Maternal and Child Health
Issue Brief

July 2014 № 6

Mental Health Among Women of Reproductive Age in Colorado

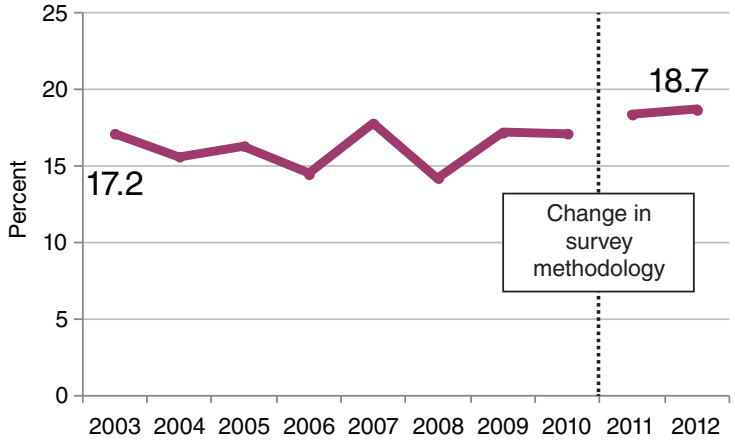
Depression Symptoms: A low or sad mood — loss of interest in fun activities — changes in eating, sleep, and energy —problems in thinking and making decisions — feelings of worthlessness, shame, or guilt — thoughts that life is not worth living — many symptoms occurring together and lasting more than a week or two.[6]

Why is women's mental health a concern?

Poor mental health, such as depression and anxiety, can diminish a woman's quality of life, work productivity and physical health, as well as have a negative impact on pregnancy.[1-3] Pregnancy-related depression (PRD) among women of reproductive age (ages 15-44) is a mood disorder that occurs during pregnancy or up to one year after giving birth or experiencing pregnancy loss.[4] Children of depressed mothers are more likely to display social and emotional problems, delays or impairments; poor self-control; aggression; poor peer relationships; and difficulty in school.[4]

More than one in every 10 (10.5 percent) Colorado women who gave birth between 2009 and 2011 experienced postpartum depressive symptoms (PDS) since their new baby was born.[5] This makes depression the most common complication of pregnancy.[4]

Figure 1. Percent of Colorado women ages 18-44 reporting 8 or more days of poor mental health in past 30 days, 2003-2012.[7]



What is the prevalence of poor mental health?

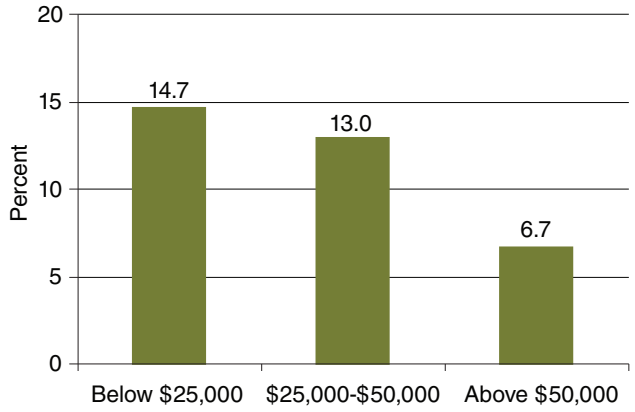
Since 2003, the number of Colorado women reporting poor mental health (stress, depression, and anxiety) has not improved (Figure 1).[7] In 2012, nearly 1 in every 5 (18.7 percent) Colorado women of reproductive age experienced 8 or more days of poor mental health in the past 30 days.[7]

Depression and anxiety often occur together. In 2012, 10.4 percent of Colorado women of reproductive age were currently depressed, and 43.9 percent ever diagnosed with a depressive disorder had also been diagnosed with an anxiety disorder.[7] Overall, 18.9 percent of women of reproductive age in Colorado reported an anxiety disorder diagnosis.[7]

Colorado's Goal:
By 2020, increase to 80 percent the number of mothers who report a healthcare provider talked to them about what to do if they felt depressed during pregnancy.

Social and economic health disparities

Figure 2. Current depression by income (ages 18-44).

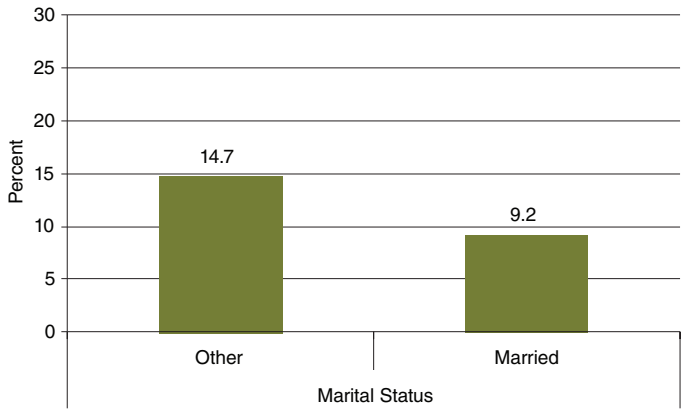


In 2012, 1 in 7 (14.7 percent) women ages 18-44 in Colorado with household incomes below $25,000 were identified as currently depressed, significantly different from the 1 in 15 (6.7 percent) with incomes greater than $50,000.[7]

Women who experience low social support and/or stress from social, economic, or structural inequality may be more likely to be depressed.[1,8]

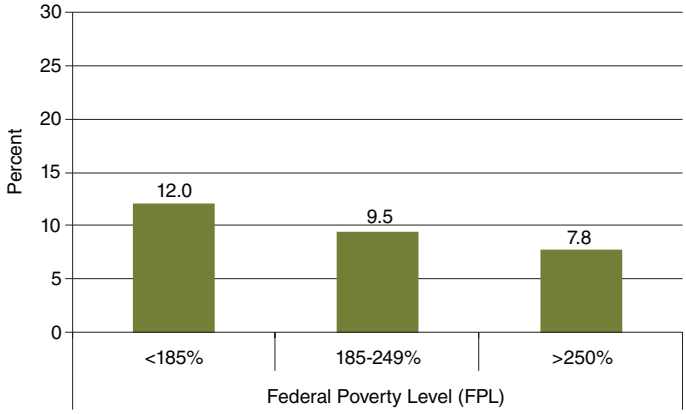
Depression is more common among low-income women ages 18-44 and among poor and non-married mothers.

Figure 3. Postpartum depressive symptoms (PDS) by marital status (ages 15-44).



In 2009-2011, 1 in 7 (14.7 percent) mothers who were not married experienced a significantly higher rate of PDS than mothers who were married.[5]

Figure 4. Postpartum depressive symptoms (PDS) by poverty status (ages 15-44).



In 2009-2011, mothers whose incomes were below 185% of the federal poverty level (FPL) experienced a significantly higher rate of PDS than mothers above 250% of the FPL.[5]

What contributes to poor mental health among women?

The experience of poor mental health among women is influenced by many factors including gender, social and cultural norms, life experiences, and social support.[2,9] Stigma and fear associated with mental illness and gender socialization affect differences in care-seeking and, ultimately, diagnosis and treatment.[10]

Many women may not realize their risks for depression or know that the feelings they experience are symptoms of depression. In a 1996 National Mental Health Association survey, more than half of female respondents perceived the experience of depression to be a "normal part of aging."[11]

In 2012, 42.9 percent of Colorado women ages 18-44 who were currently depressed had never been told by a health professional that they had a depressive disorder.[7]

Heredity and trauma, in addition to other factors and experiences, protect a woman or put her at risk for developing an anxiety disorder.[12] In 2012, an estimated 25.4 percent of divorced, separated, or widowed women and 26.1 percent of women with annual household incomes less than $25,000 experienced higher rates of anxiety than the 18.4 percent of married women or the 15.4 percent of women with incomes of $50,000 or more.[7]

Pregnancy related depression (PRD) occurs while a woman is pregnant or within one year of delivery or miscarriage.

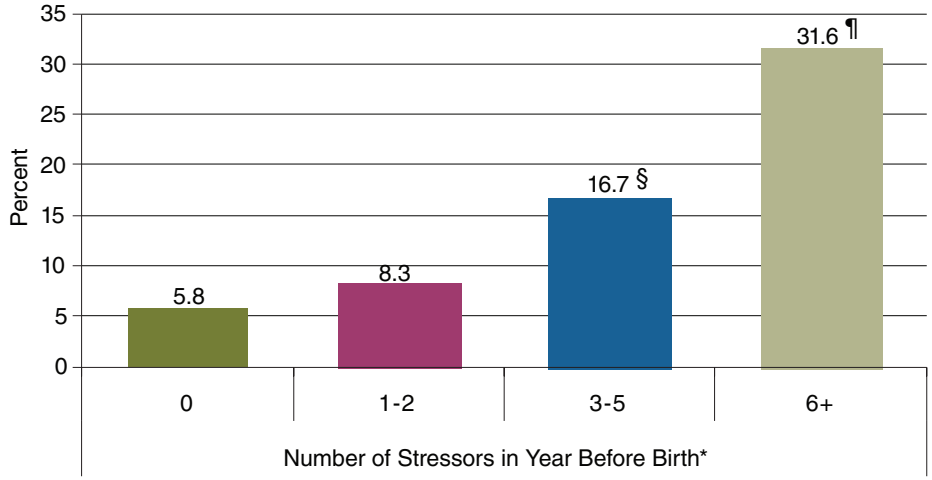
Postpartum Depressive Symptoms (PDS) occur after a delivery or miscarriage.

What risk and protective factors influence pregnancy-related depression?

The most significant biological predictors for both depression and pregnancy-related depression are personal or family history of major or postpartum depression.[13] Other biological indicators, environmental conditions, behaviors that occur together (such as eating habits or smoking), or situational stressors like pregnancy intention or infant health, can protect women or put them at risk for developing PRD or PDS.[13]

The prevalence of PDS was significantly higher among women who experienced six or more stressors in the year before birth (Figure 5) than among women with fewer stressors. Rates were higher among women who experienced unintended pregnancy, who were checked or treated for depression prior to pregnancy or who gave birth to low-birth weight infants.[5] In addition, the prevalence of PDS was significantly higher among women experiencing unique stressors such as a partner who did not want the pregnancy, who had more frequent arguments with a partner, or who were homeless.[5]

Figure 5. Prevalence of mothers with postpartum depressive symptoms (PDS) by number of stressors, women 15-44, Colorado residents, 2009-2011.[5]



*Partner-related, emotional, traumatic, and financial stresses.[5]
§ Significantly higher than those with 0, 1-2 stressors.
¶ Significantly higher than those with 0, 1-2, or 3-5 stressors.

What can prevent poor mental health among women?

Reducing stress and its causes, increasing social and health services support, and improving resiliency can protect women from developing mental health disorders.[1,2,9] Regular screening and education can increase awareness and identification of PRD and PDS, and increase the number of women receiving treatment.[13] In 2011, 76.6 percent of Colorado mothers reported that a health care provider talked to them about what to do if they felt depressed during pregnancy or after delivery.[5] Colorado's goal is to increase the percentage to 80 by 2020.

How can women receive the care they need?

Preventing and treating mental health disorders can help women and their families lead happy, healthy lives. However, treatment can be limited by social and structural barriers like misinformation and access to services.[3,10,11] Fifty-five of Colorado's 64 counties are designated as Mental Health Professional Shortage Areas (HPSAs); 48 counties are designated due to geographic isolation or lack of sufficient providers, and 7 are designated due to high populations of low-income residents.[14]

Increasing access to mental health services for Colorado women and their families can be accomplished through screening at health care visits and appropriate follow-up and referral, the implementation of the Affordable Care Act, and the expansion and integration of services by mental health centers, safety-net clinics, and other primary care clinics.[15,16]

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This project was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number H18MC00006, State Systems Development Iniative (SSDI) for $91,045. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

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