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## Exploring women's depression and the relationship of SSRI's and counseling as recommended treatments

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Exploring Women's Depression and the Relationship of SSRI's  
And Counseling as Recommended Treatments

Dissertation Presented by

Ruth Marsach-Wood

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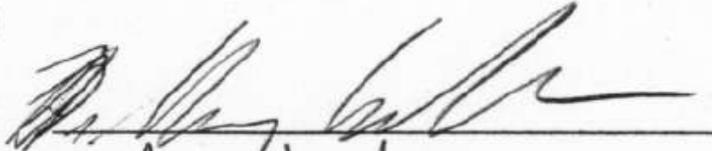
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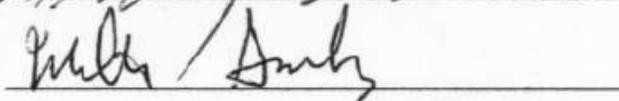
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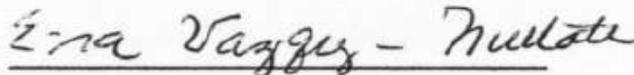
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## Abstract

Research has generally concluded that women disproportionately receive depression treatment in primary care settings when compared to men, but has rarely considered the relationship of SSRI's and psychotherapy as recommended treatment for women in this setting to date. In this study, we used quantitative and qualitative methods to explore the rate at which guideline concordant care for depression combining psychotherapy and psychopharmacology as recommended treatment is occurring. Also, personal experiences of women seeking depression in primary care settings was also explored in several PA townships. Our sample included 40 self-selected women between 18 and 65 years of age, prescribed an SSRI by their primary care physician. The participants completed semi-structured questionnaire and a select group of ten completed in-depth personal interviews. Our Quantitative findings indicated pharmacotherapy was the most widely used treatment despite evidenced-based recommendations. Of women prescribed an SSRI, 75% were not prescribed psychotherapy. A significant association was found between reported feelings of worthlessness and referral to therapy and all participants reported a stressful life event(s) precipitated their doctor's visit. Our qualitative analysis suggests women preferred combined treatment. Successful treatment for depression was also influenced by the quality of the patient-doctor communication including adequate dispensing of treatment information and physician's listening skills. Together these factors increased participants' feelings of validation, confidence in their treatment and overall sense of well being.

## **Chapter I**

### **Introduction**

Major Depressive disorder is a common disorder, associated with substantial symptom severity and role impairment. Depression is identified in the DSM IV-TR (APA, 2000) as a dysphoric mood, accompanied by lack of self-confidence, insomnia, anhedonia, and changes in appetite. In a major landmark epidemiological study in 2001-2002, Kessler et al. (2003) reported that the lifetime prevalence for major depression in U.S. households was 16% and is increasing with each younger generation. Women are particularly vulnerable. Depression presents one of the greatest disease burdens for women and the leading cause of disability when compared to men (Murray & Lopez, 1996). The Journal of the American Medical Association opines that depression is a public health challenge and calls for greater awareness on the part of physicians (Glass, 2003).

In the last half-century scientists have proposed numerous biological explanations for the cause of depression and several classes of medication have been introduced as treatments.

Despite the prevalence of these etiological models, there is no consensus among researchers on definitive genetic or neurobiological mechanisms of depression.

Representatives from the National Institute of Mental Health conclude: “We have not identified the genetic and neurobiological mechanisms underlying depression and mania, nor do we understand the mechanisms by which nongenetic factors influence these disorders” (Nestler et al., 2002, p.503). Given the lack of specificity in explanatory biological factors for depression, researchers propose additional etiological models,

which suggest that the environment and an individual's capacity for coping are equally substantial contributors to depression as are an individual's genetics and neurochemistry (Billings & Moos, 1982; Friedland & McColl, 1992; Honig & van Praag, 1997; Risch, 1997; Teasdale, 1999).

Some of the most robust psychological research on women suggest that depression can best be described as a syndrome with biological, psychological, and social vulnerability factors converging in the onset and maintenance of this disorder (Flynn & Cappeliez, 1993; Mazure, Keita, & Blehar, 2002). Women's personal experiences are complex and multi-determined. There are in fact multiple influences in the onset and maintenance of women's depression all intersecting with one another. Women's depression can best be understood with attention to the appropriate balance between the person within her environment. Psychosocial factors such as the quality of social roles that women engage in differentially affect women and men's health. Sex differences in role expectations and burdens related to the domains of work, family, and environmental qualities affect women's adaptive and coping abilities in stressful life situations. Women are more likely than men to be subjected to interpersonal violence, sexual discrimination, and harassment (Rodin & Ickovics, 1990). A woman's race, sexual preference, religious affiliation, disability, and age further compound these experiences of discrimination. Women also experience barriers in their daily lives that impede their reaching personal goals that men may not experience. They often have to negotiate the responsibilities of family, marital relationships, career issues, reproductive concerns, the role of violence and fear in their lives, physical and sexual abuse, body image and eating disorders, and problems with

self-esteem. Together these factors point to the inequalities that disproportionately affect women's lives and may explain the preponderance in the incidence of depression in women when compared to men.

### **Theoretical perspective**

One theoretical perspective that conceptualizes and synthesizes the multiple influences that interact together to affect women's lives and offers an explanation of contributing factors in the high incidence of depression in women is the feminist ecological theory (Ballou, Matsumoto, & Wagner, 2002). This multidimensional, multi-theoretical perspective acknowledges the many spheres of influence in people's lives. At an individual level a women's emotions, biology, cognitions, and spirituality intersect with her race-ethnicity, economic status, sex-gender, and age to affect the manner in which she experiences her life. At a microsystems level, we find the influences from the day-to-day interpersonal patterns and the social systems that women interact with. Inherent in these interpersonal patterns and social systems may be norms and values that perpetuate feelings of oppression and diminish a woman's sense of well being. At the exosystem level we can evaluate the impact of regional and national institutions such as state and local government, medical organizations, professional groups, and religious institutions. The interactions that occur between women visiting their primary care doctors for depression and the subsequent effects of these experiences is an example of an analysis incorporating this level of influence. Finally, at the macrosystem level we find an analysis of economic and political structures that disproportionately allocate the distribution of resources to some more than others. Mental health parity and restrictions

on mental health visits imposed by managed health care organizations is one example of the manner in which the macro-environment influences health in potent ways.

The feminist ecological model stresses the importance of valuing women's experiences as described by the women themselves. Psychological distress is understood not in the context of individual personality traits but rather seen as deeply rooted in sociocultural factors. From this perspective depression may not necessarily be defined as a disorder but rather a logical response to sociocultural factors such as power differentials found in interpersonal relationships and in the larger social, political and economic structures that operate at multiple levels of women's experience (Ballou, Matsumoto, & Wagner, 2002).

Despite the preponderance of evidence for contextual/environmental factors in the onset of depression and the lack of evidence or consensus among researchers for solely biological causal factors, mental health leaders and advocates continue to promote a neurobiological model primarily focusing on neurotransmitter dysfunction and overemphasizing the biological origins of this disorder (Callahan & Berrios, 2005). This prevailing etiological model of depression particularly evident in primary care minimizes the role of society and culture while over-estimating the biological mechanisms and pharmacological treatments. Treating depression in women solely with medication while underestimating the role of their cultural, social and interpersonal experiences may result in inadequate treatment for their depression (Callahan & Berrios, 2005; Lewis et al., 2004).

Primary care is typically considered the site where the treatment of depression begins, particularly for women, and the most common treatment available by far is a course of antidepressant medication. However, epidemiological studies and clinical trials of primary care patients clearly demonstrate the limitations of this current treatment model. Naturalistic studies of “usual care” in primary care practices demonstrate that the response rates of treated patients for depression are as low as 10% to 30% (Cole et al., 1999; Ormel & van den Brink, 1993; Schulberg et al., 1997; Thase 1999). Rates of depression have not fallen with the advent of pharmacological treatments (Callahan & Berrios, 2005). This underscores the need to address cultural and environmental factors when treating women’s depression.

The category of antidepressants referred to as Selective Serotonin Reuptake Inhibitors (SSRIs) are typically the preferred course of treatment for depression in primary care. The United States Federal Drug Administration (FDA) first approved SSRIs for the treatment of depression in 1987. The relatively safe side effect profile and the ease of dosing contribute to the unprecedented expansion in the prescription of SSRI’s by psychiatrists, internist, gynecologist/obstetricians, and family practitioners for depression and an increasingly greater number of conditions such as chronic fatigue and anxiety. During the past decade research has demonstrated that syndromes such as these, defined by subjective symptoms and lacking in unique pathophysiological characteristics, not only share similar abnormal pain processing, but also are typically comorbid with mood disturbances such as depression (Goldenberg, et al., 2004; Hudson, Mangweth, Pope et al., 2000). The research regarding depression, associated illnesses and effective

treatments is voluminous. However, the consensus is that medication and psychotherapy is a superior standard of care (Conte et al., 1986; Manning & Frances, 1990; Pettit, Voelz, & Joiner, 2001; Weissman et al., 1979).

Enhancing the treatment of depression in primary care settings is a central goal of the World Health Organization strategy for mental health (Gilbody et al., 2003). National surveys suggest that only 41.9% of respondents seen for depression in primary care settings receive adequate care compared to 63% respondents in specialty mental health care settings. Indications are that with the recent increase and popularity of SSRI antidepressants, there has been a corresponding decline in the percentage of persons receiving psychotherapy from 71% in 1987 to 60.2% in 1997 (Olfson, et al., 2002). These trends continue despite research evidence demonstrating combined treatment of pharmacotherapy and psychotherapy for the treatment of depression and associated illness as the best practice (Pettit, Voelz, & Joiner, 2003).

The Depression Guideline Panel of the Agency for Health Care Policy and Research published recommendations for treating depression in primary care (U.S. Department of Health and Human Services, Public Health Service, 1993). The results indicate that both antidepressants pharmacotherapy combined with depression targeted psychotherapies are more efficacious than either treatment alone. Strategies that incorporate patient education and shared care among the primary care physician, psychiatrist, psychologist and/or mental health counselor are associated with patient treatment adherence and recovery. In other words, the addition of psychotherapy, patient education and/or counseling services

helps to keep patients in treatment, provides more effective care, and helps prevent relapse.

Medical training programs are currently making advances towards this end. According to new requirements from the accreditation council for graduate medical education (ACGME), medical residency programs have instituted curricula change in order to meet several core competencies that promote an integrated collaborative approach to primary care effective July 1, 2001. Teaching teamwork and how to partner with other professionals to provide effective care is now being incorporated into residency training (Daw ,2001).

Dennis Butler, director of behavior sciences for The Columbia Family Practice Program, has set precedence for collaborative care in their residency program for family physicians. He believes that medical practices are increasingly turning to psychologists, psychiatrists and other health professionals to help address psychosocial issues and the psychological needs of their patients (Daw, 2001).

Incorporating psychotherapy in primary care is critical to addressing the contextual factors that contribute to the onset and maintenance of depression in women. The convergence of recent literature suggest that for women, stressful life events act both as a trigger of depressive reactions and an indicator of vulnerability to depression. Contextual dimensions shape a woman's identity to the extent that sole focus on biological interventions in the treatment of depression is actually not therapeutic in the long term.

### **The importance of this study**

Critical psychology theory encourages psychologist to serve as agents for social change and advocates social justice that promotes the equal distribution of resources and access to care (Prilleltensky & Fox, 1997). It is clear from the research that providing psychotherapy is a critical and necessary component in the treatment of women's depression and that not all women have access to this comprehensive level of care. This study attempts to address this potential gap in the treatment of women's depression in primary care settings.

There is substantial potential to improve the management of depression in primary care settings. Guideline concordant care recommends combined treatments with pharmacology and psychotherapy in order to provide optimal treatment for depression. Research suggest that the current preference for treating depression solely with psychopharmacology may merely be addressing the symptoms of depression without necessarily addressing all the underlying causes of depression (Callahan & Berrios, 2005). Women who are the predominant seekers of treatment for depression in primary care settings stand to be the most affected by this particular biological approach because cultural, environmental factors together with psychological vulnerabilities that predispose women to depression are not being sufficiently addressed in this environment. Shedding light on the experiences of women under these circumstances helps to elucidate a medical situation that is oppressive to women's health and wellbeing. Health treatment for women's depression that is solely biological in primary care settings also raises specific

concerns. For example, 70% of all psychoactive medications such as antidepressants are prescribed to women partly because women's health complaints are perceived to be more emotionally laden and psychosomatic than men's (Ogur, 1986). The personal experiences of women in this setting deserve attention and examination. Power differentials between doctors and women patients in their communications may further impede women obtaining the medical treatment they need. A study by Beckman and Frankel (1984) suggests that communication between practitioners and patients is often faulty. In a sample of seventy-four office visits, only 23% of the patients had a chance to finish their explanations of concerns. Their doctors interrupted patient's communications in 69% of the visits on average after only 18 seconds. If women are not able to adequately describe their experiences they may be less likely to be referred to psychotherapy. The unequal power balance in the patient doctor relationship points to the need for fundamental changes in the medical establishment to democratize the patient-doctor relationship (Prilleltensky & Prilleltensky, 2003).

Currently there is no research that investigates whether combined recommendations for SSRIs and psychotherapy are given to women patients who seek help for depression and its associated symptoms. Investigating the experiences of women with depression who seek treatment in primary care practices and giving women an opportunity to voice their personal stories in this setting is important in that it accomplishes several goals. It contributes to research that critically examines current systems and structures in the delivery of mental health care to women. It potentially can promote models for patient-provider communication in order to improve service delivery by joining psychological

services with medical interventions. It can identify effective psychological, medical and behavioral interventions in primary care that reduce psychological distress and improve treatment outcomes.

If compliance with this best practice falls short then this research would suggest the development of a curriculum for in-service training to inform and encourage medical staff in primary care setting to educate and refer to psychotherapy when SSRIs are prescribed. Organizational interventions prove successful when they support collaborative care and quality improvement initiatives. Improvement initiatives combine clinician, nurse and patient education together with the enhanced support of psychological services. These factors together are shown not only to be clinically effective but cost effective in the long run as well.

### **Purpose of this study**

Given that the indications for best practices prescribe the combined use of pharmacotherapy and psychotherapy in the treatment of depression, this study is a preliminary investigation to examine the rate at which this guideline concordant care occurs in primary care facilities in the Pennsylvania region. A triangulation mixed methods design will be used to collect different but complementary data concurrently on the experience of women seeking treatment for depression and associated symptoms in primary care settings. A telephone survey will be used, the purpose of which would be to determine the extent to which psychotherapy or mental health counseling is prescribed along with pharmacotherapy treatment with SSRIs. Limited managed care time for

primary care physicians alone cannot account for such an increase in the prescriptions for SSRIs and decrease in combined treatment (Olfson, 1998). SSRIs were selected because research data reveals these antidepressants are the most prevalent intervention for the treatment of depression in women by primary care doctors. Currently there is no research available that critically examines whether women prescribed SSRIs by their primary care doctor for depression and its associated disorders are also evaluated for current stresses and advised to seek psychological services. Concurrent with the telephone survey, qualitative individual interviews with a smaller number of participants will also be completed. Given that the context within which women are most likely to seek initial treatment for depression is primary care settings, this study will focus specifically on exploring the experience of women when prescribed an SSRI for depression in primary care settings and whether they have experienced a stressful life event that precipitated their depression.

The rationale for this two phase and concurrent approach is that the quantitative data and subsequent analysis helps us begin to explore and understand the research questions. The qualitative data and their analysis in phase two provides a phenomenological research approach that helps refine and explain the statistical results by exploring the participants' views in more depth. It also allows for the confirmation of information from one data set to the other (Creswell, 2003; Creswell, Plano Clark, 2007; Rossman & Wilson, 1985; Tashakkori & Teddie, 1998).

The strength and weaknesses of this mixed method design has been widely discussed in the literature (Brewer & Hunter, 1989, Creswell, 2003; Tashakkori & Teddie, 1998). Its advantages include the opportunity for deeper exploration of the issues of the research

into the treatment of women's depression in primary care settings which can be best understood by using qualitative data to enrich and explain the quantitative results in the personal words of the participants. The Feminist Ecological model will inform our study when considering the compendium of etiological factors that contribute to the onset and maintenance of depression in women. The reasons for collecting both quantitative and qualitative data is to converge the strengths of both forms of research to obtain a more comprehensive view of this research phenomena on women's depression treatment.

### **Research Questions**

- What are women's experiences in primary care settings when they are prescribed an SSRI for depression and associated symptoms.
- Are the majority of women prescribed an SSRI for depression and associated symptoms by their primary care physician also prescribed psychotherapy?
- Have the majority of women identified as having been prescribed an SSRI for depression and or associated symptoms by their primary care also experienced a precipitating stressful life event prior to onset of depressive symptoms?

### **Summary**

It is clear there has been a significant increase in the pharmacological treatment for depression in women in primary care settings. Additionally medical training programs are addressing the need for integrating psychological services in combination with

pharmacological treatments for depression because of its proven effectiveness. Currently there are pressures on contemporary medicine to accomplish this integrated approach to treatment. This study proposes to investigate the extent to which these goals are currently being implemented in primary care facilities.

If findings warrant, the information garnered from this study would prove invaluable to foster multidisciplinary collaboration between psychologists and primary care medical staff. It could also help improve primary health care providers' knowledge and understanding of women's voiced experiences when seeking help for depression. This study aims to underscore the importance of psychological and behavioral factors in women's health thereby enhancing the delivery of mental health services and fostering treatment adherence.

Furthermore, this information could also be used to facilitate the development of an in service training program where results of the study can be shared. Topics for in service training can include issues pertaining to dealing with resistant patients, helping physicians become more comfortable approaching patients about their mental health needs and experiences and determining whether mental health services are adequate to meet the current needs of the patient population. Ultimately, the goal is to enhance the treatment of depression and mental health needs of women patients visiting primary care facilities.

## **CHAPTER II**

### **REVIEW OF THE LITERATURE**

The prevalence of depression in women is one of the most robust findings in epidemiological research (Kessler et al., 1993; Kessler et al., 2003; Weissman et al., 1988). For the first time in the U.S. data from a structured psychiatric interview administered nationally revealed women are 1.7 times as likely to experience a major depressive episode when compared to men (Kessler et al., 1993). The prevalence of depression is also a growing cause of women's disability (Murray & Lopez, 1996). Nearly half of the treatment for depressive disorders occurs in primary care settings (Kessler et al., 1994; Regier et al., 1993) and 90% of women seeking treatment for symptoms of depression visit their primary care doctor at least once a year (Kessler et al., 1994; Regier et al., 1993; Shelbourne et al., 2001). There have been marked changes in the treatment for depression in the last decade with antidepressants established as the primary course of treatment whereas the use of evidence-based psychotherapy has declined (Olfson et al., 2002). The limitations of this approach are evident in epidemiological studies and clinical trials resulting in the inadequate treatment of women's depression in primary care settings (Callahan & Berrios, 2005; Kessler et al., 2003; Ustun & Sartorius, 1995; WHO, 2000). Treatment models that integrate women's psychological, psychosocial, macrosocial risk factors as they intersect with biological/endocrine responses better address the prevalence of depression in women (Kuehner, 2003). This section presents relevant literature that addresses these issues.

### ***Prevalence and Societal Impact of Depression among Women***

Women's health research has revealed important information. Women's health and prevalence for depression is complex and multi-determined by physiological, biochemical, psychological, environmental and social factors. Sex differences in morbidity and mortality suggests that health risk for depression in men and women are different and merit distinct research. Furthermore, women and men's health, are distinctly affected by psychosocial factors. Social role imbalances that differentially allocate power, equality and control are likely to adversely affect women's health (Rodin & Ickovics, 1990).

Women face chronic illnesses that are of concern for public health because they disproportionately affect them. Of these illnesses depression appears to be one of the most disabling disorders affecting women today. Major Depressive disorder is a common disorder, associated with substantial symptom severity and role impairment. Depression is identified in the Diagnostic Statistical Manual of Mental Disorders-Fourth Edition, Text Revision (DSM IV-TR American Psychiatric Association, 2000) as a depressed mood, accompanied by a markedly diminished interest or pleasure in daily activities. Psychomotor retardation, lack of self-confidence, feelings of worthlessness or guilt, insomnia or hypersomnia, difficulty concentrating, anhedonia, changes in appetite and or weight, and recurrent thoughts of death may also be part of the symptom presentation with depression. One third of individuals with depression may experience a prolonged chronic course of depression with incomplete remission. This chronic form of depression can last two or more years. Chronic forms of depression not only include Major

Depression (i.e., depression lasting at least two years), but also dysthymic disorder, double depression (i.e., major depression superimposed on dysthymia), and recurrent major depressive disorder with incomplete interepisode recovery (DSM IV-TR, 2000).

According to a World Health Organization report on the Global Burden of Disease, depression will present one of the greatest disease burdens for women between the 1990 to 2020, particularly when compared to men. Unipolar major depression was found to be the fourth leading cause of worldwide disability and is expected to become the second leading cause by 2020. This global study was designed to measure not only years of life lost (YLL) prematurely to mortality but also projected years of life lived with functional disability (YLD) associated with a condition. For the first time, research emphasis on the burden of illness shifted from focusing solely on premature mortality to include the burden of illness accounted for by long-term chronic illness (Murray & Lopez, 1996).

Depression is not only shown to be highly prevalent in women, it is the leading cause of disability among women worldwide today (Murray & Lopez, 1996). In a landmark epidemiological study of major depression for the year 2001-2002, the lifetime prevalence for major depression disorder in U. S. households was 16% (Kessler et al., 2003). Of these, 6.6% met criteria for major depression over a 12 month period with severity in both symptoms and role impairment. The results also suggest that although 57% of respondents with depression over 12 months received some form of treatment, only 21.7% of those met criteria for treatment that was considered minimally adequate. Women are particularly at risk since they are twice as likely to experience a major

depression at least once in a lifetime when compared to men (Kessler, McGonagle, Swartz, Blazer, & Nelson, 1993; Mazure, Keita, & Blehar, 2002).

Cross-national comparisons of temporal trends in major depression suggest that major depression is also increasing with each successive younger birth cohort over time (Cross-National Collaborative Group, 1992; Klerman & Weissman, 1989; Lewinsohn, Rhode, Seeley, & Fischer, 1993). The course of depression suggests an early onset in adolescence or young adulthood followed by a recurrent or chronic course. Rates of depression appear to be the highest in mid-life with an attenuation of symptom severity in late life. However, relative difference seemed to be maintained throughout the life cycle between men and women. The initial onset of depressive episodes are not only greater in women but early onset of depression often leads to disruptions of normal social and interpersonal development with adverse effects on educational and occupational endeavors (Blehar, 2003).

Depressive disorders affect the social, occupational and role functions of individuals with detrimental effects on daily functions and quality of life matching those of heart disease and exceeding diabetes, arthritis and peptic ulcers (Hirschfield, Montgomery, Keller et al, 2000; Johnson, Spitzer, Williams, Kroenke, Linzer, Brody et al., 1995; Wells & Sherbourne, 1999; Wells et al., 1989). The adverse economic impact of depression is most salient in its effect on work productivity. Of the health conditions that affect the ability to work, depression is among the most costly because it is not only highly prevalent but is also co-morbid with other conditions. Lost labor time in the U.S.

workforce and its associated costs from work absence and reduced performance while at work is well documented by Stewart et al. (2003). Lost productivity time (LPT) by workers with depression was found to be significantly higher in workers with depression with an average loss of 5.6 hours of LPT per week compared to workers without depression who averaged 1.5 hours per week. Reduced performance for depressed workers while at work accounted for the majority LPT and greatest costs to employers (Stewart et al., 2003).

### ***Etiology of Gender Differences in Depression***

For decades gender differences in depression have been consistently found across educational, racial and economic groups with a variety of psychosocial measures. In fact, some of the most robust findings in psychology suggest that women are twice as likely as men to develop a diagnosable depressive disorder (Kessler, McGonable, Swartz, Blazer, & Nelson, 1993; Robins & Regier, 1990; Weissman, Leaf, Bruce, Florio, & Holzer, 1988). In October 2000, The American Psychological Association convened a summit on Women and Depression. Notable experts on women and depression from various disciplines came together to share current information on causes, treatment and prevention of depression. Recommendations were made on how to incorporate research findings into health policy, practice and future research. Some of the findings of this summit on the etiological basis of depression in women, as well as current research will be reviewed.

Understanding depression requires careful consideration of etiological differences in the onset of depression between men and women particularly since rates of depression in North American women are consistently higher than for men and often poorly understood. Depression is often described as a syndrome, a symptom or a spectrum of biopsychosocial manifestations (Flynn & Cappeliez, 1993; Mazure, Keita, & Blehar, 2002). Biological, psychological and social vulnerability factors together contribute to this higher incidence of depression in women.

### *Genetics*

Genetic vulnerability can be a critical factor in the development of depression. Depression appears to aggregate in families with the risk of developing major depressive disorder being highest in first-degree relatives of individuals with major depression (Gershon & Nurnberger, 1982). The degree to which this association is due to genetics or environmental factors remains unclear. Recent cumulative trends in data support genetic contributions as risk factors for depressive episodes (Kendler, Neale, Kessler, Heath, & Eaves, 1992; Kendler, Thornton, & Gardner, 2001; Lyons et al., 1998). Results from a twin study by Kendler and Prescott (1999), found major depression (MD) to be equally heritable in men and women, with genetic risk factors influencing liability for MD similar for both men and women. Heritability of liability in MD amounted to about 39%. With the remaining 61% variable due to individual-specific environmental variables. Bierut et al. (1999), found only a modest familial aggregation of depression in men (24%) compared to the familial heritability estimates found in women (31%).

Some researchers suggest that genes may exist that differentiate the risk for MD in men and women. Family and twin studies designed to identify a specific gene, as a cause of depression are mostly inconclusive. However, a recent study by Zubenko et al. (2003) identified CREB1 as a sex-limited gene for which researchers believe women are susceptible for unipolar depression. These researchers point to the challenges to gene research posed by the potential genetic heterogeneity across families. The complexity of brain functions underlying depression is difficult to identify and understand. According to Insel and Charney (2003), reporting in the Journal of the American Medical Association, the etiology and pathophysiology of depression have yet to be precisely defined.

### ***Hormones***

Some investigators have focused on the unique biology of women to explain the higher prevalence of depression. Women's reproductive cycle and ensuing hormonal changes over the lifespan have been linked by researchers to the increased vulnerability for depression (Parry, 2000). Estrogen and progesterone have been shown to affect the synthesis and release of serotonin and norepinephrine. This process appears to affect neurotransmitter, neuroendocrine, and circadian systems implicated in mood disorders (Young et al., 2002). Furthermore an adolescent girl's pubertal status is a greater predictor of risk for depression than is her chronological age (Angold et al., 1998; Patton et al., 1997). The luteal phase of the menstrual cycle is often associated with dysphoric mood changes or worsening of a major depressive episode due to the substantial decrease of estrogen and progesterone levels (Endicott, 1993; Kornstein et al., 1996). The prevalence of premenstrual emotional and behavioral symptoms in women is estimated at about 75% (Johnson, 1987).

The perimenopausal period of life is also commonly associated with depressive symptoms. In the National Comorbidity Survey (NCS), recurrent depressive episodes during a 12-month period were higher for women between 45-54 years of age (NCS; Kessler et al., 1993). This data suggest that women are at greater risk to develop a major depressive episode during the perimenopausal years while menopause is typically a period marked by decreased risk for depression in women.

### ***Sex-Role Development***

Kessler & Mcleod (1984) and Nazaroo et al. (1997) suggest that psychological distress and depression in women relative to men for interpersonal types of events result from women's gender specific role domains. Nazroo et al. (1997) reported that women's higher risk for depression within couples was associated to crisis involving children, housing and reproductive problems. Relative to men, women have greater social responsibility for family related roles and may engage in self-blaming behaviors when problems arise in these areas in their relationship. These authors opine that the greater emotional expenditure of women in the lives of those around them and psychological distress from undesirable events is the "cost of caring" resulting from deeper interpersonal commitments.

Women's sex-role development has also been implicated as a factor contributing to their heightened vulnerability for depression (Stoppard, 1993). It is clear that the stresses of a woman's life set the stage for physical and psychological problems. Somatization (i.e.,

medically unexplained symptoms) are not only considered a predominantly female issue, but also are highly prevalent in primary care facilities (Katon & Walker, 1998). Minority women are particularly affected. Duran (1995) suggest that Hispanic women are most likely to be labeled with a somataform disorder and are highly likely to be prescribed antidepressant medication. The association of depression, distress, cultural determinants, psychosocial factors, and the patient-provider relationship provide insight into contributing factors to the somatization of the Latina. Alvidrez (1998) examined self-recognition of depression in a sample of 185 Latina, African American, and European American public care gynecology patients. This study examined variables reflecting exposure to the mental health care system as well as cultural variables relating to coping styles, levels of somatization and personal beliefs regarding mental illness and mental health services. This study aimed to determine whether self-recognition of depression is affected by the Latino culture. The results indicate that fewer than 40.5% of the women sampled and who met criteria for depression self-identified their depressive symptoms. Somatization, as well as alcohol and drug coping strategies were found to be predictors of self-recognition of depression. Severity of depression did not differ among the cultural groups but ethnic differences were found on all predictors of self-recognition. Interventions that promote guideline-concordant treatments for depression in young minority women were investigated. Miranda et al. (2003) evaluated 427 women who completed a structured psychiatric diagnostic telephone interview. Of these 267 completed a subsequent clinical interview and were randomized into the following intervention trials: antidepressant medications (Ade; paroxetine, with a switch to bupropion in cases of nonresponse) administered by a primary care nurse practitioner in

consultation with a psychiatrist (n=88), cognitive behavioral therapy (CBT) conducted by a psychologist (n=90), or referral to community mental health services n=89). A repeated-measures analysis was utilized to compare mean depression symptom and functioning scores across treatment groups over time. The results indicate that ADs were found to improve instrumental role functioning. However, combined AD and CBT were both significantly more effective improving social functioning when compare to no treatment or AD alone.

### *Life Stress and Trauma*

Literature on the association between adverse life events and subsequent episodes of depression is compelling. Women experience many stressful life events across the life span and are more sensitive to these events when compared to men. The convergence of recent literature on stress and depression seems to suggest that stressful life events act as both a trigger of depressive reactions and as indicators of vulnerability to depression. Although women do not appear to have more stress exposure nor rate this exposure differently than men, their reactions and subsequent symptoms are more intense (Brown & Harris, 1978; Kendlar et al., 1995; Mazure et al., 2000; Paykel et al., 1969). Studies employing multivariate analysis to address the multiple variables influencing the stress-depression relationship reveal that women tend to be more reactive to interpersonal stresses whereas men appear to react to events involving work and legal difficulties (Kendlar et al., 2001; Maciejewski et al., 2001;). Maciejewski, Prigerson, & Mazure (2001) conducted a secondary analysis of gender based differential responses to stress derived from data of the American's Changing Lives (ACL) study. The ACL was designed as a longitudinal study of productivity and successful aging in the middle and

later years of life and includes a variety of measures relevant to studying psychosocial influences on depression. Structured interviews were used to document the occurrence of onset of depression and instances of stressful life events within a 12-month period in a community base sample of 1024 men and 1800 women. Women were three times more likely than men to experience an episode of depression within 12 months of an experienced stressful life event. Elevated risk for depression in women was found to be more closely associated to death of a close friend or relative, change of residence, physical attack, or life threatening illness or injury. Men and women did not differ in stress related depression due to divorce or love problems, nor to events involving financial or legal problems (Maciejewski, Prigerson, & Mazure, 2001).

The trauma of physical and sexual abuse is an enormous source of stress in women's lives. Women typically experience violence from male perpetrators, usually intimate partners and family members. These acts of violence are associated with a sequelae of both short and long-term physical and psychological problems including higher rates of major depression, dysthymic disorder, post traumatic stress disorders (PTSD) and physical illnesses ( Koss, Koss, &Woodruff, 1991).

The prevalence of violence against women is alarming. In 1998, The National Violence Against Women Survey estimated roughly 15% of women in the United States had been raped (Tjaden & Thoennes, 1998). Prior research by Resnick et al. (1993), found that of 4,008 randomly selected women, 13% reported having an experience of completed rape, 14% reporting sexual assaults, and 10% experienced physical assault. Another 36% and

33% reported being the victim of a criminal act or noncriminal disaster respectively. Schoelle et al. (1998), conducted a study of rural-urban differences in mental health treatment among a community-based group of women with depression. More than half (55%) of the women in this study had experienced physical abuse as adults. Symptoms of depression, psychiatric comorbidity and physical illnesses were found to be significantly greater in the physically abused women when compared to non-abused women. Nearly all the women who were physically abused sought general medical rather than mental health care highlighting the necessity for primary care screening for physical abuse as a critical link to providing professional help for women with abuse and depression.

### ***Psychological Vulnerability in Women***

Psychological vulnerability for depression has been studied for a number of decades with a great deal of research revealing the potential role of maladaptive cognitive patterns as vulnerability factors for depression. There is consensus among these theories of depression that cognitive vulnerabilities are deeply rooted in a stress-diathesis perspective. In other words, negative cognitive factors have a propensity to emerge in the face of a major life stress (Scher et al., 2005). Individual's vulnerable to depression are uniquely characterized by a cognitive reactivity that is associated with the onset, relapse, and recurrence of depression. Major works on the stress-diathesis aspects of cognition and depression have focused on dysfunctional beliefs, learned helplessness, and hopelessness (Abramson, Alloy, & Metalsky, 1989; Beck, 1967; Haaga, Dyck, & Ernst, 1991; Ingram, Miranda, & Segal, 1998). The stress-diathesis models of cognition and depression can trace their origins to Beck's proposals which provided a framework for

much of the subsequent research regarding cognitive vulnerabilities in the manifestation of depressive symptoms (Scher et al., 2005). Beck (1967), theorized that cognitive structures or schemas are negative representations of self-referent knowledge influencing selective attention, memory, and cognitions. For example, it is hypothesized that early life experiences of abuse, neglect or maltreatment can lead to the development of negative schemas. Negative schemas are comprised of dysfunctional attitudes, such as an individual's belief that their worth depends on being perfect or on others' approval. These negative perspectives may not only be about the self but about others as well. Negative schemas direct attentional resources and memory toward negative events, which can be rigid and overly pessimistic and can lead to the distortion of information (Beck, 1967, 1987; Kovacs & Beck, 1978). Beck's theory presented a caveat to the association of negative schemas to the development of depression. Beck hypothesized that the sole presence of a negative self-schema was insufficient to precipitate depression. In fact, certain conditions were necessary to "activate the depressive constellation" (Beck, 1967, p.278). This activating component of stressful life events in Beck's theory was generally unattended to in early research. Instead depression research assessed cognitive processes in isolation of stressful life events leading some researchers to conclude that dysfunctional cognitive processes could not be detected once the depressive episodes remitted. Furthermore, these cognitive features were presumed to be correlates or consequences of depression (Coyne, 1992; Scher, Ingram, & Segal, 2005).

It wasn't until the late 1980s that research began taking into account this activating feature of Beck's original proposal and focus shifted to a stress-diathesis model in the

study of depression. This stress-diathesis model began linking cognitive vulnerability and depression onset, relapse and recurrence. Cognitive reactivity in individuals is a fairly stable process in so far as the cognitive vulnerabilities to stress are purported to remain even after the remission of depressive episodes and may predispose individuals to recurring depression.

One cognitive style that is theorized to place women at increased risk for depression is a ruminative style of thinking. Nolen-Hoeksema (1991) proposes that women have a greater propensity to engage in ruminative thinking when compared to men. Ruminative responses involve engaging in repetitive and passive thoughts about negative emotions with an emphatic focus on symptoms of distress (e.g., “feel so sad”) and their meaning (e.g., will I ever stop feeling depressed?”) (Lyubomirsky, Caldwell, & Nolen-Hoeksema, 1998; Nolen-Hoeksema, 1991; Nolen-Hoeksema, Morrow, & Fredrickson, 1991). Longitudinal studies on ruminative responses demonstrate individuals who ruminate during periods of depressed moods are more likely to experience depressive symptoms over time, even when accounting for their baseline levels of depression (Nolen-Hoeksema & Davis, 1999; Nolen-Hoeksema, Larson, & Grayson, 1999; Nolen-Hoeksema & Morrow, 1991; Nolen-Hoeksema, Morrow & Fredrickson, 1993; Nolen-Hoeksema, Parker, & Larson, 1994).

Ruminative responders may have greater difficulty, when compared to non-ruminators, feeling they can manage and control their circumstances (Lyubomirsky, Tucker, Caldwell, & Berg, 1999). As a result, they have difficulty employing instrumental

behaviors toward problem solving. Rumination appears to reflect attempts to understand and control difficult circumstances of life. Uncertainty over one's ability to control these situations may contribute to anxiety or mixed anxiety and depressive symptoms. In a study that more clearly specified the relationship between ruminative responses, major depression and mixed anxiety/depression symptoms, Nolen-Hoeksema (2000) analyzed data from respondents of three major urban, ethnically diverse, metropolitan cities in the U.S. Two interviews were conducted a year apart with 1132 participants. The purpose of the study was to examine whether individuals with ruminative styles to personal distress were more likely to experience a clinically diagnosed depressive disorder and or anxiety. To accomplish this the researchers employed the Structured Clinical Interview for DSM-IV Axis I disorders (SCID; First, Spitzer, Gibbons, & Williams, 1997). Participants were also indexed for anxiety by responses to The Beck Anxiety Inventory (BAI; Beck & Steer, 1990). The results indicate that ruminative responses predicted major depressive disorders and to some extent longer more chronic episodes. In addition mixed anxiety/depressive symptoms were also found to be characteristic of ruminative response styles.

However, this longitudinal analysis had limitations. The effect sizes for the impact of rumination on the diagnosis of depression were small and raise questions regarding the role of rumination in depressive disorders. The analysis of the anxiety/depression groups relied primarily on self-reports of respondents and would have been more effective if an analysis of a clinical diagnosis of anxiety disorder was employed. Finally, several

respondents from the study attrited between the first and second interviews, which may have effected the statistical significance of the predictive analysis.

Women who have the propensity to focus on others at the expense of themselves have also been found to have vulnerabilities for depression. Research by Hegelson & Fritz, (2000) describe a dimension of personality called “unmitigated communion” where individuals tend to subjugate their personal needs for those of others leading to substantial self-neglect, inhibition of self-expression, repression of anger. Furthermore, validation of self worth is garnered from feeling important and indispensable to others. Women are more likely to exhibit these traits because relationships are more central to their self-concept when compared to men. Social isolation and problem relationship are not uncommon. Individuals with this characteristic (unmitigated communion) may be perceived as overprotective and intrusive. During times of personal stress, these individuals have difficulty turning to others for assistance and are reluctant to accept support. They perceive other’s assistance as inadequate. Unmitigated communion has also been linked to poor physical and psychological adjustment to illness and poor outcomes at recovery (Piro, Knight, Zeldow, Vassy, & Mytko, 1997).

Although these authors opine that characteristics of “unmitigated communion” help to account for gender differences in symptoms of depression research, the Relational-Cultural Theory of women’s development offers an alternative explanation (Jordan, 1997; Jordan, Kaplan, Miller, Stiver, & Surrey, 1991; Miller & Stiver, 1997). Relational-Cultural Theory posits that the pursuit and development of mutually empathic

relationships with others is a fundamental and significant goal of women's psychological development. In other words the sense of self is conceptualized as "being in relation" (Jordan et al., 1991; Miller, 1976). From this feminist perspective, a woman's self-concept is based on mutual participation in a relationship involving support given as well as received. In relationships where the women is less powerful and unable to represent herself and her feelings, she will withhold aspects of herself, twisting herself to fit the relationship while becoming increasingly less authentic. This is referred to as *the central relational paradox* in relational cultural theory. Healthy psychological functioning results from relational mutuality through personal connection and growth-enhancing relationships. Conversely, lack of mutuality may significantly contribute to the development of psychological symptoms and disorders. Jack (1991) investigated a model of female depression derived from a longitudinal study of clinically depressed women. The results suggest that women employ relationship-preserving strategies in the form of cognitive schemas in order to create and maintain safe, intimate relationships. The cognitive schema takes the form of silencing certain feelings, thoughts, and actions when self-expression is deemed to be unacceptable to one's partner. From this perspective women may subjugate their needs or inhibit self-expression because their relationship lacks the relational mutuality so essential to their psychological well being. Self-silencing strategies may be employed in order to avoid conflict or loss of relationship. According to Jack (1991), self-silencing contributes to feelings of low self worth and "loss of self" over time as women self-negate to maintain schemas directing feminine social behavior. Low mutuality and high self-silencing have also been linked with depression among female cancer survivors (Kayser, Sormanti, & Strainchamps, 1999). A

woman's ability to cope with the stresses of life will be positively enhanced and supported by relationships characterized by mutuality.

### ***Interaction of stress and biology***

It appears that the complex and reciprocal interaction of psychological, social, and biological factors appear to account for the etiology of differential rates of depression for men and women. This interaction is elucidated by evidence of the interaction of stress and biology in the onset of depressive illness. It is well documented that depression is greatly impacted by stress-related conditions. In the majority of depressive disorders (i.e., approximately 75%) there is a precipitating stressful event. In fact the incidence of depression is very low in the absence of environmental stresses (Brown & Harris, 1978; Frank et al., 1994; Kendler et al., 1995). Stressful events activate a wide variety of neurotransmitters and neuromodulators that serve as a response mechanism aimed at preserving homeostasis in a woman's body. Corticotropin-releasing hormone (CRH), vasopressin, and neuroendocrine are the principal effectors in the response to stress (Chrousos & Gold, 1992). Once CRH is triggered it releases the adrenocorticotropic hormone (ACTH) which triggers the release of adrenal glucocorticoids. The glucocorticoid feedback at the brain and pituitary is the body's design mechanism for turning off this stress response. Depression in women may result from a decreased sensitivity to glucocorticoid feedback regulation. As a result, depression is hypothesized to be a maladaptive and exaggerated response to stress. Abnormalities in Hypothalamic-pituitary- adrenal (HPA) axis regulation such as hypercortisolemia and the disruption of

the circadian rhythm of cortisol secretion are widely established in research as hormonal factors in the onset of women's depression (Carroll et al., 1976; Sachar et al., 1973).

Severe childhood stress has also been linked to impaired HPA function, predisposing women to depression. Heim et al. (2000) suggest that early life experiences of physical, sexual or psychological abuse occurring during developmental periods associated with neuronal plasticity may impair the HPA function. Depressed women with histories of childhood abuse were found to have abnormal cortisol reactivity to a stress task. Early life-stress results in a persistent sensitization of the hypothalamic-pituitary-adrenal axis to later adulthood experiences of stress, contributing to vulnerabilities in women with this past history. In a subsequent study, Penza, Heim, & Nemeroff (2003), hypothesized that sensitization of the HPA axis is in part mediated by corticotropin releasing factor (CRF) systems, possibly having a toxic effect on neurons in the hippocampus. Adrenocortical responses to stress in women were found to reflect differing effects of duration of childhood abuse, depression, and ongoing adult stress. These factors appear to eventuate in disorders of depression and anxiety.

Thyroid function is an additional hormonal factor contributing to women's vulnerability for depression. Abnormalities in the thyroid axis are not only more prevalent in women but are often associated with symptoms of depression and may significantly affect postpartum mood disorders and premenstrual syndrome (Reuss, 1989; Whybrow, 1995).

The literature thus provides evidence that depression in women is an etiologically complex disorder involving the interaction of an array of biological, psychological, and societal risks factors that cascade together to account for the incidence of increased depression among women (Kendler, Gardner, & Prescott, 2002; Kuehner, 2003).

### *Treatment of Women's Depression in Primary Care*

For many women, their first line remedial approach to treat their depression is to visit their primary care physician. Primary Care systems are used extensively by women and have potential to provide mental health diagnosis and treatment. Data from the National Ambulatory Medical Care Survey reveals that women utilize approximately 60-65% of all visits to primary care physicians (Woodwell, 1996).

Depression also co-occurs with a wide range of psychological and physical problems. Patients with depression that visit their primary care physicians typically present with complaints of anxiety, fatigue, chronic pain and other vague symptoms as is often the case with fibromyalgia and chronic fatigue syndrome. Over the past decade research has demonstrated that syndromes such as these, defined by subjective symptoms and lacking in unique pathophysiological characteristics, not only share similar abnormal pain processing but also are typically comorbid with mood disturbances such as depression and anxiety (Goldenberg, et al., 2004; Hudson, Mangweth, Pope et al., 2003; Walker, Keegan, Gardner, Sullivan, Katon, & Bernstein, 1997). There is significant evidence that persons with chronic fatigue syndrome have higher rates of current and lifetime mood disorders, including and more typically major depression when compared to healthy

subjects without fatigue (Afari & Buchwald, 2003; Katon, Buchwald, Simon et al., 1991; Wood, Bentall, Gopfert, et.al., 1991). Wessely et al. (1996) conducted a prospective cohort study followed by a nested case-control study in order to assess the relationship between chronic fatigue and past or current psychiatric disorder of patients. Out of 1,985 subjects between the ages of 18-45 who presented with viral or other medical problems to primary care facility, 214 were identified with chronic fatigue and compared to 214 subjects without fatigue. Questionnaires, Interviews and medical records were utilized to assess history of fatigue, somatic symptoms, psychiatric disorder, and functional impairment. The results suggest a trend for previous psychiatric disorders to be comorbid with fatigue. The results of interviews and questionnaires indicate that the prevalence of current and lifetime mood disorders was 75-78% in persons with chronic fatigue when compared to those participants without chronic fatigue 19% and 31%.

### ***Increase use of SSRIs in treatment of depression***

Guideline concordant care for depression in primary care settings suggests that antidepressant medications combined with psychotherapy are effective in treating mild to moderate depressions (The Agency for Health Care Policy and Research: U.S. Department of Health and Human Services, 1993). However, evidence indicates that primary care physicians are increasingly treating depression through use of antidepressants and less through psychotherapy (Callahan & Berrios, 2005; Olfson, 2002)

Data from the 1987 National Medical Expenditure Survey (NMES) and the 1997 Medical Expenditure Panel Survey (MEPS) indicate that between 1987 and 1997 there were

significant changes in the delivery of mental health services in the outpatient treatment of depression that support this trend. These surveys included nationally representative samples and allowed for a comparison to be made across two points in time (Olfson et al., 2002). Rates of outpatient treatment for depression increased from 0.73 in 1987 per 100 persons to 2.33 in 1997. Concomitant with this increase was greater involvement of physicians, expanded availability of third-party payment and increase use of psychotropic medication. There was an increase in the proportion of individuals receiving psychotropic medication from 44.6% in 1987 to 79.4% in 1997. Selective Serotonin Reuptake Inhibitors (SSRIs) accounted for more than half (58.3%) of the increase in medications prescribed to those seeking outpatient treatment. Most of the patients treated were between the ages of 18-64 with women accounting for the majority of patients. The primary reasons for increased use of antidepressants among primary care physicians include (1) a greater prevalence and access to effective antidepressants and (2) rapid and efficient diagnosis in clinical practice.

According to research from the CDC, antidepressants have surpassed hormone replacement drugs as the leading therapeutic class of medications prescribed to women. Research data was collected from the National Ambulatory Medical Care Survey (NAMCS) and The Hospital Ambulatory Medical Care Survey (NHAMCS), both component surveys to the National Health Care surveys for the Center for Disease Control (CDC). Prescribing trends from 1995 to 2000 for ten therapeutic drug classes of medications most mentioned by women during ambulatory care visits were evaluated. The results reveal antidepressants topped the list for ten therapeutic drug classes most

frequently mentioned by women visiting ambulatory care. Women visiting outpatient departments including visits to physicians offices and hospital outpatient departments, also listed antidepressants as the most frequently prescribed medication for 1999-2000 (Burt & Bernstein, 2003).

The United States Federal Drug Administration (FDA) first approved SSRI's for the treatment of depression in 1987 (Breggin, 2001; Crogan, 2001) The relatively safe side effect profile and the ease of dosing contributed to its popular use to become the number one drug prescribed by psychiatrists, internist, gynecologist/obstetricians and family practitioners. As a result there has been an unprecedented expansion in the use of SSRIs for an increasingly greater number of physical conditions such as fibromyalgia, chronic fatigue and anxiety (Kramer, 1994).

Today SSRIs are being prescribed for conditions not included in the diagnostic statistical manual as depression but an array of other disorders some of which include obsessive compulsive disorder, generalized anxiety disorder, Premenopausal Dysphoric Disorder (PMDD) among many others. The ease of dosing and relatively safe side effect profile has contributed to the marked increase and prescriptions by doctors (Kramer, 1994). SSRIs are also being called the new Hormone replacement therapy (HRT) and promoted as a possible alternative to treat menopausal symptoms (Polak, 2003).

Although there are no specific findings indicating that certain antidepressant medications are superior to others in treating depression, the general category of SSRIs is often

avored largely because they lead to fewer side effects. Gender may also moderate the response to this type of antidepressants. Differential response of men and women to antidepressant agents may result from sex differences in endogenous central nervous system levels of serotonin (Nishizawa et al., 1997). Some findings indicate women with chronic depression appear to respond more favorably to SSRIs, whereas men may have better response rates to tricyclics (Kornstein et al., 2000).

With the recent increase and popularity in the use of SSRI antidepressants, there has been a corresponding decline in the percentage of persons receiving psychotherapy from 71.1% in 1987 to 60.2% in 1997 (Olfson, et al., 2002). Hence the focus on symptom alleviation through the use of antidepressants has become a mainstay and has overshadowed attending and remedying interpersonal problems faced by patients.

These trends continue despite evidence in research demonstrating that for the treatment of depression and associated illness, combined treatment of pharmacotherapy and psychotherapy provides guideline concordant care and assures best practices (Elkins et al., 1989). The U.S. Preventive Service Task Force (2002) made recommendations for screening depression in 2002. Physicians were advised to utilize screening tools (e.g., the Zung Self-Assessment Depression Scale or Beck Depression Inventory) and or at minimum physicians should ask two simple questions about mood and anhedonia; “Over the past two weeks have you felt down, depressed, or hopeless?”; “Over the past two weeks have you felt little interest or pleasure in doing things?” (USPSTF, 2002, p. 760) The American College of Obstetricians and Gynecologists also recommends that

clinicians ask patients about psychosocial stresses and family history of depression. It may be that current pressure on physicians result in a focus on symptom alleviation through the use of antidepressants, which overshadows attending and remedying interpersonal problems faced by patients.

### ***Enhancing Treatment of Depression among Primary Care Physicians***

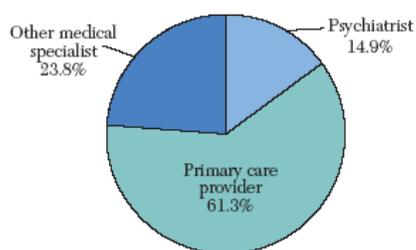
According to Richard Glass (2003) reporting in the Journal of the American Medical Association, depression is a public health challenge that calls for greater awareness on the part of physicians. The research regarding depression and associated illnesses is voluminous. However, the consensus is that while an increase in the research and treatment of depression is encouraging, inadequate treatment continues to be a serious concern (Kessler et al., 2003).

Enhancing the treatment of depression in primary care settings has been a central goal of the World Health Organization strategy for mental health (Gilbody, et al., 2003). Results from a National Comorbidity Survey suggest that only 41.9% of respondents seen in primary care settings receive adequate care compared to 63% respondents in specialty mental health care settings (Kessler, et al., 2003). There are specific challenges to the treatment of depression in primary care settings. Patients with depression that visit their primary care physicians typically present with somatic complaints of fatigue, chronic pain or other vague symptoms (Arnold 2005; Dietrich, 2003; Ebell, 2003). Education about depression and redirection of patients help-seeking toward avenues where guideline concordant care can be provided is essential.

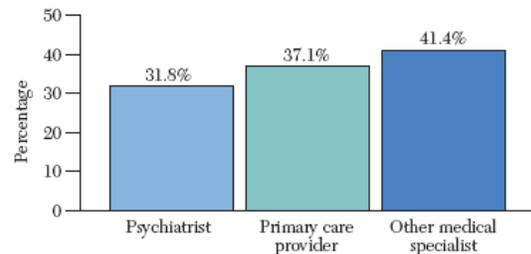
Gilbody et al. (2003), following a systematic review of interventions to improve the treatment of depression in primary care suggests that effective strategies incorporate patient education and shared care among the primary care physician, psychiatrist, and psychologist. These interventions were associated with patient treatment adherence and recovery.

The rise in the use of SSRIs over the past decade has led to widespread concern about the quality of antidepressant treatment in primary care. Primary care treatment guidelines for depression recommend a minimum of six to eight weeks of antidepressant treatment, followed by an additional six to nine months of continued treatment. However, early discontinuation (i.e., failure to refill a prescription) of SSRI medication is prevalent with rates at about 37% in primary care practices (Lewis et al., 2004). A primary care doctor usually gives the majority of first prescriptions. Figure 1-show results from a study by Lewis et al., (2004) demonstrating how this prescription trend compares to other medical specialties.

Prescription of selective serotonin reuptake inhibitors by medical specialty (N=21,830 patients)



Patients' early discontinuation of antidepressants by medical specialty (N=21,830 patients)



From: Lewis et al., (2004) Patients' early discontinuation of antidepressant prescriptions

The increase in pharmacological treatments over the last decade as the sole treatment for depression in primary care settings may not be as effective as combined treatment. Adherence to antidepressant medication use is often a problem in clinical practice that can usually be resolved when pharmacological treatment is combined with psychotherapy. Psychotherapy and antidepressant treatments were found equally effective in the treatment of mild to moderate depression in several studies (Elkins et al., 1989).

Recent research suggests that treatment with both pharmacotherapy and psychotherapy in combination is more efficacious than either treatment alone particularly with more chronic forms of depression. Current theorists believe biological and psychological factors mutually influence one another (Pert, 1997; Schwartz 1996).

There are many debates about the most effective treatment for depression. Some argue that medications such as SSRIs that alter neurotransmitter functions in the brain are the most effective treatment (Thase & Holland, 1995). However, functional imaging studies of major depression also demonstrate that there are response-specific changes in brain activity when a full course of cognitive behavioral treatment is applied. A recent study on the modulation of cortical-limbic pathways in major depression illuminates the longer lasting benefits of therapy when compared to medication. Goldapple et al. (2004), examined brain changes underlying CBT by using resting-state fluorine-18-labeled deoxyglucose positron emission tomography. These researcher found that like antidepressants, cognitive behavioral treatment (CBT) affects clinical recovery in patients

with major depression by modulating specific sites in the limbic and cortical regions of the brain. However, while the antidepressants appear to reduce activity in the limbic systems, results with CBT quieted the overactivity in regions of the cortex responsible for processing tasks in rethinking and reappraisal of emotional feelings. Most notable were the results found in the relapse rates one year following the end of treatment. The rate of relapse for patients in this research study was 25% compared to 80% rates of relapse for individuals on antidepressants. This study was the first to demonstrate that depressed patients respond differentially to the two kinds of treatment. There are equally convincing and well studied arguments for the treatment of depression through the use of interpersonal psychotherapy which examines issues of grief, role disputes, role transitions and role deficits as they relate to interpersonal relationships (Klerman et al., 1984; Weissman, Markowitz, & Klerman, 2000). However, most researchers agree that there are limitations to each of these approaches. Hollon, DeRubeis, and Evans (1990) describe this phenomena by suggesting that combined therapies, that is, both psychotherapy and psychopharmacology provides the benefits of either single approach while compensating for the limitations of each. Sammons & Schmidt (2001), conducted an extensive review of literature on combined therapies for the treatment of depression. They conclude that combined treatment is more effective than either approach alone particularly when dealing with chronic or severe depression. Meta-analytic and qualitative review studies also demonstrate the effectiveness of combined treatment (Friedman, et al., 2004; Pampallona, et al., 2004). Combined treatment approaches have also been incorporated into a stepped collaborative care program in primary care settings. Stepped collaborative care is a systematic approach designed to improve patient

education, integrate mental health professionals in primary care clinics in order to facilitate providing evidenced based guideline treatments that combine psychopharmacology with psychotherapy (Katon et al., 1996; Pampallona et al., 2004).

The Depression Guideline Panel of the Agency for Health Care Policy and Research (AHCPR) in 1993 published recommendations for treating depression in primary care. The results indicate that antidepressants pharmacotherapy combined with depression targeted psychotherapies are more efficacious than either treatment alone. Strategies that incorporate patient education and shared care among the primary care physician, psychiatrist, psychologist and/or mental health counselor are associated with patient treatment adherence and recovery. In other words, the addition of psychotherapy, patient education and/or counseling services helps to keep patients in treatment, provides more effective care and helps prevent relapse (Schulberg et al., 1998).

Katon (2003) has conducted extensive research on improving primary care services for the treatment of depression and associated symptoms particularly for women who are the greatest utilizers of primary care and addresses some of the financial barriers for patients with lower incomes to mental health services.

Katon points out additional barriers to mental health treatment in primary care including: (a) competing demands and lack of time to provide adequate education and activation of patient's to become partners in care; (b) patient non-adherence to antidepressant treatment; and (c) lack of access to mental health care specialist.

Katon recommends using a stepped care principle approach in primary care which is essentially a three tiered treatment approach depending on the severity of symptoms. For example, patients with subclinical depression and or anxiety can be followed up by the primary care physician with supportive collaborative counseling during visits. For the more chronic cases, involving a nurse, counselor or psychologist working collaboratively with the physician is advised. Finally, recommendations are made for the use of psychiatrist or referral out to mental health specialty services for more severe cases. Psychologists and mental health counselors should not only be involved in direct services but also in training and development of staff in brief evidenced therapies, program development, and evaluation/consultation to primary care physicians.

Medical training programs are currently making advances towards this end. According to new requirements from the Accreditation Council for Graduate Medical Education (ACGME), medical residency programs will institute programs to meet several core competencies that promote an integrated collaborative approach to primary care effective July 1 2001. Teaching teamwork and how to partner with other professionals to provide effective care is now being incorporated into residency training. This will be increasingly the case with medical practices, as medical professionals turn to psychological professionals to deal with their patient needs (Daw, 2001).

### *Integrating a biological and psycho/social approach to treatment of depression*

It is clear that there has been a significant increase in the pharmacological treatment for depression in primary care settings. Additionally medical training programs are addressing the need for integrating psychological services in combination with pharmacological treatments for depression because of its proven effectiveness. Currently there are pressures on contemporary medicine to accomplish this integrated approach to treatment. However, a history of the treatment of depression in primary care reveals that current etiological models underestimate the roles of society and culture in causing depression while overemphasizing biological factors (Callahan & Berrios, 2005). Most patients seeking treatment for depression in primary care are women. Their depression may in part be the result of adverse environmental influences and psychological vulnerabilities that place them at risk for recurring depressive episodes. There is an important need for treatments that deal with the social and personal contexts of women's lives and not solely on their symptoms (Hammen & Mazure, 2003). Despite all the evidence against singular treatment approaches, women with depression and associated symptoms are typically prescribed solely antidepressant medication when visiting their primary care.

The medicalization of women's experiences, popularized by British endocrinologist Katharina Dalton have promoted a one-dimensional medical explanation for reproductive and hormonal related events in women experiences (as cited in Chrisler, 2002). Women's experience of depression and associated symptoms are often reduced to hormonal imbalances. Events once considered normative life experiences are now viewed as

inappropriate and in need of control. The propensity to medicalize women's experiences at the expense of an examination of women's experiences of stress and life changes may further compound their experiences of depression; discouraging women from finding alternative solutions that emerge from self-awareness, self-discovery, self-empowerment; and ultimately invalidates their own health story. As a result women have become increasingly dependent on the medical system to resolve problems that might more adequately be resolved with psychotherapy. There is little evidence however, that despite this over-dependence on the medical system the overall burden for depression in society has decreased (Callahan & Berrios, 2005). There are multiple influences that interact together to affect women's lives and contribute to the onset and maintenance of depression. Psychological distress can best be understood not in the context of individual personality traits but rather seen as deeply rooted in sociocultural factors. From this perspective, depression may not necessarily be defined as a disorder, but rather a logical response to sociocultural factors such as power differentials found in interpersonal relationships and in the larger social, political and economic structures that operate at multiple levels of women's experience. A feminist ecological model accounts for the multiple contextual and personal factors impinging on women's experiences (Ballou, Matsumoto, & Wagner, 2002). It also stresses the importance of valuing women's experiences as described by the women themselves. An analysis of women's depression from this theoretical vantagepoint may help us gain a comprehensive and more accurate view of how women are treated for depression in primary care settings. There is a dearth of information regarding the experiences of those who are treated for depression in primary care.

There is substantial potential to improve the management of depression in primary care. Organizational interventions prove successful when they support collaborative care and quality improvement initiatives. Improvement initiatives combine clinician, nurse and patient education together with the enhanced support of psychological services. These factors together are shown not only to be clinically effective but cost effective in the long run as well (Cabana, Rushton, & Rush, 2002; Peveler & Kendrick, 2001).

Given that the indications for best practices prescribe the combined use of pharmacotherapy and psychotherapy in the treatment of depression, this author would like to propose a study to explore the experience of women who receive treatment for their depression by a primary care physician and establish the rate at which this guideline concordant care occurs in primary care facilities. The purpose would be to determine the extent to which psychotherapy or mental health counseling is prescribed along with pharmacotherapy treatment with SSRIs. SSRIs were selected because research data reveals these antidepressants are the most prevalent intervention for the treatment of depression in women by primary care doctors. Currently there is no research available that critically examines women's experiences when prescribed an SSRI by their primary care doctor for depression and its associated disorders. Also whether women prescribed an SSRI are also concurrently evaluated for current life stresses and advised to seek psychological services.

**Research Questions:**

- What are women's experiences in primary care settings when they are prescribed an SSRI for depression and associated symptoms.
  
- Are the majority of women will be prescribed an SSRI for depression and associated symptoms by their primary care physician also prescribed psychotherapy?
  
- Have the majority of women identified as having been prescribed an SSRI for depression and or associated symptoms by their primary care had a precipitating stressful life event prior to onset of symptoms?

## **CHAPTER III**

### **METHODS AND PROCEDURES**

#### **Design**

The present investigation is a mixed method concurrent triangulation design research study including qualitative and quantitative methods (Creswell, Plano-Clark, 2007). In this design, data is collected for quantitative analysis, while concurrently a separate qualitative analysis builds on the first phase finally converging and integrating those results in order to provide a comprehensive analysis of the research problem.

The first phase includes a quantitative analysis that was completed following a semi-structured telephone survey. Concurrently, select participants during phase one participated in a qualitative analysis that included personal interviews consisting of open-ended questions.

A cross-sectional survey design with data collected at one point in time was used in this study. Although the sample selected is not random, nor necessarily a sample representation of the general population, rather respondents were chosen based on their availability in response to advertisements requesting participants. This survey design examined the personal experiences of women with depression visiting their primary care doctors. This design was selected as a method to begin exploring the prevalence and frequency with which psychotherapy is prescribed when an SSRI is given in a primary care setting. It also provided an efficient point of data collection with rapid turnaround. Secondly this study examined whether individuals who were prescribed an SSRI for

depression and associated disorders in the last five years by their primary care physician were also prescribed psychotherapy. Guideline concordant care for depression recommends that combined psycho-pharmacotherapy and psychotherapy is the recommended treatment for depression (AHCPR, 1993). This investigation sought to examine whether severe, undesirable life events preceded the onset of symptoms of depression and associated disorders. This chapter includes a detailed description of the methods and procedures that were employed in this study. Information is included concerning subject selection, the procedure involved in data collection, as well as measurement instruments used and analysis.

## **Participants**

Participants were comprised of a self-selected sample of 54 participants the total of which comprised the original respondents. Volunteer participants were recruited through printed media and posted advertisements at several community health clinics and wellness centers in three Pennsylvania township communities. Advertisements requested female volunteers between the ages of 18-65 who have been prescribed a Selected Serotonin Reuptake Inhibitor (SSRIs e.g., Prozac, Zoloft, Paxil, Celexa, and Luvox) by their primary care physician in the last five years. A phone number was also provided in the advertisement for the volunteers. Eligibility for the present study was determined by three factors: self-reports of unipolar major depression, dysthymic disorder and/or associated symptoms (e.g., fatigue, anxiety) and confirmation of prescription of an SSRI. A primary care physician must have prescribed the SSRI. Of the 54 respondents, 14 (25%) did not qualify for the study. Of these, four participants were prescribed an SSRI by a psychiatrist not a primary care doctor, two had a diagnosis of Bipolar disorder, and

eight initially agreed to the study but later declined to be interviewed and did not return the consent forms. Reasons for nonparticipation were primarily confined to reluctance to share personal information. A total of 40 women were included for the analysis.

Ten participants were selected from the 40 for in-depth personal interviews. Criteria for selection included an expressed desire to participate in the second phase involving an in-depth personal interview that was audio-taped. All 10 participants were prescribed an SSRI by their primary care physician. In order to ensure adequate representation of the participant population for psychotherapy prescription (yes or no), age, educational background and socioeconomic status, the 10 participants were selected as follows: Of the 10 participants three had received counseling/psychotherapy, one prescribed by their primary care doctor and two were self-referred. The remaining seven were not prescribed psychotherapy. Of the ten participants three were between 18-29 years of age, four were between 30-49, and three were between 50-65. Two participants had completed high school, 1 had a technical school degree, one was completing her masters degree, five had obtained a bachelors degree and one was medical doctor. For socioeconomic status, five of the participants met criteria for the low-income category, three for the middle income, and two for the high-income category.

## **Procedure**

The study was conducted in two phases concurrently. For the first phase telephone interviews were conducted using an investigator administered semi-structured questionnaire. Throughout this first phase ten participants of the forty who volunteered

and met certain criteria were selected for the second phase which involved completing in-depth personal interviews.

### ***Phase I***

During the first phase, participants who responded to the ad were informed via telephone of the purpose of the study. They were told by the researcher that the study proposed to gather information regarding women's experiences when they are prescribed an SSRI by their primary care physician. Each respondent was evaluated for eligibility. Eligible participants were asked to complete a written consent form and for times of availability to complete telephone interviews. The consent form was subsequently sent to participants in the mail with a self-addressed stamped envelope. Once the researcher received the signed consent, the researcher called the participants and conducted a telephone interview with the semi-structured survey. In order to minimize the potential effects of recall bias, only events and onset of depressive symptoms reported to have occurred in the past five years were included in the current analysis. All forty participants selected received a modest financial remuneration of \$25.00 for their participation upon completion of the telephone interview.

### ***Phase II***

In-depth personal interviews were conducted with 10 participants selected from the 40 respondents during the telephone survey phase. In-depth personal interviews were scheduled at least two weeks following the participants' completion of the telephone survey in order to minimize potential bias.

The personal interviews included open-ended questions regarding participant's personal experiences with their medical visit, their opinion regarding the SSRI prescription, and their attitude towards psychotherapy. Additionally questions regarding participants' reasons for responding to the ad and their particular interest in the study were asked. Permission to tape record interviews was requested and granted. The interviews were conducted by the author who is a mental health clinician with 15 years of experience. This information was utilized to provide narrative accounts of women's experiences when they seek medical help in primary care settings for psychological problems of depression and associated symptoms.

## **Instruments**

### **Semi-Structured Survey**

During the first phase of the study, both occurrence and time of occurrence (calendar year and month) of: (i) onset of depressive symptoms; (ii) SSRI prescription (iii) stressful life events were reported retrospectively and documented within the context of a semi-structured interview administered by the investigator. Demographic information was also reported. The following is a description of the instruments.

#### ***Depressive episodes and associated symptoms***

The first instrument to assess major depression utilized the ten individual symptoms representing the nine 'category A' criteria for a major depressive episode from The Diagnostic and Statistical Manual of Mental Disorders- Fourth edition-text revision (DSM-IV-TR, 2000). This instrument has been commonly used in earlier research for the purpose of assessing episodes of depression (Maciejewski et al., 2001). Similarly, dysthymic disorder was assessed utilizing the seven individual symptoms representing

the six 'category B' criteria from the DSM-IV-TR (American Psychological Association, 2000). Participants with symptoms of mania were excluded to focus on a unipolar versus bipolar depression typology. In addition to criteria for measuring depression, time frames for symptoms were documented via participant responses to the following question: "are your symptoms current, remitted, first episodes, or lifetime events?"

Symptoms such as fatigue and anxiety were assessed through self-report. Symptoms of fatigue and anxiety were included based on research suggesting these symptoms are typically comorbid with mood disturbances such as depression (Goldenberg, et. al 2004; Hudson, Mangweth, Pope et al., 2000; Walker et al., 1997). These symptoms are also found to be highly prevalent in women visiting primary care for depression, as evidenced by cross national epidemiological studies (Maier et al., 1999). Prevalences of comorbid anxiety disorders with depression patients have varied between 28-51% in primary care patients (Melartin, 2000).

### ***SSRI prescription by primary care physician***

Prescription of SSRI by primary care physician will be determined by asking the following questions: what type of SSRI were you prescribed?; Who prescribed your SSRI?, Do you happen to recall what year and month it was prescribed?, How many milligrams were you prescribed?; How long were you on this medication?; Are you currently taking this medication?; How often did or do you currently take the medication?

### ***Demographic questionnaire***

For the purpose of this study a straightforward questionnaire was used. Selected participants were asked question regarding their age, marital status, level of education, cultural background, income level and employment status. These variables were operationalized as follows:

1. Age: Selected participants were asked their current age: (1)18-29, (2) 30-49, (3) 50-65.
2. Marital status: participants were asked to report whether they are married or not, in same sex relationship, single in relationship, single not in relationship.
3. Level of education achieved or attained: participants were asked to report years of education attained; non high school graduate, high school graduate, two years college, bachelors degree, masters and/or doctorate.
4. Racial/ethnic background: Participants were asked to specify the Race/ethnic group they most identify with; (1) Caucasian, (2) African-American, (3)Hispanic, (4) Asian (5)Other
5. Income levels were classified into six categories in the thousands: (1)0-19, (2)20-39, (3)40-59, (4) 60-79, (5) 80-99, (6) 100+.
6. Employment status: participants were asked if they are employed full-time, part-time, unemployed, retired, on medical disability.

### ***Stressful life events***

In order to assess major life events that are stressful, severe and undesirable stressful life events were queried. Events such as these have been previously researched and

demonstrated by Brugha et al., (1985); Grant et al., (1981); Kendlar et al., (1995). These events have been clearly associated with depression (Dohrenwend et al., 1995;). The utility and reliability of this measure was previously studied by Maciejewski, Prigerson, & Mazure (2001). These researchers used this inventory approach and found it to be a reliable indicator for stressful life events but were limited by omitting contextual information in the assessment of stressful life events. This study will use this inventory with the inclusion of contextual data to improve the reliability of the findings.

The occurrence and time of occurrence of stressful life events within the last five years were documented via participants responses to a 13 item list of the following specific stressful life events: (i) death of a child; (ii) death of a spouse; (iii) death of a parent; (iv) death of a close friend or relative; (v) divorce; (vi) other love or marital related problems; (vii) personal financial problems; (viii) financial or legal problems within one's family unit; (ix) move to a new residence or geographic relocation; (x) physical assault; (xi) life threatening illness or injury; (xii) loss of employment; (xiii) managing multiple family and/or career roles. For each of these events, the interviewer will ask the respondent if and when (most recently) the specific event occurred and whether any additional undesirable stressful event occurred to them not included in the list. A determination was made regarding the timing of the stressful event relative to the depressive symptom episode to help identify whether stressful events preceded the respondents visit to their primary care doctor.

## **Analysis**

Descriptive statistics were used to describe demographic characteristics of participants: age, socio-economic status, ethnic background, marital status, level of education and employment status.

Descriptive statistics were also used to describe symptoms and stressful life events reported by participants.

A 95% confidence interval was constructed to provide a measure of the precision of the estimated proportion of women prescribed an SSRI with psychotherapy in the population sampled and the proportion of women referred for counseling or psychotherapy by their primary care physician.

Fisher's exact test was used to evaluate associations between (1) Individual depressive symptoms and referral for psychotherapy, (2) participants who felt that stressful life events precipitated their visit to the primary care physician (yes or no) and referral for psychotherapy, and (3) demographic characteristics and referral for psychotherapy. Several of these comparisons had small cell counts so the Fisher's exact test was more appropriate than the Chi square test.

A Spearman rank correlation appropriate for the analysis of ordinal data was used to determine if there was a correlation between the number of life events (0-12) and the number of reported symptoms (0-7).

The number of stressful life events reported by each participant were summed into a stressful life events score variable. The possible number of stressful events is 0 to 12. The number of depression symptoms reported were also summed. The possible number of stressful events is 0 to 7.

To better understand participants' experiences when visiting their primary care and being prescribed an SSRI, information most pertinent to this experience was identified. A qualitative content analysis was used for this second phase of the study. This analysis was comprised of interrelated conceptual thematic material obtained from personal interviews. Identified themes served to orient the clinician for listening to participants with the intent to capture their experiences and have their voices go forward. The first interview was utilized to determine and establish thematic material for the subsequent 9 interviews. Names were given to each thematic unit of information. The resulting analysis of interview responses yielded the following nine themes: (1) Symptoms that brought them to treatment, (expressed as symptom identification and description); (2) Physician interaction and expectations (described in terms of level of personal comfort with physician, ability to communicate concerns and receiving feedback and instruction as well as expectations such as statements about what they hoped would result from their visit); (3) Expectations satisfied (statements about whether the manner in which their expectations were or were not met with their primary care visit); (4) Prescribed an SSRI (described in terms of factors that influenced how the prescription for an SSRI was made); (5) Prescribed psychotherapy (described whether or not a prescription for psychotherapy was made along with the SSRI); (6) Stressful life events (responses related

to description of stressful events that precipitated visit to primary care; (7) Feelings about efficacy and success rate of medications alone (statements about their perceived experience treating their symptoms solely with medication, and information about their experience with the effectiveness of medications); (8) Feelings about success rate of combined treatment (statements regarding their beliefs regarding the effectiveness of both medication and psychotherapy); (9) attraction to the study and suggestions (statements regarding their motivation for responding to the study and suggestions for improving primary care services ). These themes were initially generated by the researcher and subsequently audited and verified by an academic advisor who listened to the first two audio-taped transcripts. Each interview was transcribed and the responses relevant to each of the nine themes were categorized. The resulting theme transcriptions were then examined for emerging patterns.

In order to triangulate the findings and explain complex responses from the survey data, both the qualitative and quantitative data sets were merged in the discussion section in developed into a comprehensive picture of the analysis. The focus was to determine how the qualitative data informs the quantitative results and provides confirmation or disconfirmation of the two data sets.

A graphical representation of this mixed method study is included in figure 2. In order to illustrate the concurrent data collection of both methods and the convergence of the two data sets within this study. The importance of providing a visual model of the procedures has long been documented in the mixed-method literature (Creswell, 2005; Creswell et al., 2003; Morse, 1991; Tashakkori and Teedlie, 1998).

**FIGURE 2.**

**Visual Model for Mixed-Methods**

**Concurrent Triangulation Design Procedures**

P  
H  
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I

- Procedures:**
- Semi-Structured questionnaire (n=40)

QUAN data collection

- Products:**
- Numerical Item scores

- Procedures:**
- Indepth Personal Interviews (N=10)

QUAL data collection

- Products:**
- Transcript of audiotaped Interviews
  - Personal observation notes

- Procedures:**
- Score Responses
  - Frequencies
  - 95% Confidence intervals
  - Fisher's exact test
  - Spearman's rank correlation

QUAN data analysis

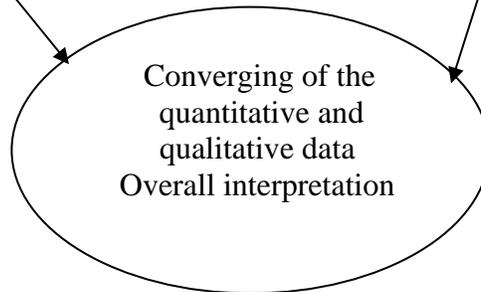
- Products:**
- Group Classification
  - Descriptive Statistics
  - Categorical data analysis

- Procedures:**
- Coding and thematic analysis
  - Within-case and across- case theme development
  - Cross thematic analysis

QUAL data analysis

- Products:**
- Codes and themes
  - Similar and Different themes and categories
  - Across thematic material

- Procedures:**
- Compare and contrast of quantitative and qualitative results



- Products:**
- Discussion
  - Implications
  - Future research

## **CHAPTER IV**

### **RESULTS**

The results of this study are presented in two sections. First, findings from the analysis of the survey data will be reported followed by the results from the qualitative data analysis.

#### **Quantitative Data Analysis**

##### **Analysis of Survey results for SSRI Telephone survey**

Forty women were surveyed regarding experiences related to SSRI prescription. Data from the survey was entered into an excel spreadsheet and assigned a dichotomous variable value of 0 or 1. All 40 women had been prescribed an SSRI. No analysis was done relating to the type, dose or frequency of medication used. Ninety two percent of the women were prescribed the SSRI by their family doctor or primary care physician (37/40 = 92%). The remaining 8% (3/40) were prescribed by an oncologist, a physicians assistant, and a general practitioner.

##### **Proportion of women referred to counseling**

The primary outcome of interest for this study is the proportion of women prescribed an SSRI who were also referred to counseling by their primary care doctor.

Thirty (75%) were not referred to any counseling or psychiatric care. Six of these women were already receiving some type of counseling or therapy prior to the SSRI prescription.

Ten (25%) of women surveyed were referred to some type of counseling (counselor, psychologist, psychiatrist or both) resulting in an overall referral rate for this sample of 0.25.

The table 1 provides the 95% Confidence Interval for this referral rate based on this sample size of 40. Confidence Intervals for larger sample sizes (n= 100, n=500) are also included to demonstrate the increased precision of the estimate with a larger sample size, assuming the same referral rate of 0.25 referred was obtained in larger samples. Based on the confidence interval, this study provides 95% confidence that between 12% to 38% of women prescribed an SSRI are also referred to some type of counseling.

---

**Table 1**

**Referral Rate**

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<u>Referral rate</u>	<u>95% CI</u>	<u>Sample size</u>
0.25	(0.12, 0.38)	This sample of 40 I
<u>If the estimate was:</u>	<u>Projected 95% CI</u>	<u>if sample size was:</u>
0.25	(0.17, 0.33)	n = 100
0.25	(0.21, 0.29)	n = 500

---

Table 2 provides the 95% confidence interval for the ‘Non-referral rate’ from this sample of 40 women. Confidence intervals for this rate based on larger samples are also included (assuming the same rate was observed in these larger samples) Based on the confidence interval, this study provides 95% confidence that between 62% to 88% of women prescribed an SSRI are not referred to some type of counseling.

**Table 2**

**Non-Referral Rate**

---

<u>Non-Referral rate</u>	<u>95% CI</u>	<u>Sample size</u>
0.75	(0.62, 0.88)	This sample of 40
<u>If the estimate was:</u>	<u>Projected 95% CI</u>	<u>if sample size was:</u>
0.75	(0.67, 0.83)	n = 100
0.75	(0.71, 0.79)	n = 500

---

**Demographic Characteristics**

The table 3. summarizes the demographic characteristics of the women surveyed. Fisher's exact tests\* to look for associations for information that is in categories were done to evaluate whether any of these characteristics were significantly associated with referral to counseling. No significant associations were identified.

Table 3

**Demographic Characteristics**

	N(%) Of total (40)	N(%) of those referred to counseling	N(%) of those not referred to counseling	Fisher' Exact test p-value
<b>Age Group</b>				
18-29	6(15)	2(20)	4(13.3)	0.479
30-49	19(47.5)	6(60)	13(43.3)	
50-65	15(37.5)	2(20)	13(43.3)	
<b>Education</b>				
No HS diploma	2(5)	1(10)	1(3.3)	0.362
HS graduate	9(22.5)	2(40)	7(23.3)	
2-year college	7(17.5)	4(40)	3(10)	
Other professional	3(7.5)	0(0)	3(10)	
Bachelors	13(32.5)	2(20)	11(36.7)	
Masters	4(10)	1(10)	3(10)	
MA and Doctorate	2(5)	0(0)	2(6.7)	
<b>Marital Status</b>				
Married	22(55)	7(70)	15(50)	0.798
Same Sex	0(0)			
Single	9(22.5)	2(20)	7(23.3)	
In Relationship	3(7.5)	1(10)	2(6.67)	
Divorced	4(10)	0(0)	4(13.3)	
Widowed	2(5)	0(0)	2(6.7)	

Table 3

**Demographic Characteristics** (continued)

	N(%) Of total (40)	N(%) of those referred to counseling	N(%) of those not referred to counseling	Fisher'Exact test p-value
<b>Income Level</b>	N=39 due to 1 missing	N=10	N=29	
0-19,000	6(15.4)	0(0)	6(20.7)	0.560
20,000-39,000	7(17.9)	3(30)	4(13.8)	
40,000-59,000	9(23.1)	2(20)	7(24.1)	
60,000-79,000	2(5.1)	0(0)	2(6.9)	
80,000-99,000	6(15.4)	2(20)	4(13.8)	
100,000+	9(23.1)	3(30)	6(20.7)	
<b>Ethnicity</b>				
Caucasian	40(100)	10(100)	30(100)	NA
<b>Employment</b>				
Full-time	17(42.5)	6(60)	11(36.7)	0.554
Part-time	7(17.5)	1(10)	6(20)	
Unemployed	16(40)	3(30)	13(43.3)	
<b>Health Insurance</b>				
HMO	12(30)	3(30)	9(30)	0.626
Medicaid	3(7.5)	0(0)	3(10)	
PPO	21(52.5)	5(50)	16(53.3)	
Uninsured	4(10)	2(20)	2(6.7)	

## **Symptoms**

Thirty nine of the forty women reported that they had experienced a depressed mood for at least 2 weeks or much of the time. One response to this question was missing.

All 40 women reported that their symptoms influenced their decision to visit their primary care doctor.

Individual symptoms are listed in table 4 along with the percent of women reporting them and, within each group (referred or not), the percent of women who reported each symptom. There was a significant association between the report of feelings of worthlessness and referral. Sixty percent of the women referred to counseling reported feelings of worthlessness, whereas 96.7% of the women not referred to counseling reported feelings of worthlessness (p-value for Fisher's exact test = 0.01). No other significant associations, by Fisher's exact test, were found between reported symptoms and referral.

**Table 4****Individual Symptoms**

	N (%) Of total	N (%) of those referred to counseling	N (%) of those not referred to counseling	Fisher's Exact test p-value
Weight change				
Yes	28 (70)	6 (60)	22 (73.3)	0.451
No	12 (30)	4 (40)	8 (26.7)	
Insomnia/hypersomnia				
Yes	36 (90)	8 (80)	28 (93.3)	0.256
No	4 (10)	2 (20)	2 (6.7)	
Psychomotor problems				
Yes	30 (75)	6 (60)	24 (80)	0.232
No	10 (25)	4 (40)	6 (20)	
Fatigue				
Yes	36 (90)	9 (90)	27 (90)	1.00
No	4 (10)	1 (10)	3 (10)	
Worthlessness				
Yes	35 (87.5)	6 (60)	29 (96.7)	0.010
No	5 (12.5)	4 (40)	1 (3.3)	
Concentration problems				
Yes	34 (85)	7 (70)	27 (90)	0.153
No	6 (15)	3 (30)	7 (10)	

**Table 4****Individual Symptoms** (continued)

Suicidal thoughts				
Yes	15 (37.5)	2 (20)	13 (43.3)	0.269
No	25 (62.5)	8 (80)	17 (56.7)	

For all symptoms except suicidal thoughts, 70% or more of the women surveyed reported that they had experienced this symptom.

The number of symptoms reported by each woman were summed into a symptom score variable. The possible range of number of symptoms was 0 to 7. Results from the women surveyed are summarized in table 5:

**Table 5**  
**Symptom Score Variable**

Number of symptoms reported	N(%) of 40 women	N (%) of those referred to counseling	N (%) of those not referred to counseling	Fisher's Exact test p-value
0	0	0	0	0.006
1	0	0	0	
2	0	0	0	
3	3 (7.5)	2 (20)	1 (3.3)	
4	7 (17.5)	4 (40)	3 (10)	
5	18 (45.0)	4 (40)	14 (46.7)	
6	12 (30.0)	0	12 (40)	
7	0	0	0	

There was a significant difference in symptom score distributions between the group that was referred to counseling and the group not referred (p-value for Fisher's exact test = 0.006). All 12 women with a symptom score of 6 (indicating that they reported 6 of the symptoms) were not referred to counseling or therapy. However, 5 of these 12 women were already receiving counseling or therapy prior to the SSRI prescription.

### **Stressful Life events**

All 40 women indicated that stressful life events influenced their decision to visit their primary care doctor. Individual stressful life events are listed in table 6 along with the % of women reporting them and, within each group (referred or not) the percent reporting each life event. No significant associations, by Fisher's exact test, were found between reported stressful life events and referral.

Table 6.

**Stressful Life Events**

	N (%) Of total	N (%) of those referred to counseling	N (%) of those not referred to counseling	Fisher's Exact test p-value
<b>Death of Child</b>				
Yes	2 (5.0)	0 (0)	2 (6.7)	1.00
No	38 (95.0)	10 (100)	15 (93.3)	
<b>Death of spouse</b>				
Yes	2 (5.0)	0 (0)	2 (6.7)	1.00
No	38 (95.0)	10 (100)	15 (93.3)	
<b>Death of parent (missing 1)</b>				
Yes	8 (20.5)	1 (10)	7 (24.1)	0.653
No	31 (79.5)	9 (90)	22 (75.9)	
<b>Death of friend</b>				
Yes	7 (17.5)	1 (10)	6 (20)	0.656
No	33 (82.5)	9 (90)	24 (80)	
<b>Divorce</b>				
Yes	3 (7.5)	0 (0)	3 (10)	0.560
No	37 (92.5)	10 (100)	27 (90)	

**Table 6. Stressful Life Events**

(continued)

Love / Marital problems				
Yes	22 (55.0)	6 (60)	16 (53.3)	1.00
No	18 (45.0)	4 (40)	14 (46.7)	
Finance / Legal problems				
Yes	20 (50.0)	6 (60)	14 (46.7)	0.716
No	20 (50.0)	4 (40)	16 (53.3)	
Move				
Yes	10 (25.0)	4 (40)	6 (20)	0.232
No	30 (75.0)	6 (60)	24 (80)	
Physical assault				
Yes	3 (7.5)	1 (10)	2 (6.7)	1.00
No	37 (92.5)	9 (90)	28 (93.3)	
Illness				
Yes	7 (17.5)	3 (30)	4 (13.3)	0.338
No	33 (82.5)	7 (70)	26 (86.7)	
Loss of employment				
Yes	10 (25.0)	3 (30)	7 (23.3)	0.689
No	30 (75.0)	7 (70)	23 (76.7)	
Managing multiple roles				
(missing 1)				
Yes	27 (69.2)	7 (70)	20 (69.0)	1.00
No	12 (30.8)	3 (30)	9 (31.0)	

The number of life events reported by each woman were summed into a stressful events score variable. The possible range of number of stressful events is 0 to 12. Results from the women surveyed are summarized in table 7 for all women and by referral:

**Table 7.**

**Summed Stressful Life Events**

Number of stressful events reported	N(%) of 40 women	N (%) of those referred to counseling	N (%) of those not referred to counseling	Fisher's Exact test p-value
0	0	0	0	
1	7 (17.5)	2 (20)	5 (16.7)	
2	11 (27.5)	1 (10)	10 (33.3)	
3	9 (22.5)	4 (40)	5 (16.7)	
4	3 (7.5)	0	3 (10)	0.312
5	8 (20.0)	2 (20)	6 (20)	
6	1 (2.5)	1 (10)	0	
7	1 (2.5)*	0	1 (3.3)	
8 -12	No women reported more than 7 stressful events			

\*The 1 woman with 7 stressful life events who was not referred to any counseling was a widowed, unemployed, woman age 30-49 on Medicaid.

A larger proportion of women referred to counseling reported 3-7 stressful events (70%) than those not referred to counseling (50%). Table 8 depicts these results. This difference was not significant, however.

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**Table 8.**

**Stressful events proportion**

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Number of stressful events reported	N(%) of 40 women	N (%) of those referred to counseling	N (%) of those not referred to counseling	Fisher's Exact test p-value
1 – 2	18 (45)	3 (30)	15 (50)	0.465
3 – 7	22 (55)	7 (70)	15 (50)	

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**Stressful events and symptoms**

All 40 women reported that they felt their stressful life events contributed to their symptoms. Spearman rank correlation appropriate for correlation analysis of ordinal data was used to find the correlation between the number of stressful life events and the number of reported symptoms. The results were not significant ( $p = 0.97$ ). The Spearman rank correlation coefficient was  $< 0.01$ , indicating essentially no correlation between these two score variables. Spearman rank correlation was used due to the small range of values for the two score variables.

## **Qualitative Data Analysis**

Ten respondents participated in one-on-one in-depth interviews. A brief narrative description of each participant is provided in order to facilitate the development of a comprehensive analysis of the complex personal and distinct life characteristics that brought them to treatment. Each participant is identified by their initials for reference purposes and in order to protect their identity and ensure confidentiality.

### **Description of Participants**

DD is a young woman in her early twenties from a lower middle income Italian American family. She recently graduated from college and is living with her parents in a mid-size town in southwest, PA. At the time of her interview she was working as an administrative assistant for a federal credit union, a division of a large pharmaceutical company. She presented to her primary care physician following a two-year bout of depression that was precipitated initially when transitioning from home to college and exacerbated by the break up with her boyfriend of two years. She struggled with poor appetite, feelings of worthlessness, hopelessness, and an unsuccessful suicide attempt. At the time she visited her doctor she had already been seeing a psychologist at her university counseling center.

LM is a Caucasian woman of German descent in her mid twenties currently living with and caring for her ailing mother. She is enrolled in a master's program in counseling psychology and working part-time. LM suffers from anxiety, panic attacks, and depression precipitated by feeling stressed towards the end of her senior year in college

over finding a job and establishing a career path as well as the subsequent and sudden death of her older brother from a heroine overdose. After six months of failing to sleep through the night, frequent crying bouts and increasing withdrawal from friends and social activities LM visited her primary care doctor for help, direction, and alleviation of her symptoms.

SP is in her mid-forties. She is of Italian American descent, currently unemployed and was recently granted disability insurance due to her longstanding physical and psychological ailments. She lives with her elderly mother and although gregarious in personality tends to socially isolate and has lost contact over the last few years with her friends. SP presented with symptoms of depression, low self worth, anxiety involving chest pain and chronic gastrointestinal problems which she attributes to long-term chronic work related stresses spanning a ten year period. Her work related problems became more pronounced when her employer fired his long time assistant and placed her in a that job without proper training. Around the same time SP's cousin was diagnosed with cancer and rapidly declining in health. Together these events precipitated her visit to her primary care doctor.

AB is a single Caucasian woman in her early 50's living alone. She is gainfully employed and earns a substantial income but is dissatisfied at her job. She was recently diagnosed with osteoarthritis, had bariatric surgery which she describes as "a horrible experience" and reports she is perimenopausal. AB complains of loneliness and loss of hope after her surgery. She reports feeling dissatisfied and unhappy with her life. She had hoped her

surgery and subsequent weight loss would improve her social relationships but that did not happen. She presented to her primary care with tearfulness, feelings of worthlessness, hopelessness, insomnia, depression and arthritic pain.

KK is a Caucasian woman of middle income, in her mid forties, divorced and now separated from her long-term boyfriend. She lives alone and works full-time with two jobs. She reports suffering from a bouts of depression after college and had felt she recovered until the last few years when she has suffered numerous career and relationship disappointments. She failed to accomplish her goal to open up her own insurance agency, feels she obtained two teaching degrees and never used any of them and is generally disappointed remarking that she is “settling career wise”. She initially went to her primary care for muscle pain and suspicions of Lyme disease or fibromyalgia. She concurred with her physician that she was indeed depressed, has trouble with low self-worth, insomnia and continues to struggle with a poor quality of life.

BS is a Caucasian woman of middle income in her late 50’s. She has three adult children and two grandchildren one of which she helps take care of. BS is a college professor and enjoys doing anthropology research. She is very aware of her health, makes it a point to be very informed and has tried numerous alternative treatments to help her mood and improve migraine headaches she has suffered with for years. Recently, her symptoms became exacerbated following a change in teaching jobs and increase child care responsibilities for her granddaughter while her own daughter finishes massage school. She also reports increased conflict in her marital relationship. BS presented to her

physician with severe headaches, insomnia, irritability, fatigue, feeling generally out of control in her life.

MH is a Caucasian woman of middle income in her early 60's. She is married and lives with her husband. She has two adult children and four grandchildren. Her daughter was in a long term severely abusive marital relationship with a police officer. Marilyn reports her symptoms began after her son-in-law shot her daughter and killed himself. Her daughter was left disabled unable to care for her children for some time. MH husband also had a nervous breakdown after the incident feeling he had failed to protect his daughter. As a result he had to leave his job and MH was left to care for her husband, grandchildren and daughter while she recovered. MH presented to her physician with symptoms of depression and panic, insomnia and fatigue.

KL is a Caucasian woman in her early forties. She is an optometrist physician and of upper income status. Currently she lives alone but is in a relationship. KL presented to her physician with substantial weight loss, feeling tired but wired, feelings of guilt over her past relationship with her brother, depression and diminished ability to concentrate. At the time she had ended a long-term relationship with her boyfriend and subsequently discovered her younger brother had committed suicide. She recounts that these events preceded the September 11 attacks. Afterwards she had difficulty coping with work and normal daily routines. She was on numerous unsuccessful trials of antidepressant medications with her primary care before she switched to the care of a psychiatrist and psychotherapist counselor.

DM is a Caucasian woman in her mid forties, currently living in an abusive relationship with her boyfriend. She is sometimes employed cleaning houses and has numerous financial debts and legal obligations. Together they have a daughter. DM went to her primary care with feelings of depression, worthlessness and angry outburst which caused her to lose several jobs and caused strain in her interpersonal relationships. She felt physical and emotional stress feeling forced to stay in an abusive relationship because she is financially dependent and can barely work a cleaning job to support her daughter because of a back injury.

CJ is a Caucasian single woman in her mid- twenties currently engaged to be married. She is a college graduate and currently is unemployed. She reports having difficulty adjusting to working after graduating from college. She kept switching jobs and reported it was the hard schedule and long work hours that caused her to experience crying bouts, feelings of worthlessness, depression and general difficulty sustaining employment. She had poor mental health benefits and went to her physician seeking guidance and a referral. She reports that there is some troublesome family history that she has not dealt with and recalls as a young woman trying always to pretend to be happy when she was not. She developed a positive relationship with her physician assistant and was referred to subsidized counseling services.

## **Themes and Subsequent Patterns Emerging from Interviews**

Besides understanding the prevalence with which psychotherapy is prescribed along with SSRI's, reporting the prevalence of depression symptoms and stressful life events, additional and more in depth information could be explained only after personal interviews with the participants were completed. The content of the interviews translated into the following themes:

\*The initial R is used to represent the researchers questions and comments.

### **Symptoms that brought them to treatment**

Interviews with respondents indicated that a broad range of symptoms were presented to their primary care for treatment. These symptoms not only met criteria for major depressive episodes but also were often comorbid with symptoms of anxiety and at times accompanied by physical pain (e.g. head and body aches). These symptoms frequently affected respondents ability to work and interact interpersonally in their daily lives.

DD-I wouldn't get out of bed. I had no appetite. I was completely restless and felt worthless and hopeless" "I mean both of us had been drinking...that was the night I swallowed...there were probably about 15-20 tablets of acetaminophen...I was attempting suicide.. but I also knew that wouldn't be lethal.

LM-I was up at night over six months straight where I didn't sleep at night..started having a couple of panic attacks kinda like isolating a little bit more. I didn't want to go out with friends as much." "I wasn't sleeping didn't want to go out I guess I didn't want to do as much as I was before and a lot of anxiety. I was afraid to fall asleep and a lot of things.

R-did you have any depression you think?

LM-I think a little bit..yea I think I did but the way she explained it to me..I remember her (Primary Care doctor) saying that anxiety and depression were so closely related that you really don't have one without the other. She felt I was depressed.

KK-Started when pain..unusual to what I had experienced before, uh discomfort..I actually believed it was arthritis at the time. Had also had Lyme disease previously and I had it severely and was afraid that this was a repercussion of that. Had a suspicion that I might have fibromyalgia. So I went to my primary and he did some tests which were very basic to rule out anything more serious...he did feel that I did have it. He also felt that I was somewhat depressed. I had been that road before you know when I got out of college I had a bout of depression years ago and I didn't feel that same way. My primary stated that whether or not I realized it I probably was a little bit and might help prevent for anything deeper.

DM-Uhum, and angry all the time. I was angry all the time. So that's basically what got me into see him. I couldn't keep a job. Somebody would criticize me in any little way and I would walk out the door and troubled relationships for years and years. You know that didn't help because I couldn't tell him anything. I didn't tell him about my upbringing until I don't know ....until eight years into the relationship.

### ***Physician interactions and expectations going into treatment***

The interaction that all the respondents had with their primary care physician proved to be an important theme for participants. It is apparent that the quality of the relationship, level of comfort and the kinds of information dispensed in the patient-physician relationship had an important impact on improving participant's sense of confidence in their doctors and feeling of well-being. In general participants expressed a desire and expectation to have a dialogue with their physician about their symptoms, their current life problems and to feel validated. They wanted to feel that their doctor was interested in them personally and in their experiences and not merely just prescribing them medication. A thorough discussion of adverse side effects was a desired component of the visit which some respondents felt was lacking. Some participants felt that the adverse side effects were either minimized or denied altogether during the initial office visit before treatment began. Some participants felt that their doctors' decision to mitigate

patients concern by only selectively warning of adverse side effects had discouraging effects on them. Two participants were surprised at not having a discussion about the length of time they would be on the treatment and the physiological effects from discontinuing the medication. They resorted to doing research on her own for information.

One participant was disappointed to find that contrary to her expectations, she was not able to assume a fuller quality of life after taking the medication. Quality of insurance coverage and benefits also had an impact on one participant who insisted that once she changed to an HMO the quality of the treatment she received and options for treatment changed to adversely affect her with the same doctor. One respondent who was a physician, had difficulty finding and titrating the right medication. After several failed attempts with a number of different medications under the supervision of her primary care, she went to a psychiatrist to resolve her medication dilemma.

BS-it got to the point....I was like you know what, maybe I do need to do the antidepressant. Um but I guess the thing I'm kicking myself a little bit is that I just didn't do more research. My doctor assured me that not only would I have good results but there would not be weight gain. And he didn't talk about addiction at all because it just wouldn't have entered my mind. Something that at some point I would want to get off and would have trouble getting off.... As far as expectations was .... I did call my physician to say look. I need to come in and talk to you about what I am experiencing. A- my sex drive is gone, B- I don't feel very good on this and this was early on and my headaches weren't gone it took a while. So I felt like...there was a second opportunity for the doctor to talk to me about what to expect with the antidepressant. I really got the sense she really didn't have a whole lot of information. I got the sense that I could've looked it up online and got more answers or read a book and got more answers. My primary care physician didn't have any answers. She said I don't understand why you don't have a sex drive anymore? That shouldn't be part of the SSRI...it is I can tell you that's the difference, one of the differences that I see. The fact that she

had no awareness that that could be.... I've since found out that that is a symptom. Um you know that would have been too big of a trade off for me.  
BS-You know I um we never discussed length of time. I never in my own mind...I never assumed I'd be on it the rest of my life and some people had said to me once you go through menopause it could shift. So my thought was o.k. I am going through menopause let me see if it has shifted, thinking that if I would stop taking the antidepressant never realizing that it would take me a full three months to come off the antidepressant and its an expensive drug for me.

AB- So I went to the doctors for pain killers for my knee....and I knew I was depressed because I had lost interest in everything..I still have no interest except for work....um when I was talking to him about my knee I said to him..you know I am really depressed and I just started crying in his office. And he said o.k. and he handed me a kleenex and he said will get you some pain killers and a prescription for Lexapro....” “It was very short. I mean this time....he handed me a kleenex and took out his pad and wrote the script and that was the end of that visit.

R-Did you talk at all about the stress that you were going through in your life?

AB-At this time I know I remember saying, my life is crap, my job is crap. I've lost my friends and I just started crying....He didn't ask any questions.

AB- I don't like that he refers for everything....I don't know he just refers so quickly that you know its almost meaningless.

R- So you would appreciate more interest in what's going on with you rather than always....getting a script for something?

R-So when you went to your primary care how did you present things? Were you able to?

CJ- Yea luckily...um my primary care doctor um...I was never really comfortable with him. That's why I went to the physician assistant. Um he was also very helpful ... he was also someone I knew that I could talk to a little bit better the actual head doctor there.

R-Cuz you had experiences before?

CJ-Yea yea him the doctor in particular the main doctor. I was going to him for years just because he was my parents doctor but um I was never really comfortable with him unless I had a cold or something.

R-So he never knew about any of this?

CJ- He did. He was actually the person that first prescribed Celexa.

R- Tell me about that experience and what that was like for you.

CJ-Um it was awkward and he.... actually I can reference him as well because I went back, probably about a year after I was on the Effexor and I wanted to get tapered off of it to see how I would do. To see if I could be off of it because I don't want to be on the medications if I don't need to. And again he made me feel like I was making it up.... and I had had that experience with him before but physician assistant wasn't in. He was on vacation or something. So I had to go to the primary which....well.

R- When you had that visit, what was his response that made you feel that way, like you were making it up?

CJ-Um don't remember exactly what he was saying...I just remember....I just don't like him.

R- You didn't feel you could talk to him?

CJ- No, not at all...Um and you know before....just this person in particular, just before when I was on something...I think it was the Celexa at the time. He had said when I was getting off of it...I said that I was gaining weight from it....he said no, you're gaining weight because you're eating...like that sort of thing...you he was just kind of obnoxious. That's why I went to the other, the physician's assistant the next time that I needed...that I felt like I needed a little something.

SP- When I went to my family doctor...as I mentioned there were a lot of work issues at the time." "I was an open book....and definitely told him....he's kinda not real warm and fuzzy. Not the kind that you need for...you know if your going and you're scared and ...your depressed and you need comfort..sort of and you want some reassurance from your family doctor... My anxiety was mounting and my ability to get to work from anxiety and depression symptoms was lessening...and a lot of GI symptoms, stomach pains..I also find and I don't know if other people have found this, when you go to particularly a family physician and if he's treating you or medicating you for depression or anxiety symptoms, if you come with anything else they tend to attribute a lot of it to your anxiety ...or depressive symptoms...so it kinda colors their view....sometimes it is anxiety related but sometimes its not. I don't want other things to be overlooked cuz you are automatically assuming...you know...I need a Klonopin or something...my dose of Lexapro.

SP- As far as he..did pay attention to it. Did give me something from medication standpoint. Was kind enough to sample me when I didn't have any resources. At that point I was fine with anything the would have made me feel better.

So those expectations. But as far as feeling o.k., now I can get out there...no not particularly no.

R-So you life is scaled back?

SP-Very much, very limited.

### *Were expectations satisfied*

The most successful physician-patient interactions seemed to occur with participants that felt supported. Respondents that felt satisfied with their primary care experience tended to express similar sentiments. They felt validated and listened to by their physician because their physicians took a genuine interest in their problems and had good listening

skills. They felt their physicians were effective communicators, providing sufficient guidance, direction and instruction. They tended to have more frequent interaction with their patients to assess their progress.

On participant who had a negative experience with her primary care, went to his physician assistant instead. She felt very fortunate in this new relationship finally feeling like she was receiving the kind of care she wanted. She was glad to have made that change.

DD- She was a very good physician, cared a lot about her patients and she always knew personally what is going on with our lives. My physician did call at that like two three week mark to check to see how I was feeling.

R-Now what do you find was most helpful in that whole experience with your visit with your primary care.

MH-She was very ahh..she was a listener. I found that the best help of all. Someone that's sensitive to somebody else's feelings, listened to my problems and she gave me a direction. Directed me for further help and gave me some medication.

R- Now um and...so you found the most helpful is your ability to communicate what was going on with your doctor and for her to give you a plan and it sounds like she gave you a referral which is fantastic.

MH-She's a wonderful, wonderful doctor. She's very young took over our other family doctor's practice who we had had for oh I guess about 35 years. We just love her. She puts her finger on the problem like some doctors do not.

R- Had you had any other experiences with primary care doctors that were different that made you think she was more...

MH- We had had an HMO in between the time our doctor retired and she took over the practice and that doctor, not only was he arrogant he didn't listen and he wouldn't refer anyone to anywhere.

R-do you feel like your expectations going to the primary care were satisfied...  
If you had something to tell other women what would you say?

CJ-I think I was lucky in the fact that I got someone who spent time with me cuz usually you go in the doctors office and they give you 20 minutes and you're in and out. That for whatever time of day or whatever day I was there telling my

feelings and my situation that um they did spend time with me and kind of say that it was normal and things like that.

R-And that was the physician assistant?

CJ-Yea, yea because I think other doctors either primary care or specialty doctors they're usually in and out. You wait forever in the waiting room and then you're in there for two seconds

### *Prescribed SSRI*

The decision to prescribe an SSRI was generally initiated by the primary care physician. At times the decision was made with little questioning of the patient about their symptoms and few follow-up instructions. However, several participants went with the expectation that they would be given some medication. One participant was hoping to be prescribed based on advice from relatives who had been on the medication despite being discouraged by her psychologist to take medication. Another participant, herself a physician, called into her doctor and was given prescriptions of an SSRI over the phone after she called in crisis following her brother's suicide. One other participant hoped for rapid relief of her symptoms when her daughter was shot by her husband who later committed suicide.

DD- Then in late October I had my scheduled appointment with my primary care... and I brought up even to my psychotherapist upon recommendation of my mom and some of her friends that were on antidepressants that I should say to him what do you think about this and he advised against it. He is just a psychologist who doesn't like to prescribe drugs at all. Um but when I went in there in October with my check-up she (primary care doctor) did say well does it sound like something you want to try and kind of left it up to me. "Do you want me to write a prescription?...I am going to make the dosage obviously low and it's my choice to take it or not" so she prescribed Lexapro for me 10mgs.

MH-I went for help immediately after that because my husband had a nervous breakdown...he wasn't able to protect his daughter and I needed to be in good condition to take care of him, six year old twins, eleven year old granddaughter

and my daughter in the woods fighting for her life in the hospital. I went to the doctor who put me on Zoloft.

R-This was your primary?

MH-Primary doctor.

KL-And um..so I called my medical doctor and we decided to start some antidepressants.

R- How did that decision come about? When you said you called did you visit or did you actually call on the phone?

KL-On the phone.

R- O.K.

KL-There wasn't even time to make an appointment. My brother committed suicide on Tuesday and I had to travel to upstate NY by Thursday or Friday. There wasn't even time to make an office visit.

R-Now when you called were you calling with the expectation that you would be given something?

KL-I knew I needed something. I knew I was not going to be able to proceed. I was just a mess. I didn't even realize how bad I was in the first few days.

R- And what medication were you put on?

KL- The first..I think we started with Celexa and Trazadone and ended up adding. We tried Nerontin and Wellbutrin. I went through a lot of medications trying different things.

LM- I was very upset, I broke down crying in the office and everything..that's when she suggested Lexapro 10mgs which I have been taking since then.

I was given the prescription for Lexapro and I guess just to check back in you know like a couple of months..that wasn't helping. I believe I had refills on that prescription maybe two months. I think at which point it was helping me...um but I really wasn't given too many other instructions um..she did talk a little bit about side effects because I was concerned.

### ***Prescribed Psychotherapy***

The majority of the respondents were not prescribed psychotherapy when first prescribed an SSRI. One respondent was already seeing a psychologist at her university counseling center. Of the other respondents who were referred, one was to a psychiatrist. She eventually went instead to see her daughter's psychologist on her own. Another respondent with a long history of sexual abuse, frequent job losses and relationship difficulties reported she was finally referred to a psychologist after many years of

treatment with medication only and appeared to blame herself for not being referred even though her doctor was aware of her anger, chronic problems at work and with relationships. Another respondent was referred by both her primary care and a physician assistant in the same practice. She was also given a card with referral names and was also told to look up referrals. She had problems with insufficient coverage for mental health benefits on her medical insurance but with encouragement was able to find subsidized counseling services. She found the physician's referrals and the empathic communication process to be very supportive. This was the exception as the rest of the respondents were not referred for psychotherapy and several went to look for psychologist on their own, some without success.

DD- at the time...I was seeing sometimes bi-weekly my psychotherapist at school." "My psychotherapist wanted me in there as often as he could see me and he recommended that I keep a journal.

AB-At this time I know I remember saying, my life is crap, my job is crap. I've lost my friends and I just started crying...He didn't ask any questions."

R- did he say..this is an antidepressant. Usually people who are going through experiences like you should also be seeing a therapist. Did he say anything like that?

AB-No..no In fact I... in between that year when I was on it.. I was trying to find a therapist and I couldn't find one....It was very difficult.....I just gave up."I actually did go to a psychiatrist.

MH- But before that...now I talk openly about it. Before that nobody knew that my daughter was being abused. I never talked about it...I held it all inside and that's why I needed help. The primary doctor suggested that I go for help..someone to talk to someone who might give me further medication. If I needed it...she recommended a psychiatrist that was the head of the department at Einstein Hospital and my daughter had been going to a psychologist. She went to a psychologist on her own and I went to her psychologist for someone to talk to but I didn't continue the psychiatrist because my primary doctor was able to give me the Zoloft or prescription for the Zoloft.

R- Now when you first got medication during that very first visit do you recall whether the primary told you to go to the therapist at that time...?

LM- It was years later because I didn't relay why I was depressed. I mean It was just I was crying all the time, quitting jobs left and right.

R- With the same doctor you were trying different medications?

R-How did you find your first therapist?

LM- He actually referred me to Penn Foundation.

R- This was after how long?

LM- Probably eight years after... because...that's when I finally told him why I was so depressed.

R-It took eight years for you to get a referral to a psychotherapist?

LM-Because I just was depressed and didn't tell him why and I finally did because I needed help.

R-o.k....Now in retrospect now if you had gone when you first went to your doctor, if you had gotten the medication and a referral to therapy do you think that would have been helpful to have started back then?

LM-Definitely...cuz I might of talked more openly to strangers you know because they know what they are doing...you know I've never wanted to tell friends. Admit to family or friends you know cuz again I thought I didn't tell anybody.. .it's my fault. You know I was sad when he didn't come to me. You know its something you want to admit to anybody. It was shameful. I was very ashamed of myself...I think if I would have started earlier I would be further along then I am now.

R- when he put you on the Zoloft based on your history did he suggest at that point that you get psychotherapy or no.

LM-No...cuz I don't know if he really reviewed records or knew anything about my past.

R-o.k. when you went to the physician assistant what was that experience like.

CJ- that was a little better. You know I explained to him my problems, what was going on and ah you know I've been feeling this way for a while...there is no significant tragedy I just cry all the time. So anyway I was telling him stuff like that and he had also suggested that I couple it with psychology but like I said my insurance didn't cover it. I just wanted to take any step that I could.

R-so where in that interim...you saw the physician assistant two years ago? And where in that interim did you say you saw a psychologist?

CJ-Um probably I guess it was over this past summer and into the fall so..we just stopped in November.

R-Was that the person that the physician assistant referred you to or was that somebody you found?

CJ- Yea that was um somebody I had found that did it...had done psychology through a group so they..it was kind of charity. It was like a discounted rate.

R-Oh good

R-When you were told by either the physician or the physician assistant about going to therapy, did they give you a list of people or was it just suggested that you see somebody. How did that happen?

CJ-The first time they had given me a card with I guess they were coupled with the psychologist. The second time he had suggested that I go to psychology as well with the medication and to look up on line if there was anything. There is one around here called The Indio foundation I think it might be national. It is you now discounted.

R-so that was his suggestion?

CJ-yea

### *Stressful life events*

Chronic and episodic stress seemed to be a substantial contributor and trigger of depressive episodes. This is consistent with literature that suggest most stressful life events and circumstances can precipitate a diagnosable depression (Brown & Harris, 1989). Some of the respondents exhibited a great sense of social responsibility in their family related roles and at times this occurred at the expense of their own physical and psychological well-being. The lives of some of the women appeared embedded in highly stressful family and work environments that persisted over long periods of time creating a fertile environment for the development and exacerbation of symptoms of depression. The death and physical injury of loved ones, difficult life transitions, overwhelming sense of responsibility within work and family roles, and oppressive work environments were but some of the issues reflected in their responses and precipitated their primary care visits.

MH- Started in 1999 but I really needed it before that because things were falling apart in my family. Um my son in law was a wife beater and an abuser and he tried to commit suicide a couple of times...have his small children shoot him with his...he was an officer in Philadelphia and had a revolver. He was deranged which was pretty frightening. So we were all falling apart and then it came to a climax on January 12<sup>th</sup> 1999. When my daughter called and said he had a gun on her and

was going to shoot her and I got in my car. She lived ten minutes from me and I made the trip in about three minutes. I went up on the sidewalk ..I was going like a crazy person but ahh., It wasn't the first that I had run over there. By the time I got there the house was surrounded by police cars and ambulances and fire engines and they wouldn't let me down the street so I said...heck with it and I rode over lawns and I went down the street but they said my daughter was shot. My son in law was dead.

KL-in July 2001my youngest brother committed suicide.

2001...It was before 911. There I was watching the twin towers come down on T.V. over and over again. I was just sitting there on the sofa thinking I shouldn't feel so bad that ...here I lost my kid brother but look how many people are losing their kid brother today and what all these people are going to have to experience. It kind of was a traumatic re-exposure. It was within a few months. It was July 3<sup>rd</sup> when my brother killed himself.

R- So that must have exacerbated.

KL-It was within two months!

LM-“Well I think it was the whole...I am going to graduate..what am I going to do with my life type of thing. At the end it was a huge change. I went to college about six hours away..from here so it was you know if I'm going to go to move back here, stay down there. Where am I going to be ...and if I'm going to graduate school? What am I going to do?”..”I think the grief too..um my brother passed away suddenly..he overdosed on heroine..which we didn't even know he was doing. He was thirty one..I mean he always had some drug problem as a teenager but ...we kinda thought, you know that things had straightened out. So it was sudden and very difficult. Oh yea at that time my sister was getting married...that was probably another stressor but he died actually months before my sister got married...he was supposed to walk her down the aisle and all. It was just a lot of things at that time...because I was going through so many changes.”

DM- Well I basically started medication because of my upbringing and because of a turbulent relationship which brought it all to head basically. I guess the last straw where I actually started getting help was I finally told my mom about my past and she was dying at the time so I felt...I mean she had already known about my other sister and what she had been through. So that's basically what started me on the medications. I finally started dealing with the past.

R- It was five years ago your mom was dying?

LM-Actually it was six years ago

R- And then you told her about...?

LM- Um step father sexually abusing us.... And you know that was always a depressed thing and I always avoided it for so long and finally I just couldn't do that any longer. I mean it was making big changes in relationships. I couldn't trust anybody.

I mean I'm getting better but the relationship that I am in is...I'm in it because of my past basically. I go with people that treat me badly. And I deserve better and I finally know that. I'm still struggling always and that's because of the relationship I'm in first of all. You know and I just don't have no way out.

R-Because of?

LM-finances, basically it always comes down to finances. I have a lot of credit card debt. Two accidents within a year, two surgeries. I was doing really well for a while but financially anyway.

R- And you have a daughter...six years old?

LM- Six years

R-Yea it sounds like a lot is going on recently.

LM- Always, always...it seems like that's always been my life

R- between the car accident...

LM-Knee surgery last year, troubled relationship...yea seems like that's my life, this stress.

### ***Feelings about effectiveness and success rate of medications alone***

For some the medication helped them cope with transitions and stressful events. One participant described it "I could feel it almost suppressing my emotions" another stated "It dulled my sense enough that I could cope...It levels out the surface for me." Several respondents also felt relief from physical pain from the medication. However, there was a general consensus that the medication would often start losing its effectiveness over time usually after one year. This often led to increasing or changing the dosage at times with ill effects. Several participants expressed concerns about the side effects and length of time they would have to be on the medication as well as fears of discontinuing due to withdrawal symptoms. Most respondents who expressed these concerns had little information from their doctors about how long they would need to stay on the medication and some took it upon themselves to find research and information on their own. Difficulty with titrating and finding the right medication was also raised by one respondent who is a physician.

DD-I did definitely notice a change in myself... so the medication started to work and I feel that it continued to work till fall of 2004. I felt like I was getting used to taking it... the effect...it wasn't as beneficial as when I started taking it...a year later I was planning to study abroad in Italy the following year...I continued taking he medication for the time I was in Italy...till April 2005. After I had gotten back from Italy, I think I felt better about myself..away from Tom...he was a lot of the problem in my depression...was able to stabilize my life a lot more and I think the medication did help definitely in my transition over there...at times I could feel it almost suppressing my emotions...then I started to wean myself of it... I haven't been back on since.

MH-The Zoloft helped enormously. The only problem I had with it was it made me drowsy, that was the minor thing. I dulled my sense enough that I could cope and ah..what else do you want to know?

R-So how do you feel your symptoms are right now because you had gone through a depression when all that went on.

MH- It helps...It levels out the surface for me. I still have some high moments and sometimes when I sit in the corner and don't want to leave the corner but I do leave the corner and I do pull myself out of the depression now. Before I couldn't.

R- Now...when you went and were given the Zoloft were you given any kind of instruction, how long you would be on it? Or

MH-No... No and I've been on it for ten years. The only thing that changed is now its generic which saves us money but I've never seen any studies of how long you can stay on it and frankly I'm ...I'm scared to stop it.

R-Have you talked to...are you still seeing the same doctor?

MH-Yes

R-Have you talked to her about your concerns or anything..regarding stopping?

MH-Well I did but she said If I would like she'll put me on another medication but she didn't sound concerned about taking it longer.

KL- The first..I think we started with Celexa and Trazadone and ended up adding. We tried Nerontin and Wellbutrin. I went through a lot of medications trying different things. R-Well why was that?

KL-Nothing was working.

R-O.K. so

KL- And maybe nothing works when your kid brother kills himself.

R- Yea.

R-So you were then..what did you end up with that worked

KL- Wellbutrin and Nerontin,and Trazadone as needed for sleep. Actually we even tried Clonopin for a while for sleep but I don't take that one anymore

KL-Maybe time is part of that.

KK-Um has the Celexa been helpful in that manner or Lexapro now? I think to a degree it has. Uh my fears again are if I would try to remove myself from it, would I be able to. And that's a fear I have only recently disclosed to anyone and that was you. I'm very very fearful..that I will not be able to get off of it now.

R-Now how has it been because you were on the Celexa for three years and then you got on the Lexapro. Can you recall the course of that decision?

KK-The decision was because A- we (primary care and KK) kind of felt the Celexa was.. might not be working as it had been. That perhaps I had built up some kind of immunity to it. Tried taking more of it..twice a day. There were times that I would end up in such a lag....feeling of fatigue which was definitely the drug at that point. Tried the Lexapro, rather new but he felt cleaner version from what I had been on and I did well on it um felt good...relief of symptoms again for a couple of years and now I'm kinda back in the same boat again. Wondering if its working..wondering if I could wean off..now I'm kinda grasping for straws I really don't know what to do.

KK-I think it would be to really just investigate and not just have faith in your primary that this is the way that you should do it just because this is what they say...Its always great to have faith in your doctors but there are so many ways of researching a drug now. You can get a very talkative pharmacist who's actually very well informed..look it up on line..read about it, go to the library..other doctors...medical professionals...Don't be afraid to ask because you could end up addicted to something that you might not be able to get off of. I would hate to see that happen to someone else. That's the place I am afraid I am in and there are so many research methods today that five, ten years ago were not available to the public. The only thing that I did for myself was get a second opinion from someone that had even more degrees than the primary. Just for my sanity."

BS-I spent six months doing reiki and massage. I'm still not having any luck and I went to three different accupuncturist and it got to the point...I was like you know what, maybe I do need to do the antidepressant. Um but I guess the thing I'm kicking myself a little bit is that I just didn't do more research. So like anything I was going to give it six months and in six months I was finding that I wasn't getting the headaches anymore...It took a while. I was pretty sick when I started with the SSRI. But I was told to take it at night, which I did and I noticed that my mood was getting sunnier, my headaches were leaving me so I thought this is pretty good. It just so happened that it happened just around the same time that my thyroid was just beginning to show problems. I was finding I was extremely tired..um I forget all the symptoms that I had..so I had started taking SSRI and my headaches were getting better but I was also experiencing other symptoms that were confusing for me. The big one was weight but I never associated the weight gain with the antidepressant because I was told there wouldn't be weight gain. So I associated it with the thyroid or these other symptoms that were going on for me so I started focusing on my thyroid and all that goes into trying to treat a thyroid...Um and a couple of times during the process I just felt like I was losing my mind and that maybe I should be going back on the darn thing because I

couldn't imagine living like this. Um and so It took a lot of determination. I went on line and started to look at people coming off these kinds of antidepressants and it wasn't pretty. And so I thought well I need to either forge ahead knowing that other people are suffering as well or I need to go back on it and recognize that I'm going to have to live with whatever the consequences are of being on it. Which wasn't o.k. with me. I didn't feel like it wasn't anything life threatening that I should be on prescriptions for the rest of my life.... I just am not interested. I'm not interested in what the pharmaceutical industry is pushing. If there is a consequence to that then I'll have to live with that consequence. I spoke with my primary care giver she said I know that it's a risk that I choose not to be taking the drug. Even though this SSRI was not a quick fix for me.

### *Feelings about success rate of combined treatment*

The experience of psychotherapy when combined with the medication appeared to strengthen and support respondents emotional well-being and reduce depression symptoms. It was the psychotherapy, however, that seemed to provide respondents with the necessary coping skills to deal with stressful life events such as grief, sexual abuse, and anxiety symptoms over the long-run. Some respondents reported that despite being on medication for a number of years, their quality of life did not improve until actually spending time in psychotherapy and actually talking about their problems.

SP-Absolutely the medication is needed. There is a place for it no question but I think teaching people to a lot of like cognitive skills and behavioral changes that can make such difference in depression and in your ability to cope with certain anxiety symptoms. Whereas a pill won't always do that."

R-"And do you find that with the Lexapro do you feel..now that...the quality of your life has improved?

SP-No not particularly.

R- So it really augmenting it with some kinda support talk, therapeutic experience might really get you where you want to be?

SP-Exactly

KL-It was a tough year. It was a year before I was getting my head together. Maybe time is part of that..So but in terms of medications alone versus therapy and medications. For me I found that therapy and medications was the best combination. There's a lot of talking that you have to do about it.

R-Were you able to get what you needed from the grief counselor?

KL-Yea for the acute first six months yes that's what I needed.

R-so how are you doing today given all of that?

KL- good...I still miss my brother.

R- are you on the medication still or go to a counselor still?

KL- I still go to a therapist...I don't see him very frequently maybe every couple of months...It's like going in for a little tune-up.

R- How was the therapy most helpful to you...in addition to the medication?

KL- I think just talking about it otherwise you just keep it bottled all up inside.

DM-I did get...I went through some therapy and that's what started helping me get better. First I was on the medications for years and so many different kinds.

DM- that wasn't working. But I can understand why it wasn't working because I wasn't dealing with anything either. You know just covering it up with meds. It did finally help me to tell him because that's you know..the door was cracked open you know it just went a little from there widening the door.

R-Before that in all those visits did he ever ask you what is going on in your life?

DM-It was always because of my relationship with Dave. You know he doesn't treat me nicely, verbally abusive and that's what always contributed to why I was depressed. That's what he(the doctor) knew at the beginning.

R-So he gave you the medication in hopes that that would sort of help the situation but you weren't in therapy at that time?

DM-yea

R- So what helped when you got into therapy?

DM-Um...dealing with it basically, admitting it...not thinking it was my fault. What happened. Cuz that was my biggest struggle, it was just...my fault because I didn't tell anybody...

R- that's a huge burden to carry..

DM- The therapist also told me that you know...the biggest thing was...sometimes I'd get upset because he wouldn't be coming to me, my step father...he'd always go to my sister. And my therapist said you know that's the love I knew. You know...that's what I knew. Cuz I couldn't get over the shame of..not that I wanted it to happen but it was how he showed closeness. You know and I know that's not the right way but when you're young...I was nine..ten.

R-You were just a baby

DM-Yea

R-o.k....Now in retrospect now if you had gone when you first went to your doctor, if you had gotten the medication and a referral to therapy do you think that would have been helpful to have started back then?

DM-Definitely...cuz I might of talked more openly to strangers you know because they know what they are doing...you know I've never wanted to tell

friends. Admit to family or friends you know cuz again I thought I didn't tell anybody.. it's my fault. You know I was sad when he didn't come to me. You know its something you want to admit to anybody. It was shameful. I was very ashamed of myself...I think if I would have started earlier I would be further along then I am now.

R-Yea..so..how would you...we talked a little bit about...so you feel like the combined treatment of medication and the therapy is the best approach?

DM- I don't think it would have worked with just medication...in my situation. That's just my situation."

R- Now how was the...you said you went to see your daughter's psychologist?

MH-Yes

R-How was that experience?

MH-Wonderful. That was the first time that I had ever gone to a psychologist and she offered conversation back and forth that...some of her suggestions were good.. I can't remember what they were because it's been seven or eight years since I've been to her but um...she was wonderful.

R- Do you find that the combination of the two the medication and the psychotherapy was what helped the most?

MH-absolutely...yes and my granddaughter and daughter went for the same psychologist and now they are still continuing treatment.

R-What are your responses to medication alone...to how effective that is? Versus the medication in conjunction with psychotherapy?

CJ- Well I was..eventually I did go to a psychologist. It took me a little while I guess but then I did go to see the psychologist while I was on the medication and it went well...it went well.

### *Attraction to the study and suggestions*

There was a great deal of interest on the part of respondent to know whether other women were experiencing similar problems. Respondents appeared to draw some comfort and feel a sense of universality knowing that they were not alone. One respondent remarked that she was "so glad" someone was finally addressing this issue and felt strongly that there was a need for more collaboration among medical and psychological professionals to provide more comprehensive approaches to the treatment of depression and associated symptoms. Some wanted to express

frustration over their experiences when seeking treatment while other respondents expressed an interest in telling their story not only as a way to feel supported but also from a desire to give back and help others who might be experiencing similar situations.

KK-you are doing a research project on this which leads me to believe there's other women in the same boat.

R-yes.

KK-which I find comforting but not a positive thing but I felt comforted knowing that I wasn't alone, if that makes sense. There must be enough folks out there in the same boat to warrant a project on it.

R-Absolutely

KK-I wish you the best of luck.

R-Well I appreciate your taking time to do this.

BS-And I just come to the conclusion that none of those people come into the same room and talk together. There's no comprehensive approach to a person's mental, physical and social well-being. It's all done piecemeal so I've had to be the one to try and connect those dots and I think the average person is left to try and figure out what's going on. I wonder how many others feel like they're losing their mind sometime.

R-o.k. so overall what as a physician going into treatment what would you have to say to other women experiencing a stressful life event.

KL- I would say you know call your medical doctor or your therapist and get on medications cuz there's medicines for this kind of problem just like there's medicines for high blood pressure or diabetes or glaucoma. There's kind of a social stigma about being treated for depression and mental illness which I think is just wrong. So I do encourage my patients if you are having trouble to go and try something.

R- Now do you find that when you are going through a life event like that, that that will suffice? Or what would you suggest?

KL- Would medication alone suffice? No No. Therapy and medication. Talk therapy

R-If you had something to tell other women what would you say?

CJ-I think I was lucky in the fact that I got someone who spent time with me cuz usually you go in the doctors office and they give you 20 minutes and you're in and out. That for whatever time of day or whatever day I was there telling my feelings and my situation that um they did spend time with me and kind of say that it was normal and things like that.

R-And that was the physician assistant?

CJ-Yea, yea because I think other doctors either primary care or specialty doctors they're usually in and out. You wait forever in the waiting room and then you're in there for two seconds. Or you other things...I don't know if its related to the study but other times you know its kind of like when you go to the mechanic for squeaky wheel and then you go to the mechanic and its not there. Sometimes I would think that that would kind of happen in primary care as well. Kind of like you would freeze up kinda thing...like you're feeling sad but not really explaining.

R-Not knowing how to explain when you get there?

CJ-Yea, yea kinda..I don't know luckily I just felt open at the time...that I just knew that I just needed something.

R- Well that was good that that happened. That you were able to be open and someone was there listening...so that's a big piece of it you're saying?

CJ-Yea, yea I did feel pretty comfortable. I don't imagine that would be the situation every time.

R- I'm really glad that you had that experience...so that's helpful because that's the point, we to be able to see what really makes someone feel like they are getting the help that they need.

## **CHAPTER V**

### **DISCUSSION**

#### **Summary and Discussion**

The present study highlights the importance of comprehensive research to aid in our understanding of women's depression treatment experience in primary care practices.

This study was distinctive because of its use of multiple research methods that enables researchers to investigate trends and characteristics of depression treatment in primary care practices as well as capture the nuanced perspectives of women who were direct recipients in this medical setting.

The quantitative data, collected using the semi-structured telephone survey questionnaire, was designed to examine the prevalence and frequency with which psychotherapy is prescribed when an SSRI is given. All 40 women were prescribed an SSRI as it was a condition for eligibility for this study. This investigation also examined whether severe undesirable life events preceded the onset of symptoms of depression and associated disorders precipitating the primary care visit.

Findings from the statistical analysis reveal that the majority (75%) of the women surveyed were not prescribed psychotherapy when prescribed an SSRI. Although six of these women were already receiving counseling services, these results highlight a definite trend toward the prescription of antidepressants as a single and primary intervention for depression treatment in primary care settings. It is also consistent with research

suggesting that the proportion of treated individuals using antidepressant medications increased from 37.3% to 74% from 1987 to 1997 whereas the opposite was found with prescriptions for psychotherapy which declined from 71.1% to 60.2% (Olfson et al; 2002). This study focused on women because the probability of receiving prescriptions particularly for antidepressants and anxiolytics is 55% higher in women than for men. Furthermore, gender's predictive power for antidepressant use is significant and positive when women were compared to men visiting office based practices (Simoni-Wastila, 1998). For demographic characteristics, no significant associations were found for age, education, marital status, income level, ethnicity, and type of health insurance coverage and referral to counseling.

Women in the study presented with a broad spectrum of depression symptoms to their primary care, including weight changes, problems with sleep, fatigue, and psychomotor problems. Women with the highest reported number of symptoms were often not referred to counseling. Eighteen (45%) respondents endorsed five symptoms and twelve (30%) of the respondents endorsed as many as six of the seven possible symptoms of depression. Of the eighteen respondents who endorsed five symptoms only four were referred to counseling with the remaining fourteen not referred to counseling. Of twelve women who endorsed six symptoms five were already receiving counseling before their SSRI prescription, the remaining seven participants were not referred to counseling by their primary care despite presenting with such a broad range of symptoms.

A significant association was found between feelings of worthlessness and referral. Of the women referred to counseling 60% reported feelings of worthlessness. Whereas 96.7% of women not referred to counseling reported feelings of worthlessness. These findings suggest that nearly all the women who were not referred to counseling endorsed feelings of worthlessness, a strong indicator of depression. Worthlessness is also often associated with introjective depression which occurs when individuals feel they have failed to meet their own standards or the standards of significant others and are therefore failing in some way to gain highly desired approval, recognition and love (Blatt, 2004; Layne, Porcerelli, & Shahar, 2006). Throughout their lives, women's feelings of worth, sense of meaning and wellbeing are anchored in their interpersonal relationships (Jordan, 2001; Walker and Rosen,). Women often nurture and care for others at the expense of their own needs. The caring they extend may often not be reciprocated by those they care for leaving them feeling overburdened and depressed. Research on the interaction between gender and social role expectations also sheds light on women's feelings of worthlessness and depression. Expectations for women to manage multiple roles as wives, mothers and employees coupled with the low value society placed on these role places them at higher risk for depression (Canino et al; 1987).

It is clear that the majority of women who endorsed many of the symptoms typically associated with depression did not receive guideline concordant care. National treatment guidelines for primary care from the Depression Guideline Panel suggest that for major depression the most effective treatments include antidepressant medications and cognitive-behavioral and interpersonal psychotherapies. The quality of care for

depressive and anxiety disorder was studied by researchers using data from a cross-sectional survey from the Health Care for Communities, part of the Robert Wood Johnson Foundation's health tracking initiative. Poor quality care was defined as no care or inappropriate care. The results reveal that over a one-year period only 30% of the adults with depression or anxiety disorders that visited a health care provider received appropriate treatment. Most of these visits were primary care visits only. Compared to specialty care patients, PCP patients were less likely to report their mental health problems were evaluated (35% vs. 65%), psychiatric medications were recommended (11.4% vs 55.7%) or were referred to mental health services (4.1% vs. 23.5%) (Young, Klap, Sherbourne & Wells, 2001). This research supports the findings of this study and points to the need for more careful evaluation of the broad spectrum of depression symptoms women are bringing to treatment.

According to Hyde et al. (2005) lack of recognition of symptoms and subsequent undertreatment of depression in primary care settings has become less of a focus of policy makers in mental health treatment. Recently concern has shifted towards the over treatment, specifically with prescriptions for antidepressants and the medicalization of the problems of living. This is of particular importance when considering women's responses to questions regarding stressful life events. All 40 women in this study indicated that stressful life events contributed to their symptoms and precipitated their decision to visit their primary care doctor. The research on women's diagnosable depressive episodes in response to an array of stressful life events is overwhelming and supports these findings

(Brown and Harris, 1989; Kessler & McLeod, 1984; Maciejewski, Prigerson & Mazure, 2001; Nazroo et al., 1997; Paykel et al, 1969; Rosenfield, 1989).

Several hypotheses are posited to explain this association between stressful life events and depression. Women may experience more psychological distress than men due to the particular types of stressful events that have greater impact on women. Women have greater emotional involvement in the lives of those around them. Their vulnerabilities to stressful events are the “cost of caring” associated with close interpersonal commitments. Furthermore, there are greater expectations for women to bear social responsibility for family members which can result in self-blame when problems arise in these relationships putting women at increased risk for depression (Kessler & McLeod, 1984; Nazaroo et al., 1997). Rosenfield (1989) provides yet another explanation. Survey findings from three U.S. communities indicating higher levels of depressive symptoms in women result from coupling of high demands with low personal control and relative powerlessness in their lives. Although it is true that not all women become depressed in the face of stress, for many, chronic and episodic stress are proximal determinants to depressive episodes (Hammen, 2002).

The impact of stress from the imbalanced expenditures women make of their emotional and psychological resources without reciprocity and empathy from others is often unacknowledged. The resulting symptoms of depression are instead pathologized and attributed to psychological weaknesses and biological causes. This may often be the case in primary care settings. The lack of consideration that is often paid to contextual factors

in women's lives represents a denial of women's experience. As a result, women keep aspects of themselves and the stressors of their lives that precipitate depressive episodes out of the doctor-patient conversation. The importance of reciprocity in women's relationships is addressed by the relational cultural theory. According to this theory "healing occurs in growth fostering connections". At a societal level "judgements, prejudice and bias from more powerful others" such as that found in the doctor-patient relationship, results in women becoming "inauthentic" to themselves and to their doctors. Although women may desire a more reciprocal relationship with their physicians, in this relationship they may bring only "certain parts of themselves" for fear of disconnection, being looked down upon or fear of losing the relationship (Jordan, 2001).

The range of stressful events endorsed by the respondents was broad encompassing events including the death of loved ones, marital and relationship problems, financial and legal problems, illness of self or significant others, managing multiple roles and loss of employment. These reported events were summed into a stressful events score variable indicating the possible number of stressful events from 0-12. The largest proportion of women (55%) endorsed between 3-7 stressful life events. The remaining (45%) endorsed between 1-2 events. Although seven of the 22 women reporting the highest number of stressful events (3-7) were referred to counseling, the remaining 15 were not referred.

Careful analysis of these results may reveal possible explanations. The summed score for stressful life events garnered from participant responses do not necessarily equate to the actual severity of stress experienced by each woman. Not every woman reacts with

higher symptom intensity and depression given the same level of stress. For example, one participant may experience a single stressful life event and yet exhibit numerous and intense depressive symptoms while another may have several stressful life events with fewer depressive symptoms. This proposition was actually borne out in the study. Findings from a correlation between stressful life events and number of reported symptoms was not significant. It is evident that women's stress-related responses are affected by personal coping styles, as well as family and social supports. Researchers posit a stress-diathesis model that addresses psychological and biological vulnerability factors predisposing some women to depression more than others, when faced with stressful life events. Vulnerabilities that serve as the diathesis provoked by stress may stem from dysfunctional beliefs, hopelessness, and learned helplessness (Abramson, Alloy, & Metalsky, 1989; Beck, 1967; Ingram, Miranda, & Segal, 1998).

These factors together point to the importance of prescribing combined psychotherapy with antidepressants. As women struggle to make sense of their depression symptoms and subsequent suffering it is important for them to find meaning for it in the particular context of each of their individual lives (Heath, 1999). The process of finding meaning, making sense and learning to understand and cope with symptoms is more likely to occur in therapy. There is little evidence that sole biological treatment of depression improves outcomes to the extent that justifies accepting medical explanations for symptoms that may in part result from the struggles of life.

The findings for the survey data make an important contribution but become more meaningful when integrated with personal responses of participants who shared a perspective meaningful to their personal life situation. Comparison of the results of the survey data with the qualitative interview results reveal several similarities and additional nuances regarding aspects of the relationship between doctor and patient, the rate of psychotherapy prescribed, stressful life events, and women's perceptions of their treatment for depression, all of which would otherwise have remained latent.

In most cases the women's subjective preferences for treatment of depression symptoms was not in concordance with what their physicians may have considered to be effective treatments. The results from the personal interviews concurred with the survey data revealing that most participants were not prescribed psychotherapy despite presenting a broad range of depression symptoms. Participants presented with symptoms that not only met criteria for major depressive episodes but some also experienced physical pain (e.g., headaches and body aches) while others presented with co-morbid anxiety symptoms. These symptoms interfered with their daily functioning, interpersonal relationships, school activities, and employment.

There were expressed concerns regarding the doctor-patient relationship. In fact one of the most important demands for improving their health care was more time with the physician with ample doctor patient communication beyond the usual pressure of time. Women came with the expectation that their interactions with physicians would provide comfort for their concerns, sufficient and thorough information about treatment options

and explanations about adverse side effects. Specifically, the respondents thought the more information, advice and instruction they received with respect to their particular symptoms, the greater the improvements to their emotional well-being. These treatment expectations were seldom met, with only a minority of the respondents reporting feeling satisfied with their patient-physician relationship and treatment outcomes.

These findings converge with the literature that suggest good communications between physicians and patients substantially improve positive treatment outcomes (Sarrel, 1999; Svenson, Kjellgren, Ahlner & Saljo, 2000) although research regarding patient physician communication in the treatment of depression is limited, available research suggests that explicit instructions from physician to patient regarding expectations with antidepressant treatment duration helps reduce discontinuation in treatment (Lin, Von Korff, Kanton, Bush et al, 1995). There are discrepancies between what physicians recall telling their patients when compared to patients memory of their communication. This is particularly evident when primary care physicians prescribe antidepressants (Bull et al., 2008). It is essential for treatment adherence and success that explicit instructions regarding expectable length of therapy and a thorough discussion of potential adverse effects throughout the course of treatment, including frequent patient-physician appointments, will enhance the effectiveness of treatment (Bull et al., 2008). Some of the women respondents reported that they were not given clear follow-up instructions regarding their next appointment. One participant said her physician mentioned coming back in a couple of months, others did not recall receiving any direction about subsequent appointments. Two participants expressed satisfaction with the level of follow-up they received that

included receiving phone calls and frequent check-ins from their doctor. The new Health Plan Employer Data and Information Set measure for antidepressant management developed by The National Committee for Quality Assurance as one of the accreditation criteria for managed care organizations requires at least 3 follow-up visits during first 12 weeks of treatment. (National Committee for Quality Assurance, 2000).

There was an overwhelming response during both study conditions regarding stressful life events. Many of the women experienced highly stressful problems in their interpersonal and family lives as well as in school and work environments over long periods of time. Most of the women concurred that combined psychotherapy and prescription medication would have been the preferred approach to address the multiple and complex symptoms precipitated by their stressful life events. One woman's doctor saw her for several years with chronic depression, anger and interpersonal conflicts before suggesting she see a psychotherapist. This woman along with several other participants expressed regret at not having psychotherapy earlier in their treatment. Participants also expressed concern that their quality of life did not markedly improve after taking the prescribed medication. Some women's symptoms were ameliorated to a degree but continued to suffer with problems of living and interpersonal relationships. Others felt that the antidepressants helped them begin to cope and were then better able to benefit from psychotherapy. Many expressed relief having someone to talk to about their grief over deceased or abused loved ones and grievances regarding problems in interpersonal and work relationships. The research concurs with these findings. Depressed patients strongly prefer psychotherapy compared to medication and frequently

attribute improved well-being to psychotherapy, but rarely to antidepressants (Bedi, Chilvers, & Churchill et al., 2000; Brody, Khaliq, & Thompson, 1997; Dwight-Johnson, Sherbourne, Liao & Wells, 2000; Van Schaik, Klijn, Van Hout et al., 2004). Other study results reveal that this preference for psychotherapy might be explained by patients' beliefs that their emotional problems are caused by problems that can be remediated such as interpersonal, job related and or health problems (Lowe et al., 2006).

An editorial piece cited in the journal *Acta Psychiatrica Scandinavica* makes a compelling argument supporting the results found in this study. The writers remark that the scientific evidence that should guide general practitioners practices and opinions regarding antidepressant prescriptions seems to have less of an effect on their decisions than a strong marketing campaign that has succeeded in "decreasing the threshold of antidepressant prescribing..."(Barbui & Garattini, 2006, p.450). Significant associations have been found between an increase willingness to prescribe newer antidepressants such as SSRI's and frequent contacts with pharmaceutical drug representatives (Figueras, Caamano, & Gestal-Otero, 2000; Watkins, Moore, Harvey et al., 2003; Wazana, 2000). The authors cite several problems resulting from a dramatic increase in antidepressant prescriptions: prescriptions become an "automatic" answer to the treating of depressive symptoms; physicians may adopt a passive attitude by selecting the prescription of antidepressants as their sole intervention without consideration of more specific individualized treatment plans which include a "wait and see" approach or psychological/psychosocial interventions supported by evidence based practice guidelines; and finally patients also may be induced into adopting a "passive" attitude by

receiving the impression that symptoms of mood, thoughts and behavior can be ameliorated and improved through pharmacological means alone.

Antidepressant treatments were recently reviewed by National Institute for Health and Clinical Excellence (NICE). Their conclusions go beyond guidelines published by the American Psychiatric Association. Antidepressants were not recommended for initial treatment of mild depression citing too high risk over benefits. Whereas in moderate to severe depression antidepressants combined with psychotherapy were advised (NICE, 2004). NICE recommendations appear to represent a trend in public opinion and perceptions that usually precede clinical practice. In other words, whereas research data on effective treatments has primarily defined treatment criteria and decisions in the past, patient's choice and risks of adverse side effects are increasingly gaining equal significance and emphasis compared to treatment effectiveness (Ebmeier, Donaghey, & Steele, 2006).

### **Implications**

Findings of this study support efforts to improve depression treatment in primary care practices through both public education and quality improvement initiatives. These findings are summarized in Table 9. There is a dearth of information readily available to female consumers regarding effective treatments for the management of depressive symptoms. Women consumers of mental health services in this study resoundingly expressed desire for more information regarding antidepressant treatments than was provided to them by their physicians. They often resorted to conducting individual

research on the internet and were eager to find a sense of community and universality with others in their journey towards recovery. Research geared towards assessing carefully the needs of women consumers of depression treatments could develop comprehensive information made readily accessible and that would enhance public and patient education. National treatment guidelines for major depression could be made available to woman consumers. These guidelines document that effective treatments for major depression include antidepressant medications and cognitive-behavioral and interpersonal psychotherapies (American Psychiatric Association, 1993; Depression Guideline Panel, 1993; Schulberg et al; 1998). Research also supports these findings for dysthymia (Markowitz, 1994; Snow et al; 2000; Thase et al; 1996). Educating patients to ask their primary care provider to collaborate with their psychologist would also enhance their treatment. Patient centered approaches that focus on empowerment and self-management have been recommended in the literature (Bodenheimer et al; 2002; Coulter & Elwyn, 2002; Os et al; 1999).

There are numerous factors that contribute to the inadequate care of women's depression. For example, appropriate and comprehensive detection, willingness on the part of the patient to understand and demand quality care, adequate insurance coverage, mental health parity, knowledge and opinions of physicians and providers regarding effective treatments and the impact of contextual factors on mental health and destigmatization of psychiatric disorders. Research reveals quality care problems exist with those who are both insured and uninsured. The simple provision of insurance does not necessarily improve or guarantee adequate care for mental health (Druss & Rosenheck, 1998).

Quality improvement programs implemented in both the public sector and within insurance programs serves to increase awareness and utilization of effective treatment protocols. Furthermore, individuals who do not receive appropriate care were less likely to believe they needed mental health treatment, particularly for individuals with lower family incomes, fewer years of education, more life and physical health challenges, no medical insurance or little knowledge of their specific mental health benefits (Young et al., 2001). Although the results of this study showed no associations between demographic characteristics and referral to psychotherapy, additional research with a larger and random population may reveal these demographic disparities.

A stepped-collaborative care model that has been highly successful improving treatment outcomes in primary care was designed and researched by Katon and colleagues (1995). Patients in two large studies treated for major depression by their primary care physician were randomized into either a continued usual care group or a collaborative intervention group that included a mental health practitioner. The intervention patients were provided literature and a videotape with information regarding the biology of depression, its relationship to stress, physical and emotional symptoms and recommended treatment options of both psychopharmacology and psychotherapy. Advice was also provided on how to become an active partner with their physician. The results for the collaborative intervention group suggests that patients were more satisfied, showed greater adherence to medication and had improved depression treatment outcomes. Compared to the 40-44% recovery in the usual care patients, the collaborative care patients showed a 75% recovery.

Physician training programs designed specifically to facilitate identifying nuances in the presentation of the broad range of depression symptoms could be developed. For instance, developing a measure to use with patients in primary care practice that can identify contextual factors such as stressful life events that may precipitate depression symptoms and mental health visits may encourage women to share these experiences with their practitioners. It would also assist physicians in determining whether counseling and a “wait and see” approach may be more beneficial given the temporary nature of some life crisis or whether the presence of more enduring and recurrent depressive episodes indicate the application of more comprehensive combined treatment approach. In a qualitative study that explored how general practitioners prescribe antidepressants, the “wait and see” approach regarding the prescription of medication was a preferred management approach when physicians wanted time to gain a more comprehensive understanding of the depression symptoms and determine whether symptoms were self-limiting (Hyde et al; 2005).

Increase collaboration and cooperation between medical practitioners and psychologist would improve the likelihood that patients will receive more comprehensive and effective treatments. According to new requirements from the Accreditation Council for Graduate Medical Education (ACGME), trends in physician education training programs already exist which stress the importance of collaboration between psychologist and physicians in the care of patients with mental health problems (Daw, 2005). The American Psychological Association's new president, Sharon Stephens-Brehm, Ph.D., has made her first initiative to integrate health care for an aging population. She reports that the

collaboration between psychologists and physicians will promote the treatment of the “whole person”(Antonucci, 2007). Professional training programs can also ensure that students are provided with thorough grounding in current research on gender and depression. Practitioners can become well versed in the various treatments found to be effective in the treatment of women’s depression, treatments geared toward interventions in the family and interpersonal domains of women’s lives (Hammen, 2003; Stoppard, 1993).

Public policy that ensures mental health parity that provides equal medical benefits for both medical and psychological conditions is supported by the abundant evidence linking higher levels of depression for women and the precipitating stressful life events (Hammen, 2003). Public policy can also address the unequal burden for women when they are responsible for child-care, caring for their home as well as working to earn an income. Policies can ensure that work benefits are extended to include more flexible hours at work, the provision of good quality day-care services and recognition and support for the non-paid work in the home.

Further research combining qualitative and quantitative research efforts linking the increasing rates of depression in women to stressful life events is warranted. This is important particularly when considering that women are less likely to address the impact of these events on their symptoms in primary care settings. Also, pharmacotherapy has been found to be the most widely used treatment in primary care settings despite evidence based recommendations to include therapy (Olfson et al; 2002; Robinson et al; 2005).

These findings also suggests that despite this treatment approach women patients with depression in primary care settings continue to suffer from unfavorable outcomes in their treatment. Studies that incorporate the nuances of women’s experience when seeking depression treatment provide research strategies that yield a more comprehensive picture of the complex etiology and contextual factors that together affect women’s mental health.

**Table 9**  
**Summary of Implications for Research**

<b>Policy Implications</b>	<b>Training Implications</b>	<b>Practice Implications</b>	<b>Research Implications</b>
<ul style="list-style-type: none"> <li>➤ Mental health parity</li> <li>➤ Flexible workplace Hours and quality daycare</li> <li>➤ Public policy that gives appropriate recognition to work women do in the home including childcare</li> </ul>	<ul style="list-style-type: none"> <li>➤ Professional training programs provide thorough grounding in research on gender and depression.</li> <li>➤ Increase training on effective treatments for women with depression</li> </ul>	<ul style="list-style-type: none"> <li>➤ Intervention models using mental health specialist</li> <li>➤ Patient centered approaches promoting empowerment and self-management</li> <li>➤ Developing measures to assess contextual factors contributing to depression</li> </ul>	<ul style="list-style-type: none"> <li>➤ Research linking depression to stressful life events</li> <li>➤ Mixed method research to provide more comprehensive analysis of women’s depression treatment</li> </ul>

**Limitations and Future Directions**

This study has several methodological limitations. Major depressive episodes were determined retrospectively and singularly according to DSM-IV-TR symptom criteria. No secondary measures were used to assess symptoms of depression. However, relevant

information regarding clinically significant impairment in areas of functioning were assessed by this author with 15 years mental health experience and supported the use of this diagnostic criteria.

This was an exploratory study therefore, only a small number of self-selected respondents were examined in this study in order to begin inquiring into this research phenomenon. Self-selection does limit the transferability of results limiting generalizing these findings to the general population. Another limitation is the potential for bias due to the nonrandom sampling in this study which makes it difficult to determine whether the referral rate estimate captures the true referral rate in the population. These respondents may in general be more motivated to learn of mental health concerns and interested in accessing various forms of information to support improving their own mental health situation than might be found in a larger, randomly selected sample of participants. Due to the small non-probability sample of participants, non-parametric tests were utilized. These tests do not require the data to fit a normal distribution and hence required less restrictive assumptions about the data. Furthermore they allow for analysis of categorical data. Although the small self-selected non-probability sample does pose a limitation in this study, samples such as these have been useful for exploring and developing hypothesis for future research. Furthermore, when these results are considered in combination with the qualitative analysis they provide a more comprehensive view of the overall results.

The respondents were not entirely representative of the general population. The respondents were all Caucasian limiting the representation of women from diverse racial backgrounds. The method for soliciting participants was primarily through printed media and flyers posted at designated medical settings. Newspaper ads and flyers were placed in communities with cultural and racial diversity; however, no clients of color responded to the ads. The information described was in English and may not have reached a culturally diverse, non English speaking population who are also consumers in primary care practices and may prefer word of mouth or a more personal approach to enlist participation.

The present study suggests that future research could incorporate methodology that would ensure inclusion of a more racially diverse population perhaps through randomly selecting participants from mental health clinics that service a more racially diverse population. Furthermore, conducting this research with a larger population may enhance the accuracy of the results that may have been affected by the small number of respondents.

## Conclusion

This study proposed to investigate several issues related to women's depression treatment in primary care settings. The following questions were posed: What are women's experiences when prescribed an SSRI in this setting? Are these women being prescribed psychotherapy together with medication as recommended by guideline concordant care? Have stressful life events precipitated the women's visit to their doctors and contributed to their depression symptoms? The findings yielded from this study are consistent with research that suggests pharmacotherapy is the most widely used treatment for depression and associated symptoms in primary care settings, whereas psychotherapy was least frequently used despite evidenced based recommendations for combined treatment (Olfson et al; 2002; Robinson et al; 2005).

Women overwhelmingly reported experiencing a stressful life event(s) that precipitated their doctors visit. Personal accounts of their treatment experience suggest they desire a more informative and reciprocal relationship with their physician. They desire a relationship that takes into account the personal problems in their lives that directly impact their symptoms. Women also expressed a preference for combined treatments for their symptoms. The medicalization of women's distress coupled with the lack of sufficient information regarding additional depression treatment options disempowers women to make informed choices. This is consistent with research that finds women are empowered when they are able to draw on both medical and social perspectives when speaking of their experiences with depression treatments. As a result they derive the

benefit of each approach (Gammell & Stoppard, 1999). It is important that future research be grounded in women's experiences in order to truly understand how to best treat their depression.

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## Appendix A

### Telephone Survey

#### Semi-Structured Questionnaire

- Personal introduction
- The purpose of this interview is to gather information regarding women experiences when they are prescribed an SSRI by their primary care physician.
- Topics that will be covered :
  - Symptoms that brought you to treatment
  - Treatment recommendations by primary care physician
  - Stressful life events that have occurred during or prior to visit to physician
- This study maintains anonymity of all participants
- Questions that participants do not want to answer may be skipped.
- Typically the interview takes about 15 minutes
- A \$20.00 dollar participation fee will be awarded upon completion of interview.
- Are you willing to be a participant in this study?

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#### Survey Questions

#### Section I

1. Were you prescribed an SSRI (e.g. Prozac, Zoloft, Paxil, Celexa, Lexapro, Wellbutrin, Luvox) in the last five years?
2. Do you recall the month and year?
3. Who prescribed this medication to you?
4. How many milligrams were you prescribed?
5. How often did you or do you currently take the medication?
6. What were the symptoms that brought you to treatment?
7. Were you advised to seek counseling or psychotherapy or were you given a referral to a counselor or psychologist by your primary care doctor?
8. Did you seek psychotherapy on your own?
9. In the last five years have you experienced a depressed mood (e.g. feeling sad or empty) and or loss of interest or pleasure in all or almost all activities for at least a two- week period or much of the time?

If answer is no: proceed to section II

If answer is yes:

- Have you experienced significant weight loss or weight gain( change of more than 5% bodyweight) when not dieting or an increase or decrease in appetite nearly daily.  
Yes or no  
If yes did this contribute to visit
- Have you experienced insomnia or hypersomnia nearly daily
- Psychomotor agitation or retardation nearly daily
- Fatigue or loss of energy nearly daily
- Feelings of worthlessness or excessive or inappropriate guilt nearly daily
- Diminished ability to think and concentrate, or indecisiveness
- Recurrent thoughts of death, suicidal ideation.
- What year and month did you experience this?
- Did any of these symptoms influence your decision to visit your primary care doctor?

## Section II

In the last five years have you experienced an undesirable stressful life event such as:

- Death of a child- Year and month      -yes-    -no-  
If yes was it before visit to doctor?
- Death of a spouse -Year and month    -yes-    -no-  
If yes was it before visit to doctor?
- Death of a parent- Year and month      -yes-    -no-  
If yes was it before visit to doctor?
- Death of a close relative or friend- Year and month    -yes-    -no-  
If yes was it before visit to doctor?
- Divorce- Year and month      -yes-    -no-  
If yes was it before visit to doctor?
- other love or marital problems- Year and month      -yes-    -no-  
If yes was it before visit to doctor?
- financial or legal problems within one's family unit- Year and month    -yes-    -no-  
If yes was it before visit to doctor?
- move to new residence or geographic location- Year and month      -yes-    -no-  
If yes was it before visit to doctor?
- physical assault- Year and month      -yes-    -no-  
If yes was it before visit to doctor?
- life threatening illness or injury- Year and month    -yes-    -no-

If yes was it before visit to doctor?

➤ loss of employment- Year and month-yes- -no-  
If yes was it before visit to doctor?

➤ managing multiple family and/or career roles- Year and month -yes- -no-  
If yes was it before visit to doctor?

Are there any additional undesirable stressful life events that you have experienced but are not mentioned here?

Did this event/s result in your visit to your primary care doctor?

Do you feel your stressful life event/s contributed to your symptoms?

### Demographic information

#### **Is your current age between:**

18-30-

30-40-

40-50-

50-65-

#### **What is the highest level of education you've obtained:**

High school

Two year college

Bachelors

Masters

MA/and or Doctorate

#### **Marital Status:**

Married

Single/never married

In Relationship

#### **Income level**

Low

Low-middle

Upper-middle

High

#### **Cultural/ethnic background:**

Caucasian  
African-American  
Hispanic  
Asian  
American Indian  
other

**Employment Status:**

Full-time  
Part-time  
Hours of work per week  
Not employed

*Health Insurance:*

Insured by HMO  
Medicaid  
PPO

## **Appendix B**

### **Consent To Treat-Part 1**

**Northeastern University, Counseling and Applied Educational Psychology**  
**Investigator: Ruth Marsach-Wood**  
**Title: Exploring Selective Serotonin Reuptake Inhibitors (SSRI's) and**  
**Psychotherapy In Women's depression**

#### **Consent to Participate in a Research Study-Part 1**

We are inviting you to take part in a research study. This form will tell you about the study, but the researcher will explain it to you first. You may ask this person any questions that you have. When you are ready to make a decision, you may tell the researcher if you want to participate or not. You do not have to participate if you do not want to. If you decide to participate, the researcher will ask you to sign this statement and will give you a copy to keep.

#### **Why am I being asked to take part in this research study?**

We are asking you to be part of this study because we are trying to gain a better understanding of women's experiences when they visit their primary care physician for symptoms of depression, anxiety and or fatigue.

#### **Why are you doing this research study?**

The purpose of this research is to help improve our knowledge and understanding of women's health experiences and to have a better understanding of psychological and environmental factors that impact women's health when visiting their primary care doctors.

**What will I be asked to do?**

If you decide to take part in this study, we will ask you to complete the survey questionnaire via the telephone with the researcher for the first phase of the study. The questionnaire will ask for information regarding SSRI's you have been prescribed, any symptoms of depression, anxiety and of fatigue and life stressors you may have experienced and recommendations for treatment provided to you by your primary care doctor.

Additionally you will be asked if you would be interested in being interviewed in person to further share about your experiences when prescribed an SSRI by your primary care provider. Participants are randomly selected from individuals who respond to the newspaper ad or posted flyer.

**Where will this take place and how much of my time will it take?**

The interview will take place over the telephone. The telephone survey should take about 15-20 minutes. If you consent to be interviewed in person for the second phase of the study, you will be interviewed either in your home or at location that that is convenient for you and ensures your confidentiality. If you agree to the personal interview, it should take about 30-45 minutes to complete.

**Will there be any risk or discomfort to me?**

There should be no foreseeable risk or discomfort to you from participating in this study.

**Will I benefit by being in this research?**

There will be no direct benefit to you for taking part in the study. However, the information learned from this study may help to determine if medical services for women seeking help from their primary care practices are adequate to meet the current needs of women patients and the goal is to enhance the mental health treatment of patients in primary care facilities.

**Who will see the information about me?**

Your part in this study is anonymous. That means no one will know that the answers you give me are from you. All names will receive codes (e.g. a set of numbers) and identifying information including audiotapes for the second phase of the study will be destroyed after the study is completed.

**Will there be limits to confidentiality?**

Your confidentiality will be maintained under all circumstances except when the information you share poses a serious threat to your health or safety or the health and safety of others.

**What will happen if I suffer any harm from this research?**

There is no foreseeable risk of physical, psychological, or financial harm for participating in this study. No special arrangements will be made for compensation or for payment for treatment solely because of my participation in this research.

**Can I stop my participation in this study?**

Your participation in this study is completely voluntary. You do not have to participate if you do not want to. Even if you begin the study, you may quit at any time.

**Can the researcher stop my participation in this study?**

The researcher may stop my participation in this study at any time if they determine that information you share poses a serious threat to your health or safety or the health and safety of others.

**Who can I contact if I have any questions or problems?** If you have any questions or problems you may contact Ruth Marsach-Wood at (215) 262-5837

**Who can I contact about my rights as a participant?**

If you have any questions about your rights as a participant, you may contact Vivienne A. Conner, Coordinator, Human Subjects Research Protection, Division of Research Integrity, 413 Lake Hall, Northeastern University Boston, MA 02115 Tel. 617-373-7570. You may call anonymously if you wish.

**Will I be paid for my participation?**

You will be paid a \$20.00 fee as soon as you complete the telephone interview. If you agree to the personal interview you will be paid an additional \$20.00 upon completion of the interview.

**Will it cost me anything to participate?**

You will not have any costs associated with completing the telephone survey. If you agree to participate in the personal interview the only cost to you will be parking if you agree to a meeting place other than your home.

**I Agree to take part in this research.**

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**Signature**

**Date**

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Printed name of person above

Date

## **Appendix C**

### **Consent To Treat Part-II**

**Northeastern University, Counseling and Applied Educational Psychology**  
**Investigator: Ruth Marsach-Wood**  
**Title: Exploring Selective Serotonin Reuptake Inhibitors (SSRI's) and**  
**Psychotherapy In Women's depression**

#### **Consent to Participate in a Research Study-Part II**

We are inviting you to take part in the personal interview portion of this research study. This form will tell you about the study, but the researcher will explain it to you first. You may ask this person any questions that you have. When you are ready to make a decision, you may tell the researcher if you want to participate or not. You do not have to participate if you do not want to. If you decide to participate, the researcher will ask you to sign this statement and will give you a copy to keep.

#### **Why am I being asked to take part in this research study?**

We are asking you to be part of this study because we are trying to gain a more personal understanding of women's experiences when they visit their primary care physician for symptoms of depression, anxiety and or fatigue.

#### **Why are you doing this research study?**

The purpose of this research is to help improve our knowledge and understanding of women's health experiences and to have a better understanding of psychological and environmental factors that impact women's health when visiting their primary care doctors.

**What will I be asked to do?**

If you decide to take part in the personal interview, you have already completed the survey questionnaire. The personal interview will involve being interviewed in person by the examiner. You will be asked several questions about your experiences when prescribed an SSRI by your primary care provider.

Participants are randomly selected from individuals who respond to the newspaper ad or posted flyer and who volunteer for personal interviews.

**Where will this take place and how much of my time will it take?**

If you consent to be interviewed in person for the second phase of the study, you will be interviewed either in your home or at location that that is convenient for you and ensures your confidentiality. If you agree to the personal interview, it should take about 30-45 minutes to complete.

**Will there be any risk or discomfort to me?**

There should be no foreseeable risk or discomfort to you from participating in this study.

**Will I benefit by being in this research?**

There will be no direct benefit to you for taking part in the study. However, the information learned from this study may help to determine if medical services for women seeking help from their primary care practices are adequate to meet the current

needs of women patients and the goal is to enhance the mental health treatment of patients in primary care facilities.

**Who will see the information about me?**

Your part in this study is anonymous. That means no one will know that the answers you give me are from you. All names will receive codes (e.g. a set of numbers) and identifying information including audiotapes for the second phase of the study will be destroyed after the study is completed.

**Will there be limits to confidentiality?**

Your confidentiality will be maintained under all circumstances except when the information you share poses a serious threat to your health or safety or the health and safety of others.

**What will happen if I suffer any harm from this research?**

There is no foreseeable risk of physical, psychological, or financial harm for participating in this study. No special arrangements will be made for compensation or for payment for treatment solely because of my participation in this research.

**Can I stop my participation in this study?**

Your participation in this study is completely voluntary. You do not have to participate if you do not want to. Even if you begin the study, you may quit at any time.

**Can the researcher stop my participation in this study?**

The researcher may stop my participation in this study at any time if they determine that information you share poses a serious threat to your health or safety or the health and safety of others.

**Who can I contact if I have any questions or problems?** If you have any questions or problems you may contact Ruth Marsach-Wood at (215) 262-5837

**Who can I contact about my rights as a participant?**

If you have any questions about your rights as a participant, you may contact Vivienne A. Conner, Coordinator, Human Subjects Research Protection, Division of Research Integrity, 413 Lake Hall, Northeastern University Boston, MA 02115 Tel. 617-373-7570. You may call anonymously if you wish.

**Will I be paid for my participation?**

If you agree to the personal interview you will be paid \$20.00 upon completion of the interview.

**Will it cost me anything to participate?**

You will not have any costs associated with completing the telephone survey. If you agree to participate in the personal interview the only cost to you will be parking if you agree to a meeting place other than your home.

**I Agree to take part in this research.**

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**Signature**

**Date**

---

**Printed name of person above**

**Date**

