PREGNANCY-RELATED DEPRESSION AND ANXIETY IN COLORADO

Why pregnancy-related depression and anxiety are problems

Pregnancy-related depression and anxiety are mood disorders that occur during pregnancy or up to one year after giving birth or experiencing pregnancy loss. Postpartum depressive symptoms appear similar but are distinct from the “baby blues” which is more common, milder, and lasts only a few weeks.\(^1,2\) Pregnancy-related depression and anxiety are the most common complications of pregnancy. However, they are the most underdiagnosed obstetric complications in America with more than 75 percent of new mothers remaining untreated.\(^3,4,5,6\)

If untreated, depression and anxiety can have long-lasting impacts on the health and well-being of mothers and children. Depression and anxiety are associated with problematic safety practices in mothers and negative mother-child interactions.\(^7\) Children born to mothers with pregnancy-related depression and anxiety have an increased risk of health concerns and long-term emotional, behavioral, and cognitive problems.\(^1,7\) Untreated depression and anxiety can have lasting impacts. However, with the help of supportive environments, the effects of pregnancy-related depression and anxiety can be reduced.

Nearly 1 in 10 (9.6 percent) women who had a recent live birth between 2012 and 2014 in Colorado reported experience of postpartum depressive symptoms since their new baby was born (Figure 1).\(^8\) This estimate likely underreports the number of women suffering from postpartum depression in Colorado, falling short of national estimates of roughly 1 in 7.\(^9\)

Figure 1. Percent of Colorado women who self-reported experience of postpartum depressive symptoms, 2004-2008 and 2012-2014.\(^8\)
Social and economic health disparities

Figure 2. Percent of Colorado women who self-reported experience of postpartum depressive symptoms, by maternal age, 2012-2014.\textsuperscript{8}

Among women giving birth between 2012 and 2014, 19.2 percent (95% CI: 11.3-27.1) of those ages 15-19 reported experience of postpartum depressive symptoms, significantly higher than the 7.7 percent (95% CI: 6.3-9.2) of women ages 25-34 (Figure 2).\textsuperscript{8}

All women, irrespective of age, race, and income, are at risk of pregnancy-related depression and anxiety; however, younger and low-income Colorado women report even higher rates of postpartum depressive symptoms than their older, higher-income counterparts.

Figure 3. Percent of Colorado women who self-reported experience of postpartum depressive symptoms, by race/ethnicity, 2012-2014.\textsuperscript{8}

In 2012-2014, report of postpartum depressive symptoms was highest among Black, non-Hispanic women; however, no statistically significant differences were found by race/ethnicity (Figure 3).\textsuperscript{8}

Figure 4. Percent of Colorado women who self-reported experience of postpartum depressive symptoms, by prenatal care insurance type, 2012-2014.\textsuperscript{8}

In 2012-2014, 14.0 percent (95% CI: 11.6-16.3) of women enrolled in Medicaid, Child Health Plan Plus (CHP+), or Colorado Indigent Care Program (CICP) during prenatal care reported experiencing postpartum depressive symptoms, significantly higher than the 6.6 percent (95% CI: 5.2-8.0) of privately insured women (Figure 4).\textsuperscript{8}
Among Colorado women in 2012-2014...

- 34.3% of women who experienced interpersonal violence during the 12 months before delivery
- 28.8% of women who experienced food insecurity during the 12 months before delivery
- 18.5% of women who had trouble paying rent, mortgage, or bills during the 12 months before delivery
- 15.6% of women who were very close to someone who had problems with drinking or drugs during the 12 months before delivery

...also experienced postpartum depressive symptoms.8

Risk factors for pregnancy-related depression and its impact on women

Similar to general depression, pregnancy-related depression and anxiety are caused by a combination of biological, psychosocial, and environmental factors. Strong predictors of postpartum depressive symptoms include a personal or family history of mood or anxiety disorders, sensitivity to hormonal changes, life stress, and poor social support.2 Pregnancy and birth complications and infant health issues are also associated with depression and anxiety.1

Life stress before and during pregnancy, such as losing a job, arguing with a husband or partner more than usual, homelessness, or having a close family member hospitalized, appears to have a cumulative effect on a woman’s increased risk for pregnancy-related depression and anxiety. In 2012-2014, the prevalence of postpartum depressive symptoms was significantly higher among women who experienced six or more stressors8 in the year before birth (23.7 percent, 95% CI: 16.6-30.9) compared to those who experienced no stressors (5.0 percent, 95% CI: 3.2-6.7) and 1-2 stressors (7.5 percent, 95% CI: 5.9-9.1) (Figure 5).8

Stressors that can increase a woman’s risk for developing depression and anxiety are not always visible or obvious. Among women who experienced intimate partner violence during the 12 months before delivery and among those who experienced food insecurity during the 12 months before delivery, 34.3 percent and 28.8 percent also experienced postpartum depressive symptoms, respectively.8

Women with untreated depression and anxiety during pregnancy not only have an increased risk for social isolation and future mood disorders, but are also more likely to retain excess gestational weight than women without untreated pregnancy-related depression and anxiety.10,11 Women with postpartum depressive symptoms are also less likely to attend well-child visits, complete immunizations, and place children in recommended sleeping positions.1

Figure 5. Percent of Colorado women who self-reported experience of postpartum depressive symptoms, by number of stressors* experienced during the 12 months before birth, 2012-2014.8

You can’t tell by looking. Life stressors, important risk factors of pregnancy-related depression and anxiety, are oftentimes not apparent. Healthcare providers are often unaware of life stressors women may be experiencing, underscoring the need to screen all women for pregnancy-related depression and anxiety.
Getting women the help they need

Additionally, untreated depression and anxiety are major contributors to maternal mortality. Approximately one-third (30 percent; n=63) of pregnancy-associated deaths occurring in Colorado between 2004 and 2013 were attributed to self-harm through accidental overdose or suicide, reiterating the need to address a woman’s mental health during the pregnancy and postpartum time periods. Regular screening and education can increase awareness and identification of pregnancy-related depression and anxiety and increase the number of women receiving treatment. However, not all women are screened or know what to do if they experience symptoms of depression or anxiety. Likewise, their family members and/or friends may not recognize symptoms or know how to help connect them with available resources to address their depression or anxiety.

Many women do not seek care or report their symptoms of depression and anxiety. In one study fewer than 20 percent of women diagnosed with postpartum depression reported their symptoms to a health care provider. Stigma surrounding mental health as well as financial and logistical challenges create barriers to women seeking and receiving treatment. In 2015, 13.3 percent of Colorado women of reproductive age reported that during the past 12 months they did not get needed counseling health services, with 60.2 percent of these women reporting they were concerned about the cost of treatment and 35.4 percent concerned about what would happen if someone found out they had a problem.

The American Congress of Obstetricians and Gynecologists recommends that all women receive at least one screening for depression and anxiety symptoms during the perinatal period, and the American Academy of Pediatrics also recommends additional screening during the 1-, 2-, 4-, and 6-month well-child visits. In 2016, healthcare providers submitted claims for Medicaid reimbursement for a depression screen for 21.6 percent of all pregnant beneficiaries, up from 16.1 percent in 2015. Though screening is not yet universal in Colorado, 77.6 percent (95% CI: 74.8-80.4) of women reported that a health care provider talked to them about what to do if they felt depressed during pregnancy or after delivery in 2014, up from 72.6 percent (95% CI: 69.8-75.4) in 2009 (Figure 6). By 2020, Colorado aims to increase to 85.8 percent the number of women who report a health care provider discussed depression during prenatal care. Preventing and treating pregnancy-related depression and anxiety can help Colorado women and families lead happier, healthier lives.

The Colorado Department of Public Health and Environment acknowledges that social, economic and environmental inequities result in adverse health outcomes and have a greater impact than individual choices. Reducing health disparities through systems change can help improve opportunities for all Coloradans and have an important impact on population health measures.
References


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