ABSTRACT

Post-Partum Depression:

A Multi-Provider Examination In McLennan County

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This thesis examines Postpartum Depression and Perinatal Mental Health through a cross-disciplinary examination of the current care models and overall provider perspectives in McLennan County, Texas. It looks to examine current practices and provider insights in relation to the prevalent current research discussion in the Perinatal Mental Health community. This thesis includes perspectives from three different disciplines and analyzes their individualized perspectives and opinions on the current processes for the identification, diagnosis, and treatment options for women in McLennan County who are diagnosed with Postpartum Depression.

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POST-PARTUM DEPRESSION:

A MULTI-PROVIDER EXAMINATION IN MCLENNAN COUNTY

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CHAPTER ONE

Background and Current Research

Overview

Postpartum depression (PPD) is a serious mood disorder that can appear days to months after a mother's delivery and can severely affect a woman's ability to care for her child and herself if left untreated. According to the American Psychological Association, PPD affects 1 in 7 of women in America and 1 in 5 women in the world regardless of income, age, race, or ethnicity (Postpartum Depression, 2020). In order to understand the prevalence and severity of postpartum depression it is crucial to distinguish between postpartum blues, postpartum depression, postpartum anxiety, and postpartum psychosis. Postpartum blues, as defined by the Mayo Clinic, typically begins within the first few days after delivery and can last for up to two weeks (Postpartum Depression Symptoms, 2001). Women who experience postpartum blues after childbirth often experience mood swings, crying spells, anxiety, and difficulty sleeping. PPD is a more severe and longer lasting depression that can easily be mistaken for postpartum blues. PPD can develop during pregnancy, after delivery, or even as late as a year postpartum. PPD is categorized by more intense and long-lasting symptoms that can interfere with a woman's ability to care for their baby and handle other daily tasks. Postpartum anxiety (PPA) can present itself throughout the pregnancy and postpartum period, either alone or in combination with postpartum depression. PPA can be identified with its symptoms of restlessness, constant worry, disturbances in sleep or appetite, as well as physical symptoms

such as nausea, dizziness, or hot flashes. Finally, postpartum psychosis is a rare condition that generally presents itself within the first week after delivery with severe symptoms such as obsessive thoughts, paranoia, hallucinations, or attempts to harm oneself or the baby (Postpartum Depression Symptoms, 2001). In addition to these four diagnoses, it is also important to differentiate the different time periods of pregnancy and childbirth. The two main time periods that will be utilized in this thesis are the perinatal period and the postpartum period. The perinatal period commences at 22 weeks gestation (154 days) and concludes seven days after childbirth (Maternal and Perinatal Health, 2013). The postpartum period begins immediately after childbirth when the woman's body, including hormone levels and uterus size, returns to a non-pregnant state (Maternal and Perinatal Health, 2013). According to the American College of Obstetrics and Gynecology (ACOG), depression, the most common mood disorder in the general population, is twice as common in women as in men. For women specifically, the initial onset of depression peaks during reproductive-age years. Therefore, it should not be surprising that postpartum depression is one of the most common medical complications during both pregnancy and the postpartum period. PPD can have devastating effects if it is not properly screened for, identified, and treated in a timely manner. In fact, maternal suicide exceeds hemorrhage and hypertensive disorders as a preventable cause of maternal mortality. This is important to note because high maternal mortality rates are a prevalent issue for the American healthcare system, and an even bigger problem for Texas specifically (ACOG Screening, 2020). Barriers to care for women with PPD

include: inability to receive proper identification, diagnosis, and treatment, extreme stigma around mental health, lack of comprehensive care between providers, possible inadequate processes and training, and access to care providers. According to ACOG, treatment is progressively "stepped up" as PPD becomes more severe. Treatment for mild cases include seeking therapy, support options, and possible medication treatment. For more severe cases, treatment often includes a psychiatric referral, medications, and therapy (Addressing Perinatal Mood Disorders, 2020). Thus, in this thesis, it is imperative to take into consideration the implications of PPD's identification, assessment, and treatment through the lens of the McLennan County community and its inhabitants. This thesis will place an emphasis on McLennan county's demographic diversity, as well as the present non-profit organizational aid, and alternative PPD treatments, to account for both the low-income individuals in the community as well as middle and upper-level incomes.

Risk Factors, Race, and Socioeconomic Status

The risk factors for PPD include, but are not limited to, a change in hormone levels after childbirth, previous experience of depression or anxiety, family history of depression or mental illness, stress involved with caring for a newborn and managing new life changes, having a challenging baby who cries more than usually, is hard to comfort, or whose sleep and hunger needs are irregular. Additionally, having a child with special needs, first-time motherhood, young motherhood (teenage pregnancies), older motherhood (ages 35 and above), personal-life stressors, financial or employment problems, or isolation and lack of

social support can also impact a woman's likelihood for diagnosis. (Postpartum Depression, 2020) However, the American Journal for Managed Care (AJMC) highlights that the biggest risk factor for Postpartum Depression is a prior history of Postpartum Depression (Obstetricians are well positioned, 2020).

It is important to note the additional risk factors, or possible deterrents to care, faced by women in racial-ethnic minority groups. Three main issues facing racial-ethnic minority groups are treatment initiation, follow-up care, and differing symptom identification and expression that could lead to possible misdiagnosis. In a study by the U.S. National Library of Medicine, posed to highlight racial and ethnic disparities in PPD care among low income women, psychologists examined different racial-ethnic groups and the percent of individuals within each group who initiated PPD care, treatment, and follow-up treatment continuation recommendations. This study aimed to identify barriers to care, as well as racial and ethnic dipartites, to further push for policy change. The study concluded that 9% of white women initiated postpartum mental health care after delivery while only 4% of black women and 5% of latina women initiated the same treatment. In addition, among those women who initiated treatment, black and latina women were significantly less likely to receive follow-up treatment and refill their antidepressants in comparison to white women. This study highlights a major discrepancy between overall PPD rates and the rates of women in racial-ethnic minority groups who received care. Thus, women in these minority groups have the same likelihood of diagnosis but are less likely to report symptoms and, correspondingly, receive care. The varying rates of PPD symptom reporting by

women from racial and ethnic minority groups could also be attributed to differences in cultural perceptions of motherhood and mental health as a whole. According to the study, "Reasons for the complex relationship between race-ethnicity, depressive symptoms, and mental health treatment may include differences in risk factors, perceived need for care, socioeconomic status, and access to health insurance, as well as provider factors and patient-provider communication (Kozhimannil, Trinacty, Busch, Huskamp, Adams, 2011)."Overall, the psychologists presented evidence of low rates of postpartum depression treatment initiation and continuation, which indicate barriers to care among low-income mothers, in addition to racial and ethnic disparities, that imply challenges for black and latina women (Kozhimannil, Trinacty, Busch, Huskamp, Adams, 2011).These barriers to care ultimately point to the need to highlight and create aid programs, current care model revisions, as well as institutional policies that address these disparities.

One third of all births in the United States occur to women enrolled in Medicaid, which is allotted for low-income individuals (Wisner, 2013). For women in higher-income groups, the risk factors appear to remain the same as stated above; however, the likelihood of diagnosis can increase correspondingly with changes in the four major socioeconomic risk factors: employment, marital status, monthly income level, and education levels (Wisner, 2013).

According to an article written by Dr. Katherine Wisner, screen positive women were more likely to be younger, African American, publicly insured, single, and less well educated (Wisner, 2013). In addition, the AJMC points out

low-income individuals are at an additional risk because of complicating stressors that come with lower socioeconomic statuses that can have severe impacts on mental health and overall well-being (Obstetricians are well positioned, 2020).

Women with more financial flexibility differ from low-income women in the increased ability to quickly identify, diagnose, and treat PPD through higher quality healthcare access and the financial means to procure additional treatment options. Wealthier women are not subject to some of the additional contributing risk factors that coincide with lower socioeconomic status such as lower income levels, lower education levels, and decreased access to care.

To conclude, Goyal, Gay, and Lee, discuss the effects of low socioeconomic status in relation to the increased risk of postpartum depressive symptoms in first-time mothers (Goyal, D., Gay, C., & Lee, 2010). Participants that were studied were chosen from paid upper-class childbirth classes as well as from Medicaid funded hospitals serving low-income communities. The women were interviewed during the third trimester of their pregnancies, as well as one, two, and three months postpartum. The study results state that lower socioeconomic status was associated with increased depressive symptoms in late pregnancy and months two and three postpartum. They authors stated "Women with four SES risk factors (low monthly income, less than a college education, unmarried, unemployed) were 11 times more likely than women with no SES risk factors to have clinically elevated depression scores at 3 months postpartum, even after controlling for the level of prenatal depressive symptoms (Goyal, Gay, Lee, 2010)." In conclusion, although women from all socioeconomic statuses are at

risk for Postpartum Depression, SES factors such as unemployment, being low-income, being unmarried, and lower education levels, increased the risk of developing Postpartum Depression in the study (Goyal, Gay, Lee, 2010).

Symptoms and Diagnosis

Symptoms for Postpartum depression differ on a person-to-person basis but, according to ACOG's Postpartum Toolkit, they may include:

> "Feeling sad, hopeless, empty, or overwhelmed, crying more often than usual for no apparent reason, worrying or feeling overly anxious, feeling moody, irritable, or restless, oversleeping or being unable to sleep even when the infant is asleep, having trouble concentrating, remembering details, and making decisions, experiencing anger or rage, losing interest in activities that are usually enjoyable, suffering from physical aches and pains, including frequent headaches, stomach problems, and muscle pains, eating too little or too much, withdrawing from or avoiding friends and family, having trouble bonding or forming an emotional attachment with her infant, persistently doubting her ability to care for her infant, or thinking about harming herself or her infant (ACOG Postpartum Toolkit, 2020)."

The current mode of identification and diagnosis for PPD is through screening questionnaires given at differing times in the perinatal and postpartum periods. ACOG recommends that obstetrician-gynecologists and other obstetric care providers screen patients at least once during the perinatal period using a standardized and validated tool (ACOG Screening for Perinatal Depression,

2020). Additionally, it is also recommended that women are to be screened with a full workup of mood and emotional well-being, including screening for Postpartum Depression and anxiety, during the comprehensive postpartum exam (ACOG Screening for Perinatal Depression, 2020). There is clinical evidence that the completion of mood and emotional well-being screening during these comprehensive postpartum visits have benefits on the individual. However, providers should be prepared to provide recommendations for mental health professionals if needed, as these are proven to provide the maximum benefits to mothers (ACOG Screening for Perinatal Depression, 2020). In addition, if a woman presents with risk factors such as current mood disorders, past mood disorders, or suicidal thoughts, they should undergo close monitoring, evaluation, assessment, as well as receive a possible referral to a more specialized provider (ACOG Screening for Perinatal Depression, 2020). ACOG recommends that systems be in place to ensure the proper follow-up care to ensure accurate diagnosis and treatment for all mothers.

According to ACOG, there are seven validated screening instruments for use during pregnancy and the postpartum period evaluation. These screening tools include the Edinburgh Postnatal Depression Scale (EPDS), the Postpartum Depression Screening Scale (PDSS), the Patient Health Questionnaire 9 (PHQ-9), the Beck Depression Inventory, the Beck Depression Inventory-II, the Center for Epidemiologic Studies Depression Scale, and the Zung Self-Rating Depression Scale. These scales range from nine to thirty-five questions, with completion time averaging from five to ten minutes. Additionally, all but the Zung Self-Rating

Depression Scale are available in Spanish. Of all of these screening tools the EPDS is the most frequently used in both a research and clinical setting due to its availability in fifty languages, health literacy, and its ability to be completed quickly (ACOG Screening for Perinatal Depression, 2020). ACOG reports that the EPDS includes many symptoms of anxiety; however, it lacks constitutional symptoms of depression that should be accounted for and are present in other screening tools. In the ACOG summit, both providers highlighted that 60% of depressive symptoms begin before birth and around 40% of symptoms present during the postpartum period (Addressing Perinatal Mood, 2020). Despite ACOG's current recommendation of two screenings, it seems evident that more than two checkups could be beneficial to the emotional and physical well-being of many mothers. Additionally, effective collaboration between OBGYN providers, mental health providers, and pediatricians could allow for mothers to be screened more effectively during the birthing process. If a patient screens positive, ACOG proposes that there needs to be further assessment, ruling out of other possible medical diagnoses, as well as a proper screen for bipolar disorder, prior to diagnosis and treatment (Addressing Perinatal Mood, 2020). ACOG also conveys the importance of severity screening and stresses the importance of the consideration of differential diagnoses as an important aspect of further assessment (Addressing Perinatal Mood, 2020). Prior to prescribing medication, further assessment should be conducted to rule our other mental health disorders, such as bipolar disorder, as some mental health medications can precipitate mania and increase the risk of other unintended negative outcomes (Addressing Perinatal

Mood, 2020). Furthermore, the assessment for comorbidities such as Post Traumatic Stress Disorder (PTSD), anxiety disorders, substance abuse, and other medical conditions can aid in the accurate diagnosis and treatment plan. Studies indicate that childbearing is an opportune time for intervention because women have increased contact with health care professionals, the healthcare system, and are motivated towards positive behaviors to invest in their child's wellbeing (Wisner, 2013).

In assessing the available screening method options for Postpartum Depression, it is important to look at the economics of these methods when evaluating the issue as a whole. According to the Maternal Child Health Journal's Cost-Effectiveness Analysis of Postpartum Depression, screening for PPD is a cost-effective intervention and should be considered as part of usual perinatal and postnatal care (Wilkinson, 2017). Screening and treatment for both postpartum depression and psychosis produced 29 more healthy women at a cost of $943 per woman out of the 1,000 women studied (Wilkinson, 2017). This analysis assumed that in outpatient visits, physicians under the mentorship of a psychiatrist via telemedicine, can provide basic therapy and possible prescriptions for screen positive women. The analysis also recommended that pediatricians implement discussions about PPD when they discuss breastfeeding issues, as breastfeeding issues commonly appear at the same time as PPD symptoms. Wilkinson's study looks at the utilization of Inter-Personal Treatment (IPD) for women diagnosed with PPD. IPD typically aims to help the patient understand that their interpersonal stress is connected to their symptoms of depression. IPD works

specifically to aid the patient in understanding that their maladaptive communication patters are causing issues in their current relationships. Wilkinson's study concluded that the average time of recovery, with the proper utilization of IPD, is around 29 weeks with a standard deviation of around +/-17.5 weeks (Wilkinson, 2017). Screening with EDS typically takes around 5 minutes and is 10 simple questions. Thus, it is a relatively easy process, provided the patient is truthful and honest in reporting their symptoms. Overall, it can be concluded that the screening for PPD is both cost-effective and beneficial for the psychological well-being of new mothers.

Treatment

If an individual believes they are displaying symptoms of PPD, it is crucial to seek help quickly as early detection is important and can lead to shortened treatment times down the road. Additionally, it is important to talk openly about the feelings that come with motherhood with loved ones or available motherhood support groups. Open communication with loved ones has shown to aid in the process of fighting PPD. The APA proposes asking for aid from a loved one, talking to a licensed professional, or working to balance the strain on the body during early motherhood (Postpartum Depression, 2020). These symptoms often get confused or shoved under the rug as they mirror the changes and feelings attributed to many normal pregnancies and postpartum changes (ACOG Screening for Perinatal Depression, 2020). However, in a small study reported by ACOG, only 20% of women diagnosed with PPD had reported their symptoms to their health care provider (ACOG Screening for Perinatal Depression, 2020).

Stigma around mental health and its relation to an individual being a "fit mother" presents itself as a lead cause for the lack of reporting of PPD symptoms by many women. At the Addressing Perinatal Mood and Anxiety Disorders-Strategies for Women's Health Care Providers Summit hosted by ACOG, they discussed the possible problems with the current model. They highlight the evident mental health stigma for many mothers as well as the importance of the involvement of mental health providers and OBGYN collaboration in the screening process. They also note that many obstetric providers, historically, have been inadequately prepared to address perinatal and postnatal mood disorders due to a lack of processes in place and even a lack in pre-professional and professional training (Addressing Perinatal Mood, 2020). According to ACOG, recent evidence suggests that collaborative care models between OBGYN providers and mental health providers, when implemented effectively, can improve long-term patient outcomes (ACOG Screening for Perinatal Depression, 2020). Thus, the work to combat current mental health stigmas, in addition to the practice of provider collaboration, can work towards improving outcomes for many mothers.

The main types of treatment options for mothers with PPD are psychological therapies, pharmacological therapies, or a combination of the two. The International Journal of Women's Health states that, "A Cochrane meta-analysis of ten randomized controlled trials of psychosocial and psychological treatments for postpartum depression concluded that both psychosocial and psychological interventions are effective in decreasing depression and are viable treatment options for postpartum depression (Fitelson, Kim, Baker, Leight,

2010).” Despite both options’ effectiveness, psychological therapies may be a better option for many mothers who are concerned about the potential side effects or the possible effects of infant exposure to pharmacological medications through breast feeding. The current psychotherapy options to treat Postpartum Depression are Interpersonal Therapy (IPT), Cognitive Behavioral Therapy (CBT), and Nondirective Counseling. IPT focuses on addressing the connection between interpersonal problems and mood and frames depression as a medical illness occurring in a social context. CBT focuses on showing the patient that perceptions and behaviors are linked to mood and helps patients modify distorted behavior patterns of negative thinking to reduce overall distress. Finally, Nondirective Counseling focuses on the use of empathetic and nonjudgmental listening and support to aid in depression. The available pharmacological treatment options include antidepressant medications, hormone therapies, and Zulresso (Brexanolene). Antidepressant medications are typically used to treat generalized depressive disorders; however, according to the growing literature, this class of medications are also effective for PPD treatment as well. Hormone therapies work by combatting the major drops in estrogen and progesterone at the time of childbirth that can aid in combatting depression. Finally, Zulresso, or intravenous Brexanolene, is a breakthrough therapy designed specifically for the treatment of Postpartum Depression (Fitelson, Kim, Baker, Leight, 2010). This medication works by interacting with the Gamma-Aminobutyric System (GABA) to increase neural connections to aid in more balanced mood regulation. Due to the stigma surrounding pharmacotherapy during pregnancy and breastfeeding,

pharmacotherapy as a whole has been a highly discussed and controversial topic for many mothers. However, ACOG argues that absolute risk of birth defects when antidepressants are taken in the first trimester is small. In addition, there is a small increased risk of preterm labor and low birth rate, but these can also be caused by untreated depression and anxiety (Addressing Perinatal Mood, 2020). Absolute risk of persistent pulmonary hypertension (PPHN) in newborns also appears to be an extremely small risk as a result of taking antidepressants during pregnancy. Selective serotonin reuptake inhibitors (SSRIs), a type of antidepressant medications, are considered a reasonable option during the breastfeeding periods and it is advised that breastfeeding should not preclude pharmacological mental-health disorder treatment. Finally, studies do not suggest that pharmacological treatment during pregnancy will have long-term neurobehavioral effects on children (Addressing Perinatal Mood, 2020). However, despite the lack of evidence for the adverse effects of pharmacological treatment on the fetus from medication taken during pregnancy and during the breastfeeding period, it is important to follow set prescribing principles that emphasize lowest effective doses, the minimization of switching therapies, monotherapy, and the continuity of treatment throughout childbirth (Addressing Perinatal Mood, 2020). In addition to pharmacological and psychological treatments for Postpartum Depression, there are some other non-medical alternative options that are utilized to treat postpartum depression as well. These include electroconvulsive therapies, bright light therapies, omega-3 fatty acids, acupuncture, massage, and exercise (Fitelson, Kim, Baker, Leight, 2010). ACOG

also identifies that in addition to pharmacotherapy and or psychotherapy treatment options, women should attempt to follow a provided "self-care" plan that includes plans for adequate sleep, a healthy diet, and exercise (Addressing Perinatal Mood, 2020).

Barriers to Care

Some of the modern issues facing PPD identification and treatment are the stigmas surrounding mental health, lack of proper continuity of care, and the current care model not mirroring current scientific postpartum suicide research. According to AJMC, less than 25% of the women who screen positive for the condition receive follow up care (Obstetricians are well positioned, 2020). The reasoning for this is broad and ranging in scope from stigma to the lack of continuity in follow-up care and its relation to patient relocation and referral to mental health providers (Obstetricians are well positioned, 2020). AJMC also reports that the lack of time, childcare, and knowledge of available resources can prevent women from seeking help as well (Obstetricians are well positioned, 2020). Greater than 50% of postpartum depression cases can go undiagnosed without proper screening precautions and, even when properly screened, less that 25% of patients receive follow-up care. As previously noted, suicide is the leading preventable cause of maternal mortality in perinatal women (Perinatal Suicide, 2019). However, perinatal suicide is often under-reported and under-researched. According to the Massachusetts General Hospital's Center for Women's Mental Health (MGH), most suicides happen between nine and twelve months postpartum by more lethal methods compared to women outside of the perinatal

period (Perinatal Suicide, 2019). The highest perinatal suicide rates often occur among women who live in rural areas. The findings from this study highlight how important it is to screen perinatal women for suicide in primary care or obstetric offices. Pediatricians could also play a crucial role in PPD treatment as mothers also visit frequently after childbirth for check-ups. Thus, PPD identification, assessment, and treatment is and will always be an interdisciplinary effort (Perinatal Suicide, 2019). Overall, modern PPD awareness advocates need to work to fight the stigma of mental-health within their practices by encouraging open communication, work to ensure continuity of care in their practice if the patient is in need of follow-up mental health care, and work to advocate for PPD screening in the first year following childbirth.

Demographics of McLennan County

Baylor University is located in McLennan County, Texas, and this thesis discusses the implications of Postpartum Depression through the specific lens of women seeking medical care in this county. In McLennan county, the median household income is around $48,199.00, 18.4% of the population is uninsured, and the total population is 256,623 as of July 1, 2019, according the US Census (U.S. Census, 2020). The Census identifies that the average uninsured rate for a county is around 10.6%. Furthermore, women make up 51% of the population, 55.4% of the population is White Non-Hispanic, 14.8% are Black or African American alone, 27% are Hispanic or Latino, followed by Asian alone at 1.8%, American Indian at 1.1%, and two or more races at 2.2% (U.S. Census, 2020). According to the Census, 46,457 individuals in McLennan County are living in

poverty, from which we can deduce that the poverty rate, in relation to McLennan County's total population, is 18.9%. This poverty rate is extremely high in relation to Texas' 14.9% and the nation's average of 13.1%. Thus, when talking about possible prevention and self-care techniques it is important to take into consideration the economic diversity of McLennan County. Within the low-income population issues such as, time constraints with "work/life balance", transportation access, internet access, time off of work, as well as a lack of social support and aid can inhibit many women from receiving proper care. Many low-income individuals can have harder times accessing proper therapy, medications, and self-care time, due to the stressors involved with poverty, employment, and healthcare access. ACOG also recommends the use of the lifeline4moms app, located at www.mcpapformoms.org, and identifies that 14 states currently have a Perinatal Access Program to educate and provide resources for families, providers, and communities to learn about the implications of childbirth on mental health. However, Texas is not currently one of the states with an implemented Perinatal Access Program (Addressing Perinatal Mood, 2020). Overall, this thesis will aim to focus on the demographic of individuals in McLennan county and will aim to highlight the available options for women in the area as described by the providers and local women's health non-profits and organizations that were interviewed.

CHAPTER 2

Interview Questions

1. To begin, what are your opinions on PPD and the awareness, discussion, and treatment options for women in McLennan county as well as our nation as a whole? What services do you offer for women within your practice?
2. In your practice/position, how often and when do you believe women should be screened for PPD and what method do you use to screen for PPD? Do you find this effective? What suggestions have you made, or would you make to this tool?
3. In recognizing that women of color experience, self-identify, and report depression and its symptoms differently, how can the maternal health community work to combat these issues?
4. Lack of financial resources is also a contributing factor to PPD. What are options or possible remedies for low-income women who need to receive treatment for their PPD in McLennan county?
5. Upon screening positive for PPD, how does your practice work to ensure patients are getting the necessary follow up care? What are issues with this? According to the APA, less that 25% of patients receive follow up care, does your practice have any suggestions or processes to combat this issue?
6. What opinions and preconceived notions are you seeing from patients about PPD, mental health, and possible medications during pregnancy?
7. Lack of awareness and stigma can stop women from seeking help for PPD. How do you see this played out in your practice and how do you combat this issue?

8. Within the diverse community of McLennan county, how do you see different access to care, access to resources, and access to follow up care issues presented?
9. According to the severity levels, even mild presentations of PPD recommends therapy, support options, and possible medical interventions, are most women in McLennan county able to receive these care recommendations?
10. What is currently being done in McLennan county to aid the lower income and women belonging to racial-ethnic minority groups? Are there resources or nonprofits in the community?

CHAPTER 2

Jaja Chen

McLennan County Licensed Clinical Social Worker

Jaja Chen is a licensed clinical social worker in the McLennan County area that specializes in trauma, burnout, and perinatal mental health. Jaja focuses on reproductive trauma, perinatal post-traumatic stress disorder, and specializes in EMDR therapy. She is also trained in and incorporates a trauma-sensitive care approach to her work. Additionally, Jaja works to integrate her patients racial, ethnic, and cultural background into her sessions while also offering the option to ethically integrate faith and spirituality into her therapy as well. She also has her Maternal Mental Health Certificate through Postpartum Support International and integrates it into her therapy sessions as well.

INTERVIEW

1. *To begin, what are your opinions on PPD and the awareness, discussion, and treatment options for women in McLennan county as well as our nation as a whole? What services do you offer for women within your practice?*

   "Postpartum depression is an issue a lot of women experience and is lot more common than people realize. Unfortunately, in Waco, a lot of individuals are still not getting the treatment they need, especially when it comes to screening and diagnosis early on. So, from my perspective, I see a lot of people who have been experiencing postpartum depression or perinatal mental health concerns for quite a long time, sometimes years. Many people simply think they are just an angry parent and that these intense feelings are what being a parent is supposed to feel like. They additionally often feel high levels of stress, loss of motivation, and loss of who they are. My work specifically, as a private practice therapist, is to work with individuals who have gone through trauma and my specialty is birth trauma and postpartum Post Traumatic Stress Disorder (PTSD) specifically. I also find that these often overlap and that there are many co-diagnoses or misdiagnoses between trauma, PTSD, and postpartum depression."

2. *In your practice/position, how often and when do you believe women should be screened for PPD? What suggestions have you made, or would you make to this tool?*

"I feel like every woman and man should be screened for any kind of perinatal mental health concern. There are many different tools and the most common tool that medical professionals use is called the Edinburgh scale. However, usually by the time patients are seeking my services they are already diagnosed, have multiple diagnoses, or are trying to clarify their current diagnoses. So, typically patients are already past the screening phase when we meet. I do believe every parent should be screened either by an OB, midwife, or pediatrician. In fact, I think there is a growing push for pediatricians to start assessing parents for PPD instead of solely focusing on the baby. Many of these screenings can take extra time, but thankfully the scales are relatively short and take less than five minutes to complete. The hardest challenge for many medical providers is more so being able to refer patients to the best fit providers, knowing the resources available, and knowing who to connect patients with. This is difficult as perinatal mental health is a very particular field and, with my experience as a practicing therapist, I have found that not many people in McLennan county specialize in it. This highlights a need, in our county, for qualified and trained mental health professionals who are both passionate and eager to work in this area."

3. *In recognizing that women of color experience, self-identify, and report depression and its symptoms differently, how can the maternal health community work to combat these issues?*

"I think that we should recognize depression and anxiety as manifesting themselves not only in our minds, but also in our bodies. I think the word "mental health" can sometimes prevent us from realizing that there is truly a mind-body connection that so many individuals recognize and feel through physical impacts of mental health. In fact, so many people have their first panic attack and immediately go to their primary care provider thinking something is wrong with their heart, lungs, or chest rather than a panic attack. We see this a lot, especially within the Hispanic and Asian American communities, where it is more common for patients to reach out to their doctors, or alternative health providers, when experiencing the physical manifestations of anxiety and depression. I work with a lot of minorities and many of them are shocked to hear that they have anxiety or depression rather than a physical ailment. Many of these individuals also have a hard time believing and coming to terms with the anxiety diagnosis because they first believed it was a heart problem. The emphasis on the word "mental" can sometimes lead individuals to believe that they are thinking it or making symptoms up in their heads. A lot of traditional therapy focuses on cognitive behavioral therapy, what I was originally trained in, and many minorities believe going to therapy means they are going to talk to someone to somehow change their thoughts. However, in today's time, there are many forms of therapies and there is an increased emphasis on the mind-body connection. Many of these therapies are being connected with practices such as mindfulness, meditation, and yoga that

have existed in eastern medicine for hundreds of years. Overall, the mind-body emphasis and understanding, in the realm of therapy and holistic practice, is just now becoming popular in the western world."

4. *Lack of financial resources is also a contributing factor to PPD. What are options or possible remedies for low-income women who need to receive treatment for their PPD in McLennan county?*

   "The MHMR is the main Texas mental health facility, here in McLennan County, who works with Medicaid and Medicare clients. Under this umbrella is the Heart of Texas Counseling Center who works with individuals on a sliding scale and offers special funds to help contribute to patients who don't have any ability or means to pay. I also believe they have trained staff now who work specifically with perinatal mental health concerns. Additionally, the Family Health Center has a counseling center on site at their main office. It's great because the therapists at the Family Health Centers have a setup where the therapists can coordinate with the doctors on staff so they are able to provide a more integrated treatment.'

5. *What opinions and preconceived notions are you seeing from patients about PPD, mental health, and possible medications during pregnancy?*

   "I think the most common misconception with medication is that so many moms think they cannot take medications during their pregnancy. Some patients even tell me their OB told them that! There is such a stigma around medications, especially during pregnancy and breastfeeding, that is concerning for mothers with pre-pregnancy conditions that require

medications. Especially when mothers halt all medications during the pregnancy period because of these stigmas. If they were at a place where they were doing well with their mental health conditions and medication was a great support for them, discontinuation of the medication can have detrimental effects. This is a very common misconception often stemming from friends and family recommendations that are not backed by research. The exposure to untreated depression, anxiety, and mental health concerns in the way that they affect your neurochemicals can often be worse than the exposure of medications on the baby."

6. *Lack of awareness and stigma can stop women from seeking help for PPD. How do you see this played out in your practice and how do you combat this issue?*

"Postpartum Support International, an advocacy organization, is doing a lot of work to try to advocate, on a local and federal level, through support groups and social media campaigns. This is such important work because they are bringing to many people's attention that perinatal mental health concerns are way more common than many people often realize. I think the last statistic was 1 in 7 moms and 1 in 10 dads will experience some sort of perinatal mental health problem. The largest stigma comes from news stories where women who experience either postpartum psychosis or perinatal and postpartum obsessive-compulsive disorder experience extreme outbursts due to the scary nature of their conditions. These are often the cases, although they are rare, that are covered in the news. Often these cases are a result of an untreated psychotic episode or a previous

mental health condition where medication was stopped during pregnancy. These news stories can often add more stigma to the perinatal mental health community. People typically don't realize the full context of these news stories and there needs to be more of an emphasis on the possible preventative measures women can take through identification, diagnosis, as well as proper medication and medical care. I have many patients that have gone years without a proper diagnosis when they could have been diagnosed two weeks postpartum if they would have had a proper screening. Overall, combatting the stigma is so crucial because we can lower these numbers and reduce the length of time moms go through postpartum mental health concerns without proper treatment."

7. *Within the diverse community of McLennan county, how do you see different access to care, access to resources, and access to follow up care issues presented?*

"I believe the last statistic was that 30% of McLennan County is considered to be low income. As a result, access to care difficulties would be not having insurance or the financial means to receive the proper care. Additionally, in McLennan County, there is a large shortage of proper psychiatrists as well. Financial access is probably the biggest difficult in regard to access to care. This is why the Family Health Center and the Heart of Texas Counseling Center are so great for our community. These two facilities do experience difficulties due to the number of patients they can serve, waitlists, and availability concerns, as they provide services, not

only for perinatal mental health, but all mental health concerns in McLennan County. In addition, understanding the legitimacy, prevalence, and treatment options of perinatal mental health concerns are also barriers to care as well. In my position I often hear, from folks in all income groups, that mental health issues are a result of that individual's personal faith not being strong enough. I also hear that the presence of a mental health concern is thought to be a result of a demon or something of that nature. I think being in the Bible belt often coincides with high levels of shame after being diagnosed with a mental health condition due to their own theological upbringing and the individual's belief of the validity of mental health concerns. These beliefs often add a whole different level of stigma to the treatment process."

8. *According to the severity levels, even mild presentations of PPD recommends therapy, support options, and possible medical interventions, are most women in McLennan county able to receive these care recommendations?*

    "There are financial access barriers but the greatest barrier to our local resources is definitely time restraints as well as transportation. COVID-19 has made telehealth more of an accessible option for many individuals. However, pre-pandemic many of the counseling services were all in person which created a larger transportation issue for our community. There are bus lines but the public transportation system in McLennan County is not the best. In addition, the hours of availability are also hard to

coordinate with for many people as well with weekend and after-hours availability.

9. *What is currently being done in McLennan county to aid the lower income and women belonging to racial-ethnic minority groups? Are there resources or nonprofits in the community?*

   "Community Doulas of Waco is a nonprofit started by a postpartum doula named Tonja Carpenter who has been providing postpartum and lactation services for quite a long time in the area. Before she started the nonprofit, she had a private practice with employed doulas. Now she has started a nonprofit out of her passion and her desire for there to be more accessible resources for the community. They partner with Carnet to provide free doula services for up to three months postpartum, I believe. This coincides with the growing research that states that this postpartum doula community can often lead to lower the effects that depression has on families. This nonprofit also hires on lower income women that will then be trained to become doulas in order to benefit the individual and the community. In addition, there is also the Waco Birth Center and 3 Sisters Midwifery that are often flexible with their payment plans and can cater to the low-income communities. Carenet provide parenting classes, diapers, and free ultrasounds as well. WIC, through the government, provides many resources for food, but what people often don't know is that they also partner with the local Waco Farmer's Market to accept WIC. They also have a special grant where individual's WIC funds double to spend at

the farmer's market so that individuals can get fresh produce, eggs, and milk."

FINDINGS

Jaja Chen was able to provide many insightful points about PPD from a local McLennan County level that gave light to a therapist's perspective. In Jaja's practice she sees many individuals who have been experiencing PPD symptoms, undiagnosed, for long periods of time. She even went as far as to state that many of these women believed these extreme emotions and bursts of anger were normal parts of pregnancy due to lack of awareness of the symptoms of perinatal mental health conditions. She stated that the stigma around the word "mental" health and the apparent disconnect between the mind-body connection, for many people, can lead them to confuse the physical manifestations of mental illnesses to be physical ailments rather than mental health symptoms. Many therapists are also utilizing alternative practices to focus more on the mind-body connection. Therapists are now working to intertwine eastern traditional practices such as mindfulness, meditation, and yoga into their practices to help treat individuals with mental illness. Stigma is also seen among television and news outlets who seemingly only highlight the most extreme perinatal mental health outbreaks, such as those from postpartum psychosis. Jaja pointed out that these cases are rare, and their coverage leads to more stigma rather than if they used that same story to promote local resources and showed that these events can be prevented with proper diagnosis and treatment. Also, Jaja has noticed that there is a shame that comes after a diagnosis of a mental illness that is specifically seen in patients with religious backgrounds that can add another layer of stigma. In areas such as McLennan County, where there is a lack of specialized therapists and providers in perinatal mental health, there is also a higher stigma and fear around medications during pregnancy. Jaja combatted this stigma and stated that there is no

current research proving this common misconception and instead proposes that increased specialization and teaching will hopefully rid of this stigma in the future. In conclusion, McLennan County's main issues, when it comes to perinatal mental health, are the number of individuals trained and specialized in perinatal mental health disorders, continuity of care after diagnosis, stigma, and pre-COVID-19 transportation issues.

CHAPTER 3

Dr. Emilie Cunningham

MPH, PHD

Emilie Cunningham is the Director of Programs for Women and Children at the Family Health Center in Waco, Texas. This position was created specifically to address the public health side of the Family Health Center's patients in order to enhance clinical care. This program also looks to identify the external social determinants of health in an innovative way by trying evidenced based innovations in order to improve outcomes.

INTERVIEW

1. *To begin, what are your opinions on PPD and the awareness, discussion, and treatment options for women in McLennan county as well as our nation as a whole? What services do you offer for women within your practice?*

    "I think there is a continuum of beliefs among providers that women are more emotional when they are pregnant and giving birth and there is a widespread discounting of the impact of PPD. Fortunately, this discounting is less so here at the Family Health Center. However, PPD as a whole in our nation has not been prioritized like it needs to be. We know this as it is reflected in the scarcity of treatment options available. There are very few therapists who are trained in Perinatal Mental Health and there are significant waiting periods to see them. Additionally, many of these therapists also do not take Medicaid or may limit the percentage of Medicaid patients in their panel. This is a significant hinderance that can cater to disparities. We can see already that the disparities have affected women of color and low-income women. At the Family Health Center, we offer integrative health management in our care for the women in McLennan County that is evidenced based which includes, but is not limited to, counseling, behavioral health specialties, and substance abuse care for pregnant women. We are the only obstetric care in town that has the availability of Licensed Clinical Social Workers on staff who can do a warm handoff with the woman's provider so there can be continuity with all necessary care."

2. *In your practice/position, how often and when do you believe women should be screened for PPD and what method do you use to screen for PPD? Do you find this effective? What suggestions have you made, or would you make to this tool?*

    "To begin, some of the problems with healthcare provided in rural areas are that screening for PPD is often followed by a lack of treatment and care options. Additionally, there are currently no Spanish speaking counselors in Waco. I believe the Family Health Center screens once every trimester which is key as screening happens several times during the prenatal and postpartum periods. According to the state of Texas, "postpartum" is defined as the first six weeks after a woman gives birth which is quite absurd. A woman should be screened, at least, through the first year of that infant's life according to evidence-based studies. Many symptoms and presentations of PPD symptoms arise far beyond what the state defines as the "postpartum" period. We also use the Edinburg scale that is administered by our Integrated Health Management (IHM) who can then direct effectively in our clinic after the screening is completed. Additionally, 25% of our IHM's are fluent in Spanish as well."

3. *In recognizing that women of color experience, self-identify, and report depression and its symptoms differently, how can the maternal health community work to combat these issues?*

    "It is so important for healthcare overall to realize that the messenger matters. What I mean by this is that it is important that we are intentional in our IHM recruitment process so that they include women of color from

our community than can have a shared experience and express empathetic social support through their practice. We also are lacking, and we need to prioritize, opportunities for leadership for women of color in our community to run and direct these programs."

4. *Lack of financial resources is also a contributing factor to PPD. What are options or possible remedies for low-income women who need to receive treatment for their PPD in McLennan county?*

   "I will discuss this question later in question seven and eight."

5. *Upon screening positive for PPD, how does your practice work to ensure patients are getting the necessary follow up care? What are issues with this? According to the APA, less than 25% of patients receive follow up care, does your practice have any suggestions or processes to combat this issue?*

   "Yes, this is a huge need. There are three things that immediately come to mind when you mention follow-up. First is that warm handoff between a woman's provider and the IHM that can directly address these issues in a team-based care model. We must have a baseline of providers understanding the importance of PPD and the necessity of screening as simply part of routine prenatal care not just an "extra feel good thing." Secondly, we have implemented a position entitled the Women's Health Navigator that, in this context, on a monthly basis follows-up with our high-risk women in order to identify who shows up to their appointments, who hasn't scheduled appointments, and to identify other barriers. We are proactively identifying high-risk women and reaching out to them to

remove all potential barriers to care. Finally, we are working on combining the infant's pediatric appointments with the mother's appointments to implement the Implicit Model of Care that we believe can aid in follow-up care."

6. *What opinions and preconceived notions are you seeing from patients about PPD, mental health, and possible medications during pregnancy?*

   "I am a lactation counselor so that is the context of my direct patient contact, so I am not positive of the current stigmas out there. With my experience of talking to mothers in general, I know the stigma is lessening in part due to the numerous times we screen during the prenatal period. However, this is me speculating and I do not know for sure. What I do believe is that many preconceived notions often result from the providers not educating and prioritize this issue."

7. *Lack of awareness and stigma can stop women from seeking help for PPD. How do you see this played out in your practice and how do you combat this issue?*

   "This isn't as applicable to my specific position; however, I would point out that the logistics get in the way as much as stigma and awareness. A lot of women don't have a way to pay for it, get there, the ability to take off of work, or therapist options that accept Medicaid. These are the main things that, I believe, hinder women from care. A woman's Medicaid currently expires on day 60 which is tragic when 25% of maternal mortality happens after day 60. I believe the main problems are the

availability of coverage and how we help women get there that are the most pressing issues."

8. *Within the diverse community of McLennan county, how do you see different access to care, access to resources, and access to follow up care issues presented?*

   "I believe my answer above answers this question as well. I would like to stress the importance of an increase in women of color involved in this work as I think it would go a great distance in reducing the stigma. This takes intentionality, the cultivation of relationships, and requires extra effort to recruit women of color in this field in order to create equity."

9. *According to the severity levels, even mild presentations of PPD recommends therapy, support options, and possible medical interventions, are most women in McLennan county able to receive these care recommendations?*

   "If you have private insurance you will be just fine. I also wanted to point out the importance that a positive experience with breastfeeding has in reducing PPD as it is somewhat of a natural antidepressant. Breastfeeding is an important piece of this conversation in either direction as well because it can reduce, or increase, PPD symptoms based on the woman's individual experience with it. Thus, lactation aid and the diversity of specialists is crucial to have in many communities, including McLennan County, to push towards equity."

10. *What is currently being done in McLennan county to aid the lower income and women belonging to racial-ethnic minority groups? Are there resources or nonprofits in the community?*

    "A couple of exciting things are happening. Here at the Family Health Center we do "Centering Pregnancy" which is a form of group prenatal care where women are grouped according to their due dates which is linked to better birth satisfaction and lower rates of PPD. There is also no waiting room, so women are able to spend a full two hours with their provider to ask questions and create an open dialogue. Postpartum Doulas are also an important piece this puzzle and Waco has a nonprofit called Community Doulas of Waco that offers free doula services. Postpartum Doulas are closely linked to PPD presentation and severity."

FINDINGS

After interviewing Emilie Cunningham, there were numerous new ideas that were explored in relation to PPD and Perinatal Mental Health stigma, treatment, and systemic problems from both a national and local viewpoint. Her perspective was derived from her public health education and her passion for the marginalized in the local community. Emilie brought up three main points during the interview that paralleled the literature review as well as sparked interest as potential improvement opportunities for McLennan County. These ideas were intentionality in equitable hiring and employee representation that mirrors the population, different and innovative evidenced based care models, as well as the Women's Health Navigator position that can all work to lower PPD numbers and severity presentation levels. The literature review posed a very interesting and complex question of how to best care for women of color who, according to the research, report and describe PPD and mental health symptoms differently than white women. Emilie illustrated that, in order to best combat this issue, it is crucial to have minority representation in the navigator and provider positions within the practice. This equitable hiring basis, although occasionally difficult in implementation, would allow for women of color to feel connected and able to speak freely to the providers and navigators. Emilie stated that this connection results from being from the same shared experience and community as well as being able to empathize with their situations. Emilie pointed out that the open dialogue that comes from the navigators and providers that mirror the population base can go hand in hand with the number of PPD cases identified earlier on and more effectively. To continue, Emilie illustrated two different innovative and evidenced-based care models that her position at the Family Health Center has allowed

her to research and implement. The two models are the Implicit Model of Care and Centering Pregnancy. The Implicit Model of Care, although not yet in effect at the Family Health Center, allows for the newborn check-up and the mother's postpartum check-up to be within the same time slot. This model would directly affect the number of women who do not receive follow-up care that was identified in the literature review research. By combining these two appointments there will be a direct link to higher levels of care provided to many of the mothers who might have not gone to their own maternal follow-up appointment. Centering Pregnancy is something that is currently offered at the Family Health Center that focuses specifically on having group interactions for eight to ten women at the same time that are grouped according to estimated due date. This model centers on a communal experience with the provider that allows for the elimination of waiting room times while providing a space for open dialogue about perinatal mental health and other possible questions. This open dialogue, as Emilie highlights, can also be linked to earlier diagnosis, increased connection with available resources, and decreased severity of PPD. Thirdly, Emilie mentioned the Family Health Center's utilization of specific Maternal Health Navigators in order to provide high quality care to their patients, aid in the reduction of stigma, and to best place patients with the necessary follow-up care resources. The use of Navigators, in the Family Health Center, is associated with a higher number of women who receive follow up care as the position is dedicated to ensuring women, especially high risk women, receive the proper resources and are set up with providers for the necessary follow up care. The Navigator position, and its effectiveness in ensuring women have and receive the necessary follow up care, addresses the disparity in follow-up care that was identified during the literature review.

Overall, Emilie brought up many interesting, novel, and evidence-based models that she works on that coincide, and work to remedy, many of the prevalent issues discussed in the literature review. Furthermore, Emilie's specific position at the Family Health Center and her background in Public Health allow for a fresh and innovative approach to women's health in McLennan County that is both inspiring and crucial for the future of Perinatal Mental Health.

CHAPTER 4

Dr. Samuel Clark MD

Pediatrician

Dr. Sam Clark is a general Pediatrician at Baylor Scott and White that sees both mothers and newborns in the McLennan County area. He serves all people by providing personalized health and wellness through exemplary care, education, and research.

INTERVIEW QUESTIONS

1. *To begin, what are your opinions on PPD and the awareness, discussion, and treatment options for women in McLennan county as well as our nation as a whole? What services do you offer for women within your practice?*

   "By and large, I feel like mental health in general is vastly underserved. When it comes to PPD, I believe that we are even worse off than other counties for a couple of reasons. Number one, I think there is a current under culture of women who feel as if you should simply grin and bear it. Overall, I don't think we have the screening or the providers to be able to deal with these issues as a county. However, this is not just our county, there are numerous counties that are ill prepared across the nation as well. Additionally, mental health in general is not viewed as a "real" medical issue by a lot of people on the outside or general public and a lot of individuals do not take it seriously. In our practice, we screen the parents at the first four visits (3-5-day checkup, 2-week checkup, 2-month checkup, and the 4-month checkup) and we use the Edinburg scale. Around 6 or 7 years ago they instructed us to do this screening test in addition to all of our other screens. Occasionally, I am not equipped to deal with the mother's mental health as I wasn't trained to do this, she isn't my patient, and I try my best to aid her whether that be to ask the mom to make a follow-up with her OB/GYN provider who often is better equipped to deal with their depressive symptoms. This is often difficult to

ensure follow-up care when the patient and the follow-up provider rarely report back to me."

2. *In your practice/position, how often and when do you believe women should be screened for PPD and what method do you use to screen for PPD? Do you find this effective? What suggestions have you made, or would you make to this tool?*

   "I think the Edinburg scale is good as it is a pretty granular scale. We do all kinds of screens for all kinds of things in general pediatrics and some of these screens are 6-7 pages long. So, the Edinburg scale is a good size and is practical for the parents to fill out in time. It is also one where I can quickly look at it and asses what needs to be done for the patient's mental health. To be fair, simply seeing the Edinburg scale in the room is a reminder for me to check in with mothers and ask how they are doing. Even moms who screen 0 often admit to depressive symptoms and sadness and I am able to address this through further questioning as well."

3. *In recognizing that women of color experience, self-identify, and report depression and its symptoms differently, how can the maternal health/pediatric community work to combat these issues?*

   "This is a difficult issue as I do not know why they do that. If I were to understand why they did that I would be better able to combat the issue as a whole. It is interesting that you indicated that this is an ethnicity issue because I would propose that this as more of a socioeconomic issue. To your point, sometimes these two can align very closely. Again, you have done the literature review and data analysis, so my view is very anecdotal.

I would say in general, the more well off white, Hispanic, and African American populations tend to be much more open to talking about mental health issues. On the other hand, the poorer populations of these three racial groups tend to stigmatize mental health more. This points to me wondering if this is an issue of ethnicity or more of a value system."

4. *Lack of financial resources is also a contributing factor to PPD. What are options or possible remedies for low-income women who need to receive treatment for their PPD in McLennan county?*

   "Almost all of my low socioeconomic families are on Medicaid. This is often through traditional Medicaid or Right Care which is Baylor Scott and White's version. The problem is that we have many less options for those who are on those types of insurance versus private insurance. The more obstacles that are in an individual's way correlates with lessened compliance with proper care and follow-up care. We do have resources, there just simply aren't enough. Again, this is not simply a McLennan County issue, it is a statewide and nationwide issue as well. I would say that utilizing support structures in your community is beneficial (family, church, etc.). The problem is for PPD, moms a lot of the time simply need to be put on medications which can only be prescribed by a physician."

5. *Upon screening positive for PPD, how does your practice work to ensure patients are getting the necessary follow up care? What are issues with this? According to the APA, less than 25% of patients receive follow up care, does your practice have any suggestions or processes to combat this issue?*

"It's hard. For me specifically it is hard as I don't have their chart because I am not their physician. I guess there is two aspects of this as I will see them back because they will need to follow-up for their child. However, I may not in all cases put something in the baby's chart that indicates that the mom is depressed. There is a place in my chart designated for the Edinburgh scale and I will often put a number there that indicates the mom's score; but, I don't always take the time to write a lot of notes on the mom's mental health unless it is an extreme case. Again, it's a resource issue, if I had a coordinator in my clinic, I would just send my patient to them and they could aid in follow-up care."

6. *What opinions and preconceived notions are you seeing from patients about PPD, mental health, and possible medications during pregnancy/breast feeding?*

   "It is interesting, a lot of my mom's with PPD had prepartum depression. I am unsure of the numbers but often times I will hear of moms stating that they are feeling better as they went back on their mental health medications after giving birth. Actually, those who had depressive issues prior to pregnancy have less stigma and are more open to formula feeding instead of breastfeeding. There are certain medications that you can't be on while you're pregnant and these mom's talk with their OBs about symptoms prior to, or at the beginning, of pregnancy."

7. *Lack of awareness and stigma can stop women from seeking help for PPD. How do you see this played out in your practice and how do you combat this issue?*

"Generally, what I see as far as stigma goes is people feeling like mental health is not an issue or it is just an issue on their part. If I sense this at all I always try to speak against it. One analogy I use for mental health in general is if you had someone in front of you that was having a heart attack you wouldn't ask them why they are having a heart attack. In the moment they are having a cellular problem they need help and medicine. This is the same thing with mental health as there is often an issue with the neurotransmitters that you can't simply hope and wish away. This cellular and molecular issues, in regard to mental health, is often something that a lot of people don't realize is related. Increasing the amount of neurotransmitters really helps a person feel better. Helping my patients understand that mental health is a medical issue and not their individual inability to cope is really helpful for most people."

8. *Within the diverse community of McLennan county, how do you see different access to care, access to resources, and access to follow up care issues presented?*

"Honestly, we have such little resources as it is in McLennan county that most people are in the same boat. The people who have less stigma and are more persistent are the people who will get help. A lot of times it is really the attitude of the mom that is the driving force of whether she gets care or not. With this I recognize that a problem in this could be that if the mom is already depressed there is a lack of driving force already."

9. *According to the severity levels, even mild presentations of PPD recommends therapy, support options, and possible medical interventions, are most women in McLennan county able to receive these care recommendations?*

    "Yes and no. On one level when I tell moms they need to go seek follow up care whether or not they get help is dictated by whether or not moms see mental health as a serious issue and the amount of obstacles that arise in the process of getting follow-up care. On the other hand, you are pointing out that even the mild presentations in mom often need help and I don't know. One of the things I tell my mild presentation mothers (0-4), is to observe and monitor their symptoms and seek help if it persists or increases. Honestly, I focus on the moms who score high on the scale. This is an area where we fail and need improvement."

10. *What is currently being done in McLennan county to aid the lower income and women belonging to racial-ethnic minority groups? Are there resources or nonprofits in the community?*

    "I am aware of a couple of options. Baylor often offers services and research opportunities that can be beneficial. Starry kids also might have options for mothers, and it is on the nonprofit side. However, other than that I am not sure what nonprofit options there are for moms in the McLennan county area."

FINDINGS

After interviewing Dr. Samuel Clark there were numerous insightful points that allowed for a more medicalized and physician specific perspective on the PPD treatment, stigma, and processes. Dr. Clark highlighted issues of stigma, socioeconomic status, need for additional aid, and the mental health community's need for resources. To begin, some of the stigma that Dr. Clark pointed out resulted from differing views on the legitimacy of mental health. Dr. Clark said that he spent the most time discussing and explaining to patients that mental health is not simply made up but that it can be caused by chemical imbalances and can require medications and therapy. He uses a variety of metaphors to aid in the explanation of this medical view of mental health as he relates it to other legitimate medical issues of the body that have proven to be effective. Dr. Clark also discussed how he sees PPD resource utilization as being more of a socioeconomic status issue rather than a racial-ethnic one. He has seen this because the more well off an individual is the more likely that they are to go get the resources they need no matter what racial-ethnic group they identify as. He also identified that no matter how well off an individual is in McLennan County, there are not many resources that will aid them further than prescribing medications as the perinatal mental health resource availability is slim. Dr. Clark also noted that the perinatal mental health resources are slim, not only in McLennan county, but also in many other counties around the nation. This points to the need for additional resources in our county and an increased focus on decreasing the stigma of mental health around the country. He stated that no matter the wealth level of an individual in McLennan County, there were simply not enough resources to be able to provide the best and most effective follow-up care other than prescribing necessary

medications. Overall, Dr. Clark is well versed and passionate about making sure both his pediatric patients and their mothers receive effective care that coincides with current standards of care modeled by ACOG.

CHAPTER 6

Overall Trends and Conclusion

Overall Trends

After interviewing and analyzing all three of the provider interviews, there were a couple of common findings among all of them. These common findings were the use of the Edinburgh scale, the necessity for screening multiple times during the pregnancy and postpartum period, the importance placed on reducing stigma surrounding mental health, the lack of resources in McLennan County, a need for increased specialized Perinatal mental health training, as well as the benefits of the Navigator position. To begin, all three providers pointed out that their practice used the Edinburgh scale when screening women. Dr. Clark found this useful because it reminds him to check on the mothers in addition to simply routinely checking his pediatric patients. Jaja stated that the Edinburg was effective because it is short, concise, and easy to complete and implement into her sessions. Finally, Emilie noted that the scale was easily applicable and accurate for most women in addition to it being relatively easy to complete. All of the providers understood and expressed the importance of screening women for PPD multiple times during the perinatal and postnatal period. Dr. Clark stated that his position allows him to check in on mothers multiple times during the postpartum period when he is doing his pediatric check-ups. Emilie added that, in addition to four postpartum check-ups, women should be screened up to a year postpartum as the research identifies that women continue to be at risk up to a year after childbirth. The providers also understood and spoke to the need for a decrease in stigma surrounding, not only perinatal mental health, but mental health in general. Jaja detailed in her interview that many people have developed stigma towards

mental health as resulting from their religious actions or "lack of faith." Dr. Clark also pointed out that mental health is a medical issue as well that can result from chemical and neurotransmitter imbalances that occasionally requires medication. He also mentioned that aiding his patients in understanding that mental health is a medical issue often helps individuals overcome the stigma that surrounds mental health. All three of the providers also highlighted an evident need for mental health resources, not only in McLennan County, but in the nation as a whole. They all highlighted that mental health care is something that is just being normalized and spoken about as the stigma surrounding it has been going on for such a long period of time. In addition to creating more mental health aid resources there was also a common push among the providers for an increase in individuals who are trained in perinatal mental health both in McLennan county and the nation. Finally, the Navigator position was discussed by all of the providers as being helpful or potentially helpful if implemented in their practice. Emilie illustrated the effectiveness of her Navigators in ensuring the proper follow-up care and Dr. Clark illustrated that a Navigator position in his practice would be extremely beneficial in ensuring follow-up care for at risk women.

Conclusion

In conclusion, there are many highly skilled and educated providers that are looking to combat PPD and perinatal mental health issues in McLennan county. However, there is an evident need for more resources and a current confusion around what resources are available. This discovery, when conducting this thesis, illustrated an evident need in the community for an evaluation of the current nonprofit resources as well as an accumulation of all of the available resources for women in the county.

Chapter 7 will detail a list of all of the non-profit resources available for women in McLennan County while also providing an accurate phone number and website for each of them. Chapter 8 presents the McLennan County Perinatal Mental Health Resource Guide that was created as a result of the identified need of a comprehensive multi-provider list that highlights the county's available resources. This resource guide also highlighting which ones take Medicaid or offer a sliding scale which allows for patients of all socioeconomic statuses to find resources that will be the best match for their individual financial situations. This resource guide includes therapists, doulas, midwives, non-profits, online resources, and internet resources that can be utilized by women seeking aid for PPD in McLennan County.

CHAPTER 7

Notable Waco PPD Resources and Nonprofit Aid

Community Doulas of Waco

Community Doulas of Waco is an organization located in Waco, Texas that provides doula services and basic breastfeeding support to birthing or adoptive families of newborns through 12 weeks of age who could not otherwise afford them. They additionally aim to create a pathway for mothers who have received these services to train and become community doulas themselves. This is in hopes of increasing their income earning potential (Community Doulas of Waco).

Phone: (254) 753-1987

Website: communitydoulaswaco.org

Waco Birth Center

Waco Birth Center is a faith based non-profit in the Waco area that offers a variety of services including water births, primary care, prenatal care, annual exams, postpartum care, contraceptive care, birth photography, menopause, home births, as well as problem visits. Waco Birth center strives to provide safe birthing choices for women in the McLennan County area through their implementation of holistic care and the midwifery model (Waco Birth Center and Clinic).

Phone: (254) 265-9226

Website: wacobirthingcenter.com

3 Sisters Midwifery

3 Sisters Midwifery is a team of midwives based in Waco that aims to make birth both affordable and enjoyable through the services they provide for mothers. They offer

labs, appointments, end of pregnancy supplements, co-care with a physician (if needed), childbirth classes, breastfeeding/postpartum classes, non-gmo pregnancy tea, and organic dehydrated fruits and vegetables. 3 Sisters was also founded on the idea that health care should be accessible and affordable, and they aim to apply this fundamental belief to their practice (3 Sisters Midwifery).

Phone: (254) 791-5767

Website: 3sistersmidwifery.com

Starry Counseling

STARRY Counseling services are available at no cost to families with children up to 17 years old. Counseling services include individual, group, and family counseling as well as parenting classes. With the aid of DFPS Prevention and Early Intervention's STAR Program funding, along with the generosity of their donors, services are provided at no cost to clients. Insurance and money are never an issue, as STARRY serves clients from varying backgrounds and income levels (Starry).

Phone: (254) 399-6552

Website: www.starry.org

Family Health Center and Heart of Texas MHMR

The Center provides a full array of Psychiatric Medical Services for patients. The professional staff includes psychiatrists, nurse practitioners, registered nurses, pharmacy assistants, support staff, a program director, and therapists. The staff conduct regular and crisis assessments of all consumers, prescribe and manage medications, coordinate distribution of psychiatric medications, assist consumers in accessing Pharmacy Assistance Programs, manage medication samples, monitor metabolic symptoms, and

provide the clinical leadership for all consumers served by the Center. They also work through an integrated health model and can support through their outpatient clinic at the Heart of Texas Counseling Center. Additionally, counseling services are offered in both English and Spanish (Heart of Texas).

Phone*:* 1-866-752-3451

Website*:* https://www.hotrmhmr.org

Catholic Charities of Central Texas

Catholic Charities of Central Texas offers high-quality mental health services in order to help individuals and families overcome life's challenges. They offer virtual therapy, individual counseling, group or family counseling, psychosocial evaluations, and optional faith-based counseling that are all offered in both English and Spanish (Catholic Charities of Central Texas).

Phone: (979) 822-9340

Website*:* https://www.ccctx.org

Postpartum Support International

Postpartum Support International (PSI) was founded in 1987 by Jane Honikman in Santa Barbara, California. The purpose of the organization is to increase awareness among public and professional communities about the emotional changes that women experience during pregnancy and postpartum. Additionally, PSI has members all over the world and volunteer coordinators in every one of the United States and in more than 36 other countries. PSI aids by giving information and resources through its volunteer coordinators, website and annual conference, and online support groups. Its goal is to

provide current information, resources, education, and to advocate for further research and legislation to support perinatal mental health (Postpartum Support International).

Phone: 1-800-944-4773

Website*:* www.postpartum.net

CHAPTER 8

McLennan County Perinatal Mental Health Resource Guide

McLennan County Perinatal Mental Health Resource Guide:

Perinatal Mood Disorders affect 1 in 7 women in America regardless of income, age, race, or racial-ethnic group. This resource guide is an accumulation of all of the available resources in McLennan County for women (and men). This guide will hopefully provide ease of access to the community's available resources in addition to reducing stigma and bringing awareness to the prevalence of perinatal mental health struggles.

Astric Denotation (*) Indicates resources that take Medicaid or offer a sliding payment scale

Local Therapists

- **Jaja Chen *LCSW, CDWF***
  - *254-739-9200*
- ***Rachel Craig, LPC***
  - *254-218-3972*
- ***Tancy Horn-Johnson, LCSW***
  - *254-239-0784*
- ***Emma Wood, PsyD***
  - *254-339-1052*
- ***Family Health Center Counseling Services****
  - *254-313-4610*
- **Starry Counseling***
  - *254-399-6552*

Local Aid & Non-Profits

- **Family Health Center MHMR*** (Pregnancy Groups,, Coordinators, Lactation Services, Counseling)
  - *254-313-4610*
- **Waco Birth Center*** (Birthing Center, Prenatal Care, Postpartum & Newborn Care, Counseling)
  - *254-265-9226*
- **Catholic Charities of Central Texas*** (*Prenatal Education, Postpartum Education, Basic Needs Assistance English y Español)*
  - Call for Information: 979-822-9340

Local Doulas

- **Community Doulas of Waco***
  - *254-753-1987*
- **Postpartum Doula Services of Waco***
  - *254-753-1987*
- **Birth Waco**
  - *254-495-6759*
- **Revdoula**
  - *512-552-8531*
- **Nova Birth Services**
  - *254-315-1108*
- **3 Sisters Midwifery***
  - *254-304-6648*
- **Lunaria Birth & Wellness Center**
  - *512-585-4389*

Internet Resources

- **Lifeline 4 Moms Phone Application**
- **Postpartum Support International Facebook Group for Moms**
  - www.facebook.com/groups/25960478598/
- **PSI Chat with an Expert For Moms** (Every Wednesday)
  - www.postpartum.net/chat-with-an-expert/
- **Mom & Mind Podcast on Maternal Mental Health**
  - http://www.momandmind.com/
- **Mother to Baby** (Information on Medications during pregnancy and breastfeeding)
  - https://mothertobaby.org/

Local Midwifery Practices

- **3 Sisters Midwifery***
  - *254-304-6648*
- **Waco Birth Center Midwifery***
  - *254-265-9226*
- **Ascension Medical Center Midwifery***
  - *254-772-5454*
- **Central Texas Birth Center**
  - *512-763-7569*
- **Lunaria Birth & Wellness Center**
  - *512-585-4389*

Other Resources:

- **Lactation Services of Waco, LLC**
  - *254-753-1987*
- **Information for Dads**
  - **Information:** PostpartumDads.org
  - **PSI Chat With an Expert for Dads** (First Monday of Each Month at 7:00 PM Central)
    - http://www.postpartum.net/chat-with-an-expert/chat-with-an-expert-for-dads/
  - **PSI Coordinator for Dads**
    - Joshua Maze: 317-721-1359

Online Support Groups:

- **Mamas for Mamas** (Mondays from 1:30-3:00 PM via Zoom) Free
  - *https://us02web.zoom.us/j/87477349882?pwd=U1RhaEtWKzZGalRsTENtRFpiQnVvdz09*
- **Ascension Seton Northwest's** (Tuesdays from 11:00-Noon via link provided) Free
  - *(Register online for meeting link) ascn.io/perinatalsupport*
- **Dr. Kelly Boyd's Online Support Group** (Wednesdays from 11:00-12:30 via Zoom) $20 Suggested Fee
  - *Zoom Meeting ID: 285 865 5283 or email Drkellyboyd@yahoo.com*
- *Any* **Baby Can Support Groups** (Register online for link) Free
  - *Para Registrar/To Register: https://anybabycan.org/programs/counseling/*
  - *Para Español: Los primeros y treceros Miercoles cada mes a las 10:00*
  - *English: Thursdays at 10:00 AM*
- **Postpartum Support International** (Several online support group options in both English and Spanish)
  - *Reserve Spots via: http://www.postpartum.net/psi-online-support-meetings*

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