



Having our say: African-American and Latina mothers provide recommendations to health and mental health providers working with new mothers living with postpartum depression

Robert H. Keefe PhD, LMSW, ACSW, Carol Brownstein-Evans PhD, LMSW, ACSW & Rebecca S. Rouland Polmanteer LMSW


To cite this article: Robert H. Keefe PhD, LMSW, ACSW, Carol Brownstein-Evans PhD, LMSW, ACSW & Rebecca S. Rouland Polmanteer LMSW (2016): Having our say: African-American and Latina mothers provide recommendations to health and mental health providers working with new mothers living with postpartum depression, *Social Work in Mental Health*, DOI: [10.1080/15332985.2016.1140699](https://doi.org/10.1080/15332985.2016.1140699)

To link to this article: <http://dx.doi.org/10.1080/15332985.2016.1140699>



Accepted author version posted online: 15 Mar 2016.
Published online: 15 Mar 2016.




[Submit your article to this journal](#) 



Article views: 13



[View related articles](#) 



[View Crossmark data](#) 

Having our say: African-American and Latina mothers provide recommendations to health and mental health providers working with new mothers living with postpartum depression

Robert H. Keefe, PhD, LMSW, ACSW^a, Carol Brownstein-Evans, PhD, LMSW, ACSW^b, and Rebecca S. Rouland Polmanteer, LMSW^a

^aSchool of Social Work, University at Buffalo, State University of New York, Buffalo, New York, USA;

^bDepartment of Social Work, Nazareth College, Rochester, New York, USA

ABSTRACT

Although the research on postpartum depression has grown substantially within the past 20 years, very little research has focused on mothers of color. This article draws on first-person accounts of 30 (19 African-American and 11 Latina) mothers who experienced postpartum depression and links their experiences to existing research to guide health and mental health care providers to render culturally relevant services. The mothers were interviewed regarding their perspectives on postpartum depression, the informal and formal services they used, and their recommendations for service providers. Informal social networks offering emotional and instrumental support partially relieved the mothers of childcare burdens, but were absent or even detrimental for other mothers. Formal services offering responsive and accommodating services were identified as helpful. In contrast, rigid formal mental health treatment and antidepressant medications were identified as unhelpful.

KEYWORDS

Depression; maternal; mental health

The problem of postpartum depression has come to the forefront of the public's consciousness during the past 20 years. Sensationalized cases of mothers harming their young children while suffering from postpartum depression have catalyzed many legislators to begin addressing the problems associated with this and other perinatal mood disorders (Rhodes & Segre, 2013). One legislative action is the passing of the Patient Protection and Affordable Care Act (2010), Section 2952: Support, Education, and Research for Postpartum Depression, which mandates ongoing research to better understand the frequency and course of postpartum depression, address differences in treatment needs among racial and ethnic groups, and develop culturally competent evidence-based treatment approaches (Rhodes & Segre, 2013; United States Department of Labor, 2012).

CONTACT Robert H. Keefe, PhD, LMSW, ACSW ✉ rkeefe@buffalo.edu 📍 School of Social Work, University at Buffalo, State University of New York, 685 Baldy Hall, Buffalo, NY 14260-1050.

© 2016 Taylor & Francis

Postpartum depression has the highest prevalence rate of all perinatal mood disorders (Gaynes et al., 2005). Although prevalence rates vary, the most consistent estimates indicate that postpartum depression affects 13% to 19% of all new mothers (O'Hara & McCabe, 2013) and upward to 38% of new mothers of color (Gress-Smith, Luecken, Lemery-Chalfant, & Howe, 2012). The Centers for Disease Control and Prevention (2008) estimates that African-American and Hispanic mothers have the highest rates of postpartum depression among all racial and ethnic groups; however, research focused on mothers from racially and ethnically diverse groups is scarce. Moreover, the onset and presentation of symptoms often vary among mothers (Gaynes et al., 2005) regardless of their race and ethnicity. Likewise, the current best practices research has yet to conclude which mental health treatment is effective in eliminating postpartum depression although common approaches include medication or mental health therapy (Cattaruzza, 2014).

This article uses excerpts from 30 qualitative interviews with new mothers of color who have had postpartum depression. Specifically, the article discusses the mothers' descriptions of how they experienced postpartum depression, their thoughts about the informal and formal services they used, and their recommendations to service providers to make postpartum services more effective and culturally relevant.

Mothers' experiences with postpartum depression

The symptoms of postpartum depression are similar to symptoms of major depressive disorder (Jolley & Betrus, 2007) including changes in sleep, appetite, energy, libido, concentration, self-esteem, startle response, and feelings such as sadness, guilt, hopelessness, and irritability (American Psychiatric Association [APA], 2013). But, unlike the symptoms of major depressive disorder, which appear within 2 weeks of the psychosocial stressor (APA, 2013), symptoms of postpartum depression can take several months to manifest (Jolley & Betrus, 2007; O'Hara & McCabe, 2013). Many mothers living with postpartum depression report having no joy in life, wanting to be alone, and feeling stressed, worried, anxious about their children, and doubtful of their abilities to be good mothers (Knudson-Martin & Silverstein, 2009).

Consequently, many mothers living with postpartum depression do not seek mental health and other services, or if they do, find the services to be irrelevant or ineffective (Almond & Lathlean, 2011; Callister, Beckstrand, & Corbett, 2010). A problem for service providers is that nearly one half of postpartum depressed mothers do not seek treatment (Andersson, Sundström-Poromaa, Wulff, Åström, & Bixo, 2006). Of the mothers who seek treatment, up to 80% do not disclose their symptoms to their service providers (Howell et al., 2012).

Whereas many mothers have difficulty accessing services during the postpartum period because of structural barriers (Almond & Lathlean, 2011), mothers of color may be less likely to receive needed services because of personal reasons including insufficient time, inconvenient appointment times and locations (Callister et al., 2010), and fewer providers of color from whom to receive services (Almond & Lathlean, 2011; Callister et al., 2010).

Because much of the research on postpartum depression has focused on White mothers (Abrams & Curran, 2007) who have an ongoing relationship with their health and mental health care providers, are married, have supportive families and friends, and earn adequate incomes, many health and mental health care professionals working with new, low-income, mothers-of-color are unfamiliar with the mothers' experiences that are not well represented in the research. Professionals must be sensitive to the challenging roles low-income mothers, mothers of color face that may differ from White mothers whose life situations are well articulated in the existing research. Life situations complicated by poverty, underemployment, single parenthood, a lack of resources, and living in unsafe neighborhoods have been largely overlooked in the existing literature. These stressful and overwhelming issues may lead many mothers of color to believe their depression is a normal part of motherhood and inhibit them from reaching out for help. Moreover, social workers in all settings have few research studies authored by social workers that are published in social work journals to guide them in their practice (Keefe, Brownstein-Evans, Lane, Carter, & Polmanteer, 2015).

Interview process and procedures

Between January 2012 and November 2014, 30 mothers of color (19 African American and 11 Latina) between the ages of 18 and 44 with histories of postpartum depression were interviewed. Flyers were posted in the waiting rooms of a large urban-based health care agency and its two satellite locations, inviting mothers who experienced sadness, irritability, sleeplessness, stress, and worry to participate. Audio-taped face-to-face interviews were conducted by one or both of the first and second authors. During the interviews, mothers were asked to specifically reflect on their own understanding of postpartum depression, their assessment of the quality of the formal and informal services they received, and their personal recommendations to service providers wanting to provide high quality and culturally relevant services to other new mothers of color living with postpartum depression.

Interviews were conducted by the first and second authors, either separately or conjointly. Prior to conducting any interviews, the interviewers obtained input on possible topics and questions from health and mental health providers who work with new mothers from various racial and ethnic

groups; this information guided the development of interview questions. Next, six research assistants sat in on several practice interviews to provide feedback and take notes on the interview process, and help transcribe the initial interviews. Even though 11 of the mothers were Hispanic and an interpreter, who is also a licensed social worker, was available, all of the mothers described themselves as proficient in English and preferred not to use the interpreter's services. The richness of the mothers' responses led the interviewers to begin focusing on key aspects of the informal and formal services used and the recommendations for service providers.

Experiencing postpartum depression

The interviewees provided much information concerning the services they used and the recommendations they would make to service providers. Pertinent interview findings are presented below, which focus first on the mothers' descriptions of their experiences with postpartum depression, followed by their assessments of the helpfulness of both their informal support systems and the formal support services they used, and finally the recommendations they wish to provide to health and mental health care services providers to make services more effective to new mothers.

Mothers explain postpartum depression using a wide range of colloquial descriptions including positive and negative feelings or symptoms (Jarosinski & Pollard, 2014). The mothers in this study conveyed both positive and negative feelings they encountered during pregnancy and while caring for their infants, and reflected on how the role of motherhood and family responsibility affected their experiences. Positive feelings included feeling "joyful," "happy," and "loving my kids." Negative feelings including "depressed/sad," "irritated," "frustrated," "aggravated," "angry," "upset," "burdened," "nervous," "anxious," "worried," "stressed," and "tired." One mother emphasized, "My kids is what I live for ... they are what make me happy." Many mothers emphasized loving their children despite experiences with depression. For example, one mother said that being a mother is "... a good thing. It's good stress... I don't mind. I love my kids. Love them to death." Another mother stated, "... my feelings was mixed all up and stuff. But I love my baby very much." Moreover, mothers experiencing postpartum depression may transition between positive and negative feelings, which was evident in the interviews we conducted. For example, one mother explained, "I can say I am happy today, but in 10 minutes, I am easily irritated. I can get frustrated so it's like an emotional roller coaster."

The experience of postpartum depression is further affected by various ecological and contextual variables (Eastwood, Kemp, Jalaludin, & Phung, 2013). According to one mother, "I don't have friends ... I don't go outside. My neighborhood isn't the safest, so I don't do anything. So I don't have any

time for myself to cope at all.” The feelings shared by these and the other mothers we interviewed both affected and were affected by the context of motherhood and family responsibilities. Similarly, for mothers of color who have limited incomes, the experience of postpartum depression is compounded by the reality of scarce and even insufficient resources. The impact of financial hardship on postpartum depression symptoms can be partly explained by limited social support that may accompany or precede hardship (Rich-Edwards et al., 2006). Therefore, it is understandable that financial stress is a significant factor at the onset of postpartum depression, particularly in African-American women (Amankwaa, 2003).

Despite the mothering experience encompassing both burdens and rewards, the mothers interviewed continued to care for their children and fulfill their family responsibilities. Although their perseverance can be explained by many variables, research supports the role of individual factors, such as optimism, internal locus of control, and self-efficacy, in promoting mental health well-being (Grote & Bledsoe, 2007). Additionally, contextual factors such as social support can positively influence maternal distress during the postpartum period (Eastwood et al., 2013). The mothers interviewed persevered through coping with the assistance of informal supports and formal service providers.

Informal supports

Mothers are more likely to receive support from family members than from formal mental health service providers in caring for their infants (Leahy-Warren, McCarthy, & Corcoran, 2012). Therefore, having a helpful family support system is critical to promote the mother’s and child’s physical and mental health (Jarosinski & Pollard, 2014; Negron, Martin, Almog, Balbierz, & Howell, 2013). For mothers experiencing postpartum depression, receiving emotional (e.g., listening and offering sympathetic support) and instrumental (e.g., offering tangible or physical assistance such as financial support) from their family or partner can positively influence their mental health well-being (Leahy-Warren et al., 2012; Negron et al., 2013) and lessen their depressive symptoms (Leahy-Warren et al., 2012).

Fathers

Positive partner support can promote a mother’s well-being during the postpartum period (Hassert & Kurpius, 2011; Negron et al., 2013). The mothers interviewed identified that their partners or the fathers of the infant provided both emotional and instrumental support. Emotional support included validation and words of encouragement. One mother described the emotional support she received from the baby’s father as, “He just told

me how proud he was of me ... that I'm a great mom ... he was emotionally supportive." Another mother stated of her children's father, "He was there for me. He was the only one that stepped up."

Fathers can also offer instrumental support (Negron et al., 2013). For example, one mother stated, "... last week, he did the laundry, so I only came home to folding and putting away the clothes. And you have no idea how much help that was ... just for him to go downstairs and do the laundry and bring it back up."

While many fathers are supportive and involved, others are not present or have an unhealthy, conflictual relationship with the infant's mother. Conflict with one's partner has been shown to be the strongest predictor of postpartum depression (Gee & Rhodes, 2003) particularly for Latina mothers (Hassert & Kurpius, 2011). Some mothers provided examples where the fathers were not available to them and their newborns. One woman said, "my baby dad walked out ... it's like, how would I be able to provide [for my baby] alone?"

In the most extreme situations, a few mothers reported instances of abuse. For example, one mother identified being abused by the baby's father until shortly before she delivered, explaining, "the minute that I found out I was pregnant, things just changed. I was getting hit on my whole 9 months that I was pregnant.... [I] delivered her with a black eye, he beat me so bad 3 days before I had her." Intimate partner violence is highly correlated with increased postpartum depression (Faisal-Cury et al., 2013). However, social support from other informal support systems can serve as a buffer in the relationship between interpersonal violence and postpartum depression (Faisal-Cury et al., 2013).

Immediate and extended family

Many postpartum mothers also receive valuable emotional and instrumental support from immediate and extended family members (Negron et al., 2013). The mothers interviewed defined family as including maternal and paternal biological and non-biological relatives. Of her experience with postpartum depression, one mother said, "It's a struggle but sometimes you have your family to help you."

Family can provide mothers with someone to listen or provide advice (Negron et al., 2013). Mothers in the early postpartum period frequently consult their own mother for emotional support (Leahy-Warren et al., 2012). Of her female relatives, one mother reported, "If I feel like I need more advice in anything, I'll call my mom, and she'll talk to me about everything that I need to know." Another mother shared, "anytime I'm depressed or anything, or I'm overwhelmed, I can talk to [my aunt] about my problems."

Family may also provide instrumental support (Leahy-Warren et al., 2012; Negron et al., 2013) by offering the mothers time to themselves and helping them with day-to-day activities. One mother described the instrumental support she received from her mother: “When I did not have food in my house, she caught the bus from across town.... She brought me her benefit card, and I went shopping [for food].... She keeps my kids while I go to work and school and she picks up my kids from daycare.” Another mother summarized family support as, “Doing what needs to be done family-wise, whether it’s cooking, cleaning, emotional support ... just listening.”

Obviously, not all mothers had supportive families. For many mothers, the absence of familial support is troublesome as mothers who have negative interactions with their families tend to have worse symptoms of postpartum depression than other mothers (Tammentie, Tarkka, Astedt-Kurki, Paavilainen, & Laippala, 2004). When asked to which family members she turned to for support, one mother replied, “Nobody really ... my sisters are in New York City, my father was a drunk, my mother was a crack head, so you can add it up.... I keep my distance from them.”

Formal service providers

Mothers report that various services were helpful to overcoming postpartum depression. Often, those services were not specifically related to mental health care for postpartum depression but instead were no-cost services that helped mothers provide for their children. One mother reports, “If I see something going on in the community and it’s free.... I’m in. You can’t rely on everybody to help you out. You have to be your own resource and call around.” Another mother conveyed that the formal services that offered something tangible were the most helpful: “It was a social worker who used to come help me out ... diapers and toys for the baby.”

Having positive and long-term relationships with service providers was often vital to success. One mother pointed out, “We all had the same doctor, and then, my mom’s grandkids got all the same doctor. We been here since 1995.” It is quite likely that these long-term relationships helped the mothers trust their health and mental health care providers, which relieved their postpartum well-being. Research supports that White mothers benefit from feeling cared for, listened to, and having service providers validate their experiences (Nicole et al., 2007). In fact, mothers’ symptoms worsen when health professionals are inattentive to postpartum concerns (Nicole et al., 2007). Although exacerbated by their lower socioeconomic status, the problems for the mothers interviewed were similar.

Mothers also reported that some formal services were less helpful, particularly traditional mental health care that focused solely on therapy and did

not assist the mother with concrete needs. One mother explained, “I admitted myself for a week ... they just have too many crazy people in there.... I just needed something to get away from all the issues I was going through, but it didn’t make things any better.” Another mother reported that mental health services were not consistent with her needs, explaining, “They signed me up at mental health. But I didn’t ever go... I don’t feel like I’m crazy, I’m just depressed a little bit.” Prior studies have found similar results. Miller, Shade, and Vasireddy (2009) reported that many mothers who scored high on depression scales did not think of themselves as depressed. Similarly, Lucero, Beckstrand, Callister, and Sanchez-Birkhead (2012) concluded that Hispanic mothers were reluctant to talk about depression and were resistant to receiving treatment. Interestingly, the Latina mothers interviewed felt similarly; however, as reported earlier, the relationship with the service provider often mitigated their reluctance.

Almost uniformly, the interviewees reported the least helpful treatment options were anti-depressant medications. The mothers indicated the medications had no effect or actually made matters worse. One mother reported, “I felt moody, indifferent. I did not care, and that was not me. So I stopped taking the medication.” Similarly, a second mother stated, “I feel the medicines don’t really help me. Medicine makes me feel crazier. I didn’t feel good at all, like I felt ... more anxious, depressed ... so I just stopped.” Another mother said, “I felt even worse ... than not actually taking it...and at the end of the day your problems are ... still there.” Although much research concludes that antidepressant medications used to treat major depression can be equally effective treating postpartum depression (Patel et al., 2012), emerging evidence suggests antidepressants may not be as effective as previously thought (Willner, Scheel-Krüger, & Belzung, 2013). Clearly, the mothers in this study were dissatisfied with the limited therapeutic effect achieved by antidepressant use.

Despite the difficulties mothers face, all of the mothers interviewed indicated they wanted to work on their depression. It was clear that some mothers wanted and needed formal mental health intervention to treat their depression and to develop problem-solving skills for the circumstances that contributed to their depression. However, the issues that they needed and wanted to address were often the same issues that kept them from accessing care. As one mother stated, “I would go but I have so much stuff going on in my life that it prevents me from going to all the meetings for counselling.... I really did try ... when you have one thing happening after another...it’s hard to attend all the appointments and then you get cut off ... something always happened or always went wrong in my life to stop me from getting the counseling I needed.”

Recommendations to health and mental health care providers

The 30 mothers interviewed provided recommendations to health and mental health professionals. Among the most common recommendations were for professionals to develop strong therapeutic alliances by (1) conveying knowledge and understanding of postpartum depression; (2) listening carefully to the mothers' concerns and empathizing with them; (3) offering validation and reassurance that the mothers' symptoms would improve; (4) providing emotional support; (5) building trusting relationships; and (6) establishing more services that are accessible, have flexible appointment times, and are parent- and child-friendly.

The mothers wanted their providers to convey knowledge of the experience of motherhood. As one mother said, "I think it is important that people know what mothers go through." The mothers desired providers to be good listeners, empathetic, supportive and offer to reassurance. One mother stated, "All women need help to do what they need to do. Even if it is a strong mother who has it all down pat, she still needs a bit of help. Even if it is to talk to somebody and let it out. It helps so much." Another mother praised her mental health counselor saying, "She was just a good counselor. I never met a counselor like that. They just have to feel your pain." Another mother expressed, "I don't care if you can't give me anything, just reassure me and tell me if I'm doing the right thing or tell me that I'm going to be okay."

Mothers also wanted health and mental health care service providers to take the time to build strong, therapeutic relationships. One mother explained, "I see you the first time, or second time, I may not feel comfortable. But, seeing you, grow a connection, a relationship with you, I can answer the questions [you ask me]." Mothers also desired more time with providers as a way to promote the relationship. One mother praised her primary care physician stating, "... he takes time ... he listens." In contrast, mothers did not want to be rushed. The mothers with postpartum depression wanted their providers to be available, listen, and build relationships with them. These findings are similar to other researchers who conclude that postpartum mothers are more satisfied with their providers who are sensitive to the psychosocial strengths as well as problems they face (Minde, Tidmarsh, & Hughes, 2001).

A final recommendation was to develop more services. Several mothers mentioned needing more shelters for mothers and children, and services specific to children and single mothers. One mother suggested that communities should, "make a mother-and-child shelter for ... us Spanish and blacks who have nowhere to turn." Several mothers also expressed interest in peer-support groups. One mother explained, "It would be great if mothers who feel the same way could get together. Because you understand each other, you understand what another person is going through. And you will be able to

express it to someone that is going through the same thing ... because they had a child and they are going through it. It helps a lot to see that you are not the only one who is going through that. And I think that is a little comforting.”

Various researchers (Cox & Holden, 2003) emphasize that service providers should assess, treat, refer, and educate while being mindful of cultural issues. Consistent with these findings, the mothers interviewed in this study were looking for a strong relationship with their service providers who recognize and validate their commitment to be good mothers despite limited resources. Mental health providers must recognize and validate the mother's efforts and strengths and deliver culturally competent, supportive, individualized, and flexible services. Likewise, providers must know the service-delivery system and link mothers to services the mothers believe are appropriate and helpful, and that will enable them to meet their needs and the needs of their children.

Acknowledgments

An earlier version of this article was presented at the 141st annual meeting of the American Public Health Association, Boston, MA.

Funding

Funding for this project was made available by a grant from the Fahs-Beck Fund for Research and Experimentation.

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), 289–296. doi:10.1093/hsw/32.4.289
- Almond, P., & Lathlean, J. (2011). Inequity in provision of and access to health visiting postnatal depression services. *Journal of Advanced Nursing, 67*(11), 2350–2362. doi:10.1111/j.1365-2648.2011.05669.x
- Amankwaa, L. C. (2003). Postpartum depression, culture and African-American women. *Journal of Cultural Diversity, 10*(1), 23–29.
- American Psychiatric Association (APA). (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.
- Andersson, L., Sundström-Poromaa, I., Wulff, M., Åström, M., & Bixo, M. (2006). Depression and anxiety during pregnancy and six months postpartum: A follow-up study. *Acta Obstetrica et Gynecologica Scandinavica, 85*(4), 937–944. doi:10.1080/00016340600697652
- Callister, L. C., Beckstrand, R. L., & Corbett, C. (2010). Postpartum depression and culture: Pesado corazón. *MCN, The American Journal of Maternal/Child Nursing, 35*(5), 254–261. doi:10.1097/NMC.0b013e3181e597bf

- Cattaruzza, A. (2014). Difficulties in the treatment of depression during pregnancy and postpartum depression. *Journal of Infant, Child, and Adolescent Psychotherapy, 13*, 75–87. doi:10.1080/15289168.2014.880296
- Centers for Disease Control and Prevention. (2008). Prevalence of self-reported postpartum depressive symptoms—17 states, 2004–2005. *Morbidity and Mortality Weekly Report, 57* (14), 361–366.
- Cox, J. L., & Holden, J. (2003). *Perinatal mental health: A guide to the Edinburgh Postnatal Depression Scale (EPDS)*. London, UK: Gaskell.
- Eastwood, J. G., Kemp, L. A., Jalaludin, B. B., & Phung, H. N. (2013). Neighborhood adversity, ethnic diversity, and weak social cohesion and social networks predict high rates of maternal depressive symptoms: A critical realist ecological study in south western Sydney, Australia. *International Journal of Health Services, 43*(2), 241–266. doi:10.2190/HS.43.2.d
- Faisal-Cury, A., Menezes, P. R., Flavia, A., d'Oliveira, P. L., Schraiber, L. B., & Lopes, C. S. (2013). Temporal relationship between intimate partner violence and postpartum depression in a sample of low income women. *Maternal and Child Health Journal, 17*, 1297–1303. doi:10.1007/s10995-012-1127-3
- Gaynes, B. N., Gavin, N., Meltzer-Brody, S., Lohr, K. N., Swinson, T., Gartlehner, G., ... Miller, W. C. (2005, February). *Perinatal depression: Prevalence, screening accuracy, and screening outcomes*. Evidence report/technology assessment no. 119. (Prepared by the RTI-University of North Carolina Evidence-Based Practice Center, under contract no. 290-02-0016). AHRQ Publication no. 05-E006-2. Rockville, MD: Agency for Healthcare Research and Quality.
- Gee, C. B., & Rhodes, J. E. (2003). Adolescent mothers' relationship with their children's biological fathers: Social support, social strain and relationship continuity. *Journal of Family Psychology, 17*(3), 370–383. doi:10.1037/0893-3200.17.3.370
- Gress-Smith, J. L., Luecken, L. J., 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 and Child Health Journal, 16*, 887–893. doi:10.1007/s10995-011-0812-y
- 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. doi:10.1093/hsw/32.2.107
- Hassert, S., & Kurpius, S. E. R. (2011). Latinas and postpartum depression: Role of partner relationship, additional children, and breastfeeding. *Journal of Multicultural Counseling and Development, 39*(2), 90–100. doi:10.1002/j.2161-1912.2011.tb00143.x
- Howell, E. A., Balbierz, A., Wang, J., Parides, M., Zlotnick, C., & Leventhal, H. (2012). Reducing postpartum depressive symptoms among Black and Latina mothers: A randomized controlled trial. *Obstetrics & Gynecology, 119*(5), 942–949. doi:10.1097/AOG.0b013e318250ba48
- Jarosinski, J. M., & Pollard, D. L. (2014). Postpartum depression: Perceptions of a diverse sample of low-income women. *Issues in Mental Health Nursing, 35*, 189–197. doi:10.3109/01612840.2013.848960
- Jolley, S. N., & Betrus, P. (2007). Comparing postpartum depression and major depressive disorder: Issues in assessment. *Issues in Mental Health Nursing, 28*, 765–780. doi:10.1080/01612840701413590
- Keefe, R. H., Brownstein-Evans, C., Lane, S. D., Carter, D. B., & Polmanteer, R. S. R. (2015). Postpartum depression and the Affordable Care Act: Recommendations for social work educators. *Advances in Social Work, 16*(2), 202–213.

- Knudson-Martin, C., & Silverstein, R. (2009). Suffering in silence: A qualitative meta-data-analysis of postpartum depression. *Journal of Marital and Family Therapy*, 35(2), 145–158. doi:10.1111/jmft.2009.35.issue-2
- Leahy-Warren, P., McCarthy, G., & Corcoran, P. (2012). First-time mothers: Social support, maternal parental self-efficacy and postnatal depression. *Journal of Clinical Nursing*, 21(3/4), 388–397. doi:10.1111/j.1365-2702.2011.03701.x
- 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*, 1–9. doi:10.1111/j.1745-7599.2012.00744.x
- Miller, L. J., Shade, M., & Vasireddy, V. (2009). Beyond screening: Assessment of perinatal depression in a perinatal care setting. *Archives of Women's Mental Health*, 12(5), 329–334. doi:10.1007/s00737-009-0082-5
- Minde, K., Tidmarsh, L., & Hughes, S. (2001). Nurses' and physicians' assessment of mother–infant mental health at the first postnatal visits. *Journal of the American Academy of Child & Adolescent Psychiatry*, 40, 803–881. doi:10.1097/00004583-200107000-00015
- Negron, R., Martin, A., Almog, M., Balbierz, A., & Howell, E. A. (2013). Social support during the postpartum period: Mothers' views on needs, expectations, and mobilization of support. *Maternal & Child Health Journal*, 17, 616–623. doi:10.1007/s10995-012-1037-4
- Nicole, L., Duffett-Leger, L., Stewart, M., Hegadoren, K., Dennis, C.-L., Rinaldi, C. M., & Stoppard, J. (2007). Canadian mothers' perceived support needs during postpartum depression. *Journal of Obstetric, Gynecologic & Neonatal Nursing*, 36(5), 441–449. doi:10.1111/j.1552-6909.2007.00174.x
- 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
- Patel, M., Bailey, R. K., Jabeen, S., Ali, S., Barker, N. C., & Osiezagha, K. (2012). Postpartum depression: A review. *Journal of Health Care for the Poor and Underserved*, 23, 534–542. doi:10.1353/hpu.2012.0037
- Patient Protection and Affordable Care Act, 42 U.S.C. § 18001. (2010). Retrieved from <http://www.hhs.gov/healthcare/rights/law/index.html>
- Rhodes, A. M., & Segre, L. S. (2013). Perinatal depression: A review of US legislation and law. *Archives of Women's Mental Health*, 16, 259–270. doi:10.1007/s00737-013-0359-6
- Rich-Edwards, J. W., Kleinman, K., Abrams, A., Harlow, B. L., McLaughlin, T. J., Joffe, H., & Gilman, M. W. (2006). Sociodemographic predictors of antenatal and postpartum depressive symptoms among women in a medical group practice. *Journal of Epidemiology & Community Health*, 60(3), 221–227. doi:10.1136/jech.2005.039370
- Tammentie, T., Tarkka, M.-T., Astedt-Kurki, P., Paavilainen, E., & Laippala, P. (2004). Family dynamics and postnatal depression. *Journal of Psychiatric and Mental Health Nursing*, 11, 141–149. doi:10.1111/j.1365-2850.2003.00684.x
- United States Department of Labor. (2012). *Affordable care act*. Retrieved from <http://www.dol.gov/ebsa/healthreform/>
- Willner, P., Scheel-Krüger, J., & Belzung, C. (2013). The neurobiology of depression and antidepressant action. *Neuroscience & Biobehavioral Reviews*, 37(10), 2331–2371. doi:10.1016/j.neubiorev.2012.12.007