DOCUMENT RESUME

ED 462 657 CG 031 599

TITLE	Depression: What Every Woman Should Know.
INSTITUTION	National Inst. of Mental Health (DHHS), Bethesda, MD.
REPORT NO	NIH-00-3679
PUB DATE	2000-08-00
NOTE	26p.; Originally developed for the Depression Awareness, Recognition, and Treatment (D/ART) program. Revised by Margaret Strock. For Spanish version, see CG 031 583.
AVAILABLE FROM	Office of Communications and Public Liasion, Information Resources and Inquiries Branch, National Institute of Mental Health, 6001 Executive Blvd., Rm. 8184, MSC 9663, Bethesda, MD 20892-9663. Tel: 301-443-4513; Tel: 301-443-8431 (TTY); Fax: 301-443-4279; e-mail: nimhinfo@nih.gov; Web site: http://www.nimh.nih.gov. For full text: http://www.nimh.nih.gov/publicat/depwomenknows.cfm.
PUB TYPE	Guides - Non-Classroom (055) -- Information Analyses (070)
EDRS PRICE	MF01/PC02 Plus Postage.
DESCRIPTORS	*At Risk Persons; Biological Influences; *Depression (Psychology); Developmental Stages; Emotional Problems; Environmental Influences; *Females; Intervention; Outcomes of Treatment; Pharmacology; Predictor Variables; Psychopathology; Psychotherapy; Social Influences; Symptoms (Individual Disorders)
IDENTIFIERS	Electroconvulsive Therapy; Herbal Medicine

ABSTRACT

This publication, written in English, explains why women are at greater risk for depression than men. Types of depressive illnesses are explained along with the symptoms. It states that some women are predisposed genetically to depression but biochemical, environmental, psychological, and social factors also contribute to its occurrence. Depression is considered at the different stages of a woman's life, including during adolescence, childbirth, and old age. Depression is a treatable illness and interventions can include a combination of medication, herbal therapy, psychotherapy, and electroconvulsive therapy. Where to go for help is discussed and several national organizations are listed for additional information. (JDM)

Depression

What Every Woman Should Know

DEPARTMENT OF HEALTH AND HUMAN SERVICES • PUBLIC HEALTH SERVICE • NATIONAL INSTITUTES OF HEALTH

NIMH
National Institute of Mental Health

Life is full of emotional ups and downs. But when the "down" times are long lasting or interfere with your ability to function, you may be suffering from a common, serious illness—depression. Clinical depression affects mood, mind, body, and behavior. Research has shown that in the United States about 19 million people—one in ten adults—experience depression each year, and nearly two-thirds do not get the help they need.[9] Treatment can alleviate the symptoms in over 80 percent of the cases. Yet, because it often goes unrecognized, depression continues to cause unnecessary suffering.

Depression is a pervasive and impairing illness that affects both women and men, but women experience depression at roughly twice the rate of men.[1] Researchers continue to explore how special issues unique to women—biological, life cycle, and psychosocial—may be associated with women's higher rate of depression.

No two people become depressed in exactly the same way. Many people have only some of the symptoms, varying in severity and duration. For some, symptoms occur in time-limited episodes; for others, symptoms can be present for long periods if no treatment is sought. Having some depressive symptoms does not mean a person is clinically depressed. For example, it is not unusual for those who have lost a loved one to feel sad, helpless, and disinterested in regular activities. Only when these symptoms persist for an unusually long time is there reason to suspect that grief has become depressive illness. Similarly, living with the stress of potential layoffs, heavy workloads, or financial or family problems may cause irritability and "the blues." Up to a point, such feelings are simply a part of human experience. But when these feelings increase in duration and intensity and an individual is unable to function as usual, what seemed a temporary mood may have become a clinical illness.

The Types of Depressive Illness

1. In ***major depression***, sometimes referred to as unipolar or clinical depression, people have some or all of the symptoms listed below for at least 2 weeks but frequently for several months or longer. Episodes of the illness can occur once, twice, or several times in a lifetime.

2. In ***dysthymia***, the same symptoms are present though milder and last at least 2 years. People with dysthymia are frequently lacking in zest and enthusiasm for life, living a joyless and fatigued existence that seems almost a natural outgrowth of their personalities. They also can experience major depressive episodes.

3. ***Manic-depression***, or bipolar disorder, is not nearly as common as other forms of depressive illness and involves disruptive cycles of depressive symptoms that alternate with mania. During manic episodes, people may become overly active, talkative, euphoric, irritable, spend money irresponsibly, and get involved in sexual misadventures. In some people, a milder form of mania, called hypomania, alternates with depressive episodes. Unlike other mood disorders, women and men are equally vulnerable to bipolar disorder; however, women with bipolar disorder tend to have more episodes of depression and fewer episodes of mania or hypomania.[5]

Symptoms of Depression and Mania

A thorough diagnostic evaluation is needed if three to five or more of the following symptoms persist for more than 2 weeks (1 week in the case of mania), or if they interfere with work or family life. An evaluation involves a complete physical checkup and information gathering on family health history. Not everyone with depression experiences each of these symptoms. The severity of the symptoms also varies from person to person.

Depression

- Persistent sad, anxious, or "empty" mood
- Loss of interest or pleasure in activities, including sex
- Restlessness, irritability, or excessive crying
- Feelings of guilt, worthlessness, helplessness, hopelessness, pessimism
- Sleeping too much or too little, early-morning awakening
- Appetite and/or weight loss or overeating and weight gain
- Decreased energy, fatigue, feeling "slowed down"
- Thoughts of death or suicide, or suicide attempts

- Difficulty concentrating, remembering, or making decisions
- Persistent physical symptoms that do not respond to treatment, such as headaches, digestive disorders, and chronic pain

Mania

- Abnormally elevated mood
- Irritability
- Decreased need for sleep
- Grandiose notions
- Increased talking
- Racing thoughts
- Increased activity, including sexual activity
- Markedly increased energy
- Poor judgment that leads to risk-taking behavior
- Inappropriate social behavior

Causes of Depression

Genetic Factors

There is a risk for developing depression when there is a family history of the illness, indicating that a biological vulnerability may be inherited. The risk is somewhat higher for those with bipolar disorder. However, not everybody with a family history develops the illness. In addition, major depression can occur in people who have had no family members with the illness. This suggests that additional factors, possibly biochemistry, environmental stressors, and other psychosocial factors, are involved in the onset of depression.

Biochemical Factors

Evidence indicates that brain biochemistry is a significant factor in depressive disorders. It is known, for example, that individuals with major depressive illness typically have dysregulation of certain brain chemicals, called neurotransmitters. Additionally, sleep patterns, which are biochemically influenced, are typically different in people with depressive disorders. Depression can be induced or alleviated with certain medications, and some hormones have mood-altering properties. What is not yet known is whether the "biochemical disturbances" of depression are of genetic origin, or are secondary to stress, trauma, physical illness, or some other environmental condition.

Environmental and Other Stressors

Significant loss, a difficult relationship, financial problems, or a major change in life pattern have all been cited as contributors to depressive illness. Sometimes the onset of depression is associated with acute or chronic physical illness. In addition, some form of substance abuse disorder occurs in about one-third of people with any type of depressive disorder.[7]

Other Psychological and Social Factors

Persons with certain characteristics—pessimistic thinking, low self-esteem, a sense of having little control over life events, and a tendency to worry excessively—are more likely to develop depression. These attributes may heighten the effect of stressful events or interfere with taking action to cope with them or with getting well. Upbringing or sex role expectations may contribute to the development of these traits. It appears that negative thinking patterns typically develop in childhood or adolescence. Some

experts have suggested that the traditional upbringing of girls might foster these traits and may be a factor in women's higher rate of depression.

Women Are at Greater Risk for Depression than Men

Major depression and ***dysthymia*** affect twice as many women as men. This two-to-one ratio exists regardless of racial and ethnic background or economic status. The same ratio has been reported in ten other countries all over the world.[11] Men and women have about the same rate of ***bipolar disorder*** (manic-depression), though its course in women typically has more depressive and fewer manic episodes. Also, a greater number of women have the rapid cycling form of bipolar disorder, which may be more resistant to standard treatments.[5]

A variety of factors unique to women's lives are suspected to play a role in developing depression. Research is focused on understanding these, including: reproductive, hormonal, genetic or other biological factors; abuse and oppression; interpersonal factors; and certain psychological and personality characteristics. And yet, the specific causes of depression in women remain unclear; many women exposed to these factors do not develop depression. What is clear is that regardless of the contributing factors, depression is a highly treatable illness.

The Many Dimensions of Depression in Women

Investigators are focusing on the following areas in their study of depression in women:

The Issues of Adolescence

Before adolescence, there is little difference in the rate of depression in boys and girls. But between the ages of 11 and 13 there is a precipitous rise in depression rates for girls. By the age of 15, females are twice as likely to have experienced a major depressive episode as males.[2] This comes at a time in adolescence when roles and expectations change dramatically. The stresses of adolescence include forming an identity, emerging sexuality, separating from parents, and making decisions for the first time, along with other physical, intellectual, and hormonal changes. These stresses are generally different for boys and girls, and may be associated more often with depression in females. Studies show that female high school students have significantly higher rates of depression, anxiety disorders, eating disorders, and adjustment disorders than male students, who have higher rates of disruptive behavior disorders.[6]

Adulthood: Relationships and Work Roles

Stress in general can contribute to depression in persons biologically vulnerable to the illness. Some have theorized that higher incidence of depression in women is not due to greater vulnerability, but to the particular stresses that many women face. These stresses include major responsibilities at home and work, single parenthood, and caring for children and aging parents. How these factors may uniquely affect women is not yet fully understood.

For both women and men, rates of major depression are highest among the separated and divorced, and lowest among the married, while remaining always higher for women than for men. The quality of a marriage, however, may contribute significantly to depression. Lack of an intimate, confiding relationship, as well as overt marital disputes, have been shown to be related to depression in women. In fact, rates of depression were shown to be highest among unhappily married women.

Reproductive Events

Women's reproductive events include the menstrual cycle, pregnancy, the postpregnancy period, infertility, menopause, and sometimes, the decision not to have children. These events bring fluctuations in mood that for some women include depression. Researchers have confirmed that hormones have an effect on the brain chemistry that controls emotions and mood; a specific biological mechanism explaining hormonal involvement is not known, however.

Many women experience certain behavioral and physical changes associated with phases of their menstrual cycles. In some women, these changes are severe, occur regularly, and include depressed feelings, irritability, and other emotional and physical changes. Called ***premenstrual syndrome*** (PMS) or ***premenstrual dysphoric disorder*** (PMDD), the changes typically begin after ovulation and become gradually worse until menstruation starts. Scientists are exploring how the cyclical rise and fall of estrogen and other hormones may affect the brain chemistry that is associated with depressive illness.[10]

Postpartum mood changes can range from transient "blues" immediately following childbirth to an episode of major depression to severe, incapacitating, psychotic depression. Studies suggest that

women who experience major depression after childbirth very often have had prior depressive episodes even though they may not have been diagnosed and treated.

Pregnancy (if it is desired) seldom contributes to depression, and having an abortion does not appear to lead to a higher incidence of depression. Women with infertility problems may be subject to extreme anxiety or sadness, though it is unclear if this contributes to a higher rate of depressive illness. In addition, motherhood may be a time of heightened risk for depression because of the stress and demands it imposes.

Menopause, in general, is not asssociated with an increased risk of depression. In fact, while once considered a unique disorder, research has shown that depressive illness at menopause is no different than at other ages. The women more vulnerable to change-of-life depression are those with a history of past depressive episodes.

Specific Cultural Considerations

As for depression in general, the prevalence rate of depression in African American and Hispanic women remains about twice that of men. There is some indication, however, that major depression and dysthymia may be diagnosed less frequently in African American and slightly more frequently in Hispanic than in Caucasian women. Prevalence information for other racial and ethnic groups is not definitive.

Possible differences in symptom presentation may affect the way depression is recognized and diagnosed among minorities. For example, African Americans are more likely to report somatic symptoms, such as appetite change and body aches and pains. In addition, people from various cultural backgrounds may view depressive symptoms in different ways. Such factors should be considered when working with women from special populations.

Victimization

Studies show that women molested as children are more likely to have clinical depression at some time in their lives than those with no such history. In addition, several studies show a higher incidence of depression among women who have been raped as adolescents or adults. Since far more women than men were sexually abused as children, these findings are relevant. Women who experience other commonly occurring forms of abuse, such as physical abuse and sexual harassment on the job, also may experience higher rates of depression. Abuse may lead to depression by fostering low self-esteem, a sense of helplessness, self-blame, and social isolation. There may be biological and environmental risk factors for depression resulting from growing up in a dysfunctional family. At present, more research is needed to understand whether victimization is connected specifically to depression.

Poverty

Women and children represent seventy-five percent of the U.S. population considered poor. Low economic status brings with it many stresses, including isolation, uncertainty, frequent negative events, and poor access to helpful resources. Sadness and low morale are more common among persons with low incomes and those lacking social supports. But research has not yet established whether depressive illnesses are more prevalent among those facing environmental stressors such as these.

Depression in Later Adulthood

At one time, it was commonly thought that women were particularly vulnerable to depression when their children left home and they were confronted with "empty nest syndrome" and experienced a profound loss of purpose and identity. However, studies show no increase in depressive illness among women at this stage of life.

As with younger age groups, more elderly women than men suffer from depressive illness. Similarly, for all age groups, being unmarried (which includes widowhood) is also a risk factor for depression. Most important, depression should not be dismissed as a normal consequence of the physical, social, and economic problems of later life. In fact, studies show that most older people feel satisfied with their lives.

About 800,000 persons are widowed each year. Most of them are older, female, and experience varying degrees of depressive symptomatology. Most do not need formal treatment, but those who are moderately or severely sad appear to benefit from self-help groups or various psychosocial treatments. However, a third of widows/widowers do meet criteria for major depressive episode in the first month after the death, and half of these remain clinically depressed 1 year later. These depressions respond to standard antidepressant treatments, although research on when to start treatment or how medications should be combined with psychosocial treatments is still in its early stages.[4,8]

Depression Is a Treatable Illness

Even severe depression can be highly responsive to treatment. Indeed, believing one's condition is "incurable" is often part of the hopelessness that accompanies serious depression. Such individuals should be provided with the information about the effectiveness of modern treatments for depression in a way that acknowledges their likely skepticism about whether treatment will work for them. As with many illnesses, the earlier treatment begins, the more effective and the greater the likelihood of preventing serious recurrences. Of course, treatment will not eliminate life's inevitable stresses and ups

and downs. But it can greatly enhance the ability to manage such challenges and lead to greater enjoyment of life.

The first step in treatment for depression should be a thorough examination to rule out any physical illnesses that may cause depressive symptoms. Since certain medications can cause the same symptoms as depression, the examining physician should be made aware of any medications being used. If a physical cause for the depression is not found, a psychological evaluation should be conducted by the physician or a referral made to a mental health professional.

Types of Treatment for Depression

The most commonly used treatments for depression are antidepressant medication, psychotherapy, or a combination of the two. Which of these is the right treatment for any one individual depends on the nature and severity of the depression and, to some extent, on individual preference. In mild or moderate depression, one or both of these treatments may be useful, while in severe or incapacitating depression, medication is generally recommended as a first step in the treatment.[3] In combined treatment, medication can relieve physical symptoms quickly, while psychotherapy allows the opportunity to learn more effective ways of handling problems.

Medications

There are several types of antidepressant medications used to treat depressive disorders. These include newer medications—chiefly the selective serotonin reuptake inhibitors (SSRIs)—and the tricyclics and monoamine oxidase inhibitors (MAOIs). The SSRIs—and other newer medications that affect neurotransmitters such as dopamine or norepinephrine—generally have fewer side effects than tricyclics. Each acts on different chemical pathways of the human brain related

to moods. Antidepressant medications are not habit-forming. Although some individuals notice improvement in the first couple of weeks, usually antidepressant medications must be taken regularly for at least 4 weeks and, in some cases, as many as 8 weeks, before the full therapeutic effect occurs. To be effective and to prevent a relapse of the depression, medications must be taken for about 6 to 12 months, carefully following the doctor's instructions. Medications must be monitored to ensure the most effective dosage and to minimize side effects. For those who have had several bouts of depression, long-term treatment with medication is the most effective means of preventing recurring episodes.

The prescribing doctor will provide information about possible side effects and, in the case of MAOIs, dietary and medication restrictions. In addition, other prescribed and over-the-counter medications or dietary supplements being used should be reviewed because some can interact negatively with antidepressant medication. There may be restrictions during pregnancy.

For bipolar disorder, the treatment of choice for many years has been lithium, as it can be effective in smoothing out the mood swings common to this disorder. Its use must be carefully monitored, as the range between an effective dose and a toxic one can be relatively small. However, lithium may not be recommended if a person has pre-existing thyroid, kidney, or heart disorders or epilepsy. Fortunately, other medications have been found helpful in controlling mood swings. Among these are two mood-stabilizing anticonvulsants, carbamazepine (Tegretol®) and valproate (Depakote®). Both of these medications have gained wide acceptance in clinical practice, and valproate has been approved by the Food and Drug Administration for first-line treatment of acute mania. Since some studies indicate that valproate can interfere with hormonal function in adolescent girls, young girls taking valproate

should be monitored carefully by a physician. Other anticonvulsants that are being used now include lamotrigine (Lamictal®) and gabapentin (Neurontin®); their role in the treatment hierarchy of bipolar disorder remains under study.

Most people who have bipolar disorder take more than one medication. Along with lithium and/or an anticonvulsant, they often take a medication for accompanying agitation, anxiety, insomnia, or depression. Some research indicates that an antidepressant, when taken without a mood stabilizing medication, can increase the risk of switching into mania or hypomania, or of developing rapid cycling, in people with bipolar disorder. Finding the best possible combination of these medications is of utmost importance to the patient and requires close monitoring by the physician.

Herbal Therapy

In the past few years, much interest has risen in the use of herbs in the treatment of both depression and anxiety. St. John's wort (*Hypericum perforatum*), an herb used extensively in the treatment of mild to moderate depression in Europe, has recently aroused interest in the United States. St. John's wort, an attractive bushy, low-growing plant covered with yellow flowers in summer, has been used for centuries in many folk and herbal remedies. Today in Germany, *Hypericum* is used in the treatment of depression more than any other antidepressant. However, the scientific studies that have been conducted on its use have been short-term and have used several different doses.

Because of the widespread interest in St. John's wort, the National Institutes of Health (NIH) is conducting a 3-year study, sponsored by three NIH components—the National Institute of Mental Health, the National Institute for Complementary and Alternative Medicine, and the Office of Dietary Supplements. The

study is designed to include 336 patients with major depression, randomly assigned to an 8-week trial with one-third of patients receiving a uniform dose of St. John's wort, another third an SSRI commonly prescribed for depression, and the final third a placebo (a pill that looks exactly like the SSRI and the St. John's wort; but has no active ingredients). The study participants who respond positively will be followed for an additional 18 weeks. After the 3-year study has been completed, results will be analyzed and published.

The Food and Drug Administration issued a Public Health Advisory on February 10, 2000. It stated that St. John's wort appears to affect an important metabolic pathway that is used by many drugs prescribed to treat conditions such as heart disease, depression, seizures, certain cancers, and rejection of transplants. Therefore, health care providers should alert their patients about these potential drug interactions. Any herbal supplement should be taken only after consultation with the doctor or other health care provider.

Psychotherapy

In mild to moderate cases of depression, psychotherapy is also a treatment option. Some short-term (10 to 20 week) therapies have been very effective in several types of depression. "Talking" therapies help patients gain insight into and resolve their problems through verbal give-and-take with the therapist. "Behavioral" therapies help patients learn new behaviors that lead to more satisfaction in life and "unlearn" counter-productive behaviors.

Research has shown that two short-term psychotherapies, interpersonal and cognitive-behavioral, are helpful for some forms of depression. Interpersonal therapy works to change interpersonal relationships that cause or exacerbate depression. Cognitive-behavioral therapy helps change negative styles of thinking and behaving that may contribute to the depression.

Electroconvulsive Therapy

For individuals whose depression is severe or life threatening or for those who cannot take antidepressant medication, electroconvulsive therapy (ECT) is useful.[3] This is particularly true for those with extreme suicide risk, severe agitation, psychotic thinking, severe weight loss or physical debilitation due as a result of physical illness. Over the years, ECT has been much improved. A muscle relaxant is given before treatment, which is done under brief anesthesia. Electrodes are placed at precise locations on the head to deliver electrical impulses. The stimulation causes a brief (about 30 seconds) seizure within the brain. The person receiving ECT does not consciously experience the electrical stimulus. At least several sessions of ECT, usually given at the rate of three per week, are required for full therapeutic benefit.

Treating Recurrent Depression

Even when treatment is successful, depression may recur. Studies indicate that certain treatment strategies are very useful in this instance. Continuation of antidepressant medication at the same dose that successfully treated the acute episode can often prevent recurrence. Monthly interpersonal psychotherapy can lengthen the time between episodes in patients not taking medication.

The Path to Healing

Reaping the benefits of treatment begins by recognizing the signs of depression. The next step is to be evaluated by a qualified professional. Although depression can be diagnosed and treated by primary care physicians, often the physician will refer the patient to a psychiatrist, psychologist, clinical social worker, or other mental health professional. Treatment is a partnership between the patient

and the health care provider. An informed consumer knows her treatment options and discusses concerns with her provider as they arise.

If there are no positive results after 2 to 3 months of treatment, or if symptoms worsen, discuss another treatment approach with the provider. Getting a second opinion from another health or mental health professional may also be in order.

Here, again, are the steps to healing:

- Check your symptoms against the list on page 3.
- Talk to a health or mental health professional.
- Choose a treatment professional and a treatment approach with which you feel comfortable.
- Consider yourself a partner in treatment and be an informed consumer.
- If you are not comfortable or satisfied after 2 to 3 months, discuss this with your provider. Different or additional treatment may be recommended.
- If you experience a recurrence, remember what you know about coping with depression and don't shy away from seeking help again. In fact, the sooner a recurrence is treated, the shorter its duration will be.

Depressive illnesses make you feel exhausted, worthless, helpless, and hopeless. Such feelings make some people want to give up. It is important to realize that these negative feelings are part of the depression and will fade as treatment begins to take effect.

Along with professional treatment, there are other things you can do to help yourself get better. Some people find participating in support groups very helpful. It may also help to spend some time with other people and to participate in activities that make you feel

better, such as mild exercise or yoga. Just don't expect too much from yourself right away. Feeling better takes time.

Where to Get Help

If unsure where to go for help, ask your family doctor, OB/GYN physician, or health clinic for assistance. You can also check the *Yellow Pages* under "mental health," "health," "social services," "suicide prevention," "crisis intervention services," "hotlines," "hospitals," or "physicians" for phone numbers and addresses. In times of crisis, the emergency room doctor at a hospital may be able to provide temporary help for an emotional problem and will be able to tell you where and how to get further help.

Listed below are the types of people and places that will make a referral to, or provide, diagnostic and treatment services.

- Family doctors
- Mental health specialists such as psychiatrists, psychologists, social workers, or mental health counselors
- Health maintenance organizations
- Community mental health centers
- Hospital psychiatry departments and outpatient clinics
- University- or medical school-affiliated programs
- State hospital outpatient clinics
- Family service/social agencies
- Private clinics and facilities
- Employee assistance programs
- Local medical and/or psychiatric societies

For Further Information

National Institute of Mental Health
Information Resources and Inquiries Branch
6001 Executive Boulevard
Room 8184, MSC 9663
Bethesda, MD 20892-9663
Telephone: 1-301-443-4513
FAX: 1-301-443-4279
Depression brochures: 1-800-421-4211
TTY: 1-301-443-8431
FAX4U: 1-301-443-5158
Website: http://www.nimh.nih.gov
E-mail: nimhinfo@nih.gov

National Alliance for the Mentally Ill
2107 Wilson Boulevard, Suite 300
Arlington, VA 22201-3042
Telephone: 1-703-524-7600; 1-800-950-NAMI
Website: http://www.nami.org
A support and advocacy organization of consumers, families, and friends of people with severe mental illness—over 1,200 state and local affiliates. Local affiliates can often give guidance to finding treatment.

National Depressive and Manic Depressive Association
730 N. Franklin, Suite 501
Chicago, IL 60601-3526
Telephone: 1-312- 642-0049; 1-800-826-3632
Website: http://www.ndmda.org
Purpose is to educate patients, families, and the public concerning the nature of depressive illnesses. Maintains an extensive catalog of helpful books.

National Foundation for Depressive Illness, Inc.
P.O. Box 2257
New York, NY 10016
Telephone: 1-212-268-4260; 1-800-239-1265
Website: http://www.depression.org
A foundation that informs the public about depressive illness and its treatability and promotes programs of research, education and treatment.

National Mental Health Association
1021 Prince Street
Alexandria, VA 22314-2971
Telephone: 1-703-684-7722; 1-800-969-6642
FAX: 1-703-684-5968
TTY: 1-800-433-5959
Website: http://www.nmha.org
An association that works with 340 affiliates to promote mental health through advocacy, education, research, and services.

References

[1] Blehar MC, Oren DA. Gender differences in depression. *Medscape Women's Health*, 1997;2:3. Revised from: Women's increased vulnerability to mood disorders: Integrating psychobiology and epidemiology. *Depression*, 1995;3:3-12.

[2] Cyranowski JM, Frank E, Young E, Shear MK. Adolescent onset of the gender difference in lifetime rates of major depression. *Archives of General Psychiatry*, 2000; 57:21-27.

[3] Frank E, Karp JF, and Rush AJ. Efficacy of treatments for major depression. *Psychopharmacology Bulletin*, 1993;29:457-75.

[4] Lebowitz BD, Pearson JL, Schneider LS, Reynolds CF, Alexopoulos GS, Bruce ML, Conwell Y, Katz IR, Meyers BS, Morrison MF, Mossey J, Niederehe G, and Parmelee P. Diagnosis and treatment of depression in late life: Consensus statement update. *Journal of the American Medical Association*, 1997;278:1186-90.

[5] Leibenluft E. Issues in the treatment of women with bipolar illness. *Journal of Clinical Psychiatry* (supplement 15), 1997;58:5-11.

[6] Lewisohn PM, Hyman H, Roberts RE, Seeley JR, and Andrews JA. Adolescent psychopathology: 1. Prevalence and incidence of depression and other *DSM-III-R* disorders in high school students. *Journal of Abnormal Psychology*, 1993;102:133-44.

[7] Regier DA, Farmer ME, Rae DS, Locke BZ, Keith SJ, Judd LL, and Goodwin FK. Comorbidity of mental disorders with alcohol and other drug abuse: Results from the epidemiologic catchment area (ECA) study. *Journal of the American Medical Association*, 1993;264:2511-8.

[8] Reynolds CF, Miller MD, Pasternak RE, Frank E, Perel JM, Cornes C, Houck PR, Mazumdar S, Dew MA, and Kupfer DJ. Treatment of bereavement-related major depressive episodes in later life: A controlled study of acute and continuation treatment with nortriptyline and interpersonal psychotherapy. *American Journal of Psychiatry*, 1999;156:202-8.

[9] Robins LN and Regier DA (Eds). *Psychiatric Disorders in America, The Epidemiologic Catchment Area Study.* New York: The Free Press, 1990.

[10] Rubinow DR, Schmidt PJ, and Roca CA. Estrogen-serotonin interactions: Implications for affective regulation. *Biological Psychiatry*, 1998;44(9):839-50.

[11] Weissman MM, Bland RC, Canino GJ, Faravelli C, Greenwald S, Hwu HG, Joyce PR, Karam EG, Lee CK, Lellouch J, Lepine JP, Newman SC, Rubin-Stiper M, Wells JE, Wickramaratne PJ, Wittchen H, and Yeh EK. Cross-national epidemiology of major depression and bipolar disorder. *Journal of the American Medical Association*, 1996; 276:293-9.

Helpful Books

Many books have been written on major depression and bipolar disorder. The following are a few that may help you understand these illnesses better.

Andreasen, Nancy. *The Broken Brain: The Biological Revolution in Psychiatry.* New York: Harper & Row, 1984.

Carter, Rosalyn. *Helping Someone With Mental Illness: A Compassionate Guide for Family, Friends and Caregivers.* New York: Times Books, 1998.

Duke, Patty and Turan, Kenneth. *Call Me Anna, The Autobiography of Patty Duke.* New York: Bantam Books, 1987.

Dumquah, Meri Nana-Ama. *Willow Weep for Me, A Black Woman's Journey Through Depression: A Memoir.* New York: W.W. Norton & Co., Inc., 1998.

Fieve, Ronald R. *Moodswing.* New York: Bantam Books, 1997.

Jamison, Kay Redfield. *An Unquiet Mind, A Memoir of Moods and Madness.* New York: Random House, 1996.

The following three booklets are available from the Madison Institute of Medicine, 7617 Mineral Point Road, Suite 300, Madison, WI 53717, telephone 1-608-827-2470:

Tunali D, Jefferson JW, and Greist JH, *Depression & Antidepressants: A Guide*, rev. ed. 1997.

Jefferson JW and Greist JH. *Divalproex and Manic Depression: A Guide*, 1996 (formerly Valproate guide).

Bohn J and Jefferson JW. *Lithium and Manic Depression: A Guide*, rev. ed. 1996.

Depression: What Every Woman Should Know was originally developed for the Depression Awareness, Recognition, and Treatment (D/ART) program. The brochure has been revised by Margaret Strock, staff member in the Information Resources and Inquiries Branch, Office of Communications and Public Liaison, National Institute of Mental Health (NIMH). Expert assistance was provided by Mary Blehar, PhD, Matthew Rudorfer, MD, Melissa Spearing, and Clarissa Wittenberg, NIMH staff members, and by Ellen Frank, MD, Western Psychiatric Institute, University of Pittsburgh Medical Center. Their help in assuring the accuracy of this brochure is gratefully acknowledged. Editorial assistance was provided by Lisa Alberts, NIMH staff member.

For more information on research into the brain, behavior, and mental disorders contact:

National Institute of Mental Health
Information Resources and Inquiries Branch
6001 Executive Boulevard, Room 8184, MSC 9663
Bethesda, Maryland 20892-9663
Telephone: 1-301-443-4513
TTY: 1-301-443-8431
FAX: 1-301-443-4279
Mental Health FAX 4U 1-301-443-5158
E-mail: nimhinfo@nih.gov
Website: http://www.nimh.nih.gov

NIH Publication No. 00-3679
August 2000

U.S. Department of Education
Office of Educational Research and Improvement (OERI)
National Library of Education (NLE)
Educational Resources Information Center (ERIC)

NOTICE

Reproduction Basis

This document is covered by a signed "Reproduction Release (Blanket)" form (on file within the ERIC system), encompassing all or classes of documents from its source organization and, therefore, does not require a "Specific Document" Release form.

This document is Federally-funded, or carries its own permission to reproduce, or is otherwise in the public domain and, therefore, may be reproduced by ERIC without a signed Reproduction Release form (either "Specific Document" or "Blanket").