WHITE PAPER

EMERGING INTERVENTIONS FOR PERINATAL MOOD AND ANXIETY DISORDERS

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OBJECTIVES

Perinatal mood and anxiety disorders (PMADs), typically defined as occurring during pregnancy or the first year postpartum, can have lasting negative impacts on maternal and child health. The goal of this white paper is to explore and assess community and home-based psychosocial interventions for PMADs utilizing volunteers or paraprofessionals to expand evidence-based treatment options.

PROBLEM BACKGROUND

About 13% of women experience postpartum depression (PPD), and the rate can be as high as 25% in certain populations (Mundorf et al., 2018). Rates of antenatal depression can be even higher (Mersky & Janczewski, 2018). Women should be screened for PMADs during pregnancy and after birth, and the most reliable predictors of PMADs are a history of psychosocial stressors, low income, a poor partner relationship, low social support, and stressful life events (Mundorf et al., 2018). PMADs can be effectively treated with medication and psychotherapy interventions, but barriers such as stigma and lack of access can worsen disparities in treatment. There is a need for interventions that can reach more women via risk reduction or protective factor amplification approaches (Mundorf et al., 2018).

PICOT STATEMENT

For pregnant or postpartum people (P), how do volunteer and home-based interventions for PMADs (I) compared to traditional psychotherapy and medication treatments (C) impact PMADs symptoms, risk factors, and protective factors in the perinatal period (T)?

THE SOLUTION

Evidence supports informal psychosocial support as an effective intervention for many mothers in reducing symptoms of PMADS. Among interventions for PMADs including psychosocial support, professional postpartum home visits, cognitive therapy, and interpersonal psychotherapy, unstructured and non-directive psychosocial support is the only intervention that significantly reduces depressive symptoms (Anokye et al., 2018). Social support, including hands-on or childcare support, may be particularly effective as it helps parents meet children's needs, enhances parents' confidence, promotes positive views of child behavior, and increases parent emotional resources (Martinez-Torteya et al., 2018). Moms who report high rates of social support show increased attachment scores with their infants and decreased fatigue scores one-month post-partum (Yesilcinar et al., 2017).

The impact of adverse childhood experiences (ACEs), trauma, and social determinants of health (SDOH) in relation to PMADs cannot be ignored. PPD is significantly correlated with increased exposure to ACEs and PPD rates are high among low-income women (Mersky & Janczewski, 2018). Intimate partner violence, perceived stress, and antenatal depression further mediate the impact of ACEs on PPD. Women with low depression scores and high resilience factors show high levels of parenting sense of competence, even when they have a history of maltreatment as children (Martinez-Torteya et al., 2018). For adolescent moms in particular, home-visitation interventions, an educational program across the entire prenatal to postpartum period, and infant massage training are successful in reducing PPD symptoms (Sangsawang et al., 2019).

Several community and home-based interventions show positive results. Trained, non-professional home volunteers can deliver an effective cognitive-behavioral PMADs intervention called Mothers and Babies (MB) (Tandon et al., 2018). Postpartum moms find this modified MB program enjoyable, easily understandable, and useful. MB can also be delivered in a group-based format, and paraprofessional home visitors delivering the intervention produce similar results as mental health professionals (Tandon et al., 2021). Home visits with planned training on topics like coping with stress and basic baby care result in improved quality of life scores for moms (Tel et al., 2018). Community health worker (CHW)-led interventions for at-risk pregnant women are shown to reduce PPD scores, especially for single moms (Mundorf et al., 2018). Finally, distance-delivered programs using paraprofessionals are also effective. Moms report high satisfaction with these treatments including handbooks, videos, and telephone-based coaching, and are more likely to experience PDD diagnostic remission (Wozney et al., 2017).

FRAMEWORK FOR INTERVENTION IMPLEMENTATION

The Promoting Action on Research Implementation in Health Services (PARIHS) framework aims to promote research implementation into clinical practice, and proposes evaluating the evidence, context, and facilitation elements surrounding an implementation. The framework stipulates that the most successful implementation occurs when evidence is scientifically robust and matches the preferences of clinicians and patients, when the context is receptive to change, and when there is high facilitation in the environment (Roohi et al., 2020).

MEASURES OF PRACTICE CHANGE

The main measure of practice change will be reduction in PMADs symptoms as shown through reduced scores on validated measures like the Edinburgh Postnatal Depression Scale. Measures of social support, maternal-infant attachment, fatigue, and ACEs may also be measured pre and post-practice change as they are noted, important factors in the screening and intervention of PMADs.

DISCUSSION AND LIMITATIONS

Recent research highlights several insights and promising interventions regarding non-traditional treatment for PMADs and their application in today's healthcare system. Unstructured, non-directive social support can be an essential component of care aimed at reducing PMADs. Risk factors such as prior trauma and low socioeconomic status can be important mediators, and further research is needed to determine the most effective intervention for special populations of interest. Non-mental health professionals can have an impact in reducing symptoms in at-risk populations across the perinatal period, especially for populations of low-income, single moms with limited support networks. Future studies can further clarify which type of non-professional support is most appropriate for various populations. More randomized controlled trials are necessary to further validate the proposed interventions. Healthcare professionals and programs aiming to reduce the burden of PMADs should consider these less traditional modalities as they develop or modify perinatal interventions.

IMPLICATIONS FOR PRACTICE

It is time to utilize interventions for PMADs that fall outside the typical treatments of medication and psychotherapy. Strengthening connections to social support resources should be a focus of healthcare providers working with antenatal and postpartum moms. Populations with increased exposure to ACEs, like childhood maltreatment, require special screening and intervention, potentially targeting depressive symptoms and building resiliency in the antenatal period. Home-visitation interventions and educational programs across the entire prenatal to postpartum period should be considered in antenatal care of adolescent mothers. Finally, targeted interventions delivered by non-mental health professionals in the home or remotely can reduce PMADs symptoms in at-risk groups.

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