

# Peer Support for Mothers with Postnatal Depression

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## Abstract

The number of mothers suffering from postnatal depression (PND) continues to rise at an alarming rate. Recent NICE guidelines (2015) have highlighted the need for the utilisation of psychosocial support – as opposed to the, use of antidepressant medication – as an appropriate intervention. One of the main reasons for PND is a lack of social interaction and isolation (Dennis, 2009). Could, therefore, disclosing to a fellow mother – who has previously shared a similar journey – help to assist in the recovery from this debilitating illness?

In order to explore this question, eight peer support workers (PSWs) were recruited to offer one to one home visits within the postnatal period to a mother considered to be at elevated risk of PND – as suggested by the Edinburgh Postnatal Depression Scale (EPDS). The PSWs visited the mother on a weekly basis, within their own homes, from week six postnatally for a period of six weeks.

Data were gathered both quantitatively and qualitatively by the recording of the EPDS scores, log book entries and one to one interviews. Results revealed that the PSWs had a positive effect upon the mothers' mental health, outlook and indeed, their relationship with their baby.

Keywords: postnatal depression; peer support; mixed methods research; questionnaires; empathy.

## Introduction

Postnatal depression (PND) is a global problem and an important public health issue (Morrell, 2009). It is estimated that approximately 20% of women experience depression during the first postnatal year but there are problems in recognition because its clinical assessment can be complex. The incidence of postnatal depression continues to rise resulting in serious consequences for the mother, her child and the extended family and a risk of suicide (the leading cause of maternal death in England and Wales) and infanticide in a minority of severely depressed mothers (Morrell 2009).

## Literature review

### *Psychological Interventions*

Treatment programmes vary considerably but many studies are suggesting that psychological interventions can be equally, if not more, clinically effective in the management of depression as routine care from a general practitioner or anti-depressants in the short term – and may be more cost effective. The incidence of PND is high and the treatment programmes available, which will be discussed within the study, vary greatly. Although the causes of PND are multifactorial, many studies have consistently highlighted the great importance of psychosocial support (O'Hara et al 1991, Cooper et al 1998, Beck 1995). As observed by Dennis et al (2009), previous studies clearly show a significant increase in the risk of PND in mothers who do not have someone with whom they can talk openly (Brugha et al 2002, Paykel et al 1999,

O'Hara et al 1991). Small et al (1997) conclude that mothers become depressed because of a 'distinct lack of support' and 'social isolation'. Within Small et al's study, when participants were asked what advice they would give to new mothers with PND, the most common suggestion was simply 'find someone to talk to'. Cox et al (1987) found that the Edinburgh Postnatal Depression Scale scores were significantly reduced with maternal perceptions of support from other women with similar age children. Well-controlled research trials have revealed that post-natal depression responds to treatment in the short term (Appleby et al 1997, O'Hara et al 2000), with treatment roughly doubling the spontaneous recovery rate. However, it is unclear whether this short-term effect is maintained and it is also not clear whether different forms of psychological intervention might have different impacts. There have been a number of studies using a variety of psychological and psychosocial interventions (Abramowitz et al 2003, Arizmendi et al 1984, Cooper et al 1998, Dennis 2009, Stuart et al 1995) and indeed, several of these studies have found that psychotherapeutic interventions for the treatment of PND are highly acceptable. However, despite an exhaustive literature search, there did not appear to have been any studies focusing upon a one to one peer support network for mothers at risk of PND. Dennis (2009) studied the effectiveness of telephone based peer support in the prevention of PND but this did not incorporate any face to face meeting.

### *Exercise*

Further recent studies have explored the option of the effectiveness of exercise for both the prevention and treatment of antenatal and postnatal depression (Haruna et al 2013, Daley et al 2014, Lewis et al 2014). Daley et al (2014) concluded that exercise as a treatment for antenatal depression was potentially a positive factor but the trial did not report a significant difference between exercise and the usual interventions used for postnatal depression. Fatemeh et al (2014) introduced a home-based exercise intervention to women diagnosed with postnatal depression but the results did not show any significant difference or evidence to show any preventive or treatment effect on postnatal depression. However, Haruna et al (2013) found a significant improvement in the psychological well-being of an exercise programme for postnatal mothers, although this trial did not focus specifically on mothers with postnatal depression but simply mothers in general postnatally. The study did report that the exercise intervention did not produce any significant changes in the EPDS scores recorded. Studies within this field are limited. Further research is required to determine the effectiveness of exercise as an intervention as well as to examine the possible link between sedentary behaviour and postnatal depressive illness.

### *NICE guidelines*

NICE have recently updated their antenatal and postnatal mental health guidelines (2015) and have made a number of positive recommendations. It has been suggested that all women of childbearing age, who have an existing or past mental health problem, are asked about any plans for pregnancy and are informed as to how pregnancy and childbirth may affect a mental health issue, including the risk of relapse. They have also recommended that all women should be asked a number of targeted questions about their mental health on their initial booking appointment with their midwife, thus recognising potential problems early and signposting to relevant agencies. These questions should be repeated regularly both during the antenatal period and in the first year post delivery.

If a woman is considered to be 'at risk' of a mental health issue, then an integrated care plan should be established providing the interventions required and agreeing the outcomes. Women should be fully informed prior to conception, antenatally and postnatally, about the possible risks of mental health problems, the benefits and risks of treatment and the potential harm if treatment is not accessed.

Care has also been recommended for women who experience a traumatic birth, miscarriage or stillbirth. Follow up care for these women should be coordinated by an experienced healthcare professional and have a structured approach.

These recommendations may be viewed as a positive step in the recognition of maternal mental health. The guidelines emphasise recognition of mental health problems during both the antenatal and postnatal periods. It also emphasises the need to include anxiety disorders as well as depression. It is hoped that improved recognition will come from staff training and revision of routine care pathways, thus providing prompt access to further assessment, including that by specialist perinatal mental health services. The guidelines recommend a raised threshold for using psychotropic drugs for some disorders and more emphasis on providing psychological therapies both antenatally and postnatally. These guidelines positively promote both early recognition, intervention and the use of psychological treatments as utilised within this study.

### *Aims of the study*

The aim of this exploratory pilot study is to identify whether the support, on a one to one basis, from a Peer Support Worker (PSW) may help to reduce the effects of PND in new mothers.

### *The Research Question*

Could the provision of support from a fellow mother, who has suffered and recovered from PND, have the potential to reduce PND in new mothers?

## **Method**

### *Participants*

Eight PSWs were recruited following an advert in three local medical practices. Each PSW had previously suffered from mild to moderate postnatal depression but had recovered and were not currently receiving any form of psychological support or taking any medication. They were employed, on a six-month contract, by the local NHS trust. References and enhanced criminal records clearance were obtained. A confidentiality statement was also signed by the PSW.

Thirty mothers were also recruited by their own Health Visitor. This was carried out using the Edinburgh Postnatal Depression Scale (EPDS) alongside a clinical assessment. The EPDS cut off score, as agreed by both the lead researcher and the Health Visitors involved in the study, was 11. Fully informed consent was obtained and participant information sheets given. The mothers were allocated into either a Control group or an Intervention group using number alternating.

All of the participants were first time mothers, aged between 25 years and 35 years. Their first language was English. Each participant had been/was employed in some capacity prior to having their baby and had some level of higher education after leaving school (College of Further/Higher Education or University). They had no previous experiences of any mental health issues and had unremarkable obstetric histories. Mothers with a previous history/family history of any mental health issue, miscarriage or still birth were excluded from the study. The three medical practices were all based within similar areas – more rural than urban but with relatively small pockets of deprivation. Each had a comparable sized population and an analogous percentage of ethnic minorities.

### *Peer Support Workers – Training*

The PSWs received formal training about child protection procedures/safeguarding children in addition to the relevance and importance of confidentiality. However, apart from this, a structured training programme was not adhered to. The PSWs strongly felt, as a combined group, that they wanted to provide the intervention simply as a 'fellow mum who had survived the rollercoaster journey of PND'. Each PSW wanted to identify the nature of the problem, find a possible solution, and design their own proposed 'support package' from the outset of the study. The PSWs, as a combined group, discussed their experience of PND, how they felt, their despair, what made them feel better, what made them feel worse. Many stories were shared and lots of emotions displayed. Although both the researcher and two of the Health Visitors were present during the discussion, it was merely as bystanders and a back seat was taken.

The PSWs all felt very strongly about the fact that they wanted to 'lead' the support, design the intervention, and focus upon what they individually felt they could offer to help their mothers. Each worker wanted to attempt to find their own possible solution to their mother's problem: to identify the route of the low mood/anxiety and, through their own ideas and thoughts, work out a strategy to attempt to help. There were to be no formal structured guidelines as to how each support session was either conducted or where they even met their mother. Of course, issues around child protection and confidentiality were unanimously agreed but otherwise the design of the support visit and service offered was left, from the outset, to each Worker.

### *Procedure*

The PSWs visited the mother in their home environment, or a location of their choice, for a period of six weeks on a once weekly basis for approximately an hour (intervention group). The family Health Visitor visited on a weekly basis too but on a separate occasion. Results for this group were then compared to a number of mothers who received support from their family Health Visitor (HV) alone (control group). Data collected was both qualitative and quantitative in the form of EPDS scores, log book recordings, notes from supervisory sessions and face to face interview recordings. The PSWs and the mothers from both the control group and the intervention group were asked to maintain a log book reflecting upon their feelings and thoughts after each visit (either from their PSW or their HV). Individual and group supervisory sessions were also offered by the lead researcher to both the mothers within the intervention group, and the control group, in addition to the PSWs. A number of the participants were interviewed on a one to one basis when their infant was six months old. Data from the interviews was subsequently transcribed, coded and categorised, and key themes identified.

Quantitative data were collated in the form of an Edinburgh Postnatal Depression Scale (EPDS), an assessment tool which is routinely used to identify mothers at risk or suffering from postnatal depression. The EPDS score was recorded prior to the support commencing by either a PSW or the Health Visitor (at approximately two weeks postpartum), after completion of all six visits, and when the infant was six months old.

### *Data Analysis*

The EPDS scores recorded at 6 weeks, 12 weeks, and again when the infant was six months old, were analysed and summarised using graphs and charts. The decision was taken to use non parametric tests to distinguish differences between the intervention and the control groups. Both a Kolmogorov-Smirnov test and a Shapiro-Wilk test were performed to confirm the appropriate use of non-parametric tests. As demonstrated in Table 1 below, the first set

of data recorded showed a measurable difference in the mean and median scores for the intervention and control groups.

A constant comparative method was used as a means of analysing the qualitative data collected from both log books and interview transcript (Denscombe 2008). The lead researcher consistently read and re-read text data, compared new codes and categories as they emerged and repeatedly compared them against existing versions. This process enabled the researcher to refine and improve the explanatory power of the concepts and theories generated from the data. Similarities and differences were highlighted and categories and codes were identified. On completion of this analysis, all participants were contacted to ensure that each participant agreed with the researchers interpretation of all of the data collected.

## Results

Qualitative and quantitative findings from this study suggest that the input from a PSW does assist in the reduction of PND in new mothers. This is demonstrated in both the analysis of the quantitative data and the qualitative data.

### *Quantitative analysis*

The EPDS scores demonstrated little difference between the two groups at 6 weeks but the statistics started to diverge at 12 weeks – the mean at 12 weeks for the control group is recorded at 12.46 and the intervention group is 10.33 – a difference of 2.13. The EPDS at six months demonstrates a difference between the two mean scores of 2.67 (the control group mean recording is 11.60 compared with the intervention mean which is 8.93). These results are given in the tables below.

**Table 1: Score of EPDS at 6 weeks**

	<b>N</b>	<b>Mean</b>	<b>Median</b>	<b>Standard deviation</b>	<b>Minimum</b>	<b>Maximum</b>
Control	15	13.00	13.00	1.30	11	15
Intervention	15	13.20	14.00	1.38	11	16

**Table 2: Score of EPDS at 12 weeks**

	<b>N</b>	<b>Mean</b>	<b>Median</b>	<b>Standard deviation</b>	<b>Minimum</b>	<b>Maximum</b>
Control	15	12.46	12.00	2.50	9	16
Intervention	15	10.33	10.00	2.35	6	15

**Table 3: Score of EPDS at 6 months**

	<b>N</b>	<b>Mean</b>	<b>Median</b>	<b>Standard deviation</b>	<b>Minimum</b>	<b>Maximum</b>
Control	15	11.60	12.00	3.18	6.00	16.00
Intervention	15	8.93	9.00	3.30	4.00	16.00

The mean and median scores for the intervention and control groups at six weeks diverged only slightly. By 12 weeks, the scores had diverged further, and this difference greater still at six months. However, two outliers were noted: participants 19 and 23 in the control group whose respective scores on their EPDS questionnaire were 12,11 and 10 and 15, 16 and 13 thus displaying an overall improvement in their mental health over the period of the research study.

### *Qualitative analysis*

Semi-structured interviews were carried out after the peer support intervention. This approach was selected because the interviewer still required the option of a clear list of issues to be addressed and questions to be answered.

The search for core elements begins by taking the raw data (the interviews and log book reflections) and searching for themes that recur within the data. This was initially commenced by coding and categorising the data. As the lead researcher progressed through the data, initial open codes began to be identified. Careful scrutiny of both the log books and the interview transcript allowed the researcher to ascertain that certain areas of the data did have common themes. Statements were highlighted in different colours according to which theme the researcher felt that they fitted into. Many statements referred to similar issues and carried similar emotions (feelings of despair, worthlessness, guilt, low mood, failure). The areas of data that did have a common theme as identified by the researcher were coded (tagged) as belonging to a broader category (Denscombe 2008).

The key themes identified were the immeasurable value of 'social support' and 'shared experiences'. The resounding factor that appears repeatedly throughout the analysis of data is the fact that the mothers could 'truly relate to their Worker.' Their PSW gave them 'hope', made them feel as if they were 'not a failure' and gave them an overwhelming 'sense of normality'. This, in turn, increased their self-esteem, their positivity towards their parenting role, and their ability to therefore be 'a good mother.' A major strength of the work was the involvement of the PSWs in both the planning and the implementing of the intervention. It was their design, their creation, and their feelings about what may really help their mother.

A number of other themes were also identified that were, interestingly, commonalities across the entire data set (participants and PSWs). These included recognition of their own changing perspective, a realisation that there simply is no 'quick fix' solution, that both time and support are required. The PSWs described feelings of 'personal benefit', 'self-awareness' and the 'provision of closure' for themselves. The intervention group also talked, at length, about their 'personal benefit' from the PSW, and their own self-awareness about how they truly felt, their emotions and, in some instances, why they felt this way. The control group recognised the huge advantage from talking to other mothers and, although they did not have the formal support sessions from a PSW, they embraced the opportunity of sharing their thoughts and feelings with 'fellow mums'. Each participant and PSW discussed the sharing of experiences, empathy, the feeling of 'release' and, particularly on the mothers' part, the importance of knowing that, actually, they are not 'alone' (see Table 4).

**Table 4: Combined themes of the PSWs and all participants.**

<b>MAIN THEME</b>	<b>SOURCE</b>	<b>EXAMPLE OF QUOTES</b>
Changing perspective	Peer Support Worker Mothers from both the control and the intervention group	'No quick fix'. 'Time and patience required.' 'Pre- conceived ideas abandoned.' 'Hope to make a small difference'. 'Humbled by experience - surprisingly'.
Personal benefit	Peer Support Worker Mothers from both groups (control group who sought own support)	'Reflect upon their own Journey'. 'Positively helps them to see how far they have come'. 'What worked for them – share'. ' Sheer relief'. 'Hope.' 'Therapy'.

Abandoning	Peer Support Worker	'Worry that all the hard work will be undone.' 'Guilty'.
Hiding from their Health Visitor	All Mothers	'Falseness'. 'Putting on a brave face'. 'Relief when visit is over'. 'Artificial, tick box exercise'.
Getting help from fellow mothers	All Mothers	'Sheer desperation – seeking help'. 'Relief to talk to another mother.' 'Share experiences/feelings'.
Inability to relate to Health Visitor	All Mothers	'Has no personal experience'. 'Does not understand'. 'Simply a tick box exercise'. 'Doesn't get it'.
Therapy/Support/Hope/Empathy	PSWs and Mothers	'Their PSW actually understands'. 'Has experienced the same despair'. 'A pillar of hope'. 'Really seems to get it'. 'Not a failure'. 'Hope for the future'. 'Appreciating their own recovery'.
The PSW is the expert	Mothers from the intervention group	'Personal experience'. 'Vast knowledge'. 'Complete empathy'. 'Akin to their worker'. 'A survivor'. 'Expert'.
Social Support/ Emotional Support	PSWs and Mothers (control group who sought support)	'Supportive role'. 'A fellow mum'. 'A companion'. 'Increases confidence to attend social groups'. 'Empathy'. 'Feels at ease'. 'Can be true self'.

## Strengths and Limitations of the study

The Mixed Methods approach and the use of both qualitative and quantitative data, on reflection, enhanced this study. This approach provided a more comprehensive account of the PSW intervention and its subsequent impact on the mothers. The qualitative data collected is rich in its content and description, real-life experiences, feelings and emotions are shared and it is possible to almost feel, at times, the despair that the mothers are experiencing. The quantitative data, the EPDS scores, provide the formal, scientific, statistical data – the calculated evidence that the PSWs did really make a difference. The quantitative element of

this study provides the analyses with an 'aura of scientific respectability and credibility' (Denscombe 2008). Each data set complements the other.

A pragmatist approach guided the research study; an emphasis was placed upon a practical approach to the problem (reducing postnatal depression). The approach operates on the premise that the value of any theory can only be measured by how well it addresses real life, practical needs and how well it works in practice. Locke (2001) suggests that the test of a good theory is whether or not it 'works on the ground'. On reflection and analysis of all of the data, this theory did just that – it was a practical solution (providing support to mothers) that worked coherently in a real life situation.

An overwhelming strength of the study was the designing of the support intervention by the PSWs themselves. The Peer Support Workers collaboratively decided that they did not want to adhere to any formal model of counselling - they wanted to design and implement their own support package and, on reflection, this was a very positive factor.

Despite the many strengths of the study the results may be limited in that the clinical diagnostic data for PND may be questionable. Although the EPDS is administered alongside a clinical assessment the results may produce a false positive as the mothers' mood may be particularly low on the day the assessment is performed (Paykel et al 1999). In addition the EPDS was only repeated at six months, if it had been repeated again at 12 months or 24 months the results may have portrayed a different outcome. A longitudinal study would be a further recommendation.

A further confounding factor that requires consideration is the variation in the type of activity undertaken within the intervention group – for example swimming or attendance at a toddler group. However, although a consideration, the majority of meetings were held within the mother's own home and only on an occasional basis was a meeting held or outing arranged at an alternative venue.

Other limitations include the pragmatic exclusion of women who did not have English as their first language. This was agreed by the Ethics Committee as funding for the study was strictly allocated to the PSWs' travel expenses. A translator would have been a further expenditure. A further limitation was the number of participants selected: this is a relatively small study due to funding, time and resources, it is a 'stand-alone' pilot study. A greater number of recruits to both the control and intervention group may have produced different results.

## **Recommendations and Implications for Practice**

Recommendations from this pilot study would be further exploration around peer support intervention for mothers with an elevated EPDS score and positive clinical assessment as determined by a trained practitioner. A suggestion for future practice is that a PSW works in collaboration with the HV. The HV could conduct the initial assessment and if required offer the option of a PSW to a mother. Both practitioners could complement one another's role by providing a package of care attuned to the mother's needs - to achieve the best possible outcome for that particular mother. Group peer support could also be an option. Antenatal peer support requires further intensive investigation too. However, a major strength of the study was the involvement of the PSWs in the designing and implementation of the intervention. Formal training was not adhered to and the Workers planned their own strategy - which evolved as they got to know their mother and became familiar with her needs, anxieties, and perceived goals. This must be an important consideration in the utilisation of PS's. Patient-public and service user involvement should be advocated and utilised to its full potential and its benefits widely recognised.

The recent NICE guidelines (2015) emphasise the need for early recognition of mental health problems during both the antenatal and postnatal period. Improved recognition will come from intensive staff training and revision of routine care pathways. Prompt access to further assessment and/or intervention is now acknowledged as a priority (Daley et al 2014).

In addition, easily available public health information is needed to promote recognition, rectify women's misplaced but understandable concerns about disclosing how they really feel. Psychological interventions – for example peer support - require further exploration prior to the administration of psychotropic drugs. The NICE guidelines recommend a raised threshold for using medication to treat depression within the antenatal and postnatal period – and, hopefully, this will encourage practitioners to explore other options prior to automatically prescribing medication. This will require greater and faster availability of psychological interventions that meet the needs of both pregnant women and those with new-born babies.

As previously mentioned, Health Visitors need to be more proactive and visible in the promotion of their role and the wealth of guidance and support that they can offer to parents. As discussed earlier, with the expansion of the number of Health Visitors by 2015-time allocation may increase to accommodate this. The general public needs to be more aware of the services offered by the Health Visitor, their wide range of capabilities and, indeed, what a Health Visitor actually is. This may reduce the 'myths' that consistently surround the role and, in turn, parents' confidence/awareness may increase and their relationships with their HV may become positive.

A replication of the study offering Peer Support for specific vulnerable groups - for example asylum seekers, ethnic minorities or teenage mothers, would further enhance the credibility and generalizability of the research paper. There is certainly a role for PSWs to work alongside the Health Visitor/Midwife and, indeed, they could enhance and continue the support programmes that are offered to the mothers. However, funding would need to be explored and employment contracts/suitability of candidates scrutinized.

The outcome of this study demonstrated the positive influence that a Peer Support Worker had on a mother with PND. As consistently highlighted with this research study, PND is a debilitating, sometimes life threatening illness and its incidence is rising at an alarming rate. Earlier research indicates that social support is a major contributory factor towards either the prevention of PND or a reduction in the severity and longevity of the illness (O'Hara et al 2000, Honey et al 2003, Morrell et al 2009). This study assists in the confirmation of this. Any treatment programme/intervention that may potentially make a difference to the lives of sufferers, and their families, needs to be fully explored and, subsequently, rolled out in practice.

## **Conclusion**

The aim of this study was to provide early intervention to mothers who were classed as 'at risk' of suffering from PND, and, indeed, the support from the PSWs did appear to have a positive impact upon the mothers' mental health and wellbeing. However, this was a small scale, pilot study over a relatively short period of time. Larger, more longitudinal studies are certainly required. The importance of the pilot study presented here lies in its usefulness in shaping research to investigate and explore further whether there are indeed beneficial factors to postnatally depressed mothers who receive one to one support from a PSW. The positive results from this study can, potentially, have a huge impact within practice and, most importantly, upon the lives of those affected by postnatal depression.

## **Where are we now?**

Following the completion of the study there are now five Peer Support Workers currently employed within the Derbyshire area providing support to mothers with postnatal depression. As replicated within the study, the PSWs visit the mothers weekly and provide support, advice and guidance. They have also established, and now successfully run, a number of PND support groups within the area. This provides the mothers with the opportunity to meet up with fellow sufferers, to share experiences, and to simply acknowledge that they are not alone in their

feelings and emotions. The Workers organise outings to a variety of places – toddler groups, swimming pools, libraries and, in addition, the mothers, and fathers have been to social events together. As within the study, there is no formal model of counselling adhered to, the PSWs design and implement their own support strategy and this evolves as they become more familiar with their mothers' needs, anxieties and personal goals. Feedback has been extremely positive.

Funding has also been secured from the National Society of Prevention of Cruelty to Children (NSPCC) to pilot a further study within the Nottinghamshire area for the employment of 5 PSWs commencing in Spring 2016.

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