**Exploring the feasibility of tailoring an effective postpartum depression evidence-based treatment intervention for use with African American mothers.**

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## Abstract

Black women account for some of the largest health disparities, with one of the largest being maternal health. African American women are 5.2 times more likely to die from pregnancy related causes and 1 out of 3 are impacted by postpartum depression, as compared to 1 out of 7 White women. Scholarly research supports the lived experiences and prolonged exposure to chronic stress due to racism, sexism, discrimination, and oppression impact African American women's overall health and maternal health. Despite these risks, there are no evidence-based treatment interventions specific to Black women with postpartum depression. This project addresses this gap. Guided by the first 4 phases of the ADAPT-ITT intervention adaptation framework, community based participatory research approach, intersection theory, Black feminist thought and ecological systems theory, this project describes the formative work done in collaboration with Black mothers with recent histories of postpartum depression (n=6) to culturally tailor an existing evidence based perinatal treatment intervention for use with Black mothers specifically. The Mothers and Babies course, the intervention in question, is an 8-week, facilitator led, group course grounded in cognitive behavioral therapy, attachment theory and the Reality Management approach. In the current study, two focus groups were conducted virtually with the same participants (n=6). Participants were college educated, middle-class African American women ranging in age from 30-44 years old who self-identified as having postpartum depression within the last 3 years. Topics that pertained to Black women, motherhood, and postpartum depression such as the Superwoman schema, systemic discrimination and the influence of maternal figures were introduced and discussed during the focus groups. Focus groups were recorded, transcribed, thematically coded, and the emergent used to guide and introduce cultural congruent themes to the intervention. The findings from this project suggest

most interventions of this sort pilot studies with populations of low-income women, leaving middle class women unaccounted for while they are also greatly impacted by postpartum depression. Policy change recommendations include expanding funding for group focused research efforts, organizations, and programs to implement culturally tailored interventions for all women experiencing postpartum depression to make services more accessible. Implications for social workers and researchers include conducting more group focused research, addressing implicit bias, and culturally tailoring current interventions and theoretical frameworks to speak to Black women's experiences using an ecological systems theory lens.

***Keywords***: *Postpartum depression treatment interventions, maternal mental health, African American women, maternal health, group cognitive behavioral therapy, cultural adaptation*

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## Introduction

African Americans continue to experience poorer health status than any other racial or ethnic group and the quality of healthcare varies largely by race (Lekan, 2009). In the United States the racial disparities that exist between African Americans and White Americans is substantial across several categories (Ray et al., 2017). But when it comes to African American women specifically, they experience a higher mortality, prevalence, and incident rate for poor birth outcomes despite the scientific advancements in treatment (CDC, 2009). One of the largest health disparities that exists is between Black and White women's maternal health (CDC, 2020). According to the Center for Disease Control (CDC, 2019), between 2007-2016 overall pregnancy-related mortality rates increased from 15.0 to 17.0 pregnancy related deaths per 100,000 births. And the rate for (non-Hispanic) Black college educated women was 5.2 times more than (non-Hispanic) White women (CDC, 2019). These disparities persist in the postpartum period (after birth) as 1 in 3 African American women suffer from postpartum depression (PPD) compared to 1 in 7 white women (Feldman & Pattani, 2019).

These specific disparities are now considered a public health crisis (CDC, 2020) and an issue of social justice (Lekan, 2009). Despite scholarly evidence that these large disparities exist, the gap continues to widen, supporting the need for further group focused research to explore and find solutions to address the maternal health disparities. Currently there are gaps that exist in the literature and there is a lack of treatment interventions that consider the intersectionality of an individual's identity (Crenshaw, 1991). This Capstone project sought to tailor an existing evidence based perinatal treatment intervention, The Mothers and Babies Course (MBC) (Muñoz et al., 2011), through the facilitation of focus groups with African American mothers who self-identified as recently having postpartum depression. The MBC is a cognitive behavioral therapy, facilitator led, 8-week group perinatal depression intervention (Muñoz et al., 2011).

Guided by community based participatory research (CBPR)(Speights et al., 2017), the goal of the focus groups was to better understand PPD amongst African American mothers and their mental health needs during the postpartum period. Data collected from the focus group will be infused into, the MBC, to ensure cultural congruency in addressing, treating, and reducing the effects of postpartum depression among African American women using the four phases in the ADAPTIT model (Wingood & DiClemente, 2008) as a guide.

## Review of the Literature

African American women have disproportionately high rates of adverse health outcomes including poorer birth outcomes as compared with their White counterparts, and untreated or misdiagnosed mental health conditions (Hamilton et al., 2009). The research suggests these disparities may partly be related to how African American women experience and cope with the daily stressors they encounter (Woods-Giscombe, 2010). To fully understand the gaps within the health disparities that exist amongst African American women and White women one must first consider the social conditions that created them and the severity of the racial tension and stress that perpetuates them (Anderson, 2012). The literature reports the lived experience of African American women exposes them to varying levels of stress throughout their lifespan (Geronimus, 2001). This contributes to their physiological detriment and incites the early onset of disability and disease which adds to the health disparities gap between Black and White women (Woods-Giscombe & Lobel, 2008), specifically when it comes to postpartum depression.

### *Postpartum Depression*

Postpartum depression (PPD) is a debilitating and serious illness that affects approximately 20% of women who give birth (Gavin et al, 2005). It negatively impacts mothers and their infants (Leger & Letourneau, 2014). Mothers go through a multitude of rapid transitions during pregnancy which includes physiological, societal, and psychological shifts (Otchet, et al., 1999).

The transition into motherhood heightens the risk for women to experience mental distress (i.e., elevated stress, depression, and anxiety) (Evans, et al., 2001). In fact, depression is the most diagnosed condition during the antepartum and postpartum periods (Robertson, et al., 2004); however only 15% of all mothers receive effective treatment (Lieshout et al., 2019). One in seven white mothers experience postpartum depression compared to one in three African American mothers (Feldman & Pattani, 2019). Although African American mothers have higher rates for PPD they are far less likely to receive treatment (Kozhimannil et al., 2011) for various reasons that will be addressed in a later section.

Postpartum mood changes (in order of least to most severe) include postpartum blues, postpartum depression, and postpartum psychosis (Muresan-Madar, A. & Baban, A., 2015). Postpartum psychosis is rare however the extreme cases could result in attempted or complete suicide or infanticide (Jones et al., 2013). Common symptoms of PPD include irritability/ anger, sleep/ appetite disturbance, crying spells, sadness, lack of interest in baby or other things use to enjoy, possible thoughts of self-harm and/ or harm to baby, and feelings of shame, guilt, or hopelessness (Postpartum Support International, 2019). The symptoms can appear between two weeks after birth and 1 year postpartum; between 25%-50% of women with PPD have symptoms that lasts 6 months or more (Beck, 2002). Women who were generally found to be at higher risk of developing PPD are those who have inadequate support caring for baby, multiple children, financial and martial stress, complications in pregnancy, birth or breastfeeding, baby in NICU, a major life event (i.e., job loss, move), thyroid imbalance or women with any form of diabetes (Postpartum Support International, 2019). Intersecting race and socioeconomic status with those forementioned factors put those mothers at even higher risk for developing PPD (Kozhimannil et al., 2011) which further supports the finding of 1 out of 3 African American mothers are impacted by PPD (Feldman & Pattani, 2019).

### *Postpartum Depression in African American Women*

African American women experience a higher prevalence of perinatal mental health disorders, relative to the US population (Matthews et al., 2021). 40% of Black women experience postpartum depression, which is more than double the rate of the general population (Matthews et al., 2021). It is predicted this number is higher given maternal mental health issues are largely underreported (Kozhimannil et al., 2011) and symptoms often go unaddressed (Iturralde et al., 2021). However, Black women are less likely to seek treatment, and if they do, they are less likely to receive quality treatment due to structural racism and the disjointed systems of mental health care (Matthews et al., 2021).

Studies have proven cultural factors play a significant role in PPD (Bina, 2005). These studies have explored multiple cultures and emphasized PPD can only be fully understood when social perspectives, psychological, biomedical, and cultural factors are all taken into consideration (Cox, 1999; Harkness, 1987). Furthermore, cultural factors have a significant impact on the individual's emotional state (Lazarus & Folkman, 1984) and cultural beliefs and practices play an important role in pregnancy, birth, and motherhood (Raphael-Leff, 1991). For African American women there are many contributing factors, which can range from lack of diversity in healthcare to higher levels of chronic stress and trauma to perceived racial and/ or gender discrimination, which can lead to overall distrust in the healthcare system and adverse birth outcomes.

### *The Effects of Postpartum Depression*

Postpartum depression has consequences that are far reaching as it is a condition that not only effects the mothers' functioning, but also has negative effects on the cognitive, behavioral, and emotional development of her infant (Muresan-Madar, A. & Baban, A., 2015). PPD has consequences that goes beyond the first year of the child's life (Murray et al., 1996). In addition, according to the biopsychosocial model of PPD, the mother's symptoms of PPD interferes with her abilities to mother, specifically her emotional and behavioral interactions with her baby

(Milgrom, et al., 1999). Furthermore, women who experience PPD are at higher risk for poor mother-infant attachment, future depressive episodes, functional impairment, and delay of child reaching developmental milestones and developing future mental health diagnosis amongst other detrimental factors (Ohoka, et al., 2014; Moehler, et al., 2006; Deave, et al., 2008).

There is research that also supports marital and interpersonal relationships, of mothers affected by PPD, are also adversely affected (Burke, 2003). A maternal mortality report composed of reviews from committees across the U.S. found mental health problems in African American women that went unreported and unidentified was a contributing factor in the pregnancy-related deaths (Review to Action, 2019). This supports the need for better screening tools for PPD in African American women, cultural competency, and sensitivity training for providers and for accessible and effective treatment options created specifically for African American mothers.

### *The Effects of Chronic Stress on African American Women*

There is a positive correlation between racism and the physical and mental stress that results from an individual's experience with it (Geronimus, 2001). According to Nevid & Rathus (2003) stress is the physiological demand placed on the body when one must adjust, adapt, and cope. Continuous activation of the stress response (chronic stress) can disrupt all the body's processes and increases the risk for health complications (Mayo Clinic, 2011; NIH, 2011). Chronic stress associated with health disparities include maternal stress, perceived discrimination, daily stress, environmental stress, and neighborhood stress (Djuric et al., 2010; NIH 2011). Furthermore, severe stress has great effects on the reproductive system (Shiel, 2018) and experiences of racism can contribute to adverse birth outcomes, especially when combined with the effects of the day-to-day stressors, gender bias and discrimination (Nuru-Jeter et al, 2009; Dominguez et al., 2008; Canady et al., 2008). With racism being a historical and present structure in the United States on

every level of the ecosystem (micro, meso, exo, macro, chrono) (Shavers and Shavers, 2016; Ray et al., 2017), African American women experience chronic stress and are disadvantaged due to the day-to-day encounters living within an oppressive society (Mullings, 2002).

**Maternal Health Disparities among African American and White Women**

In the last several years increasing attention has been directed to the significant racial disparities that exists between African American and White women regarding maternal health. Severe maternal morbidity impacts 600,000 women a year in the U.S. and has increased over the last several decades (Callaghan et al., 2012). African American women had the fastest rate of increase between 2007 and 2014 with rates in some cities in the U.S. being 12 times higher than White women (Moaddab et al., 2016). This disparity has existed for over a century however the gap has grown more between African American and White women over the last few decades (Saftlas et al., 2000). For example, when data from 1979 to 1992 was analyzed, the overall pregnancy-related mortality ratio was 25.1 deaths per 100,000 for Black women, 10.3 for Hispanic women, and 6.0 for non-Hispanic White women (Hopkins et al., 1999; Flanders-Stepans (2000). These rates had not improved between 1987 and 2016; in fact, the rate increased from 7.2 in 1987 to 16.9 in 2016 (Burns, 2020). According to the CDC (Hoyert, 2019), from 2018 to 2019 the deaths per 100,00 live births increased for all women from 17.4 to 20.1 and for Black women it went from 37.3 to 44.0 and White women 14.9 to 17.9.

The risk of a pregnancy-related death for African American women, especially in the Southern region of the U.S., is like risk for women in some developing countries (Howell, 2018), however most other developed countries ratios are in the singular digits (Nelms, 2019). In 2018, Georgia ranked number one in the U.S. for the highest maternal mortality rate by 25.5% (Moore, 2019). In 2018 the national maternal mortality rate was 20.7 deaths per 100,000 live births and for Georgia the ratio was 46.2 (Nelm, 2019). Recent CDC data reported African American

mothers are 243% more likely to die from childbirth and/ or pregnancy related causes than White mothers (CDC, 2020). 11.7% of pregnancy related deaths between 2011 and 2015 occurred during the postpartum period, more than 42 days up to 1 year after birth (Peterson et al., 2019). These higher rates persist across education and income levels for Black women (Singh, 2010; Petersen et al., 2019). It is important to mention scholarly research supports that an alarming 80% of the overall maternal morbidities and mortalities of African American women are preventable (Braveman, 2014).

Unfortunately, these traumatic birth and pregnancy experiences and their adverse outcomes greatly impact these mothers in the postpartum period (Kendall-Tackett, 2014). Although the prevalence of postpartum depression is substantially high there is a lack of African American mothers receiving effective treatment (Parker, 2021). The following section will explore the theoretical frameworks that was used to tailor the MBC course for use with African American mothers experiencing PPD.

## Theoretical Frameworks

### Ecological Systems Theory

The ecological systems theory was originally developed by Urie Bronfenbrenner (1992) in the 1970s. This theory assists with explaining the influence of social environments on the human experience (Noursi et al., 2021). The influence is considered a reciprocal interaction as behavior impacts and is affected by these different levels of influence (Alio et al., 2010). Ecological systems theory suggests the postpartum depression disparity amongst African American women results from a combination of factors on multiple levels of influence which include micro (individual), meso (interpersonal), exo (community), macro (societal) and chronosystems (sociohistorical events). Figure 1. illustrates how these varying levels impact the Black motherhood experience utilizing an ecological systems theory lens.

### *Micro (Individual) level factors of influence on PPD in African American mothers*

In a previous study by Amankwaa (2003), African American women were found to try to live up to the idealization of motherhood in which themes included "Strong Black Woman," "Superwoman," and "Good Mother." Struggling to live up to these terms exacerbated the progression of PPD (Amankwaa, 2003). One study suggested African American mothers deny stressors they encounter regularly and keep their feelings to themselves, the tendency to non-disclose is likely a sign of control and independence, rather than denial (John & Crowley, 1996). Another study found African American women associated PPD with weakness and mental inability and stressors brought on by PPD was largely handled by praying (Amankwaa, 2000). Having anxiety and depression was associated with being an unfit mother and unable to handle their responsibilities (Amankwaa, 2003) and consequently there was shame associated with having symptoms associated with depression and anxiety which led to not seeking treatment. Black women historically have maintained these mindsets as a means of necessity for survival (Minoo, 2015).

### *Meso level (interpersonal) factors of influence on PPD in African American mothers*

Many African American women have reported a fear of child protective services taking their children into custody if they admit to symptoms of PPD (Amankwaa, 2003). Studies done on a national level found child welfare workers deem African American mothers unfit at a higher rate than they do White women, even when factors such as poverty and education are controlled for (Dettlaff & Boyd, 2020). Black children are four times more likely than White children to enter foster care although they make up less than a third of the population in comparison to White children (Gonzalez & Ye, 2015). Reports show stereotypes of black parents include they are "more troubled" which contributes to the unfair treatment of black families in the welfare

system (Gonzalez & Ye, 2015). Additionally, a previous study on PPD amongst African American women (Amankwaa, 2000) found a major theme of "Dealing with it." Participants expressed symptoms of depression would not be readily disclosed amongst the African American community due to the stigma and the perceived negative consequences attached to it (i.e., being deemed as unfit, having child(ren) taken away) (Amankwaa, 2000).

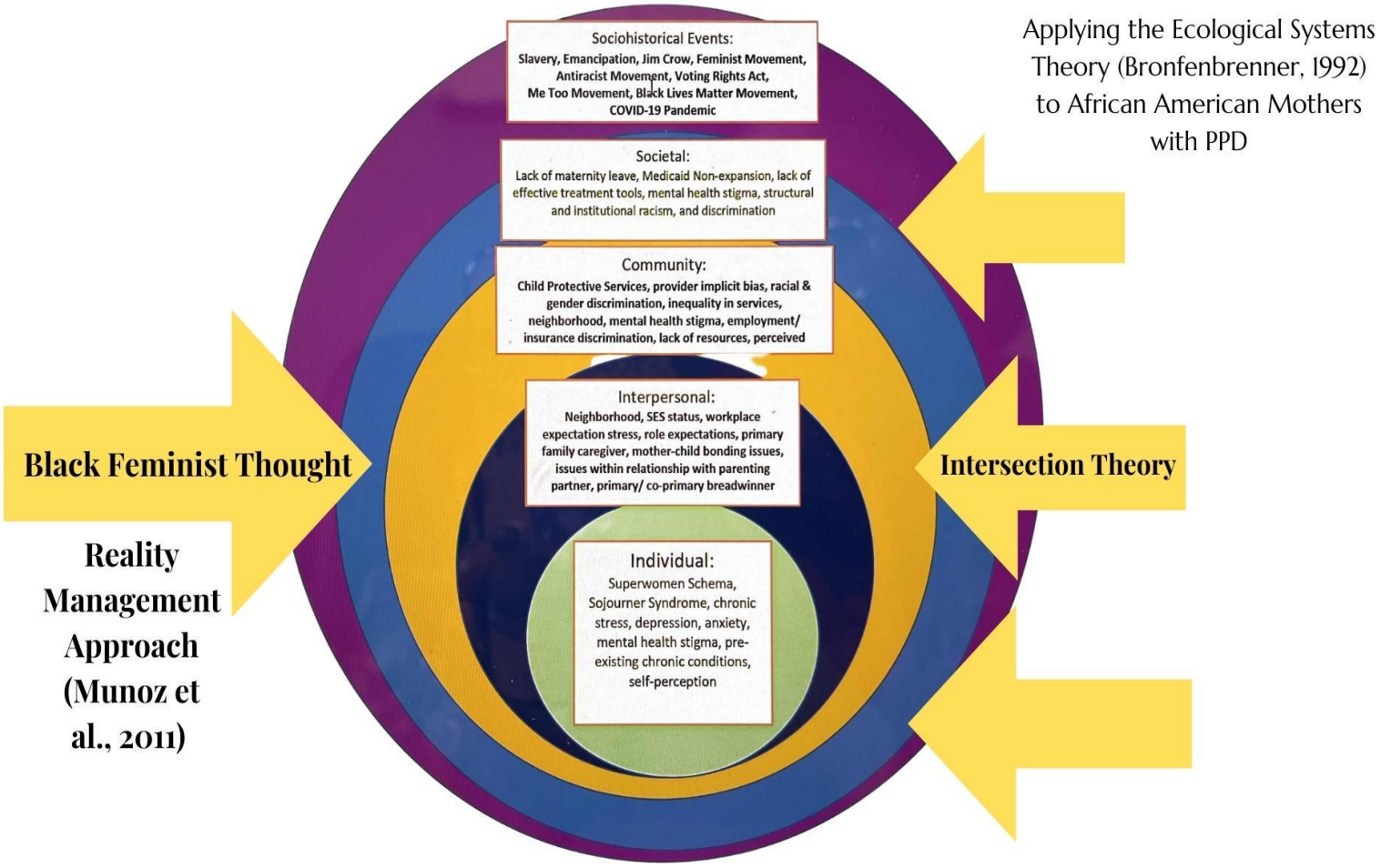
***Macro level (Community) factors of influence on PPD in African American mothers***

There is a distrust for the medical system, government entities and fear of employment and insurance discrimination which largely contributes to African American women experiencing symptoms of PPD not seeking treatment when they need it most (Amankwaa, 2000). Furthermore, structural racism, poor access to quality care, lack of social and political policies to protect African American women and failing healthcare institutions serving predominantly African American patients are also macro level factors that exacerbates the forementioned disparities (Kilbourne et al., 2006).

In addition, within the medical community there is a lack of knowledge, implicit bias and poor communication and less attention to details leading to poor care by providers (Warnecke et al., 2008). These factors play a significant role on a systematic level in maintaining the disparity amongst African American and White women during the prenatal and postpartum periods. This leads to lack of appropriate diagnosing and failure to provide treatment resources to African American women with PPD (Warnecke et al., 2008). The next subsection will further explore Intersection Theory (Crenshaw, 1991) as it is at the intersection of African American women's identities and the above categories that the identical and complex lived experience of African American women can be better understood and can help to inform effective interventions to this disparity.

**Figure 1.**

*Applying the Ecological Systems Theory to African American Mothers with PPD*




## Intersection Theory

Kimberlé Crenshaw (1991), coined the term *intersectionality*, which defined the exclusion of Black women from the antiracist and feminist movements. The term further explains how the multiple social identities of Black women intersect to reflect the interlocking systems of privilege and oppression at the micro and macro-social structural levels (Bowleg, 2012). Furthermore, this theory and term recognize that power, privilege, and oppression flow in multiple directions, often based on combinations of variables such as race, gender, sexuality,

class, and other factors (Garcia, 2020). Another term that parallels intersectionality is *multiple jeopardy* which was coined by Deborah King (1988). King (1988) stated if a person is conscious of these multiple jeopardies they would be identified as having *multiple consciousness*. In having multiple consciousness, one is aware of how the multiple systems of oppression work together to maintain inequality and racial disparities (Harnois, 2015).

Cultural scholar Bell Hooks noted "No other group in America has had their identity socialized out of existence as have Black women" (Hooks, 2014). African American women have been oppressed by race, gender, class, and other conditions throughout their existence in this country (Hooks, 1995) which supports the notion that one's identity is inseparable from their experiences. This should be considered when assessing the impact of how being a Black woman with multiple consciousness in America can cause substantial stress emotionally, mentally, and physically (King, 1988) which gets more severe during pregnancy and in the postpartum period (Leger & Letourneau, 2014). In summation, intersection theory helps to provide a theoretical perspective as to why the maternal mental health disparities between African American and White women exists. In considering Black Feminist thought (Collins, 2009) which breaks down intersectionality from a critical social theory framework, it offers guidance on how to counteract the detrimental mental impacts of being an African American woman with PPD, which is essential in culturally tailoring an effective treatment intervention.

**Black Feminist Thought**

Black feminist thought (BFT) is concerned with oppression as well as resistance, activism, and empowerment (Minoo, 2015). "Black feminist thought exposes the way that domination is organized and operates in various domains of power…it also shows the path of struggle to empowerment…" (Minoo, 2015, ¶3). Important concepts of BFT includes the U.S.

matrix of domination (gender, race, sexuality, class, and nation). Additionally, BFT addresses the collective identity of Black American womanhood shaped around the logic of resistance and oppression. And within that collective identity African American women have internal divisions and differences, however despite those differences there is a shared history and daily experience for African American women. Furthermore, it discusses the significance of change for BFT as a critical social theory (Collins, 2009; Minoo, 2015).

In BFT, hegemonic ideologies are defined as culture, consciousness, and knowledge (Minoo, 2015) and it highlights the use of counter-hegemonic which focuses on empowerment (Collins, 2009). According to Collins (2009), empowerment is gaining awareness to unpack hegemonic ideologies and construct new knowledge (p. 305); which is an essential focus to include in any psychological intervention, such as a PPD treatment intervention, for African American women.

## Evidence-based Social Work Intervention: *The Mothers Babies Course*

*"Mamas y Bebes"/Mothers and Babies Course (MBC)* is the evidence-based treatment intervention that was used in this Capstone project. The MBC is a perinatal intervention that takes a cognitive behavioral, attachment theory and reality management approach (Muñoz et al., 2001) to teach mood regulation skills to English- and Spanish-speaking low-income women at high risk for perinatal depression (Muñoz, et al. 2011). The primary goal of the intervention is to reduce the symptom frequency, intensity, and duration of PPD, to enhance the mother-child relationship and to promote and teach healthy mood management (Muñoz et al., 2011). These aims are achieved partly by emphasizing and focusing on the differences between mental reality (subjective) and physical reality (objective) which is a concept better known as the reality management approach (Muñoz et al., 1996).

## The Historical Context

Muñoz and Le (1997) founded the *"Mamas y Bebes"/ Mothers and Babies: Mood and Health Project* in 1997. The course originated from multiple manuals that focused on the prevention and treatment of major depression (Muñoz et al., 2011). In 1999, Muñoz and colleagues started to revise the Depression Prevention course (Muñoz, 1984) to develop an intervention explicitly for pregnant women, which is known today as the MBC. The original intervention was 12 weeks with four booster sessions during the postpartum period (Muñoz et al., 2011). Following that, the 8- week adaptation was initiated to compress the 12-week course to improve participant retention (Muñoz et al., 2011).

The 8-week adaptation of the MBC was piloted through a community-based randomized trial with 217 Latina immigrant women primarily from El Salvador and other countries from South and Central America to test the efficacy of the adaptation (Le et al., 2011). The intervention was originally designed for use with Latina mothers and incorporated Latina socio-cultural issues and values (Muñoz et al., 2007). The intervention has since been also used with other populations of women including low income Black and White women during the perinatal period. The intervention was originally adapted from the Depression Prevention Course and the Group Cognitive Behavioral Treatment manuals which were developed in the 1980s to be used with public sector patients at the San Francisco General Hospital (Muñoz et al., 2007).

## Content

The MBC treatment intervention used for this Capstone project is an 8-week structured, facilitator led, course composed of eight weekly 2-hour classes. There is one introduction class followed by three modules: Thoughts (composed of two classes), Activities (composed of two

classes) and Contact with Other People (composed of three classes). Table 1 provides an overview of the MBC eight-week intervention.

**Table 1.**

*Overview of the MBC Intervention (Muñoz et al., 2011).*

| Week | Theme | Topics Covered |
|---|---|---|
| 1 | Participant introduction to the intervention | Introduction to the course |
| 2 | Thoughts | Thoughts and my mood |
| 3 | Thoughts | Fighting harmful thoughts and increasing helpful thoughts that affect my baby and myself |
| 4 | Activities | Activities and my mood |
| 5 | Activities | Pleasant activities help make a healthy reality for my baby and myself |
| 6 | Contact with Other People | Contact with other people and my mood |
| 7 | Contact with Other People | How to get support for me and my baby |
| 8 | Contact with Other People | Planning for the Future and Graduation |

Each module includes didactic instruction, psychoeducational information, group discussion and practical strategies to apply (Muñoz et al., 2011). Additionally, the treatment intervention includes interactive exercises throughout the course, in addition to homework after each module which includes a quick mood scale for participants to track their moods daily in between group meetings. Table 2 provides an overview of the class content covered in the MBC eight-week intervention.

There are two manuals to assist with facilitating the intervention: an instructor and a participant manual. The instructor manual is composed of an introduction to the intervention, an explanation of the theoretical approaches that guide the intervention along with key elements, discussion on the cognitive behavioral therapy (CBT) group format used, teaching strategies, potential limitations, class-by-class instructions, and appendices which include the quick mood scale, the reality of management model, table of materials needed for each course, course evaluation form and the Instructor Fidelity form (Muñoz et al., 2011). The participant manual includes outlines for each class with class activities and discussions including alternative exercises (Muñoz et al., 2011).

Table 2. Overview of MBC Content

| MBC Class Session | MBC Content |
|---|---|
| 1 | **Introduction to Mothers and Babies Course:**<br>• Introductions<br>• Group guidelines<br>• Review purpose<br>• Overview and benefits of course<br>• Video: "My parents, my teachers"- (video was developed by El Valor created for Latino parents; all actors are Latino)<br>• Review stressors that impact the mother-baby relationship<br>• Personal reality = external + internal reality<br>• Personal project: Complete Quick Mood Scale (Mood tracker) |
| 2 | **Thoughts and my mood:**<br>• Relaxation Exercise (Deep breathing exercise)<br>• "Violet & Mary"-Interactive activity that highlights the connection between what we think and how we feel. And how what we do can affect how we feel.<br>• Common Mood Problems During Pregnancy and after birth<br>• The Path that leads to a healthy mood<br>• What are thoughts?<br>• Types of thoughts<br>• Helpful & Harmful thoughts<br>• Types of harmful thought patterns & talking back<br>• How to give myself good advice |
| 3 | **Fighting harmful thoughts and increasing helpful thoughts that affect me and my baby:**<br>• Relaxation exercise<br>• "Violet & Mary's days" activity<br>• Thoughts About Becoming a Mother<br>• Pregnancy, Birth & Parenting-Helpful & Harmful Thoughts<br>• Helpful Thoughts During Pregnancy & Motherhood<br>• Ways to Change Harmful Thoughts that Affect Me and My Baby |

| MBC Class Session | MBC Content |
|---|---|
| | • Thoughts I want to learn to teach my baby<br>• Thinking about your future<br>• Thinking about your baby's future |
| 4 | **Activities and my mood:**<br>• Relaxation exercise<br>• "Violet & Mary's days" activity<br>• How does what we do affect how we feel?<br>• What do you like to do?<br>• Balancing stress and fun? |
| 5 | **Pleasant activities help make a healthy reality for my baby and myself:**<br>• Activities and my baby's mood<br>• What do babies like to do?<br>• Some things babies like to do<br>• Pleasant activities and my baby<br>• Overcoming Obstacles |
| 6 | **Contacts with other people and my mood:**<br>• When I am with others I feel better<br>• The people in my support network<br>• People in my life and the ways they support me<br>• Communication styles and your mood<br>• Getting your needs met<br>• What keeps you from expressing your needs |
| 7 | **How to get support for me and my baby:**<br>• Can we break the vivacious cycle?<br>• People who will provide support for me and my baby.<br>• Interpersonal relationships and depression: Role Change or Transition<br>• Interpersonal relationships and depression: Role disagreements of dispute<br>• Safety in relationships is the #1 Priority |

| MBC Class Session | MBC Content |
|---|---|
| 8 | **Planning for the Future**<br><br>• The attachment or bonding relationship between parents and baby<br>• How to meet your baby's needs<br>• Babies' needs change as they grow<br>• Learn about your baby's temperament<br>• Three types of temperament<br>• Role models for me and my baby<br>• Final activity |

## Theoretical Models of the Intervention

### *Cognitive Behavioral Therapy (CBT)*

CBT is one of the most common psychological/ psychosocial interventions with strong evidence on clinical efficacy for treating PPD (O'Hara et al., 2000; Sockol, 2015). CBT aims to address dysfunctional patterns of cognitions and maladaptive behaviors (Beck, 1995, Butler et al., 2006). There is evidence that CBT for PPD should include perinatal-specific concerns (e.g., culturally endorsed beliefs about motherhood, the impact of pregnancy and of a new infant on a woman's identity, and the ability to sustain and engage in previously valued and meaningful activities) and interpersonal domains (e.g., improving appropriate social support) (O'Mahen et al., 2012).

Additionally, there are four key CBT elements that were identified as essential in the MBC. These four key elements included providing a rationale for why the intervention was important to the participants at the beginning of each class, training participants on the practical skills to change their mood related behaviors and thoughts, encouraging participants to practice the skills learned consistently outside of sessions and for participants to attribute improvement to skills learned and lastly creating the expectation that their improvement would continue far beyond the end of the course (Muñoz et al., 2011).

### *Attachment Theory*

Attachment theory focuses on the importance of those early relationships in a child's development (Ainsworth et al., 1978; Bowlby, 1969). The premise is the quality of the child's bond with their primary caregiver (the mother) has a sustained effect on the child's developing personality and psychopathology (Ainsworth et al., 1978; Bowlby, 1969). Mothers who are depressed have difficulty providing appropriate attention and responsiveness to their infants

which plays a central role in babies forming a secure attachment (Belsky, 1999; Martins & Gaffan, 2000; Teti et al., 1995). The MBC intervention aims to show the importance of the parent-infant bond and provides psychoeducation on ways to strengthen the bond while also reviewing the impact of perinatal depression on attachment (Muñoz et al., 2011).

*Reality Management Approach*

This approach was developed over the last 30 years during the researchers work with patients at San Francisco General Hospital. Muñoz (2011) and his team found through their work an additional focus needed to be added in their approach to CBT outside of solely focusing on changing thoughts and behavior. "We needed to face the reality of these patients' lives and help them change that reality" (Muñoz et al., 2011, pg.13, ¶1). In the original CBT model, techniques to control your depression are taught, however Muñoz (1996) pointed out there are certain realities that ethnic minorities have no control over such as experiences with discrimination and racism. As a result, this approach focuses on the shaping of participants subjective (mental and internal) reality and objective (physical and external) reality. This approach was found to be helpful in providing context for participants in which to implement the CBT techniques taught during the course (Muñoz, 1996).

**Existing Evidence of the Mother and Babies Course Effectiveness**

Efficacy of the MBC has been demonstrated among high-risk, low-income, underserved perinatal populations in several studies (McFarlane et al., 2017; Le et al., 2011; Tandon et al. 2014, 2018). Additionally, it was highlighted for its effectiveness in preventing PPD by the U.S. Preventive Task Force (2019). McFarlane et al. (2017) completed a randomized trial of the MBC to address maternal distress in mothers during home visits. The results from the study were improved coping and reduced stress and depression post-intervention amongst participants.

Statistical significance ($p < .05$) was found in the post intervention and at 6 months follow up for self-controlling, involvement in child's activities, reasonable expectations, encouragement, and planful problem solving (McFarlane et al., 2017). Another study (Le et al., 2011) found after participants completed the MBC intervention, they had significantly lower depressive symptoms and reported fewer cases of moderate depression (BDI-II >20).

Tandon et al. (2014) study tested the efficacy of the MBC in a home visitation program with 78 low-income pregnant women. Depressive symptoms declined at a greater rate for intervention participants at 1-week, 3- and 6-months post intervention in comparison to the group that received usual care (Tandon et al., 2014). Only 15% of women reported depressive symptoms compared to 32% of the women in the usual care group at 6 months post-intervention (Tandon et al; 2014). The versatile use (i.e., hospital, groups, home visits, online) and success of the MBC intervention supports its adaptability for use with African American women with PPD.

## Capstone Project Rationale and Aims

As previously mentioned throughout this paper, African American women experience health disparities of multifactorial etiology and account for some of the largest disparities (especially when compared to White women) and yet are underrepresented in research (Speights et al., 2017). These racial health disparities, including but not limited to maternal health and postpartum depression, have remained consistent or have grown over the last decade (CDC, 2020). This is evidence for the need of more clinical interventions and research that is culturally tailored to aid in the reduction of mental health disparities to increase access and positive outcomes in treatments (National Research Council and Institute of Medicine, 2009).

The science of psychology has been able to explore the human phenomena as it pertains to universal characteristics but has fallen short when it comes to specific cultural norms and

group focused knowledge (Muñoz & Mendelson, 2005). Clinical theory, practice and research has been largely based on work with European middle-class populations meaning very few treatment efficacy studies have been conducted with marginalized and ethnic populations (Miranda, Azocar, Organista, Munoz, & Lieberman, 1996). With 1 out of 3 African American mothers being affected by PPD (Postpartum Support International, 2020), which also has been proven to have negative long-term effects on their children (Moehler, et al., 2006), a treatment intervention specific to African American women that addresses their cultural experiences is essential in the goal of improving the existing maternal health disparity. This supports the critical need for this Capstone project.

**Approaches Guiding the Capstone Project**

This project covers the first stage of tailoring the intervention for use with African American mothers. The ADAPT-ITT model (first four phases) (Wingood & DiClemente, 2008) was used to tailor the intervention and the community based participatory research (CBPR) approach was used to attain group focused knowledge with an aim to better understand the experiences and needs of African American women during the birth and postpartum periods (Speights et al., 2017). This project is needed to inform the cultural tailoring of the MBC intervention in hopes of adapting and/ or developing an effective treatment intervention that will alleviate the symptoms of PPD in African American women. The goal is the intervention adaptation, once fully adapted utilizing the eight phases of the ADAPT-ITT model, it will assist in creating awareness, treating, and alleviating symptoms of PPD and provide a community and safe space for African American mothers and can be used as a standard treatment.

### *Community-Based Participatory Research (CBPR)*

CBPR is a collaborative approach that helps to gain perspective on the intricate determinants of health within a specific population or community through engagement and partnership to reduce the disparity that is being addressed (Speights et al., 2017). With CBPR the researcher is the facilitator and through interactions with the participants new knowledge is gained to assist with informing the design of the intervention (Marcus et al., 2004). CBPR has been reported as being an effective way to address and reduce health disparities (Speights et al., 2017). Furthermore, the research supports CBPR is an effective approach (Speights et al., 2017) to explore, engage, and partner with African American women to better understand their needs as it pertains to adapting a treatment intervention to address and alleviate symptoms of PPD.

To decrease the gap in disparities, forming partnerships within the community is vital (Secretary's Advisory Committee on National Health Promotion & Disease Prevention Objectives for 2020, 2008); there is an abundance of value in engaging with the community as they are the experts. Community members play an integral role and should be included in the design of any intervention designed for use within that community (Brown et al., 2008); and this can be accomplished by using a CBPR approach. Those impacted by the disparity serve as core partners and CBPR capitalizes on the strength and expertise of the participants. Therefore, utilizing a CBPR framework through focus groups could be successfully used as a tool to illuminate ways to diminish disparities and improve the overall health of African American mothers during the postpartum period. The prevalence, negative long-term effects of PPD on African American mothers, their children and families and the lack of effective evidence based (population specific) treatment interventions, further speaks to why it is important to explore the feasibility of adapting the intervention, the MBC, to assist African American mothers in

overcoming PPD. An addition to CBPR, the ADAPT-ITT (Wingood & DiClemente, 2008) model was used to guide the initial tailoring of the intervention.

### *ADAPT-ITT*

The ADAPT-ITT model was originally developed as a framework to adapt HIV-related evidence-based interventions (Wingood & DiClemente, 2008) however it has been successfully used for other prevention adaptations (Davis et al., 2020). The ADAPT-ITT model is composed of eight phases that provides steps to systematically adapt evidenced-based interventions without competing with or contradicting the core elements of the intervention (Wingood & DiClemente, 2008). Below shows the phases of the ADAPT-ITT model completed during the Capstone project and how each phase was applied. The remaining phases will be discussed later in the paper when exploring next steps.

**Phase 1: Assessment- Review of the current literature and conduct focus groups.** After reviewing the literature, two focus groups were conducted with African American mothers who self-reported experiencing PPD within the last 3 years. These focus groups were completed to explore the feasibility of adapting the MBC.

**Phase 2: Decision**- After reviewing the literature of prenatal treatment interventions, the MBC was selected.

**Phase 3: Adaptation-** Focus groups were held, and participants provided insight on topics that would be important to cover in a PPD treatment intervention through talking through their own experiences. The themes that emerged from both focus groups (based on the thematic coding of the transcript) coupled with the research was utilized in tailoring the MBC intervention.

**Phase 4: Production**- The initial tailoring of the intervention was produced based on the feedback from the focus groups.

According to the research and the statistics mentioned throughout this paper, the need for an effective, accessible, evidence-based treatment intervention to address PPD in African American mothers is long overdue. Having an accessible, affordable, and evidence-based intervention to address, treat, alleviate, create increased awareness of PPD symptoms and healthy coping mechanisms, and provide a community of support, are all goals that are included in the aims of the adaptation of the MBC treatment intervention. This culturally tailored intervention could reduce the severity of PPD symptoms, improve professional help seeking behaviors, improve mother-child bonding and their baby's development, can potentially reduce healthcare system costs, and make treatment more effective and accessible for African American mothers. In addition, the long-term goal is the complete adaptation of this intervention will contribute to the resources within the healthcare community and become a standard of care for the effective treatment and management of PPD in African American women. The hypothesis is this will ultimately decrease the PPD disparities gap currently present between African American and White mothers and will alleviate and prevent PPD.

## Methodology

### Project design

The capstone project design is a pre-experimental design and non-probability (purposeful) sampling was used in this qualitative study which was completed in the form of focus groups. The project (Protocol ID: 21-07-4789) was approved by the University of Alabama at Tuscaloosa's Institutional Review Board. This capstone project aims to explore the feasibility of adapting an evidence-based intervention (*Mothers and Babies Course*) to address PPD amongst African American women who have given birth within the year. Considering this, the specific aims for this study were Aim 1: to engage in exploratory and formative work that

examines the needs of African American mothers who identified as experiencing depression during the postpartum period ("postpartum period" defined as the first year after giving birth) to culturally tailor an effective intervention to meet these needs. Aim 2: To understand the nature of and barriers to receiving effective treatment amongst the study population and Aim 3: To qualitatively characterize the birth and postpartum period and the mental impact of becoming a mother amongst the African American women who participated in the study.

The actual treatment intervention was not a part of this capstone project. The focus groups were the first phase and is required as an initial step to guide the cultural tailoring and the exploration of the feasibility of culturally adapting the MBC intervention. This was the only phase completed for the capstone project; however, the goal is to complete the full adaptation and testing of the intervention. During this project, the PI, met with the current MBC research team, including the current principal investigator of the MBC intervention, Dr. Darius Tandon, at Northwestern University via a teleconference to discuss the details of this project as well as converse about the intervention and the feasibility of its potential use with Black women exclusively in the postpartum period.

***Hypothesis***

The hypothesis is stated in terms of the goal once all phases are completed. The hypothesis for phase one is using a CBPR approach through focus groups with African American mothers a better understanding of African American mothers' needs during the postpartum period will be gained and will assist in successfully tailoring the MBC intervention and will guide the adaptation (Phase two) of an effective treatment intervention for African American mothers with PPD if found to be feasible to do so. The hypothesis for phase 2 is the adapted treatment intervention will successfully alleviate PPD in African American women.

## Participants

### *Recruitment*

The recruitment flyer (see attachments) was posted on social media (with the moderator's permission) to recruit participants on the following platforms: Facebook, Instagram and other listservs (including Georgia Therapists Network, Clinicians of Color, Therapy For Black Girls, The Melanated Mommy Tribe, The Black Girl Clinician Collective) that included providers who work with the intended participant population. Interested participants completed a prescreening survey via Qualtrics accessible through a web link to ensure participants met the eligibility criteria to participate in the focus groups.

### *Inclusion/ Exclusion Criteria*

The eligibility criteria for the project were participants must identify as an African American woman, be at least 18 years of age, born female, had given birth within the last 3 years, had no recent substance use or dependency issues, not suicidal and no previous diagnosis of bipolar or any other psychotic mood disorder (i.e. schizophrenic, etc.). Prescreening surveys were completed by all interested participants and were reviewed by the Principal Investigator (PI). Those who completed the prescreening questionnaire survey who met the eligibility criteria were sent the informed consent with both focus group dates electronically via Qualtrics. Participants who completed the informed consent were automatically enrolled. After the desired number of participants (10) were enrolled, enrollment was closed. The participation in the first focus group automatically qualified the participants for the second focus group which took place approximately 2 weeks after the first group. Focus groups were conducted via the teleconferencing platform Zoom. The PI provided a passcode protected Zoom link with the time and dates to report for each focus group.

### *Project Site*

The project site was virtual and conducted via the Zoom teleconferencing application hosted from the PI's secure and private office on a personal password protected laptop. As mentioned previously, the participants joined the focus groups from their respective locations. The participants all identified as Black women and met the eligibility criteria. In the initial focus group, there were six participants that attended and in the follow up focus group all the same participants returned except for one.

## Procedures

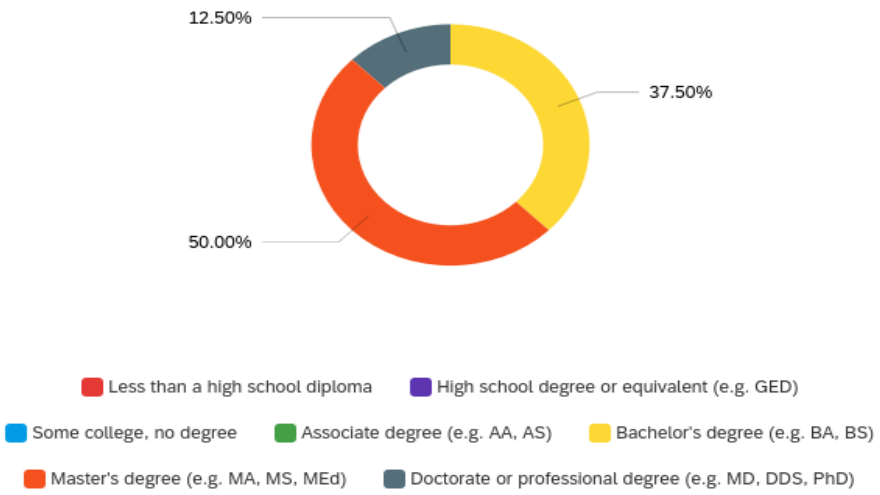
Participant involvement took place over a 3-month period. The timeline for the participant's participation included recruitment which began in September 2021 and went through late October 2021. The first focus group took place on November 4th, 2021 from 6:00 PM – 7:30 PM EST and the second focus group was held November 18th, 2021 from 6:00 PM-7:30 PM EST via the teleconferencing application Zoom. The total amount of time each individual participant was actively involved in the study was 180 minutes (3 hours).

### *Demographics*

The ages of the women that completed the survey ranged from 25-44 years old; there were 15 who were 25-34 and 9 who were 35-44 years old.

**Figure 2.**

*Highest Level of Education Completed for Prescreening Questionnaire Participants*




As shown in Figure 2 above, approximately nine women had at least a bachelor's degree, 12 had a master's degree and 3 had a Doctorate or professional degree. Three identified as single and never married and 20 as married or in a domestic partnership (3 of these participants did not complete the survey). Sixteen were employed full time (40 or more hours a week), 2 were employed part time and 3 were self-employed. Twenty-one women identified as giving birth within the last 3 years. Out of the 20 women who completed the questionnaire in its entirety, 70% (n=14) completed the informed consent. Due to scheduling issues or for other unknown reasons 43% (n=6) participated in the first focus group and 25% (n=5) participated in the second focus group. The goal was to have a focus group of no more than 10 participants.

## Focus Group

### *Focus Group One*

A visual presentation made using the Canva application was used to guide the focus group. The initial presentation included 13 slides. The introduction slide included the title of the

capstone project and the name of the PI. Slide 2 listed the purpose and intended outcome of the project which was to explore and better understand the unique needs of Black mothers during the first year after giving birth and to tailor an existing treatment intervention that will culturally address the Black motherhood experience with the goal being to alleviate symptoms of PPD. Slide 3 introduced the PI; this introduction included the PI being a Doctor of Social Work (DSW) student at the University of Alabama Tuscaloosa and her research interest and past experiences that support said research interests. Slide 4 included the agenda for the focus group which included the welcome, brief review of informed consent and focus group etiquette, participant introductions, exploration of four topics as it pertains to the Black motherhood experience and final wrap up and reminder about the next focus group.

Slide 5 included key information from the informed consent and reminded participants of resources and protocol if they felt uncomfortable feelings or emotionally triggered by the topics discussed. Slide 6 reviewed focus group etiquette and encouraged participants to add anything that they felt was important to add. Slide 7 welcomed participants and encouraged introductions. Each participant was asked to share first name (or nickname) and one interesting fact about their self. Slide 8 asked "Do most moms know what postpartum depression is?" Two YouTube videos were then watched: *Postpartum Depression and the African American Community* (1:30 minutes) (Postpartum Support International PSA, 2020) and *Taj George Opens Up About Her Postpartum Depression* (1:36 minutes) (Black Love, Oprah Winfrey Network, 2018) and feedback on the videos was discussed. Slide 9 reviewed stressors as a new mom. Some of these stressors were finances, work, chores, problems with partner or others, time pressures, problems with breastfeeding, headaches or other health problems, lack of social support, coping with birth trauma, self-image, and questioning "Am I doing this right?" The last four slides (Slide 10-13)

included the 4 topics: Balancing multiple roles and expectations, mental health stigma, community, and sisterhood.

***Focus Group 2 Content***

Focus group 2 consisted of 11 slides. Slide 1 was an introductory slide identical to the first focus group. Slide 2 was the same as focus group 1 to remind clients of the purpose and intended outcome for the capstone project. Slide 3 included the agenda for the group session: Review of focus group etiquette, brief recap from focus group 1 and discussion of themes and review of the last four topics. Participants were asked what they would add or remove regarding the themes that arose from the initial focus group. Slide 4 was the refresher for focus group etiquette and reminded participants about confidentiality. Slide 5 included a table of the four themes that emerged (after PI coded the transcript) from group 1 and each theme was discussed to assess if the participants felt it fully captured their experiences that were shared in the initial group. The participants agreed on the themes and titles Dear Mama, I'm Every Woman, I am my Sisters' Keeper and Help A Sista Out.

Slide 6 asked the question "How is the black motherhood experience different from other ethnicities?" This was the opener for the topics: Systemic Issues, loss of partner (depicted through pictures of black women who loss their partners to gun or police violence), spirituality, and self-care. Participants were also asked "What components are important to have in a group to provide support specifically for black mothers?" The final slide was a thank you to participants with PI contact information and a reminder that once all phases were completed the final results would be shared with participants who were interested.

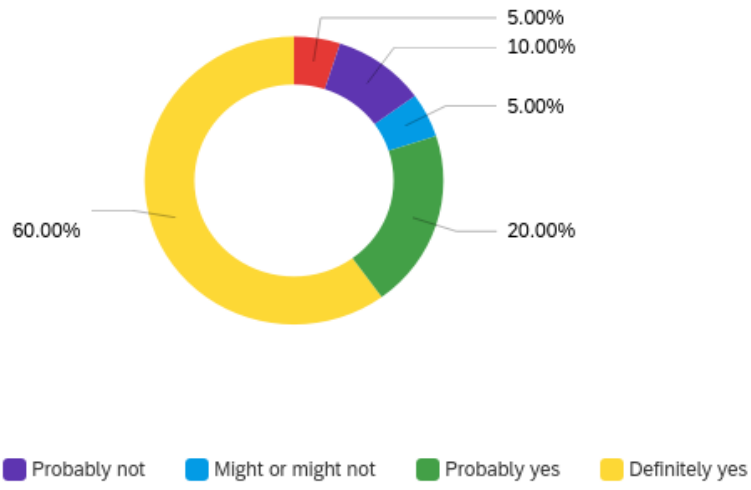
**Compensation.** Participants were given an electronic $20 VISA gift card for each focus group they participated in. The gift card was sent to the participant's email at the completion of each group.

**Data Collection Procedures**

All data was collected, including the demographic information, using Qualtrics. The transcription feature on the Zoom application was used to transcribe the focus groups. The Qualtrics survey was used to assess self-reported depression, substance abuse use, suicidal ideation, and previous mental health diagnosis. The questions and results were as follows: Q10 - Did you experience symptoms of depression (i.e., crying spells, isolation, trouble bonding with your baby, increased worry, intrusive negative thoughts about something happening to your baby, change in appetite, change in relationships with others, etc.) at all during the first year after giving birth? The participants' response results are below (Fig 3).

**Figure 3.**

*Prescreening Question 10: Did you experience symptoms of depression at all during the first year after giving birth?*



Question 11 on the survey was “Did you seek any professional help (i.e., mental health therapist, OB-GYN, etc)?” 45% (n=9) responded no and 55% (n=11) responded yes. Question 12: “Within the last 6 months have you had any substance use and/ or dependency issues (i.e., alcohol, prescription pills, marijuana)?” 85.71% (n=18) responded no, 4.76% (n=1) responded I’m unsure and 9.52% (n=2) responded yes. Question 13: “Do you currently have thoughts of harming yourself (suicidal thoughts) or someone else (homicidal thoughts)?” 100% (n=21) responded No. Question 14: “Do you have a previous diagnosis (diagnosed by a medical/ mental health professional) of bipolar or any other psychotic mood disorder (i.e., schizophrenia, dissociative identity disorder, etc.)? 95.24% (n=20) responded no and 4.76% (n=1) responded yes.

**Data Analysis**

Primary data was collected from the focus groups conducted. The transcriptions from the focus groups were analyzed using qualitative content analysis and thematic coding (reflexive thematic analysis) (Braun and Clarke, 2013) to find common themes among the participants’ experiences as African American mothers who experienced PPD. Inductive coding was used as there were no preconceived themes prior to the facilitation of the focus groups. The PI carefully examined the data (transcript) line by line to identify common themes and then applied the six-step process to thematic analysis (Braun and Clarke, 2013). The six steps applied were 1.) *familiarization* with the content, which was accomplished by thoroughly reviewing the transcript, 2.) *coding*, meaningful quotes from the participants were identified that spoke to the African American motherhood experience, 3.) *generating themes*, common topics and expressed experiences were identified, 4.) *reviewing themes*, themes were reviewed with project advisor and co-advisor, interrater reliability was assessed by the reviewing of transcripts and codes by

the project's committee advisor 5.) *defining and naming themes*, themes were further defined utilizing the research literature and experiences of the participants and lastly writing out the results ("*the write up"*) from the thematic analysis; the emerging themes are covered in the next section.

## Results

### Emerging Themes

There were six themes that emerged after completing the full data analysis process.

#### *Ain't I am woman?*

This theme developed from the shared experiences of the expressed systematic issues faced by participants. They expressed feeling that they carry the burden of having to tirelessly advocate for basic rights that women who identify with other cultural and ethnic groups have access to. Participants expressed there is a constant fear when working with the medical community during birth and in the postpartum period. This theme spoke to the importance of having resources that include providers who are culturally sensitive and competent and understand the plight of Black American women. Participant quotes to support this theme included "they wouldn't let me go home to the point that they brought a lady in from CPS...it felt very threatening to be honest and I don't like to be threatened and I didn't understand..." and "I'm looking at my vital signs I'm looking at my baby's vitals I'm looking at all these things. I don't see anything wrong so I'm like why are you pushing a C section on me?" "...I kind of had to let her know you're going to have to explain to me why you keep coming in here with this clipboard. If you cannot give me a reason why then the conversation is over, you know, and she couldn't."

#### *Dear Mama*

This theme emerged as there were shared experiences amongst the participants discussed

about the importance of the influence (negative and positive) of their maternal figures on their motherhood experience. Quotes that supported the formation of this theme included "…back in the day our mothers and grandmothers were doing all the stuff and I don't think I ever even saw them cry...." and "...as a new mom it's like that pressure of like your elders, your mom, your grandma…you just feel like you ain't doing nothing right...like they had it figured out..."

***For Us by Us***

This theme emerged as participants conversed about the importance of raising their children in environments with influential figures that are inclusive of African Americans. This was expressed as being essential in helping with easing worry regarding a negative encounter or adverse experience happening to themselves, their child(ren) or partners. They expressed the desire of cultivating safe spaces within their communities for Black women and their families. Quotes from participants included "I'm not moving to no white neighborhood to send my kids to white schools, I don't ever want my daughter to be the minority anywhere if she doesn't have to be" and "..I try to stay around my [Black] people...our neighbors, teachers, doctors...a lot of people I know that's why they moved to Atlanta...it makes a difference…"

***Help a Sista out***

The importance of the communication and support from the parenting partner was a shared expression amongst participants that impacted their experiences with PPD. Quotes from the focus group that support this theme includes "...it's honesty and being a team that gets lost in motherhood and in the relationship" and "...centering a part of the group [intervention] around family not just the moms...bringing in the dads and helping them to understand the weight of it all."

***I am Every Woman***

"If I don't do it who will?" is the notion the participants expressed they felt during their postpartum experience. Most of the participants identified as being the primary breadwinner, primary parent, feeling required to always be understanding of their partner and their parenting flaws (without frustration), is the go-to person for their family (caregiver), "token" black person at work and expressed the expectations and demands of them feels endless. Quotes from participants included "In our generation black women being the primary breadwinner or if not our salaries are very comparable to our partners and so we don't have the option to possibly not work, so it's hard to really feel like you can take a break" and "…being rooted in societal issues and tokenism on our jobs and one of the few black individuals on our jobs is just kind of like a mindset that we carry into our family life as well, in everything it seems."

***I am my sister's keeper***

This theme spoke to the importance of having access to services during and after birth for mental, physical, and emotional support. The significance of having a community of moms who have similar experiences and feels safe to talk to and receive advice from without fear of being judged was voiced. Having peer support (a community) was a component participants identified as being essential for a treatment intervention for moms with PPD. Quotes from the focus group that supported this theme included "Having a community with women who are closer in age to you, who are having children now is very important, and you can be open with them you can have conversations like this [those had in focus group] about your spouse or about the baby or about needing help cleaning up your house without being judged..." and "…we need peer mentors to be able to call and chat with even if it's just having someone who is up too to text in the middle of the night…"

Based on the collective feedback from focus group participants and the literature from the

research, the suggested adaptations (Table 3) were made to the MBC 8- week course intervention.

**Table 3.**

*MBC Culturally Tailored Content*

| MBC Class Session | Culturally tailored content for use with African American women: | Themes |
|---|---|---|
| **1** | **Welcome to the Mothers and Babies Sessions:**<br>• Adapted the look and feel by adding images of black women throughout the intervention and removed Latina video<br>• Added: Postpartum Depression and African American mothers video<br>• Remove: "My parents, my teachers" video<br>• Personal reality = external + internal reality (explore how personal reality is impacted by their intersectionality using the ecological systems theory).<br>• Add private peer support groups for each cohort to check in and have a safe space to share between group sessions; this will provide a space to "vent" and be validated in experienced personal reality | **"I am my Sister's Keeper"** |
| **2** | **Thoughts and My Mood:**<br>• Revise: Common mood problems during the fourth trimester<br>• Remove: The portion on common mood problems during pregnancy<br>• Add: Explore healthy coping mechanisms in conjunction with how to give myself good advice<br>• Remove: Violet & Mary activity<br>• Add: Activity: Discuss factors that influence self-perception and how intersecting identities affects this.<br>• Add: Homework activity: Write 5 positive affirmations (about you as a mother) and say these to yourself every day until the next session; maintain a daily mood journal and rate your mood each day. | **"Ain't I a Woman"** |

| MBC Class Session | Culturally tailored content for use with African American women: | Themes |
|---|---|---|
| **3** | **Addressing harmful thoughts:**<br><br>• Discuss intergenerational transmission on thoughts of being a mother<br>a.) Review the pros/cons of this and ways to break the cycle<br>b.) Review how this thinking impacts bonding with baby<br>• Review ways that were helpful in your upbringing and ways you may want to parent differently.<br>• Focus on helpful and harmful thoughts during postpartum<br>• Identify factors that impact internal and external reality.<br>• Implement visualization activity—create a vision board (or visual representation) to assist with creating goals that will shape their future and goal setting after birth.<br>• Remove: Violet & Mary's days<br>• Remove: Thoughts I want to learn to teach my baby<br>• Thinking about your future<br>• Thinking about your baby's future | **"I Am Every woman"** |
| **4** | **Taking Care of Self**<br><br>• Add activity: Self-care: What does self-care look like to you? Identify pleasant activities that improve your mood.<br>• Remove: Violet & Mary's days activity<br>• Add activity: Create a self-care routine: (i.e. hot shower with a candle (aromatherapy) and favorite playlist daily, daily walk, daily yoga, daily 20 min stretching session, journaling and prayer time etc.<br>• Add homework activity: This week eliminate an activity that impacts your mood and record how you feel at the end of each day.<br>• *Add activities: Select 1-2 things you can do on your own without | **"Ain't I a Woman"** |

| MBC Class Session | Culturally tailored content for use with African American women: | Themes |
|---|---|---|
| | having to rely on others for fun<br>• Identify activities you can do with and without baby.<br>• Review daily stressors and discuss/ identify those things that need/ must get done vs those things we want to do.<br>• Access feelings and emotions as it relates to thoughts about these stressors and completing these daily tasks.<br>• Discuss mindfulness practices, relaxation techniques, self-care methods | |
| **5** | **Happy mommy happy baby**<br>• Bring babies to in person group and do hands on activities to foster growth and bonding with baby.<br>• Establish playdate partners<br>• Foster growing a supportive community and sisterhood.<br>• Look at the differences between "I have to" vs "I want to" | **"I am My Sisters Keeper"** |
| **6** | **Identifying my tribe (support system)**<br>• Revise: When I am with others, I feel better<br>• Discuss traits of healthy interpersonal relationships vs unhealthy<br>• Revise and combine: The people in my support network and the ways they support me<br>• Identify support system and review creating healthy boundaries and give examples of what this looks like.<br>• Revise: What keeps you from expressing your needs and getting your needs met<br>• Discuss the misconceptions of asking for help.<br>• Review what asking for help looks like and healthy communication.<br>• Activity: How to use assertive communication and state a positive need. | **"Help a Sista Out"** |

| MBC Class Session | Culturally tailored content for use with African American women: | Themes |
|---|---|---|
| | • Create positive connections within the group; form a connection with a peer/ small group within the group.<br>• How to effectively communicate to your healthcare providers?<br>• Discuss how having a child(ren) impacts relationships<br>• Review expectations<br>• Review effective communication skills<br>• Discuss creating meaning and traditions together as a family unit | |
| **7** | **Building my Village**<br>• Identify support network: Breakdown to personal (i.e. family/ friends), community (i.e. church, community center), etc.<br>• Reviewing healthy boundaries<br>• Introduce the philosophy: "Control what you can control" (Objective vs subject reality)<br>• Identify community resources that support black mothers and provide safe spaces for them and their children to receive care.<br>• Have midwives, postpartum doulas, pediatricians, OB-GYNS, mental health therapists and other healthcare professionals to be a part of the session | **"For Us by Us"** |
| **8** | **The Future:**<br>• Remove: Role models for me and my baby<br>• Add:<br>• Activity: Write a letter to your child that they will read when they are 18.<br>• Identify some ways that you bonded with your mother/ caregiver in your childhood.<br>• Identify some ways you wish you would have bonded but were unable to.<br>• Share positive words about participants you bonded with | **"Dear Mama"** |

| MBC Class Session | Culturally tailored content for use with African American women: | Themes |
|---|---|---|
| | • Receive certificate of completion with personal note<br>• Join community of other mothers who have completed the intervention<br>and be a part of ongoing support and receive ongoing services<br>• Opportunity to be a peer mentor for future group participants<br>• Celebrate with pampering session, photos, videography, and refreshments<br>• Photos will be provided as a keepsake to all participants | |

## Discussion

The findings from this capstone project support the need for a postpartum intervention specific to African American mothers. All the themes that emerged from the focus groups were parallel to the research findings in considering intersection theory (Crenshaw, 1991), Sojourner syndrome (Mullings, 2002), the Superwoman Schema (Woods-Giscombe & Black, 2010) and the impact of PPD amongst African American women using an ecological systems theory (Bronfenbrenner, 1992) lens. There are multiple systems at work that negatively impact the holistic health of African American women and motherhood adds another crucial layer of health complexities.

When considering adverse birth outcomes and PPD it is important to know the frequent occurrence of the early onset of morbidity in African American women in response to persistent chronic stress and active coping associated with meeting the day-to-day demands in conjunction with having multiple caregiving roles is explained in the concepts of the Superwoman Schema (SWS) and the Sojourner syndrome (Lekan, 2009; Woods-Giscombe & Black, 2010; Slopen et al., 2010). The Sojourner syndrome framework, developed by Mullings (2002), portrays the historical multiple roles and social identities of African American women and adaptive behaviors that fostered survival and resilience under oppressive circumstances (Lekan, 2009). Furthermore, this concept provides a symbolic representation that traces the current health disparities African American women face and it describes the various effects of African American women's intersecting identities on their lived experience and health outcomes (Mullings, 2002). The Sojourner syndrome examines and helps to explain the inequalities faced by African American women in daily life that are conditioned by gender, race, class, structural and environmental constraints ultimately influencing health in all aspects (Lekan, 2009).

This conceptual framework is named after Sojourner Truth, an abolitionist and former slave, that fought for equal rights and freedom for African Americans. In her famous poem "*Ain't I a Woman"* (Truth, 1851), she gave voice to the resilience of African American women and highlighted how they were treated so vastly different than White women. Even after slavery and to the present day African American women are still not treated equally to their White counterparts or to African American men. African American women are positioned at the bottom of the social hierarchy (Lekan, 2009). Truth's speech captured the essence of intersection theory (Crenshaw, 1991) and highlights the value of resilience and survival amongst Black women. After slavery African American women became the head of the household to limit family disruption (Lekan, 2009). This included maintaining economic stability, preserving family values, participating in community activism and empowerment to sustain the culture and maintain racial pride (Mullings, 2002). However, it is these continued responsibilities that have detrimental effects on African American women's overall health (Geronimus, 2001; Woods-Giscombe & Lobel, 2008) which is only exacerbated during pregnancy and after birth.

Like the Sojourner Syndrome, Superwoman Schema (SWS) is a conceptual framework that aims to describe the occurrences that influence African American women's experiences and reports of stress (Woods-Giscombe, 2010). The concept of Superwoman partly developed as African American women tried to combat the negative societal stereotypes and highlight the attributes that developed even amid adversity and oppression (Beauboeuf-Lafontant, 2003; Harris-Lacewell, 2001). The climate in America caused by racism, limited resources due to discrimination, gender-based oppression and disenfranchisement for African American women leads to them taking on multiple roles out of necessity for survival purposes (Woods-Giscombe, 2010; Mullings, 2005).

These frameworks and the research literature supports the findings from this capstone project

which supports the need for a postpartum depression intervention specific to African American women. Given Black women's historical and present-day experiences suggests and supports the need for a treatment and/ or prevention intervention that addresses the intersectionality of Black women during motherhood utilizing an ecological systems framework lens coupled with the concepts of the Black Feminist Theory.

**Strengths and Limitations**

There were several strengths found in conducting this capstone project. First, it enabled the initial exploration of essential factors needed in an intervention to effectively address PPD in Black women. Secondly, this project will aid in filling the gaps in the literature by contributing to group focused research within this population and could lead to a standard evidence-based treatment intervention for Black women experiencing PPD. Third, the focus groups created a space for African American mothers to feel safe, heard and validated in their experiences with PPD and to find community amongst other mothers with similar experiences.

The limitations of the capstone project included first, there were no women involved in the study with lower socioeconomic statuses and with less than a bachelor's degree. Second, participants were not actively experiencing their most severe symptoms of postpartum depression at the time of this study. Third, there were no teenagers that were a part of this study as participants had to be at least 18 years of age to participate. Fourth, surveying if the moms attending the focus group had multiple kids was not assessed as this is a factor that impacts the severity of PPD. Fifth, incarcerated moms, moms dealing with substance abuse issues and/ or reported interpersonal violence were also not included as a part of this study.

When it comes to accessibility of getting treatment the participants of this project, middle class Black women, reported financial issues as being a factor in accessing services. In addition,

middle class Black women experience anxiety and fear surrounding advocating for themselves within healthcare settings. *In Invisible Visits: Black Middle-Class Women in the American Health System* (Sacks, 2019) is a book composed of interviews and focus groups conducted with Black women to analyze their perception of bias and stereotyping received in the healthcare system (Sacks, 2019). The introduction of the book discusses Black women anticipate being stereotyped and often feel pressure to have to mention their skills, education/ career in attempt to push back against provider bias and discrimination (Sacks, 2019). The focus group participants that were a part of this capstone project reported identical experiences to these. Many of them expressed advocating for themselves in some cases only led to further discrimination.

Historically, when Black women have advocated for themselves, they have been stereotyped as "Angry Black Women" (Ashley, 2014). Characteristics of an "angry black woman include aggressive, ill tempered, illogical, overbearing, hostile, and ignorant without provocation" (Ashley, 2014, p.27, ¶1). This negative stereotype that plagues African American women is pervasive and impacts their self-esteem and affects how they are treated by society (Morgan & Bennett, 2006). Additionally, the book highlights the research data and health outcome disparities amongst middle-class Black women. Middle class Black women are 49% more likely to have a premature birth and three times more likely to die from a pregnancy related cause than White women (CDC, 2021). Yet accessible and affordable services are extremely limited amongst this population specifically when it comes to PPD despite income or education level. According to the regional price parity (RPP) data for 2019 from the Bureau of Economic Analysis, the household income needed to be considered middle class ranged from $25, 246-$122,417 in Georgia (Young, 2021). Focus group participants mentioned cost and time as being a variable in interest and retention in a PPD treatment intervention.

## Implications for Future Research

The limitations are implications that more group focused research amongst African American women with PPD within all income levels is needed for social workers to provide the best treatment options regardless of income or education level. In several studies, socioeconomic status (SES), educational attainment and prenatal care have been considered some of the main determinants of the adverse pregnancy and birth outcomes mentioned through this paper (Howell, 2018). However, when these sociodemographic factors are controlled for, African American women with a college degree still have far worse birth outcomes than White women who never graduated from high school (CDC, 2020; Howell, 2018). This creates an issue as middle class African American women are often overlooked in social science research and although they are not "poor" (Young, 2021) they remain socially and economically vulnerable with a lack of resources due to their income level which many times over qualifies them for services (Sacks, 2019).

Additionally, conducting research that speaks to the true etiology of PPD in African American women. Researchers in the field of social work and mental health should do their due diligence to start back at the basics in doing CBPR with African American women to better understand how their lifespan experiences impacts them during motherhood and in turn culturally adapt widely used treatment interventions that currently exists, such as CBT, interpersonal therapy (IPT), Dialectical Behavioral Therapy (DBT), etc. utilizing the ecological systems lens. The literature suggests doing this type of research may help to improve provider bias and foster greater cultural sensitivity, humility, and competence for and understanding of African American women with PPD. This capstone project also implicates the need for policy change amongst state funding for programs that are accessible and inclusive of all individuals

who are statistically impacted by PPD. Improving screening tools for medical providers to identify symptoms of PPD during postpartum checkups and pediatrician visits is also recommended. And having a resource base created where providers can refer patients/ clients who identify as having moderate to severe PPD is warranted.

Lastly, implications to do further research on the success of online treatment interventions with African American mothers with PPD is also necessary. Participants expressed having a hybrid treatment intervention option (initially online and then in person attendance) would be ideal. Access to an online intervention can overcome PPD treatment uptake barriers given their reduced costs, flexibility, and improved accessibility (Lal & Adir, 2014). In addition, women in the postpartum period already use the internet frequently to search for information about PPD (Maloni, 2013). Emerging web-based interventions, for PPD treatment based on CBT, have proven to be effective in the reduction of postpartum depressive symptoms (Branquinho et al., 2020). In addition, treatment was shown to be most effective when given in the postpartum period (Dennis & Dowswell, 2013).

***Next Steps***

As previously mentioned, this capstone project was the first phase of culturally tailoring the MBC intervention utilizing the ADAPT-ITT model framework (Wingood & DiClemente, 2008). The phases to be completed include:

**Phase 5: Topical Experts**. Continue to consult with experts in the postpartum field that work with African American mothers by conducting individual interviews and focus groups. These subject matter experts include OB-GYNS, midwives, doulas, mental health therapists and other maternal health providers.

**Phase 6: Integration**. Create draft #2 of the tailored MBC intervention based on the feedback from the interviews and focus groups with the subject matter experts.

**Phase 7: Training.** Train volunteers, who will be identified as peer mentors which is defined as African American mothers who have experienced PPD, and was successfully treated. Their role will include assisting mothers who need additional support during the intervention and will contact participants throughout the intervention. Additionally, if interested they will have the opportunity to be trained to facilitate the intervention.

**Phase 8: Testing.** Composed of two steps. 1.) A pilot of the intervention will be conducted to test the adaptation efficacy; the results from the adapted intervention will be analyzed. 2.) Conduct a phase 2b study and randomly select new participants and provide the adapted intervention. Measures will include a baseline assessment, process measures and a 3-month (or more) post intervention (Wingood & DiClemente, 2008). Additionally, conducting focus groups with varying subgroups of Black mothers is essential in exploring if the treatment intervention speaks to Black women across all intersecting identities or if there needs to be specific and separate treatment interventions for each varying group.

## Conclusion

African American mothers continue to have disproportionate adverse health outcomes when considering maternal health and PPD. The research and existing literature suggest to effectively treat African American women one must first, understand the impact the lived experiences of Black women in America have on their overall health and second, recognize the effects are not exclusive to how some of this population's identities intersect (i.e., income status, education, marital status, etc). This capstone project was an important step in the direction of conducting more group focused research with the goal of creating an effective PPD treatment intervention thereby improving symptoms and the mother-child bond of Black women. This capstone project was a necessity as the interventions that currently exists for African American women with PPD specifically does not exist. The hope is not only will more attention be drawn

to these maternal health disparities that exists between African American and White women but because of this public health crisis social workers and researchers will step up to the meet the needs and save the lives of African American mothers and their families; it would save the future generations of Black communities.

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