THE RELATIONSHIP BETWEEN SIGNIFICANT LIFE EVENTS
AND DEPRESSION IN WOMEN

by

Yolanda M. Rhorer

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has been approved

April 1997

APPROVED:

[Signatures]

ACCEPTED:

[Signature] Shenise L. Snyder
Associate Dean for Graduate Studies
ABSTRACT

The purpose of this study was to examine significant events in women's lives and the relationship of these events to depression in women. This study also examined whether patterns of psychological disturbance in women varied according to age, marital status, level of education, or annual household income.

Life events have long been implicated in the onset and course of depression among both clinical and nonclinical populations. An individual's psychological well-being is often compromised by the demand for change and the subsequent readjustment process triggered by significant life events. Life events are interrelated and may not, in and of themselves, be the sole cause of depression, but the number and intensity of the life events make depression more likely.

The Beck Depression Inventory, a life events checklist, and a demographic questionnaire were administered to a sample of 100 women. The subjects consisted of students from two universities in the southwestern United States, participants of various state agency programs, employees of several business organizations, and neighbors and friends of the researcher.

The findings indicated that there was a significant correlation between significant life events and depression in women. When the respondents were divided into demographic groups, the findings showed that the highest levels of
depression were found in women of age 60 and above, divorced and separated women, women with high school level education, and women whose income was between $49,000 and $70,000. Thirty-two percent of the participants in this study could be categorized as depressed.
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CHAPTER 1
THE PROBLEM

Introduction

Depression is presently the greatest mental health problem in the United States (Papp, Klein & Seibel, 1996). Comer (1995) defines depression as "a low, sad state in which life seems bleak and its challenges overwhelming" (p. G-6). Depression is one of the five major illnesses from which people are dying (Hengemuehler, 1996). An estimated ten million people in the United States suffer from clinical depression each year (Helpful Facts About Depressive Illnesses, 1996). Beck et al. (1979) state that "some authorities have estimated that at least 12 percent of the adult population have had or will have an episode of depression of sufficient clinical severity to warrant treatment" (p. 1).

Twice as many women as men report depressive symptoms or diagnosable depressive syndromes in the course of their lives. One in ten women can expect to have a serious episode of depression in her lifetime (Brems, 1995).

There are many factors that appear to contribute to depression which are common to both women and men. However, there are various internal and
external factors related to depression that are unique to women's lives and are believed to increase their susceptibility to depression. These factors include certain significant life events that are either unique to women or are common to both men and women, but are interpreted or responded to differently by women (Brems, 1995; Nolen-Hoeksema, 1990).

**Development of the Problem**

Life events have long been implicated in the onset and course of depression among both clinical and nonclinical populations (Cronkite & Moos, 1995). In particular, studies by Barbara and Bruce Dohrenwends conclude, with reasonable certainty, that stressors precede and trigger depressive reactions in some people and that these stressors include terrible and difficult life events that happen to people (cited in Hammen, 1992).

Traditionally, life events have been defined as “objective experiences that are sufficiently disruptive or threatening as to require a substantial readjustment on the part of the individual” (Cronkite & Moos, 1995, p. 572). The variances in severity of life events range from death of a spouse to violations of the law. However, there are traumatic life events that are primarily specific to women such as abortion, rape, and sexual assault among others. Significant life events demand change and a subsequent readjustment process which may compromise an individual’s psychological well-being (Cronkite & Moos, 1995).
There is a division in thought over what is the appropriate manner to measure the ways in which something external (life events-stressors) is translated into something internal (depression). The use of checklist instruments completed by respondents is preferred by American researchers (Avison & Turner, 1988) whereas the use of personal interviews has been largely favored by Europeans (Brown, 1993). Brown (1993) promotes the semi-structured interview method and investigator based ratings, and he points out the cumulative evidence obtainable by this method. Brown (1993) believes this method has the ability to bring about information regarding acute onset or relapse in a variety of disorders and diseases.

Avison and Turner (1988) recognize the desirability of obtaining the type of detailed information that a drawn out interviewing procedure might yield, but emphasize that most research programs have limited time requirements that make the personal interviewing procedure impractical. Avison and Turner (1988) believe that they have been able to effectively acquire valuable information for their purposes by modifying a life events checklist to include questions that distinguish impact, duration, and resolution of the effects of significant life events on individuals.

From another perspective, Hammen (1992) objects that contemporary studies of depression have had an intra-individual emphasis, either on individual cognitive vulnerability to depression or genetic transmission of
disordered neuroregulatory systems and have excluded environmental factors, including the important role of stressors. Hammen (1992) believes that the omission of environmental factors have impeded understanding of depression.

**Need for the Study**

Although there has been notable research on life events and depression by Brown (1993), Hammen (1992), Avison and Turner (1988), and Paykel, Rao and Taylor (1984), the subject remains controversial and deserves further scrutiny. Some researchers still question the extent, if any, to which life events impact the lives of people (Paykel, Rao & Taylor, 1984). Others argue that current methods of reporting and measuring life events are not appropriate (Brown, 1993; Paykel, 1992; Avison & Turner, 1988). Still others believe that researchers are too concerned with the aspect of life events creating an onset to depression and are neglecting the effect of life events over the course of depression (including remission) once it has begun (Monroe et al., 1983). Some life-events researchers complain that too much emphasis is put on the life event itself and that the individual's vulnerability to specific types of stressors and family transmission of depression has been neglected (Hammen, 1992).

Clearly, there is a need for further progress in understanding the cause and effect relationship between significant life events and their relationship to depression in women. It is also essential that some advancement be made in the
capacity to estimate more accurately the extent and nature of experienced stress and resulting depression caused by life events.

**Purpose of the Study**

The purpose of this study was to examine significant events in women’s lives and the relationship of these events to depression in women.

**Research Question**

What is the relationship between significant life events and depression in women?

**Definition of Terms**

**behavior**: The response that an organism makes to the stimuli in its environment (Comer, 1995, p. G-3).

**behavioral model**: A theoretical perspective that emphasizes ingrained behavior and the ways in which it is learned (Comer, 1995, p. G-3).

**bipolar depression**: A disorder marked by alternating or intermixed periods of mania and depression (Comer, 1995, p. G-3).

**cognition**: The intellectual capacity to think, remember, and anticipate (Comer, 1995, p. G-4).

**cognitive model**: A theoretical perspective that emphasizes the process and content of the thinking that underlies behavior (Comer, 1995, p. G-4).

**endocrine system:** A set of glands which secrete hormones carried in the bloodstream. They influence neural and muscular tissue in other parts of the body (Bootzin et al., 1986, p. 731).

**endogenous depression:** A depression that develops without apparent antecedents and is assumed to be caused by internal factors (Comer, 1995, p. G-7).

**exogenous depression:** A depression that appears to follow on the heels of clear-cut precipitating events (Comer, 1995, p. G-8).

**genetics:** A study of hereditary factors affecting development (Papalia & Olds, 1992, p. 558).

**gonadotropins:** A hormone capable of promoting gonadal growth and function (Spraycar, 1995, p. 738).

**interpersonal:** Being, relating to, or involving relations between persons (Woolf, 1981, p. 599).

**interdependent:** Mutually dependent (Woolf, 1981, p. 597). The dependence of the outcome of an interaction between two or more people on what each does as in the relationship between husband and wife (Sutherland, 1989, p. 212).

**intrapsychic:** Conflicts or processes that take place within the psyche (i.e. the mind, personality or self) (Statt, 1990, p. 73).

**learned helplessness:** A condition characterized by an expectation that bad events will occur and that there is nothing one can do to prevent their
occurrence. Results in passivity, cognitive deficits, and other symptoms that resemble depression (Rosenhan & Seligman, 1984, p. 673).

**neuropharmacology:** That branch of pharmacology dealing especially with the action of drugs upon various parts and elements of the nervous system (Thomas, 1993, p. 1302).

**neurotransmitter:** A chemical that, released by one neuron, crosses the synaptic space to be received at receptors on the dendrites of adjacent neurons (Comer, 1995, p. G-14).

**predisposition:** An inborn or acquired vulnerability for developing certain symptoms (Comer, 1995, p. G-16).

**psychosocial:** Caused by both psychological and social factors (Bootzin et al., 1986, p. 739).

**schizophrenia:** A psychotic disorder lasting for at least six months in which personal, social, and occupational functioning that were previously adaptive deteriorate as a result of distorted perceptions, disturbed thought processes, deviant emotional states, and motor abnormalities (Comer, 1995, p. G-19).

**serotonin:** A neurotransmitter whose abnormal activity is linked to depression, eating disorders, and obsessive-compulsive disorder (Comer, 1995, p. G-20).

**somatic:** Having to do with the body (Rosenhan & Seligman, 1984, p. 676).

**stress:** A term without precise meaning; sometimes defined as any stimulus that places a strain on a person’s physical or psychological capacity to adjust;
sometimes defined as an internal response to some disruptive or disquieting situation (Bootzin et al., 1986, p. 742).

**stressor:** An event that creates a degree of threat by confronting a person with a demand or opportunity for change of some kind (Comer, 1995, p. G-21).

**syndrome:** A cluster of symptoms that usually occur together (Comer, 1995, p. G-21).

**tryptophan:** An essential amino acid present in high concentrations in animal life and fish protein. It is necessary for normal growth and development. Tryptophan is a precursor of serotonin, a chemical important in the transmission of nerve impulses across nerve cell connections (Thomas, 1993, p. 2049).

**unipolar depression:** Depression without a history of mania which is followed, upon recovery, by a normal or nearly normal mood (Comer, 1995, p. G-23).
CHAPTER 2

THE LITERATURE REVIEW

Introduction

Chapter two reviews the pertinent literature on depression and its categories, symptoms and causes in the sections entitled Depression, Symptoms of Depression, and Causes of Depression. In the sections, Stress and The Implications of Stress, the issues of stress and its sources, as well as, how stress relates to depression are further explored. Depression in women and men will be evaluated, together with the likelihood of women being more vulnerable to depression than men, in the sections Women versus Men and Depression in Women. Lastly, the section, Significant Life Events focuses on critical life events experienced by women that may predispose them to depression. These events include: marriage, widowhood, divorce, death of a child, abortion, the empty nest syndrome, postpartum syndrome, menopause, hysterectomy, victimization, sexual harassment, rape, spousal abuse, employment, and discrimination.

Depression

Most people experience feelings of sadness and dejection from time to time; however, normal dejection is seldom so severe that it significantly alters
daily functioning. Furthermore, these feelings of sadness and dejection usually lift within a reasonable period (Comer, 1995). Sometimes these downturns in mood can even lead people to use these periods in contemplation, exploring themselves, their values, and their situations (Comer, 1995). People can often emerge from these periods with a sense of greater strength, clarity, and resolve (Comer, 1995).

However, Comer (1995) contends that clinical depression has no redeeming characteristics and that it is a serious psychological disturbance which brings severe and long-lasting psychological pain that may intensify as time goes by. Clinically depressed persons may reach a point where they are unable to carry out the simplest of life’s activities. Depression can be so painful and debilitating that people may try to end their lives (Comer, 1995).

Comer (1995) cites that the DSM-IV criteria for major depressive disorder is as follows:

A. At least five of the following symptoms have been present during the same two-week period and represent a change from previous functioning:
   1. Depressed mood most of the day, nearly every day
   2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day
   3. Significant weight loss when not dieting, or weight gain, or decrease or increase in appetite nearly every day
   4. Insomnia or hypersomnia nearly every day
   5. Psychomotor agitation or retardation nearly every day
   6. Fatigue or loss of energy nearly every day
7. Feelings of worthlessness or excessive or inappropriate guilt nearly every day
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day
9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
(p. 129)

Comer (1995) cautions the need to distinguish whether these symptoms may be the result of taking drugs or a general medical condition.

**Exogenous versus Endogenous Depression.**

Clinicians used to consider it important to distinguish between exogenous (reactive) depression and endogenous (internal) depression, since the circumstances of origin and onset of depression seemed to vary (Comer, 1995). Exogenous depressions were believed to follow clear-cut precipitating events, whereas endogenous depressions did not seem to have any apparent antecedents and were assumed to be caused by internal factors. Comer (1995) emphasized the difficulty in determining whether a depression is reactive or not; and that if stressful events have occurred before the onset of depression, clinicians cannot be certain that the depression is reactive. On the other hand, even when a depression seems to emerge in the absence of stressful events, clinicians cannot assume that the depression is endogenous (Paykel et al., 1984). It is because of this dilemma that today’s clinicians usually concentrate on
recognizing both the internal and the situational components of any given case of depression.

**Unipolar Depression versus Bipolar Depression**

Empirical studies have indicated that people who suffer only from episodes of depression and people who suffer from alternating episodes of mania and depression have two distinct types of depression. Nolen-Hoeksema (1990) cites the American Psychiatric Association (1987) in explaining that people who suffer only from depression are said to have a unipolar depressive disorder, and those who suffer from both depression and mania are said to have a bipolar disorder. People with unipolar depression have different genetic histories, different biochemical abnormalities, and different reactions to drugs from people with bipolar disorders (Nolen-Hoeksema, 1990). To date, almost all the discussions of sex differences in depression and life events have been concerned with unipolar depression (Nolen-Hoeksema, 1990; Comer, 1995).

**Symptoms of Depression**

Comer (1995) emphasizes that depression has many symptoms other than sadness and that symptoms often reinforce one another. For example, chronic indecisiveness may lead to poor job performance, which in turn may lead to a lower self-image, less self-confidence, and still more indecisiveness (Comer, 1995). Moreover, depression can be expressed in various ways with different people.
Comer (1995) explains that the symptoms associated with depression span five areas of functioning—emotional, motivational, behavioral, cognitive, and somatic.

**Emotional Symptoms**

Most people who are depressed feel intensely sad and dejected. They describe themselves as feeling miserable, empty, and humiliated. They report getting little pleasure from anything, and they tend to lose their sense of humor. Some depressed people also experience anxiety, anger, or agitation. There may be frequent crying spells, and those who do not actually cry describe themselves as beyond tears. Many depressed people seem to lose their feelings of affection for others. (Comer, 1995).

**Motivational Symptoms**

Depressed people usually lose their desire to participate in their accustomed activities. Almost all report a lack of drive, initiative, and spontaneity, and they may have to force themselves to go to work, converse with friends, eat meals, or have sex. Aaron Beck has described this state as a "paralysis of will" (Comer, 1995, p. 275).

Since suicide represents the ultimate escape from life's activities and pressure, many depressed people wish to die; some wish that they could kill themselves and others actually try (Beck, 1967).
Cognitive Symptoms

Depressed people hold negative views of themselves. They consider themselves inadequate, undesirable, and inferior. They may also view themselves as unattractive. Depressed people rarely credit themselves for positive achievements, and they usually blame themselves for negative events, even if these events have nothing to do with them. At the same time, they feel helpless to control or improve any aspect of their lives. (Comer, 1995).

Another cognitive symptom of depression is a negative view of the future and a resignation that nothing will ever improve. This sense of hopelessness makes depressed people especially vulnerable to suicidal thinking. Beck (1967) refers to research that implies that depressed people have difficulty in concentrating, have problems with attention span, and have difficulties with memory.

Behavioral Symptoms

"The activity of depressed people usually decreases dramatically" (Comer, 1995, p. 275). They seem to lack energy, and they are less productive. Even their speech pattern may change to being slow, quiet, and monotone. They spend more time alone and may lie in bed or sit in a chair for long periods. (Comer, 1995).
Somatic Symptoms

Physical ailments such as headaches, indigestion, constipation, dizzy spells, unpleasant sensations in the chest, and generalized pain are often expressions of depression. Depression is also often accompanied by disturbances in appetite and sleep, as are complaints of constant tiredness. Because of these physical manifestations, depression is frequently misdiagnosed as a medical problem. (Comer, 1995).

Causes of Depression

Weissman and Paykel (1974) explained that the causes of clinical depression are complex. They believe that depression may be caused by stressful life events, genetic predisposition, vulnerability to certain stresses based on personality and other factors, biological changes, or brain neuropharmacology abnormalities. Another set of potential biological causes may be hormonal (Weissman & Paykel, 1974). There has also been much interest relative to female sex hormones and depression. However, it is the contention of Weissman and Paykel (1974) that most often depression in a single patient results from a combination of various causes. On the other hand, Weissman and Paykel (1974) note that some depressions arise in the absence of any obvious precipitant.

The most obvious cause of depression is stress that is caused by life events (Weissman & Paykel, 1974). A variety of these stressful events tend to be
reported by patients at the onset of depression (Weissman & Paykel, 1974).
Although most people experience such events most of the time, Weissman and Paykel (1974) report that “there is little doubt that depressives have experienced more stress” (p. 7).

Stress

“Stress is a pattern of disruptive psychological and physiological responses to events that interfere with a person’s ability to function” (Bootzin et al., 1986, p. 524). Bootzin et al. (1986) describe the symptoms of stress as “physiological arousal (increases in pulse rate, blood pressure, and respiration); higher levels of certain hormones; cognitive disorganization (inability to concentrate, obsessive thoughts); and emotional upset (fear, anxiety, excitement, anger, embarrassment, depression)” (p. 524).

Ashurst and Hall (1989) state that stress may be acute, as in sudden bereavement or sudden illness and that it may also be chronic, as when an employee is constantly picked on by a superior. Furthermore, stress may be intermittent as in the experience of an unwanted pregnancy, when the problem may be forgotten at intervals, but as time progresses the dreaded event looms larger (Ashurst & Hall, 1989). A certain amount of stress is an inevitable part of living, but some situations impair individuals more than others. Bootzin et al. (1986) note that loss and separation, traumatic events, work-related problems, and an accumulation of aggravations are major sources of stress.
Comer (1995) explains that the state of stress has two components: (1) a stressor, the event that creates the demands; and (2) the stress response, a person’s unique reactions to the demands. A person’s reaction to stressors is influenced by how he or she appraises both the event and his or her capacity to respond to the event (Comer, 1995). People who sense that they have sufficient ability and resources to cope with the event are more likely to respond effectively to stressors, take them in stride, and avoid having negative emotional, behavioral, and cognitive reactions to them (Comer, 1995).

Another psychological factor presented by Bootzin et al. (1986) that can influence a stressful reaction is whether a person believes that he or she can predict and control events in his or her environment. Predictable events are less stressful because people can prepare for them (Bootzin et al., 1986). When unpleasant events are not predictable, anticipatory stress remains constantly high (Bootzin et al., 1986). However, Bootzin et al. (1986) noted that a feeling of being in control may be even more important than being able to predict events and that the inability to control or avoid danger can be more stressful than danger itself.

The Implications of Stress

The studies of Makosky (1982) reveal that a variety of physiological changes and subjective feelings are likely to be experienced when environmental demands (stressors) threaten well-being. Such stress has been implicated in the
causes of numerous physical and mental health problems ranging from ulcers to depression (Makosky, 1982).

Much of the research on stress has focused on stress resulting from change, hypothesizing that any change which requires readjustment in one's life causes stress (Makosky, 1982). The volume of change that is experienced is important. It has been found that people experience elevated risks for physical and emotional problems when they undergo numerous life changes in a short period of time (Makosky, 1982). Makosky (1982) also contends that a clustering of life events or a high level of life change has been found to precede suicide, hospitalization for depression, or schizophrenia.

**Women versus Men**

The preponderance of depression in women versus men has been documented throughout recorded history and has been accepted as truth by most mental health practitioners (Brems, 1995). Nolen-Hoeksema (1990) states that “the rate of depressive disorders in females is higher than the rate for males across all age groups of adults” (p. 32). An average of 205.5 women versus 138 men were treated for diagnosable depression in psychiatric facilities in the United States per 100,000 persons in the general population (Nolen-Hoeksema, 1990) (see Table 1 on page 20).

In 1980, the National Institute of Mental Health reported that an average of 10.2 percent of the general population had diagnosable depressive syndromes;
of these, 70 percent were women and 30 percent were men (Nolen-Hoeksema, 1990). Brems's (1995) findings indicate that women are also overrepresented among mental health service agency consumers. However, it must be qualified that these differences generally apply only to unipolar depressions (Brems, 1995). Overall, bipolar disorders are not likely to show a preponderance among women (Brems, 1995).

Others have suggested that women are not more vulnerable to depression than men, but simply express or label their symptoms differently (Corob, 1987). It is further believed by others that women may be more likely to admit feelings of depression, brood about their feelings, or seek professional assistance (Corob, 1987). Men, on the other hand, may be socially conditioned to deny such feelings or to bury them in alcohol, as reflected in the higher rates of alcoholism in men (The Many Dimensions of Depression in Women, 1996). However, Nolen-Hoeksema (1990) adamantly disagrees with this theory and states that there is little evidence that sex differences in depression result only from men's reluctance to admit to depression or from a tendency for depressed men to become alcoholics. Brems (1995), Corob (1987), and the internet article entitled “What You Should Know about Women and Depression” (1996) conclude their findings by stating that in order to explain the sex differences in depression, consideration must be given to the various factors unique to women's lives that are suspected of contributing to depression. These factor are biological (e.g.,
genetic, hormonal, developmental, reproductive), social (e.g., socioeconomic issues, social roles, discrimination), and psychosocial/psychological differences (e.g., socialization and personality development, interpersonal violence), together with other factors such as life events. The life events factor will be elaborated further in this study.

Table 1
Rates of Persons Treated for Depressive Disorders, per 100,000 People

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Females</th>
<th>Males</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-24 years</td>
<td>151</td>
<td>123</td>
</tr>
<tr>
<td>25-44 years</td>
<td>266</td>
<td>178</td>
</tr>
<tr>
<td>45-64 years</td>
<td>251</td>
<td>141</td>
</tr>
<tr>
<td>65+ years</td>
<td>154</td>
<td>110</td>
</tr>
</tbody>
</table>


Depression in Women

Social and psychosocial perspectives together present useful insights that suggest that women who have internalized societal prescriptions of female behavior and those who fulfill stereotypical female roles are especially vulnerable to depression. This vulnerability is likely to be increased by adverse social circumstances (The Many Dimensions of Depression in Women, 1996).
Scarf (1980) explains that it is her belief that the female's inherently interpersonal, interdependent, affiliative nature (her affectionateness and orientation toward other people) is what underlies her greater vulnerability. Scarf (1980) points out that as early as infancy, female infants are much more reactive and responsive to other human beings than are male infants.

From a feminist perspective, Corob (1987) notes that women's susceptibility to depression seems to be related to their frequent low self-image, their vulnerability to violence, the effects of their losses, and their all too often constraining and unsatisfying roles in society. Furthermore, the societal roles of women typically remain unrecognized and unrewarded (Corob, 1987).

Socialization experiences may also expose women to depression. Stereotypical patterns of socializing females do not seem to adequately equip them for dealing with stress in later life. For centuries, women have been brought up to feel that they are second-class citizens, inferior to men. This belief induces feelings of helplessness and low self-esteem in women, and these feelings are later reinforced by messages from the media and society in general. While these messages may be changing slowly, many women have already internalized them and have come to believe them (Corob, 1987).

Women who do not tend to have problems with depression are those who have multiple roles (e.g., a job, children, a marriage, volunteer work, all at once). This is because these women have many different support sources and various
outlets for their competence. If things are not going well in one area, they can compensate by feeling satisfied with their successes in other areas (What You Should Know about Women and Depression, 1996).

**Significant Life Events**

It has been noted by clinicians that episodes of unipolar depression often seem to be triggered by stressful events (Comer, 1995). Eugene Paykel, a British psychiatric researcher, found that depressed people as a group experience a greater number of stressful life events just before the onset of their disorder than do nondepressed people during the same time period (cited in Comer, 1995). In the groups that Paykel studied, stresses had started to multiply up to a year before the onset of depression, but in most cases the stresses were greatest during the months before onset.

Studies conducted in England found that people who are more likely to become depressed after experiencing stressful life events are women who have three or more young children living at home, lack a close confidant, have no employment outside the home, or have lost their mother before the age of 11 (Comer, 1995). In addition, people who are separated or divorced, as well as those living in nursing homes or prisons, are also more likely to become depressed after experiencing stressful life events (Comer, 1995). In summary, people whose lives are generally stressful, are isolated, and lack social support seem more likely than others to become depressed when stresses multiply.
Marriage

Corob (1987) believes that both women and men tend to have unrealistic expectations of marriage and that they often believe that marriage will fulfill their every need for love, friendship, support, sexual satisfaction and others. Moreover, men’s needs are more apt to be met, since men are generally better at asking for what they want and since women are more sensitive to meeting the needs of others than men are (Prince & Jacobsen, 1995). Also, Corob (1987) contends that men are less likely to depend solely on women for the satisfaction of their needs, because they tend to retain relationships and opportunities outside of marriage through their world of work. In contrast, married women, especially those with young children, are often totally dependent on men, emotionally and financially (Belle, 1982). There are also some women who totally submerge their personal identity in their relationships with their husbands and children. Such a position may leave women vulnerable to feelings of frustration, lack of fulfillment, and low self-esteem (Corob, 1987).

Corob (1987) also emphasizes that a woman’s social role may also contribute to her poor mental health in marriage. The role of housewife, in particular, is considered to be inherently stressful; it is routine, monotonous, and frustrating. Furthermore, housework affords little social prestige and is rarely acknowledged, appreciated, or rewarded (Corob, 1987).
Conflict in marriage is another precipitator of depression in marriage, especially for women. Studies show that marital conflict not only precipitates depression, but it is the most predictive indicator of relapse (Papp, Klein & Seibel, 1996).

**Relationship Losses**

The loss of a spouse through death or divorce are two of the most stressful events that a woman can experience (Bootzin et al., 1986; Ashurst & Hall, 1989; Paykel, 1992). The experiences of these two losses are very different from each other. However, both the divorced woman and the widow experience the same identity crisis of being single again, instead of being half of a couple (Ashurst & Hall, 1989).

**Widowhood.** Losing a spouse is virtually a female experience. Women are four times more likely than men to lose a spouse, are more likely to be widowed at an earlier age, and are more likely to remain widows with many years of life ahead of them (Ashurst & Hall, 1989).

The loss of a life partner causes great suffering, even if the relationship had not been very loving. Additionally, losing the mutual identity that was acquired through habit and familiarity, together with the feelings of being alone and abandoned, are a great shock to the widow (Papalia & Olds, 1992; Ashurst & Hall, 1989). A third of widows meet the criteria for major depressive episode in
the first month after the death of their spouses, but only half of these remain clinically depressed one year later (Ashurst & Hall, 1989).

Papalia and Olds (1992) explain that the death of a spouse may be especially difficult for women who have structured their lives around caring for a husband and enjoying his company. Furthermore, those women who are most likely to need counseling six months after their husband’s death are those who have few friends, do not feel close to their children, and have suffered a recent disability (Papalia & Olds, 1992). Most widows do not need formal treatment, but many who are moderately or severely sad appear to benefit from self-help groups or various psychosocial treatments (Papalia & Olds, 1992).

**Divorce.** For a woman, divorce seems to be an implicit admission of failure, either because she was not able to keep her man or because she did not make the right choice of husband in the first place (Ashurst & Hall, 1989).

Depression, during the stages that divorce is contemplated, as it is finalized, and in the aftermath, is common (Ashurst & Hall, 1989). A new crisis will usually occur if her former partner remarries, regardless of whether she may herself have a new and more satisfying relationship.

Whereas a widow slowly adapts herself to the loss of her spouse and learns not to expect the presence of her partner, the divorcee knows he is alive, existing somewhere; and in her fantasy, he is giving good things to other people and not to her (Ashurst & Hall, 1989). She cannot put her former partner out of
her mind because she will need to contact him, or even meet with him, in order to make arrangements about finances, legal proceedings, and care of or access to the children (Ashurst & Hall, 1989). If her ex-partner is violent, she may fear or dread his approach.

Other stressors that a woman experiences as a result of divorce are losing the status and the life style that the marriage afforded her. Her earning power may decrease as much as 70 percent, as opposed to men, whose earning power after divorce tends to increase as much as 42 percent (Brems, 1995; Nolen-Hoeksema, 1990). Having to experience this drop in income, women often are trapped in a double bind presented by the social support system in the United States, in which women are unemployed or have low-paying jobs (Nolen-Hoeksema, 1990).

**Loss of Children**

Women who lose their children, for whatever reason, or regardless of what stage of development or age the children are, experience profoundly deep distress. Ashurst and Hall, (1989) explain that when the child who has grown within the woman occupies her arms, a woman has a precious extension of herself to love and nourish. To lose this child, for whatever circumstances, is a major blow to her self-esteem and diminishes her confidence in herself both as a woman and as a mother (Ashurst & Hall, 1989). By being sensitive to and appreciating the impact that these events have on women, professionals, family,
and friends can help a woman to cope with the inevitable distress, rather than delay her recovery by failure to recognize her misery (Ashurst & Hall, 1989).

**Death of a Child.** Ashurst and Hall (1989) stress that although failures of conception and birth may constitute major areas of distress for women, all these traumas pale in significance to the death of a child. The death of a child is an unexpected blow that runs counter to parental expectations (Ashurst & Hall, 1989). Some women who have lost a child may feel that life has lost its meaning for them; and if a child’s death is sudden and without warning, the shock of this type of loss may perpetuate the mother’s grief (Ashurst & Hall, 1989).

Sometimes the death of a child is accompanied by a series of other negative life experiences—previous, simultaneous, and subsequent—so that each of the blows that might have been coped with singly becomes part of a sequence that overwhelms the mother’s resources (Ashurst & Hall, 1989). Ashurst and Hall (1989) also relate that other aspects of a mother’s life and relationships are often damaged, and by the time the mother seeks help, the damages may be irreparable.

**Abortion.** An abortion can be a profoundly distressing event because a woman loses a part of herself. However, recent studies indicate that a woman’s ability to make an effective adjustment after an abortion is more dependent on interpersonal, social, and perhaps even intrapsychic factors than on biological or hormonal factors (Ashurst & Hall, 1989). In order to prevent depression after
abortion, Brems (1995) recommends dealing with pertinent issues before the abortion by evaluating the meaningfulness of the pregnancy, by understanding what to expect from the abortion, and by learning to cope with it in advance. In many respects, however, an abortion can be very much like any loss of a child, especially when the woman has not received the necessary support (Ashurst & Hall, 1989).

**Empty Nest Syndrome.** Weissman and Paykel (1974) state that the inability for women to deal successfully with their termination of child-rearing and to adjust to the childless-mother status can contribute to a depression in middle-aged women that has been described as the “empty nest syndrome.” When the children leave home, the mother must find a new way of life, expand old interests, and seek gratification through roles other than the maternal role. This conflict is described by Weissman and Paykel (1974) as more common in less-educated women from traditional backgrounds, where the spouse is either absent or emotionally unavailable.

Corob (1987) describes women who are more prone to experience the “empty nest syndrome” as those who are exclusively family-centered, are enmeshed with their children, and feel that their lives are pointless and worthless when their children leave home. These women suffer multiple losses: the loss of role, of self-esteem, of purpose and of meaningful relationships and experiences.
On the other hand, current studies from Papalia and Olds (1992) cast doubt on “the empty nest syndrome” as an explanation for depression in older women. They believe that the lack of increased rates of depression among women at this stage of life suggests that most women do not get depressed when children leave home and that most women find it liberating not to have children at home anymore.

Reproductive Life Cycle Issues

Significant life events attributed to the reproductive life cycle of women include, but are not limited to, the postpregnancy period, menopause, and hysterectomy. These events bring changes in mood that for some women include depression (The Many Dimensions of Depression in Women, 1996).


Brems (1995) hypothesizes that endocrine events after delivery, namely, the surge in gonadotropins and hormones, may result in depressive symptoms. Nolen-Hoeksema (1990) also suggests that neurotransmitter environments are affected by pregnancy and delivery, and that subsequent low levels of
tryptophan (the precursor of serotonin) may bring about increased levels of depression.

For many women, depression after childbirth seems likely to be associated with difficulties in negotiating the transition to motherhood, plus the stressful nature of women's lives at this time (Corob, 1987). Women who had previously been in the work force may find that the arrival of a new baby may be accompanied by a sense of loss—loss of independence, relative freedom, social contacts, status, earnings and perhaps an exclusive relationship with a partner (Corob, 1987).

"The Many Dimensions of Depression in Women" (1996) points to studies that suggest that most women who experience depressive illness after childbirth often have had prior depressive episodes. Nevertheless, for most women, postpartum depressions are brief and have no adverse consequences (Brems, 1995).

Menopause. Menopause is a period during which a woman moves from reproductive to nonreproductive life and has been reported to include symptoms of sleep disturbance, fatigue, irritability, and mood changes (Brems, 1995). There seems to be an overlap between these symptoms and the diagnostic criteria for mood disorders as defined by DSM-IV, and it is this overlap that has led to a belief that menopause results in an increase in depression among women (Brems, 1995). Despite this belief, there is little empirical evidence that
menopause is associated with an increased risk of depression (Brems, 1995).

"The Many Dimensions of Depression in Women" (1996) also notes that depressive illnesses are no different at menopause than at other ages.

However, Corob (1987) states that while there is no increased risk of depression during menopause, many women do feel vulnerable and low about the changes that menopause brings. For those women who wanted children, but were never able to have them, the final realization of the impossibility of conceiving may cause a deep depression (Corob, 1987). The cessation of menstrual periods may for some women imply a loss of femininity, and with this sometimes comes fears of being no longer attractive, youthful and desirable (Brems, 1995). Papalia and Olds (1992) note that a societal view toward aging can influence a menopausal woman's well being far more than the levels of hormones in her body. In a society, such as ours, that overvalues youthfulness and female attractiveness, growing older and losing youthful looks can be very depressing (Corob, 1987).

In addition, Brems (1995) notes that the period of life that coincides with a woman's menopause can be filled with stressful changes that could produce depressive symptoms. These changes could include children leaving home, family members and friends becoming ill or dying, the spouse or the woman, herself, facing retirement, and physical changes that may require adjustment in activities (Brems, 1995).
As is the case with other significant life events, the women most vulnerable to change-of-life depression are those with a history of past depressive episodes (Corob, 1987; The Many Dimensions of Depression in Women, 1996).

**Hysterectomy.** Brems (1995) reports that depression is more often a consequence of a hysterectomy than menopause (not induced by surgery). Nevertheless, when depression occurs after a hysterectomy, the symptoms are short lived; and the depression is more related to a perceived loss of femininity and the loss of fertility than to hormonal or biological factors (Brems, 1995; Paykel, 1992). Depression is more likely if a woman has had a previous psychiatric disturbance or if her marital relationship is strained (Ashurst & Hall, 1989). In general, however, there is very little evidence that hysterectomies lead to more depression than any other type of surgery (Brems, 1995).

**Interpersonal Violence/Victimization**

Women who experience forms of abuse, such as rape, physical abuse and sexual harassment on the job, may experience high rates of depression. It has been suggested that victimization may lead to depression by fostering low self-esteem, worthlessness, a sense of helplessness, self-blame, social isolation, and fear (The Many Dimensions of Depression in Women, 1966).

**Sexual Harassment.** Brems (1995) provides a basic definition of sexual harassment which is "repeated, unwanted, and objectionable interpersonal
interaction with sexual connotations" (p. 556). This harassment can range from mild (e.g., a pat or ogling) to severe (e.g., explicit propositions, rape) (Brems, 1995). Brems (1995) notes that in 1985, L. P. Cammaert reported prevalence rates of sexual harassment from 40 to 88 percent.

The results of sexual harassment are many. Nolen-Hoeksema (1990) contends that the literature shows that sexual harassment on the job results in decreased mental and physical health and sets up a situation that promotes the development of learned helplessness. Brems (1995) further explains that sexual harassment leads to increased psychological distress, decreased income (due to quitting jobs or taking demotions to escape the perpetrator), and depression.

Rape. A 1986 study by the Federal Bureau of Investigation reported that 90,000 women are raped every year (cited in Nolen-Hoeksema, 1990). Nolen-Hoeksema (1990) considers this number to be considerably underestimated, since many rapes go unreported, especially if the rape was committed by someone the woman knew.

Brems (1995) reports that as many as 24 percent of all rape victims have a diagnosable mood disorder for some time after the assault. Acute effects include depression, self-blame, anxious mood, and helplessness. The longer-term effects of rape are only indirectly related to depression and include symptoms such as a sense of loss of control and loss of predictability in one's life (Brems, 1995).
Spousal Abuse. Wife abuse appears to be significantly related to depression, with 80 percent of victims reporting symptoms of depression and 53 percent reporting symptoms sufficiently severe to warrant a diagnosis of mood disorder (Brems, 1995). Based on the American Psychological Association Task Force on Women and Depression’s review of the literature, it was reported that 25 to 50 percent of married women are victimized by their spouses (Brems, 1995).

Documentation on the effects of battery on wives suggests a significant mediating factor of learned helplessness which increases as the amount of abuse escalates in the spousal relationship (Brems, 1995). Decreased self-esteem and interpersonal passivity (part of learned helplessness) create a vicious cycle that results in a greater likelihood of victimization, which in turn increases feelings of worthlessness, contributes to depression, and continues the cycle (Brems, 1995).

Employment

Research has shown that paid work not only provides women with a source of income, but also with social contacts; and it alleviates boredom and raises self-esteem (Corob, 1987). Respondents of a survey conducted by Tebbets (1982) on working women from lower socioeconomic groups reported that work was important in these women’s lives and that it gave them a sense of confidence, accomplishment, dignity, and independence, as well as a more secure economic base. In general, working women tend to be less depressed
than homemakers, especially among lower socioeconomic groups where employment appears to function as a buffer against depression (Tebbets, 1982).

Unfortunately, many women in the workforce are underpaid, undervalued, and are provided with little opportunity for advancement (Corob, 1987). They often find themselves in jobs that are not commensurate with their educational backgrounds. Paid employment can be especially complicated for mothers, since full-time jobs do not accommodate the demands and needs of children. Ensuring adequate child care can be a continuing source of anxiety to working mothers, and the additional tasks of attending to children before and after a full working day can be demanding and exhausting (Ashurst & Hall, 1989).

Brems (1995) states that dual-role career women have higher rates of depression and more health problems than career men. This difference may be related to the fact that career women may have to work harder than men to achieve the same level of recognition or status and are more likely to be burdened with child care problems (Brems, 1995). Brems (1995) notes that at least 50 percent of career women have to take time off from work at some point in time to take care of children who are ill, as compared to one percent of career men.

In addition, the “overload of role” theory reviewed by Nolen-Hoeksema (1990) suggests that when individuals are asked to perform more roles than they
can satisfactorily complete, they are likely to despair and experience depression, because they cannot live up to expectations in all arenas of functioning. This role theory may apply to women who attempt to be full-time workers, full-time mothers, traditional wives, homemakers, and so on (Brems, 1995). Other investigators report that it is not the number of roles that is predictive of depression, but the effect of a person’s perception of the ability to fulfill these roles (Brems, 1995).

Therefore, while employment may sometimes be beneficial and rewarding to women, it may also contribute to stress. The inconsistencies that have been found in the effect of employment on women appear to be influenced by variables such as husband’s support, parental status, child care accessibility, discrimination on the job, identity conflicts, role conflicts, and other related factors (Brems, 1995). Nevertheless, Corob (1987) is convinced that the mental health benefits of work for women can be high if their employment conditions are positive and if the demands of the family do not interfere.

**Discrimination**

The effects of discrimination have been extensively investigated, and these investigations have shown that discrimination is related significantly to emotional stress (Brems, 1995; Nolen-Hoeksema, 1990; Steele et al. 1982). These effects lead to anger, resentment, bitterness, hurt feelings, hopelessness, helplessness, and subsequently to depression (Brems, 1995). Discrimination
against women is a fact of life in many aspects of their lives, including work, marriage, and social status (Nolen-Hoeksema, 1990). Related to discrimination are beliefs and stereotypes held about women (and by women) that compound the effects of discrimination (Brems, 1995).

Nolen-Hoeksema (1990) explains that many professional working women show high rates of depression, and this affect is often linked to prejudice against women on the job and sexual harassment. When women are evaluated for promotions or when they apply for employment, employers tend to evaluate them lower than they do men, regardless of their experience, skills, or history of performance (Brems, 1995). The lack of relationship between performance and evaluation can be linked to feelings of learned helplessness in women, which in turn can result in depression (Brems, 1995). Additionally, women are taken less serious and have less influence in problem-solving situations on the job (Nolen-Hoeksema, 1990).

Discrimination occurs not only on the job, but also in women's intimate relationships (Steele et al., 1982). Nolen-Hoeksema (1990) notes that the effects that result from women being discriminated in intimate relationships are also harmful on women's mental health. There is a strong relationship between marital inequity and depression (Brems, 1995). Cooper, Chassin, Braver and Zeiss conducted a study in 1986 that revealed significant inequities between husbands and wives, even among couples who expressed the belief that women
and men should be equal (cited in Brems, 1995). Both the men and women perceived men as having more impact on joint decisionmaking, and they viewed men as making final judgments. Additionally, husbands’ opinions consistently prevailed over those of their wives (Brems, 1995).

Discrimination and stereotyping also occurs in settings unrelated to employment or marital status. For instance, women who depend upon welfare benefits are often perceived by society as lazy, cheating, promiscuous, dependent freeloaders, and of poor character (Brems, 1995). Brems (1995) stresses that these women not only face the negative effects of poverty, but also the added stigma of being undesirable members of society.

**Summary**

There are many complex factors and significant life events that may lead women to depression. Some of these events relate to women’s experiences in relationships, such as marriage, divorce and widowhood. Some relate to the loss of a child—death of a child, abortion, and the empty nest syndrome. Other significant events arise from issues related to a woman’s reproductive life cycle, such as postpartum syndrome, menopause, and hysterectomy. The impact of interpersonal violence and victimization of women, i.e., sexual harassment, rape and spousal abuse are also significant factors to consider. Lastly, the effects of employment, together with the impact of discrimination on women’s lives can play a key role.
All these life events are interrelated and may not, in and of themselves, be the sole cause of depression. The number and intensity of the life events certainly make depression more likely. However, like with many life experiences, people are affected differently, depending on personality and circumstances. The more vulnerable the person is, the more likely the event will cause psychological distress.

The focus on stressful events in women’s lives does not mean that women never gain any satisfaction or derive pleasure from their lives. Instead, it is important to acknowledge the potential significance of these events and to produce an awareness of the various threats or demands for change that may compromise a woman’s psychological well being. By recognizing that these events are stressful or relapse-inducing situations, clinicians and patients can identify coping and social resources that can be drawn upon to deal with these situations more effectively.
CHAPTER 3

METHODOLOGY

Introduction

The purpose of this study was to examine significant events in women’s lives and the relationship of these events to depression in women. The research question addressed in this study was, what is the relationship between significant life events and depression in women?

Research Design

This study utilized a descriptive design approach. According to Merriam and Simpson, (1995):

the central focus of descriptive research is to examine facts about people, their opinions and attitudes. Its purpose is not to give value to sets of relationships between events, but simply to draw attention to the degree two events or phenomena are related. Description may include: (1) collection of facts that describe existing phenomena; (2) identification of problems or justification of current conditions and practice; (3) project or product evaluation; or (4) comparison of experience between groups with similar problems to assist in future planning and decision making. (p. 61)

This study collected facts on the various levels of depression that women experience by administering the Beck Depression Inventory (BDI) (Beck, 1996) to a sample of 100 women. Additionally, data was collected relative to the number of significant life events with which these women were confronted, together
with the degree of stress related to those events, by assessing the results of a life events checklist the participants completed. This life events checklist was prepared by the researcher and adapted in part from Holmes and Rahe (1967) (included as Appendix A). Accompanying these instruments was a demographic questionnaire, which is included as Appendix B, requesting information on age, relationship status, family, education, work status and approximate annual household income. The test materials were distributed to the participants with a transmittal letter, which is included as Appendix C, explaining the purpose of the study, descriptive information regarding the instruments, and a statement that participation in the study was anonymous and voluntary.

**Sample and Population**

The population of interest in the study was adult females. A convenience sampling method was used to select participants for this study. The ages of the women who participated in the study ranged from 19 years to 71 years, and the mean age of the respondents was 41.1 years. There was a total of 100 participants.

The data was collected during the month of February, 1997. The subjects consisted of students from two universities in the southwestern United States, participants of several state agency programs, employees of various business organizations, and neighbors and friends of the researcher.
Assumptions and Limitations

A limitation of this study was that it was based on a convenience sample and the findings may not be a representative of the general population of adult women. Additionally, the influence of other extraneous variables such as ethnic background was not accounted for in this study. Honesty in the responses was assumed.

Instrumentation

Two instruments were chosen for investigation in this study: (1) the BDI, to determine the depression level of participants; and (2) a life events checklist, designed by the researcher for this study, which lists and weighs various significant life events that are associated with depression in women.

The BDI is the most frequently used self-report method of assessing severity of depression (Katz et al., 1995). This 21-item scale is clinically derived and designed to measure both attitudes and symptoms which are specific to depression and were consistent with descriptions in the psychiatric literature (Katz et al., 1995). Each item in the inventory consists of four self-evaluative statements which are scored from 0 to 3, with increasing scores indicating greater severity of depression. Responses are added to yield a total score ranging from 0 to 63 (Thompson, 1989).

BDI scores are categorized into levels of depression as follows: 0 to 13 indicates minimal depression, 14 to 19 reflects mild depression, 20 to 28 indicates
moderate depression, and 29 to 63 denotes severe depression (Beck, Steer & Brown, 1996).

A comprehensive examination of the internal consistency of the BDI scale has been reported in the literature. Katz et al. (1995) state that "split-half reliability coefficients have been reported in the range of .58 to .93 and that item-total correlations ranged from .22 to .86, with the average being .68" (p. 70). Katz et al. (1995) also report that test-retest reliability ranged from .69 to .90.

The BDI has been reported to have good concurrent validity. Katz et al. (1995) referred to Beck, Steer, and Garbin (1988) who cited 35 studies where correlations were reported between the BDI and well-established instruments that measure depression, including the Hamilton Depression Rating Scale, the Zung Self-Rating Depression Scale, Minnesota Multi-phasic Personality Inventory-D, the Multiple Affect Adjective Checklist’s Depression Scale, and the clinicians’ ratings of depth of depression (cited in Katz et al., 1995).

The limitation of the BDI is the ease of ability for the tester to fake good or fake bad if he or she wishes. Even with this weakness, the instrument has proved to be a very useful tool in a clinical setting (Thompson, 1989). The BDI is a useful tool because it gives a rapid assessment of the level of depression and may also highlight certain symptoms such as suicidal wishes (Beck et al., 1979).

The second instrument that was used for this study was a life events checklist. While this life events checklist was prepared by the researcher, its
validity has not been formally assessed. However, it was deemed appropriate and functional for purposes of this study.

This life events checklist included 28 significant life events that were identified by authors who specialize in the area of life events and depression, i.e., Paykel (1992), Weissman and Paykel (1974), Brown (1993), Cronkite and Moos (1995), Brems (1995), Corob (1987), Nolen-Hoeksema (1990), Ashurst and Hall (1989), and Makosky (1982). A stipulation was made that the significant life events in question must have occurred within the last 12 months to avoid assigning undue weight to distant minor events. The weights that were assigned to each life event are similar to those weights common to many life events indices (Holmes & Rahe, 1967; Henderson, Byrne & Duncan-Jones, 1981; Sarason, Johnson & Siegel, 1978). In addition, a point rating scale was developed that established four levels of stress for accumulated life events—minimal, mild, moderate, and severe.

Procedure

The researcher personally administered and collected the instruments and kept all test materials secure and confidential. Each participant was given two instruments to complete, the BDI and the life events checklist, accompanied by a transmittal letter explaining the purpose of the study, descriptive information regarding the instruments, and a statement that participation in the study was anonymous and voluntary.
Method of Analysis

A mean score on the BDI was computed. The weighted values from each of the 28 items on the life events checklist of each respondent were added, and a mean score was calculated for the sample as a whole. The data were also examined to determine if the mean BDI or life events checklist score varied by marital status, age, education level or income. The last step included an analysis to determine the correlation between the scores on the BDI and the scores on the life events checklist.
CHAPTER 4

PRESENTATION AND ANALYSIS OF THE DATA

Demographics

The ages of the women surveyed in this study ranged from 19 years to 71 years, with a mean age of 41.4 years. Forty-nine (49%) of the women were involved in a committed relationship with a spouse or significant other, and 51 (51%) were not. Of these women, 36 (36%) were married, 30 (30%) were divorced, 22 (22%) were single/never married, 8 (8%) were separated, and 4 (4%) were widowed.

The level of education reported by these women was as follows: 48 (48%) had an undergraduate degree, 36 (36%) had a high school diploma or equivalent, 12 (12%) had a graduate degree, and 4 (4%) had not completed high school. Fifty-nine (59%) of the women were currently working outside the home. The annual household income reported by the largest group of women (35%) was between $10,000 to $29,000.

Findings

The guidelines used to measure the various levels of the participants' depression were those guidelines described in BDI-II: The Beck Depression Inventory Manual (Beck et al, 1996). These guidelines are as follows:
<table>
<thead>
<tr>
<th>Total Scores</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 13</td>
<td>minimal depression</td>
</tr>
<tr>
<td>14 - 19</td>
<td>mild depression</td>
</tr>
<tr>
<td>20 - 28</td>
<td>moderate depression</td>
</tr>
<tr>
<td>29 - 63</td>
<td>severe depression</td>
</tr>
</tbody>
</table>

On the BDI, the mean score for level of depression for the participants in this study was 12.69 out of a total possible 63 points. The standard deviation was 10.84. Of the 100 respondents, 62% of the participants scored 0 to 13 points on levels of depression, 16% scored from 14 to 19 points, 14% scored from 20 to 28 points, and 8% scored over 29 points. The participants obtained the following mean scores for levels of depression: minimally depressed, $M = 5.73$, $SD = 3.90$; mildly depressed, $M = 16.8$, $SD = 1.90$; moderately depressed, $M = 24.6$, $SD = 2.76$; and severely depressed, $M = 37.5$, $SD = 7.01$.

The guidelines that the researcher established for the life events checklist to categorize the levels of intensity of stress-related accumulated life events are presented as follows:

<table>
<thead>
<tr>
<th>Total Scores</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 75</td>
<td>minimal stress</td>
</tr>
<tr>
<td>80-160</td>
<td>mild stress</td>
</tr>
<tr>
<td>165-245</td>
<td>moderate stress</td>
</tr>
<tr>
<td>250 and above</td>
<td>severe stress</td>
</tr>
</tbody>
</table>

(individual life event scores were weighted in multiples of 5)

On the life events checklist, the mean score for stress related to life events for the participants of this study was 106.95, out of a total possible 1,510 points. The standard deviation was 93.5. Of the 100 respondents, 41 (41%) scored from
0 to 75 points on stress related to life events, 33 (33%) scored from 80 to 160 points, 17 (17%) scored from 165 to 245 points, and 9 (9 %) scored over 250 points. The participants obtained the following mean scores for stress levels related to life events: minimal stress, M= 22.80, SD =26.53; mild stress, M= 110.30, SD = 21.76; moderate stress, M= 197.94, SD = 26.75, severe stress, M= 306.11, SD = 52.84.

This study also examined whether the level of depression or level of stress related to life events varied according to marital status, age, educational level, or annual household income. The findings on marital status, as shown on Figures 1 and 2 on page 49, indicated that the highest level of depression and the highest level of stress related to life events were reported by the respondent group of separated women. Divorced women ranked second in levels of depression and stress related to life events. Widowed women ranked third on depression, but they tied with the married women group for the lowest score in stress related to life events. Married women ranked fourth on depression level. The single/never married group of women had the lowest depression level and ranked third on stress related to life events.

By separating the respondents into groups according to age, as shown on Figures 3 and 4 on page 50, it was found that women over 60 had the highest level of depression and ranked second in stress related to life events. Women between 50 and 60 years old ranked second in level of depression and third in stress related to life events. The group of women from 40 to 50 years old
Figure 1
Mean Beck Depression Inventory Scores by Groups According to Marital Status

Figure 2
Mean Life Events Scores by Groups According to Marital Status
Figure 3
Mean Beck Depression Inventory Scores by Groups According to Age

Figure 4
Mean Life Events Scores by Groups According to Age
ranked third in level of depression and fourth in their stress-related life events scores. The group of women from 30 to 40 years old ranked fourth in level of depression and ranked the highest for experiencing stress related to life events. The group of women under age 30 reported both the lowest depression level and stress-related life events scores.

When the respondents were divided into groups according to education level, as shown on Figures 5 and 6 on page 52, the women whose education level was high school or equivalent had both the highest depression level and stress-related life event scores. The women whose educational level was undergraduate ranked second both in depression level and stress-related life event scores. Women who had less than a high school education ranked third on level of depression and last on stress related to life events. Graduate level women ranked fourth in depression level and third on stress-related life events scores.

Lastly, the women were grouped according to yearly household income, as shown on Figures 7 and 8 on page 53. These women whose household income was from $49,001 to $70,000 reported the highest level of depression, but they tied for third place for stress related to life events with the women whose household income was over $70,000. The women whose household income was over $70,000 ranked second in level of depression. Those respondents whose income was between $29,001 and $49,000 ranked third in level of depression and last in stress related to life events. Ranking fourth in level of depression was the
Figure 5
Mean Beck Depression Inventory Scores by Groups According to Education Level

Figure 6
Mean Life Events Scores by Groups According to Education Level
Figure 7
Mean Beck Depression Inventory Scores by Groups According to Income

![Graph](image1)

Figure 8
Mean Life Events Scores by Groups According to Income

![Graph](image2)
group of respondents whose household income was between $10,000 to $29,000, and they ranked second in stress-related life events scores. The group whose household income was under $10,000 ranked fifth in level of depression and had the highest stress-related life events scores.

The findings of this study also indicated a correlation between depression and life events. The results of the data examined showed a Pearson r of .50 (p<.01) between the mean score on the BDI and the mean score for the life events checklist. A scatterplot of this relationship is shown on Figure 9 as follows:

Figure 9
Comparison of Depression Levels with Life Events
CHAPTER 5

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Summary

The purpose of this study was to examine significant life events in women's lives and the relationship of these events to depression in women. Since life events have long been implicated in the onset and course of depression and since women report a preponderance of depressive symptoms, the researcher believed that the relationship between these two factors warranted further investigation.

This study reviewed pertinent literature on depression and its categories, symptoms and causes. The issues of stress and its sources, as well as, how stress relates to depression were further explored. Depression in women versus men was reviewed, together with the likelihood of women being more vulnerable to depression than men. Lastly, significant life events that may predispose women to depression were examined. These events included marriage, widowhood, divorce, death of a child, abortion, the empty nest syndrome, postpartum syndrome, menopause, hysterectomy, victimization, sexual harassment, rape, spousal abuse, employment, and discrimination.

Various factors that are unique to women's lives that are suspected of contributing to their depression are biological (e.g., genetic, hormonal,
developmental, reproductive), social (e.g., socioeconomic issues, social roles, discrimination), and psychosocial/psychological differences (e.g., socialization and personality development, interpersonal violence), together with other factors such as life events.

Significant life events are interrelated and may not, in and of themselves, be the sole cause of depression; however, the number and intensity of the life events make depression more likely. Like with many life experiences, people are affected differently by life events, depending on personality and circumstances. The more vulnerable the person is, the more likely the event will cause psychological distress.

This study examined a sample of 100 women and collected data on the level of depression that each woman had experienced, together with the life events that she had encountered. A convenience sampling method was used to select participants for this study. The ages of the participants were from 19 years to 71 years, with a mean age of 41.4 years.

Two instruments were used in this study: (1) the Beck Depression Inventory (BDI) (Beck, 1996) to determine the depression level of participants; and (2) a life events checklist to collect data relative to the number of significant life events the participants had experienced and the degree of stress related to those events. Participants were also asked to complete a demographic
questionnaire which requested information on age, relationship status, family, education, work status and approximate annual household income.

The main findings indicated that there was a significant correlation between significant life events and depression in women. When the respondents were divided into demographic groups, the findings showed that the highest levels of depression were found in women of age 60 and above, divorced and separated women, women with high school level education, and women whose income was between $49,000 and $70,000. Thirty-two percent of the participants in this study could be categorized as depressed.

Conclusions

The findings from this study indicate that significant life events are associated with depressive symptoms. A correlation of .50 (p<.01) was found between the mean score of the BDI and the mean score of the life events checklist.

By using Beck et al.’s (1996) recommended cutting score of 17 for research studies to determine “as pure a group of persons with depression with regard to symptomology” (p. 11), it was found that 32 percent of this study’s participants could be categorized as depressed. Furthermore, in reviewing the life events experienced by the participants, it was determined that 26 percent of the participants had a level of life events that could produce substantial or severe stress.
Marital status seemed to effect both depression and the stress associated with significant life events. Divorced and separated women experienced both the highest levels of depression and stress related to life events. These results correspond to the literature which emphasizes the high level of stress and frequency of depression during divorce and separation. Also, the elevated number of life events during this period substantiate the findings in the literature that divorce triggers other events such as problems with children, arguments with ex-spouse (on matters such as legal proceedings, finances, or children), loss of income, loss of a sexual partner, personal illness, or problems at work.

Age also seemed to be related to depression. The group of women over 60 years of age showed the highest rate of depression. This increase in depression in later life corresponds to the studies of Comstock and Helsing (cited in Futterman et al., 1976). Comstock and Helsing's studies also used the self report test method and included the BDI as one of their test measures. This increase in depression in later life may be attributed to declining health; loss of spouse, siblings, friends, and sometimes children; a lower income; or use of mood altering medications. Additionally, the group of women over 60 years of age ranked second in the amount of stress-related life events they experienced.

Women with only a high school education or equivalent showed the highest levels for both depression and stress related to life events. The high level
of depression found in this group agrees with the literature (Brems, 1995; Tebbets, 1982) that states depression is significantly correlated with lower levels of education. Lower levels of education limit earning power and career opportunities, and there is often a delayed effect of low education occurring many decades after schooling is completed.

The group of women whose annual household income was between $49,000 to $70,000 reported the highest level of depression. These findings are not consistent with the literature on depression. The literature (Brems, 1995; Makosky, 1982) points to a high correlation between low income and depressive symptoms. The inconsistency between the researcher’s findings for this group of women and the literature may be attributed to the researcher’s use of a convenience sample in this study. The limitation of a convenience sample is that it may not be representative of the general population of adult women. From another perspective, these results may bring to light that having a good income does not immunize a woman from becoming depressed. It is also possible that women in these higher income brackets may have higher expectations regarding personal needs such as achievement, success, quality of life, affection and a sense of belonging, than women of lower income brackets.

**Recommendations**

The findings of this study indicate the possible direction for future research and potential clinical applications. By recognizing that significant life
events can bring about stressful or relapse-inducing situations, clinicians can help identify coping and social resources that clients can acquire and draw upon to help them deal with these situations more effectively. Additionally, by being able to anticipate the level of subsequent stress that significant life events may bring about, clinicians can make more accurate decisions about appropriate treatment. Furthermore, efforts to prevent depression may be aimed at strengthening personal resources, reducing stressors, enhancing social resources, and teaching cognitive and behavioral coping skills.

There remain areas of life events assessment in need of further research and development. These areas include the following:

1. The extent to which the impact of life events is influenced by other variables, such as social, biological, psychological and personality characteristics of the individual.

2. Development of assessment measures that effectively differentiate for age and gender, in order to understand why people adapt differently to life events.

3. Better measures to assess the effects of variables such as socioeconomic status and interpersonal support systems.

4. A focused assessment of the psychological components that account for well-adjusted persons.
5. A study into the range of effects that each stressful life event produces in people according to age, gender, socioeconomic group, ethnicity, education, marital status, and personality type.


APPENDIX A

LIFE EVENTS CHECKLIST

(researcher's copy that includes point values)

The following is a list of events. Place a check in the left-hand column for each of those events that has happened to you during the last 12 months.

<table>
<thead>
<tr>
<th>Life Event</th>
<th>Point Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>___ Marriage</td>
<td>50</td>
</tr>
<tr>
<td>___ Death of a spouse</td>
<td>100</td>
</tr>
<tr>
<td>___ Divorce</td>
<td>75</td>
</tr>
<tr>
<td>___ Separation from husband or significant other</td>
<td>65</td>
</tr>
<tr>
<td>___ Increase in number of arguments with spouse or significant other</td>
<td>35</td>
</tr>
<tr>
<td>___ Major problems with children</td>
<td>40</td>
</tr>
<tr>
<td>___ Sexual problems</td>
<td>40</td>
</tr>
<tr>
<td>___ Marital reconciliation</td>
<td>45</td>
</tr>
<tr>
<td>___ Death of a child</td>
<td>100</td>
</tr>
<tr>
<td>___ Abortion</td>
<td>65</td>
</tr>
<tr>
<td>___ Gave up a child for adoption</td>
<td>65</td>
</tr>
<tr>
<td>___ Miscarriage</td>
<td>55</td>
</tr>
<tr>
<td>___ Pregnancy</td>
<td>60</td>
</tr>
<tr>
<td>___ Empty nest syndrome (the transitional period after the last child leaves home)</td>
<td>40</td>
</tr>
<tr>
<td>___ Postpartum syndrome</td>
<td>40</td>
</tr>
<tr>
<td>___ Menopause</td>
<td>40</td>
</tr>
<tr>
<td>___ Hysterectomy</td>
<td>55</td>
</tr>
</tbody>
</table>
___ Mastectomy
___ Severe personal illness or injury
___ Sexual harassment
___ Discrimination (based on gender)
___ Rape
___ Spousal abuse
___ Fired from work
___ Husband or significant other fired or laid off from work
___ Began new job or ended current job voluntarily
___ Change in work conditions or responsibilities
___ Problems with your boss
APPENDIX B

DEMOGRAPHIC QUESTIONNAIRE
APPENDIX B

DEMOGRAPHIC QUESTIONNAIRE

Please answer the following questions by placing a check mark next to the appropriate response for each question.

Age: ___

Relationship Status
Are you currently involved in a committed relationship with a spouse or significant other?

___ Yes
___ No

Marital Status
___ Married
___ Separated
___ Single, Never Married
___ Widowed
___ Divorced

Family
Number of Children ___
Number of children living with you under age 18 ___
Number of children living with you over age 18 ___

Education
Indicate the highest level of education you have completed.

___ Less than high school diploma
___ High school diploma or equivalent
___ Undergraduate college degree
___ Master’s degree
___ Doctoral degree
Work Status

Currently working  ___ Yes  ___ No

Employed outside the home  ___ Yes  ___ No

Approximate Annual Household Income

___ under $10,000  ___ $10,000 to $29,000  ___ $29,001 to 49,000

___ $49,001 to $70,000  ___ over $70,000
APPENDIX C

LETTER OF TRANSMITTAL TO PARTICIPANTS

February 1997

Dear Participant:

I am currently collecting exploratory data on the level of psychological distress caused by significant life events that are specific to the lives of women and the relationship of these life events to depression. The instruments used for this survey are the Beck Depression Inventory and a life events checklist wherein participants will report significant life events that have occurred in their lives during the last 12 months.

I would greatly appreciate your completing both instruments and the attached demographic sheet. Since the validity of the results depends on obtaining a high rate of responses, your participation is important for the success of this project. The completion of the demographic sheet, the Beck Depression Inventory, and the life events checklist will require about 15 to 20 minutes.

Your participation in this survey is anonymous and voluntary. When I receive your responses, I will enter them into a computer program for statistical analysis, and the inventory, the checklist and the demographic sheet will be destroyed. In my Master's Research Project, all data collected will be reported for the sample only as a whole. Individual results will not be retained or reported.

Thank you for your participation in this project.

Sincerely,

Yolanda Rhorer
Master's Student in Counseling
Ottawa University