

Incorporating Family Members Into Treatment for Perinatal Psychiatric Disorders: A Pilot Program

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ABSTRACT

INTRODUCTION AND OBJECTIVE: Though perinatal psychiatric disorders affect the entire family, most perinatal mental health interventions only include mothers. Here, we detail the implementation of a single-session, virtual, family support group for partners and family members of mothers with perinatal psychiatric disorders.

METHODS: The family support group was created within a mother-baby partial hospital program for people experiencing perinatal psychiatric disorders. Patients in the program provided consent to contact their partner or family member. This person was offered participation in a complementary, one-hour virtual support group. Led by a clinical psychologist, the support group was designed to serve as a standalone psychoeducational intervention on perinatal mood disorders. Sessions were offered bi-weekly to facilitate access. Participants were asked to complete an anonymous survey soliciting mixed-method feedback about the group.

RESULTS: Of 105 people who consented to contacting their family members regarding the support group, 70 (65%) family members reported interest, and of these, 45 (64%) attended a support group session. Among the 13 participants who provided feedback (29%), there was a high level of satisfaction (Client Satisfaction Questionnaire-8 $M=27.25$; score >24 =high satisfaction) and the perception that participation increased their knowledge of and empathy toward their family member's experiences. The most common feedback was a desire for more sessions.

CONCLUSIONS: In this pilot study, a virtual family support group was feasible and yielded high participant satisfaction. Future research should examine how this or other digital programs could make perinatal mental health care more accessible for partners and family members.

KEYWORDS: non-birthing partner; perinatal mental health; family-based care; virtual support groups; digital health

INTRODUCTION

Postpartum depression (PPD), the most common mental health concern during the perinatal period, affects up to 15% of mothers (who will be referred to interchangeably as birthing parents in this manuscript).¹ A history of depression is often identified as the most important risk factor for PPD.^{2,3} However, inadequate and perceived lack of social support—especially family member support—is a major risk factor for PPD as well.³⁻¹¹ Unlike fixed risk factors, such as past psychiatric illness, family and partner support can feasibly change. High levels of marital satisfaction and perception of partner support can even serve as a protective factor for the development of antenatal anxiety and depression and later PPD.^{12,13} Furthermore, in two parent households there is a clear, bidirectional relationship between parents' well-being, such that when one parent develops PPD, the other parent is at significantly increased risk of developing PPD themselves.¹⁴⁻¹⁸ Despite the awareness of the interplay between PPD of both parents, recent meta-analyses have concluded that the vast majority of interventions that aim to prevent or treat maternal PPD focus exclusively on the patient, at the expense of the partner or other family members.^{19,20} This exclusion has resulted in non-birthing partners or other family members feeling marginalized from treatment,²¹⁻²³ despite a desire to be included in their partner or family member's mental health care.²⁴

Prior pilot studies have demonstrated that incorporating partners or other family members into interventions designed to prevent^{25,26} or treat²⁷ maternal PPD is feasible and can improve PPD symptoms for both parents.²⁵⁻²⁷ However, these studies describe interventions that require intensive, longitudinal partner engagement,²⁵⁻²⁷ which may limit their feasibility outside the research setting. In addition, most interventions were limited to partners,^{25,26} which downplays the role that non-partners may have in perinatal mental health outcomes. Thus, we created a single-session, virtual, psychoeducational support group for partners and family members of patients undergoing intensive therapy for perinatal psychiatric conditions at an established mother-baby partial hospital program. We then evaluated the feasibility and acceptability of the support group within a clinical treatment setting to gauge interest, follow-through, and participant reactions.

MATERIALS AND METHODS

This study includes partners and family members of birthing parents engaged in an established mother-baby partial hospital program for patients experiencing perinatal psychiatric disorders.²⁸⁻³⁰ To be a patient in this partial hospital program, women must have moderate to severe symptoms of any psychiatric disorder while being concurrently pregnant or within 12 months of childbirth.

Patients in the partial hospital program were given information about the family support group at admission. Those who were interested in having a family member outreached provided family members' contact information to program staff. Family members were then contacted and given information on the group. If they elected to participate, they were provided with group information and a link to join virtually on their specified date. The hour-long group occurred bi-weekly and was only offered virtually. The support group was designed as a standalone session, but family members were offered to join multiple sessions, per their preference.

Although patients in the program were experiencing a range of psychiatric concerns, family support group programming primarily focused on perinatal depression, given that it was the most common presenting concern. Group content included psychoeducation on symptoms of perinatal depression and anxiety, an overview of partial hospital programming, specific strategies for supporting their loved ones' mental health treatment, and signs of postpartum depression in non-birthing parents. Each session was led by a clinical psychologist with expertise in perinatal mental health and family functioning. Sessions were designed to serve as a standalone psychoeducational intervention by providing an overview to the major topics identified above, with additional content and discussion based on participant interest.

To examine participant perspectives of the family support group, all participants were invited to complete an optional, anonymous survey via Research Electronic Data Capture (REDCap) within one week after attending the group. This survey solicited both open-ended and structured feedback regarding the family support group. The survey included the Client Satisfaction Questionnaire (CSQ), an 8-item measure assessing satisfaction on a 1-4 Likert scale, with higher indicating greater satisfaction.³¹ The CSQ-8 is a validated tool widely used in health, mental health, and social services settings.³¹ Demographic data were not collected on patient feedback surveys in order to protect the anonymity of respondents.

RESULTS

One hundred and five partial hospital patients consented for hospital staff to contact their family members to participate in the family support group and provided informed consent to contact. Of 105 family members who were contacted, 65% (n=70) reported interest in participating in the group.

Among those with interest, 64% (n=45) of these individuals participated in the program.

Regarding acceptability, among respondents who completed the REDCap feedback survey (n=13), average scores on the CSQ-8 suggest a high level of satisfaction among family members ($M=27.25$; $SD=3.4$). Qualitative feedback was also positive, with common themes noting that participating in the virtual support group increased not only their understanding of perinatal mood disorders symptoms and treatment but their empathy for their loved one's mental health struggles [Table 1]. Participants also felt supported by the program, as it validated their caregiver fatigue and made space for peer support from others who also had loved ones undergoing psychiatric treatment. When asked about things to change about the group, over two-thirds indicated a desire for more frequent or longer group sessions.

Table 1. Qualitative feedback among participants in a virtual support group for family members of perinatal patients with moderate or severe psychiatric illness

Theme	Quote
Validation and support for family caregivers	"It really spun my situation to a more positive place/feeling than I had prior to the session." "It provided basic tools and advice."
Useful information re: perinatal mood disorders	"I liked how personable the environment was and the valuable information that was provided." "It helped give me a better perspective [regarding] how to handle situations."
Wish for longer/more sessions	"Longer sessions, so people would have more time to share." "I would offer additional sessions."
Normalization and peer support	"Loved hearing others' stories and knowing you're not alone in this." "It helped me to hear other people's experiences and to be able to receive valuable general suggestions or recommendations that could empower me to be a better supporter of my partner."
Increased empathy towards family member	"Helped me put everything into perspective and understand what my wife is going through."

Note: No demographic information was captured among survey respondents.

DISCUSSION

In this preliminary study, a novel, virtual, 60-minute psychoeducational support group for family members of patients undergoing treatment for moderate to severe perinatal mood disorder symptoms was shown to be feasible. In addition, high levels of participant satisfaction with the program

were noted. Qualitative data suggested the reasons for the favorable perception included not only peer support but psychoeducation from a trusted source, which allowed participants to increase their knowledge of perinatal mood disorder symptoms and treatment and empathy towards their loved one with the psychiatric illness. Findings from this pilot project support further research powered to detect whether the program improves mental health symptoms for the perinatal person or their family members.

These findings contribute to the growing body of literature describing the feasibility and acceptability of novel psychoeducational or psychotherapy-based programs designed for partners or family members of perinatal people to prevent or treat psychiatric conditions.²⁵⁻²⁷ Similar to these prior studies,²⁵⁻²⁷ partner or family-member engagement with our psychoeducational program was high. However, unlike the prior family-based interventions—which comprised anywhere from five²⁶ to 12 distinct sessions,²⁷ the majority of which were in-person²⁵⁻²⁷—our program provided comprehensive psychoeducation and peer support with one virtual session, though family members were allowed to attend group as many times as they desired. Thus, this work expands the potential of family-based, perinatal psychoeducational support by demonstrating that a single virtual session is not only feasible but viewed highly favorably by attendees.

This study also introduces important clinical and academic considerations in terms of programmatic sustainability. First, although this support group was designed as a standalone virtual session, participants could attend as many sessions as they desired. However, no participants engaged in the group more than once, despite some individuals providing feedback that they wished there were longer or more frequent sessions. Unfortunately, we do not have explicit feedback on why they did not attend multiple sessions. It is possible that participants believed a single session was sufficient to improve their understanding of what their affected partner or family member was experiencing, rendering additional attendance unnecessary. Alternatively, some family members may not have attended more than once given their awareness that similar content was covered in each session. It is also possible that partners and family members did not have the bandwidth to attend more than one session. Indeed participants often attended during a break from work or while caring for their baby, suggesting that they were juggling multiple demands.

Future programming could consider a hybrid model in which families are offered multiple drop-in sessions covering a range of topics (i.e., attend as often as desired). Second, this program was created and implemented by a trained clinician whose salary was not based on the number of hours she billed each week. This financial flexibility allowed her to provide the program free-of-charge to attendees as part of her clinical schedule. However, this also led to the program being paused when the clinician's work hours and responsibilities changed. Third, as our initial focus was on program feasibility and acceptability, we did not collect data

on clinical outcomes of the patient or participating family member. Thus, the potential effect of this program on stress or perinatal mental health symptoms for both program participants and their family members is unknown. It would also be important to assess the extent to which participant knowledge of perinatal mental health symptoms and treatment changed from participating in this program, as increased knowledge may translate into improved support for the perinatal psychiatric patient, potentially reducing their mental health symptoms. We anticipate this study will serve as proof of concept to support a larger randomized trial powered to detect clinically meaningful outcomes.

This study has both strengths and limitations. Study strengths include the fact that this program was assessed via a mixed-methods approach, allowing for participants to provide feedback on the program via both validated quantitative surveys and qualitative research. In addition, the program was staffed by the same perinatal psychologist, ensuring the content provided was consistent and evidence-based. In terms of limitations, participant demographics were not assessed. While this decision was intentional to protect the anonymity of patients and their family members, it is therefore impossible to determine whether those who participated in the study were racially, ethnically, or sociodemographically diverse. In addition, less than one-third of participants in the program provided feedback regarding program satisfaction and acceptability, increasing the risk of selection bias. Lastly, we did not collect data on the number of patients with moderate or severe depression symptoms who were offered the program for their family members, though these data would have provided additional understanding of family members' interest in the program.

CONCLUSION

In conclusion, inadequate and perceived lack of social support from partners and family is a known risk factor for PPD.³⁻¹¹ It is possible that participating in support groups for family members of patients with moderate or severe perinatal psychiatric conditions may increase the support they provide to their loved one, thereby reducing their psychiatric symptoms and expediting treatment. In this study, we demonstrate the feasibility of a single-session, virtual, psychoeducational support group for family members of patients undergoing treatment for moderate or severe perinatal psychiatric symptoms. The value of the session was evidenced by patient uptake and the favorable evaluations of participants. We also identified challenges for future programming in terms of the need to financially support clinician effort. Thus, these results provide both a roadmap for other partial hospital programs seeking to include partners and family members in treatment, as well as an important foundation for future research exploring the clinical effect of virtual family support for patients experiencing perinatal psychiatric disorders.

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