoanalytic interpretation of depression comes largely from reports of successful analyses and hence rests on a very small number of cases. Objective verifiable evidence for the psychoanalytic model is sparse (Weissman and Klerman, 1977) and indeed, the psychoanalytic model, with its emphasis on intrapsychic events, does not lend itself to objective studies. Friedman did a study on hostility factors and clinical improvement and found that depressed patients exhibited less hostility than normal controls both during and after depression. (Friedman, 1970) However, as Friedman notes, his study would not be acceptable as a disconfirmation of the psychoanalytic theory of hostility and depression since psychoanalysts would argue that the hostility exists at a deeper level than the survey can measure. Indeed, it seems that it is necessary to be immersed in the psychoanalytic model in order to see evidence of its validity. As a model, it has been very difficult
to confirm or disconfirm by standard objective measures, and there has been little enthusiasm among psychoanalytic practitioners to engage in this type of study. (Hendelson, 1974)

We now must look at how a psychoanalytically oriented clinician would understand and treat Ester Greenwood's problem. Of course, the understanding would vary from clinician to clinician depending on each clinician's view of the problem, but one fact with which they would all agree is that the symptom only provides a clue to the underlying personality disturbance. Ester's problem would probably be viewed as a reaction to an imagined loss of love object. Her depression would be seen as triggered by her rejection from her summer school course. This blow to her self esteem would be understood as triggering repressed and unconscious unresolved conflict in early childhood, probably revolving around early maternal deprivation. Ester's personality would be seen as fixated at the oral stage. Her dependency could be seen in her tremendous reliance upon external supplies of love, attention and affection in order to maintain her self esteem. This, of course, would make Ester's drive to overexcel in school understandable. It would also explain her compulsive attitude towards work. Her aggression towards her mother and her reaction to her father's death would have been turned inward to produce the fuel for her self punishing behavior. Due to her fixation at this early stage of development, Ester would not have been able to successfully resolve her oedipal situation. As a result, a central part of her problem would be seen as her difficulty with gender identification and her unresolved penis envy. This can be seen in her choice of a
masculine career, her intense striving for success, her rejection of marriage, her uncertainty about wanting children and her generalized anger about being treated unfairly because she is a girl.

Given this analysis, Ester would undoubtedly be seen as in need of treatment. The focus of that treatment would not be on removing or curing the depressive symptomatology, but would aim at structuring Ester's personality so that she could be freed of her oral fixation, resolve her oedipal problem and accept her innate feminine role. The treatment would take the form of frequent analytic sessions extending over a long period of time, which aimed at exposing the repressed and unconscious material, perhaps through a detailed analysis of her dreams. Ester would be encouraged to enter into a transference relationship with her therapist and through that relationship gain insight into her unresolved intrapsychic conflict. Successful analysis would lead to an acceptance of the mature feminine role, a restructuring of the personality and would result in complete and permanent symptom relief. It is, therefore, clear that an understanding and treatment of Ester's problem relies not only on an understanding of depression but also on the psychoanalytic theory of personality and normal feminine development.

Psychoanalytic theory has been questioned, criticized and attacked from many points of view and on many grounds. Many of the critics of psychoanalytic theory direct their criticism at the basic assumptions which the Freudian model of human development makes. As we have seen, Freudian analysis assumes a universally determined course of personality development. Critics argue that this fundamental assumptions fails to
address the role which culture plays in the formation of personality, nor does it recognize cross cultural differences in the development of personality. The general argument is that psychoanalytic theory grew out of an understanding of European middle class culture at the turn of the century and takes the very ethnocentric position that the experience of growing up in that culture should be seen as representative of the universal human experience. (Mead, 1974) Allied to this criticism is the argument that Freudian theory overemphasizes the role of sexual stages of development (because it reflects the experience of a sexually repressed society) and fails to take into account. In postulating a tension reduction model of development, it fails to adequately explain exploratory behavior in humans and as the theory is limited to the development of personality in early childhood, it ignores the effect of later social experience on personality development. (Deutsch and Krauss, 1965) Ultimately, psychoanalytic theory rests on the assumption that the analogy between physical development and illness and mental development and illness is valid, and its ties to the medical model are central. This view assures a search for the explanation of the disorder within the 'ill' person and does not deal with interactional and situational components which may be relevant. Finally, as psychoanalysis relies on interpretation of intrapsychic life, it does not allow for confirmation or disconfirmation by objective measures, and bases its universal conclusions on a small number of cases. It has been severely criticized by behaviorists and others for its narrow and restricted vision which is based on so unproven a theoretical position.
The therapeutic aspects of psychoanalysis have been criticized on the grounds that they are ineffective, rely too heavily on insight and require too much of the patient's time and money. This therapy system has also been criticized for imposing its therapeutic aims and goals on the patient. For in psychoanalysis, although the patient may approach a psychotherapist for relief from the symptoms of depression, the psychoanalyst's aim will not be to relieve her symptoms but to restructure her personality. (Tennov, 1975) As a result symptom relief may not be a measure of treatment success. Psychoanalytic based therapy has been criticized by Szasz and others on the ethical grounds that it adopts a narrow and unproven view of psychological difficulty and elevates that view to the level of science (proven fact) without meeting scientific criteria of validity and reliability.

The psychoanalytic theories of the etiology and treatment of depression are subject to all of the criticisms which have been raised above, as these theories rest on the same assumptive base. In addition, theories of depression are not unified, and there is considerable disagreement among practitioners about which of the many interpretations is correct. Despite these disagreements, Mendelson finds that all too many practitioners are prepared to offer definitive statements about the nature and causes of depression. These practitioners "mistake partial insights for universal statements." (Mendelson, 1974, p. 291) As we have seen, the nature of the general theory encourages such universal pronouncements. Finally, psychoanalytic theories of depression have been criticized for being overly simplistic and not addressing findings in other related fields.
Again, the parochial and narrow views of many practitioners are considered to be responsible for this problem. (Mendelson, 1974)

Psychoanalytic theory, as it relates to women and mental illness, has been most strongly attacked by feminist writers. As the majority of women who receive psychiatric help are diagnosed as depressed, the feminist critique is relevant to the understanding and treatment of the depressed woman. Feminists agree with the other critics in asserting that psychoanalytic theory represents an ethnocentric view of the human condition. They add one important factor to that criticism, for feminists believe that Freudian theory is essentially a male view of human development. Thus feminist critics argue that Freudian theories of both normal development and pathological states represent an understanding of how a male would see these processes based on his position in the world. Karen Horney's critique of the Freudian view of female development points out that each critical stage in the pre-oedipal period can be taken to represent how a male might feel if he were castrated. (Horney, 1974, Person, 1974) What so enrages feminist critics is that this male construction of female development is taken to represent a universal, scientific and factual analysis of female development, not the biased account which they believe it to be. All this leads to an understanding of the normal woman which indicates that she is passive, somewhat masochistic and morally inferior to males and further asserts that this is the way she is meant to be. Her psychological task is to accept her femininity which means that she must accept her inherent inferiority and give up her penis envy. Treatment for her pathological condition,
depends on helping her to gain insight into her problem and accept her normal feminine role. Feminists argue that feminine traits which Freudian's believe to be normal, in fact, reflect the oppressive social conditions and cultural stereotypes under which women are raised and exist, and that feminine development can best be understood through an understanding of these social conditions. (Janeway, 1974, Kovel, 1974)

Feminists point out that the psychoanalytic therapy process involves long term analysis and that this analysis is predominantly done by males. (Tennov, 1975, Chesler, 1972) During this process, the woman must learn to accept the analyst's construction of her character and depression. She must depend on his interpretation, as her problems are seated in her unconscious which her analyst can see but she cannot. The feminists argue that what she is asked to do is to accept a negative, male, cultural stereotype of femininity and to allow a male view to construct and define her. As we have seen, this entire process of construction is open to serious criticism.

A final question which must be addressed in reviewing the psychoanalytic theory of women and depression is oddly enough why look at the Freudian position at all. After all, criticisms of the Freudian view are now well accepted among clinicians and fewer and fewer patients are being treated by traditional analytic techniques. While it is true that Freudian therapy as a whole is currently out of favor among clinicians, many parts of the Freudian view of both women and depression are in common use. Perhaps the most widely accepted aspect of Freudian theory in use is the notion that depressed women are really angry women. Another
view which is favored is that depressed women are really very depen-
dent and needy people. Still another view is that depressed women have
an underlying personality which is obsessive compulsive, and of course,
the term castrating female still survives in some circles. These un-
derstanding of depression and women are outgrowths of the Freudian view
and are dependent on all of the assumptions of that view. Yet, for
many clinicians, they have become well established clinical 'facts'.
Just like the statistic which is taken to represent hard, objective
evidence, these views stripped from their assumptive base take on an
aura of fact. It is, therefore, important to reconnect these well
known facts with their theoretical base in order to gain some under-
standing of them.
iii. Cognitive Theories of Depression

Clinicians who adopt a cognitive model to understand depression make the assumption that depression is primarily a thought disorder which is characterized by specific cognitive distortions of reality and is caused by the depressed woman's early childhood experiences and the reflected appraisal of others. (Beck, 1967) Aaron Beck, the leading proponent of a cognitive theory for depression, identifies a triad of negative cognitions which can be activated in the predisposed or susceptible woman and create the negative or depressed affect. This triad of cognitions is thought to be: construing experiences in a negative way; viewing self in a negative way; viewing the future in a negative way.

This conception presupposes that the depressed woman's actual experience in the world is not negative; it is merely constructed as negative.

Beck's theory also rests on the assumption that depression is caused by distorted perceptions and that it does not work the other way around.

Beck's theory shares the basic assumptions of the medical model. Depression is viewed as an illness within the woman. The specific affective and vegetative symptoms are clues to the underlying psychopathology which lies in the thought processes. Depression is, therefore, seen as similar to schizophrenia in that both are assumed to involve distortions of reality. Indeed, Beck speculates that "a thinking disorder may be common to all types of psychopathology." (Beck, 1967)

Beck also shares some of the assumptions of the psychoanalytic school, in that he offers a psychological explanation for the etiology of depression.
In fact, Mendelson includes a discussion of Beck's theory of depression in his review of psychoanalytic theories. Like psychoanalytic theories, Beck's theory locates the causes of adult depression in early childhood experiences. Unlike his psychoanalytic counterparts, he is interested in a more detailed and empirically based understanding of the symptomatology of depressive disorders, and he has been criticized by psychoanalysts for offering a superficial understanding of the problem. (Mendelson, 1974)

Evidence to support Beck's theory generally stems from studies which Beck and his colleagues have undertaken. Beck's studies found that depressed patients differed significantly from non-depressed controls in what Beck terms idiosyncratic thought content. This thought content is characterized by themes of 'low self-esteem, self blame, overwhelming responsibility and desires to escape.' (Beck, 1967, p.230) These cognitive distortions were measured by an analysis of dream content, and other psychological projective tests and were found to be relatively successful in differentiating depressed patients from other clinical groups. These findings led Beck to adopt a continuum hypothesis to explain depression with psychotic depressions representing more severe cognitive distortions. His theory of causation in depression has not been subject to the same empirical tests and rests on the assumption that cognitive distortions precede depressed affect and have their origins in early childhood.

Beck's findings can be criticized for their reliance on projective tests which require a great deal of interpretation by researchers.
Furthermore, his contention that depression is preceded by cognitive distortion is not well supported by evidence and does not explain those cases in which depression is rapidly alleviated by psychopharmacological agents or ECT. (Mendelson, 1974)

Beck does address the issue of depression and women. In his article "Cognitive Therapy with Depressed Women", Beck expands his ideas about causal factors in depression to include cultural influences which may lead women more than men to perceive themselves as negative and worthless. He maintains his belief that when these negative self evaluations become severe or disabling, they represent a thought disorder and require therapeutic involvement to help the woman gain a more realistic and less distorted view of her experience, her self and her future. (Beck, 1974)

In looking at how a cognitively oriented clinician would understand and treat Ester Greenwood's problem, it is clear that he would concentrate on understanding those thought processes which led Ester to have such a negative view of herself and her environment. He would immediately be struck by the paradox between the facts of Ester's situation (that she is a bright, gifted young woman with a promising future) and the way in which Ester interprets those facts (that she is ugly and stupid and that her future is without hope). He would see the discrepancies between the objective facts of Ester's situation and the subjective experience which Ester reports as representing evidence of a thought disorder. He would assume that Ester's rejection from her summer school course activated her already established but dormant idiosyncratic cognitive schema which had probably been formed in her childhood. He would
note the tendency for these activated schema to dominate her thinking and produced depressive affective and motivational phenomena. (Beck, 1967, Mendelson, 1974) The severity of Ester's symptoms would indicate a diagnosis of psychotic depressive reaction, and Ester would clearly be in need of treatment.

Ester's treatment would consist of two parts. During the acute phase of her illness, the therapy would aim at alleviating her symptomatic distress by helping her to gain some objectivity and control over her negative automatic patterns. When the acute symptomatic distress subsided, therapy would be directed at modifying the underlying causes of the disorder, the idiosyncratic thought processes. This would be accomplished through the use of insight oriented therapy. The aim of the therapy would be to review the patient's life history, and to demonstrate to her the ways in which she distorts certain situations and events. She would be helped to see how these distortions were learned in early childhood. (Mendelson, 1974) More specifically, the therapist would challenge the patient's generalizations, deletions and distortions in her construction of reality, and hope to give her insight into how these misconstructions are produced. This therapy would attempt to give Ester mastery over her experience and allow her to recognize her overreactions. In this way, the therapist would hope to prevent future depressions.

The role of the therapist is that of a teacher as he helps the patient to learn to identify and correct her cognitive distortions.

Beck's theory of depression has generally received favorable review, however, in evaluating it, certain problems are evident. As we
have seen, the studies which Beck cites to support his theory are based on somewhat unreliable projective tests and subject to a range of interpretations. His assertion of the etiological primacy of cognitive distortions does not rest on extensive evidence and does not explain the successes of organic treatments of depression. Furthermore, cross-cultural studies have failed to confirm the universality of cognitive distortions in depression, and the cognitive symptomatology of depression has been found to present different clinical pictures among different cultural groups. (Katz, 1971) These findings would tend to support a theory which stresses cultural factors in the incidence and prevalence of depression rather than one which stresses early childhood experience. While Beck's discussion of women and depression does acknowledge cultural factors in higher incidence of depression in women, the weight of his theory and therapy tends to mitigate those factors. Thus Beck speaks of the paradoxes in depression, and in his major work, Depression, presents case example which exclusively highlight these paradoxical components. He cites examples of the rich man who believes he is poor, the beautiful young woman who believes that she is ugly, the gifted young scholar who believes that he is stupid.' In such cases, it makes sense to assume that the problem lies not in the person's experience in the world but in their construction of that experience. But, of course, we must ask what of the poor man who feels useless and incompetent because he cannot find or hold a job; or the homely woman who believes that she is unattractive and unloved; or the poorly educated woman who believes that she has no opportunities in life because she has no skills
to offer. All these people may also feel depressed and experience the world as negative and hopeless. Are there feelings best understood as a distortion of reality? Would they be seen as clinically depressed?

Many feminists would argue that women feel depressed because their experience in the world is more negative, and because they are less valued and esteemed than their male counterparts. (Chesler, 1972, Tennov, 1975, Smith, 1975) They would argue that a therapy which tells its patients to look on the bright side, to construe reality as more positive, implicitly tells women to accept their situation and to change the way that they think about it. Thus, Beck's cognitive therapy can be criticized for its overemphasis on seeing pathology in the way the patient perceives herself in the world, and deemphasizing those societal and interaction components which participate in this ongoing constructive process.
Behavioral Theories of Depression

Behavioral theories of depression assume that depression is an unadaptive response to psychological stress rather than an illness, and see depressed behavior as caused by inadequate, insufficient or ineffective reinforcement. (McLean, 1976, Orr, 1977) Behavioral theories are generally concerned with explaining and analyzing observable behavior based on an application of learning principles without recourse to intrapsychic structures. This approach relies on rigorous experiential methodology and finds its support in research in both animal and human behavior. Behaviorist theories rest on three underlying orientations: the methodological outlook of behaviorism, the structural principles of associationism; and the motivational principle of hedonism (the pleasure principle in Freud). Thus, behaviorists are concerned with the association between observable behaviors, and use the concept of conditioned response as the basic unit of analysis. Like psychoanalytic theories, behavioral theories rely on a tension reduction model of human behavior, and place emphasis on the role which 'rewards', 'drive reduction', reinforcers' play in establishing and strengthening the connections between stimulus and response. As Homans states, behavioral theories rest on the assumption that "human behavior is a function of its payoff; in amount and kind human behavior depends on the amount and kind of reward and punishment it fetches." (Deutsch and Krauss, 1965, p. 79)

As with the other theories of depression, there are a number of behavioral theories of depression, which while sharing the same assumptive base, stress different aspects of depression and offer somewhat
different interpretations to explain the phenomenon. This review will briefly consider the theories proposed by Lewisohn (1971) and Seligman (1973) as their theories can be taken to represent the dominant positions in behavioral theories of depression.

Lewisohn, like his colleagues Lazarus and Ferster, postulates that depression results from inadequate, insufficient or ineffective reinforcement. He assumes that a variety of life events or stresses (loss of spouse, job, money etc.) can disrupt the individual's usual pattern of reinforcement and result in a low rate of positive reinforcement. His low rate of response contingent positive reinforcement will elicit the unconditioned response of certain depressive features (i.e. fatigue, sadness etc.) and negative verbal statements. As the person receives less positive reinforcement which is contingent on her behavior, she becomes less behaviorally productive. In behavioral terms, she is on an extinction trial. (Orr, 1977, McLean, 1976)

Lewisohn hypothesizes that the occurrence of such a situation depends on 3 factors. The first factor which must be determined is the number of events which are potentially reinforcing to the individual. This will be subject to individual differences and will therefore be expected to vary for each individual. The second factor is the availability of potential reinforcers to the individual. The third factor is "the extent to which (s)he has the skill to emit the behavior which will elicit reinforcement." (Orr, 1977, p.80) To put it more simply, does she possess the social skill to get the rewards which she requires?

The central issues in the development of depression are the amount
of response contingent reinforcement, and the degree of social skill which the person possesses. "The individual must experience praise or blame, reward or punishment, as dependent on her behavior and not on some extraneous factor. She also must have access to reinforcers and possess the social skill necessary to gain those rewards. If some of these central factors are not in operation, then the woman is likely to become depressed.

Seligman's theory of depression assumes that depression can be best understood in terms of learned helplessness. Reinforcement is critical in Seligman's theory, and the theory stresses both reinforcement contingency and prior learning experiences with respect to mastery. According to Seligman's theory, if a person learns that she has little control over the conditions under which she is rewarded or punished, she will learn that she is helpless. When this person encounters events which are aversive (loss of spouse, job or money), her learned belief in her inability to exercise control or mastery over those events will result in depressed feelings, cognitions and behavior. (Seligman, 1973)

Behavioral theories of depression reject the assumptive base of the medical model. They do not make the assumption that the woman is mentally ill, but rather they see the problem as caused by past learning and present environmental circumstances.

Behavioral theories do not specifically speak to the issue of the greater prevalence of depression in women. However, behaviorists have recast some of the findings of feminists and others into behavioral terms. Thus, one can find many examples of behaviorists using feminist
explanations to support their analysis of depression and vice versa. For instance, findings that married women with young children have the highest incidence of depression, can be explained in terms of these women's relative social isolation and the lack of availability of positive reinforcement in an isolated setting. Findings that 70% of all depressed individuals experience marital discord can be explained in terms of the lack of positive reinforcement by the spouse. (McLean, 1976) Behaviorist theories of learned helplessness find support in the feminist position that women are culturally conditioned to be more passive and to lack assertiveness.

As stated previously behavioral theories rest on research in both human and animal behavior. Studies by Lewisohn, Costello, Klerman, McLean, Seligman and others are cited to support these theories. Behavioral research relies heavily on animal research. Seligman's study of learned helplessness was generated from experimental studies with animals, and behaviorist's findings have been criticized for drawing a false analogy between animal and human behavior. (Deutsch and Krauss, 1965) Another major critique of behavioral studies has been the circularity of its definition of reinforcement. All behavioral studies rely on an operational definition of reinforcement, for they measure the degree to which depression is associated with the lack of response contingent reinforcement. However, behaviorists have yet to develop an adequate understanding of what is reinforcing, and they can only establish reinforcers with certainty after the fact. This difficulty creates problems in their measurement of behaviors and is thought to effect the validity of their results. (Deutsch and Krauss, 1965)
As we look at how a behaviorally oriented clinician would explain and treat Ester's problem, it is clear that he would understand her depression as an unadaptive response to stress. In hearing the facts of Ester's situation, he would see her rejection from her summer school course as critical in setting off the chain of behaviors that led to her depression. He would note that the rejection from the course had the behavioral consequence of cutting Ester off from her usual pattern of reinforcement which had been associated with her academic environment and school friends. Ester would have been left in an isolated environment with few potentially reinforcing events available to her, since she had little interest in the people and events in her home town. Ester might be seen as lacking the social skills and experiences of mastery to remold this less than rewarding environment into one which would be more satisfying. As a result of her lack of assertiveness and her general lack of response contingent reinforcement, her behavioral productivity would decrease. With this decrease in productive behavior, there would be even less behavior available for reinforcement, and in this way, a downward spiral into depression would be produced.

Ester would be seen as needing behavioral therapy to help her break this downward spiral. The treatment for her depression would focus on helping her develop more effective methods for coping with stress and on changing her current pattern of reinforcement. The focus of the treatment would be on the depressed behavior rather than the thoughts and feelings associated with depression. The changes in behavior would be expected to produce changes in thoughts and feelings. If Ester were treated as a
single person, she would be expected to learn certain self management strategies to cope with her depression. Her behavioral productivity would be increased with the introduction of small graduated tasks which she could successfully complete each day. Her goals would be examined and reduced to prevent frustration. She would be expected to plan a number of social contacts for each day to decrease her isolation and increase the availability of social reinforcement. She might undergo specific behavioral training to help her become more outgoing and assertive in social situations. She might be trained in decision making and problem solving to help her achieve mastery over some of the issues in her life. She would also be taught how to monitor her thoughts to prevent the intrusion of depressive thoughts. However, behaviorists have found that their therapies work most effectively if the depressed woman is reinforced by others. As a result, Ester's mother might be involved in the therapy as a collaborator with the therapist, and would be trained in ways to more effectively reinforce Ester for her positive, non-depressed behavior.

In evaluating behavioral theories of depression certain problems are evident. Behaviorism, as a whole rests on a tension reduction model of human behavior and is subject to the same criticism as Freudian theory in that it fails to adequately explain or deal with exploratory or purposeful behavior in humans. Behavioral theories, therefore, do not offer very satisfactory explanations for the cognitive and affective components of depression. They assume that these components result from depressed behavior but are unable to prove primacy of behavior in the etiology of depressive disorders, nor can they adequately explain the interaction between
cognition, affect and behavior as they rely on an overly simplistic causal model. There have been some recent attempts to incorporate cognitive and behavioral components (self-regulating models), but these theories are broad and offer a simplistic explanation for what is generally considered to be a complex process. (Orr, 1977) In emphasizing behavioral components, behavioral theories also cannot explain the effectiveness of organic treatments of depression nor explain instances in which there appears to be rapid spontaneous remission of symptoms. Since behavioral theories rest on an assumption of precipitating stress, behaviorists have generally been successful in locating stressors in the depressed person's background history. With the introduction of the concept of microstressor, the concept has become even more elastic. The difficulty is that many people's history would reveal a rather large number of microstressors in their environment, yet not all these people become depressed. To date, behavioral theories have been unable to successfully predict when a person will become clinically depressed, rather they can offer an explanation after the fact. Part of the problem is that behavioral theories rest heavily on the concept of reinforcement, and as we have seen, behaviorists are unable to define this concept. The in definition stems from the fact that what is taken to be reinforcing will vary from individual to individual and may vary as a result of who provides the reinforcement, how is provided and the context in which it occurs. Therefore, what is reinforcing to one individual may not be reinforcing to another. In addition the value of the reinforcement may alter depending on the context in which it occurs. To reframe this in social interactionist terms, the
meaning of a particular reinforcement must be created by participants in social interaction. As behaviorists have no method of establishing before the fact how this will be done, they are forced to rely on a retrospective explanation of the process.

The difficulty which behaviorists have in defining and understanding reinforcement creates serious problems in the application of behavioral theories in a therapy situation. The normal way in which behaviorists surmount the problem of definition is to accept the consensus of opinion about what is generally taken to be reinforcing in this society and to assume that it is also true for the specific individual in treatment. Behaviorists have been criticized for their acceptance of a consensual definition of reinforcement and critics have charged that behavioral therapists use their techniques to enforce social conformity on individuals who are relatively powerless. In treating depression, some feminists and others would criticize behaviorists' use of husbands and other relatives to treat the depressed women. They object on the grounds that those individuals in concert with the therapist might try to manipulate the woman into conforming to culturally stereotyped and socially discriminatory roles (i.e. the husband systematically reinforcing his wife for performing household and child care chores) and behaving in socially acceptable ways. However, others in the field point to the value free base of behaviorism and argue that behavioral techniques can be used for good or ill depending on the goals to which they are applied.
v. Summary and Conclusions

In reviewing the 4 theoretical positions on the etiology of depression, it is evident that each theory rests on its assumptive base about the nature of the disorder. Furthermore, the psychoanalytic, cognitive and behavioral theories also rest on their assumptions of what is normal and desirable behavior, thoughts and feelings. Thus for the psychoanalyst, normalcy for women implies a 'mature acceptance' of their inherent femininity and passivity. For the cognitive clinician, normalcy implies that the woman perceives the world as basically positive, that she perceives herself as worthwhile, and sees her future as hopeful. For the behaviorist, normalcy implies the capacity to adapt to most types of stressful situations, and implies an ability to conform to her environment. All of these positions represent normative or moral statements, although they are not usually specifically identified as such. Three of the four theories rest on the implicit assumption that clinical depression represents a pathological condition or illness which resides in the woman and assume an underlying unitary causal disease process which is manifest in the depressive symptomatology. The behaviorist position rejects the illness assumption and assumes that depressed behavior can be understood as a reaction to stress.

All of the theories rest on a base of evidence which can be taken to support the theory. However, the evidence upon which each theory rests differs in the degree to which the research base conforms to the expectations of scientific inquiry (from subjective case analysis to rigorous double blind experiments). A review of the available evidence indicates
that none of the theories rests on conclusive evidence, and the foremost researchers in the field are quick to point out the difficulties in making definitive statements about a disorder which to this day defies definition.

Clinicians who operate on the basis of any of the 4 models may be aware of the confusion within the field, but their position vis-à-vis the depressed woman may lead them to act with more certainty than the evidence would allow. Given the same case example, clinicians operating under the assumptions of each of the theories presented would select out those aspects which their theory believes to be primary in depression. However, none of the theories can predict whether or not a specific individual will become depressed nor can any of the theories establish a priori what set of biological, psychological, or environmental variables will necessarily cause an individual to become clinically depressed. While some research on life stress claims to be able to predict some form of physical and emotional difficulty as a result of an accumulation of life stress, this research is unable to predict what specific type of difficulty will occur. Thus, all theories of depression fail in their predictive ability and rely on retrospective accounts and explanations.

As we have seen, all of the theories can explain what happened to Ester Greenwood with relative ease and offer a coherent and logical account of her depression. That is, her experience can be fitted into the models explanatory hypotheses, once their basic assumptions are accepted. They all start with the depressed individual and look backward to explain what is wrong with her personality or behavior.

Each theory places the clinician in a central and powerful role in
interpreting what is wrong with the woman, and in helping to remedy the situation. The organic position will lead the clinician to construct the woman as biologically ill and prescribe a chemical or organic remedy. The psychoanalytic position will lead the clinician to focus on the woman's inner mental life and to interpret for the woman the meaning of that life. The cognitive position takes a wider view of the problem in that it is concerned with the woman's current perceptions of herself and her world, but places the clinician in the role of teacher or judge with respect to the correct interpretation of that world. The behavioral position takes a still wider view in that its analysis includes both the woman and her environment, but it may place the clinician in the role of helping the woman to adapt or conform to that immediate environment and measures success in adaptive terms.

Each or all of these orientations will have impact on the clinician's definition, diagnosis and treatment of the woman and the way in which he interacts with her in a therapy situation. In addition, the clinician's assumptions about normal female adjustment, mental illness, and psychiatric diagnosis will effect his interaction with the patient and the meaning which is created.

Finally, the clinician's expectation that it is his role to assess diagnose and treat the patient may create in him an expectation that he must be more knowing than the patient and that his perceptions of reality ought to be more objective, and sensible than hers are. For he is expected to speak from his role as an acknowledged authority, while she is expected to speak from her role as a mentally ill or maladapted individual.
In addition, if the clinician is a male (and if the therapist is a psychiatrist or psychologist, this is very likely), he will bring with him his socially conditioned sex role and his experience in the world as a male. The male sex role may include a definition of self as actor, protector and provider. It will, of course, coalesce with the expectations of his role as a therapist, and the assumptions of the model of human behavior which he has adopted.

Regardless of the clinical situation, we cannot overlook the impact of depression on the depressed woman's life: financially, her marriage, her family, her role as a worker, wife or mother.
II. The Feminist's View - Issues and Problems
Having completed a review of the 4 dominant theoretical approaches to understanding women and depression, it is important to examine an approach which does not attempt to discover what is wrong with the depressed woman or to understand how her personal history produced her depression. The modern feminist approach to women and mental illness represents such a view. Modern feminism can be understood as a political and social movement, an ideological position about women in North American society, and a theoretical position on female behavior and development. It attempts to analyze, criticize and change the nature of western society.

The feminist approach to women and mental illness does not represent a single unitary theory, but an amalgam of various approaches to understanding the problem. However, feminists who write about this issue do share a basic orientation to the problem. This orientation seeks to locate the source of the woman's difficulty in the construction of the social order rather than in the biological or psychological pathology of the individual. It takes sex role as the central variable in how an individual is constructed by that social order. It also takes sexual identity as the most crucial element in personal identity and makes the assumption that sexual identity and sex role are products of ongoing social construction rather than the innate characteristics which they are often taken to be. It assumes that men and women encounter the world from different experiential bases as a result of differences in the way their sex roles are divided.

The feminist orientation takes the position that an individual's experience of depression (sadness, loss of self esteem, hopelessness)
cannot be stripped away from her experience as a woman in North American culture, for the two are seen as inextricably linked. Furthermore, a woman's experience of depression as a clinically diagnosed entity cannot be understood in isolation from the psychiatric system which produces such diagnoses. Thus, women, society and the mental health system must all be considered if depression and the treatment of depression as a mental illness in women is to be understood. (Smith, 1971)

As a result, this analysis of the feminist position on women and depression will include: a review of the feminist critique of current approaches to understanding and treating 'mentally ill' women; the feminist understanding of female socialization and societal attitudes towards women, and feminist theories of depression and women; feminist alternatives to the present methods of treating depressed women. The analysis will outline the major assumptions upon which the feminist position rests and the evidence which is cited to support this position. Major criticisms of the feminist position will be reviewed and discussed in relation to the treatment of depressed women.
A. The Feminist Critique of Current Approaches to Women and Mental Illness

The feminist orientation to women and mental illness must be understood in the context in which it developed. The feminist position developed as a reaction against the Freudian position on women and as a reaction against the institution of psychiatry as it exists in North America. (Strouse, 1974) The feminist critique has special relevancy to an understanding of the treatment of depressed women, because as we have seen, depression is the most prevalent complaint of women who are undergoing psychiatric treatment.

As we have seen, the profession of psychiatry rests on a medical model of mental illness. Psychiatry also rests on the assumption that its findings in human behavior represent objective facts and are free of cultural and other forms of bias. Feminists and other radical therapists specifically challenge this assumption, and with this challenge strike at the foundations of the mental health system. The feminist orientation does not accept psychiatrists and other mental health practitioners accounts, interpretations and reports of what they do, but rather looks at the interpersonal consequences of psychiatric treatment for women. (Smith, 1975)

As psychiatry is a male dominated profession, feminists look at the psychiatrist's interaction with the woman not only as reflecting a doctor/patient relationship, but also as reflecting a relationship between a male and female and seek to understand the relationship on that basis as well.

By placing sex role at the center of the analysis, feminists ask some very different questions about the relationship of psychiatry, mental illness and women than the profession itself has addressed. In this respect
the feminist orientation to the problem falls within the definition of a sensitizing theory as outlined by Blumer and Scheff for it directs "attention towards new data or to new ways of perceiving old data which challenge taken-for-granted assumptions and shatter "the attitude of everyday life." (Scheff, 1975)

The feminist orientation directs attention to a number of these common sense societal and psychiatric ideas about women and mental illness. Specifically, it questions:

1) psychiatry and allied profession's claims that they speak from an objective and factual basis; (Smith, 1975)

2) the psychiatric assumption that mental illness is rooted within the inner mental life of the individual; (Tennov, 1975)

3) societal and psychiatric ideas about normal female development and mental health practitioners attitudes and belief about mental health in women. (Strouse, 1974)

With respect to the practice of therapy, the feminist orientation questions:

1) the power relationship which exists between the patient and the therapist, and specifically, how that power relationship reflects the relationship of men and women in larger society; (Tennov, 1975, Chesler, 1972)

2) the taken for granted assumption that it is the individual's responsibility to fit into his/her place in the society, and that the function of therapy is to help the individual to adjust to prevailing social norms; (Chesler, 1972)
Many feminists and critics of modern psychiatry take the position that mental illness as a separately defined clinical entity does not exist, as "mental illness can't be separated as a thing, object, stated disease entity (or what have you) from the social operations of psychiatry." (Smith, 1975, p. 89) As we have seen, Szasz points out that mental illness rests on an unproven analogy with physical illness. He finds that people come to psychiatric agencies with various kinds of problems and that part of the work which the mental health system must do is to reformulate and sort these problems to fit its diagnostic categories.

The mental health system is authorized to fit people's experiences into illness categories. While the system does not create the many forms of suffering and despair which humans experience, it packages these experiences as mental illnesses. Thus, in Szasz' view, "the mentally ill are the people upon whom this work is done." (Smith, 1975, p. 90)

Thomas Scheff's work arises out of a similar orientation. He suggests that mental illness can be better understood as a violation of social rules. Scheff asserts that society uses many standard categories to deal with violations of commonly accepted social rules (i.e. violations of legal statutes, violations of etiquette etc.). There are, however, rule violations which do not fit into standard categories and are conceived of as residual rule violations. The category mental illness is like a miscellaneous file which is available for use in cases of residual rule violations. Usually, these violations are not categorized or labelled. However, when they are treated by the mental health system, then the category mental illness is attached to them, and the vague
social deviations and violations become symptoms. If the individual who is categorized accepts the mentally ill label, she will be encouraged to conform to the societal stereotype of mental illness and to see her behavior as a product of that illness. Thus, in this view, mental illness is a social construction which is produced by the patient and therapist in the context of the treatment setting. (Scheff, 1966)

Becoming mentally ill has many implications, and feminists are concerned with negative implications which being labelled as mentally ill has for women. The key to understanding the process is that it is circular or reflexive. The woman comes to the therapist with a series of difficulties. These difficulties are reframed as symptoms and lead to a diagnosis of illness. Once the illness has been diagnosed, these same difficulties are explained by the illness. To put it more simply, she is crying, therefore, she is depressed. Why is she crying? Because she is depressed. As Smith points out, this process really involves separating the person's problem from the context in which the problem occurs. As problems are stripped of the contexts which give them meaning, they become sensible only as 'sick', 'crazy', or 'mentally ill' behavior. Rosenhan's study shows how the act of writing can be transformed into 'writing behavior' and a symptom of mental illness. (Rosenhan, 1973) During this process, the woman is given a new set of instructions to understand her problem and those instructions tell her to "locate her problems arising in her relations to her situation inside herself." (Smith, 1975, p. 7)

In depression, she is given a further instruction to locate the problem in herself in the way that she feels.
Smith offers a set of instructions which tell us how to treat someone who is mentally ill. Such treatment will ensure that they are produced as sick. They are summarized as follows:

"1) Find out how to see this person's behavior as not making sense...
2) . .Separate the person's behavior from situations in which it belongs...Lift pieces of behavior out of context..
3) Don't relate to this person as if you could look at the world from the same place..
4) Don't take what she says seriously."

(Smith, 1975, p. 92)

Smith believes that this set of instructions will seal off people who are labelled mentally ill from ordinary social participation. They will not be able to speak with authority or to offer their own understanding of their problems. As we have seen, 3 of the 4 major theories of depression instruct practitioner to locate the problem within the woman, either in her biological makeup, the structure of her personality or her thought processes. These instructions may lead practitioners to see the depressed woman as mentally ill and to seal her off from ordinary social participation, and feminists assert that this labelling process is damaging to women who seek help from the mental health system. (Chesler, '72)

"Of course, one need not be a woman to be labelled as mentally ill and treated as sick. However, feminist's argue that women are particularly vulnerable to this process and are more greatly harmed by it. Their argument rests on a number of factors.

Feminists take the position that the mental health system is dominated by men and has a negative stereotype of women. Feminists see psychiatry as part of the larger patriarchal structure of society and believe that psychiatry mirrors that structure. Their argument is supported
by statistics that show the 90% of all psychiatrists and 85% of all psychologists are males and that women predominate only in social work and nursing, the least prestigious and powerful of the mental health professions (Tennov, 1975). They conclude that the mental health system is dominated by a male point of view and that that point of view has a negative stereotype of women. Inge Broverman’s study of sex role stereotyping among mental health practitioners supports this contention. The Broverman study found that the practitioner’s stereotype of normal healthy women indicated that they were "more submissive, less independent, less adventurous, less aggressive, less competitive, more excitable in minor crises, having their feelings more easily hurt, more conceited about their appearance, less objective, and disliking math and science" than the average healthy male. The study also found that the clinician’s views of normal healthy males and normal healthy individuals were consistent but that their profile of the normal healthy women was not. The study indicates that practitioners subscribe to the traditional negative feminine stereotype and that the stereotype represents a double bind for women. Women can be healthy adults but not healthy women or they can be healthy women but not healthy adults. They cannot be both. (Broverman, 1970) Thus feminist conclude that even before she enters into a relationship with a therapist, the female client is at a disadvantage.

Feminists argue that the traditional therapeutic relationship can be damaging to women. They point out the the therapeutic relationship mirrors the traditional relationship between men and women. Chesler sees it as replicating the husband/wife and father/daughter relationship.
Szasz sees it as mirroring the master/slave, oppressor/oppressed relationship. All this highlights the great difference in potential power between the woman/patient and the male/therapist. In interactional terms, he is one up and she is one down. Feminists contend that a woman is particularly vulnerable to the power of the male therapist because she has been socialized to accept male authority, and therefore, has had little opportunity to speak with authority or to define herself. Feminists believe that the process of therapy can be harmful to the woman because her socialization leads her to more readily accept the therapist's interpretation of her problem. As that interpretation often tells the women to see the problem within herself, she is encouraged to turn inward. This inward turn is believed to reinforce her passive, and helpless stance towards the world. She does not act in the world; she talks about her feelings. Thus, in following the therapist's instruction to change the way that she feels, she is given the implicit instruction to accept her existential situation and change her view of it. Feminists and other radical therapists interpret this instruction to accept her situation as one of the ways in which the mental health system acts as an agent of social control. They believe that this system acts to maintain the status quo and to help women adjust to it. (Chesler, 1972)

This critique has particular relevancy for the treatment of depressed women because feminists believe that the depressed woman's passive and powerless stance towards the world is at the root of her difficulties. They, therefore, believe that a system of therapy which encourages that passivity and holds a negative stereotype of women will be detrimental to the depressed woman.
3. Feminist Theories of Depression in Women

Feminist theories of depression in women are based on the ideological position which feminists take about the nature of women's position in western society. It should be noted that other theories of human behavior also rest on ideological positions; however, feminists are more explicit in outlining the value stance upon which their analysis rests.

Feminists take the basic position that western society is patriarchal and is oppressive to women. They see the relationship between men and women as the fundamental problem in society and believe that while society's rigid sex role stereotyping is damaging to all its members, it is especially damaging to women. Feminists view women's emotional difficulties as an expression of their relative oppression, and see the ultimate solution to mental illness and emotional problems as political. They believe that such a solution can only come from a reevaluation of sex role stereotyping and a redistribution of political power between women and men. (Friedan, 1963, Greer, 1971, Chesler, 1972, Smith, 1975, Tennov, 1976 etc.)

Feminists describe women's experience in North American society as one in which women are systematically denied mastery over their lives. (David, 1975, Smith, 1975, Tennov, 1976) Feminists believe that women are socialized to accept a narrow and restricted sex role. To support this contention, they cite studies in early childhood socialization patterns which find that female children are less vigorously handled and are kept closer to their mothers for longer periods of time than male children. These studies also find that young girls are not encouraged to explore or initiate activities and are more likely to ask for help when confronted...
with an obstacle than their male peers. (David, 1975)

Later socialization teaches women that their role is expected to complement the male role. Women are encouraged to view their success in terms of the reflected achievement's of their husbands and children, rather than on their own accomplishments. They are discouraged from becoming economically independent and are often denied equal access to opportunities in education and employment. The traditional female role teaches women that their ultimate fulfillment in life is to marry, bear and raise children. Women are taught that their role is to be passive supportive and nurturing to their husbands and to find their happiness in their families pleasure. Women are seen as the providers of care and their role is to meet others needs. Women also learn that the work that they do in caring for their families is not highly valued within society, and they are encouraged to accept this low prestige as part of their contribution to their family. Women are taught to value self sacrifice, to place their families needs ahead of their own and to depend on others for their definition of self and for their self esteem.

The above represents part of the cultural stereotype of femininity to which women are expected to aspire. It does not represent a complete explication of the female role. However, the key elements which feminist's point to are there. Women's roles are largely defined in relation to men, to serve the needs of men and are dependent on men. Women's happiness, security, fulfillment and success are all defined in terms of husband and family. There is little room in the traditional female
role for an independent definition of self, or for experience of mastery in the world.

The combination of female socialization and societal attitudes towards women will, in the feminist view, lead to feelings of self doubt and worthlessness, frustration, anger, helplessness, and hopelessness. Feminists argue that this combination of socialization and societal attitudes roughly approximates the conditions which behaviorists outline as leading to the behavior of learned helplessness, and to the symptoms which many clinicians take to indicate depression. Feminists differ from a behaviorist explanation in that they do not take this learned helplessness to indicate a maladaptation within the individual woman but rather see it as an adaptive response to oppressive societal conditions. Women's feelings of hopelessness, helplessness, and despair are seen as a direct result of their socialization and their ongoing interaction in a society which maintains that socialization. Some feminists view depression as an intensification of normally socialized female behavior. (Bernard, 1971, Bart, 1971) Bart makes the point that female socialization teaches women to suppress their anger and subordinate their needs to the needs of their family. Women are led to believe that they will be rewarded for this self sacrifice with the lifelong love of their husbands and children. Bart believes that depression in middle aged women occurs when women realize that the anticipated rewards are not forthcoming, and discover that their lives have lost meaning. (Bart, 1971) Higher rates of depression among married women are understood in terms of the effect which the ongoing monotonous
experience of being a housewife, mother, and wife can produce in women who have little experience or opportunity to do anything about their situations.

It is clear that the feminist understanding of depressed feelings in women closely approximates the behavioral analysis of depression, as it outlines the precipitant stressor and learned helplessness which are seen as produced by traditional feminine roles. However, feminists depart from behaviorists in the interpretation which they give depressed feelings and behavior. Feminists consider those feelings to be an act of protest against the oppressive conditions under which women exist. (Chesler, 1972, Smith, 1975, Bart, 1971) Thus feminist theories of depression share some similarities with psychoanalytic understandings of the phenomena in that they accept the idea of suppressed anger in depression. They differ from psychoanalytic interpretations in that they locate the source of that anger in the oppressive societal conditions, and believe that female socialization, not innate characteristics, has inhibited women from expressing their anger in more direct and assertive ways.

While feminists who address the question of women and depression tend to agree that depression can be understood as a protest and see depression as related to both sex role and stress, they are not unified in how much emphasis to place on each factor. As we have seen above, Bernard and Bart see depression as an intensification of normally socialized female behavior as a reaction to stress. Chesler, one of the most strident voices in feminism, downplays the role of additional
stress in depression and other mental illnesses, and focusses on depression as a rebellious act. Chesler's basic position is that depression and all forms of mental illness in women are caused by societies oppression of women. This oppression causes women to become mentally ill in greater numbers than men. Mental illness is reinterpreted to mean a rebellion against sex role. In depression, it takes the form of a complete acting out of sex role stereotypes. (Chesler, 1972)

Feminist theories of women and depression rest on evidence from a wide range of sources. They share the same base of evidence as behavioral theories, for as we have seen, they have much in common with behavioral explanations. Feminist theories like other explanations are not predictive and rely on retrospective interpretations. They do not specifically address cross-cultural variations in depression, nor do they explain why some women are helped by chemical and electroshock treatments. Chesler's argument that women become mentally ill in greater numbers than men is not well supported by evidence. As Smith points out the statistics which Chesler cites in support of that conclusion have been edited to eliminate some categories in which males predominate. When these figures are reintroduced, there is virtually no difference between men and women in the treatment of mental illness. (Smith, 1975)

The alternate explanations of depression, which argues that women are handicapped both by their socialization and social discrimination, and are therefore less prepared to cope with life stress in an active assertive way, stands on firmer ground. Feminist analysis of women and society rests on an analysis of images of women in the media, statistics on
differences between men and women in education and employment, studies on the socialization of young children, subjective accounts of individual women, interpretations of myths etc. It is, of course, not a scientific theory but an ideological position.

An ideological position, it reflects the values, beliefs and attitudes of its proponents. As a social and intellectual movement, modern feminism has been articulated and has found its prime support among white, middle class, well educated women. Just as Freudian psychology can be seen to represent an interpretation of conditions in 19th century European society from a male's position within that society, modern feminism can be seen as representing an interpretation of modern societal conditions by middle class women from their experience of that world. This is not to say that the feminist's explication of the female role is incorrect, but it does reflect the proponent's experience of that role and therefore, must be taken as a statement about mid 20th century society from her position within that society. The women, who have articulated the feminist position (that is who have had books published and widely distributed) have primarily been successful products of the liberal western system of higher education. That system highly values success and individual achievement. It also relies on a belief that success will be based on an individual's achievement not on their ascribed characteristics (i.e. sex, race). A woman who at some point accepted that liberal democratic belief and experienced some recognition for her academic accomplishments,
would be far more sensitive to the disjunctures between that belief and the role which women are expected to play in larger society. As she moved from the academic world, where an idea is supposed to rest on its own merits and an individual's achievements are supposed to receive recognition on the basis of merit alone to the 'real' world, where she found that her ideas were not really listened to with equal interest and her recognition was dependent on the reflected achievements of her mate and children, that disjuncture would have powerful impact. It is precisely because this woman is white and middle class that sex emerges as a central concern. If she was black, she might explain the disjuncture in terms of race prejudice. If she was poor, she might seek a class analysis. But she is neither, so her sex role becomes central. It is not being argued that what she sees is not important or meaningful, but rather that the lack of other complicating factors (race, economic deprivation) allows sex role discrimination to emerge in high relief. She can see its effect precisely because she doesn't have those other factors with which to contend.

The feminist ideological position accepts the widely espoused value of equality among people and seeks to extend that concept to the relationship between men and women. Feminists also accept the widely held belief that self actualization is a desirable end, and place high value on independence and self assertion. This emphasis on independence undoubtedly reflects women's recent experiences in a society which is both highly mobile and rapidly changing. Under such changing and stressful conditions both independence and assertiveness are
necessary and useful qualities. Given this experience in society, it makes sense for feminists to highlight both women's lack of equality and their lack of assertiveness and independence in their explanation of why so many women feel sad, helpless and hopeless. The feminist understanding of depression does not represent a universal or 'completely objective' view of the problem, and therefore may not be applicable to other cultures or other times. However, it does represent the ideas, observations, and conclusions of women within this society, who are considering a problem in which women predominate, and as such, it offers insights and understanding which other views lack.
C. Feminist Alternatives to the Treatment of Depressed Women

As we have seen, feminists have focused on analyzing and understanding women's oppression in relation to her sex role and have attempted to explicate how that sex role oppression is reflected in women who are treated for mental illness and in the nature of that treatment. Feminist therapy represents an attempt within the woman's movement to define how women 'ought' to be and to elaborate certain therapeutic principles which will be helpful to women in reaching that goal. Feminist therapy, therefore, is prescriptive in nature. It relies on much of the analysis of women's role and feminist criticisms of traditional therapy systems which have emerged from the woman's movement, and offers feminist therapy as an alternate way of helping women. It does not establish its therapeutic principles only for women who are experiencing emotional distress, for it believes that to some extent all women and men have been damaged by sex role stereotyping in this society. Feminist therapists believe that sex role stereotyping causes individuals to have a narrow and restricted definition of self and produces a fragmentation of the personality. Therefore, it follows that therapy should help individuals to reintergrate those fragmented parts of their personality, and many feminist therapists share a gestalt orientation to therapy.

(Sprei-Ott, 1976) Anica Mander, a feminist therapist, defines feminism as "integrating the subjective/objective, rational/intuitive, the mystical and scientific, the abstract and concrete aspects of the universe and considers them harmonious parts of a whole rather than in opposition to one another."(Mander and Rust, 1974, p. 14) Therapy is seen as healing
through integration.

Feminist therapy is based on humanist principles. It believes in the natural goodness of humans and sees that goodness distorted by experience in society. It takes the position that self actualization is inherently good for people and believes in each woman's potential to self actualize. It also believes that each woman knows what she wants a and what is best for her, although she may have had little experience in articulating her needs and wants. (Thomas, 1977)

Feminist therapists believe that psychological health is the same for both males and females. They contend that there is not one psychological profile for a healthy woman and another profile for a healthy male. (Sprei-Ott, 1976) They see balance as the key to psychological and emotional maturity. The Feminist Counselling Collective sees the healthy person as both strong and vulnerable. (Feminist Counselling Collective, 1975) Feminists believe that among the characteristics which healthy people share are: self acceptance and the acceptance of others; spontaneity; involvement in deep interpersonal relationships; personal autonomy; a wide range of interests; an approach to life which calls for individuals to be "ruled by the laws of their own character rather than the rules of society." (Sprei-Ott, 1976) Thus feminist therapy shares a similar view of health with many self actualization psychologies and the human potential movement.

Feminist therapy is not, however, a restatement of humanistic psychology. Its principle difference is that it does not focus on how an individual is blocked from self actualization as a result of personal problems,
but would focus on problems within society which block self actualization. It tries to reestablish the connection between the personal and the political. It addresses and explicates the ongoing societal constraints which result in fragmentation on a personal level by analyzing sex role stereotyping within the society. Therefore, feminist's understanding of society is an inherent part of therapy. In addition, unlike humanistic schools, feminist therapy incorporates a belief in political and social action as part of personal solutions.

A central understanding within feminist therapy is that women have been denied the right to speak with the authority of their own experience. Feminist believe that that experience has been devalued within society, and disconfirmed within psychiatry. Therefore, feminist therapy wants to help women gain back this power to speak. (McDonald and Smith, 1975) To make this point more clearly, let us look at how a feminist therapist and traditional therapists would differ in understanding self punishing behavior in a depressed woman. How would each interpret the actions of a depressed woman who remained in a bad and even brutal marital situation?

The traditional therapist would probably interpret the woman's failure to leave her husband as an indication of a personal problem within her personality. As Smith points out, there is a psychiatric maxim that if an individual stays in a punishing relationship when they could leave, then that individual must like the punishment. This traditional approach would transform the woman's problem in her marriage, into a personal problem—namely her masochism. Feminists see this as a tendency
within psychiatry to blame the victim. They believe that this process would deny the woman's right to speak with the authority of her experience. (McDonald and Smith, 1975)

Feminist therapy would reject this approach. Instead, it would help the woman to examine all of the social and personal pressures which cause her to remain in a situation which is painful for her. It would help her to paint a full portrait of the trap that she is in as she experiences it, and would accept that it is a very difficult trap to get out of. The therapist would help the woman to make the connection between her personal experience and her situation. Beyond this, the therapist would help her to see the pressures in her life as part of the pressures which women face in this society. Her experience of being trapped, unable to act in her situation is unique, but the trap itself is common to all women. Essentially, the therapist tries to help the woman see her behavior as sensible by helping her reestablish the context in which the behavior occurs. She encourages the woman to speak with authority. However, the therapist also acknowledges that the woman finds her situation to be painful. Once the woman has gained authority to speak, then together, therapist and client begin to find solutions which are 'actionable'. (Smith and McDonald, 1975)

The process of feminist therapy rejects some commonly held psychiatric beliefs. It rejects the idea that: 1) the problem rests within the woman and can be diagnosed and treated by the therapist; 2) the woman's experience can be fitted into a particular model; 3) the role of the therapist is to interpret and reformulate the experience for
Instead, feminist therapy asserts that equality between therapist and client is essential. It believes that inequality within the therapeutic relationship leads the woman to feel one down. This one down situation enhances the woman's already strong feelings of powerlessness and undermines her ability to speak with authority and self worth. This is particularly relevant for depressed women who often experience intense feelings of helplessness. Feminist therapists believe that the therapy situation should enhance a woman's sense of her own power rather than intensify her powerless feelings.

Feminist therapy promotes equality in the therapeutic situation in a number of ways:

1) the therapist shares her values and beliefs with the client;
2) the therapist acknowledges that she like the client is struggling to self actualize and emphasizes the commonality of the experience;
3) the therapist works to demystify the process of therapy;
4) the therapist sees the client as a consumer of a service, encourages her to shop around and to complain if she doesn't like the service which she is getting;
5) the therapist sometimes uses contracts to specify mutual expectations of therapy and to evaluate how the therapy is progressing;
6) the therapist shares her own conflicts and difficulties where this is appropriate;
7) the therapist emphasizes the strengths not the weaknesses of the client. (Sprei-Ott, 1976)
Feminist therapy emphasizes changes rather than adjustment, and encourages women to express anger which they feel about their situation and their position in society. Feminist therapy also encourages women to learn self nurturance. It does this by encouraging the woman to see how she has been devalued and then to learn to revalue herself. It helps her to recognize that her needs do count, that she has a right to be selfish, that she does not have to assume responsibility for other people's feelings, and that she has a responsibility to take care of her body. It encourages her to take responsibility for her life while still recognizing all of the societal blocks which she must face. (Sprei-Ott, 1976, Mander and Rush, 1974, Williams, 1977)

Feminist therapists use a wide range of therapeutic techniques and borrow from other schools of therapy. Feminists see consciousness raising groups as an essential tool for both societal and personal redefinition. Griffith states that consciousness raising is not "therapy, nor is it counselling, nor is it political in the traditionally defined manner. And yet it is all three and more." (Griffith, 1975, p.151) They also provide training in assertiveness to help women learn to overcome learned passivity. They use 'body work' to help women integrate body and mind and to deal with negative feeling about their own body and their sexuality (Mander and Rush, 1974) Feminist therapists prefer group rather than individual therapy as they believe that women can learn from each other.

The above represents a summary of some of the principles and techniques which are associated with feminist therapy. The summary is
incomplete as feminist therapy is still in its early stages of development and written descriptions of the process are relatively scarce.

It is important to look at how a feminist therapist might understand and treat a depressed woman. To accomplish this task, we will again turn to the case example of Ester Greenwood.

Feminists would understand Ester's depression as an intensification of normal female socialization and a protest against the restrictions of her societally defined sex role. Like other theories of depression, feminists would probably see Ester's depression as triggered by her rejection from summer school. They would understand that for Ester school represented a place where she was free to express herself, to pursue her own interests and to be rewarded for her own achievements. However, when Ester was cut off from this protected environment, she found herself unable to cope with the 'real' world of women. Feminists would see Ester as having to face a world which expected her to marry, to have children, to limit her vocational interests to traditionally feminine areas (i.e. working for a fashion magazine) and which provided little support for a female who wanted to be a poet, not a secretary and who was not sure that she ever wanted to marry and have children. Ester's depression would be seen as an expression of her inability to adjust to that narrow sex role and as an expression of her feeling that she was helpless to change the oppressive conditions which her sex role imposed upon her. Her feelings of helplessness would be understood as a product of her socialization as a woman since that socialization taught her to accept a passive and nonassertive stance towards the
world. Her feelings of worthlessness and self doubt would also be seen as a product of her socialization in a society which taught her that because she was a woman, she was of less valued than her brother. Ester would be seen as blocked from self definition and thwarted in her attempts at self expression. Her depression would be seen as her protest against conditions which she felt were both unfair and insurmountable.

In attempting to help Ester, a feminist therapist would not try to impose her understandings of depression on Ester's situation. Instead, she would help Ester to develop her own understanding of her situation. She would begin by assuming that Ester had inherent strengths and had the potential to both define her distress and to know what would be best for her. For her part, Ester would probably enter the relationship believing that she could do neither. The task of the therapist, therefore, would be to help Ester find her voice. The therapist would not try to make sense out of Ester's experience but rather to help Ester to see her own experience as sensible. She would do this by helping Ester to understand her feelings and behavior in the context of her experience in the world. The therapist would try to help Ester make some of the connections between feelings and situation, between herself and other women, and between herself and her position in society as she experienced it. All of Ester's experience would be relevant. Her feelings about her rejection from summer school, her concern over her future as a poet, her refusal to learn to type, her uncertainty about marriage and children, her anger over the double standard which society
sets for men and women would all be considered. In a sense, Ester would be allowed to see her many good reasons for feeling depressed, and her normalcy would be confirmed. This would only be a beginning because Ester would also be helped to make connections between her situation and the situation which women face in this society. The therapist would try to establish equality within her relationship with Ester and might share some of her own feelings of uncertainty, anger and powerlessness. She would let Ester know what her values were and how she understood the process of therapy. She would encourage Ester to participate in evaluating the therapy experience. Ester would be encouraged to join a consciousness raising group so that she could share her experiences with other women, to help and be helped in the group, and to recognize the commonalities in women's experience. As Ester was helped to establish her feelings and behavior as sensible (related to her situation), Ester would be helped to express her anger over her situation and her position in society. Since Ester's depression immobilized her, therapy would aim at reestablishing her capacity to act. Expression of anger about her situation would be seen as one step towards a more active and assertive stance. Ester's desire to change would also be recognized and she would be offered help to unlearn some of her socialized sex role (i.e. assertiveness training etc.) She would be helped to revalue herself through self nurturance. The aim of therapy would not be to help Ester to adjust to her situation but to change and she would be encouraged to become socially and politically active in bringing about societal changes.
All of the above represents some of the ways in which a feminist therapist would offer help to a depressed woman. The strength of this approach is that it rejects the idea that the depressed woman is sick and that her behavior and feelings are reflections of her illness. Furthermore, this approach asserts that human behavior requires its context to make sense and supports the idea that the depressed woman must be given the right to speak with authority and to act in the world.

Despite its strengths, feminist therapy is not a panacea, and has both limitations and difficulties. One limitation of feminist therapy is that it, like all insight therapies, does not deal well with acutely depressed or suicidal women, and these women are usually referred to psychiatric facilities. (Sprei-Ott, 1976) Feminist therapy does offer help following hospitalization to mitigate some of the negative effects of that experience and to assist women in reaffirming their strengths and sanity.

An important concept in feminist therapy is that the therapist does not impose her definition of the problem on the client, but rather helps the client to define her problem for herself. This concept presents some difficulties, for the feminist therapist does enter the therapy situation armed with her ideological position about women and society and with her own system of values based on her ideology. To some extent, she will use these resources to help the client to formulate the problem. While it is true that a feminist therapist is expected to openly share her values and assumptions with the client,
they will nevertheless effect how the problem is defined and understood. It is unlikely that a woman emerging from successful feminist therapy would decide to adopt a traditional feminine role nor that the therapist would see that choice as a desirable result.

Another issue in feminist therapy is the question of equality between therapist and client. Some feminist believe that equality is impossible in a therapy situation, and therefore, reject the notion of feminist therapy. (Tennov, 1975) Others assert that it is a difficult but reachable goal. It seems to me that while feminist therapists do mitigate the power relationship between client and therapist, a difference does and must exist. A woman comes to a feminist therapist because she is experiencing distress and wants help. In approaching the therapist, she acts on the assumption that the therapist may have something to offer which she herself does not. While it may be true that the woman has strengths and has much to offer to the therapist, it is still the case that the woman comes seeking some answers and the therapist comes with some ideas and tools which she believes will be of help. It seems preferable to acknowledge that difference than to deny it.

As Jo Freeman point out, differences in power exist in all relationships. If they are denied, then they cannot be addressed, and problems in this aspect of the therapeutic relationship cannot be dealt with. Freeman calls this the tyranny of structurelessness. (Freeman, 1973) It seems preferable therefore to acknowledge and specify power differences, so that difficulties which arise can be addressed.
Another criticism which can be made of both feminism and feminist therapy is that they offer an overly simplistic understanding of the male role within this society. It appears that in order to more fully explicate the woman's role in this society, feminists have held the male role in a fixed position, and have left it relatively unexplicated. Feminists do recognize that both males and females suffer from sex role stereotyping, but contend that since the male is in a dominant position, he suffers less and causes women to suffer more. I do not argue with the position that males dominate. The evidence is clear. However, even dominance has its costs, and these costs have not been examined to any extent within feminist literature.

Feminists have strong reasons for their refusal to deal more extensively with the male role. They argue that virtually all of human history has been written from the male point of view, and therefore, males' views are already well documented. They believe that it is the female view which has not been heard, and they want to focus their attention in this area. Finally, they state that if males want to look at the negative implications of sexism for males, they should do it themselves.

Despite the internal adequacy of the reasoning of feminists on this issue, the limited explication of the male role may present problems for feminist therapists who are working with depressed women. An unexplained and stereotypical view of the male role may lead to a distortion of how women do experience their relationship with males and male domination, and may not fully equip women to understand or deal with the
complexity of their interactions with men. Given the high incidence of depression among married women, and the finding that many depressed women report significant marital conflict (McLean, 1976), therapists working with depressed women are frequently asked for help in this area. Therapists working with married couples may require a deep understanding of how sex role stereotyping affects both the male and female and the ways in which both stereotypes are mutually maintained.

The limited analysis of the male role presents another difficulty for feminist therapy. This problem is related to the goals of therapy and the image of a balanced, healthy person. The image which feminist therapy portrays of the healthy individual is very attractive, and the idea of balance between masculine and feminine traits certainly makes sense. It is, however, not very specific. What is a balanced view? How much assertiveness is enough? How much is too much? How much aggressiveness is desirable? It seems to me that while balance is clearly the goal, feminist therapy helps women to add to their concept of self (or rejoin parts of themselves) traits which have traditionally associated with males. While these additions may be desirable in achieving a more balanced stance, they may also have some costs. Indeed, in the 1920's, women considered their right to smoke in public a symbol of their emancipation. Today, some of us are paying the price for that particular emancipatory gesture. What kinds of costs can women expect to pay for a more aggressive stance in the world? What are the privileges which she currently enjoys that she will have to abandon?
Weissman notes that recent statistics indicate a rise in female alcoholism and criminality - difficulties which have predominantly affected men. (Weissman, 19??) Despite their dominance, the males existential situation can hardly be called idyllic. High rates of heart disease, alcoholism, drug addition etc. speak to some of the difficulties. A more complete explication of the restrictions and ramifications of sexism on males and females may be helpful in assessing some of the hazards to be avoided. As the goal of feminist therapy is change, it is important to have as clear an understanding as possible of the implications of that change.

Feminism has been criticized for failing to acknowledge women as responsible. The argument which has been presented is basically that feminism encourages women to blame society and males for their problems and discourages women from taking personal responsibility for their situation. (Beck, 1974) While this may be a valid criticism of the position of some feminists (Chesler in particular), it is not a valid criticism of feminist therapy. Feminist therapy asserts that there is a difference between accepting responsibility for problems and accepting one's position as a responsible adult in society. The first notion of responsibility can quickly be turned into blaming the distressed individual for whatever problems she may be experiencing. Feminist therapy avoids this pitfall. However, in openly affirming the woman's right to speak with authority, and by encouraging the woman to take an active role in society, feminist therapy treats the woman as a responsible person. It does not infantilize her by offering
pre-packaged psychological explanations for her problems, but rather legitimates her right to participate in society as an adult and strengthens her view of herself as a responsible person.

In summary, feminist therapy offers an alternative view of helping depressed women. The alternative is based on both a feminist analysis of women and society and feminist critiques of current therapeutic ideologies and techniques. The core of the feminist approach is to affirm the basic strength and competency of the woman and to reject the idea that she is a sick and helpless individual. Feminist therapy seeks to help women by establishing therapeutic relationships which are based on equality and mutual respect, and by helping women to see the difficulties which they are experiencing in a larger social and political context. Its aim is to help women see themselves and their behavior as sensible and to view themselves as competent and responsible individuals who can act in the world. Feminist therapy does have both limitations and difficulties. The prime difficulties lie in the problems inherent in establishing equality in a therapeutic relationship and in feminisms incomplete analysis of the implications of sexism on both sexes. It must be noted, however, that feminist therapy is in its early stages of development, and that some of these difficulties may be more fully addressed as it continues to develop and grow. Despite its current limitations, feminist therapy represents the most genuinely sympathetic approach to understanding the depressed woman and her problem. Given the self doubt, self blame, and lack of self esteem which so often accompanies depressed feelings, it seems to me that a truly sympathetic approach to the problem has much to offer. Contributions which feminist therapy can make to social work will be more fully addressed as we now look at conclusions and implications for social work.
III. Conclusions and Implications for Social Work
Now that we have completed an examination of the dominant traditional approaches to understanding and treating depression in women and the feminist alternative, we are left with the pressing question of what conclusion to draw. How are we to understand and work with depressed women? Which theories or parts of theories should we adopt in understanding depression? What therapeutic principles should we follow in offering help to her? These questions are particularly relevant to social work as in our work, we are often intimately involved in the lives of depressed women.

Let us begin by reviewing the 'facts' about depression to see what we can say with certainty about the problem. We can say that depressed feelings are common feelings in people and that depression represents a feeling of inner sadness and despair. Beyond this much is asserted, and little is known with certainty. All serious researchers agree that depression is a complex problem which has defied many attempts at definition. Definitional problems have created difficulties for both diagnosticians and epidemiologists. Researchers have found that there is little agreement among clinicians in diagnosing the problems. Difficulties in diagnosis present problems for epidemiologists as they rely heavily on clinical findings in generating the statistics which they study. If the diagnoses are unreliable, then their studies must reflect that unreliability. Even the most widely supported finding that females preponderate has been questioned on that basis. One finding which can be established with certainty is that females are treated for depression twice as often as males, and that when females come into contact with
psychiatry they are fitted into affective and neurotic categories more than 60% of the time.

As we examined the process of psychiatric diagnosis of depression, we found that it relies on an illness assumption. We also found that the diagnostic process depends on a number of assumptions which the clinician makes about the nature of depression and the way in which he interprets his interaction with the patient. Psychiatry is not an exact or objective science, and the art of psychiatric diagnosis represents the ways in which psychiatrists abstract and fit people's experiences into illness categories. It is important for social workers to understand this, for many things which appear fixed and certain are less so once this is understood.

This paper has examined the dominant causal theories of depression and women. All of these causal theories have some evidence which supports their explanation but none rests on conclusive evidence. Each theory highlights different aspects of depression and rests on different assumptions. For the psychoanalyst, depression is caused by anger turned inward. For the organic theorist, it is caused by a chemical imbalance. Cognitive theorists view it as a thought disorder, and behaviorists conclude that it is caused by insufficient reinforcement. Feminists understand it as a response to oppressive societal conditions and a narrow and restricted sex role. Each causal explanation provides certain insights into the problem; however, given the present state of our knowledge about depression, we must conclude that all theories represent an incomplete understanding of the problem. None of the theories is predictive. They
all rely on a retrospective analysis to support their hypothesis.

As it is clear that we will be unable to find a complete and satis-
factory explanation for the nature and causes of depression in women,
we will have to draw conclusions based on our limited knowledge, recog-
nizing that our understanding will be incomplete. Our task is to decide
which approach (or combination of approaches) will provide the most as-
sistance in understanding and helping the depressed woman.

In order to help reach these conclusions, we return to the case
example of Ester Greenwood. This time we will look at the insights
which Plath gives us in understanding Ester's difficulty. How does Ester
make sense of her problem? How do we, as readers, feel about Ester's
situation?

In reviewing Plath's account of Ester's situation, we find that
the central character does not offer us a consistent and logical struc-
ture with which to make sense of her depression. Ester's sad and hope-
less feelings are not abstracted out of her daily living, they are an
integral part of that life experience. She experience depression in the
context of other things. As readers, we require the background of her
life to help us make sense of it. Plath's account provides that back-
ground, and Ester never emerges as crazy or non-sensible. However,
Plath does not provide us with a logical orderly process of becoming
depressed. If we want such a structure, we will have to bring it to the
material.

Neither is it likely that the 'typical' depressed woman will be able to give us a rational, orderly explanation for why she feels the
way that she does. Instead, she may tell us that she is not sure how to make sense of her feelings and that she feels confused and uncertain. As we read Plath's account, it is clear that Ester feels that her life is hopeless and without meaning and that Ester herself feels unable to give it meaning. Her inability to make sense out of her depression is a central concern. It frightens her, leads her to doubt herself and question her own sanity. Ester concludes that there is something wrong with her, that she is abnormal, that she is incompetent, that she is not like other women and that she is not 'supposed to feel the way that she does. As Ester is unable to explain her depression, she feels completely powerless to cope with it or change.

In approaching her first interview with a psychiatrist, we understand that Ester experiences a mixture of emotions - sadness, fear, desperation, powerlessness and hope that the clinician will offer her reasons and relief. She brings to the clinician not only her depressed feelings but her own acknowledged 'failure' to cope with those feelings. This attitude makes Ester exceedingly vulnerable to the suggestions and interpretations of the clinician, who she hopes and believes is more knowing than she is and who may have the ability to make sense of all the inexplicable parts of her total experience, and offer some relief.

Plath's account of Ester's first clinical interview speaks to both the vulnerability and hope which she invests in the clinician.

"I had imagined a kind, ugly, intuitive man looking up and saying "Ah!" in an encouraging way, as if he could see something I couldn't and then I would find the words to tell him how scared I was, as if I were being stuffed farther and farther into a black, airless sack with no way out."
"Then he would lean back in his chair and match the tips of his fingers together in a little steeple and tell me why I couldn't sleep and why I couldn't read and why I couldn't eat and why everything people did seemed so silly because they only died in the end. And then, I thought, he would help me, step by step to be myself again."

(Plath, 1971, p. 105)

All theories and therapies which deal with depression acknowledge the vulnerability of the depressed woman and her lack of confidence in her own ability to handle her problem. Psychoanalysts speak of the dependent personality of the depressed individual. Cognitive psychologists point out that she lacks self esteem and construes herself in a negative way. Behaviorists speak of learned helplessness, and organic researchers point out that the effectiveness of placebos in treating depressed patients indicates their extreme suggestibility and hence vulnerability.

Feminist therapists also recognize this difficulty, and they too speak of the woman's learned helplessness and inability to speak with authority. However, feminists therapists differ from the others in that they examine the consequences which this vulnerability and lack of self esteem has in the depressed woman's interaction with the clinician in the treatment process.

Feminist therapists point out that the depressed woman enters the treatment situation already convinced of her failure, her incompetence, and her inability to help herself. She not only acknowledges these problems but blames herself for them. She sees herself as the problem, and is fully prepared to assume and accept the one down position vis a vis the therapist. The feminist view suggests that the woman's acceptance of self blame and failure is a central part of the problem and point out
that the therapist can act in many ways to confirm that view. If the therapist agrees that the problem is within the woman, assumes that his understanding of the woman is more adequate than her own, and offers his assistance in locating all the ways in which she and her personal history cause her trouble, then he confirms this negative view and increases her feelings of dependency and self doubt.

As we have seen in our review of the four dominant approaches to understanding and treating depressed women, the organic, psychoanalytic, and cognitive approaches, all assume that the problem is within the woman. Only the behaviorists reject this assumption and consider her environment, and behaviorists often conclude that she is maladapted to that environment. All of the four dominant theories place the clinician in a central and powerful role as definer of the problem, and psychoanalytic and cognitive theories offer her assistance in locating the way she and her personal history cause the problem. Only the feminist orientation focuses attention on the interaction of the depressed woman and the therapist and offers an explanation and treatment approach which does not confirm the depressed woman's negative and self-blaming view but instead actively seeks to counter it in working with her. I believe that this represents a major strength in the feminist orientation.

I would like to suggest that the feminist approach to understanding and helping the depressed woman offers the most assistance to social workers engaged in this work and should be adopted as the profession's basic theoretical and treatment framework in working with this problem. I take this position because I believe that the feminist orientation speaks most directly to the core concerns of the depressed woman, recognizes and engages a central problem in working with her and provides a viable alternative
to understanding and helping her. I also believe that the feminist orientation is the most compatible with social work's theoretical orientation to the world and with the value stance on which the profession rests.

As a profession, social work has adopted a theoretical orientation to the world which focuses on the individual within her social environment. This orientation has stressed the importance of social factors in human development and sought to understand how individual's interact within their social environment. This concern for the person-in-situation has differentiated the social work approach from the other helping professions. We have understood that a person's behavior requires its context in order to be meaningful and have recognized that an individual's self concept is developed in interaction with self and others. Given our social orientation, we have long accepted the idea that social discrimination and stereotyping will have impact on an individual's view of self. In Hathaway's view, it seems then compatible with our background orientation to the world, that we should accept a social and interactional understanding of depression and women, and I think that the feminist theory speaks to that orientation most clearly. It offers us a way of understanding depression in women not as an individual psychological problem but as a problem in the woman's relation to her situation and her position in the larger society. It accepts the importance of social factors in the development of self concept and understand the woman's problem as a product of both her socialization and her ongoing interaction in society. Finally, its analysis helps to establish important links between social discrimination and stereotyping and the problem of depression. It does not represent a
complete understanding of the problem for none of the theories can do that. However, it most clearly addresses the problem of the depressed woman in her situation and speaks most directly to social work's orientation and the work which we do.

Just as the feminist orientation is compatible with social work's theoretical orientation, the feminist approach to treatment is compatible with the value position on which the profession rests. In offering help to the depressed woman, a feminist therapist seeks to interact with her in ways which will confirm: her basic sanity and health; her ability to define her own problem; and her right to participate in the helping process as an equal partner. In taking this approach in her interaction with the depressed woman, the therapist strikes at the core of the depressed woman's negative self concept and gives her the right to speak with the authority of her own experience. As we examine the values which the feminist therapist tries to operationalize in the relationship, we find an affirmation of strength and health, a right to be treated with dignity and a right to self determination - the core values of the social work profession.

Feminist therapy's approach to the problem of depression rests on one other crucial understanding. It tells the depressed woman that she is not alone - that other women feel or have felt the way that she does. It offers her a broader context in which to understand her problem and emphasizes the depressed woman's commonality with other women not her differences. It operationalizes this understanding by encouraging the woman to be involved in mutual self help groups where she can both help
others and be helped by them. In taking this approach, feminist therapy strikes at the feelings of isolation and self blame which are central to depression. Again, the belief in mutual self help is central to social work and the mediating model in group work shares many similarities with the feminist approach. It seems clear that feminist therapy and social work share similar values and beliefs. As feminist therapy makes a concerted attempt to implement those values in the helping relationship, it has much to offer social work.

The basic position which feminist therapy takes in interaction with the depressed woman directly addresses and deals with the concerns of the depressed woman, and offers the most sympathetic view of the woman and her situation. It is particularly important for social work, which has traditionally been a woman's profession, to accept an approach to depression which recognizes the woman's concerns, emphasizes the commonalities among women and offers the woman sympathy and support.

I believe that all of the above supports the basic premise that social work should accept the feminist orientation in understand and helping depressed women. However, an acceptance of a feminist framework does not mean that we cannot draw on other approaches to depression, not recognize the contributions which they make in understanding and treating the problem. It seems clear that both the behaviorist and cognitive approaches offer important insights into working with depressed women and that these insights can be integrated into a feminist-interactionist orientation.

We have already seen that the feminist orientation shares much in
common with the behavioral approach, and that many behavioral tech-
niques are incorporated within feminist therapy. Behaviorism more than
any other theory recognizes that individuals do not change by insight
alone, and has demonstrated the importance of helping depressed women
restore their self confidence by setting reachable goals and slowly build-
ing from one small success to the next. Behaviorism has introduced the
concept of learned helplessness and offers assertiveness training to help
change this behavior. This technique is widely used by feminist thera-
pists. Behaviorists have also contributed to our understanding of the
effects of lack of reinforcement and social isolation on depression and
offer help in this area. All of these techniques are compatible with
the feminist orientation and add much to the approach.

The cognitive approach to depression and women makes an important
contribution to our understanding of how depressed women participate in
producing a negative view of self. In evaluating the cognitive approach,
we have seen that it stresses the ways in which the depressed woman pro-
duces her own difficulties by construing herself, her experience and her
future as negative. As a total understanding of depression, the cogni-
tive approach is not compatible with a feminist orientation for it does
not address the woman and her situation. The feminist orientation does,
however, acknowledge that women participate in producing a negative view
of self and link this to their socialization as females and the devalued
female role. Cognitive theorists provide a more complete understanding
of how women participate in creating and maintaining a negative self image
than is available within feminism and offers ways of helping the women
To change this negative self concept, I suggest that a cognitive approach coupled with a feminist analysis and orientation will enhance our effectiveness in helping women in this area.

To sum up, it is the basic position of this paper that social work as a profession should accept a feminist analysis of depression and a feminist orientation to helping depressed women. This requires that we accept the basic feminist position that women are handicapped by both their socialization and social discrimination, and are therefore less prepared to cope with life stress in an active assertive way. This position also asserts that depression represents depressed women's protest against conditions which they feel they can neither accept nor change. This position is based on a belief that the feminist orientation is most compatible with social work's theoretical orientation and with the basic value stance upon which the profession rests. The feminist approach also speaks most directly to her concerns and offers the most sympathetic and supportive approach to the problem. This supportive approach is seen as a major strength because self blame and self doubt are central aspects of the problem of depression.

Within this basic orientation, it has been suggested that social work should integrate the contributions which both behavioral and cognitive approaches make in understanding and treating depression in women. Such an approach would lead to a more integrated understanding of the problem and would increase our effectiveness in helping depressed women.

This paper has addressed the implications which the feminist orientation has for understanding and working directly with depressed women.
However, in our roles as social workers, we are often in positions where we offer indirect help. We are sometimes involved in program planning and development or in the management of social services which effect depressed women. We are often expected to work with the mental health system in preparing a woman for treatment, in providing practical support during treatment and in dealing with the social ramifications of her depression on her children and family. What implications does a feminist orientation have for these situations?

In concluding this paper, I will not attempt a complete discussion of the implications for social work in all these situations but rather offer some brief suggestions which may be of some help. I would hope that if social workers seriously consider bringing a feminist orientation to their work in this area that these and other implications would be discussed in more detail and with more elaboration.

A feminist orientation to depression would imply that when we as social workers interact with the mental health system, we would reject the illness assumptions and instead seek to affirm the depressed woman's basic normalcy and strength. It would also mean that we would insist that the depressed woman's situation be considered in understanding her problem. It would imply that we would try to make her actions and feelings sensible rather than crazy and would not accept the mental health system's interpretation of her problem over the woman's own interpretation. This orientation would require that we affirm the woman's right to be treated as a responsible adult and speak with authority. It would also require that we support her right to participate in the planning of her treatment,
and to be aware of the benefits and hazards which that treatment might involve.

A feminist orientation would mean that we would lend our support to alternative non-psychiatric methods of helping depressed women. It would lead us to actively support and encourage self-help groups for women. These groups might include separation and divorce groups, single parent groups, assertiveness training groups, consciousness-raising groups, etc. It would also mean that we would support the development of resources which would offer practical support to women and seek to mitigate the negative effects which social isolation can have on women. Reliable, affordable day care is only one example of such services.

A feminist orientation would imply a concern for current societal conditions which discriminate against women and increase the pressure and stress in their everyday lives. Thus, unequal employment opportunities, inadequate government support to women on public assistance, etc., would be of concern and social workers would be expected to actively support changes in these areas.

Finally, a feminist orientation to women and depression would imply that social workers recognize the real life difficulties which depressed women encounter and the sometimes insurmountable obstacles which they face. This orientation would insist that we recognize that depressed women have many good reasons for their sad and hopeless feelings. It would direct our attention to the life stresses which are inherent in her role as a woman and would lead us to recognize that those stresses are not solvable through therapy or counselling but through social and
political action. It would instruct both social worker and client to seek political solutions. The aim of feminist therapy with depressed women is change not adjustment. If we adopt this orientation, we must recognize that our aim would be to enable the woman to act in the world and to address her and other women's real concerns in a more active and assertive way.
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