



Notes from the Field: Engaging and Treating Low-Income Mothers for Postpartum Depression

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Sampson

Abstract

The prevalence of postpartum depression (PPD) among low-income populations is nearly twice as high as it is among the general population. This brief article provides prevalence and predictors of PPD while also highlighting reasons for low treatment engagement. The author describes a brief, home visiting intervention (that could be delivered via video conferencing if needed) and provides some lessons learned. The article concludes with a call to action for social workers to be aware of higher rates of PPD but less likelihood to get treatment among low-income mothers. Recommendation for heightened awareness of PPD risk during COVID is also made.

Introduction

Postpartum depression (PPD) is one of the most frequent complications of pregnancy and childbirth in the United States (Grace, Evindar, & Stewart, 2003; Kendig et al., 2017). Approximately one-quarter of low-income mothers experience postpartum depression (PPD; Chung, McCollum, Elo, Lee, & Culhane, 2004; Goyal, Gay, & Lee, 2010; Gress-Smith, Luecken, Lemery-Chalfant, & Howe, 2012; Segre, O'Hara, Arndt, & Stuart, 2007; Tandon, Leis, Mendelson, Perry, & Kemp, 2014). This is about twice the prevalence rate of PPD in the general population which is estimated at 8-13% (Hahn-Holbrook, Cornwell-Hinrichs, & Anaya, 2018; Le Strat, Dubertret, & Le Foll, 2011; O'Hara, 2009). PPD is defined in the DSM-5 as a major depressive episode with peripartum onset which refers to the most recent occurrence of depression during pregnancy or up to four weeks after delivery (American Psychiatric Association, 2013). Clinicians and medical experts advocate that PPD should have its own diagnosis because of distinct features of hormonal fluctuation and a longer time period for identification than just four weeks after birth (O'Hara & McCabe, 2013). Two of the strongest predictors of PPD are a history of depression and depression and or anxiety during pregnancy

(Hirst & Moutier, 2010; O'Hara, 2009) but several social determinants of health also predict onset of PPD. Factors such education, income, and life stressors related to childcare stress, marital stress, and low social support (Beck, 2001) are important contextual factors in the mother's environment that affect her mental health.

Untreated depression during pregnancy or the postpartum period can adversely affect maternal functioning and potentially influence mother/child bonding, infant development, and predict risk of anxiety and depression for the child (Accortt & Schetter, 2014; Goodman, Vesely, Letiecq, & Cleaveland, 2017; Hirst & Moutier, 2010; Stein et al., 2014). On a positive note, the extant research on treatment for PPD resoundingly supports the hypothesis that PPD is treatable (Dennis & Dowswell, 2013; Gaynes et al., 2005), especially if it is detected early and interventions are made to scale for severity of symptoms (Gaynes et al., 2005). However, treatment rates among uninsured and low-income mothers are lower than higher income peers, making the need for engagement and retention of low-income mothers a critical need. According to a report by the Urban Institute, one in 11 low-income mothers with young children had depression in the year prior to the survey (McDaniel & Lowenstein, 2013). Nearly 40% of the mothers surveyed had no mental health treatment compared to only 25% of the higher income mothers with depression. Low-income mothers most often live in an environmental context where they face multiple stressors and multiple barriers to effective mental health treatment; the barriers include access, expense, lack of childcare, stigma or fear of stigma, and chronic life stressors (Abrams & Curran, 2009; Lutembacher, Elkins, Dietrich, & Riggs, 2018; Mundorf et al., 2018). Helping professions that serve low-income women, such as social work, should be aware of the high risk for depression but high probability of no entry to treatment for this population.

In the last ten years, much has been done to establish prevalence, predictors, and potential solutions for PPD, but public awareness of easy to

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administer, affordable solutions for mild to moderate PPD lags behind. The profession of social work is characterized by the ability to adapt and be innovative and tenacious when it comes to connecting people to resources that can improve their overall mental health and wellbeing. In this article, I briefly describe an intervention named PST4PPD I created by adapting components of a federally funded intervention with a Nurses for Newborns program that existed from 2009-2012 (NIMHR34MH083085; PI Jonson-Reid). The original study utilized eight PST sessions. For the PST4PPD protocol I added some content with motivational interviewing rapport-building techniques and shortened the number of PST sessions from eight to four sessions. The intervention was designed to be delivered via home visits (to eliminate the often-cited barrier of transportation), but it could also be delivered via an online video platform if needed for safety protocols during a pandemic.

Use of the PST4PPD Home Visit Intervention to Lower Postpartum Depression Symptoms

The "PST4PPD" described in this paper is a 5-session, psychoeducational intervention designed to be delivered in home visits by social workers or community health workers. The use of home visitors has been cited as a favored method of intervention and also an effective strategy to limit the numerous barriers low-income mothers face when trying to access help for PPD (Hansotte, Payne, & Babich, 2017; U.S. Department of Health and Human Services, 2013). The PST4PPD curriculum adopts fundamental principles and tools from a cognitive behavioral evidence-based modality, Problem Solving Therapy (PST). Problem Solving Therapy (PST) is a enhances one's ability to cope effectively with stressors in everyday life to mitigate the effects of chronic stress on existing mental or physical health problems (D'Zurilla & Nezu, 1999; Malouff, Elkins, Dietrich, & Riggs, 2007; Nezu, 2004; Schutte, Malouff, Thorsteinsson, Bhullar, & Rooke, 2007). Specifically, research shows that an increase in problem solving skills has a positive benefit on lowering depression (Berry, Elliott, Grant, Edwards, & Fine, 2012; Karyotaki et al., 2018). A guiding premise of PST is to encourage the learner to focus on everyday stressors and to choose one manageable problem to work on each

week. Theoretically, as one's self efficacy increases through mastery of skills to solve everyday stressors and problems, one's depression will decrease (Bell & D'Zurilla, 2009).

Each session takes approximately 45-60 minutes to deliver. The first session is primarily used to deliver baseline measures and establish rapport. The PST sessions are delivered in four subsequent home visits. Two depression-related instruments are used to assess the outcome of depression. One is the Edinburgh Postnatal Depression Scale (EPDS), which is widely used and has very good internal consistency and validity for assessing risk of neonatal and postnatal depression (Cox, Holden, & Sagovsky, 1987). It is administered after consent in the first session and then later administered at the end of the final PST session. The other outcome measure is the PHQ-9, which measures the severity of depressive symptoms (Kroenke, Spitzer, & Williams, 2001). It is administered at the first session and again the end of the final (4th) PST session. In the second feasibility implementation of the PST4PPD we added measures of self-efficacy: maternal self-efficacy (Teti & Gelfand, 1991) and general self-efficacy (Chen, Gully, & Eden, 2001).

The Process for Implementation of PST4PPD

The PST4PPD protocol has been implemented as a one group pre-test, post-test study in three different settings to date. Although it may be considered a limitation that no studies of the PST4PPD protocol have included a comparison group, we have been able to establish promise for the use of the intervention for mild to moderate PPD. It is important to note that when the idea of pilot testing the intervention is proposed by the PI to an organization, the leadership in the community organization does not want a comparison group due to concerns over withholding a helpful intervention. None of the community-based organizations (CBOs) where the PST4PPD protocol was tested had an existing postpartum mental health program to serve as a control group. Suggestions for building evidence for community-based intervention research is offered in the conclusion.

The study design has been aligned with recommendations by Rounsaville, Carroll & Onken (2001), who support the process of Phase

1 intervention research that examines feasibility and makes iterative improvements to a behavior therapy protocol before moving to Phase 2. In 2012, the first pilot study was implemented within a Healthy Start family services program located in low-income neighborhood near an anonymous University (Sampson, Villarreal, & Rubin, 2016). The first pilot study had only 14 participants, all Hispanic and non-Hispanic Black; 79% were single and the average monthly income was less than \$1,500. Study results showed an overall decrease in both measures of depression and a 93% retention rate. In 2014 the PST4PPD protocol was delivered by a counselor at a residential treatment facility for mothers coping with substance use disorder (Sampson & Yu, 2017; Sampson, in press). Thirty-four women completed all five sessions. Forty percent of the sample was Non-Hispanic White, 43% Non-Hispanic Black, 13% Hispanic, and 4% self-reported other. Results revealed significant pre and post reductions in postpartum depressive symptoms and consistent decline in the PHQ-9 scores. There was also a statistically significant increase in self-efficacy among participants. At this setting there was a 90% retention rate.

In the largest implementation, the PST4PPD protocol was delivered by bilingual lay health workers across five community faith-based organizations in the U.S. through our partnership with a not-for-profit organization that provides technical assistance and program consulting for community faith-based organizations serving disenfranchised Hispanic populations. Lay health workers used electronic tablets to allow the participant to enter her answers to standardized tools and distributed workbooks to participants for use during PST home visits. In total, 76 out of the 90 enrolled mothers completed all PST sessions. All participants were Spanish speaking. With a 76% completion rate, demonstrable improvements were seen in participants' depression and general and maternal self-efficacy (Sampson & Yu, 2020).

Our strategy for implementation of the protocol has been to partner with community-based programs and organizations that already have a vested interest in maternal health but do not have specific services for postpartum depression. All projects have been associated with funding, and that enabled us to provide gift cards and stipends to compensate the organizations and staff for their time. Social work

graduate research assistants and I, as the P.I., typically work with CBOs that offer family services to low-income mothers to help them deliver the PST4PPD. In preliminary meetings to discuss the possibility of using PST4PPD I am transparent that the staff at their organization will be the people who recruit and intervene with the research participants and the University faculty and staff will be the people who receive, clean, and analyze the data. We offer the training on how to recruit, discuss consent, and deliver the intervention. The on-site interventionist (staff) uses a workbook (developed in prior pilot studies; Sampson et al., 2016) with visuals and text to help the participants increase their awareness of their own problem orientation and problem-solving style and then leads the participant through a 7-step process to identify and develop a plan to solve a problem each session.

The staff who administer the intervention are instructed to assign codes to each participant upon consent and thereafter use the code on all study materials for that individual. One doctoral research assistant on my team is appointed as the "data lead" who will be responsible for receiving the list of names matched with codes from the self-appointed lead person at the organization. The data lead R.A. ensures deidentification of data and cleans data before passing along de-identified data to a second R.A. for analysis. The P.I. offers weekly calls with the interventionists at the study site to provide technical assistance and coaching on the steps of PST for the delivery of the protocol. With every project, we have disseminated findings back to the organization with infographics and/or a brief presentation and opportunity to be co-authors on the manuscript.

Key Takeaways to Inform Social Worker Training

Problem Solving Orientation and Definition as Part of Training

Problem Solving Therapy (PST) could be delivered as a standalone modality to use for any population seeking behavior change (AIMS Center, n.d.). PST4PPD is a specific adaptation of PST for use with postpartum depression. The usefulness of this approach among populations with variability in literacy levels or limited resources is apparent in the easy to understand

and follow 7-step process of PST. One takeaway that we have learned from training different organizations on the use of the protocol is that the hardest step is usually the first step: identifying and defining the problem. Most of the social workers and community health workers we have trained in this method often want to jump straight to problem solving. By doing this, we disempower the participant. For mothers with depression, the interventionist should be trained to engage in collaborative brainstorming to help the participant identify a problem and break down the problem into smaller steps. When training on the protocol, it is important to spend time discussing the idea that problems can be solved and seen as challenges rather than threats. Trainers of PST4PPD should engage the audience in activities that allow ample time for practicing Step 1, identification of the problem, with their mock client since this is a critical step to effective PST.

Provide Motivation to the Organization and Staff

Because the implementation of PST4PPD relies on intensive help from the CBOs, buy-in from organizational leadership must occur. We have found success in our partnerships when we provide transparent information about timelines and the effort needed to implement the protocol. We usually enter into a partnership with a site only when there is at least one person in the operational and/or clinical leadership who will be a champion for the project. It takes consistent communication, cheerleading, and coaching from the research side of the project to keep the community organization side invigorated when recruitment is slow or workloads shift, causing staff to juggle too much.

Communication, Communication, Communication

We have learned the value of facilitation of early conversations about expectations from the research team and expectations from the organization's team. Often, the leadership will buy in fully to the idea of having a PST4PPD protocol in place, but the staff who are expected to implement the 5-session intervention are often focused on more projects than just ours. Weekly check-ins to provide coaching on the overall goals and data collection requirements of the intervention help to ensure fidelity. We often use the weekly sessions to help troubleshoot common

questions such as what to do when the mother seems to “always be in crisis and not able to focus” or “can’t choose an everyday problem.” With the weekly calls we can also address questions of eligibility. In all the studies, we rule out severe depression or suicidal ideation for eligibility in the PST4PPD program. We ensure that the organization has an internal process for how to immediately help women who may report these severe symptoms at screening.

Conclusion

As a profession, we should be asking ourselves: “where does social work stand in regard to social justice for mothers”? Women who live in poverty, are uninsured, and are Black or Hispanic are at higher risk of receiving no or ineffective treatment for depression (McDaniel & Lowenstein, 2013). The bottom line is that mothers who live in poverty face health inequities, and for mothers who are also women of color, those inequities are disproportionate; such is the case with drastically higher maternal mortality rates among Black women in the U.S. (Howell, 2018). So maybe the question should be: “how can the social work profession not have a role in the quest for maternal health equity”? The role of social work in research, education, and practice in maternal health should be obvious and well-articulated given that we are committed to eliminating disparities and social injustice. Being aware of the prevalence of PPD is a good start and, having knowledge of protocols such as PST4PPD is useful. PST4PPD has been largely appealing to all audiences because of its accessibility—delivery of it does not require mental health credentialing nor does it require high health literacy—and its affordability, which makes it appealing to agencies with limited resources. We typically receive positive feedback from the interventionists who deliver the brief protocol. One interventionist said, “I really like this intervention because it empowers my client to make her own decisions and build her confidence. Sometimes I feel like it’s helping her break a generational cycle of helplessness she usually feels”. Research on the PST4PPD will hopefully continue but with efforts to secure comparison groups.

Especially in light of the pandemic, there is a critical need for the field of social work to stay abreast of maternal mental health and to stay current on evidence informed, affordable

interventions. COVID-19-related stressors coupled with changes in hospital protocols that result in birthing in isolation are associated with increased numbers of PPD seen in 2020 (Davenport, Meyer, Meah, Strynadka, & Khurana, 2020). Social workers are skilled in systems theory and can apply that to understanding disparities in maternal health. Fragmented systems of care and disrespectful systems of care play a role in low-income mothers not seeking or returning to mental health and postpartum medical care (Krohn & Matone, 2017). Social workers are well equipped to help with engaging mothers who may be reluctant to enter treatment for PPD. The field of social work is predominately female, and approximately 47% of social workers work directly with children and families (Salsberg et al., 2017). This overrepresentation of women in the profession of social work should naturally predict research, practice, and policy emphasis on issues related to women's health. Although not all women have children, all humans have mothers, and all mothers are typically part of a family system. When a mother's health suffers, families and communities are impacted.

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