Episode 265—Dr. Lorinda F. Parks and Dr. Robert H. Keefe: Using "Centering Pregnancy" to Address Postpartum Depression

[00:00:08] Welcome to inSocialWork, the podcast series of the University at Buffalo School of Social Work at www.inSocialWork.org. We're glad you could join us today. The purpose of inSocialWork is to engage practitioners and researchers in lifelong learning and to promote research to practice and practice to research. We educate. We connect. We care. We're inSocialWork.

[00:00:37] Hello, I'm Louanne Bakk and I'll be your host for this episode of inSocialWork. Recent reports by the Centers for Disease Control and Prevention show that approximately one in nine women experience symptoms of Postpartum Depression and it is estimated that African-American and Hispanic mothers have the highest rates of Postpartum Depression among all racial and ethnic groups. However, research focused on mothers of color is scarce, particularly in relation to how to effectively intervene. In this podcast Dr. Lorinda F. Parks and Dr. Robert H. Keefe discuss Centering Pregnancy and how this multifaceted group based care model can be particularly beneficial when working with at risk populations. The forms and symptoms of Postpartum Depression are described by Dr. Parks as well as the relationship between Postpartum Depression in various societal costs. Dr. Keefe emphasizes why the topic of Postpartum Depression is particularly relevant to social work and the profession's role in effectively intervening with communities of color and ensuring appropriate services and supports are provided. The Centering Pregnancy group model, including the phases of care, is described and potential benefits associated with the intervention are highlighted. The episode concludes by stressing the need for continued collaboration between universities and communities in relation to innovative interventions such as the Centering Pregnancy model in order to promote health and well-being. Having done medical work in Bolivia, Nicaragua in Washington State with farmworkers, Dr. Lorinda F. Parks is bilingual and dedicated to community health. She has been at Jordan Health in Rochester for six years and has embraced Centering Pregnancy and Centering Parenting. Dr. Parks has facilitated 12 cohorts using this model of care over four years. Dr. Robert H. Keefe joined the UB School of Social Work faculty is an associate professor in 2005. Passionate about public health social work, community health and health and disability, Dr. Keefe possesses several years of post MSW health and mental health care practice experience as a medical and psychiatric social worker in facilities in Ohio and New Hampshire and as a case manager clinical care reviewer in New York. Doctors Parks in Keefe were interviewed in April 2019 by Dr. Rebecca S. Rouland, assistant professor in social work at Nazareth College.

[00:03:29] Hello my name is Dr. Rebecca Rouland and today I'm speaking with Dr. Robert Keefe and Dr. Lorinda Parks. Dr. Parks, can you tell us what Postpartum Depression is?

[00:03:40] Postpartum Depression comes in several forms and runs along a continuum. Most of us have heard of a general feeling of sadness after having our babies, but we'd like to divide it up into three areas, really for the explanation of the conversation today. The first one is what we kind of called Baby Blues, and this might be considered the most mild form of Postpartum Depression. This often starts in the hours or for sure in the first days following pregnancy and can come with some tearfulness, but in general the mom is functioning very well and can do her tasks of bonding with the infant. The more severe form is what we officially call Postpartum Depression, which can last for quite a bit longer. Usually we say more than four to six weeks, sometimes is a gradual onset. So we will not notice Postpartum Depression while the mother is recuperating in the hospital. But it would be more noticeable in the visits when the mother brings the baby back or when she herself

goes back to see her pregnancy doctor. But Postpartum Depression has some features which also make us feel like it's just part of the usual baby care and postpartum period. For instance a mother may describe that she has lack of energy, that she's tired all the time, that she has difficulty sleeping, that her weight seems to be changing. Obviously all of those could be in the normal course of a woman after she gave birth to a baby. However, Postpartum Depression also includes changes in her appetite and the overall feeling of sadness. Now as we compare this to Baby Blues we see that it is more significant in our societal cost because the mother is more isolated and usually starts having trouble taking care of her baby or feeling less bonded. So these will show a higher toll in the mother's care of her baby and her functioning, and that's when we're able to actually call it Postpartum Depression. We see the cost associated with the loss of her ability to return to work, the impaired bonding that she has with her infant, sometimes even to the degree that the infant is malnourished. The duration is longer and we see that more people notice, the people around her will notice that she is significantly different from another mom who would have just delivered a baby. On the far end of this continuum is actually something called Psychosis, which is where mothers become so depressed that they do these alarming actions which we sometimes hear about in the news. For instance they may harm or even kill their child or other children, they may hurt themselves, and obviously this has an immense toll on our society. And this is only a further example of the same spectrum of Postpartum Depression. First Baby Blues and Postpartum Depression and later something called Psychosis. We do believe that if we catch Postpartum Depression early that we can sort of stop this continuum before it gets to something severe like Psychosis.

[00:06:47] Great, thank you. Dr. Keefe, you and your colleagues have been conducting research in Rochester, New York at an agency where Dr. Parks is a physician. Can you tell our listeners why Postpartum Depression is such an important problem for social work?

[00:07:00] Well we know that roughly 12 percent of all new mothers will develop Postpartum Depression. Now this certainly is much different, as Dr. Parks indicated than the Baby Blues. So when we see mothers with the Baby Blues, yes we're concerned. But many of these very same mothers will move along just fine in their bonding with their child and not develop Postpartum Depression, but twelve percent of the mothers will. Some researchers have found the percentage from mothers of color with Postpartum Depression to be over 35 percent, which is an alarming disparity. As a professional group, social workers are more likely to provide services to new mothers and children than professionals in most other disciplines. As social workers will to be seeing a lot of mothers, so we need to be able to screen for Postpartum Depression. When we focus on low income mothers, we have learned that providing individual therapy is not going to eliminate their depression when they also had to face multiple systemic problems including poverty, neighborhood dysfunction, high crime rates and lack of opportunities in a lot of our inner cities that many low income individuals and low income mothers of color have to face. Social workers as professionals are skilled in providing individual therapy, but unlike professionals from some other disciplines, social workers are also skilled in working with small groups and within larger communities. And as a result can more likely reach mothers in need of services, and I would argue could therefore intervene more effectively than many other professionals.

[00:08:31] Thank you for sharing that information. Dr. Keefe, can you share with us what makes Postpartum Depression among mothers of color of particular importance?

[00:08:39] Sure. The bulk of the research on working with mothers who have Postpartum Depression does not come from social workers. Most of the research has been conducted by medical professionals, including nurse midwives, psychiatrists, maternal and child

health nurses, and some from obstetricians and even from pediatricians. This research, although important, tends to focus on individual level factors, including biomedical factors that can lead to depression. Likewise very few studies have included mothers of color, but instead has focused largely on white mothers who are well insured have ongoing relationships with service providers and are heterosexually coupled. Because social work has done so little to contribute to the knowledge base on Postpartum Depression, they've had to turn to the literature in other fields. Which in some cases is very helpful, but does not address how to intervene effectively within communities of color and how to help new mothers of color with Postpartum Depression form a sense of community that will support them as they work through their depression.

[00:09:36] Great, thank you. What have you found in your research that is applicable to social workers working with this population?

[00:09:42] Well so many of the mothers that I've interviewed told me that social workers need to help them form connection with other mothers. That sense of connection is more important than often formalized services. The mothers indicate that many services are not particularly helpful, including the psychiatric medications such as anti-depressants. As one mother told me you can give me all the Zoloft in the world and it's not a way to put food on the table or money in my bank account, which I thought was a very poignant statement. What mothers tell us they need is help negotiating the maze of social service systems and the never ending paperwork they have to complete for services. It's often these problems that they need help with. All the paperwork, all the negotiating their way into services, that they need help with. But ironically it's often these issues that deter them from accessing care. They also need help in addressing the problems they face while living in high crime communities. So I believe social workers who can really roll up their sleeves and get into the communities, work with faith based and other organizations that focus on community and work within communities are more likely to help mothers and services that focus solely on providing individual therapy and the dissemination of medications.

[00:10:51] Where do you believe the research on Postpartum Depression needs to focus?

[00:10:54] Well I think for social work, research that focuses on helping mothers with Postpartum Depression forge relationships with new mothers, that helps them connect with service providers that offer concrete services such as transportation and that helps mothers without much education to finish high school and their GEDs, and that can provide job training and childcare will be especially helpful. I'm not saying that mothers don't need the individual therapy and that they don't need medication, in some instances they do. But social workers and social work researchers who can study and focus on these other macro kind of things, macro issues, I think will be of much help to these mothers as we work with mothers living with Postpartum Depression.

[00:11:35] Thank you for sharing that. Dr. Parks, the research on providing OB services to expectant mothers finds that offering services in a group format can be more helpful than the traditional office visit. Can you share more information related to this point especially from your own practice?

[00:11:51] Certainly. We have many, many years of experience with this project called Centering Pregnancy. It's really a model that was started because there is a particular problem called Preterm Delivery that has stymied the medical community for quite some time. We prefer that babies are born around their fortieth week of gestation or ten months, nine months of pregnancy. But there are many, many women who deliver their babies

early and it takes a high, both financial and emotional toll on the families and on our community. But it's not just one medical problem that causes preterm delivery. In fact many women who deliver early, we cannot even isolate a particular reason why their body decided to deliver their baby early. And so Centering Pregnancy was developed and we were able to show that doing pregnancy care in a group format was able to reduce the early deliveries that we see in moms of all socioeconomic classes, and this was really exciting. Because they were able to show this they got further funding and Centering Pregnancy grew and grew. The basic model for Centering Pregnancy is that you form groups of women who are going to deliver their babies at approximately the same time, so say June of 2019. You backed them all the way up till they're first pregnant, maybe in their third month of pregnancy and you have them all come to the doctor's office at the same time. They will meet with a social worker often, sometimes a nurse, and usually a provider, either a nurse practitioner or a family physician or an obstetrician. In that time, they are not sitting together for the usual 15 or 20 minutes of an OB visit. They are expected to stay for the entire two hour session and they continue to meet with all of the moms that are pregnant and these additional providers and social workers at the first visit all the way up to the 10th visit. So they're expected to come to 10 groups, which will culminate around the time when they're finally having their baby. By doing this model and engaging women in this intensive two hour visit every month, which then gets a little closer at the end about every two weeks, we recognize that we were able to reduce the stress of pregnancy on moms. Again moms of all socioeconomic classes, and probably that reduction in stress was the reason why we were able to keep these moms pregnant longer, closer to the entire 40 weeks, which we desire for a pregnancy. The 40 weeks is golden because it allows the baby to fully develop their lungs and brain, and that bonding that they need with the mom. It also reduces the type of outside medical care that they need so that the bonding can be between the mother and the baby and doesn't need to have incubators in the way, or other doctors or health care providers sort of impeding that bonding process. So because Centering Pregnancy was found to be so helpful in the reduction of stress, which then reduced the Preterm Delivery, it also has a lot of possibility of reducing Postpartum Depression because this also is related to stress in moms, which is what Dr. Keefe pointed out. The way it's centering is helpful in my eyes is really based on three things. The first one is building a safety net. Now building a safety net that's really going to hold you when things get tough, like Postpartum Depression, takes time. It is very difficult to do that in just a series of 20 minute visits with your provider, who may or may not have additional social work available or therapy available at those visits. The two hour visits allow you to form a stronger connection with the provider. So I feel much more bonded with the women that I see in centering group because I've been able to listen to them. They have a chance to talk rather than just me trying to get all the information out to them in a timely manner. The second is probably the most important thing for reducing stress, and again Dr. Keith alluded to this when he talked about that Zoloft is not going to be the thing that helps get food on the table and gets you to your appointments. And that is the bond with other moms. So because other moms are sitting in the room and it's in a format where we encourage everyone to participate, the other moms are giving all kinds of advice about how to navigate the systems in their community with real life experience. And I would say obviously better experience than I have. I can share my knowledge of medical care and treatment, but I don't have some of those day to day tidbits of information which can help them navigate real problems in their life. The second way that I see Centering Pregnancy as being so helpful is that we have the time component available to help women understand what's happening to their brain. There is a lot of hormone changes that are happening during pregnancy and if we don't fully appreciate that it might be difficult for moms to recognize that when they deliver there is such a dramatic change in these steroid hormones that it would be natural that their depression will manifest itself in a more broad

way. For instance all throughout the pregnancy there is a hormone that's a metabolite of progesterone that's building up. It starts at low levels in the first trimester and builds in the second trimester until it's at all time high levels in the third trimester. Then when you deliver your baby and the baby and the placenta leave, we have a sudden drop in this hormone called allopragnanolone. We believe that this may be one of the things that leads to Postpartum Depression. But just as I explained this to you, it takes a little bit of time to understand what's going on in the brain and it takes other moms asking questions to verify and question me on why this would be happening inside their brain. So this process of teaching goes over much better when I do it in a group visit where people have time to ask questions or sort of verify what I'm saying. During this time other women are also giving examples. Because sitting in the Centering Pregnancy group are not only first time moms there are other moms who've maybe had two or three pregnancies prior to this and they can give you concrete examples of just what they recall happening in those days and weeks following delivery. Lastly, the piece of cultural appropriateness in Centering Pregnancy is really golden. Obviously I from my own cultural background can't be and meet the needs of all my different patients who come from quite a variety of broad spectrum of cultural backgrounds, but often in our Centering Pregnancy group we will have moms that share a cultural background and in that way it reduces the stigma of what one mom may say and it shares some of the cultural understanding. Oftentimes the way they describe things in group my patients will use a lexicon that's very different than I would. And yet it seems very well received by moms. They also are more willing to share examples from their life and more willing to take on advice from moms who seem to have a lot of street cred with things that they have tried in the past. So centering pregnancy differs from traditional obstetric care in the time component, which offers us time to build a safety net, offers us more time to teach what is happening in the brain, which could make them predisposed or at risk for Postpartum Depression. And it helps us to overcome the cultural barriers between provider and patient.

[00:19:07] Thank you for that overview on Centering Pregnancy. Now Dr. Parks, the Centering Pregnancy program at your agency has provided services for many years to all mothers. How do you see Centering Pregnancy to be helpful to expectant mothers, given the research you and Dr. Keefe have cited?

[00:19:23] The research is important because as Dr. Keefe mentioned, it really allows us to get social workers involved in this process. Centering Pregnancy allows them the format to be welcomed into a group and to have the ability to be participating as a group member, so you know we're all participating together, and it really allows us this time, as I mentioned before, to go through what moms are thinking at the beginning of pregnancy, what they're thinking in the middle of their pregnancy and then what they are thinking in the end as all of these changes come about. For instance, in the beginning we really talk about preparation for parenthood. This is such a broad concept, but as they became pregnant it wasn't maybe on their radar screen that they were going to have to do so much preparation, as most of us don't plan ahead for our lives, things happen and the fact that they had to do eight or nine months of preparation in parenting maybe wasn't in the forefront of their mind when they became pregnant. Secondly the parents who have lived in disarray have spent their whole life unprepared for things. Think about going to a test and not having had time to study. By the time I got to medical school I can media only no one or two times where I had forgotten that I was going to have an exam that day when I arrived in class and I was always used to being prepared. That's really different than most of my patients who have because of social stressors, had to show up unprepared for many many events in their life. For instance, tests. They may have been living in a homeless shelter and had to show up or were switched schools a thousand times and had to sit

down in front of a classroom with a test put in their lap when they didn't know it was ready. Maybe they'd had to go to school without the proper clothes many many days. Maybe they'd had to transport themselves someplace where they were not expecting to have to go and had to catch a bus or a ride from someone that they barely even knew. Maybe they were even placed in a shelter or in a foster home where they didn't have any preparation for what the caregiver was going to be like. This constant living in a set of disarray where you don't have preparation makes you think that preparation is not important or is not necessary. So by having this time set aside, two hours every month of their pregnancy, we can help them see why preparation for parenthood actually has some benefits. So in the beginning we focus on preparation and why it would be important and how it could help us. In the middle part of the Centering Group we do some of the hard work to teach them about planning. Once you've sort of bought into the idea that you can prepare for something, then you may spend some time sitting down to do some planning. We do things like "What will it be like when you come home from the hospital three days after you have your baby and you need to ask for help in preparation of food, or you need to ask someone to do your laundry, or you need to ask someone to care for your baby? How could you go about having that conversation? What if your partner isn't willing to do those things? What might you say to them? What if your partner does take care of the baby for an hour and you don't like how they're caring for the baby? Let's plan ahead for what you could do in that situation." So we throw out all sorts of scenarios, not only with getting these tasks done but trying to find the financial resources to pay to have your laundry done or to pay to have some food. Some of our moms are 16 or 17 and they've really never even had to live under a budget. They've lived under a budget which is so minimal that you only get what you absolutely need. But then they're planning ahead for a baby and they'd like to have a baby shower and buy extra clothes for the baby. All of these things require them to plan ahead for what may be appropriate for them to spend their money on and what may not be appropriate. In terms of depression, it helps us plan ahead for where your social network is, where is your safety net. They may have never thought about trying to reach out and plan ahead for a network because they've only gotten what they absolutely need and have not had time to plan ahead. So it's exciting to get social workers involved in this planning process so that if they would notice some symptoms of Postpartum Depression, in other words they'd be isolated, they would start feeling sad or tired more often, that they would have one or two people that they would be able to reach out to. Now these might even be people in our centering group because we focus so strongly on forming a bond with the other mothers that they often reach out to each other during the process of delivery and that immediate postpartum period. The end of Centering Pregnancy we really focus on trying out what they have learned. Some of the women deliver a slightly earlier than others, they'll bring their babies there, we'll ask them how they made decisions about things like what they were going to use for birth control Postpartum or what they were going to do about their baby getting a circumcision or not. They'll try out their decision making skills, they'll share with us what they've learned. We'll also ask them how they feel and if they notice any depression and the moms will be able to give you concrete examples about what brought them to tears in the first days following their baby or how they had to ask the father to not be involved in their life because it brought them so much angst. So the process of the research is really important to help us know which of these tools we can teach in the early, the middle and the end of our Centering Pregnancy groups to write the best curriculum so that we can prepare the moms the best way possible if this should happen. We also hope that by forming these bonds that we may actually be seeing less Postpartum Depression because just having the fortitude and reducing the stress will allow them the benefit of overcoming the hormonal changes after their delivery.

[00:25:00] Thank you so much for that thorough overview. Dr. Keefe or Dr. Parks, before we end our conversation today do you have anything else that you would like to add?

[00:25:08] One point that I would certainly get across is how Centering Pregnancy as a program, as an evidence based and empirically supported practice has always been very open to try out new interventions that may help new mothers. So I see Centering Pregnancy as a wonderful opportunities, the Central Pregnancy programs as a wonderful opportunities for university community collaborations in working together to help new mothers have successful pregnancies and to have children infants born at full term so that we can have happy healthy families.

[00:25:43] Wonderful thank you for that point. Dr. Keefe or Dr. Parks, are there any additional comments you would like to share?

[00:25:49] I would just like to say how much of a joy it is to participate in Centering Pregnancy. Anytime that you feel like your patients are getting a lot out of it it's very motivating to put more effort into the participation, and Centering Pregnancy really offers that. So I think that really focuses on the bond that you have between provider and patient and that is always a benefit because those relationships can be very helpful if and when anything like Postpartum Depression would come out. So has been a joy and one of the highlights of my career.

[00:26:18] Wonderful. Those were some excellent closing thought. Thank you for joining us today Dr. Keefe and Dr. Parks. It was a pleasure talking with you.

[00:26:26] Thank you.

[00:26:26] Thank you.

[00:26:28] You've been listening to Dr. Lorinda F. Parks and Dr. Robert H. Keefe's discussion on the use of Centering Pregnancy to address Postpartum Depression. I'm Louanne Bakk. Please join us again at inSocialWork.

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