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ABSTRACT

Women more frequently report depressive symptoms, are diagnosed as depressed, and in far greater proportion than men, seek outpatient treatment for depression. Therefore, the ambulatory treatment of depression is of particular importance when reviewing the mental health of women. This paper reviews the data on sex differences in rates and treatment of depression, reviews the evidence based on controlled study for the efficacy of traditional therapies for depression, and describes some of the non-traditional therapies and speculates on their utility. The discussion of traditional therapies include pharmacotherapy and psychotherapy. The non-traditional therapies included are self-help groups and counsciousness-raising groups. (Author/KRP)

DEPRESSED WOMEN: TRADITIONAL AND NON-TRADITIONAL THERAPIES

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Considerable attention has recently been directed to the quality of psychiatric care, especially psychotherapy, which women receive (Chesler, 1972). This attention has paralleled the growth of the feminist movement of the 1970's and is part of a larger reexamination of women's roles and rights. Much of the writing, however, has been in the nature of an expose (Guttentag, Personal Communication, 1975). Nonetheless, the following facts cannot be ignored. Women are by far the largest consumers of outpatient psychotherapy. Most psychiatrists and, therefore, most psychotherapists, are men. Psychotherapy as an educational process is influenced by the therapist's theoretical framework and implicit notions about what is normal behavior. Much psychotherapy is based on Freudian concepts which can include suggestions that women are incomplete and inadequate versions of men and that the appropriate feminine role is one of nurturance, vicarious living, and subordination.

The feminists argue that the traditional feminine role leads to helplessness, noting that depression, a state of helplessness, is predominantly a female disorder and that traditional therapies encourage women to adjust to situations which are depressing. To correct this situation there has been a burgeoning of informal non-traditional therapies initiated and led by women.

Despite the interest in women's mental health treatment and the increase in these alternate therapies, it is almost impossible to draw conclusions as systematic data on these new therapies are unavailable. The situation is confounded by the fact that traditional therapies are diverse (e.g., compare Freudian psychoanalytic therapy with behavior therapy); non-traditional therapies are also diverse (e.g., compare a consciousness-raising group with a self-help career center)· there are little systematic data on users, types of efficacy

of the non-traditional therapies;[1] there are no published data on the effectiveness of female as compared to male therapists in traditional therapies.[2]

This paper will not be able to shed new light on most of the issues as the data are lacking. However, a reexamination of the epidemiologic and clinical data that are available can suggest the next phase of the study.

This paper has several purposes: to review the data on sex differences in rates and treatment of depressive disorder which will demonstrate the most common mental health problems and help-seeking of women, to review the evidence based on controlled study for the efficacy of traditional therapies for depression; to describe some of the non-traditional therapies and to speculate on their utility.

The Psychiatric Disorders of Women

Whereas alcohol and drug abuse are predominantly male disorders and schizophrenia shows no clear sex trend, depression is by far the most prevalent psychiatric condition among women. This observation has been confirmed by numerous epidemiologic studies.

Table 1 summarizes these findings for depression. For brevity, this review is limited to recent studies and to data from the United States. However, the figures are representative. Gerald Klerman and I have recently reviewed the data on sex ratios in psychiatric disorders covering the last forty years and including countries outside the United States, and have found essentially the same results (Weissman & Klerman, 1975a).

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(1) Marcia Guttentag, Ph.D., Harvard University, has recently undertaken a study of women's mental health services which will examine self-help groups.

(2) D. Orlinsky and K. Howard at University of Chicago and Northwestern University, respectively, have undertaken a reanalysis of data collected on women in outpatient psychotherapy who had been assigned male or female therapists in order to determine the effect of the therapist's sex on outcome.

Data are available from two sources: clinical observations of patients coming for treatment either as inpatients or as outpatients; or surveys of persons in the community.

- - - - INSERT TABLE 1 ABOUT HERE - - - -

Women More Frequently are Diagnosed as Depressed

Studies of patients coming for treatment provide an estimate of illness of moderate to serious intensity as scrutinized and processed by clinical professionals and institutions. Rates of diagnosed disorders are subject to the availability of treatment facilities and the person's willingness to seek and ability to afford treatment.

Hospital admissions usually represent the more severe forms of the illness. Looking at Table 1 we can see that in the United States women predominate among hospital admissions for depression. There are approximately 175 women to every 100 men admitted for depressions. The sex difference is much more striking when one looks at the figures for outpatient services where there are 238 women for every 100 men, over a twofold difference.

Are Women More Depressed?

Treated cases do not represent true incidence since many persons who are ill do not seek treatment and epidemiologic evidence requires data from community surveys. Such surveys usually include a random sample of persons in a community or a defined non-clinic population. Therefore, information on persons who are both in treatment as well as those who have never received any treatment and would not have been included in the previous figures, can be recorded.

We can see that depressed women still predominate in surveys (Table 1). However, the sex ratios for surveys are comparable to ratios found in hospitalized patients and not as high as in outpatient treatment. The outpatient sex

ratio for depression are consistent with patterns of help-seeking and treatment utilization of women, in general. For example, the National Ambulatory Medical Care Survey for 1973-74 showed that women outnumbered men 3 to 2 in number of office visits for all illnesses.

We can conclude that women not only have different mental health problems, but different methods of coping with them. These differences are reflected in differing diagnosis and utilization of psychiatric facilities. Women more frequently report depressive symptoms, are diagnosed as depressed, and in far greater proportion than men, seek outpatient treatment for depression. Therefore, the ambulatory treatment of depression is of particular importance when reviewing the mental health care of women.

How Effective are the Treatments for Depression?

Treatments for depression on an ambulatory basis can be divided into pharmacotherapy and psychological therapy. Electroconvulsive therapy is used for the severe forms of depression in those patients where drugs are not indicated for medical reasons or in patients who have not been responsive to pharmacologic treatments. With rare exception it is not an ambulatory treatment and will not be discussed here.

While we are interested, for this discussion, in the efficacy of psychotherapies it is important to review the evidence for pharmacotherapy since in practice both treatments are employed either separately, alternately, or combined. Moreover, there has been concern from those involved in women's issues that women may be over-medicated in order to encourage them to adjust to intolerable situations which, in fact, might require social and political change. Therefore, clarity as to what condition and on what outcomes we can expect the different treatments to be effective may help us to understand their utility. For this discussion we will examine acute and maintenance therapy separately.

Antidepressants - Acute Treatment

The discovery in the late 1950's of the monoamine oxidase inhibitors and the tricyclic compounds revolutionized the treatment of depression. These and other antidepressant drugs have been tested in well designed, double blind placebo controlled studies and the results have been well reviewed (Klerman and Cole, 1965) (Klein and Davis, 1969). These results leave little doubt as to their efficacy, as compared to placebo, in reducing the acute symptoms of depression over 2-4 weeks. Acutely depressed patients receiving these medications report improvement in mood, sleep, appetite, sexual functioning and reduction of suicidal ideation (Haskell, et al, 1975). Although these drugs do not help some depressed patients and many patients improve with placebo, the accumulated evidence is still strong that these drugs, especially the tricyclics, are effective treatments.

Antidepressants - Maintenance Treatment

Maintenance treatment is particularly important since a substantial proportion of depressed patients (40-50%) experience recurrence and a small portion (10-15%) become chronic (Weissman & Klerman, 1975b) (Robins & Guze,1972).

Until recently there were no acceptable data on the place of maintenance therapy in preventing relapse. It was unclear how long patients should remain on drugs and how best to prevent a recurrence of symptoms. Over the last three years such evidence has become available.

Table 2 summarizes the results of four maintenance trials of tricyclic antidepressants, all of which involved outpatients. The New Haven-Boston and the Baltimore studies included only women. The Philadelphia study was 80% and the London study 65% female. All of these studies showed an effect for tricyclic antidepressants in preventing relapse and reducing symptoms. Interestingly, the Baltimore study found that diazepam at 12 months was less

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covery from a depressive episode who continued on maintenance
the most benefit. The three studies reporting data on social
owed either no or a minimal effect. The New Haven-Boston study
erence between amitripytline, placebo or no pill on the patient's
ment. The Philadelphia study found a small effect on participation
e in family roles, and the Baltimore study noted an effect on
interpersonal perceptions.

- - - - INSERT TABLE 2 ABOUT HERE - - - - -

, the similarity in findings between studies offer clear
for the outpatient treatment of depression. There is value in
ntidepressants in preventing relapse and symptom return especially
has lingering symptoms following an acute episode. Moreover, there
that caution should be exerted in substituting the minor tranquilizers
antidepressants as maintenance therapy in patients with a definite
epression.

ome recovery of social performance undoubtedly occurs as a
reduction of symptoms, medications themselves may have only a
on problems in living, and many investigators have proposed that
would be effective in these areas.

- Acute Treatment

inical testimony about the value of psychotherapy for acute treatment,
ind any controlled clinical trials of psychotherapy which specifically
treatment in a homogenous sample of depressed patients, although
patients have undoubtedly been included in studies testing the
ychotherapy (Luborsky, et al, 1975). There are suggestive pieces of

evidence, e.g., Auerbach (1972) has fou
was a positive prognostic sign for a ps

The Philadelphia study, although de
patients during the acute phase when th
minimal contact. This study showed a m
for marital therapy at the end of four
study, also designed as a maintenance t
after one week on improvement in mood.
weeks (Lipman, et al, 1975).

There are studies underway, however,
acute psychotherapeutic treatment of de
recently reported preliminary results fr
severely depressed outpatients using twi
as compared with imipramine. While the
cognitive behavior therapy was as effect
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The New Haven-Boston Collaborative D
16-week study of the acute treatment of
including individual psychotherapy alone
treatment and no planned treatment. Thi
results will be available in the coming

Psychotherapy - Maintenance Therapy

Whereas the goal of acute treatment
therapy there is concern with prevention
and enhancement of social functioning.
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Table 3 shows the results of the maintenance psychotherapies. The New Haven-Boston trial, which used individual psychotherapy given by psychiatric social workers, showed a positive effect for psychotherapy on social and interpersonal functioning, but only in patients who completed the trial without relapsing. This effect was not apparent on symptoms or relapse rate and took 6-8 months to develop. Patients who became symptomatic and did not complete the trial showed no benefit from psychotherapy.

The Baltimore study showed an effect for group therapy which was stronger on areas related to interpersonal functioning, empathy, sensitivity and hostility, rather than symptom. This effect was evident at 16 weeks, earlier than noted in the New Haven-Boston study.

The Philadelphia study which was the briefest (12 weeks) and used marital therapy, showed an early effect. The effect was strongest on social functioning and family participation and on attitudes and behavior in marriage. There was also an effect on symptom relief but this was not as large as on social adjustment or as shown overall for drugs.

All three studies show a positive effect for the psychological intervention, which is strongest on areas related to problems in living--interpersonal relationships--and which are less strong or are absent on the symptoms of depression per se. The rapidity of the onset of effect suggests that marital therapy may have some additional benefit over the other therapies but this requires further testing.

- - - - - INSERT TABLE 3 ABOUT HERE - - - - -

Traditional Therapies do not deal with Primary Prevention

The evidence from controlled trials is most encouraging. In several independent studies, we have shown the efficacy of traditional therapies, both antidepressants and psychotherapy, in reducing symptoms of depression,

preventing their return and enhancing the social functioning of women after a depressive episode. There is no evidence, however, that any of these therapies are more than symptomatic treatments or that they will prevent the recurrence of depression once the treatment ends.

This observation has led feminists and others to challenge the value of traditional therapies. Since women predominate in the diagnosis, treatment and reporting of depression, they argue the best primary prevention may be found in reducing the conditions which depress women and in the social retraining of women by other women. This view is exemplified in the writings of Pauline Bart (1975), but other persons, both professional and non-professional, are emerging.

Why Women Get Depressed

There are, of course, many possible explanations for the predominance of depressed women. The finding can be an artifact of women's willingness to acknowledge symptoms, seek treatment, or of men's tendency to deal with depression by alcohol, drug abuse, or aggression. Alternately, the finding could be real and the result of physiologic, genetic, or social role differences. A review Gerald Klerman and I have just completed on this subject suggests that the predominance of depressed women cannot be fully explained as an artifact (Weissman & Klerman, 1975a). We could not find conclusive evidence that genetic and/or endocrine differences between the sexes could account for all of the differences, and we concluded that at least some of the difference has to do with the role of women.

The female social role explanation asserts that depression in women occurs in greater frequency than in men because women are indeed more helpless. The helplessness is related to real social inequities, as well as learned helplessness, which is part of the stereotypical female role.

The social inequity theory of female depression is embodied in those who emphasize the discrimination against women in work, education, and marriage. This discrimination they note leads to chronic low self esteem, low aspirations, real helplessness, dependency on others, and clinical depression. These real social inequities make it difficult for women to achieve mastery by direct action and assertion. The implied "treatment" for social inequities on a societal level is political, legal and social change, and on a personal level is the development of technical skills.

The learned helplessness model emphasizes that the stereotypical ideas of femininity create in women a cognitive and emotional set against assertion and independence. This helplessness, which is learned early and is reinforced by society, is the prototype of depression (Seligman, 1975). Embodied in this view is the belief that women are trained not to be aggressive but are devalued for being passive and dependent. The treatment for learned helplessness is the development of emotional awareness of the condition, i.e., "raising one's conscience," as well as direct cognitive change - learning to be independent and not helpless.

Self-Help Groups

One proposed treatment for helplessness is self-help and self-help groups have become popular among women. The ideas of small groups of persons with common problems working together to achieve a specific goal antedates the women's movement (Dumont, 1974). Alcoholics Anonymous is the earliest of self-help groups. These groups have expanded to the overweight, the lonely, nursing mothers, problem drinkers, gamblers, homosexuals, runaway youths, widows, single parents, the divorced, mental patients, unemployed women, child abusers. In the last five years there has been a remarkable growth in these peer oriented groups. While the diverse composition of these groups defy any

serious generalization, Dumont (1974), in attempting to organize self-help groups in Massachusetts, has identified underlying themes which are useful to review.

He notes that self-help groups are rooted in the American tradition. Group affiliation creates a source of cohesion and a sense of optimism that change is possible through community affiliation and grass roots hard work. They have been given impetus by the community mental health movement. This movement pointed out the role of social disorganization in the development of mental illness and challenged the label of disease arguing that mental disorders are forms of social deviance and problems in living which can best be treated by members in the patient's neighborhood rather than professionals who distance themselves by their education. They use peer influence both to maximize change in the undesired behavior through identification and role modeling and by offering the reward of a meaningful socialization experience.

For the most part there has been little acknowledgement of the self-help movement by professionals and almost no formal study of the nature of the different groups, their effects and whom they serve. Therefore, no systematic data are yet available and one must rely on testimonial and descriptive experience.

Against this background I'd like to describe two different types of self-help groups - one task oriented towards improving skills and teaching women to be less helpless (Women's Educational and Counseling Center) and the other psychologically oriented towards making women conscious of the forces in society which presumably keep them helpless (Consciousness Raising). I've been directly involved with the first group as part of a research study. The information on consciousness raising is second hand, through reading and testimonials of friends, who have at times displayed behavioral changes which were impressive.

Becoming Less Helpless as Therapy (Women's Educational & Counseling Center)

The Women's Education and Counseling Center is a self-help center for women with a college education. It offers career related services including information about employment, education, career development, child care and sponsors' groups for women with related concerns such as reentry into a career after child rearing. It is staffed by volunteers, some of whom have professional training and many of whom have come through the program.

The users include educated married women who typically have had an interrupted career or education due to moves resulting from their husbands' professional advancements, or because of rearing children. Others come because of a conscious rethinking of roles, either a wish to overcome boredom and social isolation they felt in housework, or after direct involvement in a women's group.

We undertook to survey the applicants at the Center when the Director of the group expressed concern about the numbers of applicants who seemed depressed. We surveyed 100 consecutive applicants to the Center and assessed their clinical status using the same systematic techniques we had applied to patients coming for treatment to the Yale Depression Research Unit Outpatient Clinic. We also followed the applicants over a four-month period.

We found that about a third of the applicants had mild to moderate symptoms and about 20% would probably have been accepted for outpatient treatment with antidepressants (Weissman, et al, 1973). However, when we compared the individual symptoms of the depressed counseling center applicants, whom we termed the normal depressives, with a matched group of women under treatment with antidepressants at the Depression Research Unit, we discovered certain important differences (Weissman, et al, 1975). The normal depressives were similar to the depressed patients in disturbances of mood, but not in

symptom pattern. The normal depressives had a relative absence of somatic complaints and somatic anxiety. Moreover, over the next four months none of the normal depressives had received psychiatric treatment or medication; all of them had worked out a career or educational plan for themselves and all of them were asymptomatic. The normal depressives had attributed their symptoms to feeling lonely, dislocated, having recently moved, being in a state of transition. They attributed their improvement to receiving practical help and to group support through a transitional period.

Without an appropriate experimental design we can only speculate. It may be that the direct assistance offered by the Center may have helped to hasten their adaptation, prevented the development of their symptoms into a full blown depressive syndrome and avoided the necessity of psychiatric treatment.

Several points emerged which warrant further study. Women's self-help groups such as this one probably include a number of women with preclinical or early depressive disorders. If the group can help the woman overcome helplessness and find a way to achieve new skills and develop a sense of mastery, then the group experience can have important preventive implication. The group may, in fact, achieve early, if not, primary prevention.

Raising Consciousness as Therapy

Another alternate to traditional therapy for women are the consciousness-raising groups (C.R.). These groups began to sprout during the early 70's. Unlike the self-help group previously described which emphasized skills, these groups are concerned with the social roots of women's helplessness. According to Martha Kirpatrick (1975), C.R. groups are an outgrowth of a social technique used during the revolution in China. Women's organizations were formed to encourage women to resist traditional bondage to husband and family and to become competent and independent.

The traditional C.R. group is small, 6-10 members, leaderless, and has the goal of examining each member's social condition, and its ramification in her personal life. Members encourage one another to become aware, chall[illegible]ge and intervene in those conditions which limit their personal freedom and [illegible]tion.. The C.R. groups were adopted by persons involved in the women's movement because of dissatisfaction with traditional therapies which were seen as male dominated, anti-women, and which encouraged women to accept a submissive role.

C.R. groups have some similarities to traditional therapies (Table 4). There is opening up, sharing of feelings and opinions in a supportive and confidential relationship. Improvement of morale and self-esteem are the overall goals.

However, there are also important differences. The C.R. group is leaderless, emphasizes peer equality, and relates the women's problems to social, economic and political problems of the women's minority status. Most important, the C.R. group starts with the assumption that environmental rather than intrapsychic dynamics play the major role in the person's difficulties (Kirsh, 1974).

- - - - - INSERT TABLE 4 ABOUT HERE - - - - -

Women who attend have reported more independence, confidence, higher ambition and general well being. Consciousness-raising groups could be alternative mental health resources for preventing depression in women. They present intriguing possibilities for preventing that portion of depression which may be associated with women's role. Unfortunately, the efficacy of C.R. groups has been largely unstudied.

CONCLUSION

There is no doubt that women have more depression, both treated and untreated. There is good evidence that traditional treatments, both pharmacotherapy and psychotherapy, have value. Drugs essentially reduce the acute symptoms of depression and prevent their return and psychotherapy enhances interpersonal satisfaction and adjustment in the major roles. These treatments, however, do not touch on the basic cause of depression and little has been achieved in terms of primary prevention. If anything, the rates of mild depression in women, as seen in outpatient clinic attendance and suicidal attempts, have increased. At least one reason for the predominance of depressed women may be related to social inequality and learned helplessness. The remedy for learned helplessness, in fact, may be self help. Self help can come in several forms: improving skills, acting less helpless, expecting less helplessness, and changing institutions and beliefs which encourage helplessness. The very act of self help invariably reduces helplessness.

Experience with at least one of these groups showed that many of the users were mildly depressed when they came for help and were asymptomatic after they had worked out a plan for themselves which left them feeling less helpless. This is of course not experimental evidence. As careful investigators, testimonial or even pre-post ratings of self selected samples cannot be considered evidence. On the other hand, the concept of self help for learned helplessness has a certain intuitive appeal. The predominance of depressed women is a numerical fact. I suspect that C.R. groups probably wouldn't be too helpful and certainly not as rapid as antidepressants for the full blown syndrome of depression. Self-help groups require more energy, engagement and optimism than someone with a moderate clinical depression can muster. I would speculate that self-help groups may help prevent more serious symptoms in many dissatisfied,

unhappy and lonely women. Self-help groups are certainly as difficult to evaluate as the traditional psychotherapies, probably even more so since women in the movement share a distrust of behavioral scientists (Kravetz, 1974). However, a deeper understanding of non-traditional therapies such as women's self-help groups and a critical evaluation of their role in preventing mental disorders and in delivering mental health services is both timely and warranted.

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TABLE 1

Sex Ratios in Depression from Hospital Admissions, Outpatient Clinics and Community Surveys

SOURCE OF DATA	PLACE AND TIME	DISORDER	Rates Females Per 100 Males	REFERENCE
Hospital Admissions (State, Private, General and Community Mental Health Center	United States, 1970	All Depressive Disorders	175	Cannon and Redick, 1970
Outpatient Psychiatric Services	United States, 1970	All Depressive Disorders	238	Cannon and Redick, 1970
Community Surveys	New York City, 1965	Anxiety and Depression	Women have more symptoms	Benfairi, et al, 1972
	Baltimore, Md., 1968	Depressive Symptoms	160	Siassi, et al, 1974
	No. Florida, 1968	Depressive Symptoms	180	Schwab, et al, 1973
	Carroll County, Md., 1968	Depression, Helplessness	Women have more symptoms	Hogarty & Katz, 1971
	New Haven, Conn., 1967-69	Suicidal Feelings	120	Paykel, et al, 1974

TABLE 2

Summary of Evidence for the Efficacy of Maintenance Tricyclic Antidepressants

PLACE	LENGTH OF MAINTENANCE	DRUG	EFFECT OF ANTIDEPRESSANTS	REFERENCE
New Haven, Ct. Boston, Mass.	8 Months	Amitriptyline/Placebo/ No Pill	Reduced relapse rate and prevented symptom return. No effect on social adjustment.	Klerman, et al, 1974
Baltimore, Md.	16 Months	Imipramine/Diazepam/ Placebo	Reduced relapse rate and prevented symptom return, improved interpersonal perception.	Covi, et al, 1974
Philadelphia, Pa.	12 Weeks	Amitriptyline/Placebo	Reduced symptoms at 4 weeks and a trend toward maintaining symptom reduction at 6 to 12 weeks. No effect on participation and performance in family roles and on marital relationships.	Friedman, 1975
London, England	6 Months	Amitriptyline/Placebo	Reduced relapse rate. Social adjustment data not reported.	Mindham, et al, 1973

TABLE 3

Summary of Evidence for the Efficacy of Maintenance Psychotherapies

PLACE	TIME	TYPE OF TREATMENT	OUTCOME OF TREATMENT	REFERENCE
New Haven-Boston	8 Months	Individual Psychotherapy	Improved overall social functioning performance, communication. Reduced dependency, friction. No effect on relapse rate or symptoms.	Weissman, et al, 1974
Baltimore, Md.	16 Weeks	Group Therapy	Improved empathetic understanding. Reduced interpersonal sensitivity, hostility and anxiety. No effect on relapse rate or symptoms.	Covi, et al, 1974
Philadelphia, Pa.	12 Weeks	Marital Therapy	Positive symptom relief but not as great as for drugs. Positive effect on participation and performance of family roles, perception of spouse's attitude and behavior in marriage.	Friedman, 1975

TABLE 4

Comparison of Traditional Psychotherapies and Consciousness-Raising Groups

TRADITIONAL PSYCHOTHERAPIES	CONSCIOUSNESS-RAISING GROUP
Improve morale and self esteem.	Improve morale and self esteem.
Confidential relation with therapist.	Confidential relationship with group.
Supportive relationship	Supportive relationships.
Power in Therapist.	Power in Group.
Therapist is in charge.	Leaderless
Problems are related to inner dynamics.	Problems are related to society.
Emphasis on personal problems.	Emphasis on society, economics and politics.
Therapist defines goals.	Group defines goals.
Change the person to adjust to society.	Change society.
Talking.	Social action.
Source of discomfort is internal.	Source of discomfort is in society.
Patient-Therapist unequal.	Peer equality.

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