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ORIGINAL ARTICLE

Beyond weeping and crying: a gender analysis of expressions of depression

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Abstract
Objective. To explore depression from a gender perspective, by capturing depressed women's and men's formulations of their experiences and understanding of their situation. *Design.* Qualitative interview study. *Setting.* A healthcare centre in northern Sweden. *Subjects.* Eighteen patients who had been diagnosed with depression and treated for at least 6 months were interviewed in depth, both women and men of different ages and social status. Open questions were posed around the themes of Malterud's key questions, focusing especially on *how* the informants conveyed their experiences. Interviewing and qualitative data analysis went on simultaneously. *Results.* The experience of depression held similarities for men and women, but the outward manifestations differed by gender as well as socioeconomic status. Though experiences of high demands underlay the narratives of all informants, home or work had different priority. Men talked more easily about physical distress – often the heart – than about emotions. Women verbalized more readily emotional distress – shame and guilt – while physical symptoms often revolved around the stomach. Men dealt with insecurity by aggrandizing their previous competence, women by self-effacement. *Conclusion.* As clinicians we must listen attentively not only to the manifest but to the avoided or unarticulated. By doing so we might counteract normative gender patterns that highlight the depression of women and conceal that of men.

Key Words: *Class, depression, gender, guilt, primary care, qualitative analysis, shame*

Statistics regarding depression hold several paradoxes. While women are diagnosed as depressed twice as often as men [1], men commit suicide twice as often as women [2]. Attempts to understand differences in the epidemiology of depression have relied most often on psychological [3] or biological factors [4]. Few attempts have been made to examine depression with regard to gender, which also includes the sociopolitical and cultural aspects of being a woman or a man [5]. From a social constructivist viewpoint femininity and masculinity are not biologically fixed givens, but positions and conditions that are created in relation to prevailing societal structures of dominance and sub-ordinance [6] – circumstances that can and do change over time and place.

Our study aims to explore depression from a gender perspective. How do women and men construct and make sense of their depression? We want to explore if, and how, gendered behaviours and cognitions can shed light on the paradoxical dis-

Exploring depression from a gender perspective might reveal why women are diagnosed to a higher degree than men.

- Expressions of depression differ with regard to gender as well as socioeducational background.
- Women readily verbalize emotional distress – shame and guilt; men talk more easily about physical distress – shame remains non-verbalized but powerfully present.
- Normative gender patterns tend to underscore women's expressions of depression and conceal men's, a tendency to bear in mind to avoid over-diagnosing women and under-diagnosing men.

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crepancies in women's and men's mental health and suicidal behaviour.

Material and methods

Study population and procedure

Over a period of three years (2000–2003) informants were selected from among patients at a healthcare centre in a university city in northern Sweden. All informants had received a diagnosis of depression according to ICD-10 criteria and had been treated – with antidepressive drugs and/or psychotherapy – for at least 6 months. Informed consent, both oral and written, was elicited. The Research Ethics Committee of Umeå University approved the study.

The process of selection was designed so that women and men of different ages, professions, family, and working backgrounds were represented. Our final population comprised 8 women and 10 men, interviewed by one or the other of the two authors (Table I)

Interviews were performed either at the healthcare centre or in the informant's home. Each interview lasted 1–2 hours and was taped and transcribed. The in-depth interviews were semi-structured and we explored the themes of Malterud's five key questions: problem definition, explanations for the illness, expectations of treatment, experiences of handling the illness, and salutogenic factors [7]. By posing open questions, and by follow-up queries such as "Can you explain...?" we aimed at letting the informants describe symptoms and experiences in their own words.

Analysis

Data were analysed qualitatively, inspired by the steps of grounded theory [8], modified according to Malterud's recommendations [9,10], but also considering criteria of scientific rigour [11,12]. Data analysis was undertaken directly after each interview, making it possible to follow up analytical hypotheses in the next interview, and to look for confirmation or negative cases. Each interview was read independently by both authors and analysed by means of open coding. Thereafter the two researchers met, codes were compared and sorted, and categories were condensed in selective coding.

Thereafter, to investigate the impact of gender, all data from female and male informants were scrutinized separately and then compared. We found that the experience of depression held strong similarities for men and women, but the outward manifestations differed markedly. Gender bore influence, but also socioeducational background. Therefore we present the overriding concepts according to gender and class.

Results

Perceiving high demands and expectations on them lay behind the narratives of all informants in our study, expressed in the core category '*branded with demands*'. However, women and men had different ways of conveying their perceived demands, their bodily expressions, and their vocabulary of mood. For instance, the focus of commitment varied. Although commitment was gendered it was also influenced by socioeconomic status. For women with low education the family was foremost; for middle-class men – well educated or well paid – it was work engagement. Highly educated women and men with low income resembled each other in their dual commitment to both family and profession, and they also shared the possibilities of double arenas. Table II presents a "reader's guide" to the patterns of interactions gender and class had on our findings.

Branded with demands

For F, a female home-help assistant, the expectation of being a good mother was foremost. She blamed herself for failing, even when expectations were inordinate. "*I remember my daughter having her birthday, I had promised to make a hurdle race track like in 'Prisoners of the fortress'* [a popular TV contest]*, and this I had promised two months before and I thought I had time I postponed it every day and the day of her birthday I hadn't done it yet and I couldn't do it in such a short time.... She was terribly disappointed and I felt no, how mean I am, this is not the me I am used to being.*"

Highly educated and well-paid women like E and G also gave priority to family but saw their work as a lifesaver: "*I was happy, I had a very stable family. Both my own family, that's my husband and my children but also my old family, my siblings and so on. They could acknowledge that of course I was a very precious and particularly competent person (laugh)*" *(G)*. E, an academic, summed up the most frequently recurring theme appearing in all narratives – that of expectations imposed by self and by others: "*I am branded 'demand'*" ('*kravmärkt*'). In Swedish her expression is a play on words. 'Demand' is the store label certifying organic production (i.e. highest standards of excellence) as well as the word for urgent need and due claim. Although the theme repeated itself, the content, *narrative tone* (see Table II) and colouring [13] varied with gender, women giving more and compelling examples from the home, men from the work arena.

Table I. Sociodemographic background data.

	Age	Diagnosis	Medication	Marital status/children	Highest level of education[1]	Occupation
Women						
A	21	Depression	(SSRI) discontinued	Cohabitant	Upper secondary unfinished	Unemployed
B	22	Depression	SSRI	Single	University	Academic studies
C	26	Depression	SSRI/SNRI	Single	Upper secondary unfinished	Unemployed
D	31	Depression	SSRI	Cohabitant/two children	Upper secondary	Assistant nurse
E	43	Stress reaction	Psychotherapy	Married /two children	University	Academic
F	46	Depression	SSRI/SNRI	Married/three children	Lower secondary	Home-help assistant
G	49	Depression	SSRI	Married/two children	University	Academic
H	54	Depression	SSRI+psychotherapy	Single	University	Teacher
Men						
I	24	Depression	SSRI	Cohabitant	Upper secondary	Computer engineer
J	30	Depression/anxiety	SSRI	Cohabitant	University	Academic
K	34	Depression/stress	SSRI/SNRI	Married/two children	Upper secondary	Entrepreneur
L	35	Depression	(SSRI) discontinued	Separated/one child	Upper secondary	Entrepreneur
M	53	Depression/anxiety	SSRI	Cohabitant/one child	Primary school+1 year of lower secondary	Janitor
N	54	Depression	SSRI/SNRI	Married/two children	Primary school+1 year of lower secondary	Civil service employee
O	55	Depression	SSRI	Married/three children	University	Academic
P	58	Depression	SSRI/SNRI	Married/two children	Upper secondary	Technician
Q	60	Depression	SSRI	Divorced/four children	Primary school	Home-help assistant
R	66	Depression/anxiety	Selective MAO inhibitor	Married/two children	Primary school	Janitor

[1]1–6 primary school, 7–9 lower secondary, 9–12 upper secondary.

Table II. Pattern of themes in relation to gender and socioeducational background.

	Women		Men	
	Working class[1] A C D F	Middle class[1] B E G H	Working class I M N Q R	Middle class J K L O P
Demands	Home (work)	Home and work	Work and home	Work
Narrative tone	Pessimistic: self-restrained	Optimistic: self-assertive	Optimistic: open-hearted	Pessimistic: downhearted
Bodily expressions	Stomach and non-specific bodily symptoms		Heart and vessels	
Emotional expressions	Fatigue			
	Weeping		Shouting and crying	
	Shame (verbalized)	Guilt	Weakness (verbalized)	Shame (non-verbalized)
Expressions of self-esteem	Self-effacing			Self-aggrandizing

[1]By these concepts we mean: working class = low education and/or low income; middle class-high education and/or high income.

Men with a low-income job presented their ambitions to do their utmost in both the work and family arena, in that order. N, who was working within the civil service, was juggling the demands of his job and active engagement in his local community athletics club with caring for his wife who was seriously ill. Regarding the work, he and other informants with low-income jobs could imagine change in new directions. Q, for example, a welder, channelled the frustration of family problems and a divorce into a change of job – from a male-dominated to a female-dominated occupation (home-help assistant).

Men with a well-paid career and high education tended to give highest priority to work and had difficulty refraining even when ill. For O, an academic, work stood in the forefront. References to family and children appeared rarely. Expressions such as "*work oneself to death*" were presented almost as a badge of merit, a heroic achievement. "*I remember, it was sometime in October, work was getting rough, when I simply collapsed. It was at night and I was going to the john, I jumped out of bed, conked out and fell against the bedpost and punctured a lung and broke a few ribs etc.... And given the way I was at that time I went to the intensive care ward Friday and was back at work on Monday morning*". Despite the strength of his commitment, he and other middle-class men remained disappointed with their efforts at work. K, an entrepreneur, stated, "*I could never do enough preparation, I never thought it was good enough.*"

Bodily expressions

All informants described physical symptoms and these had prompted them to contact the healthcare service. However, few recognized these symptoms as signs of depression. Physical symptoms were described concretely and dramatically conveying strong emotional undertones of weakness – "*I couldn't even stand upright*" – or oversensitivity. N was overwhelmed by sounds: "*All sounds were twice as loud as I'd heard them before. I could almost hear when it was snowing outside....*"

Men, on the whole, called attention to their physical symptoms more intensely than women did. Symptoms centred on the heart – high blood pressure, chest pain. "*It was a relief when I got problems with the heart, then I had something that could be cured. Sure, I had pain ... a pain that went right through the chest and into the backbone, but still that was nothing compared with having anxiety.*" (R)

Women, on the other hand, were less insistent about their physical symptoms. When they did talk of such symptoms they assigned them more often to the stomach as exemplified by E: "*And then I got a bodily pain in the stomach, so I felt as if I had got a hole, that something had exploded, there's nothing left, it's empty ... it was a bodily pain, it wasn't any mental pain, I felt I had a hole*". Most often, however, women in the study described non-specific symptoms. F, for instance, who in fact turned out to have a serious heart problem, made no mention whatsoever of her heart on interview.

Gendered vocabulary of mood

Women had a greater variety of words and metaphors to describe their mood than men had. Shame and guilt figured prominently, "*it feels so shameful to be depressed*" (D). The women in our study shared an idea that sadness was acceptable only if there were reasonable grounds for it, not when it came out of nothingness. "*Grief of course is painful and you remember them* [the ones you've lost] *and you weep and there are adequate expressions for it all. But this*

wasn't at all that way. It was without feelings . . . just grey and tedious."(G)

Women described a feeling of overwhelming fatigue, bordering on emotional alienation. For A, in her twenties, every autumn and winter from age 14 bore that feeling – "*an insane tiredness*" left her without energy for schoolwork and a feeling of being "*just lazy*". E refers to it as a state of unconsciousness. "*I was healthy and yet I was dreadfully tired. So I slept from March 2000 to March 2001 and by that I mean I slept . . . not just slept, I was unconscious.*"

Most men, on the other hand, defined their mood as displaying short temper and aggressiveness. L called it a state of having "*no padding*". His anger was easily triggered by small setbacks, for example when the lawnmower broke down. But when things were at their worst, he thought of suicide: "*The rope was hanging there in the air above*". Although few of the men used the word shame, fear of disgrace pervaded many of the narratives. Men said that they were taught to hold back feelings. O recalls how proud he was as a child about controlling himself. "*And when, I don't know how old, around five–six–seven, fifteen–sixteen, I remember hurting myself and I didn't cry. Huh.*" N remarked about depression: "*It's not like an ordinary disease . . . even if it really is one, but it isn't considered proper in some way by other people. To be weak and depressed, what's that, that's nothing for a man. . .?*"

Self-effacing or self-aggrandizing

Women and men in our study shared a feeling of low self-esteem, but spoke of their insecurity in different terms. Women, especially those with low education, resorted to self-effacement. Self-confidence faded, fear and insecurity surfaced, as when D envisioned returning to work as "*indefinably dangerous. . . . I had a kind of feeling that I couldn't manage a job . . . and I know I even thought . . . but perhaps – I can always manage being a cleaning woman*". Cleaning had never been her forte, but was socially regarded as a "natural part" of being a woman, she said.

Most men on the other hand called attention to their former competence in heroic terms: "*I was highly appreciated at work, had unlimited possibilities, resources. . .*" (O). K also exaggerated when describing his efforts at work: "*I prepared my classes 400%.*" Yet underneath men's exaggerated expressions lay a feeling of still not being good enough, and failing in the middle of a budding career was depicted as a devastating pitfall.

Our results indicate that gender is but one factor of importance. It interacts with social class and educational background. Middle-class women, although depressed, found strategies to retain a degree of self-assurance. Despite feelings of inadequacy in the face of high-performance demands both at home and at work, women held on to a sense of being good enough, which helped to maintain a positive attitude toward life. For middle-class men the shame of not performing capably enough stood unopposed, threatening ties to life itself – leaving no way out but "a heart attack".

Women in our study talked openly of both physical symptoms and emotional distress, while men's narratives revolved more one-sidedly around the physical. Further, men localized their bodily symptoms preferentially to the heart, women to the stomach. Both men and women referred to feelings of low self-esteem. Women, particularly from a lower socioeducational background, reacted with self-effacement, men, especially the middleclass, conveyed dramatic and aggrandizing self-portraits.

Discussion

The findings in our study cannot be generalized as quantitative results, as strategic selection, relatively few informants, and provinciality cannot claim representativity. On the other hand, a qualitative analysis undertaken parallel to data collection gave us the opportunity to produce new inputs, to ground, test, and saturate concepts, and to elaborate how they varied due to social circumstances. These findings might be recognized and transferable to other clinical settings. A gender analysis of depression has not been undertaken before and differences in how women and men construct and make sense of depression might cast light upon the epidemiological paradoxes of mental illness. Table II should, however, not be read as a scheme of "true" differences in separate social categories, rather as a reader's guide to the tendencies and the complexity of the findings. Gender and social class are not stable categories but instead intersectional and shifting social constructs. We found no "negative cases" according to age and have not considered ethnicity as all the informants but one were majority culture Swedes.

Our findings disclosed gendered circumstances, emotions, and modes of expression that might put women at risk of being over-diagnosed with depression. Several factors contribute to this predicament. Femininity, as a social construct, has been created with a readiness to articulate and communicate disturbances in emotional well-being and a language rich in feelings and emotional nuances. Thus, women might find it easier to seek medical assistance [14,15]. For a long time, the apparent congruence in stereotypes of femininity – submission, timidity, low

self-esteem – and depression has been highlighted, as Willadsen [16] pointed out: "Depression – your name is woman".

Then too, ill health itself adheres to a socially defined hierarchical order, with gender implications [17]. Certain diseases, such as those of the heart, have higher social status than those of the stomach or mental sphere [18]. Women in our study often expressed non-specific, bodily signs that correspond to a lower social status, while men were quite articulate regarding their cardiovascular complaints. The healthcare system itself underscores this tendency. In fact women – like one of those in our study – might be under-diagnosed regarding heart disorders. Recent findings make it clear that women are received, examined, and treated for heart diseases differently from men [19].

At the same time, men risk being under-diagnosed for depression. A study of women general practitioners' pattern of diagnosing men points in this direction [20]. Masculinity has been assigned sovereignty, self-assurance, confidence, and a language more emotionally impoverished. In the face of psychological disturbance, men might therefore retreat into silence or resort to the rhetoric of physical symptoms, aggression, and drug abuse. However, in our study the expressions were not solely a question of traditional gender roles, but revealed the impact of social position, status, and options. Men with a lower socioeducational background were less reticent and more open-hearted about revealing their weaknesses and open to change, while men with a higher socioeducational background were eager to appear at their best and had problems in finding ways out. Women with well-paid occupations expressed self-confidence and hope, while women with low-paid work were more silent and trapped. Whether there is a correspondence to these findings and suicidal readiness would be an interesting subject to investigate further.

It might be wide-ranging to speculate whether class and gender affect feelings of guilt and shame. Shame is painful, and seeks recourse in escape and silence. Guilt is easier to confess, apologise for and repair. Guilt and shame are strong tools in the construction of morality [21]. It has been suggested that morality is gendered: women's morality is judged in relation to body, sex, and reproduction, while men's is viewed in relation to property and money [22]. We saw a tendency for women to be more prone to guilt and men to shame. Perhaps this, together with women's strategies of seeking help and understanding, might help explain why men, when risking the shame of "losing face", seek a solution in suicide.

Clinical implications

In conclusion, as clinicians we must listen attentively not only to the manifest (that which the patient expresses in words) but to its counterpart – that which is avoided or unarticulated. By doing so we might counteract the straitjacketing of normative gender patterns – patterns that make it difficult to suspect heart disease in the woman who is extremely fatigued, and depression and risk of suicide in the man presenting as having problems with the heart.

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