Lieutenant Governor’s Task Force on Women and Depression in Wisconsin Report
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Report of the Task Force on Women and Depression in Wisconsin

Office of the Lieutenant Governor
State of Wisconsin

May 2006

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Executive Summary

The Lieutenant Governor’s special initiative, *Wisconsin Women = Prosperity*, is a statewide, broad-based project to improve the lives and economic prospects of women in Wisconsin. Recognizing that depression and mental health are key factors in overall workforce productivity and quality of life, that there are substantial costs to untreated depression, and that there are significant gender differences in depression, a Task Force on Women and Depression in Wisconsin was convened in 2005. Based on national and statewide research, evidence-based practice, and the experience of clinicians regarding the needs of women and girls in Wisconsin who are experiencing depression, the following factors emerge as key in understanding the causes and effects of depression and the implications for public policy:

**Frequency, Causes, and Risk Factors**

- **Twice as many women are depressed than men nationwide.** This 2:1 ratio is found in most other nations and is found specifically in Wisconsin.

- **Untreated depression causes great suffering to women and girls.** It can impede their progress in education and employment and moreover, have ripple effects in the family and workplace.

- **Biological factors contribute to depression in women.** These biological influences include genetic predispositions, stress hormones, and sex hormone changes (estrogen, progesterone, testosterone) that are related to puberty and that are influential at other times as well (e.g., premenstrually, postpartum, and during the perimenopause).

- **Environmental factors play a major role in triggering depression.** Many of these factors occur more frequently among girls and women, including exposure to parental depression; socialization to passive roles; exposure to trauma such as child sexual abuse, adult sexual assault, and partner violence; poverty; and inequality and discrimination.

- **Economic factors specific to Wisconsin may create higher rates of depression in Wisconsin women.** These include a greater gender wage gap in Wisconsin than the nation, causing greater economic disadvantage and the high poverty rate in Milwaukee.
Screening, Diagnosis, and Treatment

◆ **Depression often co-occurs with other illnesses.** These include heart disease, stroke, diabetes, cancer, alcohol and other drug abuse, anxiety disorders, eating disorders, and post-traumatic stress disorder.

◆ **Depression is highly treatable.** Treatments include psychotherapy, antidepressant medications, psychosocial support, and healthy lifestyle measures. Treatment should be based on evidence-based practice and research and should be individualized based on the client’s gender and ethnicity; women must have a voice in and collaborate in their treatment. Community-based supports should be activated as well. Providers should be trained in gender-specific and culturally competent treatments.

◆ **Numerous barriers prevent women from seeking treatment for depression.** These include stigma about mental illness, lack of information about the effectiveness of treatment, lack of insurance coverage, and poverty.

◆ **Early screening, identification, and intervention are crucial factors.** Early intervention reduces human suffering, as well as the cost to society.

Prevention

◆ **Programs to prevent depression in girls and women are available and cost effective.** Effective programs focus on specific risk groups and build on girls’ and women’s competencies.
Policy Recommendations

Recommendations of the Task Force include the following:

1. **The Governor and the Wisconsin Legislature** should pass legislation providing for mental health parity in insurance coverage, i.e., coverage for mental health needs that is equal to coverage for physical health needs.

2. **The State of Wisconsin** should use its purchasing power to address the treatment needs of women and girls with depression.

3. **Employers, Unions, Preferred Provider Organizations, Health Maintenance Organizations, the Secretary of Health, and the Commissioner of Insurance** should address insurance company issues that limit access to effective treatment for depression.

4. **Wisconsin United for Mental Health, the Department of Public Instruction, and Wisconsin Universities and Colleges** should conduct a statewide multicultural campaign to educate women and girls, employers, educators, health care providers, and others about depression and to help eliminate stigma attached to depression.

5. **The University of Wisconsin System and the Medical College of Wisconsin** should include, in university training programs, training on gender-sensitive, age, and culturally appropriate approaches to the diagnosis and treatment of depression in women.

6. **Medical, Educational, and Social Service Settings** should incorporate appropriate screening for depression and referral for follow-up care to achieve early intervention.

7. **Health Care Providers** should provide treatment for depression that is evidence-based, is tailored to the needs of the individual woman, and produces positive, measurable outcomes.

8. **The State of Wisconsin**, through universities and colleges, incentive programs, and telemedicine, should increase access to qualified mental health providers.

9. **Treatment Providers and State Agencies** should include prevention outreach in treatment services and programs.

10. **Public Agencies and Private Organizations** should collaborate to address the problem of women and depression in Wisconsin.
I. Background

My depression came about slowly. After two extremely stressful years, everyone kept saying “I don’t know how you do it all.” I would smile through the deep hopeless pain, but eventually even the fake smile disappeared. I spent more and more time in bed, unable to get out. The stressors had left and I was surrounded by all the things that people would associate with a wonderful life. I had a loving husband, wonderful children, a beautiful new home. Yet I could not feel any joy in this life. I’d head to the bathroom or car and try to muffle the sounds of my painful sobbing.

One beautiful morning, the pain that had swallowed me became so intense that I knew I couldn’t go on any longer. I packed my children a lovely picnic lunch and asked them to play outside for the day. As I stood before the medicine cabinet contemplating what would be the best pills to eat to end my suffering, I saw my own tear-streamed face in the mirror. A moment of recognition hit as I thought about the tears that would be wiped from my precious daughter’s eyes when she found me. I thought of how she might blame herself for something that was totally not her fault. It was then that I realized I needed help.

I called the number of a psychotherapist that I had known several years earlier. Amazingly, she answered. As I lay on the floor sobbing, telling her incoherently that I couldn’t go on, she listened and promised to help. We agreed to meet the next day. She called to check on me throughout the afternoon and evening and the morning arrived. I kept the appointment with her. I began my road to recovering from depression. Throughout the next year my treatment consisted of many things: cognitive-behavioral therapy for myself and therapy with my family, medications, exercise, dietary changes, supplements, self care, and talking to friends and family about my diagnosis. The recovery wasn’t easy, but I have come to the other side.

The most amazing thing was taking my children sledding. We were all laughing as we rolled and flew down the hills, landing in the soft snow. My daughter told me, “Mama, it feels so good to hear you laughing. It’s been such a long time.” I hugged her close and told her it had been a long time … but I knew I was back.

Lieutenant Governor Barbara Lawton’s special initiative, Wisconsin Women = Prosperity, is a statewide, broad-based project to improve the lives and economic prospects of women in Wisconsin. Recognizing that depression and mental health are key factors in overall workforce productivity and quality of life, that there are substantial costs to untreated depression, and that there are significant gender differences in depression, a Task Force on Women and Depression in Wisconsin was convened in 2005.
**Charge to the Task Force**

This task force was charged with:

- Reviewing the available science on the various causes of depression among women and girls;
- Collecting available existing information on the extent of the problem of depression and co-morbidity issues among Wisconsin women and girls and the social and economic implications;
- Reviewing the scientific evidence on effective treatments, supporting structures, and resources for prevention programs;
- Recommending policies that would reduce the risk for depression and associated problems of depression for women and girls in Wisconsin including the problem of stigma and access to care;
- Writing a report on the findings and recommendations to be completed by January 2006.

**Guiding Principles of the Initiative on Women and Depression in Wisconsin**

Several overarching principles guided the work of the Task Force.

**A Belief in Early Prevention, Growth, Learning and Recovery.** Progress in improving the status of women's mental health begins with initiatives that instill hope and are imbued with compassion, dignity, and respect for individual resilience, growth, learning, and ultimate recovery from depression. Planning, policies, and research that address a woman's unique qualities and identified strengths are used to support strategies to facilitate recovery.

**Consumer-Centered and Consumer-Driven.** Women must have a strong voice in the process of assessment, treatment, and follow-up as well as in research initiatives and policies that affect their lives and recovery from depression. Women's involvement in the process is empowering and increases the likelihood of cooperation, ownership, success, and recovery.

**Recognition of Co-Occurring Conditions.** Depression is frequently accompanied and closely related to other conditions such as substance abuse, anxiety disorders, eating disorders, and trauma conditions. It is crucial for practitioners, researchers, and policy makers to adopt a broad approach that incorporates recognition of co-occurring conditions.

**Biopsychosocial Model.** Decades of in-depth interdisciplinary research have demonstrated the importance of a model that incorporates attention to both biological and social psychological factors in assessment and treatment of...
depression. It is important to understand the ways in which stress interacts with a person’s biology to create depression and to devise treatment strategies that incorporate multiple, integrated approaches that can include psychotherapy, psychopharmacology, alternative treatments, and community resources.

**Relational Model.** We recognize the critical importance of relationships for women in their psychosocial development and throughout their life cycle. Women function in many caregiving roles. Thus strategies and policies for change must recognize and incorporate interactional models of women living, struggling, and succeeding with their partners, children, and families.

**Overall Wellness for Women.** This initiative focuses on a women-centered, holistic approach that emphasizes a wellness and recovery model rather than a disease model. A women-centered approach means that women’s voices, needs, and concerns are completely integrated into policies and strategies for change. A holistic approach means that all aspects of a woman’s life including psychological, social, biological, economic and spiritual factors are considered in their interaction.

**Variations among Women.** It is widely recognized today that research, policies, and services must reflect an understanding of the issues specific to gender, age, disability, race, ethnicity, and sexual orientation. A consideration of these individual factors in isolation, however, is inadequate; cutting edge research and our initiative are based on an approach that considers the complex interactions of these many variables, as well as diversity among groups of women. The mental health needs of a poor woman may be very different than those of an affluent woman, a lesbian single parent, or an isolated rural woman.

**Comprehensive Services.** Our premise is that effective strategies and treatments must involve comprehensive services. These include individual outpatient and inpatient approaches and treatment based within the community, including peer support networks and recovery services. Such a multi-faceted and multi-level approach recognizes and creatively utilizes all resources in the community to identify and treat high-risk populations in early intervention.

**Men and Depression.** We recognize that men, too, suffer from depression. The recommendations of this Task Force, if implemented, will benefit not only women, but also men with depression, as well as men with depressed family members or work colleagues.
Defining Depression

Depression is a common, under-diagnosed, yet highly treatable disease. Left untreated, it results in enormous costs to individuals, their families, and their employers.

Depression exists on a continuum, from one or two depressive symptoms, to sub-clinical depression (which does not quite meet the criteria for an official diagnosis), to dysthymia, adjustment disorder with depression, and major depressive disorder. We use depression in this report to refer collectively to all of these patterns. Depression is also found in bipolar disorder (sometimes called manic depression) and cyclothymia (which involves chronic mood swings, but is not as severe as bipolar disorder); however they are not the focus of this report.

Professionals in the field recognize a number of types of depression. The official diagnoses of depression are specified by the American Psychiatric Association in its Diagnostic and Statistical Manual (DSM-IV) (American Psychiatric Association, 2000).

Major Depressive Disorder (MDD) is characterized by depressed or “down” mood and loss of interest or pleasure in activities as well as a frequent loss of the ability to function socially and/or vocationally. Additional symptoms include changes in appetite or weight (either up or down), sleep (sleeplessness or excessive sleeping), or motor activity (either sluggish or agitated), decreased energy, feelings of worthlessness or excessive guilt, difficulty thinking (concentrating, making decisions), and thoughts of death or suicide including a plan or attempt at suicide. To meet the official criteria for a diagnosis of MDD, the individual must have the depressed mood or loss of interest, plus four of the other symptoms, consistently most of the day every day for at least 2 weeks. Children and adolescents with MDD will sometimes be irritable and cranky rather than sad. Elderly women who are depressed often have bodily complaints.

Dysthymia is a milder form of depression than major depressive disorder, but lasts longer. To meet the official criteria for a diagnosis of dysthymia, the individual must have experienced depressed mood for most of the day, for the majority of days, over a period of at least 2 years (1 year for children and adolescents). Two more of the following symptoms must also be present: poor appetite or overeating, insomnia or hypersomnia (sleeping too much), low energy, low self-esteem, poor concentration or difficulty making decisions, or feelings of hopelessness.

Depression in the Postpartum Period can range from “baby blues,” which is milder in intensity and lasts less than 10 days, to postpartum depression that meets the criteria for Major Depressive Disorder, to postpartum psychosis. In Major Depressive
Disorder with Postpartum Onset, the symptoms are the same as for MDD, and may also include fluctuations in mood and preoccupation with the infant’s well-being. According to the DSM IV-TR criteria, the onset must be within 4 weeks of the birth, but clinicians and researchers in postpartum depression recognize that it can occur any time in the first year after delivery. The baby blues affect roughly 50 to 80% of women after birth; 10 to 15% of women experience postpartum depression and 1% experience postpartum psychosis.

The essential features of Premenstrual Dysphoric Disorder are markedly depressed mood, anxiety, mood swings, and decreased interest in activities, typically occurring during the week prior to menses. Symptoms diminish shortly after the onset of menstruation and are absent in the week following menstruation. This cyclical pattern of symptoms must have occurred for most months over a twelve-month period.

Adjustment disorders involve psychological responses to identifiable stressors (such as getting divorced or having unintended birth outcomes) that result in the development of significant symptoms. Adjustment Disorder with Depressed Mood refers to this kind of adjustment disorder, when the main symptoms are depressed mood, tearfulness, or feelings of hopelessness. Other depressive disorders requiring treatment include Minor Depressive Disorder, Brief Depressive Disorder, and Depression—NOS (Not Otherwise Specified).

As important as it is to define depression, it is equally important to advance a positive vision of mental health. The U.S. Surgeon General, in his important Mental Health: A Report of the Surgeon General (Department of Health and Human Services, 1999) defined mental health as follows:

Mental health is the successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity; from early childhood until late life, mental health is the springboard of thinking and communication skills, learning, emotional growth, resilience, and self-esteem.
II. Frequency, Causes, and Risk Factors for Depression

Prevalence and Consequences of Depression

Depression is a common, under-diagnosed, yet highly treatable disorder. This section examines national data, and the next section reviews available data specific to Wisconsin. In any given 1-year period, 9.5% of the adult population in the United States, or almost 20 million adults, suffers from a depressive illness. There are similarly high rates of subclinical symptoms, which, although less debilitating, also interfere with psychological and interpersonal well being and can lead to the development of a depressive disorder. While the economic costs to society are enormous, the cost in human suffering is incalculable. Depressive illnesses and symptoms interfere with normal functioning. They cause pain and suffering not only to those with the problems, but also to partners, children, other family members, friends, and co-workers. Serious depression left untreated can irreparably damage family life as well as the life of the ill person.

Depression leads to workplace absenteeism twice as often as in non-depressed persons and interferes with work productivity. Compared with community samples, depressed persons are 7 times more likely to be unemployed, employed part-time, or in jobs below their education levels (Druss, et al., 2001). In addition to these occupational costs, the medical costs of depressed persons average twice those of non-depressed persons. Depression is one of the most common conditions found in the primary care setting. It can increase the risk of cardiac problems, cerebrovascular events, overall mortality, and other physical health-related problems (Van Rholes & Gelenberg, 2005). Depressive disorders also raise the risk for suicide attempts and suicide completions.

The Experience of Depression

I felt like I would never stop crying. Everything around me felt like a blur. Everyday decisions were so difficult and when I finally did make a choice I would get so upset because it was always the wrong one. Once in a blue moon, though, I would have good days; I would be laughing and having fun and the next thing I knew things would seem even worse than before. Then I started having anxiety attacks. Sometimes it would be twice a week or none for two weeks. There was never a pattern.
Gender Differences in Depression

Women are at least twice as likely as men to experience depressive disorders and symptoms, and some studies report even higher ratios (Kessler, et al., 1993; Piccinelli & Wilkinson, 2000; Weissman, et al., 1988). Thus women and those close to them are much more likely than men to suffer the economic, psychological, and social consequences. Women consistently have higher rates of depression than men across all cultures (Kleinman & Cohen, 1997), though the ratios vary. For example, women in China have rates of depression nine times that of men and also higher rates of completed suicides.

Because depression is so much more common in women than men, the search for causes has begun to focus on reasons for their greater susceptibility. Before adolescence, rates of depression are low and similar for boys and girls. Depression becomes more prevalent in females than males beginning around ages 13-15, according to studies based both on diagnostic interviews and standardized self-reports (Hankin, et al., 1998; Zahn-Waxler, et al., 2004). By 15-18 years the gender disparity reaches the 2:1 ratio that persists throughout most of adulthood. Adolescence is a developmental period of high risk for many girls. Anxiety becomes more prevalent as do eating disorders. Depression is also linked with drug use, heavy alcohol use, and cigarette smoking, which may serve as ways to self-medicate for depression. Since girls are likely to become physiologically dependent on substances more quickly than boys (Andrews, 2005) and have greater difficulty stopping, there may be greater adverse consequences for their physical health as well as their mental health. Because depression co-exists with these and other problems in females more than males starting in adolescence (Loeber & Keenan, 1994), females are likely to become more functionally impaired with these symptoms earlier in their lives (Zahn-Waxler, et al., 2006).

Depression that begins in childhood and adolescence often continues into adulthood and is especially likely to be associated with risk for suicide. A large proportion of apparent new cases of depression in adulthood, in fact have origins in childhood or adolescence (Kessler, et al., 2005). At the same time, many new cases are diagnosed in women at different points in adult development. Depression has been called the most significant mental health risk for women, especially younger women of childbearing and child-rearing age, and the rate appears to be increasing in recent decades (Cross National Collaborative Group, 1992). Postpartum depression is particularly serious, both for the mother and for the offspring. Due to the
dramatic increase in rates of depression in girls in adolescence, most explanations for the causes have focused on this period of development and beyond (as new cases of depression emerge in adulthood). Even in childhood, though, some risk factors are more common among girls than boys and may contribute to their later, greater vulnerability (Zahn-Waxler, et al., 2004).

There are gender differences in how adolescents and adults show their depression (Zahn-Waxler, et al., 2004). In addition to their greater anxiety, depressed females also show more physical symptoms, including excessive sleep, weight gain, increased appetite, fatigue, slowed motor activity, and body image disturbance. Higher rates of crying, sadness, self-control, and negative self-concept are also seen in depressed girls than boys, as well as less irritability and self-aggrandizement. Although many of the symptom differences are physiological in nature and could suggest biological differences, others are likely to reflect environmental processes.

Although some causes and risk factors for depression are similar for males and females, others are likely to differ. The explanations for higher rates of depression in females than males include a number of biological, psychological, and social factors.

Genetic and Other Biological Causes and Risk Factors

Genetic Factors. Major depression clusters in families and depression in a first-degree relative is a risk factor for depression. Although some investigators find similar levels of heritability of depression in women than men, several others have found higher genetic loadings for females. Moreover, some genetic linkage studies suggest that the impact of some genes on risk for major depression differ in women and men (Kendler, et al., 2001). Genes are also involved in the causes of depression through their effect on sensitivity to environmental events. Persons who are at greater genetic risk for depression are twice as likely to develop depression in response to severe stress as those at lower genetic risk.

Puberty and Sex Hormones. Because the unique biology of women may explain, in part, their greater prevalence of depression beginning in adolescence, early puberty and sex hormones are likely to play a role (Ge, et al., 1996, 2003; Zahn-Waxler, et al., 2004). Early puberty is a risk factor for depression for girls, but not boys. Genes, as well as environmental factors like nutrition, exercise, and weight, play a role in the onset of puberty. Depression in mothers may induce early puberty in daughters; the presence of unrelated male father figures in the home may also induce early puberty for girls. Animal studies suggest that chemicals known as pheromones produced by unrelated adult males accelerate female pubertal development. In addition to the hormonal and other biological changes that come with early menarche, young adolescent girls also may not have acquired sufficient skills for coping with the social pressures and stresses of early physical maturation. There is no biological counterpart for boys that creates a similar level of risk for depression.
The sex hormones testosterone and estrogen, which are associated with pubertal development and reproduction, are related to depression in adolescent girls (Angold, et al., 1999). Estrogen has been shown to predict depression in adolescent girls, even as long as a year later (Paikoff, et al., 1991). There is some support for the hypothesis that women may be vulnerable to disturbances in the interaction between the sex hormone system and brain chemistry (neurotransmitters such as serotonin). This dysregulation may also make women more sensitive to psychosocial, environmental, and other physiological factors (Mazure, et al., 2002).

**Premenstrual Depressive Symptoms.** As many as 75% of women experience some premenstrual behavioral and emotional symptoms (Mazure, et al., 2002). These depressive menstrual symptoms are disabling in small but sufficient numbers of women to warrant a diagnosis of premenstrual dysphoric disorder (PMDD). The positive response of these women to treatment with antidepressants (specifically, selective serotonin re-uptake inhibitors or SSRIs) suggests that their serotonin may be altered via hormone-neurotransmitter interactions. Other treatment studies have shown that the female hormone progesterone may promote the cyclic symptoms of PMDD, while a metabolite of this hormone (allopregnanalone) may have a calming effect.

**Postpartum and Menopausal Phases.** Depression associated with the postpartum and menopausal times of life is now being studied in relation to hormonal factors and interactions between hormones, neurotransmitters, and other biological systems (Mazure, et al., 2002). The shifts in sex hormones and major changes in the stress-response physiological system (the hypothalamic-pituitary-adrenal [HPA] axis) during these periods are well known. Pregnancy and delivery produce marked changes in estrogen and progesterone levels as well as major shifts along the HPA axis. Depression in pregnancy is associated with biological disturbances that may affect the developing fetus. Postpartum depression may interfere with the development of a secure mother-child attachment and hence with the quality of the relationship that is established. Failures to reproduce, such as infertility, miscarriage, and surgical menopause, are also associated with depression. Natural menopause results in substantial fluctuations in estrogen and changes in other hormones as well. The effects of these changes have not yet been clearly linked to the onset of depression but the questions merit further inquiry.

While maternal depression is a consistent risk factor for childhood anxiety, depression and disruptive disorders, the positive news is that recent research shows that vigorous treatment of a mother’s depression can reduce symptoms of anxiety and depression in her child. A 2006 study of 151 mother-child pairs, with children ranging from 7 to 17 years old, found 33% remission among children with a baseline diagnosis for depression whose mothers’ depression remitted, compared to 12% remission among children whose mothers’ depression did not remit (Weissman, et al., 2006).
Psychological and Social Factors

Socialization Experiences. Parental depression (most often studied in mothers) creates substantial risk for depression in offspring and more so if both parents are depressed (Rohde, et al., 2005; Williamson, et al., 2004; Zahn-Waxler, et al., 2004). The lifetime risk for depression in children with a depressed parent has been estimated at 45%. It is often assumed that these children are at risk due to genetic risk factors; however, these children’s experiences often differ markedly as well. Depressed mothers are less reciprocal, attuned, and engaged in interactions with their children beginning in infancy. Depressed mothers often model helpless, passive styles of coping and negative emotions that their children also then experience and may imitate. A number of problematic child-rearing and discipline practices have also been identified. In childhood and adolescence, girls of depressed mothers are more susceptible to the influences of maternal depression than boys, showing greater depression and anxiety.

The effects of maternal depression on adolescent girls’ depression become stronger as girls mature (Zahn-Waxler, et al., 2004). Adolescent daughters provide more support to their depressed mothers than do the sons. They also express more sadness, worry and responsibility for the mother’s depression. Parental conflict and divorce (which often accompany parental depression) are more likely to lead to depression and related problems in girls than boys. In adulthood, too, women’s higher levels of caring for others more often become burdensome and create risk for depression. Maternal depression often occurs in the context of other environmental factors (see below) that create additional risk.

Socialization practices directed more often to girls than boys can reflect the beginnings of the adverse environments that create risk for depression (Zahn-Waxler, et al., 2006). Parents are less likely to encourage independence and more likely to foster interpersonal closeness in their daughters than their sons. Girls are more often socialized in ways that interfere with self-actualization, that is, to be dependent, compliant, and unassertive. Parents are more restrictive and demanding of mature interpersonal behavior in girls than boys and are less tolerant of girls’ anger, aggression, and mistakes. Such practices may contribute to the development of maladaptive cognitive styles and coping patterns (described below) that can contribute to depression. In early adolescence, pubertal changes combine with intensified pressure for gender-role conformity increase the likelihood of depression in girls.

Life Stress, Trauma, and Violence. Life stress and trauma throughout the life cycle play a major role in the onset and continuation of depression (Mazure, et al., 2002). More than 80% of cases of depression are preceded by a serious adverse life event. Women are more likely than men to experience depression in response to stressful life events. Traumatic stressors such as childhood sexual abuse, adult
sexual assault, and male partner violence are consistently linked to higher rates of depression, other psychiatric disorders, and physical illness in women. National statistics indicate that the lifetime chance of a woman being raped is between 15 and 25 percent (Koss, 1993). The psychological impact of rape can be severe. It includes not only major depression and long-term depressive symptoms, but also smoking, alcohol use, reduced activity, and physical injury. Each year an estimated 588,000 women in the United States are beaten by their intimate partners (U. S. Department of Justice, 2003). Thus depression among women who experience male partner violence is very high and male partner violence is the greatest single cause of injury to women who require emergency medical treatment. Women more often experience other stressors associated with depression, including caring for elderly parents (often with severe physical and cognitive impairments), while simultaneously caring for their own children.

Higher rates of depression in women have also been linked to other forms of chronic stress, including poverty, little education, inequality, immigration, and discrimination. Depression is more common among low-income persons, particularly mothers with young children (Belle, 1982; Brown & Moran, 1997). The more children a woman has, the more likely she is to experience depression. Depression is more common in single mothers and women of color; women are also more likely than men to have incomes below the poverty line. Seventy-five percent of people living in poverty in the U.S. are women and children, reflecting a trend termed the feminization of poverty. Because adults in poverty are over twice as likely to experience major depression as adults who are not poor (Bruce, et al., 1991), poor women are disproportionately at risk. Poor women have more frequent and uncontrollable adverse life events than the general population, which are known to contribute to depression. In addition to dire poverty, economic inequality contributes to negative health outcomes and is linked to depression in women. Similarly, sex discrimination in the work place and elsewhere is associated with depression, anxiety, and an overall diminished sense of well being (Klonoff, et al., 2000). Refugee women, particularly those who escaped from traumatic situations such as war, are at heightened risk for depression or post-traumatic stress disorder (Fazel, et al., 2005).

The stress associated with discrimination can be particularly severe for women of color since they experience both racial/ethnic and sex discrimination.
The higher rates of depression for these women primarily reflect their poorer life circumstances rather than their ethnicity. That is, women from ethnic and racial minorities in the U.S. are more likely than White women to experience social and economic inequities that include greater exposure to racism, discrimination, violence, and poverty (U.S. Department of Health and Human Services, 2001). They also are more likely to experience lower educational and income levels, segregation into low-status and high-stress jobs, unemployment, poor health, larger family sizes, marital dissolution, and single parenthood.

**Personality Characteristics.** Some psychological characteristics make people more likely to become depressed in the face of life stress (Abramson, et al., 1989; Mazure, et al., 2002; Nolen-Hoeksema, 2001). These include maladaptive beliefs (for example, that they are at fault for most of their own and others’ problems), accompanied by feeling helpless and hopeless. One predisposing style seen more often in women than men is ruminative thinking. Rumination involves a repetitive and passive mental focus on one’s symptoms of distress and their causes and consequences. It leads to impaired problem solving and difficulty engaging in actions that would allow one to take greater control over one’s life. Excessive rumination predicts longer and more severe episodes of depression and an increased likelihood of being diagnosed with major depressive disorder (Nolen-Hoeksema, 2000).

In childhood girls are more likely than boys to experience anxiety that includes dwelling on problems even before depressive symptoms are identified. This may help to set the stage of later depression. Early socialization practices that emphasize gender-stereotyped roles for girls and discourage independence and active problem solving may contribute to dysfunctional beliefs and rumination, which help to create risk for later depression (Zahn-Waxler, et al., 2004).

By adulthood, women who build their identity narrowly, e.g. mainly around family (a possible consequence of assuming gender-stereotyped roles as children) are more prone to rumination and depression in part due to their narrow base for self-esteem and social support (Law, 2005). More generally, depression is associated with perfectionism and an excessive relational focus (Law, 2005). Excessive relational focus, more common to women than men, is the valuing of relationships to the point of maintaining them regardless of personal costs. Women are more sensitive than men to relationship-based stressors, which can lead to depression.

**Other Factors.** Family history and context also influence the expression of depression in women. Many depressed women were raised in dysfunctional families with parents who had mental health problems (Hammen, 1991). These conditions contribute to antisocial behavior in girls and antisocial girls are prone to depression (Gunter, 2004). Compared with nondepressed women, depressed women are more
likely to experience conflict in their marriage and divorce, in part because depressed women are more likely to marry men with psychiatric disorders, which include antisocial behaviors that can be directed toward the woman (Hammen, et al., 1999). Depressed women also have fewer social networks and supports (Belle, 1982) and their friendships tend to be with other depressed women. Thus when their young children do get to play with other children, the mothers of their playmates are more often depressed. Although some of these factors are reflections rather than causes of depression, they tend to perpetuate problems by creating adverse experiences for children that contribute to intergenerational transmission of depression.

### Section Highlights

- Depression is a very common, but under-diagnosed, disorder. Both nationally and in Wisconsin, twice as many women as men are depressed.
- One of the key factors contributing to depression is poverty. Policies that reduce poverty and that give greater access to treatment for those in poverty will reduce the number of cases of depression.
- The gender difference in depression is not present in childhood, but emerges by 15 years of age. Policies should address the risk factors for depression among adolescent girls.
- Women are especially at risk for depression during the postpartum period. Postpartum depression can be debilitating for the woman and can have negative effects on her child and other family members. Policies must focus on postpartum depression.
- Both biological factors (genetics, hormones) and stressors contribute to depression. Rape and battering are two extreme stressors that disproportionately affect women and increase their risk for depression. Policies that reduce the incidence of rape and battering will help to reduce women’s depression.
- Chronic stressors, such as poverty and discrimination, also contribute to depression, putting poor women and women of color at greater risk.
III. Depression in Wisconsin Women

The research reviewed in the previous section is based on national data. What is known specifically about women and depression in Wisconsin? According to a 2001 national study, the gender difference found nationally is evident specifically in Wisconsin (National Center for Chronic Disease Prevention, 2005). Thirteen percent of Wisconsin women, compared with six percent of men, reported that they had been diagnosed with depression at least once in their lifetime. In raw numbers, this equates to 259,000 women and 124,000 men who have been diagnosed. This is an underestimate, of course, because many people with depression never seek treatment and therefore are never diagnosed. A longitudinal study conducted with all graduates of Wisconsin high schools from the class of 1957 also found a 2:1 ratio of depressed women to men when assessed at 54 years of age (Wisconsin Longitudinal Study, 2005).

In 2002, Wisconsin Lieutenant Governor Barbara Lawton launched the Wisconsin Women=Prosperity Initiative to improve the well-being of women in the state. The Initiative has its roots in a national report, Status of Women in the States, a biennial state-by-state comparison compiled by the Institute for Women’s Policy Research (IWPR). Among other troubling findings, the IWPR gave Wisconsin a poor evaluation on women’s mental health (Institute for Women’s Policy Research, 2002).

As part of their overall health index, the Institute for Women’s Policy Research used two measures to assess states on women’s mental health: poor mental health days and mortality from suicide. On poor mental health days, Wisconsin ranked a low 48 of 51 states. Wisconsin women self-reported an average of 4.4 poor mental health days (depressed and anxious) per month compared with 3.8 for women nationally. On death from suicide, Wisconsin ranked more favorably at 16 of 51 states.

Caution should be used when interpreting the meaning of the IWPR rankings because they are based on few measures and a broad definition of mental health. These data cannot be viewed as a substitute for a more comprehensive, uniform assessment of depression in Wisconsin women, which is needed to assess the true extent of the problem. The findings, however, suggest that women in Wisconsin experience high levels of subclinical depression, which
when ignored, often escalates to more severe clinical depression. At the end of this section we highlight a number of factors that may put Wisconsin women at greater risk for depression.

The other measure of mental health status in the IWPR report was suicide, which is most likely a result of depression. While the rates of suicide are relatively low in Wisconsin women, there is still cause for concern. Although men more often complete suicide attempts, women are much more likely to make them. In the past these attempts have been viewed as cries for help and not taken seriously; however, the reason women often do not “succeed” may have more to do with their inability to access methods that more likely guarantee completion of the attempt. As more women gain access to firearms and other more certain methods, these ratios may change. The most promising way to prevent suicide is through early recognition and treatment of depression (Wisconsin Department of Health and Family Services, 2002).

Suicide is the second leading cause of death for individuals between the ages of 15 and 34 years. Young people in Wisconsin may be particularly vulnerable. Suicidal thoughts among Wisconsin teenagers are high, with 1 in 5 high school students having considered suicide. While the rate of youth suicide has declined by 24% nationally over a 9 year period, the rate in Wisconsin declined by only 8% (Eisenberg, et al., 2005). As with older adults, young females are less likely than males to commit suicide; however, they are over twice as likely to be hospitalized for self-inflicted injuries and the medical costs are high. American Indian youth have the highest rates of suicide and hospitalization of all ethnic groups (Eisenberg, et al., 2005).

Other causal factors that increase risk for depression have special relevance to Wisconsin women, e.g. economics, location, education, employment status, reproductive control, and health risk behaviors. Although Wisconsin has a high proportion of high school graduates (ranking 21st in the nation), it ranks low (40th in the nation) relative to other states in terms of levels of higher education (graduate and post-graduate) (U.S. Census Bureau, 2004). Although this education deficit will affect incomes for both women and men, it may have a greater negative impact on women. Women in Wisconsin also rank low on self-owned businesses (33rd in the nation), and, compared with women in the nation as a whole, they work less frequently at higher level jobs such as managers or professionals.
Low income and poverty are associated with higher rates of depression and Wisconsin women have a lower income than women in most other states. Moreover, the wage gap—the differential between the income of men and women—is also greater in Wisconsin than the national average. Women’s earnings as a percent of men’s in 2004 was 80.3% in the United States as a whole and 75.2% in Wisconsin, with Wisconsin ranking 40th in the country on this measure (U.S. Department of Labor and U.S. Bureau of Labor, 2005). The wage gap would be expected to increase women’s rates of depression and cause greater economic disadvantage and deprivation, as well as contributing to their lower status as members of society.

Because a relatively large proportion of Wisconsin women live in rural areas they may experience greater isolation, which also contributes to depression. Northern climates, with their shorter days and longer nights during part of the year, are associated with a seasonal form of depression. Another major risk factor for Wisconsin women involves substance abuse, particularly their rates of binge drinking that are almost twice as high as the national average. Alcohol use is commonly linked to depression. It may be a form of self-medication for existing depression, but it may also lead to the development of depression. There are physical health consequences as well, both for the woman and for her children, if she drinks during pregnancy. A risk factor particularly germane to Wisconsin women concerns their lack of control (a factor that contributes to depression) of their own bodies (Institute for Women’s Policy Research, 2002). Wisconsin ranked near the bottom of all states (48th) on reproductive rights.

The vast majority of women in Wisconsin (90%) are White. In absolute numbers they represent most of the depressed women in need of treatment; however, as noted, women of color are disproportionately more likely to experience depression and are less likely to be in a position to access treatment. Therefore, it is important to be sensitive to their special needs as can be seen in several examples. Although African American women make up only 6% of the Wisconsin population, they account for 20% of all sexual assault victims (Wisconsin Women’s Health Foundation, 2001). They are also incarcerated at disproportionate rates (Gunter, 2004). Both violence against women and women’s antisocial behavior are linked to higher rates of depression. These conditions occur most commonly in circumstances of poverty. The city of Milwaukee, with a large African American population, has the seventh highest poverty rate of all cities in the nation, with 26% of all individuals and 41% of children living below the poverty line (U.S. Census Bureau, 2004).

**Women of color are disproportionately more likely to experience depression and are less likely to be in a position to access treatment. Therefore, it is important to be sensitive to their special needs.**
Poverty is also characteristic of large numbers of other ethnic minority women in Wisconsin. Hmong have an unemployment rate of 27% (Hmong Population Research Project, 2000). In a study conducted in western Wisconsin, among Hmong postpartum women, 43% met the criteria for depression (Schaper, 2000). Depression is also common among American Indians in Wisconsin. American Indian women have the highest rates of hospitalization for depression in Wisconsin—1.8 times greater than the rate for White women (Wisconsin Department of Health and Family Services, 2005b).

As ethnic minority populations in Wisconsin increase, more attention will need to be paid to depression in these groups. To the extent that women in Wisconsin, regardless of race/ethnicity, disproportionately experience risk factors for depression, their mental health will remain a significant problem unless these needs are further addressed. There is little reason to think that Wisconsin women differ from women in other states in terms of biologically based vulnerability factors; however, the environmental factors discussed here may contribute to even higher levels of depressive symptoms in Wisconsin women than women in most other states. Cumulatively these risk factors function to interfere with the self-actualization, independence, and positive contributions to society that help to prevent depressive experiences.
IV. Screening, Assessment, Diagnosis, and Treatment of Depression

The previous section provided an overview of the extent, causes, and risk factors for depression in women and girls nationally and in Wisconsin. The next question is: How is depression identified and treated? The broad term “treatment” can be considered in successive phases: screening, assessment, diagnosis, and modes of actual treatment. Following a discussion of these strategies, we will also consider some of the key barriers to treatment and some of the best practices and promising initiatives.

Screening

Screening for depression in women is crucial given its high rate of occurrence in women. Screening may be effective in a wide variety of settings. Medical settings are likely to come to mind first, especially primary care settings (family practice, general medicine, pediatric, and obstetrics and gynecology), but daycare, Headstart centers, Women, Infants, and Children clinics, child welfare centers, nursing homes, elder services, schools, and churches are other sites where screening could occur and be helpful. Issues regarding confidentiality need to be addressed in all settings, but particularly in nonmedical settings.

Whereas depression in women has serious consequences across all stages of development, it may be especially critical to screen for it during the child-bearing years when risk for depression in mothers and its consequences for their infants and other family members is significant (Perfetti, et al., 2004). Major depressive disorder (MDD) during the postpartum period is a significant public health problem and has been estimated to occur in 10% to 15% of new mothers (O’Hara, 1997) with prevalence rates for new mothers living in poverty as high as 30% (Hobfoll, et al., 1995; Patel, et al., 2002). The symptoms of postpartum depression tend to be more severe than for non-postpartum depression and cause impairment for women in their multiple roles, including parenting. Depression in women may also impact their children. Interactions between mothers with postpartum depression and their infants are characterized by more negative emotions and behavior (Cohn & Tronick, 1989; Field, et al., 1990). Children of depressed mothers are more at risk for developmental delays and behavioral, social, and emotional problems in early and middle childhood (Lyons-Ruth, et al., 2000).

To screen for depression in a medical setting, the U.S. Preventive Services Task Force recommends asking two simple questions at every patient visit: (1) over
the past two weeks, have you felt down, depressed or hopeless? and (2) over the past two weeks, have you felt little interest or pleasure in doing things? These simple questions can help identify approximately 90% of people who suffer from major depression. If the answer to either of these questions is “yes,” further assessment is recommended (U.S. Preventive Services Task Force, 2002).

Assessment

If screening indicates that further assessment for depression is necessary, then a thorough psychological evaluation is necessary to diagnose accurately and recommend treatment options. Depression is a clinical diagnosis accomplished by interviewing; there is no specific laboratory test for depression.

Clinical assessment of depression requires an evaluation that includes biological, psychological, and social aspects and history. Biological assessment includes assessment of genetic vulnerability; other medical illness(es); medications that induce depression (prescribed, over-the-counter, herbal); alcohol and other substance abuse, dependence and withdrawal; seasonal variation; and hormonal influences (menarche, premenstrual, postpartum, perimenopause, menopause). Psychological assessment includes evaluating early childhood experience; trauma; psychological development; response to life transitions and major life events; and the individual’s coping strategies. Social assessment includes evaluation of relationships and support (intimate, family, friends); occupational, financial, and legal status; living situation; religion/spirituality; culture and ethnicity; and past and present stressors (transient, recurrent, persistent), including history of violence and trauma. In all assessments, the safety of the patient and others must be evaluated. Some persons with depression have other mental illnesses, such as anxiety disorders, panic disorder, obsessive compulsive disorder, posttraumatic stress disorder, or substance abuse or dependence, and these, too, must be evaluated. Essential in the assessment for depression is evaluating for bipolarity (the presence of hypomania or mania, characterized by the presence of periods of significantly increased activity and markedly euphoric mood).
Diagnosis
Criteria for diagnosing depression in the Diagnostic and Statistical Manual of Mental Disorders –IV-TR include five or more of the following symptoms for a two week period: (1) depressed mood (which may be irritable mood in children/adolescents); (2) loss of interest or pleasure; (3) change in weight (gain or loss greater than 5%) or appetite (increased or decreased); (4) change in sleep (increased or decreased); (5) psychomotor agitation or retardation; (6) fatigue nearly every day; (7) guilt or feelings of worthlessness; (8) decreased ability to think, concentrate or make decisions; and (9) thoughts of death or suicide. These symptoms must cause distress or impairment in social, occupational, or other areas of functioning, and at least one of the symptoms must be either (1) depressed mood or (2) loss of interest or pleasure (American Psychiatric Association, 2000).

Women often display the “atypical symptoms” of depression including more variations in mood, increased appetite, weight gain, increased amount of sleep, and increased sensitivity to rejection in personal relationships.

Treatment
Today treatment of depression focuses on remission and recovery, which means functioning normally in daily life with the absence or the near absence of depressive symptoms. Simply “getting better” with one’s depression is not enough to ensure full remission and recovery.

The risks of not achieving remission of symptoms are well established and include greater risk of relapse/recurrence, more chronic depressive episodes, and shorter durations between episodes (Judd, et al., 2000), and continued impairment in work and in relationships (Miller, et al., 1998). Sustained depression may increase all-cause mortality (Murphy, et al., 1987). It may increase the risk of other diseases including stroke (Everson, et al., 1998), diabetes (de Groot, et al., 2001; Lustman, et al., 2000), myocardial infarction (Frasure-Smith, et al., 1993), cardiovascular disease (Penninx, et al., 2001), congestive heart failure (Vaccarino, et al., 2001), and HIV (Ickovics, et al., 2001). It is also important to understand the consequences of long-term, chronic depression. Over the course of depressive illness, the onset of episodes becomes increasingly random and less obviously linked to environmental stress. This pattern suggests a sensitization or “kindling” to the depressive state that occurs in long-term depression and underscores the need for early screening and effective treatment.
Once assessment has occurred, there are effective treatments for depression. Depression is highly treatable. A variety of treatments are available and the choice of treatments needs to be made in a collaborative relationship between the care provider and patient, and individualized to the person, with a sensitivity to gender, cultural, and ethnic issues. Treatments include: psychotherapy, anti-depressants, psychoeducation, psychosocial support, maintenance of a healthy lifestyle, light therapy, electroconvulsive therapy, and alternative treatments.

1 **Psychotherapy.** Cognitive behavioral therapy and interpersonal therapy have the best documented effectiveness among the psychotherapies for the treatment of major depressive disorder (Elkin, et al., 1989). Cognitive-behavioral therapy focuses on changing the underlying maladaptive beliefs about one’s self, the world, and the future that contribute to depression. Interpersonal psychotherapy is a brief treatment that addresses current interpersonal problems related to unresolved grief, poor social skills, and role transitions. Psychodynamic psychotherapy can help with symptom relief and development of insight and may have broader psychosocial goals. Family, couples, and parent-child psychotherapy can be very helpful in increasing communication and problem-solving strategies and reducing stress by treating the relationship milieu within which women are functioning. Group psychotherapy, particularly groups composed of women clients, can reduce social isolation and provide social support and validation for women.

2 **Anti-depressant medication.** Many effective anti-depressant medications are available. Newer drug therapies with fewer side effects have been developed. They need to be used for the appropriate length of time in order to be effective and to achieve remission. There are gender differences in drug absorption, bioavailability, distribution, metabolism and elimination, and gender differences in treatment response. There may be potential risks to the developing fetus and infant during pregnancy and lactation.

3 **Combined treatments.** Pharmacotherapy (anti-depressant medication) and psychotherapy, for example, can often be effectively combined.

4 **Psychoeducation.** Information about depression is important for patients and significant others to understand the causes and effects of depression.

5 **Psychosocial support services.** These community resources and services may include employment counseling, housing, transportation, child care, and economic counseling.

6 **Maintenance of a healthy lifestyle.** Treatment needs to emphasize the importance of a healthy lifestyle (exercise, diet, leisure, relationships, and absence of substance abuse).
Light therapy. Light therapy is the treatment of choice for seasonal depression, although seasonal depression responds to antidepressant medications as well.

Electroconvulsive treatment (ECT). ECT is used on a limited basis for severe depression.

Alternative treatments. Alternative treatments are sought by many individuals with depression and may include meditation and relaxation (Broota & Dhir, 1990), acupuncture (Allen, et al., 1998), herbal agents such as St. John’s Wort (Linde, et al., 1996) and SAM-e (Mischoulon & Fava, 2002) and nutritional supplements including DHEA (Block, et al., 1999), omega-3 fatty acids (Freeman, 2000), and folic acid (Alpert, et al., 2000). Despite the popularity of these alternative depression treatments, many are not sufficiently tested to examine efficacy, effectiveness, and safety, specifically for women of different ages.

Comprehensive, effective treatment of depression needs to include treatment of other psychiatric and medical conditions that may be present and trauma history contributing to depression. Anxiety is often a prominent feature of depression in women, and studies have found that up to 66% of depressed individuals also have an anxiety disorder (DiNardo & Barlow, 1990).

Barriers to Treatment

We can consider barriers in terms of two concepts, barriers to access and barriers to effectiveness, which are often inter-related. For example, a woman living in a rural area with no qualified provider may be less likely to obtain effective treatment. Four major barriers to the access of effective treatment are stigma, lack of information, lack of insurance coverage, and lack of availability.

Stigma. Stigma and discrimination against persons with mental illness influence many individuals not to seek treatment. (Blue Ribbon Commission, 1997; New Freedom Commission, 2003; Wisconsin Department of Health and Family Services, 2005a). Even though great advances have been made in understanding the basis for mental illness and the availability of treatment has expanded, stigma has not been significantly reduced over the past 50 years (U.S. Department of Health and Human Services, 1999). Stigma may be greater in ethnic minority communities.

Lack of Information. Many individuals experiencing depression may also not obtain effective treatment because they lack information about what treatments are available and what has been demonstrated to work. Such information is not widely available among the general population and may not be forthcoming from primary health care providers (Mazure, et al., 2002; U.S. Department of Health and Human Services, 1999). Even when women do seek treatment for depression they may face barriers in accessing effective treatment.
Lack of Insurance Coverage. Health insurance, including Medicare, generally provides inadequate benefits for mental health treatment. In Wisconsin, legislation requiring parity between benefits for physical and mental health care has failed to pass the legislature (Blue Ribbon Commission, 1997; Mazure, et al., 2002; New Freedom Commission, 2003; U.S. Department of Health and Human Services, 1999). Women without health insurance must rely on the public mental health system or, if they are poor or disabled, on Medicaid. Unfortunately, the public system is significantly underfunded, with waiting lists for many services. Medicaid reimbursement rates for outpatient psychotherapy are also inadequate, making it very difficult for many women to find providers (Blue Ribbon Commission, 1997).

Availability of Treatment Providers. The availability of treatment providers is a problem in many rural areas (Blue Ribbon Commission, 1997; New Freedom Commission, 2003; U.S. Department of Health and Human Services, 1999). When mental health care is not available, women often turn to primary health care providers. While some provide good treatment for depression, others do not have the training and information needed to do so (Mazure, et al., 2002; U.S. Department of Health and Human Services, 1999).

Other Barriers. Women also have many barriers to obtaining treatment in their own lives. They may not be able to find child care or someone to stay with an elderly relative for whom they are providing care. Transportation to services may be an issue. They may be reluctant to tell an employer that they need time off to obtain treatment for mental illness (Mazure, et al., 2002; Newmann, et al., 2001).

Appropriate Treatment. The treatment that is available may not be appropriate for the needs of women with depression. Treatment needs to be based on evidence-based practices, or those practices that have been demonstrated to be effective by research; however, there is a significant knowledge gap between research and practice (New Freedom Commission, 2003; U.S. Department of Health and Human Services, 1999). Treatment should be gender specific, taking into account the special needs of women (Mazure, et al., 2002; Newmann, et al., 2001; U.S. Department of Health and Human Services, 1999). Some women with depression have co-occurring disorders, such as substance abuse or post-traumatic stress disorder. Some women also have very complicated lives involving issues of poverty, domestic violence, isolation, child illness or special needs, and so on. Treatment must be comprehensive enough to address these co-occurring disorders and various problems in living, working, and heading families (Mazure, et al., 2002; Newmann, et al., 2001).

Treatment should also be culturally appropriate or persons from many segments in our society will be discouraged from seeking treatment or staying in treatment (Blue Ribbon Commission, 1997; Mazure, et al., 2002; New Freedom Commission, 1999).
Practitioners need to be aware of and implement guidelines for gender- and culturally appropriate treatment (American Psychological Association, 2003, 2005). Some persons who use mental health services find that these services themselves may be stigmatizing, promote dependence, and decrease hope for the future. This interferes with effective participation in treatment. The concept of recovery, which has been embraced by both Wisconsin and the federal government, is designed to counteract these perceived negative effects of treatment. (Blue Ribbon Commission, 1997; New Freedom Commission, 2003). Thus mental health services should be based on a partnership between the consumer and mental health treatment provider, built on individual strengths, and engage the person in the process of building a full, productive life (Blue Ribbon Commission, 1997; New Freedom Commission, 2003; U. S. Department of Health and Human Services, 1999).

**Best Practices**

A final step in the treatment process is the evaluation of treatment effectiveness. An additional goal of this task force is to promote the identification of mental health care organizations in Wisconsin that are doing an effective job in treating patients’ depression. There are at least two methods of gauging the effectiveness of these treatments. The first is to examine the extent to which mental health care organizations in Wisconsin follow best practice guidelines for the treatment of depression. The second method is to collect information on the actual effectiveness of patients’ treatment in terms of patients’ achievement of desired outcomes.

Best practices are judged in relation to “what works” for clients in treatment. There are numerous guidelines for the treatment of depression including guidelines set by the American Managed Behavioral Healthcare Association (1998), the American Psychiatric Association (1993) and the Agency for Health Care Policy and Research (1993). Much of this information is now compiled on the National Guideline Clearinghouse’s web site, http://www.ahrq.gov/clinic/ngcfact.htm. These guidelines were reviewed by a panel of academic and clinical practice experts and consist of a one-page quick-reference sheet and an eight-page reference booklet, which can be used as a standard by which to judge the extent to which mental health care organizations are treating depression effectively.
A second method for identifying outstanding mental health care organizations is by examining data on their own patients directly, rather than using indicators of effective treatment. To the extent that these organizations follow up with patients’ improvement, information can be collected to determine the extent to which treatment has achieved the desired outcomes for patients. This information can be collected in a survey of Wisconsin mental health care organizations. An important future step for the treatment of depression in Wisconsin would be to determine which mental health care organizations in Wisconsin are effectively treating depression in terms of following best practice guidelines, and in terms of their own patient data. The section on prevention that follows will also offer some examples of programs based on effective practice, which offer promising initiatives in not only treating, but preventing depression.

◆ Because many cases of depression go undiagnosed and untreated, screening for depression is essential. Screening in high-risk groups, such as women in the postpartum period, is particularly effective.
◆ Symptoms of depression include depressed or sad mood, loss of interest or pleasure, change in weight or appetite, and changes in sleep patterns.
◆ Untreated depression decreases the individual’s functioning in every day life and increases the risk of diseases such as stroke and heart disease.

◆ Several barriers keep women from seeking treatment for depression: the stigma attached to mental illness, lack of information about depression and effective treatments, lack of insurance coverage, and lack of culturally sensitive treatment. Policies should be implemented to lower these barriers.
◆ Effective treatments for depression are available, including especially cognitive-behavioral and interpersonal therapy and antidepressant medications.
V. Prevention of Depression

Depression is the number one cause of disability in women (SAMHSA, 2005). Within five years of recovery, the risk of depression recurrence can be as high as 50%; within 15 years, the risk can be as high as 85% (Hefner, et al., 2003). Although understanding the causes, extent, and treatment of depression is essential, clearly a first goal is the prevention of depression.

A broad-based view of the prevention of depression carries strong implications for social policies that address better health access and care, reduction in poverty, education, and supportive legislation. Suggestions for public policy that relate to prevention appear in the final section of this report.

This discussion of prevention focuses on prevention programs and specifically on identifying key factors that are related to effective prevention programs. Because prevention programs are intended to protect the health, well-being, productivity, and prosperity of all women and girls, as well as those at risk, effective programs quickly pay for themselves by promoting the many social and economic contributions of women and girls to society. This discussion is organized around two key ideas: 1) effective prevention depends upon identifying both risk and protective factors for targeted groups; and 2) effective prevention results when culturally competent interventions are tailored for diverse population groups.

Risk and Protective Factors

Effective depression prevention programs for women and girls target specific risk and protective factors. A risk factor, for example, might be a low income, a family history of depression, or a co-occurring disease like diabetes or substance abuse. A protective factor could be higher education, good overall health, or the support of a close family. In an effective prevention program, specific risk factors are identified that have been shown to increase the probability of depression onset. In addition, specific protective factors are identified that may reduce the risk of depression onset, promote recovery immediately after an episode of depression, reduce the risk of recurrence years after recovery,

Stigma

I remember walking to my therapist’s office week after week, thinking, if I could only put a bag over my head, then no one would see me. I thought, how are people going to view me now, both personally and professionally?
or prevent long-term impairment and disability related to chronic depressive illness. Prevention programs that can produce these outcomes offer important health resources to women and girls who have never experienced an episode of depression, and they are vital for those who have been depressed and those in recovery (Magyary, 2002).

**Targeted versus Universal Prevention**

Levels of prevention services typically are organized according to need and expected outcomes. Public health services usually represent universal levels of prevention. Prevention at this level is considered to be a general health benefit for all. Specific or clinical levels of prevention represent the other end of the prevention continuum where needs and outcomes are defined for an individual. Midrange or targeted prevention services are designed to meet the specific needs of defined groups that are at increased risk for both the condition itself and its complications. Each of these levels of prevention has important advantages and disadvantages, but targeted prevention is more effective and efficient than universal prevention and, compared with clinical prevention, targeted prevention addresses illness-related problems sooner rather than later (Offord, 2000).

A range of innovative targeted prevention interventions have been tested under research conditions and have been shown to be both clinically and cost effective. For example, a 50-minute, one-time interactive web-based computer intervention designed to produce significant reduction in symptoms in persons with a history of depressive illness was more effective than a similarly designed web program that only delivered general information about depression (Patten, 2003).

Targeted prevention programs designed for women and girls at increased risk for depression rely on well-defined risk and protective factors. This level of prevention also has defined, measurable outcomes such as the absence of depressive symptoms for a defined period of time and/or increased behavioral functioning.

A review of 30 studies that evaluated the effectiveness of programs for the prevention of depression in children and adolescents concluded that targeted or selective programs are effective and are more effective than universal programs (Horowitz & Garber, 2006). The selective intervention
programs targeted youth who were at risk for depression due to factors such as parental depression or divorce. Most programs focused on cognitive, behavioral, and relationship skills. Interventions tended to be more effective with adolescents than with children.

Prevention programs that target diverse population groups of women and girls (who range from the not-depressed and depressed to those who are recovering or already recovered) are likely to focus on fewer, but more diverse risk factors and protective factors. In part this focus has to do with the observation that specific risk and protective factors that characterize individuals who have experienced a single episode of severe depression can differ greatly from the risk and protective factors that characterize individuals who have experienced recurrent or subclinical symptoms or disabilities. Differences in developmental, socioeconomic, and genetic influences on risk and protective factors also are likely.

Therefore, in order to achieve the highest possible levels of clinical effectiveness and cost effectiveness, targeted risk and protective factors must be practical with clear policy implications (Le & Munoz, 2003). Practical risk and protective factors are evidence-based with clear relevance to symptom onset, treatment outcomes, or recovery. Multiple risk and protective factors must be considered for effective prevention outcomes. Practical risk and protective factors are linked with multiple prevention outcomes (Durlak, 1998).

**Competency Building**

Other characteristics of effective prevention programs are that they allow adequate time and collaboration methods to build competency in at-risk persons. This was demonstrated in a large meta-analysis of 69 programs designed to prevent depression, rather than to treat depression. The meta-analysis identified specific characteristics of effective, efficient programs (Jane-Llopis, et al., 2003). Participants included children, adolescents, adults, and elders. The majority of the programs included far more females than males. All three levels of prevention—universal, targeted, and clinical—were represented. The most effective programs provided participants with adequate time, i.e., at least 8 or more sessions that were 60 to 90 minutes each. The most effective staffing included

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**Postpartum Depression**

I remember carrying my baby thinking, what would happen if I dropped her. It was horrifying. I would be in the kitchen using a knife and my daughter was a safe distance away from me, and I thought oh my god, what if the knife fell and cut her. I was always bursting into tears. . . . I was irritable and anxious. I was afraid to be alone. I felt a constant sense of impending doom. Something bad was going to happen to me or my baby, I did not want to be alone with her. I begged my husband to stay home from work.
a collaboration of both professional and lay persons, and the most effective interventions were focused on competency building. Competence building was found to have the largest effect on nearly all outcome measures, whereas interventions designed to produce change in behaviors had the smallest effect.

Other findings from an interview study of recovery in women who either were depressed or no longer depressed also reinforce the importance of adequate time and collaboration methods to build competency in at-risk persons (Vidler, 2005). The interview included one question that asked the women to describe the sorts of things that have or would help them feel better. Women who were no longer depressed listed obtaining paid employment, entering educational or employment training, being closer to people who supported them, spending more personal time on self-reflection, self-help, self-care, and gaining a better understanding of the negative events in their life as being important to them. Women who were depressed at the time of the interview listed sports, music, better physical health, better diet, more exercise, and weight loss as important. In other words, the type of prevention services that were most likely to be effective made it more possible for each woman to become competent in a variety of areas. They achieved self-defined psychological and social gains that helped to reduce the multiple and complex barriers and risk factors associated with depressive illness.

**Culturally Competent Prevention**

Effective depression prevention programs for women and girls also use interventions that are tailored to be culturally competent for diverse population groups. Culturally competent prevention can address culturally specific risk and protective factors related to symptoms, recovery, and disability. Distressed early adolescent girls, women coping with poverty, pregnant women, women with disabilities, women with addictions, retired women, working women, lesbian women, and women of color are among the many population groups that are characterized by unique depression-related risk and protection factors. Such women can be far more vulnerable to the harmful short-term and long-term effects of depression because, for social or cultural reasons, they are less likely to be treated or if treatment is started, they are more likely to drop out when the services offered are insensitive or not particularly relevant to their daily life (Cardemil, et al., 2005; Garland, et al., 2005). Some experts now conclude that ethnic disparities in depression may
primarily occur as the result of reduced likelihood of receiving any care at all rather than care that is less than or different from recommended care (Harman, et al., 2004). For example, a comparison study of older White and Black patients showed that Black patients received less active management of their depression when treated by primary care physicians (Gallo, et al., 2005).

Defining important social and cultural characteristics of a population group gives specific meanings to what otherwise can appear to be generic female depression risk and protective factors. Although a great deal of research in depression deals with culturally competent care for high-risk subgroups, just being female also has implications for culturally competent interventions. For example, more females than males are severely obese and severe obesity is an independent risk factor for depression (Onyike, et al., 2003) as is childhood sexual abuse (Kendler, et al., 2004), partner violence (Ebell, 2004), other traumatic life events (Rayburn, et al., 2005), and stressful work environments (Wang, 2004). Gender differences have been observed with seemingly gender-neutral depression risk factors such as folic acid deficiency (Sachdev, et al., 2005).

Other research highlights the critical importance of considering the complex interactions of gender and ethnicity in prevention programming. A large comparison study of the effects of race and income on depression scores in middle-aged women showed that race and income together created a greater risk for depression than did either alone (Bromberger, et al., 2004). Ethnic differences in co-occurring (comorbid) mental disorders showed that 66% of both Black and White depressed women had at least one additional disorder, but the nature of the disorder differed significantly (Franko, et al., 2005). The co-occurrence of depression and panic disorders was much stronger in Black women than White women. A closer analysis of the timing and sequencing of co-occurring disorders showed that depression consistently was the first onset condition. Similar findings of maternal depression co-occurring with parenting stress in drug- and alcohol-involved mothers have been reported (Kern, et al., 2004). Culturally competent models of prevention programming are ultimately more cost efficient and successful as they address the complexities of identifying special risks and protective factors for diverse groups.

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Prevention and Treatment Adherence

Treatment adherence and preventing treatment dropout have also been sometimes identified as a focus of prevention. The rationale for such a view is that many of the complications of depressive illness may be the result of undertreatment. Prevention interventions that can improve patient adherence to treatment would reduce time in treatment; however, once again a seemingly straight-forward prevention outcome proves to be complicated. Despite the obvious risks involved, significant proportions of persons treated for depression make the decision to discontinue their treatment. Treatment dropout has been attributed to distressing co-occurring conditions and ambivalence about treatment. Better and more explicit information about treatment, a stronger treatment alliance between the provider and the patient, and concurrent psychotherapy with medication and more frequent appointments are thought to reduce the risk of treatment dropout (Ruoff, 2005).

Model Prevention Programs

In this last section, two programs are briefly presented that exemplify the key factors we have identified and discussed in effective prevention programs. The first program uses early targeted screening to assess high risk factors for depression in postpartum mothers. The second program embodies a culturally competent model that emphasizes multiple protective factors and competence building for low-income Latina mothers. In Wisconsin, such programs might target low-income young women of color who are new mothers, Hmong women and their families, and rural women, as unique communities most likely to benefit from depression prevention programs.

**Prevention based on risk factors: Detection of postpartum depression in new mothers by screening at all well-child visits.** A busy urban primary care practice serving low-income families elected to adopt the U.S. Prevention Task Force recommendation of depression screening for all new mothers as the targeted group (Chaudron, et al., 2004). Starting with the 2-week visit, each woman was given a self-administered postnatal depression questionnaire along with other materials at each pediatric well-child visit. Feasibility analysis of screening showed that during the first year, 46% of 223 visits yielded a completed screen. Twenty one per cent of the women displayed elevated scores
on the depression questionnaire. The adoption of universal screening increased the rate of detection of depression from 1.6% before it was instituted to 8.5%. Referrals to mental health care increased from 0.2% to 3.6% of patients. Without additional resources, a statistically significant increase in the early detection and treatment of depression was accomplished in this high-risk population of new mothers.

Prevention based on multiple protective factors and competence building: A culturally competent family coping skills program for low-income Latina mothers. The aim of this program was to provide nonstigmatizing mental health services in nontraditional settings to high-risk women who otherwise might not utilize or receive care. Services primarily were group-based and were intended to build competence through improved resiliency to stress and better coping abilities. The family focus used in the program created meaningful supportive roles for family members who might also benefit from participation. The family focus also appreciated the importance of family in Latino culture and reduced the risk of stigmatizing participants. Program content included psychoeducation about depression, stress, and coping, language choice, and role playing activities that addressed important culturally relevant life experiences. Transportation needs of participants were addressed and the professional providers de-emphasized their roles as expert on all matters other than mental health. The leaders were ethnically and racially diverse, experienced or trained in Latino culture, and the majority were fluent in both Spanish and English. Acculturation stress was included as a specific population risk factor. Participation rates for the 6-session program ranged from 40% to 85%. Over half of the participants (55%) had greater than a 50% reduction in depression scores. Participants who attended none of the groups that included family members experienced no change in their depression scores (Cardemil, et al., 2005). By using protective factors and paying close attention to culturally relevant areas of competence, a community-specific program of prevention was effective in meeting the needs of a high-risk population group.

Effective prevention programs may differ a great deal in terms of service delivery, but ultimately, for women, effective prevention produces gains in important life goals that in turn, reduce the risk of depression.
Effective programs for the prevention of depression focus on risk factors and protective factors. For example, they focus on high-risk groups such as women during the postpartum period, girls and women who have been abused or are living in poverty, and elderly women, and they identify protective factors such as a supportive family and other relationships.

Effective programs build competency in multiple areas of life.

Effective programs are culturally competent. That is, they are tailored to the particular cultural characteristics of the group, especially in regard to ethnicity and social class.

This section highlights two successful model prevention programs, one that targeted a specific risk factor and one that targeted multiple protective factors and competency building.
VI. Policy Recommendations

Depression, especially among women, is a major public health problem. It exacts high costs on individuals, their families, and the economy. A high level of commitment from both the public and private sectors is needed to address depression.

Fortunately, depression can be prevented and it can be treated effectively. We offer a set of policy recommendations for preventing, detecting and treating depression among women. The adoption of these recommendations would benefit men as well as women. It is crucial, however, to note that some of the critical biological, social, and psychological factors related to depression are gender specific. This report is a response to the relatively high incidence of depression in women and to the need to recognize gender specific issues and needs. We have also noted throughout the report the need to recognize the relationships between gender, age, and culture when preventing, detecting and treating depression. Concern for these relationships is integrated in our recommendations.

The incidence and the severity of depression are clearly linked to rates of poverty and economic inequities based on gender, to discrimination in the workplace, and to violence against women and abuse both in childhood and as an adult. While we offer specific recommendations below for ways in which depression might be prevented and treated, we strongly emphasize the importance of addressing the more general issues of poverty, discrimination, stigma and abuse. We fully understand the challenges in making significant changes in socioeconomic conditions. We are confident, however, that as businesses and governments recognize the costs in productivity and health care that are due to depression, they will take the steps necessary to end discriminatory practices. We are also hopeful that more will be done to address the issues of violence against women. Violence is a powerful risk factor not only for depression, but for multiple other chronic, disabling medical conditions across the lifespan including chronic pain syndromes, fibromyalgia, irritable bowel syndrome, and chronic fatigue syndrome. Violence in multiple forms also makes women poor and keeps them poor.
There is an overall message that we wish to convey to employers, to state government, and to Wisconsin residents: depression is a serious, but treatable illness and should be a concern that informs policies and practices generally. State government, for example, should align its policies and practices in welfare, education, employment, as well as health, in ways that are sensitive to the issues of depression among women. Employers should develop programs that recognize signs of depression among their employees and help them get appropriate treatment. Organizations and individuals throughout our state should counter stigma and other barriers faced by women with depression.

We encourage the Lieutenant Governor to request each agency mentioned in the recommendations to appoint a key contact to ensure that these recommendations are reviewed and considered. We request that the Lieutenant Governor convene these agency liaisons within a year to provide an update on progress made in the agencies. We also encourage the Lieutenant Governor to consult with her corporate advisory board members on how best to implement the recommendations related to businesses.

The first three recommendations concern ways to achieve adequate funding and coverage for mental health treatment which we deem most critical to achieving the other goals recommended in this report. Funding recommendations number one and two address necessary legislation and the third concerns employers, unions, and insurance providers. Further recommendations follow in the areas of education, training, stigma reduction, screening, treatment, prevention, and collaboration.
Recommendations for Legislation and Funding for the Treatment of Depression

**Pass legislation providing for mental health parity in insurance coverage; i.e., coverage for mental health needs that is equal to coverage for physical health needs.**

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**A**

The Governor and Wisconsin Legislature should enact legislation providing the coverage of treatment for mental illness in parity with coverage for physical illness, noting that a cost of living adjustment for mental health does not equal parity. Presently 33 states have enacted parity legislation and fiscal analyses show that such a policy is cost effective, especially in states like Wisconsin that rely heavily on managed care; our neighbor state, Minnesota, has had mental health parity legislation since 1995.

**B**

The Governor and Legislature should enact legislation to increase the minimum mandated insurance benefit for mental health treatment based on cost of living adjustments in the interim before parity is enacted (AB 252).

**C**

The Wisconsin Legislature should increase Medicaid rates to a level that will encourage providers to provide adequate and appropriate treatment for depression. Medicaid fees for service reimbursement rates for psychotherapy are significantly below the costs of providing the service.

**D**

The Wisconsin Legislature should establish a Legislative Council Study Committee on Mental Health Issues Facing Wisconsin’s Women. Among the issues that this panel should review are the following:

- evaluating access in the Wisconsin health market for mental health services;
- quantifying the cost-effectiveness of treatment alternatives;
- assessing marketplace factors including reimbursement levels, limited panel health plans, visit limitations, and recruitment and retention of providers; and
- identifying effective means of screening for postpartum depression.
2 Use the purchasing power of state government to address the treatment needs of women and girls with depression.

A The Department of Employee Trust Funds should ensure adequate coverage for the screening and treatment of depression for all persons covered under its health insurance programs.

B The Department of Health and Family Services should ensure that all of its contracts and program expectations for Medicaid contain adequate funding and requirements to ensure appropriate screening and treatment for depression.

C The Department of Employee Trust Funds should commission a study of its claims data to identify mental health utilization trends, quality of care, provider efficiency, and variation in costs and outcomes among its members.

3 Address insurance company issues that limit access to effective treatment for depression.

A Employers and Unions should work with insurance companies to provide coverage that pays for effective treatment of depression.

B Employers and Unions should work with insurance companies to address limits on access to appropriate medication and limits on the amount or extent of mental health treatment.

C PPOs and HMOs should increase reimbursement rates and expand treatment coverage that will enable providers to provide continued and appropriate treatment for depression.

D The Wisconsin Secretary of Health and Commissioner of Insurance should create a joint task force to study industry best practices related to mental health coverage. This panel, including public members and industry representatives, should be charged with the creation of care and coverage guidelines related to mental health treatment.
Recommendations for Education, Training, and Stigma Reduction

4 Conduct a statewide multicultural campaign to educate women and girls, employers, educators, health care providers, and others about depression and to help eliminate stigma attached to depression.

A Wisconsin United for Mental Health should pursue outside grant funding to:
- Support and develop programs and educational materials on women and depression to distribute to women’s groups, employers, libraries, aging and disability resource centers, civic groups, the general public and the media.
- Work with a public relations firm to develop a tag line or other symbol to promote awareness of the problem of women and depression.
- Work with women who have recovered from depression to be trained as presenters in educational and anti-stigma programs.

B The State of Wisconsin should designate a Women’s Health Officer to coordinate intra- and inter-agency initiatives. This public health official would also serve as a clearinghouse for information and liaison with other public and private sector entities on matters concerning women’s mental and physical health.

C The Department of Public Instruction should develop curricula and materials on signs of depression in teen mothers that can be used in middle and high school health classes as well as informational materials for teachers at all levels.

D The Department of Public Instruction and the Department of Health and Family Services should provide training and technical assistance to student services personnel including school counselors, nurses, psychologists and social workers to build capacity to screen and appropriately refer students to community mental health resources.

E Wisconsin Universities and Colleges should include a section on women and depression, including the problem of stigma, in their introductory psychology courses.
The Department of Health and Family Services, the Department of Public Instruction, and the Department of Work Force Development should work with Businesses and Employee Assistance Programs to develop policies, initiatives and materials that:

- Educate their employees about warning signs of depression and risks for depression and that depression is a real, common, and treatable illness.
- Encourage employees to take annual "Health Risk Assessments" or other self-assessment surveys to help identify untreated depression.
- Eliminate stigma against depression in the work place.
- Increase access to information and referral sources on treatment for depression.
- Provide supportive work environments for those experiencing depression.

Health Care Providers should make explicit efforts to educate their patients that depression is real, common, and treatable; that depression sometimes accompanies other illnesses or physical conditions; that people with depression often have a previous traumatic event such as childhood abuse or neglect or military combat; and that research indicates that both medication and psychotherapy are efficacious for treatment.

Include training on gender-sensitive, age, and culturally appropriate approaches to the diagnosis and treatment of depression in women in university training programs.

The University of Wisconsin System and the Medical College of Wisconsin should include specific training in their medical, pharmacy, nursing, psychology, and other mental health specialty programs on appropriate diagnosis, treatment, and the safety of medications for women of all ages with depression.
6

To achieve early intervention, appropriate screening for depression and referral for follow up care should be incorporated into the routine health services of medical, educational and social service settings; these settings include:

- Primary care clinics
- Obstetric and gynecology clinics
- Cardiology clinics
- Pediatricians’ offices
- Parish nurses / Faith-based organizations
- Alcohol and drug abuse treatment programs
- Public health programs
- Early childhood programs
- Correctional facilities
- Schools / Day care
- Elderly services and nursing homes
- Child welfare programs
- Domestic abuse and sexual assault programs
- Community centers
- Programs for immigrants

A The State of Wisconsin should establish a pilot project to evaluate the effectiveness of public awareness, patient education, and screening activities of all pregnant and postpartum women for depression.

B Medical Health Providers and Services should screen and promote the screening of all pregnant and postpartum women for depression and refer women found to have depression to other appropriate providers for further evaluation and treatment.

C The Department of Public Instruction and the Department of Health and Family Services should promote and help schools screen all pregnant and postpartum teenagers and refer teen parents found to have depression to appropriate providers.

D The Department of Health and Family Services should seek to incorporate these recommendations into the programs it funds, including Medicaid, BadgerCare, HealthyStart, and state-certified day care centers.
Provide treatment for depression that is evidence-based, is tailored to the needs of the individual woman, and produces positive, measurable outcomes.

**A Primary Care Providers**, especially in rural areas:

- Must receive continuing education, training and information to provide necessary treatment and to make referrals for their patients when appropriate.
- Should recognize that women with a first episode of depression must be a priority to receive high-quality, continued treatment in order to prevent recurrences.

**B The Department of Health and Family Services** should:

- Develop program expectations and standards that promote clinical assessment and treatment for depression based on a biopsychosocial model that includes recognition of biological, psychological, and sociocultural factors that contribute to depression.
- Promote access to recovery-focused, evidence-based psychotherapy and medications.
- Require substance abuse treatment programs that are funded by DHFS for women to screen and provide treatment for depression as part of an integrated mental health and substance abuse treatment approach.
- Promote peer support programs for women who have experienced depression. The Wisconsin Task Force on Perinatal Mood Disorders should be a collaborator in this effort.

**C The Department of Health and Family Services** should develop and implement administrative rules for mental health and substance abuse programs that promote recovery-based, trauma-informed, gender sensitive, age, and culturally appropriate treatment for depression.

**D Wisconsin Counties and Community Organizations** should help with transportation, child care services, respite, and other supports that a woman may need in order to recover from an episode of depression.
Increase access to qualified mental health providers.

A Wisconsin Universities and Colleges should increase the supply of mental health providers, especially child and geriatric psychiatrists and psychologists, as well as those specializing in postpartum depression.

B The Wisconsin Legislature should expand incentive programs, such as loan forgiveness, to retain Wisconsin graduates in mental health specialties. Such programs should promote serving rural and other underserved populations.

C Preventive, Primary, Outpatient, Inpatient, Crisis, and Community Practice settings should increase utilization of Psychiatric Mental Health Nurse Practitioners as a means of increasing access to appropriate medications.

D Health Care Practices in rural areas should increase the use of telemedicine as a means of access to qualified mental health professionals.

Recommendations for Prevention

Include prevention outreach in treatment services and programs.

A Treatment Providers and Services should work to prevent treatment disparities due to income, race, or age. Outreach services should aim to promote the mental health of all women as a high public health priority which will have the significant benefit of reducing avoidable admissions to hospital care, crisis care services, and emergency departments.

B Treatment Providers and Services should work to prevent physical and psychosocial complications due to lack of effective treatment and treatment dropout. Outreach services should promote recovery as the benchmark of effective treatment and should decrease the social stigma of treatment by promoting culturally competent care.
Health Care Providers, Human Service Providers, the Department of Corrections, the Department of Workforce Development, and the Department of Health and Family Services should aim at preventing depression onset in women and girls who are at acute risk by promoting ongoing screening services for:

- Victims of abuse and violence
- Socially isolated elderly women
- Daughters of incarcerated women
- Adolescent mothers of children ages five and younger
- Immigrant women
- Working women enrolled in W2 programs

The Department of Health and Family Services, in collaboration with the Department of Public Instruction, should investigate the FRIENDS program for prevention of depression in children and adolescents currently being implemented in British Columbia, to determine the feasibility of implementing it or a similar program in Wisconsin.

Recommendations for Public/Private Collaboration

Public agencies and private organizations should collaborate to address the problem of women and depression in Wisconsin.

The Department of Health and Family Services, Business Community Members, the University of Wisconsin Center for Excellence on Women’s Health, the University of Wisconsin’s Women’s Studies Research Center, and the Wisconsin Women’s Health Foundation should work in partnership to:

- Evaluate the benefits and costs of programs to prevent and treat depression in women and girls in order to make a strong business case for the importance of investing in the prevention and treatment of depression.
- Design and promote improved treatment and prevention programs.

The Department of Health and Family Services, the University of Wisconsin Center for Excellence on Women’s Health, and the University of Wisconsin’s Women’s Studies Research Center should develop a statewide data base of resources related to women and depression and collect detailed data that would allow for evaluations of efforts to prevent and treat depression.
References


