Center for Prevention
and Health Services
ISSUE Brief

March 2005

# Preventing, Identifying and Treating Maternal Depression: *Tools for Employers*

## Introduction

Maternal Depression is a term used to describe a spectrum of depressive conditions. It includes perinatal depression (depression that occurs during a pregnancy), postpartum depression (depression that occurs soon after the birth of a child), postpartum psychosis (a psychotic episode that occurs soon after the birth of a child) and major depressive disorder. Maternal depression is a serious and common disorder. Depression compromises a woman's health, reduces her quality of life and functional status and may worsen perinatal (pregnancy) outcomes.

### Table of Contents:

Introduction....1
Epidemiology....2
Health Risks of Maternal Depression....3
Effects of Perinatal Depression on Fetal Development....5
Effects of Postpartum Depression on Infants....5
Affects of Depression on Toddlers & Children....6
Long-term Affects of Maternal Depression Exposure....6
Economic Consequences of Maternal Depression....7
Treatment/Management....9
Prevention and Screening....12
What Employers Can Do to Address Depression....13
Case Study....16
Summary....17
Resources....17
Citations....18

Depression can also negatively affect infant and child development, leading to cognitive, emotional and behavioral problems in childhood and adolescence. Maternal depression also exacts economic costs from both employees and employers. Maternal depression 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 for workplace costs.[1] Depression is the leading cause of disability among women and is a major cause of incidental absence and lost productivity.[2]

## Epidemiology

### *Depression is a serious, common and treatable disorder.*

In a given year, depression affects 12.9% of women. Due to hormonal changes, stress and changes in life roles, pregnant women and postpartum women are at risk for depression. Many factors affect an individual's risk for depression including genetic factors, sex hormones, life stress and trauma, interpersonal relationships and cognitive style. While the cause of depression is unknown, risk factors for depression have been established. Women who have suffered from depression in that past have a higher risk of becoming depressed during pregnancy and the postpartum period.[3] Other risk factors include a history of mood disorders, a family history of psychiatric illnesses, having a child with special healthcare needs, stress, a lack of social support and drug abuse.[4] Maternal depression also appears to be more common among women who experience marital instability, low self-esteem, lower education level, lack of medical insurance and young maternal age.[5]

The most serious risk factor for maternal depression is a previous episode of perinatal or postpartum depression. Approximately 50%–62%[6] of women with a history of postpartum depression and 33% of women with a history of perinatal depression will experience depression during or after their next pregnancy.[7] Only 2%–5% of women without a history of depression are likely to develop postpartum depression after their next birth.

### *Perinatal Depression — Depression that Occurs During Pregnancy*

The symptoms of perinatal depression parallel the symptoms of major depression *(see insert below)*. Perinatal depression is a serious, but treatable disorder.

**Symptoms of Major Depression Disorder (MDD)**

- Depressed mood, all or most of the day, nearly everyday for at least two weeks
- Loss of interest or pleasure in activities previously enjoyed
- Fatigue or loss of energy
- Feeling of guilt or worthlessness
- Difficult concentrating
- Trouble sleeping
- Recurrent thoughts of death or suicide

**Symptoms of Maternal Depression**

**S** leep disturbance
**A** gitation or psychomotor retardation
**D** epressed mood most of the day
**F** atigue or loss of energy
**A** ppetite disturbances
**C** oncentration difficulties
**E** steem diminished or feelings of guilt
**S** uicidal or recurrent thoughts of death

### *Postpartum Blues, Postpartum Depression and Postpartum Psychosis*

Many women experience the postpartum "blues," usually in the first ten days after childbirth. Symptoms of the "blues" include tearfulness, fatigue, feelings of loss and a feeling of being overwhelmed. Postpartum blues is common, temporary and does not require treatment. For some women however, the "blues" persist and develop into a more serious condition: postpartum depression. Postpartum depression is a major depressive episode that may last from a period of weeks to a year or more. The symptoms of postpartum depression parallel the symptoms of perinatal depression and major depression (*see previous page*). In addition, women suffering from postpartum depression may experience a loss of interest in the child, despair and have thoughts of harming themselves or their child.[9] In order for a diagnosis of postpartum depression to be confirmed, symptoms must last for at least four weeks and must occur within one month of the birth of a child.[8]

Postpartum psychosis is the most serious form of maternal depression. Women with postpartum psychosis suffer depressive symptoms as well as psychotic symptoms. Psychotic symptoms include hallucinations — hearing or seeing things that are not actually present, and/or delusions — paranoid thinking. Women with postpartum psychosis may also experience agitation, rapid speech, racing thoughts, paranoia, an inability to care for oneself or baby and thoughts about harming oneself or baby. Postpartum psychosis is a serious disorder that requires immediate treatment.

| Type of Depression | % affected in the year following the birth of a child |
| --- | --- |
| Perinatal (during pregnancy) depression | 20% experience depressive symptoms and 10% experience major depression[10] |
| Postpartum "blues" | 50-60%[11] |
| Postpartum depression | 8-15%[12] |
| Postpartum psychosis | 0.1%[13] |

*Maternal depression is a serious disorder. Depression compromises a woman's health, reduces her quality of life and functional status, and can impair her ability to maintain important social relationships. Maternal depression may lead to complications during pregnancy and childbirth and can also negatively influence a woman's children and family.*

## Health Risks of Maternal Depression

Depression among pregnant and postpartum women is of particular concern due to its deleterious effects on women and infants. The associations between maternal depression, behavior and child outcomes are 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.[14] 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, the identification and early treatment of maternal depression is particularly important.

| | Behavioral Problems | Cognitive Problems (difficulty in acquiring language, thinking and memory skills) | Physical Complications |
|---|---|---|---|
| **Prenatal** | | | • Pre-term delivery<br>• Miscarriage |
| **Infant** | • Passivity<br>• Anger<br>• Withdrawal<br>• Attention and arousal problems | | • Low-birth weight<br>• Low-weight gain |
| **Toddler** | • Passive noncompliance<br>• Less independence<br>• Less interaction with others | • Less creative play<br>• Lower performance on verbal and memory tests | |
| **School age** | • Impaired adaptive functioning<br>• Depressive disorders<br>• Anxiety disorders<br>• Attention disorders /ADHD | • Lower IQ scores | |
| **Adolescent** | • Depressive disorders<br>• Anxiety disorders including phobias and panic disorder<br>• Substance abuse<br>• Conduct disorders<br>• Attention disorders /ADHD<br>• Increased risk of psychiatric hospitalizations | • Learning difficulties | |

## Effects of Perinatal Depression on Fetal Development

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/or use illicit drugs than are non-depressed women. They are also more likely to engage in risky behavior including suicidal behavior. These behaviors put their pregnancy at risk for complications and their babies at risk for negative outcomes.

**Women who suffer from depression during pregnancy are at risk for complications during pregnancy and delivery. Depressed women are:**

- 3.4 times as likely to have a premature delivery,
- 4 times as likely to delivery a low birth weight baby, and
- are more likely to suffer obstetrical complications than are non-depressed women.

Women who suffer from depression while pregnant are more likely to deliver preterm and to have low birth weight babies. They are also more likely to suffer obstetrical complications such as pre-eclampsia, excessive bleeding, placental rupture and premature rupturing of the waters.

## 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 child development and well-being.

Infancy is a crucial period in development. It is during this period that children develop social interaction skills, experience parental attachment and learn the importance of communication. If a mother's ability to interact with her child is compromised, her infant may fail to develop these important skills. Infants of depressed mothers commonly suffer developmental delays, especially the ability to respond to positive emotion and interact with others.

Maternal depression compromises a mother's ability to interact with her infant. Depressed mothers have difficulty displaying and responding to positive emotion. They may display hostility or they may withdraw from the infant. Hostile behavior in the mother interferes with the infant's normal interaction pattern. Infants may ignore the mother or become angry. Withdrawn mothers are disengaged and unresponsive to their infant. They may have a flat affect and not show appropriate emotion or fail to initiate infant learning activities such as play. Because infants of depressed mothers do not receive consistent interaction or response, they learn to cope by withdrawing themselves — this is expressed by looking away, sucking on their thumb or otherwise ignoring external stimuli.[16]

Infants of depressed mothers also have difficulty with attention and arousal. Because depressed mothers are less likely to offer consistent stimulation to their infants such as looking at them, cooing, or initiating play, infants have difficulty in learning nonsocial tasks such as eye tracking, recognizing objects, etc. Because depressed mothers are less responsive and attentive to their infants and are unable to serve as models for mood regulation and problem-solving, infants may also have difficulty developing important skills such as initiating creative play or asserting independence.[17]

## Affects of Maternal Depression on Toddlers and Children

Women who experience postpartum depression often suffer from stress, fatigue and feeling overwhelmed. This makes positive parenting difficult. Depressed mothers are less confident in their parenting skills than are non-depressed mothers, and often have problems coping with problems as they arise.[18] Postpartum depression is a major predictor of negative parenting styles such as yelling or spanking. And research has shown that with each additional depressive symptom experienced by a mother, there is a loss of positive parenting behaviors such as direct interaction with the child, reading to the child, etc.[19]

Ineffective maternal-child interaction is predictive of poor cognitive functioning in children. Children of depressed mothers have difficulty acquiring language, thinking and memory skills. Because of this, children of depressed mothers often score lower on standardized intellectual attainment tests (similar to an IQ test) and cognitive-linguistic tests, which test a child's ability learn and use language. These deficits are independent of maternal education, family income level, social support, birth order and other factors.[20] Studies have also shown that children of depressed mothers have poor adaptive functioning meaning that they have difficulty in understanding and dealing with problems that arise in their everyday life.[21]

Children of depressed mothers are also more at risk for injuries and accidents. Maternal depressive symptoms are associated with poor prevention practices; depressed mothers are less likely to use car seats, cover electrical outlets and take other safety measures.[22]

## Long-term Affects of Maternal Depression Exposure

Children of women with depression are at high risk for depression and anxiety in childhood and adolescence.[23] 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 than later onset depression.[24] Children of depressed mothers are also more likely to experience

panic disorders, phobias and substance abuse or alcohol dependence than are their peers.

A recent study showed that 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 co-morbid disorders.[25] They also have an increased risk of medical problems and psychiatric hospitalizations throughout their lives.[26] While some of the psychiatric problems noted in the children of depressed parents may indeed have a strong genetic component, the environment in which children are raised, their interpersonal relationships and the functionality of the caregiver play a strong role in children's mental health.

It is important to remember that not all children of depressed mothers suffer physical, emotional, cognitive or behavioral problems. Many children show resistance to even the most extreme negative interactions. More research is needed in order to determine what internal coping strategies or external support help children develop. Some studies have shown that non-depressed fathers may act as a buffer for children and can help them learn age appropriate interaction skills.[27] When designing interventions or outreach programs for women struggling with maternal depression, it is important to consider how fathers or partners can be included in treatment and subsequent prevention.

## Economic Consequences of Maternal Depression

### *Healthcare Costs*

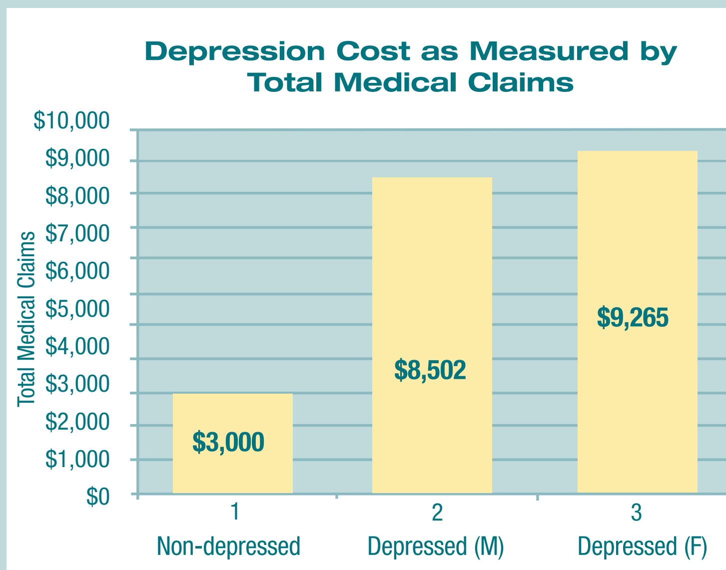
The economic cost of depression is substantial. In 2000, over $83.1 billion dollars were spent on depression in the United States; $26.1 billion dollars (31%) for direct medical costs, $5.4 billion dollars (7%) for suicide-related mortality costs and $51.5 billion dollars (62%) for workplace costs.[28] Workplace costs include absenteeism, presenteeism and disability. While maternal depression is responsible for only a portion of these costs, it remains an important cost consideration.

- Depressed employees average $3,000 more in total medical claims than do non-depressed employees. And women with depression have higher medical claims than do men with depression (averaging $9,265 compared to $8,502 per year).[29]
- Women who suffer from depression during pregnancy are at risk for costly complications.

• Children of depressed mothers have higher medical claims than do children of healthy women. This is because they bear a higher burden of illness, use healthcare services more frequently, and have more medical office and emergency department visits than do children of non-depressed mothers, even when variables such as health are controlled for. For example, 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.[30]

### *Loss of Productivity*

Depressed women who return to work after the birth of a child may have lowered productivity. Symptoms of depression such as fatigue, difficulty concentrating and agitation make work difficult. Loss of productivity presents yet another cost to employers.




### *Disability Costs*

Depression is the leading cause of disability among women.[31] And 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 that are women with other chronic health conditions.[33]

Employees (both male and female) with depression are four times as likely to take disability days than employees without depression.[34] And on average they take 1.5–3.2 more short-term disability days per month than do non-depressed workers.[35]

## Treatment/Management

Treatment for maternal depression is effective, yet due to lack of screening, treatment barriers and stigma, experts estimate that only 50% of women with perinatal or postpartum depression are properly diagnosed.[36]

Psychotherapy may be used as a treatment method for perinatal and postpartum depression. Psychotherapy offers benefits such as social support, interpersonal relations, the opportunity to build positive bonding and parenting skills, and does not carry the potential risks that medications do. However, for serious cases of depression, psychotherapy may not be enough.

> **"Identifying and treating maternal depression leads to improvements in productivity and hard dollar costs."**
>
> Mary Beth Chalk
> COO, Resources for Living

Treating depression in a woman trying to conceive, a pregnant woman or a breastfeeding woman can be complicated. The most effective treatment for depression is psychotherapy paired with prescription antidepressant use. However, because prescription medications cross the placenta and may harm the fetus, there are concerns about using antidepressants during pregnancy, especially during the first trimester (the first 12 weeks of pregnancy). Research on the safety of antidepressant use during pregnancy is limited. However, information from hospital registries, pharmaceutical companies and others has shown that prescription antidepressants do not cause fetal abnormalities or pregnancy complications. Due to the limited information available, most physicians use caution when prescribing antidepressants to pregnant women or women trying to conceive.

### *Recommendations for treatment while a woman is trying to conceive*

- Women who have suffered only one episode of depression in the past and have been feeling well for the previous six months can usually 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. It is also recommended that they begin or continue psychotherapy to reduce the risk of another episode.[37]
- Women who have suffered one or more previous episodes of severe depression should continue taking their medication at the full dose. Women using a medication for which there is limited safety information available

(usually the newer types of antidepressants) should switch to a medication thought to be safer.[38] 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) that the dosage is correct and 3) that 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, experts recommend that she begin medication.[39]

### Treatment during pregnancy

Fetal organ development occurs during the first trimester of pregnancy. Some medications can interfere with this development and cause serious malformations that can result in miscarriage or birth defects. There is less concern about medication use in the second and third trimesters of pregnancy, since the fetus' organs are already formed and there is less risk for malformations. However, medication use still carries the risk of miscarriage or developmental problems and should thus be considered carefully.

- 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 on antidepressants who experience an unplanned pregnancy are advised to taper off their medications if their symptoms are mild and if they have had only one previous episode of depression.
- Women advised to continue their medication, due to a prior history of recurrent and severe depression, are advised to switch to a safer medication if there is little information on their current medication.
- If there has been reason to use medication in the first trimester, medication should be continued.
- 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.[40]

*Note: Because all mediations, 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 regiment.*

### *Antidepressant Medications*

Selective serotonin reuptake inhibitors (SSRI's) are the most widely prescribed antidepressant in the United States. 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 to use fluoxentine (Prozac), sertraline (Zoloft) and paroxetine (Paxil) in pregnant women. These medications were introduced earlier, thus clinicians have more experience with them and have documented their efficacy and safety in pregnant women. Tricyclic antidepressants are also used to treat depression in women. While they have not been shown to increase the rate of birth defects or otherwise harm fetuses, many doctors are wary of prescribing them due to lack of experience with the medication and a lack of scientific research supporting their safety.[40] New research suggests that hormonal supplement medications may also be effective in treating postpartum depression.

Experts recommend that women suffering from postpartum psychosis combine antidepressant medication with antipsychotic medications. Electroconvulsive therapy, a treatment that uses a small electric shock to produce a seizure that "resets" brain chemistry, is considered safe to use during and after pregnancy.[41] Electroconvulsive therapy is an effective treatment for some severe cases of depression, mania or psychotic episodes. Psychotherapy can be used to alleviate symptoms and help a woman adjust to her new role as a mother. However, given the serious nature of postpartum psychosis, experts recommend against psychotherapy as a sole method of treatment.[42]

Because of the high relapse rate and the significant harms associated with untreated postpartum depression, experts recommend that women with a history of severe depression or a history of postpartum depression take antidepressants as a preventive measure.[43] Depending on a woman's risk factors, she may begin antidepressant therapy in the last trimester of pregnancy or in the first week after birth.

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.[44]

Medications of all types are excreted in the breast milk of lactating mothers. However, there is no evidence that antidepressants transmitted through breast milk pose a threat to infants or children.[45]

## Prevention and Screening

Strategies for preventing first-time onset of perinatal or postpartum depression have not been well documented. While risk factors for depression have been established, it remains difficult to predict which women will be most at risk for depression and therefore difficult to determine what interventions are indicated. Because prevention appears to be a difficult task, the early identification of women suffering from depression and early initiation of treatment are essential.

For women who have experienced one or more bouts of depression, preventing a relapse is particularly important. Recent research has shown that antidepressant therapy begun in the last trimester of pregnancy can prevent recurrent postpartum depression in most women.[46]

Treatment for maternal depression is effective. As described above, both pharmacological and talk therapy treatments can be successful in treating maternal depression. However, experts estimate that 50% of women with maternal depression are undetected and if detected are under-treated.[47]

**The Unites States Preventive Service Task Force (USPSTF) recommends that physicians screen all adults, including pregnant and postpartum women for depression.**

### *Screening for Depression*

Screening pregnant and postpartum women for depression during routine prenatal and postpartum 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 the opportunity to identify women suffering from maternal depression.

OB/GYN's report that they screen for depression in pregnant women only 23–45% of the time. Reasons for their low screening rate include lack of time to screen patients (72%), lack of reimbursement (48%) and stigma associated with the diagnosis of depression (45%).[48] Family physicians and general practioners, who also provide care for pregnant and postpartum women, have similarly low rates of screening.

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 healthcare system. Experts recommend that physicians of all types screen pregnant and new mothers for depression as appropriate.

## What Employers Can Do to Address Maternal Depression

### *Provide Support Services for Mothers, Children and Partners*

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.[49] 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:

***Health Plan Design Recommendations***

- Ensure that health plans are encouraging their providers to screen for and treat maternal depression.
- Remove barriers that prevent physicians from counseling and treating women for maternal depression.
    - Incorporate maternal depression screening in well-baby and well-child visits.
    - Ask your health plan to alert pediatricians, family physicians, OB/GYNs, nurse practioners, and other providers who care for pregnant and postpartum women to its mental health care referral policy.
    - Ask your health plan to provide information on maternal depression to expectant mothers including information on where to go for depression care.
    - If your health plan offers depression disease management programs, consider creating a specialized program within for women with maternal depression.
    - 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 assess — in the home — a new mother's risk of depression and refer a new mother to medical or mental health care if necessary.

***Health Promotion/Wellness Program Design Recommendations***

Isolation can exacerbate symptoms of depression. Educational materials can help women understand and be better prepared for the many hormonal, body and role changes that occur with pregnancy and childbirth.

- Use your existing prenatal program to alert women to maternal depression. For example, distribute material on maternal depression in the prenatal program enrollment pack, offer prenatal education and support classes for pregnant women and their partners, and encourage pregnant women to ask their physicians about prenatal depression during prenatal visits.
- Offer positive parenting classes for expectant or new parents.
- Support a community peer education or support group for new mothers by offering space in your facility.

**"Increasingly, employers are systematically addressing depression through disease management programs or maternal and postpartum depression support programs."**

Mary Beth Chalk
COO, Resources for Living

### Employee Assistance Program (EAP) Design 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.

***For Pregnant Women and New Mothers***

Outreach to expectant and new mothers can help reduce their isolation: many new mothers, especially young mothers, mothers in rural areas and mothers living in poverty face isolation. This can exacerbate symptoms of depression.

- Provide EAP counselors with 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 EAP for assistance.

***For Fathers and Partners***
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 support and information on depression. EAP services can be a valuable resource for fathers/partners.

***For Children***
Children of depressed mothers may be helped by high-quality infant/toddler care by caregivers who can give special attention to their developmental needs. If a child's social or emotional development has been compromised by maternal depression, s/he may need the opportunity to develop stable relationships with caregivers who are able to express the full range of emotion. This will allow them to experience a full range of affect, to have their own behaviors and cues responded to consistently and to develop healthy interaction skills. Caregivers could include a father or partner, grandparent or other relative or a childcare professional.

- If your company offers an onsite daycare, train your providers on the importance of positive interaction with infants.
- Train your EAP counselors to work with families affected by maternal depression. To be helpful in the treatment process, fathers and older siblings need information and support.

> **"We acknowledge depression as a part of life and position it as an issue that is important to us all.."**
>
> Sheryl Niebuhr, PhD LP
> 3M

## Model Program: Case Study

The 3M Corporation is a national leader in disease management and health promotion programs. Like many companies they are concerned with rising healthcare and disability service costs. To promote the health of their employees and stabilize costs they offer a range of disease management programs and health promotion programs to their employees.

To assist women and other employees with maternal depression, they offer a variety of education programs aimed at bolstering employees' coping skills and resiliency, work and life management skills and personal health management knowledge. These workshops and other offerings feature information and resources on work (e.g. dealing with a conflict with a co-worker), personal life (e.g. bereavement, chronic illness) and family (e.g. parenting, care-giving). The resiliency programs also cover more general topics such as responding to life's disruptions and managing transition. 3M offers a complimentary program for managers and supervisors on how to recognize troubled employees and respond to their needs effectively.

The workshops are supplemented with education materials adapted from the National Institute for Mental Health and other resources.  When not otherwise available, 3M also develops its own resources such as the 3M Family Resiliency Kit, the 3M Coping Kit and various healthcare consumerism resources. Educational and informational offerings also routinely alert employees to 3M's various help lines, Employee Assistance and work/like services, maternity program and behavioral health care benefits available to employees.

3M also offers a "Living with Depression" education program comprised of a series of "lunch and learn" education and support programs and web-stream presentations. These programs educate, inform and support employees suffering from depression. They serve to normalize the disease, debunk misunderstandings about the causes of depression, promote early intervention and cultivate support in the workplace for people suffering from depression.

EAP professionals are available to assist individuals adjusting to living and working with a depression or other serious medical disorder, address behavioral health clinical care gaps or other treatment concerns, coach individuals in making informed care decisions and link them with providers who fit their needs. Help line and disease management health coaches, disability managers, and occupational health nurses also link employees to EAP when employees experience psychosocial stressors that may complicate or compromise their health and functioning. EAP professionals are integrated into the return to work process for employees returning from an episode of disability or family/medical leave to help employees and their supervisors address work concerns.[50]

## Summary

Maternal depression is a common, serious and treatable disorder. Employers can help prevent and treat maternal depression by offering medical, behavioral health and support services to women at risk of 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 early.

The benefits of prevention and early treatment are manifold. Women benefit by regaining their functional status, avoiding medical complications and better attaching to their baby. Infants and children benefit by regaining a full relationship with their mother and thereby improving their emotional, cognitive and behavioral development. Employers benefit by reducing their medical costs by preventing costly complications, and reducing lost work time and disability costs associated with depressed employees.


## Resources

✓ The National Women's Health Information Center, Department of Health and Human Services — http://www.4woman.gov/faq/postpartum.htm

✓ Depression After Delivery — http://www.depressionafterdelivery.com

✓ The National Business Group on Health

- *"Preventing, Identifying, and Treating Maternal Depression: Tools for Employers"* http://www.businessgrouphealth.org/prevention/webinar011305.cfm
- Improving Health. Improving Business: An Employer's Guide to Preventive Services: http://www.businessgrouphealth.org/services/depression.cfm

✓ To find a postpartum depression support group in your state search the Postpartum Support International website database at http://home.earthlink.net/%7ethonikman/SOCIAL_SUPPORT_NETWORK.htm

✓ For immediate support or assistance call the National Postpartum Depression Hotline **1-800-PPD-MOMS (773-6667)**.

## Citations

1 Greenburg PE. Kessler RC. Birnbaum HG. Leong SA. Lowe SW. Berglund PA. Correy-Lisle PK (2003). The economic burden of depression in the United States: How did it change between 1990 and 2000? The Journal of Clinical Psychiatry. 64(12); 465-1475.

2 Murray C J. Lopez AD. (1996) The Global Burden of Disease. Cambridge MA: Harvard School of Public Health.

3 Kahn DA. Moline ML. Ross RW. Cohen LS. Altshuler LL (2001). Major depression during contraception and pregnancy: A guide for patients and families. Treatment of Depression in Women: Expert Consensus Guideline Series. A Postgraduate Medicine Special Report. 110-111.

4 Bernard-Bonnin AC. Burrows K. Ford-Jones A. Fortin G. Longstaffe S. Prince T. Shea S (2004). *Position statement: Maternal depression and child development.* Psychosocial Paediatrics Committee. Canadian Paediatric Society. Paediatrics & Child Health. 9(8); 575-583.

5 Gaynes B. Gavin N. Meltzer-Brody S. Sleath B. Sutton S (2003). Perinatal depression: feasibility study. RTI-UNC EPC. Evidence Report / Technology Assessment. Agency for Healthcare Research and Quality. Publication No. 290-02-0016

6 Bernard-Bonnin AC. Burrows K. Ford-Jones A. Fortin G. Longstaffe S. Prince T. Shea S (2004). *Position statement: Maternal depression and child development.* Psychosocial Paediatrics Committee. Canadian Paediatric Society. Paediatrics & Child Health. 9(8); 575-583.

7 Doskoch P.(2001). Which is more toxic to a fetus — antidepressants or maternal depression? NeuroPsychiatry Reviews. 2(5).Kahn et al, 2001).

8 Diagnostic Statistical Manual IV (DSM-IV-TR) 2000. American Psychiatric Association.

9 Clark R. Fenichel E (2001). *Mother, Babies, and Depression: Questions and Answers. Zero to Three.* August/September.

10 Marcus C. Flynn H. Blow FC, Barry K. (2003). Journal of Women's Health. 12 (4).

11 Pregnancy Risk-assessment Monitoring Survey (2000). Centers for Disease Control and Prevention.

12 Clark R. Fenichel E (2001). *Mother, Babies, and Depression: Questions and Answers. Zero to Three.* August/September.

13 Clark R. Fenichel E (2001). *Mother, Babies, and Depression: Questions and Answers. Zero to Three.* August/September.

14 Bernard-Bonnin AC. Burrows K. Ford-Jones A. Fortin G. Longstaffe S. Prince T. Shea S (2004). *Position statement: Maternal depression and child development.* Psychosocial Paediatrics Committee. Canadian Paediatric Society. Paediatrics & Child Health. 9(8); 575-583.

15 ibid

16 ibid

17 ibid

18 Olson AL. Kemper KL. Kelleher KJ. Hammond CS, Zuckerman BS. Dietrich AJ. (2002). Primary care pediatricians' roles and perceived responsibilities in the identification and management of maternal depression. Pediatrics. 110:1169-1176.

19 Doskoch P.(2001). Which is more toxic to a fetus — antidepressants or maternal depression? NeuroPsychiatry Reviews. 2(5).

20 Bernard-Bonnin AC. Burrows K. Ford-Jones A. Fortin G. Longstaffe S. Prince T. Shea S (2004). *Position statement: Maternal depression and child development.* Psychosocial Paediatrics Committee. Canadian Paediatric Society. Paediatrics & Child Health. 9(8); 575-583.

21 ibid

22 Olson AL. Kemper KL. Kelleher KJ. Hammond CS, Zuckerman BS. Dietrich AJ. (2002). Primary care pediatricians' roles and perceived responsibilities in the identification and management of maternal depression. Pediatrics. 110:1169-1176.

23 Mazure CM. Keita GP. Blehar MC (2002). *Summit on women and depression: Proceedings and recommendations.* Washington, DC: American Psychological Association.

24 Mazure CM. Keita GP. Blehar MC (2002). *Summit on women and depression: Proceedings and recommendations.* Washington, DC: American Psychological Association.

25 Bernard-Bonnin AC. Burrows K. Ford-Jones A. Fortin G. Longstaffe S. Prince T. Shea S (2004). *Position statement: Maternal depression and child development.* Psychosocial Paediatrics Committee. Canadian Paediatric Society. Paediatrics & Child Health. 9(8); 575-583.

26 Mazure CM. Keita GP. Blehar MC (2002). *Summit on women and depression: Proceedings and recommendations.* Washington, DC: American Psychological Association.

27 Bernard-Bonnin AC. Burrows K. Ford-Jones A. Fortin G. Longstaffe S. Prince T. Shea S (2004). *Position statement: Maternal depression and child development.* Psychosocial Paediatrics Committee. Canadian Paediatric Society. Paediatrics & Child Health. 9(8); 575-583.

28 Greenburg PE. Kessler RC. Birnbaum HG. Leong SA. Lowe SW. Berglund PA. Correy-Lisle PK (2003). The economic burden of depression in the United States: How did it change between 1990 and 2000? The Journal of Clinical Psychiatry. 64(12); 465-1475.

29 Birnbaum HG. Leong SA. Greenberg PE (2003) The economics of women and depression: an employer's perspective. The Journal of Affective Disorders. 74; 15-22.

30 Olson AL. Kemper KL. Kelleher KJ. Hammond CS, Zuckerman BS. Dietrich AJ. (2002). Primary care pediatricians' roles and perceived responsibilities in the identification and management of maternal depression. Pediatrics. 110:1169-1176. Bartlett SJ. Kolonder K. Butz AM. Eggleston P. Malveaux FJ. Rand CS (2001). Maternal depressive symptoms and emergency department use among inner-city children with asthma. Archives of Pediatric Medicine. 155; 347-353.

31 Murray, C J. Lopez A.D (1996). The Global Burden of Disease. Cambridge MA: Harvard School of Public Health.

32 Mazure CM. Keita GP. Blehar MC (2002). *Summit on women and depression: Proceedings and recommendations.* Washington, DC: American Psychological Association.

33 ibid

34 Leopold RS (2003). A Year in the Life of a Million American Workers. Metlife Group Disability. New York, New York; Metlife Group Disability.

35 ibid

36 Clay EC. Seehusen DA. (2004). A review of postpartum depression for the primary care physicians. Southern Medical Journal. 97(2); 157-161.

37 Kahn DA. Moline ML. Ross RW. Cohen LS. Altshuler LL (2001). Major depression during contraception and pregnancy: A guide for patients and families. Treatment of Depression in Women: Expert Consensus Guideline Series. A Postgraduate Medicine Special Report. 110-111.

38 ibid

39 ibid

40 ibid

41 MedlinePlus.(2004). National Institutes of Health. Medical Encyclopedia. Electroconvulsive therapy. http://www.nlm.nih.gov/medlineplus/ency/article/003324.htm. Accessed 1-30-05.

42 Kahn DA. Moline ML. Ross RW. Cohen LS. Altshuler LL (2001). Major depression during contraception and pregnancy: A guide for patients and families. Treatment of Depression in Women: Expert Consensus Guideline Series. A Postgraduate Medicine Special Report. 110-111.

43 Doskoch P.(2001). Which is more toxic to a fetus — antidepressants or maternal depression? NeuroPsychiatry Reviews. 2(5).

44 ibid

45 ibid

46 Wisner KL, Perel JM, Peindl KS, Hanusa BH, Piontek CM, Findling RL.(2004). Prevention of postpartum depression: a pilot randomized clinical trial. American Journal of Psychiatry, 161(7); 1290-2.

47 Chalk MB. (2005). *Preventing, identifying, and treating maternal depression: Tools for employers.* Invited presenter. National Business Group on Health. Washington, DC: January 13, 2005.

48 Chalk MB. (2005). *Preventing, identifying, and treating maternal depression: Tools for employers.* Invited presenter. National Business Group on Health. Washington, DC: January 13, 2005.

49 Olson AL. Kemper KL. Kelleher KJ. Hammond CS, Zuckerman BS. Dietrich AJ. (2002). Primary care pediatricians' roles and perceived responsibilities in the identification and management of maternal depression. Pediatrics. 110:1169-1176.

50 Niebuhr S (2005). Personal communication. 2-11-05.

Textbox "Sadfaces": Yonkers K (2004). Presentation to the Secretary's Advisory Committee on Infant Mortality. Washington, DC November 11-13, 2004.

Center for Prevention and Health Services

ISSUE **Brief**

March 2005

# Preventing, Identifying and Treating Maternal Depression: *Tools for Employers*

## Acknowledgment

This issue brief was based, in part, on material presented during The National Business Group on Health's webinar: *"Preventing, Identifying and Treating Maternal Depression: Tools for Employers."* The Center for Prevention and Health Services would like to thank webinar presenters, Susan Meikle MD, MPH, Medical Officer, Agency for Healthcare Research and Quality (AHRQ), Mary Beth Chalk, Chief Operating Officer, Resources for Living, Sheryl Niebuhr PhD, LP, Manager of Total Health & Productivity, 3M Corporation, and Karen Hench RN, MSN, Program Director, Healthy Start and Perinatal Services, The Maternal and Child Health Bureau (MCHB), Health Resources and Services Administration (HRSA). We also thank the Maternal and Child Health Bureau (MCHB) for their generous funding.

The *"Preventing, Identifying and Treating Maternal Depression: Tools for Employers"* Webinar presentation can be accessed at: http://www.businessgrouphealth.org/prevention/webinar011305.cfm.

This issue brief was written by Kathryn Phillips, MPH, Program Analyst in the Center for Prevention and Health Services at the National Business Group on Health.

## About the Center for Prevention and Health Services (CPHS)

The Center houses the Business Group's projects and resources that relate to the delivery of preventive and other health services through employer-sponsored health plans and worksite programs. Through the Center, employers can find practical toolkits to address preventive health and health promotion issues at the worksite. Employers will find current information and recommendations from federal agencies and professional associations, model programs from other employers, and the latest clinical and health services research results. In addition, the Center provides opportunities for employer participation in teleconferences and in-person solutions workshops. Currently, the Center has initiatives in racial and ethnic disparities in health and health care, terrorism and public health emergency preparedness, maternal and child health, preventive services, health services research and quality, health and work performance, benefit design, and wellness programs.

For more information, visit http://www.businessgrouphealth.org/prevention/index.cfm
or contact Kathryn Phillips at phillips@businessgrouphealth.org.

## About the National Business Group on Health

The National Business Group on Health, formerly the Washington Business Group on Health, is the national voice of large employers dedicated to finding innovative and forward-thinking solutions to the nation's most important health care issues. The Business Group represents over 200 members, primarily Fortune 500 companies and large public sector employers, who provide health coverage for approximately 50 million U.S. workers, retirees, and their families. The Business Group fosters the development of a quality health care delivery system and treatments based on scientific evidence of effectiveness. The Business Group works with other organizations to promote patient safety and expand the use of technology assessment to ensure access to superior new technology and the elimination of ineffective technology.

Helen Darling, President

National Business Group on Health

50 F Street NW, Suite 600 • Washington DC 20001

Phone (202) 628-9320 • Fax (202) 628-9244 • www.businessgrouphealth.org