THE IMPACT OF SCREENING ON POST-DEPRESSIVE SYMPTOMS

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B.A., California State University, Sacramento, 2009

PROJECT

Submitted in partial satisfaction of
the requirements for the degree of

MASTER OF SOCIAL WORK

at

CALIFORNIA STATE UNIVERSITY, SACRAMENTO

Spring 2009
THE IMPACT OF SCREENING ON POST-DEPRESSIVE SYMPTOMS

A Project

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Abstract
of
The Impact of Screening on Post-Depressive Symptoms
by
Nona Khara

The rationale for the study is to help understand four research questions: 1). What is the awareness and knowledge level of postpartum depression, resources and self care techniques among women in the postpartum period? 2). What level of awareness exists and impact the risk factors of postpartum depression? 3). Are the risk factors of postpartum depression among mothers going unrecognized, undetected or undiagnosed, and untreated? 4). Can increased awareness of postpartum depression lead to better self-care and decrease the risk factors of post depressive symptoms? The data were obtained by interviewing clinicians via survey questionnaire from different disciplines, including social work, counseling, psychology, and medical who had experience in working with women with history or current diagnosis of postpartum depression. The relevant findings highlight the pertinent factors of consideration during postpartum period, including increased awareness or knowledge of post-depressive symptoms, self-care, available support and/or resources.

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5-1-09
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ACKNOWLEDGEMENTS

I would like to acknowledge two people for believing in me. First is my mom who has always been there for me and has supported me through all the hardships of my life. My mom taught me to believe in myself and never to give up. Second, I would like to commend myself for putting in so much hard work to complete this project. Being a full-time student, Intern, and employee, along with fulfilling the roles & responsibilities of a mother, wife, and a daughter-in-law in a culturally traditional family was one of the most challenging tasks of my life. However, believing in myself helped me to accomplish my goal.
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Chapter 1
THE PROBLEM

Introduction

Postpartum depression is an important social and health problem for women and their families (Boyce & Stubbs, 1994; Cox, 1986; O'Hara, 1994 & 1995). Depression tears at the fabric of a woman's self-esteem and her marital relationship with her children (Weissman & Paykel, 1974). The authors discuss that postpartum depression is particularly devastating at a time when a woman and her family expect joy and happiness to be the rule of the day and not sadness and depression. Childbirth exerts a profound physical, mental, emotional, and social effect because it involves pain, emotional stress, vulnerability, possible physical injury or death, permanent role change, and responsibility for the child (Kendall-Tackett, 2005). Postpartum depression has many consequences for a new mother, her family, and especially for her infant, (Andre, 2005). Postpartum depression has been described as a dangerous thief that robs mothers of the love and happiness they expected to feel toward their newborn babies (Beck, 1999). Mothers suffering from postpartum depression often feel cheated and robbed of the first few months of their infant’s lives (Beck, 1999). Several studies reveal the adverse effects of postpartum depression on a child’s social, cognitive, and emotional development. Unfortunately, many times, postpartum depression goes undetected and hence untreated. Postpartum depression can be a significant disability for women if left untreated (Scrandis, 2005). With early and accurate detection and screening (including awareness/education of risk factors,
resources, and appropriate self care), postpartum depression can be treated. There is evidence in literature that supports the significance of early detection and prevention of postpartum depression before the severe form of treatment is necessitated which is hospitalization.

The author became interested in exploring and educating herself about postpartum depression after experiencing some slight postpartum symptoms such as mood swings and baby blues after giving birth. At the time of childbirth, the author felt vulnerable while taking care of her infant. The author was unaware of the risk factors and constraints of motherhood because it was a first time pregnancy to a young mother who lacked awareness, and received minimal support of partner after birth. Later she discovered a support group at a hospital setting. The support group helped the author normalize the postpartum symptoms and cope with the demands of her new role as a mother. Hence, the author found it absolutely necessary to educate women of the risk factors, available community resources, and self care techniques to help them cope with the demands of motherhood. The author’s interest grew stronger in doing research on postpartum depression while going to graduate school and working with children and families at a mental health agency. There, she worked with women of children who often complained of different risk factors that led to child abuse and neglect.

Background of the Problem

Postpartum depression is a disease that can cripple both mother and infant and may prevent a mother from caring for her newborn (Berry, Harrington, Jevitt, and
Zapata, 2005). Women experience this crippling mood disorder after giving birth to the child in the postpartum period which is 6 weeks after delivery, although research suggests postpartum depression can occur within one year after delivery and might last up to a year (Abell, 2007). The American Psychiatric Association defines postpartum depression as the first four weeks after childbirth. Approximately, 13% of new mothers experience this mood disorder at some point during the first year after delivery (O’Hara & Swain, 1996). A meta-analysis of 59 studies estimate the average prevalence rate to be 13% (Mallikarjun & Oyebode, 2005). Postpartum depression has significant morbidity and mortality attached to it with long term consequences on maternal mental health, depression in the partner, and detrimental effects on infant development (Mallikarjun & Oyebode, 2005). Statistics show that about 10% to 24% of women experience some form of depression after birth ranging from baby blues to postpartum psychosis (Thomas, 2000). Mood disturbances after birth come in a range of severity. The mildest form known as “the baby blues,” during which women may experience mood swings, anxiety, sadness, and fatigue usually starts in the first few days after the baby is born in approximately 50% to 80% or 8 in 10 new mothers (Abell, 2007). It tends to be milder in degree than true postpartum depression and can last up to a week or two.

The worst of the mood disorders is the rarer condition of postpartum psychosis which occurs in approximately 1-2 out of 1000 women after childbirth (Abell, 2007). Symptoms usually appear within three months of giving birth. Women with this disorder lose touch with reality and may experience hallucinations, delusions, extreme
anger and agitation, confusion, disorientation, paranoia, feelings of guilt or unworthiness, disinterest in the baby, rejection of the baby, actual thoughts of harming one self or the baby, etc (Abell, 2007).

Dalton & Holton (2001) discuss that the most severe form of postpartum depression is infanticide that is, when a mother kills her baby. This usually occurs in a rare condition of a mother’s bizarre mental state that lacks a nurturing response to the newborn. In many cases, the mother is able to fight the fears which may include hallucinations of killing the baby. Occasionally, instead of killing her own baby, she kills herself, other children, her husband or partner, or her parent (Dalton & Holton, 2001). Literature indicates that the rate of infanticide is 1 in 125,000.

Literature identifies at least 20 different psychiatric disorders which occur in the postpartum period. Among the 20 disorders, the main ones are: 1) Stress reactions, 2) Anxiety disorders, 3) Depression, 4) Disorders of the mother-infant relationship, 5) Psychosis.

Postpartum depression can be very dangerous and that fact needs to be recognized by both the pediatrician and the mother’s obstetrician because of the devastating impact of depression on mother, infant, and family (Abell, 2007). The increased contact with health services during pregnancy and the postnatal period provides an ideal opportunity to screen women for risk factors, identify those at risk, implement interventions to prevent the occurrence of postpartum depression (Mallikarjun & Oyebode, 2005). They indicate that women at risk need to be identified by a valid and reliable accurate detection and screening procedure.
Recognition and treatment of depression in pregnancy are vital to the health of both mother and infant (Berry, Harrington, Jevitt, and Zapata, 2005). Postpartum depression is treatable and can be treated with psychotherapy, medications or hormone therapy, or a combination of these. Postpartum psychosis can be treated with medications, including anti-psychotic medicines and mood stabilizers. Practitioners need to be trained to accurately detect women with postpartum depression (through screening which also includes education of the risk factors, community resources, and self care) and make appropriate referrals as needed for further treatment, if deemed appropriate.

Statement of Research Problem

There are four research questions that attempt to address the research problem for this study. The rationale for the study is to help understand four research questions. The research of these variables in this study will contribute to an understanding of the following four research questions: 1). What is the awareness and knowledge level of postpartum depression, resources and self care techniques among women in the postpartum period? 2). What level of awareness exists and impact the risk factors of postpartum depression? 3). Are the risk factors of postpartum depression among mothers going unrecognized, undetected or undiagnosed, and untreated? 4). Can increased awareness of postpartum depression lead to better self-care and decrease the risk factors of post depressive symptoms?
Purpose of the Study

The purpose of this project is to assess the opinions of professionals of postpartum screening on women diagnosed with postpartum depression using a survey questionnaire. The questionnaire is completed by professionals from different disciplines who serve clients suffering from this mood disorder. The survey questionnaire will assess the significance of awareness of risk factors of postpartum depression.

Theoretical Framework

The strengths perspective can be useful when applying to working with mothers suffering from postpartum depression. The strengths perspective encompasses a "collation of principles, ideas, and techniques" that enable "resources and resourcefulness of clients" (Saleebey, 1997). The strengths perspective approach would encourage mother's resourcefulness and enable them to utilize the available resources in the community. This would promote competence in mothers to cope with the demands of motherhood. Practitioners observe the resilience of clients by helping clients focus on solutions rather than problems, they support confidence-building. The therapist can help mothers believe in themselves and their ability using the strengths modality as the central organizing principle. The mothers possess an inner ability or inherent capability, resilience, and power to transform themselves within the context of vulnerable postpartum depressive symptoms. According to the strengths perspective, human beings are inherently self-actualizing. Even when mothers are faced with the demands of the new role, they can strive for autonomy, self
determination, competence, and connection by recognizing their strengths, abilities/potentials, and creative resources in transaction with the role of motherhood.

The principle goal of the strengths perspective is to encourage mothers to use their strengths, abilities, and resources (social support system and community network) in their environmental context which is vital to self-actualization and social competence, mothers feel a sense of empowerment. The empowerment-based approach using the strengths perspective helps mothers to take charge of their lives and improve their vulnerable condition for their betterment and well-being through awareness of the risk factors, available resources, and self-care techniques. The trusting relationship between a practitioner and a mother (client) expands learning based on supporting the development of these strengths to help mothers overcome the sense of helplessness or powerlessness and to come to believe in themselves.

The strengths perspective has both strengths and weaknesses when applying it to working with mothers suffering from postpartum depression. One of the strengths of this perspective is its empowerment-based practice that accentuates the resiliency of mothers in the face of obstacles to enable them to strive for self-actualization. One of the weaknesses of strengths perspective is its tendency to romanticize problems in the face of resiliency.

Assumptions

The assumption that the author wishes to explore in the study are the professional’s opinions which are very relevant to consider for study because these
professionals work directly with a large number of women who are clients dealing with postpartum depression.

**Definition of Terms**

Awareness is the consciousness or alertness of symptoms and self care is the ability to take good care of your self under difficult or vulnerable circumstances. The definition of self care is varied based upon individual, cultural, and socio-economic factors.

**Justification**

An increase in the awareness and knowledge of postpartum depression (which includes symptoms, risk factors, reality of motherhood, and available resources) will lead to better self care. The increase knowledge of postpartum depression will help mothers to recognize and hence seek necessary treatment for the betterment and well-being of themselves, their children, and their family. It is important that health care professionals and social work practitioners maintain a current knowledge base of available community resources to educate and provide to clients.

**Limitations**

One limitation of this study is that only professionals are surveyed and not mothers who are actual clients. A survey of mothers who experience postpartum depression might yield different outcomes.

**Summary**

The study is interviewing clinicians from different disciplines of practice with children and families, including mothers with history or current experience of
postpartum depression. There is a lack of empirical research in literature that explores the connection between awareness and knowledge of postpartum depression, as it impacts the risks of post depressive symptoms. The author gathered and relied heavily on information from literature review and professionals working directly and currently with children and families, including mothers who are at risk for postpartum depression.
Chapter 2
REVIEW OF THE LITERATURE

Introduction

The review of literature is organized into six themes. The first theme throws light on the risk factors of postpartum depression (which further comprises of subsystems). The second theme identifies the social construction of motherhood (incongruity between expectations and reality of motherhood) with culture and social class as subsystems. The third theme reviews literature pertaining to the prevalence of postpartum depression. The fourth theme examines the impact of postpartum depression on the child. The fifth theme highlights the importance of detection and screening processes and tools for postpartum depression. The sixth and final theme discusses literature on prevention and treatment methods of postpartum depression.

Risk Factors

Aiken (2000) found four contributing risk factors of the myth of perfect mothering:

1. The media image of motherhood: Aiken identifies that media paints a very pretty picture of motherhood - smiling mother with a squeaky clean baby which is usually not the case but women prepare themselves for this image and attempt to live up to it.

2. Society’s attitude: The author describes that society expects women to play the perfect role as a mother portrayed by the media, regardless of her own personal needs. As a result, women strive to live up to the perfect role in taking care of
their infants by neglecting or disregarding their personal self and become a victim of postpartum problems.

3. Women’s own parents’ influence: Even parents project an image of perfect parenting on part of mothers for instance, when women try to seek or cry for help parents encourage mothers to be a little more patient and may not offer help or support by giving the mother a break (Aiken, 2000).

4. Effects from women’s own childhood: Aiken discusses that some women who have ‘perfect childhood’ with ‘perfect parents’ aim to give their own children the same upbringing or may have imperfect childhood. As a result, women may fight with added pressure of their own upbringing to avoid inflicting the same upbringing on their own children (Aiken, 2000).

Numerous authors examine different factors that put mothers at risk for postpartum depression (Campbell et al., Cohn, Gotlib, Mount, Whiffen, & Wallace, (1991); Dunnewold, (1994); Gotlib, (1990); Grace, (2004); Kendall-Tackett, 2005; Mount, (1991); Mauthner, (2002); Miller, (1999); Mallikarjun, (2005); Martin & Negri, (1999); Oyebode, (2005); Robertson, (2004); Stewart, (2004); Sanford, (1994); & Wallington, (2004).

*lack of support.*

Kendall-Tackett (2005) found that lack of support during labor increased the risk for depression (Fisher & Rowe-Murray, 2001 as cited in Kendall-Tackett, 2005). Their study compares the experiences of 203 women who had undergone different types of delivery. The authors found three variables related to postpartum depression which
were a high degree of postpartum pain, a perceived lack of support during labor and childbirth and less than optimal contact with their babies.

Dunnewold and Sanford (1994) indicate that the lack of a social support system/network from the spouse/partner, family, and/or friends is related to postpartum depression. The study indicates that inadequate social support system might be particularly true in the cases of single mothers who have little or no support for their babies. Although this is not characteristic of all single mothers, it may be true for many. It may also be particularly true in case of teenage mothers who comprise a large portion of the single mothers in the United States and have unplanned pregnancies. The prediction is that single mothers often find themselves in a position of financial strain, doing all the household chores, and assuming care for their children alone. The single mothers may find that they can accomplish all the child-care tasks, but sorely miss a backup system to provide breaks, back rubs, and breadwinning (Dunnewold & Sanford, 1994). A single mother is expected to give all day long to her infant, with no built-in mechanism to get her own needs met because when she is tackling parenthood without a partner or another adult to provide reassurance and respite, the task can seem overwhelming (Dunnewold & Sanford, 1994). The authors discuss that becoming a mother for the first time can be of greater risk as a postpartum reaction than for women who having their second or third child. The authors further discuss the reasons which are that life changes dramatically with the transition to parenthood with a profound effect on the emotional self because a first-time mom experiences strong feelings of sadness and discomfort at the loss of old self and pre-
baby lifestyle. The study indicates that although child-birth is usually thought of as a
time of new beginnings of, it is also a time of significant losses: the loss of pregnancy,
the loss of freedom of being childless, the loss of being a couple, and the loss of old
self. Literature further supports that first time moms, older moms, and women with
certain personality characteristics seem to be more at risk for postpartum problems
than women who do not have these traits (Dunnewold & Sanford 1994). The study
identifies that the main three personality characteristics that appear to put women at
higher risk for a postpartum reaction are: need for control, perfectionism accompanied
by high expectations, and a tendency toward negative thinking and excessive worrying
(Dunnewold & Sanford 1994).

A similar prediction of lack of support from partners or spouses was made by
Mauthner (2002) who describes that lack of domestic involvement of partners or
spouses created a burden of work and responsibility that the women found physically
and emotionally draining. The women felt that their partners had no understanding of
their day-to-day lives as mothers. They experienced lack of assistance as an absence of
care, love, and concern, and as a result, they felt emotionally detached or isolated from
their partners. When these women asked for help, they felt that their partners were
non-responsive. Repeated rejection led them to withdraw gradually from the
relationships (Mauthner, 2002). Mauthner (2002) found that the strongest predictor of
postpartum depression was the availability of companionship and feelings of
belonging to similar others, and the quality of intimacy with the husband (Cutrona,
2002 as cited in Mauthner, 2002). The article indicates that there is a pervasive
assumption among researchers that relationships with male partners are more conducive to women’s happiness and well-being than are other relationships. The article further reports that even friends tend to be seen as secondary to spousal support and in some cases, back-up support was considered when partner was not available.

Kendall-Tackett (2005) conducted a study on 191 low-income women and found that women with good social support were less likely to become depressed (Ritter et al., 2000 as cited in Kendall-Tackett, 2005). The author found that social support was significantly related to self-esteem and women who had high levels of support systems were more likely to have high levels of self-esteem.

*maternal age.*

Another study conducted by Kendall-Tackett (2005) found the correlation between postpartum depression and maternal age. The study indicates that mothers on the high and low ends of the age spectrum have the highest risk for depression. One recent prospective study of 901 women found that women under the age of twenty were at high risk for postpartum depression (Dibley, Linnane, Pritchard, & Webster, 2000: Kendall-Tackett’s article). Another study of 465 women under ages twenty to twenty-four or thirty and older was significantly more likely to be depressed at four months postpartum depression (Chaudron et al., 2001: Kendall-Tackett’s article). Thus, the study indicates that mothers at either end of the age spectrum are vulnerable to depression. Kendall-Tackett (2005) describes that young mothers are more at risk because they have a higher likelihood of single marital status, low socio-economic
status, and possible past abuse, while on the other side older mothers may have been through infertility assessments, high-risk pregnancies, and possible pregnancy loss.

*history of mood or psychiatric disorders.*

The second prediction was made by Miller (1999) who indicates a history of postpartum mood disorder or family illness of psychiatric disorder as risk factors of postpartum depression. The prediction indicates risks that include highly stressful life changes and medical conditions and/or medications that can contribute to depression or psychosis. This is supported by Mallikarjun and Oyebode, (2005) who found that postnatal depression has significant morbidity and mortality which is associated with long-term consequences on maternal mental health, depression in partner, and detrimental effects on infant development. The study further identifies psychiatric illness as the second leading cause of maternal deaths.

*lack of awareness or knowledge.*

The third prediction was lack of awareness or knowledge of postpartum depression and available resources (Campbell, Cohn, Gotlib, Mount, Whiffen, & Wallace, 1991). This is supported in a study (Dalton & Holton, 2001) that necessitates the level of awareness of the symptoms of postpartum depression through early detection or screening and education of the risk factors of postpartum depression, available resources, and the importance of self care to help mothers cope with the demands of motherhood.
Mallikarjun and Oyebode, (2005) examine child deaths and found “The Confidential Enquiries into Maternal and Child Deaths reported that about two-thirds of the women who died from psychiatric causes had a previous psychiatric history, out of which half the cases were not identified during the index pregnancy” (pg. 125). Women with histories of major mood disorders are about 300 times more likely than women in the general population to have a postpartum recurrence (Hamilton & Sichel, 1992). This study further substantiates the connection between poor communication and lack of screening of risk factors between the practitioner and the patient with postpartum depression. The same study highlights the increased contact with health services during pregnancy and the postnatal period that provides an ideal opportunity to screen for the risk factors and identifying those at risk and implementing interventions to prevent the occurrence of postnatal depression.

infant temperament and hormonal changes.

Another prediction was made by Mallikarjun and Oyebode, (2005) who identify infant temperament or low infant viability and hormonal changes that fluctuate rapidly within a mother’s body as risk factors of postpartum depression. The infant temperament or low infant viability include premature/low-birth weight babies who were colicky or had poor feeding problems, traumatic birth or delivery. Martin and Negri (2005) examine how infant temperament complicates maternal depression for instance, they identified that mothers who have infants who are more difficult to
manage and who receive less positive reinforcement from the mother-child interaction are more likely to feel as a failure as a parent.

Recent research was conducted by meta-analysis on prenatal risk factors for postpartum depression (Grace, Robertson, Stewart, & Wallington, 2004). The meta-analysis study indicates prenatal depression, prenatal anxiety, stressful life events, low levels of social support, and a previous history of depression as strong predictors of postpartum depression. Literature indicates that consistent evidence is accumulating that the same predictors are significant around the globe. For example, numerous authors (Halmesmaki, Nurmi, Saisto, & Salmela-Aro, 2001) in Finland predicted prenatal depression and prenatal anxiety as risk factors of postpartum depression. Boyce (2003) conducted a research in Australia that predicted that stressful life events, a past history of depression, a past history of marital relationship, and low social support were significantly related to postpartum depression.

Social Construction of Motherhood

Several authors have researched the reality of motherhood and its congruency, or lack thereof, and to the expectations of motherhood (Berggren-Clive, 1998; Beck, 2002, 2005, & 2006; Dalton, 2001; Driscoll, 2006; Dunnewold, 1994; Gable, 2005; Holton, 2001; Kumar, 1994; Mauthner, 1999 & 2002; McIntosh, 1993; Martin & Negri, 1999; Nicolson, 1990; and Sanford, 1994). The research discusses the dangerous myths operating among both professionals and lay people that equate becoming a mother with total fulfillment and happiness (Nicolson, 1990). These myths created by the society set expectations that are impossible for mothers to attain and
place women’s mental health at risk (Berggren-Clive, 1998). The research shared how the dreams and unrealistic expectations held by mothers are shattered by the reality of motherhood. Women experience conflict between how they expected motherhood to be and their own experiences as mothers (Mauthner, 1999). The study indicated that women become disillusioned with motherhood, as they perceived that they failed to fulfill their expectations of themselves as the perfect mother. Furthermore emotions of despair and sadness start the mother’s spiral downward into postpartum depression (Mauthner, 1999).

Another social construction of motherhood is explored in Mauthner’s (2002) article that highlights feminist’s views of mother’s lives in terms of a home/work split that neglects women’s involvement in maternal, community, and other networks and friendships that transcend these boundaries. The article further discusses that women who had already set high standards for themselves shared that they continued to do so when they became mothers. They expected perfection from themselves and from their children. Their compulsion to be perfect mothers was understood within the context of the cultural devaluation of motherhood (Mauthner, 2002). Despite the fact that Western cultures idealize motherhood, mothers often are compelled to justify time devoted to the unpaid work of motherhood, as though just being a mother was not enough. Women are expected to be perfect and exceptional mothers (Mauthner, 2002). The article further identified the first-time mothers for example, who had very romanticized images of motherhood. These mothers painted soft portraits of serene
mothers gazing at peaceful and beautiful babies. They pictured themselves with calm babies who fed every four hours and slept much of the time. The women who became depressed after a second and third baby knew, from experience, the reality of motherhood. They realized that looking after a young baby is hard work, both physically and emotionally. Their main concern was to appear to others as though they were coping well (Mauthner, 2002). In reality, these mothers felt guilty, shameful, inadequate, and experienced a profound sense of failure. Many felt unable to cope with daily tasks and with their children. Some had suicidal thoughts of harming themselves and others had thoughts of harming their children (Mauthner, 2002).

Kendall-Tackett’s (2005) article throws light on social class, another aspect of the social construction of motherhood. Kendall-Tackett (2005) discusses, The American Psychological Association, in its report on women and depression, noted that poverty was an independent risk factor for depression in women (Keita, McGrath, Russo, & Strickland, 1990 as cited in Kendall-Tackett, 2005). Kendall-Tackett (2005) suggests that poverty increases the likelihood of depression because it limits support, access to medical care, and access to community resources. Furthermore, poor mothers often face additional stressors as they deal with uncertain income, dangerous housing or neighborhoods, and the negative effects of being at the bottom of the social strata (Kendall-Tackett, 2005). The findings further implies the connection between poverty and depression in both American and International samples (Kendall-Tackett, 2005).

Numerous surveys indicate that depression after childbirth can also exist in higher socio-economic classes (Dalton & Holton, 2001). The support of a lovely home,
financial security, and a nanny or other support systems are no guarantee against depression and its owner can suffer the same way as a lonely, single mother living on public welfare benefits. The study indicates that different results from surveys occur because of different definitions are used and different samples of women are included or excluded. For example, a survey in a known economically deprived area will tend to focus on poor socio-economic status and lack of support from partner, family, and friends in identifying causes for depression (Dalton & Holton, 2001).

Beck (2002) suggests four perspectives involved with the social construction of motherhood. Those include the following: conflicting expectations/shattered dreams, fear of moral condemnation/being labeled, cultural context, and social class (Beck, 2002).

*conflicting expectation and shattered dreams.*

Beck’s (2002) research indicates that myths related to the constraints of motherhood are so rampant in society that women view themselves as bad or abnormal mothers. The research describes that women held unrealistic expectations of motherhood which were shattered by the reality of their lives as new mothers (Beck, 2002). These conflicting expectations experiences of motherhood led them to the path of being or feeling overwhelmed, perceiving themselves as failures, and bearing a suffocating burden of guilt (Beck, 2002).

In a metasynthesis of eighteen qualitative studies, Beck (2002) found that expectations played a large role in postpartum depression on several different levels. Beck described that how mothers and professionals harbor the belief that motherhood
brings total fulfillment to women which is contradictory in reality. Women in the study did not confide in others because they wanted to keep up to the myth of perfect mothers. The study indicated that first-time mothers in particular struggled more with the myth of perfect motherhood than mothers who were having their second or third child who focused on coping with the new addition to their families. Thus mothers are more likely to experience postpartum depression, if they have unrealistic expectations of themselves as mothers and of their babies (Kendall-Tackett, 2005).

Beck discusses three kinds of conflict in mothers’ narratives, all of which centered on the desire to be the perfect mother (Mauthner, 1998 as cited in Beck, 2002). The author found that the three conflicts involved care for their infants include the following: 1.) breastfeeding and being employed, 2.) women’s depression and unhappiness which were in direct conflict with their expectations that they would be happy with their infants, and 3.) women’s expectations that they could cope with their new infants although the reality was they needed help (Mauthner, 1998). All eighteen mothers in Mauthner’s study experienced one or more of these sets of conflicts. All women in Mauthner’s study expressed that their recovery from postpartum depression involved acceptance or resolution of the conflicts they had experienced during their transition to their new role as mother.

Dunnewold and Sanford (1994) discuss that the expectations of motherhood are based on what their own mothers experienced based on culturally learned attitudes about motherhood, and personal ideology of good mothers. The problem arises when women set their expectations too high and end up getting angry with them for now
falling short of the heightened expectations (Dunnewold and Sanford (1994). The researchers describe that there is inadequate scientific knowledge about what makes a good mother, so it becomes a process of trial and error to figure out the role of motherhood. Many times, women are also taken aback by the images of a perfect, beautiful looking, and a calm baby and compare themselves poorly to the perfect image. In an effort to make up for the difference women push themselves to be perfect mothers and the more they do, the more difficulties they are likely to create for themselves (Dunnewold and Sanford (1994).

\emph{fear of moral condemnation and of being labeled.}

Women fear moral condemnation and do not want to be labeled as failed mothers in the postpartum period (Beck, 2002). Beck describes the work of another researcher who conducted a study on 38 depressed women in the postpartum women (McIntosh, 1993 as cited in Beck, 2002). The study found that only 18 out of 38 women sought help for depression. The study further indicated that the main reason these mothers chose to suffer in silence was that they were ashamed or embarrassed because of the fear of being labeled bad mothers or failures at mothering (McIntosh, 1993). Berggren-Clive (1998) concluded that the stigma associated with being depressed after childbirth was a source of concern that at times prevented women from seeking help.

\emph{cultural context.}

Beck (2002) believes that cultural context can intensify the conflicting expectations and experiences of motherhood for instance; Jordanian women are held to have very high expectations of the performance of motherhood. Beck discussed another
study by Amasheh and Nahas (1999) who explored the experiences of postpartum depression among Jordanian women living in Australia. The research indicates that Jordanian women are not supposed to be sad or depressed, because according to their culture that would mean that they are not able to cope and are bad mothers. Beck and Gable (2005) conducted an international study of postpartum depressive symptoms in nine countries (i.e. United States, Australia, Sweden, Finland, Italy, Korea, India, Guyana, and Taiwan) with a total sample of 892 women whose findings indicated that mothers living in South America reported the second highest levels of depressive symptoms in the world (Affonso, De, Horowitz, & Mayberry, 2000 as cited in Beck & Gable, 2005).

Kendall-Tackett (2005) found that postpartum depression is not limited to white middle-class American women and that it is relatively common in other countries as well (O'Hara, 1994 as cited in Kendall-Tackett, 2005). Kendall-Tackett (2005) describes the fact that postpartum depression affects women in many different cultures and at all income levels, as evidenced by the revelations of postpartum depression among popular women such as Princess Diana and Marie Osmond.

Martin and Negri (1999) found that cultures that allow increased social support and supportive rituals around the first six weeks after delivery appear to have lower rates of depression (Cox, 1996; Carter, 1992; Fleming, 1992; Kruckman, 1983; Klien, 1992; & Stern, 1983 as cited in Martin & Negri, 1999).

This is supported by Beck and Driscoll (2006) who argue that rituals and customs around postpartum period are critical for a mother to feel accepted and that her
new role was valued by her culture as evidenced by a surrounding network of support system of family and friends because without the rituals which included the support system, mothers are stripped of the protective layers (Seel, 1986 as cited in Beck & Driscoll, 2006).

Kumar (1994) believes that sometimes, postpartum depression may go unrecognized in non-Western cultures because of the cultural stereotyping. Mauthner (2002) describes that the unpleasant experiences of motherhood and indicates that women have perceptions of having fallen short of the cultural ideal. The research further indicates that postpartum depression may feel real and meaningful to women who are experiencing it, but that has a historically and culturally specific medical construct as well. Dalton and Holton (2005) believe that postpartum depression is prevalent worldwide and is not limited to any specific culture or exclusively to developed countries.

Prevalence of Postpartum Depression on the Child

Several authors examine the prevalence of postpartum depression in a study pertaining to postpartum depression (Coste, Curet, Dorato, Harrison-Hohner, Hatton, & McCarron, 2005). The authors found that postpartum depression afflicts from 10% to 20% of mothers after childbirth. The study further indicated the risk factors of postpartum depression which included prior history of depressive disorder and/or premenstrual dysphoric disorder, depression during pregnancy, inadequate social support, and negative life events.
Kendall-Tackett (2005) found that the point prevalence of postpartum depression was 9 percent at fourteen weeks, and 17 percent at thirty weeks postpartum (Couser, Stuart, Schilder, & O’Hara, 1998 as cited in Kendall-Tackett, 2005). The study further indicates that for depression, the incidence of and the time of most risk is 23 percent at fourteen weeks, and 19 percent at thirty weeks. These same researchers noted that higher percentages of women had either depression or anxiety in the postpartum depression. Kendall-Tackett (2005) define several conditions as comorbid with postpartum depression which include panic disorders, generalized anxiety disorders, social phobia, obsessive-compulsive disorder (OCD), and post-traumatic disorder (PTSD). Kendall-Tackett (2005) examine several other factors that accompany postpartum depression, including additional responsibilities and changing social, family, and professional roles (Rapkin et al., 2002 as cited in Kendall-Tackett, 2005).

\textit{Impact of Postpartum Depression on the Child}

Several authors discuss the impact of postpartum depression on the child (Beck, 2002; Coste, Curet, Dorato, Harrison-Hohner, Hatton, Kendall-Tackett, 2005; McCarron, 2005; Miller, 1999; Milgrom, Martin, & Negri, 1999). Coste, Curet, Dorato, Harrison-Hohner, Hatton, and McCarron (2005) found that unlike the more common ‘baby blues’ that affect more than 50% of new mothers, PPD (postpartum depression) can engender long-term risks to children including cognitive and behavioral problems.

Research studies that assess the impact of postpartum depression on infants, found that the symptoms of depression, such as withdrawn affect and maternal preoccupation bear a direct impact on the infant’s experience (Milgrom, Martin, &
Martin and Negri (2005) discuss that depression may have long-term consequences on child development and may entrench the mother-infant relationship in a negative vicious cycle. Infants develop not only a sense of self but also a secure attachment relationship from experiencing appropriate maternal responsiveness (Ainsworth, 1979; Stern, 1985; & Winnicott, 1965 as cited in Martin & Negri, 2005). The study further indicates that appropriate attachment with mother early on can have long term positive effects on a child’s cognitive and language development.

Depression during pregnancy can lead to elevations of stress hormones in neonates and has a profound and devastating impact on the health of mothers (Kendall-Tackett, 2005). Findings from the Global Burden of Disease Study found that major depression was the fourth most common cause of early childhood death and disability throughout the world (Lopez & Murray, 1997 as cited in Kendall-Tackett, 2005). A study that recruited sixty-three mothers during the last trimester of pregnancy revealed that thirty six of whom had depressive symptoms: The depressed mothers and their infants in the first seven days of life were tested and it was found that these same depressed mothers and their infants had high cortisol, norepinephrine levels, and lower dopamine levels (Field, Jones, Lundy, & Nearing, 1999 as cited in Kendall-Tackett, 2005). The study further found that their infants as neonates also performed poorly on the orientation, reflex, excitability, and withdrawal clusters on the Brazelton Neonatal Behavioral Assessment Scale.

Kendall-Tackett (2005) also discussed the fact that women’s expectations about their babies can also lead to depression (Alexander, Boris, & Smyke, 2002 as cited in
Kendall-Tackett, 2005). The study includes a sample of sixty-eight at-risk African American women, who worried about spoiling their babies and who reported more depression and had more inappropriate developmental expectations of their babies than mothers who had not worried about spoiling their babies. The findings suggest that fear of spoiling may influence maternal responsiveness in mothers who are at risk and may lead to potentially disturbed mother-infant relationships.

Miller (1999) discusses a few studies that documented behavior problems in the offspring of mothers with postpartum depression disorders. Muller (1992) discusses that infants and toddlers of mothers with postpartum depression experience more sleep disturbances, eating problems, and temper tantrums than did infants of non depressed mothers. Miller found that significant cognitive delays were reported in infants whose mothers had untreated postpartum depression (Lyons-Ruth et al., 1990 as cited in Miller, 1999). The study found that at age 18 months, these infants were several months behind other infants whose mothers had been treated for depression. Miller (1999) discusses that untreated postpartum depression may place a family at considerable risk and may interfere with the mother-child interaction.

Beck (2002) discusses the impact of postpartum depression with infant’s loss of relationship with the depressed mother. Due to the inability of mother to cope with more than one child at a time; the women came to resent their older children and pushed them away because the mothers felt that older children were suffocating them (Beck, 2002).
Beck (2006) conducted a qualitative study on 12 postpartum depressed mothers to explore their personal experiences as mothers caring for and interacting with their infants and older children. The study found several themes pertaining to the impact of postpartum depression on the child which include:

1. Postpartum depression overtook mothers' minds and bodies preventing them from reaching out to their infants and depriving them of any feelings of joy, because pleasure and enjoyment were not experienced as components of maternal care-taking role.

2. Overwhelmed by the responsibilities for caring for their children, the women were petrified that they would not be able to cope.

3. To survive, some mothers erected a wall to separate themselves emotionally and physically from their children.

4. Stripped of a strong desire to interact with their children and plagued by oversensitivity to stimuli, mothers often failed to respond to their infants' cues.

5. Guilt and irrational thinking pervaded mothers' minds during their day-to-day interactions with their children.

6. Uncontrollable anger erupted periodically toward the children to the degree that feared that they might harm their children.

7. As postpartum depression engulfed the mothers, they perceived that detrimental relationships with their older children were materializing.

8. Feelings of loss enveloped the mothers as they focused on their relationships with their older children.
9. Striving to minimize the negative effects of postpartum depression on their children, mothers attempted to put their children's needs above their own.

Detection and Screening

Beck and Driscoll (2006) believe that postpartum depression or mood disorder does not have a homogenous or a single cause or symptom but constellations of varying symptoms which in turn need different treatment approaches. Beck and Driscoll (2006) emphasize that screening for postpartum depression requires sensitivity on the part of clinicians. Women who experience this mood disorder may find it difficult to confide their feelings because of social stigma surrounding depression after childbirth. The authors suggest that a clinician must begin screening by discussing the mother's expectations and role of her new motherhood. Mothers believe the myth that new motherhood should lead to all positive emotions and they may later on, be hesitant to disclose or share the feelings that do not fit with these ideals. The research indicates that by gently normalizing the wide range of feelings, both positive and negative that often accompany new motherhood, a health care provider can help the mother to complete the screening scale in an open and honest manner (Beck & Driscoll, 2006).

In one of the studies pertaining to the significant need for screening for postpartum depressive symptoms, one of the most difficult challenges in dealing with postpartum depression has been early recognition because a striking feature of this mood disorder is how covertly it is experienced (Berchtold, Honikman, & Harberger, 1992 as cited in Beck, 2006). The study further found that because the postpartum
mood disorder often goes unrecognized by clinicians, mothers in the community suffer in silence, fear, and confusion. Undiagnosed postpartum depression can plunge mothers into the depths of despair and turn their first months of motherhood into blackness (Berchtold, Honikman, & Harberger, 1992). Kleiman and Raskin (1994) found that approximately 400,000 mothers in America experienced this postpartum mood disorder each year starting at about 6 to 8 weeks after delivery (as cited in Beck & Driscoll, 2006). Furthermore, clinicians only identify a small percentage of these mothers as depressed (Beck & Driscoll, 2006). The study identifies some of the reasons for under assessment were that mothers with postpartum depression may not seek treatment due to lack of knowledge about postpartum mood disorder or social stigma (Beck & Driscoll, 2006). In a qualitative study conducted on women with postpartum depression in Australia who sought help for their depression, the women expressed that they did not know how and when to seek help (Holopainen, 2001 as cited in Beck & Driscoll, 2006). These mothers realized that something was wrong with them but they did not actively seek help because they are not aware that they had postpartum depression.

Screening provides women with an opportunity to discuss their experiences regarding the risk factors for which interventions can be planned to address women’s problems (Beck, 2006). Beck found that once risk factors are identified, clinicians can target interventions to help decrease a woman’s risk for developing this mood disorder. The research further indicates that although risk factors are indicators of an increased probability of developing postpartum mood disorder, they may or may not
be related directly to its cause. Beck (2002) emphasizes that it thus becomes important for clinicians to keep in mind that the presence of a risk factor does not necessarily mean that a woman will develop postpartum depression.

Miller (1999) suggests that the recent advances in treatment have markedly improved the prognosis of women with postpartum mood disorders. Research suggests that early identification and intervention for women at risk may preserve family structure and prevent long term damaging effects on women's families and offspring (Miller, 1999).

The process of early detection and screening of postpartum depressive symptoms involves several screening tools that have been developed. For example, The Postpartum Depression Screening Scale (PDSS) is developed by Beck and Gable (2002). It is a 35-item self-report scale that is designed to assess the presence, severity, and type of postpartum depression symptoms. The PDSS screens for postpartum depression by identifying women who have a high probability of meeting diagnostic criteria for a depressive disorder with postpartum onset, as defined by the Diagnostic and Statistical Manual of Mental Disorder, Fourth Edition-Text Revision (DSM-IV-TR; American Psychiatric Association, 2000).

One of the most commonly used screening and diagnostic tools for postpartum depression is the EPDS (Edinburgh Postnatal Depression Screening Scale). The Edinburgh Postnatal Depression Screening Tool is an internationally used instrument with proven validity and reliability. The 10-question Edinburgh Postnatal Depression Screening Tool is a valuable and efficient way of identifying patients at risk for post
depressive symptoms. The tool is easy to administer and has proven to be an effective screening tool to detect post-depressive symptoms in the postpartum period. O'Hara (1994) found that EPDS has been reported to accurately detect 86-95% of women identified as depressed. Unfortunately, postpartum depression can be easily missed and not unrecognized as an illness. It may be considered as a defect of personality (Dalton & Holton, 2001). However, it is real and it can be helped and treated once it is recognized as a hormonal illness which is preventable (Dalton & Holton, 2001).

Seale et al. (1988) conducted a group treatment program that found a significant reduction in women's scores on the EPDS at the end of treatment (as cited in Martin & Negri, 1999). This is further supported by Martin and Negri (1999) who discuss that PND often goes unrecognized due to its slow and insidious onset and to the fact that many women tend to hide their depressive symptoms from others. The authors of this study discuss that only a minority of women who suffer from PND seek professional help and benefit from early intervention to reduce avoidable, prolonged emotional distress and limit consequences on the infant or family (Martin & Negri, 1999). The study identifies a number of strategies to improve the process of early detection and screening of PND which are:

1. Normalizing the possibility of PND through discussions and community education, both antenatally and postnatally.
2. Early identification through awareness of symptoms by health professionals at routine visits or check ups after childbirth.
3. Close attention to women showing evidence of risk factors.
4. Routine screening following birth (Martin & Negri, 1999 discuss that this is emerging as the single most effective and cost-effective means of identifying mothers at risk of PND, enabling early treatment of mothers who would otherwise remain undetected. Literature indicates that routine screening educates women of the importance of self care (to help them cope with the demands of motherhood) and available resources in the community.

**Prevention and Treatment of Postpartum Depression**

Beck and Driscoll (2006) suggests that the aim of primary prevention is the prevention of postpartum depression and the goal of secondary prevention is to limit the severity of postpartum depression and prevent complications and sequelae. According to Beck and Driscoll, (2006) the secondary interventions mainly fall into four categories: support groups, health visitors’ interventions, interpersonal psychotherapy, and massage/relaxation therapy.

*support groups.*

According to Beck and Driscoll (2006), the primary aim of support groups is to provide postpartum depressed women with an opportunity to be in contact with other women who are having similar experiences to help normalize the process of PPD and to share problems and discuss solutions. They suggests that the goals of the group are to increase women’s knowledge of postpartum depression, to discuss expectations of motherhood to help them better adjust to it, decrease social and emotional isolation, to learn relaxation and coping techniques, to learn ways to control anger and to deal with
premenstrual tension and stress, and to discuss relationships, and to increase assertiveness.

Kendall-Tackett (2005) suggests that support groups help to increase self esteem and self efficacy, act as a buffer to help women deal with demands of motherhood, and alter woman's attributional style. The author finds that social support groups must be included in the prevention and treatment program of postpartum depression. Literature suggests that social support involves general support, partner support, and community network.

health visitors' interventions.

Literature suggests that health visitors listen to postpartum depressed mothers using a nondirective listening approach at the routine postnatal visits. The trained health visitors detect the mood disorder using the EPDS or other effective screening tools and makes appropriate referrals as needed for further treatment.

interpersonal psychotherapy (IPT).

The literature indicates that IPT is based on the belief that mothers who experience social disruptions are at an increased risk for developing postpartum depression which then focuses on mothers' interpersonal relationships as the basis for intervention. IPT helps women in changing their relationships or their expectations of those relationships with their partners. In 2000, researchers, Gorman, O'Hara, Stuart, and Wenzel assessed the efficacy of IPT for postpartum depression and found that the common problematic areas focused on were conflicts with partners or family
members, a loss of work relationship and/or social relationships, and other losses related to birth.

*massage and relaxation therapy.*

According to Driscoll (2006), postpartum period is a time of major hormonal changes and psychological demands. She suggests that although talk therapy is a major adjunct to physiological healing, medication is necessary to help women's brain chemistry to reset and reregulate to meet her psychological demands. Based on the expert consensus guidelines published in 2002 recommend the combination of antidepressant medications and psychosocial interventions for the treatment of postpartum depression (Altshuler et al., 2002).

**Summary**

Postpartum depression continues to prevail in our society until now. Postpartum depression continues to go unrecognized or undiagnosed and hence untreated (Andre, 2005). Postpartum depression has a detrimental effect on women and their children in the postpartum period. Postpartum depression negatively impacts children's cognitive, social, and emotional development due to insecure or poor attachment with mothers in the postpartum period. Furthermore, women's relationships not just with children but also with their partners and families are affected leading to marital problems. Women need to educate themselves of the risk factors and take necessary measures or steps, including participating in support groups and other forms of treatment methods to address and overcome their depression. The health care professionals need to accurately detect and make appropriate referrals as needed for further treatment.
Literature holds evidence that accurate diagnosis and available resources can successfully treat postpartum depression (Andre, 2005).
Chapter 3

METHODS

Introduction

The following chapter focuses on the methods used for the project. The methods provide the description of the design, sample source, the process, and organizing principles used in gathering information required to complete the project.

Design

The research study design is a survey using both qualitative and quantitative questions that will render numerical data suitable for statistical analysis by SPSS. It is a one-time only study. The data is collected using the sampling design known as ‘Snowball Sampling’, where the available participants are requested to participate (interviewed) in the completion of the survey questionnaire.

The methods used for collecting data is a survey questionnaire that is completed by professionals from different disciplines, including social work, psychology, and counseling who are currently working with children and families, including mothers who have history of, are currently at risk, or have a diagnosis of postpartum depression. The questionnaire is handed out to participants in person during the interview. The participants are recruited on the basis of their consent or willingness to participate in the study and who have experience in working with women with either history or status of a diagnosis of postpartum depression.

The researcher found this method appropriate for conducting research because the
survey seeks the opinions of professionals who work with mothers (clients) with either history or current experience of postpartum depression. The research is a quantitative and qualitative study, as it lacks random sampling and validly normed instrumentation. The study is restricted against use of actual clients because of HIPPA regulations. The professionals are asked about their observations and knowledge of women who they know as clients diagnosed with postpartum depression.

Research Questions

The variables used in this study are ‘awareness’ and ‘self-care’. The research of these variables in this study will contribute to an understanding of the following four research questions: 1). What is the awareness and knowledge level of postpartum depression, resources and self care techniques among women in the postpartum period? 2). What level of awareness exists and impact the risk factors of postpartum depression? 3). Are the risk factors of postpartum depression among mothers going unrecognized, undetected or undiagnosed, and untreated? 4). Can increased awareness of postpartum depression lead to better self-care and decrease the risk factors of post depressive symptoms?

The variables will also help explore the tentative hypothesis which is that “high awareness of post-depressive symptoms will lead to better self-care”.

Participants

The participants are professionals at River Oak Center for Children from different disciplines including social work, psychology, and counseling who are currently working with children and families, including women. A total of 10 subjects
will comprise the study population. The participation will be recruited by the researcher at the weekly team meeting of River Oak. The researcher will go to the meeting, where the researcher will explain the purpose of the project, design, and procedures of the study. The subjects will also be informed that the project is a only a one-time evaluation study used entirely for the sole purpose of research. The researcher will solicit volunteers from the meeting to participate in the study (the volunteers will be recruited on the basis of their consent and willingness to participate in the study and who have experience in working with women with either history or current status of suffering from or have history of postpartum depression). The researcher will obtain the contact information of the participants and will send out emails to set up an appointment to complete the interview which involves using a survey questionnaire.

Instrumentation

The instrument used in gathering data is a survey questionnaire that has a set of 13 questions that are designed to analyze the impact of screening on post-depressive symptoms (See Appendix C for copy of questionnaire). The questionnaire is developed by researcher based on review of the literature. Although, the questionnaire has not been tested for validity and reliability, the questions are derived from available research. The instrument was developed to support the purpose of the study which is, among other things, to assess the impact of screening on post-depressive symptoms. The rationale for the study is to help understand the four research questions discussed previously.
Validity/Reliability

The study has not been tested for validity and reliability, although the instrument designed to assess the impact of screening has been derived from literature. The study lacks empirical evidence because it does not actually interview mothers (clients) who are suffering from postpartum depression due to HIPPA regulations.

Data Gathering Procedures

A total of 10 subjects comprise the study population. The participation is recruited by this researcher at the weekly team meeting of River Oak. The researcher went to a meeting to explain the purpose of the project, the design, and the procedures of the study. The subjects were informed that the project is an only one-time evaluation study that is used entirely for the sole purpose of research. The researcher solicited volunteers from the meeting to participate in the study (the volunteers were recruited on the basis of their consent or willingness to participate in the study and based on having experience in working with women with either history or current status of suffering from or with a diagnosis of postpartum depression). The researcher obtained the contact information of the participants and sent out emails to set up an appointment to complete the interview. The researcher then met with interviewees in person in their private offices during their lunch break to complete the interview. On completion of the interview, the researcher sent out an email expressing gratitude for participating in the interview. There were no other inducements offered to the participants.
Protection of Human Subjects

The researcher submitted the human subjects application package, including screening questionnaire, and consent to participate in research to the human subjects committee at the agency requesting permission to interview clinicians. The human subjects committee at CSUS, Division of Social Work; who reviewed the package in detail and enquired about specifics before granting conditional permission. The researcher was required to make appropriate changes to the project as requested for final approval. On submission of required corrections to human subjects, the committee approved the proposal (with the approval number 08-09-081). It was approved at posing “minimal risk” to participants on February 18, 2009. On approval of human subjects by the Division of Social Work, the human subjects committee at the agency also granted unconditional and full permission to interview staff (See Appendix A for a copy of the letter from the agency).

The participant’s (subject’s) right to privacy and safety was protected by several actions. The obtained data from completed survey questionnaire was transcribed in such a manner that subjects are not identified directly or indirectly. In the data collection process, each subject or participant was assigned a random record number to be used in the database file. The obtained data was kept separate from the database file and in a locked cabinet accessible only to the researcher. The database was deleted and hard copies from the database were destroyed by shredding the documents following the submission and approval of the research thesis project. The subjects were educated of their withdrawal rights before the onset of the interview process. The
withdrawal rights will include their right to withdraw from participating in the research (interview) at any time without any penalty. The subjects were informed that they could decline to answer any question they wish and request to stop the interview process at any time. If any subjects experience discomfort during the interview process, those subjects were provided with a list of professional resources to utilize for personal support. Hence, the research study is consistent with the standards of maintaining the safety and confidentiality of the participants. The research study is at 'minimal risk' due to the fact that answering the questions subjected to participants was at no more risk than would be encountered in normal daily activities which as professionals, the respondents encounter in their normal work days. The participants who experience discomfort due to personal bias or emotion related to their own pregnancy or of their client will be provided assistance and offered resources to utilize for personal support.

Summary

The researcher obtained data by interviewing clinicians (with experience in working with clients who have history or current diagnosis of postpartum depression) via survey questionnaire to support the sole purpose of the study, while ensuring protection and maintaining the protection of human subjects as participants. Therefore, the methods for designing the research sampling and conducting the study were described in this chapter.
Chapter 4
THE PROJECT

Introduction

This chapter is organized into sections that reflect the major subject areas of the questionnaire using SPSS tables. Also included in this chapter are data which have been analyzed. This chapter is concluded by a summary. This author explains the results of the findings that are displayed using tables from the collected data.

Demographic Findings

According to the demographic characteristics of participants, 9 are female participants with a percentile of 90% and only one male participant with a percentile of 10%. The demographic characteristics indicate a lack of diverse ethnic professionals. There are a majority of 8 White/Caucasian professionals with a percentile of 80%, 1 Hispanic with a percentile of 10%, and 1 is Non-Hispanic with a percentile of 10%. The ages of the participants were clustered from early to mid adulthood with 70% being below age 45. The age distribution included 3 participants fell in the age range of 24-34 with percentile of 30%, 4 who are the majority fell in the age range of 35-45 with a percentile of 40%, 2 in the age range of 46-55 with a percentile of 20%, and 1 in the age range of 55-65 with a percentile of 10%.

In terms of the marital status of participants, 2 are single with a percentile of 20%, 5 are married with a percentile of 50% who held the majority, 2 are divorced with a percentile of 20%, and 1 is widowed with a percentile of 10%. Of the 10 participants, 7 participants indicate having children with a percentile of 70% and 3 participants
have no children with a percentile of 0%.

In response to the question enquiring participants about having experienced any post-depressive symptoms on a personal level, only 3 participants indicate having experienced post-depressive symptoms at a personal level with a percentile of 30% and the rest of the 7 participants indicate having experienced no post-depressive symptoms. Out of 10 participants, 5 are social workers with a percentile of 50%, 3 are marriage and family therapists with a percentile of 30%, 1 is in the field of psychology with percentile of 10%, and 1 is a physician with a percentile of 10%.

Table 1
Demographic Characteristics of Participants

<table>
<thead>
<tr>
<th>Category</th>
<th>Participants</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>Female- 9</td>
<td>Female- 90%</td>
</tr>
<tr>
<td></td>
<td>Male- 1</td>
<td>Male- 10%</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>White- 8</td>
<td>White- 80%</td>
</tr>
<tr>
<td></td>
<td>Native American- 1</td>
<td>Native American- 10%</td>
</tr>
<tr>
<td></td>
<td>Non-Hispanic- 1</td>
<td>Non-Hispanic- 10%</td>
</tr>
<tr>
<td>Age</td>
<td>24-34 = 3</td>
<td>24-34 = 30%</td>
</tr>
<tr>
<td></td>
<td>35-45= 4</td>
<td>35-45= 40%</td>
</tr>
<tr>
<td></td>
<td>46-55= 2</td>
<td>46-55= 20%</td>
</tr>
<tr>
<td></td>
<td>55-65= 1</td>
<td>55-65= 10%</td>
</tr>
<tr>
<td>Marital Status</td>
<td>Single- 2</td>
<td>Single- 20%</td>
</tr>
<tr>
<td></td>
<td>Married- 5</td>
<td>Married- 50%</td>
</tr>
<tr>
<td></td>
<td>Divorced- 2</td>
<td>Divorced- 20%</td>
</tr>
<tr>
<td></td>
<td>Widowed-1</td>
<td>Widowed-10%</td>
</tr>
</tbody>
</table>
Findings from the Survey Questionnaire

There are 13 questions on the survey questionnaire. Each question on the survey questionnaire is identified by a specific variable. For example, in the question, how does media idealize the concept of motherhood, motherhood is identified as the variable media. Further, the question is analyzed in terms of its impact on motherhood and so on. This way, each question is analyzed. The variables identified are Media, Genetic, Mocv (More than 1 child vulnerability), Single, Young, Older, Culture, SES (Socio-Economic Status), Aware, Support, Self care, Health, and Impact.

*influences in the larger social environment.*

The data explains the findings of 13 different variables. The first 6 variables (influences in the larger social environment) are as following: The findings indicate that 6 of the 10 participants with a percentile of 60% believe that media idealizes the concept of motherhood to some extent, while 20% which is 2 participants believe that

| How many participants had Children | 7 | 70% |
| How many participants experienced post-depressive symptoms | 3 | 30% |
| Discipline | Social work- 5 | Social work- 50% |
| | MFT- 3 | MFT- 30% |
| | Psychology- 1 | Psychology- 10% |
| | Physician- 1 | Physician- 10% |

**Findings from the Survey Questionnaire**

There are 13 questions on the survey questionnaire. Each question on the survey questionnaire is identified by a specific variable. For example, in the question, how does media idealize the concept of motherhood, motherhood is identified as the variable media. Further, the question is analyzed in terms of its impact on motherhood and so on. This way, each question is analyzed. The variables identified are Media, Genetic, Mocv (More than 1 child vulnerability), Single, Young, Older, Culture, SES (Socio-Economic Status), Aware, Support, Self care, Health, and Impact.

*influences in the larger social environment.*

The data explains the findings of 13 different variables. The first 6 variables (influences in the larger social environment) are as following: The findings indicate that 6 of the 10 participants with a percentile of 60% believe that media idealizes the concept of motherhood to some extent, while 20% which is 2 participants believe that
media idealizes the concept of motherhood to a great extent and the other two
participants believe the impact of media on the concept of motherhood to be very
little. When asked about the influence of the culture of the mother on post-depressive
symptoms, 5 of the 10 participants with a percentile of 50% indicate that there is some
impact of the culture, while 30% of the participants indicate that there is no impact, 1
participant indicates a response of not sure, and the remaining 10% which is 1
participant believes that the impact of the culture of the mother on post-depressive
symptoms is very much so.

In response to the socio-economic status (SES), 70% which is 7 of the 10
participants believe that the socio-economic status of the mother can sometimes have
an impact on the risks of post-depressive symptoms, while the remaining 30% which
is 3 participants believe that they definitely think that the socio-economic status of the
mother impacts the risk of post-depressive symptoms. Social support was considered
very important to respondents as evidenced by their responses. Because majority of
the participants which is 90% or 9 of the 10 participants (with 5 participants indicating
a response of yes that women with postpartum depression are able to seek or cope
better with available support and 4 indicating a response of most of the time) believe
that women who have postpartum depression are able to seek or cope better with
available support and only one participant which is 10% believes that it is hard to say.

When asked about the recommendation of routine screening in the postpartum
period, in order to improve women’s health and well-being, majority which is 90% of
the respondents or 9 of the 10 participants believe that routine screening in the
postpartum period should definitely be recommended to improve women's health and well-being, while the remaining 10% which is only 1 participant believes lack of assurance on the recommendation of routine screening. In response to the impact of routine screening on post-depressive symptoms, about half the participants which is 50% or 5 of the 10 participants believe that routine screening during postpartum period definitely has an impact on the risks of post-depressive symptoms, 40% which is 4 participants believe that they are not sure and 1 participant indicates that routine screening does not impact the risks of post-depressive symptoms.

Table 2

Influences in the Larger Social Environment

To what extent does media idealize the concept of motherhood?

<table>
<thead>
<tr>
<th>Great extent</th>
<th>2</th>
<th>20%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Some extent</td>
<td>6</td>
<td>60%</td>
</tr>
<tr>
<td>Very little</td>
<td>2</td>
<td>20%</td>
</tr>
</tbody>
</table>

Do you think the culture of the mother impacts the post-depressive symptoms?

<table>
<thead>
<tr>
<th>Very much so</th>
<th>1</th>
<th>10%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Some impact</td>
<td>5</td>
<td>50%</td>
</tr>
<tr>
<td>No impact</td>
<td>3</td>
<td>30%</td>
</tr>
<tr>
<td>Not sure</td>
<td>1</td>
<td>10%</td>
</tr>
</tbody>
</table>
Do you think socio-economic status of the mother impacts the risk of post-depressive symptoms?

<table>
<thead>
<tr>
<th>Choice</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definitely, yes</td>
<td>3</td>
<td>30%</td>
</tr>
<tr>
<td>Sometimes</td>
<td>7</td>
<td>70%</td>
</tr>
</tbody>
</table>

Do you think women with postpartum depression are able to seek or cope better with available support?

<table>
<thead>
<tr>
<th>Choice</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definitely, yes</td>
<td>5</td>
<td>50%</td>
</tr>
<tr>
<td>Most of the time</td>
<td>4</td>
<td>40%</td>
</tr>
<tr>
<td>Hard to say</td>
<td>1</td>
<td>10%</td>
</tr>
</tbody>
</table>

Do you think routine screening in the postpartum period should be recommended to improve women’s health and well-being?

<table>
<thead>
<tr>
<th>Choice</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definitely, yes</td>
<td>9</td>
<td>90%</td>
</tr>
<tr>
<td>Not sure</td>
<td>1</td>
<td>10%</td>
</tr>
</tbody>
</table>

Do you think routine screening during postpartum period impacts the risk of post-depressive symptoms?

<table>
<thead>
<tr>
<th>Choice</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, for sure</td>
<td>5</td>
<td>50%</td>
</tr>
<tr>
<td>No, for sure</td>
<td>4</td>
<td>40%</td>
</tr>
<tr>
<td>Not sure</td>
<td>1</td>
<td>10%</td>
</tr>
</tbody>
</table>
**Risk factors internal to the mother.**

The other 7 variables (opinions of possible causes of postpartum depression related to the mother): In response to the question asked, whether postpartum depression is genetically driven or not, about half the participants which is 50% of the participants think that postpartum depression is genetically driven, while 20% of the participants indicate responses that it is hard to say whether the condition of genetics is explainable or not. Two participants indicate that they are not sure on their response and one participant indicates that postpartum depression is very much genetically driven.

To the question relating to the increase in vulnerability of mothers having more than one child to experiencing postpartum depression than mothers having only one child, 30% of the 10 participants believe that mothers with more than one child are not vulnerable to experiencing post-depressive symptoms than mothers with only one child. Three participants believe that mothers with more than one child can sometimes be vulnerable to experiencing post-depressive symptoms than mothers with only one child, 3 participants indicate responses of not being sure, and one participant believes that mothers with more than one child are vulnerable to experiencing post-depressive symptoms than mothers having only one child.

Being a single mother is perceived by 50% which is 5 of the 10 participants at greater risk for experiencing post-depressive symptoms than mothers who are not single. Four participants believe that single mothers are at greater risk than mothers who are not single and one participant believes that single mothers are not at greater risk for experiencing post-depressive symptoms than mothers who are not single.
The age of the mother is believed to impact the risk to depression during postpartum period. Being a young mother may increase susceptibility to depression is perceived by 6 of the 10 participants, while 3 participants indicate that they are not sure whether being a young mother makes mothers susceptible to depression or not and one participant believes that it is hard to answer the question. And being an older mother is perceived by 40% of the participants as being unsure whether or older mothers are susceptible to feeling depressed during postpartum period or not. Three respondents think older mothers are susceptible, 2 participants indicate that it is hard to say, and 1 participant indicates that older mothers are not susceptible to feeling depressed during postpartum period.

The influence of knowledge and awareness of postpartum depression on mothers during postpartum period lead 60% which is 6 of the 10 participants to believe that women with awareness or knowledge of postpartum depression are sometimes less likely to be depressed during postpartum period. Three participants indicate that women with awareness or knowledge of postpartum depression are definitely less likely to be depressed during postpartum period. And one participant indicates a response of being unsure about the question asked. When mothers engage in habits of self care during postpartum period, they are able to better de-stress which is believed by 9 of the 10 participants (5 participants who indicate a response of most of the time and 4 with a response of yes). And only one participant believes that women who engage in self-care are sometimes able to better de-stress.
### Table 3
*Risk Factors Internal to the Mother*

Do you think postpartum depression is genetically driven?

<table>
<thead>
<tr>
<th>Response</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very much so</td>
<td>1</td>
<td>10%</td>
</tr>
<tr>
<td>Think so</td>
<td>5</td>
<td>50%</td>
</tr>
<tr>
<td>Can’t say</td>
<td>2</td>
<td>20%</td>
</tr>
<tr>
<td>Not sure</td>
<td>2</td>
<td>20%</td>
</tr>
</tbody>
</table>

Do you think mothers with more than one child are vulnerable to experiencing post-depressive symptoms than mothers with only child?

<table>
<thead>
<tr>
<th>Response</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definitely, yes</td>
<td>1</td>
<td>10%</td>
</tr>
<tr>
<td>Definitely, no</td>
<td>3</td>
<td>30%</td>
</tr>
<tr>
<td>Sometimes</td>
<td>3</td>
<td>30%</td>
</tr>
<tr>
<td>Not sure</td>
<td>3</td>
<td>30%</td>
</tr>
</tbody>
</table>

Do you think single mothers are at greater risk for experiencing post-depressive symptoms than mothers who are not single?

<table>
<thead>
<tr>
<th>Response</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definitely, yes</td>
<td>4</td>
<td>40%</td>
</tr>
<tr>
<td>Definitely, no</td>
<td>1</td>
<td>10%</td>
</tr>
<tr>
<td>Sometimes</td>
<td>5</td>
<td>50%</td>
</tr>
</tbody>
</table>
Do you think young mothers are susceptible to feeling depressed during postpartum period?

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>6</td>
<td>60%</td>
</tr>
<tr>
<td>Not sure</td>
<td>3</td>
<td>30%</td>
</tr>
<tr>
<td>Hard to say</td>
<td>1</td>
<td>10%</td>
</tr>
</tbody>
</table>

Do you think older mothers are susceptible to feeling depressed?

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>3</td>
<td>30%</td>
</tr>
<tr>
<td>No</td>
<td>1</td>
<td>10%</td>
</tr>
<tr>
<td>Hard to say</td>
<td>2</td>
<td>20%</td>
</tr>
<tr>
<td>Not sure</td>
<td>4</td>
<td>40%</td>
</tr>
</tbody>
</table>

Do you think women with awareness or knowledge of postpartum depression are less likely to be depressed during postpartum period?

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, most of the time</td>
<td>3</td>
<td>30%</td>
</tr>
<tr>
<td>Sometimes</td>
<td>6</td>
<td>60%</td>
</tr>
<tr>
<td>Not sure</td>
<td>1</td>
<td>10%</td>
</tr>
</tbody>
</table>

Do you think women with postpartum depression are able to seek cope better with available support or community resources?

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Definitely, yes</td>
<td>4</td>
<td>40%</td>
</tr>
<tr>
<td>Most of the time</td>
<td>5</td>
<td>50%</td>
</tr>
<tr>
<td>Sometimes</td>
<td>1</td>
<td>10%</td>
</tr>
</tbody>
</table>
Some of the major findings are cross tabulated, in order to answer the four research questions. The findings include the impact of screening on risks of PPD (postpartum depression) when cross tabulated with variable self care which implies whether depressed women who engage in self-care in the postpartum period were able to better de-stress or not. On cross tabulating the variables, the findings indicate that majority of 9 of the 10 participants (4 with a response of yes and 5 with a response of most of the time) identify that screening definitely impacts the risks of post-depressive symptoms, along with the fact that depressed women who engage in self-care in the postpartum period are able to better de-stress. The chi-sq value of the variables (impact of screening on risks of PPD and self care) is 5.6000 with a df (degree of freedom) of 4. This indicates that the level of significance is greater than .05 or 5% implying that the data is useful because it substantiates the research questions.

Table 4
Cross Tabulation of the Impact of Screening on Self Care

<table>
<thead>
<tr>
<th></th>
<th>yes</th>
<th>no</th>
<th>not sure</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Most of the time</td>
<td>2</td>
<td>0</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Sometimes</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>5</td>
<td>1</td>
<td>4</td>
<td>10</td>
</tr>
</tbody>
</table>
Chi-square tests of variables (impact of screening on risks of postpartum depression and self care)

<table>
<thead>
<tr>
<th></th>
<th>Value</th>
<th>Df</th>
<th>Asump. Sig. (2-sided)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pearson Chi-Sq</td>
<td>5.600</td>
<td>4</td>
<td>.231</td>
</tr>
<tr>
<td>Likelihood Ratio</td>
<td>7.638</td>
<td>4</td>
<td>.106</td>
</tr>
<tr>
<td>Linear-by-Linear Association</td>
<td>3.377</td>
<td>1</td>
<td>.066</td>
</tr>
<tr>
<td>N of Valid Cases</td>
<td>10</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

On cross tabulating the variables (impact of self care and awareness), the findings indicate that 6 of the 10 participants identify that women with awareness or knowledge of postpartum depression are sometimes are less likely to become depressed during postpartum period and 3 participants believe that women with awareness or knowledge of postpartum depression are definitely less likely to become depressed in the postpartum period. And 9 of the 10 participants (4 with a response of yes and 5 with a response of most of the time) indicate that depressed women who engage in self-care in the postpartum period are able to better de-stress. The chi-sq value of the variables (impact of self care and awareness) is 6.667 with a df (degree of freedom) four. This indicates that the level of significance is greater than .05 or 5% implying that the data is useful because it substantiates the research questions.
Table 5

Cross Tabulation of the Impact of Self Care on Increased Awareness

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>Most of the time</th>
<th>Sometimes</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aware yes</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>sometimes</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>not sure</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>4</td>
<td>5</td>
<td>1</td>
<td>10</td>
</tr>
</tbody>
</table>

Chi Square tests/analysis of variables (impact of self care and awareness)

<table>
<thead>
<tr>
<th></th>
<th>Value</th>
<th>df</th>
<th>Asump-Sig.(2-sided)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pearson Chi-Sq</td>
<td>6.667</td>
<td>4</td>
<td>.155</td>
</tr>
<tr>
<td>Likelihood Ratio</td>
<td>8.456</td>
<td>4</td>
<td>.076</td>
</tr>
<tr>
<td>Linear-by-Linear</td>
<td>.029</td>
<td>1</td>
<td>.866</td>
</tr>
<tr>
<td>N of Valid Cases</td>
<td>10</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Summary

According to the data gathered and encoded into various variables and values, it is found that out of a total of 10 participants, 9 participants (5 who indicate most of the time and 4 who indicate yes) have a favorable response indicating that depressed women who engage in self-care activities in the postpartum period are able to better de-stress. Also, 6 participants out of 10 thought that sometimes women with awareness or knowledge of postpartum depression are less likely to be depressed during postpartum period. Further, 9 participants (5 with yes and 4 with most of the
time) indicate that women with postpartum depression are able to cope better with available support. Furthermore, 9 participants indicate the response of yes implying that routine screening in the postpartum period should definitely be recommended to improve women's health and well-being. Lastly, 5 participants indicate that routine screening during postpartum period definitely impacts the risks of post-depressive symptoms.

Thus, the findings answer the four research questions with 6 participants indicating that sometimes women are less likely to be depressed in the postpartum period, even when there is awareness and knowledge among them. Although 9 participants indicate that women who engage in self care activities, including those who seek available support in the postpartum period are able to better de-stress. Almost all participants except one strongly recommends routine screening in the postpartum period to improve women's health and well-being to help it get recognized, detected, diagnosed, and hence treated at the right time. Therefore, increased awareness of postpartum depression can lead to better self-care and decrease the risk factors of post depressive symptoms.
Chapter 5

CONCLUSIONS AND IMPLICATIONS

Introduction

The purpose of this chapter is to discuss the relevant findings, conclusions, and implications for future research in related area. This is concluded by a summary.

Relevant Findings

Some of the relevant findings highlight the pertinent factors of consideration during postpartum period, including increased awareness or knowledge of post-depressive symptoms, self care, available support and/or resources. The results indicate that women with awareness or knowledge of post-depressive symptoms are less likely to become depressed and women who engage in self-care and who seek available support or resources are able to better de-stress in the postpartum period. As a result, participants make strong recommendations for routine screening in the postpartum period to improve women’s health and well-being to help it get recognized, identified, detected, and hence, treated.

Conclusions and Implications

The findings contribute to the field of social work by means of emphasizing the relevance of screening (identification, recognition, detection) of clients as necessitated for appropriate diagnosis and treatment, if applicable. The screening will promote the well-being of clients through education of necessary tools, including self care, available support, and resources in the community.
However, for future research the author recommends the use of bigger sample size and actual client system with diverse population, rather than professionals, if possible for direct evidence-based research. Another recommendation that the author would like to make is to include the opinions and feedback of partners and spouses on the impact of screening on the mothers-to-be due to the fact that together they make the difference in promoting health and well-being of the mother.

Summary

The purpose of the project was to assess the significance of screening on post-depressive symptoms among women in the postpartum period. Screening is the identification or recognition of post-depressive symptoms for effective diagnosis and treatment, if applicable. By interviewing clinicians (which though was a limited number) from different disciplines (who by history or are currently working with women in the postpartum period) on the significance of screening strengthened the empirical-based research on the recommendation for routine screening to improve women’s health and well-being and hence, promote social justice.
APPENDIX A

River Oak Center for Children

Letter from the Agency

February 18, 2009
Division of Social Work
Sacramento State University

Dear Committee,

This letter is presented to Nona Khara from the River Oak Center for Children Human Subjects Review Committee to serve as proof of her full and unconditional approval of her Masters Degree Thesis/Project. This approval permits Nona Khara to interview clinical staff that has or are currently working with families who have experienced or are currently dealing with post depressive symptoms. If you have any questions or concerns feel free to contact Jaynette M. Underhill, MA Vice President Compliance and Quality Management at 916-609-5153.

Sincerely,

Jaynette M. Underhill, MA
Vice President Compliance and Quality Management
TO: Nona Khara

FROM: Committee for the Protection of Human Subjects

RE: YOUR RECENT HUMAN SUBJECTS APPLICATION

We are writing on behalf of the Committee for the Protection of Human Subjects from the Division of Social Work. Your proposed study, "The impact of screening on post depressive symptoms."

X approved as _____ EXEMPT ____ NO RISK X MINIMAL RISK. Your human subjects approval number is: 08-09-081. Please use this number in all official correspondence and written materials relative to your study. Your approval expires one year from this date. Approval carries with it that you will inform the Committee promptly should an adverse reaction occur, and that you will make no modification in the protocol without prior approval of the Committee.

The committee wishes you the best in your research.

Professors: Tania Alameda-Lawson, Jude Antonyappan, Teiahsha Bankhead, Chrystal Barranti, Andy Bein, Ron Boltz, Joyce Burris, Serge Lee, Sue Taylor
APPENDIX C

Survey Questionnaire

This is a survey designed to assess the impact of screening on post-depressive symptoms. Please circle the closest response to the question asked.

Discipline: ____________ Ethnicity ____________

Age: ____________ Marital Status: ____________

Do you have any children? _____ If yes, how many? _____

Did you ever experience any post-depressive symptoms? ____________

Date: ____________

1. To what extent does media idealize the concept of motherhood?
   - To a great extent
   - To some extent
   - Very little
   - Hard to say

2. Do you think postpartum depression is genetically driven?
   - Very much so
   - Think so
   - Can’t say
   - Not sure

3. Do you think mothers with more than one child are vulnerable to experiencing post-depressive symptoms than mothers with only one child?
   - Definitely, yes
   - Definitely, no
   - Sometimes
   - Not sure
4. Do you think single mothers are at greater risk for experiencing post-depressive symptoms than mothers who are not single?

- Definitely, yes
- Definitely, no
- Sometimes
- Not sure

5. Do you think young mothers are susceptible to feeling depressed during postpartum period?

- Yes
- No
- Hard to say
- Not sure

6. Do you think older mothers are susceptible to feeling depressed during postpartum period?

- Yes
- No
- Hard to say
- Not sure

7. Do you think the culture of the mother impacts the post-depressive symptoms?

- Very much so
- Some impact
- No impact
- Not sure

8. Do you think socio-economic status of the mother impacts the risk of post-depressive symptoms?

- Definitely, yes
- Sometimes
- Not at all
- Not sure

9. Do you think women with awareness or knowledge of postpartum depression are less likely to be depressed during postpartum period?
10. Do you think women with postpartum depression are able to seek or cope better with available support (from partner, family, friends, relatives, etc.) or community resources?

- Definitely, yes
- Most of the time
- Sometimes
- Hard to say

11. Do you think depressed women who engage in self-care activities (relaxing or leisure) in the postpartum period are able to better de-stress?

- Definitely, yes
- Most of the time
- Sometimes
- Hard to say

12. Do you think routine screening in the postpartum period should be recommended to improve women's health and well-being?

- Definitely, yes
- Definitely, no
- Not sure
- Hard to say

13. Do you think routine screening during postpartum period impacts the risks of post-depressive symptoms?

- Yes, for sure
- No, for sure
- Not sure
- Hard to say
APPENDIX D

Consent to Participate in Research

You are being asked to participate in research that will be conducted by Nona Khara, a graduate student in the Master's of Social Work Program at Sacramento State. The research study focuses on the impact of screening (awareness or knowledge) of post-depressive symptoms on women in the postpartum period.

The interview process will take place in your office during lunch break which will last for approximately 15-20 minutes. You will be interviewed and asked 13 questions related to your perspective on client’s post-depressive symptoms through a survey questionnaire. The survey questionnaire has a set of 8 questions focused on the importance or impact of screening during postpartum period on clients diagnosed (by history or current) with postpartum depression.

Some of the questions asked might make you feel uncomfortable or upset because it may remind you of your own pregnancy (former or current) or of your clients that might mean a lot to you. You are free to decline to answer any question that you wish and you can stop the interview process at any time without any penalty. If you experience any emotional discomfort during the interview, or would like help at any time during research, you may let the researcher know and the interview process will then be stopped. And if you complete the interview and feel any discomfort, the following resources will be provided to you to utilize for personal support. The resources are as following:

1. Cori Morgan, LCSW (License # 24938), Clinical Program Manager, River Oak Center for Children, 5030 El Camino Ave, Carmichael, CA. 95608. Ph: (916) 609 5123. cmorgan@riveroak.org
2. Kristy Schreader, LMFT (License # MFC 42534), Clinical Program Manager River Oak Center for Children, 5030 El Camino Ave, Carmichael, CA. 95608. Ph: (916) 609 4940. kschreader@riveroak.org

Participation in this research study may either personally benefit you by raising your level of awareness of the post-depressive symptoms or the information obtained might benefit you as practitioner in field to serve clients (who are diagnosed with or suffering from postpartum depression) more effectively.

The information that you share will be kept completely confidential. Your interview will randomly be assigned a number to ensure the confidentiality. In the data collection process, you will not be identified directly or indirectly. The obtained data will be kept separate from the database file and in a locked cabinet accessible only to the researcher. The database will be deleted and hard copies from the database
will be destroyed by shredding the documents following the submission and approval of the research thesis project.

If you have any questions about the research at any or at a later time, you may contact either the researcher, Nona Khara in person at the agency of River Oak or via email: nonamunny@hotmail.com or by phone at (916) 335 2812 or you may contact Dr. Burris at (916) 278 7179 or by email at burrisj@csus.edu

Your participation in this study is entirely voluntary. Your decision to participate in this study is totally voluntary. You may change your mind to participate in the study at any time and stop your participation without any consequences. Your signature below indicates that you have read and understood this consent form and you are willing to participate in this research study.

Signature of Participant ___________________________ Date ____________
REFERENCES


