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ORIGINAL PAPER

An Illness of Power: Gender and the Social Causes of Depression

Alex B. Neitzke[1]

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Abstract There is considerable discourse surrounding the disproportionate diagnosis of women with depression as compared to men, often times cited at a rate around 2:1. While this disparity clearly draws attention to gender, a focus on gender tends to fall away in the study and treatment of depression in neuroscience and psychiatry, which largely understand its workings in mechanistic terms of brain chemistry and neurological processes. I first consider how this brain-centered biological model for depression came about. I then argue that the authoritative scientific models for disorder have serious consequences for those diagnosed. Finally, I argue that mechanistic biological models of depression have the effect of silencing women and marginalizing or preventing the examination of social-structural causes of depression, like gender oppression, and therein contribute to the ideological reproduction of oppressive social relations. I argue that depression is best understood in terms of systems of power, including gender, and where a given individual is situated within such social relations. The result is a model of depression that accounts for the influence of biological, psychological, and social factors.

Keywords Depression · Gender · Biopsychosocial · Relations of power · Feminist psychology

✉ Alex B. Neitzke
neitzkea@msu.edu

[1] Department of Philosophy, Michigan State University, 368 Farm Lane, 503 South Kedzie Hall, East Lansing, MI 48824-1032, USA

Introduction

Much has been made in psychology and biomedicine about the fact that women in the United States and much of the West are diagnosed with depression at about twice the rate as that of men. The exact female/male ratios of diagnosis vary among different countries and cultures from 1.6 to 3.1 to one, but rates of depression are consistently higher among women across all of those cultures (Weissman et al. 1996; Weissman and Olfson 1995). In terms of risk, women are said to be 70 % more likely to experience depression in their lifetime (Kessler et al. 2005). There appears to be some difficulty in addressing such statistics from a mental health perspective, particularly when explanatory disease models for depression require explanation with reference primarily to women's brain functions and neurological mechanisms (including notions of chemical imbalance).

In this paper, I present the complex conceptual ground of depression, women, and gender in order to (re-)orient causal explanations of depression—and especially its prevalence in women—toward social factors external to individuals. These theoretical insights come from my review of the literature presented here, and are intended to offer an alternative account to dominant brain-centric psychiatric/biomedical explanatory models. I argue that such models harm women in numerous ways, but primarily by removing the opportunity to examine and attest to the social conditions that surround them, namely, a patriarchal system of gender as it interacts with a social, political, and economic order. This paper proceeds in three parts: first a brief historical narrative of the biomedical model of depression, a look at why explanatory disease models are particularly significant for women (and, indeed, all others) diagnosed with depression, and finally a refocusing of the conceptual approaches to depression.

While this paper focuses on gender-based oppression, my arguments may be extended to considerations of class, race, and economic disempowerment. At the most foundational level, I argue that the predominance of mechanistic understandings and disease models of neuro- and cognitive science approaches to psychiatric biomedicine contribute to the continued reproduction of harmful social relations—patriarchy, white supremacy and racism, capitalism—by limiting or altogether preventing the examination of social and economic mechanisms in the causal pathways of mental disorders, and indeed all illness.

A Brief History of Psychiatry's (Re-)medicalization

Early on in psychiatry's disciplinary infancy, its practitioners worked mostly in institutions focused on physical or bodily treatments for various forms of debilitating 'madness.'[1] But by the middle of the twentieth century, psychodynamic theories overtook the previous treatments of madness as disability and psychosis.

[1] I refer mostly to 'psychiatry' but for my purposes in this paper it could be treated interchangeably with 'psychology,' because my focus is mostly on the authoritative knowledge base that the two entangled disciplines share.

Instead of looking for physical and bodily treatments, psychodynamic theories examined mental processes and one's internal psychological workings, where relationships and childhood experience caused difficulties for which talk therapies were the remedy (Magnusson and Marecek 2012:132–3). This time saw an expansion of mental health professionals where they were called upon for a variety of problems in living in addition to severe disability, and they made their way out of institutions and largely into outpatient settings (Magnusson and Marecek 2012:133). Thus the space of influence for psychiatry expanded to offer insights in how to navigate society instead of focusing solely on institutionalizing and treating those deemed mad.

Meanwhile, in the early 1960s, the apparent effectiveness of the newly discovered tricyclic antidepressants in fighting depressive symptoms fueled the transformation of how depression was conceptualized. It had become a manageable *disease* rather than its previous classification as what was referred to as a "reactive" disorder with causes *external* to the brain (Gordon 2010:49). However, beginning in the 1970s, psychodynamic theories were repudiated for more (once again) biomedical approaches and disease models (Magnusson and Marecek 2012:133). Allan Horwitz (2002) argues that this re-medicalization was brought about by shifts in the economic, political, and social environments of medicine. That is to say that psychiatry was influenced by larger forces moving outside the scope of psychiatry as a discipline and knowledge base. But it is also the case that the apparent efficacy of pharmacological interventions helped in shifting disease models for depression. A series of academic papers beginning in 1965 on the pharmacology of tricyclic antidepressants introduced the idea of "chemical imbalance" that would later be popularized in the aggressive marketing of Prozac (Gordon 2010:49).

Laura Hirshbein (2009), a psychiatrist and historian of psychiatry, argues that by the 1970s researchers "worked backward from the presumed effects of antidepressant medications to hypothesize about the mechanism of depression" (92). Researchers did not understand specific mechanisms causing depression, but only presumed brain chemistry explanations based on the effectiveness of antidepressants. Yet psychologists Magnusson and Marecek (2012) remind us that as this reinvention took place, psychiatry did not revert back to its institutions and disabled clientele. Instead "its purview remained the expansive and amorphous collection of personal difficulties and dissatisfactions," and "this collection of experiences became recharacterized as diseases" (133). When psychiatric models of illness returned to more medicalized or physical understandings of the mechanisms of mental illness, which marked the beginnings of psychiatry, the explanatory models shifted under a system of psychiatric practice that was much broader and more influential than before. More people were seeing psychiatrists for help in ways of living that pertained to social and economic relations, and were not merely removed from society on the basis of debilitating madness. Psychiatry had become one way to understand the social world.

Perhaps the most significant symbol of psychiatry's dramatic shift toward medicalization is in the 1980 publication of the authoritative *Diagnostic and Statistical Manual of Mental Disorders*, third edition, or DSM-III (American Psychiatric Association 1980). First, the third edition (and those since) mimicked

biomedical disease categories by defining psychiatric conditions in the form of a checklist of symptoms (Magnusson and Marecek 2012:134). Second, authors of the DSM-III eliminated the category of 'reactive' conditions that denoted those caused by the outside environment as opposed to "endogenous" conditions with internal causes (Gordon 2010:51). And third, the DSM-III blurred the lines between psychological and physical characteristics by placing them in one and the same diagnostic category (Gordon 2010:51), so for example, weight gain or loss would be in the same series of checkboxes as feelings of hopelessness. In these ways, the DSM-III positioned depression to be medicalized in an era of biomedical psychiatry.

It may be fruitful here to briefly explore one particular argument from Laura Hirshbein (2009), who argues that characteristics deemed 'feminine,' as perceived through a lens of patriarchal gender norms and assumptions, actually permeated through concepts of depression from the very beginning. She describes a circular process in which the original criteria for depression came from a period in psychiatry where notions of sex (as most aspects of gender were then attributed to biology) overtly grounded their research and disease concepts. Depression then was *identified with women*, as primarily a disease *of women*, and thus they made up the majority of those studied and identified with the disease. So by the publication of the DSM-III, Hirshbein argues, "patients were defined as depressed because they matched researchers' *assumptions* about what depression looked like" (99, emphasis added). The disease category was shot through with notions of femininity and gender—that is, "what depression looked like" was coded feminine. Thus the symptoms enumerated in the DSM-III came from being the most consistently observed across a group of almost entirely women identified by a gendered category, yet appear in the book with no reference to sex or gender. Then women's predominance in subsequent depression statistics acted to confirm that women were ('objectively') depressed more than men (Hirshbein 2009:90). This helps illustrate how the category of depression that was shaped by patriarchal norms of femininity came to be taken as an objective biomedical category applied universally through the medicalization of psychiatric disease categories. Hershbein's argument further complicates considerations of gender and depression, but also motivates ongoing study of the interactions of gender norms—including how these intersect (or interact) with race and class—with the personal experiences and professional understandings of psychiatric diagnoses.[2]

The final significant shift in the medicalization of gendered suffering came with the 1987 arrival of Prozac on the United States pharmaceutical market. A selective serotonin reuptake inhibiter (SSRI), the drug had fewer side effects than the tricyclic and could be prescribed to a wider range of patients. Thus "the era of depression as an epidemic illness that could be treated was launched" (Healy quoted in Gordon 2010:52). Applbaum (2009) argues that the marketing of Prozac is an instance of *strategic* medicalization, which "occurs specifically as a result and by means of the

[2] For more on intersectionality, see Collins (1986), Crenshaw (1998), and the final section of this paper. For examples of works that study gender norms and intersections with race, class, and socioeconomics and their interactions with illness experiences and professional understandings of psychiatric diagnoses, see: Brown (2003); Cannon, Higginbotham, and Guy (1989); Donaldson (2002); Emslie et al. (2006); Simonelli and Heinberg (2009).

strategic intent to expand the commercial sphere of pharmaceuticals and other medical products" (189). Therein the diagnosis of depression could be lashed to "some of the most powerful engines of capitalist commercialization and expansion in history" through the employment of synergistic power (Applbaum 2009:189). This expansion muddied the waters even further, because now primary care physicians took on the additional role of diagnosing depression and prescribing its pharmacological treatment as this capitalist motive arose.

The explosion of SSRI prescriptions for reasons far beyond just severe (or even moderate) depression all the while endorses the individualized biomedical model of psychological suffering underlying it (i.e., "chemical imbalance"). The result is what Gordon (2010) calls an "unwritten ideology" in contemporary biomedical psychiatry that considers experiential differences between men and women—undeniable through the social or *reactive* lens of gender—to be of little consequence for the increasingly *endogenous* models of psychiatry (63). After all, "both male and female brains are driven by serotonin, and both have the same essential neurocircuits involving the prefrontal cortex, subgenual cingulate, and amygdala" (Gordon 2010:63). Thus biomedical models that focus on mechanistic neurological functioning allow more easily for ignoring or bracketing-out gender and other social influences. Meanwhile, the engineering-like approaches of psychopharmacological interventions and these mechanistic models lend themselves to vast corporate, capital-driven systems of profit.

These shifts in epistemological categories of biomedical psychiatry entail the most troubling aspect of medicalization as it is conceived; in other words, by making certain aspects of everyday social conditions a part of biomedical concern, those conditions are subject to the study, treatment, and regulation of biomedical institutions and their authoritative knowledge systems.

Why the Disease Model Matters

The interrelations among biomedical institutions, psychiatric knowledge systems, and capitalistic pharmaceutical firms are an illustration of Good's (2010) notion of a medical imaginary. This refers to when biotechnology and biomedicine foster an enthusiasm in lay and professional imaginations for the advancement of certain goals and research priorities or the development of certain technologies. The medical imaginary is one instance of the ways that authoritative knowledge comes to penetrate how persons understand or explain illness concepts in a given culture, and even shape the ways that suffering and illness are experienced by persons within that culture. Indeed, Good (1997) observes:

> anthropological and cross-cultural studies have found that cultural interpretations of mental illness held by members of a society or social group (including mental health professionals) strongly influence their response to persons who are ill and both directly and indirectly influence the course of illness. [233]

For instance, Good explains, when an illness is considered in biomedical knowledge systems to be chronic, it is more likely to *be chronic* in those identified with the illness. Thus the ways that societies conceive of depression will influence both how it is treated and experienced. This is no less true in an era increasingly fascinated with neuroscience.

In this section, I consider those ways that the psychiatric disease model may actually be harmful, particularly to women. As Crossley (2004) argues, "much of the power of psychiatry is a symbolic power of definition and judgement, and its violence is the symbolic violence of stigmatization and disqualification" (162). By utilizing the power of defining who is depressed and who is not, biomedical psychiatry may act to deny some of those diagnosed with a 'disease' or 'disorder' the ability to attest to anything but individual biological pathology. However, if depression prevalence in women is actually an indicator of an oppressive system of gender—which I argue below—then the resulting responsibilities and stigma of the depressed sick role under current biomedical understandings act to prevent diagnosed women from attesting to any social oppression as influencing their suffering. Diagnosis of depression therefore can act to silence those who suffer from social oppression by focusing attention on individuals, brains, and neuro-pathways instead of social causal pathways. This not only threatens to misplace important resources and prevention efforts, but also has serious social and political consequences for women and other oppressed groups.

Psychiatric ideology surrounding depression does indeed permeate into lay understandings of the sort of symptoms that define such suffering and how to behave once such symptoms are identified. Karasz (2005) performed an ethnographic study examining the differences in the conceptualization of depressive symptoms among middle class women of "European-American" ethnic origins compared to recently immigrated south-Asian women in New York. In the responses of both groups of women, Karasz found that,

> the notion of needing professional help rather than relying on friends and family appeared to be associated with the idea of the cause of the depression being unknown or obscure…. a professional would be able to determine whether the depression was biological or not and whether biological treatments would be likely to work. [1631]

Such attitudes reflect that, in addition to personal conceptions, these women were willing to defer important causal explanations to authoritative psychiatric knowledge—particularly in regard to the *biological* nature of their condition. Reliance on professionals and biological explanations may lend credence to the argument that clinical treatment and prescription actively downplay the influence of social forces and prevent their further consideration. In this instance, a woman's experience of suffering must be mediated through psychiatric authority.

Karasz continues:

> Often, EA ['European-American'] responses suggested that if the depression related to an event or situation, it was likely to be a minor, temporary problem and one that a person could control herself. [1632]

That is to say, if one's depression has its causes in a certain life event like the death of a loved one or more importantly one's 'situation' like being in poverty or subject to gendered oppression on a regular basis, then it is not the serious kind of depression that requires professional interventions. In this way, the social influences of depression are denied their reality.

Without overgeneralizing from this particular study of 37 ethnically European-origin women in New York, the tendency noted in this ethnographic study may reflect a dominant Western mindset where the 'social' or 'environmental'—if considered at all—is afforded a relatively minor role or thin conception. Without a broader view of the social structure and its workings, many women may be less likely to consider depression as somehow indicative of larger, though diffuse, workings of gender and patriarchy. While Karasz's study was based on interviews with women considering the suffering of another (in the form of a written vignette), there is reason to believe that biomedical psychiatric knowledge is also internalized in those suffering.

Vanthuyne (2003) performed an extensive study on the narrativization of persons' mental illness experiences in Quebec, Canada based on public discourse, observation in public mental health settings, and direct private interviews. From her research, Vanthuyne describes the three common "idioms" that patients use as a narrative-linguistic template for describing and making sense of their illness experiences. These idioms are psychiatric, emotional, and political. The dominant "psychiatric" idiom "frames the experience of mental illness in two ways: on the one hand, it legitimizes the illness one suffers from, and, on the other hand, it allows him or her to 'get back to normal.'" (424). The psychiatric mindset in those suffering allows for the relative social acceptance of a legitimate diagnosis; however, there is also the silencing impetus to return to the status quo as quickly as possible. The psychiatric idiom, Vanthuyne notes, "seems to inevitably *impose itself* on people's articulation of their mental health problems, pushing to the margins one's exploration and use of narrative structures that the emotional and political idioms provide" (429, emphasis added). Where other idioms provide for an exploration of alternative causal explanations and a reassigning of value and meaning in the illness experience in light of external and social considerations, the psychiatric idiom dominates and demands that one's disorder be understood only individually.

Further, Gaines and Farmer (1986) illustrate the extent to which one's cultural surroundings, through positive and negative sanctions, help shape the ways that one experiences and expresses emotions. Gaines and Farmer use this idea to argue that clinical depression as it is conceived in the West may not be applied well to Mediterranean cultures, as it may in fact misidentify certain women as depressed. In the woman Gaines and Farmer choose to highlight, "Madame Lorca," what would appear to be clinical depression by standard psychiatric instruments and measures is disconfirmed as such through ethnographic data, which point instead to her fitting a familiar cultural role that they call the "visible saint" (323). What their study also suggests is that Mediterranean women do not have the same latitude in public expressions of anger as they do of sadness, where the latter is more widely permitted

than the former (320–1). The opposite, meanwhile, is the case for Mediterranean men (321). Thus the visible saint is a social role that one might adopt in the face of suffering yet within gendered sociocultural strictures.[3] For my paper, Gaines and Farmer's findings suggest the possible influences of a psychiatric disease model for depression in forming the social strictures placed on women where biomedical psychiatry pervades the medical imaginary and health ideology.

What begins to emerge here is that the psychiatric disease model of depression may actually be disempowering women by legitimizing the pathologies of a social system of gender as it delimits one's expression of suffering and testimony to its causes. Magnusson and Marecek (2012) argue that the use of a 'disease' metaphor in mental illness implies that one's psychological suffering is "an outward manifestation of an underlying internal illness or pathology," and as a result there seems to be little need to look for external factors and causes (136). They argue that psychological suffering does not fit the disease concept applied to physical conditions (though arguably often still misapplied) because social context is central to its coming about and because it gives one's suffering meaning (136). This way of understanding mental disorder threatens to change the way that psychiatry is looked upon in relation to women and gender. Hook (2004) argues that mental health professionals acted to legitimize and justify colonial rule by depicting native populations as psychologically incapable of governing themselves (while also ignoring contexts of power and colonial domination). I argue that contemporary psychiatry plays a similar role toward women in an environment where, as Inhorn (2006) argues, "medicalization is part and parcel of women's health experiences" (355). Fabrega (1993) adds that, "in medicalizing the behaviors of actors, [psychiatry] can … exculpate or depoliticize their action, and stigmatize or otherwise label them in ways that undermine their social credibility" (169). The attributions of pathology to women suffering from feelings of disempowerment are a means of silencing many women or covering over the social origins of their condition.

In medicalization, mental illness becomes conceived of as a problem of individuals, and largely unrelated to the workings of social systems in which they are embedded. Even if their feelings of distress seem social in nature (e.g., "lack of confidence," or "feeling hopeless"), the answer is still attributed simply to the individual's brain, and is thus conceived of as that individual's responsibility to ameliorate or 'fix.'[4] Hirshbein (2009) writes that because diagnosis of depression reflects the social and gender norms of its 1970s and 1980s emergence, it is worrisome "that a diagnosis of depression that is so historically contingent should be the basis of ongoing research that looks at the difference between brains of men and women in order to uncover the biochemical basis of this disease" (101). The historical processes that led to women being identified more often as depressed, melancholic, or mad seem to be stripped away in the biological present, creating a problem for illness experience and the medical imaginary. This relegates operations of gender, at best, to the margins of psychiatry and neuroscience. Instead, depression is better understood as a biomedical disease *construction* as one part of social knowledge construction,

[3] On visible saints as "social cynosures," see Gaines and Farmer (1986:296–8).

[4] I owe the latter line of emphasis to an anonymous *CMP* reviewer.

one for which its apparent physiological explanations must also be understood and emphasized as social in their interactions and this sociality must be reflected in research. This topic occupies the final portion of my paper.

Refocusing the Lenses

While the 1990s were marked by some dismay among social scientists regarding a lack of funding from the National Institutes of Health for approaches to mental illness that integrate social and biological sciences (Good 1997; Manson 1997), more recent years do not seem to echo this concern. Yet this does not seem to be because of any significant heeding of such concerns—as there is still an apparent lack of integrated inquiries—but is instead perhaps because of the achieved dominance of physiological models for depression. There are, nonetheless, several good examples of thinkers in the social sciences considering depression's social nature. The problem is in crossing over to a *truly* biopsychosocial model—one where depression's psycho-physiological components are understood as inseparably entangled with the social, where the former is not considered whole without also considering the latter.

There are significant reasons to refocus understandings of depression away from a biological one and toward an understanding of depression as influenced primarily by social oppression and thus gender. One possible indicator of the significance of gender and society in depression comes from comparing depression to bipolar disorder. While rates of depression vary across countries while showing gendered disparities, the rates of bipolar disorder are much more consistent across cultures and sex ratios are nearly equal (Weissman et al. 1996). Thus "it is conceivable that there are universal social factors that depress women and account for the cross-cultural predominance of depression in women" (Weissman and Olfson 1995:800). I would argue that depression is a matter of *power* and is therefore every bit at work within a system of gender, in addition to all other avenues of power and oppression. Patriarchy and gender-based oppression arguably are such "universal social factors" and could help explain the variations among cultures not seen in bipolar.

Harris (2003) argues that the general consensus among researchers is that depression's causes are indeed multifactorial, and "that its study belongs quite properly to a large number of disciplines ranging from sociology via psychology to various branches of neurophysiology" (103). For Harris, only with a biopsychosocial conception of the disease can its causal pathways be understood (Harris 2003:103). I would argue, of course, that Harris's range of disciplines should extend further than Harris implies to also include philosophy, anthropology, social work, and even literature, history, and economics. It appears therefore that this alleged consensus must go a bit further in its call for interdisciplinarity—particularly in order to change the ways that depression is conceived of in psychological science, biomedicine, the social consciousness, and the medical imaginary.

There are some contemporary theories of depression that offer promising potential to bridge the gaps between the inaccurately individualized conceptions of brain chemistry and the more integrated understandings of depression in a socially

responsible mindset. One such model comes from early work of George Brown and Tirril Harris, offered in detail in their (1978) *Social Origins of Depression*. Harris (2003) offers an updated account of their social theory of depression through a review of more recent literature on depression in women. Harris argues for a psychiatric model of depression's causal links where its onset in some individuals and not others is linked to a certain "vulnerability" (103). Now, Harris may be understood to use 'vulnerability' in an ordinary biomedical way, in which for instance a person's suffering from immune deficiency is *vulnerable* to some infectious diseases that the otherwise immuno-secure are not. This kind of vulnerability can relate to genetic predisposition and its relations to environmental epigenetic influences, though it is not necessarily or always genetic. Yet the concept of vulnerability as Harris presents it offers potential to blur the lines between the psycho-physiological and the social. For Brown and Harris (1978), the foremost positive influences on vulnerability (i.e., influences that *reduce* vulnerability to depression) were found to be enduring relationships of emotional and practical support, with qualitative measures of intimacy the predictive factor (173, 177). Negative influences, which increased vulnerability, included the loss of one's mother before the age of eleven, having three or more children under fourteen living at home, and lack of employment outside the home (179). Yet we might understand vulnerability to be very much entangled also with the ordinary *social and political* notions of vulnerability understood as the increased potential for harm in the face of inequities in relations of power. Such social notions of vulnerability are discussed and examined at length in the critical scholarship of race, class, gender, disability, environmental justice, and globalization. Thus we might think of vulnerability in both ways—the biomedical and the social—at once.

Harris (2003) goes on to explain that the onset of depression has a structure where some individuals experience a severe life event that would be a major stressor for any person. However, for such vulnerable persons, the resulting feelings of hopelessness are more likely to generalize to other aspects of one's life.[5] Harris offers an example where such a woman "would react to her teenage son's being picked up by the police with thoughts not just involving this lapse in parenting but also perhaps by generalising her feelings to include her performance in all her role identities" (103). These generalized feelings of helplessness are arguably more likely in people who already belong to some disempowered population—and particularly one more likely to be subject to the 'major stressors' of severe life events. Brown and Harris's (1978) model puts ongoing self-esteem (feelings of mastery, confidence, and self-worth)—and the sense of one's influence over their world and thus their ability to repair the damage of loss—as a crucial determinant in the development of generalized hopelessness (235; see also Brown et al. 1986, 1990).

Regardless of the potential role of biology in a conception of vulnerability, it stands to reason that persons who are subject to diminished social influence and

[5] There are, however, "small groups of severely and recurrently depressed persons" for whom "psychosocial factors have not been found to have the same relevance" as is found generally (Harris 2003:106).

control because of violence and oppression are more likely to experience severe events. Moreover, such persons may be predisposed to such generalized hopelessness in the face of relations of power by which they are oppressed. In this way, the tools by which oppressed peoples find solidarity and unity against oppressors may also be the tools by which to protect their mindful or psychological wellbeing. Because self-esteem and efficacy are so immediately related to one's social influence and control, this links understandings of depression and its social prevention to the political sphere via concepts beyond just gender, including relational autonomy (see Mackenzie and Stoljar 2000), opportunity and "equality of opportunity," political recognition (see Fraser and Honneth 2003; Honneth 2004), and epistemic oppression, silencing, and injustice (see Dotson 2011; Fricker 2007). Upholding strict or easily discernible distinctions between the psycho-/bio-/physiological from the social is simply not tenable in thinking causally, thus illustrating many possible connections between social and political thought and social psychology. Indeed, this premise is at work in all discourse on the social determinants of health in the medical humanities and social sciences.

Calls for further research crossing disciplines cannot be echoed here much louder—yet the call to *action* must also become essential. Indeed, Harris (2003) notes that while the psychosocial effects in bringing about depression in women have been (relatively) more thoroughly researched, "the guidelines on treatment to be offered have not succeeded in integrating this social perspective" (109). What is known about the influence of social factors and oppression has not translated into workable therapies or approaches to treatment. This fact draws further attention to the problematic relations noted above between treatments and causal explanations of depression, that psychologists have historically worked backward from what works in treating symptoms to explain what's at work in causing an entire disorder. The fact that social understandings of depression are less amenable to capital-friendly, profit-motivated structures is one major challenge to their earnest and mainstream research. There are no shortages in the more practical challenges for a social conception of depression that takes women and gender as central to its elucidation. But the potential benefit is massive.

Magnusson and Marecek (2012) consider what psychiatry would look like if it took gendered asymmetries as a starting point for thinking about individual behavior.[6] This "radical departure from conventional psychological theorizing" is what they call *thinking from the outside* (42). Such psychologists, they argue, do not consider whether there are 'real' differences between men and women's psychology, but instead recognize that "cultural ideologies about *intrinsic* psychological sex differences are produced by *extrinsic* gender orders" (41). As a result, the supposed differences call attention to the external conditions that bring those differences about and demand that they be interrogated.

An example of psychological research that puts gender first helps show that concepts like 'social control' (which I use above) alone are not capable of

[6] For Magnusson and Marecek (2012), gendered asymmetries include that men and women "are treated differently when they do the same thing," including unequal pay for equal work (41), that men "have more freedom of movement than women in many societies," that women "are more often victims of sexual violence" while "men are more often victims of street violence" (42).

grasping the complicated effects of gender as they influence depression. Pudrovska and Karraker (2014) study the mental health effects of job authority as they differ among genders. Job authority includes control over one's own work but also over the work of others, including hiring/firing power and influence over pay. Previous research that does not look at data separately for gender tends to conclude that job authority is beneficial because the incidence of depression is reduced (Pudrovska and Karraker 2014:425). Also, if we take seriously the idea that increased social control should decrease the likelihood of severe life events and the of generalized feelings of helplessness, then increased job authority should be expected to decrease depression in women. However, when researchers look at the effects of job authority through a lens of gender, the results become more complex. Pudrovska and Karraker argue from their research that job authority decreases depression in men yet increases women's depression (436). They argue that these results may be understood in terms of the differing norms of masculinity and femininity that create interpersonal stress in women's daily operations in authority positions. Factors include that "stress is more pronounced for social groups whose authority is not perceived as legitimate," that women in authority positions are assessed more critically than men, that overt and subtle gender discrimination can increase social exclusion, and that women in authority positions experience more harassment "because women's divergence from gender expectations is perceived as threatening and elicits hostile responses" (Pudrovska and Karraker 2014:437–8). Studies like this show that, while I argue that depression should be understood in terms of power and oppression, these concepts cannot be easily reduced to singular concepts like social control or job authority without retaining careful attention to gender and other sources of oppression within their contexts. This research appears to show that more control for women in one sector can still have unexpected consequences because of complexities in a system of gender.

Calls to understand depression socially and through the lens of women and gender like that of this paper are of little worth if they do not ultimately lead to hearing, heeding, and acting on the voices of women both with and without the diagnosis. Ethnography is clearly one important avenue among many for such purposes. Unfortunately, in a confounding way that many medical anthropologists and critical scholars of medicine perhaps share, the majority of overtly ethnographic studies of women with depression currently available are in non-Western cultures and not where biomedicine *is* cultural ideology. Thus more ethnographic work in the so-called developed world would be fruitful.

Finally, no discussion of the oppression of women would be a very honest one without the specific consideration of the differentiated experiences of women of color and of intersectionality more generally. The concept of intersectionality, a profound insight from Black feminist scholarship, contends that the constrictive forces of race and gender often look different when they act in combination, and that the models for race and gender offered predominantly by Black men and white women in foundational critical race and feminist theories, respectively, cannot

adequately account for the experiences of Black women.[7] Intersectionality, of course, applies to all combinations of multiple oppressive social forces. As Audre Lorde argues (2007), "the oppression of women knows no ethnic nor racial boundaries, true, but that does not mean it is identical within those differences" (70). Lorde reminds us that within the call for greater exploration of women's experiences of depression (in their own words) must also be an explicit call to hear the voices of women of color, lesbian women, poor women, and women from so-called developing countries among the varied and too numerous intersections of oppression.[8] Understanding women's experience of depression as different—and insightfully so—from some 'normal' concept must not lead to its collapse into sameness under the concept 'women.' Indeed, because depression may be generally conceived of as an illness of power and oppression, the many channels through which power operates must be exposed through many voices. While I refer rather equivocally to depression in 'women,' it must be only to call for collective attention to turn to the differentiated voices among all those who identify as women in order to begin considering better ways of explaining and ameliorating the suffering of all those who are oppressed—and who at some point may get labeled as 'depressed.'

Compliance with Ethical Standards

Conflict of interest Alex Neitzke declares that he has no conflict of interest.

Human and Animal Rights and Informed Consent This article does not contain any studies with human participants or animals performed by any of the authors.

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[7] For more on intersectionality, see Collins (1986) and Crenshaw (1998).

[8] It should be noted that some argue that the configuration of feelings, thoughts, and bodily states that the West calls depression is actually specific only to Western, high-income countries (Magnusson and Marecek, 2012), while others cast doubt on its application in Mediterranean cultures, broadly defined (Gaines and Farmer 1986). Thus, this may necessitate re-conceiving depression or something like it from the experiences of women in the so-called developing world and other cultures largely outside of Western biomedical hegemony.

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