



**Postpartum Depression: A Critical Area for Continuing Social Work Education**

<b>Journal:</b>	Professional Development: The International Journal of Continuing Social Work Education
<b>Article Title:</b>	Postpartum Depression: A Critical Area for Continuing Social Work Education
<b>Author(s):</b>	Robert Keefe, Rebecca S. Rouland Polmanteer & Carol Brownstein-Evans
<b>Volume and Issue Number:</b>	<i>Vol.20 No.1</i>
<b>Manuscript ID:</b>	<i>201003</i>
<b>Page Number:</b>	<i>3</i>
<b>Year:</b>	<i>2017</i>

Professional Development: The International Journal of Continuing Social Work Education is a refereed journal concerned with publishing scholarly and relevant articles on continuing education, professional development, and training in the field of social welfare. The aims of the journal are to advance the science of professional development and continuing social work education, to foster understanding among educators, practitioners, and researchers, and to promote discussion that represents a broad spectrum of interests in the field. The opinions expressed in this journal are solely those of the contributors and do not necessarily reflect the policy positions of The University of Texas at Austin’s School of Social Work.

Professional Development: The International Journal of Continuing Social Work Education is published two times a year (Spring and Winter) by the Center for Social and Behavioral Research at 1923 San Jacinto, D3500 Austin, TX 78712. Our website at [www.profdevjournal.org](http://www.profdevjournal.org) contains additional information regarding submission of publications and subscriptions.

Copyright © by The University of Texas at Austin’s School of Social Work. All rights reserved. Printed in the U.S.A.

ISSN: 1097-4911

URL: [www.profdevjournal.org](http://www.profdevjournal.org)

Email: [www.profdevjournal.org/contact](mailto:www.profdevjournal.org/contact)

# Postpartum Depression: A Critical Area for Continuing Social Work Education

---

*Robert Keefe, Rebecca S. Rouland Polmanteer & Carol Brownstein-Evans*

## Abstract

Up to 25% of new mothers develop postpartum depression (PPD) following childbirth. Given their education and training to work in various healthcare settings and with systems of all sizes, social workers are among the professionals most likely to work with these mothers. However, social work journals and textbooks have published little on this topic, and few continuing education programs have provided workshops to train social workers to provide quality services to mothers with PPD. This article provides an overview of a workshop that continuing education programs can use to help social workers work effectively with mothers who have PPD. Key words: Postpartum depression, perinatal mood disorders, continuing social work education.

## Postpartum Depression: A Critical Area for Continuing Social Work Education

The Centers for Disease Control and Prevention (2015) reported there were 3,932,181 babies born in the United States in 2013. Of these babies, roughly 96.5% were singleton births, and the remaining 3.5% were twin, triplet, and higher-order multiple births (Martin, Hamilton, Osterman, Curtin, & Matthews, 2015), resulting in a rough estimate of 3,795,554 mothers having given birth in 2013. Of these new mothers, researchers conclude that between 13% and 25% (493,422 to 948,000) will develop postpartum depression (PPD; Gaynes et al., 2005; Schaar, 2012). For mothers from traditionally oppressed backgrounds such as low-income mothers, mothers of color, and very young mothers, the rates of PPD are as high as 38% (Abrams & Curran, 2007; CDC, 2008; Leigh & Milgrom, 2008).

Although the literature on PPD has grown substantially over the past 25 years, social work has contributed very little to it (Keefe, Brownstein-Evans, Lane, Carter, & Polmanteer,

2016). As a result, social workers must consult nursing, psychiatric, obstetrics, midwifery, and pediatrics journals, which although helpful do not provide guidance on rendering multi-system level interventions. Of the scant literature that has been published in social work journals, virtually none addresses working with systems of all sizes. Instead, the majority of the literature addresses working almost exclusively at the micro level of practice.

## The Social Problem of Postpartum Depression

Since the early 1990s, the public has become increasingly aware of the problem of PPD. Sensationalized cases of mothers harming their children catalyzed many legislators to address the problem (Rhodes & Segre, 2013). One legislative action is the passing of the Patient Protection and Affordable Care Act (ACA), Section 2952: Support, Education, and Research for Postpartum Depression, which mandates ongoing research to better understand the frequency and course of PPD, address differences in treatment needs among racial and ethnic groups, and develop culturally competent evidence-based treatment approaches (Rhodes & Segre, 2013; U.S. Department of Labor, 2012) to ensure the well-being of extended family members (U.S. Department of Labor, 2012). Section 2952 presents a wonderful opportunity for social workers, who unlike professionals from many other disciplines, are trained to practice at the micro, mezzo, and macro levels. Moreover, because the evidence-based practice literature largely ignores working at larger system levels, social workers are well positioned to take a leadership role in filling the gap in the evidence-based literature and practice.

## The Problem of Postpartum Depression

PPD is the most common form of maternal morbidity following childbirth (Stocky & Lynch, 2000; Robertson, Grace, Wallington, & Steward,

---

*Robert Keefe, PhD, is an Associate Professor at the State University of New York at Buffalo. Rebecca S. Rouland Polmanteer, LMSW, is from the State University of New York at Buffalo. Carol Brownstein-Evans, PhD, is an Associate Professor at Nazareth College.*

2004). The disorder is often debilitating (American Psychiatric Association, 2013) and has ramifications for new mothers, their infants, spouses/partners, other children, and extended families and friends (Letourneau et al., 2012a). While the disorder occurs in mothers as early as the first month postpartum (American Psychiatric Association, 2013), other mothers do not manifest symptoms until 12 to 14 weeks or even as late as one year postpartum (Gaynes et al., 2005).

Mothers with PPD report experiencing disrupted sleep (Glavin, 2012; Lucero, Beckstrand, Callister, & Sanchez Birkhead, 2012), poor concentration and appetite (Glavin, 2012), decreased self-esteem, feelings of failure, anergia (Glavin, 2012), anxiety (Glavin, 2012; Lucero et al., 2012), social withdrawal, guilt (Lucero et al., 2012), sexual dissatisfaction (Morof, Barrett, Peacock, Victor, & Manyonda, 2003), obsessive thoughts (Lucero et al., 2012), hopelessness (Sealy, Fraser, Simpson, Evans, & Hartford, 2009), and ongoing fears of harming their baby (Sealy et al., 2009), and committing suicide (Lucero et al., 2012).

Despite these negative feelings, upwards to 50% of mothers with PPD do not seek treatment (CDC, 2008) or fail to recognize their symptoms as problematic (Keefe & Brownstein-Evans, 2013). Many other mothers who experience their symptoms as negative choose either to go without treatment (Sampson, Zayas, & Seifert, 2012) or not to disclose their symptoms to service providers (Lucero et al., 2012) whom they fear will judge them for having negative feelings.

#### **Assessing Mothers for Postpartum Depression**

The literature reports that mothers who experience physiological changes such as broad hormonal and endocrine fluctuations (Dennis & Ross, 2005), premenstrual tension (Boyce & Hickey, 2005), diabetes (Anderson, Freedland, Clouse, & Lustman, 2001) including gestational diabetes (Crowther et al., 2005), and obesity (Andersson, Sundstrom-Poromaa, Wulff, Astrom, & Bixo, 2006) are often at increased risk of developing PPD. Psychosocial issues including the fear of being a “bad mother” (Mauthner,

1999), being of lower socio-economic status (Grote & Bledsoe, 2007; Kozinsky et al., 2012; Leigh & Milgrom, 2008;), having few social supports (Leigh & Milgrom, 2008), poor maternal health (Luke et al., 2009), experiencing job-related (Grote & Bledsoe, 2007) or other stressors (Kozinsky et al., 2012), having had a difficult (Boyce & Hickey, 2005) or unplanned pregnancy (Kozinsky et al., 2012), experiencing negative prior birth outcomes, having had abortions (Kozinsky et al., 2012), and witnessing abuse or being abused as a child (Blackmore et al., 2006) including sexual abuse (Buist & Janson, 2001) have all been shown to increase a mother’s risk for PPD.

#### **Use of Screening Instruments**

In order to assess mothers, various screening instruments normed on mothers from differing backgrounds exist. However, social workers and other healthcare providers do not routinely screen mothers for PPD (Gaynes et al., 2005; Schaar, 2012; Keefe, Brownstein-Evans, & Polmanteer, 2015), despite the majority of mothers indicating they are willing to be screened (Gemmil, Leigh, Erickson, & Milgrom, 2006). Moreover, of the healthcare providers who screen, many do not use the results for follow-up care (Gjerdingen & Yawn, 2007). Consequently, some mothers report their healthcare providers actually contribute to the depression by minimizing their symptoms (Dennis, 2009), providing minimal education on PPD (Letourneau et al., 2007), and not discussing mental health issues when the mothers themselves want (Kahn et al., 1999).

#### **Who Should Treat Mothers with Postpartum Depression**

Due to the problems associated with PPD, the question emerges: Who should provide treatment? Some argue that healthcare professionals must be convinced of the seriousness of PPD (Logsdon, Wisner, Billings, & Shanahan, 2006). Obstetricians, however, argue that they have only one visit with mothers post-delivery, which typically occurs six weeks post birth (Liberto, 2012). Because the most

common detection periods for PPD are two and six months postpartum (Gaynes et al., 2005), the likelihood that obstetricians will be able to accurately assess a mother for PPD is doubtful. Conversely, pediatricians see mothers on average of eight times during the first two years of the child's life while treating children (Liberto, 2012). However, their role is to treat the child, not the mother, resulting in many pediatricians feeling uncomfortable screening new mothers when they are unable to provide treatment to them (Liberto, 2012). Primary care physicians report they are too busy and not properly trained to treat psychiatric disorders (Logsdon et al., 2006; Seehusen, Baldwin, Runkle, & Clark, 2005). Finally, although social workers identify PPD as a significant problem very few screen for it or are trained in rendering effective treatment (Keefe et al., 2015).

Given their work in various settings including hospitals, well-child clinics, and other public health settings, social workers are more likely to work with new mothers than other helping professionals (Lind & Bachman, 2012). Given their training in cultural competence, advocacy, policy development, intervening within multiple systems, and providing services to individuals from vulnerable groups, social workers are able to bring a broad range of perspectives to address the needs of new mothers with PPD (Lind & Bachman, 2012).

Given the mandates from Section 2952 of the ACA, social workers working with new mothers must become competent in rendering evidence-based services. The question emerges, where should social workers receive the necessary training to work with these new mothers? Keefe, Brownstein-Evans, Lane, Carter, and Polmanteer (2016) reported that social work journals are nearly bereft of any research on PPD. With these points in mind, we argue that it is incumbent on continuing social work education programs to provide ongoing workshops to practitioners so they render appropriate and effective evidence-based services for mothers with PPD. In this article, we provide an overview of a curriculum that continuing social work educators can use to educate social workers to work effectively with

mothers who have PPD.

### **Planning a Continuing Education Workshop Curriculum**

To begin developing a workshop, we looked at 24 publishing houses that publish social work texts to ascertain if there were any textbooks or book chapters published on PPD. We searched specifically for the following terms: "postpartum," "perinatal," "depression," "maternal," and "mental health," and found only one textbook (i.e., Lind & Bachman, 2012) explicitly written from a social work perspective. Other PPD texts that were written by non-social workers focused only on the medical or psychiatric aspects of the disorder and not on working with systems of all sizes.

We then contacted the national and state chapters of the National Association of Social Workers (NASW) to learn if they offered any continuing social work education programs on PPD. We found that only the national chapter and four state chapters have offered any continuing education workshops on any perinatal mood disorders. We then sent emails to continuing social work education programs at schools/ departments of social work to ask if their programs offered workshops on perinatal mood disorders in the past and if they were planning on offering any in the future. Only 6 of the 70 programs that responded had hosted any workshops on perinatal mood disorders in the past, and only three planned to host any in the future. Most of the content we received from the six workshops focused largely on psychiatric and medical issues, with little-to-no focus on psychosocial issues or on work with families and communities.

Interestingly, many of the continuing education program directors and NASW chapter executive directors informed us that they believed PPD was an important topic and they would like to host a workshop. However, none knew of any practitioners who specialize in PPD to conduct the workshop or a curriculum that could be used to facilitate one.

**Appendix A: Workshop Overview**

1. **Introduction:**
  - a. Review the PPD literature from various professional fields
  - b. Focus on an overview of the problem of PPD and its key elements
    - i. Engaging mothers in the treatment process,
    - ii. Conducting an assessment
    - iii. Intervening at all system levels,
    - iv. Providing tips on accessing Internet and community-based resources.
  
2. **Set the Tone:**
  - a. Start with a definition of PPD.
    - i. *Diagnostic and Statistical Manual, 5th edition*
      1. A form of major depressive disorder with onset during pregnancy or one month Post-birth,
      2. Dominant symptoms are depressed mood and anhedonia.
    - ii. When discussing PPD symptoms
      1. Bear in mind the conflicting data on when symptoms manifest, and
      2. Encourage attendees not to adhere too rigidly to the time criterion;
        - a. Instead, appreciate that many mothers do not manifest PPD symptoms for many weeks or months after giving birth.
      3. Next, leaders should spend a brief amount of time discussing the prevalence rates.
        - a. Although many conclude that PPD affects 13% of the population,
        - b. Others report it can affect up to 25%,
        - c. And as many as 38% of mothers in communities of color.
    - iii. Etiological and predisposing factors should also be briefly summarized including the biological and social factors, consistent with holistic approach typical of social work.
  
3. **Working with the New Mother:**
  - a. Encourage the attendees to focus on successful approaches to engage reluctant clients.
    - i. Engaging the mothers in a warm and non-threatening manner is essential.
    - ii. Among the key ingredients to successful relationship building is
      1. Having flexible appointment schedules,
      2. Allowing the newborn to be with the mother during sessions, and
      3. Not 'medicalizing' PPD.
    - iii. At the micro level, mothers benefit from being validated and empowered by healthcare providers who can share their experiences of working with other mothers and the difficulty they had in discussing their burdens as new mothers.
  
4. **Assessment:**
  - a. As a part of a good assessment social workers must screen new mothers for depression. Include the following:
    - i. Barriers to care,
    - ii. Housing stability,
    - iii. Unintended pregnancy,

## Postpartum Depression: A Critical Area for Continuing Social Work Education

---

- i. Barriers to care,
  - ii. Housing stability,
  - iii. Unintended pregnancy,
  - iv. Nutrition,
  - v. Alcohol and other drug use,
  - vi. Depression,
  - vii. Safety,
  - viii. Intimate partner violence, and
  - ix. Stress.
- b. Be proactive in educating the mothers about the risks for PPD.
- i. The use of various screening instruments.
  - ii. Conduct a Structured Clinical Interview-Depression for all mothers who score in the depressed range to understand the extent of the depression.

### 5. Intervening at Various System Levels

- a. Individual/Micro level
- i. Empirically supported interventions include cognitive-behavioral and interpersonal therapy and psychoeducation.
  - ii. Based on the mother's needs, strengths, and preferences the attendees should be encouraged to consider other treatment alternative approaches including light therapy, acupuncture, and massage.
- b. Family and Group/Mezzo level
- i. Psychoeducation and developing effective communication skills.
  - ii. Groups that have helped mothers to bond with their newborns and that have provided peer support have had some positive effect.
- c. Community/Macro level
- i. Focus on assessing the mothers' social support systems.
  - ii. Use of various services such as faith-based organizations, neighborhood groups, and WIC and other clinics.
  - iii. Providing education at various clinics, neighborhood groups, and faith-based organizations may be of much help to new mothers.
  - iv. Decide when to bring in outside help.
    - 1. Integrate a multidisciplinary approach to PPD treatment.
    - 2. Use other professionals such as physicians, midwives, and psychiatrists for evaluation of antidepressants or other medications.
    - 3. Working alongside other helping professional as co-therapists.
  - v. Locate and refer mothers to reputable resources.
    - 1. Some of the most common resources include Web-based and non-mental health services.
      - a. Postpartum Support International,
      - b. The Postpartum Stress Center, and
      - c. Postpartum Progress have various blogs, helpful information, and referral sources that can be of use to the mother and her family.

### 6. Evaluation:

- a. Pre and post-tests on the attendees' knowledge of PPD and evidence-based treatment approaches. Assess intent to practice using skills learned in the workshop.

### **Curriculum**

Workshop facilitators must draw from the professional literature to be familiar with the most current information on PPD. The curriculum should focus on providing an overview of the problem of PPD, engaging mothers in the treatment process, conducting an assessment, intervening at all system levels, providing tips on accessing Internet and community-based resources, and evaluating the workshop's effectiveness. The overview of the workshop is provided in Appendix A.

### **Setting the Tone**

The overview should start with a definition of PPD. We propose using the definition adopted by the American Psychiatric Association's (2013) *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition, which identifies PPD as a form of major depressive disorder with onset during pregnancy or one month postpartum, in which the dominant symptoms are depressed mood and anhedonia. When discussing PPD symptoms, workshop leaders must bear in mind the conflicting data on when symptoms manifest and encourage attendees not to adhere too rigidly to the time criterion, but rather to appreciate that many mothers do not manifest PPD symptoms for many weeks or even months after giving birth. Next, leaders should spend a brief amount of time focusing on the varying prevalence rates noting the highest rates are found in new mothers from traditionally oppressed groups. Consistent with the holistic approach typical of social work, etiological and predisposing factors including the biological and social factors should briefly be summarized.

### **Working with the New Mothers**

Because many mothers with PPD are reluctant to seek services, the workshop leader should encourage the attendees to focus on successful approaches to engaging reluctant clients. Mothers with PPD benefit from having their experiences validated by their healthcare providers (Byatt, Simas, Lundquist, Johnson, & Ziedonis, 2012) who can share their experiences of working with other mothers and the difficulty of discussing the

burdens of new motherhood. New mothers have reported they need professionals who have flexible appointment schedules, that allow the newborn and other children to be with the mother during sessions, and who do not "medicalize" their symptoms (Keefe, Brownstein-Evans, & Polmanteer, 2016).

### **Assessment**

Social workers must screen new mothers for depression, and include an assessment of barriers to care, housing stability, unintended pregnancy, nutrition, alcohol and other drug use, depression, safety, intimate partner violence, and stress (American College of Obstetricians and Gynecologists, 2001). The use of various screening instruments including the Edinburg Postnatal Depression Scale (Cox, Holden, & Sagovsky, 1987) and the Antenatal Psychosocial Health Assessment Tool (Blackmore et al., 2006) are easy to use, have been normed on mothers from various backgrounds, and can serve as a guide to help the mother and social worker measure client progress. Individual questions from the scales – such as "how does your partner (spouse) feel about your pregnancy?" (Blackmore et al., 2006), can also serve as good starting points for interviews. Finally, social workers must conduct a Structured Clinical Interview-Depression for all mothers who score in the depressed range so as to understand the extent of the depression (First, Williams, Karg, & Spitzer, 2015).

### **Intervening at The Individual/Micro, Family and Group/Mezzo, and Community/Macro System Levels**

#### **Individual/Micro Level**

A continuing education curriculum should emphasize various empirically-supported treatment approaches used at the micro, mezzo, and macro levels. At the micro level cognitive-behavioral and interpersonal therapy and psychoeducation have been helpful in relieving PPD symptoms (O'Hara & McCabe, 2013). Evidence is also mounting on the use of alternative approaches including light therapy

## Postpartum Depression: A Critical Area for Continuing Social Work Education

---

(Lee, Aycock, & Moloney, 2012), acupuncture (Manber, Schnyer, Allen, Rush, & Blasey, 2004), and massage (Field, Diego, & Hernandez-Reif, 2007).

Working to empower the mother to practice self-care is essential. Encouraging the new mother to nap when her baby naps (Dennis & Ross, 2005), eat a healthy diet (Lobel et al., 2008), and share the burden of child rearing and household tasks with other family members (Barclay & Lupton, 1999) have been shown to mitigate the effects of PPD. Finally, because many mothers fear being considered a “bad mother,” attendees should discuss and perhaps roleplay situations in which they discuss what makes a “good mother” (Mauthner, 1999).

### **Family and Group/Mezzo Level.**

Although PPD is associated with mothers only, researchers have found that other family members often develop depression after the birth of the child (Letourneau et al., 2012a, 2012b). Attendees should learn about interventions at the mezzo level such as family psychoeducation and communication-skills building to assure all family members’ concerns are addressed and that lines of communication are open among family members. Groups that demonstrate to mothers how to bond with their newborns (Clark, Tlucaek, & Brown, 2008); develop peer-support networks with other new mothers (Jones, Watts, & Romain, 1995); and develop skills such as how to maintain eye contact, breastfeed, and communicate with the newborn have had some positive effects relieving PPD. Workshop leaders should provide information on the predictors of PPD and available community resources that would be helpful to the attendees and the mothers.

### **Community/Macro Level**

Workshops focusing on interventions at the macro level can help social workers assess the mothers’ social support systems and use of various services such as faith-based organizations, neighborhood groups, and WIC and other clinics (Keefe, Brownstein-Evans et al., 2016). A key issue for the workshop leader to address is no matter how well-meaning members of these organizations are, many of them do not

know how to be of help (L. Clark, personal communication March 31, 2015). Helping workshop attendees strategize ways to provide in-service trainings to these community organizations will in turn be helpful to new mothers who access them. Factsheets that provide an overview of PPD and available sources could be helpful to all service providers. Involving professionals such as physicians, psychiatrists, and midwives who can provide psychoeducation on various issues such as evaluating the need for, and addressing the controversies of, various medications, antidepressants, or estrogen therapy would be helpful. Working with community agencies such as Women Infant and Children (WIC) and well-baby clinics to train staff on how to recognize PPD would potentially enhance a new mother’s entry into care.

Finally, workshop leaders should point out reputable resources, such as Internet websites and community agencies that focus on mental/emotional health and wellness. Internet-based supports offering free, confidential, and stigma-free space to obtain information effective (Kantrowitz-Gordon, 2013). Postpartum Support International (2015), The Postpartum Stress Center (2015), and Postpartum Progress (2015) have various blogs, helpful information, and referral sources that can be of use to the mother and her family. Finally, community resources that do not necessarily focus on PPD can be of great value. For instance, Keefe, Brownstein-Evans, and Polmanteer (2015) concluded that accessing supports that provided concrete services including free diapers, transportation, child care, and access to healthy foods were more helpful than many other services focused specifically on mental health care.

### **Evaluating the Workshop**

An effective continuing education workshop focusing on PPD must address many areas, which include recognizing the predictors and symptoms of PPD; using empirically-supported interventions; matching the mother’s needs, values, and preferences with effective treatment approaches; and documenting her ongoing improvement. Assessing the attendees’ knowledge of PPD with pre- and post-tests is



necessary. At post-test, assessing the attendees' intent to practice using the skills they learned in the workshop as well as their sense of self-efficacy in rendering services will provide the workshop leader with information on how to improve the training.

### **Conclusion**

Despite the fact that social work has historically been at the vanguard of providing services to new mothers and children (Keefe & Evans, 2013; Rudolph, 2000), it has done little to address the growing problem of PPD. The research available to social work practitioners comes largely from the fields of nursing, psychiatry, pediatrics, midwifery, and obstetrics. Much of this literature focuses solely on rendering services to the mother herself with only scant attention to providing services to the mothers' families and the communities in which they live. It is therefore incumbent on continuing education and professional development programs to train practicing social workers to provide services to this population so that new mothers, their children, and related social systems can live healthy and fulfilling lives.

### **References**

- Abrams, L. S., & Curran, L. (2007). Not just a middle class affliction: Crafting a social work research agenda on postpartum depression. *Health & Social Work, 32*(4), 82-92.
- American College of Obstetricians and Gynecologists. (2011). *Clinical Management Guidelines for Obstetrician-Gynecologists: ACOG Practice Bulletin No. 30*. Washington, DC: Author.
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders (5th ed.)*. Washington, DC: Author.
- Anderson, R. J., Freedland, K. E., Clouse, R. E., & Lustman, P. J. (2001). The prevalence of comorbid depression in adults with diabetes: A meta-analysis. *Diabetes Care, 24*(6), 1069-1078.
- Andersson, L., Sundstrom-Poromaa, I., Wulff, M., Astrom, M., & Bixo, M. (2006). Depression and anxiety during pregnancy and six months postpartum: A follow-up study. *Acta Obstetrica et Gynecologica, 85*, 937-944.
- Barclay, L., & Lupton, D. (1999). The experiences of new fatherhood: A socio-cultural analysis. *Journal of Advanced Nursing, 29*(4), 1013-1020.
- Blackmore, E. R., Carroll, J., Reid, A., Biringer, A., Glazier, R. H., Midmer, D., & Steward, D. E. (2006). The use of the Antenatal Psychosocial Health Assessment (ALPHA Tool) in the detection of psychosocial risk factors for postpartum depression: A randomized controlled trial. *Journal of Obstetrics and Gynecology Canada, 28*(10), 873-878.
- Boyce, P., & Hickey, A. (2005). Psychosocial risk factors to major depression after childbirth. *Social Psychiatry and Psychiatric Epidemiology, 40*, 605-612.
- Buist, A., & Janson, H. (2001). Childhood sexual abuse, parenting and postpartum depression – a 3-year follow-up study. *Child Abuse & Neglect, 25*, 909-921.
- Byatt, N., Simas, T. A. M., Lundquist, R. S., Johnson, J. V., & Ziedonis, D. M. (2012). Strategies for improving perinatal depression treatment in North American outpatient obstetric settings. *Journal of Psychosomatic Obstetrics & Gynecology, 33*(4), 143-161. doi:10.3109/0167482X.2012.728649
- Centers for Disease Control and Prevention (CDC). (2008). Prevalence of self-reported postpartum depressive symptoms - 17 states, 2004-2005. *Morbidity and Mortality Weekly Report, 57*(14), 361-366.
- Centers for Disease Control and Prevention (CDC). (2015). Births and natality. Retrieved from <http://www.cdc.gov/nchs/fastats/births.htm>
- Clark, R., Tlucaek, A., & Brown, R. (2008). A mother-infant therapy group model for postpartum depression. *Infant Mental Health Journal, 29*(5), 514-536.
- Cox, J. L., Holden, J. M., & Sagovsky, R. (1987). Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *The British*

## Postpartum Depression: A Critical Area for Continuing Social Work Education

---

- Journal  
of Psychiatry, 150(6), 752-786.
- Crowther, C. A., Hiller, J. E., Moss, J. R.,  
McPhee, A. J., Jeffries, W. S., & Robinson, J.  
S. (2005). Australian Carbohydrate Intolerance  
Study in Pregnant Women (ACHOIS) Trial  
Group Effect of treatment of gestational  
diabetes mellitus on pregnancy outcomes. *New  
England Journal of Medicine*, 352(24), 2477-  
2486.
- Dennis, C. (2009). Preventing and treating  
postnatal depression. *BMJ British Medical  
Journal*, 338(7689), 246-247.
- Dennis, C. L., & Ross, L. (2005). Relationships  
among infant sleep patterns, maternal fatigue,  
and development of depressive  
symptomatology. *Birth*, 32(3), 187-193.
- Field, T., Diego, M., & Hernandez-Reif, M.  
(2007). Massage therapy research.  
*Developmental Review*, 27, 75-89.
- First, M. B., Williams, J. B. W., Karg, R. S., &  
Spitzer, R. L. (2015). *Structured clinical  
interview disorders SCID-57*. Arlington, VA:  
American Psychiatric Publications.
- Gaynes, B. N., Gavin, N., Meltzer-Brody, S.,  
Lohr, K.N., Swinson, T., Gartlehner, G.,  
Miller, W. C. (2005, February). Perinatal  
depression: Feasibility study. Final report from  
the RTI-International-University of North  
Carolina Evidence-Based Practice Center  
to the Agency for Healthcare Research and  
Quality under contract No. 290-02-0016.  
Research Triangle Park, NC. Retrieved from  
[http://archive.ahrq.gov/downloads/pub/  
evidence/pdf/peridepr/peridep.pdf](http://archive.ahrq.gov/downloads/pub/evidence/pdf/peridepr/peridep.pdf).
- Gemmill, A. W., Leigh, B., Ericksen, J., &  
Milgrom, J. A. (2006). A survey of the clinical  
acceptability of screening for postnatal  
depression in depressed and non-depressed  
women. *BMC Public Health*, 6, 211.
- Gjerdengen, D. W., & Yawn, B. (2007).  
Postpartum depression screening: Importance,  
methods, barriers, and recommendations for  
practice. *Journal of American Board of Family  
Medicine*, 20(3), 280-288.
- Glavin, K. (2012). Screening and prevention of  
postnatal depression. In M. G. R. Castillo  
(Ed.), *Perinatal depression* (pp. 1-19).  
Retrieved from  
<http://cdn.intechopen.com/pdfs-wm/26569.pdf>
- Grote, N. K., & Bledsoe, S. E. (2007). Predicting  
postpartum depressive symptoms in new  
mothers: The role of optimism and stress  
frequency during pregnancy. *Health & Social  
Work*, 32(2), 107-118.
- Jones, A., Watts, T., & Romain, S. (1995).  
Postnatal depression: Facilitating peer group  
support. *Health Visitor*, 68, 153-158.
- Kahn, R. S., Wise, P. H., Finkelstein, J. A.,  
Bernstein, H. H., Lowe, J. A., & Homer, C. J.  
(1999). The scope of unmet maternal health  
needs in pediatric settings. *Pediatrics*, 103, 576  
-581.
- Kantrowitz-Gordon, I. (2013). Internet  
confessions of postpartum depression. *Issues in  
Mental Health Nursing*, 34, 874-882.  
doi:10.3109/01612840.2013.806618
- Keefe, R. H., & Brownstein-Evans, C. (2013,  
November). Assessing postpartum depression  
among low-income mothers: Culture, race, and  
ethnicity. Paper presented at the 141st annual  
meeting of the American Public Health  
Association, Boston, MA.
- Keefe, R.H., Brownstein-Evans, C., Lane, S.D.,  
Carter, D.B. & Roulund Polmanteer, R.S.  
(2015). Postpartum depression and the  
Affordable Care Act: Recommendations for  
Social work educators. *Advances in Social  
Work*, (16)2, 202-213. doi: 10.18060/18502.
- Keefe, R.H., Brownstein-Evans, C., & Roulund  
Polmanteer, R.S. (2016). Addressing access  
barriers to services for mothers at risk for  
perinatal mood disorders: A social work  
perspective. *Social Work in Health Care*, 48  
(1), 1-11.  
doi:10.1080/00981389.2015.1101045.
- Keefe, R. H., Brownstein-Evans, C., &  
Polmanteer, R. S. R. (2015, October). Social  
workers' approaches to screening mothers who  
have postpartum depression. Poster presented  
at the 61st annual program meeting of the  
Council on Social Work Education, Denver,  
CO.
- Keefe, R.H., & Evans, T.A. (2013). Introduction  
to public health social work. In *The Social*

- Work Section (Ed). Handbook for public health social work. (pp. 3-20). New York: Springer.
- Kozinsky, Z., Dudas, R. B., Devosa, I., Csator dai, S., Toth, E., Szabo, D., . Pal, A. (2012). Can a brief antepartum preventive group intervention help reduce postpartum depressive symptomatology? *Psychotherapy and Psychosomatics*, 81, 98-107.
- Lee, S. Y., Aycok, D. M., & Moloney, M. F. (2012). Bright light therapy to promote sleep in mothers of low-birth-weight infants: A pilot study. *Biological Research for Nursing*. Advance online publication. doi: 1099800412445612.
- Leigh, B., & Milgrom, J. (2008). Risk factors for antenatal depression, postnatal depression and parenting stress. *BMC Psychiatry*, 8, 24-34.
- Letourneau, N. L., Dennis, C-L., Benzies, K., Duffett-Leger, L., Stewart, M., Tryphonopoulos, P. D., Watson, W. (2012a). Postpartum depression is a family affair: Addressing the impact on mothers, fathers, and children. *Issues in Mental Health Nursing*, 33, 445-457. doi:10.3109/01612840.2012.673054
- Letourneau, N. L., Tryphonopoulos, P. D., Duffett-Leger, L., Stewart, M., Benzies, K., Dennis, C-L., & Joschko, J. (2012b). Support intervention needs and preferences of fathers affected by postpartum depression. *Journal of Perinatal and Neonatal Nursing*, 26(1), 69-80. doi:10.1097/JPN.0b013e318241da87
- Letourneau, N., Duffett-Leger, L., Stewart, M., Hegadoren, K., Dennis, D. L., Rinaldi, C. M., & Stoppard, J. (2007). Canadian mothers' perceived support needs during postpartum depression. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, 36, 441-449.
- Liberto, T. L. (2012). Screening for depression and help-seeking in postpartum women during well-baby pediatric visits: An integrated review. *Journal of Pediatric Health Care*, 26, 109-117. doi:10.1016/j.pedhc.2010.06.012
- Lind, R. F., & Bachman, D. H. (Eds.). (2012). *Fundamentals of perinatal social work: A Guide for clinical practice with women, infants, and families*. New York: Haworth Press, Inc.
- Lobel, M., Cannella, D. L., Graham, J. E., DeVincent, C., Schneider, J., & Meyer, B. A. (2008). Pregnancy-specific stress, prenatal health behaviors, and birth outcomes. *Health Psychology*, 27(5), 604-615.
- Logsdon, M. C., Wisner, K., Billings, D. M., & Shanahan, B. (2006). Raising the awareness of primary care providers about postpartum depression. *Issues in Mental Health Nursing*, 27, 59-73.
- Lucero, N. B., Beckstrand, R. L., Callister, L. C., & Sanchez Birkhead, A. C. (2012). Prevalence of postpartum depression among Hispanic immigrants. *Journal of the Academy of Nurse Practitioners*, 24(12), 726-734. doi: 10.1111/j.1745-7599.2012.00744.x.
- Luke, S., Salihu, H. M., Alio, A., Mbah, A. K., Jeffers, D., Lo Berry E., & Mishkit, V. R. (2009). Risk factors for major antenatal depression among low-income African American women. *Journal of Women's Health*, 18(1), 1841-1846.
- Manber, R., Schnyer, R. N., Allen, J. J., Rush, A. J., Blasey, C. M. (2004). Acupuncture: A promising treatment for depression during pregnancy. *Journal of Affective Disorders*, 83 (1), 89-95.
- Martin, J. A., Hamilton, B. E., Osterman, M. J. K., Curtin, S. C., & Mathews, M. S. (2015). Births: Final data for 2013. *National vital statistics reports*, 64(1), Hyattsville, MD: National Center for Health Statistics.
- Mauthner, N. S. (1999). Feeling low and feeling really bad about feeling low: Women's experiences of motherhood and postpartum depression. *Canadian Psychology*, 40, 143-161. doi: 10.1037/h0086833.
- Morof, D., Barrett, G., Peacock, J., Victor, C. R., & Manyonda, I. (2003). Postnatal depression and sexual health after birth. *Obstetrics and Gynecology*, 102(6), 1318-1325.
- O'Hara, M. W., & McCabe, J. E. (2013). Postpartum depression: Current status and future directions. *Annual Review of Clinical Psychology*, 9, 379-407. doi:10.1146/annurev-clinpsy-050212-185612

## Postpartum Depression: A Critical Area for Continuing Social Work Education

---

- Postpartum Progress. (2015). Postpartum progress: Together, stronger. Retrieved from <http://www.postpartumprogress.com/>
- Postpartum Stress Center. (2015). The Postpartum Stress Center. Retrieved from <http://postpartumstress.com/>
- Postpartum Support International. (2015). Postpartum Support International. Retrieved from <http://www.postpartum.net/>
- Rhodes, A. M., & Segre, L. S. (2013). Perinatal depression: A review of US legislation and law. *Archives of Women's Mental Health*, 16(4), 259-270.
- Robertson, E., Grace, S., Wallington, T., & Stewart, D. E. (2004). Antenatal risk factors for postpartum depression: A synthesis of recent literature. *General Hospital Psychiatry*, 26, 289-295.
- Rudolph, C. S. (2000). Educational challenges facing health care social workers in the twenty-first century. *Professional Development: The International Journal of Continuing Social Work Education*, 3(1), 31-43.
- Sampson, M., Zayas, L. H., & Seifert, S. B. (2012). Treatment engagement using motivational interviewing for low-income, ethnically diverse mothers with postpartum depression. *Clinical Social Work Journal*, 41(4), 387-394.
- Schaar, G. L. (2012). Nurses facilitate change in medical practice: Unmasking postpartum depression. *Journal of Obstetric, Gynecologic, and Neonatal Nursing*, 41(Suppl 1), S7.
- Sealy, P. A., Fraser, J., Simpson, J. P., Evans, M., & Hartford, A. (2009). Community awareness of postpartum depression. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, 38, 121-133.
- Seehusen, D. A., Baldwin, L., Runkle, G. P., & Clark, G. (2005). Are family physicians appropriately screening for postpartum depression? *Journal of the American Board of Family Medicine*, 18(2), 104-112.
- Stocky, A., & Lynch, J. (2000). Acute psychiatric disturbance in pregnancy and the puerperium. *Baillieres Best Practice and Research Clinical Obstetrics and Gynecology*, 14, 73-87.
- United States Department of Labor. (2012). Affordable Care Act. Retrieved from <http://www.dol.gov/ebsa/healthreform/>