Published in final edited form as:

J Reprod Infant Psychol. 2016 ; 34(1): 35–48. doi:10.1080/02646838.2015.1101753.

Depression treatment delivered at the point-of-care: a qualitative assessment of the views of low-income US mothers

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Abstract

Background/Objective—Within the first months of childbirth, clinically significant depressive symptoms are experienced by 19% of mothers in the US, and are even more prevalent among low-income and ethnic-minority women. Paradoxically, low-income and ethnic-minority mothers are faced with unique barriers that make them less likely to receive professional mental health care. To find ways to remove these barriers, a recent US trial extended use of a United Kingdom intervention, Listening Visits (LV), an evidence-based treatment delivered by home visitors/office nursing staff.

Methods—A qualitative content analysis was conducted with participants' (N=19 in an open trial and N=49 in a randomized controlled trial) responses to a post-treatment semi-structured interview assessing their views of LV. The percentage of participants endorsing each thematic code is presented.

Results—When the provider first introduced the LV intervention, 77.9% of women retrospectively reported having positive views of trying this new approach. Recipients most frequently mentioned as helpful two aspects of LV: empathic listening/support and the collaborative style of the LV provider. Half of the women (50%) did not suggest changes to how LV were delivered. Among those who suggested changes, the most frequent (42.6%) suggestion was to increase the number/duration of sessions.

Conclusion—Listening Visits is an acceptable depression treatment approach, as perceived by low-income, ethnic-minority mothers, which health and social service providers who serve this population can use.

Keywords

depression; depression treatment; culture and psychotherapy; qualitative research methods; low-income; ethnic-minority mothers

Clinically significant depressive symptoms are reported by approximately 19% of early postpartum mothers from general community samples in the United States (US; Gavin et al.,

2005). Among impoverished women in the postpartum period, estimates of mild to moderate depressive symptoms are markedly higher, ranging from 40 to 49% (Mayberry, Horowitz, & Declercq, 2007; Segre, O'Hara, Arndt, & Stuart, 2007). Similarly, the prevalence of Major Depressive Disorder (MDD) is higher among impoverished women (23.4%; Mayberry et al., 2007), compared to the 7% in general community samples (Gavin et al., 2005).

Compounding this problem, another significant risk factor for postpartum depressive symptoms is African-American ethnicity, regardless of income level (Segre, Losch, & O'Hara, 2006). Thus, postpartum depression disproportionately affects low-income minority women with pervasive, long-term consequences, including loss of welfare support, household food insecurity and less optimal child health (Casey et al., 2004), as well as a broad range of developmental delays in children, e.g., behavioral problems and cognitive delays in the form of poor language and lower IQ (O'Hara & McCabe, 2013).

Despite the availability of efficacious depression treatments for perinatal women in general (Sockol, Epperson, & Barber, 2011), and low-income women in particular (Levy & O'Hara, 2010), few depressed perinatal women utilize care. In one obstetrics clinic setting, for example, only 33% of pregnant women who met MDD diagnostic criteria were currently receiving some form of treatment (Flynn, Blow, & Marcus, 2006). The barriers that prevent perinatal women from utilizing or receiving treatment are numerous and well documented (Dennis & Chung-Lee, 2006); and among impoverished mothers, these barriers are compounded by the inability to pay for treatment or the need for transportation and day care. Moreover, even if financial barriers were addressed, a lack of trust can also erect a significant barrier to receiving treatment (Miranda et al., 2003). Specifically, in this study, the psychologists had to make at least 10 phone calls before finally being able to engage a woman in treatment. Based on this observation, in this population of depressed mothers, getting women to accept treatment is a key hurdle. Interestingly, the study by Miranda et al. (2003) concluded that women would be more willing to engage in treatment if they knew it would be provided by a familiar and trusted person.

In the United Kingdom (UK), depression treatment with a familiar, trusted provider is already a model in broad clinical use (Cowley, Caan, Dowling, & Weir, 2007). In the early 1980's, a team of mental health specialists and a health-visitor developed a depression screening tool and intervention for perinatal women (Cox, Holden, & Sagovsky, 1987). This intervention was **Listening Visits (LV)**, a talk therapy provided by home visiting nurses (i.e., health visitors). A description of LV, including what a health visitor does during a single visit, the overall sequence of the six visits, and two illustrative case-reports have been provided elsewhere (Siewert, Cline, & Segre, 2015). Briefly described here, LV contain two core components: exploration of a woman's problems through reflective-listening and, once a genuine understanding is achieved, collaborative problem solving. In the first two sessions, the interaction focuses on building a trusting relationship and fostering the sharing of women's unique experiences and needs. In sessions 3-5, interactions become more personal with the use of active reflective listening to further explore thoughts, feelings, and concerns. Collaborative problem solving is used to put in place a plan of action that addresses the problems identified. The last session is used to summarize what has been accomplished and to discuss next steps and long term goals. Referrals for additional mental health services are

provided if needed (Siewert et al., 2015). In recognition of the significant empirical evidence supporting the efficacy of LV (Cooper & Murray, 1997; Holden, Sagovsky, & Cox, 1989; Morrell et al., 2009; Wickberg & Hwang, 1996), UK's *National Institute for Health and Care Excellence* recommended LV for mild to moderate postnatal depression (National Collaborating Center for Mental Health, 2007).

The US healthcare system is vastly different from that of the UK, so in preparing to disseminate this intervention in the US, the LV approach was empirically evaluated in this new setting. The results of both an open and randomized controlled trial of LV in the US indicate statistically and clinically significant improvement in low-income, ethnic-minority women who received LV from their point-of-care provider (Segre, Brock, & O'Hara, 2014; Segre, Stasik, O'Hara, & Arndt, 2010). Women in both trials indicated satisfaction with LV, giving high ratings on the Client Satisfaction Questionnaire (CSQ; Larsen, Attkisson, Hargreaves, & Nguyen, 1979). These quantitative assessments of satisfaction, however encouraging, provided no insight into what particular aspects of the treatment the women valued.

In the United Kingdom (UK), two studies have taken a qualitative approach to assess women's views of receiving LV delivered by a health visitor. In the first published report, 39 women were interviewed and themes regarding their views of LV were based on the transcripts of 16 women who had received LV from their health visitor (Shakespeare, Blake, & Garcia, 2006). Four factors were identified as influencing whether the woman had a positive or negative view of LV: having a good relationship with the health visitor, self-recognition that she was suffering from postpartum depression, having had the opportunity to select LV from a range of presented treatment options, and having the opportunity to talk with an objective listener. With regard to the latter however, some women felt uncomfortable about the unstructured sessions because they were not sure what to talk about. In the second published report, 22 women were interviewed about their experiences with LV delivered by a research health visitor (Turner, Chew-Graham, Folkes, & Sharp, 2010). Three main themes emerged: 1) all participants believed that LV were beneficial; 2) most participants indicated that LV delivered by a research health visitor provided them with an opportunity to discuss their feelings and situations; and 3) women indicated that they felt comfortable talking with the research health visitor because she was nonjudgmental, kind, and not attached to their general practitioner, thus providing some degree of confidentiality.

While both UK-based studies provide important qualitative information about how LV recipients feel about this intervention, these findings have limited relevance to US women, particularly because most of the women in both US trials had limited financial means and the majority identified as belonging to an ethnic-minority group. This demographic profile differs significantly from women who participated in the UK-based qualitative studies. This paper thus reports the results of a qualitative assessment of the views of the US women who received LV from their social service or health-care provider in the context of the open and randomized controlled trials of LV.

Method

Brief overview

Open and RCT trials—The data used in this report were obtained from the participants of the two US-based evaluations of LV. The open trial, conducted from 2007 to 2009, enrolled 20 women (Segre, Stasik, O'Hara, & Arndt, 2010) from a home visiting program. The RCT, conducted from 2009-2012, enrolled 66 women (Segre, Brock, & O'Hara, 2014) from three home visiting programs and an ob-gyn clinic. The procedures in both trials were approved by the institutional review board; and informed consent was obtained from all participants.

The methods of both clinical trials are fully described elsewhere (Segre et al., 2014; Segre et al., 2010). In brief, for both trials, women were screened by their home visitor/office nursing staff for depression using the Edinburgh Postnatal Depression Scale (EPDS), a 10-item self-report scale that assesses depressive symptoms in postpartum women (Cox, Holden, & Sagovsky, 1987). Those scoring ≥ 12 were flagged as having reported elevated depressive symptoms (Cox & Holden, 2003) and their home visitor/office nursing staff, with the permission of the woman, gave their name to the research study team. A member of the research team contacted the woman, verified the EPDS elevated scores and conducted a clinical structured interview to ensure the woman did not meet criteria for any exclusionary diagnoses (i.e., current or past manic episode/s, current alcohol or substance abuse, or psychotic symptoms). If eligibility criteria were met, they were enrolled in the study with informed consent. In both of these US-based trials, the research protocol specified that women would receive 6 LV sessions within an 8-week timeframe. While four LV sessions are standard clinical practice in the UK (Shakespeare et al., 2006; Turner et al., 2010), the number of LV sessions in UK-based trials has varied from 6 (Wickberg & Hwang, 1996) to 8 (Cooper, Murray, Wilson, & Romaniuk, 2003; Holden et al., 1989; Morrell et al., 2009). The choice of 6 sessions for the US based trials was consistent with one prior study and was feasible for the U.S. clinical settings in which LV would be implemented. Although 6 sessions were the stipulated protocol, in both US trials the average number of LV sessions completed was 5 and the modal number was 6, indicating that most women completed all 6 sessions. For research assessments, women completed three interviews consisting of a diagnostic clinical assessment and completion of self-report measures to assess depression, quality of life, and work and social adjustment (please see Segre et al., 2014 for a detailed description of the assessments administered during these interviews). The first and second interviews were conducted at 0 and 8 weeks after study enrollment. A third and final interview was conducted 20 weeks after enrollment into the open trial and 16 weeks after enrollment into the RCT.

Participants

The participants in this qualitative assessment of LV were those who completed the open trial and RCT evaluations. Of the 20 open trial participants, 19 completed the "Views of Listening Visits Interview." Of the 66 RCT participants, 49 completed the "Views of Listening Visits Interview." The demographics of the two samples were compared (two-sample t tests for continuous demographic variables and chi square tests for categorical demographic variables). Because the two samples did not differ significantly

demographically, we combined the responses from both studies (N=68) in our analysis of acceptability.

In the combined sample (Table 1), participants reported an average age of 27 years and an average of 2 children. The majority identified as ethnic-minorities: 26.5% identified as Black and 50.0% identified as Hispanic/Latina. More than one third of participants (42.6%) were single mothers (e.g., never married or separated/divorced and living alone). More than half were unemployed (58.8%); 39.7% did not have a high-school diploma; and one third had a yearly income of less than \$10,000 (33.8%).

Procedures

Participants in both trials completed the “Views of Listening Visits Interview.” In the open trial, in which all participants received the intervention, this qualitative assessment was completed after LV (at the second interview, 8 weeks after enrollment). In the RCT, in which some women received LV immediately after being enrolled in the study (i.e., between 0 and 8 weeks) while others did not (randomized to a delayed LV condition delivered 8 weeks after study enrollment), the “Views of Listening Visits Interview” was completed after all women had received LV (at the third assessment, 16 weeks after enrollment) in order to preserve the interviewer's blindness to the treatment condition.

In both trials, the study assessments (including the “Views of Listening Visits Interview”) were conducted by a PhD clinical psychologist or a bilingual, advanced graduate student in clinical/counseling psychology. For the “Views of Listening Visits Interview,” interviewers recorded the woman's responses verbatim in the form of notes, a process that was facilitated by women's generally short and concise responses. For the interviews that were conducted in Spanish, the interviewer took verbatim notes in Spanish and then rewrote these notes in English. The interviewer notes were then entered into a data-management system for subsequent extraction and analysis, described below. Our decision to not audio-record the interviews stemmed from our concern that this vulnerable population of women, some of which were undocumented, would be reluctant to participate in a study where they would be audio-recorded. Instead, we opted to safeguard the climate of trust by training interviewers to record women's responses verbatim in written form. Interviewers encouraged participants to share their honest opinions about LV and expressed how valuable any feedback, be it positive or negative, was for the improvement of these services.

Measures

Demographic questionnaire—A questionnaire assessed participants' demographic characteristics, including age, race, ethnicity, education, income, and employment status.

Views of Listening Visits interview—Three open-ended questions assessed participants' views about LV, around three main domains. Participants' first impressions of this treatment were assessed retrospectively by exploring their openness to receiving LV when their home visitor/health care provider first suggested LV (Q1: *When your home visitor/health care provider first told you that she wanted to do this treatment with you, what did you think about this idea?*). We recognize that asking this question immediately after the

woman was offered treatment would have minimized potential bias associated with already having received LV. Importantly, however, to preserve the blindness to condition of the interviewer, this question was asked retrospectively after LV sessions were completed. The second domain assessed was whether the treatment was helpful. Participants' were also asked to provide specific examples (Q2a: *What do you think about the treatment in terms of its helpfulness?* and Q2b: *Can you describe for me a specific example of how the treatment was helpful to you?*). Finally, participants were asked if the way LV were delivered might be improved: we wanted to find out whether women would prefer a different setting or service provider, or suggest ways to improve the quality of the treatment for others (Q3: *What would you change about the treatment?*).

Data Analyses

Demographic questionnaire—Descriptive statistics were used to analyze the demographic characteristics of participants using IBM Statistical Package for the Social Sciences (SPSS) software, version 21.

Views of Listening Visits interview—A qualitative content analysis was conducted to describe themes that emerged from women's responses to the three questions assessing their views of LV (Bryman & Burgess, 1994; Strauss & Corbin, 1998). This analytic approach is ideal for the identification of themes or patterns that naturally emerge from the data and the systematic classification of these themes into codes, thus emphasizing participants' unique perspectives on a given topic (Elo & Kyngäs, 2008; Rubin & Rubin, 2012). This content analysis was conducted using a two-step inductive approach, described in detail below, which is consistent with a “goal-free” evaluation (Scriven, 1991) in which women's genuine views about the acceptability and helpfulness of LV were assessed.

Step #1: Developing a coding manual—A team of undergraduate students majoring in psychology and nursing who were naïve to the treatment condition of the women, and who were not involved in the delivery of LV, objectively developed a coding manual and coded these interviews. Coders first read all of the women's responses to each question and independently generated a list of themes that emerged from the data. These themes were subsequently converted into a set of codes. To unify these into a single coding manual, they met in a group, compared and combined their lists into a comprehensive set of codes for each question. Additionally, the coders defined each code, including key characteristics, scope, and delineations of what *not* to include. This refinement process continued until all coders agreed the manual was comprehensive such that the set of codes for each question captured all of themes that emerged from the women's responses. These procedures align with the recommendations for creating a data-driven codebook by DeCuir-Gunby and colleagues (2011) by which the responses to the questions in the semi-structured interviews (i.e., raw data) are thoroughly examined in order to develop a comprehensive codebook that captures all possible themes that emerge from the data.

Step #2: Coding responses—The unit of analysis was the entire response that a woman gave to the specific question being coded. A minimum of three coders independently coded each woman's response to the three questions. The coders met to establish a consensus code

for each of the woman's responses (e.g. the code(s) selected by at least two of the three coders). In the event that consensus was not met among the three coders, a fourth coder independently coded the woman's response (Thomas, 2006). If, after the fourth coder, no consensus was established, then the woman's response was marked "Unable to code." Finally, the data analysis included a quantitative summary (i.e., number and percentage) of the participants' coded responses reflecting how many participants endorsed a specific code. Paraphrased participant responses¹ are provided for illustrative purposes and are identified with the participant number and trial in which they were enrolled (i.e. O= Open trial and RCT=Randomized Controlled Trial).

Results

Initial views

Women's first impressions of LV (i.e., when their point-of-care provider first suggested the intervention) were captured by four themes that emerged from the data (Table 2). Most (77.9%) endorsed or approved of LV.

I was interested in it [LV] right away. I definitely needed to talk to someone not related to me. I was open to it [LV]. -P52, O

A few (5.9%) were open to or curious about receiving LV, but expressed some uncertainty.

I had never heard about this program [LV] so I didn't know what to think, but I was curious about it so I decided to go ahead and try it. -P66, RCT

Some (10.3%) were initially hesitant or skeptical about LV but elected to try it anyway, mainly because they trusted the provider as is illustrated below.

I was really hesitant at first. It is hard for me to trust other people and be open about things. She [LV provider] had to talk me into it. Knowing that [Name of LV provider] was going to be the one doing it and not some complete stranger helped. -P54, RCT

Finally, three participants (4.4%) initially had a negative view about the treatment.

I was a little confused. I did not know what it was going to be about. I thought 'what is the point of talking with her listening and not helping?' I did not mind, but I also did not see what benefit it would have. -P58, RCT

Examples of how LV were helpful

Three women (4.4%) indicated that LV were not helpful. Far more (67.6%), however, mentioned the importance of having a person listen empathically to them, be supportive, and give them an opportunity to talk (Table 2).

¹Participant's responses were recorded in note form. Although interviewers were instructed to record women's responses verbatim, the lack of audio-recording renders it impossible to verify that these were the women's exact words. For this reason, we refer to these as "paraphrased participant responses" as opposed to participant quotes.

It [LV] was really good. I looked forward to going. She is a really good listener. I was having an issue and once I was able to talk to her and speak it out loud, it was better. –P35, RCT

The second most frequently mentioned helpful component of LV, noted by 44.1% of women, was collaborative problem solving with the advice of a provider.

We talked; she gave me options and ways to distract myself. She would help me think and we would discuss options and solutions. –P7, RCT

Women also reported that their LV providers helped them see their problems from a new perspective (20.6%), and helped them feel calmer and relaxed (19.1%). Not feeling judged (8.8%) by their provider and feeling as if they could trust her (14.7%) were also mentioned as helpful components of the treatment.

Very effective, very relaxed, very nonjudgmental. I got to vent. I thought it helped a lot. It allowed me to view things outside of the box. I didn't feel like I was the only person with these problems. [I] relieved some stress. [LV] helped [my] relationships. –P36, RCT

A small minority of women (7.4%) also reported they believed it was helpful to talk to someone who didn't know them, that LV helped them feel less alone (both physically and emotionally; 5.9%), and that LV connected them with other resources and information (e.g., housing services, information about child development, medical information; 4.4%).

Since I don't go out that much it [LV] helped me have someone to talk to that could give me information about my girls' development. She brought me a lot of [information] and I liked that. I learned a lot of things. –P61, RCT

Suggested Changes²

When asked, "What would you change about the treatment?" half of the participants (50.0%) reported they would not change anything.

I don't think I would change anything. [Name of Provider] was able to work around my schedule. We decided together when to meet. I think everything was good. –P11, O

Of the women who did endorse wanting to make a change, 42.6% reported wanting more or longer sessions.

I would have liked more sessions. I didn't want them to end. [I preferred] longer [sessions] because I really looked forward to talks [with] her. –P61, RCT

As indicated in Table 2, 8.8% of the women suggested that LV be delivered differently, either in terms of format, location, and/or time. Examples of suggestions include: doing LV in a group format with other women, and having a provider with a more directive style (e.g., ask her more questions). Others (4.4%) would like to have received extra resources (e.g.,

²In the Listening Visits Open trial study (Segre, Stasik, O'Hara & Arndt, 2010), a small part of the manuscript reports on treatment acceptability and suggested changes for treatment for this relatively small sample (N=19). The findings reported in the current manuscript are much more comprehensive (N=68) and the complete focus of this paper.

childcare, information about housing). Finally, two women (2.9%) who felt that they had been struggling with depression for quite some time, suggested that medication (i.e., antidepressants) be given in conjunction with LV.

Discussion

At-risk, low-income, and ethnic-minority women are the least likely to receive treatment from a mental health professional (Levy & O'Hara, 2010). This study assessed their views toward a new treatment approach: LV delivered by a familiar and trusted social service or health care provider. To summarize the results, three key findings emerged from this qualitative analysis. First, when women first heard about this novel approach, most (77.9%) had definitively positive views. Second, the most frequently mentioned helpful components of LV were having someone to listen empathically and collaborate with them to solve problems. Third, half of the women would not have changed anything about how LV were delivered, and an additional 42.6% reported wanting more or longer sessions.

The positive views of women in this study, when first introduced to the idea of LV, contrasts with the report of researchers evaluating Cognitive Behavioral Therapy (CBT) among this at-risk population (Miranda et al., 2003). In that study, despite their team's concerted efforts to engage women in treatment and remove all barriers to receiving care, it was very challenging to deliver the intervention. Although they determined CBT was helpful to those who ultimately accepted care, difficulties getting to that point suggested this approach would not work in real-world settings, without the engagement supports afforded by a funded trial. In contrast, we found 77.9% of women had positive first impressions of LV. Our data did not explore why our study participants welcomed LV from the outset; however, in accordance with the speculation of the team of CBT evaluators that "engaging them through trusted providers could prove easier" (Miranda et al., 2003, p. 64), it will be important in future research to directly explore whether the delivery of LV by trusted, point-of-care providers might be playing a key role in our success.

After receiving LV, two-thirds of the women in our study noted that the *most* valued aspects of LV were empathic listening, support, and the opportunity to talk. The power of empathic listening has been long recognized as one critical element of therapeutic change (Rogers, 1957). The women in our studies were members of a disenfranchised group: economically poor, African-American or Latina mothers of very young children. It is not surprising that they valued both having the opportunity to talk and to be listened to by someone that they trust, as well as to feel that a person was genuinely interested in their well-being. The second most frequently mentioned element of LV, valued by 44.1% of women in this study, was the collaborative problem solving style of the LV provider, and the advice she offered. Almost half of women in this study were not currently living with a partner. As a consequence, it is not surprising that this group of single mothers valued the collaboration and advice provided by their LV provider.

Finally, LV recipients in this study liked the way the intervention was delivered. Half would not have changed anything about LV, including the provider, the venue, or the schedule. Even the suggested changes, such as wanting more or longer sessions, reflected positive

views of LV. These positive views of LV contrast with findings from Shakespeare and colleagues (2006), who found that women believed the LV sessions were not a significant factor in their depression recovery, but rather that it was the passage of time and the baby settling into a routine that helped improve their symptoms. They also found that most women valued LV only if they had a good relationship with their provider, but that chronically depressed women in particular had a negative view that any treatment would be beneficial (Shakespeare et al., 2006). The authors suggest that these generally negative views could be a result of women not being able to choose their own health visitor, not having a say in the type of treatment that they would like to receive for their depression, or viewing their health visitor in a different role than that of a therapeutic agent. In the present study, women had already established a trusting relationship with their home visitor/office nursing staff and LV were introduced as a possible alternative to help with their depression, possibly contributing to the difference in findings.

Strengths and Limitations

This is the first US study that qualitatively assessed women's views of LV. The large sample (N=68), which included women from both an urban setting and a rural US state, is the first to explore the views of LV among a group of low-income, primarily ethnic-minority women. Because low-income, ethnic-minority women are at risk of experiencing depressive symptoms (Segre et al., 2006; Segre, O'Hara, & Arndt, 2004), yet are least likely to access services from a mental health professional, their positive views provide a strong signal that the LV intervention is a promising first-line treatment approach for this group of underserved women. Another strength is that LV were implemented and tested with actual point-of-care providers, which addresses the previously identified barriers to receiving depression treatment, including trust, treatment costs, transportation, and childcare (Dennis & Chung-Lee, 2006). As is shown in the current study, the majority of women viewed their point-of-care LV providers as supportive and empathic, which likely is a major factor in making LV an acceptable treatment option for depressed perinatal women.

Despite these strengths, our study also has some limitations. First, we did not audio-record the interviews. Despite interviewers being trained to record the participant's responses verbatim in note form, we are not able to verify that these were in fact the participant's exact words. Second, the positive views noted in this report are limited to a self-selected sample of women who opted to participate in a treatment trial evaluation of LV. It is not clear that their views are generally representative of this population of women. Although our sample was large, the broad appeal of this intervention has yet to be definitively established for this population. A survey regarding their views of different types of treatment and healthcare services, including LV, would be informative. Third, while most of the women received LV in their home, in the multisite RCT, LV were delivered in an ob-gyn office in one of the study sites. These two different settings could have influenced women's views. For example, two of the women who received LV in the ob-gyn office suggested a change in setting for LV. Future examinations of LV delivered by point-of-care providers might therefore assess where patients feel most comfortable receiving LV. Fourth, women's initial views of LV were assessed retrospectively. Thus, their recollection of having positive views of LV when their

point-of-care provider first introduced them may have been influenced by their subsequent experience. Finally, we did not assess the initial views of the women who declined LV.

Clinical Implications

The clinical implications of this study for the mental health care of US, low income, ethnic-minority women are substantial. In the UK, LV are already part of regular clinical practice as recommended by NICE guidelines of 2007 (National Collaborating Center for Mental Health, 2007). With empirical support for the effectiveness of LV in home visiting settings in the US (Segre et al., 2014; Segre et al., 2010) and the results of the present study showing acceptability by these women, LV could be broadly disseminated within the well-established network of existing home visiting programs across the US for this population (Leis, Mendelson, Tandon, & Perry, 2009).

Conclusions & Future Directions

In their own voices, this group of at-risk women indicated that they valued LV as a depression treatment approach. This is significant because these women typically do not seek treatment from a mental health professional. Nevertheless, even in the face of substantial empirical evidence, the diffusion of innovative practices like LV is often slow and hindered by skepticism on the part of all stakeholders (Rogers, 2003). Listening Visits, which rely on delivery by point-of-care providers who are not mental health specialists, is particularly susceptible to this skepticism (Durlak, 1979; Montgomery, Kunik, Wilson, Stanley, & Weiss, 2010). Although the results reported here indicate that the women valued LV, we did not assess the views of the providers, who are not mental health specialists and therefore may have concerns about assuming this new role. To determine the potential for wide adoption, it will also be important to assess these providers' views. Additionally, it would be interesting to contrast women's views of LV with their views of other healthcare experiences in order to further elucidate the positive qualities about this treatment in comparison to other services. Furthermore, it would be useful in the future to examine how many of the women who expressed positive views of LV and who provided examples of helpfulness actually experienced clinically significant changes in depressive symptoms; a comparison that would help elucidate the relation between perceived versus actual efficacy. Finally going forward, as the implementation of LV extends beyond research into clinical settings, the views of women voicing their appreciation of LV should be incorporated into the LV-provider training sessions. Sharing positive views with providers may help mitigate skepticism by highlighting how much their expanded role is valued.

Acknowledgments

This research was supported in part by grants from NIMH K23 and ARRA supplement (MH075964). The authors acknowledge Sydney Farnsworth, Laura Houghton, Megan Leibforth, Elizabeth Tuchscherer, and Karolina Wartalowicz for their invaluable assistance with coding; Nancy Grote, PhD, Cynthia Battle, PhD, Michael O'Hara, PhD, and Briana Woods-Jaeger, PhD for their helpful suggestions and comments; Diana Colgan PhD, the College of Nursing editor; and the women who provided their views.

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Table 1
Participant Demographics (N=68)

Variable	(<i>M</i> ± <i>SD</i>); [range]
Age	27.54 (5.8) [14-40]
No. children	2.26 (1.5) [0-8]
	N (%)
Race	
White	32 (47.1)
Black	18 (26.5)
More than one race	4 (5.9)
Asian	1 (1.5)
Unknown/Did not want to report	13 (19.0)
Ethnicity	
Hispanic/Latino	34 (50.0)
Not Hispanic/Latino	34 (50.0)
Relationship Status	
Currently living with a partner (married or not married)	39 (57.4)
Currently single (never married or separated/divorced)	29 (42.6)
Employed	
Yes	28 (41.2)
No	40 (58.8)
Yearly Income	
< \$10,000	23 (33.8)
\$10,000	35 (51.5)
No answer provided	10 (14.7)
Education	
< High school diploma	27 (39.7)
High school diploma	40 (58.8)
No answer provided	1 (1.5)

Table 2
Themes: Women's responses in semi-structured interviews (N=68)

Initial Views about Listening Visits	Number (percentage)*
Endorsed	53 (77.9)
Uncertain Positive	4 (5.9)
Uncertain Negative	7 (10.3)
Negative	3 (4.4)
Other	1 (1.5)
Examples of How Listening Visits were Helpful	Number (Percentage)
Provided empathic listening, support, and opportunity to talk	46 (67.6)
Were collaborative in problem solving and in giving advice	30 (44.1)
Fostered a new perspective	14 (20.6)
Were calming or relaxing	13 (19.1)
Provided by trusted person	10 (14.7)
Provided by a non-judgmental person	6 (8.8)
Helped her feel less isolated	4 (5.9)
Provider did not know the client (was not a family member or friend)	5 (7.4)
Extra resources were provided	2 (2.9)
Medical information was provided	1 (1.5)
Other examples	2 (2.9)
No specific examples were given	3 (4.4)
Participant did not find LV helpful	3 (4.4)
Unable to code answer	1 (1.5)
Suggested Changes to Listening Visits	Number (Percentage)
No change	34 (50.0)
More sessions/Longer length	29 (42.6)
Fewer sessions/Shorter length	1 (1.5)
Medication	2 (2.9)
Extra resources	3 (4.4)
Different method of delivery	6 (8.8)
Unspecified change	1 (1.5)
Other	3 (4.4)

* Note: Women could mention more than one theme, thus the total of percentages may exceed 100%.