

# TREATING PERINATAL DEPRESSION IN HIGH-RISK POPULATIONS

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# Perinatal Depression and Child Outcomes

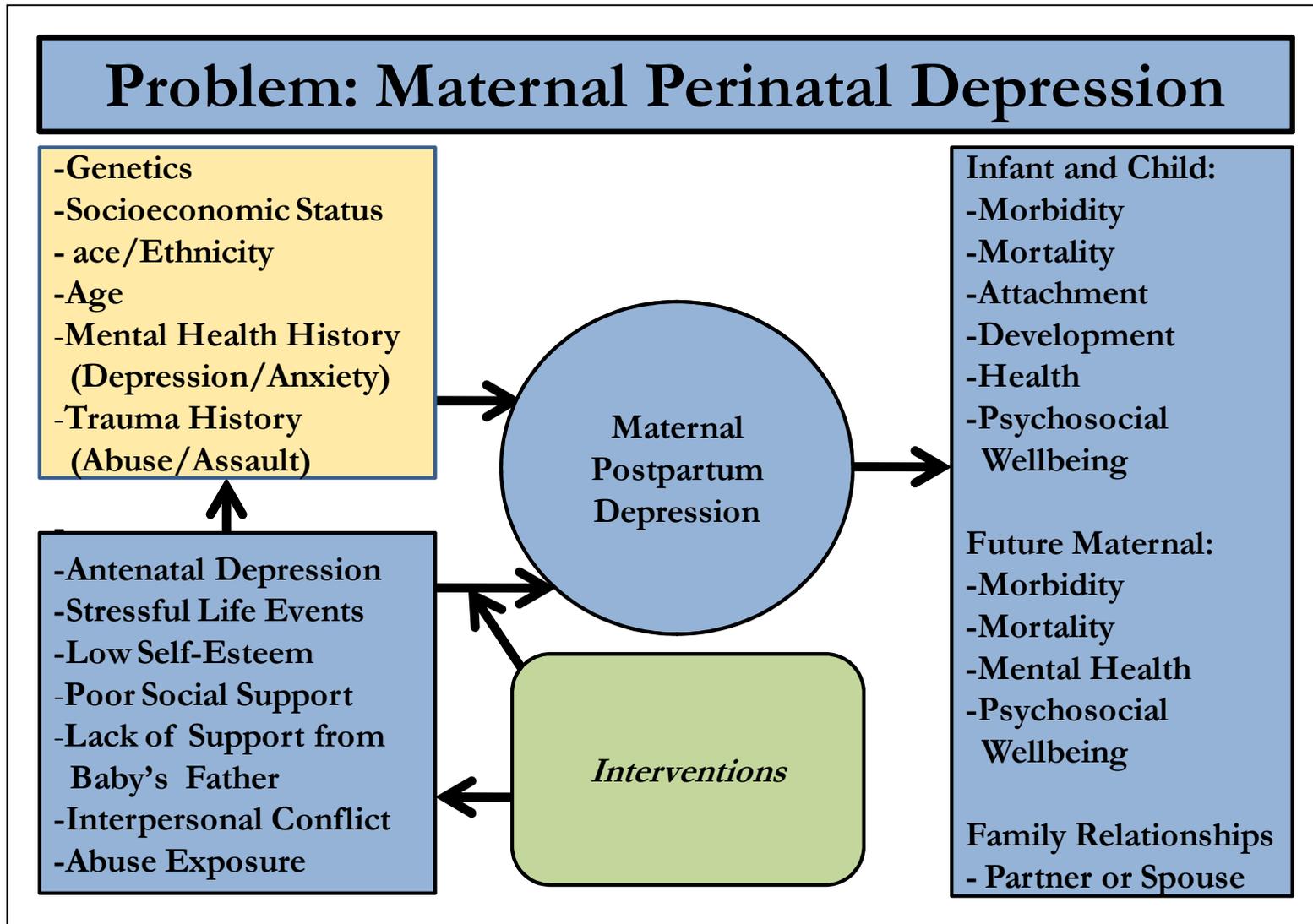
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- 2009 Report on Depression, Parenting and Children by the National Research Council and the Institute of Medicine
  - Depressive symptoms compromise mothers' provision of cognitive and emotional developmental support for their infants and toddlers.
  - Few studies have been conducted with mothers challenged by financial hardship.

# Perinatal Depression Estimates

- **Major Depression vs. Depressive Symptoms**
- **Estimates of Major Depression**
  - Middle Class Women: 10-13%
  - **Low-Income Women: 20-26%**
  - **Adolescents: 16-44%**
- **Estimates of Depressive Symptoms**
  - Perinatal Depression: 19-75%
  - **1 Year Postpartum: 30-50%**
  - **2 Years Postpartum: 33%**
  - NC Mothers: 19%
  - **Low Income Mothers: 23-51%**
  - **NC Latina Mothers: 51-64%**
  - **NC Adolescent Mothers: 28-75%**

# Targeting Perinatal Depression Interventions



# Evidence Based Treatments for Perinatal Depression

## □ Metaanalysis (Bledsoe & Grote, 2006)

*Meta-Analysis: All Interventions Grouped by Intervention Type*

Type of Intervention	Number of Intervention Trials	Number of Participants	Effect Size	p Value
Medication + CBT	1	N = 30	3.871	p < .001
Medication	2	N = 45	3.048	p < .001
Group <sup>a</sup>	1	N = 30	2.046	p < .001
IPT	4	N = 181	1.260	p < .001
CBT	3	N = 172	.642	p < .001
Psychodynamic	1	N = 95	.526	p = .014
Counseling	2	N = 147	.418	p = .014
Educational	2	N = 222	.100	p = .457

<sup>a</sup> Group therapy with cognitive behavioral, educational and transactional analysis components.

## □ Sokol, Epperson, & Barbar, 2011

# Evidence Based Treatments for Adolescent Perinatal Depression

## □ Metaanalysis (Bledsoe, et al, 2009)

Type of Intervention	Number of Studies	Sample	Effect Size	p Value
<i>Continuous Outcome Data</i>				
<i>Experimental/Quasi-Experimental Design</i>				
Interpersonal Psychotherapy	1	n = 27	.911	p = .003
Comprehensive Care	3	n = 214	.326	p = .027
Parent Training	2	n = 35	.332	p = .275
<i>Single Group Pre/Posttest</i>				
Interpersonal Psychotherapy	2	n = 25	.869	p < .001
Public Health Nursing Care	1	n = 47	.466	p = .028
Home Visiting	1	n = 55	.430	p = .028
Parent Training	2	n = 35	.057	p = .811
<i>Dichotomous Outcome Data</i>				
<i>Experimental/Quasi-Experimental</i>				
Home Visiting	1	n = 62	-.009	p = .937
Comprehensive Care	2	n = 2305	.006	p = .795
<i>Single Group Pre/Posttest</i>				
Interpersonal Psychotherapy	1	n = 11	.018	p = .001
Multiprofessional Groups	1	n = 32	-.094	p = .320

# Treatment Considerations

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- Screening and Treatment During Pregnancy
  - ▣ Depression During Pregnancy Increases the Risk of Infant Morbidity and Mortality
  - ▣ Significant Health Differences Exist Between Infants Born to Depressed and Non-depressed Mothers
  - ▣ Strongest Predictor of Postpartum Depression
  
- Recognizing and Treating Depressive Symptoms
  - ▣ Sub-syndromal Depressive Symptoms Affect Child Outcomes
  - ▣ Mothers who Do Not Meet Criteria for Major Depression are Currently Unlikely to be Treated

# Treatment Considerations

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- Frequent Screening and Rapid Treatment Postpartum and Beyond
  - Maternal Depression Impacts Child Health and Development Beyond 1 Year Postpartum
  - Infants/Toddlers Exposed to Maternal Depression Longer Than Six Months Have Increased Risk For Negative Outcomes

# Treatment Considerations

- Frequent Screening and Rapid Treatment Postpartum and Beyond
  - Maternal Depression Impacts Child Health and Development Beyond 1 Year Postpartum
  - Infants/Toddlers Exposed to Maternal Depression Longer Than Six Months Have Increased Risk For Negative Outcomes
- Prevent Child Abuse, Sexual Assault, and Intimate Partner Violence
  - Childhood Physical and Sexual Abuse increase Risk
  - Sexual Assault and Abuse as Adults increases Risk
  - Rates in Treatment Studies:
    - 75% in Adults (PA, NC)
    - 93% in Adolescents (NC)

# Treatment Considerations

- Combine Postpartum Treatment with Mother-Infant Dyad Intervention
  - Treating Maternal Depression Alone is Insufficient (Forman, O'Hara, Stewart, et al, 2007)
  - Mother-Infant Dyad Intervention is Needed
    - Anticipatory Guidance
    - Interaction Guidance
    - Attachment-based Interventions
    - Parent-Infant/Toddler Psychotherapy
    - Infant Massage
    - Psychoeducation
    - Parenting Interventions

# Treatment Utilization

- If Perinatal Depression is Identified Few Women Receive Any Form of Treatment
  - 12% Receive Psychotherapy
  - 3.4-6% Receive Medication
  - Major Depressive Disorder
    - Psychotherapy: 23.3-26.1%
    - Medication: 10-17.4%
  - Depressive Symptoms
    - Psychotherapy: 8.1%
    - Medication: 1.1-3.2%
- To Reduce the Impact of Perinatal Depression Barriers to Treatment Must Be Addressed

(Horowitz & Cousins, 2006)

# Practical Barriers to Treatment

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- Health Insurance
- Financial Strains
- Knowledge of Depressive Symptoms
- Knowledge of Services
- Transportation
- Child/Family Care
- Competing Demands/Confounding Life Circumstances
- Concerns with Safety of Medication
- Delay in First Appointment
- Language

# Psychological Barriers to Treatment

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- Stigma
- Negative Perceptions or Past Experiences
- Fear of Child Abuse Reporting
- “Good Mothers Don’t Get Depressed”
- Fear of Being Labeled Crazy
- Denial by Family and Friends of Symptoms

# Cultural Barriers to Treatment

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## African Americans

- Cultural Stigma
- Cultural Attitudes
  - Strong Ethic of Self-Reliance
  - Mistrust of Health/Mental Health Professionals
  - Preference for Religion
  - Rejection of Medications
  - Preference for Culturally Sanctioned Services over Formal Services

## Latinas

- Cultural Stigma
- Cultural Attitudes
  - Strong Family Ethic
  - Marianismo
  - Preference for Religion
  - Rejection of Medications
  - Preference for Culturally Sanctioned Services over Formal Services

# High-Risk Populations

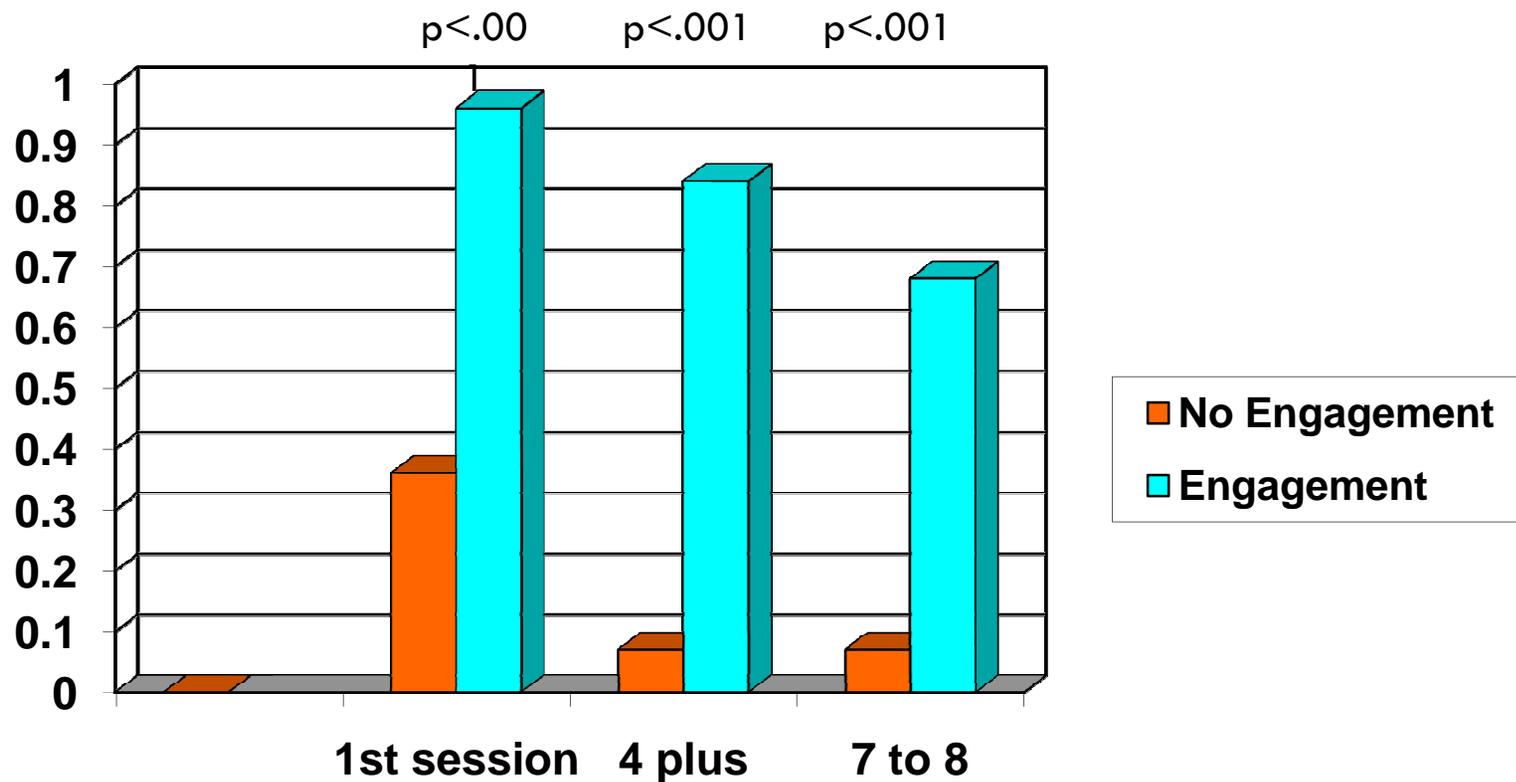
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- Low-Income, Ethnic/Racial Minority Women
  - Promoting Healthy Families (Grote)
- Adolescent Mothers
  - Better Beginnings
- Mothers of Infants and Toddlers
  - Hilda Project (Beeber)
- New Destination Latina Mothers
  - Alas Project (Beeber)

# Promoting Health Families Project: Treating Perinatal Depression in Prenatal Care Clinics

(Nancy K. Grote, University of Washington)

## Results for Treatment Engagement and Retention: % Attending 1 - 8 Treatment Sessions

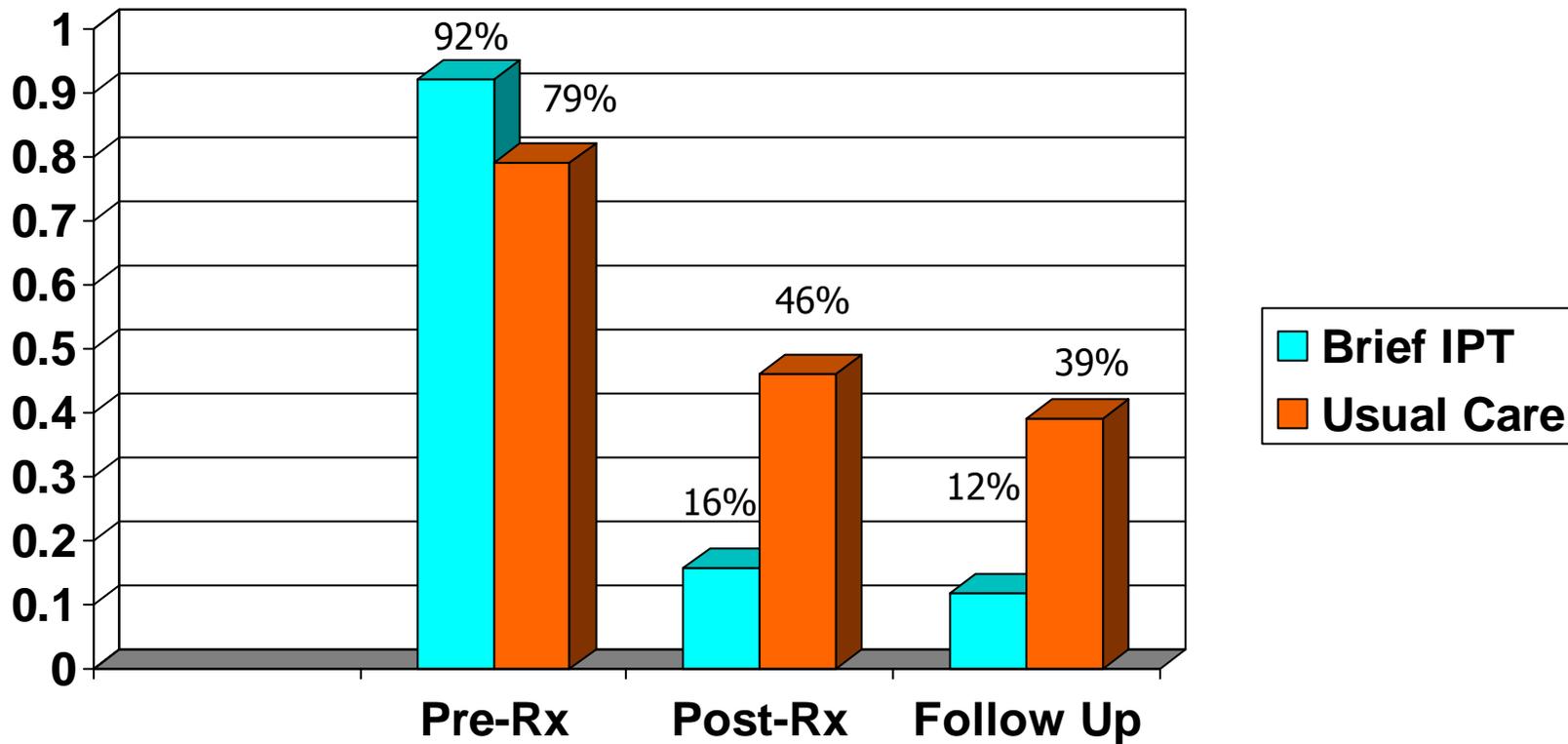


- Less than 1/3 of phone intakes attend 1 Rx session in community mental settings
- Modal (typical) number of Rx sessions attended in community mental health = 1

# Promoting Health Families Project: Treating Perinatal Depression in Prenatal Care Clinics

(Nancy K. Grote, University of Washington)

## *% with Major Depression Diagnoses*



Pre – Post-Rx:  $p < .05$

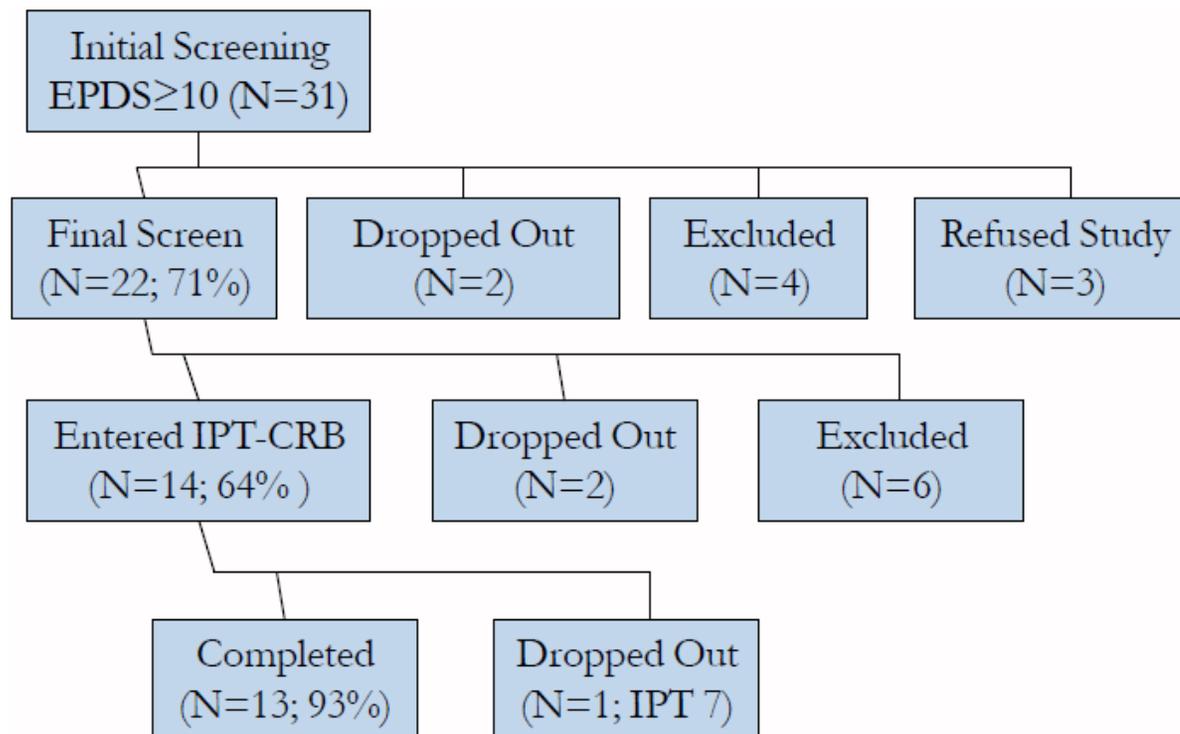
Pre – F/U:  $p < .05$

# Better Beginnings: Treating Adolescent Antenatal Depression in Public Health Clinics

Study Sample	Total (n=14)	Completers (n=13)
Race/Ethnicity		
- African American	50%	46.2%
-Latina	42.9%	46.2%
Mean Age (SD)	16.9 (1.7)	16.85 (1.8)
Weeks Pregnant (SD)	18.3 (6.2)	19.0 (5.9)
# of Pregnancies (SD)	2.7 (1.0)	2.8 (1.0)
Unplanned Pregnancy	71.4%	69.2%
Cohabiting	42.9%	46.9%
Household Income < 20,000	50%	53.9%
Unemployed (Never Employed)	100% (42.9%)	100% (46.9%)
Dropped Out of School	57.1%	53.8%
History of Severe Trauma	92.9%	92.3%

# Better Beginnings: Treating Adolescent Antenatal Depression in Public Health Clinics

Can we recruit, engage and retain pregnant depressed adolescents in a treatment program, IPT-CRB, offered at public health prenatal care clinics?



**73% of screened adolescents were eligible to enter the study.**  
**88% of eligible adolescents entered and 93% completed.**

# Better Beginnings: Treating Adolescent Antenatal Depression in Public Health Clinics

Can IPT-CRB reduce depressive symptoms in low-income adolescents during pregnancy?

Variable	Baseline T1	Posttreatment T2	Paired t Test T1 vs. T2
EPDS (depressive symptoms)	15.4 (2.2)	9.1 (6.2)	-6.3 (5.2)*
CES-D (depressive symptoms)	28.0 (9.9)	14.0 (13.2)	-14.0 (14.9)*
17-HRSD (depressive symptoms)	19.8 (5.7)	9.6 (6.5)	-10.2 (9.5)*
BAI (anxiety symptoms)	22.1 (10.7)	11.8 (10.3)	-10.2 (11.0)*
IIP (interpersonal difficulties)	1.1 (0.8)	1.0 (0.8)	-0.2 (0.9)
SAS (social adjustment)	2.8 (0.9)	2.1 (0.9)	-0.6 (0.7)*

† Completers only. \*p<.01, NOTE: EPDS(Edinburgh Postnatal depression Scale) cut point=10; CES-D (Center for Epidemiological Studies Depression Scale) cut point=16; HRSD (Hamilton Rating Scale for Depression) cut point=8; BAI (Beck Anxiety Inventory) cut point=7; IIP (Inventory of Interpersonal Problems) cut point=1.1; SAS (Social and Leisure Domain of the Social Adjustment Scale) cut point 2.2. Standard deviations of the means are in parentheses.

# Hilda & Alas Projects: In Home Intervention for Low-Income Depressed Mothers of Infants and Toddlers

(Linda S. Beeber, University of North Carolina School of Nursing)

Sample Characteristics	HILDA (n = 226) Mean (SD)	ALAS (n=80) Mean (SD)
Age (yrs)	26 (5.7)	26.3 (5.9)
Education (yrs)	11.8 (2.2)	8.7(2.9)
Partnered	37%	84%
Employed	64%	38%
Income to need ratio	.5	--
Race/Ethnicity	60%AA,26%C	100% Latina
CES-D	26.5 (12.2)	24.5(13.0)
Years residing in US	--	5.3(3.5)
Low Acculturation (SASH <2.8)	--	78%
Child's Age (months)		
Health Problems	24.3 (13.5) 54%	15.9(11.5) 20%

# Hilda & Alas Projects: In Home Intervention for Low-Income Depressed Mothers of Infants and Toddlers

(Linda S. Beeber, University of North Carolina School of Nursing)

## Retention:

- HILDA (English speakers): > 70% completed intervention
- ALAS (Spanish speakers): > 80% completed intervention
- Participants in both groups expressed high satisfaction

# Hilda & Alas Projects: In Home Intervention for Low-Income Depressed Mothers of Infants and Toddlers

(Linda S. Beeber, University of North Carolina School of Nursing)

<b>Treatment Target</b>	<b>Pilot/Feasibility (n = 16) (16 weeks, 3 Timepoints)</b>	<b>ALAS DHHS/ACF Study (n = 80) (26 weeks, 4 Timepoints)</b>	<b>HILDA NIMH Study (n = 226) (26 weeks, 4 Timepoints)</b>
Depressive Symptom Reduction	Intervention group significantly reduced	Intervention group significantly reduced	Intervention and attention-control equally reduced
Maternal Negative Perceptions of Child	Not measured	Intervention group significantly reduced	Not measured
Maternal Interaction Behaviors	Yes, trend toward more positive mothering interactions	Not significant	Intervention mothers significantly greater positive mothering interactions
Child Behaviors	Not measured	Not significant	Not significant

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### **□ Participants and their families**

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Clinical Social Worker

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- Deborah Howell  
Physician Assistant Director
- Rebecca Moore-Patterson, MSW, LCSW  
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# Thank You. Questions?

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*If we hope to create a nonviolent world  
where respect and kindness replace fear and hatred,  
we must begin with how we treat each other at the beginning of life.  
For that is where our deepest patterns are set,  
from these roots grow fear and alienation ~ or love and trust. - Suzanne Arms*