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African American Women and Postpartum Depression

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Table of Contents

Table of Contents

List of Tables

Abstract

Bringing a child into the world can be a joyous and exciting occasion for some new mothers, but for some mothers it can be a time of intense anxiety and fear. This literature review will look closely at the post-partum period; differentiating between "baby blues" and the symptoms of post-partum depression (PPD). Focusing on African American females who live in low socioeconomic urban environments, culture, biology, family history, and both emotional and instrumental support, will be explored. Despite the dearth in literature, the author will build upon the existing research by examining how these factors may influence the development of PPD in African American mothers. Additionally, counseling implications will be discussed in regards to treatment options and the importance of social support among women who suffer from PPD.

Keywords: Post-partum depression, African American mothers, development, treatment and social support

African American Women and Postpartum Depression

For many women, the experience of pregnancy and welcoming a new child into their lives is an exciting and joyful time. Conversely, for about 19.4% of the population, it is a time of fear, isolation and unexplained sadness, shame and guilt (Posmontier & Waite, 2011). Thio, Browne, Coverdale and Argyle, 2006, found that 1 out of 3 mothers with infants suffers from what is commonly referred to as Post-Partum Depression (PPD). PPD is defined as a "moderate to severe depression in a woman after she has given birth." (Zieve, & Merril, 2012). Typically, it occurs within the first three to six months after delivery with symptoms presenting up to one year after the birth. The symptoms of PPD include expressing more negative emotions, distancing themselves from their infants (Cullen-Drill, Morris, & Smith, 2008), experiencing changes in appetite, and having fears or thoughts of hurting their child. Additionally, women may experience anxiety, sleep issues, depressed mood and thoughts of death and/or suicide (Verbeek, Bockting,Van Pampus, Ormel, Meijer, Hartman, & Burger, 2011).

Depression itself is a prevalent issue in our society, and is projected to be one of the top three leading causes of death in the world by the year 2030 (Zittel-Palamara, Cercone, & Rockmaker, 2009). In the year 2011, the prevalence rate for major depressive disorder in African Americans was found to be 6% and 10.4% over the lifetime (Williams et al., 2007). Previous research has identified prevalence rates as high as 30% among low income women of color (Boyd, Zayas, & McKee, 2006). African American women are twice as likely to develop depression than African American males (Molina, & Kiely, 2011). This literature review will explain the difference between baby blues, PPD and PPD Psychosis, it will review literature about African American female mothers with depressive symptoms, examine the risk factors,

barriers, the importance of social support and both biological and cultural influences that could contribute to the development and treatment of PPD.

PPD occurs more frequently in individuals who are socially and emotionally disadvantaged (Luke et al., 2009). One in four minority low income mothers are likely to develop PPD (Sampson, Zayas, & Seifert, 2013). Numerous studies exist looking at PPD within Caucasian middle class women, however, few studies have been dedicated to the experiences of low income African American women (Luke et al., 2009). This literature review will seek to build upon existing literature by explaining the difference between baby blues, PPD and PPD Psychosis. A review of the literature will be conducted identifying African American female mothers with depressive symptoms, examining the risk factors and barriers these women face. Additionally, the importance of social support, biological and cultural influences will be taken into account as the factors may contribute to the development and treatment of PPD.

PPD and Baby Blues

Soon after a mother gives birth she may experience what is called the "Baby Blues". Symptoms of depression, tearfulness, anxiety, irritability, headaches and variable moods may be present in this phenomenon. The "Baby Blues" are common, due to fluctuations in hormones, as it tends to occur in 50-80% of new mothers and lasting 24 -48 hours and up to 10 days (Beck, Reynolds, & Rutowski, 1992; Harding 1989). If symptoms persist past this time period or are severe in their intensity, the mother is likely to have developed PPD. In rare cases, 2 in 1,000 women may develop post-partum psychosis, which presents with symptoms such as hallucinations, delusions and gross disorganization (Harding, 1989). Post-partum psychosis typically develops within the first two weeks after delivery.

Risk Factors

Research indicates that women who are at the highest risk of developing PPD have a history of depression, experience depression during pregnancy and have an episode of major depression after the delivery (Thompson & Fox, 2010). A common theme among mothers with PPD, especially urban, low income African American mothers is isolation and a lack of social support. Additional risk factors include experiencing stressful life events during pregnancy: including a difficult pregnancy or delivery, marital problems, a history of mood disorders, and feelings of anxiety during pregnancy (Sejourne, Onorrus, Goutaudier, & Chabrol, 2011; Tian et al., 2011). For women who live in an urban environment, have a low income and are African American, there are other risk factors that need to be considered. Members of this population are exposed to various sources of stress throughout their lives. The impact this stress has on these women is likely to contribute to poor psychological well- being (Warren, 1995), and potentially higher rates of infant morbidity and mortality (Jackson, Hogue, & Phillips, 2005; Orr & Miller, 1995; Orr, James, & Prince, 2002). One of these stressors is striving for financial independence. Hobfoll, Ritter, Lavin, Hulsizer, and Cameron (1995) found that pregnant African American women who were financially impoverished had twice the rate of depression than those found in middle-class samples.

Sociodemographic factors are additional issues that may influence the onset of depressive symptoms in African American women.   Education level, maternal age, marital status and a history of interpersonal violence can exacerbate current symptoms or contribute to the development of depressive symptoms. Previous studies have indicated the prevalence rates of moderate or severe interpersonal violence are up to 20% among low income pregnant women (O'Campo, Gielen, Faden, &Kass, 1994). Understanding these elements is important when

examining this population since they are at an increased risk for both depression and intimate partner violence during pregnancy (IPV) (O'Campo et al, 1994).

Family History

Numerous studies have shown that both environmental and genetic factors are related to depression, and some studies have found that there is a strong heritability of depression (Sejourne et al., 2011). These findings have led to further research into family histories over generations with links to depression. Sejourne et al., (2011) found that if a woman's mother had PPD or depressive symptoms, their daughters were more likely to develop PPD. Moreover, PPD was shown to have an impact on the mother-daughter relationship. Mothers and daughters who had tumultuous relationships resulted in the daughter being at a higher risk of developing PPD with a higher intensity of depression. Therefore, close attention should be paid to family history when trying to identify if a mother is presenting with symptoms of PPD.

Biological Factors

When a woman conceives her body begins to change biologically to adjust to the pregnancy and its new role of caring for the fetus. The most common change women experience biologically is an increase in hormones. The levels of estrogen and progesterone increase considerably allowing for the uterus to expand, preserve the uterine lining and maintain the placenta (Komaroff, 2011). After the birth of the baby, these hormones drop significantly within 48 hours after delivery. This sudden crash can cause new mothers to experience an emotional unsteadiness making them more vulnerable to depressive symptoms (Komaroff, 2011). During this time, the mother's hormones that are responsible for regulating stress may also be disturbed adding to the new mother's distress. Other biological risks that have been identified comprise of changes in cortisol levels, thyroid dysfunction. More recently neurological components such as

brain sensitivity in the hypothalamus, the limbic system and the cortex which can work together and function differently have been identified in mothers who experience depressive symptoms. Although research has identified a biological influence regarding PPD, more research is needed in order to identify what biological changes may cause the development of PPD in women (Komaroff, 2011). As of now, research has identified hormonal changes as the main biological factor in the development of PPD.

Cultural Factors

Culture is defined as the learned, shared, and transmitted values, beliefs, norms, and lifeways carried by a group of people, guiding their decisions, thoughts and actions in patterned ways (as cited in Amankwaa, 2003 by Leininger, 1991 p. 47).   Cultural influences also can impact an individual's perceptions around mental health and treatment. Women from different cultural backgrounds may display different behaviors and actions when suffering from depression. Some cultural differences that have been identified are how one expresses their anxiety, their presentation of symptoms, and how depressive symptoms are reported. Another identified cultural difference is the variability of what is appropriate when expressing one's feelings and the acceptance of external emotions such as crying and laughing (Amankwaa, 2003). Depression and mental illness in general, has a stigma attached that in some cultures, is considered to be a weakness.   Amankwaa, (2000, 2003) found that many African American women identified with the theme 'Dealing with it', to live up to the symbols of being a "good mother" and a "strong black woman" in regard to depression. The women in the study disclosed that depression would not be discussed easily among African American people because of the stigma attached and a mistrust in the health care system. In order to "deal with it" the mothers

would have to ignore the daily stressors and keep their feelings to themselves, increasing their likelihood to develop depressive symptoms.

Social Support

Social support in the form of emotional and physical support has been identified as a protective factor in the development and treatment of PPD. Support during pregnancy and after delivery can significantly impact a mother's prognosis with depression. Ritter, Hobfoll, Lavin, Cameron, and Hulsizer (2000), identified social support as a factor to help decrease depression in African American women. Differentiating between the importance of emotional support versus instrumental support (e.g. help with household responsibilities), and its impact on PPD has been conflicting (Hopkins & Campbell, 2008). Hopkins and Campbell (2008) found emotional and instrumental supports to be crucial when looking at the construct of social support because moms who had social support were less isolated. Furthermore, this study illustrated that social support is related to the development of depression in the postpartum period. Therefore, establishing a social support network that fulfills both the emotional and instrumental needs of the mother is a crucial protective factor in the development and treatment of PPD.

African American pregnant women are in need of such protective factors as they are at an increased risk for developing PPD due to chronic environmental stressors and lack of social support. Vigod, Tarasoff, Bryja, Dennis, Yudin, and Ross (2013) found that women in highly populated urban areas are at an increased risk of developing PPD due to risk factors such as immigration status, interpersonal violence, self-perceived health and social support. One solution is to increase support services that targets increasing connections for isolated women living in these settings (Vigod et al., 2013). Targeting services that are relevant and accessible

are important when working with this population so that treatment is effective. Understanding

the obstacles these women face on a daily basis is prudent in order to provide effective treatment.

Limitations of Treatment for Low-income Mothers

Although women with PPD may benefit from treatment, it is estimated that about 50% of

PPD cases go undiagnosed (Luke et al., 2009). Women who suffer from PPD may experience

feelings of shame and embarrassment making it difficult for them to seek treatment. For African

American mothers in low income environments, there are additional barriers that may stand in

the way of receiving treatment.   These barriers include a mistrust of the health systems, cultural

perceptions of depression and lack of resources.

Perceptions of PPD From The AAW

In a qualitative study by Amankwaa (2003), six themes were identified to illustrate

African American women's experiences with PPD. These themes were: *stressing out, feeling*

down, losing it, feeling better, and dealing with it. The stressors contributing to these themes

were physical, mental and external stressors such as a colicky infant or financial strain.

Experiencing multiple stressors during the post-partum period may lead to fatigue, irritability

and an overall decline in physical health in the depressed mother.

Previous studies have identified that having multiple stressors built up over time can lead

to the mother exhibiting maladaptive behaviors such as sleeplessness and irritability (McCubbin,

Thompson, & McCubbin,1996). This concept compliments the second theme identified: feeling

down. In this stage women experienced sadness, uncontrollable crying, a decrease of energy and

overall dissatisfaction with their lives. In this stage, mothers reported that they were able to

identify a change in their feelings and behaviors. Although these mothers were able to recognize

the emotional and behavioral changes, they did not necessarily identify that there was a problem

(McCubbin et al., 1996).

Having multiple stressors after the birth of their baby, followed by uncontrollable

sadness, mood and behavior changes, the mother's then expressed they believed they were

"losing it", which is the third theme identified in the study. It is during this time that the

stressors increased causing the mother to emotionally breakdown leading her to lose the ability to

care for herself, her baby, or her family. This was identified as the most difficult time for the

mothers. The mothers felt a lack of control on many levels. Areas where mothers identified

feeling out of control were in their environment, managing daily activities, and having negative

or harmful thoughts. Due to the complexity of this theme, the research created three subthemes:

losing control, thinking harmful thoughts, and losing myself.

In the study done by Amankwaa (2003), the women identified feeling a loss of control

during two separate times: within the first two weeks and around six weeks after birth. The

mothers described their experience with PPD as "being on a mental rollercoaster", feeling

distanced, uncontrollable crying, insomnia, loss of appetite, tiredness, difficulty concentrating,

making decisions, and staying focused. Experiencing panicky or anxious feelings, in addition to

emotional mood swings have also been identified. During this time the mothers withdrew from

their support systems such as family and friends further isolating themselves. During this period

of isolation is when the next subtheme emerged of "thinking harmful thoughts" such as harming

themselves or their baby. The last subtheme of "losing my self" was described as: experiencing

a loss or disconnect with who they were before the baby, loss of appearance, a loss of autonomy

and time, loss of femininity and sexuality, and a loss of occupational identity.

Barriers to Treatment

Barriers to treatment include physical, psychological and cultural components. The shame and stigma associated with PPD is one of the main emotional barriers preventing women from seeking treatment. In this population, there are also life barriers that may prevent treatment such as: child care, transportation, lack of knowledge regarding resources available and cost. Psychological barriers such as feelings of failure, the stigma attached to mental health, and a mistrust of the system may also be present. In addition, there may also be language barriers, cultural stigmas related to mental health, and the everyday stressors that this population faces every day (Amankwaa, 2003).

Amankwaa (2003) identified shame as a barrier when looking at the theme "seeking help". Feelings of shame were expressed by some of the mothers for having symptoms of depression. Depression was viewed as a weakness, when they were expected to be strong. These feelings of shame may impede on mothers seeking treatment due to the embarrassment of sharing their inability to cope, leading to feelings of failure and inadequacy.

Effects on Children of Depressed Mothers

PPD has been identified as a potential risk factor in a child's development (Hay, Pawlby, Waters, & Sharp, 2008). Maternal PPD can affect the child's cognitive and emotional functioning. Those who suffer from PPD and the symptoms mentioned above tend to have difficulty bonding with their infants. The first few months after birth are an important period for a mother and infant. When the mother is experiencing symptoms of PPD and unable to attend to the needs of her infant, the infant may show early problems in sensorimotor and later issues with emotional functioning in adolescence (Hay et al., 2008). Furthermore, due to the negative emotions that the mother is expressing, the child may also have other detrimental consequences

such as: attachment insecurity, a delay in emotional development, social and interaction difficulties, as well as an increased risk of developing violent behaviors (Verbeek et al., 2011).

It is during this time that a mother's possible ability to care for or connect with her child could be at risk. Those who suffer from PPD are thought to have difficulty understanding and processing the emotional states of others and themselves (Paris, Bolton, & Spielman, 2011). Since the mother cannot identify different emotional states, it is difficult to connect with her child and care for their needs effectively. As a result of a mother's inability to connect and care for her child in a nurturing and loving manner, infants themselves may be less likely to connect with their mothers or even maintain interactions. Infants are also likely to seem withdrawn, show a decrease in activity level, appear fussy and may even have difficulty expressing positive facial expressions and vocalizations, to the degree that they seem to be copying their mother's depressive cues (Paris et al., 2011).

Identifying PPD early on is essential to the wellbeing of the mother, child and entire family unit. The longer the mother goes without treatment, the more likely the child and family will be impacted negatively by the mother's behaviors. The damaged relationship with the mother could lead to the infant experiencing long term developmental outcomes, such as behavioral problems and difficulty with self-regulation (Borovska & Muzik, 2010). The impact and severity of the effects on the children can lead to lifetime struggles with depression or even ADHD (Hay et al., 2008).

Possible Interventions

Support is an important factor when looking at the PPD prevention and treatment. The shame associated with PPD may be one reason why the percentage of mothers who seek treatment is low (Goodman & Santangelo, 2011). The treatments currently available in the

mental health care settings are: antidepressants, individual psychotherapy, and group therapy. Antidepressants have been found to be effective, but women may not want to take medicine or cannot take the medicine because they are breastfeeding (Goodman, 2009). Individual therapy has also been found to be effective, but may not be accessible or affordable to mothers living in an urban setting. Currently there is little research on the effectiveness of treating PPD through group therapy. Scandis (2005) on the other hand found that women suffering from depressive symptoms postpartum wanted to be with other women to help normalize their experience (as cited in Goodman et al., 2011). These mothers also sought to connect with other women who experience similar symptoms. These connections can help with the new mother's emotional and psychological well-being. Group treatment addresses one of the major risk factors in developing and treating PPD in that it addresses the issue of social support by automatically creating a support network.

Group therapy provides an opportunity for women to feel less isolated, to have their feelings and experiences validated and normalized while providing the opportunity to both give and receive support (Goodman & Santangelo, 2011). Women who participate in treatment groups for PPD may also develop better relationships with their babies, have a better understanding of PPD, and assess their role as a mother with ease (Scope, Booth, & Sutcliffe, 2012). The mothers learn coping strategies and challenge their distorted depressive thought patterns, allowing them to bond with their infant and function on a daily basis. The group process enables the mothers to feel "normal" knowing they are not alone in their struggle (Scope et al, 2012).

PPD is a debilitating and insidious disorder that if left untreated can have severe ramifications for the mother and child. As noted in previous research the bond between mother

and child in those first months is critical. This is the time where mother and child form

attachments and create trust. In a relationship where a mother suffers from PPD and remains

untreated, the child may suffer. In extreme cases the child may suffer developmentally, but if the

mother develops post-partum psychosis, tragically the child could lose their life due to their

mother's untreated illness.

For mothers who are African American and live in low income urban environments,

there is a greater risk of developing PPD. A lack of social support after giving birth combined

with external stressors such as financial problems have been found to be risk factors for this

population. Therefore, it is important to explore the type of treatment needed for these women.

Group therapy has been found to be effective when treating PPD because of the need for social

support, but research on PPD and low income African American women is limited. The current

study will seek to explore the impact of having an antenatal and PPD support group for low

income women. It will focus on the experiences the mothers have within the group and identify

whether the social support provided within the group helped to reduce depressive symptoms.

Method

Setting

The population served were women who lived in an urban setting and lived below the

poverty line. Most of the women are single parents who have multiple children with different

fathers. A large percentage of the population served received services from the Department of

Human Services, for assistance in rent, gas, insurance, and child care. Most of the women were

unemployed and unable to seek employment due to a lack of education, transportation and the

cost of childcare. Women being served are at an increased risk of having experienced a

traumatic event and not have a strong support network.

Participants

Eleven women enrolled in a mental health outreach program, ranging in age from 20 to 36, voluntarily participated in this experiment. Eight women participated in the 12 week experimental group. The self-reported racial identity for this group was three African American, three Latino and two Caucasian. Additionally, there were four self-reported African American women in the control group. The four women who participated in the control group received individual counseling and were not exposed to the group. Those who participated in the experimental group engaged in individual counseling sessions with their primary therapist in addition to attending the 12 week group. Participants selected for the group were referred by their primary therapist. Individuals within the control group were recruited during the first week of the 12 week study, when they arrived for their individual therapy session. The restrictions in the selection process included, (1) the participant's current enrollment in the specific mental health program, and (2) have a diagnosis of Depression, such as Major Depressive Disorder. The participants are representative of women the population of women living below the poverty line in an urban setting.

Materials

The Edinburg Depression Scale (EPDS) was used to assess depressive symptom severity (see Appendix). The EPDS consists of 10 items that concentrates on the cognitive and affective aspects of depression (Kheirabadi, Maracy, Akbaripour, & Masaeli, 2012). The Edinburg is the only approved scale for use in pregnancy and post-natal period as it has been found to be a valuable tool in identifying post-partum depression (PPD) within various cultures. The EPDS is reliable in detecting depressive symptoms in pregnant women as well as post-partum (Kheirabadi, Maracy, Akbaripour, & Masaeli, 2012). The EPDS has been found to have a

reliability of .79, with a high test-retest reliability and concurrent validity (Bergink, Kooistra,

Lambregtse-van den Berg, Wijnen,Bunevicius, van Baar, & Pop, 2011) .

      An interview was conducted after the twelve weeks with each individual who participated

in the group. A list of 17 questions were asked to the participants. These questions were:

1. *How would you describe your symptoms of depression before your participation in the support group?*

2. *How long have you been experiencing depressive symptoms?*

3. *Tell me about the first time you recognized that you were depressed.*

4. *What is a typical day like for you when you are experiencing depression?*

5. *Describe your support network.*

6. *Have you ever received treatment for your symptoms in the past?*

7. *If you have received treatment in the past, what was effective or ineffective?*

8. *If you have not received previous treatment, what prevented you from receiving treatment?*

9. *What was your experience attending the group?*

10. *What was helpful to you and what was not helpful?*

11. *What were your needs in the beginning of group?*

12. *What are your needs now?*

13. *Tell me about a typical day in your life now after you have been in the group for 12 weeks.*

14. *How was it for you to talk about your experiences with other women?*

15. *Is there anything that you want to share with me that I have not asked you?*

16. *How do you think you will cope with your depressive symptoms after this experience?*

17. *How was it for you to talk about this experience with me?*

Follow up questions were allowed if needed for clarification. The questions sought to help identify the women's experience within the group and illuminate the presence of benefits the group experience may or may not have provided in regards to the reduction of depressive symptoms.

Procedure

The study originated from the need to understand the importance of group support in treating women with depression. All of the group participants were referred by their primary therapist based on their diagnosis of depression. The control group participants were randomly selected during the first week of group.

This study used a between-group design. The participants were separated into two groups, the experimental group and the control group. Both groups were given a pre and post-test to determine if group support versus individual therapy aided in the reduction of depressive symptoms. The independent variable was the group experience and the dependent variable was the degree of depressive symptom reduction.

The participants were informed that they were participating in a research project to investigate whether group support helps reduce depressive symptoms. Both groups, the experimental, and control group were asked to complete a pre and post-test of the Edinburg Depression Scale. Additionally, the experimental group was informed an individual interview would occur at the end of 12 weeks regarding their experience in the group and its effect on their depressive symptoms. Interviews were audio recorded with participants' consent with the exception of one that was dictated onto paper by the researcher.

Results

The results from this study were used to help determine the effectiveness of group support in reducing depressive symptoms. A pre and post-test were used to measure depressive symptoms. An interview was also conducted with the experimental group to provide an in depth understanding of the group experience.

Quantitative Results

The analysis focused on the pre and post-test results of the Edinburg Scale within the control group and the experimental group. Descriptive statistics were used to compare the control group's symptoms with the experimental group. The study consisted of four participants in the control group and eight participants in the experimental group, however, three participants withdrew from the experiment. One from the control group and two from the experimental group left due to unforeseen circumstances. Additionally, two participants from the experimental group did not answer the questions on the Edinburg Scale in its entirety therefore their results could not be utilized in the quantitative part of the study.

The mean for the pre-test for the control group was 14, the median was 9, the range was 15 with a standard deviation of 8.66. For the post-test, the mean was 16, the median was 14, the range was 8 and the standard deviation was 4.36. The pre-test for the experimental group had a mean of 10.25, a median of 16, a range of 14 and a standard deviation of 7.3. For the post-test the mean was 10.75, the median was 10, the range was 14 and the standard deviation was 5.90.

Table 1

Edinburg Scale Items	Control Group N=3		Difference	Experimental Group N=4		Difference
	Pre-test Means	Post-test Means		Pre-test Means	Post-test Means	
Able to Laugh	0.33	0.67	0.33	0.50	0.50	-
Looking forward to things	0.67	0.67	-	-	0.50	0.05
Self blame	2.00	1.67	0.34	2.00	1.75	0.25
Feelings of anxiety/worry	1.33	1.67	0.33	1.50	2.50	1.00
Feelings of fear	1.33	1.67	0.33	1.75	2.00	0.25
Feeling overwhlemed	2.00	2.33	0.33	1.50	1.75	1.67
Difficulty sleeping	2.00	2.00	-	1.25	1.00	0.25
feeling sad or miserable	1.67	2.00	0.34	0.50	0.25	0.25
Crying	1.67	2.00	0.34	0.75	0.25	0.50
Self-harm	1.00	1.33	0.33	0.50	0.25	0.25
Total Means	14.00	16.00		10.25	10.75	

Table 1 illustrates the performance of the participants on the 10 scale items. In the control group the participant's scores on the depression scale were higher than those in the experimental group. Self –blame, Feeling overwhelmed, and Difficulty sleeping, Feeling sad and Crying were found to have the highest scores. In the experimental group Self-blame, Feelings of anxiety/worry, Feelings of fear, and Feeling overwhelmed were found to have the highest scores.

Qualitative Results

The interview questions were developed to understand the participants experience with depression and explore how the group experience impacted their depressive symptoms. Three themes were identified: Need for Isolation, Human Connections with the sub-theme Lack of Support, and I'm Not Alone. A sub-theme was also identified within I'm Not Alone, which has been identified as I'm Not Crazy. The themes were derived across multiple interviews. Quotations were used to further illustrate the themes.

 Isolation

Isolation was the first theme identified. The term isolation was chosen as this was a common term utilized by the participants when describing their experience with depression. The women verbalized wanting to separate from others when they experienced depressive

symptomology. Isolation depicts how the participants avoid seeking out others and how they push others away when experiencing depressive symptoms. The women expressed experiencing a lack of motivation to do activities, and a decrease in energy that made it difficult to seek out others. Furthermore, the participants wanted to be alone, typically in their bedrooms away from everyone. This time of isolation was described as a dark and lonely period by all the women. One mother was quoted as saying:

"I want to sleep all day. I would sleep all day and all night"

Another mother reports:

"I would take showers, but it wouldn't be often, not that I want to feel dirty, it's just I wasn't interested in doing nothing at one point in time, I stopped communicating with my children, my children."

Human Connections

Another theme that emerged among the participants in the experimental group was a Need for Human Connections. A sub-theme identified was Lack of Support. All the women expressed a yearning for someone to trust and communicate their thoughts and feelings with who would accept them and not judge them. Human connections refers to the need the women expressed in regards to connecting with the group and the impact those connections had on the participants. The women addressed difficulty in trusting others and fears of how they would be perceived. However, after the group experience the participants shared that connecting with other women who experienced similar circumstances had a significant impact on them. One woman stated:

"It was nice being able to relate to somebody else and feeling that they know what it feels like".

The woman sounded relieved to have someone to talk to that has had similar feelings and thoughts. It meant a lot to her to have others to confide in and understand her pain. Another woman noted:

"Being able to relate to somebody else and feeling that they know what it feels like." Being understood and not feeling judged was important to these women. Having people to trust and support them was an experience they were not expecting, and it allowed them to explore their pain in a safe and supported environment.

Another woman described how much it meant to her to be heard:

"I needed to be heard and to be understood and to be part of the group and to be comfortable and I was. I wish we could have another one."

Finding their voice and having it be heard and validated was another step in the process of connecting with others in the group. These women had their voices silenced through their pain and feelings of shame. It empowered them to help each other find their own voices.

All of the women stated they missed the group experience and wanted to rejoin the group upon its completion. Such statements included:

"I'm still missing being able to and relate to everybody in the group at the same time." Another woman stated:

"I loved group. I like being around others instead of being just around myself."

When asked if they would contact members within the group if they needed support they all answered yes, but followed their answers with a reason why it may be difficult such as having busy lives and recognizing within themselves that reaching out would be difficult. The women's responses identified the benefits of the group, but also the benefits of having a routine.

Lack of Support

When asked about their support networks, many of the women described their support networks as non-existent, small or dysfunctional.

Examples by the women were:

"My therapist is my support network".

"I go to counseling, go to counseling. I was going and that's all the support and I talk to my baby's father (in jail) and that's about it."

"I have very few friends."

Many of the women mentioned during the group that they have difficulty trusting and prefer to be on their own because there is too much "drama" when they let people in. The women also expressed that family support is conditional and there is fear of judgment.

I'm Not Alone

The last theme identified was I'm Not Alone. This theme addresses the discovery that their problems are not unique to them and that there are others who experience the same problems within their unique circumstances.

All of the women were quoted as saying:

"I'm not the only one."

Another woman stated:

"Hearing the other girls going through the same thing that I'm going through, like I know it's just not me, other people are going through the same thing."

I'm Not Crazy

Many of the women verbalized that they "felt crazy" and this feeling significantly contributed to them not wanting to reach out to others and instead chose to isolate.

An example of this sub-theme was when one of the women stated:

"I realized I was not the only person, I'm not really crazy."

This was also a common theme identified in group that was brought up by all members at least one time during the 12 week group process.

Discussion

The focus of this research was to explore the impact of group support in reducing depressive symptoms among low socio-economic status (SES) ethnic women. Previous research has found that women who are socially and emotionally disadvantaged are more likely to develop PPD (Luke et al., 2009). Research has found that women who are at the highest risk of developing PPD have a history of depression, experience depression during pregnancy and have an episode of major depression after the delivery (Thompson & Fox, 2010). The women who participated in this study all fit into at least one of the categories depicted in the article by Thompson, and Fox (2010). As previously mentioned, isolation and lack of social support was also reinforced by the women who participated in the study.

The results of this study indicate that having a support network was beneficial in reducing and managing depressive symptoms based on the responses given in the interviews. Looking at Table 1 it is evident that there was an increase in the post-test results for the experimental group in the following areas: looking forward to things, anxiety/worry, feelings of fear and being overwhelmed. The increase in the areas of anxiety/worry, feelings of fear and being overwhelmed could be contributed to transitioning out of group. The participants were vocal about their fears of the group ending and whether they could move forward without the routine of group support. These women have been exposed to various sources of stress throughout their lives and experience high degrees of stress on a daily basis. The impact of this

stress is likely to contribute to a poor psychological well- being (Warren, 1995). Therefore the increase in anxiety, fear and stress follows suit with what the participants vocalized within the group and in the interviews. They would be facing their stressful environments and lives without the support of the group, and the idea of being "alone" again scared them.

The slight increase in the area of looking forward to things referred to activities and could indicate that the participants had an increase in energy due to the group experience or because of the timing of when group ended which was in the summer. The other six areas measured showed a slight decrease indicating that the participants had a reduction in some of their depressive symptoms.

In the quantitative section the control group's pre and post test scores indicate that they had a higher degree of depressive symptoms compared to the experimental group. These results could be contributed to the control group not being exposed to the group experience, but due to the size of the sample and lack of statistical evidence, a direct correlation could not be determined. However, the responses from the qualitative part of the study reinforce what previous studies have found regarding the importance of social support when suffering from symptoms of depression. Previous research has found that women want to bond with other women because it helps normalize their experience (Scandis, 2005). The participant's responses in the interview appear to support this idea.

Limitations

This study had several limitations. The study was primarily limited by the small sample size. This could be addressed by running multiple groups allowing more participants to partake in the research as well as account for the high no-show rate. The researcher could personally contact individuals in mental health that have the appropriate diagnosis and arrange for their

primary therapist to help in filling out the measurement tool and consent form. This could help to increase the sample size.

Another limitation that was encountered was the accuracy in which the measurement tool was completed. In the future it would be helpful if the researcher or primary therapist could be present to answer any questions and confirm that the tool was completed successfully. In this study, the participants were given the consent form and the measurement tool when they checked in for their appointment and the researcher was not always present during this process.

A limitation was also found when evaluating the qualitative results. This study focused on the experience in the group. The control group was used for the pre and post-test, but not the interview. By not interviewing the control group about their experience with individual therapy and exploring their needs, the pre and post-test results for the control group can only be interpreted through the lens of the researcher without any explanations from the control participants. If this study was to be replicated, the control group should also be interviewed to help establish a more holistic picture.

Future Research

This study was comprised of a small sample of the urban population that could be used as a stepping stone to further research in this area. The population being researched is a difficult population to maintain contact usually due to their chaotic environments. Therefore, when conducting research in the future, it is important to be aware of the limitations of the population and plan accordingly to combat those limitations as much as possible. This could include incentives, providing transportation and increasing recruitment to account for the high percentage of no-shows.

In future research it would be beneficial to interview the control group, as well as the experimental group to help provide a more holistic representation of the results. Furthermore, the importance of having routine group support should be looked into further since in this study the participants vocalized the importance of "having a place every Wednesday to go and talk with other women." A future study could explore the difference between routine group support and sporadic group support.

Another area to explore is reaching out to participants a few weeks after group to see how they are and if they have reached out to any of their group members when they are experiencing depressive symptoms. It would be beneficial to know what motivated them to reach out or what kept them from reaching out.

As mentioned earlier, there is little research on the effectiveness of treating depression through group therapy. There is even less research on treating urban low SES ethnic populations. This is a population that experiences a significant amount of trauma and often lives in a chaotic environment that contributes to their overall mental health. This is an area where future research is needed in order to properly care for these individuals.

Implications

Depression is insidious and individuals who suffer from depression find it difficult to move out of the darkness. If your environment is violent and chaotic it may be even more difficult to find a light of hope. Therefore, mental health professionals working with low SES ethnic women in an urban setting need to be aware of the challenges and limitations this population lives with on a daily basis. This awareness will allow the professional to connect with the client, establish a relationship of trust, where the professional can educate the client on their diagnosis and assist them in seeking out resources to help them manage their symptoms

effectively. This study identified that education of the symptoms was an important step in the healing process. Education coupled with group support showed that there is a need for these women to connect with others who have walked in their shoes.

All of the women in this study stated that they wanted to come back to group, but due to insurance purposes and the stipulations of the research study this was not possible. In the future, the limitations of group support should be explored. 12 weeks seems long, but for these women who do not trust easy or let people into their lives it was just the beginning. One woman spoke to this in her response to asking her if there was anything else she wanted to share with the researcher, "Yeah. We definitely need to do it again (Group) I think it needs to be longer than an hour and I think it should be longer than 12 weeks.   If insurance is an issue, then you come deal with us and our lives and tell me if you need the class or not. Trade lives for a week. It helped a lot."

Conclusion

This study strived to identify the importance of group support in the reduction of depressive symptoms. Although, this study had a small sample size, it is evident from the qualitative portion that the participants in this study benefited from the group experience. The need for human connections and a feeling of being understood and accepted appeared to contribute to their reduction in depressive symptoms and ability to manage their symptoms. Further research is needed in this area to help this population successfully manage their symptoms and cope with their daily psychosocial stressors.

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Appendix A

Edinburgh Postnatal Depression Scale[1] (EPDS)

Name: _____   Address: _____

Your Date of Birth: _____   _____

Baby's Date of Birth: _____   Phone: _____

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt IN THE PAST 7 DAYS, not just how you feel today.

Here is an example, already completed.

I have felt happy:
L   Yes, all the time
☒   Yes, most of the time   This would mean: "I have felt happy most of the time" during the past week.
⊐   No, not very often   Please complete the other questions in the same way.
⊏   No, not at all

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   ⊏   As much as I always could
   ⊓   Not quite so much now
   ⊏   Definitely not so much now
   ⊐   Not at all

2. I have looked forward with enjoyment to things
   ⁻   As much as I ever did
   ⊐   Rather less than I used to
   ⊐   Definitely less than I used to
   ⁻   Hardly at all

*3. I have blamed myself unnecessarily when things went wrong
   ⊐   Yes, most of the time
   ⊐   Yes, some of the time
   ⁻   Not very often
       No, never

4. I have been anxious or worried for no good reason
   ⁻   No, not at all
   ⁻   Hardly ever
   ⊐   Yes, sometimes
   ⊐   Yes, very often

*5 I have felt scared or panicky for no very good reason
   ⁻   Yes, quite a lot
   ⁻   Yes, sometimes
   ⊏   No, not much
   ⊏   No, not at all

*6. Things have been getting on top of me
   ⊐   Yes, most of the time I haven't been able to cope at all
   ⁻   Yes, sometimes I haven't been coping as well as usual
   ⊐   No, most of the time I have coped quite well
   ⊐   No, I have been coping as well as ever

*7 I have been so unhappy that I have had difficulty sleeping
   ⊐   Yes, most of the time
   ⁻   Yes, sometimes
   ⁻   Not very often
   ⁻   No, not at all

*8 I have felt sad or miserable
   ⊐   Yes, most of the time
   ⁻   Yes, quite often
       Not very often
   ⊐   No, not at all

*9 I have been so unhappy that I have been crying
   ⁻   Yes, most of the time
   ⊐   Yes, quite often
   ⊐   Only occasionally
   ⁻   No, never

*10 The thought of harming myself has occurred to me
   ⁻   Yes, quite often
   ⁻   Sometimes
   ⁻   Hardly ever
   ⁻   Never

Administered/Reviewed by _____   Date _____

[1]Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale.   British Journal of Psychiatry 150:782-786 .

[2]Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

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Edinburgh Postnatal Depression Scale[1] (EPDS)

Postpartum depression is the most common complication of childbearing.[2] The 10-question Edinburgh Postnatal Depression Scale (EPDS) is a valuable and efficient way of identifying patients at risk for "perinatal" depression. The EPDS is easy to administer and has proven to be an effective screening tool.

Mothers who score above 13 are likely to be suffering from a depressive illness of varying severity. The EPDS score should not override clinical judgment. A careful clinical assessment should be carried out to confirm the diagnosis. The scale indicates how the mother has felt *during the previous week*. In doubtful cases it may be useful to repeat the tool after 2 weeks. The scale will not detect mothers with anxiety neuroses, phobias or personality disorders.

Women with postpartum depression need not feel alone. They may find useful information on the web sites of the National Women's Health Information Center <www.4women.gov> and from groups such as Postpartum Support International <www.chss.iup.edu/postpartum> and Depression after Delivery <www.depressionafterdelivery.com>.

SCORING

QUESTIONS 1, 2, & 4 (without an *)
Are scored 0, 1, 2 or 3 with top box scored as 0 and the bottom box scored as 3.

QUESTIONS 3, 5-10 (marked with an *)
Are reverse scored, with the top box scored as a 3 and the bottom box scored as 0.

Maximum score: 30
Possible Depression: 10 or greater
Always look at item 10 (suicidal thoughts)

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Instructions for using the Edinburgh Postnatal Depression Scale:

1. The mother is asked to check the response that comes closest to how she has been feeling in the previous 7 days.

2. All the items must be completed.

3. Care should be taken to avoid the possibility of the mother discussing her answers with others. (Answers come from the mother or pregnant woman.)

4. The mother should complete the scale herself, unless she has limited English or has difficulty with reading.

[1]Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786.

[2]Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

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