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The self-stigma of depression for women

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Abstract

Background: Self-stigmatizing women who avoid seeking treatment for depression could believe that they have pragmatic personal reasons for their decision. As a preliminary step towards testing this hypothesis, the aim of this study was to assess diverse, low-income working women for shared self-stigmatizing beliefs about depression.

Methods: Depression and depression self-stigma were assessed in a targeted sample of African American, Caucasian and Latina women who qualify for public health services and have access to health care services.

Results: Depression and self-stigmatizing beliefs about depression were positively correlated (*r* = .30–.64). Over one third of the women in the study (37.5%) said they would do what they could to keep their depression secret. Over half (55%) indicated that the person they normally would disclose depression to is their best friend. A majority (80%) of the women in the study said they would choose not to disclose personal depression to a health care professional. Pairwise *t* tests for group differences showed that Caucasian women, women recently seen by a health care professional and women with more years of education had higher self-stigma scores.

Conclusion: Self-stigmatizing women who feel depressed could knowingly decide to keep their depression secret with the hope of avoiding loss.

Keywords
stigma, self-stigma, women, depression

Introduction

Depressed women who choose not to seek treatment could believe that their decision can reduce their risk of being socially stigmatized by others. However, this belief can be self-stigmatizing and it exposes women to the serious health and psychosocial burdens of untreated depression. This theoretical understanding of the self-stigma of depression for women draws on the concepts of social distancing, discredited social identity, identity reclassification (Goffman, 1963), self-stigma (Corrigan, 2004) and derived female social identity (Gilligan, 1982). Goffman's central thesis, partially replicated by Rusch, Bodenhausen, Olschewski, and Corrigan (2010), states that the ability of social groups to stigmatize individuals largely depends on the extent to which the group is able to socialize individuals to respond to the group with feelings of shame and avoidant behaviours.

Social distancing, or shunning, is a normative value held by stigmatizing social groups. In addition to social exclusion, the behaviour also makes it possible for social groups to identify stigma targets as individuals who could be 'bad, dangerous, or weak' (Goffman, 1963, p. 3). As explained by Goffman (1963, p. 141), it is this 'social distance game' that allows social groups to discredit the target's social identity and restrict his or her access to beneficial social group resources (e.g. belonging, assistance) simply as a matter of group social preferences. Individuals who find themselves the target in a game of social distancing could try to seek social group resources outside of the stigmatizing group. However, to the group this solution can appear to be avoidant behaviour, and avoidant behaviour can facilitate the game of social distancing. However, to achieve this level of effectiveness in the game of social distancing, everyone in the group must be 'well-trained' (Goffman, 1963, p. 134). Everyone must know how the game of social distance is played, including the rule against challenging the social authority of the group to identify targets. Some experts theorize that it is this training that can harden later

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self-stigmatizing beliefs. Consequently, Corrigan (2004) and others have largely defined self-stigma as the stigmatizing beliefs of others that individuals learned to internalize (self-accept) and personalize (self-apply).

Background

Women who feel depressed could believe that if they avoid diagnosis and treatment they may be able to avoid becoming a target of social stigma and social distancing (Vidler, 2005; Vogel, Wade, & Hackler, 2007). For example, a depressed unemployed woman could believe that diagnosis and treatment would allow others to identify her and then stigmatize her in ways that could make it more difficult for her to find employment (Quinn & Chaudoir, 2009). National anti-stigma campaigns, aimed at informing the public of the lifelong benefits of timely diagnosis and treatment for depression, have been successful. These campaigns help to educate the public of the risks of impairment and disability if treatment for depression is delayed. What is needed now are population-based education campaigns that can help individuals to rethink learned self-stigmatizing beliefs and behaviors that do not support timely help-seeking (Alonso et al., 2008; Dumesnil & Verger, 2009).

Of the many discouraging personal concerns shown to interfere with timely help-seeking, one of the most complex is the possibility of feeling ill enough to seek professional health care only to encounter a clinician who appears to be pessimistic or condescending or is unhelpful (Wang et al., 2005). Second to this is the similarly disconcerting concern that family, friends and co-workers might associate clinical depression with disturbing media images of bizarre behaviour (Vogel, Gentile, & Kaplan, 2008). Researchers also have shown that some people could be unwilling to seek help for depression because they are concerned that their personal and social problems might be diagnosed as a biological condition (Rusch, Kanter, & Brondino, 2009). Similar to the 1960s, when large numbers of African American males were diagnosed with paranoid schizophrenia and the diagnosis itself came to represent a sign of danger (Mentzl, 2009), today women with children could be concerned that should they be diagnosed and treated for depression, authorities might identify them a woman who might be dangerous to others.

Relationship concerns in women have been linked with care-taking as a social expectation for females that also defines the nature of womanhood and the female social identity (Gilligan, 1982). For some women, being diagnosed and treated for depression or developing depression-related impairments of their psychosocial functioning is personally and socially unacceptable and a threat to social identity. Feminist research suggest that an important source of these learned beliefs are the ubiquitous cultural messages that exalt male social privileges and submerge female social identity in female social roles (Ackerly & True, 2010). Even women who are exposed to cultural messages that are empowering, such as African American women who learn to challenge female social identity messages that disadvantage them, could nevertheless have concerns about the effect their illness might have on their relationships (Collins, 2000; Taylor, 1998). This concern is exemplified by the findings of a small study of serious illness and spouse abandonment.

Researchers (Glantz et al., 2009) interested in testing their clinical observations of gender differences in spouse abandonment followed a cohort of married couples after one spouse was diagnosed with either a malignant/non-malignant primary brain tumour or multiple sclerosis. Their longitudinal study found that ill spouses who were divorced within one year of being diagnosed had worse treatment outcomes, and 53 of the 60 divorced ill spouses were women. These findings led the researchers to conclude that healthy wives were more willing to be caretakers for ill husbands but they were unable to explain why ill wives were more likely to be divorced by healthy husbands. Although it would seem reasonable to speculate that relationship quality may have impacted the risk of spouse abandonment, these findings help to illustrate the concern that illness could result in undesirable relationship changes.

In comparison to gender, the available data provide inconclusive evidence of ethnicity (Rue & Xie, 2009) as a direct influence on depression self-stigma in women. Regardless of ethnicity, being female is a risk factor for depressive illness (Kendler, Kuhn, & Prescott, 2004). Major secondary predictors of women's mental health include role overload, lack of job satisfaction, and inequality at work and in the home (Glynn, Maclean, Forte, & Cohen, 2009). The influence of ethnicity on women's mental health and self-stigmatizing beliefs appears primarily to be socially mediated by racial prejudice (Nicolaidis et al., 2010), income (Falconnier, 2010), social barriers to treatment (Ward, Clark, & Heidrich, 2009), health care disparities (Das, Olfson, McCurtis, & Weisman, 2006), health care costs (Ojeda & McGuire, 2006), immigration status (Nadeem et al., 2007), language barriers (Hodgkin, Volpe-Vartanian & Alegria, 2007) and symptom recognition (Epstein et al., 2010).

However the data provide convincing evidence of two stable ethnic variations the stigma of depression for women. African American women who believe dysphoria and disengagement are appropriate psychological and social responses to living in distressing social circumstances are less accepting of treatment for depression and more accepting of interventions aimed at building their personal strength and composure (Nadeem, Lange, & Miranda, 2008; Schreiber, Stern, & Wilson, 2000). Similarly, Latinas consistently have been shown to be more willing to accept talk therapy as treatment for depression and less willing to accept antidepressant medication if they believe taking medication is a sign of personal weakness and disability (Interian et al., 2010). Beyond these two variations the evidence of ethnic differences in the self-stigma of depression for women is inconclusive. Elevated depression self-stigma scores have been reported for Caucasian women (Givens, Katz, Bellamy, & Holms, 2007), African American women (Menke & Flynn, 2009) and Latinas (Vega, Rodriquez, & Ang, 2010).

In summary, self-stigmatizing women who feel depressed but decide not to seek timely diagnosis and treatment could believe they have practical reasons for their decision. Thus, as the next step towards being able to test this hypothesis, the aim of the present cross-sectional survey study is to identify the major self-stigmatizing belief shared by ethnically diverse, low-income working women.

Methods

Participants

Targeted sampling methods for reaching hidden population groups (Watters & Biernacki, 1989) were used to recruit African American (black) women, Caucasian non-Latina (white) women and Hispanic-Latin (Latina) women. The study participant inclusion criteria were current age of 18–50 years, current employment or employed within the last six months, access to and/or recent utilization of public health department services or health care services, state residency and proficiency in English. Volunteers were not invited to participate in the study if they were less than six months post-partum or were experiencing severe distress, depression, poor health, serious illnesses or suicidal thoughts.

Recruitment occurred at five public health department programme sites in three health department regions across Wisconsin (northeastern, northern and western). Sites were selected based on the available pool of women meeting participant inclusion criteria. The selected sites offered public health department programmes that included programmes for women and children (e.g. Women Infants and Children Program (WIC)). Three study sites could be described as suburban and two were major urban sites serving either African American or Latin families. The study used a wide assortment of printed recruitment materials (ads, flyers, announcements) designed for use at each site. One suburban site included our study flyer with various public health department materials routinely mailed to families. All recruitment materials informed potential volunteers of the study inclusion and exclusion criteria and invited those who were interested to call the study office for more information. A paper checklist of participant inclusion and exclusion criteria was used to screen all volunteers and, if needed, to obtain contact information in order to schedule participation for a later date.

Ninety-six (96) women were screened. Of these, 13 were lost to follow-up after three failed attempts to reach them by phone. Thirty (30) were ineligible either because they were too young or old ($n = 9$), not employed currently or within the last six months ($n = 9$), did not have access to public health services or had not utilized health care services within the previous six months ($n = 4$), were less than six months post-partum ($n = 6$), or were currently experiencing severe distress, depression or serious illness ($n = 2$). Four screened volunteers who agreed to participate in the study were no-shows. The final total sample of 49 women who completed the study included 17 African Americans, 19 Caucasians and 13 Latinas.

Procedures

All study procedures were reviewed by the appropriate university institutional review board for the protection of human subjects, the ethical conduct of research and health information privacy. All data collection was conducted using individual face-to-face interactions with study participants. Study locations were conference rooms made available by the participating health department or programme. Informed consent procedures with volunteers were conducted individually by qualified members of the research team. After consenting to participation, study volunteers completed paper versions of the study questionnaire then joined each other at a conference table where they participated in one audio-taped focus group interview. Focus group data are not presented in this paper. Each participant received one $50 merchant gift card.

Measures

Depression symptoms were assessed with the Beck Depression Inventory-II (BDI-II; Beck, Steer, & Brown, 1996; Steer, Brown, Beck, & Sanderson, 2001). This 21-item summed score measure has a possible score range of 0–63. The developers defined four sets of score ranges to indicate minimal (0–13), mild (14–19), moderate (20–28) and severe (29–63) symptom severity. The study used scores of 19 and below to define low depression symptom severity (minimal and mild scores) and scores of 20 and above to define high symptom severity (moderate and severe scores). The BDI-II contains two subscale scores representing two distinct symptom profiles: cognitive symptoms (e.g. pessimism) and somatic symptoms (e.g. loss of energy). There is substantial evidence supporting the reliability and validity of the BDI-II in diverse community and clinical, rural and urban, male and female population groups. Cronbach's α in the total sample was .92.

Depression self-stigma was assessed with the Depression Self-Stigma Scale (DSSS; Kanter, Rusch, & Brondino, 2008; Rusch, Kanter, Manos, & Weeks, 2008). This is a 32-item summed score measure with a seven-point item response scale (1 = disagree, 7 = completely agree). The DSSS assesses five stigma constructs: (1) *General Self-Stigma*, defined as self-blame (nine items, e.g. 'People have told me that becoming depressed is what I deserve'); (2) *Secrecy*, defined as efforts to hide personal depression from others (nine items, e.g. 'When I meet people for the first time, I make a special effort to keep the fact that I am depressed to myself'); (3) *Public Stigma*, defined as negative beliefs about people who are depressed (four items, e.g. 'Other people with depression are morally weak'); (4) *Treatment Stigma*, defined as negative beliefs about receiving treatment for depression (four items, e.g. 'Receiving treatment for depression carries a social stigma'); and (5) *Stigmatizing Experiences*, defined as objective experiences of being stigmatized by others (six items, e.g. 'I have stopped socializing with some people because of their reactions to my being depressed'). The developer reported evidence supporting the reliability and validity of the DSSS in community and student populations. The DSSS was developed for use with persons with self-reported current sadness or blues. Participants in the current study responded to all DSSS items based on their most recent or last experience of sadness or depression. The developer reported DSSS Cronbach's α of .78 to .93.

Background items were age (today), general health today (poor, fair, good, very good, excellent), professional health care services received in the last six months (yes, no, why), employment status today (none, part-time, full-time), age, ethnicity, marital status and highest year of school completed. Participants also responded to a single disclosure question: 'Who do you normally communicate sad/depressed feelings to?' (spouse/partner, mother, father, female relatives, male relatives, best friend, health professionals, co-workers, clergy, pet, my online community, prayer).

Results

Participant characteristics

Table 1 presents background information and mean scores for the total sample and the low (minimal to mild) and high (moderate to severe) depression subgroups. The mean age of the total sample was 28 years old (SD = 7.37). Over half had completed or attended high school (*n* = 27). Most were currently employed either full-time (*n* = 15) or part-time (*n* = 17) and a similar number rated their current health either as fair (*n* = 19) or good (*n* = 16). Slightly less than 60% (*n* = 29) said they had been seen by a licensed health care professional within the previous six months. Participants with minimal to mild symptoms of depression (*n* = 25, BDI-II *M* = 8.23, SD = 4.91) and those with moderate to severe symptoms of depression (*n* = 24, BDI-II *M* = 28.30, SD = 7.01) were nearly equal in number. The two depression subgroups did not differ in age, ethnicity, marital status, education, employment or recent health care visit. More than half (55%) of the total sample identified their best friend as the person they normally would communicate their feelings of sadness or depression to. Slightly fewer said they would normally express these feelings to their mother (47%) or spouse/partner (43%). A small number said they normally would communicate sadness or depression to a health care professional (20%).

Table 1. Participant characteristics and means (SD) for total sample, low and high depression subgroups.

	Total Sample *M* (SD)	BDI II 0–19 *M* (SD)	BDI II 20–63 *M* (SD)
Age			
18–25	18.85 (12.16)	9.65 (3.95)	29.90 (8.79)
26–50	16.81 (11.86)	6.92 (5.48)	27.51 (5.79)
	***n* (%)**	***n* (%)**	***n* (%)**
Race			
White	19 (38.8)	11 (44.0)	8 (33.3)
Black	18 (36.7)	7 (28.0)	11 (45.8)
Hispanic/Other	12 (24.5)	7 (28.0)	5 (20.8)
Marital Status			
Single	17 (34.7)	9 (36.0)	8 (33.3)
Separated/Widowed/Divorced	12 (24.4)	8 (32.0)	4 (16.7)
Married/with partner	18 (36.7)	8 (32.0)	10 (41.7)
Education			
High school or less	27 (55.1)	12 (48.0)	15 (68.2)
More than high school	20 (40.8)	13 (52.0)	7 (31.8)
Health care in last six months			
Yes	29 (59.2)	16 (64.0)	13 (54.2)
	***M* (SD)**	***M* (SD)**	***M* (SD)**
BDI- II score	18.06 (11.77)	8.23 (4.91)	28.30 (7.01)

Table 2. DSSS scores for total sample, low and high depression subgroups.

Subscale	Range	Total sample (N = 49) M (SD)	BDI-II 0–19 (n = 25) M (SD)	BDI-II 20–63 (n = 24) M (SD)
General Self-Stigma	9–54	26.90 (13.91)	18.84 (10.27)	35.31 (12.22)*
Secrecy	8–55	29.04 (13.68)	22.86 (12.12)	35.48 (12.36)*
Public Stigma	4–28	8.31 (5.05)	6.57 (3.43)	10.13 (5.85)*
Treatment Stigma	4–23	13.45 (5.10)	12.57 (4.63)	14.37 (5.49)
Stigmatizing Experiences	6–40	19.04 (10.32)	14.12 (7.91)	24.17 (10.17)*

*$p < .05$

Descriptive analyses

Performance analysis of all DSSS items showed that item 7 in the *Secrecy* subscale ('There is no reason for me to hide the fact that I am depressed') did not perform as expected. Removing this item showed no impact on the internal consistency of the *Secrecy* subscale. The modified eight-item *Secrecy* subscale was used in all analyses and had a Cronbach's α of .91. Cronbach's α for the *General Self-Stigma*, *Public Stigma* and *Stigmatizing Experiences* were .93, .74 and .90, respectively. Cronbach's α for the *Treatment Stigma* subscale was .61. Variance in participant interpretation of treatment items appeared to lower the internal consistency of the *Treatment Stigma* subscale. We speculated that this was due, in part, to our decision to consider BDI-II scores rather than self-reports of depression or treatment.

Response frequencies for each DSSS item were calculated for the total sample using the two highest response options (6 = mostly agree, 7 = completely agree). The single item most frequently/highly endorsed (37.5%) was *Secrecy* item 12 ('I am very careful about who I tell about having depression'). The second (29.2%) and third (28.6%) items most frequently/highly endorsed were *Secrecy* item 8 ('In many areas of my life no one knows I am depressed') and *Secrecy* item 5 ('When I meet people for the first time, I make a special effort to keep the fact that I am depressed to myself'). The item least frequently/highly endorsed (2.0%) was *Public Stigma* item 23 ('Other people with depression are not worth the time and resources'). The second (4.1%) and third (4.1%) least frequently/highly endorsed items were *Public Stigma* item 22 ('Everyone can plainly see that other depressed people are inferior') and *General Self-Stigma* item 18 ('People I cared about stopped calling after learning I was depressed'). Few participants said others had socially distanced them by no longer calling.

Table 2 presents the DSSS total sample and high and low depression subgroup scores. Our analyses included tests for bivariate relationships between these scores using the Pearson product moment correlation coefficient. These analyses showed that all self-stigma scores were positively correlated with depression. In order of decreasing magnitude, depression was correlated with *General Self-Stigma* (r = .64, p < .001), *Secrecy* (r = 61, p < .001), *Stigmatizing Experiences* (r = .59, p < .001), *Public Stigma* (r = .32, p < .05) and *Treatment Stigma* (r = .30, p < .05).

Between-group differences

Pairwise t test results for age, ethnicity, marital status, education and recent health care visit are presented in Table 3. Ethnic group differences were found in two stigma subscales. White *Treatment Stigma* scores were higher than Latina *Treatment Stigma* scores and white *General Self-Stigma* scores were higher than black *General Self-Stigma* scores. Education group differences also were found. Participants with high school or more years of education had higher *Treatment Stigma* scores. Participants who had received any professional health care services within the previous six months had higher *General Self-Stigma* scores. The purpose of the recent health care visit was assessed with a single write-in question. All of the participants who said that they had received health care (n = 29) wrote in one or more conditions or problems as the purpose of their visit. Nine (n = 9) identified more than one condition but less than half (n = 11) said the purpose of their health care visit was depression or mental illness. Other identified conditions were categorized, in order of decreasing frequency, either as injury, headache, allergy, annual gynaecological exam, skin conditions, ear infection or thyroid disorder.

Discussion

Self-stigmatizing beliefs about depression were assessed in a targeted sample of diverse, low-income, working women who have access to public health services and/or health care. Secrecy was the single most shared self-stigmatizing belief of the African American, Caucasian, and Latina participants in the study. Our findings showed that the women believed they would do what they could to keep their depression secret. Most (80%) said they normally would not communicate feelings of sadness or depression to a health care professional. Caucasian women were generally more self-stigmatizing than African American women and had more self-stigmatizing treatment beliefs than Latina.

Table 3. Pairwise *t* tests of between-group differences for background, DSSS subscale scores and BDI-II scores.

	n	General Self Stigma	Secrecy	Public Stigma	Treatment Stigma	Stigmatizing Experiences	BDI- II
Age							
18–25	22	28.03 (14.14)	30.68 (11.47)	9.70 (6.30)	13.92 (4.72)	20.64 (10.13)	18.85 (12.16)
26–50	26	25.78 (14.42)	27.44 (15.84)	7.00 (3.48)	13.00 (5.60)	18.32 (10.69)	16.81 (11.86)
Race							
White	19	31.64 (14.71)*	31.32 (17.59)	6.53 (3.20)	15.11 (5.29)*	20.95 (11.66)	17.68 (15.10)
Black	18	23.48 (12.11)*	30.61 (9.50)	9.73 (4.81)	13.99 (4.38)	18.78 (9.45)	19.99 (7.29)
Latina	12	24.56 (14.15)	23.10 (10.94)	9.00 (7.03)	10.03 (4.48)*	16.42 (9.51)	15.76 (11.70)
Marital status							
Single	17	23.04 (15.04)	30.26 (12.35)	7.95 (4.69)	12.83 (5.74)	17.29 (9.96)	16.93 (11.82)
Widowed/Divorced	12	25.00 (15.49)	27.93 (14.60)	8.17 (7.26)	14.00 (5.58)	20.67 (12.94)	14.58 (10.88)
Married/Partner	20	31.35 (11.11)	28.67 (14.79)	8.71 (3.89)	13.65 (4.40)	19.55 (9.17)	21.11 (12.05)
Education							
High school or less	27	27.50 (13.29)	29.59 (13.09)	8.75 (4.60)	12.08 (5.40)*	18.85 (9.10)	20.04 (11.63)
More than high school	20	25.95 (15.61)	28.11 (15.26)	7.6 (5.83)	15.25 (4.33)*	20.15 (12.12)	14.70 (11.88)
Health care in last six months							
No	17	22.06 (13.55)*	29.79 (14.17)	9.71 (6.66)	12.43 (5.46)	19.35 (11.10)	16.05 (9.22)
Yes	29	29.16 (14.11)*	28.15 (14.12)	7.52 (3.96)	13.83 (5.01)	19.48 (10.33)	18.28 (13.24)

*$p < .05$

Although we expected to find a statistical relationship between depression and self-stigmatizing beliefs about depression the magnitude of the association in our data suggests that there could also be clinical implications. Our measures of depression and depression self-stigma included the assessment of a wide range of cognitive experiences. The two measures also could be similar in terms of their sensitivity to depression related changes in thought content and thought processes. Women have been found to be more likely to develop clinically significant cognitive ruminations as the severity of their depression worsens (Corrigan & Calabrese, 2005; Nolen-Hoeksema, 1991). To explore the possibility of association of depression rumination and depression self-stigma in women we conducted post hoc analyses of all self-stigma subscales and the cognitive and somatic subscales of the BDI-II. Our results showed that no depression symptom set, cognitive or somatic, was differentially related with any of the self-stigma scores. Consequently, we considered the possibility of a basic clinical observation. That increasing symptom severity might fuel ruminating worries about unspoken depression becoming more apparent and recognizable to others (Goffman, 1963). The design of the current study did not include the clinical assessment data necessary to conduct meaningful tests of the potential rumination pathways linking depression and depression self-stigma.

African American women in the study were generally less self-stigmatizing and Latinas were specifically less self-stigmatizing about being treated for depression. These findings could partially replicate those of Nadeem and colleagues (2008). As suggested by Feminist researchers, African American women in our study might be generally less self-stigmatizing if they are less willing to blame and shame themselves if their social circumstances or distressing. Similarly, our finding that Latinas were less self-stigmatizing about treatment could partially replicate the findings of Interian and colleagues (2010). If the Latinas in our study believed that taking medication to treat depression is highly stigmatizing, we would expect this subgroup to have lower treatment self-stigma scores because antidepressant medication was not the major focus of the treatment self-stigma items.

With these two ethnic variations in mind, our findings suggest that Caucasian women in the study were more self-stigmatizing than African American women and Latinas. According to Goffman (1963), this finding could suggest that the Caucasian women in this study could have been exposed to more negative social beliefs about depression then African Americans and Latinas, and those were more likely to have learn and perhaps more willing to self-apply stigmatizing beliefs (Rusch et. al, 2010). Or African American women and Latinas in the study might have been less exposed to the social beliefs that promote the personal shame and blame of depression.

Best friend was the most common choice of confidant reported. This finding provides further evidence supporting the hypothesis that women may be more likely to then men to make social support choices that are psychologically protective for them (Harris, Brown, & Robinson, 1999; Wang, Iannotti, & Nansel, 2009). However research shows that in all female social groups, members can be more likely to use their social relationships to socially distance female stigma targets and to use rumors to cause others to also social distance the target. For example workplace studies of status-driven all female social groups have found that women can be more likely to use aggressive relationship tactics and bullying (Vessey, Demarco, Gaffney, & Budin, 2009). Similar studies of authoritarian female work environments (Simons & Mawn, 2010) found that women's heightened concerns over the possibility of becoming a target of aggressive female relationship tactics could result in some women choosing to limit their interactions with co-workers and limit the amount of time they spend in their work environment (O'Donnell, MacIntose, & Wuest, 2010). As previously noted, both responses would likely be considered by others to be avoidant behaviour that, according to Goffman (1963), could increase the risk of being targeted (Schön, Denhov, & Topor, 2009).

We did not expect to find that relatively few women in the study would normally disclose their depression to a health care professional. In addition, those women in the study who had been recently seen by health care professional were more self-stigmatizing than women not recently seen. Add to these findings, few women rated their health currently as very good or excellent. Taken together these health findings provide further evidence suggesting the possibility of interactions between health status and stigmatizing beliefs (Rusch et al., 2008). The inclusion criteria for our study did not require current depression or current treatment. However, our depression scores for high-depression women were consistent with moderate to severe clinical depression and about a third of our sample said that they had recently been seen by a health care professional for depression or a mental health condition. These observations suggest that women who were less healthy may have been more self-stigmatizing. Alternatively, some women could have encountered clinicians who might have been unhelpful to them. Without objective health data we could not conduct meaningful tests for interactions between these factors. Therefore we concluded that low-income working women with fewer health concerns might be less self-stigmatizing then women with more health concerns.

More than a third of the women in the study said that they would do what they could to keep others from knowing that they feel depressed. Our study did not directly assess women's motivation for secrecy. However, secrecy, though stressful, is a fundamental method of living with a stigmatizing social identity that is concealable (Corrigan, 2004; Goffman, 1963; Quinn & Chaudoir, 2009). Some women in the study might have considered their secrecy about their feelings of depression as a decision that could be necessary, effective, and practical. Alternatively, some could have knowingly calculated that for them the social risks of stigma might be worse than the health risks of untreated depression. Experts have found that secrecy at any cost can be consistent with learned automatic shame (Lesesne & Kennedy, 2005; Rusch et al., 2010) and avoidance (Goffman, 1963; O'Donnell et al., 2010; Quinn & Chaudoir, 2009). Alternatively, instead of being a calulated decision, secrecy might also be better explained as an automatic reaction to social threat.

Our findings show that many women in the study were willing to keep their depression secret but the study did not determine their motivation. Secrecy was positively correlated with self-stigmatizing beliefs, stigmatizing treatment beliefs, and stigmatizing experiences but further research is needed to test for interaction effects. Nevertheless these data offer evidence of the potential significance of personal life context to the stigma of depression in low-come working women. The findings support the premise that self-stigmatizing women who are depressed could believe that for them, secrecy is a solution, not a problem. As stated by one focus group participant '…you make up lies, you learn to lie, you learn to make up all these excuses…'.

Limitations

Generalization of the study findings to other low-income, working women is limited by our targeted sampling methods and study aims. The study did not directly assess gender identity, ethnic identity, social support, stress, satisfaction with health care visit, depression treatment history, coping style, or personal history of psychological, physical, or social trauma. Nor did the study assess women for perceived or actual hazards of disclosing depression to health care professionals, family or co-workers. Also, we intentionally refrained from asking women if they were parenting minor children. These potentially confounding factors could have influenced our findings.

Conclusions

Despite these limitations our findings nevertheless provide direction for our ongoing research aimed at improving our understanding of the self-stigma of depression for women. Self-stigmatizing beliefs about depression are thought to represent the self-application of learned social values and norms associated with social identity (Corrigan, 2004; Goffman, 1963; Rusch et al., 2010). Our findings suggest that self-stigma reduction interventions for low-income working women that can decrease positive beliefs in personal secrecy are needed.

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