4-1999

Women Experiencing Depression [within] the Three Denominations of Judaism: Orthodox, Conservative and Reform

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WOMEN EXPERIENCING DEPRESSION THE THREE DENOMINATIONS OF JUDAISM: ORTHODOX, CONSERVATIVE AND REFORM.

Amy Kopman, B.A.

An Abstract Presented to the Faculty of the Graduate School of Lindenwood University in Partial Fulfillment of the Requirement for the Degree of Master of Art, April 16, 1999

Abstract

The purpose of this study was to investigate women experiencing depression in the three denominations of Judaism: Orthodox, Conservative and Reform. Participants were divided into thee groups consisting of Orthodox (n=20), Conservative (n=32), and Reform (n=28). The volunteer participants completed a demographic sheet and the Beck Depression Inventory II (BDI-II), answering 21 different questions measuring the severity of depression. A chi-square determined there is no significant relationship between the different scores of the various denominations of the Jewish women. The implications of these findings are discussed.

WOMEN EXPERIENCING DEPRESSION THE THREE DENOMINATIONS OF JUDAISM: ORTHODOX, CONSERVATIVE AND REFORM.

Amy Kopman, B.A.

A Thesis Presented to the Faculty of the Graduate School of Lindenwood University in Partial Fulfillment of the Requirement for the Degree of Master of Art, April 16, 1999

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CHAPTER 1

Explanations of gender differences in mental illness have generally been concerned with explaining why women are more likely to be depressed than men (Lowenthal, Goldblatt, Lubitsch, Bicknell, Fellowes, & Sowden, 1995) Stress levels for women and men differ. Women may suffer more depression inducing stress. Hobfall (1991) found that Israeli women were more likely to report moods of depression than Israeli men were.

In a 1990 study Brogha and Bebbington reported that women with several young children to care for were more vulnerable to depression than women with lighter family responsibilities. Newman (1986) reported that hardships had an equal effect on men and women in contributing to depression; however, women were found to report more instances of hardship than were men.

Responses to stress play a major role in determining the degree of depression in both men and women. Gender differences in depression may be explained by differences in ways of handling stress and psychological pain. These differences may be a result of social-situational differences rather than social circumstances that may cause the following to arise:

- Women and men differ in their way of thinking. Women are more likely to ruminate than are men, possibly as a result of powerlessness or a lack of resources. Men are more likely to engage in distracting behaviors. (Potts, Burnam & Wells, 1991)
- Men may be more reluctant to seek help for depression (Potts, Burnam, & Wells, 1991), which is also less likely to be diagnosed among men than among women given similar symptoms.
- Men who attempt suicide are more likely to succeed than are women, which accounts for less likelihood men being diagnosed and treated for depressive disorders. (Potts, et. al, 1991).
- Depressed men seek other outlets, such as alcoholism as a response to stress. (Golding, Burnam & Wells, 1997)
- Depressed men simply fail to report depression, perhaps to maintain self-esteem. (Vrendenburg, Krames & Flett, 1996 and Wilhelm & Parker, 1989).

That gender is a critical variable affecting the distribution of mental disorders is one of the most consistent findings of psychiatric research (Schwartz, 1991). According to Idler, (1987); Levin & Schiller,

(1987); Maton & Pargament, (1987); and Vaux, (1976), it was reported that religion can have a positive or a negative impact on mental health. Positive impacts on mental health include:

- Helping people enact positive health practices.
- Encouraging social cohesiveness.
- Providing such mechanisms as prayer for anxiety and tension.
- Helping establish meaning in life.
- Providing means of connections to higher power.

Deleterious impacts on religion include:

- Sponsoring abnormal mental content, such as through cults.
- Subscribing to excessive guilt or shame.
- Strenuous religious demands which may cause stress.
- Using religion as a means of escape.
- Deviant religious ideas that promote hatred and violence.

The literature on religion and mental health is vast, with hundreds of studies, most correlational, linking religion to some form of mental function or behavior (Bergin, 1983).

Statement of Purpose

The purpose of the current study was to assess the levels of depression among women in the Orthodox, Conservative and Reform denominations. This theses proposes to test the following hypothesis: There is a significant difference in levels of depression among the three denominations.

CHAPTER 2

Literature Review

A review of the literature on the subject of depression was conducted and divided into five categories: 1) depression, 2) depression and women, 3) depression and ethnicity, 4) depression and Judaism and other sub-populations, and 5) depression and the role of women in various denominations. Also reviewed was the role of women in various religious denominations.

Literature indicates that depression can be treated by a general practitioner, and can mean anything from a description of normal unhappiness to psychosis Brugha & Bennington, 1990). According to Sprock and Yoder, (1991),depression strikes women twice as often as men. One critical variable explaining why women evidence higher rates of depression is the fact that women experience stress accompanying their social roles (Schwartz, 1991).

Over the past two decades a significant amount of research has outlined major problems that relate to psychiatric diagnostic classification and standardized research instruments in cross cultural settings. (Jadhav, 1996). Hobfall, Ritter, Lavin, Hullsizer and Cameron (1995), found no difference in rates of depression for African-American and Caucasian poor

inner-city, pregnant and post-partum women. Israeli women found war to be senseless and were unable to justify the way by finding deeper meaningfulness (Hobfall, Lomranz, Eyal, Bridges & Tzemach, 1989).

Sprock and Yoder, 1997, reported that another group that needs further research was that of the elderly. The lessening of the disparity rates in depression in older age may be due to similar risk factors for men and women at that time (Brown, Milburn &Gary, 1992).

Depression

The majority of depressed patients are treated by general practitioners. Approximately 5% of those consulting with general practitioners may display major depression; another 5% have milder forms of depression, and an additional 10% have some depressive symptoms (Floyd, 1997). Some researchers have expressed concern that current criteria for major depression has a low threshold (Floyd, 1997). Therefore, a number of milder cases of depression are incorrectly diagnosed a more serious mood disorders which may impact the actual incidence of major depression in both male and female patients. Physicians' personal concepts of psychiatric disorders, as well as the threshold they adopt for case identification, also influence diagnostic

determinations (Floyd, 1997). Practitioners may diagnose depression just because a patient mentions a depressed mood during a consultation. Since depression is a symptomatic diagnosis, physicians need to examine the wide range of phenomena that characterizes this disorder (Floyd, 1997).

Beck (1979) found several common themes in depressive disorders, such as self-criticism, low self-esteem, deprivation, and exaggeration of problems, self-demands and suicidal ideation. Beck (1979) defines these themes through the use of a cognitive triad: 1) A negative interpretation of the subject's own experience that they see themselves as prone to failure and commonly misreads unconscious statement made about themselves as meaning they are bad; 2) a devaluation of the self (i.e., the individual will negatively view their experience with the world); and 3) a negative view of the future, implying that the individual will display a pessimistic attitude built on their past experiences.

Depression may actually be underdiagnosed in certain patients, since physicians may conclude that some emotional reactions are consistent with an alleged heath status (Beck, 1979). Some patients not only suffer unnecessary emotional distress, but their

physical health may also be compromised as a result of undetected depression.

Depression is a complex neuropsychiatric disorder which is characterized by changes in mood and cognition (Floyd, 1997). Depressive disorders create difficulties in cognition, perception, behavior, mood and somatic functioning. Individuals with depression often reported feeling consistently sad or hopeless (Koenig, 1993). Depressive disorders could also be characterized by anhedonia, a painful inability to experience pleasure (Kessler & McLeod, 1984).

Research also suggests that symptoms of depression are infrequently induced by the interaction between a genetic predisposition and psycho-social stressors (Kobayashi, 1989). Depression is a heterogeneous disorder which is usually treated by a general practitioner (Lamothe, 1996). Depression can mean anything from a description of normal unhappiness to psychosis. Many depressed people have triggering life events, especially in the first episode of depression. A large portion of depressed individuals show physical symptoms (somatization), and some individuals may show other symptoms of depression, like absence of low mood "masked" depression (Hale, 1997). Less serious depression has been referred to in many different terms

which include neurotic depression, minor depression, and reactive depression. (This type of depression is when reactivity to evens in the surroundings is preserved). Reactive depression has more recently been referred to as dysthymia, a persistent low-grade condition (Lamothe, 1996).

Mild, but persistent symptoms suggest dysthymia (Koening, 1993). The more symptoms or more serious symptoms that an individual has suggests a depressive disorder (Levin & Schiller, 1987). Hallucinations and/or delusions (psychotic symptoms) or depressive stupor are only present in severe depression (Lowenthal, 1992). According the Pettone (1997) the most common risk period for the onset of depression is adolescence. Lowenthal, Goldblatt, Amos & Mullarkey, (1993) stated that depression has been signaled out as the diagnosis that raises significant issues of cultural validity. If the cultural validity of depression can be taken as local experiences that are clarified and validated on their own terms, then depression can be perceived as a culturally valid concept for western settings (Lowenthal & Goldblatt, 1993).

Beck, 1979, stated that depressed patients may inaccurately perceive their medical symptoms; cognitive

distortions may interact with reduced levels of self-efficacy, promoting hopelessness and helplessness about symptom management.

Depression and Women

Depression is a serious mental disorder that strikes women twice as often as men. Women manifest higher rates of other disorders frequently associated with depression, including eating disorders, somatization disorder, agoraphobia, panic disorder, and borderline personality disorder (Sprock & Yoder, 1997). The relationship between AXIS I and II disorders are important since the presence of these disorders can increase the vulnerability to depression. Depressed women demonstrate increased comorbidity with psychiatric and medical disorders, which may account for the poorer treatment response and less successful outcome (Lowenthal, Goldblatt, Lubitsch, Bicknell, Fellowes, & Sowden, 1995).

The role of the quality of a woman's relationship as a significant factor in depression has been pointed out by several researchers who have found that the presence of an intimate, supportive relationship can reduce stress and protect women from depression. Heifner (1996) identified women's depression as related to daily life issues such as: 1) the emphasis on

relationship; as defining success or failure as a women; 2) loss of possible choices such as access to careers and mastery-related jobs; 3) equating self-esteem with appearance; 4) self-denial embedded in self-esteem; 5) lack of access to emotional and financial resources; 6) invisibility of connection of children and grandchildren; and 7) having responsibility for what one cannot control.

One critical variable explaining why women evidence higher rates of depression is the fact that women experience stress accompanying their social roles (Schwartz, 1991). Also, numerous studies have revealed a history of distress for female patients in their attempts to establish accurate medical diagnosis. It has been suggested that up to 50% of females diagnosed with a depressive disorder may be misdiagnosed (Floyd, 1997). A female's depression may go undetected if she consults a physician for a sore throat; however, fatigability is more likely to receive recognition as a possible indication of depression (Wartik, 1997). Depression could possibly be underdiagnosed in certain females, due to the fact that physicians may conclude that certain emotional reactions are consistent with changes in one's health (Sered, 1997). It has been suggested by research that treating depression may

hinder a woman's ability to engage in healthy activities (Wartik, 1997). Another important aspect of how female demographic characteristics may affect diagnoses would be the fact that elderly female patients may face discriminations when their depressive symptoms are automatically assumed to reflect their advanced age (Davies, Avison, & McAlpine, 1997). However, younger females' complaints could be prematurely dismissed because they suggest a diagnosis that generally occurs in an older population (Spinelli, 1997).

Another factor of how female demographic characteristics may affect diagnosis could be a woman's menstrual cycle (PMS), which may result in the most significant factors while interpreting her complaints (Spinelli, 1997). Depressive symptoms of full-time housewives may be assumed to reflect discontent with their role (Spinelli, 1997). Ambitious career-oriented women's symptoms may be dismissed as evidence of the inability to tolerate their excessive occupational demands (Carr, Gilroy & Sherman, 1996). A reactive depression may be induced in women who initially receive the wrong medical diagnosis (Koening, 1993). Even more damaging would be the increased likelihood of a diagnosis of depression which would serve to act as a

self-fulfilling prophecy in some female patients and may affect a woman's self-image (Koening, 1993).

Previous findings indicate that gender differences in depression occur across cultures, emerge in early adolescence , and lessen in older age. This suggests that biological factors, in particular hormones, play a role (Lomranz, Hobfall, Johnson, Eyal & Zemach, 1994).

Socio-cultural factors, particularly parenting and educational practices, may promote development of the gender differences in cognition and personality (e.g. favoring sons over daughters) results in the development of low self-esteem characterized by feelings of non-belonging and chronic feelings of depression in women (Manikam, Matson, We & Hillman, 1995).

Recently, a new theory of development for women called the Self-In-Relation model has been presented that has serious implications regarding women and depression (Marcus & Rosenberg, 1995). The Self-In-Relation model states that unlike men, women do not have to separate from their mothers in order to establish their gender identity. Their development occurs within the context of their relationship and connection to the mother (Mattalon, Seyal & Mazor, 1994). Therefore, for women, identify is based on the

ability to grow and develop within a relationship. For women, affiliation and interdependence, not individuation, are seen as benchmarks of successful adult development (Maton & Pargament, 1987).

Adolescence is the time that depression rates for women begin to rise (Nolen-Hoeksema, 1991). Unfortunately, the Self-In-Relation model is not widely recognized or valued in western society. Although some cultures, particularly Asian and African (Mickley & Caron, 1995) value and foster interdependence, connection and communality, western patriarchal tradition places heavy emphasis on independence, autonomy, competition and achievement. The interest in and commitment to relationships is frequently cited as evidence of women's dependency on others for a sense of self, which, in turn is seen as leaving women vulnerable to depression should they lose these extended sources of self-esteem (Newman, 1986).

The role of the quality of women's relationships as a moderating factor in depression has been pointed out by various researchers (Bell, 1982 and Notman, Zelbach, Miller & Nidelson, 1986) who have found that the presence of an intimate, supportive relationship can alleviate stress and protect women from depression,

whereas the absence of such a relationship correlates highly with distress and depression.

Premenstrual syndrome (PMS) refers to physiological distress, specifically depression, which correlates with changes in the menstrual cycle and is believed to be caused by changes in the level of hormones in a woman's body (Notman, Zelbach, Miller & Nadelson, 1986). Even though PMS is common (20-50% of women), only 3-5% of women fit the criteria for PMS (Paloutzian, 1981). Recent research has added to the literature showing an association between PMS, post-partum depression, and non-reproductive related depressive episodes in women (Davies, Avison & McAlpine, 1997). Women who have PMS are more likely to have a history of major depression or post-partum depression and currently depressed women are more likely to have premenstrual worsening of symptoms (Schwartz, 1991).

Women are not more likely to develop depression during menopause, and depression that may develop is associated with previous history of depression or multiple fears and role demands (Spinelli, 1997). Differences in the social situations of women could possibly explain gender differences in depression. Such explanations include the following: a) women are

in less powerful positions which leads them to develop styles of coping that are already contributing to depression, such as compliance, passivity and helplessness; b) marriage and homemaking and taking care of children all tend to fall on women; c) women are less likely to be gainfully employed and employment has been suggested as generally protective where it provides a social support system, income status and other resources. In another attempt to explain higher rates of depression in women, the American Psychological Association in 1990 described increased depression in women over men related to several social factors, including; avoidance, passivity, and dependent behavior patterns; pessimistic, negative cognitive styles; and focusing too much on depressed feelings instead of action and mastery strategies.

Social support has also been explored as a variable which influences the ability to cope with difficult life events (Pargament, Sullivan, Balzer, Haltsma & Raymcuk, 1995). Generally women are more likely to maintain intimate relationships with others and to provide more frequent and more effective social support than men (Pearlin, 1989).

Having supportive social networks can protect women from depression (Belle, 1987). Supportive

aspects of social networks are most pronounced or women with greater personal resources such as income, educational and internal loss of control (Pettone, 1979). Social support has been explored as a variable which influences the ability to cope with difficult life events. Generally, it is recognized that women are more likely to maintain intimate relationships with others and to provide more frequent and more effective social supports than men (Pruzan, 1995). Having supportive social networks can protect individuals from depression (Riley & Echenrude, 1986), but social networks can also exacerbate distress (Kessler & McLeod, 1984). Supportive aspects of social networks are most pronounced for individuals with greater personal resources such as: income, education and internal locus of control (Ross, 1994).

The influence of poverty and violence on the sexes has been well documented. About 75% of Americans living below the poverty level are women and children, and young women who are poor, single heads of households are especially susceptible to depression (Caetano, 1987). Riley and Echenude (1986) reported that maintaining a large support network was resources helpful for women with more personal resources whereas low resource women had more problems trying to respond

to others' needs and were more likely to be distressed by their difficulties.

Recently, Veiel (1993) found that family support networks had a negative effect on recovery from a major depressive episode for women who were housewives, but not for men or working women. Possibly, women who are not employed outside the home are overloaded by emotional demands and expectations to support others, or a supportive family may reinforce depressive symptoms.

According to Sowsa and Lustman (1984), women view intimacy as significantly more important than men. However, women perceive family relationships as more stressful than men and seem to be especially vulnerable to negative effects from problematic interpersonal relations (Sowsa and Lustman, 1984). Turner (1994) found that women reported more positive and negative experiences of their relationships and that marital conflict had a more negative impact on women. Women in unhappy marriages are three times as likely as men or single women to be depressed and marital difficulty is the single most common stressor in the six months prior to the onset of depression in women (Schoelenfeld & Mestrovic, 1991).

In addition to these personal roles, the impact that women's work roles have on their adjustment has also been explored. Several studies have found no differences in depression between employed women and housewives (Sered, 1997). Taking other resources into account, family members who reported poorer health , reported feeling more burdened, and family members who reported less family cohesion reported greater depressive moods. It should be remembered, however that family cohesion and stigma interacted when accounting for depression, (Pearlin, 1989).

Aneshensel (1986) found that married, employed women with high levels of stress at home and work were likely to become depressed. On the other hand, women with comparable marital stress who were not employed outside the home were at greatest risk for depression (Spinelli, 1997). Depressed women report more symptoms of depression, than do depressed men (Ashton, 1991), even when they have been judged equally depressed, (Ernst & Angst, 1992). As a result, self-report tests and interviews may overestimate depression for women and/or underestimate depression for men. According to Golding (1988), it is important to remember that high scores on depression rating scales do not equate with a clinical diagnosis of a depressive disorder, even if a

minimum cutoff criterion is reached; clinical diagnoses must be established by meeting diagnostic criteria. Finally, women involved in family or outside jobs who experienced less strain at work or in their marriage were least likely to become depressed. Females are the primary victims of gender-related abuse and women who have experienced physical violence, spousal abuse, rape, sexual assault, and childhood abuse are at risk for developing depressive disorders (Cutler & Nolen-Hoeksma, 1991).

Depression and Ethnicity

McGrath, Keita, Strickland and Russo (1990) stated that ethnic minority women may be at increased risk for depression due to higher rates of poverty and other factors associated with their circumstances in society. Recently, Watts, (1996) questioned the cultural sensitivity of diagnostic instruments and suggested that current depression measures may not be valid for African-American women. Also, due to financial constraints and attitudes toward mental health treatment, African-American women may delay seeking treatment for depression and are more likely to seek help at general medical doctor than at a mental health setting. This may contribute to lower rates of diagnosis.

Hobfall, Ritter, Lavin, Hullsizer and Cameron (1995), found no difference in rates of depression for African-American and Caucasian poor inner-city, pregnant and post-partum women. Rates were nearly double that of middle class samples, specifically for single mothers. Therefore, higher rates reported for African-American and minority women may due to the confusion of race with other demographic factors such as low SES (Toledano, 1996).

Assessment bias may also be associated with minority group status. Previous reviews suggested that depressive disorders may be underdiagnosed in African Americans due to clinician bias (Adibimpe, 1981 and Barbee, 1992). More recently, Barbee (1992) questioned the cultural sensitivity of diagnostic instruments and suggested that current depression measures may not be valid for African American women. For example race and gender differences were found in the structure of responses on the center for Epidemiological Studies Depression Scale (ESD) in a group of elderly adults (Callahan & Wolinsky, 1994). Additionally, due to financial constrains and attitudes toward mental health treatment, African American women may delay seeking treatment for depression and are more likely to seek help at a general practitioner than a mental health

setting (Cooper, Crum, & Ford, 1994). Recent research continues to reveal fewer clinical diagnoses of depressive disorders and lower prevalence rates in Epidemiological Studies for African Americans as compared to other racial groups (Strakowski, Shelton, & Kolbrener, 1993).

According to Strakowski, Shelton and Kolbrener (1993), recent research continues to reveal fewer clinical diagnoses of depressive disorders and lower prevalence rates in epidemiological studies for African-American women as compared to other racial groups. A review by Barbee (1992) identified increased exposure to violence as an additional risk factor for African-American women. Barbee (1992) questioned the cultural sensitivity of diagnostic instruments and suggested that current depression measures may not be valid for African-American women. Additionally, due to financial constraints and attitudes toward mental health treatment, African-American women may delay seeking treatment for depression and are more likely to seek help at a regular physician rather than a mental health setting (Cooper, Crum & Ford, 1994).

In recent years (Seligman, 1975), a number of studies pointed to the similarity between symptoms of depression and behavioral deficits induced in non-

depressed subjects after exposure to uncontrollable aversive events. The phenomenon is referred to as "learned helplessness" and was proposed by Seligman (1975) and associates. The model was subsequently challenged on empirical and conceptual grounds (Buchwald, Coyne & Cole, 1978). Cooper, Crum & Ford (1994) suggested that a life history in which a person experienced both failure and success may lead to an immunization against learned helplessness.

One might speculate that subjects who were either raised in Israel or who have immigrated to Israel faced through their lives greater challenges and more difficulties than the average American. Therefore, an Israeli woman may be more immunized against the effects of exposure to uncontrollable events. So far, there are no cross-cultural reports on learned helplessness (Cooper, Crum & Ford, 1994).

Differing measure of family size in research often reflect different postulated underlying effects. (Loewenthal, Goldblatt, Amos & Mullarkey, 1993). The type of measure most widely employed, number of young children, is used to investigate effects and correlates of active child care, and of having children in the home, and/or conversely, effects of children growing up and "leaving the nest". This measure has shown to be

associated with depression in every possible direction (positive, negative and not at all). Another measure is whether or not the subject has children. (Lowenthal, Goldblatt, Amos & Mullarkey, 1993).

Paloutzian (1981) indicated that religiosity might be related to feelings of purpose. Suicide is generally strongly discouraged in Jewish religious thought (Paloutzian, 1981). It has been suggested by Prudo, Harris & Brown (1984) that family size and religiosity might have specific effects on components of depression which cannot be measured in terms of stress levels. These effects deserve closer investigation (Umberson, Wortman & Kessler, 1992).

In the Japanese culture, women are pivotal. It is women who are the primary consumers in a consumer society; it is to women that advertising and information through other media messages and images are directed. In Japanese culture women's social roles and public voices are highly restricted, women are either allowed to be or coerced into being, the primary players of consumerism. Consumerism involves the construction of an idealized dream world . (Ventis, 1995). It has recently been pointed out that Japanese women's participation in the paid labor forces has often been overlooked. Depression among Japanese

women is not discussed, mentioned or even recognized. If a Japanese woman would experience such feelings as depression, she would not express them to anyone. It would be unheard of for a Japanese woman to claim to be depressed (Edwards, 1997).

There have been quite a number of studies examining depression in Latinos and Mexican Americans (Golding & Burnam, 1990; Golding & Lipton, 1990; Roberts, 1992; Roberts, Roberts & Chen, 1995; Vernon & Roberts, 1992). Most studies have compared depressive symptoms for Mexican Americans or Hispanics with non-Hispanic whites, whereas other studies compare Mexican Americans with other Hispanic groups and/or other minority groups (Golding & Burnam, 1990 and Roberts, 1992). Among the major issues addressed in many of the cross-cultural studies reported is the extent to which ethnicity increases or reduces risk for depression (Roberts & Subhan, 1992 and Vega, Kolody & Valle, 1991). The general findings with regard to prevalence of depressive symptoms in Mexican Americans is that Mexican Americans, both adolescents and adults, tend to report a higher number of depressive symptoms than non-Hispanic whites (Golding & Burnam, 1990; Musciki, Lock, Rae & Boyd, 1989; Roberts, et al., 1995; Roberts & Subhan, 1992; Vernon & Roberts, 1982).

Depression and Other Sub-Populations

Another group of women needing further research is the elderly. There are a number of physical and psycho-social changes (e.g. menopause, retirement, widowhood, financial changes) that may affect women and increase the presence of risk factors for depression (Watts, 1996). It has been suggested that widowhood differentially impacts women and the resulting change in financial status is the primary determinate of depression (Watts, 1996). Due to increased longevity and societal patterns of women marrying men older than themselves, women are more likely to be widowed. Umberson, Wortman, and Kessler (1992), suggested that widowhood differentially impacts men and women and the resulting change in financial status is the primary determinant of depression for such women. The lessening of the disparity in rates of depression in older age may be due to more similar risk factors for men and women at that time (Brown, Milburn & Gary, 1992). Also, there may be differences in effective coping strategies for older and younger individuals who are depressed. Sherboune, Hays and Wells, 1995 found that active coping strategies were associated with better outcomes in depressed patients overall but provided few benefits for older patients and that

social support was the most helpful for older depressed patients regardless of sex.

Another group of women who presented unique risk factors for depression were lesbians. A recent survey of the mental health care of lesbians reported rates of current and lifetime depression comparable to rates for heterosexual women (Bradford, Ryan & Rothblum, 1994). However, lesbians reported a higher rate of substance abuse than is generally found in women. In addition, high rates of negative life events and stressors (e. g. rape, physical and sexual abuse) that would place them at risk for mental health problems were reported (Green, 1994). Also lesbian women had higher rates of poverty, received lower pay relative to their level of education and frequently cited a lack of resources as barriers to health care access. Finally ethnic minority lesbians may face additional stressors and issues due to the influence of other cultural factors (Green, 1994).

Depression and Judiasm

Commerford & Peznikoff, (1996), stated that depression is seen in Jewish writings as a normal human response that can be transformed into a positive and joyful state by confrontation with appropriate cognition of self instructions. Levels of depression

may be lower in Orthodox Jews than in the general Jewish population (Gove, 1972). Depression in Judaism is strongly accounted for by people who do not attend religious services (Kennedy, Kelman, Thomas & Chen, 1996). Familial, heritable factors are thought to contribute to a form of depression, melancholia Judaia (Kennedy, Kellman, Thomas & Chen, 1996). Anther factor reported among depression in Judaism is among aged Holocaust survivors. The effects of trauma early in life are compounded by late -life events (Kennedy, et al, 1996).

Contemporary, orthodox housewives evidence higher rates of depression than employed women. Modern orthodox women have begun to restructure their lives in greater conformity to ideological concepts of equality (Schwartz, 1991). The orthodox community values the housewife role and large families. The relationships of childcare to depression in orthodox women involves conflicting effects, on one hand is the widely-cited finding of Brown and Bifulco, (1990) that caring for several young children may interact with stress to produce a depressive illness. Much work has confirmed the role of severe life events and/or major difficulties in provoking depression (and other illnesses), but the vulnerability factors proposed by

Brown & Bifulco (1990) have not always been found to be important in other studies. Differing measures of orthodox family size in research often reflects different underlying effects. The type of measure most widely employed, number of young children, is used to investigate effects of active childcare, and of having children in the home, and/or conversely, effects of children growing up and leaving the nest. This measure has been shown to be associated with depression in every possible direction (positive, negative and not at all) for reasons outlined above (Lowenthal & Goldblatt, 1993).

Role of Women in Various Denominations

According to Gove (1972), traditional orthodox housewives should have the lowest rates of mental illness since they are not exposed to the stresses associated with the duties of a housewife in modern society. In contrast, modern orthodox Jewish housewives are expected to evidence the highest rates of mental illness because all of the stressors contributing to this role in contemporary western industrialized societies are applicable to their situation (Carter, 1994).

The sex role norms of the orthodox community reflect those of the more liberal elements of the

general culture (Caster, Parmlee, Keban, Lawton & Katz, 1995). Modern orthodox women have begun to restructure their lives in greater conformity to ideological concepts of equality (Schwartz, 1991). This community values the housewife role and large families. Women in this community who are employed, and some are mainly to supplement the income of their husbands who are engaged in high status but low paying occupations of rabbis, religious community workers, and Yeshiva teachers, would be expected to evidence higher rates (Schwartz, 1991). The conditions under which women may work are very conducive to the stresses described as related to employment: 1) employment should be secondary to the housewife role; 2) career involvement should be limited and role overload is increased because household chore s are viewed as the women's responsibility (Wilhelm & Parker, 1989).

The liberal denominations (including Reform and Conservative Judaism) roles are much more lenient than the Orthodox role. The role of a Conservative woman is to be a housewife and a working woman. Conservative women usually always belong to a synagogue and attends services religiously.

The role of the Reform Jewish woman is very casual. A Reformed Jewish woman sometimes belongs to a

synagogue, but not always. A Reformed Jewish woman may work, be a housewife, or do both. The importance of the role of the Reformed Jewish woman is to remember that they are Jewish and that their family is very important. Even though Reformed Jews are not know to be religious, they are still recognized as very important people to their religion, to their synagogue, and most importantly to their family. In Reform Judaism, family is the most important aspect of one's life (Veiel, 1993).

Summary

The issues of depression, depression and women, depression and ethnicity, depression and other sub-populations, and depression and Judaism and the role of women in various denominations is complex. The relationships of these variables has been generally unexplored to date. Depression is being incorrectly diagnosed, which may impact the actual incidence of major depression in both males and females. Rsearchers have looked at factors including: 1) Self criticism; 2) low self-esteem; 3) deprivation; 4) exaggeration of problems; 5) self demands and, 6) suicidal ideation (Beck, 1979) have all been explored. Each theme is defined through the use of a cognitive triad: 1) a negative interpretation, or the individual's own

experience that they see themselves as prone to failure and commonly misreads unconscious statement made about themselves as meaning they are bad; 2) a devaluation of the self; and 3) a negative view of the future, implying that the individual will display a pessimistic attitude built on their past experiences.

Women who have depression come from many different minority and ethnic backgrounds. These women may be African-American, Japanese and Israeli. Reasons why a woman may experience depression would be: exposure to violence, financial constraints, and family size.

Depression has been described in Jewish writings as a normal response that can be transformed into a positive and joyful state by confrontation with appropriate cognition of self-instructions (Gove, 1972). Throughout the research, depression has been shown to be affected by factors including low self-esteem, emphasis on relationship, loss of choice, financial constraints, family size and having responsibility for what one cannot control. Studies that have been done on depression and ethnic minority women experiencing depression, had some similarities in the results.

CHAPTER 3

Method

Participants

The subjects for this study were 80 adult Jewish women. The subjects attended various synagogues in the St. Louis County area, and were given the option to fill out the Beck Depression Inventory. The Jewish women who participated in the research were attending their monthly women's group at their own respective synagogue. Subjects represented the three denominations of Judaism: Orthodox, Conservative and Reform. The subjects ranged in age from 33-83, with a mean age of 60.87 and a modal age of 49. N= 75% of the sample survey were between the age of 30-44;n= 41.25% were between the ages of 45-59; n= 33.75% were between the ages of 60-74; and n= 17.5% were age 75 and above.

Table 1: Distribution of Age.

Age Range	Frequency	%
30-44	6	7.5%
45-59	33	41.25%
60-75	27	33.75%
75 & Older	14	17.5%
	80	100%

Table 2: Distribution of Education

Education	Frequency	Percent
Grade School	1	1.25%
High School	14	17.5%
Associates Degree	21	26.25%
College	38	47.5%
Bachelors	4	.05%
Masters	2	2.5%
	80	100%

Instrument

The instrument used in this study was the Beck Depression Inventory. The Beck Depression Inventory - Second Edition (BDI-II) is a 21-item self-report instrument for measuring severity of depression in adults and adolescents aged 13 years and older. This version of the Inventory (BDI-II) was developed for the assessment of symptoms corresponding to criteria for diagnosing depressive disorders listed in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders - Fourth Edition (DSMIV; 1994). The original BDI was based on the typical descriptive statements regarding symptoms that had been reported frequently by psychiatric patients with depression and only infrequently by non-depressed psychiatric patients (Beck, 1961). Clinical observations and patient descriptions were systematically consolidated into 21 items, consisting of representative symptoms and attitudes. Items were organized according to the severity of the content of alternative statements, and each item was rated on a 4-point scale ranging from 0 to 3 in terms of severity. The correlation between the BDI-IA and BDI-II was .93. The BDI-IA and BDI-II scores were 18.92 (SD=11.32) and

21.88 (SD=12.69). The mean BDI-II score was 2.96 points greater than that of BDI-IA (Beck, 1961).

The 21 depressive symptoms and attitudes chosen by Beck (1961) to be included in the BDI were based on verbal descriptions by patients and were not selected to reflect any particular theory of depression. The items were (1) Mood, (2) Pessimism, (3) Sense of Failure, (4) Self-Dissatisfaction, (5) Guilt, (6) Punishment, (7) Self-Dislike, (8) Self-Accusations (9) Suicidal Ideas, (10) Crying, (11) Irritability, (12) Social Withdrawal, (13) Indecisiveness, (14) Body Image Change, (15) Work Difficulty, (16) Insomnia, (17) Fatigability, (18) Loss of Appetite, (19) Weight Loss, (20) Somatic Preoccupation, and (21) Loss of Libido. For the purpose of developing a screening instrument for major depression, sensitivity of the test was considered to be more important than specificity. That is, the psychological examiner would want to adopt a relatively lower threshold for detecting depression in order to decrease the probability of any false negatives.

With this information, the Beck Depression Inventory will be used with the minimal range of 0-13, a mild range from 14-19, a moderate range from 20-28, and a severe range from 29-63. In evaluating BDI-II

scores, individuals should keep in mind that all self-report inventories are subject to response bias that is, some individual may endorse more symptoms than they actually have thus producing high scores; others might deny symptoms and receive low scores. In addition, one is cautioned that the BDI-II may simply reflect the degree of depression, not the diagnosis of depression (Beck, 1996).

An estimate of the stability of the BDI-II over time was based on the responses of a subsample of 26 Philadelphia outpatients who were administered the BDI-II at times of their first and second therapy sessions, approximately one week apart. The test-retest correlation of .93 was significant (PL.001). Several different types of analyses were conducted to estimate the convergent validity of the BDI-II. First, 191 Kentucky and New Jersey outpatients were administered the BDI-IA and BDI-II during their initial evaluations; the order of the presentations was counterbalanced, and at least one other instrument was given between administrations of the two versions of the BDI.

The correlation between the BDI-IA and BDI-II was 93 (PL.001). The mean BDI-IA and BDI-II score were 18-92 (SD=11.32) and 21.88 (SD=12.69), respectively. The

mean BDI-II score was 2.96 points greater than that of the BDI-IA.

An important finding is that the BDI-II was more positively correlated (0=.71) with the Hamilton Psychiatric Rating Scale for Depression (HRSD; Hamilton, 1960), scored with revised procedures recommended by Riskind, Beck, Brown & Steer (1987), than it was with the Hamilton Rating Scale for Anxiety (HARS; Hamilton, 1959) scored with revised procedures (Riskind, 1987), r=47.

Procedure

Data was collected in August of 1997. The women were given the BDI-II at their home synagogue during their regular monthly meeting in the basement of their temple. The women were given an ink pen as they entered the room and informed that they would be participating in a study for a graduate thesis. Participants were told that their participation was voluntary and that their identify would be confidential. They were also told that data would be handled anonymously so that on one could be identified by the report of the results.

The subjects were given a demographic page and asked to complete all of the information on it (See

Appendix B). The subjects were then asked to fill out the Beck Depression Inventory and instructed to pick out the one statement in each group that best describes the way they have been feeling during the past two weeks, including today. Also, the subjects were asked to complete all of the information.

The subjects completed the inventories in groups of ten to fifteen, with a total of seven groups of subjects to obtain adequate sampling. The subjects were all tested within the same week, and once the group of subjects was surveyed, the inventories were immediately put in an envelope by the researcher and sealed for confidentiality. The subjects were asked not to discuss the BDI-II with women of other synagogues.

Data Analysis

A summary was run of the women's BDI scores by their denomination to detect any differences between the denominations. A cross-tabulation of BDI scores by denomination was used to compare the three groups of women.

CHAPTER 4

Results

The total number of subjects for this study was 80. There were 30 conservatives who had minimal BDI score, one conservative who had a mild BDI score and one conservative who had a moderate BDI score. A total of 27 Reform women had a minimal BDI score, one had a mild BDI score, and no one in the Reform denomination had a moderate BDI score. There were 20 orthodox women who had a minimal BDI score, and no women in the orthodox denomination had a BDI score in the mild or moderate range.

Table 2: Denomination by BDI

	BDI			
	Minimal	Mild	Moderate	
Conservative	30	1	1	32
Reform	27	1		28
Orthodox	20			20
	77 (96.28%)	3 (2.5%)	1 (1.25%	

This table shows the count of each cross tabulation and the column percentage. The table shows that the majority of the women fall in the minimal section (96.28%), with very few in the moderate BDI section. Both the women who had a mild BDI score (1.25%) and those who had a moderate BDI score (1.25%). The results showed that not one woman in the orthodox denomination reported a BDI score in the mild or moderate range.

CHAPTER 5

Discussion

The present study looked at the levels of depression among women in the Orthodox, Conservative and Reform denominations. The hypothesis for the study proposed that there would be a significant difference in levels of depression among the three denominations. 96.28% of the women in this study had a BDI score in the minimal range, which was very restricted.

According to the results of this study, the majority of the women who participated in the study, reported that they were not experiencing symptoms of depression. Many of the women in the study either have not experienced symptoms of depression, or may not actually be reporting any symptoms of depression. Numerous women of the Jewish faith, do not report symptoms of depression, due to: A) unable to recognize symptoms; B) denial; C) unaccepted; D) uninformed and E) fear of a diagnosis(Beck, 1996).

In the Jewish faith, women see themselves as caregivers and are sometimes unwilling to acknowledge symptoms of depression. Also, many Jewish women who may be seen by an internist who may be referred to a mental health professional, due to experiencing physical symptoms of depression, would tend to ignore

the symptoms. Therefore, Jewish women in all three denominations may actually be experiencing some form of depression. Significance was unable to be determined due to the low number of all counts (Lowenthal, 1992).

According to Gove (1972), levels of depression may be lower in Orthodox Jews than in the general Jewish population. This coincides with the results that were found in this study, where Orthodox women had the majority of their scores fall in the minimal BDI range.

Limitations

The most important limitation in this study is that most of the individuals fell in the mild range for the BDI. If more individuals had scored in the moderate range, more questions would have been raised about depression in Judaism, and more information would have been necessary to assess what impact religion has on depression. There was very little available research on depression in Judaism, and very few studies in which depression in Judaism was done, thus limiting research subjects. It would have been helpful to know about the women's mental states prior to distributing the BDI. Knowing the women's prior mental state would have allowed this researcher to look at more factors that are related to women and depression and would affect their diagnosis.

This study is also limited because the test was distributed in a group setting and the women may not have felt as comfortable answering the questions. If the test had been given individually, the women may have answered the questions more honestly.

Recommendation

For future research, it would be interesting to be able to interview the women individually in order to gain more background information. It would also help to include other variables such as: socioeconomic status and family history of depression. Each of these variables would help produce a more thorough study into what effects a woman's level of depression. A future study might include participants from other various Jewish women's groups in order to generalize to the general population. Future research may also want to include Jewish women who are leader's in the community such as Rabbis, Presidents of Jewish organizations, political Jewish women, and leaders of charitable organizations. Future research might also want to include the general Jewish population, who do not belong or attend synagogues. Future studies should also include other religious women's groups such as: Christian, Buddhist, Muslim and several others in order

to compare and contrast various religions to one another. Future studies may also include both genders.

APPENDIX A

Demographic Data Questionnaire

RESEARCH PROJECT:

WOMEN EXPERIENCING DEPRESSION

IN THE THREE DIFFERENT DENOMINATIONS OF JUDAISM

Please take a few minutes to respond to this Master's Degree thesis project on participation is greatly appreciated. Your anonymity will be completely confidential and not reported. Please fill out the Beel< Depression Inventory and then put it in the sealed envelope given to you, and researcher will then collect envelopes.

Education:

Grade school ____ High School____ A.A. Degree_____

College degree____ Bachelor's Degree_____

Master's Degree ____

Age:____

Marital status: Single ____ Married_____

Widowed ___ Divorced _____

Denomination:

Reform ____ Conservative____

Orthodox _____

BDI-II

Date:

Name: _____ Marital Status: _____ Age: _____ Sex: _____

Occupation: _____ Education: _____

Instructions: This questionnaire consists of 21 groups of statements. Please read each group of statements carefully, and then pick out the **one statement** in each group that best describes the way you have been feeling during the **past two weeks, including today**. Circle the number beside the statement you have picked. If several statements in the group seem to apply equally well, circle the highest number for that group. Be sure that you do not choose more than one statement for any group, including Item 16 (Changes in Sleeping Pattern) or Item 18 (Changes in Appetite).

1. Sadness

0 I do not feel sad.
1 I feel sad much of the time.
2 I am sad all the time.
3 I am so sad or unhappy that I can't stand it.

2. Pessimism

0 I am not discouraged about my future.
1 I feel more discouraged about my future than I used to be.
2 I do not expect things to work out for me.
3 I feel my future is hopeless and will only get worse.

3. Past Failure

0 I do not feel like a failure.
1 I have failed more than I should have.
2 As I look back, I see a lot of failures.
3 I feel I am a total failure as a person.

4. Loss of Pleasure

0 I get as much pleasure as I ever did from the things I enjoy.
1 I don't enjoy things as much as I used to.
2 I get very little pleasure from the things I used to enjoy.
3 I can't get any pleasure from the things I used to enjoy.

5. Guilty Feelings

0 I don't feel particularly guilty.
1 I feel guilty over many things I have done or should have done.
2 I feel quite guilty most of the time.
3 I feel guilty all of the time.

6. Punishment Feelings

0 I don't feel I am being punished.
1 I feel I may be punished.
2 I expect to be punished.
3 I feel I am being punished.

7. Self-Dislike

0 I feel the same about myself as ever.
1 I have lost confidence in myself.
2 I am disappointed in myself.
3 I dislike myself.

8. Self-Criticalness

0 I don't criticize or blame myself more than usual.
1 I am more critical of myself than I used to be.
2 I criticize myself for all of my faults.
3 I blame myself for everything bad that happens.

9. Suicidal Thoughts or Wishes

0 I don't have any thoughts of killing myself.
1 I have thoughts of killing myself, but I would not carry them out.
2 I would like to kill myself.
3 I would kill myself if I had the chance.

10. Crying

0 I don't cry anymore than I used to.
1 I cry more than I used to.
2 I cry over every little thing.
3 I feel like crying, but I can't.

_____ Subtotal Page 1

Continued on Back

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11. Agitation

0 I am no more restless or wound up than usual.

1 I feel more restless or wound up than usual.

2 I am so restless or agitated that it's hard to stay still.

3 I am so restless or agitated that I have to keep moving or doing something.

12. Loss of Interest

0 I have not lost interest in other people or activities.

1 I am less interested in other people or things than before.

2 I have lost most of my interest in other people or things.

3 It's hard to get interested in anything.

13. Indecisiveness

0 I make decisions about as well as ever.

1 I find it more difficult to make decisions than usual.

2 I have much greater difficulty in making decisions than I used to.

3 I have trouble making any decisions.

14. Worthlessness

0 I do not feel I am worthless.

1 I don't consider myself as worthwhile and useful as I used to.

2 I feel more worthless as compared to other people.

3 I feel utterly worthless.

15. Loss of Energy

0 I have as much energy as ever.

1 I have less energy than I used to have.

2 I don't have enough energy to do very much.

3 I don't have enough energy to do anything.

16. Changes in Sleeping Pattern

0 I have not experienced any change in my sleeping pattern.

1a I sleep somewhat more than usual.

1b I sleep somewhat less than usual.

2a I sleep a lot more than usual.

2b I sleep a lot less than usual.

3a I sleep most of the day.

3b I wake up 1–2 hours early and can't get back to sleep.

17. Irritability

0 I am no more irritable than usual.

1 I am more irritable than usual.

2 I am much more irritable than usual.

3 I am irritable all the time.

18. Changes in Appetite

0 I have not experienced any change in my appetite.

1a My appetite is somewhat less than usual.

1b My appetite is somewhat greater than usual.

2a My appetite is much less than before.

2b My appetite is much greater than usual.

3a I have no appetite at all.

3b I crave food all the time.

19. Concentration Difficulty

0 I can concentrate as well as ever.

1 I can't concentrate as well as usual.

2 It's hard to keep my mind on anything for very long.

3 I find I can't concentrate on anything.

20. Tiredness or Fatigue

0 I am no more tired or fatigued than usual.

1 I get more tired or fatigued more easily than usual.

2 I am too tired or fatigued to do a lot of the things I used to do.

3 I am too tired or fatigued to do most of the things I used to do.

21. Loss of Interest in Sex

0 I have not noticed any recent change in my interest in sex.

1 I am less interested in sex than I used to be.

2 I am much less interested in sex now.

3 I have lost interest in sex completely.

6 7 8 9 10 11 12 A B C D E

_____ Subtotal Page 2

_____ Subtotal Page 1

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