fACT for Perinatal Depression:

A Hybrid Telehealth-Psychoeducational

Intervention for Patients With Perinatal Depression

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Perinatal Depression: Introduction and Prevalence

The importance of healthy parent-child attachment, especially between mothers and their children, has been supported for several decades (Bretherton, 1992). While tragic stories of mothers harming or killing their own children are generally uncommon news, there are many women suffering from the symptoms of perinatal depression who are not making the headlines. According to the Center for Disease Control (CDC), 1 in 9 women experience symptoms of Postpartum Depression (PPD) (Ko, Rockhill, Tong, Morrow, & Farr, 2017). With a total of 3,945,875 registered births in the United States in 2016 (Martin, Hamilton, Osterman, Driscoll, & Drake, 2018), we can estimate that over 400,000 women experienced PPD symptoms.

In the state of Texas, the Pregnancy Risk Assessment Monitoring System (PRAMS), a subset of the CDC, stated that only 12.8% of women self-reported Postpartum Depression symptoms (PRAMS, 2015). Being that half of the population of Texas is women (around 14 million citizens), this author surmises that creating accessible perinatal mental health services in Texas is not only a necessity, but also a serious public health issue (U.S. Census Bureau, 2017). With these statistics in mind, I decided to create an intervention directly targeting perinatal depression in primary care, specially designed to be implemented in women's health clinics, as obstetricians and gynecologists often become the primary care provider for women while they are pregnant (ACOG, 2018).

Perinatal Depression: Definition

Perinatal Depression is a collective term that includes prenatal depression (i.e., a woman experiencing depressive symptoms before her baby is born/during pregnancy) and postpartum depression (i.e., a woman experiencing depressive symptoms after her baby is born) (Wilson,

2017). According to Wilson (2017), there are several subcategories contained within the heading of perinatal depression, the most common being the following:

- Baby Blues
    - Affects 60-80% of new mothers
    - Usually occurs on the 3rd or 4th day and disappears by day 14
    - Includes a) crying for no apparent reason; b) loneliness/sadness; c) irritability; d) inability to sleep; e) food craving/loss of appetite; f) lack of feelings for the baby; g) loss of self-confidence; and h) feelings of being overwhelmed
- Postpartum Depression (PPD)
    - Although the baby blues and PPD may look similar, symptoms seem to worsen after a few weeks rather than subsiding.
    - Symptoms include a) feeling "Not yourself;" b) appetite and sleep changes; c) hopelessness; d) guilt, inadequacy, worthlessness; e) over concern/No concern/ Anger towards baby; f) loss of all interest including sex; g) fantasies/bizarre thought patterns; h) nightmares/hallucinations; i) feeling out of control; and j) frightening feelings
- Postpartum Psychosis
    - Severity is the key in diagnosing postpartum psychosis; Rarest of all the postpartum illnesses. It affects 1 in every 1,000 births; Symptoms occur between 3-14 days and initially resemble PPD
    - Symptoms include a) refusal to eat; b) loss of memory; c) excessive energy; and d) total irrationality

Literature Review

The majority of literature pertaining to perinatal depression and the mental health interventions used to treat it, focuses on depression prevention through prenatal psychoeducational groups, the use of mindfulness-based interventions, Cognitive Behavioral Therapy (CBT), and Interpersonal Therapy (IPT) (Dunn, Hanieh, Roberts, & Powrie, 2012; Werner, Miller, Osborne, Kuzava, & Monk, 2015). There is also substantial literature examining the barriers to treatment which include "fears of stigma, losing parental rights and being judged as an unfit mother" (Byatt et al., 2013). Moreover, some recent and exciting news in perinatal care comes from the American College of Obstetricians and Gynecologists (ACOG) who recently submitted a new Committee Opinion in November 2018 which states:

> If a patient is screened for depression and anxiety, clinical staff in obstetrics and gynecology practices should be prepared to initiate medical therapy, refer patients to appropriate behavioral health resources when indicated, or both.

Armed with the information provided from these studies and ACOG's Committee Opinion, I set out to create an intervention that would address the need for accessible mental health services for depression in the perinatal population.

Group Program

My proposed group program, a hybrid telehealth-psychoeducational intervention for patients with perinatal depression, was influenced by two specific studies, as well as my internship experience at a Women's Health Clinic in the Southwest region of the United States. The first study, conducted by Feros, Lane, Ciarrochi, and Blackledge (2015) used Acceptance and Commitment Therapy (ACT) with oncology patients. Their intervention included nine, face-to-face, 45-minute visits with ACT trained psychologists and a 3-month follow-up to see how the

ACT interventions held up over time (Feros, Lane, Ciarrochi, and Blackledge, 2013). The second study used ACT for Perinatal Mood and Anxiety Disorders during four, 50-minute group psychotherapy sessions where no quantitative data was collected, only "positive anecdotal impressions" (Bonacquisti, Cohen, & Schiller, 2017).

My final and most significant influence came from my internship at a Women's Health Clinic in the Southwest region of the United States. While the clinic serves regular OB and GYN patients, there are several other clinics housed inside a Women's Health Clinic in the Southwest region of the United States including Maternal Fetal Medicine (MFM), which treats mothers with high risk pregnancies, and the Gynecology-Oncology Clinic, which treats women diagnosed with any type of gynecological cancer. The patient population is predominantly female with low social economic statuses and consistent comorbities such as obesity, anxiety, and diabetes. There are also several consistent barriers to care such as cost and travel distance.

The Group

Acceptance and Commitment Therapy. My fACT for Perinatal Depression group is an amalgamation of the two ACT interventions discussed above (Bonacquisti, Cohen, & Schiller, 2017; Feros, Lane, Ciarrochi, and Blackledge, 2013) and the knowledge I have acquired while working at a Women's Health Clinic in the Southwest region of the United States. I chose to incorporate Acceptance and Commitment Therapy (ACT) into my intervention because ACT has consistently shown effective, evidenced-based treatment for a wide variety of symptoms and diagnoses including, but not limited to, diabetes, high blood pressure, mood and anxiety disorders**,** Obsessive Compulsive Disorder, and Post-Traumatic Stress Disorder (Bonacquisti, Cohen, & Schiller, 2017). It is important to note that all of these symptoms and diagnoses can be present in perinatal populations; therefore, ACT is a viable addition to mental health treatments

and interventions for perinatal populations. However, while ACT is a successful intervention, it is too long in its traditional form for use in primary care. Thus, Focused Acceptance and Commitment Therapy (fACT), which was developed by Kirk Stroshal, Patricia Robinson, and Thomas Gustavsson (2012), is better suited to the fast-paced needs of the primary care setting. fACT incorporates a contextual interview of the patient's life, the "3 T's:" time, trigger, and trajectory of their presenting problem, and an assessment of how the patient's presenting problem is affecting the Work-Play-Love aspects of their lives. ACT contains six processes of psychological flexibility which become the "Three Pillars," or pathways, of fACT which are as follows: a) open (Can the patient notice and track their thoughts? Can the patient separate themselves from their thoughts?); b) aware (Is the patient present? Can the patient engage in flexible perspective taking?); and c) engaged (Is the patient connected to their values? Is the patient able to take action on their values?)

Telehealth. I chose to combine fACT and telehealth because both interventions have shown success when working with postpartum mothers and patients who have experienced similar symptoms and comorbities that accompany postpartum depression (Bonacquisti, Cohen, & Schiller, 2017; Macnab, Rojjanasrirat, & Sanders, 2012). Additional benefits of having a telehealth group include its low cost, simple implementation, adaptability (e.g. phone or Skype), ease of access for most patients, and reduced pressure on PCPs to be present every visit.

The Visits

Visits 1, 4, and 9 will be face-to-face groups for 90 minutes which meet every week for 9 weeks. The telehealth visits (numbers 2, 3, 5, 6, 7, and 8) will be 15-25-minute-long, individual Skype or phone consults. Mothers with unmanaged addictions or serious mental illness (e.g. schizophrenia, active psychosis, etc.) will be screened out. Mothers in addiction treatment will

have to show proof of care with another provider, and receive provider clearance, before being considered for the group. Potential participating mothers can be found through the following means:

- Schedule scrubbing
- PCP referrals
- Advertisement in clinic
- Follow-up with patients who have positive PHQ-9 (score of 5 or higher) and Edinburgh results (10 or greater with greater attention to item 10, the suicidal thoughts question)

The large group meetings themselves will include a BHC, PCP, Social Worker, and Health Educator (ideally the Health Educator is also a lactation consultant and/or child birth educator). The 90-minute-long format will include two psychoeducational lectures (with varying topics such as parenting skills and breastfeeding) leaving the last 30 minutes for optional appointments with the PCP to discuss depressive symptoms and medication options, or with the Social Worker to discuss resources and needs for mom and baby. The materials list needed to conduct these three face-to-face visits are as follows: 1 large group meeting room contained within the clinic that is wheelchair accessible, 15 manuals (complied by the BHC), access to ACT Audio (Online and MP3s), 15 pens, 45 copies of Edinburgh Postnatal Depression Screener, 15 spiral notebooks with calendars, and access to a phone and computer with internet connection and a camera for telehealth consults.

The group mainly targets postpartum mothers, however, any prenatal moms who score positively for depression are welcome to join. I aim for no more than 10 patients in the group in order to maintain the quality of the interventions and level of care. The skills that will be addressed come from the ACT protocol which includes the following: Acceptance, Cognitive

Defusion, Mindfulness, Value Identification, and Goal-setting (Please see Table 1 for group protocols and visit outlines). Finally, prior to Visit 1, it is necessary that the BHC do some additional leg work in order to set the group up for success. Therefore, the BHC will complete the following before the initial group visit: a) conduct face-to-face contextual interviews with all patient participants (30-minute consults); b) administer AAQ-II, PHQ-9, GAD-7, and Quality of Life; c) set up telehealth call dates and times with patients (via Skype or phone); and d) give patients their journal and calendar to bring to every face-to-face visit.

Conclusion

The need for access to competent, cost-effective perinatal mental health services in the state of Texas, and in the United States at large, is evident. My hybrid telehealth-psychoeducational group could address that need in a primary care setting. The use of fACT assures patients and providers that all strategies implemented within the group are tested and evidenced-based. The telehealth aspect of the group creates more accessibility for mothers who might not otherwise attend a group due to barriers to care such as transportation and cost. It is my hope that this group, or another one like it, could be implemented in a primary care setting and be adjusted to fit other patient populations who could benefit from fACT strategies and the convenience of telehealth.

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