



# Women and Depression

What  
you need  
to know  
about this  
medical  
illness

 **nami**  
National Alliance on Mental Illness

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## ■ Introduction

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Everyone experiences disappointment or sadness in life. When the “down” times last a long time or interfere with your ability to function, you may be suffering from a common medical illness called depression.

Major depression affects your mood, mind, body, and behavior. Nearly 18 million Americans—one in ten adults—experience depression each year, and about two-thirds don’t get the help they need.

Women experience twice the rate of depression as men, regardless of race or ethnic background. An estimated one in eight women will suffer from major depression in their lifetimes.

Major depression, sometimes referred to as clinical or unipolar depression, is more than feeling sad after losing a loved one, or feeling irritable or down because of work-related stress or financial or family problems.

Major depression occurs when these feelings increase in duration and intensity and affect daily functioning. With the correct diagnosis, major depression can be treated effectively. Left untreated, the likelihood of having another episode increases. Suicidal thoughts and even attempts may also occur.

This brochure presents the many dimensions of depression in women throughout their lives. Having accurate information about major depression and how it is treated will enable you to help yourself or another woman you suspect has depression.

## ■ Symptoms

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Some people experience symptoms of major depression over a long period of time, while others may have a time-limited bout of depression. Without treatment, these bouts can occur frequently.

To meet the criteria for major depression, most of the following symptoms must be present for at least two weeks, or interfere with work or family life:

- Persistent sad, anxious, or “empty” mood.
- Loss of interest or pleasure in regular activities.
- Restlessness, irritability, or excessive crying.
- Feelings of hopelessness, helplessness, low self-esteem, or guilt.
- Inability to concentrate, remember things, and make decisions.
- Changes in sleep and appetite (too much or too little).
- Loss of energy and feeling “slowed down.”

## Causes

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Researchers suspect that, rather than a single cause, many factors unique to women's lives play a role in developing depression. These factors include: genetic and biological, reproductive, hormonal, abuse and oppression, interpersonal, and certain psychological and personality characteristics.

### Genetic

Depression tends to run in families, which indicates that a biological vulnerability may be inherited. However, not everyone with a family history of depression develops the illness. Major depression can also occur in people with no family history of the illness.

This suggests that other factors are involved in the onset of depression.

### Biological

Brain chemistry is a significant factor in major depression. It is known that individuals with major depression have brain chemicals called neurotransmitters that are poorly regulated. The activity of these brain chemicals—including serotonin and the effects of estrogen on these neurotransmitters—may be linked to higher rates of depression in women.

In addition, women with major depression tend to sleep more than men, and their thyroid gland appears to function differently. These differences may also explain the higher rates of depression in women.

Be sure to get a comprehensive medical evaluation to understand the potential role of *any* medical problems you may have that may mimic or compound clinical depression.

### Psychosocial

Significant loss, a difficult relationship, financial problems, or a major change in life appear linked to the onset of major depression. Acute or chronic physical illness and substance abuse also have been linked with depression.

Women with certain characteristics—including pessimistic thinking, low self-esteem, a sense of having little control over life events, and a tendency to worry a lot—are more likely to develop depression. These characteristics can increase the effect of stressful events or limit a woman's ability to cope with them.

Upbringing or sex role expectations may contribute to these traits. For example, negative thinking patterns usually develop in childhood or adolescence.

### Victimization

Sexual and physical abuse are risk factors for depression in women. The research shows that women with a history of child sexual abuse are more likely to experience major depres-

sion in their lives than women without such a history. Many abused women experience signs of depression and traumatic stress.

Depression also occurs more often in women who were raped as adolescents or adults.

Other types of abuse, such as physical and sexual harassment on the job, may increase the rates of depression in women. Abuse fosters low self-esteem, a sense of helplessness, self-blame, and social isolation.

### **Poverty**

Low economic status contributes to depression among women. For low-income women, the rate of depression among mothers is about 25 percent—double the rate for all women. More than half the mothers (52 percent) in a study of 17 Early Head Start programs reported symptoms of depression.

Low-income women often experience many stressors, including isolation, uncertainty, frequent negative events, and poor access to helpful resources. Sadness and low morale are common among people of low-income who lack social supports. However, the research hasn't confirmed whether environmental stressors such as these increase the rate of depression in low-income women.

## **Women of Color**

Middle-aged Hispanic women have the highest rates of depressive symptoms (43 percent), followed by middle-aged African-American women (27 percent), white women (22 percent), and Asian-American women (14 percent) according to a nationwide study of women's health published in the August 2004 *American Journal of Public Health*.

Poverty (as indicated both by education years and by difficulty paying for basic necessities) contributes to the higher rates of depressive symptoms among certain racial/ethnic minorities. Other risk factors are: racial/ethnic discrimination, segregation into low-status and high-stress jobs, unemployment, poor health, larger family sizes, marital dissolution, and single parenthood. Strong feelings of stigma as part of ethnic family cultures also play a role.

Women who immigrated recently to the United States and faced adjusting to a new culture were more likely to have major depression than women without such conflicts.

Hispanic and African-American women were the most likely to report current psychological distress, followed by Asian women, according to the results of a 1998 survey published in the May-June 2001 *Women's Health Issues*. Experiencing psy-

chological distress is a strong predictor of suicide attempts for low-income African-American women.

Young Asian-American women have the highest depression rates of any group and the second highest rate of suicide among 15- to 24-year-old females. American Indian/Alaska Native adolescents are the most likely to attempt suicide and die from it.

Asian-American college students suffered from low self-esteem and a limited sense of control over their lives, according to a California college student study. These young women, many from immigrant families, cited conflicting Asian and American cultural values, family expectations, and not talking about mental health problems to “save face.”

Almost two-thirds of women who are Hispanic, African-American, or Asian-American reported not receiving needed mental health care in a given year. By contrast, one-third of women who are white or of other races reported not obtaining needed mental health care.

Women of color often face more barriers to appropriate mental health care services, including language and cultural, distrust of mainstream medicine, lack of health insurance, and stigma surrounding depression and mental health disorders.

For many, the faith community is often an important source of support. It should be integrated into any care plan for a person who participates in such a community. In some cases, pastoral counseling will be a beneficial part of a comprehensive treatment program.

## ■ Life Stages

### **Adolescence**

Boys and girls have the same rate of depression until they reach adolescence. Between the ages of 11 and 13, the rate rises sharply for girls. By age 15, girls are twice as likely as boys to have depression, a trend that continues throughout adulthood.

Adolescence is a stressful time involving physical, hormonal, and intellectual changes. The stresses include identity, sexuality, separation from parents, and independence. Girls experience these stresses differently from boys, which may be a risk factor for developing depression.

### **Adulthood**

Stress in general can contribute to depression in people who are biologically vulnerable to the illness. Some professionals think that the greatest contributor to the higher rates of depression in women isn't their greater vulnerability, but the numerous stresses they face. These stresses include major

responsibilities at home and at work, single parenthood, and caring for children and aging parents. How these factors uniquely affect women is not yet fully understood.



The rates of depression are highest for people who are separated and divorced, and lowest among the married, although the rates remain higher for women than men. Reasons for the higher rates of depression in women who were unhappily married were that they lacked an intimate, confiding relationship, or they frequently and openly argued.

### Late Adulthood

As with younger women, elderly women are at a greater risk of major depression than elderly men are. Similarly, being single—including widowhood—is also a risk factor. About 800,000 men and women are widowed each year. Most of them are older, female, and experience different degrees of depressive symptoms. A third of widows/widowers in the first month after the spouse's death met the criteria for major depression, and half of them continued to be depressed one year later.

Bereavement can look similar to clinical depression. Grief may resolve without medical intervention, as the loss is metabolized, and with the support of family, faith, and friends. In some cases though, a true depression, originating in grief, does require more active intervention to help a person move forward.

## Reproductive Events

A woman's menstrual cycle, pregnancy, post-pregnancy period, infertility, menopause, and sometimes the decision to not have children, can trigger mood fluctuations and depression. Research has confirmed that hormones have an effect on the brain chemistry that controls emotions and mood.

Many women experience behavioral and physical changes during their menstrual cycle. These can be severe, occur regularly, and include depressed feelings, irritability, and other

emotional and physical changes. With premenstrual syndrome (PMS) or premenstrual dysphoric disorder (PMDD), the changes typically start after the ovaries produce and discharge eggs and the changes become gradually worse until menstruation starts. Researchers are exploring how the cyclical rise and fall of hormones, including estrogen, may affect the brain chemistry associated with depressive illness.



Major depression is highly responsive to treatment.

Post-pregnancy or post-partum changes can vary from temporary “blues” right after childbirth, to an episode of major depression, to severe, incapacitating depression. Studies suggest that women who experience major depression after childbirth often had previous episodes of depression that may not have been diagnosed and treated.

Being pregnant or having an abortion rarely contributes to higher rates of depression. Women with infertility problems may feel extreme anxiety or sadness, although it is unclear if this contributes to a higher rate of depression. Motherhood may be a time of increased risk for depression because of the stress and demands it imposes on women.

Menopause in general isn't associated with an increased risk of depression. Research has shown that depression at menopause is no different than at other ages. The women at greater risk are those with previous depressive episodes.

## ■ Depression is Treatable

Major depression is highly responsive to treatment. Most people return to their daily routines and experience relief from feeling depressed.

There are three well-established types of treatment for clinical depression: medications, psychotherapy, and electroconvulsive therapy (ECT). People with major depression tend to do best with a combination of medication and psychotherapy.

There are also lifestyle changes people can make to improve their health. In particular, there is a growing body of research that supports the use of aerobic exercise as an intervention for mild to moderate depression.

### Medications

It often takes two to four weeks for antidepressants to take effect and six to 12 weeks for them to be fully effective. Some patients have to try different doses and antidepressants to find what's effective for them.

There are different types of antidepressant medications. In general, the newer antidepressants are more popular than the older ones because they are safer and have fewer side effects.

Reuptake inhibitors are designed to increase the amount of one or more brain chemicals, called serotonin, norepinephrine, and dopamine, by blocking the recycling of their transmitters.

Selective serotonin reuptake inhibitors (SSRIs) are the most widely used antidepressants. They include fluoxetine (Prozac), sertraline (Zoloft), paroxetine (Paxil), citalopram (Celexa), escitalopram (Lexapro), and fluvoxamine (Luvox).

Serotonin and norepinephrine reuptake inhibitors (SNRIs) are the second most popular antidepressants worldwide. They include venlafaxine (Effexor) and duloxetine (Cymbalta).

Bupropion (Wellbutrin) is a very popular antidepressant classified as a norepinephrine-dopamine reuptake inhibitor (NDRI).

Mirtazapine (Remeron) targets specific serotonin and norepinephrine receptors in the brain, which indirectly increases the activity of several brain circuits.

Older agents, such as the tricyclic antidepressants (TCAs) and monoamine oxidase inhibitors (MAOIs), are used rarely now as first-line treatment. Although TCAs are similar to SNRIs, they have higher rates of side effects. Their use is generally limited to cases where other antidepressants have failed. TCAs include amitriptyline (Elavil, Limbitrol), desipramine (Norpramin), doxepin (Sinequan), imipramine (Tofranil), nortriptyline (Pamelor, Aventyl), and protriptyline (Vivactil).

MAOIs increase the levels of three chemicals in the brain by stopping enzymes from depleting them. MAOIs can be effective for people who have failed to benefit from other medications or have "atypical" depression with marked anxiety, excessive sleeping, irritability, hypochondria, or phobic characteristics. However, these are the least safe antidepressants because of important medication interactions and the necessity of adhering to a special diet.

MAOIs include phenelzine (Nardil), isocarboxazid (Marplan), and tranylcypromine (Parnate).

The pros and cons of using antidepressants while pregnant, breast-feeding, or trying to conceive must be weighed carefully because of the possible risk to the developing fetus or newborn. Large-scale studies have not shown a significant increase in birth defects in women using SSRIs or tricyclic antidepressants while pregnant, but each woman should discuss these issues with her physician.

A person who experiences a clinical depression should be mindful of the potential for a manic episode to follow it. This is so particularly if bipolar disorder (formerly known as "manic depression") is present in one's family history. Many people who have a bipolar disorder started out with an episode of depression. The question does affect what kind of treatment you might consider, and so you should discuss it with your health care provider.

### **Psychotherapy**

The most common and effective short-term therapies for depression are cognitive-behavioral therapy (CBT) and interpersonal therapy (IPT). CBT helps to create more effective and beneficial behaviors by replacing negative thought patterns with positive ones. Similarly, initiating new positive behaviors can improve thoughts and moods.

IPT focuses on improving one's personal relationships that may contribute to depression. People are taught to evaluate their interactions with others to become aware of self-isolation and problems getting along with, relating to, or understanding others.

Depression in an individual can affect everyone in his or her family. Consider how it can benefit everyone for you to work with your family, using professional or other supports, to learn how to work together through this condition.

### **Electroconvulsive Therapy (ECT)**

ECT is a highly effective treatment for episodes of major depression. It should be used when medication, psychotherapy or a combination of the two is ineffective or too slow to relieve severe symptoms (such as psychosis or thoughts of suicide), or when antidepressants can't be taken.

## **■ Preventing Recurrent Depression**

The earlier treatment begins, the greater the chance of preventing future episodes. Maintenance strategies include the continuation of medication at the same dose used for an acute episode and monthly interpersonal therapy sessions for patients not taking medication.

Untreated or only partially treated depression raises the risk of suicide. Co-occurring substance abuse—most commonly with alcohol—compounds this risk. So it's especially impor-

tant to have a crisis plan with your care providers to anticipate how to prevent such an outcome.

## Seeking Professional Help

Many women avoid seeking professional help because they don't realize the benefits. Good reasons to see a healthcare professional include these:

- A medical problem may be responsible for your condition.
- Talking to a professional may add another layer of support.
- Perhaps you can't talk openly with your family about what's really bothering you.
- You may find comfort in knowing other women feel the same way as you do.

Like certain other conditions, such as diabetes or high blood pressure, depression can raise a woman's risk of heart disease. This makes the need for treatment even more compelling. You may want to start by talking with your family doctor, obstetrician/gynecologist or a practitioner at the local health clinic. A primary care doctor can make referrals to a mental health specialist for an evaluation and possible treatment.

The following signs indicate when to seek professional help:

- You can't engage in daily activities like getting out of bed in the morning or eating or bathing.
- You are unable to attend to your or your children's medical needs, such as keeping doctor's appointments.
- You are having difficulty caring for your children.
- You can't eat and are losing a lot of weight.
- You are drinking a lot of alcohol or using recreational drugs to feel better.
- Your personality has undergone a distinct change.
- Your depression is becoming more severe.

The following conditions are considered psychiatric emergencies and require a timely mental health evaluation. If necessary, they may require a visit to your local emergency room.

- Suicidal thoughts.
- Violent thoughts directed at your children or someone else.
- You or someone else feels you're at risk for harming your children.
- You are engaging in bizarre or unusual behaviors.
- You are hearing voices or having visions.
- You are convinced of things that aren't true or rational.

## Treatment Costs

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The cost of treatment depends on the type of treatment, setting, therapist's training, and your insurance coverage. For example, being treated in a hospital or residential care setting can be more expensive than being treated in a clinic or therapist's office.

**Community mental health centers** typically provide Medicaid services and some also provide Medicare services. There may be a deductible or co-payment depending on your insurance coverage. For people without health insurance, fees are determined on a sliding scale based on personal income and medical expenses. These can range from \$5 to \$50 per hour.

**Private outpatient clinics** charge fees that range from \$50 to \$100. These clinics usually don't provide Medicaid or Medicare services, which can increase your payment. Some non-profit agencies use a sliding scale system, which may qualify individuals for a lower rate. In addition, fees for group therapy are lower than fees for individual therapy.

**Private therapists** usually accept only private insurance and some therapists don't accept any health insurance. Therapist's rates depend a lot on the years of training. For example, medical doctors who specialize in mental health, referred to as psychiatrists, will charge for medication visits and more per hour for therapy than counselors or psychiatric nurses. Rates for hourly therapy typically range from \$60 to \$150.

**Hospitalization** fees range from \$400 to \$700 per day depending on the particular setting. Some hospitals specialize in psychiatry and others have psychiatric units. Admissions criteria can be restricted, depending on health insurance status, voluntary or involuntary commitment status, and whether the family will participate in the person's recovery plan.

## Helping Yourself

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There are some practical things you can do to manage stress and depression. These include remembering to take care of yourself—to eat well, exercise, relax, and get enough sleep. There is good evidence that regular exercise and a healthy diet can help reduce stress and have positive effects on your mood. Some women find yoga relaxing and a good stress reliever.

Another way to reduce stress is learning to manage your time realistically and developing realistic expectations of yourself so that you can accept less than perfection.

Building a strong reliable support network is essential to good mental health. Women who are depressed need the support and help of others.

Support may come in many forms and places, including one's partner, family, friends, neighbors, and religious community. It may be someone who is a good listener or keeps you company when you're feeling low. But, you may have to ask people for support and be specific about your needs.

Some women find that a good support group is a safe place to share their problems with people who understand. A wide variety of support groups are available: from ones that work on coping with and recovering from depression to others dealing with a difficult loss, such as a miscarriage or infertility.

Mental health specialists often know of support groups for depression. Other places to look are your local newspaper's community calendar, hospital Web sites, and local mental health associations. See also the resources listed later in this brochure.

## ■ Talking to a Woman with Depression

If a friend or loved one has depression, you may be trying to figure out how you can talk to her in a comforting and helpful way. This may be difficult for many reasons. She is probably feeling isolated, emotionally withdrawn, angry or hostile, and sees the world in a negative light.

Although you may feel your efforts are rebuffed or unwelcome, she needs your support.

You can simply be someone she can talk to and let her share her feelings.

It's important to remember that depression is a medical illness. Her symptoms are not a sign of laziness or of feeling sorry for herself. She can't just "snap out of it" by taking a more positive outlook on life.

Helpful responses include, "I am sorry you're in so much pain," or, "I can't imagine what it's like for you. It must be very difficult and lonely."

A woman with depression often expects to be rejected. You can reassure her that you will be there for her and ask if there's anything you can do to make her life easier.

*—Written by Christine Lehmann and Ken Duckworth, M.D.  
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## ■ What is NAMI?

The National Alliance on Mental Illness (NAMI) is the nation's largest grassroots mental health organization dedicated to improving the lives of individuals and families affected by mental illness. NAMI has over 1,100 affiliates in communities across the country who engage in advocacy, research, support, and education. Members of NAMI are families, friends, and people living with mental illnesses such as major depression, schizophrenia, bipolar disorder, obsessive-compulsive disorder (OCD), panic disorder, post-traumatic stress disorder (PTSD), and borderline personality disorder.

### **To learn more about your local affiliate:**

**Call** your state's NAMI office

**Write to:** NAMI • 2107 Wilson Boulevard, Suite 300 •  
Arlington, VA 22201-3042

**Contact the NAMI Information Helpline at**

1 (800) 950-NAMI (6264) or

**Visit NAMI's Web site** at [www.nami.org](http://www.nami.org)



## ■ Other Resources

### **Books About Depression**

Copeland, Mary Ellen, and McKay, Matthew. *The Depression Workbook: A Guide for Living with Depression and Manic Depression*, 2nd ed. Oakland, Calif.: New Harbinger, 2002.

Dukakis, Kitty and Tye, Larry. *Shock: The Healing Power of Electroconvulsive Therapy*. New York: Avery, 2006.

Fast, Julie, and Preston, John. *Get It Done When You're Depressed: 50 Strategies for Keeping Your Life on Track*. Royersford, Penn.: Alpha Publishing, 2008.

Golant, Mitch and Susan. *What To Do When Someone You Love is Depressed*. New York: Holt, 1998.

Hedeya, M.D., Robert. *The Antidepressant Survival Guide*. New York: Three Rivers Press, 2001.

Kramer, Peter. *Against Depression*. New York: Penguin, 2006.

Strauss, Claudia. *Talking to Depression: Simple Ways To Connect When Someone In Your Life Is Depressed*. New York: NAL Trade, 2004.

### **Books that Focus on Depression in Women**

Nunacs, Ruta. *A Deeper Shade of Blue: A Woman's Guide to Recognizing and Treating Depression in Her Childbearing Years*. New York: Simon and Schuster, 2006.

Sheffield, Anne. *Sorrow's Web: Hope, Help, and Understanding for Depressed Mothers and Their Children*. New York: Free Press, 2001.

**Wyeth**

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