

HRSA/MCHB 2007 FEDERAL/STATE PARTNERSHIP MEETING

Building Blocks for Promising Practice Models

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Parental Depression: From Intervention to Prevention

HUYNH-NHU (MIMI) LE: Good morning. Thank you so much for having me here. Speaking of stories, Marybeth Badura and I met at a meeting that she had convened for people who were interested in postpartum depression, very much my first year here. And seven years later, I'm presenting at this conference. I'm very excited to be here.

What I'd like to do is--let's go to the next slide--and talk a little bit about--review a little bit about the field of prevention of perinatal depression, talk to you about the project that my colleagues and I have been working on, to attempt to prevent the onset of this postpartum depression, and conclude with some practice and policy implications.

You've heard from both Jane and Diana that postpartum depression is an important problem. It's under diagnosed and it's undertreated. When we're talking about--conceptually, the differences between prevention and treatment, if you're looking at treatment, you're really trying to identify women who have passed this particular threshold where they actually meet the SM4 criteria for depression, then provide them with the evidence-based interventions to--then get them back into a normal baseline.

When we're talking about prevention, on the other hand, we're really kind of focusing--if I can focus this thing here. Oh, where is my pointer? Oh, is it gone?

UNKNOWN SPEAKER: Try to (inaudible) the slide.

HUYNH-NHU LE: No. No. I'm trying to figure out the pointer. But if you look at the left side of the--under the normalcy, we might--what we might want to do there is identify who's actually at high risk for depression, provide them with an intervention, just so that they actually do not cross the threshold, and actually resume the normalcy.

In terms of the field of prevention trials here, there's been a lot of interest in trying to understand how to prevent the onset of postpartum depression--thank you, sir--through delivery of anti-natal care preventive interventions. And to date, this area is pretty mixed. Let's see here.

Some studies, the earlier studies, have found no significant prevention effects in this area. However, more recent studies have found that it has been affected. Elliot found that a psychoeducational group providing education both during pregnancy and postpartum was effective in reducing--not only the prevalence of postpartum depression, but also symptomatology. Slatnic and colleagues found that using a group intervention based on an interpersonal psychotherapy

approach, very much a relational approach, has also been effective in preventing the incidents or onset of postpartum depression.

Some of the work that Ricardo Muñoz and I have done in San Francisco, and this was in a small study of the low-income, both English and Spanish-speaking women, predominantly in Mexican-immigrant women, and using a (inaudible) behavior approach, has found that there's some promising practice here and that women who were provided with the 12-week (inaudible) behavioral course, and followed for one year postpartum, had a lower incidence of major depression relative to women in the usual (inaudible) condition.

So fast-forward that from California to D.C. and wanting to replicate this with a larger sample. What the mothers and health have proven--I'm sorry--mothers and babies within health project is, but the goal of which is to try to reduce the onset of major depressive episodes by teaching women mood regulation skills, as well as education related to parenting and child development.

We're really focusing on the pregnant women themselves, who are very much with a long-term aim of reducing depression risk in the infants and the negative sick (inaudible) that Dr. Cheng have mentioned earlier. In doing this--this is a randomized control trial, in which we recruit women who are at high risk, and then randomly assign them, either to follow usual care and--or into our mothers and babies course, which is an eight-week (inaudible) behavioral course that's

conducted during pregnancy, following them over time and figuring out if there is an effect on reducing depressive symptoms, as well as reducing the incidents of perinatal depression.

We're very fortunate to have two community partners in the Washington, D.C. area. The first one, the Mary's Center for Maternal and Child Care was established in the 1980s to really address the needs of low-income Spanish speaking Latinos, who really did not have anywhere to go. And even to date, they are serving about, probably, 90 percent Latino immigrants predominantly from the Central American population. The Center for Life of Providence Hospital is the oldest, continuously operating hospital in the District of Columbia founded in 1861. And they also serve a large proportion of ethnically diverse women with 60 percent Latina and 36 percent African-Americans in the community. They also provide--they deliver more babies to the uninsured and underinsured women in the Washington, D.C. area and the largest numbers of that. Okay.

So the Mothers and Babies course itself are intervention, as you can see here. It is conducted during the pregnancy. I should say that all of these are conducted in Spanish. It is eight weeks based on a manual that was developed in San Francisco, (inaudible) to eight weeks here. And what we do is very much teach women about mood regulation skills, understanding about the relationship between their mood and their thoughts, their mood and their behaviors, and the

impact, potentially, of their depression or their negative mood on parenting and the infant outcomes to that.

In addition, we have three individual booster sessions during the first year of postpartum, to really figure out if women have even retained any of the information they've learned during the pregnancy period and also to try to really customize it, individually, to the women and their life circumstances, which typically includes a lot of stress. And these are conducted at six weeks, four months, and 12 months postpartum. That's based primarily on a cognitive behavioral theory, as I mentioned, focusing a lot on mood regulation skills, with a lot of personal projects and homework assignments for them to try out these things, and it also includes relevant perinatal topics.

One of the things--and moving from the West Coast to the East Coast, I'm learning about is that there is very much what we're calling a new Latino population in the D.C. area and on the East Coast, which is characterized by immigration by Central American women who--and Central American immigrants, who by definition, have had more of a history of trauma as a result of fleeing their (inaudible) countries to taking that into account.

So our eligibility criteria is, as you can see here some of the demographics, but also we wanted to target some of the risk factors that Dr. Cheng had mentioned earlier. And we're calling high risk here based either on having a history of

depression, high symptoms scores on the CST, also widely screened measure during pregnancy, and--or a combination of both. And one of things that I think is startling for this is although we're trying to prevent the first onset of nature depression; we're really not able to. And you could see here 50 percent of our women have already had reported a history of depression.

In this very busy slide, what I just really wanted to show you is that this takes a lot of work to be able to get to our sample of 220 women. We probably approached close to 2,000 women in waiting rooms. In one of our sites, we've been fortunate to get the center staff to also screen for a perinatal depression for us, those who are meeting criteria or high risk then are then referred into our study. Of the probably close to 800 women in which we've screened, about 41 percent who've been eligible and of those who've been able to randomize, about 71 percent of that almost 220 women roughly half into each group. Some of the demographics for our women, fairly young, about 25, nine years of education, the majority are either married or cohabitating and--or single without partner, about 40 percent are having their first pregnancy. And we're getting in fairly early in the--about first trimester, so since 18 weeks gestation.

As I mentioned earlier, the majority of our samples are from Central America, over half from El Salvador, we have Honduras and Guatemala as being the other Central American countries, and a smaller portion from Mexico. They've been in the U.S. for about four years and I've known with the Central American

population is that as they're becoming pregnant with their new child, 40 percent of them have at least one child living in their home country and this becomes an important issue to address in our interventions and it comes up quite a bit. Issues regarding lust, issues regarding what it means to have a new baby here.

What you can see here is of the 112 women almost 13 percent did not and were not able to attend any classes whatsoever. And one of the things we're trying to figure out is, "Are those women really the ones who are in the most need or not in figuring out what those characteristics are?" Of the women who were able to attend at least one class, they've attended an average of about five out of eight classes.

What I'd like to share with you are just our preliminary results on the depression, depressive symptoms, as well as the incidents with the 63 women who have completed all five-time points in our study. So if you recall, they get randomized into the study, they're screened, preposed and then they're also being retested or rescreened at the three times postpartum period.

So in looking at this chart here, the red line are the intervention group, the yellow line are the usual care group. And our first thing that we thought was really interesting is that depression scores are high during the pregnancy and they actually decrease over time.

The second thing to our (inaudible), and are--is that these scores look almost identical between the two groups. And so, one of the things, I think, we're trying to figure out is what's going on here as if the case that with our usual care by virtue of interviewing them at each time point where in a (inaudible) and they're providing some sort of support already and therefore we're not seeing those differences.

We are, however, starting to see a difference in the onset of nature depressive episodes between the two groups. So that we've screened women and ask them whether they're meeting criteria from major depressive episode based on a short screener that consist of nine items called the mood screener that takes about five to 10 minutes to complete.

And what you see here is this is over a one year period. Women who were in the intervention group, three percent had a clinical episode compared to about 13 percent in the controlled group. This is based on a small samples and the result is not statistically significant. But I think what it's telling us is that, perhaps, there is potentially an effect and at least reducing the onset of nature depressive episodes over time.

So in summary, the preliminary findings from our 63 compete leaders have found no differences in the levels of depressive symptoms. However, there seems to be a trend for a difference in the major depressive episodes between groups. And

this is actually pretty consistent with some of the previous research in which we've been able to find a difference in the incidents, but not necessarily in the levels of depressive symptoms over time.

What we're doing right now is following up the remaining two-thirds of our participants. We've had 21 drops, so we're able to still retain about 90 percent of our sample. We also had our--measuring other constructs in this sample, some of the other risk factors that Dr. Cheng had mentioned, marital relationships, social support. We're also looking at medical charts in order to look at whether the intervention actually has an effect on the physical health of the pregnant women, the infants and the babies.

And then finally, at that one year postpartum period, we're videotaping mother-child interactions and play activities and feeding activities to see if the intervention would have some long-term impact. So there may be some additional data to be presented (inaudible). So we certainly believe that it is feasible to screen and conduct a preventive group intervention with low-income pregnant Latinas. It's a lot of work, but it could certainly be done.

Centrums, practice implications. What I think this experience has taught for us is that mental health to pregnant women and mothers really needs to be seen as everybody's business. And this is a slogan that was coined by Head Start, but I think makes a lot of sense within the context of what we're talking about here

today. And I think MCHB is doing an important part of this work as you've heard from our other speakers today, as well as people assure that is out on your table and looking for that.

So there is a--really a need to integrate mental health prevention care into perinatal care. There's a need for ongoing screening and follow up of high risk groups in terms of policy. I think in order for psychological research in science to really make an impact in public health, there is a need to address the stigma that's still associated with mental health. There's also a need to get away from completely focusing on treatment, but also going towards prevention, given that a large majority of women are not being treated, that are not being screened in the first place. And unfortunately, not a lot of money is spent in prevention yet. Oh, I'm sorry, I'll be back really, really quick.

And then, I think, finally, when we have this medical model that focuses on one identified patient, what MCHB, I think, is doing and what's more needed is this two-generational approach and I realize in preaching to the choir. Yeah.

Certainly, this work takes place within the context of many other people and there are many to acknowledge, my research team in being able to do that. And also, to participants and the mothers and babies who are a part of our project. And our (inaudible) and there's my Web site and my information in case anyone wants more information. Thank you so much.