See article by Amani et al

Peer-Delivered Psychotherapy for Postpartum Depression: Has Its Time Come?

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Amani and colleagues[1] report on a trial of peer-delivered cognitive-behavioral therapy (CBT) for postpartum depression (PPD). The investigators recruited a cadre of women who had previously experienced postpartum depression, and who were now well, to deliver the CBT intervention in a group format. These "peers" were trained and supervised by the study authors. The intervention was delivered in 9 sessions, each of which was 2 hours in length. The first hour was devoted to CBT core skills of cognitive restructuring, behavioral activation, relaxation, and goal setting. The second hour was unstructured and devoted to discussion of topics related to PPD such as social support and sleep. Postpartum depressed women in the control group waited 9 weeks and then were offered the intervention. Women in the trial were permitted to use antidepressant medication and outside psychotherapy.

The investigators reported a significant treatment effect for depression and anxiety outcomes, which were stable through a 6-month follow-up. There were no effects for social support or the women's relationships with their offspring. A post-therapy assessment of women in the CBT group showed high levels of satisfaction with the peer interventionists. In sum, the findings of this study build on an increasing literature providing evidence that "peers" can provide effective support and deliver structured CBT to postpartum depressed women. The close of Amani and colleagues' Discussion section presents their ambition for this approach to clinical care for postpartum depressed women: "Peer-delivered group CBT may be an effective and scalable means of addressing the limitations of existing health care systems to address PPD and has the potential to reach women who would otherwise not receive treatment, significantly improving outcomes for them, their families, and society."[1(p6)] It is likely that the Discussion sections of most articles that address peer-delivered interventions for perinatal depression and other conditions describe similar ambitions.

What sets this study apart from much of the research on peer support for postpartum depression is that the "peers" were trained to provide a validated psychological intervention in addition to facilitating peer support in a group setting. These interventionists were "peers" in the way typically defined by the peer support community; peers are persons who have experienced the same problems as the persons being supported.[2,3] More common understandings of "peers" include individuals similar in age, socioeconomic status, relationship status, parental status, cultural identity, race, ethnicity, and other characteristics. There is currently no evidence as to whether the nature of peerness matters with respect to likely success of the support or intervention provided to perinatal women. This question is ripe for further research. In this commentary, I limit the term *peer* to peer interventionists who have experienced perinatal depression and use the term *lay interventionist* to describe all other interventionists.

Research suggests that evidence-based interventions for common mental health problems can be effectively delivered by persons without formal mental health training.[4,5] For example, listening visits (LVs) are often delivered by health visitors (in the UK) or by nurses and home visitors (in the US) and have been found to be effective in the treatment of postpartum depression.[6–8] In fact, Cooper et al[6] in the UK found that health visitors had a significantly greater impact on depressive symptoms than fully trained mental health professionals when the intervention was delivered in the home. Similarly, nurses in a nationwide study in Canada[9] delivered telephone-based interpersonal psychotherapy for postpartum depression to good effect for depression and anxiety. Although health visitors and nurses are not really "peers" of postpartum depressed women, they are not identified as mental health professionals and often deliver interventions in the home or in other non-stigmatizing settings. They also are likely to already have an ongoing relationship with the postpartum depressed mother. Similarly, in low-resource settings such as Africa and South Asia, investigators have trained women who are respected in their communities and who have good interpersonal skills (but not necessarily having experienced postpartum depression) to deliver interpersonal or cognitive-behavioral interventions.[10–12] These lay interventionists are not "peers" in a strict sense because they have not necessarily experienced a perinatal depression, but they are "peers" in the sense that they come from the same communities and share many of the same characteristics as the women for whom they

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provide treatment. In contrast to what was reported by Amani et al,[1] the training for these interventionists is often extensive to ensure fidelity to the target intervention (eg, the Thinking Healthy Programme[12]). Extensive training in LVs is also usually provided to nurses, home visitors, and health visitors prior to working with women experiencing perinatal depression. How much training and supervision "peers" or lay interventionists should receive is still an open question but one that has some urgency as these practices become more widespread.

Peer support programs for perinatal depressed women exist across the US and many other nations. They vary in size from individual hospital–based programs[13] to larger programs at a state or provincial level[14] to large-scale national programs such as Postpartum Support International.[15] What these programs all have in common is a dedicated cadre of former postpartum depression sufferers who have recovered and are willing to provide support to women currently experiencing depression and anxiety during pregnancy or the postpartum period. This support is provided in person one-on-one or in group settings, but frequently by telephone or even Zoom. In almost all cases, these peer support providers are volunteers who may have received support themselves from a peer at a time when they were suffering from postpartum depression.

What are the essential qualities of peer support, and are they diminished when peer support workers deliver structured interventions? In a scoping review of qualitative studies addressing mechanisms underpinning peer support, Watson[3] identified 5 distinct mechanisms or qualities of peer support—use of lived experience, love labor, a liminal position, strengths based social and practical support, and the helper role. What is striking about qualities or mechanisms of peer support is that several of them are quite distinct from what we might consider as qualities of mental health providers. For example, the peer support worker shares her own experience with perinatal mental illness with the person receiving support. This lived experience gives the peer support worker special credibility in the support context. Generally, mental health trainees are discouraged from sharing their own personal struggles that might be similar to those of their client. The nature of the relationships of the mental health provider and that of the peer support worker and the perinatal woman whom she is supporting are quite different. In principle, the power of the peer support worker is in sharing her personal struggles, modeling recovery, and offering hope for the future. These important features may be diminished or eliminated if the peer support worker is expected to deliver a structured evidence-based therapy. Love labor highlights the importance of emotional safety for both parties. The peer support worker can be as vulnerable as the peer she is supporting. A liminal position refers to the fact that peer support workers exist between two distinct identities—the user of mental health services and the mental health worker. These 3 qualities are especially relevant to the report by Amani et al[1] because the extent to which the peer support workers who delivered the CBT intervention made use of their lived experience, made themselves vulnerable, and understood their role vis-a-vis the peers to whom they delivered the intervention and the mental health professionals overseeing their work is not clear.

Peer support workers focus on strengths and offer social and practical support. In most peer support contexts, this may constitute a primary activity. However, peer support workers may find it is challenging to provide social and practical support at the same time that they deliver a structured intervention such as CBT for postpartum depression, a phenomenon that might be called "role switching" or "role conflict." This remains an open question. As for the helper role, it is likely that most former postpartum depression sufferers who volunteer as peers to provide social support or a traditional mental health intervention would identify the helper role as a fundamental motivation for their work with postpartum depressed women.

Family and friends have been the historical sources of peer support. The incorporation of peer support into the mental health system is believed to have started in the late 1980s.[2] Training peers to deliver a structured psychological intervention could be seen as either a logical endpoint in the growth of peer support in the mental health system or a distraction that undermines the fundamental character of peer support. Is this the best role or use of the talents of peer support workers? Their special expertise is in their lived experience of perinatal mental illness and their willingness to provide support to suffering women. If mental health systems have limited resources to provide care for postpartum depressed women, it may be unwise to limit potential peer therapists to women who have previously experienced a postpartum depression. Clearly, the lived experience is the key element in providing peer support, but it may not be critical to delivering a structured intervention like CBT.

Has the time come for "peer"-delivered evidence-based psychotherapy? The answer is "not yet." There are two important factors to consider before moving toward peer-delivered psychotherapy. The first is that women experiencing perinatal depression might prefer an interventionist who has experienced depression in the context of childbearing. For example, at one time, men dominated obstetrics and gynecology, but as more women entered the profession, it became clear that women preferred other women as their obstetrician-gynecologist. But do women really want minimally trained former sufferers delivering psychotherapy—is it ethical? Is it sustainable? A second factor to address when considering having peers deliver evidence-based treatments is the notion of task-shifting. It is the case that there is a significant shortage of trained mental health professionals. But should peers be the ones to fill the gap? There are real costs associated with training peers and providing ongoing supervision. It is likely that turnover among peers will be relatively high, resulting in renewed training and supervision costs. Also, even in highly structured psychotherapies, crises arise in both individual and group contexts. The mental health system must be prepared to manage these issues. Are peers to be paid, and

if so, will the cost of the care they provide be reimbursed by insurance providers? Some but not all of these problems can be mitigated by using lay interventionists (nurses, midwives) who are already in the health system. In sum, I believe that true peers should focus on providing support to other women experiencing perinatal depression. Their ability to connect with sufferers should be honored rather than asking them to provide evidence-based care for which they have almost no preparation.

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REFERENCES

1. Amani B, Merza D, Savoy C, et al. Peer-delivered cognitive-behavioral therapy for postpartum depression: a randomized controlled trial. *J Clin Psychiatry*. 2021;82(00):21m13928.
2. Stratford AC, Halpin M, Phillips K, et al. The growth of peer support: an international charter. *J Ment Health*. 2019;28(6):627–632.
3. Watson E. The mechanisms underpinning peer support: a literature review. *J Ment Health*. 2019;28(6):677–688.
4. Dimidjian S, Goodman SH, Sherwood NE, et al. A pragmatic randomized clinical trial of behavioral activation for depressed pregnant women. *J Consult Clin Psychol*. 2017;85(1):26–36.
5. Singla DR, Lawson A, Kohrt BA, et al. Implementation and effectiveness of nonspecialist-delivered interventions for perinatal mental health in high-income countries: a systematic review and meta-analysis. *JAMA Psychiatry*. 2021;78(5):498–509.
6. Cooper PJ, Murray L, Wilson A, et al. Controlled trial of the short- and long-term effect of psychological treatment of post-partum depression, I: impact on maternal mood. *Br J Psychiatry*. 2003;182(5):412–419.
7. Holden JM, Sagovsky R, Cox JL. Counselling in a general practice setting: controlled study of health visitor intervention in treatment of postnatal depression. *BMJ*. 1989;298(6668):223–226.
8. Segre LS, Brock RL, O'Hara MW. Depression treatment for impoverished mothers by point-of-care providers: a randomized controlled trial. *J Consult Clin Psychol*. 2015;83(2):314–324.
9. Dennis CL, Grigoriadis S, Zupancic J, et al. Telephone-based nurse-delivered interpersonal psychotherapy for postpartum depression: nationwide randomised controlled trial. *Br J Psychiatry*. 2020;216(4):189–196.
10. Bolton P, Bass J, Neugebauer R, et al. Group interpersonal psychotherapy for depression in rural Uganda: a randomized controlled trial. *JAMA*. 2003;289(23):3117–3124.
11. Fuhr DC, Weobong B, Lazarus A, et al. Delivering the Thinking Healthy Programme for perinatal depression through peers: an individually randomised controlled trial in India. *Lancet Psychiatry*. 2019;6(2):115–127.
12. Sikander S, Ahmad I, Atif N, et al. Delivering the Thinking Healthy Programme for perinatal depression through volunteer peers: a cluster randomised controlled trial in Pakistan. *Lancet Psychiatry*. 2019;6(2):128–139.
13. Prevatt BS, Lowder EM, Desmarais SL. Peer-support intervention for postpartum depression: participant satisfaction and program effectiveness. *Midwifery*. 2018;64:38–47.
14. Letourneau N, Secco L, Colpitts J, et al. Quasi-experimental evaluation of a telephone-based peer support intervention for maternal depression. *J Adv Nurs*. 2015;71(7):1587–1599.
15. Davis WN, Raines C, Indman P, et al. History and Purpose of Postpartum Support International. *J Obstet Gynecol Neonatal Nurs*. 2018;47(1):75–83.

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