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Peer-support intervention for postpartum depression: Participant satisfaction and program effectiveness

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ABSTRACT

Objective: Postpartum mood disorders represent a serious problem affecting 10–20% of women and support groups offer a promising intervention modality. The current study examined participant satisfaction with and effectiveness of a peer-facilitated postpartum support group.
Intervention: The program consists of a free, peer-support group, developed to increase social support and destigmatise postpartum mood symptoms. The weekly group is co-facilitated by former group attendees and maternal health professionals.
Setting: The peer-support program is offered in an urban city in the southeastern United States.
Design: To address study aims, a community-based participatory research approach was implemented. Participant satisfaction was assessed via mixed methods analyses. Differences in depression scores at follow-up between program attendees and a community sample were examined via weighted linear regression analysis following propensity score analysis. Finally, within-group change in depression scores for program attendees was examined using a repeated measures ANOVA.
Participants: Intake program data were provided by the sponsoring organisation ($n = 73$) and follow-up data were collected via an online survey from program attendees ($n = 45$). A community sample was recruited to establish a comparison group ($n = 152$).
Measurements and findings: Participant satisfaction was high with overwhelmingly positive perceptions of the program. Postparticipation depression scores were similar to those of the community sample at follow-up ($p = .447$). Among attendees, pre-post analyses revealed reductions in depression symptoms with significant interactions for time × complications ($p \leq .001$) and time × delivery method ($p \leq .017$).
Key conclusions: Overall, findings indicate this peer-support program is not only acceptable to program attendees but also they provide a potential mechanism for improving mental health outcomes; however, further evaluation is needed. Findings also emphasise the importance of integrating evaluation procedures into community-based mental health programming to support effectiveness.
Implications for practice: Peer-support groups are an acceptable form of intervention for women experiencing postpartum depression.

Postpartum mood disorders (PPMD), such as postpartum depression, are estimated to affect 10–20% of women and represent a serious health concern for mothers and their children (Centers for Disease Control, 2008; Gavin et al., 2005). PPMDs are defined as clinically significant disruptions in mood and/or sleep in the 12 months following the birth of a child (American Psychiatric Association, 2013). Without treatment, PPMD symptoms can persist well beyond the postpartum period (Goodman, 2004). In addition to the deleterious effects PPMDs have on mothers, children of mothers with PPMDs are at risk for disrupted mother-infant bonding, delays in infant cognitive development, and poor social development, as well as academic delays and psychopathology when they are school-age (Field, 2010; Murray and Cooper, 1997). Additionally, there is some evidence that the effects of untreated PPMDs can contribute to higher rates of physical illness and hospitalisation among infants (Farr et al., 2013). In response to this serious health problem multiple agencies have highlighted the necessity for universal screening and early intervention for PPMDs (American College of Obstetricians and Gynecologists, 2015; Siu et al., 2016). Accordingly, obstetrics and gynecology (OB/GYN) practices are increasingly screening women for postpartum depression (Avalos et al., 2016).

Even when screening occurs, not all women receive treatment for a variety of reasons (Goodman and Tyer-Viola, 2010). Barriers to treatment commonly include structural barriers, such as cost, lack of insur-

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ance (Santora and Peabody, 2010), time constraints, lack of childcare, and dearth of available referral resources (Gjerdingen and Yawn, 2007), and attitudinal barriers, such as stigma and fear of Child Protective Services involvement (Byatt et al., 2013; Santora and Peabody, 2010). Accordingly, strategies are necessary for women to overcome these barriers to access treatment, such as through targeted interventions that address barriers and align with preferences of new mothers to achieve maximum effectiveness and reach. For example, a peer-support model may function as an effective and appealing treatment option for women experiencing PPMDs. Indeed, research suggests that many women prefer programs that are offered in a non-mental health setting and in a group format (Goodman, 2009).

Additionally, the availability and quality of social support is an important factor related to the adjustment to motherhood. Strong evidence exists in the literature demonstrating inadequate social support as a predictor of poor postpartum mood outcomes – a relationship that remains true cross-culturally (Beck, 2002; Xie et al., 2009). Social support is particularly salient when offered by a partner and close family/friends as women who have low support from these sources have a greater risk for PPMD than when support is inadequate from other sources (Webster et al., 2011). Group-based interventions which include a social support component appear to be a logical and theoretically-informed method for treating PPMDs. As such, an intervention that is group-based, offered in a non-mental health setting, and that, in some way, overcomes barriers to treatment and access, may be most effective in improving postpartum mental health.

Peer-support intervention

In 1998, a grass-roots effort by a mother experiencing postpartum depression and her psychiatrist led to the initiation of a peer-support group in a metropolitan area in the southeast United States. The goal of the program was to increase social support and destigmatise PPMD symptoms by offering a free, peer-moderated support group. Since its inception in 1998, the program has been sustained by a group of volunteers and community stakeholders who established a non-profit organisation in 2007 committed to providing support and resources to women experiencing postpartum mood disorders. The program is delivered weekly after-hours in the large waiting room of an OB/GYN practice and lasts approximately 90 min. Fliers promoting PPMD awareness generally, and the program specifically, are provided in the discharge packet of every woman who delivers at the large birthing centre adjacent to the program meeting location, reaching approximately 5600 women each year (A. Wolf, personal communication, January 19, 2015). Also, fliers are distributed through many local OB/GYN and pediatric practices. Peer facilitators, who proctor the meetings, are mothers who have recovered from their own PPMD symptoms and are trained in group dynamics. Additionally, medical professionals with expertise in PPMDs, including psychologists, psychiatrists, pediatricians, obstetrician/gynecologists, and lactation consultants, serve as medical advisors who are also present at each meeting to co-facilitate. The meetings are led by two peer-facilitators, and the medical advisor is present to offer referral and support for attendees who may be experiencing acute distress.

Program attendees are self-referred, and the program is open, such that new members are welcome at each meeting. Meeting size ranges from one to 12 attendees with administrators estimating typical attendance of eight mothers. The format is unstructured, such that after a review of the meeting guidelines and brief introductions of attendees, participants are encouraged to discuss whatever issues are currently relevant to them. Common topics of discussion include sharing of emotional reactions to motherhood, adjusting to caring for the infant, relationship issues, feeding issues, employment, role strain, and sleep difficulties (for infant and mother), to name a few. Facilitators work to engage less vocal participants, encourage sharing of coping strategies, and provide referrals to mental health professionals as necessary. At the first meeting, each attendee completes an intake form which includes basic sociodemographic information and an Edinburgh Postnatal Depression Scale (EPDS) (Cox et al., 2014). The medical advisor reviews the EPDS with new attendees and provides referral information when warranted. In the case of suicidal ideation, the medical advisor works to connect immediately the woman with psychiatric services, as necessary.

The program is the only free, peer-led support program for PPMDs in the geographic region. The program has served numerous women and families for almost two decades, sustained by former participants returning to volunteer and a non-profit board of directors. Despite its longevity, there has been no formal evaluation of program effectiveness in improving postpartum mental health, nor has there been systematic examination of participant feedback. These two issues have been identified by stakeholders, including program administrators and others, as priority areas to enable the program to meet participant needs and improve services.

The present study

The overall goal of this project was to evaluate a peer-support program for postpartum depression in partnership with program attendees and stakeholders. Specifically, we sought to examine women's satisfaction with the program (Aim 1) and explore women's perceptions of the program, including their experiences of participation and the perceived impact on multiple domains of functioning (Aim 2). We also sought to evaluate program effectiveness by comparing postpartum depression symptoms between program attendees and a community sample (Aim 3) and by examining changes in postpartum depression symptoms over time among program attendees (Aim 4).

Methods

To address our research aims, we conducted a mixed-methods, community-based participatory research (CBPR) study. CBPR situates community members and program attendees as valuable experts who should be actively engaged in all aspects of the research project from hypothesis formulation to results dissemination (Minkler and Wallerstein, 2008). As such, research procedures, assessment development, and data collection strategies were developed in collaboration with community stakeholders, including program administrators, group volunteers, former program attendees, and community medical professionals.

Participant recruitment and procedures

The study population was English-speaking mothers aged 18 years and older in the metropolitan area of a large, southeastern U.S. city and comprised two distinct groups: 1) program attendees, and 2) comparison participants.

Program attendees

At the time of program intake, women in the peer-support group-based program completed a brief demographic form and the Edinburgh Postnatal Depression Scale (EPDS) (Cox et al., 2014). Demographic information collected at program intake consisted of *maternal age* (categorised: 18–21, 22–25, 26–30, 31–40, 41–45, 46–50), *relationship status* (single, married, divorced, separated), *race* (open-ended), and *number of children* (open ended). Intake data were available for women who entered the group between January 2012 and February 2015. Intake data were provided by program administrators for 73 participants and 45 participants completed the follow-up survey. Follow-up data were collected through an online survey that was distributed by the program administrator via email. Program follow-up data were collected from June 2015 through December 2015. A $10 gift card was provided as compensation for completing the follow-up survey. Matching intake and follow-up data was possible for 25 participants. Thus, the program sample included 45 participants for comparison with the community sample and 25 participants for within-group analyses.

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