MESSAGES OF SUPPORT:

Pregnancy Related Depression Awareness Findings

Prepared for the Colorado Department of Public Health and Environment
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merritt + grace

marketing | pr | media | brand

Allison Hastey, Partner
allison@merrittandgrace.com | 720.278.9860
Frances Tourtelot, Partner
frances@merrittandgrace.com | 303.435.1139
with
Kendyl Salcito, Ph.D.
kendylsalcito@gmail.com | 303.514.1522

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EXECUTIVE SUMMARY

Pregnancy related depression (PRD)[1] is the most common complication of pregnancy, affecting more than 1 in 10 Colorado women of reproductive age (PRAMS, 2009-2011). The Colorado Department of Public Health & Environment (CDPHE) recognizes the challenges that exist in Colorado for women to be effectively screened and referred for depression. Those who *are* properly diagnosed rarely seek out care - across the US, the majority of women who are referred for treatment do not follow through (Henshaw et al, 2012; Smith et al 2008). CDPHE is planning a public awareness campaign to increase general awareness about PRD among women and their support systems, increase willingness to seek help, and ultimately increase the number of women seeking and receiving treatment.

METHODS

CDPHE contracted with Merritt+Grace and Dr. Kendyl Salcito to gather feedback and conduct Colorado-specific market research to inform CDPHE's future public awareness campaign targeting women and their support systems. CDPHE and Merritt+Grace mutually agreed upon varied methodologies to test PRD messaging, knowledge, and attitudes among Colorado women. The demographic targeted by a future messaging campaign is low socioeconomic status and affected by (but not necessarily diagnosed with) PRD. To reach these women, however, messaging casts a wider net. This wider net incorporates the people in their support networks (e.g. friends, families, therapists, and roommates) as well as the healthcare professionals that could provide the services they need. As such, stakeholder engagement was conducted in a range of methods with an array of audiences. These engagement methods are summarized in the table below.

Method	Participant group	Location	Sample Size (N=)
Focus Group Discussion	Affected Moms	Denver	10
Focus Group Discussion	Affected Moms	Larimer	7
Focus Group Discussion	Affected Moms	Tri-County	4
Semi-Structured Interviews	Affected Moms	Logan	2
Semi-Structured Interviews	Support People	Statewide	8
Key Informant Interviews	Professionals	Statewide	9
Key Informant Group Discussion	Professionals	Logan	10
Survey	Professionals	Statewide	206

[1] While health professionals may refer to perinatal mood and anxiety disorders (PMAD) in their discussions, this report uses Pregnancy Related Depression (PRD) for consistency with existing public health usage and the messages tested. However, the scope of discussions encompassed the range of mood and anxiety disorders that affect women throughout the perinatal period.

MESSAGES OF SUPPORT:

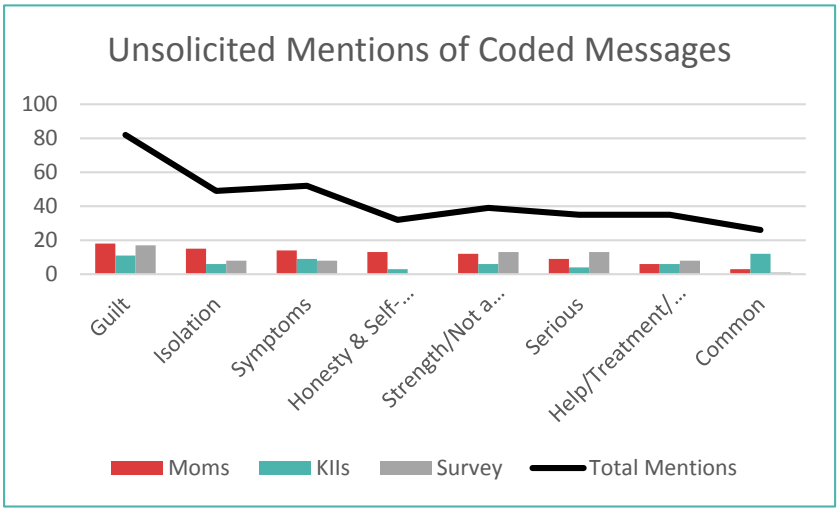
Pregnancy Related Depression Awareness Findings

Messages were tested verbatim on healthcare professionals, with survey respondents and KIIs providing feedback on message themes as fully elaborated. Message testing on affected moms and support people was indirect; messages were never directly presented, but rather organic discussion was coded according to message themes. Codes, as linked with both messages and sample responses, are available in Appendix C.

RESULTS

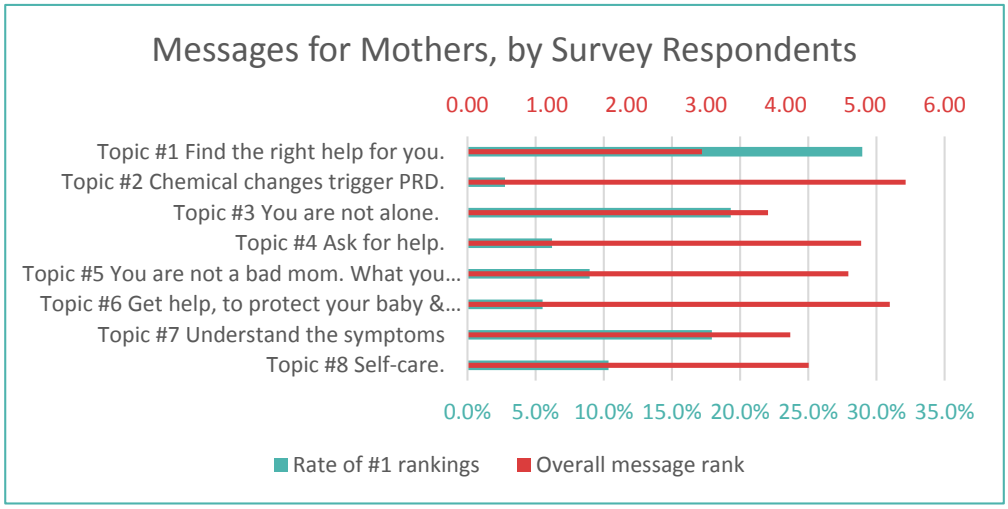
MESSAGES TARGETING AFFECTED MOMS

Messages targeting affected mothers generally received positive responses from affected mothers, key informants and survey respondents. The chart below shows the frequency with which respondents mentioned codes linked to PRD messages.



The messages that resonated most strongly with affected mothers addressed their sentiments of maternal guilt and isolation, while also listing symptoms. These messages also resonated strongly with key informants.

Survey respondents most frequently prioritized messages of help, treatment and self-care (29% of respondents ranked this first). These messages were not particularly important among focus group participants, however other highly-ranked messages from the survey aligned very closely with focus group responses. As the chart to the right shows (green bars), survey respondents gave high priority to messages tackling isolation (#3) and messages describing symptoms (#7). The survey did not include messages addressing maternal guilt or self-awareness, but these feelings were so



powerfully evoked in focus groups and key informant interviews that researchers created a new message to accommodate them. The top three messages with strongest resonance among target populations are:

#3 Topic Area - Moms: You are not alone.
Message: You are not alone. You are not to blame. You can get help.

#7 Topic Area - Moms: There are identifiable signs & symptoms.
Message: Pregnancy and life with your new baby is rewarding and can also bring big changes and challenges. For women with pregnancy related depression and anxiety, each day can be a struggle. Understanding the symptoms is the first step in taking back control of your happiness and your family's.

#9 (New) Topic Area - Moms: PRD is common, but you don't have to feel that way. (2)
Message: Pregnancy and new motherhood is supposed to be the happiest time of your life, right? Not for many women. Having a new baby is hard but support is available to make it easier for you.

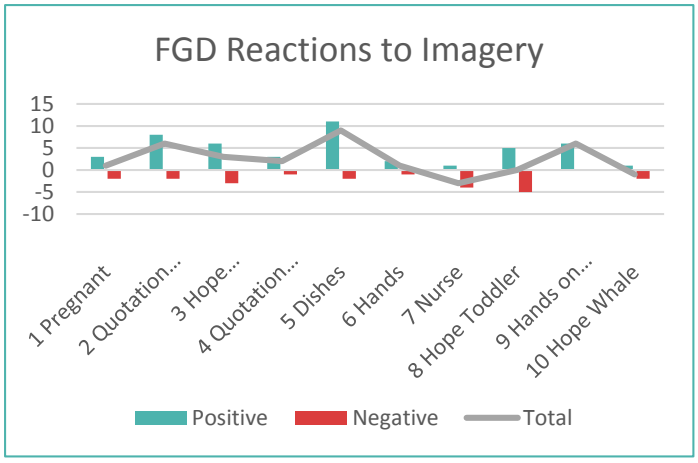
MESSAGES TARGETING SUPPORT PEOPLE

Support people (e.g. family, partner, friend) play a strong role in executing a PRD awareness campaign, as they may be the influencers persuading affected women to seek professional help. Our focus group participants referred researchers to their meaningful support people for interviews. Support people included spouses, friends, relatives and therapists. In general, support people expressed a belief that their primary role was to listen compassionately, rather than to promote key messages. As such, specific PRD symptom lists were less helpful, and instead empathetic messages focusing on directing affected women to seek professional help were found to be more relevant.

IMAGES

In addition to specific message testing, a combination of photographic, illustrative, and text-only images tested in focus groups provided further understanding of what resonates with target audiences. This testing drew out the personalized dimension of PRD, highlighting the wide variety of experiences women have with the illness. Accordingly, imagery was considerably more polarizing; women often felt strongly about images, but the same image often generated powerful averse and positive reactions. Only one image received all positive responses: image #9 - head-holding frustration. Women were also keenly perceptive to the social dimensions of the imagery presented, making note of wedding rings, model body types, and the presence of men.

The chart on the following page depicts a quantification of the qualitative inputs provided by focus group participants pertaining to images. It presents the number of positive (above the axis) and negative (below the axis) mentions in bar chart format, with a line calculating the



overall positive or negative reactions respondents had to each image. As the chart shows, Images #2, #5 and #9 scored the highest.

BARRIERS TO IMPLEMENTATION

Women expressed a strong distrust of messages that oversimplified their complex feelings, finding them neither helpful nor empathetic. While stigma may affect a woman's willingness to acknowledge the signs and symptoms of PRD, logistical barriers, including transportation, also prevented sampled women from seeking help. KIIs emphasized the importance of addressing gaps in communication with, and service provision to, affected women. Inconsistency in the availability of professional resources and in screening processes were identified across the state. A centralized PRD resource database could create better cohesion, collaboration and accessibility among service providers and facilitate more consistent referrals and reliable services to affected women. Finally, survey respondents emphasized the need to tackle misinformation fact that treatments are safe both during pregnancy and breastfeeding, and that a PRD diagnosis does not precipitate the involvement of Child Protective Services.

GENERALIZED RECOMMENDATIONS

As CDPHE moves forward with its planned outreach to affected women, Merritt+Grace has the following recommendations:

- PRD awareness messaging and creative should be targeted and relatable.
    - Focus on empathy and understanding
    - Attention to demographic context
- Strong expansion of message reach across multiple platforms will be important, with supportive frequency.
    - Build frequency by utilizing a variety of marketing tactics such as out of home, social media, and earned media.
- Messaging should be consistent at the national, state, and local levels.
- Provider resources and training should be expanded.
- Partners and stakeholders should be engaged in ongoing dialogue about message effectiveness and PRD awareness.

Research demonstrated a need for and interest in a statewide awareness campaign to educate the public on the commonness of PRD and resources available for treatment. Strategic use of consistent messages, creative and marketing tactics will help to standardize the conversation about PRD thus building awareness among the public and guiding women toward the help they need.

MESSAGES OF SUPPORT:

Pregnancy Related Depression Awareness Findings

BACKGROUND

Pregnancy related depression (PRD) is the most common complication of pregnancy, affecting 1 in 7 women nationwide, and 1 in 10 women of reproductive age in Colorado. “In 2011, 76.6 percent of Colorado mothers reported that a healthcare provider talked to them about what to do if they felt depressed during pregnancy or after delivery.” (PRAMS, 2011)

A PRD State Advisory Committee was formed in 2011 to steer Colorado-specific research, strategy, and tactics to address this significant issue. The Committee’s shared goal is to see 80% of women and their healthcare providers discuss PRD symptoms and treatment options, by the year 2020. Committee members include professionals from:

- Colorado Department of Public Health and Environment
- Local Public Health Agencies (LPHAs)
- Home Visiting Programs
- Academia
- Private healthcare providers, including mental health professionals, throughout the state

After conducting literature reviews, CDPHE determined a two phase approach was needed to implement an educational awareness effort:

- Phase one: Conduct market research on low-income women who were pregnant in the past 5 years, and their support systems
- Phase two: Launch statewide public awareness campaign

This report summarizes phase one of the project. CDPHE contracted with Merritt+Grace and Dr. Kendyl Salcito to provide research services including Colorado-specific market research, and message development, vetting, and testing among the target audiences. Research was conducted throughout Colorado with both rural and urban representation via the following:

- Focus Group Discussions - Conducted in-depth group discussions with women in Denver (N=10), Larimer (N=7), and Adams (N=4) counties.
- Semi-Structured Interviews (N=10) - Carried out by phone with two affected women in Logan County and support people in Denver, Larimer, and Logan counties.
- Key Informant Interviews (N=9) - Carried out by phone with health professionals in Larimer, Weld, Logan, El Paso, La Plata, Chaffee, Summit, Eagle, and Denver counties (Denver, Tri-County, Larimer, Northeast Colorado, Chaffee, Eagle, Summit, El Paso, Otero, Weld and San Juan Basin Health Departments).
    - KIs were identified by CDPHE or through interviews with health department personnel. Health department interviews were conducted with personnel from Denver, Fort Collins and Sterling.
- Survey (N=206)- Distributed statewide via CDPHE outreach tactics, garnering 206 individual responses from a variety of health professionals.

PROJECT PURPOSE

Mental health and PRD are critical components to an individual’s overall health. Research and trends to date have identified the health impact PRD has not only on mothers who recently gave birth, but also on pregnant women, fathers, adoptive parents, and others. Local, national, and international organizations have made strides in initiating conversations, education, and

services for those seeking mental and PRD-specific help. For this project specifically, CDPHE and the PRD State Advisory Committee recognized the need to identify Colorado-specific message testing results and trends to inform a future public awareness campaign.

CDPHE, Merritt+Grace and Dr. Salcito conducted a kick-off meeting to identify mutually-agreed upon methodologies and target audiences. The researchers incorporated input from CDPHE personnel and carried out a review of both academic and gray literature produced by local, national and international practitioners to further guide the approach. The project strategic plan was crafted to augment previous research and provide a Colorado-specific analysis of PRD perceptions, attitudes and behaviors. The methodologies captured essential input from diverse audiences including those CDPHE currently works with as well as new, untapped voices. Hence, sound message recommendations are available to inform phase two's statewide public awareness campaign.

METHODOLOGY

Research was conducted using a combination of quantitative and qualitative methods, incorporating techniques designed to achieve statewide representation of the defined target audiences:

- Low-income women currently pregnant or pregnant within the past five years who experienced the symptoms of PRD.
- Support systems for women affected by PRD symptoms.
- Healthcare personnel representing the geographic diversity within the state, and representing a variety of professional relationships with the affected women they serve.

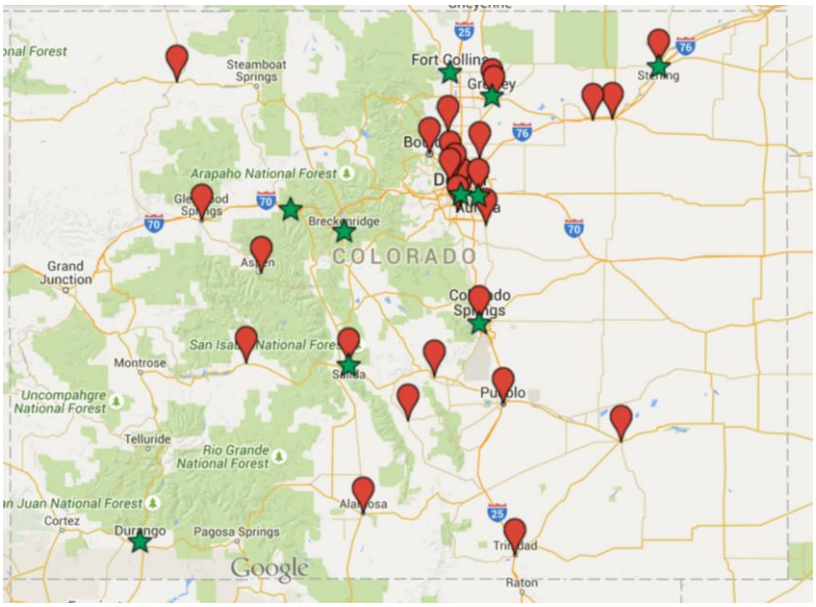
Research examined the *actual* availability of services as described by providers, as well as the *perceived* availability and accessibility of services. The experiences and perceptions of healthcare professionals (e.g. health department managers, health practitioners), affected mothers and the individuals that mothers identified as supportive were sought.

PROFESSIONALS

To gather feedback from a broad selection of practitioners and professionals, with a focus on capturing those voices not often heard from, the researchers applied a blended approach of key informant interviews and a survey. The key informant interviews provided a depth of information to the data from practitioners working with PRD-affected clients, while the survey allowed feedback from a wide healthcare professional audience across the state. The locations of respondents to the survey (red markers) and semi-structured interviewees (green stars) are marked on the map on the following page.

MESSAGES OF SUPPORT:

Pregnancy Related Depression Awareness Findings



RECRUITMENT FOR AND IMPLEMENTATION OF SURVEY

In order to reach the broadest audience of most appropriate healthcare professionals, CDPHE disseminated a questionnaire to its network across the state. The survey questionnaire was designed to generate a snapshot of the 'landscape' of maternal service providers involved in PRD support and then to define how, and how effectively, that support is provided. CDPHE reviewed, finalized and disseminated the questionnaire. CDPHE used online survey development tool Survey Monkey to provide respondents an easy, quick means to provide input. Survey Monkey has the added benefit of automatically analyzing respondent data on a question-by-question basis. CDPHE sent data outputs to Merritt+Grace weekly, which researchers cross-analyzed against the qualitative data from interviews and focus groups.

The primary recruitment effort was facilitated by CDPHE to their network. The survey was administered through 8 list serves, 4 newsletters, and 3 Facebook pages owned by CDPHE. Target audience included local public health agencies and health professionals across the state. PRD advisory committee members also distributed the survey through their professional networks. In addition, Merritt+Grace and Dr. Salcito distributed the survey to their health contacts and network including select LPHAs, family health clinics, and urban community organizations. The survey was disseminated over a four-week period from August 17 to September 11, 2015. Internal and external groups were contacted to help with dissemination of the survey including other branches within the health department serving women and families; LPHAs; and the Colorado Children's Healthcare Access Program (CCHAP).

Responses from 206 individuals, including physicians, nurses, educators, administrators, managers, therapists, social workers and mental health professionals, were received. CDPHE has managed all data pertaining to response rate and representativeness.

RECRUITMENT FOR AND IMPLEMENTATION OF KEY INFORMANT INTERVIEWS

To add context and maintain geographic and service diversity in the research, nine key informant interviews (KIIs) were employed. KIs were identified through interviews with health department officials (three health department interviews were conducted with six officials; other KIs were identified by CDPHE and contacted directly by researchers). The interviews provided depth and detail to complement the survey responses, and they provided an opportunity for the researchers to corroborate and/or weight survey responses. KIIs represented a variety of communities and LPHAs throughout the state, including Denver, Tri-County, Larimer, Northeast Colorado, Chaffee, Eagle, Summit, El Paso, Otero, Weld and San Juan Basin. Key informants were selected based on their geographical location (statewide) and the diversity of populations they serve, to include urban, rural, American Indian, African American, Latina and White-non Hispanic population groups. Researchers sought representation from communities hosting focus groups, acquiring input from both healthcare professionals and the public. Key informants were also selected for their diverse professional relationships with affected women. Interviews were conducted with six health department officials and nine health practitioners in the field including midwifery, psychology, nursing and home visiting. In addition, a group meeting was held with 10 psychologists, health workers and health managers in Sterling. Key informants were recruited primarily via identification and introduction from CDPHE, the PRD State Advisory Committee, and referrals from the interview participants themselves. Recruitment started the week of July 20, 2015 and continued until interviews had been completed in major health regions across the state (see map).

Interviews were semi-structured, focused on the relationship between PRD and the practitioners' daily activities, with the following aims:

- Identify systems for (and gaps in) screening, referral, treatment and follow-up processes for PRD care.
- Explore current approaches to increasing help-seeking behaviors.
- Examine demographic differences among affected women that may affect the acceptability of various messages.

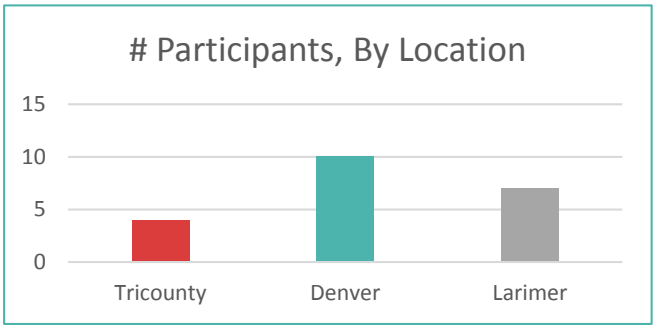
Messages were directly tested on these practitioners, and their responses were coded in qualitative data software MAXQDA. Messages were valued more highly when respondents offered message components unprompted than when messages were prompted by the interviewer. This enabled the research team to prioritize the messages that practitioners have already internalized as valuable.

AFFECTED MOMS AND SUPPORT PEOPLE

In order to test message effectiveness on the target audience of affected, low-income women, researchers engaged with the audience directly via participatory focus groups. Focus groups are a standard sociological research tool used for generating discourse among affected participants about their own personal experiences with a topic. They are particularly valid in discussion of sensitive topics, such as challenges in (and post) pregnancy, because they create a safe space for participants to build on the divulgences of others. Focus groups not only empower affected individuals to provide an understanding of attitudes, help seeking behaviors and message appeal; they also enable researchers to validate the beliefs of health practitioners. Message testing on mothers affected by pregnancy-related depression was carried out through

focus group discussions in Denver, Tri-County and Larimer County, as well as in one-on-one telephone interviews in Logan County.

RECRUITMENT FOR AND IMPLEMENTATION OF FOCUS GROUP DISCUSSIONS WITH AFFECTED MOMS



The researchers and CDPHE identified target markets to conduct focus groups with affected women. Criteria for market selection took into consideration LPHAs who have identified PRD as a priority health issue, population of participant target audience, and geographical representation. To ensure robust and diverse feedback, focus group participation was no less than four participants, and no greater than 12. This methodology is based on standard focus group techniques recognized to deliver both qualitative and quantitative data.

Recruitment tactics optimized the existing network of organizations and professionals directly serving the target audience. Examples of recruitment networks included:

- Health: LPHAs, clinics, private practices
- Service: Agencies offering family services
- Education: Daycare and pre-schools
- Community: Churches, libraries, neighborhood and online meetup groups
- Networks: Personal contacts, affected moms, peers

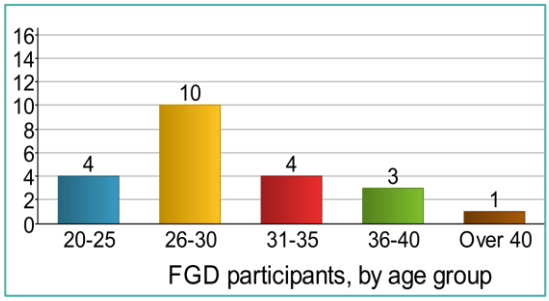
Merritt+Grace created and distributed recruitment materials for organizations to promote the focus groups to the target populations. Once content was finalized, materials were posted on a public Google Drive that could be accessed by all. Not only did this strategy keep promotion costs down, it allowed for organizations and individuals to easily and seamlessly promote while maintaining brand and message consistency. Materials provided included color flyers, social media content (image and copy), newsletter content, and e-blast content.

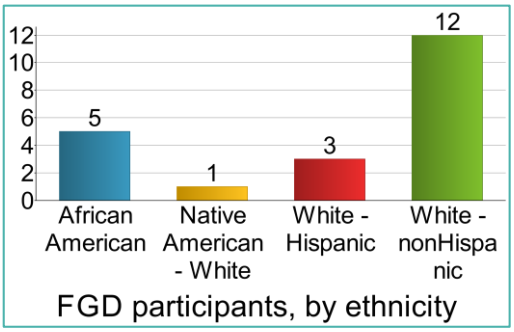
Interested women were encouraged to call to express interest. The researchers utilized Google Voice as a no-cost solution for managing telephone calls and text messages. Google Voice allowed researchers to publish a phone number in recruitment materials that was not directly tied to CDPHE or an existing business line. This provided a level of autonomy for this project and eliminated the resources required to secure, activate, monitor and deactivate an existing (traditional) phone number. Google Voice functionality also allowed researchers to pick-up calls from any phone, view text transcripts of voicemail messages from multiple devices, and track the incoming call volume and status of returned calls.

Women were screened for participation by telephone. The screen determined:

- Current county of residence
- Currently or recently (<5 years) pregnant

- Socioeconomic status, ascertained through self-reported WIC participation, enrollment in Medicaid or subsidized insurance, or household income below 200% of the state poverty line.
  - Where women did not meet any of these financial screens, a final screen inquired whether financial conditions were different during their pregnancy or in the 12 months after giving birth which created financial hardship.
- Presence of PRD symptoms as determined by oral responses to the 10 questions of the Edinburgh Postpartum Depression Screen (EPDS).
  - Women whose EPDS score was over 10 were invited to participate. All were provided contact information for PRD resources in their locality.
  - The EPDS was repurposed to apply to "the twelve months after most recent pregnancy." EPDS scores accrued during screening are not appropriate for diagnostic purposes, as the EPDS is to be completed in writing, in private, as pertinent to "the past seven days" as opposed to "in the 12 months after your most recent pregnancy". However, they were adequate for screening purposes, as demonstrated by the dynamics of each focus group discussion.
- Participants also self-reported ethnicity, which was used to ensure that samples represented the state's minority populations which are (statistically) at greatest risk for PRD. No participants were turned away for being ethnically unrepresentative of a discussion group.





A total of 23 participants attended three focus group discussions, held in Denver, Aurora and Ft. Collins. The average age of participants was 28.8 with the strongest representation in the 26-30 age group. Participants included White, Hispanic, Native American and African American respondents. Three potential participants were turned away for failing to meet the financial screen. Three potential participants were turned away for failing to meet the PRD screen. Three potential participants were invited but did not attend discussions (one was lost to follow up, two reported family illnesses). One final potential participant was invited to participate in the Sterling or Ft. Collins discussions while living in Weld County, and she opted not to attend.

Discussions were recorded with the permission of all participants. Consent for participation was obtained orally and in writing. Participants received dinner, childcare for the duration of the discussion and $30 Visa gift cards as an honorarium for their participation. Two discussions were held in private rooms at public libraries, located centrally for ease of access. A third discussion was held in a private room at a nonprofit health center.

Each focus group was opened with a rapport-building exercise, to introduce participants to each other and the facilitator. Participants were asked to introduce the woman next to her, sharing:

one thing that woman did that day; what was the hardest thing about pregnancy or the post-pregnancy period; and who provided her the best support during that time. Opening the discussion with private conversations about hardship prepared participants for a more open group discussion of those topics.

Level of familiarity with PRD was tested using an anecdote, where an invented character ("Angela Adams") experienced the signs and symptoms of PRD and respondents were asked to describe how her story made them feel. Respondents were also asked whether Angela had an illness, what caused her symptoms and how she could be treated. Researchers coded both correct and mistaken understandings of PRD, to evaluate both the misinformation and the quality information respondents had received about PRD.

Messaging was tested using probing questions, both about "Angela Adams" and about personal experiences women shared. Particular focus was on the feelings that characterized their mood and anxiety disorders and the experiences that prompted them to seek help. These self-generated comments were coded thematically to pair with messages being tested. Where self-generated comments did not fit into preexisting messages, new codes were developed to generate new messages. A table coding for each message is provided in Appendix C.

Imagery testing incorporated a combination of photographic (5), illustrative (1), and text-only images (2). Images can be seen in Appendix B. Images were gathered through online searches (e.g. mom + anxiety + picture) of common visual themes and words used for online blogs and programs about PRD. The tested materials were full color, laminated and numbered. They were distributed to the participants, and each woman was asked to share her feelings on the material she was given, as well as provide feedback on the materials distributed to others. This methodology provided perspectives to identify effective messages, without limiting the discourse to specific copy points only.

To shift from challenging and emotional topics toward a gentler closing discussion, participants were asked to share suggestions on the most effective communication tactics to ensure the messages reached the identified target audience. The open-ended structure of the question allowed participants to suggest tactics which most resonate with them, versus selecting tactics from a provided list.

Discussion closed, as it opened, with a brief discussion of support systems. Participants were asked whether the research team could contact support people for further message testing. The participants were receptive and forthcoming, making semi-structured telephone interviews with support people possible.

RECRUITMENT FOR AND IMPLEMENTATION OF SEMI-STRUCTURED INTERVIEWS WITH AFFECTED MOMS

In Northeast Colorado, a small community where privacy would be difficult to achieve, group discussion was deemed not the best approach to participation. Instead, one-on-one interviews were conducted with two local women, who were prescreened for interviews by their own therapists. These interviews were 40-60 minutes in length and conducted by telephone.

All interview and focus group discussion transcripts were cleaned and input into qualitative data analysis software MAXQDA, where they were coded according to message theme.

RECRUITMENT FOR AND IMPLEMENTATION OF INTERVIEWS WITH SUPPORT PEOPLE

In addition to testing messages with affected women, the research also encompassed feedback from the women's support systems (N=8). The public health campaign is inclusive of this audience because support systems may recognize a woman suffering from PRD and/or anxiety when she doesn't recognize it herself. They can support her, and encourage her to seek professional help.

Recruitment of support people occurred at the end of focus group discussions and semi-structured interviews. Participants were asked to share contact information for the individual they identified as most supportive of them as they struggled with PRD. The voluntary nature of this activity was emphasized repeatedly at each discussion. A subset of these individuals were contacted by telephone for semi-structured interviews to test "support person" messages.

Support people were selected for their diverse relationships with affected moms - including spouses, friends, relatives and therapists. They were also selected for their diverse ethnic backgrounds, including Hispanic/Latino, White and African American. Eight semi-structured interviews with support people were conducted by phone and lasted 20-45 minutes each.

DATA ANALYSIS

All interviews and focus group discussions were transcribed, cleaned and coded in MAXQDA. Focus group transcripts were broken up by participant, so that each participant's input was a separate document within a localized document group (e.g. "Jane Doe" comments comprise a single document within the Denver focus group folder). Disaggregating focus groups into their individual participants enabled researchers to identify situations where a single participant dominated discussions about a particular topic. In such cases, that participant's input counted as a single code, regardless of how many times she mentioned the topic. Codes were established in the following categories:

1. Imagery
2. Message theme
3. Communication outlets
4. Other themes unlinked to existing messages
5. Support person successes and failures

The aim of the first three categories was to collate data pertinent to message testing. The aim of the fourth category was to ensure that the messaging was inclusive of the direct experiences of participants, rather than limited to our pre-established themes. The aim of the fifth category was to use respondents' direct experiences to identify the ways that support people both assist and hinder help-seeking behavior. This was particularly important because in several support person interviews, respondents said they did not know what made them effective supporters, or that they "don't know what sticks" when they talk to the women that are struggling.

Coded segments were quantified for the number of times message themes were discussed per focus group, per participant and overall, as appropriate. They were also analyzed by word-

choice, to refine messages with appropriate terminology. A more qualitative process supplemented the quantitative process for parsing the reception of messages that generated polarizing discourse. For example, imagery featuring quotations garnered significant discussion, but on several occasions respondents failed to fully understand the message until hearing it out loud, a finding that contributed to the "communication outlets" code, despite being originally coded in the "imagery" category.

VERIFICATION AND VALIDATION

Every effort was made to clarify the meaning of each respondent's comments. On numerous occasions researchers discussed specific coded segments to determine the appropriateness of their coding. Professional judgment has limitations but is appropriate for early-stage, exploratory research. Coded segments were reviewed independently by two members of the team to validate the coding of each comment. Consensus among three independent researchers was required for all contested cases. This is an accepted means for establishing rigor in social science. Professional judgment was supplemented with validation by key informants when the meaning of focus group respondents' comments was unclear. For example, participants avoided using the term "crazy" when discussing fears and feelings, but survey respondents used the term frequently. To investigate the different terms used, follow-up interviews with carried out to clarify potential reasons for focus group participants to avoid the word. It was determined that there are differences between the language used to discuss PRD in public and the private experiences women have.

MESSAGE DEVELOPMENT PROCESS

The message and supporting point development process was grounded in PRD state and national data, trends, and public awareness efforts and best practices. Based on conversations with CDPHE staff, it was essential the message themes focus on:

- Support in a way women can believe and relate to
- Hopeful and empowering phrasing
- The mother, rather than the child
- A personal approach, rather than the mother as a data point
- Being inclusive of a variety of Colorado pregnancy-related / post-partum diagnoses

Merritt+Grace and Dr. Salcito reviewed the information provided by CDPHE, additional academic and gray literature, and online blogs to determine common PRD messaging and conversations from healthcare organizations and public-driven support groups. The following message areas were identified from the planning and discovery phase as key elements of PRD education and used as the foundation for message and supporting point development:

Currently and Recently (<5 years) Pregnant Women:

- There is help.
- What is PRD?
- You are not alone.
- Treatment exists (including treatment options).
- You are strong.

- PRD is serious.
- There are identifiable signs & symptoms.
- PRD is common, but you don't have to feel this way.

Support System:

- This is common but your loved one doesn't have to feel that way.
- What you can do.
- Treatment exists (including treatment options).
- There are identifiable signs & symptoms.
- What is PRD?
- PRD is serious.

These messaging areas address specific health and behavioral notions that are most promising in educating pregnant women, mothers and their support system on pregnancy related depression and anxiety. The resulting test messages and supporting points for both audiences is outlined in Appendix A. Test messages and supporting points were approved by both CDPHE staff and the PRD State Advisory Committee prior to execution across research methodologies.

RESULTS AND RECOMMENDATIONS

Findings pertaining to messages were drawn from an array of strategies summarized, alongside sample size, below.

Method	Participant group	Location	Sample Size (N=)
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Focus Group Discussion	Affected Moms	Tri-County	4
Semi-Structured Interviews	Affected Moms	Logan	2
Semi-Structured Interviews	Support People	Statewide	8
Key Informant Interviews	Professionals	Statewide	9
Key Informant Group Discussion	Professionals	Logan	10
Survey	Professionals	Statewide	206

- Focus Group Discussions - Conducted in-depth group discussions with women in Denver (N=10), Larimer (N=7), and Adams (N=4) counties.
- Semi-Structured Interviews (N=10) - Carried out by phone with two affected women in Logan County and support people in Denver, Larimer, and Logan counties.

- Key Informant Interviews (N=9) - Carried out by phone with healthcare professionals in Larimer, Weld, Logan, El Paso, La Plata, Chaffee, Summit, Eagle, and Denver counties (Denver, Tri-County, Larimer, Northeast Colorado, Chaffee, Eagle, Summit, El Paso, Otero, Weld and San Juan Basin Health Departments).
- Survey (N=206)- Distributed statewide via CDPHE outreach tactics, garnering 206 individual responses from a variety of health professionals.

The targeted sampling approach for key informant interviews (described in the Methodology section) focused on practitioners who work with currently and recently pregnant low-income women, is designed to represent best-case knowledge of PRD in communities across the state. These individuals are disproportionately aware of and engaged with issues of PRD. As such, where they describe gaps in screening, referral and treatment systems, it is more likely to be an actual gap than a result of unfamiliarity with existing processes and/or resources. This sampling approach drew from the most informed and engaged practitioners so that messaging could build upon the knowledge of those directly and most frequently interacting with women experiencing PRD in Colorado.

In contrast, the sampling approach for focus group discussions deliberately avoided diagnostic terminology. Women were asked whether they had emotional challenges, rather than whether they experienced PRD, PPD or PMAD. As such, they included both women who have sought and received treatment as well as women who have never been informed that they could be struggling with a treatable mental illness. This approach made our sample more inclusive of women at various stages in their struggle with PRD. It was ideal for early-stage research because of its high inclusivity. Future research would benefit from more targeted sampling, however (e.g. including focus groups comprising women who have never sought treatment separate from focus groups comprising women who have received treatment).

BASELINE KNOWLEDGE OF PRD

Although KIIs were selected for their involvement in PRD initiatives, only one (based in Denver) professed to have direct, formal training to manage PRD. A recent seminar organized by Postpartum Support International (PSI) was attended by two interviewees, but it did not culminate with examinations for pass/fail determinations. As such, practitioners did not view PSI's workshop as formal training. KIIs describe themselves as "self-taught." "I really didn't get any training" was a common refrain. Practitioners familiarized themselves with screening tools, particularly the Edinburgh Postnatal Depression Screen and the PHQ9, and they have independently developed resource lists for their own use. Over half of KII respondents (N=5) emphasized the need for a resource list to facilitate referral processes, noting that established PRD experts are either absent from their regions or simply unknown to them. The request for a resource list was unsolicited and unprompted. In Otero, the referral shortfall was particularly notable, where a KII who is a nurse said, "I tell women what their screen score is right when I do it, and I tell them I'll check up on them. I've sent three back to their doctor, and all went. One was already on antidepressants, the other two were put on. Unfortunately, the doctors don't send these girls to therapy." This problem is not universal; in Salida, the Early Childhood Council brought a psychiatrist in to explain to local physicians the importance of mental health screening from a medical standpoint. A demographic description of KIIs is provided in the table on the following page.

Profession	Location	# Years in Field	# Years in Maternal Mental Health
Nurse	Chaffee	3	2
RN	Summit	2	2
Mental Health Consultant	Denver	6	2
Mental Health Consultant	El Paso	20	11
Psychologist	Tri-County	6	3
Therapist	Eagle	12	1
Educator	Weld	13	0
Midwife	San Juan Basin	13	0
Nurse	Otero	4	1

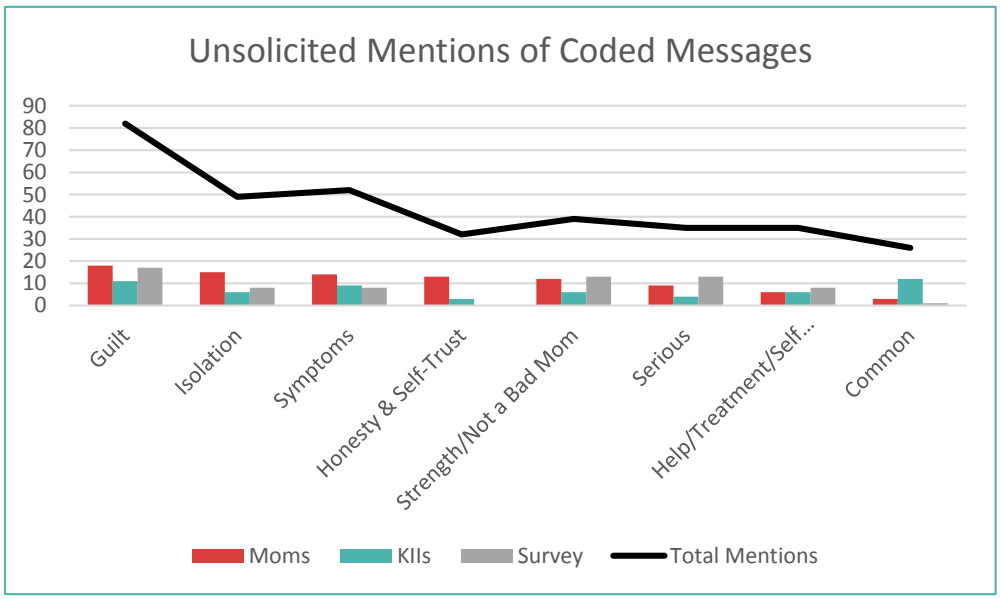
MESSAGES - MOMS

Receptiveness to messages was evaluated according to both the intensity and the extent of support for each message. Intensity refers to the ranking of a message by each respondent (messages were ranked 1 - 8, with 1 being the strongest rank), while extent refers to the number of respondents ranking the message highly. Overall, all messages were well received by both practitioners and affected women. Coded transcripts from interviews and focus groups identified strong links between the messages practitioners advocate and the messages that women find powerful. However, there was one area of interest exposed in focus groups that was absent from both pre-existing messages and survey respondents, pertaining to the ways that women manage the sense of isolation incumbent with PRD. This is addressed in detail below, under “Additional Messaging - Moms.”

Women’s reluctance to label the signs and symptoms they experience as PRD creates a degree of misalignment between their needs and their recognition of the services available to them. This may be addressed through messaging that targets symptoms without naming a diagnosis. Alternatively, one key informant put forth the perspective that naming the condition de-stigmatizes it. A cohesive, statewide approach to terminology might be beneficial and should be considered a topic for future research.

Women experiencing the isolation of PRD attributed it to a lack of women’s groups, unreliability of support people, tragic family histories, and other life complications including health or work issues, rather than to the illness itself. Furthermore, the isolation felt by women struggling with PRD made it difficult for them to accept that treatment might exist or work. One woman who has recently begun seeing a therapist was reluctant to acknowledge that PRD is an illness because

she doubted that treatment would work. “If it’s an illness, it’ll go away, but I don’t feel like it’ll ever go away.” Messaging, as such, should emphasize that overcoming PRD is a process.

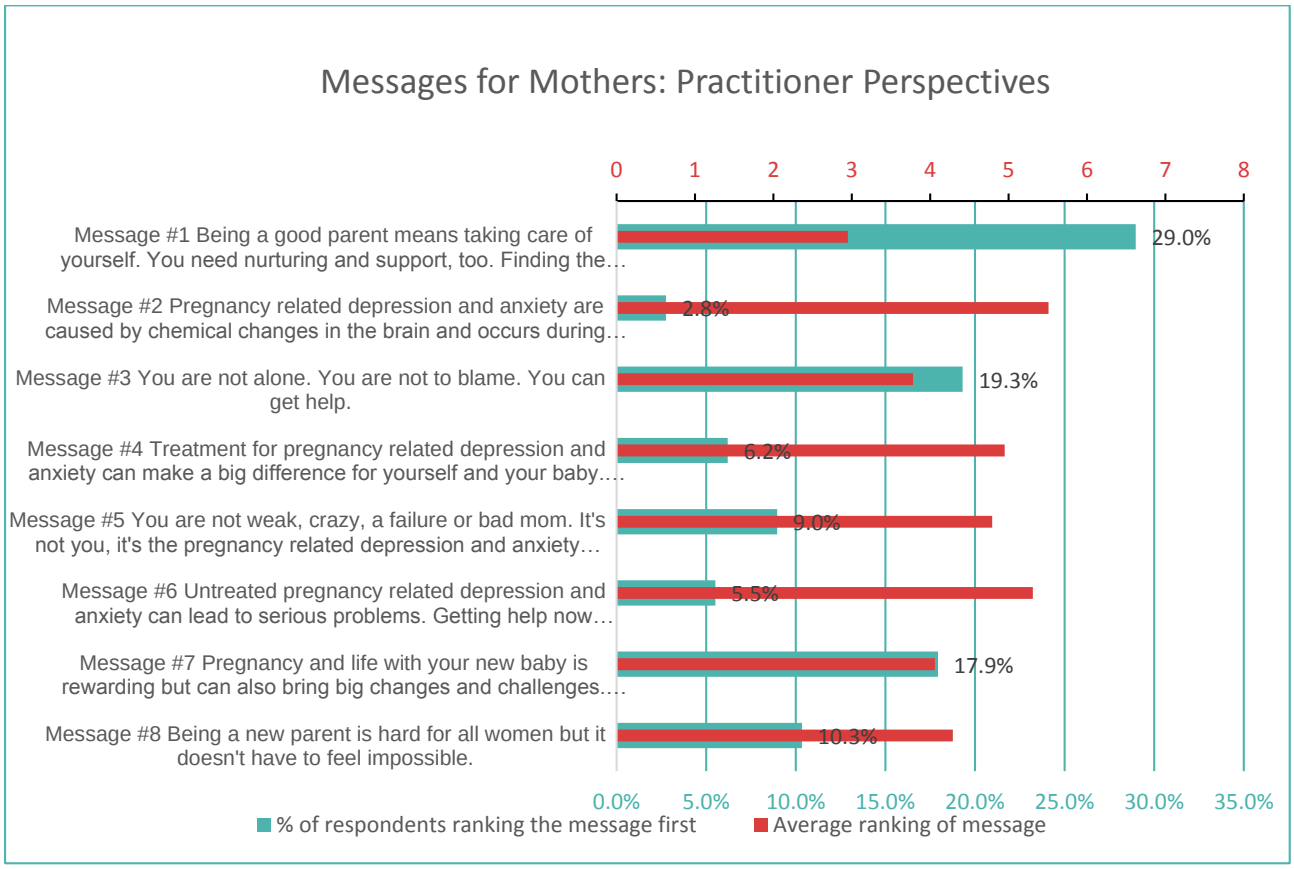


The chart to the left depicts the perspectives of moms, KIIs and survey respondents on messages, based on the frequency with which they evoked coded terms. It presents the number of unsolicited mentions of coded terms, overall (including repeat mentions by a single respondent) overlaying the number of respondents who evoked that code. As the data shows, messages addressing maternal guilt and isolation, and emphasizing the need to recognize symptoms were most frequently mentioned. The inclusion of a category labeled “Survey” refers to the extra comments provided as written-in responses by respondents. Actual survey results are presented in a separate chart.

These codes link directly to messages, as described in the table on the following page, which presents survey findings. The chart depicts both the percentage of respondents who ranked a topic 1 (on a scale of 1 to 8, with 1 being the highest score), as well as the overall rating for a topic (the average of all respondents’ ratings for a single topic).

MESSAGES OF SUPPORT:

Pregnancy Related Depression Awareness Findings



There is significant overlap in the messages and codes prioritized by survey respondents and by other respondents (KIIs and moms). Notably, messages addressing isolation (Message #3) and symptoms (Message #7) received a combined 37% of responses ranking them first. The survey did not include messages addressing guilt and self-trust, so an additional message has been added as noted below and included in Appendix A.

Message #1 - Moms: Being a good parent means taking care of yourself. You need nurturing and support, too. Finding the right help for you is important.
Messaging emphasizing the importance of self-care to good parenting ("Being a good parent means taking care of yourself…") had both high intensity and extent. Half of all survey respondents ranked it first or second (29% ranked it first) (N=42, out of 145 respondents who answered the question). These survey findings were partially reinforced by KIIs. Five of nine KIIs prioritized messages of self-care in their interactions with patients.

Both KIIs and survey respondents emphasized a corollary message that medications are available that are safe during both pregnancy and breastfeeding. This is a message that appears to be important for both mothers and their physicians. One focus group participant reported that her physician cut her off of all medications when she became pregnant, creating unnecessary complications in her mood and anxiety disorder treatment.

The word 'nurture' never surfaced in dialogue with affected moms or their support people. Self-care is described more as a "struggle," "fight" or "battle" that women face (these three terms arose eight separate times), rather than an experience they passively undergo with nurturing support. Language should cater to the sense of a protracted climb or challenge.

Message #2 - Moms: Pregnancy related depression and anxiety are caused by chemical changes in the brain and occurs during pregnancy through up to 12 months after giving birth.
The message that found overall greatest support among practitioners addressed the technical, chemical causes of depression - it is one of only two messages with an average score above 5. However, it received very few first-place rankings by survey respondents (2.8%, N=4). In essence, the message was well received most broadly, while not being *best* received.

In KIIs, practitioners did not mention chemical imbalances unprompted. Two mentioned hormones, without acknowledging that hormones balance out after the two-week period of 'Baby Blues'. After that time period, a chemical imbalance distinct from hormonal change may take place. Women seemed to appreciate having technical terminology to discuss their experiences.

Mothers, in contrast, readily volunteered the chemical, "cellular level" dimensions of PRD. At least one affected mother had learned from her therapist that PRD is a chemical imbalance, and women in all three focus groups and one-on-one interviews described hormonal imbalances as contributors to their feelings. These mixed findings may actually reinforce the importance of Message #2, as misinformation appears to be widespread.

Message #3 - Moms: You are not alone. You are not to blame. You can get help.
Although messages tackling isolation had an average score below 4 among survey respondents, 19.3% (N=28) of whom ranked it the most important message. Ten respondents reinforced this message in write-in responses, noting that the most worrying responses they've received from clients pertain to isolation. This isolation is attributed to staying home alone with the baby, lacking community support (particularly for immigrants or single-mothers), having family and friends that fail to understand what they're going through, and fearing talking about their inability to bond with their baby. KIIs elaborated on that sense of isolation among clients, including attributing it to being a working mom and feeling isolated from your workspace or having unreliable sources and unhelpful "support" networks. As one phrased it, "we are in a society that tells us that we need to do everything on our own. We used to lay in bed for a month and get waited on after giving birth, and it's not like that anymore." Compounding that, women may feel "a sense of burdening the family and support system, asking for even more care from whoever they're getting care from." KIIs described women feeling isolated when they've moved to rural areas after living in urban settings, as well as feeling isolated when they move from rural settings into cities. In both settings, help-seeking can be complicated by access to services: urban mothers may struggle to identify the *right* service providers, while rural mothers may be physically isolated from services that are only available in major towns far from their homes.

That mothers themselves are troubled by isolation was made clear in focus group discussions, not only because the issue arose 29 times, but also because women traded phone numbers

with each other after the discussions, expressing gratitude to know that, as one woman said it, "I'm not the only one." Focus group discussions revealed that isolation is yet more complex than practitioners had described. For one woman, the isolation was an "identity crisis." She was isolated from her friends, work and her own life in some ways: "I didn't know who I was as a mother until I was a mother. So then I had to ask, ok, who am I now? What am I supposed to do with my time? I associated with my work, my interests, but who am I now? Could I stand alone as an individual person anymore?"

Other women felt isolated by the sheer encompassing nature of motherhood. As one described it, "I feel a lot of solitude, being alone. You are so sleep deprived and so focused on care of your young one that you lose all contact with everyone. It's just what has to happen sometimes." The isolation may also be driven by fear, for some. Mothers struggling with PRD now recognize that their own mothers likely experienced the same condition. For one woman, the isolation of PRD has translated into a fear of losing the family she has built. Recognizing that she worked hard to overcome the isolation she felt as a child by building a loving family, she says, "Now that I'm grown up I'm scared of losing that bond. My mom is alone now, everybody left her."

One focus group participant gave a holistic perspective on both the isolation and the sadness, normalizing both: "Having my peers around me and hearing their stories, I am not alone, this is a very common thing and it's ok to feel the way I feel as long as I am not content in my misery. You have to be proactive to seek help." She described experiencing a loneliness akin to "drowning" before seeking help, noting that she could not speak to friends about her feelings because anything but joy is "taboo" in motherhood. Several mothers described the social pressure to be a "perfect mom," which ranged from having the right diaper bag, to having the right sleep training regimen, to having the right feelings about how motherhood is "supposed to be."

The perspectives from the mom scared of losing her family bond and the mom working not to be "content in … misery" add nuance to the message that PRD is an illness -- that it has such clear genetic links is frightening for moms. That it is treatable requires strong reinforcement.

Message #4 - Moms: Treatment for pregnancy related depression and anxiety can make a big difference for yourself and your baby. Sadly, most women never get the support they need. Don't be afraid to ask for help.

Very few practitioners (6.2%, N=9) gave messages about treatment top priority, but its overall score (4.95) was the third highest. As noted above, messages about treatment must be reinforced with messages about how safe certain antidepressants are during pregnancy and breastfeeding. KIIs had mixed feelings about messages regarding treatment, owing largely to a major gap in available treatment. For women who are not Medicaid recipients, several practitioners said they were unaware whether affordable services were available. A public health nurse from Chaffee County noted, "We don't have anyone who focuses or specializes in PRD. Our ECC [Early Childhood Council] asked providers, 'do you have any additional training in this area,' and no one does at all. Everyone feels like they would probably work with these moms to try to figure it out, but it would be so nice to have someone who has expertise here." Practitioners and health managers struggle with the chicken-or-egg question of whether educating the public is helpful when referral practices aren't in place. This leads to a broader question about gaps in service provision, which are addressed in a later section of this report.

At present, women are not effectively receiving the message that treatment is available. One focus group participant was pulled off of all her medication when her physician learned she was pregnant. Many physicians are not aware of which medications are safe, and many mothers express worry that medications will damage their unborn child. Another focus group participant related the question of treatment to the fear of having her baby taken away: "I am going to do everything in my power not to have that call to CPS [Child Protective Services]. I already have clinical depression so the hormones are making it worse. I am worried about taking medication because I don't want my baby to come out all jacked up."

Message #5 - Moms: You are not weak, crazy, a failure or bad mom. It's not you, it's the pregnancy related depression and anxiety and it can be treated.
The focus group participant who linked fear of CPS with fear of her depression articulated a concern that both practitioners and mothers recognize. Messages emphasizing that the emotions incumbent with PRD do not make them a bad or unfit mom received an average score of 4.79 from surveyed practitioners. Fourteen survey respondents reinforced the message in write-in responses about the most worrying comments they hear from moms. These included worries that they are "not a good mother, not strong enough," that "they have caused this," that their kids will be taken away or that "they are mentally ill and someone will find out something is 'wrong' with them."

Although both KIIs and survey respondents emphasized the need for women to recognize "I'm not crazy," women did not use the term on themselves. They described their households as "crazy," or their judgmental friends asking why they would take "crazy pills," but there appeared to be a reluctance to use the term even to negate the fear. A follow-up interview with a Denver-based therapist who works predominantly with PRD sufferers who are also domestic violence victims revealed that the term "crazy" represents a deep fear. "'I think I'm going crazy,'" is a phrase she often hears in the very first phone call she receives from women seeking help. As such, she says, "For the moms I work with and their families, that term, to be able to say 'you are not crazy' will really benefit them and their family."

During focus groups, women focused on depression and anxiety as an adversary. One woman described anxiety as a "bully." Others described an ongoing "struggle," "like drowning," or "suffocating" or a "hard time." There is a reluctance to name the condition, even among women receiving treatment. One, who has recently completed the Healthy Expectations program at Children's Hospital said, "It takes time to get over it, I am not better but I am doing better and I will continue to get better," without naming what "it" is.

Though "crazy" was not a popular term among mothers during group discussions, the fear of being a bad mom was voiced frequently. In all three focus groups, women expressed fear of being judged a "bad mom" or "bad person." This judgment can be from society, family, themselves, or their own children.

Said one woman, "I grew up in the *Leave It to Beaver* household. My mom stayed at home and it always seemed like everything was just so. Now as a mom myself, my house is generally a giant disaster, and stuff is everywhere… I just always feel inadequate and a failure." Whether moms fear that they are failing to live up to their family's or society's standards, they need to know that PRD is not their fault, and that it should and can be treated. The woman from the

Leave It to Beaver household struggles with this. “It feels like it's my fault; it’s my problem so how isn't it my fault?”

Notably, the fear of being a bad mom drove at least one focus group participant to seek help with her long-standing mental health struggles. “I was at the lowest low before I got pregnant, so when I got pregnant I was like, ‘Oh, shit!’ because I was homeless, everybody disowned me, I was on drugs, it was a whole mess. When I got pregnant, I just clicked that I just had to get better, because I just threw my whole life into her.” Both Denver- Aurora- and Northeast Colorado-based key informants noted that PRD is a good entry point to address the bigger issues. A Denver-based mental health consultant hears often, from nurses at Nurse Family Partnership (NFP) and from her clients, that women “are really trying to do something different” now that the responsibility of motherhood is a reality to them. Everyone wants to be a good mom, and as one focus group participant phrased it, “I can’t be a good mom if I am wounded. I can’t be a good mom if I am hurting myself.”

Message #6 - Moms: Untreated pregnancy related depression and anxiety can lead to serious problems. Getting help now means you are looking out for you and your baby's future.

The quote included at the end of Message #5, while pertaining to messages to manage misplaced self-blame, is in some senses a paraphrase of Message #6, reinforced by the empowering notion that women want to do what’s best and are capable of recognizing that they can take action to protect themselves and their baby from the effects of PRD -- even if it frightens them. Only 5.5% of respondents (N=8) ranked this the top message, but its overall ranking was second highest among all messages, at 5.31. KIIs try to emphasize “what the effects will be on their relationship with the child and on their own well-being,” as a mental health consultant phrased it.

One key informant tells a personal story about a friend who killed her children in a moment of postpartum psychosis. No other practitioners interviewed or surveyed advocated this approach. As a rural public health nurse said, “I think there’s a balance. We don’t want to scare them, ‘Not only are you having a baby, but you could also become dangerous,’ so the focus is that it is serious but very treatable, and the quicker we diagnose you the easier and faster to make you feel better.” Most KIIs emphasize that violent postpartum psychosis is extremely rare.

In focus group discussions, this more moderated approach was validated, as several women dissociated themselves from an anecdote about a made up woman (Angela Adams) who thought about hurting herself because the stress and anxiety of motherhood was so great. One woman linked the stigma of psychosis with an unwillingness to seek help, “You are afraid to talk to your doctors, because you only hear about the extreme cases where the moms hurt their babies.”

That untreated PRD can lead to serious problems is a lesson that some moms learned as children, when their own mothers struggled with PRD. Women who look back and recognize that their own mothers “didn’t like the way I did anything” (or weren’t role models because they were too deeply depressed) feel an urgency to do better. One even recommended that CDPHE “Start an initiative for mothers to tell their daughters [about PRD].” They stressed that if their mothers had talked to them about PRD, they may have been better prepared to experience it

themselves. It is also important for these women that their kids know they love them, "I don't want them to go through situations like I went through," said one. A two-generational approach was suggested as a long-term tactic to inform women and reduce stigma. This approach has the added benefit of potentially reaching teen moms who are often uninformed of an array of challenges in motherhood.

Message #7 - Moms: Pregnancy and life with your new baby is rewarding but can also bring big changes and challenges. For women with pregnancy related depression and anxiety, each day is a struggle. Understanding the symptoms is the first step to making your day a little brighter.

Nearly eighteen percent of survey respondents (17.9%, N=26) prioritized messages describing symptoms as a first priority, making it the third most important message among practitioners (behind Message #1, "Being a good parent means taking care of yourself…" and Message #3, "You are not alone."), even though its average rank was comparatively low. The value of symptom lists derives from the fact that (1) public understanding of PRD is weak, so women often do not associate their feelings as 'symptoms' unless they seem them listed, and (2) PRD is stigmatized, and while women are willing to describe their feelings, they may not be willing to label them.

In focus group discussions and one-on-one interviews, women closely identified with the experiences of the imaginary PRD sufferer "Angela Adams," no one outright diagnosed her with PRD, and in the course of discussions, only five women ever uttered the word depression (two specifically to clarify that anxiety and depression are related). Symptoms most commonly emphasized by KIIs were those listed in the EPDS - sleeplessness, sadness, irrational fear, crying and unpredictable fits of anger, for example. Symptoms listed by affected moms included anxiety (five distinct mentions), crying (four distinct mentions), feeling overwhelmed (four mentions), stress (three mentions), lost sleep (three mentions), worry and inadequacy (two mentions each), lost patience and tiredness, sadness and detachment. Isolation also characterized nearly every respondent's experience (Message #3). These self-described symptoms should be emphasized in messaging.

Message #8 - Moms: Being a new parent is hard for all women but it doesn't have to feel impossible.

That motherhood is hard but should not feel impossible resonated moderately strongly with practitioners. Ten percent (10.3%, N=15) of survey respondents rated it the most important message, while its overall average rank was 4.29 - the fifth most generally popular message. For most KIIs, it folded in with messages normalizing the experience, rather than as a stand-alone message. A therapist in a mountain community emphasizes to clients, "Your body is growing a human being, how could you not be overwhelmed!?" She also empathizes, telling them about her two kids and her own experiences.

Focus groups did not prompt messages, and no participants volunteered the idea that motherhood should not feel impossible. Many, however, stressed that, with treatment, things get easier. When presented with an anecdote about a woman showing signs of PRD, one respondent emphasized the ways that motherhood felt impossible, "When it got hard it just kept getting harder. The people who were closest to me in my life disappeared, because nobody wants to be around a sad person." When asked how to help this person, she continued, "The

best thing you can say to someone is to point them in the direction of [professional] help, because I can't help you."

Women in all focus groups agreed that motherhood is hard, and some found solace in describing their toughness as they overcame the challenge. One participant described it as "the Superwoman Complex," referring to her need to become self-reliant and self-aware, seeking professional help when it was clear that her family and friends could not supply the help she needed. "My mom calls it the women's supermom complex, because I don't have time, I gotta get this done, I can't feel sorry for myself, I can't rely on nobody, I don't have time to even tell you my problems. If you want to come you can come, but I got things to do. I don't need anyone else to do it because if you do it wrong, then I might snap. I know what's wrong, I know what needs to get done, so it's just to me."

The nuance to this message is that, while the respondent stopped relying on her traditional support people, who were failing her, she started receiving professional help, which better positioned her to help and support herself. Capturing a balance between self-reliance and professional support is important; mothers want to know they are doing well by their children and not just muddling through. As one woman explained the fear of shortchanging her children, "I guess I am the only mom my kids are ever going to get, so I will try my best. I want to believe [I'm doing well] but I don't."

Additional messaging - Moms: Honesty and self-reliance

Women evoked an interesting and powerful dynamic between self-sufficiency and help-seeking. At least 24 coded comments noted that in listening honestly to themselves, women became better positioned to cope with PRD. Women did not name any particular mechanisms for achieving self-honesty, but they described a need to disregard the opinions of people downplaying their needs. There is a sense that getting professional help is empowering, particularly for women who don't feel supported by friends and family. Across all focus groups and one-on-one interviews, women who have sought help acknowledge that they knew something wasn't right, that they weren't feeling like themselves. The women whose traditional support person disregarded their feelings were empowered to walk away from those relationships, while the women whose support people helped them seek proper treatment felt empowered by their own self-knowledge. In the former case, the "women's supermom complex" is meaningful. In the latter, a participant observed, "It's so easy to hear messages that 'you should be doing it this way,' but no, you know, it's your intuition [that guides you]. I had to bring it back home." Another woman put it directly: "You have to be honest with yourself."

Several KIIs noted that their clients often recognize that they're not feeling like themselves. "Moms will come to me and say, 'I need help, I don't like the way I feel." Another said more bluntly, "Everyone already knows [they're experiencing PRD]. But why don't we trust our own feelings? We look on the internet, we ask our friends, but our friends, or parents, or mothers, or sisters aren't always reliable." One woman who is a trained therapist but who was listed as a support person says she feels it is her job to model self-awareness. She talks about her own struggles with PRD and says, "my reasoning for that is that if mom doesn't know how to be honest with herself about her issues, it becomes my responsibility to model that behavior."

REFINEMENT & RECOMMENDATION:
Based on results, modifications to messages were made based on commonness of words, phrasing and overall themes. Messages for mothers were refined to include a focus on isolation, guilt, self-honesty, and the importance of support group participation. A new message for mothers was added to the "Common but don't have to feel that way" topic area, to address the expansive views of participants about what pregnancy and motherhood is "supposed to be" and the associated pressure and guilt which can be harmful to a mother's mental health. Revised messages can be found in Appendix A. While use of varying messages can be strategic over the lifespan of a campaign to speak to various audiences and avoid message saturation, the following three messages ranked highest and are recommended for use in the initial phase of the campaign:

#3 Topic Area - Moms: You are not alone.
Message: You are not alone. You are not to blame. You can get help.
Supporting Points:
- Many women have feelings of isolation, but resources are available to offer you support.
- Ask a professional about how to join a support group to learn and share honestly with mothers experiencing similar feelings.

#7 Topic Area - Moms: There are identifiable signs & symptoms.
Message: Pregnancy and life with your new baby is rewarding and can also bring big changes and challenges. For women with pregnancy related depression and anxiety, each day can be a struggle. Understanding the symptoms is the first step in taking back control of your happiness and your family's.
Supporting Points:
You know yourself best. During the past week or two, ask yourself, have I:
- been overly anxious or worried
- felt overwhelmed or stressed
- been so unhappy that I have cried
- been so worried that I have had difficulty sleeping
- blamed myself unnecessarily when things went wrong
- isolated myself from others
- felt overly scared or panicked
- felt guilty for my behavior or feelings
- let things get the best of me
- felt sad or miserable
- had unpredictable fits of anger
- thought of harming myself, or others

#9 (New) Topic Area - Moms: PRD is common, but you don't have to feel that way. (2)
Message: Pregnancy and new motherhood is supposed to be the happiest time of your life, right? Not for many women. Having a new baby is hard but support is available to make it easier for you.
Supporting Points:
- Feelings of guilt, frustration and withdrawal are common among new mothers.
- It's common to feel like you have to be "Super Mom" but that added stress can be super harmful without support.

- A professional can connect you with other women struggling with motherhood to share stories and support.

MESSAGES - SUPPORT PEOPLE

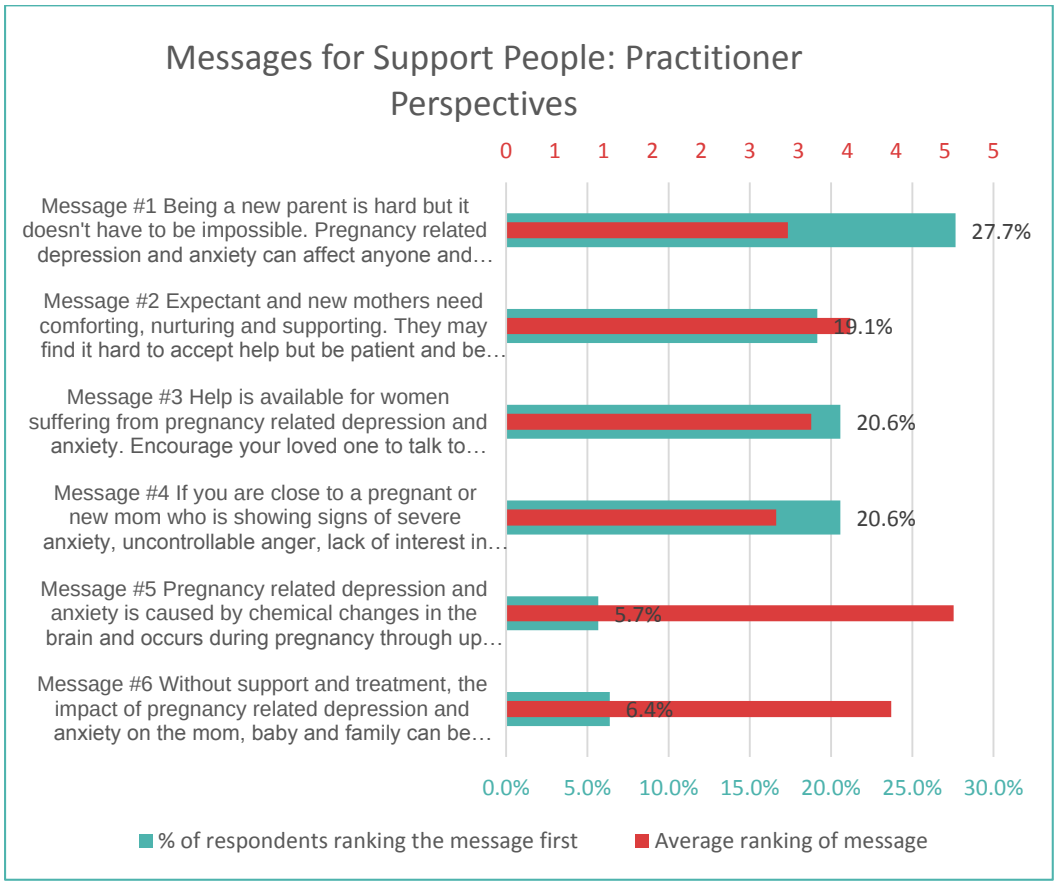
Among the target demographic, KIIs and affected moms both state that support people are not always found among family and friends. Several affected moms named counselors and caseworkers as crucial support people. Among informal support people (i.e. people identified by women as supportive but not employed as professionals to support them), messaging was generally not a component of their support. Rather than expressing opinions on women's conditions or providing guidance for action, the primary role of support people, as they saw it, was nonjudgmental listening. Said one, "Most of the time it's just listening, try to give her a different opinion about things. She thinks she knows how she needs to handle things and she starts to panic about it." This supporter describes a particular kind of listening, finding it important to "Let her say what she has to say, really hear what the problem is, to try to identify if the issue is as clear as she's trying to make it or if there's more [nuance] to it." Another had a similar experience, saying his role is to "just listen to her, just letting her talk through things," and to recognize that, "sometimes her real issue is what she says it is, sometimes she needs to talk through it to get to what's actually bothering her." In both cases, support people recognized that listening had to be judgment-free; that, as one phrased it, "I wouldn't bite her head off for whatever it is she had to say."

Support people interviewed were not necessarily aware that PRD is a medical condition meriting diagnosis and treatment. As such, messages informing them of PRD and its symptoms hold value: support people can be made aware of PRD through messaging, which can better equip them to support affected moms. Although support people saw their primary role as listeners, rather than conveyors of messages, there are ways in which nonjudgmental listening supports messages, and both support people and KIIs identified some of these overlaps.

The chart on the following page presents survey results on support person messages. Respondents ranked messages from 1 to 6 (1 being the strongest message). The chart depicts both the percentage of respondents who ranked a topic 1, as well as the overall rating for a topic (the average rating for all respondents to a single message).

MESSAGES OF SUPPORT:

Pregnancy Related Depression Awareness Findings



Message #1 - Support: Being a new parent is hard but it doesn't have to be impossible. Pregnancy related depression and anxiety can affect anyone and is the most common complication of pregnancy.

Nearly 28% of survey respondents (27.7%, N=39 out of 141 respondents who answered the question) identified messaging to normalize PRD as the top priority, although the message's overall ranking was weak. This may reflect a split in whom practitioners are identifying as support people. Practitioners prioritizing normalization messages may be assuming that support people are not familiar with PRD and are not cognizant of the challenging experiences women might be having during and after pregnancy. Respondents who did not prioritize this message may assume that support people are already effectively supportive and do not need normalizing messages to remind themselves to support the woman in question.

As a message targeting support people who generally offer weak support, this message resonates for affected women. One woman described her husband as cognizant that motherhood was hard but terrified to address it: "My husband was worried about it and conscious of it, but he would freak out and say I need to go talk to someone whenever I said something. He would shut down." Another described a similar disproportionate reaction by her husband: "I tear up at silly Facebook things, and my husband is like, 'Are you ok?' He'll freak out and say, 'Put down your phone!' I'll be reading a story, and he'll just shut it off and say, 'I don't want to see your waterworks.'"

Sisters, too, were identified as ill-equipped to recognize how common PRD is and how difficult it is for women to experience. “I called my sister and broke down and cried to her, and she was like, ‘Tara [name changed], I don't think you needed to do that, why'd you do that, what did you do? You're stupid, you're this, you're that.’ And I was like, ‘Why am I stupid? Because I told her, there was a cord sitting on my floor and I was like, I don’t care if I hang myself, I don’t care if I hurt myself.’ I called some kind of mental illness hotline and talked to them and the lady was talking to me saying, 'It seems like you're doing the right thing.' I felt like I was kind of contradicting myself, like, ‘Am I really doing this to get help? Or is it to get away from my children? What am I doing this for?’ And she said it takes a lot for someone to admit they're dealing with an issue, and she was praising me for that. So I hung up with her and called my sister again and said 'how do you feel about me doing that [calling the suicide hotline]?' So I admitted myself to a hospital.”

This same participant had said that prior to having this child, she had heard of PRD and “looked at it as, ‘Well, yeah, I've heard about it,’ but I just never thought it would be me.” She is now a strong voice that “it can happen to anybody.”

Message #2 - Support: Expectant and new mothers need comforting, nurturing and supporting. They may find it hard to accept help but be patient and be available.
Comforting, nurturing and support are words that never arose in focus groups or support person interviews. Instead, the words empathy, sympathy and patience arose. Support people identified as effective by focus group participants described themselves as people who “love her and support her” or who “reassure her.” One support person aptly noted, “I’m not a doctor so I’m not going to say, ‘Hey, you’re going through this’,’’ but acknowledging that she is going through issues.” This innate knowledge from strong support people resonates among KIIs, as well. As one phrased it, what resonates with affected moms is, “Really listening and wondering; offering an opportunity to wonder without judgment. If you can ask any question from that place, they all lead to a place where a mom might go [to get help].” Message #2 was ranked first by 19.1% of survey respondents (N=27), with a low average rating of 2.89.

Message #3 - Support: Help is available for women suffering from pregnancy related depression and anxiety. Encourage your loved one to talk to their health provider. With their help and your support, your loved one can choose a treatment plan that is right for her.
Nearly 21% of survey respondents (20.6%, N=29) prioritized the message guiding support people to direct affected moms to their health provider. Support people themselves were less clear on whether a health provider would be an appropriate source of treatment. For low-income women, there is not often consistency in the providers they see. One support person said he encouraged his affected friend to seek professional help, but logistics were a barrier: “She did go to [Location] Mental Health for a while to help her… but help falls through here and there; circumstances change.” He lamented that “the system makes you jump through a lot of hoops” to get the care you need. The notion of choice in treatment also becomes restricted in these circumstances – women can, in fact, only receive the treatment they can afford or that their insurance provides.

Message #4 - Support: If you are close to a pregnant or new mom who is showing signs of severe anxiety, uncontrollable anger, lack of interest in her baby, extreme panic or obsessive activity, she may be suffering from pregnancy related depression and anxiety.
One in five survey respondents ranked this message first (20.6%, N=29), but it had the overall lowest average ranking among support person messages. As with message #1, respondents prioritizing this message may assume the support person is not effectively supportive and requires a better understanding of PRD. Among the support people interviewed, all had longstanding relationships with the affected woman and easily recognized the difference between a bad mood and a depressive/anxious episode -- they do not find symptom lists particularly valuable, since they use personal judgment. However, for the women whose family and friends are actively unsupportive, this message might be highly valuable. Focus group respondents expressed dismay at their family and friends' inability to recognize or acknowledge that they were legitimately struggling. One woman described her sister's judgmental reaction to her desire to seek treatment, asking, "Why are you going on medicine? Why are you feeling like this? What's wrong with you?" Another describes a frequent conversation with her husband, where he asks how she's doing, she replies that she's tired and he asks, "Again?"

As with message #3, however, risks arise with healthcare providers, as insurance may not cover treatment, and physicians may not feel equipped to diagnose or refer.

Message #5 - Support: Pregnancy related depression and anxiety is caused by chemical changes in the brain and occurs during pregnancy through up to 12 months after giving birth.
Although only 5.7% (N=8) of respondents ranked this message first, it had the highest overall average ranking of all support person messages (4.59). The broad support for the message among healthcare personnel is not reflected in focus group discussions or support person interviews. On the contrary, women express resentment that their husbands attribute their emotional difficulties to hormones (which seem to be referred to interchangeably with body chemistry). Support people valued by women in our dataset do not focus on the medical reasons for their loved one's behavior, but rather focus on taking their emotions seriously.

Message #6 - Support: Without support and treatment, the impact of pregnancy related depression and anxiety on the mom, baby and family can be very serious. You can help her today for a better tomorrow.
That PRD is serious resonates broadly with practitioners (average rating 3.95, ranked first by 6.4%, N=9), but it was not voiced by support people. Support people emphasize the significance of environmental conditions creating challenges for the women they support -- PRD among the at-risk population is sometimes folded into larger issues and/or a longer history of depression. Dislocation resulting from a stark move between urban/rural or from a different country/state (including refugees and migrants), traumatic family history, and severe financial stress are among the concrete pre-existing issues that compound PRD. Support people are not well positioned to parse PRD from these other factors.

REFINEMENT & RECOMMENDATION:
Based on support system results, a stronger emphasis was made on listening to their loved one, offering empathy and suggesting professional help along with their own support. Messages and

supporting points are largely consistent with those developed for mothers to offer reinforcement and continuity of discussion around pregnancy related depression and anxiety. Revised messages can be found in Appendix A. The following three messages ranked highest when results from KIIs, focus groups and survey respondents are collated. They are recommended for use in the initial phase of the campaign:

#2 Topic Area - Support: What you can do.
Message: Pregnant and new mothers need empathy and support from loved ones. They may find it hard to be honest about their feelings and accept help in the beginning. Be patient and be available.
Supporting Points:

- Spend time listening, without needing to offer solutions and advice. Her feelings are real. Let her express them to you.
- Look after the baby or older children, or discuss other childcare options so she can have a break.
- Take a simple action like cooking and cleaning without taking over these activities or expecting anything in return.
- Encourage her to take care of herself by eating, resting, walking and limiting alcohol use.
- Encourage her to get further help from a professional and/or support group and find resources in her area to share.
- Fight the urge to give advice on how to parent, unless she asks.

#3 Topic Area - Support: Treatment exists (including treatment options).
Message: Help is available for women suffering from pregnancy related depression and anxiety. Encourage your loved one to talk to a professional. With their help and your support, your loved one can choose a treatment plan that is right for her.
Supporting Points:

- It can't be fixed overnight but treatment options do exist.
- It won't necessarily go away by itself.
- It can be treated by social support, self-help skills, counseling and sometimes medication.

#5 Topic Area - Support: What is PRD?
Message: Pregnancy related depression and anxiety is a medical condition, not a bad mood. It can occur during pregnancy and up to 12 months after giving birth. Understanding the illness is the first step in finding the right treatment for your loved one.
Supporting Points:

- Symptoms last two weeks or longer.
- It can be brought on by the stress of being a mom, or it can be triggered by other struggles a woman is facing.
- It's different from "baby blues" which usually end two weeks after the baby's birth.

IMAGES

While messages received overall strong positive responses from professionals and affected individuals, images were markedly more controversial. Some images were determined to be effective only for women who are in particular phases within a depressive curve -- a woman who

is too angry or too lonely may not be able to respond to hopeful images, for example. All focus groups were strongly opposed to imagery that depicted figures of authority, interpreting such figures as likely to take their child from them, give faulty information, or provide insincere or untrustworthy reassurances. Images depicting the stress of PRD were highly polarizing – some women appreciated the true reflection of their feelings, and others felt doubly aggravated to see their challenges visually depicted.

The chart to the right depicts a quantification of the qualitative inputs provided by focus group participants pertaining to images. It presents the number of positive (above the axis) and negative (below the axis) mentions in bar chart format, with a line calculating the overall positive or negative reactions respondents had to each image. As the chart shows, Images #2, #5 and #9 scored the highest.

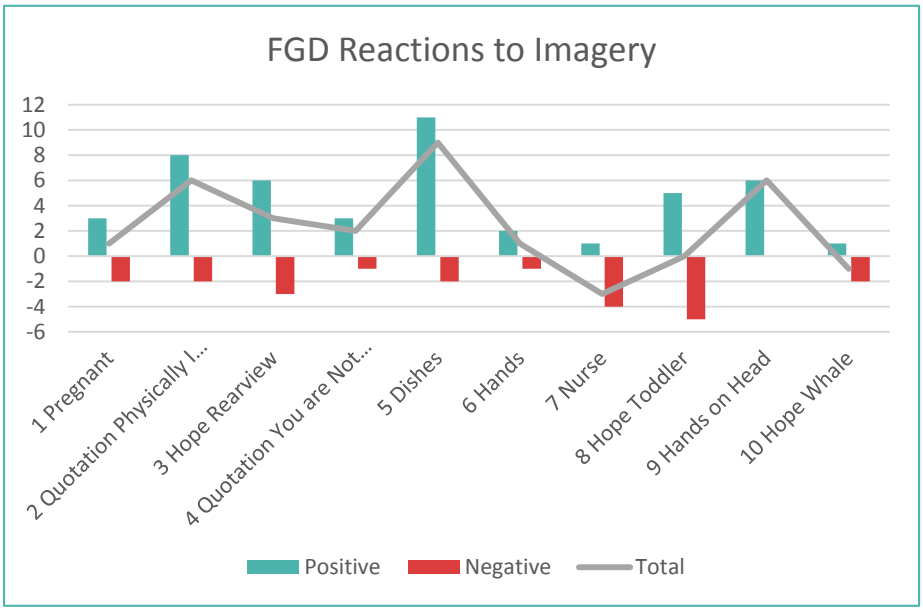


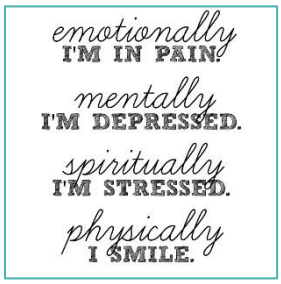
Image #1 – Pregnant woman in bed

The pregnant woman depicted in this image resonated with married women and women in committed relationships who felt isolated from their partners. It evoked the pregnancy insomnia of one and the sense that her partner was not excited about the coming baby for another. An unmarried mother swiftly parsed the components of the image that further alienated her, however: "You can tell she is married, because she has a ring on it. The bright side is at least they are together, because there's a man in the back. She looks very upset and sad, they aren't connected. She looks like she is feeling alone and there's no joy in her face. I can understand this, but *I am not this*, because there is no man in my bed." The worry and sadness of the woman resonated across the board; the wedding ring and man did not.

MESSAGES OF SUPPORT:

Pregnancy Related Depression Awareness Findings

Image #2 – "Physically I smile"



This text image had strong resonance across all focus groups, however women often misinterpreted the message when reading it silently. Two women read "physically I smile" to mean that they felt inner joy -- it was not until the message was discussed out loud that they realized it was a message of stoicism concealing deep anguish. A third woman determined that, "At the end of the day this is what you have to do. You're the only one who is going to get you through this day." She, too, found deeper resonance after discussing the image, noting later, "This is like that superwoman complex, where you know you are collapsing on the inside but on the outside you are like, 'Look, I got this.'" If this message is to be fully embraced, it may have to be employed as an audio/visual message. Reading the words does not seem to convey the message effectively.

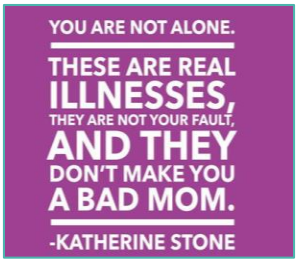
Image #3 - "Hope… Objects in mirror are closer than they appear"

This hopeful image was polarizing. One woman felt strongly supportive of it, feeling it reflected the cycles of hopefulness and sadness saying, "I really like that, because it's close, so you don't forget that it's still there, even though it's behind you."

Several other women responded negatively to the word 'hope.' "I hate that word, hope, because when it doesn't get better it makes you feel even worse." Another woman rejected the word hope, because "I'm very stubborn and independent, and that's what got me through," as opposed to a blind or passive 'hope.' Another woman elaborated, "Some people are cool with 'hope messages.' Some [hope messages] are ok, depending on the context. It's hard to say when [they're appropriate], because the situation always changes." Hearing messages of hope at the wrong moment can feel "like a cop-out, like someone is saying it to say it, not really trying to help you, but to change the topic."

Reflecting the complicated feelings women have with hope, one explained, "It gets better, but then it gets harder, and then it gets adjusted and shifts, and you have to start again." The idea is not "It'll get worse before it gets better," because the idea that it could get worse is, as one woman stated it, "terrifying," but that it is a long climb. Any message suggesting that there is a quick fix risks being poorly received.

Image #4 - "You are not a bad mom"



This second text image had strong resonance with focus group participants. "'You are not a bad mom' -- I took this very personally, because that's how I feel. I gave myself dry. I thought I was being a bad person because I couldn't do it all myself," said one. Another said that the message encapsulated "things I have to remind myself, because it's what I have to be thinking."

Two mothers mistrusted the message. "It's hard to sit there with someone telling you [that] you aren't a bad mom. You ask them, 'Do you have a kid? No? Then why are you talking to me about having a kid?'" Unless the message comes from a trusted source familiar with the family, some moms refuse to believe the message. These moms may not be the target population,

however – messaging cannot be directed at all PRD-affected moms across the spectrum of illness. Mothers who are not ready to talk about their struggles may not be ready to seek help.

Image #5 - Dishes

The image of dishes in a sink generated significant conversation in all focus groups. It was the single most discussed image, generating 14 distinct comments. Women felt guilt that the sink looked like their own, relief that it could be depicted in imagery that created solidarity among messy-sink moms, frustration at the idea of the work they have left undone, or dissociated from it because the kitchen is the one room they clean regularly.

Despite its simplicity, it generated complex reactions. Several women volunteered personal stories to describe how they related to the dishes. One woman saw the dishes as the transition in her life from being the sole breadwinner and manager of the household to being on bedrest and then the caregiver for a premature baby. “Now there are toys I don’t pick up. Bath toys now just live in the tub, I don’t put them away. The floors are mopped and clean, but I don’t do all the laundry any longer.” She said that for a long time she carried guilt about that, “until I broke down and was a disastrous mess.” Another woman described the dish imagery as “bittersweet.” “This is how my kitchen always looks. This hits home, because I always have dishes. It makes me feel like, ‘Damn, stop being lazy and do the dishes.’ I think about myself and how the rest of the house is clean but not the kitchen. It shows good *and* bad parenting, though, because, on the bright side, you can tell she must have some groceries. She’s cooking.” It ranks as, overall, one of the most popular images tested.

Image #6 - Hands

The image of a baby’s hands inside of a mother’s hands was emotionally polarizing and generated powerful, but not generally positive, responses, in all three focus groups.

One mother, in tears, said the image touched her heart because she fears that she won’t love her new baby, who is being born under challenging circumstances. Another mother saw the image as protective of a child and made her hopeful that she would protect her own children. A third woman saw it as “conflicting.” “This is supposed to be cute, but to me it’s like frustration. It’s supposed to be thoughtful, but to me it’s, ‘I need to get this diaper change done.’ It’s all bonding, black-and-white and serene, and that’s just frustration. They are telling me this is calmness, and I know better, which makes it even more irritating, because you want it to feel like this but it’s not.” These strong reactions were in no cases linked to women expressing a desire to seek help or a reflection on the moment when they might have sought help.

MESSAGES OF SUPPORT:

Pregnancy Related Depression Awareness Findings

Image #7 - Office setting, sad mom being spoken to

The image of an authority figure speaking to a despondent mother generated strong adverse reactions in all focus groups and should not be included in a media campaign. The authority is perceived as "lecturing" or representative of social services. To one woman, the authority is a nurse saying, "'It's going to be ok,' but it's really not."

Image #8 - Hope, with toddler

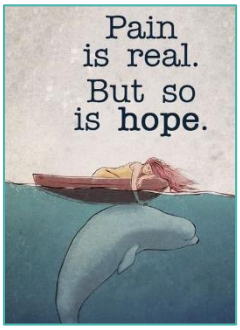
Critiques of the word 'hope' apply to this image as much as they applied to Image #3. The picture of a happy mother with a toddler was to an extent better-received than the image without people. Four moms saw this image depicting a brighter future with an older child. One mother, who, notably, did not connect with any of the imagery, was skeptical of the message of hope and distrustful of the child in the image: "The toddler looks really mischievous, like he's going to mess up her hair. You can't find hope when you're depressed."

Image #9 - Head-holding frustration

Image #9 was the only image that garnered all positive responses. Six women related directly to the image, saying, "she looks just like me 99% of the time," or "that's me." "I feel like this a lot," elaborated one: "I really struggled after [giving birth], and I really tried to keep it in for the first two months. I tried to write it off as 'this is hormones, I will get over it.' … I felt like this right before I tried to get help."

Notably women appreciated that children weren't in the picture, because their sources of stress extended well beyond the baby. As one elaborated, "This house is crazy, these kids are on my nerves. I am about to run out the house before I punch you in the face and kick the puppy." She put her hands to her head mimicking the photo as she relayed the story. Another mom attributed the sentiment to the stressful presence of her mother in law, while another linked it to a litany of household stresses: "It's more the other things that are hard, not so much mothering. I know now the middle child was jealous, so that made it stressful, to try to be mom to the newborn while the middle child says, 'I'm still #1.' You've got the stove on, things going on, the dog barks, someone comes to the door, the baby wakes up and the two-year-old wants to 'help.'

Image #10 - Hope, with beluga whale



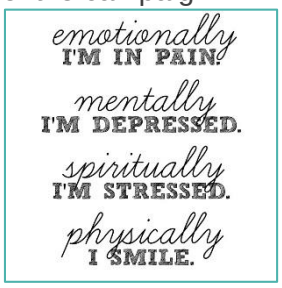
The beluga whale image alongside a message of hope had particular irony in the Denver focus group, where one woman described her self-loathing for excessive weight gain as, "I blew up like a beluga whale." This image generated the least discourse of all images and resonated with only one woman, who engaged more with the concept of hope than with the image itself.

MESSAGES OF SUPPORT:

Pregnancy Related Depression Awareness Findings

RECOMMENDATION:

As described in message recommendations, using a variety of visuals, while maintaining a level of brand consistency, is a strategic approach to an educational campaign. The following three images ranked highest when results from KIIs, focus groups and survey respondents are collated. Creative direction in line with these images is recommended for use in the initial phase of the campaign:



Best practices regarding material and creative production is outlined in the Materials and Creative section below.

MESSAGE DELIVERY RECOMMENDATIONS

From social circles to social media, pregnant women and new mothers are inundated with messaging about how to be a 'good parent.' Due to this overwhelming reality for women, it is essential for campaign messaging and creative to be strategic, targeted, and relatable. Through strong expansion of PRD message visibility and consistency across platforms, CDPHE can reach the right people, at the right time, and with the right frequency. This will increase the likelihood and effectiveness of the public awareness campaign and efforts to increase help-seeking behaviors among pregnant women and new mothers.

EXTENDING MESSAGES IN PARTNER PRACTICE

CDPHE, with support from the PRD State Advisory Committee and LPHA's, is well-positioned to create and mobilize strategic partnerships in the community to consistently promote PRD messaging. Collaboration across stakeholder groups increases access to the target audience, creates synergy, and expands the credibility and trust of support services. This can be accomplished through sharing marketing resources, tactical guidance, data, and communication best practices at varying levels of engagement. Community partners outside of the healthcare system may include state-sponsored child support programs, church groups, recreation centers, daycare centers, online social and support groups, libraries, parks and recreation, etc.

Providers and partners need to approach the conversation about PRD with empathy not judgement. Providing sufficient resources and training, as evidenced in the Message Adoption Obstacles section of this report (below), will assist partners with their comfort level in relaying the messages and supporting points on a continual basis while being aware of where to direct affected women in their area. When partners have the opportunity to interact with the entire family or with a woman's support person, it's important that he/she understand how to address

the message from a holistic manner to ensure everyone involved understands PRD and treatment options for their loved one.

Partners to the state health department should be engaged in an ongoing dialogue about message effectiveness and PRD awareness. By keeping records of how women accessed mental health services and what messages resonated most strongly, practitioners and partners can further refine messages and update them as PRD awareness increases and more advanced messaging about help-seeking becomes appropriate. Questions that both practitioners and partner institutions can ask of PRD-affected clients might include:

- How did the mother hear about your service?
- For how many weeks/months/years did the mother struggle before seeking help?
- Are their particular messages that you are finding the easiest to include in your conversations?
- How often are mothers and/or their support systems picking up the PRD brochure in your waiting room?

COMMUNICATION MATERIALS AND OUTLETS

Knowing how to reach target audiences 'where they are' is essential to a strong communication plan. Using multiple delivery outlets, tools and approaches to disseminate messages increases the likelihood of success. This expands the audience's exposure to the messages and engages them at critical health decision points. As an example, affected women may not derive the full value from a message they simply read on a bathroom stall, so reinforcement and repetition via a Public Service Announcement and social media posts could be beneficial and trigger a stronger emotional connection.

MATERIALS AND CREATIVE

From denial to actively seeking help, there is a spectrum of emotions that characterize women affected by PRD. As such, messages, creative and tactics need to be sufficiently diverse to touch on various experiences and feelings along this spectrum. Contingent on funding for phase two of this project, it is recommended to test material creative across a broad array of demographic groups. In addition, input from community partners should be gathered during development and after execution to strengthen receptiveness. Materials and creative should communicate the messages and supporting points at an **appropriate literacy level** and in a manner that is **consistent**, **culturally sensitive**, **visually engaging**, and, most importantly, **relevant.**

Based on research results, below are recommendations for creative development:

- Consider age, ethnicity and marital status of the target demographic in imagery (specifically, do not include men and wedding rings).
- Be mindful of the weight of women in images due to the insecurities of some PRD sufferers regarding their weight.
- Use a combination of imagery (e.g. photo of stressed mom) and text (e.g. motivational quotes) in materials.
- Focus on the mom, versus the baby.
- Include a source to contact for more information (e.g. statewide resource line).

- Use left justified margins, as people often read from the top left.
- Keep the text simple and emphasize information with bold lettering and short lists.
- Use similar color theme and font for consistency.
- Avoid soft lighting and pastel color theme.

It is important to create and use materials that are sustainable, low cost, and adaptable as Maternal Child Health priorities change and/or new statewide and local services are added. Including an option for partners to customize the materials to promote local efforts may help with statewide usage. This includes space for local support group information, names/logos of trusted organizations and people, upcoming events, and other details that are particularly pertinent to their populations.

Traditional health education awareness materials include flyers, brochures, postcards, business cards, and posters. Due to the sensitive nature of PRD and a pregnant or new mother's comfort level in openly discussing her feelings, it is recommended that outreach materials intended as a takeaway be limited in size for easy concealing in a purse or jacket. For example, a pocket-size brochure will be preferable to a traditional tri-fold.

OUTLETS

As with most organizations, cost is a key factor in campaign awareness opportunities. Outlets may vary by geography. For example, bus ads could be beneficial in urban centers where public transit is widely used, whereas in rural areas with minimal public transit, central locations like grocery stores and pharmacies would be preferable.

Research participants provided suggestions about what messaging tactics might be effective in their communities. Below are a selection of outlets for a comprehensive marketing campaign by average cost breakdown. The six outlets bolded are recommended for PRD message distribution based on results and experience targeting low socioeconomic families in Colorado:

High Cost

- **Public transit (including bus shelters and benches) and school buses**
- Out of home signage (e.g. billboards, bathroom stalls, changing tables)
- Radio
- Promotional items (e.g. fridge magnets, bibs, water bottles, pregnancy test box)
- **Digital (e.g. Google ad words, re-targeting, social media ads)**

Medium Cost

- **Locations reaching low-income families (e.g. grocery store, convenience store, pharmacy, laundromat, parks / playgrounds, museum free-day)**
- **New mother hospital and insurance takeaway packets**
- Direct mail
- Outreach event sponsorship / booth representation
- Informational videos in medical offices and waiting rooms
- Text message alerts (be mindful to address applicable rates in promotion)
- Newspaper
- Parent magazine

Low/Free Cost

- Social media (e.g. Facebook, Twitter, Instagram campaign page/presence)
- **Community locations (e.g. health clinics, day care centers, schools, libraries, churches, community centers, City & County Human Service offices)**
- Article in religious or community publications and newsletters
- **Local mom and dad groups (online and in-person)**
- Earned media (e.g. press releases, op-eds, guest blog posts)

Across the outlets above, it's important to gather post-placement information to track reach (number of recipients, demographic, etc.) and frequency to analyze campaign success and make modifications as needed.

MESSAGE ADOPTION OBSTACLES

To execute a successful educational awareness campaign, it is necessary to take a realistic look at barriers potentially impacting message adoption and behavior change. While some are outside of CDPHE's sphere of influence, being aware of obstacles can impact messaging and creative approaches, campaign tactics, partner support, and future efforts at the state level.

GAPS IN SERVICE

The power of a messaging campaign can sometimes be self-reinforcing -- messaging encourages behavioral changes (like help-seeking), and the positive results of those behavioral changes generate broader change, as the individuals become champions of the change they have experienced. Messages indicating that "there is help" are only partially true at present, breaking the cycle; there is no possibility for the message to self-reinforce because the message is a dead end if the 'help' that is promised is not received.

TRAINING LIMITATIONS

Only one practitioner among KIIs stated she had formal training in PRD, through a program she completed within the past 12 months. Psychology degrees do not include units on maternal mental health, so even trained mental health workers may not be equipped to address PRD. KIIs say they learned about PRD on their own, through reading, and by interacting with affected women. One KII who runs the maternal mental health program in her health district said, "The program has been around, as Mommy Loves Me, for about 6 years, but I really didn't get any training. I walked in and just go with the flow. If moms have questions they can text me on my work cell phone. I have a Facebook page with tips. When I got here the girl that started the program had shelves with labels, and one said 'depression screening,' and there's a form that says 'do 'this' at 'this' time." While that practitioner's achievements are laudable, her introduction to PRD illustrates how inconsistent training is and how easily PRD as a concern could slip past health practitioners' notice.

TERMINOLOGY INCONSISTENCIES

Use of varying terms by providers can lead to misunderstanding and confusion for affected women. Nearly two thirds of practitioners (65%, N=102, out of 156 respondents answering the

question) surveyed refer to the condition as “postpartum depression, potentially undermining the fact that it can manifest during pregnancy or recur in the wake of previous depressive episodes. One in four survey respondents (26.3%, N=41) refer to it as “perinatal mood and anxiety disorders,” which is the most concretely accurate term, but which is not clearly understandable to most non-practitioners (there is some overlap among practitioners using Postpartum Depression (PPD) and Perinatal Mood and Anxiety Disorders (PMAD), as the survey allowed respondents to select more than one option). A full 16% of survey respondents (N = 25) avoid any terminology at all to diagnose the condition.

It is important that CDPHE and partners use common terminology for the purpose of improving provider awareness and campaign consistency. However, because help-seeking is so low among affected groups, it may be more important that women recognize that the feelings of anxiety and stress are common, rather than recognize the name of the condition.

SCREENING INCONSISTENCIES

Among surveyed practitioners, only 56% use a standardized screening tool, such as the Edinburgh (EPDS) or PHQ-9. Another 32% use informal conversations to probe for symptoms, but a full 12% do no screening at all. Pediatricians and OB/GYNs that accept Medicaid have sharply increased screening in recent years, but private providers have not systematically changed, according to several KIIs.

REFERRAL INCONSISTENCIES

“People are really getting lost in the referrals.” This sentiment was present across all KIIs and health management interviews. Even in counties that have worked for years on referral systems, gaps persist. Whole counties operate without any PRD specialists. Recognizing that providers have no particular training in PRD, the Early Childhood Council (ECC) in Chaffee County has been working to develop a referral pathway. In the meantime they have deferred improving and standardizing the screening process because they do not want to screen women without being able to provide them care. In other counties, referrals are by word-of-mouth, so isolated moms in the greatest need might remain the least connected to care.

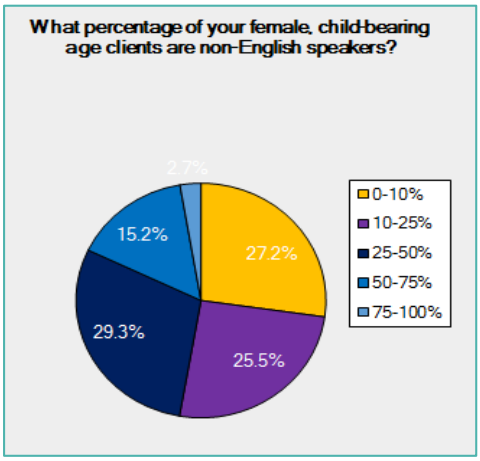
Referrals have also been hampered by billing confusion. KIIs in Sterling pointed out that private providers can take Medicaid but do not seem to know that, so women who refuse to seek help at the (highly stigmatizing) local mental health center are failing to get treatment elsewhere. A similar situation is present in Summit County, where the mental health provider, MindSpring, has strong relations with Medicare but “working with other providers can be a challenge.”

TREATMENT INCONSISTENCIES

Primary care physicians are often the first point of contact for women with PRD, but these individuals are not necessarily equipped to address mental health. As such, treatment varies. Both KIIs and affected moms reported that physicians told women their symptoms were not sufficiently severe to merit attention. In Otero, primary care physicians prescribe medications but not therapy.

MESSAGES OF SUPPORT:

Pregnancy Related Depression Awareness Findings



LIMITED FOREIGN LANGUAGE PRACTITIONERS

Among 184 surveyed practitioners, 73% operated in facilities where non-English speakers represented more than one in ten patients – 18% of practitioners operated in facilities that were *majority* non-English speaking. Practitioners listed over 20 foreign languages that represented their clients. Both the PHQ-9 and Edinburgh (EPDS) screens are available in an array of languages, but practitioners do not report using the foreign-language versions. KIIs report a shortage of foreign language speakers on staff – even among Spanish-speakers. In Denver a Spanish-speaking therapist position has sat unfilled for 6 months. The KII from that facility noted, "I do get Spanish speaking referrals, but I don't speak Spanish," so those women fall through the cracks. In Eagle, a Spanish-speaking therapist left her job for a higher paying but comparable post in a city with a lower cost of living.

RESOURCE DATABASE DISCONNECT

Practitioners have developed personal connections with mental health professionals and programs, but they lack access to a comprehensive database of services. One Tri-County KI mentioned the Green Valley Ranch region as a "desert for mental health support," because she knew of no personnel working in the area. Another noted that "just a list of mental health providers between the counties would be helpful," to empower her to refer clients effectively. Lacking a coherent resource database, KIIs found that their referrals were falling flat. "This can be shocking for nurses when they've gotten a referral and say, 'Ok, but what do you want us to do with them? We've never worked with a woman who has PRD.' That doesn't work with a nurse's training experience, which is regimented."

PERCEPTIONS OF GOVERNMENT SYSTEMS

A combination of fear, shame and distrust characterize the reluctance of some mothers to seek help. As one KII described it, "in the work I've done, often minority women don't feel like they can trust systems, so in general when there's a program, hospital or clinic offering something, even if they might ultimately feel safe there, they don't give it a chance." In Weld County, one KII estimated that only half of referred patients follow up, adding that "about 25% of the kids I work with have DHS [the Department of Human Services] involved, and they have multiple sets of eyes on them. They find that intimidating. They're already mentally unhealthy, and now they're feeling the stress of being watched by the state." Additionally, illegal immigrants avoid care if they do not know their (legal) children can receive care through the Nurse Family Partnership. In Eagle County, one KII described mothers who "think that telling a white person you're illegal will get you deported."

LOGISTICAL AND SITUATIONAL BARRIERS

There are various socioeconomic and cultural factors influencing affected women's ability to take action toward healthy behavior changes. KIIs, survey respondents, support people and affected moms all noted that the biggest hindrance to help-seeking can be logistics.

INSURANCE

Insurance issues arise across the state, in both urban and rural settings. Where insurance restricts access to therapy, women do not receive the care they need. Some practitioners have found workarounds. For example, receiving referrals through Catholic Charities, one therapist has her clients' costs fully covered by the nonprofit group. In another example, exposing behavioral issues with children enables child therapists to counsel the mother, under the child's insurance. This, however, was described as insurance fraud by one KII, who said that practitioners are increasingly pressured not to pursue this avenue for accessing moms. One woman was denied counseling sessions for PRD because her insurance company claimed it was a 'preexisting condition.'

One support person, who is also a therapist, put it in stark terms: "Insurance companies are turning people away. They want it in-and-out and that's all they get. We have a mom that is employed, we definitely hook her up and have her on a flex pay system. Medicaid is not going to let me do that. Medicaid wants to send everyone to the county mental health agency, and it's a system that fails them. They're not allowed to take their children. So some of the moms that I work with will get that and I will take kids while the mom completes her appointment. Sure, there's help out there, but if you're a poor mom, it's not going to happen."

ACCESS

Low income women without a car may be unable to visit a clinic not on a public transit route. Rural women may not attend an appointment across from the town library due to visibility and thus fear of what the community would think of her as a mom. Working moms may not have time or leave approval for therapy sessions. Insurance companies may not cover the costs of treatment, rendering it financially infeasible. In cases where stigma can be overcome, these concrete hurdles persist as barriers for women who need mental healthcare.

The logistics of transportation have been addressed in Summit County by the co-location of mental health facilities within the hospital and alongside the WIC office, so that mothers arriving for WIC checks can also be seen by other providers in a single stop. This also addresses the time demands on low-income mothers, who may not be able to make time for a mental health appointment but who could be seen by a practitioner during a child's pediatric or other appointment.

FUTURE RESEARCH

As foreseen in the Scope of Work, the phase one research was limited by language restrictions. At-risk women include native Spanish speakers, refugees and recent immigrants, who are not always comfortable communicating in English. Future research is recommended to include

focus group discussions in Spanish and other dominant languages of refugee populations (for example, in Fort Morgan where a significant Somali refugee population has been established, a focus group could be held in Somali or Arabic).

Current research has demonstrated that women experience PRD differently in different geographic locations, so extending research to additional Colorado markets via focus groups and/or semi-structured interviews would also be beneficial. Focus groups in Colorado Springs, Pueblo, and Grand Junction would be advisable. However, experience has shown that in rural communities where rumors travel swiftly, focus groups are neither feasible nor advisable – confidentiality is not possible to guarantee where recent mothers are likely to recognize each other. In these locations, one-on-one interviews are preferable to group discussions for sensitive topics like PRD.

CONCLUSION

Within Colorado, there are significant opportunities for improving help-seeking behavior among low-income women affected by PRD. Conversations with CDPHE's network of practitioners reinforced the strong desire among healthcare professionals to address the issue with the women they serve. Likewise, affected women expressed a willingness to seek help and support other affected women. The "sisterhood" of motherhood, as one woman phrased it, drives women to speak honestly about the difficulties of motherhood, as long as they feel safe and free of judgment. The messaging included within this report touch on major themes reported by affected women, the people that support them, and the practitioners that treat them. Promoting these messages across the state would be a first step in standardizing the discourse about PRD, building awareness among the public, and guiding women toward the help they need.

APPENDIX A – DRAFT & REFINED MESSAGES

Messages Targeting Affected Moms

Topic Area	Draft Test Message	Revised Message
Topic Area #1 - Moms: There is help	**Draft Message #1 - Moms:** Being a good parent means taking care of yourself. You need nurturing and support, too. Finding the right help for you is important. **Supporting Points:** Steps you can take: • Tell someone. • Ask for help from health providers, loved ones and friends. • Walk, stretch or do whatever form of physical activity makes you feel better. • Get as much rest and time for yourself as you can. • Eat healthy foods. • Join a support group in your area or online. It won't last forever. There is hope for better days.	**Revised Message #1 - Moms:** Being a parent of your baby means taking care of yourself, too. Finding the right help is important for your wellbeing. **Supporting Points:** Steps you can take: • Tell yourself how you honestly feel. • Ask for help from health providers, loved ones and friends. • Join a support group in your area or online. • Walk, stretch or do a form of physical activity. • Get as much rest and time for yourself as you can.
Topic Area #2 - Moms: What is PRD?	**Draft Message #2 - Moms:** Pregnancy related depression and anxiety caused by chemical changes in the brain and can occur during pregnancy and up to 12 months after giving birth. Understanding the illness is the first step in finding the right treatment for you. **Supporting Points:** • Symptoms last two weeks or longer	**Revised Message #2 - Moms:** Pregnancy related depression and anxiety is caused by chemical changes in the brain and can occur during pregnancy and up to 12 months after giving birth. Understanding the illness is the first step in finding the right treatment for you. **Supporting Points:** • Symptoms last two weeks or longer

	• It can also be brought on by the stress of being a new mom. • It's different from "baby blues" which usually end two weeks after the baby's birth. • It doesn't mean there's anything 'wrong' with you. It is an illness requiring treatment just like any other health problem.	• There are multiple triggers, including the stress of being a mom. • It is different from "baby blues" which usually end two weeks after the baby's birth. • It is an illness requiring treatment just like any other health problem.
Topic Area #3 - Moms: You are not alone.	**Draft Message #3 - Moms:** You are not alone. You are not to blame. You can get help. **Supporting Points:** Many women suffer from pregnancy related depression and anxiety. Ask your healthcare provider about how to join a support group to learn and share with other women.	**Revised Message #3 - Moms:** You are not alone. You are not to blame. You can get help. **Supporting Points:** • Many women have feelings of isolation, but resources are available to offer you support. • Ask a professional about how to join a support group to learn and share honestly with mothers experiencing similar feelings.
Topic Area #4 - Moms: Treatment exists (including treatment options).	**Draft Message #4 - Moms:** Treatment for pregnancy related depression and anxiety can make a big difference for yourself and your baby. Sadly, most women never get the support they need. Don't be afraid to ask for help from your healthcare provider. **Supporting Points:** • Pregnancy related depression and anxiety won't go away by itself. • Pregnancy related depression and anxiety can be treated by social support, self-help skills, counseling and medication when necessary.	**Revised Message #4 - Moms:** Treatment for pregnancy related depression and anxiety can make a big difference for yourself and your baby. Most women never get the support they need. Don't be afraid to ask for help from a professional. **Supporting Points:** • It won't necessarily go away by itself. • It can be treated by social support, self-help skills, counseling and sometimes medication.

MESSAGES OF SUPPORT:

Pregnancy Related Depression Awareness Findings

Topic Area #5 - Moms: You are strong.	**Draft Message #5 - Moms:** You are not weak, crazy, a failure or a bad mom. It's not you, it's the pregnancy related depression and anxiety and it can be treated. **Supporting Points:** Suffering from pregnancy related depression and anxiety is not a reason for someone to take your baby away. Getting help supports your right to parent your baby.	**Revised Message #5 - Moms:** You are not weak, crazy, a failure or a bad mom. It's not you, it's the pregnancy related depression and anxiety, and it can be treated. **Supporting Points:** • Be honest with yourself about how you are truly feeling and when you need to ask for help. • You're a good mom; make sure you're facing your own challenges for you and your baby. • Suffering from pregnancy related depression and anxiety is not a reason for someone to take your baby away. Getting help supports your right to parent your baby.
Topic Area #6 - Moms: PRD is serious.	**Draft Message #6 - Moms:** Untreated pregnancy related depression and anxiety can lead to serious problems. Getting help now means you are looking out for you and your baby's future. **Supporting Points:** • Untreated pregnancy related depression and anxiety can lead to poor nutrition, drinking and smoking. • Pregnancy related depression and anxiety can interfere with child development. • Suicide accounts for about 20% of postpartum deaths.	**Revised Message #6 - Moms:** Untreated pregnancy related depression and anxiety can lead to serious problems. Getting help now means you are looking out for you and your baby's future. **Supporting Points:** • It can interfere with child development. • It can affect your bond with your child. • It can limit you from being the mom that you are capable of being.
Topic Area #7 - Moms: There are identifiable signs & symptoms.	**Draft Message #7 - Moms:** Pregnancy and life with your new baby is rewarding but can also bring big changes and challenges. For women with pregnancy related depression and anxiety, each day can be a struggle. Understanding the symptoms is the first step to making your day a little brighter.	**Revised Message #7 - Moms:** Pregnancy and life with your new baby is rewarding and can also bring big changes and challenges. For women with pregnancy related depression and anxiety, each day can be a struggle. Understanding the symptoms is the first step

	Supporting Points: Ask yourself, during the past week or two, have I: • laughed • looked forward to things I usually enjoy • blamed myself unnecessarily when things went wrong • been anxious or worried for no good reason • felt scared or panicked for no good reason • let things get the best of me • been so worried that I have had difficulty sleeping • felt sad or miserable • been so unhappy that I have cried • thought of harming myself, my baby, or others Common symptoms may include feeling angry, disinterest in your baby, obsessive activity, and withdrawing from social interactions.	in taking back control of your happiness and your family's. **Supporting Points:** You know yourself best. During the past week or two, ask yourself, have I: • been overly anxious or worried • felt overwhelmed or stressed • been so unhappy that I have cried • been so worried that I have had difficulty sleeping • blamed myself unnecessarily when things went wrong • isolated myself from others • felt overly scared or panicked • felt guilty for my behavior or feelings • let things get the best of me • felt sad or miserable • had unpredictable fits of anger • thought of harming myself, or others
Topic Area #8 - Moms: PRD is common, but you don't have to feel that way.	**Draft Message #8 - Moms:** Being a new parent is hard for all women but it doesn't have to feel impossible. **Supporting Points:** • 1 out of 5 pregnant women and new moms will experience anxiety or mood disorders. • It's the number one complication of pregnancy. • It's common but you don't have to feel this way. • Pregnancy related depression and anxiety affects one 1 out of 8 mothers.	**Revised Message #8 - Moms:** Being a new parent is hard but it doesn't have to feel impossible. With help, there is hope for better days. **Supporting Points:** • 1 out of 7 pregnant women and moms will experience anxiety or mood disorders. • It's the number one complication of pregnancy. • It's common for many women but you don't have to feel this way.

MESSAGES OF SUPPORT:

Pregnancy Related Depression Awareness Findings

Topic Area #9 - Moms: PRD is common, but you don't have to feel that way.	**New Message - Moms:** Honesty and self-reliance	**New Message - Moms:** Pregnancy and new motherhood is supposed to be the happiest time of your life, right? Not for many women. Having a new baby is hard but support is available to make it easier for you. **Supporting Points:** • Feelings of guilt, frustration and withdrawal are common among new mothers. • It's common to feel like you have to be "Super Mom" but that added stress can be super harmful without support. • A professional can connect you with other women struggling with motherhood to share stories and support.

Messages Targeting Support System

Topic Area	Draft Test Message	Revised Message
Topic Area #1 - Support: This is common, but your loved one doesn't have to feel that way.	**Draft Message #1 - Support:** Being a new parent is hard but it doesn't have to be impossible. Pregnancy related depression and anxiety can affect anyone and is the most common complication of pregnancy. **Supporting Points:** • 1 out of 5 pregnant women and new moms will experience anxiety or mood disorders. • It's the number one complication of pregnancy. • Pregnancy related depression and anxiety affects one 1 out of 8 mothers.	**Revised Message #1 - Support:** Being a new parent is hard but it doesn't have to feel impossible with help from professionals and loved ones. Pregnancy related depression and anxiety can affect anyone -- it is the most common complication of pregnancy. **Supporting Points:** • Your struggling loved one is not the only one -- 1 out of 7 pregnant women and moms will experience anxiety or mood disorders.

MESSAGES OF SUPPORT:

Pregnancy Related Depression Awareness Findings

Topic Area #2 - Support: What you can do.	**Draft Message #2 - Support:** Pregnant and new mothers need comforting, nurturing and support from loved ones. They may find it hard to accept help in the beginning, but be patient and be available. **Supporting Points:** • Spend time listening, without needing to offer solutions and advice. • Offer to look after the baby or older children or discuss other childcare options so the mother can have a break. • Offer to help with cooking and cleaning without taking over these activities or expecting anything in return. • Encourage her to use self-care strategies such as eating well, exercising regularly and limiting drug and alcohol use. • Encourage her to get further help and find resources in her area to share.	**Revised Message #2 - Support:** Pregnant and new mothers need empathy and support from loved ones. They may find it hard to be honest about their feelings and accept help in the beginning. Be patient and be available. **Supporting Points:** • Spend time listening, without needing to offer solutions and advice. Her feelings are real. Let her express them to you. • Look after the baby or older children, or discuss other childcare options so she can have a break. • Take a simple action like cooking and cleaning without taking over these activities or expecting anything in return. • Encourage her to take care of herself by eating, resting, walking and limiting alcohol use. • Encourage her to get further help from a professional and/or support group and find resources in her area to share. • Fight the urge to give advice on how to parent, unless she asks.
Topic Area #3 - Support: Treatment exists (including treatment options).	**Draft Message #3 - Support:** Help is available for women suffering from pregnancy related depression and anxiety. Encourage your loved one to talk to their health provider. With their help and your support, your loved one can choose a treatment plan that is right for her.	**Revised Message #3 - Support:** Help is available for women suffering from pregnancy related depression and anxiety. Encourage your loved one to talk to a professional. With their help and your support, your loved one can choose a treatment plan that is right for her.

MESSAGES OF SUPPORT:

Pregnancy Related Depression Awareness Findings

	Supporting Points: • Pregnancy related depression and anxiety can't be fixed overnight but treatment options do exist. • Pregnancy related depression and anxiety won't go away by itself. • Pregnancy related depression and anxiety can be treated by social support, self-help skills, counseling and medication when necessary. • Lifestyle changes like physical activity, eating healthy food and taking time for themselves can help your loved one manage pregnancy related depression and anxiety.	**Supporting Points:** • It can't be fixed overnight but treatment options do exist. • It won't necessarily go away by itself. • It can be treated by social support, self-help skills, counseling and sometimes medication.
Topic Area #4 - Support: There are identifiable signs and symptoms.	**Draft Message #4 - Support:** If you are close to a pregnant or new mom who is showing signs of severe anxiety, uncontrollable anger, lack of interest in her baby, extreme panic or obsessive activity, she may be suffering from pregnancy related depression and anxiety. **Supporting Points:** • She may have trouble seeing her signs of pregnancy related depression and anxiety so it's important for you to look out for her. • If symptoms are severe or last longer than two weeks, encourage her to get the help she needs.	**Revised Message #4 - Support:** If you are close to a pregnant woman or mom who is showing signs of anxiety, anger, lack of interest in her baby, panic or obsessive activity, she may be suffering from pregnancy related depression and anxiety. **Supporting Points:** • She may have trouble expressing or understanding her signs of pregnancy related depression and anxiety so it's important for you to look out for her. • If symptoms are severe or last longer than two weeks, encourage her to get the help she needs.

MESSAGES OF SUPPORT:

Pregnancy Related Depression Awareness Findings

	• Common symptoms may include red eyes from crying, withdrawal from social interactions, and personality changes.	• Common symptoms may include red eyes from crying, withdrawal from social interactions, and personality changes.
Topic Area #5 - Support: What is PRD?	**Draft Message #5 - Support:** Pregnancy related depression and anxiety caused by chemical changes in the brain and can occur during pregnancy and up to 12 months after giving birth. Understanding the illness is the first step in finding the right treatment for your loved one. **Supporting Points:** • Symptoms last two weeks or longer • It can also be brought on by the stress of being a new mom. • It's different from "baby blues" which usually end two weeks after the baby's birth. • Pregnancy related depression and anxiety is a medical condition, not a bad mood.	**Revised Message #5 - Support:** Pregnancy related depression and anxiety is a medical condition, not a bad mood. It can occur during pregnancy and up to 12 months after giving birth. Understanding the illness is the first step in finding the right treatment for your loved one. **Supporting Points:** • Symptoms last two weeks or longer. • It can be brought on by the stress of being a mom, or it can be triggered by other struggles a woman is facing. • It's different from "baby blues" which usually end two weeks after the baby's birth.
Topic Area #6 - Support: PRD is serious.	**Draft Message #6 - Support:** Without support and treatment, the impact of pregnancy related depression and anxiety on the mom, baby and family can be very serious. You can help her today for a better tomorrow. **Supporting Points:** Untreated pregnancy related depression and anxiety can lead to poor nutrition, additional stress on the entire family, and further mental and physical health complications.	**Revised Message #6 - Support:** Without support and treatment, the impact of pregnancy related depression and anxiety on the mom, baby and family can be very serious. You can help her today for a better tomorrow. **Supporting Points:** • Suffering from pregnancy related depression and anxiety is not a reason for someone to take her baby away. Getting help supports your loved one's right to parent. • It makes it hard for a mom to bond with her baby -- that makes things harder for you, and it strains relationships

		• If your loved one is struggling, she may feel isolated and alone, and she may withdraw from you. If she does not get help, she might not be able to connect with you or her other loved ones. • She needs your support to know you understand her feelings, love her and want her to get help.

APPENDIX B – TEST IMAGES

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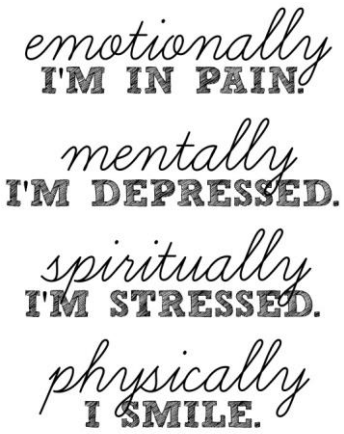

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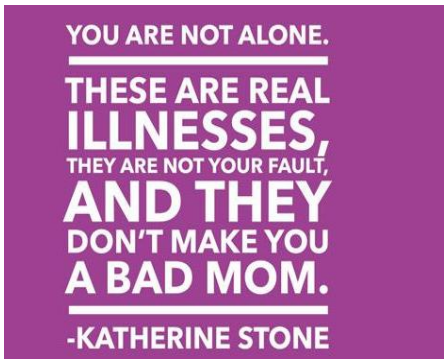

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MESSAGES OF SUPPORT:

Pregnancy Related Depression Awareness Findings

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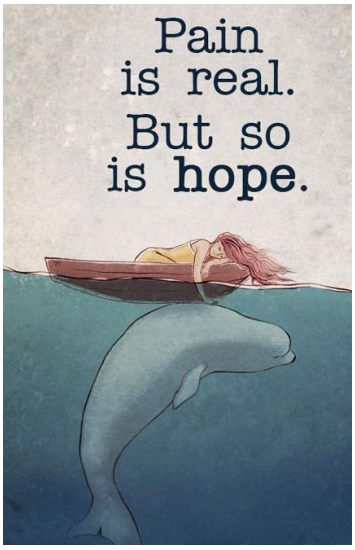

APPENDIX C – CODES

Message	Coding theme or "code word"	Example of coded text
Message #1 Being a good parent means taking care of yourself. You need nurturing and support, too. Finding the right help for you is important.	Help; Treatment; Self-Care	"The best thing I did was joining a postpartum therapy group. I am not better yet, but it helped a lot." "I try to stay motivated, get my mind on something else -- taking a walk, taking a class, going to the library. Also, I went to my doctor and they did a hormone check -- mine were way too high… so when I got the shaky feeling I could tell myself, 'I'm ok.'"
Message #2 Pregnancy related depression and anxiety are caused by chemical changes in the brain and occurs during pregnancy through up to 12 months after giving birth.	Symptoms; "Chemical"; "Hormone"	"[My therapist] explained it as something that's going on at the cellular level, and that was helpful." "I am going to do everything in my power not to have to call CPS. I already have clinical depression, so the pregnancy hormones are making it worse."
Message #3 You are not alone. You are not to blame. You can get help.	Isolation; Guilt; Kids' Judgment; Others' Judgment; Self Judgment	"You try talking to your friends, and they are like, 'That's not me, I never had a problem like that.'" "I feel a lot of solitude, being alone. You are so sleep deprived and so focused on care of your young one that you lose all contact with everyone."
Message #4 Treatment for pregnancy related depression and anxiety can make a big difference for yourself and your baby. Sadly, most women never get the support they need. Don't be afraid to ask for help.	Help; Treatment; Self-Care	"The therapist realized I had postpartum anxiety, so I went on a low dose of Zoloft. Having my peers around me [in a therapy group] and hearing their stories, I am not alone, this is a very common thing and it's ok to feel the way I feel as long as I am not content in my misery. You have to be proactive, to seek help." "If it's an illness it'll go away, but I don't

		feel like it'll ever go away. Yesterday was a really good day, but today I woke up and felt just awful."
Message #5 You are not weak, crazy, a failure or bad mom. It's not you, it's the pregnancy related depression and anxiety and it can be treated.	Strength; Not a Bad Mom	"Saying, 'You know what? Right now I am having a hard time loving my baby.' I think society judges people on that, makes you feel this big. I was afraid to ask for help but that was dumb. It got to a point I couldn't do it on my own but I was almost afraid to ask for help." "I gave myself dry. I thought I was being a bad person because I couldn't do it all myself."
Message #6 Untreated pregnancy related depression and anxiety can lead to serious problems. Getting help now means you are looking out for you and your baby's future.	Serious	"You are afraid to talk to your doctors, because you only hear about the extreme cases where moms hurt their babies, but that's really rare. To be a danger to yourself is to be a danger to your child." "I was very detached with my daughter and I regret it b/c she's a daddy's girl because he is the one who held her." "I was the suicidal one who was like, 'I want to end it all, I have nothing.' I hated my house, I felt like my house was a walking germ, and for the first year of life I didn't even really have her. I regret that I wasn't here, because I felt like I watched her childhood through [her godparents'] eyes, like they watched her grow up. I was there but I wasn't there."
Message #7 Pregnancy and life with your new baby is rewarding but can also bring big changes and challenges. For women with pregnancy related depression and anxiety, each day is a	Symptoms	"I just always feel inadequate and a failure." "I'm always so worried." "The stress."

struggle. Understanding symptoms is the first step to making your day brighter.		"The crying" "Anxiety, losing sleep, crying"
Message #8 Being a new parent is hard for all women but it doesn't have to feel impossible.	Common	"Yes, I thought I was going completely nuts, and I thought I was going to be the worst mother, so to know that this exists was helpful." "If I had known [PRD exists] that would have been helpful growing up. Knowing it's normal, it's fine, there's help."

APPENDIX D – KII DISCUSSION GUIDE

Intro: I'm Kendyl Salcito, I'm working with a marketing research firm Merritt + Grace in collaboration with the state health department on market research to target messages about perinatal mood and anxiety disorders to at-risk women. I'm grateful that you're willing to share your time today to help me understand the population group you work with and the services that are available to them. I'm going to ask you about yourself as well as your workplace, but your answers will be kept confidential, so please speak freely.

Background

Name:

Job title:

years in that position:

years in this field:

years that relationship has been established:

people in your facility working on PRD:

How are they/you trained?

Baseline PRD understanding:

- There are a variety of mood and anxiety disorders that can affect women during and after pregnancy, sometimes called postpartum depression. Experts have struggled to give a name to these experiences – what do you call these perinatal conditions in your office?
- How do your clients respond to those labels?
- How do you identify clients with signs and symptoms of PRD?
- When signs and symptoms are identified, how do you address your concerns with the client? [Probe: referral, medication, warm hand-off, schedule follow-up visit, etc]
- Do patients readily accept that PRD/PMAD is treatable? [Probe: why/why not?]
- Statistically, Colorado women do not often seek treatment, once PRD is identified? Why do you think that is?

Referral:

Messages:

What seems to be most helpful [*This section is highly conversational, structured to probe respondents for their common approaches to discussing PRD with clients and exploring what messages are effective. Each message will be discussed*]

- Common but it doesn't have to be like this?
- There is help?
- This is treatable?

- This is how you can recognize signs and symptoms in yourself?
- You are not alone?
- Messages of empowerment?

Imagery

- Should there be people in it?
- Should there be babies in it?
- Should it look hopeful or reflect the challenges?

Support system

- Who is supportive to your clients in general?
- Who is supportive for pregnancy-related challenges?
- Why do they differ, if they do?
- Feelings about husband/mother/relative as support for PRD?
- Are there additional resources that clients say they use to manage PRD? [Probe: WebMD, grandparents, neighbors, co-workers, yoga instructors, etc]

How do you currently disseminate information on PRD to clients?

What resources would help you communicate PRD to clients? Website? Brochure? Poster? Resource guide? Hotline?

APPENDIX E – HEALTHCARE PROFESSIONAL SURVEY

Thank you for taking the time to contribute to the Colorado Department of Public Health & Environment's understanding of existing identification of, referral for, and messaging regarding perinatal mood and anxiety disorders among Colorado women. This survey should take only 5-10 minutes to complete. It has been disseminated to healthcare staff across the state who work with women during and after pregnancy. The results will be used to guide a messaging campaign to encourage help-seeking behavior. We are grateful for your time and insights!

1. What is the type of setting where you work? (check all that apply)
    a. WIC clinic
    b. Family practice clinic
    c. Pediatric care
    d. Mental health
    e. Family resource center
    f. Childcare center
    g. OB/GYN provider
    h. Midwifery practice
    i. Health department
    j. Private medical or mental health practice
    k. Hospital
    l. Home visitation facility
    m. Other: _____
2. What is your role in the setting where you work?
    a. Physician
    b. Nurse/NP
    c. Physicians' assistant
    d. Midwife
    e. Administrative
    f. Therapist
    g. Licensed behavioral health (e.g. social worker or psychologist)
    h. Home visitor
    i. Case manager, care coordinator
    j. Promotora
    k. Educator/support group provider
    l. Child or family welfare worker
    m. Other: _____
3. Please select the top three most common sources of payment for services provided at your office
    a. Private insurance
    b. Medicaid
    c. Medicare
    d. CHP+
    e. State plans

   f. Self pay
   g. City or county funds
   h. Private funds
   i. Not paid/reimbursed
   j. Other, please specify:
4. What percentage of your female, child-bearing age clients are non-English speakers?
   a. 0-10%
   b. 10-25%
   c. 25-50%
   d. 50-75%
   e. 75-100%
   f. Unknown (if rough estimate is possible, please include here: _____)
5. If there are foreign languages spoken by clients in your work setting, what are they and what percent speak them? (Spanish excluded)
   a. [Open form]
6. How does your office evaluate clients for perinatal mood/anxiety disorders?
   a. Standardized screening tool (e.g. EPDS, PHQ-9 or other)
   b. Informal conversations with patients
   c. We do not screen
   d. Other: _____
7. What is the referral process if a client is suspected of suffering from a perinatal mood/anxiety disorder? (check all that apply)
   a. We have an in-office psychiatrist or psychotherapist
   b. We provide a phone number to a recommended mental health practitioner
   c. We connect the patient to a recommended mental health practitioner
   d. We provide a pamphlet of information on maternal mental health
   e. We tell the patient to seek help
   f. We send the patient to the ER
   g. None
   h. Other (including if guidance varies by circumstance): _____
8. If you suspect a client is struggling with a perinatal mood/anxiety disorder, what actions do you recommend they take? (check all that apply)
   a. I recommend exercise
   b. I recommend sleep and rest
   c. I recommend healthy eating
   d. I recommend limiting drug and alcohol use
   e. I recommend that they seek help and support from family and friends
   f. I recommend that they seek professional help
   g. I recommend that they join a support group
   h. Other: ___
   i. None, I don't feel qualified to provide guidance
9. What types of media do you think most effectively communicate PRD information to your clients? (please rank, 1 being most effective, 6 being least)
   a. __ Pamphlets
   b. __ Online resources
   c. __ Social media
   d. __ Flyers and posters

e. __ Radio
f. __ Other: _____

10. Where do you think your patients are most likely to see and read materials about PRD? (please rank top 3)
    a. __ Billboards
    b. __ Advertisements on public transportation
    c. __ Bathroom stall advertisements
    d. __ Church message boards
    e. __ Clinic waiting rooms
    f. __ Other waiting rooms (e.g. Human services, birth certificate, WIC, etc)
    g. __ Online (e.g. websites, blogs)
    h. __ On social media (e.g. Facebook, Twitter)
    i. __ Other
11. How does your office follow-up on mental health challenges of clients? (check all that apply)
    a. We maintain direct interaction with a mental health practitioner
    b. We maintain direct interaction with the client and track her progress
    c. We note mental health flags in patient charts and ask follow-up questions at ensuing appointments
    d. We carry out follow-up screening using EPDS
    e. We provide 24/7 access to a triage nurse, who notes updates in patient files when she/he is contacted.
    f. Other: _____
12. In interacting with women potentially affected by perinatal mood/anxiety disorders, what do you perceive as the greatest barrier to seeking help? (check up to three)
    a. Stigma from family/friends/self
    b. Fear (real or perceived) that insurance won't pay
    c. Lack of free time
    d. Distrust of medical or mental health personnel
    e. Fear that their children will be taken from them
    f. Please list any other barriers your clients experience when seeking help:_____
13. In your opinion, women struggling with perinatal mood/anxiety disorders often draw the greatest support from:
    a. Their mothers, sisters, and other female family members
    b. Their spouses or partners
    c. Other women affected by similar conditions
    d. Health and mental health practitioners
    e. Other: _____
14. What terms do you use to link the symptoms women experience with a diagnosis of pregnancy-related mood and anxiety disorders?
    a. Postpartum depression
    b. Pregnancy-related depression
    c. Perinatal mood and anxiety disorders
    d. Other: _____
    e. None - we just use descriptions of symptoms

15. Please describe typical or worrying responses you receive from patients when you talk about PRD.
    a. [open form]

In encouraging women to seek help for pregnancy-related depression, messaging is important.

16. In your experience, what messages are most effective? Please rank the following from strongest (1) to weakest (9).
    a. __ Being a new parent is hard for all women but it doesn't have to feel impossible.
    b. __ Pregnancy and life with your new baby is rewarding but can also bring big changes and challenges. For women with pregnancy related depression and anxiety, each day is a struggle. Understanding the symptoms is the first step to making your day a little brighter.
    c. __ Untreated pregnancy related depression and anxiety can lead to serious problems. Getting help now means you are looking out for you and your baby's future.
    d. __ Being a good parent means taking care of yourself. You need nurturing and support, too. Finding the right help for you is important.
    e. __ Treatment for pregnancy related depression and anxiety can make a big difference for yourself and your baby. Sadly, most women never get the support they need. Don't be afraid to ask for help.
    f. __ Pregnancy related depression and anxiety are caused by chemical changes in the brain and occurs during pregnancy through up to 12 months after giving birth.
    g. __ You are not alone. You are not to blame. You can get help.
    h. __ You are not weak, crazy, a failure or bad mom. It's not you, it's the pregnancy related depression and anxiety and it can be treated.
    i. __ Other
17. Friends, spouses, parents and other people who support new moms can struggle to effectively help women affected by pregnancy-related depression. In your experience interacting with these “support people” what messages do they most need to hear to help a depression-affected mom get the care she needs? Please rank strongest (1) to weakest (9).
    a. __ Being a new parent is hard but it doesn't have to be impossible. Pregnancy related depression and anxiety can affect anyone and is the most common complication of pregnancy.
    b. __ If you are close to a pregnant or new mom who is showing signs of severe anxiety, uncontrollable anger, lack of interest in her baby, extreme panic or obsessive activity, she may be suffering from pregnancy related depression and anxiety.
    c. __ Without support and treatment, the impact of pregnancy related depression and anxiety on the mom, baby and family can be very serious. You can help her today for a better tomorrow.
    d. __ Help is available for women suffering from pregnancy related depression and anxiety. Encourage your loved one to talk to their health provider. With their help and your support, your loved one can choose a treatment plan that is right for her.

e. __ Pregnancy related depression and anxiety is caused by chemical changes in the brain and occurs during pregnancy through up to 12 months after giving birth.
f. __ Expectant and new mothers need comforting, nurturing and supporting. They may find it hard to accept help but be patient and be available.
g. __ Other: _____

APPENDIX F – FOCUS GROUP DISCUSSION GUIDE

INTRODUCTION:

Turn to the person next to you and find out her name, one thing that she did today, what was the hardest thing about pregnancy and being a new mother, and who was most helpful to her during that time.

- Introduce that person to the group
- I'm so glad to have the chance to have such an interesting group assembled here. Your experiences are valuable to the research we are carrying out. The point of this discussion is to understand your emotional challenges during pregnancy and the ways that you manage the stress. In some cases, the level of stress is so great that moms need help, both in taking care of the baby and in taking care of their own mental space.

I'm going to tell a story, and then I'd like your insights on it.

There is a woman named [demographically appropriate name], she is [demographically appropriate age] and recently had a baby. After the birth, and sometimes even before, she has become incredibly stressed. She feels overwhelmed and exhausted, sometimes crying for no reason. Her sister told her this is normal, and she only has to eat well and sleep to feel better. Some days that seems to work, but now she is feeling worse and worse, becoming fearful and angry, sometimes even thinking about hurting herself. Keeping up with household responsibilities, child care, and work is more than she can handle.

What do you feel when you hear [demographically appropriate name]'s story?

In your opinion, is this an illness?

What do you see as the causes for those feelings?

What do you see as the symptoms or treatment associated with those feelings?

MESSAGES:

When you were dealing with difficult feelings during your pregnancy or afterward, what was the most helpful thing that anyone told you? *[bullet points below are probes]*

- Common but it doesn't have to be like this?
- There is help?
- This is treatable?
- This is how you can diagnose yourself?
- You are not alone?
- Messages of strength?

Did anyone give you any information about pregnancy related mood and anxiety challenges? *[Probes: What did they call it? How did that make you feel?]*

[**INSERT INDIVIDUAL MESSAGE SESSIONS HERE**] *[Probe: write down your first impressions. How this makes you feel, write what fears this evokes, what frustrations this evokes, what hopes it evokes?]*

Send back the one message you think is the most important of these nine. [review messages, check to see if there's a dominant one. *Probe: why was that important or useful?]*

IMAGERY:

I'm going to pass around some photos. When you look back on the time you were struggling with these feelings, tell me why they either resonate with you or don't. *[Probes: Should there be people in it? Should there be babies in it? Should it look hopeful or reflect the challenges?]*

COMMUNICATION TACTIC:

When you're reading about some of the topics that are hard to discuss, things like struggles in pregnancy, where do you take note of this kind of information? *[Probes: bus ads? billboards? posters or flyers in public bathrooms, above changing tables? Posters in community centers? Videos in waiting rooms?]*

If you had seen these messages around town, would they have changed the way you understood your own pregnancy challenges? Would they have changed your actions? *[Probe: Why/why not?]*

On websites and on Facebook, Twitter and elsewhere, what messages have resonated with you? *[Probe: how did you find those resources? What about them did you like? What did you find useful?]*

SUPPORT SYSTEM:

When you first arrived, you introduced your neighbor, and she told you about the person who was most helpful to her during difficult times in pregnancy and after having her baby. Having talked about the anxiety and stress you faced during that time, are there any other people who were particularly helpful to get you through those feelings? *[Probe: particularly unhelpful? Probe husband/mother/relative? Probe strangers? Probe religious community?]*

- Who are you actually willing to talk to about this? *[Probe: Are they at all qualified to help you? What do they need to know, or say, in order to be more helpful to you?]*

SEEK HELP:

Did any of you seek help from a medical or mental provider? *[Probe: Which one? Why/why not? Immediately, or at what point?]*

Having talked about it in terms of being treatable, what would make you inclined to seek medical help next time?

[Closing activity: turn to the person next to you and find out whether, after this discussion, they would have sought help in different ways or understood what they experienced differently. We'll share those changes with the group.]

[Thanks, reminder of confidentiality, request for Support Person contacts]

APPENDIX G – SUPPORT PEOPLE DISCUSSION GUIDE

INTRODUCTION - IF STRAIGHT TO VOICEMAIL:

Hi, is this _____? My name is Kendyl Salcito. _____ gave me your phone number and authorized me to contact you after she attended a discussion group meeting about the emotional challenges of new motherhood. I'm working with the state health department to help more women access the care they need in the months before and after they give birth. The aim of the discussion that ____ attended, and the aim of my call to you today, is to understand what prevents moms from asking for help, and what their supporters do to help them carry the heavy burden of motherhood. The work of so-called 'support people' like you is complicated but incredibly important. I would like to ask you about the things you do and say that seem to help the most -- your inputs will help guide a messaging campaign across the state of Colorado.

INTRODUCTION:

Hi _____, thanks so much for taking some time to talk to me. _____ authorized me to contact you about how you've managed to be a support to her as she struggles with motherhood. I know she is dealing with particular circumstances, but she's also experiencing some pretty classic signs and symptoms of pregnancy related mood and anxiety challenges.

Helping a new mom with those feelings is tough. First I wanted to ask about your personal experience with what words and actions seem to really help _____. Then I'd like to ask you about a few messages we've been generating, to see if any of them sound like things that could help you either understand what she is experiencing, or help her cope.

PERSONAL EXPERIENCE QUESTIONS:

1. What is your usual reaction when you see her getting anxious, or angry?
2. What is your usual reaction when she seems tired all the time, or the house isn't clean?
3. What is the #1 thing you say that seems to help her? That I love her, that I miss her.
4. What is the #1 thing you do that seems to help her? I think just talking to her, reaching out randomly to her, letting her know that I need her on occasion as well. The other day I called her and said I need you to be here at 5:00. Her being able to talk to me and listen to me made it so we were on more equal level.

MESSAGING:

Topic Area: Common but don't have to feel that way

Message: Being a new parent is hard but it doesn't have to be impossible. Pregnancy related depression and anxiety can affect anyone and is the most common complication of pregnancy.

Supporting Points:

- 1 out of 5 pregnant women and new moms will experience anxiety or mood disorders.
- It's the number one complication of pregnancy.
- Pregnancy related depression and anxiety affects one 1 out of 8 mothers.

MESSAGES OF SUPPORT:

Pregnancy Related Depression Awareness Findings

Topic Area: **Common signs & symptoms**

Message: If you are close to a pregnant or new mom who is showing signs of severe anxiety, uncontrollable anger, lack of interest in her baby, extreme panic or obsessive activity, she may be suffering from pregnancy related depression and anxiety.

Supporting Points:

- She may have trouble seeing her signs of pregnancy related depression and anxiety so it's important for you to look out for her.
- If symptoms are severe or last longer than two weeks, encourage her to get the help she needs.
- Common symptoms may include red eyes from crying, withdrawal from social interactions, and personality changes.

Topic Area: **PRD is serious**

Message: Without support and treatment, the impact of pregnancy related depression and anxiety on the mom, baby and family can be very serious. You can help her today for a better tomorrow.

Supporting Points:

Untreated pregnancy related depression and anxiety can lead to poor nutrition, additional stress on the entire family, and further mental and physical health complications.

Topic Area: **Treatment exists / options**

Message: Help is available for women suffering from pregnancy related depression and anxiety. Encourage your loved one to talk to their health provider. With their help and your support, your loved one can choose a treatment plan that is right for her.

Supporting Points:

- Pregnancy related depression and anxiety can't be fixed overnight but treatment options do exist.
- Pregnancy related depression and anxiety won't go away by itself.
- Pregnancy related depression and anxiety can be treated by social support, self-help skills, counseling and medication when necessary.
- Lifestyle changes like physical activity, eating healthy food and taking time for themselves can help your loved one manage pregnancy related depression and anxiety.

Topic Area: **What is PRD**

Message: Pregnancy related depression and anxiety caused by chemical changes in the brain and can occur during pregnancy and up to 12 months after giving birth. Understanding the illness is the first step in finding the right treatment for your loved one.

MESSAGES OF SUPPORT:

Pregnancy Related Depression Awareness Findings

Supporting Points:

- Symptoms last two weeks or longer
- It can also be brought on by the stress of being a new mom.
- It's different from "baby blues" which usually end two weeks after the baby's birth.
- Pregnancy related depression and anxiety is a medical condition, not a bad mood.

Topic Area: What you can do

Message: Pregnant and new mothers need comforting, nurturing and support from loved ones. They may find it hard to accept help in the beginning, but be patient and be available.

Supporting Points:

- Spend time listening, without needing to offer solutions and advice.
- Offer to look after the baby or older children or discuss other childcare options so the mother can have a break.
- Offer to help with cooking and cleaning without taking over these activities or expecting anything in return.
- Encourage her to use self-care strategies such as eating well, exercising regularly and limiting drug and alcohol use.
- Encourage her to get further help and find resources in her area to share.
- Fight the urge to give advice on how to parent, unless she asks for it.