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RESEARCH

Missed Opportunities for Postpartum Behavioral and Psychosocial Health Care and Acceptability of Screening Options

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ABSTRACT

Objective: To examine occurrence of health care provider discussion of postpartum women's behavioral and psychosocial health, acceptability of screening, and access to a health care provider with whom to comfortably discuss sensitive topics. Q1

Design: Mail survey during the first postpartum year.

Setting: Community dwelling.

Participants: Postpartum women ($N = 168$) from diverse backgrounds.

Methods: Using vital records, we drew a random sample that was stratified on race/ethnicity and income from a Southwestern U.S. community. Potential participants were mailed a questionnaire about health care and screening in the areas of depression, diet, physical activity, smoking, and alcohol use during the postpartum period.

Results: Women reported that discussion of depression most often occurred (51%) during health care encounters, and discussion of weight least often occurred (14%). More than 94% of women indicated they would "welcome" or "not mind" screenings for depression, diet, physical activity, alcohol use, or smoking at health care visits. More than 90% welcomed screening during their infants' pediatric health care visits. Most (86%) reported that screening on an electronic device at their health care visits was acceptable. Most (84%) were interested in completing a screening at home on a Web site, with African American women more likely to prefer this option (100%) than White (80%) or Hispanic (79%) women, $\chi^2 = 8.48$, $p < .05$. Also, 58% of women without health insurance compared with 24% of those with insurance indicated that they lacked a health professional with whom they could comfortably discuss sensitive topics such as depression.

Conclusion: Wide gaps exist in postpartum behavioral and psychosocial health care. Most women find a variety of screening settings and methods acceptable.

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The first year after childbirth, the extended postpartum period, often constitutes a missed opportunity to promote health and prevent disease among American women (Suplee, 2014). Although breastfeeding and family planning are important foci of postbirth health care and public health efforts, preventive care of women requires consideration of a broader perspective (Walker, Sterling, Guy, & Mahometa, 2013). In this article we focus on the behavioral and psychosocial health care of postpartum women for several reasons. First, to improve the "health and wellness for the entire U.S. population," the National Prevention Strategy prioritized seven areas, including healthy diet, active living, mental/emotional health, and reduction of tobacco and excessive alcohol use (Surgeon General, 2011, "Priorities" para.). Second, data from the Institute for Health Metrics and Evaluation (2013) indicated that the leading risk factors for mortality of U.S. women ages 15 to 49 years (roughly the childbearing years) are in the areas of diet, physical activity, excess body weight, smoking, and alcohol use. Third, research shows that the postpartum transition after pregnancy may be marked by an assortment of less

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Despite the acceptability of screening, previous researchers found that women often reported that depression was not discussed during health care encounters in the postpartum period.

healthy practices or unfavorable changes in the areas of dietary patterns and nutrition (Berge, Larson, Bauer, & Neumark-Sztainer, 2011; Nasuti et al., 2014), physical activity (Ainsworth et al., 2013; Berge et al.; Hull et al., 2010), increased weight (Berge et al., 2011; Walker, Fowles, & Sterling, 2011), smoking relapse (Park et al., 2009), high-risk alcohol use (Jagodzinski & Fleming, 2007; W. Liu, Mumford, & Petras, 2015), and depression (Gavin et al., 2005). Taken together, the evidence from these varied sources points to the importance of focusing on behavioral and psychosocial health for women during the extended postpartum period, including the areas of diet (for dietary quality and weight management), physical activity, smoking prevention, moderate alcohol use, and depression reduction.

These behavioral or psychosocial areas have been studied extensively with regard to their prevalence and correlates among postpartum women (e.g., Berge et al., 2011; Gavin et al., 2005; Jagodzinski & Fleming, 2007; W. Liu et al., 2015; Nasuti et al., 2014; Tong et al., 2013). By contrast, far fewer studies have been conducted about the frequency with which these areas are discussed or assessed in health care after pregnancy. In addition, a better understanding is needed of the acceptability to women of screening in these areas, especially among women of diverse racial/ethnic and economic backgrounds, because screening may potentially increase attention to behavioral and psychosocial disparities in postpartum health care. Of these areas, most is known about postpartum depression, which has a prevalence of 19% in the first 3 months postpartum (Gavin et al., 2005). Greater prevalence may occur in high-risk populations, such as immigrant women (Falah-Hassani, Shiri, Vigod, & Dennis, 2015) and illiterate women (Veisani, Delpisheh, Sayehmiri, & Rezaeian, 2013). Postpartum depression is a major concern in postpartum care because of the potential adverse effects on infants and parenting (Balbierz, Bodnar-Deren, Wang, & Howell, 2015; Gress-Smith, Luecken, Lemery-Chalfant, & Howe, 2012) and maternal suffering (Beck, 1993). The frequency with which screening for depression takes place is important in view of the recommendation of the American College of Obstetrics and Gynecology (ACOG, 2015) that screening for depression be done "at least once during the perinatal period" (p. 1268) and a related recommendation from the U.S. Preventive Services Task Force (USPSTF; Siu & USPSTF, 2016). In their recent systematic review of more than 20 studies, El-Den, O'Reilly, and Chen (2015) found that screening for postpartum depression was acceptable to most women except in one small British study (Shakespeare, Blake, & Garcia, 2003). Despite the acceptability of screening, previous studies show that 39% to 66% of postpartum women reported that depression was not discussed in health care after pregnancy, with discussion varying by type of clinical setting, and maternal race, age, and nativity (C. H. Liu & Tronick, 2012; Walker, Im, & Tyler, 2013).

With regard to behavioral health, 54% to 64% of postpartum women have reported no discussion of smoking during their or their infants' health care, and 77% to 79% have reported no such discussions related to alcohol use (Walker, Im, & Tyler, 2013). Similarly, Ferrari et al. (2010) found that only 11% and 23% of women reported receiving advice about weight and physical activity, respectively, from a health care provider in the first 3 months postpartum. Except for a study of postpartum weight (Ohlendorf, Weiss, & Ryan, 2012), we were unable to locate studies on the frequency of discussion or screening specifically related to diet during health care of postpartum women, despite the importance of diet in breastfeeding (American Academy of Pediatrics, 2012), postpartum weight management (van der Pligt et al., 2013), and overall health. Finally, unlike the area of depression, few researchers have probed the acceptability to postpartum women of screening for smoking and alcohol use (Kahn et al., 1999; Walker, Im, & Tyler), and none, to our knowledge, of diet and exercise screening.

Comprehensive study of the spectrum of women's postpartum behavioral and psychosocial health care is needed to identify gaps in care. The identification of these gaps, in turn, can be a stimulus to improve care and meet guidelines for preventive health care, for example, in the areas of mental health, diet, physical activity, smoking, and alcohol use (ACOG, 2012, 2015; Siu & USPSTF, 2016; USPSTF, 2015). Of particular interest are gaps that may be contributory to health disparities among racial/ethnic minorities or low-income women. Furthermore, deeper

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