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Maternal Depression: What Employers Need to Know and What They Can Do

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Introduction

Maternal depression is a serious and common disorder that can compromise a woman's health, reduce her quality of life and functional status and may negatively impact pregnancy outcomes. Although effective treatments for maternal depression are available, because of lack of screening, treatment barriers and stigma, experts estimate that only 50% of women with maternal depression are properly diagnosed.[1]

This *Issue Brief* provides an overview of the spectrum of conditions associated with maternal depression, including risk factors, preventive and treatment measures and potential impacts on the infant. It also discusses why some population groups are more susceptible to maternal depression than others. Of particular interest to employers is a summary of the costs associated with this condition and suggestions about how employers can address the problem proactively—by working with their vendors and developing internal policies and programs to address maternal depression in the workforce.

The term "maternal depression" describes a spectrum of depressive conditions in pregnant or postpartum women, including the following:

- Perinatal depression (occurring during pregnancy);
- Postpartum depression (occurring soon after birth); and
- Postpartum psychosis (a psychotic episode occurring soon after birth).

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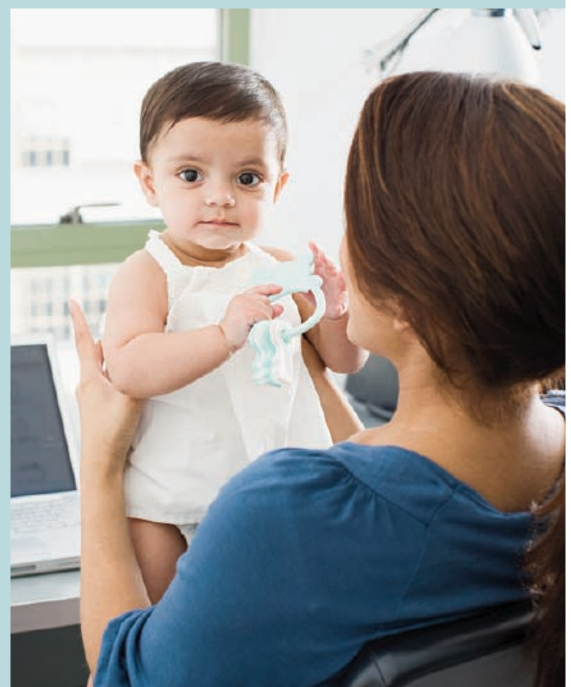
Maternal depression may also negatively affect infant and child development, leading to cognitive, emotional and behavioral problems in childhood and adolescence. The depressed new mother may develop a hostile or intrusive maternal style or may be withdrawn from her child. Both of these behaviors may affect how infants develop and how babies internalize coping mechanisms and self-regulatory behaviors.[2] In addition, children of depressed mothers may be subject to substandard care and poor nutrition due to the mother's negligence.[3]

Along with these serious emotional and developmental consequences, maternal depression results in economic costs for both employees and employers. It is responsible for a portion of the approximately $26.1 billion dollars spent annually on direct medical care for depression and the $51.5 billion dollars spent annually for workplace costs, including absenteeism, presenteeism and disability.[4] Major depressive disorder is the leading cause of disability in the U.S. for people ages 15-44 and is more prevalent in women than in men.[5, 6]

Overview of Maternal Depression

Although depression is a serious disorder, it is quite treatable. During their lifetime, women are twice as likely as men to experience depression.[7] Pregnant and postpartum women are at risk for depression due to hormonal variations, stress and changes in life roles. While the cause of depression is unknown, potential risk factors for maternal depression have been well established:[8]

- Maternal anxiety
- Life stress
- History of depression
- Lack of social support
- Unintended pregnancy
- Medicaid insurance
- Domestic violence
- Low income
- Low education
- Smoking
- Single status
- Poor relationship quality



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Women who have suffered from depression in the past have a higher risk of becoming depressed during pregnancy and the postpartum period. Estimates of the prevalence of depression during the stages of pregnancy vary, with 7.4% experiencing depression during the first trimester, 12.8% during the second trimester and 12% during the third trimester. The average prevalence of postpartum depression is 13%.[9]

Some of the risk factors for maternal depression may be more prevalent in specific populations. African American and Hispanic women have the highest teen pregnancy rates, nearly triple the rate of non-Hispanic whites.[10] In addition, these same populations of women are 1.5-2 times more likely to have an unplanned pregnancy.[11] African Americans and Hispanics are more likely than whites to be unemployed and uninsured, and when they are employed, they are more likely to work in low-paying jobs, with lower employer health benefits coverage rates.[12] As a result, it is not surprising that African American and Hispanic women have higher rates of depression than other groups.[13]

Postpartum Blues, Depression and Psychosis

Postpartum Blues

Up to 70% of women may experience postpartum blues, usually within the first two weeks following childbirth.[14] Symptoms include fluctuating mood, tearfulness, irritability, fatigue, anxiety, feelings of loss and a feeling of being overwhelmed. These feelings usually peak on the fourth or fifth day after delivery and last for several days, but they are time-limited and spontaneously end within two weeks postpartum.[15] Women experiencing more severe symptoms or symptoms lasting longer than two weeks may have postpartum depression.

Depression During Pregnancy and Postpartum

Symptoms of depression may occur at any point during pregnancy or the postpartum period. One recent study found that women with even mild symptoms of depression are 60% more likely to deliver earlier than other women, and those who are severely depressed have double the risk of premature birth.[16] Postpartum depression occurs most often during the first four months following delivery, but can occur anytime in the first year and is more persistent and debilitating than postpartum blues. The symptoms of postpartum depression parallel those of major depression, which could occur at anytime during a woman's life. These symptoms may include:[17]

- Depressed mood most of the day
- Anxiety
- Loss of interest or pleasure in activities previously enjoyed
- Fatigue or loss of energy

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- Feelings of guilt or worthlessness
- Difficulty concentrating
- Trouble sleeping or sleeping too much
- Suicidal or recurrent thoughts of death

The most vulnerable time for women to develop psychiatric illness is during the postpartum period. Women who have experienced depression during or following childbirth in the past have nearly a 25% chance of recurrence.[18] As noted earlier, the symptoms of postpartum depression may interfere with the mother's ability to function and to care for herself or the infant, with risk of harm to mother or infant.[19]

Table 1 summarizes the differences between postpartum blues and full-blown postpartum depression.

Table 1: The Differences Between "Baby Blues" and Postpartum Depression[20]

Characteristic	Baby Blues	Postpartum Depression
Predominant mood state	Happiness (but cries easily and is emotionally reactive)	Sadness and/or lack of ability to feel pleasure
Prevalence	~ 50% of new mothers	~ 20% of new mothers
Time of onset	3-5 days after delivery	Up to a year after delivery
Duration	Days to weeks	Up to months or years, if untreated
Triggering stressors	No association	Often present
Sociocultural influence	Present in all cultures studied	Prevalence varies widely by culture
History of depression	No association	Often
Family history of depression	No association	Often
Tearfulness	Yes (due to emotional reactivity)	Yes (due to sadness)
Mood lability	Yes	Sometimes, but usually mood is uniformly sad
Hopelessness	Not present	May be present

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Postpartum Psychosis

Women experiencing postpartum psychosis suffer from symptoms of depression as well as psychotic symptoms such as hallucinations and delusions. The condition is rare and women with a history of bipolar disorder or a previous episode of postpartum psychosis are at highest risk.[21, 22] Other symptoms may include agitation, rapid speech, racing thoughts, paranoia, inability to care for oneself or the baby and thoughts about harming oneself or the baby.[21] Postpartum psychosis is a serious disorder that requires immediate intervention and treatment since risks for infanticide and suicide are high among women who are untreated.[23, 24]

Health Risks of Maternal Depression for Mother and Child

Depression among pregnant and postpartum women is of particular concern because of its negative effects on the women's quality of life, their other children and their infants. The relationship between maternal depression, behavior and child outcomes is complex. Variations in the timing, severity and duration of maternal depression, as well as the presence or absence of external stressors and supports, contribute to differences in the outcomes of children born to depressed mothers.[2] While not all children of depressed mothers have poor outcomes, many do. The effects of maternal depression can be serious and even permanent. For this reason, identifying maternal depression early and treating it promptly are particularly important.

Effects of Maternal Depression on Fetal Development During Pregnancy

Depression during pregnancy can pose serious health risks to both the mother and fetus. Depressed women are more likely to have poor nutrition and to smoke, drink and use illicit drugs. They are also more likely to engage in risky behavior, including suicidal behavior. These behaviors put their pregnancy at risk for complications and the babies at risk for negative outcomes.

Women who suffer from depression during pregnancy are nearly twice as likely to experience a preterm delivery and to have low-birthweight babies as a result.[25]

Effects of Postpartum Depression on Infants

Because depressed mothers are often unable to provide consistent care for their baby, postpartum depression can have permanent effects on their infants' health, development and well-being, resulting in long-term special health needs. Researchers estimate that 8.6% of employees provide care to a child with a special health care need, which can also negatively impact their productivity.[26]

Infancy is a crucial period in a child's development. It is during this period that children develop social interaction skills, experience parental attachment and learn the importance of

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communication. If a mother's ability to interact with her child is compromised, her infant may fail to develop these important skills.

Women with postpartum depression also may have trouble meeting their babies' nutritional needs, feeding the infant less than is optimal. This lack of attention could result in "failure to thrive" in infants, where their weight or rate of weight gain is significantly below what is expected for the infant's age group and gender.[27] In about half of these children, failure to thrive also causes slower development, particularly in gaining verbal skills. These children often develop other social and emotional problems that may follow them into adulthood.[28]

Most of an infant's early development is based on regular interactions with the mother. If this mother-child bonding is disrupted, then the infant is more likely to develop behavioral problems such as sleeping and eating difficulties. As the infant grows into a toddler, other problems, including temper tantrums, hyperactivity and language delays, may emerge.[14] This, in turn, makes being a mother a stressful experience and can exacerbate the sense of hopelessness and helplessness she already feels.

Effects of Maternal Depression on Toddlers and Preschoolers

Women who experience depression often suffer from stress, fatigue and feeling overwhelmed. This makes positive parenting difficult. Children of depressed mothers have difficulty acquiring language and developing thinking and memory skills. Table 2 describes problems that may emerge beginning before birth and continue through adolescence. These deficits occur independent of maternal education, family income level, social support, birth order and other factors.[2]

Children of depressed mothers often experience negative effects associated with the mother's condition. These can either be manifested by the mother as direct effects, such as abuse or neglect, or as indirect effects, such as lack of attendance at well-child visits and failure to take preventive actions such as using car seats or ensuring that their children receive immunizations.[29]

The Impact of Maternal Depression into Adolescence and Adulthood

Maternal depression can create problems that can continue into adolescence. Adolescents with a history of exposure to maternal depression have higher rates of major depression and other disorders, such as anxiety, conduct disorders and substance abuse disorders.[2] This is of particular concern because depression that begins early in life is associated with a greater severity of illness and a higher risk of suicide and other violent behavior than later onset depression.[30] Children with

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major depression are also more likely than their peers to experience panic disorders, phobias, substance abuse or alcohol dependence, Internet addiction, self-injury, reckless behavior and eating disorders.[30]

In addition to bearing a higher burden of illness, children of depressed parents have longer episodes of mental illness, earlier onset of symptoms and a greater number of comorbid disorders.[31] They also have an increased risk of medical problems and psychiatric hospitalizations throughout their lives.[32]

Nevertheless, it is important to remember that not all children of depressed mothers suffer physical, emotional, cognitive or behavioral problems. Many children show resilience in the face of even the most extreme negative parental interactions. Some studies have shown that non-depressed fathers can compensate for some of the negative effects of maternal depression by interacting positively with the infant and helping him or her adapt positive behaviors.[33] But new fathers are not immune to depression either. Nearly 10% may experience depression during the postpartum period.[34] Therefore, when designing interventions or outreach programs for women struggling with maternal depression, considering how fathers or partners can be included in treatment and subsequent prevention is key.

Table 2: Summary of the Effects of Maternal Depression at Different Stages of a Child's Development

Stage	Behavioral Problems	Cognitive Problems	Physical Problems
Prenatal			Preterm delivery or miscarriage[35]
Infant	Passivity, anger, withdrawal, attention and arousal problems		Low birthweight and low weight gain
Toddler/ Preschooler	Passive noncompliance, less independence, less and negative interaction with others, mood regulation problems[2]	Less creative play, lower performance on verbal and memory tests, difficulty problem-solving	
School age	Impaired adaptive functioning, depressive disorders, anxiety disorders, attention disroders/ADHD	Lower IQ scores	
Adolescent	Depressive disorders, anxiety disorders, including phobias and panic disorder, substance abuse, conduct disorders, attention disorders/ADHD	Lower IQ scores	

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Treatment and Management

Psychotherapy may be used as a treatment method for maternal depression. It offers benefits such as social support, interpersonal relations and the opportunity to build positive bonding and parenting skills, and it does not carry the potential risks that medications do. However, for serious cases of depression, medication combined with psychotherapy may be needed. Employee Assistance Programs (EAPs) are well positioned to provide initial screening and referral to a professional clinician for further assessment and treatment.

Treating depression in a woman trying to conceive, a pregnant woman or a breastfeeding woman can be complicated. Although the most effective treatment for depression is psychotherapy paired with prescription antidepressant use, because prescription medications cross the placenta and may harm the fetus, there are concerns about using antidepressants during pregnancy, especially during the first 12 weeks. To make matters even more confusing, research on the safety of antidepressant use during pregnancy is limited. That said, however, information from hospital registries, pharmaceutical companies and others has shown that prescription antidepressants do not cause fetal abnormalities or pregnancy complications. But because of the limited information available, most physicians use caution when prescribing antidepressants to pregnant women or women trying to conceive.[8]

Treating Women Trying to Conceive

The following recommendations for women trying to conceive come from the *Expert Consensus Guidelines Series.* These recommendations are accepted by most practitioners in the field.

- Women who have suffered only one episode of depression in the past and have been feeling well for the previous six months may be able to stop taking medication before they want to conceive. Women should discuss the potential benefits and risks to stopping medication with their physician and should taper off their medication slowly and under their physician's guidance. It is also recommended that they begin or continue psychotherapy to reduce the risk of another episode.[36]
- Women who have suffered one or more previous episodes of severe depression should continue taking their medication at the full dose. A physician should closely monitor a woman on antidepressants who is trying to conceive to 1) ensure that the medication she is using is the safest alternative possible, 2) the dosage is correct and 3) the woman's mental health remains stable or improves.
- If a woman is currently depressed, is not being treated and wants to conceive, experts recommend that she begin psychotherapy. If her symptoms are severe or persist and worsen, then she should begin medication.[36]

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Screening for Maternal Depression

Screening pregnant and postpartum women for depression during routine prenatal, postpartum and well-child physician visits is an effective, but underused, method of identifying women suffering from depression. Despite the availability of inexpensive and simple screening tools, primary care and specialty doctors continue to miss screening opportunities. Ideally, women at high risk for postpartum illness should be identified prior to delivery, and women who experience depression during pregnancy should be considered at high risk for postpartum depression as well. Employers can make sure that their health plans, absence management partners and on-site wellness programs all routinely screen for depression, especially when a woman is pregnant.

The U.S. Preventive Services Task Force (USPSTF) found strong evidence to support screening of all adults, including pregnant and postpartum women, for depression.[37] The USPSTF reported that screening improves the accurate identification of patients with depression in primary care and that treating these patients reduces clinical morbidity.

For many new mothers, well-baby and well-child visits to a pediatrician or family physician are the most frequent contact they have with the health care system. Therefore, the USPSTF recommends that physicians of all types screen pregnant and new mothers for depression as a routine part of the visit.[38]

Economic Costs of Depression

The economic cost of depression is substantial. Recent studies have reported societal costs ranging from $36 - $83 billion a year.[39, 40, 41] When these costs are broken down further, research shows that of the $83 billion spent on depression per year, direct medical costs represented $26 billion; suicide-related mortality costs were just over $5 billion; and workplace costs, including absenteeism, presenteeism and disability, totaled nearly $52 billion.[42] Individual costs for patients with severe major depressive disorder (MDD) were almost double of those with mild MDD.[42]

Employers incur many of the costs related to employees with depression. This is due to depression's impact on medical and pharmaceutical costs, disability claims, workers' compensation costs, absenteeism and presenteeism. Depression may also be related to limitations in time management, interpersonal/mental functioning and overall output.[43] Individuals with depression are absent more often and are less productive than employees without depression. In a three-month period, depressed employees miss an average of 4.8 workdays and suffer 11.5 days of reduced productivity.[32] In a given year, these employees lose approximately 27.2 days to their illness.[42] According to data from two large community surveys, depression was associated with a 2.5-fold increase in the probability of missing work and a 50% increase in lost work time.[31, 32] Furthermore, individuals with depression may have a negative impact on their families, their coworkers and the workplace culture.

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Major depression is the second leading cause of disability-adjusted life years lost in women and the tenth leading cause in men.[44] In one large study, employees who reported experiencing depression resulted in claims that were 70% more expensive than their non-depressed counterparts.[31] Although maternal depression costs account for a just a portion of this total, it can represent a significant overall cost for employers, especially if the condition goes undiagnosed. Recent studies have shown that working mothers are less likely to pursue help or receive adequate treatment for depression due to either a lack of free time or a lack of knowledge that a problem exists.[45]

In total, it is estimated that depression causes 200 million lost workdays each year. The cost to employers ranges between $17 billion and $44 billion.[4] Below is a further breakdown of costs related to depression and maternal depression.

- Depressed employees average $3,000 more in total medical claims than do non-depressed employees.[46]
- Women with depression have higher medical claims than do men with depression (averaging $9,265 compared to $8,502 per year).[46]
- Women who suffer from depression during pregnancy and their infants are at risk for costly complications. Nearly $15 billion dollars is spent on childbirth-related hospitalizations and half of those costs are billed to private insurance.[47]
- Children of depressed mothers have higher medical claims than do children of healthy women because they bear a higher burden of illness, use health care services more frequently and have more medical office and emergency department visits than do children of non-depressed mothers. One study found that depressed mothers who have children with asthma take their children to the emergency room 30% more often than do non-depressed mothers of asthmatic children because of a general lack of coping skills.[46]
- Depressed women who return to work after the birth of a child may be less productive due to fatigue, difficulty concentrating, anxiety and agitation.

Disability Costs

Depression is the leading cause of disease-related disability among women worldwide.[48] Women with depression report more impairment in physical, social and role function than do women with other types of chronic health problems such as hypertension, diabetes and back pain.[32] Depressed women are also more likely to receive disability payments than are women with other chronic health conditions.[32] Both male and female employees with depression are four times more likely to take disability days than employees without depression.[49] On average, depressed employees take 1.5-3.2 more short-term disability days per month than do non-depressed workers.[49]

In sum, the costs of maternal depression in terms of disability can be significant, particularly when other potential complications of pregnancy associated with this condition are taken into account.

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Overall, complications of pregnancy account for over 4,000 cases of short-term disability per million covered lives. The average length of a pregnancy-related short-term disability is seven days.[49]

Treatment During Pregnancy and the Postpartum Period

Treatment Options During Pregnancy

During the first trimester of pregnancy, fetal organ development occurs, making it the most vulnerable time for the fetus. Some medications can interfere with this development and cause serious malformations that can result in miscarriage or birth defects. During the second and third trimesters of pregnancy, the organs of the fetus are already formed, so there is less risk for malformations. Even so, medication use in the later stages of pregnancy still carries the risk of miscarriage or developmental problems; thus, it should be considered carefully.

Other treatment considerations include the following:

- Women with depression during pregnancy can often be treated with counseling and support services such as psychotherapy, couples therapy, parenting coaching and support networks.
- Women who were advised to continue or begin antidepressants while they were trying to conceive are usually advised to continue medication throughout the duration of their pregnancy.
- Women advised to continue their medication should be prescribed a well-researched and recommended medication with demonstrated minimal and manageable side effects on infants.[20, 50]
- If a woman has not been taking medication but becomes depressed in the later stages of pregnancy, experts recommend that she first begin psychotherapy. If this does not relieve symptoms or if symptoms worsen, she may consider taking medication. For some women with a history of depression, especially a previous episode of postpartum depression, experts advise they begin taking antidepressants during the last month of their pregnancy to prevent another postpartum depression episode.[51]

Postpartum Blues

Postpartum blues is typically mild and will generally disappear naturally within a few days or weeks. No specific treatment is needed other than support and reassurance. New mothers can alleviate symptoms by resting, connecting with other new mothers, and avoiding alcohol, which can intensify mood swings. Some studies have shown connections between low thyroid levels and symptoms of depression. What's more, thyroid levels can also drop following pregnancy.[52] A physician may prescribe thyroid medication if he or she believes this connection is present in a patient.[14] If symptoms persist more than two weeks, further evaluation may be needed.

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Postpartum Depression

Symptoms of postpartum depression generally fall along a continuum, from relatively mild or moderate to more severe forms of depression, characterized by impaired functioning.[18, 53] Traditional treatments for postpartum depression include counseling, antidepressants, hormone therapy or a combination of these. Six to 12 months of treatment is recommended for the first episode of maternal depression, but for mothers with a recurrence, longer-term maintenance treatment may be needed.[18]

Postpartum Psychosis

Postpartum psychosis requires immediate medical attention, usually in a hospital setting. Postpartum psychotics are traditionally given a combination of antidepressants, antipsychotic medications and mood stabilizers.[54]

Because all medications, including antidepressants, carry risks when used in pregnancy, women should consult their doctor to discuss the benefits and risks of medication use during pregnancy before beginning or stopping a medication regimen.

Antidepressant Medications

Selective serotonin reuptake inhibitors (SSRIs) are the most widely prescribed antidepressant in the United States.[50] The few research studies that have been conducted have shown that these antidepressants do not cause birth defects and that they are safe to take while pregnant. Experts prefer fluoxentine (Prozac®), sertraline (Zoloft®) and paroxetine (Paxil®) in pregnant women. These medications have well-documented efficacy and safety in pregnant women. While the vast majority of studies support the safety of antidepressant use during pregnancy, a few studies have documented negative outcomes. Minor abnormalities, poor neonatal outcomes such as respiratory distress and jitteriness, as well as symptoms of withdrawal such as tremor and sedation, have been noted in infants with prenatal exposure to antidepressants.[37]

All psychotropic medications are secreted into breast milk, including antidepressants, but the concentrations may vary widely.[55] Data on tricyclic antidepressants has indicated that the levels in the breastfed infant are either low or undetectable; however the long-term effects of exposure are unknown.[56]

- Breastfeeding women should avoid taking lithium since it is secreted at high levels in breast milk and may cause toxicity in the nursing infant.[55, 56]
- A premature infant's liver may have difficulty metabolizing medications present in breast milk. Therefore, this factor should be considered by mothers taking medications for depression.[56]

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What Employers Can Do to Address Maternal Depression

Although the extent of maternal depression and the consequences of untreated depression are widely known, less than half of depressed mothers receive the services they need.[43] Employer-sponsored health plans, health promotion programs and health education services can offer assistance and make simple policy changes that will help women access depression care services.

Employer and Health Plan Recommendations

- Ask your health plans to encourage their providers to incorporate routine screening for maternal depression prior to conception, during pregnancy, in the postpartum period and during well-child visits.
- Ask your health plan to alert pediatricians, family physicians, obstetricians/gynecologists (OB/GYNs), nurse practitioners and other providers who care for pregnant and postpartum women and their infants to the plan's mental health care referral policy.
- Employers and health plans should encourage women of childbearing age to have an ongoing relationship with a primary care physician. Depression is much easier to detect when the doctor knows the patient and there is a trusted relationship.
- Ask your health plan to provide information on maternal depression to pregnant women, including where to go for depression treatment.
- Reduce or eliminate point-of-care cost sharing or provide other incentives for women to participate in prenatal education programs.

- Ask your health plan to reimburse approved providers for screening, assessing and diagnosing behavioral health conditions as a primary or secondary health condition as recommended.[43]
- Include a visiting nurse program in your maternity care package. Visiting nurses can help relieve stress on new mothers by providing them with information and education on feeding, sleeping and care techniques for their infants. Most importantly, they can screen and assess a new mother's risk for depression and refer her to appropriate care.
- Pharmacy benefit management (PBM) consults should be prepared for questions about taking antidepressant medications during pregnancy.
- Any case manager who has an infant with health problems should screen for maternal depression and provide appropriate referrals.

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- Make sure your health plan provides benefit coverage that includes a behavioral health condition management program for patients diagnosed with depression or anxiety.[38]
- Condition management administrators should screen all patients being treated for a general medical condition, including pregnancy, for depression and coordinate care with behavioral health specialists.[38]

Health Promotion/Wellness Program Recommendations

- Use your existing prenatal program to alert women to the risk factors and symptoms of maternal depression. Distribute educational materials on maternal depression in the prenatal program enrollment pack, offer prenatal education and support classes for pregnant women and their partners and encourage them to ask their physicians about maternal depression during their prenatal visits.
- Offer parenting classes for both expectant and new mothers and fathers.
- Target education and outreach based on risk and the demographics of your employee population.
- Incorporate education and treatment resources for maternal depression in live and online health fairs.
- Support a community peer education or support group for new mothers by offering space in your facility.
- If your company has an on-site day care facility, train your providers on the importance of positive interaction with infants.

EAP Recommendations

Returning to work after the birth of a child can be a very stressful time. Women having difficulty with this transition or experiencing personal or family issues can be helped by EAP services. EAP counselors can serve as a point of first contact for women suffering from depression and for their families. Train your EAP counselors to work with families affected by maternal depression. To be helpful during the treatment process, fathers and older siblings also need information and support.

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For Pregnant Women and New Mothers in the Workplace

- Outreach to pregnant women and new mothers can help reduce their isolation, which can exacerbate symptoms of depression. Provide EAP counselors with screening, prevention and intervention materials on maternal depression.
- Encourage mothers returning to work to meet with an EAP counselor to discuss developing strategies for a positive transition back to the workplace.
- Train managers and supervisors to identify the symptoms of depression and encourage them to refer women with such symptoms to the EAP for assistance.

For Fathers and Partners of Working Women with Depression

The partners of women suffering from depression also need support. They are usually worried about their depressed loved one and may be overwhelmed by the demands on them if the woman is unable to care for herself or the child. Parenting classes and support groups for new fathers can offer much-needed support and information on depression.

Summary

Maternal depression is a common but serious disorder. It is also quite treatable. Employers can help prevent maternal depression by offering medical, behavioral health and support services to women at risk and by offering accessible treatment to women who have developed maternal depression. Health plans can play a key role in preventing maternal depression by identifying those at highest risk, especially women who have suffered a prior episode of perinatal or postpartum depression, and managing their care. Innovative yet simple interventions such as including information on maternal depression in prenatal education classes and maternity leave information or offering visiting nurse services during the postpartum period can be extremely helpful in identifying women with depression and getting them into treatment promptly.

The benefits of prevention and early treatment are significant. Women benefit by regaining their functional status, avoiding medical complications and being better able to bond with their baby. Infants and children benefit by gaining a full relationship with their mother, improving their emotional, cognitive and behavioral development. Employers benefit by reducing their medical costs, largely through the prevention of costly complications, and reducing lost work time and disability costs associate with depressed employees.

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Racial and Ethnic Disparities and Maternal Depression

A 2003 study on racial differences in depression rates among preretirement adults found that major depression was most prevalent among Hispanics (10.8%), followed by African Americans (8.9%) and whites (7.8%).[57]

There are many different explanations for these trends. For instance, some beliefs and practices may be shaped by culture, and some cultures deny the existence of mental illness or discourage individuals from seeking medical attention for problems. In addition, several factors identified as strong indicators of major depression are more prevalent in minority populations than among whites. These include socioeconomic factors such as lower education level, lack of income and lack of private health insurance coverage or employment.[57]

That said, however, the relationship between race and depression is complicated and needs to be examined through a variety of different lenses, including cultural, psychological, biological and sociological factors. In the following sections, these factors are discussed in the context of Hispanic and African American populations.

Hispanics and Maternal Depression

According to a recent study, Hispanic mothers (along with African American mothers) are more likely to report early postpartum depression symptoms than white mothers.[58] This finding is interesting in light of the fact that Hispanic women report having the highest levels of partner support, followed by white women and then African American women.[13] In most cases, lack of social support is cited as a cause of maternal depression. What's more, in addition to the partner, the Hispanic family can be a tremendously supportive structure for a pregnant Hispanic woman. In particular, Hispanic mothers are known to be very supportive throughout their daughters' pregnancies.[13]

With so much support, why are Hispanic women so susceptible to maternal depression? In fact, many social and cultural factors have been identified. According to the U.S. Census Bureau, Hispanics are expected to become the most dominant population in the country by 2020.[59] In the context of the American population as a whole, Hispanics are younger, have lower income and education levels, are less likely to speak English and are less likely to have adequate health insurance.[59] They often lack access to culturally appropriate resources, which is a concern, especially since Hispanics are at higher risk for developing major depression with each generation born in the United States.[59] This finding, along with the fact that the highest risk period for onset of depression for all women is during their childbearing years, helps explain why Hispanic women have a higher incidence of depression than other population groups.[59] Although Hispanic families are known for their support, if they are not in this country, the women may feel alone and isolated, increasing their likelihood to experience depression.

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African Americans and Maternal Depression

Although African American women are more likely to report depressive symptoms associated with postpartum depression and major depression, they are also less likely to seek treatment, which can make the effects worse for family members and their children.[13, 58]

One of the reasons for this phenomenon is that depression remains a very private problem for much of the African American population. This is because part of African American culture is that women view mental illness — and admitting the need for therapy — as a personal weakness rather than a health problem.[60]

Some studies have found that other social characteristics may increase an African American woman's risk of developing maternal depression, particularly stress, poverty, lack of education and experience with discrimination. One study reported that the prevalence of depression among African Americans was reduced by 41% when sociodemographic differences, other health disparities and economic differences were controlled. Adjusting for these three factors created a shift from 88.5 per 1000 to 52.3 per 1000 reporting depression, compared to the 77.5 per 1000 incidence of white respondents, indicating the strong impact of these factors on African Americans' development of depression.[57] Another study found that African American women were especially susceptible to a "weathering effect," in which risk of maternal depression increased each year as negative life experiences from poverty or discrimination accumulate. This study reported that older women were about five times as likely to be at risk for major maternal depression as teen mothers.[61]

Other studies have reported that maternal depression among African American women was conditional upon their employment. A study conducted in 2008 found that after adjusting for maternal sociodemographic characteristics, rates of maternal depression among African American women were only higher than the rates for white women among the unemployed.[62] Researchers suggested that African American women do not benefit from employment the same way that white women do, citing lower workplace control, fewer workplace promotion opportunities and lower salaries as contributing factors to this phenomenon. African American women with higher levels of education and income were still more likely to live in poor neighborhoods and/or earn lower salaries than their white peers.[62]

The relationship between African American women and employment is complicated. One study found that employment was a risk factor for severe depressive symptoms and that employed, pregnant African American mothers, especially those who lacked social support, were significantly more likely to fall into the severely depressed category.[63]

This study theorized that paid employment during the mother's first year with her child disrupts the mother's work-life balance. Employment is a necessity, not an option, for many women. As a result, new mothers are often forced to adjust to their maternal roles while working, creating additional stress that can lead to depressive symptoms.[63]

Social support, particularly from friends and family, seems to provide a positive quality in African American women's lives. Those women with support have a lower risk of developing depressive symptoms.[63]

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  Postpartum Depression.
- The National Business Group on Health
  - Depression Screening. Moving Science into Coverage: An Employer's Guide to Clinical Preventive Services.
  - Depression. Benefit Manager Guide.
  - Investing in Maternal and Child Health: An Employer's Toolkit.
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ISSUE**Brief**

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Maternal Depression: What Employers Need to Know and What They Can Do

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About the National Business Group on Health

The Business Group is the only non-profit organization devoted exclusively to representing large employers' perspectives on national health issues and providing solutions to its members' most important health care and health benefits challenges. The Business Group fosters the development of a safe health care delivery system and treatments based on scientific evidence. Members share strategies for controlling costs, improving patient safety and quality of care, increasing productivity and supporting healthy lifestyles.

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