Social Workers' Screening Practices for Postpartum Depression

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Abstract: *The Affordable Care Act specifies mothers living with postpartum depression (PPD) are a group in need of services. Although mothers with PPD prefer to receive services from social workers than from professionals from other disciplines, limited research has addressed where social workers learn how to screen for PPD, the instruments they use, in what contexts they screen, and at what point during the perinatal period they screen mothers. The authors used an online survey to study a national sample of perinatal social workers (n=261) on their screening practices of mothers with PPD. More than half (n=149, 57.1%) of the respondents indicated they neither learned how to screen nor how to diagnose PPD during their undergraduate or graduate school education. Despite the availability of easy-to-use PPD screening instruments, only 25% (n=66) of the respondents indicated they have used any screening instruments. Of added concern is that many of the respondents indicated they do not consult the professional literature on PPD from social work and other disciplines to guide them in their practice. We recommend social workers integrate relevant findings from evidence-based research about PPD into their practice as appropriate, and that BSW and MSW curricula incorporate relevant information on PPD into their programs.*

Keywords: *Social work practice; postpartum depression; maternal and child health; assessment and evaluation*

Postpartum depression (PPD) affects up to 25.0% of all new mothers (Gaynes et al., 2005) and an even greater proportion of new mothers from racial and ethnic minority backgrounds (Centers for Disease Control and Prevention [CDC], 2008). Because mothers living with PPD are more likely to seek services from social workers than from professionals from other disciplines (Zittel-Palamara, Rockmaker, Schwabel, Weinstein, & Thompson, 2008), social workers are in an excellent position to screen new mothers for PPD (Abrams & Curran, 2007). To date, however, there has been limited research that has investigated whether or not social workers screen new mothers at risk for PPD.

Despite the fact that social workers have a long-standing history of providing services to mothers and children, there has been little research published in social work journals to guide them in their work with mothers with PPD (Keefe, Brownstein-Evans, Lane, Carter, & Rouland Polmanteer, 2015). Although relevant to the population of mothers living with PPD, research from other professional fields such as nursing and psychiatry is more likely to address individual/biomedical factors such as hormonal fluctuations than to consider issues known to affect maternal and child well-being such as neighborhood safety and domestic violence (Lane et al., 2008). The authors of this study conducted a nationwide

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online survey to learn what screening instruments social workers use, in what contexts they screen, and at what point during the perinatal period they screen new mothers for PPD.

Literature Review

Understanding Postpartum Depression (PPD)

PPD has come into the public's consciousness over the past 30 years, when highly publicized accounts of new mothers harming their newborn infants catalyzed legislators to begin addressing the problem (Rhodes & Segre, 2013). One result is Section 2952 of the Patient Protection and Affordable Care Act: Support, Education, and Research for Postpartum Depression (2010), which mandates research on the course of PPD, consideration of the differences in treatment needs among mothers from various racial and ethnic groups, and the development of culturally competent, evidence-based treatment approaches (Rhodes & Segre, 2013).

The American Psychiatric Association (APA, 2013) classifies PPD as a major depressive disorder. The primary symptoms include sadness, hopelessness, worthlessness, thoughts of self-harm or of harming the infant, and behavioral changes such as slowed body movements (APA, 2013). Although other forms of major depression manifest within one month of the causative stressor, PPD often does not emerge until one year after childbirth (O'Hara & McCabe, 2013; O'Hara & Wisner, 2014). PPD can be a debilitating disorder (APA, 2013) that has severe consequences for new mothers and their infants (Letourneau et al., 2012). 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, (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 of committing suicide (Lucero et al., 2012).

Despite these negative feelings, an estimated 50% of mothers with PPD do not seek treatment (CDC, 2008) or do not consider their symptoms 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 negatively or consider them unfit.

Relevance of PPD to Social Work

Among the mothers most at risk for PPD are mothers from racial and ethnic minority groups (Liu & Tronick, 2013), lower socioeconomic status (Liu & Tronick, 2013; O'Hara & McCabe, 2013), and rural communities (Villegas, McKay, Dennis, & Ross, 2011). These same mothers are often less able to afford ongoing health care, and therefore are often forced to access lower-cost or non-fee-for-service agencies, which often bring them to the

attention of a practicing social worker. Social workers working in maternal and child health settings are thus well placed to address this problem.

Screening New Mothers for PPD

The American College of Obstetricians and Gynecologists (ACOG) and the U.S. Preventive Services Task Force (USPSTF) strongly encourage prenatal screening for depression in pregnant women (ACOG, 2015; USPSTF, 2016). Although various easy-to-use screening instruments normed on mothers from differing backgrounds exist, social workers who are qualified to administer the instruments, have been reluctant to regularly screen mothers for PPD (Gaynes et al., 2005; Keefe, Brownstein-Evans, & Rouland Polmanteer, 2016). Interestingly, the majority of mothers in one study indicated they were willing to be screened (Gemmill, Leigh, Ericksen, & Milgrom, 2006). Of the healthcare providers who screen, many do not use the results to advise mothers on providing follow-up care (Gjerdingen & Yawn, 2007). Consequently, the majority of mothers with PPD do not receive adequate screening, depression diagnoses, or appropriate follow-up care (USPSTF, 2016).

Given the mandates from Section 2952 of the ACA, social workers working with new mothers must become competent in screening for PPD and providing evidence-based services. To learn about current screening practices, the authors surveyed perinatal social workers nationwide with the goal of being able to offer guidance to social workers working with new mothers.

Methods

The purpose of this study was to learn more about how social workers working with new mothers and young children screen new mothers for PPD, where they learned how to screen new mothers, when they screen, and what screening instruments they use.

Methodology and Measurement

The authors obtained institutional review board approval to conduct a survey of perinatal social workers nationwide. The authors then obtained approval to adapt the scale developed by Seehusen, Baldwin, Runkle, and Clark (2005) on family practitioners' screening behaviors for PPD. The Seehusen et al. scale consists of 24 close-ended questions and one open-ended question: five questions on the frequency that family practitioners screen mothers for PPD, the scales they use, and the contexts in which the practitioners screen; 12 questions on the practitioners' ideas about the importance of screening and the impact of screening on various family members; one question on where the practitioner learned to screen for PPD; five questions on practitioner demographics; and one open-ended question for the respondent to add additional information.

The survey was adapted by adding seven questions specific to social work practice, including one question on where practitioners refer new mothers with PPD, four questions on the respondent's practice setting, and two additional demographic questions (race and year of birth). The 32-item instrument was then pilot-tested with five social workers from the National Association of Perinatal Social Workers at their annual meeting in Baltimore

and on 10 social workers from perinatal networks around New York State whose feedback was incorporated into the survey. The adapted survey was administered in the winter of 2014 using SurveyMonkey (2013).

Sampling Frame

Study criteria included being age 18 or older and currently working with new mothers. An e-mail describing the purpose of the survey, the informed consent form, and the link to the survey was sent to contact persons at the National Association of Perinatal Social Workers and state perinatal associations who were asked to submit the email with the accompanying documentation and survey link to their listserv members. Additionally, the program directors of all Bachelors (BSW) and Masters of Social Work (MSW) programs accredited by the Council on Social Work Education were asked to submit the email with the accompanying documentation and survey link to their alumni listserv members.

Results

Respondent Characteristics

The final sample resulted in 261 respondents. Because we do not know the total population of social workers practicing in maternal and child health settings or which contact people at the perinatal organizations and BSW and MSW programs sent the email with accompanying survey to their listserv members, we are unable to assess if our respondents are representative of the total population of maternal and child health social workers nationwide.

Of the 261 respondents, 158 (60.5%) provided complete demographic information (see Table 1). Most of the respondents identified their role as a social work practitioner (n = 120, 76.0%) working full-time (n = 123, 77.9%) and having a Master's degree in social work (n = 130, 82.3%). The respondents are employed in a variety of settings including hospitals (n = 95, 60.1%), health centers (n = 32, 20.3%), child and family programs (n = 16, 10.1%), and private practice (n = 9, 5.7%). The responding social workers were overwhelmingly female (n = 153, 96.8%), and worked in urban areas (n = 102, 64.6%), were between 20 to 70 years of age ($\bar{x}$ = 44.100, σ = 11.874) and self-identified predominantly as white, non-Hispanic/Caucasian (n = 125, 79.1%).

Source of Learning About PPD

Of the 261 respondents, 112 (43%) reported learning about PPD while enrolled as undergraduate or graduate students (see Table 2). While eight (3.1%) respondents reported having learned about PPD in their BA or BS programs, 27 (10.3%) reported learning about PPD in their BSW programs, and 77 (29.5%) reported having learned about PPD in their MSW programs.

Table 1. *Characteristics of the Respondents who Screen New Mothers for PPD*

Variable	***n* (%)**
Social work role	
Practitioner	120 (76%)
Supervisor	18 (11.4%)
Degree	
Master's degree in social work	130 (82.3%)
Bachelor's degree	21 (13.3%)
Doctoral degree	7 (4.4%)
Employment status	
Full-time	123 (77.9%)
Part-time	35 (22.2%)
Geographic location	
Urban	102 (64.6%)
Suburban	43 (27.2%)
Rural	10 (6.3%)
Employment setting	
Hospital	95 (60.1%)
Health Center	32 (20.3%)
Child or Family Program	16 (10.1%)
Private Practice	9 (5.7%)
Gender	
Female	153 (96.8%)
Male	4 (2.5%)
Prefer not to disclose	1 (0.6%)
Race/Ethnicity	
White, Non-Hispanic/Caucasian	125 (79.1%)
Black/African American	14 (8.7%)
Hispanic	10 (6.3%)
Multiracial	3 (1.9%)
Asian	2 (1.3%)
American Indian	2 (1.3%)
White, Hispanic	2 (1.3%)

Note. Percentage totals for each variable may not add to 100% due to missing data or rounding error.

Learning How to Screen New Mothers for PPD

The respondents reported receiving information about PPD screening (see Table 2) through on-the-job training (n = 119, 45.6%) followed by continuing education programs (n = 96, 36.8%), professional conferences (n = 69, 26.4%), and field/internship experiences (n = 53, 20.3%). The respondents also reported obtaining information from medical (n = 82, 31.4%) and social work journals (n = 98, 37.5%).

Table 2. *Characteristics of Screening Practices*

Variable	*n* (%)
Where do social workers learn about PPD?	
Master of Social Work	77 (29.5%)
Bachelor of Social Work	27 (10.3%)
Bachelor of Science/Arts	8 (3.1%)
Where do social workers learn about screening for PPD?	
On the Job Education	119 (45.6%)
Social Work Literature	98 (37.5%)
Continuing Education Credits	96 (36.8%)
Medical Literature	82 (31.4%)
Conferences	69 (26.4%)
Field Education	53 (20.3%)
When do social workers screen for PPD?	
Delivery to one year postpartum	92 (35.2%)
When symptoms are present	72 (27.6%)
Prenatally	46 (17.6%)
At well child visits	15 (5.7%)
Delivery to two years postpartum	7 (2.7%)
What screening instruments do social workers use?	
Edinburgh Postnatal Depression Scale (EPDS)	66 (25.3%)
Patient Health Questionnaire (PHQ-9)	17 (6.5%)
Postpartum Depression Checklist (PDC)	10 (3.8%)
Postpartum Depression Screening Scale (PDSS)	9 (3.4%)
Beck Depression Inventory (BDI)	9 (3.4%)
General Health Questionnaire (GHQ)	7 (2.7%)
Structured Clinical Interview for the *DSM* (SCID)	5 (1.9%)
Centers for Epidemiologic Studies Depression Scale (CES-D)	3 (1.1%)

Note. Due to the potential for multiple responses to the corresponding survey item, percentages provided in parentheses are calculated using the total sample size (n=261).

Timing of PPD Screening

The respondents identified screening for PPD most frequently between delivery and one year postpartum (see Table 2). Of the 261 participants, 46 screened prenatally (17.6%), 92 screened from delivery to one year postpartum (35.2%), seven screened from delivery to two years postpartum (2.7%), and 15 screened during well-child visits (5.7%). Additionally, 72 social workers (27.6%) reported screening only when symptoms were present.

Screening Instruments Used

Of the respondents who reported screening for PPD (see Table 2; n = 135), 83 (61.5%) indicated they used a validated tool with the most common being the Edinburgh Postnatal Depression Scale (Cox, Holden, & Sagovsky, 1987) (EPDS; n = 66, 48.8%). Additional instruments included the Patient Health Questionnaire (Spitzer, Kroenke, Williams et al., 1999) (PHQ-9; n = 17, 12.6%), Postpartum Depression Checklist (Beck, 1998) (PDC; n = 10, 7.4%), Postpartum Depression Screening Scale (Beck & Gable, 2002) (PDSS; n = 9, 6.6%), the Beck Depression Inventory (Beck, Steer, & Garbin, 1988) (BDI; n = 9, 6.6%),

the General Health Questionnaire (Goldberg & Williams, 1988) (GHQ; *n* = 7, 5.2%), the Structured Clinical Interview for the *DSM* (Gormanet al., 2004) (SCID; *n* = 5, 3.7%), and the Centers for Epidemiologic Studies Depression Scale (Radloff, 1991) (CES-D; *n* = 3, 2.2%).

Implications and Discussion

The results from this study highlight that 43% of the responding social workers learned about PPD and how to screen for it during their educational training. This finding is similar to the findings from Gaynes et al. (2005) who found more than half of practitioners did not learn about PPD while in their professional training. Most of the respondents in this study learned how to screen for PPD while on the job, through continuing education programs, or at professional conferences. Some of the respondents also reported learning about PPD through empirical literature, including social work journals. We were somewhat stymied by this outcome given the dearth of research reported in social work journals on PPD (Keefe et al., 2015). Although we were pleased to find that some of the responding social workers screen mothers from birth to one year, results from other studies conclude that PPD may not manifest until after one-year post-childbirth (O'Hara & McCabe, 2013; O'Hara & Wisner, 2014). Likewise, the recommendations set forth by ACOG (2015) and USPSTF (2016) encourage maternal health service providers to screen all pregnant women and new mothers for PPD throughout pregnancy and the first postpartum year.

As in the Gaynes et al. (2005) report, many of our respondents reported learning about PPD while employed and not while enrolled in their academic programs. This finding is particularly troublesome given the sample in this study was comprised only of social workers working with pregnant and new mothers and children. Research has begun to address the problem of too few knowledgeable social workers screening new mothers for PPD. For example, recently published research concludes that BSW and MSW programs can incorporate content on PPD seamlessly into their curricula (Keefe, et al., 2015), and specific recommendations have been made for developing social work continuing education workshops to train social workers on how to work with mothers who have PPD (Keefe, Rouland Polmanteer, & Brownstein-Evans, in press).

Social Work Education

Instructors of social work research courses can help students develop and test interventions with individuals, families, groups, and communities at various service sites used by postpartum mothers. In human behavior and the social environment courses, instructors can include course content on PPD risk and protective factors. Social work practice courses can include various case scenarios that emphasize engagement, contracting for services, and intervention practices, as well as forming coalitions with service providers working with new mothers. In social policy courses, instructors can require students to trace the development of the ACA while also considering other landmark maternal and child health legislation including the Sheppard-Towner (Moehling, & Thomasson, 2012) and Melanie Blocker-Stokes Acts (Rhodes & Segre, 2013). Finally, field educators can assign students in maternal and child health placements to work with new mothers at risk for PPD and the mothers' families. Students should be instructed on

the use of standardized screening instruments, which would help prepare them to work with new mothers who may develop PPD after childbirth (O'Hara & McCabe, 2013; O'Hara & Wisner, 2014).

Social Work Practice

Only about one-third of the responding practitioners reported consulting evidence-based practice literature, including the social work (37.5%) and medical literature (31.4%). Using existing evidence-based practices is crucial to effective social work practice (NASW, 2008). However, given the limited best practices research on PPD published in social work journals, we were not surprised by this finding. We recommend that social workers integrate relevant findings from evidence-based practice research about PPD into their own practice as appropriate.

Social Work Research

In accordance with the ACA, it is recommended that social work researchers systematically investigate the risk factors, screening and assessment approaches, and interventions for all new mothers with a particular focus on mothers from diverse or vulnerable groups. Finally, researchers should publish their findings in social work journals not only as a way to reach other social work professionals but also to ensure that a social work perspective is infused in the developing research.

Summary and Conclusion

The interpretation of these findings should be made in light of the study's limitations. To begin, data were collected electronically. Although electronic data collection provided the opportunity to reach social workers nationwide, social workers who are uncomfortable with technology or who are without access to the Internet were likely excluded. Additionally, the data collection was limited by missing data. Although there were 261 respondents, only 158 provided full demographic information. In addition, the sample was not randomly selected, so the results cannot be considered generalizable.

Despite these limitations, this study is the first to examine how social workers screen mothers for PPD, which thus adds to the very limited body of knowledge on PPD in social work journals. Most of the responding social workers did not learn about PPD during their formal education or field placements. These findings, along with federal mandates put forward through the ACA, should encourage maternal and child health social workers to focus more thoroughly on the needs of new mothers at risk for and who may have PPD.

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