Routledge
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Daily Life or Diagnosis? Dual Perspectives on Perinatal Depression within Maternal and Child Health Home Visiting

Sarah Kye Price

School of Social Work, Virginia Commonwealth University, Richmond, Virginia, USA

Katherine Cohen-Filipic

Department of Psychology, Ithaca College, Ithaca, New York, USA

This study describes a qualitative inquiry–informing program development in a maternal and child home visiting program. Low-income women's perceptions of the meaning and experiences of depression were ascertained through focus groups and interviews. Simultaneously, the study examines staff member perceptions and roles related to depression. Specific findings from clients and staff reveal culturally situated beliefs about depression and stressful life events; comparing and contrasting these beliefs offers a novel perspective on identification and intervention for maternal depression. This study offers a foundation for a translational research agenda that will be used for program and policy development to enhance mental health services situated within maternal and child health home visiting programs.

Keywords: Perinatal depression, home visitation, women's mental health, mothers, maternal and child health

Although society at large often portrays pregnancy and new parenting as a period filled with happy expectation, many women struggle with stress, depression, and loss during this same timeframe. Undeniably, the daily lives of most pregnant and newly parenting women are filled with moments of joy as well as times of stress. Likewise, hormonal and behavioral changes associated with pregnancy and childbirth contribute to potential fluctuations in mood and emotional affect, accentuating the anticipated stresses of changing daily life when a newborn child is added to the family system (Dennis, Ross, & Grigoriadis, 2007; Wisner, Chambers, & Sit, 2006). Compounding these typical stresses of pregnancy are the challenges to psychosocial well-being faced by many low-income women, including heightened risk for fetal and infant mortality, cyclical poverty, discrimination, housing concerns, and unemployment.

Maternal and child health (MCH) home visiting programs, situated in the public health infra-structure, are increasingly challenged to address women's mental, as well as physical, health during and around pregnancy. To respond to perinatal depression in culturally relevant and responsive ways, MCH home visiting programs must discern culturally situated beliefs about what constitutes a normal response to stressful life events and simultaneously assess how these wider community beliefs and experiences integrate with, or differ from, clinical approaches to the identification and treatment of depression. This article offers a foundation of knowledge that addresses the subjective and interpretive perspectives of loss and depression among low-income pregnant and parenting women, along with the perceptions of depression among the home visiting staff members working with them. The convergence of divergence of their viewpoints affords the opportunity to more closely consider relevant and responsive approaches to mental health service delivery within the MCH home visiting infrastructure.

Perinatal Depression and MCH Home Visiting

Maternal and child health programs throughout the United States have become increasingly concerned about identification and treatment of perinatal depression. Empirical research and public health outreach and awareness programs emphasize the dual impact of maternal depression on women and children in the family system (Kavanaugh et al., 2006; Weissman & Jensen, 2002). One reported consequence of untreated depression is the deterioration of the mother's own functioning, which may subsequently limit her ability to bond with her child (Boyd, Zayas, & McKee, 2006; Boyd, Pearson, & Blehar, 2002; Field, 2000). We know from additional studies that children of chronically depressed mothers are at elevated risk for risk for their own depression, poorer health outcomes, and impaired social functioning (Diego et al., 2006; DiPietro, Novak, Costigan, Atella, & Reusing, 2006; National Institute of Child Health and Development [NICHD], 1999). A recent study suggests that these risks may be magnified for children in low-income families experiencing multiple life stressors (Feder et al., 2009). Importantly, when depression is identified and treated, child and maternal outcomes may be significantly improved (Weissman et al., 2006).

Maternal and child health programs across the United States have emphasized the importance of depression screening and intervention during and around the time of pregnancy, particularly in groups deemed to be at elevated risk. Epidemiological studies report that women from ethnic minority groups, including African American and Latina women, experience disproportionate rates of depression (Beeghly et al., 2003; Boury, Larkin, & Krummel, 2004; Howell, Mora, Horowitz, & Leventhal, 2005). Low socioeconomic status likewise compounds the likelihood of experiencing adverse pregnancy outcomes and mental health challenges (Beeghly et al., 2003; Rosen, Warner, & Tolman, 2006). Furthermore, low-income women may be disproportionately affected when mental health services are inaccessible and/or unaffordable to them (Feder et al., 2009).

Help Seeking and Self-Perception

Many low-income women encountered within MCH home visiting programs rely on public sector mental health services, such as those offered through community mental health centers. Often, services within the public mental health system must be triaged to serve those with greatest symptom and/or diagnostic severity. Even in situations where formal mental health services are desired, they may be inaccessible or unaffordable to low-income women (Alegria et al., 2002). Tangible issues such as child care, transportation, and lack of insurance create structural barriers to help seeking for many low-income women (Price, 2010). Indeed, a concern raised in the mental health services literature is that low-income and ethnic minority women are significantly less likely to use mental health services than other women (Song, Sands, & Wong, 2004). This is particularly

alarming in light of other studies that report that less than one fourth of women with a mental health disorder, regardless of income, received treatment during the past year (Rosen et al., 2006).

Women's perceptions of the experience and treatment of depression may also influence help seeking. Intangible barriers to care have been described across studies by low-income and ethnic minority women including lack of trust, judgment and stigma from others, system dissatisfaction, not wanting to receive help, perceived inability of psychiatric services to alter life situations, and fears of being perceived as less-than-adequate parents (Anderson, 2006; Jesse, Dolbier, & Blanchard, 2008). Women who are identified as clinically depressed through screening do not necessarily view themselves as depressed (Alvidrez & Azocar, 1999). Furthermore, the role of structural forces, such as racism and the perpetuation of the "strong Black woman" image, may be important influences on self-perception of depression in some groups (Nicolaidis et al., 2010). With regard to intervention, low-income women may view psychiatric medications as their first or only treatment option (Abrams, Dornig, & Curran, 2009), and their views on whether to take medication during pregnancy and the postpartum are complex and varied (Price & Bentley, 2013).

Enhancing Mental Health Services for Perinatal Depression

Disparities in access, quality of care, and overall levels of unmet need augment the personal challenges of seeking mental health treatment for many low-income women. The interrelationships among race/ethnicity, socioeconomic status, and stressors within the social environment that have been discussed (i.e., Alegria et al., 2002) highlight the need for translational research that can build on existing clinical innovations and research to appropriately reach low-income women. In the past several years, there has been an emphasis on the need for rigor and cultural relevance in appropriate screening and identification of depression among low-income and ethnic minority women (Boyd, Le, & Somberg, 2005; Price & Hendrick, 2009). The intervention literature has also proposed treatment modifications, moving toward the design of culturally relevant research and evidence-based practice approaches that address the unique needs of low income mothers with depression (Abrams & Curran, 2007; Bledsoe & Grote, 2006). Evidence-based interventions for perinatal depression include prevention strategies (Zlotnick, Miller, Pearlstein, Howard, & Sweeney, 2006) and treatment engagement (Grote, Zuckoff, Swartz, Bledsoe, & Geibel, 2007) as well as specific clinical intervention models largely based in cognitive-behavioral and interpersonal psychotherapy models (Grote, Swartz, & Zuckoff, 2008; Klier, Muzik, Rosenblum, & Lenz, 2001; Weissman, 2007). Mental health services research has simultaneously focused on improving access to care (Miranda et al., 2003), designing colocated mental health services (Pfefferle, Cooper, Layton, & Rohrbach, 2009), and addressing the tangible and intangible barriers to care experienced by many low-income women (Price, 2010).

In spite of these promising improvements in screening and intervention, the next challenge is effective translation of these mental health services to the wider community of low-income women. The MCH sector of the national public health infrastructure offers unique opportunities for connecting with low-income families using nursing, social work, and paraprofessional home visitors. Maternal and child health home visiting programs may be directly funded by state allocations from Title V of the Social Security Act and are also located within targeted communities with significant disparities fetal and infant mortality through federal initiatives such as Healthy Start. Similarly, nationally recognized programs such as Nurse-Family Partnership, Healthy Families, and Parents as Teachers offer a range of opportunities for family support combined with women's and infant's health promotion and/or parenting education. Specifically, home visiting programs in MCH encompass several evidence-based models that incorporate health education with parenting education on attachment, child development, and promotion of practices that reduce the likelihood of abuse, mistreatment, or neglect. However, little is known about the most effective (and cost-effective) ways to integrate mental health services within this sector. Expansion of evidence-based

MCH home visiting is a current federal priority, with national directives emerging through the Affordable Care Act authorizations and allocations. Consequently, this sector of care may be a vital resource for future intervention programs thoughtfully designed with attention to integrating MCH with mental health promotion and treatment (Price, 2010; Ley, Copeland, Flint, White, & Wexler, 2009). This study offers insight into the background and conceptual design of one emerging model of integrated MCH home visiting.

Study Scope and Research Questions

This study represents the first stage of an ongoing community-based participatory research project. The overarching objective of the research is to utilize women consumer and provider perspectives to collaboratively design, research, and disseminate an enhanced care intervention model that will concurrently offer preventative support and targeted mental health intervention to low-income women served by MCH home visiting programs. In this initial phase, we utilized a qualitative, interpretive paradigmatic framework that maximized the detection of subjective variability in the ways that depression and loss are expressed and experienced by low-income mothers and the home visiting professionals engaged with them. The bounds of the study sample are low-income, urban women who are pregnant or newly parenting, and the interdisciplinary MCH home visiting program staff working with them. In this study, the home visiting program utilized a registered nurse (RN) and outreach worker (paraprofessional) model with social work/mental health specialists (MSW and LPC) as part of the home visiting team.

The study described in this article encompasses three specific research questions: (a) What are low-income women's perceptions of loss and depression in their daily lives? (b) How are these perceptions similar to or different from the perspectives and diagnostic definitions of the interdisciplinary professionals who work with them? And (c) How can these identified areas of commonality and difference be effectively integrated into the planning, design, and research of an enhanced care MCH intervention?

METHOD

The study utilized a community-based participatory research (CBPR) lens, where study participants, including consumers as well as staff, were engaged in the interpretation of study findings and helped to generate the next phases of research and service design. The study was reviewed and approved by the University Institutional Research Board under expedited review with specific guidelines to ensure that participants, who may serve as respondents and advisory panel members, would receive training in research ethics and confidentiality. All participants signed written, informed consent documents that outlined the extent of their desired participation in the project. Data collection occurred in two stages over the course of 6 months. First, we conducted focus groups using open-ended "stem" questions with low-income mothers participating in two home visiting program sites in adjacent urban areas within one metropolitan region (four groups; $N = 14$). The focus group stems asked participants to discuss their experiences with depression and loss, self-defined, either personally and/or with family members, friends, or within their community at large. Subsequently, we conducted in-depth interviews that were informed by questions and statements emerging in the focus groups.

Focus groups were digitally recorded, and the open-ended format allowed the conversational topics across groups to differ substantially while ensuring all stem questions were addressed at some point. Data from the focus groups was used to identify congruent definitions and experiences of depression among low-income mothers and reach consensus around cultural and community

norms related to both loss and depression (Denzin & Lincoln, 2011; Keiffer et al., 2005). Thematic analysis was conducted by the first and second authors independently; the first pass themes were then compared by the authors to determine consistent overarching themes; a second round of thematic analysis was conducted to distill remaining subthemes. Themes and subthemes from the focus groups were brought back to the community research advisory panel composed of community women, direct providers, administrators, and researchers to build from the focus group themes into desired areas of further exploration during the subsequently scheduled individual interviews.

In the second phase, individual interviews were conducted within a purposively selected sample of the agency that included clients ($n = 8$) and direct care staff members ($n = 12$) of the home visiting agency. Interviews were semistructured with four task-oriented questions to which participants responded either verbally or in writing according to their own choice. The first task involved critiquing specific terms and descriptions of depression; the second task was an observed role-play between a client and staff member discussing depression; the third task was responding to a nondirective question to assess the nuanced meaning one very commonly used phrase, "take care of yourself"; and the fourth task was a card-sort to prioritize preferences regarding service delivery formats for a depression-oriented intervention, including identifying possible benefits and barriers for each format.

Data analysis for the Phase 2 interviews was again conducted by the two authors as independent coders. Primary themes from each coder were then compared to develop a list of consistent overarching themes and accompanying subthemes for presentation back to the advisory panel. Member checking of themes was conducted with the research advisory panel and wording modifications made as needed to the overarching themes and subthemes. In addition, a content analysis was conducted by phrase count to define specific wording recommendations for educational materials and client-worker conversations; the card-sort preference summary was coded quantitatively for rank order of overall service preferences and qualitatively to offer detail around specifically desirable elements consistent between proposed service delivery formats.

RESULTS

Perceptions of Women Consumers

Data analysis from the focus groups revealed several consistent themes in the lives of low income women. Each theme is highlighted in Table 1 with differences between women consumers and staff listed in Table 2. Details from the qualitative interviews and exemplars from participants are presented in the narrative.

Depression as a Personal and Community Reality

Participants openly dialogued about their personal stories of depression, as well as depression experienced by members of their families, friends, and community. General expressions of loss (jobs, housing, relationships, custody, incarceration, illness, death) were highly interwoven with descriptions of depression in the multistressed lives of women who participated in the focus groups. Women responded to each other's stories with resounding support, "Everyone has depression . . . it's not 'them' it's 'us' . . . and we need to talk about it more." There was a clear determination to live out their daily lives, even if feelings of depression emerged: "You've got to go on doing everything even though its killing you." Participants used terms suggesting a difference between inner emotion and daily, outer presentation including "making it," "trying to survive," "having inside tear time," and "being strong no matter how I feel." Across groups, the voiced desire was

TABLE 1
Summary of Focus Group Themes and Subthemes (Women Only)

Depression as a personal and community reality
   Embracing personal experiences as a part of life
   Weak vs. strong presentation to others
   Social stigma influencing self-perception ("bad mom stigma")
   Normalcy and solidarity among group members in face of depression
Mental health services as extension of personal support network
   Comfort discussing depression only with known and trusted providers
   Sense of abandonment from negative past experiences
   Misfits between need, access, and availability
   Personal investment between providers and consumers
   Hierarchy of desired services
Reproductive losses as undiscussed and undisclosed facts of life
   Reproductive loss as a new term for a common set of experiences
   Privacy and internalization of reproductive losses
   Acknowledgment of personal and social impact
   Spiritual understanding and acceptance
Medication as a common, challenging, and self-directed treatment
   Antidepressants as a common form of treatment
   Medication side-effects or depression: Which is worse?
   Self-management of medication

to support each other and get through daily tasks of life, not to deny the challenges or seemingly give up when confronted with depression.

Mental Health Services as Extension of Personal Support Network

Participants described trust combined with a sense of personal connection to a helping professional as the strongest influence on whether they disclosed feelings of depression truthfully and openly. Phrases frequently used to describe trusted providers included "she knows I'm a good person," "he believes that I'm trying to do the best I can to take care of my kids," "she's my lady, she knows me and she believes me." Conversely, negative encounters made a lasting impact. Stories echoed subthemes of being made to feel minimized, a burden, or a bad person: "the one time I thought I was bad off and went to the clinic and they told me I wasn't crazy enough ... yep, that's what they said ... if I was not bad enough to get services there ... how bad am I supposed to get?" Summative comments across groups revealed that the perceived personal relationship between

TABLE 2
Comparative Summary of Interview Themes (Women and Providers)

Women	Providers
Comfort talking about depression with trusted providers	Discomfort talking directly about depression with clients
Fears and stigma regarding seeking outside treatment for depression	Concerns around feasibility of in-home and agency-based services
Known and experienced service barriers	Understanding of barriers that limit community service use
Attending to different levels of severity of depression	Need for varied services based on symptoms and client preference
Importance of connection with peers	Concerns regarding privacy and confidentiality of clients

women and professionals is central to trust-building. For example: "I went to see my lady and she told me that they might have to cut her job, she might have to move to doing substance abuse only … I don't know what I will do if she leaves, because she's my one and only friend I can call on" and "seriously, I thought about getting pregnant again just so I could keep going back to him [Obstetrician] because I really like him and he really likes me, he knows me, we can talk about anything that's happening and he just listens and tries to help." Participants also voiced that trusted providers who invested time, spoke with them and listened were highly sought after and worthy of loyalty while, "if they are just giving a pill or changing my meds around, I can see anyone."

Reproductive Losses as Undiscussed and Undisclosed Facts of Life

A stem question regarding reproductive losses was deliberately included based on the primary author's research interests. The term *reproductive loss* was defined to encompass miscarriage, stillbirth, and terminations of pregnancy irrespective of cause; participants affirmed that this is a common life event that is personally experienced but not publicly discussed. Participants appreciated the encompassing term *reproductive loss* as a new concept for describing pregnancy-related losses that often remain unspoken but for which they could not find the right word or label. "You know, we can't talk about that … we all know we've been there, had to deal with it but no one else wants to hear about it." Participants acknowledged that there is a personal and a social impact from experiencing a reproductive loss that is shared by many women in the community, "they need to have some kind of group for that, you know, but it's hard too because no one wants to be the one who shows up to that group unless you call it something else."

Medication as a Common, Challenging, and Self-Directed Treatment

Strong views regarding medication utilization for depression emerged across groups. Nearly all participants had been prescribed (although had not necessarily taken) an antidepressant at some point in their lives. Women were frustrated that antidepressants were often the first (or only) treatment recommended to them for depression during pregnancy and post-partum in spite of women's concerns about the impact of medication on the pregnancy/infant: "You say you're feeling down, they give you a pill." Several women who were pregnant spoke with a drug store pharmacist when they went to fill their antidepressant prescription and subsequently decided not to take it. Others took medication and adjusted encouraged practices such as breast-feeding, "I thought my milk supply was going down from the meds … I drank lots of water and that helped." Participants openly debated which was worse—the depression symptoms or the medication side effects: "I was depressed, you know, and I took that medication but then it made me so tired I slept all night while my baby was laying there crying and I didn't even know it … so which is really worse?" Symptoms were attributed to medication, for example: "pills made me more crazy" and "I felt hyped all the time" or "I didn't feel like doing anything already and then I felt even more sluggish." Finally, women centered on their personal choices for self-managing their mental health medications to navigate the side effects: "I fill my prescription, but I know when I need to take it and when I can do without it so I make that decision on days I feel down."

Comparative Perceptions among Women Consumers and Home Visiting Staff

Subsequent individual interviews with women clients ($n = 8$) and agency staff ($n = 12$) revealed similarities and differences in the way each perceived depression and how they felt treatment should be approached. Women clients and staff members voiced awareness that trust and honesty went hand in hand when discussing depression; each valued genuine interest in a woman's

emotional well-being via open conversation over simply trying to complete an assessment by asking a series of questions in a detached way. Both groups were aware of tangible barriers as well as stigma regarding mental health treatment, especially public sector mental health services. Consensus was not reached by either group in rank order preference regarding the most desirable service delivery format, but women were most assertive about the reality that child care and transportation needed to be addressed if services were going to be accessed consistently. Women clients and agency staff members emphasized attentiveness to different levels of severity of depressive symptoms when structuring services. For example, one woman client said: "We each need different things . . . a support group might help a lot of women but someone who's seriously depressed probably needs more than that." Similarly, one staff member said, "Just one kind of service isn't enough. Some women just need a group and some only want to meet in their own homes. When they are more depressed, we need to offer more services to them."

Conversely, there was a marked difference between groups in general comfort talking directly about depression. Women wanted a clear discussion of depression so it could be acknowledged as real and linked with their lives and experiences; they were fine with the term *depression* although clearly differentiated experiencing situational depression with being labeled as "depressed." Agency staff members were generally uncomfortable with the subject of depression, often citing presumed client discomfort as the main reason ("it's an invasion of their privacy," "clients have a hard time answering questions about depression," "can we find a different word?"). Staff preferred more general words (*blues* or *feeling low* or *stress*) to the term *depression*. Staff cited multiple pros and cons to each service delivery format discussed but generally felt women were more comfortable in their own homes than in a group with others. To women, however, the importance of connection with peers and normalizing of experiences was prominent in their discussion of service preferences with more positive discussion overall of group-based interventions as an augment to home visiting.

DISCUSSION

The study data offers insight into the perceptions of low-income women as well as home visiting workers regarding loss and depression in their own lives and communities. Themes related to being outwardly strong, confronting social stigma including "bad mom" fears, as well as acknowledging tangible access barriers compliment previous research in other communities (Abrams, Dornig, & Curran, 2009; Nicolaidis et al., 2010; Price, 2010). An intriguing finding was the level of personal attachment that consumers expressed regarding trusted professional providers; further exploration of the overlap between professional roles and personal investment is important to assist professionals in maintaining appropriate worker–client boundaries while exhibiting building authentic trust with clients with whom they work. This finding is particularly important because home visiting professionals enter the personal abode of clients in a way that other health and mental health professionals generally do not. This may lead to a heightened importance of trust along with a potential blurring of perceived relationships.

The Language of Loss and Depression

For women in this study, there was a strong comfort in ownership of "depression" as situated in the experiences of their lives which overlapped with concerns of poverty, job loss, discrimination, and grief. This "depression of daily life" was familiar and understood to low-income women in this study, but women did not wish for it to define their individual life experiences or ability to parent. In contrast, depression of daily life was differentiated from "being depressed" that

was perceived as a serious concern requiring intervention, and one which potentially labeled and defined the individual. Being depressed was considered a state of sickness, and the person who was depressed was presumed to take on a sick role. The emphasis placed in focus group dialogues on differentiating between what one feels and what one projects to others reinforces the social sanction of strength in the face of challenges of daily life, and further speaks to the potential stigmatization of "being depressed" as a form of personal weakness if internalized or even embraced as a label for one's experiences.

Loss and grief are real and poignant experiences in the lives of women in this study. In spite of the known high prevalence of fetal and infant mortality in low-income communities, reproductive losses were viewed as isolating, personally challenging and often non-disclosed. These findings echo qualitative studies with low-income families experiencing perinatal loss (i.e., Kavanaugh & Hershberger, 2005). Notably, themes of loss were also very real in the lives of many staff members as well. Although not within the parameters of this study, the role of loss as a common phenomenon of human experience may account for some of the empathy and perceived "connection" described between home visiting professionals and their clients which may be a subject for future inquiry.

One of the interesting juxtapositions observed in this study is that there are presumptions by women clients and professionals regarding each other's meaning and use of the term *depression*. Women clients were comfortable with self-application of the term, but there was an awareness of mental health stigma that became apparent when given a "label" or diagnosis that conveyed a different meaning. One commonality expressed within both groups was that nature of intervention should depend on severity of depressive symptoms and the degree to which symptoms affect daily life. Both groups also voiced that assessment via questionnaires and screening instruments was highly appropriate once trust was established; consumers wanted to be clear, though, that a score on an instrument would not be used by staff to convey a "label" that might be associated with personal weakness. There was also common ground around the realization that there were not enough providers or services in the community to meet the needs of all women in a formal way; this was particularly true in one of the home visiting program sites over the other.

Designing Responsive Services

One notable difference between groups involves what happens once it is known that a woman is experiencing depression in her life. Home visiting professionals were comfortable conducting screening but then wanted to find available and responsive outside mental health resources to which their clients could be immediately referred for intervention. Understandably, frustration with a lack of adequate community resources was most evident among home visiting professionals. Conversely, consumers preferred talking about depression with their already trusted home visiting agency staff, rather than "new" outside mental health professionals. The conundrum within these perspectives may stem from the same question of how *depression* is defined and situated. For consumers, many daily experiences of depression were situated within circumstances and life stressors associated with poverty and new parenting; home visiting professionals were already aware and understanding of these facets of clients' lives. This desire for support amid personal sadness and stressful life situations reinforces Horwitz and Wakefield's (2007) argument for more professional attentiveness to the role of personal sadness as its own psychosocial challenge worthy of intervention, rather than blanketing situational depression under a clinical diagnosis of major depression in order to more readily facilitate diagnosis, treatment and reimbursement. Given the nonavailability of specialized mental health services in many communities, the role of the home visiting program personnel in responding to situational depression triggered by stressful and sad events of daily life may be increasingly important in program design and evaluation.

Additionally, the fear of outside professionals judging a woman as a "Bad Mom" was particularly strong, and most women had a real story of a friend or family member to corroborate this fear.

This implies that stigma continues to be perpetuated in low-income communities whether through individual experiences or collective exposure to gaps in the service delivery system. Women clients did voice an awareness of the need for mental health services when they reached self-defined and specifically described "tipping points" in their daily lives and were open to trusted staff members helping them identify and secure services at those particular points in time. Frustrations emerged when women were ready to seek help and engage in services and those services were not accessible or available to them.

Implications for Practice and Research

This study continues to expand the knowledge base regarding the subjective experiences of loss and depression as encountered by low-income women, and to consider the practice and research implications for maternal and child health home visiting programs who serve this population. Trust was essential to honest reporting of symptoms and willingness to engage in services. To client participants, a home visiting worker was someone with whom they could discuss their emotions and experiences and who believed in their capacity to positively parent. The MCH infrastructure emerged as a vital mechanism to empower capacity for positive parenting while simultaneously discussing, screening, and building interventions to address perinatal depression. These findings underscore the importance of developing promising practices and conducting rigorous research that can identify evidence-based models of home visiting which integrate mental health, health, and positive parenting simultaneously into maternal and child health home visiting programs. A tiered service delivery intervention based on these findings is now subsequently under development.

From a policy perspective, targeted screening may be only one element to detecting depression in low-income mothers. Screening that differentiates situational sadness from chronic depressive symptoms and is accompanied by psychoeducational messages about available treatment options by level of severity may further help to dispel mental health stigma. Depression screening, which can be universally conducted by home visiting programs, should also not be confused with a full mental health assessment. Screening can be described as a way to identify the symptoms that may interfere with a woman's well-being on a daily basis, as well as suggesting the level of risk for what professionals may identify as a clinical mood disorder such as depression. Policies that facilitate reimbursement and communication between public health home visiting and publicly supported mental health centers for women with elevated symptomatology upon screening will result in a less fragmented infrastructure that responds appropriately when risk for clinical depression, substance abuse and/or other mental health challenges are identified in the MCH sector.

CONCLUSION

In this study, depression is reinforced as a significant concern among low-income women and the home visiting professionals engaged in working with them. Women are willing to reach out to trusted providers but fearful of the stigma that may emerge if a concern for "labeling" outweighs a belief in their ability to work through depressive symptoms and engage in healthy parenting. Focus groups and individual interviews highlight the role of grief, loss, and other stressful events of daily life as contributing factors to a perceived normalcy of situational depression for many low-income women. Concurrently, women and home visiting professionals discussed the importance of trust and the development of responsive, tiered interventions that offer psychosocial support options, behavioral treatment, and more adaptive linkages to the public mental health sector when more severe symptoms are present.

Maternal and child health programs may be a vital mental health resource whether depressive symptoms surface amid daily stressful life events or with the severity associated with diagnostic

depressive disorders. Public health and social work professionals have an opportunity to collaborate and create system linkages between MCH and public mental health sectors that allow for continuity of care from wellness and prevention through specialized treatment. In addition, the findings augment the importance of translational research which can rigorously test the efficacy of tiered psychosocial interventions that can be delivered in home visiting, primary care, and/or community settings. Finally, social work and public health professionals must seize opportunities through federal policy shifts such as the Affordable Care Act and mental health parity coverage to address perinatal depression as a fundamental aspect of women's reproductive health from preconception through pregnancy, postpartum, and interconceptional care. By acknowledging daily experience and diagnostic concerns related to depression, we may continue to expand the public health infrastructure to holistically address the health of women and children across the United States.

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