

Psychosocial preventive interventions for depressive symptom reduction in low-SES women: Evidence and implications for public health

Review on which this evidence summary is based:

Van Der Waerden, J.E.B., Hoefnagels, C., & Hosman, C.M.H. (2011). **Psychosocial preventive interventions to reduce depressive symptoms in low-SES women at risk: A meta-analysis.** *Journal of Affective Disorders*, 128(1-2):10-23.

Review Focus

- P** Women of low socioeconomic status (SES) (e.g. welfare dependant, living below the poverty line, ≤12 years of formal education, or currently unemployed) without a diagnosis of major depressive disorder
- I** Psychological, social, or physical interventions, or policy actions
- C** Treatment as usual or information alone
- O** Reduced depressive symptoms

Review Quality Rating: 8 (strong) *Details on the methodological quality are available [here](#).*

Considerations for Public Health Practice

Conclusions from Health Evidence

This well done review is based on primary studies of moderate to high methodological quality.

Overall, interventions showed a small, but statistically significant decrease in depressive symptoms (Effect Size (ES) **0.31**, 95% CI 0.17-0.45, $p < 0.001$) with:

- Individual in-home, or group-delivered **psycho-education** interventions focused on cognitive-behavioural and stress management strategies; and,
- **social support + education** - especially among mothers of young children/infants or pregnant women.

No effect on depressive symptoms with:

- Perinatal or postpartum **interpersonal therapy** interventions.

Effects were *not* moderated by age, marital status, intervention setting or intervention duration (4-52 weeks). Benefit beyond one year is not known at this time.

General Implications

Public health *should* support:

- Individual in-home, or group-delivered psycho-education interventions focused on cognitive-behavioural strategies and stress management skills; and,
- delivery of social support (home-, group-, or telephone-based) *with* educational materials, particularly for mothers of young children/infants or pregnant women

Based on this review, public health *should not* support:

- Group-delivered interpersonal therapy among pregnant women or those in the postpartum period

Public health needs to consider evaluating the longer term impact of these interventions on this particular population.

Evidence and Implications

What's the evidence?

1. Psycho-education (7 studies)

- Psycho-education interventions (cognitive-behavioural methods, stress management skills) with parent skills training, if applicable, delivered in group or in-home settings by professionals or peers, showed a small effect on depressive symptoms compared to no intervention or educational materials alone (ES **0.38**, 95% CI 0.22-0.54, $p < 0.001$).

2. Interpersonal Therapy (4 studies)

- No impact on depressive symptoms with group-delivered interpersonal therapy focused on social network building,

Implications for practice and policy

1. Psycho-education

- Public health decision makers should support the use of group or in-home psycho-educative interventions with parent skills training (if applicable), by either professionals or peers, as a means to reduce depressive symptoms among low SES women.

2. Interpersonal Therapy

- Public health decision makers should not support group-delivered interpersonal therapy to reduce

transition to motherhood, and postpartum depression.	depressive symptoms among pregnant or postpartum women.
3. Social Support (3 studies) <ul style="list-style-type: none"> Social support - delivered in the home, via telephone, or in a group setting - <u>combined with</u> educational materials, showed a small effect on depressive symptoms (ES 0.23, 95% CI 0.05-0.4, $p < 0.05$) compared to education alone. 	3. Social Support <ul style="list-style-type: none"> Public health decision makers should encourage use of home-, group- or telephone-based social support along <i>with</i> educational materials among pregnant and postpartum women.
Legend: P – Population; I – Intervention; C – Comparison group; O – Outcomes; CI – Confidence Interval; ES – Effect Size; OR – Odds Ratio; RR – Relative Risk **For definitions see the healthevidence.org glossary http://www.healthevidence.org/glossary.aspx	

Why this issue is of interest to public health in Canada

Depression affects people of all ages, genders, and backgrounds. Compared to women with high SES, women with low SES have over double the risk of developing depressive symptoms.¹ Postpartum depression presents an additional risk for women, and 15% to 20% of Canadian women will experience postpartum depression.² A complex interaction of factors contributes to mental illness, including genetic, biological, personality and environmental factors.³ Stress is an important predictor of depressive symptoms³, and living in poverty contributes to chronic stress.¹ Additionally, women living in poverty experience more frequent and severe traumatic life events than average.¹ Finally, low SES women typically have limited access to social and economic support.¹ Depression has an impact at both the personal and societal levels often by impeding both the activities of daily living, and the maintenance of consistent employment.

- Belle, D., & Doucet, J. (2003) Poverty, inequality, and discrimination as sources of depression among U.S. women. *Psychology of Women Quarterly*, 27(2):101-113.
- Canadian Mental Health Association, Ontario. (2003). *Women and mental illness fact sheet*. Retrieved from http://www.ontario.cmha.ca/fact_sheets.asp?clD=3974
- Health Canada. (2002). *A report on mental illness in Canada*. Retrieved from <http://www.phac-aspc.gc.ca/publicat/miic-mmacc/index-eng.php>

Other quality reviews on this topic are available on www.healthevidence.org

Suggested citation

McRae, L., Graham, K., Tirilis, D., & Dobbins, M. (2011). Psychosocial preventive interventions for depressive symptom reduction in low-SES women: Evidence and implications for public health. Hamilton, ON: McMaster University. Retrieved from http://www.healthevidence.org/documents/byid/21150/VanDerWaerden2011_EvidenceSummary_EN.pdf

This evidence summary was written to condense the work of the authors of the review referenced on page one. The intent of this summary is to provide an overview of the findings and implications of the full review. For more information on individual studies included in the review, please see the review itself. The opinion and ideas contained in this document are those of the evidence summary author(s) and healthevidence.org. They do not necessarily reflect or represent the views of the author's employer or other contracting organizations. Links from this site to other sites are presented as a convenience to healthevidence.org internet users. Healthevidence.org does not endorse nor accept any responsibility for the content found at these sites. The production of this evidence summary was funded with support from the Public Health Agency of Canada. The views expressed herein do not necessarily represent the views of the Public Health Agency of Canada.