

## An Open Trial of Web-Based Mindfulness-Based Cognitive Therapy for Perinatal Women at Risk for Depressive Relapse

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*Depression occurring during pregnancy and postpartum (i.e., the perinatal period) is common and associated with adverse outcomes for women and their offspring. Mindfulness-based cognitive therapy (MBCT) has been shown to reduce risk for depressive relapse among at-risk individuals generally, and recent adaptations document the efficacy of MBCT among perinatal women specifically. In addition, MBCT, when delivered using a web-based format (Mindful Mood Balance [MMB] program), has demonstrated acceptability and feasibility for at-risk individuals generally. The aim of the present open trial study was to examine the feasibility, acceptability, and preliminary outcomes of MMB for use with pregnant women at risk for depressive relapse ( $N = 37$ ). We predicted that MMB would be feasible and acceptable as assessed by session completion and participation in phone coaching calls, home practice completion, and self-reported satisfaction via questionnaire and interview. We also predicted that women would not demonstrate significant worsening of depression symptom severity during MMB, consistent with our focus on prevention. A brief case example based on a composite of participants is presented to illustrate the MMB structure and content and the phone coaching protocol. Participants demonstrated engagement with the program, reported perceiving benefits in the intended depression prevention targets of MMB, and sustained minimal to mild depressive symptom severity over the course of the program. Given these promising results and the potential benefits of averting depression for women and their families, further development and rigorous testing of MMB among at-risk pregnant women is warranted.*

APPROXIMATELY one in eight women become depressed during pregnancy or the postpartum (Gavin et al., 2005), with negative correlates and consequences for women and their families (Stein et al., 2014). Recent reviews, including meta-analytic reviews, support the effectiveness of interventions to prevent perinatal depression in reducing depression symptoms and risk for future episodes or elevated symptom severity (Dennis & Dowswell, 2013; Sockol, 2015). One of the most robustly supported depression prevention approaches in the general population is mindfulness-based cognitive therapy (MBCT), which has been shown to reduce risk for depressive relapse among individuals with recurrent depression (Piet & Hougaard, 2011). MBCT adapted for the prevention of depressive relapse during pregnancy

and the postpartum (MBCT-PD) also has strong empirical support. Data from an open trial examination of MBCT-PD demonstrated the feasibility and acceptability of this approach among pregnant women with histories of depression (Dimidjian, Goodman, et al., 2015) and a randomized clinical trial demonstrated its efficacy with respect to usual care in preventing depressive relapse/recurrence (Dimidjian, Goodman, et al., 2015). These findings are consistent with those from other studies that support the acceptability of mindfulness interventions among perinatal women (Dimidjian & Goodman, 2014; Dunn, Hanieh, Roberts, & Powrie, 2012; Goodman, Dimidjian, & Williams, 2013; Goodman et al., 2014; van den Heuvel, Donkers, Winkler, Otte, & Van den Bergh, 2015; Vieten & Astin, 2008) and the beneficial impact of mothers' mindfulness on infants (van den Heuvel et al., 2015).

Given the efficacy of preventive interventions with pregnant women at risk for depression relapse/recurrence, and the potential benefits of averting depression for both women and their offspring, it is a priority to increase the uptake of efficacious programs. To overcome many of the

*Keywords:* pregnancy; depression; prevention; mindfulness-based cognitive therapy; dissemination

practical barriers to help seeking, recent clinical innovation has focused on the use of web-based delivery (Griffiths, Farrer, & Christensen, 2010). Meta-analytic reviews have concluded that web-based treatments for depression are effective, but suffer from attrition rates as high as 74% in interventions that offer no additional support or coaching (Richards & Richardson, 2012). Interventions that include coaching are associated with better outcomes and lower attrition (i.e., 38% for administrative-supported and 28% for therapist-supported programs; Richards & Richardson, 2012). Consistent with this framework, Z.S. and S.D. developed Mindful Mood Balance (MMB), a web-based program designed to prevent depression relapse based on the core strategies and principles of MBCT. An open trial examination of MMB for individuals with a history of depression found that the intervention was acceptable, associated with significant decreases in depression symptom severity over the course of the intervention among MMB participants, and significantly greater improvement in depression symptom severity compared with propensity-matched controls receiving usual care (Dimidjian, Beck, et al., 2014). Participant feedback further supports the acceptability and potential scalability of MMB (Boggs et al., 2014; Felder, Dimidjian, Beck, Boggs, & Segal, 2014).

The extension of interventions such as MMB to at-risk (based on a prior history of depression) pregnant women may be of particular value. Researchers have shown that many pregnant women use the Internet to seek pregnancy-related information (Lagan, Sinclair, & Kernohan, 2006) and to inform pregnancy decisions (Lagan, Sinclair, & Kernohan, 2010). Moreover, many postpartum women experiencing at least mild symptoms of depression seek information about postpartum depression using the Internet (Maloni, Przeworski, & Damato, 2013). Several recent studies have demonstrated the feasibility and beneficial outcomes of web-based depression treatments for postpartum women (Danaher et al., 2013; O'Mahen et al., 2014; Sheeber et al., 2012), but we found no published studies that examined web-based depression treatment or prevention programs for pregnant women.

In the present study, we examined the feasibility, acceptability, and preliminary outcomes of MMB for use with pregnant women at risk for depressive relapse, based on prior history of depression. Study hypotheses were informed by research supporting in-person MBCT-PD as efficacious in preventing depressive relapse among pregnant women with a history of depression (Dimidjian, Goodman, et al., 2015) and MMB as an acceptable, feasible, and promising format for delivering MBCT among individuals with a history of depression (Boggs et al., 2014; Dimidjian, Beck, et al., 2014; Felder et al., 2014). First, we predicted that women would demonstrate engagement with MMB, as measured by session comple-

tion, participation in phone coaching calls, home practice completion, scores on self-report satisfaction questionnaires, and responses in an exit interview. Second, consistent with our focus on prevention, we explored whether women maintained minimal to mild depressive symptom severity during MMB. Details from a brief composite case example representative of the course of the MMB program are also presented.

## Method

### Participants and Procedures

The study protocol was approved by the Institutional Review Boards at University of Colorado Boulder, Kaiser Permanente Colorado, and HealthPartners Institute for Education and Research in Minnesota. All participants provided written informed consent. Participants were recruited from the Boulder community from April 2013 to December 2013 via online resources (e.g., local listservs, Craigslist), and flyers posted at local medical settings or retail stores catering to pregnant women. Participants were recruited from Kaiser Permanente Colorado from April 2013 to January 2014 via flyers, brochures, and direct referral from obstetric care providers. Participants were recruited from HealthPartners from January 2014 to April 2014. Women 18 years of age and older who were receiving prenatal care at HealthPartners were identified using electronic medical record data and the study team sent a secure message via the electronic medical record system to each woman's provider asking for approval to invite their patient to the program. If approval from the provider was received or there was no answer in 5 business days, research staff sent an invitation letter to the patient and conducted a follow-up call within 5 days.

Interested individuals completed a phone prescreen during which research staff described the study, answered questions, and assessed initial eligibility including age, access to Internet, and current and past depression. Interested individuals who passed the prescreen were invited to complete an intake interview in person or by phone to determine eligibility using the Structured Clinical Interview for DSM-IV Axis I Disorders (First, Spitzer, Gibbon, & Williams, 1994). After the intake interview, eligible participants were oriented to the website. Inclusion criteria for all participants included (a) currently pregnant, (b) 18 years of age or older, and (c) history of at least one past major depressive episode. Participants from Kaiser Permanente were additionally required to have a Patient Health Questionnaire (PHQ-9) score  $\leq 12$ . Exclusion criteria included (a) currently meeting criteria for a major depressive episode, (b) current suicidality, or (c) indication of serious mental illness or other disorders or symptoms that necessitate priority treatment. Table 1 displays participant

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