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For Immediate Release

## **NEW REPORT ON WOMEN AND DEPRESSION: LATEST RESEARCH FINDINGS AND RECOMMENDATIONS**

### **Gender Differences, Biological, Psychological and Social Factors, Treatment and Prevention Strategies Examined**

WASHINGTON - More than 19 million Americans suffer from depression yearly and women are twice as likely as men to experience a major depressive episode. Depression may occur at any age during a woman's life with certain events like puberty, pregnancy, perimenopause, trauma, substance abuse and quality of relationships increasing the risk, according to the leading authorities on the etiologies and treatments for depression.

Furthermore, depression can occur among women from all educational, economic and racial and ethnic groups and the consequences can include an increased risk of suicide, morbidity from medical illness and risk for poor self-care and reduced adherence to medical regimes. These findings are among those summarized in a new report, *Summit on Women and Depression: Proceedings and Recommendations*, just published by the American Psychological Association, and reflecting the research reviewed by 35 internationally renowned experts from a variety of disciplines who contributed papers to the Summit. By reviewing the latest research on depression, the experts offer explanations on the possible causes of depression, suggest new research directions and recommend how current research findings can be incorporated into health policy and health care practices.

Major depression can impair a person's social and physical functioning even more severely than serious medical conditions such as hypertension, diabetes or arthritis, and can result in disability and significant loss of income, according to the research cited in the report. Furthermore, a World Health Organization Report examining "The Global Burden of Disease" found that "depression presents the greatest disease burden for women when compared with other diseases."

Some of the findings that examine the possible culprits of depression are:

- **Genetic Factors:** Based on data that major depression clusters in families, having a

first-degree relative with depression (parent, sibling) is a risk factor for depression. Although results from family or twin studies have not been definitive in showing the exact contribution of genetics to depression. Evidence is accumulating that there is a genetic risk that may be different for women and men. For women, it will be particularly instructive to understand the interaction of genetic, hormonal and experiential factors in their heightened risk for depression.

- **Sex Hormones:** The link between increased rates of depression and puberty, mood and the menstrual cycle as well as mood and pregnancy suggests a role of gonadal hormones in depression. Specifically, changes in gonadal hormones, disturbances in the hypothalamic-pituitary-gonadal (HPG) axis and attendant effects on neuromodulators (e.g. serotonin) may all be key mechanisms in the initiation of depression. For example, pregnancy and delivery produce dramatic changes in estrogen and progesterone levels, as well as changes in the HPG axis, that may underlie postpartum depression.
- **Life Stress and Trauma:** Case-control and community-based studies have shown that more than 80 percent of major depression cases were preceded by a serious adverse life event. Traumatic events, such as childhood sexual abuse, adult sexual assault, male partner violence and physical illness also can lead to depression. Initial research has suggested that early trauma has a greater impact on risk for depression than later occurring trauma. Research has also indicated that women may be more likely than men to experience depression in response to a stressful event.
- **Interpersonal Relationships and Cognitive Styles:** One cognitive style more common in women than men that increases the risk for depression is ruminative thinking - repetitively and passively focusing on symptoms of distress and their possible causes and consequences. Ruminative thinking is also associated with longer and more severe episodes of depression. Current research has demonstrated that relationships are more paramount to women's self-concept than men and that women are more likely to experience stress in response to adverse events occurring in the lives of others and place their needs secondary to those of others. These interpersonal orientations illustrate major psychological differences between men and women that may help account for differences in vulnerability to depression.

Common treatments for depression in women include psychotherapies and antidepressants. Both psychotherapy and antidepressant treatments are equally effective for mild to moderate depression. In particular, with regard to psychotherapy, controlled clinical trials provide evidence for the efficacy of interpersonal and cognitive behavioral interventions. Other evidence suggests that some structured behavioral marital and family therapies are effective in treating depression. There is also some evidence that psychotherapy is useful in preventing relapse or recurrence of major depression in patients who had successfully been treated with antidepressants. Cognitive behavior therapy has been shown to have a lasting effect that prevents subsequent onset or return of symptoms regardless of whether medication was used.

Approximately 30-35 percent of individuals taking antidepressants do not respond to this form of treatment. Others seek alternative treatments. Alternative therapies include meditation and relaxation, exercise, acupuncture and herbal agents, such as St. John's Wort. Despite the popularity of these alternative treatments, many are untested or not sufficiently tested, which creates a need for research to examine the efficacy, effectiveness and safety of these agents, specifically for women in different age groups.

The contributors to this report recommend more effort to develop, evaluate and implement interventions that will prevent the recurrence of major depression in women at risk by virtue

of a prior episode. Targeted prevention was also recommended, focusing on times of heightened risk for depression, such as adolescence. Preventive strategies in women about to become mothers were seen as needed particularly for women who had risk by virtue of previous depression, especially previous postpartum depression.

Development of services for women with depression should consider the importance of affordable access to care and trained primary care providers who can recognize symptoms and offer appropriate antidepressant medication along with referrals to mental health providers. For women with serious depression, rehabilitation services must be enhanced that include residential care and independent living supports.

Lastly, according to the report, public education campaigns are an invaluable source for improving recognition and understanding of major diseases. The contributors recommend different strategies to educate the public about depression in women, which could ultimately increase the number of women who seek treatment. Professional organizations, the media, federal agencies, foundations, private industries, labor unions and health care organizations can play a role in educating the public on depression.

Report: "Summit on Women and Depression: Proceedings and Recommendations," Carolyn Mazure, Ph.D., Professor of Psychiatry, Director of Women's Health Research and Associate Dean for Faculty Affairs at Yale School of Medicine; Gwendolyn Keita, Ph.D., Director of Women's Programs and Associate Executive Director, Public Interest Directorate at American Psychological Association; Mary Blehar, Ph.D. Chief, Women's Health Program National Institute of Mental Health

(Copies of the report are available from the APA Public Affairs Office or after **March 18** at <http://www.apa.org/pi/wpo/women&depression.pdf>)

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### Integrative Speakers - Summit on Women and Depression

#### **Integration of Epidemiology, Risk Factors and Course**

Susan Nolen-Hoeksema, PhD; University of Michigan

#### **Treatment and Prevention of Depression in Women**

A. John Rush, MD; Southwestern Medical Center

## **Treatment and Prevention in Women/Targeted Populations**

Ellen Frank, PhD; University of Pittsburgh

## **Effective Integration of Services for Woman with Depression**

Jeanne Miranda, PhD; Georgetown University

### Presenters - Summit on Women and Depression

## **Developmental Changes in the Phenomenology of Depression in Girls and Young Women From Childhood Onward**

Maria Kovacs, PhD; University of Pittsburgh

## **Genetic Contributions to the Development of Depression: Are There Gender Differences?**

Laura J. Bierut, MD; Washington University in St. Louis

## **Towards an Animal Model of Female Depression**

Tracey J. Shors, PhD; Rutgers University

## **Psychosocial and Cultural Contributions to Depression in Women**

Vicki S. Helgeson, PhD; Carnegie Mellon University

## **Interpersonal Stress and Depression in Women**

Constance Hammen, PhD; University of California-Los Angeles

## **Poverty, Inequality, and Discrimination as Sources of Depression Among Women**

Deborah Belle, EdD; Boston University

## **Depression, PTSD, and Health Problems in Survivors of Male Violence: Research and Training Initiatives to Facilitate Recovery**

Mary P. Koss, PhD; University of Arizona

## **Hormones and Mood: From Menarche to Menopause**

Meir Steiner, MD; McMaster University

## **Psychotherapy for Women With Depression**

Steven D. Hollon, PhD; Vanderbilt University

*Pharmacotherapy of Depression in Women*

Kimberly A. Yonkers, MD; Yale University

## **Personality and Depression in Women: Implications for Treatment**

Thomas A. Widiger, PhD; University of Kentucky

## **Sex Differences in Depressed Substance Abusers**

Bruce Rounsaville, MD, and Rajita Sinha, PhD; Yale University School of Medicine

## **Preventing Depression in Women**

Ricardo F. Munoz, PhD; University of California-San Francisco

## **Alternative Treatments for Depression: The Quest for Empirical Support**

Rachel Manber, PhD; Stanford University

## **Hormones and Depression in Women**

Patricia D. Kroboth, PhD; University of Pittsburgh

## **Lesbians and Depression: Emerging Issues in Research on Morbidity, Treatment, and Prevention**

Susan D. Cochran, PhD; University of California-Los Angeles

## **Chronic Depression in Women**

Susan G. Kornstein, MD; Medical College of Virginia

## **Depression During Pregnancy and the Postpartum Period**

Katherine L. Wisner, MD; Case Western Reserve University

## **Premenstrual Disorders: Bridging Research With Clinical Reality**

Kimberly A. Yonkers, MD; Yale University

## **Depression During the Perimenopause**

Nancy E. Avis, PhD; Wake Forest University Medical Center

## **Aging Women and Depression**

Margaret Gatz, PhD; University of Southern California

## **What Research Suggests for Depressed Women with Children**

Myrna M. Weissman, PhD; Columbia University

## **The Epidemiology of Women and Depression**

Ronald C. Kessler, PhD; Harvard University

## **The Economics of Depression in Women**

Paul E. Greenberg and Howard G. Birnbaum, PhD; Analysis Group/Economics

## **Women With Depression: Changing Barriers to Access**

Sherry Glied, PhD; Columbia University

## **Women, Depression, and Disability: Exploring the Interconnections**

Judith A. Cook, PhD; University of Illinois at Chicago

## **Women, Depression, and the Workplace**

Mary Clare Lennon, PhD; Columbia University

## **Treatment of Ethnically Diverse Women With Depression in Primary Care Settings**

Charlotte Brown, PhD; University of Pittsburgh

## **Cost-Effectiveness of Primary Care Interventions for Depressed Women**

Kathryn Rost, PhD; University of Colorado Health Sciences Center

## **Assessment and Treatment for Depressed women in Drug and Alcohol Treatment**

Candace Fleming, PhD; University of Colorado Health Sciences Center

## **Improving Services for Women With Anxiety and Depression in Primary Care Settings**

Wayne J. Katon, MD; University of Washington

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