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. I feel 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, a disorder that strikes women nearly twice as often as men.

Depression is a wily disease, sometimes camouflageing 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. 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 new 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. "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."
DEPRESSION & WOMEN continued from page 1

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. Making it more complicated is the fact that physical complaints such as vague aches and pains, which can also be symptoms of depression, may go undiscussed or undetected.

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 providers 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.

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 Hispanic or Caucasians, although African Americans 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.
treating depression. "An antidepressant generally has only a one-in-three chance of helping the person taking it recover," she says.

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 "checkup," until you and your physician feel you are stabilized, Dr. Clayton says. After that, you may have checkups 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, scheduled for publication 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, 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 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. Physical symptoms, such as digestive problems and vague aches and pains, may also signal depression.

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.
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.

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 least partly on a gene that determines how you react to the stresses of life.

For Sherry Ingleside, of central Pennsylvania, the trigger was the economic downturn 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.

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, 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 sometime.”

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*Not her real name.*

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**Resources**

- **American Psychiatric Association**
  - 1000 Wilson Boulevard, Suite 1825
  - Arlington, VA 22209-3901
  - 703-907-7300
  - http://www.psych.org
  - Provides a variety of resources for consumers on mental disorders.

- **Depression and Bipolar Support Alliance**
  - 730 N. Franklin Street, Suite 501
  - Chicago, Illinois 60610-7224
  - 1-800-826-3632
  - http://www.dbasalliance.org
  - Resources available for people with mood disorders and their families, including online chat rooms and e-mail newsletter.

- **National Alliance for the Mentally Ill**
  - 2107 Wilson Boulevard, Suite 300
  - Arlington, VA 22201-3042
  - 1-800-950-6264
  - http://www.nami.org
  - Advocacy organization that offers information and guidance for finding treatment.

- **National Foundation for Depressive Illness, Inc.**
  - PO Box 2257
  - New York, NY 10116
  - 1-800-239-1255
  - http://www.depression.org
  - Informs the public about depressive illness and treatment options.

- **National Institute of Mental Health**
  - 6001 Executive Boulevard
  - Bethesda, MD 20892-9563
  - 1-866-615-6464
  - The premier federal research institution for the study of mood disorders; consumer information available.

- **National Mental Health Association**
  - 2001 N. Beauregard Street, 12th Floor
  - Alexandria, VA 22311
  - 1-800-959-6642
  - http://www.nmha.org
  - Provides information about medication, treatment and patient rights.

- **Postpartum Support International**
  - http://www.postpartum.net
  - Offers online support and educational forum, including chat rooms and consumer information.