National Women's Health Report
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Depression & Women

To Sondra Fine,* 48, depression feels like this: "I have been immobilized, unable to formulate thought or action. Can't get out of bed most of the time. It feels terrible—hopeless, joyless, exhausted, lost."

To Terry Wise, 39, depression feels like this: "A world of apathy, a world where nothing is enjoyable, where food doesn't taste the same and the colors don't look the same."

To Esther Nitzberg, in her 60s, depression feels like this: "As if there's a weight, a shroud, a dark cloud that follows you around."

These are just three voices of the more than 12 million U.S. women who suffer from depression,[1] a disorder that strikes women nearly twice as often as men.

Depression is a wily disease, sometimes camouflaging itself as anger or fatigue, sometimes sending you to sleep all the time or keeping you awake all night. It can come on suddenly or sneak up on you gradually. It also is a dangerous disease. In 2000, 29,350 people in the United States killed themselves. And while four times as many men as women die by suicide, women attempt suicide two to three times as often as men.[2] Plus, depression is strongly linked with other illnesses, such as heart disease and osteoporosis—diseases that women are at high risk for developing.

The good news: depression is one of the most treatable diseases doctors see. There's just one problem: people suffering from depression often don't receive adequate treatment, according to a major study published in the June 18, 2003, issue of the *Journal of the American Medical Association* (*JAMA*).

Researchers in the study, only the second nationally representative sample of depression ever conducted in this country, held face-to-face interviews with more than 9,000 randomly selected people to determine whether they had any history of depression, the quality of the treatment they received and any other mental or physical conditions they experienced.[3]

"The real surprise," says the study's lead author, Ronald C. Kessler, PhD, professor of health care policy at Harvard Medical School, "was that well over half the people surveyed with depression had severe depression, and only 10 percent were considered mild to moderate." Yet just one in five received adequate treatment. These are the people who can't get out of bed, who seriously think about killing themselves, who can't function—people like the women described at the beginning of this article. "We're finding that less than half of them are even getting minimal treatment," Dr. Kessler says.

**Not her real name.*

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In the *JAMA* study, treatment was considered adequate if it consisted of at least eight, half-hour sessions of counseling with a mental health professional, or treatment with antidepressant drugs for at least 30 days combined with four visits to any type of physician, per depressive episode. These mirror federal guidelines for the treatment of depression by family practitioners, says Dr. Kessler.

Treatment Barriers

So why don't people who are depressed receive adequate care? One reason is they may not look for it. "There's still a very large stigma attached to mental illnesses like depression," says Steven D. Hollon, PhD, professor of psychology at Vanderbilt University in Nashville.

It's also not easy to find help, says Dr. Kessler. "There's a lot more confusion in mental health treatment than in the physical health arena," he notes. For instance, if you break your arm, you know exactly where to go for treatment; but if you feel depressed, you might choose anyone from a family practitioner to a social worker to your rabbi or minister.

It took visits to every therapist and psychiatrist in the small Oregon town where she lives before Ms. Nitzberg finally found what she calls "a straight-talking psychiatrist who is willing to give me low doses of medication in the combinations that work best for me."

If you're having trouble finding a doctor you like, check with the nearest academic medical center. Physicians there are usually up to date on the latest drugs and therapies, often conducting clinical trials on new treatments. If finding the right medication is a problem, consider seeing a psychopharmacologist, a psychiatrist who has received additional training in the medications used to treat mental disorders.

But, finding treatment is only half the battle; the *JAMA* study also found that the treatment itself might be inadequate. For instance, many people interviewed in the study who had depression received just 5 milligrams (mg) of an antidepressant that should be prescribed at 20 mg. That's consistent with other studies showing that primary care physicians and nurses, who treat 70 percent of those with depression, tend to under prescribe medication for depression, says Dr. Hollon. They also tend to keep patients on the wrong dose or wrong medication for too long before trying other drugs that may be more successful.

One problem is that primary health care professionals often just don't know enough about treating depression, say Drs. Kessler and Hollon, particularly about the various medications available. In fact, many patients in the *JAMA* study had received anti-anxiety medications like valium and lorazepam for depression, says Dr. Kessler, even though these drugs are, at best, helpful only in the short term and can become addictive fairly quickly.

Getting the prescription right is no easy task, admits Paula J. Clayton, MD, professor of psychiatry at the University of New Mexico in Albuquerque, even for doctors with a lot of experience treating depression. "An antidepressant generally has only a one-in-three chance of helping the person taking it recover," she says.

The Many Faces of Depression

Depression affects 19 million people in the United States.

African Americans are 40 percent less likely to experience depression than Hispanics or Caucasians, although blacks who develop depression are 30 percent more likely to suffer lasting or recurring depression than other ethnic groups.

Additionally, people living in poverty are nearly four times as likely to suffer lasting or recurring depression as those in higher socioeconomic groups.[3]

So how far do you go? Dr. Clayton suggests if you've been on the maximum recommended dosage of an antidepressant for four to six weeks with no improvement, or if the medication causes intolerable side effects, your doctor should try another medication and/or review other treatment options. In some cases (if side effects are not a problem), adding another medication to what you're presently taking may provide better results.

If you are just beginning treatment with an antidepressant, your physician most likely will have you return once a month for a medication "check-up," until you and your physician feel you are stabilized, Dr. Clayton says. After that, you may have check-ups about every three months. "Suicidal patients should be seen more frequently," she says.

As for how long you should be on the medication, that depends on your own situation. Some people with chronic or recurrent depression may remain on it for life, while others may need medication only for a few months.

Esther Nitzberg has been taking a variety of medications for 20 years. Every few months, her psychiatrist adjusts dosages, switches medications, or adds another to help with her recurrent depression.

Even if adequate treatment is prescribed, however, many patients don't follow it, says Dr. Kessler. Part of that is tied up in how people feel about depression, he says. "They feel inadequate, that they're failures," not understanding that they have a brain disease caused in part by a chemical imbalance. So getting help is often a last-ditch effort. Once they start feeling better, they quit taking their drugs or stop going to therapy, even though they're not considered "adequately" treated. "When you ask them why they quit, the most common reason is 'I want to handle it on my own,'" he says. "That's something you'd never say about a broken arm."

Often, as Terry Wise learned, you can't handle depression on your own. On Christmas Day 2000, 15 months after her husband died of Lou Gehrig's disease, Ms. Wise tried to commit suicide by swallowing 60 doses of morphine, 200 Percocets and a large glass of gin. She'd tried therapy a year before, but quit. Amazingly, she woke up from her suicide attempt two days later.

With the help of a caring therapist and the antidepressant medication bupropion (Wellbutrin), Ms. Wise ascended out of the pit of depression and has since written a book about her experience, *Waking Up: Climbing Through the Darkness*, published in December 2003 by Pathfinder Publishing. She knows she's not cured; she knows, in fact, that because she's suffered one major depressive episode, she's at high risk for becoming depressed again in the future. But now she has the tools to deal with it.

Women in the Lead

As noted earlier, women have the dubious distinction of being significantly more likely to experience an episode of severe depression in their lifetime than men, although the *JAMA* study shows the gender gap is closing. Ten years ago, the first national study of depression found women were twice as likely to experience depression as men; in the study published in June 2003, they were just 1.7 times more likely.

"There is a real gender difference," says Carolyn M. Mazure, PhD, professor of psychiatry at the Yale University School of Medicine and Director of Women's Health Research at Yale. No one knows the exact reason for the disparity, nor why men seem to be catching up to women. But there are numerous theories for the higher rates in women. One, of course, has to do with the ways in which women's hormones affect certain brain chemicals that regulate mood. (See Ages and Stages on page 6 for more information.)

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Depression is a wily disease, sometimes camouflaging itself as anger or fatigue, sometimes sending you to sleep all the time or keeping you awake all night. It can come on suddenly or sneak up on you gradually.

Depression Defined

The symptoms of depression include a persistent sad, anxious or "empty" mood; loss of interest or pleasure in your regular activities, including sex; restlessness, irritability or excessive crying; feelings of guilt, worthlessness, helplessness and/or hopelessness; sleeping too much or too little; appetite and/or weight loss or overeating and weight gain; thoughts of death or suicide, or suicide attempts.[4]

There are three major forms of depressive illness:

Major depression, sometimes referred to as unipolar or clinical depression, lasts at least two weeks, but may last for several months or longer and may occur several times over the lifetime.

Dysthymia. Although this form includes the same symptoms as major depression, symptoms are milder and last longer, at least two years. People with dysthymia frequently lack zest and enthusiasm for life, living a joyless and fatigued existence that seems almost a natural outgrowth of their personalities. They can also experience major depressive episodes.

Manic-depression, or bipolar disorder, is not nearly as common as the other forms of depressive illness. It involves disruptive cycles of depressive symptoms that alternate with mania. [4]

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Depression is one of the most treatable diseases doctors see. There's just one problem: people suffering from depression often don't receive adequate treatment, according to a major new study published in the the *Journal of the American Medical Association*.

Another has to do with the way severe stress, like the death of a spouse or loss of a job or divorce, affects women. Dr. Mazure has conducted considerable research into this area, finding that while such stress can lead to depression for both men and women, it is three times more likely to send women into depression than men.[5]

It seems that when it comes to stress, women may be more sensitive to a wider range of events than men, including moving, a physical attack, or life-threatening illness or injury, as well as the death of a close friend or relative. Part of the reason has to do with the larger networks women have. Although these networks can provide a protective benefit against stress, they are a double-edged sword says Dr. Mazure: if something happens to someone in the network, or to a woman's place within the network, it may trigger a depressive episode.

New research published in the July 18, 2003, issue of the journal *Science* also suggests that whether or not stress pushes you into depression may rest at least partly on a gene that determines how you react to the stresses of life.[6]

For Sherry Ingleside,* of central Pennsylvania, the trigger was the economic downslide in 2001. Not only had she taken early retirement from her job as a teacher, but her husband had switched jobs and was earning less. Plus, their retirement portfolio was shrinking faster than a wool sweater in the dryer. "I knew I was feeling things were worse than they were, but I couldn't shake it," she recalls.

Ms. Ingleside exhibited another characteristic of women that may explain their propensity for depression: ruminative thinking. Women are more likely than men to think distressing thoughts and go over and over their possible causes and consequences without trying to do anything about them.[7]

Additionally, women who score high on a written test designed to rate their "concern about disapproval" were three times more likely to be depressed than men,[8] Dr. Mazure's research finds.

"Many aspects of our social interactions are really based on a sense that we want people to say we've done a good job," she explains. "And there's also a long list of literature suggesting that feeling a sense of control or mastery is really critically important to our functioning. But if you're always being told you haven't handled it well, you're never good enough, you've done it the wrong way, you start to incorporate it into your own thinking."

Finding Relief

If there's one thing you should take away from this article and this newsletter, it's that help, although sometimes difficult to find, is available and does work. All the women interviewed for this article found help for their own depression through medication, or a combination of medication and therapy, and are glad they did.

A few weeks after starting on the antidepressant citalopram (Celexa), a new antidepressant, Ms. Ingleside heard a strange sound. It was her own laughter. "It was then that I realized I hadn't heard myself laugh out loud in quite some time." ✖

**Not her real name.*

Resources

American Psychiatric Association
1-888-357-7924
www.psych.org
Provides a variety of resources for consumers on mental disorders, including fact sheets and brochures on depression.

Depression and Bipolar Support Alliance
1-800-826-3632
www.dbsalliance.org
Resources available for people with mood disorders and their families, including online chat rooms and e-mail newsletter.

National Alliance on Mental Illness
1-800-950-6264
www.nami.org
Advocacy organization that offers information and guidance for finding treatment.

International Foundation for Research and Education on Depression (iFred)
1-800-273-8255
www.depression.org
Places an international focus on researching causes of depression, supporting those dealing with depression and combating the stigma associated with depression.

National Institute of Mental Health
1-866-615-6464
www.nimh.nih.gov
The premier federal research institution for the study of mood disorders; consumer information available.

National Mental Health Association
1-800-969-6642
www.nmha.org
Provides information about medication, treatment and patient rights.

Postpartum Support International
1-800-944-4773
www.postpartum.net
Offers online support and educational forum, including chat rooms and consumer information.

Depression Treatment Options

The treatment of depression received a huge boost nearly 20 years ago with the introduction of Prozac, or fluoxetine, the first in a class of new drugs called selective serotonin reuptake inhibitors, or SSRIs, that have far fewer side effects than the older antidepressants. The old ones are still around and have their place in depression treatment.

They are not all the same, however, nor are they comparable in terms of their effectiveness or side effects, as the chart below shows.[10]

Drugs, however, are just one part of the treatment puzzle, with studies finding that 10 to 30 percent of patients taking antidepressants are partially or totally resistant to the treatment (although switching to different medications often resolves the resistance).[11] Various forms of therapy, particularly interpersonal psychotherapy (IPT), a less intensive form of traditional psychotherapy, and cognitive behavioral therapy (CBT), in which you learn to alter your perception of the world, are also recommended for treatment of depression, either alone or in conjunction with medication.[10] (These therapies are described in more detail on page 7.) Some studies also find therapy to be as effective as medicine for some mild or moderate depression.[9]

For patients with major depression that doesn't respond to drugs or therapy, electroconvulsive therapy (ECT), commonly referred to as "shock therapy," may be tried. ECT is one of the most misunderstood and feared depression-related treatments, despite the fact it is also the best-studied and most effective treatment for this form of severe depression. The most common side effect is short-term memory loss or confusion.[10]

MEDICATIONS FOR DEPRESSION

Medication Class/Type*	How it Works	What Studies Show	Potential Side Effects & Warnings
Selective Serotonin Reuptake Inhibitors (SSRIs). Includes fluoxetine (Prozac, Sarafem), sertraline (Zoloft), paroxetine (Paxil), citalopram (Celexa), escitalopram oxalate (Lexapro)	Blocks reuptake of serotonin, allowing more of this neurotransmitter to remain available to the brain.	During initial stages of taking the medicine, about 10 to 20 percent of patients quit because of side effects.	Sexual side effects, nervousness, nausea, diarrhea, insomnia.
Monoamine oxidase inhibitors (MAOIs). Includes phenelzine (Nardil), isocarboxazid (Marplan), trancylpromine (Parnate)	Inhibits the action of monoamine oxidase, an enzyme that breaks down neurotransmitters.	Particularly effective for patients who don't respond to more conventional treatments.	Dry mouth. Can cause life-threatening interactions with aged cheese and meats, and with common over-the-counter medications, such as some flu and cold remedies.
Tricyclics (TCAs). Includes imipramine (Tofranil), desipramine, (Norpramin), nortriptyline (Pamelor), amitriptyline-HCl (Elavil), maprotiline (Ludiomil)	Either inhibits norepinephrine reuptake or both norepinephrine and serotonin reuptake.	About 30 percent of people stop taking TCAs due to side effects such as fainting, weight gain and headaches.	Can be lethal with just small overdose and may require blood tests to monitor levels.
Mixed reuptake inhibitors. Includes bupropion (Wellbutrin) and venlafaxine (Effexor)	Bupropion appears to regulate transmission of both norepinephrine and dopamine, while venlafaxine appears to inhibit the reuptake of those two chemicals as well as serotonin.	Bupropion: Substantially lower incidence of sexual side effects compared to SSRIs; may be particularly useful for treatment of depressions characterized by weight gain, loss of energy and oversleeping. Venlafaxine: Seems to be better than SSRIs at treating major depression.	Nausea, headaches. Venlafaxine may result in sexual side effects as well as a risk of elevated blood pressure.
5-HT modulators. Includes nefazodone and trazodone (Desyrel)	Strong effect on blocking 5-HT (a precursor of serotonin) serotonin receptors.	Improves sleep and has a low risk of sexual side effects.	Sudden drop in blood pressure upon standing, headaches, daytime drowsiness. In rare cases, nefazodone may cause liver damage.
Norepinephrine and 5-HT modulators. Includes mirtazapine (Remeron)	Blocks serotonin receptors.	Relieves symptoms sooner than the SSRIs.	Weight gain and daytime drowsiness.

*Not all drugs within a class are listed

Source: Hollon, SD, Michael ET, Markowitz, JC. "Treatment and Prevention of Depression." Psychological Science in the Public Interest. Nov. 2003 3(2):39-70.

Depression Across the Lifespan

Researchers are fairly sure that one main reason for the nearly 2:1 disparity in depression rates between women and men lies in women's hormones. Here's how depression is associated with the major hormonal milestones in a woman's life:

Adolescence. No one knows why the depression gender gap begins in adolescence, or why it occurs so quickly. One theory is that girls going through puberty experience greater distress and are more vulnerable to stress than pre- or post-pubertal girls, says Meir Steiner, MD, PhD, professor of psychiatry and behavioral neurosciences and obstetrics and gynecology at McMaster University in Hamilton, Ontario.

- **Menstruation.** About 75 percent of premenopausal women experience some symptoms of premenstrual syndrome (PMS), such as irritability.[12] But three to eight percent of those women experience premenstrual dysphoric disorder, or PMDD, a much more severe form of PMS that greatly interferes with their daily life. The interaction of hormones with neurotransmitters is probably at play, notes Dr. Steiner.

For instance, evidence suggests that women with increased sensitivity of the serotonin system have a higher risk of developing PMDD, since the fluctuations in estrogen and progesterone levels that occur premenstrually have a direct effect on the availability of serotonin precursors. So, it's no surprise that drugs that affect the serotonin system (specifically selective serotonin reuptake inhibitors, or SSRIs) very effectively treat severe PMS and PMDD. The U.S. Food and Drug Administration has already approved two such drugs to treat PMDD: fluoxetine (Sarafem) and sertraline (Zoloft).

- **Pregnancy and postpartum.** Rates of depression in pregnant women mirror those of nonpregnant women, small wonder since the overall onset of depression peaks between the ages of 25 and 44—prime childbearing years.[10,13]

These days, doctors are likely to recommend antidepressants for pregnant women who are depressed or who want to continue taking their medication, since research indicates no increased risk of birth defects from in utero exposure to SSRIs or tricyclic antidepressants.

Postpartum depression is also a concern. Although many women experience a mild case of the "blues" after giving birth (between 26 and 85 percent, depending on the study),[9] about 10 to 15 percent of women have more significant depressive symptoms in the first weeks following birth. Most of these episodes clear up without treatment within three to six months (although you should still seek help if your symptoms last longer than two weeks). But about one in every 500 to 1,000 women will experience what's called postpartum psychosis, severely affecting her ability to function. In some extreme cases, it may lead to suicide or the murder of the baby.[12]

There is almost a definite link between the enormous psychological, physiological and hormonal changes that occur in a woman's body just after birth and these mood changes, notes Dr. Steiner, with the sharp fall in estrogen that occurs days after delivery possibly triggering a postpartum psychosis in vulnerable women.

- **Perimenopause, menopause and beyond.** The perimenopausal stage, those months or even years just before menopause, are another high-risk time for depression in women, both for those with a history of depression and those without.[13]

The increased risk is likely related to dropping estrogen levels, says Dr. Steiner, because estrogen has direct effects on the central nervous system.

Being a woman 65 and older does not, in and of itself put a woman at greater risk for depression. In fact, epidemiological surveys suggest that older adults have lower rates of depressive disorders than do other age groups. However, an estimated 10 to 20 percent of older women experience clinically significant depressive symptoms, with rates particularly common among women who are hospitalized or who are being treated on an outpatient basis for some physical illness. It may also result from side effects of medication, pain or physical or mental limitations.[7]

It's important to note, however, that depression is not a normal part of aging, and that the same treatments that work so well for younger women work just as well for older women.[7]

Treating Depression

Q Lately, I've been very irritable, and I don't enjoy the activities I used to. I think I might be depressed, but I'm embarrassed about getting help.

A Depression is a medical condition just like hypertension, diabetes and other conditions. You must address depression in the same manner that you would these conditions and be open with your physician. Depression is not your fault, and you are not weak.

You should also know that there is hope, and that you can begin the journey to wellness, but first you have to step beyond the stigma associated with mental illness. Talk to your family physician about next steps. He or she will determine if you have major depression and whether he or she will treat it or refer you to someone else who will.

Q **My doctor just put me on an antidepressant, but I'm worried that it might make me gain weight.**

A Weight gain is a cause for concern for many women due to the history of the older antidepressants. So it's important that you have an open discussion regarding your worries with your physician. There are a host of newer antidepressants that do not cause much, if any, significant weight gain when taken. Also keep in mind that the weight gain ascribed to medication may actually be caused by inactivity, a byproduct of depression itself.

–Sharon Allison-Ottey, MD
COSHAR Foundation Inc.
Baltimore, MD

Q **I was recently diagnosed with depression. How do I know which type of therapy to try?**

A Interpersonal therapy, or IPT, is a relatively new, well-researched therapy designed to target depression. One major focus of IPT is defining depression as a mental illness, a treatable condition that is not the patient's fault. It focuses on events that occurred after early childhood, and uses the connection between current life events and the beginning of depression to help you understand and overcome your depression.

It also helps you reverse the cycle of depression—social withdrawal, fatigue, poor concentration and further negative life events—by developing positive life events. Numerous studies find that IPT is very effective in treating depression, in most cases equally or more effectively than treatment with medication. However, both together—medication and IPT—appears to be most effective.

The same can be said for cognitive behavior therapy (CBT), which involves learning how to talk back to your negative beliefs and how to be more adaptable. CBT appears to be about as effective as medications and, quite possibly, longer lasting. People seem to learn things in CBT that reduce their risk for subsequent depressions even after treatment ends.

There are other promising therapies, but IPT and CBT are two of the best, according to scientific research.

–Steven D. Hollon, PhD
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Nashville, TN

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Depressed? Talk to Your Health Care Professional

Rona Barrett. Halle Berry. Delta Burke. Barbara Bush. Sheryl Crow. Ellen DeGeneres, Queen Elizabeth. All extremely accomplished women. All with a history of depression. All successfully treated. Don't be afraid to add your name to this list. You'd be in good company.

Depression is an extremely treatable disease. More than 80 percent of people who receive successful treatment recover from a depressive episode.

But with depression, perhaps more than with most diseases, successful treatment depends on you as much as on your health care professional. You have to be willing to seek out treatment, work with your health care professional to pinpoint a diagnosis, develop a treatment plan and follow the recommended treatment. All this requires that you communicate effectively with your health care professional about your illness.

Years ago, our medical system was based on a paternalistic model, in which doctors told us what to do and we listened. No more. Now the relationship between you and your physician or other health care professional should work as a partnership. That's never more important than when you're dealing with a disease like depression, for which there is no simple blood test or x-ray for diagnosis, only your own feelings and sense of what's "normal" about yourself. So it's important you find the right medical professional for you.

As you search for a health care professional, keep in mind that you have a right to expect certain things, including privacy, confidentiality, respect, sensitivity to your needs and cultural background, an understandable explanation of your condition and treatment options and the freedom to express yourself. Also know that you have the freedom to find another health care professional if things don't work out.

Be honest with your health care professional. Talk about how you've been feeling, eating and sleeping, and how it differs from your usual routine.

Bring up any major changes that have occurred in your life lately, such as relationship problems, a job loss or an illness. Tell him or her if you're drinking or using any drugs and be honest about any thoughts of death, suicide or self-harm you've had, now or ever. If you're too depressed to communicate so specifically, consider bringing someone who knows you well to share observations about how the illness affects you.

Also make sure you share which medications (prescribed and over-the-counter, including herbs and vitamins) you're already taking. Either bring them with you to the appointment or bring a list of types and dosage. This is very important, since medication is often a part of treatment for depression, and you want to avoid any possible interactions.

If you feel uncomfortable with the medical professional you've chosen, or you think the treatment isn't working, don't be afraid to find someone else to work with. In fact, 25 percent of women polled in a 1996 Commonwealth Fund survey said their healthcare professional had "talked down to them," while 17 percent said their symptoms "were all in your head."

Believe me, depression is not all in your head. It is a very real, very dangerous disease; one for which you deserve the very best in treatment. Don't let anyone convince you otherwise. ✖

By Pamela Peeke, MD, MPH
NWHRC Medical Advisor

Dr. Peeke is a Pew Foundation Scholar in Nutrition and Metabolism, and Assistant Clinical Professor of Medicine at the University of Maryland in Baltimore. She writes about health and lifestyle issues important to all women.

Questions to Ask Your Health Care Professional

- Can my depression be cured?
- Will my depression come back?
- What are my treatment choices?
- How long will I need treatment?
- How can I find out if my insurance will pay for treatment?
- Should I see a specialist for my depression (if you're seeing a primary care physician)?

If medication is prescribed:

- How and when should I take the medicine and for how long?
- Are there any side effects associated with this medication?
- What foods, drinks, other medicines, or activities should I avoid while taking this medicine?
- What symptoms should prompt me to call you?
- Are there any reasons I should stop the medication?
- Is there any danger when stopping this medication?