

THE CAPACITY OF
POSTPARTUM DEPRESSION
RESOURCES IN UNDERSERVED COMMUNITIES

By

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Abstract

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The primary purpose of this study was to assess the resources that are available to women in underserved communities to detect and treat postpartum depression. Postpartum depression continues to be a major public health issue. Although there are screening methods and treatments that are available to address this mental illness, the rates of detection are still low leading to a number of women that suffer from postpartum depression and go untreated. Two populations that have proven to be at a higher risk of postpartum depression are those from underserved communities and minority populations. This research takes a deeper look into the resources afforded for postpartum depression for those in underserved communities by utilizing a case study approach and comparing the capacity of those resources to

those in an affluent community. Based on the results from the qualitative interviews conducted, it is apparent that there is a diminished capacity of resources in an underserved community in comparison to an affluent one and the policies and procedures that are currently being used in the facilities that offer both prenatal and postnatal women's care are not currently in alignment with the policies that are in place on the local and state level. A stakeholder analysis was conducted to determine which stakeholders would be most influential in making alterations to the current policies to make them more beneficial in addressing the rising postpartum depression rates.

Table of Contents

Acknowledgements.....	iii
Abstract.....	v
List of Illustrations.....	x

Chapter	Page
1. Introduction.....	1
1.1 Postpartum Depression Defined.....	3
1.2 Potential Consequences of Postpartum Depression.....	6
1.3 Defining and Measuring Capacity.....	7
1.4 Current Policies Aimed at Postnatal Women’s Care.....	11
1.5 State of Texas Policies on Postnatal Women’s Health and Postpartum Depression.....	11
1.6 Dallas County Policies on Postpartum Depression Resources.....	13
1.7 Collin County Policies on Postpartum Depression Resources.....	14
1.8 Tarrant County Policies on Postpartum Depression Resources.....	14
1.9 Aim of the Research.....	15
2. Literature Review.....	17
2.1 Peripartum Implications: Social, Psychological, and Cultural Variables	17
2.2 Screening for Postpartum Depression.....	21

2.3 Postpartum Depression Diagnosis.....	23
2.4 Postpartum Depression Treatment.....	24
2.5 Social Resilience.....	26
2.6 Stakeholder Theory.....	29
3. Methodology.....	32
3.1 Study Design.....	32
3.2 Sample Population.....	35
3.3 Qualitative Interviews.....	36
3.4 Qualitative Analysis.....	41
3.5 Epistemological Stance.....	42
4. Results.....	44
4.1 Overview of Results Format.....	44
4.2 Summary of the Sample Population Interviewed.....	45
4.3 Measuring the Capacity of Postpartum Depression Resources.....	46
4.4 Resources.....	47
4.5 Skills.....	53
4.6 Social and Interorganizational Networks.....	61
4.7 Social, Cultural, and Psychological Variables.....	64
4.8 Alignment with State and/or Local Policies.....	67
4.9 Stakeholder Analysis.....	70
5. Discussion, Suggestions for Future Research, and Conclusion	72

5.1 Discussion of the Results.....	73
5.2 Research Significance	81
5.3 Practical Implications	84
5.4 Study Limitations	86
5.5 Research Implications.....	87
5.6 Conclusions.....	89
Appendix A-Interview Questions.....	92
Appendix B-Introduction to the Administrators Script.....	96
Appendix C-IRB Project Designation.....	98
References.....	100
Biographical Information.....	110

List of Illustrations

Figure 1-1 Postpartum Affective Disorders.....	5
Figure 1-2 Capacity as a Performance Measure.....	8
Figure 1-3 Dimensions of Community Capacity	10
Figure 2-1 Postpartum Depression Screening Tools.....	22
Figure 2-2 Barriers to Postpartum Depression Treatment.....	26
Figure 2-3 Main Effect Model of Social Ties and Mental Health.....	28
Figure 2-4 Hub-and Spoke Illustration of Stakeholder Categories.....	31
Figure 3-1 Themes and Subthemes Used for the Content Analysis.....	40
Figure 4-1 Sample Population Breakdown.....	46
Figure 4-2 Summary of Resources Based on Facility Type.....	52
Figure 4-3 Summary of Skills Based on Facility Type.....	60
Figure 4-4 Summary of Social and Interorganizational Networks.....	64
Figure 4-5 Summary of Social, Cultural, and Psychological Variables.....	66
Figure 4-6 Summary of Alignment with State and Local Policies.....	69
Figure 4-7 Stakeholder Analysis Chart.....	71

Chapter 1

INTRODUCTION

Using stakeholder theory as a conceptual framework, this study examined the relationships between organizations such as health clinics, hospital systems, and nonprofit agencies to organizational and environmental factors and their role in the capacity of resources provided to detect and treat postpartum depression in underserved communities. The measurement of the capacity of these facilities is a measurement of their ability to provide essential and quality resources for postpartum depression in underserved communities. These underserved communities are classified as Medically Underserved by the Health Resources and Services Administration. Another important aspect of this study was determining if the state, county, and local policies surrounding postnatal women's care, specifically postpartum depression, aligned with the resources that are currently being provided in underserved areas. In order to emphasize the barriers to obtaining resources to address the health disparities associated with postpartum depression, this research study used the work of previous researchers regarding social, psychological, and cultural variables of the mental illness, as well as incorporating the perceived issues surrounding cultural competency as a barrier to essential care. The intent of this research was to determine if there are adequate resources such as support groups, psychiatric services, referral services, access to medication, culturally competent services, case workers, and additional post-natal follow-up care provided for minority women suffering from postpartum depression in underserved areas.

Postpartum depression is a common and serious mental health condition that can lead to tragic outcomes such as maternal suffering and numerous negative consequences for

the offspring (Wisner et al., 2006). The onset of postpartum depression symptoms can occur even a year after childbirth (NIH, 2014). The symptoms of postpartum depression can closely resemble those of depression. Along with a sad or depressed mood, the woman may also experience appetite fluctuations, feelings of insignificance or unimportance, anxiety or irritability, feeling introverted or isolated, lack of desire or interest in most events, difficulty sleeping, contemplations of suicide or death, loss of drive, and loss of concentration (NIH, 2014). A mother experiencing postpartum depression might also be afraid to care for the baby alone, be unable to care for herself or the infant, have an intense worry in regard to the baby, and have negative feelings toward the baby. Without treatment, this could put the woman at risk for harming her baby (O'Hara & McCabe, 2013).

There is no single unified theory for the origin of postpartum depression. Many researchers associate the condition with changes in hormone levels during and after a pregnancy (Hirst & Moutier, 2010). There are also a number of psychological, social, and cultural variables that have been associated with postpartum depression. Some of those variables include anxiety, stress, low parenting knowledge, unplanned pregnancy, difficult marital relationship, low social support, financial worry, low maternal self-efficacy, and a difficult relationship with the mother-in-law (Mohammed et al., 2010). One of the most intriguing factors of postpartum depression is the difference in the prevalence rates based on race and ethnicity. Liu and Tronick (2012) concluded in one study that there are racial disparities in postpartum depression and its diagnosis especially in minority groups. Additional research has also found that postpartum depression is

more prevalent among women that are under the age of twenty and those that abuse alcohol, take illegal substances, or smoke (NIH, 2014).

An ongoing problem with postpartum depression is the low rate of detection and treatment, especially among minority populations (Keller et al., 1986). Less than half of the women that suffer from postpartum depression are identified and treated (DHHS, 1993). Due to the number of social and psychological variables that are associated with postpartum depression, it is imperative that resources provided to women to diagnose and address this mental illness are readily available, and policies that are put into place to address the illness align with the current practices.

1.1 Postpartum Depression Defined

Although postpartum depression can follow a general definition of being a depressive disorder specific to the postpartum period, the degree of severity among postpartum affective disorders can range from mild to very severe (Evins et al., 2000). One of the milder stages of postpartum affective disorders is often termed the “postpartum blues” (O’Hara, pg. 1259, 2009). The symptoms that are present during the postpartum blues stage are symptoms that are typical immediately following the birth of a child and are usually resolved without any intervention. Those symptoms include insomnia, anxiety, mood swings, and irritability (O’Hara, 2009). Postpartum blues or maternity blues occur in 50% to 70% of new mothers (Beck, 2006). Symptoms such as relationship issues, a previous history of depression, or depression that occurred in pregnancy are risk factors that can be associated with more severe cases of postpartum blues or early symptoms of postpartum depression (Beck, 2006).

Though researchers have indicated additional stages of postpartum affective disorders based on severity, the most severe postpartum disorder is postpartum psychosis (Beck, 2006). Postpartum psychosis is “associated with high rates of suicide and infanticide...the incidence is low (Beck, pg. 42, 2006)”. This disorder is characterized by psychotic thoughts, hallucinations, erratic thinking, and a severe state of depression (O’Hara, 2009). Postpartum psychosis often initially mimics bipolar disorder and is most appropriately treated by hospitalization (Doucet et al., 2009).

Given postpartum depression symptoms can vary along a spectrum, sometimes postpartum blues and postpartum psychosis are lumped with “postpartum depression” rather than delineated for diagnostic clarity. Each cluster of symptoms is distinct and differentiation is imperative for treatment planning and understanding response to intervention. Unfortunately, this is complicated by the lack of diagnostic criteria. Mental health professionals (psychiatrists, psychologists, therapists, professional counselors, and social workers) conceptualize symptoms using the *Diagnostic and Statistical Manual of Mental Disorders – Fifth Edition (DSM-5)*. *DSM-5* is published by the American Psychiatric Association and is the standard reference for clinical practice. The purpose of the *DSM-5* is “classification of mental disorders with associated criteria designed to facilitate more reliable diagnoses of these disorders” (American Psychiatric Association, 2014, p. xli). In essence diagnoses are labels we give to a cluster of symptoms to convey what we are seeing, and to categorize those clusters for administrative reasons, like insurance billing. There can be a lot of overlap in symptoms, and the same set of symptoms could indicate more than one diagnostic label (APA, 2014).

There is no distinct category for postpartum depression in the DSM-5, but there is a specifier listed that recognizes postpartum depression as a major depression disorder with a postpartum onset occurring within the first four weeks after childbirth (APA, 2014). Other symptoms that are associated with postpartum depression, and are often used to distinguish it from other postpartum disorders, include anxiety symptoms and changes in mood (Beck, 2006).

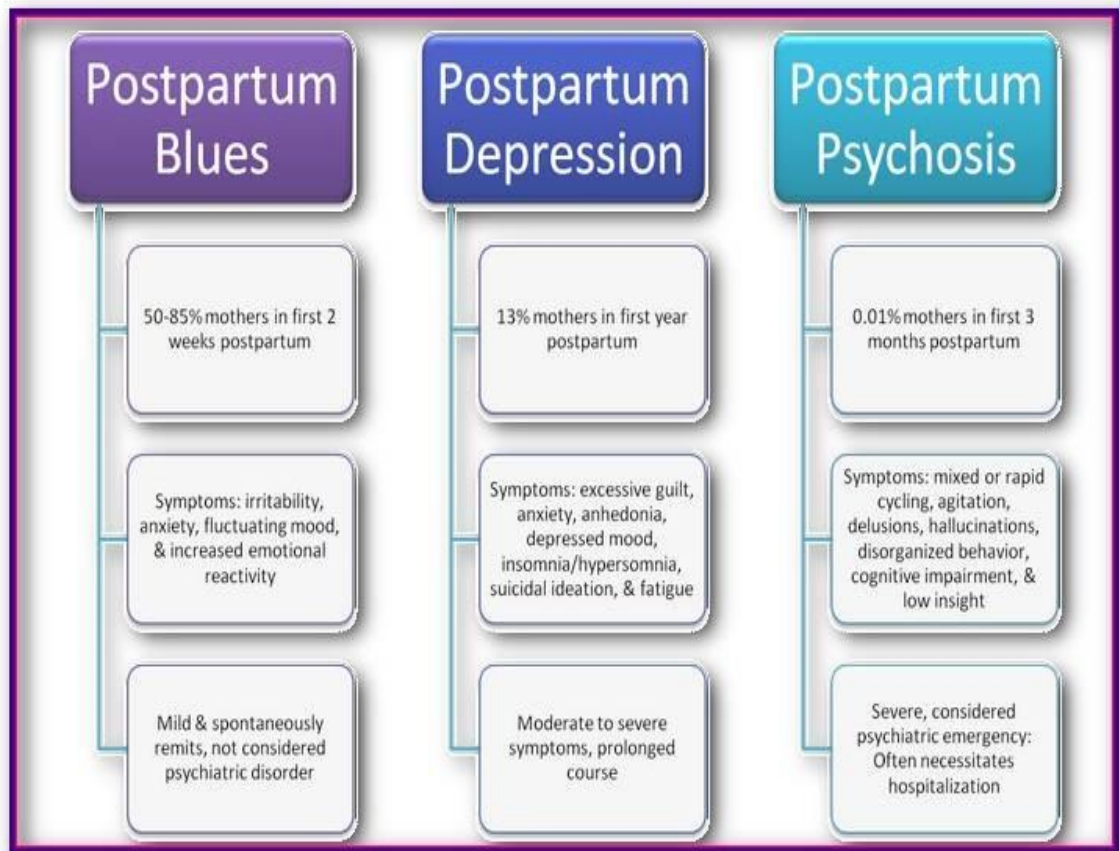


Figure 1-1 Postpartum Affective Disorders (Johnson, 2011)

1.2 Potential Consequences of Postpartum Depression

There are a number of detrimental consequences of postpartum depression that can be exacerbated by the demands of caring for a newborn baby. Having to care for additional older siblings, returning to work after a brief maternity leave, resuming normal household responsibilities, and a history of depression may lead to or exacerbate postpartum depression (O'Hara, 2009). The consequences of postpartum depression in women could include an increased risk for maternal depression subsequent to the initial onset of the postpartum depression symptoms, as well as an increase in their detachment from their newborns (Philipps & O'Hara, 1991; Forman et al., 2007). Women who exhibit postpartum depression symptoms are also at an increased risk for maternal complications such as preeclampsia, and also have an increased risk of risky behaviors such as substance abuse, drug and alcohol use, and poor self-care (O'Hara, 2009).

Certainly there is no debate about the effects of postpartum depression on the mother, but the effects to the newborn also warrant scrutiny. The increased risk of the mother having maternal complications leads to a risk of the child being born preterm, being low birth weight, or having a neurological condition (O'Hara, 2009). In addition to apparent physical complications at birth, the child might also experience some repercussions from the lack of social and emotional attachment exhibited by the mother after delivery (Weinburg & Tronick, 1998). The lack of engagement of the mother could lead to a child that suffers from insecurity and behavioral problems (Weinburg & Tronick, 1998).

1.3 Defining and Measuring Capacity

The performance measurement of an organization can be defined as the use of measures including capacity, process, and outcomes as a means to gather information. This information is then used to determine the effectiveness of an organization's activities for the public or community (Lichiello, 2002). Since the performance measurement of an organization is measured by the capacity, processes, and outcomes of that organization, these three measurements are essentially three key components of public health practice. Processes in terms of performance measurement are things that are done by the organization for the community, patients, and/or clients. The outcome measurement can be attributed to a change or a lack of change in the health status of a defined population.

There are various definitions and conceptual frameworks for capacity in terms of organizational change and health promotion (Meyer et al., 2012). The capacity of an organization or health system can incorporate numerous levels including an individual, the system, an organization, and the community. Capacity is also multidimensional in the sense that it includes the capability, knowledge, and resources of an organization and is viewed as a "critical determinant of system performance" (Meyer et al., 2012, pg. 535). The figure below helps to demonstrate not only the degree of importance that capacity plays in the performance measurement of an organization, but it also helps to illustrate the complexity of the inputs that can be included in the measurement of capacity (Turnock, 2004). This logic model indicates that capacity can be measured by including system inputs such as the workforce, information, organization and relationships, facilities, and funding. Other aspects that can be attributed to the measurement of

capacity in terms of organizational performance include staff retention rates, the diversity of the staff, the ability for different departments to work together, and the atmosphere of the health system (Ebbesen et al., 2004). These system inputs help to aid in the effective processes of an organization that in turn lead to the outcomes and improved organizational performance of the organization as a whole.

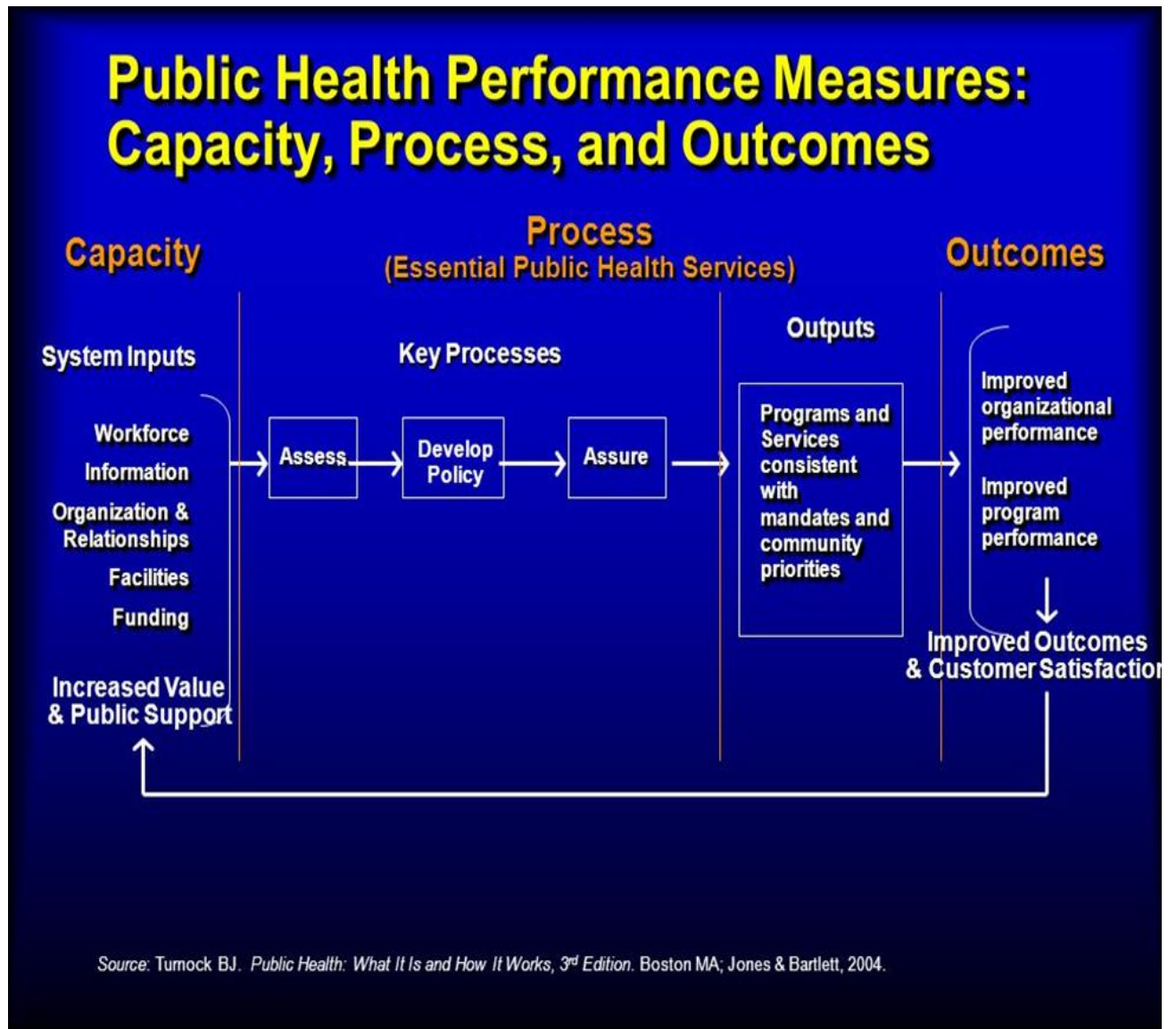


Figure 1-2 Capacity as a Performance Measure (Turnock, 2004)

The Centers for Disease Control identified 10 dimensions of community capacity that can be used to determine the potential of a community or an organization for addressing public health issues such as postpartum depression (McLeroy, 1996). Those dimensions include (McLeroy, 1996):

- Leadership
- Citizen Participation
- Skills
- Resources
- Social and Interorganizational Networks
- Sense of Community
- Understanding of Community History
- Community Power
- Community Values
- Critical Reflection

The authors also mentioned that the list of dimensions illustrated are not an exhaustive list and that the dimensions could be linked and analyzed differently based on the context of the research (Goodman et al., 1998). As a result, this research focused on analyzing the dimensions of skills, resources, and social and interorganizational networks which was evidenced by the responses from the qualitative content analysis. The following figure includes characteristics from each dimension that were evaluated to determine the capacity of postpartum depression resources in a community.

<i>Dimensions of Community Capacity</i>	
Dimension	Characteristics
Skills	<ul style="list-style-type: none"> -The ability to engage constructively in group process -Conflict resolution -Collection and analysis of assessment data -Problem solving and program planning -Intervention design and implementation -Evaluation -Resource mobilization -Policy and media advocacy -The ability to resist opposing or undesirable influences -The ability to attain an optimal level of resource exchange
Resources	<ul style="list-style-type: none"> -Access and sharing of resources that are both internal and external to a community -Social capital or the ability to generate trust, confidence, and cooperation -The existence of communication channels within and outside of a community
Social and Interorganizational Networks	<ul style="list-style-type: none"> -Reciprocal links throughout the overall network -Frequent supportive interactions -Overlap with other networks within a community -The ability to form new associations -Cooperative decision-making processes

Figure 1-3 Dimensions of Community Capacity (Goodman et al., 1998).

These three dimensional measurements of community capacity are synonymous with the system inputs previously described in the Public Health Performance Measures logic model. The dimensional measurement of resources within an organization can be determined by the workforce, the information, the facilities, and the funding that the organization possesses. In the same manner, the dimensional measurement of skills

within an organization can be characterized by the information and the influences within that organization. Finally, the dimensional measurement of social and interorganizational networks can be characterized by the organization and relationships of an organization including the stakeholders that play a vital role in making decisions regarding the resources and the overall organizational structure.

1.4 Current Policies Aimed at Postnatal Women's Care

There are policies that are currently in place that are focused on postnatal women's health and specifically postpartum depression detection and treatment resources. These policies can vary slightly or dramatically based on the entity issuing the policy. One of the goals of this research was to determine if the local policies that are currently in use to diagnose and treat postpartum depression were aligned with the state and county policies. In addition, in instances where policies are not aligned, this research considered recommendations stakeholders may make to address the differences in what is proposed and what is actually being carried out. In order to determine the policies pertaining to postpartum care that are currently in place in the State of Texas as well as in Dallas, Tarrant, and Collin counties, a comparative and critical content analysis of the policies was conducted and results of that analysis can be found below. These policies will be compared to what is in place in the facilities located in the sample population.

1.5 State of Texas Policies on Postnatal Women's Health and Postpartum Depression

In 2016 a new program, which is a consolidation of previous women's health care programs, was introduced in the State of Texas to improve the service and efficiency of

women's health services for clients and providers (HHSC, 2017). The new program, Healthy Texas Women (HTW), is under the direction of the Texas Health and Human Services agency and includes a fee-for service component for some services and a cost reimbursement component for others. This policy outlines specific risk factors for postpartum depression including lack of social support, being of lower socioeconomic status, having a history of depression, and having a history of abuse (HHSC, 2017). The HTW policy also indicates that all new mothers must be screened for postpartum depression and those who have negative screening results should be screened again at a follow-up visit. In order to ensure that all women under the HTW policy are given equivalent care in terms of postpartum depression screening, the policy puts into place a convenient approach to screening which includes allowing the postpartum patient to complete a screening tool while she waits to be seen by a health care provider, measuring that screening tool to assess the patient's risk for postpartum depression, and then following up with a discussion regarding the screening results and additional questions to further evaluate the patient's risk for postpartum depression (HHSC, 2017). The policy also outlines the three screening tools that have been validated for use on postpartum patients, which are the Edinburgh Postnatal Depression Scale, the Patient Health Questionnaire-9, and the Postpartum Depression Screening Scale (HHSC, 2017).

In addition to screening methods, the HTW policy also outlines a treatment plan for patients that are diagnosed with postpartum depression following the intensive screening process. Those patients that present with risk factors that could lead to suicide are to be automatically referred for emergent evaluation and/or hospitalization (HHSC, 2017). Patients that suffer from mild symptoms should be treated with nonpharmalologic

treatments such as cognitive behavioral therapy or the development of a Postpartum Depression Action Plan. After treatment, the patients should be screened again using a screening tool and evaluated for improvement. If there has been no improvement in their condition based on the screening tool score as well as the follow-up evaluation or the condition has worsened, then the patient should be treated with a pharmacological treatment such as an anti-depressant medication. Those patients that require a more intensive form of treatment should be referred to a provider of behavioral health services and the referral options of providers in the area should already be in place (HHSC, 2017).

1.6 Dallas County Policies on Postpartum Depression Resources

Similar to the policies that are outlined by the State of Texas, Dallas County also has policies that are aimed at addressing the rising issue of postpartum depression. The county launched a new program called the Postpartum Depression Program in partnership with Parkland Hospital (the county hospital) that was funded by the state's 1115 waiver. This waiver "integrates behavioral health services into outpatient obstetrics settings to provide increased access to mental health services" (PHHS, pg. 1, 2017). The policy includes some symptoms of postpartum depression such as having other children, lack of social support, and being of a lower socioeconomic status. Women who utilize the Postpartum Depression Program are all screened for postpartum depression at their two-week check-up and the policy indicates the use of the Edinburgh Postpartum Depression Scale (EPDS) as a standardized screening tool (PHHS, 2017). Treatment for postpartum depression under the Postpartum Depression Program can include counseling provided by the Parkland Psychiatric Clinic, pharmacological treatment, and/or hospitalization for

extreme cases. The program also provides additional services such as substance abuse counseling, counseling for domestic violence, and training related to parenting skills.

1.7 Collin County Policies on Postpartum Depression Resources

Although Collin County does have its own health department, it does not have a county hospital like Dallas County and Tarrant County. As a result, it was difficult to pinpoint how Collin County deals with postpartum depression on a county level. Based on conversations with the Collin County Public Health Emergency Preparedness Department, it was ultimately determined that Collin County does not have a distinctive policy for postpartum depression and local health clinics, hospital systems, and nonprofit agencies are expected to follow the guidelines outlined by the policy for the State of Texas.

1.8 Tarrant County Policies on Postpartum Depression Resources

The Tarrant County Public Health Department does not service pregnant women, and refers women to the county hospital, which is John Peter Smith Health Network (JPS). JPS does not necessarily have a policy to which they adhere regarding the diagnosis and treatment of postpartum depression, but they do follow a set of procedures that are outlined to help them streamline the process. According to the JPS procedures some of the symptoms associated with postpartum depression include feeling sad, feeling disconnected from your baby, and having little energy (JPS Health Network, 2017). They suggest that women are treated early in order to have the best chance of recovery and offer therapy and medication as the two common types of treatment, which are dependent

on the severity of the depression. The JPS Health Network also provides the Edinburgh Postnatal Depression Scale as a tool on their website to help women to self-assess their depressive symptoms before women present for care (2017).

1.9 Aim of the Research

This study focused on the capacity of resources available for postpartum depression screening and treatment for women in underserved areas. It was also important for this study to include a dimension that assessed the alignment of the current techniques and resources used at local health clinics, hospital systems, and nonprofit agencies to the policies that are outlined by the State of Texas.. The resources that are made available at the health clinics, hospital systems, and nonprofit agencies found in the underserved area were another area of assessment within this study including the number of referrals from the obstetrician/gynecologist and/or primary care physician and the type of assessment tool used for diagnosis.

Given previous research, it has been justified that there are limited resources available for the diagnosis and treatment of postpartum depression in underserved areas, as well as a lack of extensive knowledge of health care administrators on the symptoms and indicators of postpartum depression including cultural competent perspectives (Beck, 2006; Dennis & Chung Lee, 2006; Doucet et al., 2009; Forman et al., 2007; Halbreich & Karkun, 2006; Howell et al., 2012; Lancaster et al., 2010). It is also apparent that the factors that can contribute to the onset of postpartum depression are more prevalent in minority populations and in those of lower socioeconomic status.

The results of this research are intended to benefit minorities living in underserved communities, leading to improved policies for mental health screenings with state funded insurance or screening mandates for postpartum. This research may also be of interest to scholars and practitioners that are interested in the prevalence of postpartum depression including the associated factors and implications from its diagnosis. Finally, the research may be of importance to those researching health disparities.

Chapter 2

LITERATURE REVIEW

2.1 Peripartum Implications: Social, Psychological, and Cultural Variables

Due to the negative effects that postpartum depression can have on women and infants, it continues to receive a great deal of research and clinical attention that has so far had little to no impact on reducing the postpartum depression rates. It is important to define what the social, psychological, and cultural factors in terms of postpartum depression are and the women who may encounter it. Social factors, as they relate to postpartum depression, include the support that a woman might receive from their spouse, family members, friends, etc. This support can be considered as informational support (such as knowledge or education about something), instrumental support (such as help with a task), or emotional support (such as an expression of care) (Stewart et al., 2003). Psychological constructs that relate to postpartum depression include maternal personality characteristics such as anxiety (O'Hara & Swain, 1996). Cultural factors refer to a set of beliefs, laws, traditions, moral values, and language held in common by a group of people. Each of these factors or construct can play a vital role in the onset of postpartum depression either solo or collectively.

One factor of postpartum depression is the difference in the prevalence rates based on race and ethnicity. In a study conducted by Liu and Tronick using the Pregnancy Risk Assessment Monitoring System (PRAMS), the racial/ethnic disparities that exist in the diagnosis of postpartum depression were examined (2012). The researchers used the PRAMS Survey data from 2004 to 2007 in a population-based study that evaluated the factors associated with sociodemographics, stress experienced by the

mother, education provided regarding depression before, during, and after pregnancy, and diagnosis of either prenatal or postpartum depression (Liu & Tronick, 2012). The study concluded that there are racial/ethnic disparities in postpartum depression and its diagnosis (Liu & Tronick, 2012). Factors related to sociodemographics and stress encountered by the mother contributed to elevated rates in postpartum depression among African-Americans and Latinas compared to Caucasians. However Asian/Pacific Islander women had a decreased rate of speaking to their health care professional about depression, but were 3.2 times more likely to be diagnosed for postpartum depression (Liu & Tronick, 2012). Those women with a history of prenatal depression were also more likely to be diagnosed with postpartum depression. Although the results are significant, the limitations of the study still need to be taken into consideration. The PRAMS data that was used in the study was based on the self-reporting of those individuals participating. This introduces recall bias and may skew the results of the study. Using medical records to corroborate the results would have made the findings more viable. In addition to the recall bias, the lack of a diagnosis of postpartum depression from a physician could be determined by the physicians' inability to be culturally competent and to determine the unique needs of their patients based on their culture. The study concluded that universal postpartum depression screening would not be an adequate measurement tool based on the provider-patient interactions in relation to the lack of cultural competency (Liu & Tronick, 2012). However prenatal depression was proven to be a major indicator of postpartum depression and other postpartum depression indicators vary by race/ethnic group.

In another study conducted as part of the Iowa Barriers to Prenatal Care Project, researchers used a Barriers surveillance questionnaire to determine the rate of depression in mothers with newborns in the years 2001 and 2002 (Segre et al., 2006). The results of the study indicated that even after controlling for sociodemographic variables such as educational level, marital status, age, income, and baby's health, the depression rates among African American mothers was still significantly higher than that of any other race. Since the rates of depression in African American mothers was significantly higher than the Hispanic mothers, and the Hispanic population typically also has similar poor health outcomes as the African American population, the researchers concluded that the breastfeeding and social support were two important indicators for the differences in the depression rates (Segre et al., 2006).

Another factor that can be attributed to postpartum depression found in research studies is the connection between postpartum depression rates and socioeconomic status. There was a rapid socioeconomic transition in Hungary after their communist era in the 1990s. As a result, researchers wanted to determine the effects of the current state of the economic crisis with the prevalence of postpartum depression. A total of 1,030 mothers were used to screen for depressive symptoms 3-26 weeks post-partum (Nagy et al., 2010). The study concluded that the depression of the mother during pregnancy was the greatest predictor of postpartum depression, but housing conditions, marital relationship status, and family history of alcohol problems were also predictors of postpartum depression (Nagy et al., 2010). Based on the results, there is a need to investigate socio-cultural factors when determining contributors to postpartum depression.

In another study conducted in Iowa, researchers wanted to investigate the prevalence of postpartum depression in women of varying social status (Segre et al., 2007). The researchers used a demographic interview and the Inventory to Diagnose Depression questionnaire to determine the relationship between postpartum depression and demographic variables in mothers with newborns. The results of the study indicated that having “an annual income of less than \$20,000, less than a college education, low occupational prestige, young age, single marital status, and multiple offspring,” were all significant demographic indicators of postpartum depression (Segre et al., pg. 318, 2007). Although teenage mothers were not included in this sample (and are also at a high risk of postpartum depression) the researchers contended that based on the results, more programs for screening and treatment of postpartum depression aimed at those women that are of lower socioeconomic status are imperative in improving the overall postpartum depression rates.

Having a history of depression or anxiety can also be a peripartum implication for postpartum depression. In a systematic evidence-based review of the literature on postpartum depression and its risk factors, researchers determined that anxiety and/or depression during pregnancy, lack of social support, a previous history of psychiatric illness, and having stressful life events during pregnancy and immediately following the birth were the strongest predictors of postpartum depression (Robertson et al., 2004). A troubled marital relationship was also determined to be a moderate indicator for postpartum depression intensified by a lack of social support (Robertson et al., 2004). In a similar study, women that exhibited postpartum depression symptoms were more likely to be unmarried and lack social support (Stowe et al., 2004).

2.2 Screening for Postpartum Depression

Due to the fact that there are a number of different social, psychological and cultural factors that can be attributed to postpartum depression, it is important that the screening practices that are most commonly associated with the mental illness are examined. There are a variety of different screening methods that have been used in order to detect postpartum depression and although their self-reporting techniques are not meant to serve as a conduit for postpartum depression diagnosis, they can identify women that might be at risk for postpartum depression and warrant further evaluation by trained professionals. These screening techniques include a self-report questionnaire, a clinical interview, and a general practitioner or psychiatrist's diagnosis (Leahy-Warren & McCarthy, 2007). Three of the most common self-report questionnaires used to detect the risk for postpartum depression are The Edinburgh Postnatal Depression Scale (EPDS), The Beck Depression Inventory (BDI), and the Postpartum Depression Screening Scale (PDSS) (Boyd et al., 2005). While there are a number of screening tests that can be used to detect postpartum depression, there continues to be a large variation in the measurements used which can account for the large prevalence range both within and across countries. Other factors that can contribute to the large prevalence range include sampling methodologies, sociodemographic factors, cultural diversity, parity, and the timescale of the study (Leahy-Warren & McCarthy, 2007).

Table 1. Depression Screening Tools

Screening Tool	Number of Items	Time to Complete	Sensitivity/specificity	Spanish Available
Edinburgh Postnatal Depression Scale (EPDS)	10	Less than 5 min	Sensitivity: 59–100% Specificity: 49–100%	Yes
Postpartum Depression Screening Scale (PDSS)	35	5–10 min	Sensitivity: 91–94% Specificity: 72–98%	Yes
Patient Health Questionnaire-9 (PHQ-9)	9	Less than 5 min	Sensitivity: 75% Specificity: 90%	Yes
Beck Depression Inventory (BDI)	21	5–10 min	Sensitivity: 47.6–82% Specificity: 85.9–89%	Yes
Beck Depression Inventory-II (BDI-II)	21	5–10 min	Sensitivity: 56–57% Specificity: 97–100%	Yes
Center for Epidemiologic Studies Depression Scale (CES-D)	20	5–10 min	Sensitivity: 60% Specificity: 92%	Yes
Zung Self-Rating Depression Scale (Zung SDS)	20	5–10 min	Sensitivity: 45–89% Specificity: 77–88%	No

Data from Boyd RC, Le HN, Somberg R. Review of screening instruments for postpartum depression. *Arch Womens Ment Health* 2005;8:141–53; Sharp LK, Lipsky MS. Screening for depression across the lifespan: a review of measures for use in primary care settings. *Am Fam Physician* 2002;66:1001–8; and Spitzer RL, Kroenke K, Williams JB. Validation and utility of a self-report version of PRIME-MD: the PHQ primary care study. *Primary Care Evaluation of Mental Disorders. Patient Health Questionnaire. JAMA* 1999;282:1737–44.

Figure 2-1 Postpartum Depression Screening Tools

One research article focused on reviewing the screening instruments for postpartum depression. The authors used published psychometric data including the reliability, sensitivity, specificity, positive predictive value, and concurrent validity of each self-report measurement tool to determine their effectiveness for diagnosing postpartum depression (Boyd et al., 2005). The results of the research determined that the Edinburgh Postnatal Depression Scale was the most widely used measurement tool and exhibited moderate soundness in the psychometric data measures including internal consistency and reliability. The authors concluded that more research needs to be conducted on the screening instruments available for postpartum depression and a

standardized form of measurement should be adopted (Boyd et al., 2005). This article is important in trying to prove the necessity of a standard measurement tool for postpartum depression and the need for detection. Although there are a number of screening tools that can be used, their effectiveness has not been measured in relation to the population being studied or the effectiveness of the health care professional that is providing the measurement. In this research study, I will assess not only the resources that are being provided for women in underserved areas, but also the type of measurement tool that is being used.

2.3 Postpartum Depression Diagnosis

The classification and the clinical presentation of postpartum depression, that in turn would lead to its diagnosis, has been under debate for a number of years (Doucet et al., 2009). While the mental illness is recognized as a public health concern and there has been abundant research regarding the need for preventative measures as well as treatments to address this epidemic, postpartum depression is not classified as a distinct entity. In fact the two psychiatric classification systems that are currently used, the Diagnostic and Statistical Manual of Mental Disorders (APA, 2014) and the International Classification of Diseases (WHO, 2016), use a postpartum onset specifier instead of classifying postpartum depression as its own diagnosis. The postpartum onset specifier is distinguished by determining if the mother experienced a psychotic disorder four weeks following delivering for the DSM or six weeks following delivery for the ICD-10 (Doucet et al., 2009), and is added to a diagnosis of Major Depression (Godderis, 2013).

How do the restrictions placed on the diagnosis of postpartum depression based on these standards affect a mother that does not experience the symptoms of postpartum depression until six months or a year after delivery? With all of the information on postpartum depression, including its dire consequences, why would it not be seen as its own distinctive diagnosis? These questions and many more have prompted a number of researchers to attempt to have postpartum depression added as its own distinct diagnosis, but they are met with opposition due to the difficulty in diagnosing the disease (Godderis, 2013). The DSM-5 does not require a psychotic component for other depressive disorder diagnoses, and requiring such extreme symptoms does not align with the spectrum conceptualization of other researchers like Beck and O'Hara.

2.4 Postpartum Depression Treatment

As a result of the many contributing factors associated with postpartum depression, it is imperative that initiatives and interventions are implemented to address it. Similar to there being a number of methods that are used to diagnose postpartum depression, there are also a number of methods that have been attempted and/or implemented in order to treat the growing epidemic of postpartum depression. Four major treatment approaches that have been tested include general counseling, interpersonal psychotherapy, cognitive behavior therapy (CBT), and psychodynamic therapy (O'Hara & McCabe, 2013).

One intervention used a behavioral educational model to target the factors that were most commonly associated with postpartum depression symptoms. Researchers conducted a randomized controlled trial using 540 predominately white, high-income

mothers (Howell et al., 2013). The mothers received multi-step intervention that equipped and educated them on the variable factors of postpartum depression, social support, and heightened management abilities. Although the results of the study indicated that the behavioral educational model did not prove to make a difference in decreasing the depression rates based on the Edinburgh Postnatal Depression Scale, they did further illustrate the health disparity surrounding postpartum depression. The results of the study were compared to a previous study with the same behavioral educational model, but with a population of low-income Black and Latina women. This study showed that the depression rates were decreased by 33% (Howell et al., 2013). This behavioral educational model might be useful in reducing the health disparities related to postpartum depression, but could not be a universal model for reducing the postpartum depression rates. Although mothers that are diagnosed with postpartum depression often prefer psychotherapy for treatment, pharmacotherapy with antidepressant medication is the most common treatment (O'Hara & McCabe, 2013).

Another research article focused on the barriers to seeking assistance and the partialities for treatment that are associated with the mental illness of postpartum depression. Dennis and Chung-Lee conducted a qualitative systematic review of the literature to identify perceived maternal barriers to postpartum depression treatment along with maternal preferences for treatment (2006). The authors concluded that one of the common help-seeking barriers was the women's inability to divulge their feelings, which was often reinforced by the hesitancy of the family members and the health professionals to respond to the needs of the mother. Another help-seeking barrier was the lack of knowledge regarding postpartum depression. There were also a number of health service

barriers that were acknowledged. Many of the deficiencies related to health services in underserved areas can be attributed to culturally insensitive services and a lack of coordinated services.

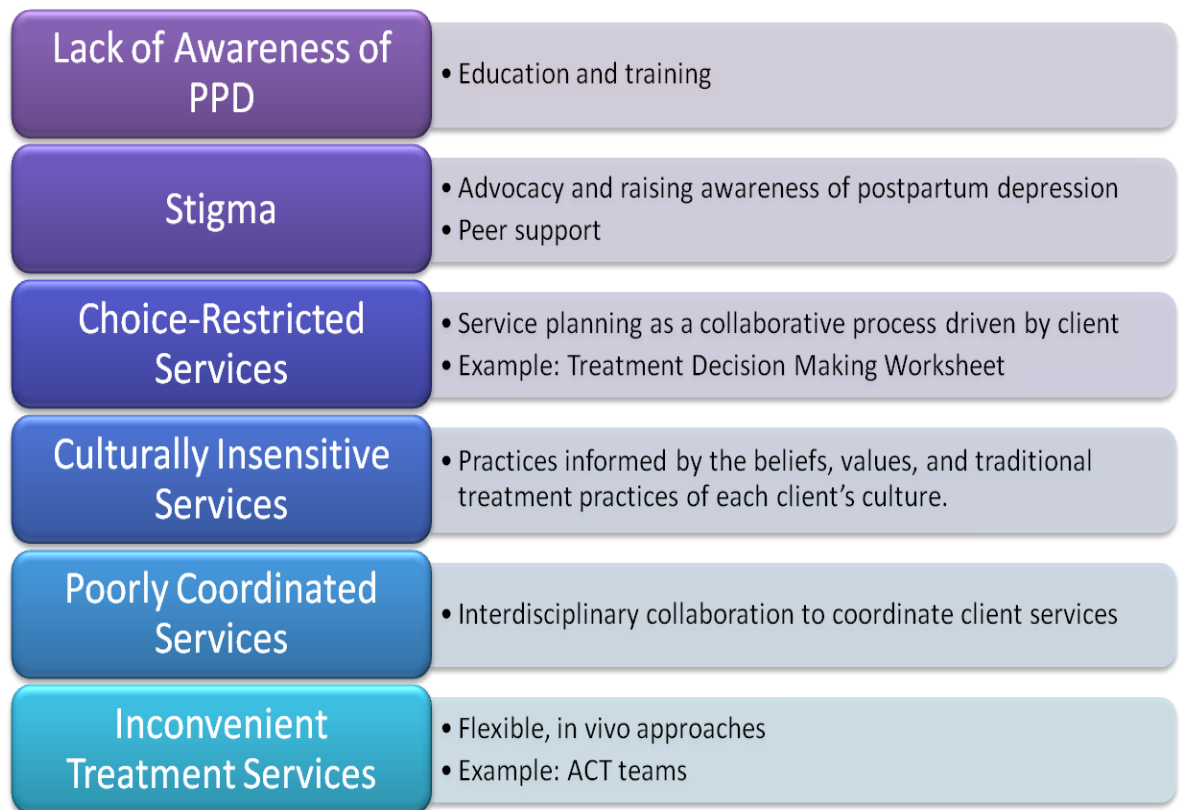


Figure 2-2 Barriers to Postpartum Depression Treatment (Johnson, 2011)

2.5 Social Resilience

As previously illustrated, the presence of social support can play a vital role in the prevention of postpartum depression. Social support can have a very broad meaning, but overall it is the attachment between individuals or groups of individuals that validate a person's identity through feedback regarding an individual's behavior, assisting that individual during emotional difficulty, providing necessary supplies, and sharing in tasks

that assist an individual in their everyday life (Israel, 1982). In one research study assessing the rates of postpartum depression in minority populations, the researchers indicated that when they controlled for mitigating variables in Hispanic and African American mothers such as socioeconomic status, education, marital status, and age, the rate of postpartum depression amongst African American women was still alarmingly higher than that of Hispanic women, which they linked to an increase of social support in Hispanic women (Segre et al., 2006).

Although social support does understandable influence the risk and rates of postpartum depression, social support is not synonymous with social networks. While social support focuses on interpersonal relationships, social networks focus on the ties between different organizations in relation to the surrounding environment and other organizations (Pershing & Austin, 2015). The congregate influence of social support can in turn form a social network, but all of the interactions that can be present within a social network do not necessarily provide social support (Israel, 1982). Having a limited social network, a lack of adequate social support, and few close relationships have all been linked to symptoms of depression (Kawachi & Berkman, 2001). Social networks have been shown in the research to have a direct influence on mental health and to assist in buffering psychological stress (Greenblatt et al., 1982). Surkan et al. (2006) took a closer look at the effects of social support and networks on postpartum depression rates in an urban setting. Their results indicated that women that lacked a social network, including social support, were more likely to suffer from postpartum depression than women that had at a social network and at least two forms of social support during and after their pregnancy (Surkan et al., 2006).

The following figure indicates one model in which social relationships influence health outcomes called the main effect model (Cohen & Wills, 1985). This model helps to illustrate multiple pathways in which social networks and social support can influence an individual's mental health and in turn their health outcomes. Having a social network can help to introduce and promote positive health behaviors in an individual by simply introducing them to education and knowledge that may lead to health prevention or diagnosis, or by providing them with reinforcement or an increased desire to want to participate in health behaviors that will be beneficial in reducing poor health outcomes (Kawachi & Berkman, 2001).

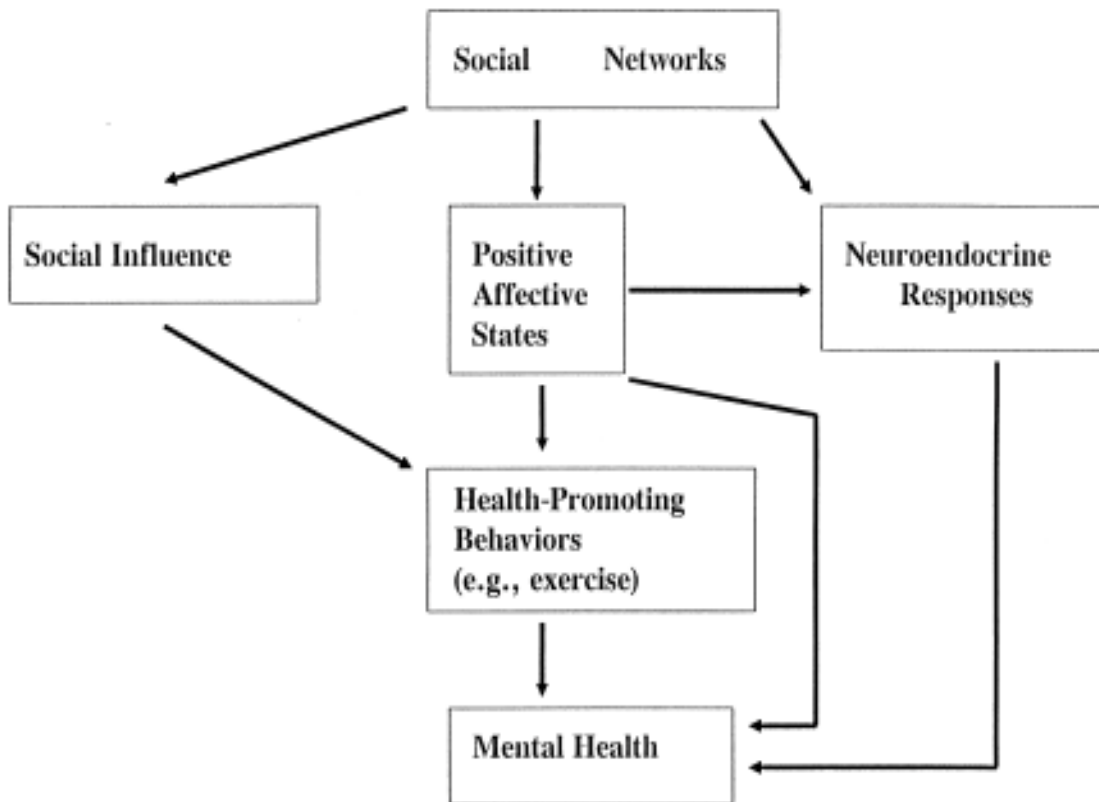


Figure 2-3 Main Effect Model of Social Ties and Mental Health (Cohen & Wills, 1985)

Given the fact that social networks, including social support, can play such a vital role in reducing the psychological stress in an individual it is imperative that we assess the social networks available to women in underserved communities to determine if the lack of a social network or the inadequacies in an existing social network could be an influence on the postpartum depression rates in the area.

2.6 Stakeholder Theory

Stakeholder Theory is a concept introduced by Freeman (2010) that argues that stakeholders can be anyone that has interest or influence in an organization including people, organizations themselves, or groups. These influences have the power to change an organization's behavior and in essence could have the power to change organizational protocols and/or policies related to the practices of the organization. Stakeholder theory has also been intended to explain the structure of an organization including its mission, values, and overall operational structure (Donaldson & Preston, 1995). Stakeholder theory has been described as having three different uses including descriptive/empirical, instrumental, and normative (Donaldson & Preston, 1995). Although all three methods could be used simultaneously, for the purposes of this research the focus will be on the instrumental aspect of stakeholder theory which includes the ability to identify the networks or the connections between different groups or stakeholders used to achieve specific methods, and the normative approach which is used to interpret the function of an organization and includes the analysis and identification of the vision and mission of an organization (Donaldson & Preston, 1995). The stakeholders identified within the

research will be important because stakeholders have the ability to limit the capacity of an organization based on their views or impact on the resources and organizational structure provided.

In Freeman's (2010) seminal work, he suggested a stakeholder analysis process in which the external environment and resources of an organization are examined in relation to the role of the stakeholders to determine their importance in making decisions for the organization as a whole. This stakeholder analysis is proposed of four distinct parts: identifying the stakeholders, identifying how the stakeholders influence the organization, identifying what the organization may need from each stakeholder, and the identification of the criteria that the stakeholders use to evaluate the performance of an organization (Bryson, 1988).

For the purposes of this research study, the potential stakeholders related to the resources for postpartum depression were identified by previous literature and then cross referenced with the information obtained on the qualitative interviews conducted with the administrators of the hospital systems, health care clinics, and nonprofit agencies. The following illustration demonstrates a "hub-and-spoke" depiction that is used to simplify stakeholder categories found in the literature that may potentially play a role in influencing the organizational structure and/or policies (Schiller et al., 2013). In addition to the ones listed in the illustration, the literature also indicates that family support and health insurance providers play a vital role in policies and decisions related to postpartum depression resources.

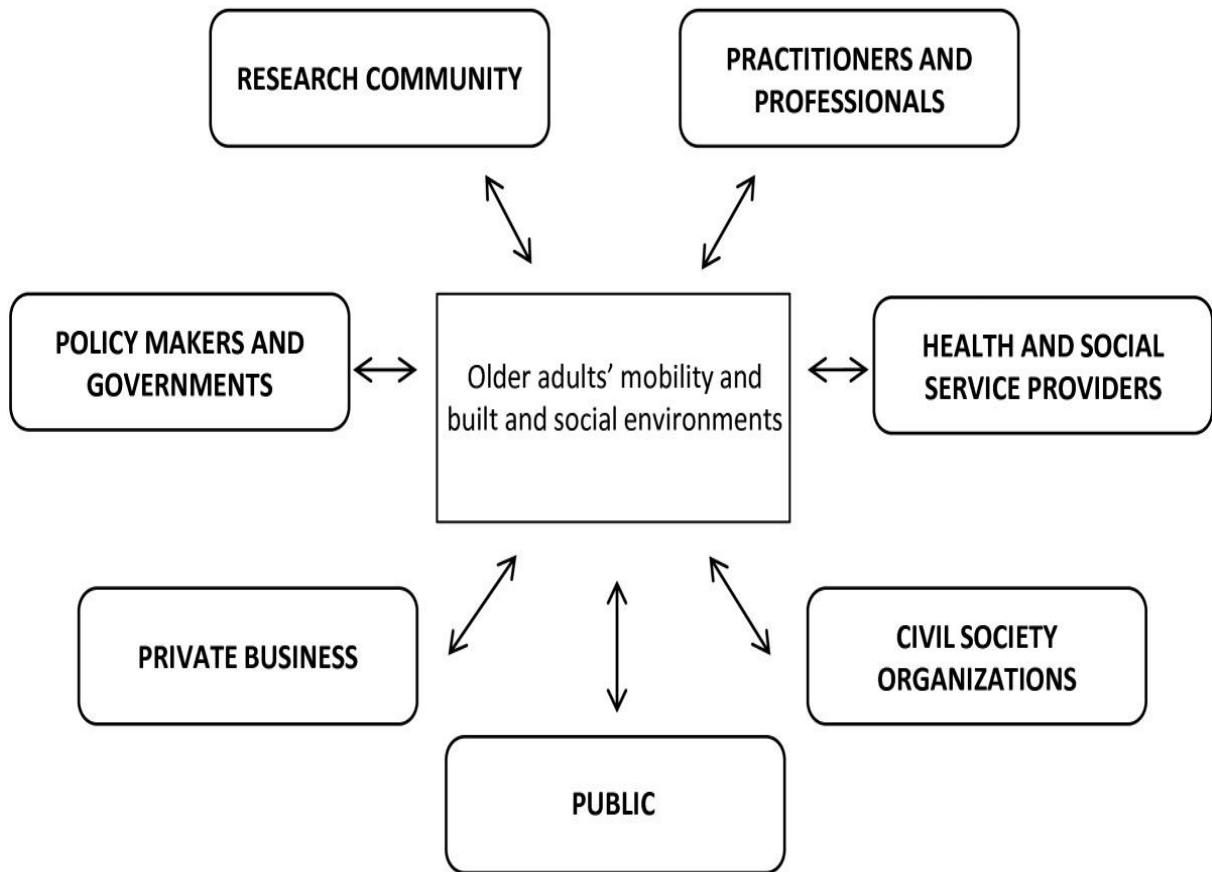


Figure 2-4 Hub-and-Spoke Illustration of Potential Stakeholder Categories (Schiller et al., 2013)

Chapter 3

METHODOLOGY

3.1 Study Design

This research study aimed to answer questions related to the capacity of resources available to women to diagnose and/or treat postpartum depression. The primary question to be addressed was if there are resources such as support groups, culturally competent services, psychiatric services, referral services, access to medication, case workers, and additional post-natal follow-up care to diagnose and/or treat postpartum depression for minority women and women who live in medically underserved areas. In addition to the availability of the resources, the study also helped to determine if the resources that are made available to postpartum women, align with the policies set by the state and county. There are a number of characteristics that can attribute to the onset of postpartum depression including race, socioeconomic status, marital status, age, an unintended pregnancy, a history of depression, prenatal care, and other social and psychological variables. Although research has shown that other risky behaviors such as drug use, smoking and alcohol use are also important factors in a postpartum depression diagnosis, those factors will not be considered in this study due to the study focusing on the organizational lens of the resources provided and not being based on the individual views of the patients (Stewart et al., 2003).

While it is apparent that race, socioeconomic status, marital status, prenatal care, and a history of depression would play a vital role in determining the risk of a woman developing postpartum depression, that risk can also be exacerbated by a lack of social support, lack of resources, and a lack of culturally competent health care services

(Cutrona & Troutman, 1986; Dennis & Chung-Lee, 2006; Gjerdingen & Yawn 2007).

Although postpartum depression rates are higher in minority women, research has strong evidence that women in underserved communities also have a higher rate of postpartum depression (Raymond et al., 2014). This research study was an attempt to better understand the relationships that may exist between the variables that can contribute to postpartum depression and the resources that are available to screen and diagnose it. In the process of assessing those variables, an attempt was made to determine if social support/social networks or the lack thereof and the presence of culturally competent practices, play a significant role in the prevalence of postpartum depression rates in minority women.

This research study was comprised of two methods. The first method consisted of a qualitative content analysis from semi-structured interviews conducted with health care administrators, physicians, and nonprofit administrators whose services include prenatal and postnatal care in both affluent and underserved communities. This analysis focused on the different variables including education status, race/ethnicity, socioeconomic status, marital status, and a history of depression that can contribute to postpartum depression and their potential influence as barriers to the diagnosis and treatment of postpartum depression. The variables that were used in this research study were based on the barriers to diagnosis and treatment of postpartum depression that was found in the literature. The responses from the interviews assisted in the instrumental and comparative case study approach of comparing the data from an affluent community to that of an underserved community. Using this case study approach was an attempt to highlight the gaps in postpartum depression that are available in an affluent community in comparison to an

underserved one. The interviews with the administrators from the health clinics, hospital systems, and nonprofit agencies were conducted between January 2018 and May 2018 with ten administrators in both the affluent and underserved communities. Each interview lasted between one to two hours. The interviews were recorded and detailed notes were taken by the researcher during each interview. The interviews were then transcribed and analyzed using the themes and subthemes found in the literature.

The other method in this research study also utilized information from the interviews to conduct a stakeholder analysis based on the responses of the influential people, organizations, and groups that could help to make policy and/or resource decisions in regards to postpartum depression. There are three steps that can be used in conducting a stakeholder analysis (Varasovszky & Brugha, 2000). The first step is to identify the potential stakeholders, which will be determined from the answers of the administrators that participate in the interviews. The second step is to prioritize the stakeholders who will also be taken from the information provided from the interviews and the final step is understand the key stakeholders. This can be done by analyzing the mission and values of the organizations that are interviewed as well as obtaining their feedback on other organizations or groups that could play a vital role in changing policies related to postnatal women's care in their community. There were some limitations regarding the stakeholder analysis in terms of direct communication to outside entities such as insurance agencies and family support systems, but this aspect of the analysis can definitely be revisited in future research. The findings regarding the stakeholders as well as their interest in postnatal women's care and their degree of power was put into a

stakeholder analysis chart and used as a means to help to make the necessary adjustments to policies related to postnatal women's care.

3.2 Sample Population

The underserved communities used for the purpose of this research were communities in which the annual median salary of the population is 120% of the federal poverty level and that can be classified as Medically Underserved Areas/Populations (MUA) by the Health Resources and Services Administration (HRSA). A MUA is designated by HRSA due to the fact that it has a high infant mortality rate, too few primary care providers, and high poverty and/or high elderly population (HRSA, 2014). For the purpose of this research study, the underserved communities were located in Dallas, Tarrant, and Collin counties and the interviews were conducted with the administrators from the hospital systems, clinics, and nonprofits that offer prenatal and postnatal services in those areas. The affluent communities were determined by having a median annual salary of over \$100,000. For the purpose of this research study, the affluent communities were located in Dallas, Tarrant, and Collin counties and the interviews were conducted on hospital administrators in hospital systems, clinics, and nonprofits that offer prenatal and postnatal services in those areas. A stratified random approach was done using an internet search to locate specific clinics, hospital systems, and nonprofit agencies in the target areas based on the guidelines described above. Stratified random sampling is a process in which the population or the community is divided into smaller groups or subgroups based on the criteria used for the sample population. In this case, some of the sample populations were located in the same city,

but based on the criteria used to determine the affluent and the underserved communities, the city was divided into groups and the clinics, hospital systems, and nonprofit agencies were then selected based on the group that they identified with. After the clinics, hospital systems, and nonprofit agencies were identified, they were then contacted to inquire about their willingness to participate in the study.

Sample Population

County	Underserved	Affluent
Dallas	South Dallas	Preston Hollow
Dallas	Oak Cliff	Highland Park
Tarrant	South East Fort Worth	Southlake
Tarrant	Diamond Hill	Mansfield
Collin	East Plano	West Plano

3.3 Qualitative Interviews

For the purpose of this study, a case study approach and a content analysis of the interviews were used in order to determine the resources that are available to detect as well as treat those women that suffer from postpartum depression and to determine if the current local policies align with State and county policies. A case study is an illustration that is used to inquire further about your research question (Denzin & Lincoln, 2011). The overarching case study approach that was used is identified as instrumental as well as collective or comparative. The case study was instrumental because it can be used as an

instrument to understand the broader issue of postpartum depression that is beyond the three counties used for this research, which can also make the results of the research generalizable (Stake, 2008). The case study was also collective or comparative because it compares the results of two types of communities (affluent and underserved), or cases, together to understand the broader issues and compares the results of the postpartum depression resources (Stake, 2008). By using this case study approach the differences in the availability and the quality of postpartum depression resources in underserved communities were highlighted.

The interviews were conducted on administrators of health clinics, private doctors' offices, and hospital systems within both the affluent and underserved communities. Although additional research should be conducted on the individual women that obtain the services from these health facilities to determine their level of knowledge of postpartum depression and the resources provided to them, this research study focuses on the resources available and administered to prenatal and postnatal women as determined by the health care administrators, physicians, and nonprofit administrators. The interviews included questions regarding the resources available for postpartum depression including the type of screening test used, when the screening is administered, what symptoms are looked for during the evaluation, is there a follow-up evaluation 6 months after birth and even a year after birth, are there significant differences in the screening offered based on race/ethnicity, and what treatment options are available (Appendix A). The interview questions were determined by reviewing the barriers to diagnosis and treatment from the literature and they also include questions adapted from the literature related to social networks and stakeholder theory (Dennis & Chung-Lee,

2006, Kawachi & Berkman, 2001, Schiller et al., 2013). The recipients of the interview invitations were determined by an Internet search of the administrators from hospitals systems, clinics, and nonprofit agencies that offer prenatal and postnatal services in the specified areas.

After obtaining the responses from the interviews, a content analysis was conducted using NVivo11 software to determine if some of the trends and/or themes from the interviews were synonymous with the trends and/or themes from the literature. There was also special attention paid to those responses that did not follow the trends that were found in the literature. A content analysis is an approach in which the context, meaning, structure, and content of text is analyzed in a manner in which you understand or interpret that data (Prior, 2008). The interpretation of the data is determined by the epistemological stance and positionality of the researcher and can be contrary to someone else's interpretation of the same data. The content analysis assisted in illustrating the postpartum depression resources that are available in the communities, determining the availability and the quality of those resources through the limited lens of the administrators, determining the vision and mission of the organization, and helping to pinpoint the stakeholders that would ultimately be influential in making decisions regarding resources and policies related to postpartum depression. The interviews were also instrumental in assessing the capacity of postpartum depression resources in these communities by addressing the skills of the health professionals as they relate to diagnosing postpartum depressions as well as their culturally competent care, reviewing the resources that are available by determining the screening test availability and the

referral and treatment options, and by assessing the social networks that might be present and their influence on the overall performance of the organization.

Themes and Subthemes Used for the Content Analysis Fig. 3-1

Theme	Description	Subthemes
Resources	Measured by the access to internal and external resources in a community, communication channels and referral services offered within and outside the community.	<ul style="list-style-type: none"> • Resources for screening • Frequency and follow-up of screening • Access to resources to treat postpartum depression • Funding
Skills	Measured by the demographic makeup of the staff because it aids in improving cultural competency, the ability of the staff to distinguish the signs and symptoms of postpartum depression, the use of diversity and/or compliance training, and the recognition of barriers to the diagnosis and treatment of postpartum depression.	<ul style="list-style-type: none"> • Demographic makeup of the staff • Distinguishing symptoms of postpartum depression • Diversity and compliance training • Barriers to the diagnosis and treatment of postpartum depression
Social and Interorganizational Networks	Measured by the referral of patients/clients to outside entities for treatment, and the social networks that are deemed beneficial for the facility and/or the patients.	<ul style="list-style-type: none"> • Referral of patients to outside entities • Beneficial social networks
Social, Cultural, and Psychological Variables	Measured by the most common social, cultural, and psychological variables of the patients through the lens of the administrators. Social variables included social support, socioeconomic status, employment status, educational attainment, and marital status. Cultural variables included race/ethnicity. Psychological variables included previous mental health status.	<ul style="list-style-type: none"> • Social: Social support, SES, employment status, educational attainment, marital status • Cultural: Race/ethnicity • Psychological: Previous mental health status
Alignment with State and/or Local Policies	Facility procedures and policies were compared to county policies and also compared to policies for the State of Texas	<ul style="list-style-type: none"> • State of Texas • Dallas County • Collin County • Tarrant County • Facilities
Stakeholder Analysis	Measured by the comments from the administrators in the interviews and their contribution was also determined by the administrators and by reviewing the overall purpose of the stakeholders in conjunction with the overall mission and values of the facilities within the sample population	<ul style="list-style-type: none"> • Impact of PPD rates on them • Influence on PPD policies • Contribution • Blockage • Engagement

3.4 Qualitative Analysis

The data obtained from the interviews was analyzed using NVivo11 software to determine the types of resources that are available to diagnose and treat postpartum depression in the sample population areas. The resources analyzed during the interviews included questions related to the screening tests used, cultural competency, recognition of postpartum depression resources, treatment options, and stakeholders. A code book was developed using the themes and subthemes found from the literature on the barriers to the diagnosis and treatment of postpartum depression, potential stakeholders, and current policies in the State of Texas as well as for Dallas, Tarrant, and Collin Counties. Each theme and subtheme from the codebook was developed into a node within the software and the responses were coded based on the nodes that the answers from the administrators correlated with. The responses from the interviews were manually coded using the Nvivo11 software. The results from the interviews in the affluent areas were then compared to the resources in the underserved areas to determine if there are significant differences in the resources provided which may attribute to the gaps in postpartum depression rates based on the demographic areas. The resources available and the policies followed were also compared to the State of Texas Policies as well as the policies used within the counties to determine if the local resources and the protocols that are offered and/or followed within the different areas actually align with State and County policies for postpartum depression.

Based on the literature, an initial list of stakeholders included the research community, practitioners and professionals, policy makers and governments, health and social service providers, private businesses, the public, civil society organizations,

community members, hospital systems, clinics, and nonprofit agencies. A content analysis was also conducted on the questions in the interviews related to the stakeholders to determine if there were additional stakeholders that should be added to the initial list, and if some of the stakeholders from the initial list should be removed based on their lack of influence in making decisions regarding postpartum depression resources. The list of stakeholders also helped to determine if the stakeholders play a role in the diminished capacity of an organization and what steps could be taken to help to increase the capacity of the organization and therefore improve health outcomes and customer satisfaction.

The content analysis of the interviews also helped to assess the capacity of the resources available in the sample population by reviewing questions aimed at the dimensions of skills, resources, and social and interorganizational networks.

3.5 Epistemological Stance

The paradigm or theme of knowledge used as a basis for this research is critical and can be viewed in both the feminist as well as the race context of epistemological views. The critical paradigm focuses on producing information that can be aimed at social change or advocacy (Denzin & Lincoln, 2011). It is also geared towards research on social structures versus power and control, which is produced to reduce or remove oppression through empowerment (Peters & Jarvis, 1991). This critical view attempts to develop a change that will create equality for all based on the subjects being researched. The subjects being researched in this case are minority women, and minority women can be seen as being oppressed based on their gender as well as their race.

The critical feminist epistemology centers on the need to create change for those individuals that are seen as oppressed due to either cultural, social, gender, racial or economic differences from those that are in power (Denzin & Lincoln, 2011). The feminist approach is also aimed at “replace[ing] models of control and domination with those of connection and nurturing” (Sprague & Kobrynowicz, 1999, pg. 32). This means that it is important for the researcher to have a connection with the research subjects in order to produce richer data and a better understanding of the research (Sprague & Kobrynowicz, 1999). This point of view was useful to help construct change in the policies that are formulated for these minority women in the realm of postpartum depression screening and treatment.

Chapter 4

RESULTS

4.1 Overview of Results Format

The purpose of this study was to examine the resources that are available to women in underserved communities to detect and treat postpartum depression. This examination of the resources was conducted by taking an in depth assessment of the capacity of those resources as a means to measure the ability of the facilities offering both prenatal and postnatal care to women. This measure included the ability of the facilities to provide essential resources for postpartum depression in underserved communities. The first three chapters of this dissertation introduced the problem surrounding postpartum depression and the implications that the social, cultural, and psychological variables can have on women, introduced the logic model that was used to measure the capacity of resources in hospital, clinical, and nonprofit facilities offering both prenatal and postnatal care to women, examined the current policies that are aimed at postnatal women's care in the State of Texas as well as in three prominent counties in the State of Texas, reviewed the significance of social support and cultural competency as influential factors for postpartum depression, and introduced stakeholder theory as a conceptual framework that can be used to assist with the necessary alterations of policies to make an impact to postpartum depression rates. This chapter will now focus on the results that emerged from the interviews that were conducted and from the data that was obtained and analyzed using the capacity logic model and the conceptual framework of stakeholder theory.

A qualitative study was conducted using both a case study and content analysis methodology with data obtained from semi-structured interviews of administrators from hospital, clinical, and nonprofit facilities that offer prenatal and/or postnatal services within the sample population areas. Although the type and general area of the facilities were used as a point of analysis and discussion, the name of the facilities as well as the administrators were omitted from the results in order to ensure that the identities were kept private. The results will be presented in a comparative case study fashion in which the results from the affluent communities were compared to those of the underserved communities. Implications regarding the postpartum depression practices and policies based on the county will be discussed in the discussion section of this paper. The findings from the stakeholder analysis will also be presented in this results section. All of results that are presented served to answer if there are resources to diagnose and treat postpartum depression for women in underserved communities and to also determine if the policies and resources that are available to these women align with the policies and resources that are to be made available according to state and local policies related to postnatal women's health.

4.2 Summary of the Sample Population Interviewed

The sample population for this study included administrators from underserved as well as affluent communities in Tarrant, Dallas, and Collin Counties. Within the underserved communities, six administrators were interviewed from the three counties including administrators employed within hospital systems, private clinics, and nonprofit agencies. Within the affluent community, four administrators were interviewed from the

three counties including administrators employed within hospital systems and private clinics. An administrator from a nonprofit agency was not interviewed within the affluent communities because a nonprofit agency offering prenatal and/or postnatal care was not identified within the affluent communities. All of the administrators were in a role within their facility to be able to answer pertinent questions in regards to the care provided by their facility as well as the protocols that are followed within their organization.

Sample Population Interviews		
Type of Facility	Type of Community	
	Underserved	Affluent
Hospital System	2	2
Health care Clinic	2	2
Nonprofit Organization	2	0

Figure 4-1 Sample Population Breakdown

4.3 Measuring the Capacity of Postpartum Depression Resources

As mentioned in a previous section, there are various working definitions and conceptual frameworks in relation to the measure of organizational capacity. For the purpose of this research study, I elected to focus on the dimensions of capacity that included skills, resources, and social and interorganizational networks. These three dimensional measurements of organizational capacity are synonymous with the system inputs in the Public Health Performance Logic model described in an earlier section (Figure 1-2). The capacity measurement of an organization in terms of resources was measured by the type of workforce and/or facility, the information or tangible resources

that are provided at the facility, and the type of funding options for treatment that are offered at the facility. The capacity measurement of an organization in terms of skills was measured by the demographic makeup of the staff, the training opportunities available to the staff, the ability to network with other referral sources, and their ability to recognize and alleviate barriers to treatment. The capacity measurement of an organization in terms of social and interorganizational networks was measured by the referral sources of the facility, and the determination of which social networks are most beneficial to patients or to the organization. The following sections will illustrate which interview questions were used to measure the capacity of resources for organizations in affluent as well as underserved communities and the responses from the administrators in those facilities. The responses are organized into the themes that were used as capacity measurements (skills, resources, and interorganizational networks) and will also include some subthemes that were discovered when analyzing the data.

4.4 Resources

The measurement of resources in terms of capacity was measured by the access to internal and external resources in a community, communication channels and referral services offered within and outside the community, the ability to build a level of cooperation amongst other community organizations, and funding opportunities.

Resources for Screening

All of the facilities that were interviewed were chosen because they offer prenatal and/or postnatal services in their community. Most of the participants in the interviews depicted a pertinent need for resources aimed at diagnosing and treating postpartum depression, but the variation of those resources differed based on the location of the facility. In the underserved communities all of the facilities indicated that they use a form of the Edinburgh Postnatal Depression Scale as their standard screening tool, although the administrators did not know the reasoning behind using this tool opposed to other ones that are available. One of the administrators indicated that the “screening tool that we use for postpartum depression is quick and easy because if we were to try to give our patients one that was more in depth then we would have less chance of them actually completing it with real true answers.”

The resources for postpartum depression screening in the affluent communities were much different. In the affluent community, the postpartum depression screening tool is given to the mother at the pediatrician’s office when going in for the baby’s well check visit and not at the obstetrician’s office. One of the administrators in the affluent community commented that “although we give our patients literature on postpartum depression during their prenatal period, we typically do not administer the screening test unless we see a reason to. That is typically done in the pediatrician’s offices. If the mother is showing any symptoms of depression during their well visit then we can refer them to someone to talk to, but it is not a standard practice to administer the screening test to every patient.”

Frequency and Follow-up of Screening

Similar to the availability of the screening tool, the frequency of screening for postpartum depression differed based on the type of community the facility was located in. In the underserved communities the facilities typically screen for postpartum depression only at the 6-week check-up unless there has been previous history of depression from the patient. If the woman is using the services of a nonprofit agency they are offered the screening up to a year after birth through that facility. One of the nonprofit agency administrators indicated that “part of our services include postpartum depression screening so we offer that screening anytime a client comes in for a visit. It is a quick and easy way to determine if our client needs additional assistance in another area.”

The frequency of screening in the affluent communities was harder to determine since the screening is typically conducted at the pediatrician’s office and not at the facilities that were included in the interview sample population. However, the women that do exhibit initial signs or symptoms of postpartum depression in their well visit are flagged to be screened at subsequent visits up to a year after birth. One of the administrators at a clinic in an affluent community stated “the patients that they see normally tell them if they are having any problems with their mental health so then we have a chance to refer them to a mental health professional if we need to. There is also a ton of literature in the waiting room, on the website, and in the patient’s rooms on a number of topics including postpartum depression. The good thing is that we have a great relationship with a mental health professional that is literally next door to our office, so if we need immediate help our patients have access to it.”

Access to Resources to Treat Postpartum Depression

The access to resources addressed in the interviews refers to the treatment options that are available at the facility as well as the preferred treatment option at the facility. In the underserved communities, treatment options were not available for patients at the facility, but there were options for the patients to get treatment by referral within the hospital network. An administrator in a hospital system located in an underserved community stated that “there are a number of programs such as the Nurse Family Partnership, and the WISH programs that help to assist our patients that are initially diagnosed with postpartum depression. Both of these programs help to educate the mother on postpartum depression and help her to find the mental health care that she needs. In order to qualify for these programs you do have to be under a certain income level which we have found to be an issue for some of our patients that work and make just a little too much to meet those guidelines. For those women there is not another option for treatment unless they have insurance through the marketplace or their job and even still, the insurance that they get might not offer services for mental health or they might have to pay a copay which they can’t afford. Those women are left to find other resources which is sad.”

Since it was not customary for the facilities in the affluent communities to provide screening for postpartum depression it was not surprising that they had very few resources to treat postpartum depression in their facility. They did have a referral list that they offered to patients in the event that they needed postpartum depression resources, but there was not a mental health professional on staff. One of the administrators in the affluent community did indicate that “we really prefer to point the patients in the

direction of group therapy or medication so we often give them referral sources that we know will offer those as treatment options. We know that the results with those two types of therapy are promising based on the responses from patients that we have sent to these doctors and we want our patients to be successful.”

Funding

The funding, in terms of capacity, was measured by assessing not only the funding sources for the facility, but also the insurance options for patients to utilize the services offered by the facility. In the underserved communities, most of the funding is offered by state or federal funding, grants, and/or donations from local businesses. The insurance options in the facilities in the underserved communities include Medicaid, Medicare, private insurance, and other managed care plans. One administrator from a hospital system mentioned “we have another option for our patients with a managed health care plan. That plan is in collaboration with Texas Health and Human Services and has the same requirements for eligibility. This is a great option for our patient because it gives them a network of care and referral sources that they can choose from.

Unfortunately it still has the same eligibility requirements as Medicaid so it limits the number of people that are able to benefit from the services.”

Within the affluent communities the funding sources differ from what was determined in the underserved communities. The funding for the facilities in the affluent community is provided by personal funds from either the overarching medical system or the individual clinic owner with very little to no funds provided by federal and/or state funding. The insurance options in the facilities in the affluent communities only include

private insurance plans. Medicaid, Medicare, and managed care plans were not accepted at any of the facilities interviewed within the affluent sample population.

Summary of Resources Based on Facility Type		
Measurement	Type of Community	
	Underserved	Affluent
Resources for Screening	<ul style="list-style-type: none"> • Use of the Edinburgh Postnatal Depression Scale • Standard Screening Tool 	<ul style="list-style-type: none"> • Postpartum depression screening done in pediatrician's office • Literature given during prenatal period
Frequency and Follow-up of Screening	<ul style="list-style-type: none"> • Screening done at 6 week well check-up only unless there is a previous history of mental illness • Screening done up to a year after birth if utilizing a nonprofit agency 	<ul style="list-style-type: none"> • Hard to determine since screening is done at the pediatrician's office • If there is a history of mental illness, the patient is flagged to be screened at subsequent visits
Access to Resources to Treat Postpartum Depression	<ul style="list-style-type: none"> • Treatment options are not available in the facility, but there are referral options within the hospital networks • The access to the referral options is often limited by the type of insurance that the patient has which interferes with access to resources for some women 	<ul style="list-style-type: none"> • Limited resources to treat postpartum depression in the facility • Offer a referral list and a network of referral options for patients for treatment • Treatment options offered are both holistic and traditional
Funding	<ul style="list-style-type: none"> • Funding to the facilities offered by state or federal funding, grants, and/or donations from local businesses • Insurance options include Medicaid, Medicare, private insurance, and other managed care plans 	<ul style="list-style-type: none"> • Funding to the facilities generally provided by personal funds or by the hospital system • Only includes private insurance plans

Figure 4-2 Summary of Resources Based on Facility Type

4.5 Skills

The measurement of skills in terms of capacity was measured by the demographic makeup of the staff because it aids in improving cultural competency, the ability of the staff to distinguish the signs and symptoms of postpartum depression, the use of diversity and/or compliance training, and the recognition of barriers to the diagnosis and treatment of postpartum depression.

Demographic Makeup of the Staff

The demographic makeup of the staff was used as a measurement of capacity in terms of its impact on the cultural competency that could be offered by the staff to the patients. In the underserved community most of the staff members that provided direct patient care were either African American or Caucasian. Those staff members included the nursing staff, the medical assistants, and the doctors. There were a few staff members that were Hispanic, but their role with patient care was minimal and they typically served in a receptionist role. All of the upper management staff members were Caucasian. One of the administrators in a clinical facility indicated “we definitely try to keep a diverse staff so that our patients feel comfortable when they are coming in to see us. I do notice that we have quite a few patients that come in that are Spanish speaking and although we have someone here that can translate for them, that is not the person that is providing the care for them.”

In the affluent community the demographic makeup of the staff was very diverse. The race/ethnicity of the doctors alone varied especially in the offices that were attached to a hospital system. Most of the staff that offered direct patient care were Caucasian, but

there were also staff members of varying race/ethnicity that were on staff as well. One of the administrators in a hospital system mentioned, “one of the best things about our staff is that we have so many varying backgrounds. Not just based on race but we have so many people from different areas and with different experience. It really helps us to use those different backgrounds to relate to our patients. I had a patient tell me that she had very specific cultural beliefs and practices when it came to delivering her children and she wanted us to help her make sure that those were met. One of her cultural beliefs was that men could not see her uncovered. We made sure to not to have any male nurses caring for that particular patient at the time of her delivery, plus we have a nurse on staff from the same culture so she was a resource to us as well.”

Distinguishing Symptoms of Postpartum Depression

In order to measure how the factor of distinguishing symptoms of postpartum depression related to the skills of the facilities in relation to the facilities’ capacity, the administrators in the sample population were asked to explain which symptoms of postpartum depression are looked for by their facility during an evaluation. In the underserved community the administrators expressed a need to look for general sadness in the mother, a lack of attachment to the baby (demonstrated by disinterest in talking about the baby when asked), lack of social support, drastic changes in the family situation, missing numerous appointments, a look of the baby or the mother not being adequately cared for, and/or self-admission from the mother. The administrator in one of the clinics mentioned that “our patients sometimes have no idea what postpartum depression is and although it sounds unreal some of them we don’t see until after the

baby is already here. We try to look out for the signs because you know there have been cases that don't end well for the mother or for the baby. That's not always the easy part. Some of these women don't want their kids taken away so they don't want us to know that anything is wrong. Some of them don't know anything is wrong at all until we start to talk to them about it. There is such a huge range of where they could fall. There is also the chance that we see them for such a short period of time that we don't get enough time to notice. We see so many patients in a day that sometimes you can't tell if a woman is sad or depressed in just ten minutes.”

As mentioned previously, the facilities in the affluent community that focus on prenatal and postnatal women's care did not typically offer postpartum depression screening. This was done at the pediatrician's office at the infant's well check-up visits. However there were signs and symptoms that they looked for in order to determine if they needed to refer one of their patients to a mental health professional. Those signs and symptoms included the mother seeming sad at her visit, no connection to the infant (if the infant was present), a lack of interest in self-care, language that the woman would want to harm herself, or self-admission from the woman about her feelings of depression. An administrator from a clinic within a hospital system indicated “our patients have the opportunity to get the help that they need through a referral from us. We might not have the actual screening tool, but we do look for other symptoms that might indicate that they are suffering from postpartum depression. You know what postpartum blues are right? Well some of our patients are just suffering from that so we try to give them some tips and tricks on how to get through it and then it kind of resolves and never really goes into postpartum depression. Some of our patients just don't want to talk about it. Even if we

mention it or offer a referral they get offended, so sometimes it is just best to wait for them to ask for the help.”

Diversity and Compliance Training

Another skill that the administrators at the facilities were queried about, were the trainings that are provided to the staff in the areas of compliance and diversity.

Compliance training refers to the annual education of employees on the policies and the procedures of the organization that they are expected to adhere to. Diversity training refers to the education of employees on the proper way to treat individuals from different backgrounds which could include a component of cultural competency training. In the underserved communities the administrators in the nonprofit organizations as well as in the clinics did not have a specific training for their employees in regards to compliance and diversity training. They indicated that “the employees are trained on new employee procedures at the beginning of their employment, but there are not additional trainings offered to all employees specific to compliance and diversity. We do have some employees that do offsite visits or work specifically in an area where they help with women in the NICU or help women in the community put car seats safely in their cars and we might train them on how to approach a certain situation or how to communicate some medical terms in a different language, but I don’t think that is the compliance or diversity training that you are talking about.” However, in the hospital systems found in the underserved communities annual compliance training was an implemented procedure. “We do offer annual compliance training because we have so many employees within our system. It helps them to understand how our procedures work, what our mission and

values are, and behavior that is not tolerated here at work such as sexual harassment, improper use of the organizations equipment, and other acts that would get them into trouble. As far as diversity training, that would really be something that our doctor's participate in. I am sure that they need it to get their continuing education hours so I am pretty sure that it is just a class that would be available for the physicians.”

In the affluent communities, all of the administrators indicated that there was a form of compliance and/or diversity training within their facility. They specified that the compliance training focused on the protocols of the organization while the diversity training helped them to understand how to address different cultures without offending them. One of the administrators in a hospital system stated that, “we noticed a rise in the immigrant population within our community, so it was necessary to put a training in place to make sure that our staff knew how to address this population and to make sure that we were doing it effectively. Some of these women are unsure of our health care system and some of these women are so modest that even our procedures go against what they believe so it was important for the staff to understand that and that increase in our understanding has I think helped with their comfort level when seeking our services.”

Barriers to the Diagnosis and Treatment of Postpartum Depression

How the staff acknowledged and/or recognized barriers to the diagnosis and treatment of postpartum depression for their patients was also seen as a skill in the measurement of capacity for postpartum depression resources. As mentioned previously, some of the most noted barriers to treatment for postpartum depression include a lack of awareness of postpartum depression, the stigma of being treated or being labeled, the lack

of having a choice for services, services that lack cultural awareness, poorly coordinated services, and treatment services that are inconvenient (Dennis & Chung-Lee, 2006).

Within the underserved community the administrators indicated a number of barriers to the diagnosis and treatment of postpartum depression. Those barriers included a lack of family support, the stigma of being labeled as crazy, lack of education on the symptoms of postpartum depression, being a young mother, not having a stable income, having more than three kids, being unmarried, not having access to transportation, and relying on government assistance. One of the administrators from a nonprofit organization stated, “there are so many things that can lead to a woman having postpartum depression. One of the things that we have noticed is that the more stress that a mother has to deal the more likely she is to get overwhelmed with day-to-day life, which can lead to depression. Not having a family support system seems to be the most drastic indicator of depression for a mother especially a young mother. Without someone to help, they are constantly trying to figure things out on their own and that can be really stressful. We often have mothers that come in here that are not even twenty years old yet that have more than three kids and no steady employment. That makes it hard for them to get back on their feet and just thinking that you are in this never ending poverty cycle and that you brought your kids into this never ending poverty cycle could make anyone down on themselves. We try to look for clues, we try to look for signs, but it’s hard. When all of your clients have the same background how can you tell which one can handle their circumstances better than the next one?”

In the affluent community, the administrators also indicated a list of barriers to the diagnosis and treatment of postpartum depression that they recognize in their patients.

Those barriers included, a change in marital status, a change in the financial information including a change in their insurance provider, inability to communicate (language barriers), lack of education on the symptoms of postpartum depression, and not being able to effectively cope with stress. An administrator in a clinic within the affluent community stated that “we try to eliminate all of the barriers to receiving care for postpartum depression by educating the mothers in the prenatal period so that when they are exhausted post pregnancy the information that they received regarding postpartum depression is already with them and they can already know the signs. It helps when they already have the knowledge of what to look for. We do have some women that have a change in their relationship status or who are trying to juggle a new baby and being a full-time worker at the same time that even with the education just do not do well with coping with stress. The problem is sometimes they try to act like they have it all together when they come to their appointments. It’s hard to help them if they don’t want to help themselves.”

Summary of Skills Based on Facility Type		
Measurement	Type of Community	
	Underserved	Affluent
Demographic Makeup of Staff	<ul style="list-style-type: none"> • Staff with direct care to patients were wither African American or Caucasian • All upper level staff members were Caucasian 	<ul style="list-style-type: none"> • Diverse staff including the doctors and the upper level staff members • Varying cultural beliefs amongst the staff
Distinguishing Symptoms of Postpartum Depression	<ul style="list-style-type: none"> • General sadness in the mother • A lack of attachment to the baby • Lack of social support • Drastic changes in the family situation • Missing numerous appointments • A look of the baby or the mother not being adequately cared for • Self-admission from the mother 	<ul style="list-style-type: none"> • Mother seeming sad at her visit • No connection to the infant • A lack of interest in self-care • Language that the woman would want to harm herself • Self-admission from the woman about her feelings of depression
Diversity and Compliance Training	<ul style="list-style-type: none"> • No specific training for employees in regards to diversity or compliance in the clinics and nonprofit agencies • Annual compliance training in the hospital systems • Administrator felt like the diversity training should be specific to doctors 	<ul style="list-style-type: none"> • Training for both diversity and compliance • Administrator found it important that all of the staff remain aware of the protocols of the organization as well as how to effectively address different populations
Barriers to the Diagnosis and Treatment of Postpartum Depression	<ul style="list-style-type: none"> • Lack of family support • The stigma of being labeled as crazy • Lack of education on the symptoms of postpartum depression • Being a young mother • Not having a stable income • Having more than three kids • Being unmarried • Not having access to transportation • Relying on government assistance 	<ul style="list-style-type: none"> • A change in marital status • A change in the financial information including a change in the insurance provider • Inability to communicate (language barriers) • Lack of education on the symptoms of postpartum depression • Not being able to effectively cope with stress

Figure 4-3 Summary of Skills Based on Facility Type

4.6 Social and Interorganizational Networks

The measurement of social and interorganizational networks in terms of capacity was measured by the referral of patients/clients to outside entities for treatment, and the social networks that are deemed beneficial for the facility and/or the patients.

Referral of Patients to Outside Entities

The presence of a referral network outside of the facility was another component used to measure the capacity of postpartum depression resources. Within the underserved community there were a number of networking opportunities for patients specific to prenatal and postnatal care. However, most of those networks were more beneficial for patients that utilized state funded insurance or participated in the managed care plans that followed the same economic guidelines that the state funded insurance used. Some of those referral options included referrals to mental health professionals, lactation consultants, nonprofit agencies that offer services, and additional help with living arrangements such as shelters or transitional housing. One of the administrators in a hospital system within an underserved community mentioned “we really see a gap in care and services when it comes to our working mothers. They really miss that cut off of receiving services but they are just as poor as the woman sitting next to them that qualified for the services. Because they work they can’t get care, but if they don’t work they can’t survive. It’s a lose-lose situation. Some of our working patients do have that Obamacare, but they can’t afford the premiums or the can’t afford the copays so they either lose the insurance all together or they keep the insurance, but they can’t afford the

care. That's the problem with a lot of these chronic diseases. I mean they can be treated, people don't have to die from them or hurt themselves or someone else because they can't control their mental illness, but they just can't get the care that they need.”

The facilities in the affluent communities also had a network of referral sources that they were able to provide for their patients. Their referral sources included mental health professionals, wellness care advocates including physical activity professionals that provided services like yoga and others that provided meal planning services, holistic medical care options, lactation consultants, and newborn sleep coaches. An administrator at a clinic stated “we want to provide our patients with any and everything that they might need to make the transition into motherhood or into expanded motherhood as easy as possible. We have a number of organizations and individuals that offer services that our patients have expressed have really made things easier for them after having a baby. Having someone come in and help with meals or housework can really take the load off of you or having a night nanny to help you can help you to not be as exhausted as you try to get through the day. We give our patients these options because it also helps them to bond with the baby when they do not have a million other things that they need to worry about.”

Beneficial Social Networks

All of the administrators in both the underserved and the affluent communities indicated that they find social networks extremely beneficial in terms of reducing the prevalence of postpartum depression rates in their patients/clients. The social networks that were seen as being the most beneficial included family support, a network of medical

care services, patient support groups, social media sites, and social activities. The administrators indicated “the patients respond better to a treatment plan or to a change in their behavior when they have the support of a family member or friend to help them with that change. We have also found that many of our patients are not waiting to get an answer from the medical staff. Oftentimes when they feel like something is wrong that are doing some research for themselves before even coming in to see a doctor. If we can provide some general information on some common health issues like postpartum depression on our website then these woman might have a better chance of actually seeking the help that they need. Another thing that we have found works well, is group support such as prenatal classes where women can come in and just ask questions in a forum where there are other women that are in the same situation as them and might have the same questions that they might have. Some of those women won’t ask the question but hopefully the input from the other women in the group will be helpful to them as well.”

Summary of Social and Interorganizational Networks Based on Facility Type		
Measurement	Type of Community	
	Underserved	Affluent
Referral of Patients to Outside Entities	<ul style="list-style-type: none"> • Number of networking opportunities for patients including mental health professionals, lactation consultants, nonprofit agencies that offer services, and help with living arrangements such as shelters or transitional housing • Referrals are limited to those patients that meet the guidelines for state funded insurance 	<ul style="list-style-type: none"> • Network of referral sources for patients including mental health professionals, wellness care advocates, holistic medical care options, lactation consultants, and newborn sleep coaches
Beneficial Social Networks	<ul style="list-style-type: none"> • Social networks are seen as being extremely beneficial for postpartum depression rates • Most beneficial social networks include family support, a network of medical care services, patient support groups, social media sites, and social activities 	

Figure 4-4 Summary of Social and Interorganizational Networks Based on Facility Type

4.7 Social, Cultural, and Psychological Variables

There are a number of variables that can contribute to postpartum depression and that can act as barriers to postpartum depression diagnosis and treatment. Of those variables, the administrators in the underserved as well as the affluent communities were asked to illustrate the potential that race/ethnicity, education, socioeconomic status, marital status and family support, and a history of depression or anxiety had on limiting the access to postpartum depression resources based on the general background of their patients/clients. When asked about the social, cultural, and psychological variables of the patients/clients within the underserved community, the administrators demonstrated that a majority of their patients/clients were African American or Latino, from a lower

socioeconomic background, lacked a high school diploma, were unemployed or underemployed, and were unmarried with minimal social support. The administrators did not have the previous mental health status of the patients/clients to be able to analyze this as a barrier to diagnosis and treatment of postpartum depression. An administrator at one of the nonprofit organizations stated that, “our services are offered free of charge to clients in specified zip codes based on grant obligations that we need to fulfill or obligations to the community to focus on the areas with the largest health disparities. Because of that we often see clients with similar backgrounds. We have a number of clients that are young mothers that are not working, qualify for Medicaid, and have very little to no support from their family. But we also see mothers that are working, but make just too much for public assistance so we try to provide them with as many resources as we can. We have found that the support groups that we offer our clients are beneficial and the resources that they get from us can make the difference in how they are able to function in society.”

Within the affluent community, the administrators indicated that a majority of their patients/clients were Caucasian, from a middle or upper class social group, at least a high school graduate, either employed or unemployed, and were married with the presence of social support. The administrators in the affluent community also did not have the previous mental health status of the patients/clients to be able to analyze this as a barrier to diagnosis and treatment of postpartum depression. An administrator within one of the hospital systems in the community stated that, “most of our patients are either working mothers or mothers that are stay-at-home moms so we try to offer resources such as support groups or mommy and me classes for women that can come during the day

and we offer similar services for women that work to come in the evening or on the weekend. There is a cost associated with our services, but compared to some of the private businesses that offer the same services I would say that it is minimal. We also offer additional courses that are not just for the moms like a sibling course, a dad’s course, and a CPR course for families that help the entire family to get involved and excited about the upcoming baby.”

Summary of Social, Cultural, and Psychological Variables Based on Facility Type		
Variables	Type of Community	
	Underserved	Affluent
Social	<ul style="list-style-type: none"> • Minimal social support • Lower socioeconomic status • Unemployed or underemployed • Lacked a high school diploma • Unmarried 	<ul style="list-style-type: none"> • Presence of social support • Middle or upper class • Employed or unemployed • At least a high school graduate • Married
Cultural	<ul style="list-style-type: none"> • African American or Latina 	<ul style="list-style-type: none"> • Caucasian
Psychological	<ul style="list-style-type: none"> • Administrators did not have the previous mental health status of patients 	<ul style="list-style-type: none"> • Administrators did not have the previous mental health status of patients

Figure 4-5 Summary of Social, Cultural, and Psychological Variables Based on Facility Type

4.8 Alignment with State and/or Local Policies

The results of the comparative and critical content analysis conducted on the current policies aimed at postnatal women's care in the State of Texas as well as Dallas, Collin, and Tarrant Counties indicated that although there are some policies and/or procedures to address postnatal women's care in place in each area, they do vary slightly and some are more stringent than others.

Dallas County

According to the administrators in both the underserved and the affluent facilities within Dallas County, their current policies to address postpartum depression are in alignment with what has been launched in their county as well as in the State of Texas. This includes using a screening tool that has been validated by the state and offering differing methods of treatment or referrals to treatment based on the severity of the woman's symptoms. An administrator from a clinic in an affluent community indicated stated, "I'm sure that we would have to follow the rules policies that are set in place or we would be sanctioned or something like that. We make sure we have a list of resources for the women if they need it. Now I did mention that we do not do the postpartum depression screening ourselves but as long as they are getting screened somewhere then I think that is all that matters."

Collin County

The administrators in both community types in Collin County were unaware of any policies that needed to be adhered to in terms of postnatal women care for their

county and the State of Texas, but indicated that if there were certain policies to follow that they were sure that they were following them. An administrator from a nonprofit agency in the underserved community stated that, “we tend to follow the regulations that are outlined by our grants or federal resources. I have been here for years I have never known of a county policy or even a state policy that we are supposed to follow. We just use the funds that we are given to offer as many resources as we possibly can. If we start having to follow strict guidelines it might actually hurt our clients because we won’t be able to do all of the things that we do now. Especially if we have to start reporting every little thing. I know that the reporting helps to reduce fraud when it comes to grant funding and people using the funds for the wrong reasons, but we have to hire more people and use more money on staff just to get the reporting done and that reduces the money that we could have been using to help twenty more people.”

Tarrant County

The administrators in Tarrant County had differing views on their adherence to the policies outlined for postnatal women’s care for their county as well as for the State of Texas. In the underserved communities the administrators indicated that they follow the county guidelines for postnatal women’s care and in most cases they assist in setting those guidelines. Those guidelines include using the Edinburgh Postnatal Depression Scale to allow the patients to use if they feel that it is necessary and having treatment options that vary based on the severity of the symptoms of postpartum depression.

Within the affluent communities, the administrators indicated that they did not know of any policies related to postnatal women’s care that needed to be followed and

were certain that since they did not receive state or federal funding or accept state funded insurance that they did not have to follow the current policies. One of the administrators at a clinic within an affluent community mentioned, “we follow the policies that are set by our medical director. I don’t think that those policies are specific to anything that the state requires because we are not using any state funding. I am sure that they are not much different than what the state suggests since there are certain ways that have proven to be effective in treating postpartum depression. I am sure that the state just has guidelines in place to make sure that those that are using state funded insurance are using the resources correctly to get the most benefit for those patients.”

Summary of Alignment with State and Local Policies Based on Facility Type		
Counties	Type of Community	
	Underserved	Affluent
Dallas County	<ul style="list-style-type: none"> • According to the administrators the current policies are in alignment with the State of Texas policies 	<ul style="list-style-type: none"> • According to the administrators the current policies are in alignment with the State of Texas policies
Collin County	<ul style="list-style-type: none"> • Administrators unaware of any policies that needed to be adhered to for Collin County and the State of Texas • Tend to follow the regulations outlined by the grants and other federal resources 	<ul style="list-style-type: none"> • Administrators unaware of any policies that needed to be adhered to for Collin County and the State of Texas
Tarrant County	<ul style="list-style-type: none"> • Administrators indicated that they follow the county guidelines for postnatal women’s care 	<ul style="list-style-type: none"> • Administrators did not know of any policies related to postnatal women’s care that needed to be followed on the local or state level. • Felt that they did not have to follow state policies since they do not receive state funding • Follow the policies set by the Medical Director

Figure 4-6 Summary of Alignment with State and Local Policies Based on Facility Type

4.9 Stakeholder Analysis

The following chart depicts the results of the stakeholder analysis conducted on the administrators in the underserved as well as the affluent communities. This analysis includes a list of stakeholders, their importance to postpartum depression policies and procedures, their influence on those policies, and strategies that could be used to engage the stakeholder into making impactful policy recommendations or decisions. Their impact and influence was determined by the comments from the administrators in the interviews and their contribution was also determined by the administrators and by reviewing the overall purpose of the stakeholders in conjunction with the overall mission and values of the facilities within the sample population. All of the administrators at the facilities in the sample population were questioned about the mission and values of their organization. Although all of them varied in their overall mission and values the underlying premise for all of the missions was patient centered care. As a result, the contribution of the stakeholders was determined by how their overall purpose aligned with patient centered care.

Stakeholder	Impact How much does postpartum depression rates impact them? (Low, Medium, High)	Influence How much influence do they have over postpartum depression policies? (Low, Medium, High)	How could the stakeholder contribute to the project?	How could the stakeholder block the project?	Strategy for engaging the stakeholder
Health Insurance Providers (Private)	High	High	Providing coverage for PPD resources (treatment)	Not providing coverage for treatment	Illustrate the cost associated with not treating PPD
Family	High	Low	Providing support	Not providing support	Illustrating the potential impact of PPD on their family member
Research Community	Low	Medium	Proposing new effective policies	Not seeing the significance of policy changes	Indicate the importance of additional research on barriers to PPD resources
Policy Makers and Governments	Low	High	Developing and implementing PPD policies	Not changing the existing PPD policies	Illustrate the importance of altering existing policy
Private Businesses	Low	Low	Providing resources for PPD	Voting against effective policy changes	Showing the impact that PPD has in the community
Practitioners and Professionals	Medium	Medium	Providing resources for PPD	Not following the proposed policies	Explain the significance of their services
Health and Social Service Providers	Medium	Low	Providing resources for PPD	Not following the proposed policies	Explain the significance of their services
Community Organizations	Low	Low	Providing resources for PPD	Not providing support	Showing the impact that PPD has in the community
Public	Low	Low	Voting for effective policy changes	Voting against effective policy changes	Showing the impact that PPD has in the community
Nonprofit Agencies	Medium	Low	Providing resources for PPD	Not following the proposed policies	Explain the significance of their services
School Districts	Low	Low	Providing resources for young mothers	Not providing resources	Illustrate the rates of teenage pregnancy in the community
State Funded Insurance	High	High	Providing coverage for PPD resources (treatment)	Not providing coverage for treatment	Illustrate the cost associated with not treating PPD

Figure 4-7 Stakeholder Analysis Chart

Chapter 5

DISCUSSION, SUGGESTIONS FOR FUTURE RESEARCH, AND CONCLUSION

This final chapter relates the results of the qualitative interviews of the administrators in the underserved and affluent communities to the body of the dissertation. There were three main research purposes of this study. The first one was to measure the capacity of postpartum depression resources in underserved communities and the comparison of that capacity to that of an affluent community by using a case study approach. The second research purpose was to determine if the policies regarding postnatal women's care that are currently being used in hospital systems, clinics, and nonprofit agencies found in the State of Texas, Dallas County, Tarrant County, and Collin County align with the policies that are already in place. The final research purpose was to conduct a stakeholder analysis using the input from the administrators interviewed to determine who would be most influential in assisting in policy changes if the policies that are currently in place were found to be ineffective. The value of this research is that it helps to determine if there are any gaps in the current resources that are provided to minority women and those that live in underserved areas that might contribute to the higher postpartum depression rates with these women. This section discloses the results of the research study and offers recommendations for policy improvements in order to increase the capacity of postpartum depression resources in underserved communities.

5.1 Discussion of the Results

Measuring the Capacity of Postpartum Depression Resources

The measurement of capacity within an organization can be used to measure the performance of that organization and can help to determine the essential processes that are needed in order to produce the most effective outcomes. The term capacity refers to the multidimensional measurement of an organization's capabilities, knowledge, and resources and can be measured using a number of different frameworks, constructs, and dimensions. For the purpose of this research I used the logic model referred to by Turnock (2004) that illustrates how capacity, process, and outcomes determine public health performance measures. Within this logic model, this notion of capacity is measured using the system inputs of the workforce, information, organization and relationships, facilities, and funding (Turnock, 2004). This logic model is also synonymous with the ten dimensions of community capacity that were introduced by the Centers of Disease Control (McLeroy, 1996). Based on the scope of my research I chose to use the dimensions of skills, resources, and social and interorganizational networks to measure the capacity of postpartum depression resources in underserved as well as affluent communities in Dallas, Tarrant, and Collin Counties. Using a case study approach I described the differences in the capacity measurements based on the two types of communities from the research (underserved and affluent) in the following sections.

Underserved Communities Capacity Measurement

Based on the comments from the administrators within the underserved community, the community has a diminished capacity of postpartum depression resources especially in comparison to that of the affluent community. Within the underserved community, there are resources available to women to both diagnose and treat postpartum depression, but those resources are often limited to the network that the initial services are provided in and the services provided are based on the insurance coverage and often lack funding for women that do not meet the criteria for state funded insurance. There are also limitations in terms of the frequency of the screening for postpartum depression. Symptoms for postpartum depression can be seen up to a year after childbirth but the facilities within the underserved communities, that were not part of a nonprofit organization, only conducted screenings up to six weeks after childbirth. The nonprofit organizations within the underserved communities did provide screening for up to a year after childbirth, but it was only for the women in specified zip codes and of a certain socioeconomic status to meet the requirements for the grant or state funding that was used to provide the services. One of the most pertinent issues in terms of resources for the underserved community was a lack of resources for women that did not meet the guidelines for state funded insurance. Most of the services that were provided and offered within the communities to treat and/or diagnose postpartum depression were services offered based on the economic status of the mother. If the mother is working and makes just too much to qualify for the insurance, then she is no longer eligible for the services. This leaves a tremendous gap in the health care services for a very significant amount of women within the sample population.

In addition to measuring the capacity of resources for postpartum depression by analyzing the resources within a community, I also used the skills within the facilities as a measurement of capacity. Within the underserved community there was diversity in regards to the demographic makeup of the staff. This would help the staff to be able to relate to patients with varying cultural backgrounds. The staff also has a thorough understanding of the symptoms of postpartum depression and what to look for in a woman that might be suffering from this mental health issue. This could help the staff to distinguish when to screen a woman for postpartum depression or when to suggest treatment options or a referral. The staff, however, does not have training in compliance and/or diversity outside of what they receive within a new employee training session. The administrators also did not indicate a pertinent need to have training for compliance and/or diversity for the staff. This could limit the chance for the staff to gain knowledge on cultural competency and other changes in policies and/or procedures implemented by the organization. The lack of being trained on cultural competency can be equated to a barrier for the diagnosis and treatment of postpartum depression as well as other barriers such as the lack of resources for women that do not meet the eligibility requirements for state funded insurance.

The last dimension used to measure capacity was the social and interorganizational networks. Although these networks include organizations outside of the facility for referral purposes, they also include the social support of the community and family members. Within the underserved community there is a network of support and services that are focused on women that are either in a managed care plan or that receive state funded insurance. These services are offered on a continuum and are often

in close proximity to each other for the ease of the mother. However, there are limited services for women that are not under the managed care plan or under state funded insurance. This leaves a gap in the health care services for the mothers and often leads to high postpartum depression rates in these underserved communities. There is also an understanding in the community that social networks and family support can play a substantial role in the reduction of postpartum depression rates, but the resources that are available to the women within this community can often be a limitation on receiving that support.

Affluent Communities Capacity Measurement

Based on the results from the interviews with the administrators in the affluent communities, there is a promising level of capacity of resources within the affluent community with just a few areas that need to be reevaluated for improvements. Within the affluent community there are resources available to women to both diagnose and treat postpartum depression. The resources are available to all of the women, with the caveat being that state funded insurance is not accepted at the facilities within the affluent communities. The frequency and the application of the screenings is an area of improvement or an area of evaluation in terms of where the postpartum depression screenings should take place and the frequency of the screenings. Although the screenings are taking place in the pediatrician's offices, the pediatrician often meets the mother for the first time when the baby is coming for their well visit, so some of the symptoms that are associated with postpartum depression would be more noticeable if the practitioner that was caring for the mother throughout the entire pregnancy were

evaluating her instead of a doctor with novice knowledge of the woman, her social background, or her previous medical history. If the screenings were taking place in the obstetrician/gynecologist offices then the frequency of those screenings could be more effectively maintained to include a time period of up to a year after childbirth.

In terms of the area of skills as a measurement of capacity, the administrators within the affluent community did express a lack of diversity among the members of their staff. However, they do offer their staff trainings in both compliance and diversity to assist them in gaining the knowledge that they need to stay abreast with the changing protocols of the facility as well as assist them in relating to patients with varying cultural backgrounds. The administrators were very adamant about the positive influences that being trained in compliance and diversity can have on the patients. Having a more diverse staff could serve a very positive purpose in terms of being able to relate to different patients, but the fact that the facilities acknowledge the need to address this issue through additional trainings for the staff illustrates that there is a connection between the knowledge of the staff and their ability to work effectively with all patients.

In the last dimension used to measure the capacity of postpartum depression resources within the affluent community, the administrators indicated that there is a network of services available to their patients that they feel has been beneficial. These resources are offered to all women, and although they are not free of charge, the women are not required to have a certain type of insurance in order to utilize most of the services. This network of support and resources helps women to receive the care and services that they need. The administrators in the affluent communities also had the same understanding as the underserved communities that includes an understanding that social

networks and family support plays a vital role in the reduction of postpartum depression rates.

Social, Cultural, and Psychological Variables

Social, cultural, and psychological variables play a significant role in the rates of postpartum depression and the access to resources to diagnose and treat postpartum depression. Based on the information analyzed from the administrators, the women in the underserved communities are often African American or Latina, of a lower socioeconomic status, unmarried, unemployed or underemployed, and have little social support. As evident from the literature, having little social support and being of a lower socioeconomic status increases the stress levels of a woman, which can lead to postpartum depression. Being from a minority group is also a risk factor for postpartum depression and all of these risk factors increase the barriers for a woman to be diagnosed and/or treated for the mental illness. These barriers in the underserved communities can be a direct link to the higher prevalence rates of postpartum depression in these areas.

In contrast, the administrators within the affluent communities indicated that a majority of their patients were Caucasian, of middle or upper class, married, unemployed or employed, and had a significant amount of social support. These factors could assist in a woman not experiencing postpartum depression or having the support and the resources to receive a diagnosis and a successful treatment of postpartum depression.

Policy Alignment

Based on the results from the interviews of the administrators in both the underserved and affluent communities, it is apparent that more stringent policies need to be implemented in regards to postpartum depression resources including screening, screening frequency, treatment, and referral services. The policy for postnatal women's care outlined by the State of Texas indicates that not only are all new mothers to be screened for postpartum depression using one of the three screening tools validated by the state, but that there are specific treatment plans to follow based on the severity of the symptoms and follow-up procedures that are to be set into place if a woman is diagnosed with postpartum depression. Unfortunately this is not the case in any of the facilities within the sample population. In the underserved community all of the mothers are being screened, but there is little follow-up care and the referral services are dependent on the type of insurance that they have. In the affluent community, there was a disconnect between the screening services and the postpartum care since the screening services are not typically offered by the same practitioner that offers the postnatal care. As a result, the frequency and the referral options and the coordination of care are not in alignment with the policy set forth by the State of Texas. The policies that are in place within the counties are also not in alignment with what has been established as a State of Texas policy under the Healthy Texas Women Program (HTW). In order for the resources, such as postpartum depression screenings, to be most effective, they need to be offered to women up to a year after childbirth and that is not evident in the county or State of Texas policies. This is an immediate change that should be made to the State of Texas policies that also should not only be contingent on a woman's previous history of mental illness.

There is also a lack of awareness among the administrators about the current state and local policies that are to be followed in all of the counties except for the underserved communities in Tarrant County. There needs to be a heightened awareness about the current policies that are in place so that protocols can be implemented within the counties to make sure that those policies are adhered to. If administrators are not made aware of current policies in place for postnatal women's care or certain resources that are to be in place to make the access to resources more manageable for women then it will not help to decrease the rates of postpartum depression in these communities.

Stakeholder Analysis

Since it is apparent that changes in the policies within the counties need to be made in order for them to be in alignment with the State of Texas policies, and changes in the State of Texas policies should also be made to make more stringent guidelines aimed at postpartum depression resources, it is pertinent to evaluate the potential stakeholders that could play a significant role in making these changes. According to the literature and the feedback from the administrators in the underserved and affluent communities, the stakeholders that play the most significant role in making policy changes regarding postnatal women's care are the insurance providers (both state and private), the policy makers and governments, practitioners and professionals, health and social service providers, and nonprofit agencies. These stakeholders have a significant influence on changes that can be made to the policies for postnatal women's care and their influence could help to improve the policies, which in turn could decrease the rates of postpartum depression.

5.2 Research Significance

Based on the results from this research, it is apparent that there is a diminished capacity of postpartum depression resources in underserved communities within the sample populations. That diminished capacity can have a direct relation to the higher prevalence of postpartum depression rates in minority populations and underserved communities, as indicated by the literature. Without the resources to properly diagnose and treat postpartum depression in these communities, the rates of postpartum mental illness can continue to rise which can lead to a number of other public health issues. The capacity of an organization as measured by the organization's resources, skills, and interorganizational relationships directly links to the key processes within the organization and then to the outcomes of the organization as a whole. When the organizational capacity of a facility is healthy, then the processes that they are able to put into place to address issues such as postpartum depression will be more productive, leading to improved outcomes for patients and in this case can lead to a decrease in postpartum depression rates in underserved communities.

While there are social, cultural, and psychological variables that play a huge role in the rates of postpartum depression, the effects of these variables can be limited when there are sufficient resources in place to address them. For example, the lack of social support that was indicated to be present in the underserved communities, can be addressed by including more support groups for women, a network of medical care options, and incorporating family members into the care options. Additional trainings for staff members such as compliance trainings and cultural competency trainings, can also

be effective when trying to address some of the barriers to the diagnosis and treatment that are obvious in terms of postpartum depression. The more training that the staff has on the protocols of the organization as well as dealing with different cultures, the more effective they can be when addressing patients.

In order to improve the diminished capacity of postpartum depression resources in underserved communities, there are a number of resources that can be utilized in addition to compliance and diversity trainings. First of all, a structured approach to addressing the diagnosis of postpartum depression is extremely pertinent. There needs to be a defined approach to screening for postpartum depression with specifics on how often that screening needs to take place and for how long. Based on the research, screening for postpartum depression should continue at least up to a year after the birth of the baby and that should be standard medical practice in order to properly diagnose women that are suffering from this mental illness. Another avenue that needs to be explored is the access to resources for women that do not meet the qualifications for state funded insurance. Many of these women are still considered impoverished, but lack the means to obtain the same essential resources afforded to their neighbor, maybe only based on an extra few hundred dollars a year. Additional resources or access to resources should be implemented in order to address the gap in health care for this population of women. This includes a network of referrals to offer treatment services for them, as well as other postnatal services that could ease the stress of a new baby. The final piece that will need to be addressed in order to improve the capacity of postpartum depression resources in underserved communities, is the alignment of local policies with those set by the State of Texas.

In order for these monumental changes to be made and new protocols to be set in place to address postpartum depression, there will need to be some alterations to the current policies in the State of Texas and Dallas, Collin, and Tarrant Counties. The State of Texas has policies in place that are more stringent than the current local policies, but those policies still do not standardize the screening methods, frequency of screening, or the available resources. To effectively address the rising rates of postpartum depression, the policies issued by the State of Texas should include screening up to a year after birth, a specified set of treatment options, standard training for medical staff in compliance and diversity, and resource options for women regardless of their ability to qualify for state funded insurance. In addition to the changes made to the state policies, there will also need to be an increased awareness of these policies to local facilities as well as stringent protocol of how the facilities are to follow these policies. Although one of the administrators indicated her concerns for additional reporting if they were required to adopt the policies used by the state, can the need for additional reporting really be compared to the wellbeing of the women in the State of Texas?

The stakeholder analysis helps to put into perspective the key players that could assist in getting these changes implemented to the current policies. It is necessary to institute a need among the health care facilities that offer postnatal care as well as the stakeholders highlighted from this research to have an attitude of change for postpartum depression policies and a need for awareness of the protocols that are being carried out in their own communities. If there is enough awareness generated through the examining the negative impacts of postpartum depression, then there is a good chance that changes can be made in the resources available to the women suffering from this mental illness which in turn

could make a tremendous impact on the overall public health of women in the State of Texas.

5.3 Practical Implications

The main aim of this study was to measure the capacity of postpartum depression resources in underserved communities. I have done so by conducting a qualitative case study on administrators of hospital, clinics, and nonprofit agencies that offer prenatal and/or postnatal services within the sample populations. Their responses to questions regarding postpartum depression resources and the barriers to diagnosis and treatment were analyzed by a content analysis to determine the resources currently available, how those resources and/or policies align with state and local policies, and who the potential stakeholders would be that might be influential in making changes to current policies and procedures. The first major contribution of this research is that it provides a much needed glimpse of the misalignment of state and local policies. Although the results of this research are limiting based on the sample population, they do introduce the need to take a closer look at the current policies used to address postnatal women's care in addition to taking a closer look at the current procedures that are being carried out in local facilities. Based on the literature, there are racial/ethnic disparities in the diagnosis and treatment of postpartum depression with African American mothers having a higher rate of depression due to a lack of social support (Liu & Tronick, 2012; Segre et al., 2006). Research also indicates that there is a need to investigate the socio-cultural factors that contribute to high postpartum depression rates and that the lack of cultural competency exhibited in health care facilities impacts the patient provider relationship and contributes to

postpartum depression rates (Nagy et al., 2010; Liu & Tronick, 2012). By taking a closer look at the current policies as well as the current local procedures, policy-makers could alter the current policies to address additional barriers to the diagnosis and treatment of postpartum depression. This would also assist in developing additional programs aimed at providing screening and treatment for postpartum depression for women of lower socioeconomic status, which was also illustrated as a need in previous research (Segre et al., 2007). Based on the lack of knowledge of current policies as illustrated by the administrators within the sample populations, it would also be beneficial to increase the awareness of these policies so that they can be carried out in local facilities to aid in the decrease of the postpartum depression rates.

Another important contribution from this research is the use of the stakeholder theory as a conceptual framework to determine groups or individuals that might be influential in making alterations to current policies and procedures in terms of postnatal women's care. Stakeholder theory is typically used to determine stakeholders in the area of organizational management. Using stakeholder theory to conceptualize those that might have an impact on policies and procedures in terms of postnatal women's care is unique and would be beneficial to lobbyist, policy-makers, and even interest groups that would want to know the impact and influence of certain groups. By making these stakeholders more knowledgeable about the potential barriers related to postpartum depression as well as to the research surrounding ways to decrease postpartum depression rates, we can increase their ability to make informed decisions about postpartum depression policies. The stakeholders identified in the research study were done so by analyzing the literature and the responses from the administrators, which could mean that

all potential stakeholders were not captured within this study. However, using this framework in an effort to improve health policies could have a positive impact on the field.

5.4 Study Limitations

Although this research does assist in determining the capacity and availability of postpartum depression resources in underserved communities, it does present some limitations as well. First, interview participant responses may be intentionally or unintentionally biased. Second, interviews are not generalizable to the larger population outside of this study because random sampling methods were not employed to select participants. Thus, the views presented in the interviews only represent the views of study participants and do not represent the views of the general population. Another limitation is that the information obtained by health care personnel does not introduce the barriers to care that can really only be distinguished by the actual patients suffering from postpartum depression (Dennis & Chung-Lee, 2006). This research was conducted based on the lens of the administrators, therefore the barriers to the diagnosis and treatment of postpartum depression are not based on the views of the patients that would actually be using the resources that are described within this study. In the same manner, the views of the administrators, especially their views on the social, cultural, and psychological variables of their patients, might not reflect the reality of the patients that they serve. The study is also limited in the sense that other variables that can be associated with postpartum depression such as genetic mental illness, inability or lack of desire to breastfeed, and use of drugs or alcohol are not taken into consideration (Lancaster et al., 2010). Although an

attempt was made in the study to address the area of previous mental illness, that information was not readily available to the administrators. Therefore other factors that might have an impact on the barriers to care for postpartum depression are not included in this study. The final limitation is the chance of social desirability bias on the part of the health care professional and their desire to not put their job in jeopardy and maintain the social norms related to their work environment (King & Bruner, 2000).

5.5 Research Implications

Although this research aims to highlight the need for changes in policies regarding postnatal women's care especially in underserved communities, there are additional areas of research that could add to a more thorough understanding of the barriers that women face to receiving a diagnosis and/or treatment for postpartum depression as well as the complexities that are encountered when attempting to change the policies related to postnatal women's care. In order to be able to understand the barriers to care for postpartum depression, it would be beneficial to conduct research on new mothers to obtain their viewpoints on the barriers to care, their cultural beliefs, and their general knowledge about postpartum depression. These revelations might help to introduce new programs or interventions aimed at increasing the knowledge of postpartum depression for women and also assist in reducing the rates of postpartum depression.

As evident from the literature, the social status of a mother can be a significant indicator of postpartum depression (Segre et al., 2007). In this research study, that social status was determined by looking at the social variables of social support, socioeconomic

status, employment status, educational attainment, and marital status. Based on this research study, not only was there a diminished capacity of postpartum depression resources in underserved communities, but there was also a lower level of social support based on social variables in these areas as well. This lack of social support has been an indicator to increased prevalence rates of postpartum depression (Surkan et al., 2006). Having programs and policies in place to address these social variables could play a huge role in reducing postpartum depression rates.

In addition to conducting additional research on new mothers to gain their insight, it would also be beneficial to gain the insight of the stakeholders identified within the research. Their potential influence or stake in postpartum depression resources could be altered based on their involvement in the process of formulating new interventions and policies aimed at postpartum depression.

Although there has been previous research on the effects of cultural variables on postpartum depression rates, it would also be impactful to take into account how those cultural variables could be addressed through policies aimed at cultural competency training and other trainings to improve the patient-provider relationship (Liu & Tronick, 2012). Previous research has indicated that even when interventions such as standardized screening tools have been put into place, the lack of cultural competency and the patient-provider relationship, often limit the effectiveness of these interventions (Liu & Tronick, 2012). This research found that there was a lack of training for cultural competency within the underserved communities in the sample population, so addressing this component might assist in reducing the rates of postpartum depression.

For future research, it would also be beneficial to have a larger sample population including facilities across the state of Texas. This would help to determine if the diminished capacity of resources in underserved communities is consistent across the State of Texas or if it is solely in the North Texas Region. It would also be suggested that the policies found in other counties across the State of Texas be compared to those postnatal women's policies outlined by the State of Texas to determine if alterations to those policies need to be addressed as well.

5.6 Conclusions

Postpartum depression is a prevalent public health issue that requires alterations in health care policies and health care practices. Although some states have mandated postpartum depression screenings, those mandates do not standardize the screenings or ensure that women in underserved areas that often times lack medical insurance are provided these screenings up to a year after childbirth. The lack of medical insurance as well as the lack of social support and social networks also contributes to the rates of postpartum depression especially in minority women. Many of the current health care practices also fail to consider cultural competency in their practice thereby adding to the existing gaps in the health care services provided.

As a result of the negative effects associated with postpartum depression for the mother as well as the child, it was necessary to investigate the capacity of postpartum depression resources. This research focused on a qualitative study aimed at determining the capacity of postpartum depression resources in underserved communities. The interviews consisted of questions concerning screening methods, symptom recognition,

cultural competency, referral to psychiatric services, access to medication, case workers, the duration of post-natal follow-up, and the influential stakeholders that would assist in making decisions related to postpartum depression resources. The results from this research indicated that there was a significant difference in the capacity of postpartum depression resources in an underserved community in comparison to an affluent one. The resources in an underserved community often lacked a coordination of care, culturally competent practices, a significant social network, and trainings for the staff that would be beneficial in assisting a culturally diverse community. Based on the results from this research study, it could be hypothesized that the capacity of postpartum depression resources could have an impact on the postpartum depression rates of a community. As a result, the policies for postnatal women's care in the State of Texas and ultimately the individual counties need to be readdressed to include more stringent guidelines on the screenings for postpartum depression including the doctor responsible for the screening and the frequency of those screenings, the network of care in case of treatment including a detailed plan on treatments that are offered to all women regardless of their insurance, and mandatory trainings for medical staff to include cultural competency training.

The rates of postpartum depression remain a public health concern that requires continuous research and development on methods and interventions to both detect and treat the mental illness. Although there are some interventions that are in place such as screening mandates, most of the interventions do not take into account the racial disparities surrounding postpartum depression or the cultural sensitivities involved in it (Beck, 2006; Dennis & Chung Lee, 2006; Doucet et al., 2009; Forman et al., 2007; Halbreich & Karkun, 2006; Howell et al., 2012; Lancaster et al., 2010). In addition to

continuous research on the causes of postpartum depression, researchers and policy makers should focus on a standardized measurement tool, screening mandates with assistance for those women of low socioeconomic status, and cultural competency training in relation to depression and depressive symptoms for health care workers.

Appendix A

The Capacity of Postpartum Depression Resources
Qualitative Interview Questions

The Capacity of Postpartum Depression Resources

Qualitative Interview Questions

Workforce/Facilities

1. What type of facility are you affiliated with?
2. In what county and city is your facility located?
3. Does your facility provide prenatal services?
4. Does your facility provide postnatal services?
5. What is the demographic makeup of your staff?
6. What is the mission and vision of your organization?

Information

7. What type of screening test(s) for postpartum depression is/are used in your facility?
8. How does your facility determine when to screen for postpartum depression?
9. Is the postpartum depression screening conducted at every well check-up visit up to a year after birth?
10. What symptoms of postpartum depression are looked for by your facility during an evaluation?
11. If the screening test illustrates postpartum depression indicators is there a health care professional on site to provide a follow-up interview?

12. Is there a follow-up evaluation 6 months after birth?
13. Is there a follow-up evaluation 1 year after birth?
14. Is there training provided to the staff specific to diversity?
15. Does your staff participate in compliance training?
16. What treatment options do you have available in your facility?
17. What is your facilities' preferred treatment option?
18. Does your facility refer patients/clients to outside entities to provide treatment if not offered by your facility?

Funding

19. Is the treatment that your facility offers contingent on the type of insurance the patient is enrolled in?
20. Does your facility accept Medicaid patients?
21. Where does the funding for your facility come from?

Organization and Relationships

22. What are some of the barriers to the diagnosis and treatment of postpartum depression that you notice in your facility?
23. Are those barriers specific to a certain group or are they generally across the board?
24. Do the postpartum depression policies that your facility adheres to align with the state, county, or local policies?

25. Who would your facility recognize as the stakeholders or the influential people, groups, or organizations that help to make decisions regarding what type of resources are provided?
26. Who would your facility recognize as the stakeholders or the influential people, groups, or organizations that help to make decisions regarding what policies are followed?
27. Based on those list of stakeholders, what is their level of importance to the decision making process of your facility?
28. What social networks (if any) does your facility see as being most beneficial to your patients or your organization?

Social, Psychological, and Cultural Variables

29. What is the marital status of the majority of your patients/clients?
30. What is the education level of the majority of your patients/clients?
31. What is the socioeconomic status of the majority of your patients/clients?
32. Do most of your patients/clients have a history of depression?
33. What is the racial/ethnic makeup of most of your patients/clients?

Appendix B

Introduction to the Administrators Script

Introduction to the Administrators Script

My name is Brandie Green and I am doctoral student at the University of Texas at Arlington completing a degree in Urban and Public Administration. For my dissertation, I am looking at the resources to diagnose and/or treat postpartum depression. I would like to ask some questions regarding your facility and the resources that you provide to prenatal and/or postnatal women in terms of postpartum depression. If you would be interested in sitting down for an interview with me either in person or over the phone, I would greatly appreciate your participation. The interview is approximately 25 questions and should take no longer than an hour. Your feedback will be completely anonymous, but could assist in increasing the awareness of postpartum depression resources in the community that you serve. I can be reached at [REDACTED] or bgreen@uta.edu. Since the questions I am asking are merely facts regarding the protocols of your organization, I was not required to obtain IRB approval according to my educational institution (I can forward a letter to you from our IRB department with detailed information on this waiver if necessary). I look forward to hearing from you!

Regards,
Brandie Green
PhD Candidate
University of Texas at Arlington
Urban and Public Administration
College of Architecture, Planning, and Public Affairs

Appendix C
IRB Project Designation



February 9, 2018

Brandie Green, MPH
PhD Candidate / Assistant Director
Division for Enterprise Development
University of Texas at Arlington

IRB Approval Inquiry – Project Designation as “Not Human Subjects Research”

Ms. Green,

Thank you for contacting the Office of Research Administration; Regulatory Services regarding a dissertation study to be conducted titled, “The Capacity of Postpartum Depression Resources in Underserved Communities.” Upon reviewing the procedures involved with the study, it appears they would not meet the definition of, “research with human subjects” as defined by the Office for Human Research Protections (OHRP) and would therefore not be subject to review or approval by the Institutional Review Board (IRB) at UT Arlington. OHRP defines research as:

- A systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge. A human subject in research is defined as, “A living individual *about whom* an investigator conducting research obtains data through intervention or interaction with the individual, or identifiable private information.”

From the description of procedures and copy of the survey questions provided, it appears that while you will be surveying employees of facilities that offer postpartum depression resources for the purposes of gathering research data, you will not be collecting data *about the people you are surveying* for your research. Instead, your survey questions ask for facts about the facilities and types of staffing practices and services that they offer. Therefore, since you are not gathering research data about living individuals, your study does not meet the above definition of “human subjects research” and is not subject to IRB review.

I have included the link for decision charts provided from OHRP from which this determination is made for your reference. If the procedures or survey questions that have been outlined and provided to our office change such that IRB approval might be necessary or you have any questions regarding this determination please do not hesitate to contact us at RegulatoryServices@uta.edu.

Thank You,

Alyson Stearns
Regulatory Services Specialist
Office of Research Administration;
Regulatory Services

OHRP reference: <http://www.hhs.gov/ohrp/policy/checklists/decisioncharts.html>

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Biographical Information

Brandie Green received her PhD from the College of Architecture, Planning, and Public Affairs (CAPP) in Public and Urban Administration at the University of Texas at Arlington (UTA). She previously earned a Bachelor of Science degree in Biology from Xavier University of Louisiana in New Orleans, Louisiana and a Master of Public Health degree from the University of North Texas Health Science Center in Fort Worth, Texas. During her time at UTA she was honored as a Diversity Scholar by the Association for Research on Nonprofit Organizations and Voluntary Action. She also had the opportunity to present her research at the Texas Rural Health Association Annual Conference. She served as the Vice President of the CAPP Consortium and also became a member of the Pi Alpha Alpha global honor society for Public Affairs and Administration. Brandie's passion surrounds improving the health and well-being of others which has been exhibited through her work surrounding health disparities, health policy, and access to health care. Her experience with teaching as well as administration at UTA has also helped to her to fulfill those goals. Upon graduation, Brandie plans to continue her career in higher education.

