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Certified Nurse-Midwives' Beliefs About and Screening Practices for Postpartum Depression: A Descriptive Study

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1 Certified Nurse-Midwives Beliefs About and Screening

2 Practices for Postpartum Depression:

3 A Descriptive Survey

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11 Abstract

12 *Purpose*

13 Defined as moderate to severe symptoms of major depression lasting greater
14 than two weeks after delivery, postpartum depression (PPD) is a crippling mood
15 disorder with extreme loss and incongruity in emotion. Despite the tools available for
16 screening postpartum depression, there is a consensus that PPD continues to be
17 underdiagnosed. Recent surveys assessing pediatricians and family physicians indicate
18 that while practitioners believe that PPD is serious, they may not feel confident that they
19 can recognize PPD, are unfamiliar with screening tools and under-estimate its incidence
20 in their practice. This study was conducted to determine the knowledge and screening
21 practices of PPD among certified nurse-midwives (CNMs).

22 *Methods*

23 A survey was distributed to 2100 CNMs attending the American College of
24 Nurse-Midwives 50th Annual Meeting. Of these, 8.3% ($n = 174$) responded. The 121
25 respondents who provide care to postpartum women and/or infants less than one year
26 of age were included. The 114 respondents who screen for PPD sometimes, often, or
27 always were analyzed for their knowledge and beliefs.

28 *Results*

29 Of the 121 who provide care at least 10 hours per week and see postpartum
30 women and/or infants less than one year of age, 94.2% ($n = 114$) currently screen
31 sometimes, often, or always. 84.2% ($n = 102$) of CNMs screen often or always.

32 Of the 114 respondents who currently screen, nearly all believe PPD is serious,
33 common and treatable. Most believe that it would be feasible (91.2%) and that CNMs

34 should routinely screen for PPD (93.0%). But half of CNMs (45.6%) believed health
35 insurance would not cover treatment for PPD for many of their patients, and the majority
36 of respondents (74.6%) believed their communities do not have adequate resources
37 available to treat PPD.

38 The majority of respondents had received formal training on postpartum
39 depression in a variety of venues. However, only half (54.4%) of nurse-midwives
40 reported the use of a specific screening tool or method, and nearly 60% estimated the
41 incidence in their practice less than the published incidence (10-15%) in the general
42 population. Over 30% are not confident that they would recognize PPD. In addition, less
43 than two-thirds (65.8%) reported familiarity with available screening tools although
44 89.5% reported that they would use a brief self-administered screening tool to screen
45 for PPD in their practice.

46 Estimated incidence of own practice and general population were positively
47 correlated ($r = 0.738$, $p < 0.01$) and age is inversely correlated with PPD reported in
48 clinical practice ($r = -0.229$, $p = 0.016$).

49 The participants' narrative responses indicated that they most frequently ask
50 informal, general questions about depression and observe patient behavior to assess
51 for PPD. They will then follow-up with a screening tool if warranted. Several cited
52 literacy, language and cost barriers to the use of self-administered screening tools.

53 *Conclusions and Implications*

54 Nurse-midwives sampled believe PPD is serious and common, however their
55 screening practices are irregular and they underestimate the incidence of PPD in their
56 own practice. In addition, many are not aware of the available screening tools and are

57 likely to miss dimensions of PPD when they screen by interview. Efforts to improve PPD
58 recognition and treatment should involve nurse-midwives in screening promotion and
59 thorough education in the use of screening tools.

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62 Certified Nurse-Midwives Beliefs About and Screening Practices for Postpartum
63 Depression: A Descriptive Survey

64 Over the last two decades, there has been a widening public awareness and an
65 increase in research on postpartum depression. Postpartum depression has been
66 described as a thief that robs women of the happiness and love they expected to feel
67 towards their infants (Beck, 1993). It is characterized as moderate to severe symptoms
68 of major depression lasting greater than two weeks. There are many far-reaching
69 effects of PPD, including depression and loss experienced by the mothers, negative
70 changes in maternal-infant interactions, and fewer positive expressions in infant
71 behavior (Beck, 1995). There are many effects that extend beyond infancy on children's
72 attention and behavior problems, social patterns of play, IQ scores and difficulties in
73 school (Murray & Cooper, 1997; Hayes, Muller & Bradley, 2001). Children have been
74 found to have small but significant impairment in three areas of cognitive, language and
75 emotional development (Beck, 1998; Grace, 2003).

76 Research has also demonstrated that postpartum depression affects 10 to 20
77 percent of all new mothers (Miller, 2002; O'Hara & Swain, 1996), and more than half will
78 be experiencing symptoms a year later (Wisner, Parry, Piontek, 2002). Depression
79 during pregnancy is highly correlated to postpartum depression, and in addition, women
80 who experience PPD are more at risk for recurrent depression (Cooper & Murray,
81 1995). Despite this knowledge, research has shown that 50% of women experiencing
82 PPD remain unidentified (Hearn, 1998).

83 PPD differs from major depression only in postnatal onset. The major
84 predictor for PPD is a generalized history of depression, as well as depression

85 during pregnancy. Routine use of any screening tool has been shown to improve
86 recognition of PPD (Georgiopoulos, 2001). To diagnose a patient, a more
87 thorough evaluation is required if a patient screens positive on one of these tools
88 (Seehusen, 2005).

89 With the increased awareness of PPD there has been the development of
90 several short and easy-to-use validated screening tools such as the Edinburgh
91 Postnatal Depression Scale, Beck's Postpartum Depression Screening Scale and the
92 Postpartum Depression Checklist. Despite the accessibility of screening tools, PPD
93 remains significantly underdiagnosed. Seehusen considers this may be because
94 practitioners are not aware of the available screening tools, or they fear their use will be
95 time-consuming and expensive (2005). Another reason may be the lack of referrals and
96 resources for those who have high scores on a tool, or the unpaid time spent finding
97 resources. In particular, there may be no resources available for Medicaid or other low-
98 income patients.

99 A number of recent studies concerning postpartum depression have begun
100 assessing practitioners' knowledge, adoption of screening tools and frequency of
101 assessment. The United States Preventative Services Task Force recommends
102 screening for depression in the general population (Pignone, 2002). Many authors
103 support the routine screening of postpartum women (Georgiopoulos, 2001; Seehusen,
104 2005; Wiley, 2004),

105 Recently, several studies have been published regarding the current screening
106 practices of several populations of health care providers (LaRocco, 2001; Seehusen,
107 2005; St. John, 1999; Wiley, 2004). These studies have examined the practices and

108 knowledge of family physicians, ob-gyns and pediatricians. Studies indicate that gender
109 of practitioner, formal training in PPD, age, and years since graduating are all
110 significantly associated with frequent or more frequent screening of PPD (Seehusen,
111 2005; Wiley, 2004). These studies are crucial to defining the future roles of health care
112 practitioners in screening and diagnosing women with PPD. When performing a
113 literature review, it was found that the screening practices and associated
114 demographics of certified nurse-midwives (CNMs) have not yet been assessed. This
115 survey was conducted to determine the postpartum depression screening practices of
116 CNMs. It explores their beliefs, attitudes, and feelings concerning postpartum
117 depression and their use of screening tools.

118 **Methods**

119 *Instrument*

120 We developed a 40-item self-administered questionnaire assessing knowledge
121 and attitudes about postpartum depression and screening practices based on two
122 previously published studies (**Seehusen....., Wiley...**). The original was based on
123 surveys conducted by St. John (1999) and LaRocco (2001).

124 We provided the survey recipients with the following statement: "*We define*
125 *postpartum depression (PPD) as depressive manifestations of at least moderate*
126 *severity lasting longer than 2 weeks after delivery. This can be distinguished from Baby*
127 *Blues, which consists of milder manifestations that resolve by 14 days after delivery.*"

128 We then asked the practitioners to complete the survey if they were practicing 10 or
129 more hours per week. The survey asked nurse-midwives to estimate the incidence of
130 PPD in the general population and in their own practices. We gathered demographic

131 data, information about practice, and sources of formal training in postpartum
132 depression, as well as their attitudes, feelings and experiences with the identification
133 and referral of mothers with PPD. The frequency of screening practices was measured
134 with a 4-point Likert scale (never, sometimes, often, or always). Attitudes and beliefs
135 were measured with a 5-point Likert scale of agreement (strongly disagree, disagree,
136 neutral, agree, or strongly agree).

137 *Human Subjects*

138 The University of Connecticut Institutional Review Board approved this study.
139 The American College of Nurse-Midwives (ACNM) Board of Directors granted
140 permission to conduct the study at their 50th Annual Conference in June 2005.

141 *Sample*

142 The ACNM has 9,371 members in all 50 states, Puerto Rico, Guam and the
143 Virgin Islands. The survey was distributed to all 2100 CNMs, students, and other
144 attendees of the American College of Nurse-Midwives 50th Annual Meeting, held in
145 Washington DC on DATES. Of these attendees, 174 or 8.3% responded. Of the
146 respondents, we excluded 53 because they did not provide care at least 10 hours per
147 week to postpartum women and/or infants less than one year of age. We considered the
148 remaining 121 the sample to assess screening practice. We then analyzed the surveys
149 of the 114 who screen for PPD “sometimes”, “often” or “always” for knowledge and
150 screening practices.

151 *Data Analysis*

152 We used SPSS 14.0 (SPSS Inc., Chicago, IL) to analyze the data. Simple
153 descriptive frequencies of participant demographics, practice type, training and beliefs

154 about PPD were used to categorize the sample. Responses to belief statements were
155 dichotomized: “Agree” and “Strongly Agree” were combined, and “Disagree,” “Strongly
156 Disagree,” and “Neutral” were combined. Associations between belief statements and
157 other variables were analyzed using Pearson correlations and Chi-square tests where
158 appropriate. Statistical significance was set at $p < .05$.

159 Results

160 *Demographics*

161 Of the sample of 114 surveys, 97.3% of the participants were female ($n = 109$)
162 and 96.4% were white ($n = 108$) with a mean age of 46.4 years ($SD = 10.36$). See Table
163 1 for practice setting characteristics. **WHERE DID MAJORITY PRACTICE? THEN SAY**
164 **SEE TABLE 1, ETC.**

165 *Sources of PPD Education*

166 ___% of respondents had received formal training on PPD in a variety of venues.
167 The most commonly reported source of training was nurse-midwifery school (92.9%).
168 Over half indicated that they received formal PPD education through continuing
169 education conferences and literature from midwifery, nurse-midwifery and medical
170 sources. In addition, over half indicated receiving education about postpartum
171 depression in nursing school. Seventy percent of those who received education from
172 nurse-midwifery school also received training from medical education conferences.

173 *Screening Tool Used*

174 Sixty-two (54.4%) of the 114 participants indicated they used a specific screening
175 tool or method, with 44 (38.6%) using a validated screening tool. The most commonly
176 used screening tool was the Edinburgh Postnatal Depression Scale (EPDS) (41.9% or

177 26) reporting they used it most often. Second, a structured clinical interview was
178 common, with 10 participants (16.1%) using this method most often. Many people
179 stated in their comments that they use an informal interview or questions and
180 observation rather than a screening tool. Other screening tools used were the Beck
181 Depression Inventory ($n = 8$, 12.9%) and the Postpartum Depression Screening Scale
182 (PDSS) ($n = 7$, 11.3%). The Hamilton and Zung Depression Scales were occasionally
183 used. The Edinburgh Postnatal Depression Scale was used for 33.3% ($n = 8$), 55.6% (n
184 = 10) and 61.1% ($n = 11$) of those who “sometimes”, “often” and “always” used a formal
185 tool to screen for postpartum depression.

186 *Practices*

187 Of the 121 participants who provide care at least 10 hours per week and see
188 postpartum women and/or infants less than one year of age, 94.2% ($n = 114$) currently
189 screen sometimes, often, or always, with 84.2% ($n = 102$) screening often or always.

190 *Beliefs*

191 Nearly all participants recognized that postpartum depression is common,
192 serious enough to warrant screening, and treatable. Of the 114 who screen sometimes,
193 often, or always, all but one indicated that they believe PPD is a valid diagnosis. Most
194 believe that it would be feasible for (91.2%) and that CNMs should routinely screen for
195 PPD (93.0%). Most believe screening would not be very time consuming on their part
196 (83.3%) or take too much effort (96.5%), but half of CNMs (45.6%) believed health
197 insurance would not cover treatment for PPD for many of their patients, and the majority
198 of respondents (74.6%) believed their community does not have adequate resources
199 available to treat PPD (Table 4).

200 Participants overwhelmingly believed that PPD has lasting effects (97.4%),
201 affects the spouses (97.4%) and children (96.5%) of affected women, and that women
202 may not realize they are depressed (96.5%). Nearly 90% indicated that they would use
203 a brief self-administered tool to screen for PPD in their practice, yet over one third were
204 not familiar with available screening tools (Table 4).

205 Over half of the participants (56.6%) estimated the incidence of PPD in their own
206 practice to be less than the published incidence (10-15%) in the general population.
207 Over a quarter of participants estimated the incidence in the general population to be
208 less than the published incidence of 10-15%, though nearly half (49.5%) of our sample
209 estimated that the incidence of PPD in the general population was 10-15% (Table 4).

210 Over two-thirds (69.3%) of participants had confidence that they would recognize
211 PPD, and over half (59.6%) of respondents stated they often encounter PPD in their
212 clinical practice. Over three-quarters of nurse-midwives reported that they or someone
213 close to them has been diagnosed with depression and some practitioners stated they
214 would be unwilling to seek treatment for depression because of concern about stigma
215 attached to the diagnosis (12.3%) and SOMETHING DELETED HERE? (Table 4).

216 *Bivariate Statistics*

217 Receiving education about PPD from medical literature and from online sources
218 were each significantly associated with frequent screening at well-child visits, but not
219 postpartum visits (Table 3). Specifically, 30% of those who received their PPD
220 education via medical literature often or always screened for PPD during well-child visits
221 during the first year of life, while only 12.5% of those who did not receive their PPD
222 education this way often or always screened during newborn visits. Likewise, 47.6% of

223 those who received their PPD education via online education screened during well-child
224 visits while only 16.7% of those who did not receive their PPD education this way
225 screened during newborn visits.

226 No PPD beliefs were found to be associated with frequency screening at either
227 postpartum or well-child visits during the first year of life (Table 4).

228 *Narrative Findings*

229 The narrative questions yielded a variety of answers. In response to the question,
230 “How do you currently screen for PPD in your practice?” participants stated all of the
231 following, and many responses were repeated at least once by another practitioner. A
232 number of CNMs reported the use of a screening tool either once during her care, or
233 multiple times, “at first prenatal visit, mid-pregnancy, 2 week checkup and/or 6 week
234 checkup.” The tool most often used was the Edinburgh Postnatal Depression Scale.
235 One participant reported that the RN will ask, “are you having any issues with
236 depression?” when checking in each patient. Others have the CNM or OB ask this
237 question. (Nearly/Over) half reported that if the patient answers “yes”, or the practitioner
238 suspects they are experiencing PPD, they will then screen with a verified tool.

239 Other participants stated that they review warning signs with all patients, and
240 many ask generalized or informal questions in order to assess for symptoms of PPD.
241 Each practitioner reported that they question patients about different combinations of
242 the following topics: sleep disturbance, eating changes, emotions, crying, sadness,
243 ability to care for self or child, worrying excessively, support, coping and exercise. One
244 asks her patients about fearfulness and energy, another about suicidal ideation, and two
245 participants questioned their patients for anhedonia. Some of these participants

246 reported that they follow up with a screening tool if they believe the patient's "verbal and
247 non-verbal cues" warrant further assessment or "if I hear any triggers", without stating
248 what these triggers were.

249 Several practitioners give the patients the surveys to fill out on their own, either
250 by leaving copies in the waiting room, or by giving it upon hospital discharge and asking
251 them to complete it and bring it to their 2-week visit. The latter commented, "Many don't
252 bring it, and then we ask them general questions about mood".

253 Narrative about the tools themselves vary. One participant noted that the
254 Edinburgh tool is "quick, easy for patient, a good way to start conversation [about PPD],
255 patients are receptive, usually grateful that someone is paying attention". A number of
256 nurse-midwives indicated that they or their OB/midwife group or clinic was excessively
257 busy and there was "no time" to screen with a tool, but if there were a short, easy to
258 administer tool they would begin. Others stated that language, literacy or culture
259 barriers prevented them from providing a self-administered verified screening tool.

260 Discussion

261 Most participants our study were aware that PPD is both a valid and treatable
262 diagnosis. They were also attentive to the far-reaching effects of PPD on the entire
263 family unit. However, over half of the participants underestimated the incidence of PPD
264 in their own practice and their screening methods were often informal irregular. Their
265 use of screening tools was common but frequently used to confirm suspected
266 postpartum depression rather than to recognize it. Many studies observe a distinct
267 increase in the diagnosis of PPD with the use of a validated screening tool (Beck, 2002;
268 Fergerson et al., 2002).

269 The narrative responses supported the lack of familiarity with available tools. The
270 narrative areas of PPD that the nurse-midwives identified covered many of the seven
271 dimensions of the experience of PPD, but it was found that they did not ask about the
272 dimensions of loss of concentration, feelings of being all alone and the failure as a
273 mother (Cognitive Impairment, Loss of Self, Guilt/Shame) (Beck, 2001). The EPDS also
274 identifies guilt and shame, a topic that none of the nurse-midwives reported as part of
275 their screening process (Beck, 2001).

276 There are a number of validated, short and easy-to-administer tools available.
277 The instruments range from a 2-question structured interview asking about feelings of
278 depression and anhedonia which is 97% sensitive and 67% specific for major
279 depression and is reasonable for screening for PPD to the 7-question short version of
280 the PDSS (Beck, 2001; Seehusen 2005; Wisner et al., 2002; Arroll, Kihn & Kerse,
281 2003). The EPDS itself is only 10-questions long (Cox, Holden & Sagovsky, 1987). To
282 increase identification of mothers with postpartum depression, additional education is
283 necessary as over a third of nurse-midwives are unfamiliar with available screening
284 tools and a greater number lack confidence in their ability to identify postpartum
285 depression. The use of a tool removes the dependence upon their ability to recognize
286 PPD and instead increases likelihood of diagnosis, for several studies have found a
287 strong correlation between use of screening tool and increased recognition of PPD (Cox
288 et al., 1987; Beck, 2001).

289 Two recent studies of practitioner knowledge and screening practices by
290 Seehusen and Wiley also recommend the increased education about available tools to
291 increase and standardize diagnosis of PPD (Seehusen, 2005; Wiley, 2004).

292 Nearly a quarter (22.8%) of participants do not believe that mothers with PPD
293 would be willing to discuss her signs and symptoms. Fewer nurse-midwives reported
294 this obstacle than the majority of pediatricians in Wiley’s study (2004), however it is still
295 an obstacle to screening. Research has shown that providers are the ones
296 uncomfortable discussing depression with their patients. A number of nurse-midwives
297 (12.3%) stated that they would be unwilling to seek treatment for depression because of
298 the concern of stigma. Olson found that many practitioners avoid the word “depression”
299 when speaking with those they suspect to be depressed (Olson et al., 2002).
300 Most interesting are the findings from Kahn indicating that more than 85% of mothers
301 welcome and appreciate questions and referral for depression (Beck, 2002; Kahn,
302 1999).

303 Limitations

304 This study was limited by a low response rate and was limited to the
305 participants who attended the 50th Annual ACNM Conference in June 2005 (see
306 demographics of their membership), however, the ACNM membership spreads all 50
307 states as well as Puerto Rico, Guam and the Virgin Islands. As the 50th Annual
308 Conference, attendance was among the highest of all ACNM conferences
309 (ACCORDING TO...). Finally, the self-selection process most likely resulted in a sample
310 with greater interest in and knowledge of PPD than that of the general population.

311 Favorable attitudes to screening may be perceived as socially desirable and bias
312 the results. This survey did not ask the CNM’s demographic area of practice, or the
313 years in practice as a CNM or other health professional.

314 Another limitation was an error in our survey instructions that resulted in many
315 people skipping the knowledge-based questions. As a result, we cannot assess all
316 people's knowledge and experience, only those who, according to instructions, were
317 asked to complete all questions. Therefore we cannot make conclusions about those
318 who do not screen their patients or comparisons between those who do and don't
319 screen.

320 Conclusions and Implications

321 Nurse-midwives sampled believe PPD is serious and common, however their
322 screening practices are irregular and they underestimate the incidence of PPD in their
323 own practice. They identified the lack of resources as barriers to treatment. Practitioners
324 identified a barrier of cost of some screening tools as well as lack of referral providers
325 available.

326 Efforts to improve PPD recognition and treatment should involve nurse-midwives
327 in screening promotion and address the knowledge barriers.

328

329

References

330

331 Table 1

332 *Demographic Characteristics of Sample (N = XXX)*

333 Table 2

334 *CNM Beliefs about Postpartum Depression (N = XXX)*

335 Table 3

336 *Frequency of Screening for PPD by CNM Demographics, Practice Setting, and*

337 *Education Characteristics (N = 114)*

Characteristic	Often or Always Screen Women at Postpartum Visits	p ¹	Often or Always Screen Mothers at Well-Child Visits	P ²
Total (n = 114)	88.5		22.1	
Demographics				
Gender				
• Women (n = 95/25)	88.0	NS	23.1	NS
• Men (n = 3/0)	100.0	NS	0.0%	NS
Age (yrs)				
• < 38 (n = 25/6)	85.2	NS	22.2	NS
• 38-47 (n = 22/5)	84.6	NS	19.2	NS
• 48-53 (n = 26/6)	96.3	NS	22.2	NS
• > 53 (n = 26/8)	86.7	NS	26.7	NS
• Missing (n = 3/0)	100.0	NS	0.0	NS

¹ p = Pearson chi-square exact significance (1-sided)

² p = Pearson chi-square exact significance (1-sided)

Characteristic	Often or Always Screen Women at Postpartum Visits	p ¹	Often or Always Screen Mothers at Well-Child Visits	P ²
Practice setting				
• Group (n = 98/25)	66.3	NS	52.0	NS
• Hospital (n = 98/25)	27.6	NS	28.0	NS
• Solo (n = 98/25)	5.1	NS	12.0	NS
• Other (n = 98/25)	18.4	NS	24.0	NS
Education in PPD				
Nursing School				
• Yes (n = 61)	88.5	NS	27.9	NS
• No (n = 49)	87.8		16.3	
Midwifery School				
Yes (n = 103)	89.3	NS	22.3	NS
No (n = 7)	71.4		28.6	

Characteristic	Often or Always Screen Women at Postpartum Visits	p ¹	Often or Always Screen Mothers at Well-Child Visits	P ²
Medical Conference <ul style="list-style-type: none"> ○ Yes (n = 72) ○ No (n = 39) 	91.7 82.1	NS	25.0 17.9	NS
Nursing Conference <ul style="list-style-type: none"> ○ Yes (n = 57) ○ No (n = 54) 	91.2 85.2	NS	24.6 20.4	NS
Lay Media <ul style="list-style-type: none"> ○ Yes (n = 30) ○ No (n = 68) 	90.9 87.2	NS	18.2 24.4	NS
Medical Literature <ul style="list-style-type: none"> ○ Yes (n = 63) ○ No (n = 48) 	92.1 83.3	NS	30.2 12.5	.022

Characteristic	Often or Always Screen Women at Postpartum Visits	p ¹	Often or Always Screen Mothers at Well-Child Visits	P ²
Nursing Literature				
○ Yes (n = 63)	92.1	NS	23.8	NS
○ No (n = 48)	83.3		22.5	
Online Education				
○ Yes (n = 21)	81.0	NS	47.6	.004
○ No (n = 90)	90.0		16.7	
Other				
○ Yes (n = 22)	90.9	NS	27.3	NS
○ No (n = 89)	87.6		21.3	

338 Table 4

339 Association between PPD Beliefs and Screening Practices (N = 114)

Statement	Often or Always Screen at Postpartum Visits	<i>p</i>	Often or Always Screen at Well-Child Visits	<i>p</i>
<i>General beliefs about PPD</i>				
PPD affects the spouses of affected women. • Agreed (n = 98/1) • Did not agree (n = 2/24)	89.1 66.7	NS	21.8 33.3	NS
PPD affects the children of affected mothers • Agreed (n = 97/23) • Did not agree (n = 3/2)	89.0 75.0	NS	21.1 50.0	NS
PPD causes no lasting effects. • Agreed (n = 0/0) • Did not agree (n = 100/25)	0.0 100.0	---	0.0 100.0	NS
PPD is not a valid diagnosis. • Agreed (n = 0/0) • Did not agree (n = 100/25)	0.0 88.5	---	0.0 88.5	---

Statement	Often or Always Screen at Postpartum Visits	<i>p</i>	Often or Always Screen at Well-Child Visits	<i>p</i>
Therapy for PPD is effective. <ul style="list-style-type: none"> • Agreed (n = 89/23) • Did not agree (n = 11/2) 	89.9 78.6	NS	23.2 14.3	NS
General beliefs about screening for PPD				
PPD is common enough to warrant screening. <ul style="list-style-type: none"> ○ Agreed (n = 97) ○ Did not agree (n = 11) 				
PPD is a serious enough problem to warrant screening. <ul style="list-style-type: none"> • Agreed (n = 99/25) • Did not agree (n = 1/0) 	90.8 25.0	.005	22.9 0.0	NS
<i>Beliefs about screening women at postpartum visits</i>				
Screening at every postpartum visit would not be effective. <ul style="list-style-type: none"> • Agreed (n = 96/2) • Did not agree (n = 4/23) 	0.0 22.1	NS	50.0 21.1	NS

Statement	Often or Always Screen at Postpartum Visits	<i>p</i>	Often or Always Screen at Well-Child Visits	<i>p</i>
Screening at every postpartum visit would take too much effort. • Agreed (n = 98/24) • Did not agree (n = 2/1)	50.0 89.9	NS	25.0 22.0	NS
Screening at every postpartum visit would be time-consuming. • Agreed (n = 15/6) • Did not agree (n = 85/19)	78.9 90.4	NS	31.6 20.2	NS
<i>Beliefs about screening mothers at well-child visits</i>				
Screening at every well-child visit up to one year of age would take too much effort. • Agreed (n = 9/4) • Did not agree (n = 91/21)	75.0 90.1	NS	33.3 20.8	NS
Screening at every well-child visit would not be effective.				

Statement	Often or Always Screen at Postpartum Visits	<i>p</i>	Often or Always Screen at Well-Child Visits	<i>p</i>
<ul style="list-style-type: none"> • Agreed (n = 6/2) • Did not agree (n = 94/23) 	<p style="text-align: center;">85.7</p> <p style="text-align: center;">88.7</p>	NS	<p style="text-align: center;">28.6</p> <p style="text-align: center;">21.7</p>	NS
<p>Screening at every well-child visit up to one year of age would take too much effort.</p> <ul style="list-style-type: none"> • Agreed (n = 13/4) • Did not agree (n = 87/21) 	<p style="text-align: center;">81.3</p> <p style="text-align: center;">89.7</p>	NS	<p style="text-align: center;">21.6</p> <p style="text-align: center;">25.0</p>	NS