Social Support, Postpartum Depression, and Professional Assistance: A Survey of Mothers in the Midwestern United States

Catherine P. Corrigan, DNP, FNP-BC
Andrea N. Kwasky, DNP, PMHNP-BC, PMHCNS-BC
Carla J. Groh, PhD, PMHNP-BC, FAAN

ABSTRACT

Transition into motherhood is generally a joyful life event; for some women, however, it is marked by emotional turmoil. Lack of support can be associated with postpartum depression and can compromise both the mother and infant. A descriptive, cross-sectional study ($N = 61$) was conducted to explore the relationship between social support and postpartum depression and to determine whether mothers overwhelmed with childcare, or overwhelmed with life in general since becoming a mother, sought professional help. The results revealed that screening for depression alone may not be sufficient, that mothers are willing to contact a professional for help in the postpartum period, and that assessments after birth should include a broader assessment of life's difficulties rather than focusing on childcare responsibilities alone.

The Journal of Perinatal Education, 24(1), 48–60, http://dx.doi.org/10.1891/1058-1243.24.1.48
Keywords: social support, depression, postpartum, United States

The process of becoming a mother generally marks a wonderful event that encompasses discovery, learning, and a positive worthwhile experience; some women, however, find the transition into motherhood defined by fatigue, frustration, and emotional turmoil. Feelings of loss of control and emotional distress not only affect the mother, but have known adverse effects for the infant as well (Stapleton et al., 2012), for instance, negative birth outcomes, poor mother-infant bonding, and long-term consequences for the child (American College of Obstetricians and Gynecologists, 2013). The early postpartum period is a crucial time to improve the health and survival of *both* the newborn and the mother, yet the World Health Organization (WHO, 2008) has reported that the postpartum and postnatal period receives less attention from health-care professionals than the prenatal period and childbirth period. In 2009, 11.9% of women in a 29-state area reported postpartum depressive symptoms (U.S. Department of Health and Human Services, 2012); however, postpartum depression frequently goes undiagnosed and untreated because of a lack of knowledge among women and their health-care providers (Groh, 2013). The United States spends more than $111 billion

annually on childbirth (Stalls, 2013), yet America has a higher infant mortality rate than 28 other developed countries (Ohio Department of Health, 2009). Disparities in health-care access continue between African Americans (especially low-income African Americans) and Whites, which can lead to poor outcomes for the mother and her infant (Subramanian et al., 2012).

Although prenatal health care is universally covered by health insurance and nationally tracked in America, postpartum health care is largely neglected (Amnesty International, 2010). The WHO guidelines recommend that if the mother and baby are discharged from hospital sooner than 48 hr after birth, a qualified professional should assess them within 24–48 hr after discharge (WHO, 2008). In the United States, women and their infants are being discharged within 2.1 days post–natural birth (Podulka, Stranges, & Steiner, 2011); yet routinely, the mother is not seen by a health-care professional for 6 weeks (American Academy of Pediatrics & American College of Obstetricians and Gynecologists, 2012), leaving her to cope during with minimal professional support during a crucial period of transition.

Even when mothers attend their 6-week obstetric checkup, the visit tends to focus on the physical aspects of care, including breastfeeding and birth control options (Fowles, Hsiu-Rong, & Milles, 2012), and emotional or coping needs are rarely met. Moreover, there is currently no U.S. standard for investigating women at risk for postpartum depression (PPD) in the first week after discharge (American College of Obstetricians and Gynecologists, 2010), despite the mounting evidence that PPD can have serious health consequences for both the mother and the infant.

Social support has been reported to be a significant predictor of the development of PPD, yet this is another area that is not consistently assessed at the 6-week visit. Assessing how mothers of newborns perceive their level of support may prove valuable in identifying specific indicators toward learning how to better support women who are transitioning into motherhood.

OBJECTIVES

The impetus for the study was derived from the U.S. practice guidelines for postpartum care and the need to better understand how mothers of newborns transition into motherhood. The objectives of this study were to gain insight into the following research questions:

1. Do mothers who screened positive for depression on the Edinburgh Postnatal Depression Scale also self-report feelings of postpartum depression?
2. Does perceived social support for mothers influence their level of depressive symptoms?
3. Do mothers who are overwhelmed with childcare responsibilities seek professional help?
4. Do mothers who are overwhelmed in life since becoming a mother seek professional help?

The WHO guidelines recommend that if the mother and baby are discharged from hospital sooner than 48 hr after birth, a qualified professional should assess them within 24–48 hr after discharge.

REVIEW OF LITERATURE

Postpartum support may contribute to improving maternal and infant well-being by helping women transition into motherhood (Stapleton et al., 2012). Social support has been described as a three-dimensional construct consisting of emotional support (concern, comfort, and encouragement); instrumental support (money, time, and tangible assistance); and informational support where advice, education, and knowledge sharing takes place (Boothe, Brouwer, Carter-Edwards, & Østbye; 2011; Chojenta, Loxton, & Lucke, 2012; Evans, Donelle, & Hume-Loveland, 2012; Leahy-Warren, McCarthy, & Corcoran, 2011). Xie, He, Koszycki, Walker, and Wen (2009) describe social support as subjective, objective, and support availability. Social support can come from society/community or from a professional source. Despite an inconsistent definition of the social support construct in research, the philosophy of societal involvement was the predominant theme addressed among researchers across the globe. Grigoriadis et al. (2009) conducted a systematic review of multiple postpartum practices that transcended nine countries to determine if these practices protected against PPD. The authors reported that appropriate support may be of some protective value, which was more important than the specific ritual/practice itself. Social support can come in many forms. In China, Japan, and Malaysia, the traditional "confinement" practices aim to help new mothers recover from pregnancy and childbirth (Cheng, Fowles, & Walker, 2006; Grigoriadis et al., 2009). The mother, receiving help from her family, remains at home for 30 days to rest and avoids physical work, which aids in the recovery of her physical

and emotional strength (Cheng et al., 2006). In Taiwan, mothers can decide to remain in private, hotel-like maternity centers for care provided by nurses (Cheng et al., 2006) during the confinement period. In all Western and Northern European countries, home visits are conducted by a health-care professional soon after childbirth (Cheng et al., 2006). In contrast, the American culture is one of rugged individualism wherein postpartum mothers are often left without support from professionals or their families and friends. Because most family members and friends are involved with their own family and work responsibilities, the social support circle is unable to provide much help (Ugarriza, Brown, & Chang-Martinez, 2007), and there is no professional support standard of care for women in America. Lack of social support has been associated with the development of PPD (Ugarriza et al., 2007), which is the main reason for the study of social support in the postpartum period.

Depression in women is second only to HIV/AIDS in terms of global morbidity (O'Hara, 2009). Depression in the postpartum period is a clinical depression that occurs within the first year after childbirth (Dennis, Heaman, & Vigod, 2012; O'Hara, 2009). The time factor and the milieu of role transition separate PPD from general depression. Some women who have not previously experienced depression are vulnerable to the hormonal changes of pregnancy and are affected by depression only during the postpartum period (O'Hara, 2009). If the "baby blues" continue for longer than 14 days, mothers may experience PPD, which can occur by 4–6 weeks after birth (Appolonio & Fingerhut, 2008; Kathree & Petersen, 2012; Logsdon, Tomasulo, Eckert, Beck, & Lee, 2012). Within the first 2 weeks after birth, 80%–85% of women experience some level of postpartum "blues," and a further 8%–15% will experience a major depressive disorder (Appolonio & Fingerhut, 2008; Ginsburg et al., 2012; Haga, Lynne, Slinning, & Kraft, 2012; Kathree & Petersen, 2012; Ugarriza et al., 2007; Wade, Giallo, & Cooklin, 2012; Xie et al., 2009). Although PPD can affect women in any population, young, minority, low-income mothers face many barriers (lack of knowledge, mental illness stigma, transportation) that make them particularly vulnerable to PPD (R. C. Edwards et al., 2012). Feelings of loss of familiarity and control and the need to feel normal again are not uncommon (Leahy-Warren et al., 2011). "Mothers with postpartum depression experience unbearable loneliness" (Cheng et al., 2006, para. 8). Support is paramount, and early recognition and treatment of PPD among disadvantaged populations in particular is an urgent health issue (Kim et al., 2012).

Many studies have found that increased levels of support were associated with lower PPD scores (Brown, Harris, Woods, Burman, & Cox, 2012; Chien, Tai, & Yeh, 2012; R. C. Edwards et al., 2012; Fowles et al., 2012; Quelopana, Champion, & Reyes-Rubilar, 2011). In a longitudinal study of adolescent mothers in the United States ($N = 120$ at baseline), Brown et al. (2012) examined social support in relation to depressive symptoms over a 1-year postpartum period ($N = 89$ at 1 year). The authors reported that depressive symptoms were common among adolescent mothers, but that higher social support scores had a strong inverse association with depressive symptoms. Similar findings were reported by Chojenta et al. (2012) in a longitudinal study in Australia ($N = 14{,}247$). The authors collected data on women before, during, and after pregnancy to identify predictors of postnatal depression. Outcome variables included demographics, a previous mental health diagnosis, number of life events, and a measure of functional support. The findings revealed that lower affectionate support and lower positive social interaction were related to a higher likelihood of postnatal depression (Chojenta et al., 2012). Alternatively, Leahy-Warren et al. (2011) showed no protective relationship between social support and PPD. Their descriptive correlational study conducted in Ireland ($N = 410$) found no association between professional support and PPD; however, the authors did report an inverse relationship between social structure, functional support, and PPD.

The infant mortality rate is the most sensitive indicator of overall societal health and well-being. America ranks 30th in the world (Centers for Disease Control and Prevention, 2012), meaning 29 countries are more effective at keeping infants alive. PPD can compromise the maternal role and the mother–infant relationship in the early postpartum period (Leahy-Warren et al., 2011; Stapleton et al., 2012). Maternal depression has been shown to significantly stress infants, causing them to have less secure maternal–child attachment; be fussier; and have lower intellectual and motor development scores, poorer academic performance, and impaired development trajectories (Dennis et al., 2012). Racial and low-income disparities have also been identified. In a U.S. study that used data from a nationally representative

Early Childhood Longitudinal Study–Birth Cohort, the authors reported that children born of U.S. (non-Hispanic) Black mothers (N = 1,350) were least likely to be securely attached (Huang, Lewin, Mitchell, & Zhang, 2012). In addition to future behavioral, cognitive, and social impairments, the child's overall physical well-being can be affected. In a sample of low-income, ethnic minority women and their infants in Canada (N = 132), Gress-Smith, Luecken, Lemery-Chalfant, and Howe (2012) investigated the impact of PPD on the infant by measuring infant physical health, weight gain, and sleep at 9 months of age. Findings showed that infants of mothers with higher depressive symptoms had more minor health problems, gained significantly less weight, and had more nighttime awakenings at 9 months of age.

The Pregnancy Risk Assessment Monitoring System (PRAMS) is an ongoing U.S. project that collects data on maternal experiences before, during, and after birth with a goal of improving the health of mothers and infants and reducing maternal and infant adverse outcomes. Kanotra et al. (2007) analyzed qualitative "free text" data from the PRAMS surveys (N = 324) to identify challenges that women faced from 2 to 9 months after birth. Among the themes that emerged (listed in order of frequency) were "the need for social support, breastfeeding issues, lack of education about newborn care after discharge and the need for help with postpartum depression" (Kanotra et al., 2007, p. 549). The lack of appropriate and consistent assessment for PPD and insufficient knowledge by health-care providers can be barriers to PPD diagnosis and treatment (Logsdon et al., 2012).

Logsdon et al. (2012) claimed that when women reported feelings of depression, health-care professionals tended to minimize their symptoms as self-limiting, which resulted in feelings of increased worthlessness and guilt, and their reluctance to pursue treatment. The minimizing of depressive symptoms is a global phenomenon. In America, mothers who sought help reported feelings of humiliation, frustration, and anger at their interaction with health-care professionals (Logsdon et al., 2012). Australian women found their physicians to be patronizing, preferring to prescribe medications that relieved the symptoms of PPD rather than offering counseling (Logsdon et al., 2012). In the United Kingdom, women reported that their complaints were not taken seriously, nor were they referred to appropriate services (Logsdon et al., 2012). In a qualitative descriptive study conducted in Canada that explored the experiences of women (N = 18) who sought care for PPD following referral, the authors reported that health system barriers included normalizing of symptoms, the offering of interventions not acceptable to the mother, and disconnected care pathways (Sword, Busser, Ganann, McMillan, & Swinton, 2008). The reaction by health-care professionals and suboptimal care signifies the urgent need to educate health-care professionals on PPD (Gillibrand, 2012).

Summary

Several studies have supported the magnitude of the effects of PPD on women, especially among minority, low-income populations, and the potential for long-lasting effects on the infant (Kim et al., 2012). The consensus among researchers is that an increased level of social support is associated with less PPD (Brown et al., 2012; Chien et al., 2012; R. C. Edwards et al., 2012; Shapiro & Fraser, 2013; Xie et al., 2009). This study sought to add to the literature by aiming to investigate the relationship between social support and depression in the Midwestern United States. In addition, the authors were interested in professional support and whether mothers who were overwhelmed since childbirth sought such help. Finally, a comparison between Whites and minorities was an area of interest because of the area's diverse cultural and ethnic populations. The vulnerable early postnatal period is a crucial time to implement interventions focusing on improving the health of the mother and her newborn (Sines, Uzma, Wall, & Worley, 2007). In the United States, the critical need for a postpartum checkup between 3 and 6 days posthospital discharge is a missed opportunity to assess for the emergence of depressive symptoms because it is not part of the standard of care for postpartum practice.

CONCEPTUAL FRAMEWORK

The WHO recommends individualizing care and placing the mother and her infant at the center of that care to meet the needs of the dyad (WHO, 2008). The conceptual framework that supports this study is based on the WHO ethos and Wiedenbach's helping art of clinical nursing theory (Wiedenbach, 2012). Wiedenbach defines *nursing* as observing a patient's behavior and symptoms and exploring the meaning and cause of the discomfort in identifying a person's need for help. The nurse assesses the

mother's symptoms, her perception of her situation in the postpartum period, and her ability to cope or resolve her discomfort to determine if she needs help. The nurse collaborates with the mother toward independence and fulfillment that can contribute to improving neonatal and maternal outcomes.

METHOD

Design

A descriptive, cross-sectional study design with a convenience sample was used to answer the research questions. Each participant completed a one-time 47-item questionnaire that elicited information related to demographic data, social support, and depression. Participants were eligible if they (a) were 18 years old, (b) were able to read and write English, and (c) had given birth within the past 8 months. The 8-month cut-off allowed mothers time to recover from their childbirth experience, yet it allowed for recall of their postpartum period.

Instruments

A 47-item questionnaire addressed demographic and background characteristics and contained a short form of the Social Support Questionnaire (SSQ; Sarason, Levine, Basham, & Sarason, 1983) as well as the Edinburgh Postnatal Depression Scale (EPDS; Cox, Holden, & Sagovsky, 1987). In addition, the researcher generated questions pertaining to prenatal and postnatal classes and postpartum visits, and specific questions pertaining to the research questions were asked. For instance, "Do you think you experienced any postpartum depression?" *and* "Did you contact any of the following health professionals for support?" The last two statements, "I feel overwhelmed daily with childcare responsibilities" and "I feel more overwhelmed in life since becoming a mother," were measured on a 4-point Likert scale ranging from *strongly agree* to *strongly disagree*.

Social Support. A modified short form (6 items) of the 27-item SSQ was used for this study. The SSQ reflects the affective aspects of relationships or the degree to which the subjects feel that they are loved and valued and the belief that they have help from people who care about them. Participants were asked if there is someone they can really count on to listen to them when they need to talk; if there is someone to help them out in a crisis situation who is dependable when help is needed; if there is someone with whom they can totally be themselves and someone they feel really appreciates them as a person. Each item on the SSQ scale was measured on a 4-point Likert scale ranging from *strongly agree* (higher score, coded as 4) to *strongly disagree* (coded as 1); higher scores mean more social support (scores range from 6 to a maximum score of 24). The Cronbach's alpha for internal reliability of the 27-item SSQ has been reported as .97 (Sarason et al., 1983). The short form SSQ has a high correlation to the 27-item SSQ and is considered a psychometrically sound instrument and an acceptable substitute for the 27-item SSQ measurement tool (Sarason, Sarason, Shearin, & Pierce, 1987). The short form SSQ scale (containing 6 items) had a Cronbach's alpha coefficient of .92 in this study.

Depression. The EPDS is the most widely used screening tool for PPD (Dennis et al., 2012; Logsdon et al., 2012). The reliability and validity of the EPDS in identifying depressive symptoms in postpartum women has been supported in numerous studies (Xie et al., 2009). The EPDS has 10 multiple-choice questions; each question scored with a 0, 1, 2, or 3 (maximum score = 30). A systematic review of the EPDS performance suggested that a score of 12/13 or higher is suggestive of "probable" depression and "possible" depression at a score of 9/10 (Gibson, McKenzie-McHarg, Shakespeare, Price, & Gray, 2009). The American College of Obstetricians and Gynecologists (2008) recommend that clinical practitioners set a lower threshold score to capture more women with possible depression; hence, the cutoff score of 9 was used for this research. Logsdon et al. (2012) recommend screening for PPD a second time (2 weeks later) for any women who screen positive in the first few days after birth. The EPDS scale (containing 10 items) had a Cronbach's alpha coefficient of .85 in this study.

Procedure

After approval was obtained by the university institutional review board, data were collected using the 47-item questionnaire that took approximately 15 min to complete. Participants were recruited by word of mouth from urban and suburban communities as well as agencies within these communities that provide health care and other forms of support to new mothers (e.g., La Leche League, Maternal Infant Health Program). An effort was made to obtain participants of racially, ethnically, and socioeconomically diverse backgrounds within the

Midwestern United States. A convenience sample of mothers completed the questionnaire from June to August 2013 and had no further obligation to the study after completion of the questionnaire. Each participant received a research information sheet explaining the study and stating that participation was voluntary as well as a list of resources for mothers of new babies. Mothers had the option of completing the questionnaire immediately or mailing it back in a stamped addressed envelope that was provided. A $10 gift card to a local retailer was provided to participants who completed the questionnaire.

Data Analysis

Descriptive statistics were computed using SPSS Version 21. A chi-square test of independence was performed to determine if there was a relationship between mothers who stated that they did experience PPD and those who stated that they did not experience PPD, with scores on the EPDS as the dependent variable. The Pearson correlation between scores on the SSQ and EPDS was computed to determine if there was a relationship between perceived social support (measured with the SSQ) and PPD (measured with the EPDS). A Mann-Whitney test was performed to determine if mothers who sought professional help were more or less likely to have feelings of being overwhelmed with childcare responsibilities. In addition, a Mann-Whitney test was performed to determine if mothers who sought professional help were more or less likely to have feelings of being overwhelmed in life (coded from 1 = *strongly disagree* to 4 = *strongly agree*) than those who did not seek professional help.

TABLE 1
Descriptive Statistics for Sample Demographic and Background Characteristics (*N* = 61)

	n	%
Race		
White	30	49.2
Black	22	36.1
Hispanic	3	4.9
Asian/Pacific islander	2	3.3
Other	4	6.6
Education		
Less than high school	6	9.8
High school/general educational development	17	27.9
Some college	7	11.5
2-Year college degree (associates)	8	13.1
4-Year college degree (bachelor of arts/science)	13	21.3
Master's degree	8	13.1
Professional degree (medical doctor/juris doctor)	2	3.3
Marital status		
Married	35	57.4
Single, never married	21	34.4
Partnered	2	3.3
Separated	2	3.3
Divorced	1	1.6
Other children		
One other child	10	16.4
Two other children	13	21.3
Three other children	7	11.5
Four other children	1	1.6
Five other children	3	4.9
Seven other children	2	3.3
	M	*SD*
Age (years)	29.89	5.35

RESULTS

There were 115 mothers who were given the questionnaire. Sixty-six questionnaires were returned for a response rate of 57%. The majority of questionnaires were completed at a later date and mailed back in the envelope provided. Three of the questionnaires were incomplete, and two arrived in the mail after the data collection deadline. Forty-nine women were given the questionnaires to complete later but did not return them. Descriptive statistics for the sample demographic and background characteristics are shown in Table 1. The average number of hours after birth for discharge was 51.19 hr (*SD* = 25.43 hr). Nearly all of the participants (*n* = 58; 95.1%) had a routine (6-week) follow-up with their obstetrician/gynecologist (OB/GYN), but a minority (*n* = 20; 32.8%) had been seen earlier than 6 weeks. Almost 50% (*n* = 10) of the women with a visit prior to 6 weeks were seen for a routine checkup after cesarean surgery; the remainder were seen for other physical problems, such as bleeding or hypertension. More than one third (*n* = 22; 36.1%) attended prenatal classes, although very few took postnatal classes (*n* = 2; 3.3%). Approximately 21% (*n* = 13) stated that they had been experiencing additional stressors at the time of birth that complicated their transition to motherhood (moved into a new home, not much help with other children, trying to remain drug-free). The most common primary support person was a spouse or partner (*n* = 51; 83.6%) with an additional 9.8% (*n* = 6) identifying their mother. Many of the participants (*n* = 44; 72%) contacted a health professional for support including a lactation consultant (*n* = 17; 27.9%), an OB/GYN (*n* = 14; 23.0%), a nurse

(n = 10; 16.4%), or a pediatrician (n = 9; 14.8%). Forty-one percent (n = 25) indicated that they had a nurse or doula contact them in the first week after birth. Among those who did not have such contact, half (n = 18; 50.0%) stated that it would have been appreciated. The information that would have been most useful to the participants during the first week after birth was breastfeeding information (n = 21; 34.4%), physical care for the mother (n = 20; 32.8%), physical care for the child (n = 14; 23.0%), and infant feeding advice (n = 13; 21.3%).

Research Question 1: Do Mothers Who Screened Positive for Depression on the Edinburgh Postnatal Depression Scale Also Self-Report Feelings of Postpartum Depression?

Two groups were created based on EPDS scores: a nondepressed group (with EPDS scores of 8 or lower) and a depressed group (with EPDS scores of 9 or higher). There were 13 individuals scoring in the depressed range of the EPDS (21.3%) and 48 individuals scoring in the nondepressed range (78.7%). Table 2 shows the cross tabulation of the EPDS depression group and responses to the question "Do you think you experienced any postpartum depression?" Among the 13 participants designated as depressed based on their scores on the EPDS, 7 (53.8%) also self-reported being depressed, whereas 6 (46.2%) self-reported not being depressed. Among the 48 participants designated as not depressed based on their scores on the EPDS, 5 (10.4%) self-reported as being depressed, whereas 43 (89.6%) self-reported as not being depressed. A chi-square test of independence was performed to determine if these two variables were related, and the result was statistically significant, $\chi^2(1) = 12.21$, $p < .001$. This indicated that group membership according to the EPDS was related to self-report as being depressed, except in about 18% of the women.

Research Question 2: Does Perceived Social Support for Mothers Influence Their Level of Depressive Symptoms?

To answer the second research question, a Pearson correlation between scores on the SSQ and EPDS was computed. The statistically significant negative correlation indicated that participants with higher levels of social support tended to have lower levels of PPD ($r = -.39$, $p = .002$).

Research Question 3: Do Mothers Who Are Overwhelmed With Childcare Responsibilities Seek Professional Help?

A Mann-Whitney test was performed to determine if mothers who sought professional help were more or less likely to have feelings of being overwhelmed with childcare responsibilities than those who did not seek professional help. Feelings of being overwhelmed were measured with a Likert scale question (coded from 1 = *strongly disagree* to 4 = *strongly agree*): "I feel overwhelmed daily with childcare responsibilities." The Mann-Whitney test was not statistically significant ($z = -1.05$, $p = .295$). This indicated that the extent to which the participants felt overwhelmed with childcare did not differ between those who sought professional help and those who did not seek professional help.

Research Question 4: Do Mothers Who Are Overwhelmed in Life Since Becoming a Mother Seek Professional Help?

A Mann-Whitney test was performed to determine if mothers who sought professional help were more or less likely to have feelings of being overwhelmed in life than those who did not seek professional help. Feelings of being overwhelmed were measured with a Likert scale question (coded from 1 = *strongly disagree* to 4 = *strongly agree*): "I feel overwhelmed in life since becoming a mother." In

TABLE 2
Descriptive Statistics for Self-Reported Postpartum Depression and Scores on the Edinburgh Postnatal Depression Scale (N = 61)

	Self-Reported Postpartum Depression (n = 12)		No Self-Reported Postpartum Depression (n = 49)	
Edinburgh Postnatal	*n*	%	*n*	%
Depression Scale Group				
Depressed (n = 13)	7	53.8	6	46.2
Not depressed (n = 48)	5	10.4	43	89.6

Note. Individuals in the nondepressed group on the Edinburgh Postnatal Depression Scale (EPDS) had scores of 8 or lower. Individuals in the depressed group on the EPDS had scores of 9 or higher. The chi-square test of independence comparing the two variables was statistically significant, $\chi^2(1) = 12.21$, $p < .001$.

seeking professional help, participants were asked if they had contacted any health professionals for support. The difference between those who sought professional help and those who did not in terms of feelings of being overwhelmed in life since becoming a mother was statistically significant. This indicated that those who sought professional help tended to feel more overwhelmed in life ($M = 2.37$, $SD = 0.62$) than those who did not seek professional help ($M = 1.94$, $SD = 0.80$; $z = -1.97$, $p = .049$).

In addition, the participants were grouped into two categories: Whites ($n = 30$) and minorities ($n = 31$). Independent t tests were performed comparing the two groups with scores on EPDS and self-reported depression as the dependent variables. Comparison of the EPDS scores for Whites ($M = 5.33$, $SD = 4.34$) and minorities ($M = 5.61$, $SD = 4.97$) revealed no significant differences between the groups, $t(59) = .234$, $p = .816$. Comparison of self-reporting depression for Whites ($n = 8$; 27%) and minorities ($n = 8$; 26%) revealed no differences between the two groups. Independent t tests were also performed comparing the two groups with scores on the SSQ, feelings of being overwhelmed with childcare responsibilities and feelings of being overwhelmed in life since becoming a mother. First, the t test comparing the two groups was statistically significant in terms of SSQ scores, $t(54.87) = 2.29$, $p = .025$. Levene's test indicated a significant p value ($p = .003$); therefore, the p value for unequal variance was used. The mean SSQ score for Whites was higher ($M = 22.37$, $SD = 2.58$) than for minorities ($M = 20.55$, $SD = 3.53$) indicating that Whites had more social support than minority participants. Second, comparison of feelings of being overwhelmed with childcare responsibilities for Whites ($M = 3.13$, $SD = 0.681$) and minorities ($M = 2.81$, $SD = 0.792$) revealed no significant differences between the groups, $t(59) = 1.72$, $p = .09$. Third, comparison of feelings of being overwhelmed in life since becoming a mother for Whites ($M = 2.77$, $SD = 0.817$) and minorities ($M = 2.74$; $SD = 0.575$) revealed no significant differences between the groups, $t(51.94) = .136$, $p = .892$. Levene's test indicated a significant p value ($p = .041$); therefore, the p value for unequal variance was used.

DISCUSSION

This study revealed some points of interest related to feelings of depressive symptoms, social support assessment, and professional assistance for mothers in the postpartum period. First, we sought to identify whether mothers who scored higher on the EPDS also self-reported feelings of depression. Based on the results, the EPDS is a valid screening tool for PPD for the majority of postpartum women. In contrast to other research findings, however, where women who had a positive PPD screen reported depressive symptoms (Beck & Indman, 2005; O'Hara, 2009; Quelopana et al., 2011), we found that nearly half of the participants who screened positive for depression according to the EPDS (score of 9 or higher), self-reported *not* being depressed. Furthermore, 10.4% ($n = 5$) of the women who scored 8 or lower on the EPDS self-reported that they *did* experience depression. A possible explanation for this discrepancy might be that questions on the EPDS pertained to feelings in the 7 days prior to completion of the questionnaire. The mothers could have had some level of depressive symptoms after birth which have since resolved. Noncongruence between self-reported depression and the EPDS was 18% in this study. Groh (2013) explored the congruence between self-reported depression and screening for depression using the Center for Epidemiologic Studies-Depression Scale in women in rural Midwestern America ($N = 140$) and reported similar results. The majority of women accurately identified if they were depressed or not; however, almost 25% of the participants were not in congruence between self-reported depression and depression scores (Groh, 2013). Some possible explanations for noncongruence among mothers who score in the depressed range on the EPDS yet report that they did not feel depressed may be that those mothers experience chronic depression; therefore, the experience of PPD is not different from their existence prior to childbirth. Stigma related to depression or mental illness, lack of knowledge about PPD, and fear of being thought of as "crazy" may also prevent women from seeking treatment for depression (Gillibrand, 2012; McComish, Groh, & Moldenhauer, 2013). Discordance between self-reporting (thinking they are/are not depressed) and coded items (scores on the EPDS) suggests that additional information may be required to obtain the most accurate data (Stein, Nadkarni, Erdos, & Miller, 2000); for instance, asking mothers what they are feeling. In a qualitative study that included 11 countries (8 European, America, Uganda, and Japan), many of the participants did not recognize their state of morbid unhappiness following birth as an illness known as PPD,

Placing the mother at the center of the dyad, childbirth educators and nurses can truly individualize care by having a holistic understanding of the mother's needs, and interventions can be anticipated at an earlier stage.

where assistance and therapy were available from health-care professionals (Oates et al., 2004). These findings demonstrate that in addition to using a depression screening tool, mothers should be asked about how they feel and what their feelings mean to them within the context of this role transition.

The conceptual framework that supported this study emphasizes individualizing the mother's care by investigating her perception about the need for support. A thorough assessment of the feelings of the mother is vital for early and accurate identification of her condition. Health-care providers should screen women for depression to understand what their baseline mood is prior to birth. Assessing for depressive symptoms or a past history of anxiety/depression in the prenatal period is essential because a history of previous mental health problems is a risk factor for PPD (Dennis et al., 2012; O'Hara, 2009). Placing the mother at the center of the dyad, childbirth educators and nurses can truly individualize care by having a holistic understanding of the mother's needs, and interventions can be anticipated at an earlier stage. In partnership with the mother, the nurse develops a multidisciplinary care pathway to address her concerns and ensure appropriate treatment and follow-up care.

A second major finding was that mothers who sought professional help tended to feel more overwhelmed in life since becoming a mother rather than being more overwhelmed with childcare responsibilities per se. A possible explanation for these findings is the heightened response to normal daily tasks with the arrival of the new infant. The woman's responsibilities adjust to attending to her infant while she recovers from the emotional and physical strain of childbirth. Not only is the mother inundated with her new role but she may also be weak and tired, contributing to her need for help. Childcare responsibilities become part of the struggle rather than being the absolute challenge. Ugarriza et al. (2007) investigated the types of social support mothers of young infants sought, and reported that assistance with household tasks and childcare was significant in adjusting to their new situation. An assessment of the mother's support should emphasize the broader aspects of life and the practicality of her everyday living situation rather than focus on childcare responsibilities alone.

In addition, more than one third of the participants in this study attended prenatal classes, yet only two participants attended postnatal classes. Although mothers obtain postpartum instruction in prenatal classes, they often have questions after they return home. Seventy-two percent ($n = 44$) of the participants contacted health-care professionals for help in the postpartum period, and half of the women who did not have contact with a nurse or doula in the first week after birth indicated that this contact would have been beneficial. Many participants contacted lactation consultants, OB/GYN, nurses, and pediatricians (listed in order of frequency) for support. This infers that even when women do not attend postnatal classes, they are still in need of professional support—knowledge that could be provided to them through a convenient means of communication from nurses and childbirth educators, in many cases.

Comparing the two categories within the group of participants, Whites and minorities, we found that Whites had more social support than minorities. This was a surprising finding because American minorities rank higher in collectivism than nonminorities—a model of interdependency and sacrificing of self-interest for the sake of the group (Vargas & Kemmelmeier, 2013). One possible explanation is that the questionnaire did not differentiate support as being societal or professional, meaning that Whites could have had more professional support, consistent with the availability of health care for this group, compared to the pervasive less-than-optimal care American minority groups receive (K. Edwards, 2011).

Implications for Future Research

Future research could seek to identify barriers to accessing postnatal care. Although postnatal classes are offered, women are at home with their newborn, striving to cope with their new role and a changing family environment (Cheng et al., 2006) and may find it difficult to get to classes outside the home. Alternate person-centered means of professional support could be explored—ways that would allow mothers to stay at home with their infants, for instance, Skype, FaceTime, or a similar method of communication. In a qualitative study that included

focus groups with mothers, doulas, and doula trainers ($N = 30$), McComish et al. (2013) sought to develop postpartum educational materials for doulas to use with new mothers. The researchers identified "someone to talk to," "flexibility," and "interactivity" as the emerging themes. An application (app) for smartphones and digital tablets as well as a trifold brochure were developed as educational/resource materials. Although there is little evidence to support the effectiveness of postpartum preventative programs (O'Hara, 2009), approaching postpartum care with real-time interventions, such as the described app, and a convenient means of communication should be further explored.

Implications for Practice

First, because of discordance between self-report and structured assessment tools for PPD, the results of this study suggest that screening must include an assessment of how the mother perceives she is feeling in addition to the use of a depression assessment tool. Although not an American standard of care for postpartum practice, the prevalence of PPD and the literature indicating a lack of knowledge regarding depression among new mothers warrants appropriate screening. Weekly phone calls after birth to screen all mothers with the EPDS could expedite early diagnosis and treatment for PPD. Second, an assessment of social support should detail the practical aspects of the mother's daily living rather than focus on maternal and newborn care alone. Childbirth professionals should assess new mothers for low-income status, lack of social support, and a previous history of depression in addition to screening for PPD. In a profound portrayal of her experience of PPD, Gillibrand (2012) indicated that women should be supported no matter what their symptoms are. The author recommends direct questioning of the mother regarding maternal functioning and emphasizes the importance of a trusting relationship that will build the mother's confidence, making it more likely for her to report depressive symptoms (Gillibrand, 2012). A process for women who either screen positive for depressive symptoms, or indicate that they feel anxious or depressed, can be facilitated by legitimizing the mother's feelings and providing a person-centered care plan that includes referrals as needed and a comprehensive follow-up (Sword et al., 2008).

Third, childbirth educators are in a prominent position to develop interventions such as short, culturally sensitive informational videos available on hospital websites that mothers can view anytime with a password provided to them prior to their discharge home. Videos such as infant feeding, care of the mother and the infant, and the necessity for follow-up if the baby blues do not resolve in 2 weeks could be considered. It is imperative that PPD awareness be universal. The onus is on the health-care provider to appropriately screen for depression and educate all women and their families, empowering them in self-care and care for the newborn infant. Gillibrand (2012) alludes to the continued failure of health-care professionals to diagnose the well-researched PPD as absurd. The author recognizes, however, that women are sometimes reluctant to divulge their feelings for fear of judgment and lack of trust (Gillibrand, 2012). Informing mothers about what to do in situations where they feel overwhelmed or hopeless is paramount. Mothers should be provided with community resources and readily available multidisciplinary team contact numbers for ease of access to a health-care provider. In addition, nurses and childbirth educators could suggest management strategies and offer resources that may assist with daily tasks.

The onus is on the health-care provider to appropriately screen for depression and educate all women and their families, empowering them in self-care and care for the newborn infant.

Limitations

As with all cross-sectional studies, a causal effect cannot be established. It cannot be determined if lack of social support led to depressive symptoms or if depressive symptoms led to lack of social support. A potential limitation was the relatively small sample size of 61 and the restriction of the data collection to maternal self-reporting. Another limitation was the fact that measurements of being overwhelmed with childcare and being overwhelmed with life in general were determined only through single-question Likert scale items. Finally, although the EPDS is an established screening tool for PPD, a clinical diagnosis of depression was not part of the diagnostic assessment for this study. Findings should be interpreted with caution; however, a sound expression that women of new infants are in need of more support than what is being offered to them can be used to guide further investigation on postpartum care.

CONCLUSION

This study has generated information toward the early detection of PPD, the need to assess mothers in terms of their support system, and the necessity for comprehensive and convenient access to knowledge in the postpartum period. Although some women may have screened negative for PPD, they reported feelings of depression. This finding has implications for health-care providers in postpartum practice; in addition to using a depression screening device, the mother's feelings should be carefully assessed. In addition, health-care professionals should be versed in the detection and management of postnatal depression. A thorough assessment of the mother's physical and psychological health needs, as well as her support system, is paramount. Assistance to include resources should be offered, especially in African American and low-income minority populations who face many barriers to care. It is clear that mothers require more knowledge than what is being offered to them. Health professionals must be educated in the recognition and care of PPD. Perhaps women who experience depressive symptoms will be more willing to seek help from an educated and accepting workforce. Childbirth educators, midwives, and nurses are in pivotal positions to connect with women, offer emotional support and care, and make recommendations and referrals to help women enjoy the postpartum experience and improve maternal and infant outcomes.

ACKNOWLEDGMENT

Special thanks are extended to Dr. Elaine Webber for her clinical guidance throughout this project.

REFERENCES

American Academy of Pediatrics & American College of Obstetricians and Gynecologists. (2012). *Guidelines for perinatal care* (7th ed.). Washington, DC: Author.

American College of Obstetricians and Gynecologists. (2008). *Perinatal depression screening tools for obstetrician-gynecologists*. Retrieved from http://mail.ny.acog.org/website/DepressionToolKit.pdf

American College of Obstetricians and Gynecologists. (2010). *Screening for depression during and after pregnancy*. Retrieved from https://www.acog.org/Resources_And_Publications/Committee_Opinions/Committee_on_Obstetric_Practice/Screening_for_Depression_During_and_After_Pregnancy

American College of Obstetricians and Gynecologists. (2013). *Depression, anxiety rates high among hospitalized pregnant women on bed rest*. Retrieved from http://www.acog.org/About_ACOG/News_Room/News_Releases/2013/Depression_Anxiety_Rates_High_Among_Hospitalized_Pregnant_Women_on_Bed_Rest

Amnesty International. (2010). *Deadly delivery: The maternal health crisis in the US*. Retrieved from http://www.amnestyusa.org/research/reports/deadly-delivery-the-maternal-health-care-crisis-in-the-usa

Appolonio, K., & Fingerhut, R. (2008). Postpartum depression in a military sample. *Military Medicine*, *173*(11), 1085–1091.

Beck, C. T., & Indman, P. (2005). The many faces of postpartum depression. *Journal of Obstetrics, Gynecologic, and Neonatal Nursing*, *34*, 569–576.

Boothe, A. S., Brouwer, R. N., Carter-Edwards, L., & Østbye, T. (2011). Unmet social support for healthy behaviors among overweight and obese postpartum women: Results from the Active Mothers Postpartum Study. *Journal of Women's Health (15409996)*, *20*(11), 1677–1685. http://dx.doi.org/10.1089/jwh.2010.2509

Brown, J., Harris, S., Woods, E., Burman, M., & Cox, J. (2012). Longitudinal study of depressive symptoms and social support in adolescent mothers. *Maternal and Child Health Journal*, *16*(4), 894–901.

Centers for Disease Control and Prevention. (2012). *Public health approaches to reducing infant mortality*. Retrieved from http://www.cdc.gov/about/grandrounds/archives/2012/October2012.htm

Cheng, C., Fowles, R., & Walker, L. O. (2006). Postpartum maternal health care in the United States: A critical review. *The Journal of Perinatal Education*, *15*(3), 34–42. http://dx.doi.org/10.1624/105812406x119002

Chien, L., Tai, C., & Yeh, M. (2012). Domestic decision-making power, social support, and postpartum depression symptoms among immigrant and native women in Taiwan. *Nursing Research*, *61*(2), 103–110. http://dx.doi.org/10.1097/nnr.0b013e31824482b6

Chojenta, C., Loxton, D., & Lucke, J. (2012). How do previous mental health, social support, and stressful life events contribute to postnatal depression in a representative sample of Australian women? *Journal of Midwifery & Women's Health*, *57*(2), 145–150.

Cox, J. L., Holden J. M., & Sagovsky, R. (1987). Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry*, *15*, 782–786.

Dennis, C., Heaman, M., & Vigod, S. (2012). Epidemiology of postpartum depressive symptoms among Canadian women: Regional and national results from a cross-sectional survey. *Canadian Journal of Psychiatry*, *57*(9), 537–546.

Edwards, K. (2011). Inequality in healthcare. *Association of Black Nursing Faculty Journal*, *22*(4), 83.

Edwards, R. C., Thullen, M. J., Isarowong, N., Shiu, C., Henson, L., & Hans, S. L. (2012). Supportive relationships and the trajectory of depressive symptoms among young, African American mothers. *Journal of Family Psychology*, *26*(4), 585–594. http://dx.doi.org/10.1037/a0029053

Evans, M., Donelle, L., & Hume-Loveland, L. (2012). Social support and online postpartum depression discussion groups: A content analysis. *Patient Education & Counseling*, *87*(3), 405–410.

Fowles, E. R., Hsiu-Rong, C., & Milles, S. (2012). Postpartum health promotion interventions: A systematic review. *Nursing Research*, *61*(4), 269–282. http://dx.doi.org/10.1097/nnr.0b013e3182556d29

Gibson, J., McKenzie-McHarg, K., Shakespeare, J., Price, J., & Gray, R. (2009). A systematic review of studies validating the Edinburgh Postnatal Depression Scale in antepartum and postpartum women. *Acta Psychiatrica Scandinavica*, *119*(5), 350–364. http://dx.doi.org/10.1111/j.1600-0447.2009.01363.x

Gillibrand, R. (2012). Surviving postnatal depression. *The Psychologist*, *25*(10), 756–758.

Ginsburg, G. S., Barlow, A., Goklish, N., Hastings, R., Baker, E., Mullany, B., . . . Walkup, J. (2012). Postpartum depression prevention for reservation-based American Indians: Results from a pilot randomized controlled trial. *Child & Youth Care Forum*, *41*(3), 229–245. http://dx.doi.org/10.1007/s10566-011-9161-7

Gress-Smith, J., Luecken, L., Lemery-Chalfant, K., & Howe, R. (2012). Postpartum depression prevalence and impact on infant health, weight, and sleep in low-income and ethnic minority women and infants. *Maternal & Child Health Journal*, *16*(4), 887–893. http://dx.doi.org/10.1007/s10995-011-0812-y

Grigoriadis, S., Robinson, G., Fung, K., Ross, L. E., Chee, C., Dennis, C., & Romans, S. (2009). Traditional postpartum practices and rituals: Clinical implications. *Canadian Journal of Psychiatry*, *54*(12), 834–840.

Groh, C. (2013). Depression in rural women: Implications for nurse practitioners in primary care settings. *Journal of the American Association of Nurse Practitioners*, *25*(2), 84–90. http://dx.doi.org/10.1111/j.1745-7599.2012.00762.x

Haga, S. M., Lynne, A., Slinning, K., & Kraft, P. (2012). A qualitative study of depressive symptoms and well-being among first-time mothers. *Scandinavian Journal of Caring Sciences*, *26*(3), 458–466. http://dx.doi.org/10.1111/j.1471-6712.2011.00950.x

Huang, Z., Lewin, A., Mitchell, S. & Zhang, J. (2012). Variations in the relationship between maternal depression, maternal sensitivity, and child attachment by race/ethnicity and nativity: Findings from a nationally representative cohort study. *Maternal & Child Health Journal*, *16*(1), 40–50. http://dx.doi.org/10.1007/s10995-010-0716-2

Kanotra, S., D'Angelo, D., Phares, T., Morrow, B., Barfield, W., & Lansky, A. (2007). Challenges faced by new mothers in the early postpartum period: An analysis of comment data from the 2000 Pregnancy Risk Assessment Monitoring System (PRAMS) Survey. *Maternal & Child Health Journal*, *11*(6), 549–558.

Kathree, T., & Petersen, I. (2012). South African Indian women screened for postpartum depression: A multiple case study of postpartum experiences. *South African Journal of Psychology*, *42*(1), 37–50.

Kim, H., Geppert, J., Quan, T., Bracha, Y., Lupo, V., & Cutts, D. (2012). Screening for postpartum depression among low-income mothers using an interactive voice response system. *Maternal & Child Health Journal*, *16*(4), 921–928. http://dx.doi.org/10.1007/s10995-011-0817-6

Leahy-Warren, P., McCarthy, G., & Corcoran, P. (2011). First-time mothers: Social support, maternal parental self-efficacy and postnatal depression. *Journal of Clinical Nursing*, *21*(3–4), 388–397. http://dx.doi.org/10.1111/j.1365-2702.2011.03701.x

Logsdon, M., Tomasulo, R., Eckert, D., Beck, C., & Lee, C. (2012). Identification of mothers at risk for postpartum depression by hospital-based perinatal nurses. *MCN: The American Journal of Maternal Child Nursing*, *37*(4), 218–225. http://dx.doi.org/10.1097/NMC.0b013e318251078b

McComish, J. F., Groh, C. J., & Moldenhauer, J. A. (2013). Development of a doula intervention for postpartum depressive symptoms: Participants' recommendations. *Journal of Child and Adolescent Psychiatric Nursing*, *26*, 3–15. http://dx.doi.org/10.1111/jcap.12019

Oates, M. R., Cox, J. L., Neema, S., Asten, P., Glangeud-Freudenthal, N., Figueiredo, B., . . . Yoshida, Y. (2004). Postnatal depression across countries and cultures: A qualitative study. *British Journal of Psychiatry*, *184*(46), s10–s16.

O'Hara, M. W. (2009). Postpartum depression: What we know. *Journal of Clinical Psychology*, *65*(12), 1258–1269. http://dx.doi.org/10.1002/jclp.20644

Ohio Department of Health. (2009). *Infant Mortality Task Force preliminary report*. Retrieved from http://www.odh.ohio.gov/~/media/ODH/ASSETS/Files/cfhs/child%20and%20family%20health%20services/infant%20mortality%20task%20force/draftrecommendations.ashx

Podulka, J., Stranges, E., & Steiner, C. (2011). *Hospitalizations related to childbirth, 2008*. Rockville, MD: Agency for Healthcare Research and Quality. Retrieved from http://www.hcup-us.ahrq.gov/reports/statbriefs/sb110.pdf

Quelopana, A. M., Champion, J., & Reyes-Rubilar, T. (2011). Factors associated with postpartum depression in Chilean women. *Health Care for Women International*, *32*(10), 939–949. http://dx.doi.org/10.1080/07399332.2011.603866

Sarason, I. G., Levine, H. M., Basham, R. B., & Sarason, B. R. (1983). Assessing social support: The Social Support Questionnaire. *Journal of Personality and Social Psychology*, *44*, 127–139.

Sarason, I. G., Sarason, B. R., Shearin, E. N., & Pierce, G. R. (1987). A brief measure of social support: Practical and theoretical implications. *Journal of Social and Personal Relationships*, *4*, 497–510.

Shapiro, G. D., & Fraser, W. D. (2013). Review: Psychosocial and psychological interventions reduce postpartum depression. *Annals of Internal Medicine*, *159*(4).

Sines, E., Uzma, S., Wall, S., & Worley, H. (2007). *Postnatal care: A critical opportunity to save mothers and newborns*. Retrieved from http://www.prb.org/pdf07/snl_pncbrieffinal.pdf

Stalls, S. (2013). *Leveraging midwives' impact on maternal and child survival globally and at home*. Retrieved from http://www.midwife.org/ACNM/files/ccLibraryFiles/Filename/000000003221/S%20Stalls%20Cong%20Briefing%206-17.pdf

Stapleton, L., Schetter, C., Westling, E., Rini, C., Glynn, L. M., Hobel, C. J., & Sandman, C. A. (2012). Perceived

partner support in pregnancy predicts lower maternal and infant distress. *Journal of Family Psychology*, *26*(3), 453–463. http://dx.doi.org/10.1037/a0028332

Stein, H. D., Nadkarni, P., Erdos, J., & Miller, P. (2000). Exploring the degree of concordance of coded and textual data in answering clinical queries from a clinical data repository. *Journal of the American Medical Informatics Association*, *7*(1), 42–54.

Subramanian, S., Katz, K., Roden, M., Gantz, M., El-Khorazaty, N., Johnson, A., & Joseph, J. (2012). An integrated randomized intervention to reduce behavioral and psychosocial risks: Pregnancy and neonatal outcomes. *Maternal & Child Health Journal*, *16*(3), 545–554. http://dx.doi.org/10.1007/s10995-011-0875-9

Sword, W., Busser, D., Ganann, R., McMillan, T., & Swinton, M. (2008). Women's care-seeking experiences after referral for postpartum depression. *Quality Health Research Journal*, *18*, 1161–1173.

Ugarriza, D., Brown, S., & Chang-Martinez, C. (2007). Anglo-American mothers and the prevention of postpartum depression. *Issues in Mental Health Nursing*, *28*(7), 781–798.

U.S. Department of Health and Human Services. (2012). *Women's health, USA 2012*. Retrieved from http://www.mchb.hrsa.gov/whusa12/more/downloads/pdf/whusa12.pdf

Vargas, J. H., & Kemmelmeier, M. (2013). Ethnicity and contemporary American culture: A meta-analytic investigation of horizontal–vertical individualism–collectivism. *Journal of Cross-Cultural Psychology*, *44*(2), 195–222. http://dx.doi.org/10.1177/0022022112443733

Wade, C., Giallo, R., & Cooklin, A. (2012). Maternal fatigue and depression: Identifying vulnerability and relationship to early parenting practices. *Advances in Mental Health*, *10*(3), 277–291. http://dx.doi.org/10.5172/jamh.2012.10.3.277

Wiedenbach, E. (2012). *The helping art of clinical nursing*. Retrieved from http://currentnursing.com/nursing_theory/Ernestine_Wiedenbach.html

World Health Organization. (2008). *WHO technical consultation on postnatal and postpartum care*. Retrieved from http://whqlibdoc.who.int/hq/2010/WHO_MPS_10.03_eng.pdf

Xie, R., He, G., Koszycki, D., Walker, M., & Wen, S. (2009). Fetal sex, social support, and postpartum depression. *Canadian Journal of Psychiatry*, *54*(11), 750–756.

CATHERINE P. CORRIGAN *is an assistant professor in the McAuley School of Nursing at the University of Detroit Mercy. Dr. Corrigan has practice experience in Ireland and America and is currently certified as a family nurse practitioner through the American Academy of Nurse Practitioners and as a midwife in Ireland. She currently practices in an acute care setting near Detroit, managing patients with an array of conditions across the life span.* ANDREA N. KWASKY *is currently dual certified as a child/adolescent psychiatric/mental health clinical nurse specialist and family psychiatric/mental health nurse practitioner through the American Nurses Credentialing Center. She has been with the McAuley School of Nursing at the University of Detroit Mercy since 2009 and currently holds the rank of clinical associate professor with continuing employment. She has a wealth of clinical experience in the specialty area of mental health treating children, adolescents, and adults in the outpatient, inpatient, and residential settings. Dr. Kwasky currently practices clinically with children and adolescents at a long-term residential facility.* CARLA J. GROH *is a professor in the McAuley School of Nursing at the University of Detroit Mercy and the project director for the McAuley Health Center, a nurse-managed primary care clinic in Detroit. Dr. Groh is currently certified as a psychiatric nurse practitioner and has an active clinical practice working with uninsured, low-income women in Detroit. She has international experience in Iceland (Fulbright Award 2004) and in Ireland as a U.S. expert on the relationship between women's mental health and poverty (2011).*