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Shorter communication

Preferences and attitudes toward approaches to depression relapse/recurrence prevention among pregnant women

Sona Dimidjian [a,*], Sherryl H. Goodman [b,1]

[a] University of Colorado Boulder, Department of Psychology and Neuroscience, 345 UCB, Boulder, CO 80309, USA
[b] Emory University, 36 Eagle Row, Atlanta, GA 30322, USA

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A B S T R A C T

Patient preferences are increasingly recognized as important in clinical research and the delivery of evidence based practice in psychology. Although the prevention of depressive relapse/recurrence among perinatal women is an important public health goal, little is known about pregnant women's preferences and attitudes toward relapse/recurrence prevention interventions. Such information is important given low rates of care seeking among this population, and the potential for a relapse/recurrence prevention to avert negative outcomes among both vulnerable women and their offspring. Pregnant women seeking routine prenatal care in obstetric clinics ($n = 200$) were surveyed to assess their preferences for and attitudes about psychotherapy and pharmacological approaches to relapse/recurrence prevention. Women preferred psychotherapy (mindfulness based cognitive therapy and interpersonal therapy) more so than pharmacotherapy and reported significantly more favorable perceptions of the psychotherapy as compared to pharmacotherapy approaches to depression relapse/recurrence prevention. Results suggest also that depression history is important to consider in evaluating women's preferences and attitudes. Clinical and research implications of these findings are discussed.

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Attention to patient preference is widely recognized as a core component of evidence-based practice in psychology (APA, 2006). Patients who are provided with preferred interventions are more likely to engage in treatment of depression (cf. Kwan, Dimidjian, & Rizvi, 2010). Knowledge of patient preferences may be especially important for the delivery of empirically supported treatments to populations who are vulnerable to non-engagement with services. Such is the case for the problem of depression among pregnant women, of whom less than half receive intervention (Ko, Farr, Dietz, & Robbins, 2012).

Although an emerging literature supports the finding that pregnant women strongly prefer non-pharmacological options as treatment for depression (Goodman, 2009; Sleath et al., 2005), no studies to date have examined pregnant women's preferences and attitudes toward depression prevention options and toward the prevention of relapse/recurrence in particular. This is an important gap given the prevalence of depression relapse/recurrence among women of childbearing age and the potential for prevention to avoid the widely documented adverse effects of depression relapse/recurrence on both mother and offspring (Goodman & Rouse, 2010).

We surveyed pregnant women about their preferences and attitudes toward depression relapse/recurrence prevention, focusing on three approaches—pharmacotherapy, interpersonal psychotherapy, and mindfulness based cognitive therapy—each of which has evidence for the prevention of depressive relapse/recurrence during the perinatal period. First, support for both maintenance and preventive pharmacotherapy among women with histories of depression comes from evidence of increased risk of relapse among such women who discontinue medication use during pregnancy as compared to those who continue use (Cohen et al., 2006; Roca et al., 2013). Additionally, Wisner et al. (2004) found that prophylactic administration of sertraline significantly prevented recurrence of postpartum depression as compared to pill placebo. Second, interpersonal therapy (IPT) has accumulating evidence supporting its efficacy as a preventive intervention among pregnant women, including women with prior histories of depression (Zlotnick, Feeny, Cochran, & Pruit, 2006; Zlotnick, Johnson, Miller, Pearlstein, & Howard, 2001). Third, mindfulness-based cognitive therapy (MBCT) has evidence specifically as an approach to relapse/recurrence prevention in the general population (e.g., Piet & Hougaard, 2011) and mindfulness shows promise among pregnant women (Vieten & Astin, 2008). We did not include cognitive

* Corresponding author. Tel.: +1 303 492 3485.
E-mail addresses: sona.dimidjian@colorado.edu (S. Dimidjian), psysg@emory.edu (S.H. Goodman).
[1] Tel.: +1 404 727 4134.

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behavioral therapy (CBT) in the survey because most evidence for CBT supports its use as an acute treatment with enduring benefits (e.g., Hollon, Stewart, & Strunk, 2006), whereas we were interested in approaches to relapse/recurrence prevention. Notable exceptions include the work of Le, Perry, and Stuart (2011) and Tandon, Perry, Mendelson, Kemp, and Leis (2011), both of which examined the preventive benefits of CBT among low-income pregnant women.

The present study also extends prior work by examining systematically different dimensions of attitudes, specifically perceived credibility and personal reactions to an intervention model, both of which have been examined in research focusing on preferences for other psychological interventions (e.g., prolonged exposure for PTSD) as compared to pharmacotherapy. Many studies of these two dimensions have sampled women in general adult populations (e.g., Zoellner, Feeny, Cochran, & Pruitt, 2003), with findings suggesting that these dimensions may be important to explore among perinatal women, although they have not been used in studies of prevention of perinatal depression relapse/recurrence. Additionally, we build on prior work that has examined predictors of engagement with treatment, particularly depression history and symptom severity. Specifically, a history of depression has been associated with greater likelihood of pharmacotherapy preference (Pearlstein et al. 2006) and, along with current symptom severity, with treatment seeking generally (Flynn, Blow, & Marcus, 2006; Flynn, O'Mahen, Massey, & Marcus, 2006).

We predicted a greater percentage of pregnant women would endorse a preference for either of the psychotherapy versus pharmacotherapy approaches to relapse/recurrence prevention based on prior work on depression treatment (e.g., Goodman, 2009; Sleath et al., 2005). Similarly, we predicted significantly lower perceived credibility and lower positive personal reactions with pharmacotherapy as compared to MBCT and IPT, consistent with research on attitudes toward intervention options for other disorders such as PTSD (e.g., Zoellner et al., 2003). Based on studies examining the relationship between help seeking and depression severity and history (Flynn, Blow, et al., 2006; Flynn, O'Mahen, et al., 2006; Pearlstein et al. 2006), we predicted that these variables would be associated with a higher general preference for services. We thus sampled a general population of pregnant women in order to understand broadly such women's preferences and attitudes toward depression relapse/recurrence prevention and in this context also specifically explored the association of depression severity and history with preference, perceived credibility, and personal reactions to particular approaches.

Method

Participants

Two hundred pregnant women were recruited at their routine prenatal visits at Kaiser Permanente medical clinics in the Atlanta, GA area. On average, participants were 29.95 years of age (SD = 5.68) years. The majority of participants were Caucasian (61%), and others were African American (20%), Hispanic (7%), Asian (4%), or American Indian/Alaskan Native (2%). Most women were employed (17%), with median household income of $60,000 – $69,999, and completed at least some college (74%). The majority were married or living with a partner (84%) and had other children prior to their current pregnancy (64%).

Procedure

Data were collected in obstetric clinics, with procedures approved by the Kaiser Permanente Georgia and Emory University institutional review boards. Participants were approached individually in the obstetric clinic waiting rooms by a research assistant and asked if they would participate in a study of pregnant women's opinions and preferences for prevention of depression during pregnancy. We surveyed pregnant women in general because we were interested in preferences and attitudes regardless of depression history. However, we also inquired about perceived history of depression, given suggestive data that a history of depression is associated with more positive attitudes toward pharmacotherapy (Pearlstein et al., 2006), and given data from clinical trials of preventive interventions showing efficacy specifically with patients with risk indicators such as a history of depression (e.g., Teasdale et al., 2001).

Women who provided informed consent were then asked to read a one-page study overview with information about the purpose of the study, definition of depression (i.e., symptoms and duration), and focal interventions (i.e., MBCT, IPT, and pharmacotherapy) and their relevance for women "who want to prevent depression from coming back during the postpartum." They were asked then to read one-page descriptions of each approach, each of which had been reviewed and endorsed by experts in each field. Each description was divided into six sections: What is the approach? How does the approach think about depression? How does the approach work? What will I do in this approach? How much time is involved? What are the risks? The descriptions are available by request from the first author. Following reading the descriptions, participants were asked to complete the survey, including a measure of current depressive symptoms. Any participant who indicated a high level of current symptom severity or suicidality was referred immediately for follow up evaluation and treatment. No incentives were provided for participation in the study.

Measures

Perceived credibility and personal reactions were assessed with the Credibility Scale (CS) and the Personal Reactions to the Rationale Scale (PRR), developed by Addis and Carpenter (1999) and used in similar studies examining preferences and attitudes to behavioral and pharmacotherapy interventions (Zoellner et al., 2003). The Credibility Scale included seven questions that participants rated on a scale from 1 (not at all) to 7 (extremely). A mean credibility score was computed, with higher scores indicating higher credibility ratings. Items were: 1) How logical does this approach seem to you? 2) How scientific does this approach seem to you? 3) How complete does this approach seem to you? 4) To what extent would this approach help an individual in other areas of his/her life? 5) How likely would you be to participate in this approach if you were concerned about preventing depression? 6) How effective do you think this approach would be for preventing depression for most people? 7) If a close friend or relative were concerned about preventing depression, would you recommend this approach to them? Internal consistency in the current study was .90, .91, and .92 for MBCT, IPT, and pharmacotherapy respectively.

The personal reaction items reflect a more self-relevant focus (Addis & Carpenter, 1999). The Personal Reactions scale included five questions that participants rated on a 7-point scale from 1 (not at all) to 7 (extremely). A mean personal reaction score was computed, with higher scores indicating more favorable personal reactions. Items were: 1) If you were concerned about preventing depression and went to see a mental health professional, how helpful do you think this approach would be for you? 2) To what extent do you think that this approach would help you to understand the causes of depression? 3) To what extent do you think that this approach would help you learn effective ways to cope with the possibility of becoming depressed? 4) If you were to seek help with preventing depression, how likely would you be to choose this

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