



INVESTIGATING OBSTETRIC AND GYNECOLOGIST PERCEPTIONS AND  
SCREENING PRACTICES FOR POSTPARTUM DEPRESSION

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## **ABSTRACT**

Literature shows that Postpartum Depression (PPD) is a very common complication of childbirth (Evans, Phillippi, & Gee, 2015). Although it is extremely common, it remains largely undetected by healthcare providers (Evans, Phillippi, & Gee, 2015). A recent study conducted by Behimehr, Curtis, Curtis, and Hart (2014) found that the public perceives OB/GYNs to carry the most responsibility in screening for Postpartum Depression. The current study was inspired by Behimehr, Curtis, Curtis, and Hart (2014) findings, and participants were assessed to obtain information about their perceptions pertaining to OB/GYNs being most responsible to screen for PPD, and whether knowledge given that the public views them as most responsible would change their perceptions of their responsibility. Screening methods employed by participants were also assessed. The current study found that OB/GYNs do not view themselves as most responsible to screen for PPD. Results also showed that OB/GYNs do view PPD screening as important and a high priority. These results have implications for not only the patients diagnosed and struggling with PPD, but also the social relationships within the family unit where a mother is suffering from PPD.

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## INTRODUCTION

Postpartum depression (PPD) is arguably a very significant complication of childbirth, but it often goes undiagnosed or undetected by healthcare providers (Evans, Phillippi, & Gee, 2015). Postpartum Depression can be described as a disorder that significantly decreases the mothers' ability to function and results in negative effects for both the mothers and their families (Wisner, Perel, Peindl, Hanusa, Piontek, & Findling, 2004). Behimehr, Curtis, Curtis, and Hart (2014) recently conducted a study where they found that the public perceives OB/GYNs to carry the most responsibility in screening for PPD. It is important that patients are screen<sup>1</sup>ed, referred, and treated for PPD in order for these mothers to be healthy and most effectively tend to their children's needs.

### **Postpartum Depression Defined**

Postpartum Depression is also otherwise clinically known in the Diagnostic and Statistical Manual of Mental Disorders, 5<sup>th</sup> edition (DSM-5) as Major Depressive Disorder with peripartum onset (American Psychiatric Association (APA), 2013). Major Depressive Disorder with peripartum onset involves having five or more symptoms within the same two-week period, impairing one's functioning, and the onset occurring during pregnancy or within the four weeks after delivery (APA, 2013). These symptoms may include feeling "sad, empty, or hopeless," markedly diminished interest or pleasure in activities most of the day, nearly every day, significant weight loss when not dieting or weight gain, insomnia or hypersomnia, feelings of worthlessness or excessive or inappropriate guilt,

diminished ability to think or concentrate, or recurrent thoughts of death (APA, 2013).

The onset of PPD can occur either during pregnancy or postpartum. “Between 3% and 6% of women will experience the onset of major depressive episode during pregnancy or in the weeks or months following delivery” (APA, 2013, p. 187). “Fifty percent of postpartum major depressive episodes have an onset prior to delivery; because of this, these specific episodes are typically referred to as ‘peripartum’ episodes” (APA, 2013, p. 187).

Postpartum Depression has negative effects that are significant, both to the postpartum mother and to the entire family. Mothers with PPD can experience a significantly prolonged postpartum recovery, as well as other obvious impacts that can take a toll on the emotional well-being of the mother. A literature review compiled by Sobey (2002) discusses that children of mothers who had a diagnosis of postpartum depression commonly exhibited increased prevalence of attention disorders, issues in cognitive skills, and inadequate development in language expression.

### **Prevalence of Diagnosis**

A study by Wood, Middleton, & Leonard (2010) has shown that about 50% of women who suffer with Postpartum Depression are never detected as struggling with PPD, because health professionals have “not properly identified or diagnosed their symptoms” (p. 250). It has been found that low-income African American and Latina women are more likely to develop PPD. This is indicated with rates that have been reported as high as 28% and 56% among women that fall into the category of minority or low socio-economic

demographics (Chaudron et al., 2010; Liu, Giallo, Doan, Seidman, & Tronick, 2016; Muzik & Borovsha, 2010). Although a significant number of postpartum patients are suffering from symptoms of PPD, research suggests that the majority of OB/GYN patients that experience depressive symptoms that are indicative of PPD do not seek services from a mental health professional (Einarson & Koren, 2007).

The known incidence and prevalence rates of Postpartum Depression are thought to be underreported, and so they are often misleading (Sobey, 2002). The rates of mothers with Postpartum Depression are underreported for several reasons, the first being the women are not always screened for PPD (Sobey, 2002). Second, health care practitioners (regardless of the specialty whether it is pediatrics, family practice, or OB/GYN) often use inadequate screening tools to diagnose and identify PPD (Sobey, 2002). Additionally, it is common for women to not present with symptoms at the time of delivery, or even as late as their 6 week postpartum follow-up appointment with their OB/GYN (Sobey, 2002). Mood disorders are also very stigmatized, and women may not want to be forthcoming with their practitioner about their mental health symptoms, or they attribute their sad feelings to “hormones,” which also causes a failure to report symptoms (Sobey, 2002). Also, untrained health care professionals may disregard a postpartum patient’s presenting symptoms of depression and anxiety, and may “attribute it to general fatigue from birth and caring for a new baby, rather than recognizing a more significant issue at play” (Sobey, 2002, p. 331).

## **Methods of Screening**

Screening for symptoms of Postpartum Depression is an important initial step to diagnosis, which then leads to the patient being able to access and pursue further treatment. However, the effectiveness of depression screening is exclusively dependent on the reliability and validity of the screening instrument used. A study conducted by Logsdon & Myers (2010) compared two widely used measures. This research article discussed the reliability and validity of the Edinburgh Postnatal Depression Scale (EPDS) and the Center for Epidemiologic Studies of Depression instrument (CED-D). The researchers found that EPDS achieved the best performance measures when compared with the CED-D (Logsdon & Myers, 2010). This particular study concluded that EPDS was the best screening tool for PPD. Another study conducted by Drake, Howard, and Kinsey (2014) also determined the EPDS screening tool to be most reliable and valid for use in screening for PPD. These researchers indicated that their results were also consistent with previous studies that had been done (Drake, Howard, & Kinsey, 2014).

After compiling an extensive literature review, Sobey (2002) mentioned a method that can more effectively be employed to screen for Postpartum Depression. Rather than just administering the screening tool, whichever one it may be, Sobey (2002) suggested including the screening tool in a packet. This packet should include “a letter explaining the importance of screening for and diagnosing PPD early, a valid PPD screening tool, an educational brochure about PPD, a letter instructing the patient to call a suicide hotline if they begin experiencing suicidal or homicidal ideations” (Sobey, 2002, p. 334). If the patient screens

positive for PPD, they should receive “direct outreach, assessment, and appropriate and prompt referral to a practitioner who can further assist with the management of the PPD diagnosis” (Sobey, 2002, p. 334).

Sobey (2002) reported that when certain clinics in the states of Wisconsin, Texas, Kentucky, Indiana, Missouri, Ohio, and Kansas used this method to screen for PPD, they saw the following results: “overall, PPD was detected and treated at a higher rate, and the majority of women who screened positively for PPD accepted referrals, thus pursuing further treatment” (p. 333). In addition, overall awareness of PPD increased in the areas surrounding the clinics that participated in the program, and the practitioners rated this new screening method as “helpful” or “very helpful.” However, this method, implemented by the American Association of Health Plans, was applied in 1999, and there was no information about whether the practitioners or clinics continued to use this method, or if it is still effective currently. Evins, Theofrastous, & Galvin (2000) conducted a study that further indicated that the use of structured assessment and screening in postpartum care settings led to increased rates of detection of PPD compared with the use of unstructured clinical interviews. However, the current study is interested to see if participants currently use a similar method in their practice (presenting a packet of information, discussing the importance of screening) and how effective it is.

In addition to administering the screening tool contained among a packet of information, a study conducted by Goodman & Tyer-Viola (2010) suggested that timing is everything, and there are implications for determining the optimal time to screen for PPD.

This study found that only 9% of women screened positive for PPD at their 6 week postpartum appointment (Goodman & Tyer-Viola, 2010). However, the researchers also found that almost half of the women who screened positive for PPD did so prenatally, or before they had given birth (Goodman & Tyer-Viola, 2010). They concluded that “early identification and effective management of prenatal and postpartum depression would have the greatest overall impact and significantly minimize negative effects for the mother and newborn baby” (Goodman & Tyer-Viola, 2010, p. 478). Researchers concluded from this that perhaps screening just once for PPD is not enough (Lind, Richter, Craft & Shapiro, 2017). A patient may screen negative for PPD at the time of their 6 week postnatal appointment, but the disorder may begin manifesting itself at a later date (Lind et al., 2017). The study conducted by Davies, Howells, and Jenkins (2003) found that participants began screening positive for PPD as late as 12 months postpartum. This is an issue because if women are screened for PPD at all, it is typically only at their 6-week postpartum appointment when the symptoms of PPD may not have manifested.

### **Issues in Screening and Referral**

Early screening for Postpartum Depression is essential because of the long-term consequences for the woman, her child, and her family as a whole (Wood, Middleton, & Leonard, 2010). A study conducted by Wisner, Parry, & Piontek (2002) reported that the “longer delay between the onset of symptoms and the beginning of therapeutic intervention, the more prolonged the depressive symptoms will be” (p. 196). Studies have shown that in some patients, PPD can be prevented with “adequate social support, medical intervention,

and therapeutic intervention within the postpartum period” (Wood, Middleton, & Leonard, 2010, p. 249). However, the issue still remains in that women are often not screened for PPD, and even then, not screened routinely. In addition to the inadequate screening process, women also do not seek out help on their own, whether it is for lack of education about PPD or not feeling as if they can discuss their symptoms with healthcare providers (Sobey, 2002). A study conducted by Goodman and Tyer-Viola (2010) found that the proportion of participants who reported they felt anxiety with depression after childbirth was “similar to the proportion of women who screened positive for PPD” (p. 484). This suggests that many women in this case were aware that they needed help and wanted it; and it is possible that this is true for women the majority of the time. Women are not always forthcoming about their symptoms at their appointments, so it is possible that practitioners are overlooking women who need help (Wood, Middleton, & Leonard, 2010; Sobey 2002). This could be prevented by screening all women for PPD at their postpartum appointments (Evans, Phillippi, & Gee, 2015; Sobey, 2002).

There are two significant factors that create barriers for adequate and productive treatment for PPD. These barriers include the “lack of insurance coverage for mental illness, and the current model of postpartum care that does not adequately incorporate screening to diagnose PPD, or scheduling follow up appointments to manage PPD” (Sobey, 2002, p. 333).

Access to mental health care when referred by another physician is often difficult to locate, and when found, many postpartum mothers are unable to afford it. Specifically, mental health services are not included in the list of services that state Medicaid programs are

required to offer by federal law (Liu et al., 2016 ; Sobey, 2002). The majority of women with PPD fall into a minority or low socio-economic demographic and a significant portion of these women who suffer from PPD require financial assistance from the government for healthcare purposes (Chaudron et al., 2010; Liu et al., 2016; Muzik & Borovsha, 2010, Sobey, 2002). In the off chance that mental health services are provided by the government, treatment for PPD is often overlooked, due to the fact that these government funds are most often given to individuals with diagnoses that are considered more “severe,” such as schizophrenia (Liu et al., 2016; Sobey, 2002).

In addition to the difficulties in funding treatment for PPD, the majority of practitioners that screen for PPD, when they actually do screen, employ a severely nonproductive method. This particular model of postpartum care includes the fact that “OB/GYNs do not routinely screen women for signs of PPD” (Evans, Phillippi, & Gee, 2015, p. 703). However, if the OB/GYN does happen to screen for PPD, and it is detected, there is not an adequate or smooth transition currently available for patients to access treatment for PPD in a timely manner (Evans, Phillippi, & Gee, 2015). Also, if a postpartum patient does not immediately show signs after delivery, or even up to 6 weeks postpartum, there is “absent to minimal follow up to assess the patient for any future symptoms that may manifest themselves” (Evans, Phillippi, & Gee, 2015, p. 705). It is essential that patients are screened and treated adequately, because like depression outside the perinatal period, PPD may become chronic, especially if there is a delay in adequate treatment (Truitt, Pina, Person-Rennell, & Angstman, 2013). All too often, women with PPD have “inconsistent, delayed,

and inadequate follow up,” even after PPD is identified by a healthcare provider, if PPD is even identified at all (Truitt, Pina, Person-Rennell, & Angstman, 2013, p. 172).

### **Roles of healthcare providers in PPD**

Behimehr, Curtis, Curtis, and Hart (2014) recently conducted a study that addressed the issue that practitioners are often pointing fingers to different types of practitioners about whose responsibility it is to screen for Postpartum Depression and not actually assuming an active role in screening for PPD or providing treatment or referrals. The responsibility is perceived by the public to either belong to pediatricians, primary care providers, or OB/GYNs (Behimehr, Curtis, Curtis, & Hart, 2014).

A study conducted by Olin, Kerker, Stein, Weiss, Whitmyre, Hoagwood, & Horwitz, (2016) argued that pediatricians are “ideally suited” for managing PPD. This argument is supported by data showing that the majority of young children are seen by pediatricians, so pediatricians are the first point of contact postpartum, since the newborn child typically has an appointment more directly after birth—more directly postpartum than the mother’s 6 week follow up appointment with her OB/GYN. However, arguments against pediatricians holding the responsibility of screening for PPD could include that the mother is not the pediatrician’s patient, the child is. This argument then passes the perceived responsibility to family practice or OB/GYN specialties.

It can be argued that family practice practitioners should be most responsible to screen for PPD, because they are the most general contact for patients. Patients typically only

see their OB/GYN for a yearly exam or as a 6 week postpartum appointment, so it is possible that OB/GYNs are not the best resource for repeated screening; especially if the patient screened negative at their 6 week postpartum appointment with their OB/GYN. Since the study conducted by Davies, Howells, and Jenkins (2003) found that patients screened positive for PPD as late as 12 months postpartum, family practice may be best able to conduct follow up screenings if the patient originally screened negative for PPD, since patients see family practitioners more regularly. It would be more logical to make regular appointments for follow up with a primary care physician for something that is not related directly to the obstetrics and gynecology specialty (Davies, Howells, & Jenkins, 2003).

It is possible that another way to effectively screen for PPD would be just after hospital delivery, by the OB/GYN. With screening at this particular point in time, by the OB/GYN, patients can be both educated about the importance of PPD, as well as obtain a positive or negative screening immediately after birth. Then, the patient can be screened again at their 6 week postpartum follow up with the specialist. In addition, since the patients could be educated early about the dangers of PPD, and what to be aware of, they would know what to discuss with their OB/GYN at their appointment 6 weeks following giving birth (Farr, Denk, Dahms, & Dietz, 2014). Collins (2006) stated that debriefing the patient just after birth about PPD was considered by new mothers to be helpful (Collins, 2006).

**Who's problem is it anyway?**

The study conducted by Behimehr and colleagues (2014) found that “college students of child bearing age believe that general physicians and OB/GYNs should carry the most responsibility for recognizing, screening, and providing a referral for further treatment and management of PPD.” Participants in the study reported this because typically the first point of medical contact after giving birth is often with an OB/GYN (Behimehr, Curtis, Curtis, & Hart, 2014).

**The current study**

Limitations to the study conducted by Behimehr, Curtis, Curtis, & Hart (2014) included that “the results do not provide information about how public perceptions of healthcare providers (specifically OB/GYNs) may affect the healthcare providers methods of practice” (p. 143). The current study aims to identify whether or not the knowledge that the public deems them the most responsible in screening for PPD would affect an OB/GYN's perception of their own screening responsibilities, and their way of practice. It is possible that “ensuring the most effective practice for diagnosing and treating women with PPD may be informing OB/GYNs of the perceptions of their patients” (Behimehr, Curtis, Curtis, & Hart, 2014, p. 143). Rather than healthcare providers being passive and pointing to others regarding the responsibility of screening for PPD, they can be informed about who the public look to specifically for answers (Behimehr, Curtis, Curtis, & Hart, 2014). It is possible that when informed of the public's perceptions, OB/GYNs will make considerable efforts in

being more effective in “recognizing, screening, and discussing PPD as well as providing referrals for treatment” (Behimehr, Curtis, Curtis, & Hart, 2014, p. 143). Further, perhaps the knowledge that the public perceives them as most responsible for screening for PPD will cause OB/GYNs to take a more active role in diagnosing and referring patients for further treatment, and thus decreasing the amount of patients who suffer from PPD that is left undiagnosed and untreated.

## OVERVIEW

### Research Questions and Hypotheses

**Question 1:** Do OB/GYNs screen for postpartum depression the majority of the time when seeing a patient for the first time postpartum?

**Hypothesis 1:** It was predicted that most OB/GYNs do not screen for PPD the majority of the time when seeing a patient for the first time postpartum.

**Question 2:** Do OB/GYNs view themselves as most responsible for screening and diagnosing PPD in a patient?

**Hypothesis 2:** It was predicted that most OB/GYNs do not view themselves as most responsible for screening and diagnosing PPD in a patient, but view the responsibility as shared between OB/GYN, family practice, and pediatric specialties.

**Question 3:** Do OB/GYNs spend time explaining the importance of early detection and treatment of PPD to their patients before administering the screening tools?

**Hypothesis 3:** It was predicted that OB/GYNs usually do not spend time with the patient and explain the importance of early detection and treatment of PPD to their patients before administering the screening tools.

**Question 4:** Do OB/GYNs usually treat the patients that are diagnosed with PPD themselves instead of referring them to a mental health professional?

**Hypothesis 4:** It was predicted that OB/GYNs do usually treat patients diagnosed with PPD themselves rather than referring them to a mental health specialist.

**Question 5:** Will OB/GYNs perceptions change after being informed that the public views them as most responsible for screening for PPD?

**Hypothesis 5:** It was predicted that OB/GYNs would view themselves as more responsible and their perceptions of their own perceived responsibilities would change after being informed that the public views them as most responsible for screening for PPD.

## METHODS

The current study recruited 31 participants ranging in age from 23 to 77 years ( $M=42.03$ ;  $SD=14.26$ ). Most participants were women (55.3%) and mostly identified as Caucasian (See Table 1). Of the 914 recruiting emails sent, only 31 participants responded to the study, resulting in a very low response rate of 3.39%.

Table 1  
*Race/Ethnicity*

Race/Ethnicity	Frequency	Percent
African American/Black	1	2.6%
Caucasian/European American	23	60.5%
Asian/Asian American/Pacific Islander	3	7.9%
Hispanic/Latina/Latino	3	7.9%
Bi Racial	1	2.6%
No Answer	7	18.4%
Total	38	100.0%

The majority of participants indicated that they were OB/GYN physicians (See Table 2), and participants ranged in years of experience from 1 to 43 years ( $M=13.88$ ;  $SD= 12.45$ ).

Table 2  
*Classification*

Classification	Frequency	Percent
OB/GYN	24	63.2%
Certified Nurse Specialist (CNS)	1	2.6%
Medical Resident	3	7.9%
Medical Student	3	7.9%
No Answer	7	18.4%
Total	38	100.0%

## **Materials**

The current study used two instruments: Demographics Questionnaire, and the Postpartum Screening methods assessment.

**Demographics Questionnaire.** The questionnaire asked participants to provide information about age, sex, gender, ethnicity and race, classification, and years of experience. Subsequently, the questionnaire also asked participants to create a unique respondent ID to assist in comparing both parts of the study for each person.

**Postpartum Screening Methods Assessment.** The Postpartum Screening Methods Assessment was developed by the current researcher to investigate the perceptions of OB/GYN physicians when given access to the knowledge that the general public views them as most responsible for screening for Postpartum Depression. This questionnaire also asked about the screening methods used (Edinburg Postnatal Depression Scale and/or the Postpartum Depression Screening Scale, etc.) and how the physicians use and administer them to patients. This assessment was also used to examine the estimated percentage of an OB/GYN's caseload that gets screening for Postpartum Depression, and subsequently referred.

## **Procedure**

The study was initially approved by the Angelo State University Institutional Review Board. It was conducted completely online through a secure research host site, PsychData.

The study's link was posted in emails that were sent to a convenience sample of the American Obstetrics and Gynecology Association directory.

Once participants selected the link to the study they were presented with an informed consent. After giving consent, the participants were asked to complete a Demographic Questionnaire. Next, participants were provided with the Postpartum Screening Methods Assessment. This concluded Part 1 of the current study.

Two weeks later, participants were given access to part 2 of the current study via email, where they were asked to read the Behimehr and colleagues' article "Whose Problem is it anyway?" (2014). The participants were then asked to complete the Postpartum Screening Methods Assessment a second time.

## RESULTS

Frequency analyses revealed that most participants indicated that PPD screening is extremely important (67.7%) and it is a high to essential priority (87%). One-third (32.3%) of participants neither agreed nor disagreed with the statement that new mothers are not screened enough; roughly one-third (32.2%) disagreed and one-third (32.3%) agreed. Most participants (64.5%) indicated that they screen for PPD every time when seeing a new mother for her 6 week postnatal appointment.

The results demonstrate that OB/GYNs think that screening for PPD is important, and that screening for PPD should be a high priority. The distribution was fairly equal in whether participants agreed, disagreed, or were neutral pertaining to the statement that new mothers are not screened enough for PPD. Most participants agreed that they screen mothers for PPD when seeing the new mother in office for the first time postpartum at the 6 week postnatal appointment. These results do not support Hypothesis 1.

In part one of the study, a repeated measures ANOVA revealed a statistically significant difference between perceived responsibility of professional to screen,  $F(2, 27) = 23.89, p < .001$ , Wilk's  $\Lambda = 0.36, \eta_p^2 = .64$ . OB/GYNs were deemed most responsible to screen for PPD ( $M = 3.41; SD = .63; p \leq .001$ ). A repeated measures ANOVA revealed a statistically significant difference between screening, where the EDPS was used most often  $F(3, 18) = 31.35, p < .001$ , Wilk's  $\Lambda = 0.16, \eta_p^2 = .84$ . The Edinburgh Postnatal Depression Scale was reported to be most used ( $M = 3.43; SD = 1.83; p \leq .05$ ). Participants (45%) indicated that they administer the PPD at least sometimes within a packet. Most (55%) participants indicated that

they do not spend time with their patient before giving the screening tool. Most participants (77%) indicated that if PPD was detected, they would treat the patient themselves and most (61%) also reported that they would refer to a specialist. Participants who read the article indicated that it was somewhat influential to not at all.

Results from the ANOVA test reveal that there was a statistically significant difference between an OB/GYN's perception of the responsibility that they hold to screen for PPD. The results from the ANOVA do not support the hypothesis that the majority of OB/GYNs do not view themselves as most responsible for screening and diagnosing PPD in a patient, but view the responsibility as shared between OB/GYN, family practice, and pediatric specialties.

The results also indicated that less than half of participants administer the PPD at least sometimes within a packet. Most participants indicated that they do not spend time with their patient before administering the screening tool. Therefore the hypothesis that predicted "OB/GYNs usually do not spend time with the patient and explain the importance of early detection and treatment of PPD to their patients before administering the screening tools," was supported. Most participants indicated that if PPD were detected they would treat the patient themselves, but most indicated that they would also refer the patient to a specialist to treat the patient's PPD diagnosis; thus our hypothesis that OB/GYNs do usually treat patients diagnosed with PPD themselves rather than referring them to a mental health specialist, was not supported.

## **DISCUSSION**

The current study found that OB/GYNs indicate that PPD screening is extremely important and also perceive it to be a high to essential priority. This finding contradicts other literature that examined the rate of women being screened for PPD, and found that generally it was alarmingly low (Sobey, 2002; Wood, Middleton, & Leonard, 2010). The results from the current study contradict those studies mentioned prior in the literature review. They could be accurate, and these frequency analyses may be representative of OB/GYNs in Texas, but it is also possible that although the study was anonymous, the participants were not entirely truthful in their answers because they did not want to admit to being part of the problem. It is also possible that practices have changed since studies conducted in 2010, or the training for these practitioners has changed. The small sample size for this study could also explain this.

Most participants reported that they screen for PPD, but although the recorded percentage of those who screen for PPD every time when seeing a new mother for her 6 week postnatal appointment is considered the majority, it is still low, because these results show that 64.5% of participants agreed to this statement, which by omission is still excluding women that are not being screened by the other 35.5% of practitioners. Women are not being screened by 35.5% of providers, which is preventing diagnosis of these women, and subsequently excluding these women from getting treatment that they may need. It is possible that the providers do not screen 100% of the time because they believe that not every patient will have PPD, and if they do, they will be in the minority, thus not everyone

needs to be screened. This explains why some practitioners do not screen every patient, but this reason was not accounted for in the study.

The results indicated that the Edinburgh Postnatal Depression Scale was reported to be most utilized by participants, which is not surprising considering that prior studies have found it to be one of the most reliable methods to utilize to screen for PPD (Drake, Howard, & Kinsey, 2014; Logsdon & Myers, 2010). Less than half of the participants indicated that they give the screening method along with a packet of information, which is concerning because studies have shown that if the screening tool is given within a packet that has resources to educate the patient, the screening process would in turn be more effective (Evins, Theofrastous, & Galvin, 2000; Sobey, 2002). More than half of the participants reported that they do not spend time with their patient before administering the screening tool. This is concerning because studies have also found that taking the time to explain to the patient the importance of screening, detection, and treatment causes the patient to take the process more seriously and be more likely to follow up with recommended referrals (Collins, 2006; Farr, Denk, Dahms, & Dietz, 2014).

The results of this study also revealed that most participants indicated that if PPD was detected, they would treat it themselves, and they would also refer the patient to a mental health specialist. There are several reasons that could explain this finding. Participants may not refer every time due to the lack of insurance coverage for patients to see mental health professionals; rather they are aware that it may be more cost effective for the patient to be treated by their OB/GYN rather than another specialist (Liu et al., 2016 ; Sobey, 2002).

## **Implications**

This study, and the literature in general, typically indirectly addresses the question of whether screening itself is effective in reducing PPD, but does not adequately address whether screening ultimately results in an increased quality of life for women themselves (Nylen, Segre, & O'Hara, 2005). If women are screened more often, perhaps we could understand if the implementation of a successful program of detection, follow-up and referral for women who suffer from Postpartum Depression actually has a significant impact in the life of the patient (Lanes, Kuk, & Howe, 2011; Nylen, Segre, & O'Hara, 2005). Understanding this and continuing to follow through with best practices in screening for PPD could have significant implications in the areas of public health for the woman, her child, and her entire family (Gress-Smith, Luecken, Lemery-Chalfant, & Howe, 2011; Lanes, Kuk, & Tamim, 2011; Nylen, Segre, & O'Hara, 2005).

The current study also has implications for areas of sociology, specifically in areas pertaining to family dynamics. Untreated Postpartum Depression has harmful effects on child development and growth, mother-child bonding and attachment, maternal interactive behavior, and the marital relationship in question (Bradbury, Fincham, & Beach, 2004; Choi & Marks, 2008; Field, Diego, & Hernandez-Reif, 2006; Horwitz, Briggs-Gowan, Storfer-Isser, & Carter, 2007; Kingston, Tough, & Whitfield, 2012; Waldron & Routh, 1981). Given these adverse effects on women and their children and familial relationships, it is extremely important to guarantee that women suffering from PPD are adequately screened and

subsequently treated (Feeley, Bell, Hayton, Zelkowitz, & Carrier, 2016; Waldron & Routh, 1981).

If OB/GYNs are aware of their perceived responsibility to screen for PPD, and thus change their methods in screening, it is possible that screening will be more effective, fewer women will be overlooked, more women will be treated, and thus their marital and child-bonding relationships would improve (Choi & Marks, 2008; Sobey, 2002; Waldron & Routh, 1981). Without being treated for PPD, postpartum mothers run the risk of the symptoms of PPD interfering with their social relationships, particularly those with their immediate family members. Postpartum Depression could also have direct implications on marriage quality and home life, which could affect the newborn child's well-being, and thus affect healthy development of the child (Bradbury, Fincham, & Beach, 2004; Choi & Marks, 2008; Cummings & Davies, 1994; Feeley, Bell, Hayton, Zelkowitz, & Carrier, 2016; Waldron & Routh, 1981).

Understanding the benefits of screening and treating PPD can also have significant implications in the area of health politics, public policy, and law; specifically in the area of maternity leave duration and its relationship to postpartum mental and physical health. Understanding the overall effects of productive PPD screening for women could have implication for maternity leave policies.

A study conducted by Dagher, McGovern, and Dowd (2014) found that new mothers who take leaves from work for less than six months after childbirth “appear to have an increased risk of postpartum depressive symptoms” (p. 411). This study also found that

“longer leaves had a protective effect on general maternal physical health in the first twelve weeks after childbirth” (Dagher, McGovern, & Dowd, 2014, p. 411). This study itself suggests the importance of maternal leave as a protective factor for postpartum women, and if the effects of PPD screening overall can be better understood, perhaps policy implementation at state and local levels can be influenced in favor of the mental health of postpartum mothers (Dagher, McGovern, & Dowd, 2014).

However, it must be considered that although there may be evidence for positive implications of adequate maternity leave, there remains the issue that maternity leave poses dilemmas for employers (Liu & Buzzanell, 2004; Martin, 1990; Mock & Bruno, 1994). Employers may consider a pregnancy and upcoming maternity leave to be a predicament because maternity leave may increase tasks for others, scheduling difficulties, and cause excess worry about project deadlines (Liu & Buzzanell, 2004; Mock & Bruno, 1994). Women may be less inclined to support extended maternity leave because they want to keep their jobs, and may try to accommodate their bosses’ concerns (Liu & Buzzanell, 2004; Martin, 1990)

### **Limitations**

There are several limitations to the current study. The first being that a comparison of part one and part two of the study was unable to be conducted, due to only two participants completing both parts one and two of the study. This specific limitation was problematic because the aim of this study was to evaluate the change of perceptions after participants

were given access to the knowledge that the public perceives OB/GYNs as most responsible for screening for postpartum depression.

Another significant limitation to the current study was small sample size. Although emails were sent to 914 potential participants, only 38 were recruited, and only 2 of those 38 participants fully completed the entire study. Due to this small sample size, it is possible that the participants in the current study did not adequately represent the entire population of practicing OB/GYNs. Additionally, there was an unequal distribution of classification among participants, with the vast majority of participants reporting they are practicing OB/GYN physicians, and significantly less participants being CNS, medical residents, or medical students. It is possible that medical residents and medical students who participated in this study did not complete the study due to not having enough experience in the field, as they are still completing their schooling and not yet practicing.

### **Future Research**

Future research could be done to complete this study a second time, but with an adequate sample size and even number of participants in each classification. It may also be considered to do this project again but focusing solely on OB/GYN physicians and Clinical Nurse Specialists, and excluding the medical students and residents altogether. It is possible medical students and residents do not have enough experience to complete the study since they are still finishing their schooling. The particular factors that influence who and when to screen for PPD could also be investigated.

Future research could also be conducted to assess both pediatric and family practice physicians, to see if they agree with the public's perceptions that OB/GYNs are most responsible for screening for PPD, as was found in the study conducted by Behimehr and colleagues (2014).

### **Conclusions**

This study promotes research within the area of Postpartum Depression screening practices and perceptions. Future researchers are encouraged to continue expanding the field relating to perceptions of responsibilities in screening for Postpartum Depression. Since the study conducted by Behimehr, Curtis, Curtis & Hart (2014) found that the general public views OB/GYNs as most responsible to screen for PPD, OB/GYN specialists may want to consider the impact they have on patients with PPD, and that they could do considerable good by making PPD screening a priority.

This study shows that OB/GYNs consider PPD screening very important and view it as high priority. Due to only two participants fully completing the study, changes in perceptions are unknown, so further research can be done to determine if reading literature can aid in altered perceptions of PPD screening and referral. Additionally, further research can be done to see if pediatricians and family practice practitioners agree that OB/GYNs are most responsible to screen for PPD.

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## APPENDIX A

### Demographic Questionnaire

Age: \_\_\_\_\_

Sex: \_\_\_ Male \_\_\_ Female \_\_\_ Intersex

Gender: \_\_\_ Woman \_\_\_ Man \_\_\_ Transgender

#### **Race/Ethnicity:**

- \_\_\_ 1) African American/Black
- \_\_\_ 2) Caucasian/European American
- \_\_\_ 3) Asian/Asian American/Pacific Islander
- \_\_\_ 4) Native American/Alaskan Native
- \_\_\_ 5) Hispanic/Latina/Latino
- \_\_\_ 6) Bi Racial
- \_\_\_ 7) Multi racial
- \_\_\_ 8) Other: \_\_\_\_\_

#### **Classification:**

- \_\_\_ OB/GYN
- \_\_\_ Certified Nurse Specialist (CNS)
- \_\_\_ Medical Resident
- \_\_\_ Medical Student

#### **Years of Experience:**

\_\_\_\_\_

Please create a unique word with a number that you can easily remember (not your name, birthdate, or anything that identifies you). You will be asked to enter this word in Part 2 of the study.

\_\_\_\_\_

## APPENDIX B

### Postpartum Depression Screening Methods Assessment Part 1

**What do you think the level of responsibility is for the following specialties to screen for Postpartum Depression (PPD):**

1. Pediatrics
2. Family Practice
3. OB/GYN

1	2	3	4
Not at all responsible	Somewhat responsible	Mostly responsible	Completely responsible

**How important do you think Postpartum Depression (PPD) screening is:**

1	2	3	4	5	6	7
Not at all important	Low importance	Slightly important	Neutral	Moderately important	Very important	Extremely Important

**How much of a priority do you think early detection of Postpartum Depression (PPD) should be:**

1	2	3	4	5	6	7
Not at all important	Low importance	Slightly important	Neutral	Moderately important	Very important	Extremely Important

**In general, new mothers are not screened for Postpartum Depression (PPD) frequently enough:**

1	2	3	4	5
Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree

**When seeing a new mother for her 6 week postnatal appointment, how often do you screen for Postpartum Depression (PPD):**

1	2	3	4	5
Never	Almost never	Occasionally/sometimes	Almost every time	Every time

**When screening for Postpartum Depression (PPD) in a patient, how often do you use these screening methods:**

1. Beck Depression Inventory (BDI-II)
2. Center for Epidemiological Studies Depression Scale (CES-D)
3. Edinburgh Postnatal Depression Scale (EPDS)
4. Postpartum Depression Screening Scale (PDSS)

1	2	3	4	5
Never	Almost never	Occasionally/sometimes	Almost every time	Every time

**How often do you administer your preferred Postpartum Depression (PPD) screening tool in a packet containing information rather than on its own?**

1	2	3	4	5
Never	Almost never	Occasionally/sometimes	Almost every time	Every time

**If you use an information packet, what information about Postpartum Depression (PPD) does your packet contain?**

Free text:

**I spend time with my patient before giving them the Postpartum Depression (PPD) measurement tool, to explain what PPD is, its importance, and to see if they are exhibiting any symptoms.**

1	2	3	4	5	6	7
Very untrue of me	Untrue of me	Somewhat untrue of me	Neutral	Somewhat true of me	True of me	Very true of me

**On average, how much time do you spend with each patient discussing Postpartum Depression (PPD) before administering the tool?**

Free text:

**What is the estimated percentage of your caseload that gets screened for Postpartum Depression (PPD)?**

1	2	3	4	5	6	7
<15%	16 – 30%	31-50%	51-70%	71-85%	86-95%	>96%

**If Postpartum Depression (PPD) is detected, how likely would you treat the patient yourself?**

1	2	3	4	5
Extremely unlikely	Unlikely	Neutral	Likely	Extremely likely

**If Postpartum Depression (PPD) is detected, how likely would you be to refer the patient to another specialist?**

1	2	3	4	5
Extremely unlikely	Unlikely	Neutral	Likely	Extremely likely

## APPENDIX C

### Postpartum Depression Screening Methods Assessment Part 2

**What do you think the level of responsibility is for the following specialties to screen for Postpartum Depression (PPD):**

1. Pediatrics
2. Family Practice
3. OB/GYN

1	2	3	4
Not at all responsible	Somewhat responsible	Mostly responsible	Completely responsible

**How important do you think Postpartum Depression (PPD) screening is:**

1	2	3	4	5	6	7
Not at all important	Low importance	Slightly important	Neutral	Moderately important	Very important	Extremely Important

**How much of a priority do you think early detection of Postpartum Depression (PPD) should be:**

1	2	3	4	5	6	7
Not at all important	Low importance	Slightly important	Neutral	Moderately important	Very important	Extremely Important

**In general, new mothers are not screened for Postpartum Depression (PPD) frequently enough:**

1	2	3	4	5
Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree

**When seeing a new mother for her 6 week postnatal appointment, how often do you screen for Postpartum Depression (PPD):**

1	2	3	4	5
Never	Almost never	Occasionally/sometimes	Almost every time	Every time

**When screening for Postpartum Depression (PPD) in a patient, how often do you use these screening methods:**

4. Beck Depression Inventory (BDI-II)
5. Center for Epidemiological Studies Depression Scale (CES-D)
6. Edinburgh Postnatal Depression Scale (EPDS)
7. Postpartum Depression Screening Scale (PDSS)

1	2	3	4	5
Never	Almost never	Occasionally/sometimes	Almost every time	Every time

**How often do you administer your preferred Postpartum Depression (PPD) screening tool in a packet containing information rather than on its own?**

1	2	3	4	5
Never	Almost never	Occasionally/sometimes	Almost every time	Every time

**If you use an information packet, what information about Postpartum Depression (PPD) does your packet contain?**

Free text:

**I spend time with my patient before giving them the Postpartum Depression (PPD) measurement tool, to explain what PPD is, its importance, and to see if they are exhibiting any symptoms.**

1	2	3	4	5	6	7
Very untrue of me	Untrue of me	Somewhat untrue of me	Neutral	Somewhat true of me	True of me	Very true of me

**On average, how much time do you spend with each patient discussing Postpartum Depression (PPD) before administering the tool?**

Free text:

**What is the estimated percentage of your caseload that gets screened for Postpartum Depression (PPD)?**

1	2	3	4	5	6	7
<15%	16 – 30%	31-50%	51-70%	71-85%	86-95%	>96%

**If Postpartum Depression (PPD) is detected, how likely would you treat the patient yourself?**

1	2	3	4	5
Extremely unlikely	Unlikely	Neutral	Likely	Extremely likely

**If Postpartum Depression (PPD) is detected, how likely would you be to refer the patient to another specialist?**

1	2	3	4	5
Extremely unlikely	Unlikely	Neutral	Likely	Extremely likely

**What do you think the level of responsibility is for the following specialties to screen for Postpartum Depression (PPD):**

1. Pediatrics
2. Family Practice
3. OB/GYN

1	2	3	4
Not at all responsible	Somewhat responsible	Mostly responsible	Completely responsible

**How influential was this study in changing your perception about who should be screening for Postpartum Depression (PPD)?**

1	2	3	4	5
Not at all influential	Slightly influential	Somewhat influential	Very influential	Extremely influential

**After participating in this study, how likely are you to change your method of approach for Postpartum Depression (PPD) screening and treatment?**

1	2	3	4	5
Extremely unlikely	Unlikely	Neutral	Likely	Extremely likely

## **BIOGRAPHY**

Jennifer Diana Lewis Larsen was born on January 22, 1996, in Layton, Utah. She received a Bachelor of Science in Psychology with Highest University Honors from Angelo State University in 2018. During this time, she also completed her Developmental Psychology certificate and minored in Biology and Chemistry. She was inducted into Psi Chi in the spring of 2015. She was also inducted as an Honors member into Beta Beta Beta Biological Honor Society in fall of 2014, where she remained an active member and was elected as treasurer. She was listed in Who's Who Among Students in American Universities and Colleges in the spring of 2017. She was an active member of the Angelo State University Honors Program. She served on the Angelo State Student Government senate as a Chemistry/Biochemistry representative for the Biochemistry Department fall of 2017. Jennifer also worked as Chief Medical Scribe at San Angelo Community Medical Center's emergency department. She served the community by heading the organization Reach Out and Read from Fall 2016 to Fall 2017. Jennifer will attend the Angelo State University BSN program in San Angelo, TX to study nursing. She plans to become a Psychiatric Nurse Practitioner.

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