



UNIVERSITY OF TWENTE.

What mothers want

The experiences and priorities of mothers in the screening trajectory for postpartum depression

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Master thesis Health Sciences
Health Technology Assessment and Innovation
September 2015

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Abstract

Background Postpartum depression (PPD) is a major public health problem that needs attention because of its serious effects on women and children. To detect PPD as soon as possible, screening with the Edinburgh Postnatal Depression Scale (EPDS) takes place in Youth Health Care (YHC) settings in the region of Twente. Where necessary, referral to the family doctor or a mental health care institute takes place. Many mothers perceived barriers in the screening, referral and follow-up for PPD. However, little is known about the experiences and especially about the priorities of mothers in the screening, referral and follow-up for PPD.

Objective The objective of this research is to gain insight on the experiences and priorities of mothers in the process of screening for PPD, referral and follow-up in the YHC setting.

Methods A total of 176 mothers that have given birth in the period of January 2013 to May 2014 in the region of Twente participated in an online questionnaire survey. The questions related to the demographics of the mother, the period during the screening (process of screening) and the period after the screening (process of referral and follow-up). Through descriptive analysis, mothers' experiences and priorities were determined.

Results The results showed that in the process of screening, the clinic was not suitable for completing the EPDS-10 and the explanation of the YHC physician at the clinic to select the right next step was not sufficient. False-positive screened mothers did not seem to suffer from the harms that false-positive screening results can bring, but were not pleased with it either. Mothers with PPD seemed to have less confidence in the YHC physician which made them talk about their feelings and thoughts and the outcome of the EPDS-10 corresponded less with their feelings than mothers without PPD. To mothers without PPD, it was more important that the YHC physician spent sufficient time on listening to their feelings at the clinic than it was to mothers with PPD. In the process of referral and follow-up, receiving sufficient explanation of the YHC physician/YHC nurse about the reason for a referral was not important but not non-important to either. Receiving sufficient explanation of the family doctor to select the right next step in treatment was not important. Receiving sufficient explanation of the family doctor to select the right next step in the 'mother-baby intervention' was not important also and the explanation of the family doctor was not sufficient.

Conclusion We advocate that researchers and YHC pay sufficient attention to mothers' bad experiences and low reported priority of aspects in the screening trajectory through further research. By gaining more clarity from further research, YHC could intervene on actions which may lead to an improvement of quality of care for PPD.

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1. Introduction

In the Netherlands, the number of births amounts to 180.000 per year (1). When giving birth, a woman experiences many changes that are both physically and hormonally but also emotionally and socially (2). These changes explain why many of these women are prone to sleeping problems, irritability, nervousness and episodes of tearfulness. The episodes of tearfulness, that are called 'baby blues', occur in 50 to 80% of the women and mostly in the third to tenth day after delivery. Usually, these baby blues stop automatically, but sometimes women stay gloomy for months. If that occurs and women are irritable, anxious and have mood changes, they are likely to have a postpartum depression (PPD). A PPD, which is also called a postnatal depression, is "an irritable, severely depressed mood that occurs within 4 weeks of giving birth and possibly as late as 30 weeks postpartum" (3). About 10% of all mothers suffer from PPD after giving birth (2). PPD is a major public health problem which is not only a problem for the mother herself, but may also have a serious impact on children of mothers suffering from PPD (4). These children have an increased risk of problems like disturbance in mental and motor development, poor self-regulation, low self-esteem and behavioral problems (1, 5, 6).

To reduce these consequences, attention must be given to better detection of PPD. Therefore, screening for PPD may be a possible solution. The UK National Screening Committee (2015) defines screening as: "a process of identifying apparently healthy people who may be at increased risk of a disease or condition. They can then be offered information, further tests and appropriate treatment to reduce their risk and/or any complications arising from the disease or condition" (7). Detecting PPD is possible through different international screening instruments. One of these screening instruments is the Edinburgh Postnatal Depression Scale (EPDS-10) which consists of 10 questions that measure the degree of PPD symptoms in the last 7 days (8). Since 2008, Youth Health Care (YHC) physicians in the region of Twente, the Netherlands, started with the use of the EPDS-10 to screen mothers on three different times; 1, 3 and 6 months after giving birth. When a mother has a raised score on the EPDS-10, a second diagnostic-stage test is necessary to confirm the diagnosis. Referral to the family doctor for further diagnosis and treatment is most commonly preceded by a home visit of a YHC nurse. When necessary, this is followed by referral to a mental health care institute.

Preparatory to the implementation of this method of screening, the quality of care regarding to the screening trajectory for PPD needs to be determined. At the moment, the effectiveness of screening for PPD in Child Health Care settings is studied to determine if screening results in detecting PPD in an earlier stage and if mothers with PPD receive treatment sooner. The experiences of mothers on the screening trajectory as well as information on the priorities of mothers towards this trajectory have not been examined yet. However, previous studies showed that mothers experienced barriers in the process of screening, referral and follow-up such as insufficient time at physician's appointments, lack of privacy in completing the EPDS-10 and knowledge barriers in the treatment for PPD (9, 10).

In a patient-centered vision, quality would be defined as "providing the care that the patient

needs in the manner the patient desires at the time the patient desires” (11). Patient-centered care is known as a measure of the quality of care and furthers adherence and leads to improved health outcomes (12). Outcomes such as patient experiences and priorities have become an important factor in improving the quality of care (13). Because of this, the patients’ experiences and priorities can be seen as a part of the effectiveness of the screening process. Therefore, this study aims to determine what mothers’ experiences and priorities are in the process of screening for PPD, referral and follow-up in the YHC setting. The results of this study could contribute to an improvement in the care of PPD in YHC.

1.1 Postpartum depression

The literally meaning of a PPD is a depression after (post) giving birth (partum). A PPD occurs within 4 weeks to 30 weeks after delivery and is recognizable by an irritable, severely depressed mood (3). It affects 1 in 10 women after giving birth and can be a major health problem to the mother and to the people around her (2). The risk of PPD is high in women who already have had PPD in the past, in women who during pregnancy experienced depressive symptoms, poor marital relationship, low social support, social isolation and in women who have a low social status (1, 14-16). Also domestic violence increases the risk of PPD (1, 17).

PPD knows several consequences that affect both the mother and her social environment. PPD is associated with an increased risk of marriage problems and divorce (1, 18), but also with an increased risk of child abuse and neglect (1, 19). Children of mothers with PPD have an increased risk of problems like disturbance in mental and motor development, poor self-regulation, low self-esteem and behavioral problems (1, 5, 6). Also the cognitive skills of children and their expressive language development may negatively be affected by PPD (1, 20).

In general, PPD is quite treatable. A mother diagnosed with PPD is treated by the family doctor or mental health care. An untreated PPD lasts four to six months but it can also last longer and sometimes it even lasts for years (21). The treatments for PPD that showed to be effective are behavioral therapy and/or antidepressants (22). In behavioral therapy, the patient is learned how to convert negative thoughts into positive thoughts and how to tackle certain situations differently. If the mother is receiving medications these usually are antidepressants and in more than half of the mothers who use antidepressants, the complaints caused by PPD reduce (2). When mothers have complaints like insomnia, anxiety and stress, tranquillizers or sleeping pills are prescribed. PPD is often not recognized in time because of a lack of focused attention of the professionals in the prenatal care (1, 23). Therefore and to reduce PPD’s consequences for both the mother and child, attention must be given to better detection of PPD. Detecting PPD early is possible through various international screening instruments and methods.

1.2 Edinburgh Postnatal Depression Scale

One of the screening instruments that can improve detection of PPD is the Edinburgh Postnatal Depression Scale (EPDS-10). The EPDS-10 is a questionnaire that is developed by Cox, Holden & Sagovsky

(1987) and which has the aim to detect PPD in mothers. Completing the questionnaire takes about 5 minutes and consists of ten questions that measure the degree of PPD symptoms in the last seven days (appendix A). All items need to be completed by the mother herself, unless there exists a lack in language or difficulties with reading. Possibilities where the mother might discuss her responding with other mothers need to be avoided (24). An example of an item's statement in the EPDS-10 is: 'I have been anxious or worried for no good reason', which can be responded in a 4-point Likert scale that varies from 'no, not at all' to 'yes, very often'. For each single question, 3 points can be gained what can reach up to a total of 30 points for the whole questionnaire. If a woman gains a score of 10 points or higher, there might be a possible depression (6). Professionals are recommended to always be aware of the score on item 10 'the thought of harming myself has occurred to me'. If this item is responded with 'yes, quite often' or 'sometimes', there might be a risk of self-harm or of possible depression and an urgent referral for psychiatric care is recommended. In women who score between 5 and 9 points, it is recommended to evaluate them again two to four weeks after the screening moment to determine whether a depression has originated or whether the symptoms have disappeared (6).

1.3 Youth Health Care

The Youth Health Care (YHC) in the Netherlands, is legally responsible for protecting and promoting the health of children and youth from 0 to 19 years (25). In practice, YHC-organizations work with families with children in different age categories. While many organizations are either working with the category 0-4 years or 5-19 years, other organizations work with both age categories. Professionals that are active in YHC are: nurses, nurse specialists, physicians and doctors assistants. However, there are also other disciplines like pedagogues, speech therapists and social workers active in YHC (26).

The YHC is committed to the physical, mental and social development of children and youths (25). This is being realized by performing various basic tasks such as monitoring and signaling the development of children, but also by performing vaccinations and screening (27). If there appear to be problems like for instance a mother suffering from PPD, the YHC provides guidance and support for the child and his parents/guardians (25). Currently, youth care is being provided by various institutions like the GGD, Homecare ('Thuiszorg') or Youth Foundations (26).

1.3.1 Screening for PPD in Twente

In 2008, YHC physicians in the region of Twente started with the use of the EPDS-10 to screen mothers for PPD that takes place on three different times; 1, 3 and 6 months after giving birth. In the screening, which is part of a whole process, an EPDS-10 manual (appendix B) is used in the course of action (28). This process starts with the postnatal home visit where the YHC nurse informs the parents when and why the YHC is working with the EPDS-10. When the parents made the decision to participate to the screening and come to the youth health care clinic for the 1, 3 and 6 months after birth visit, the YHC clinic's assistant will, prior to the visit, hand over the EPDS-10 questionnaire that needs to be completed by the

mother. Afterwards, the YHC physician discusses the questionnaire with the mother and records the score in the digital file. The YHC physician discusses the score also with the YHC nurse to determine whether and what action should be or has been taken. Subsequently, the questionnaire will be destroyed.

Depending on the score, the following actions should take place; if the score is 0 to 8 points there is no indication that PPD is present. If the score is 9 to 12 points there are probably some problems in the adjustment of life with a baby, a home visit by the YHC nurse is possible. If there is a score of 13 to 14 points, signs that resemble PPD exist and therefore the YHC nurse will visit the mother at home and if necessary this will be followed by a referral to the family doctor or mental health care where the mother receives treatment. If the score is 15 points or higher, PPD is likely and immediate referral is necessary.

Mothers that are diagnosed with PPD by the family doctor or mental health care can as part of their treatment be referred for participation in a KOPP project (28). This referral can also be given by the YHC physician or YHC nurse. KOPP stands for 'Children of parents with psychiatric problems', includes plenty of activities that all have the aim to support parents in their role as educators. For people with mental health problems and their partners, the departments of Mediant and Dimence offer 'Contact with your baby' to improve the contact between the parent and the baby (28). In up to 10 visits in the first 12 months after birth, the departments offer support to parents and spend time and attention to questions about education, care and the relationship between the parent and the baby.

As for follow-up, the YHC physician or YHC nurse checks if mothers, who were referred to the family doctor or mental health, made further contact according to the referral. Also part of the follow-up is to ask mothers if everything went as desired and if there were any difficulties.

1.3.2 Phases of screening

To obtain a better overview of the course of action of the screening trajectory for PPD it can in accordance to the description in the above paragraph be divided in six phases;

1. Preparation: information and explanation of screening by YHC nurse at home visit.
2. Screening: completing the EPDS-10 questionnaire.
3. Discussion: YHC physician discusses EPDS-10 score with mother.
4. Home visit: by YHC nurse if EPDS-10 score is 9-14 points.
5. Referral & Access: to family doctor or mental health care.
6. Treatment & Follow-up: treatment and check up by YHC physician or YHC nurse.

These phases can be divided in three categories that refer to ante screening, during screening and post screening (figure 1). The during screening category refers to the process of screening and the post screening category to the process of referral and follow-up.

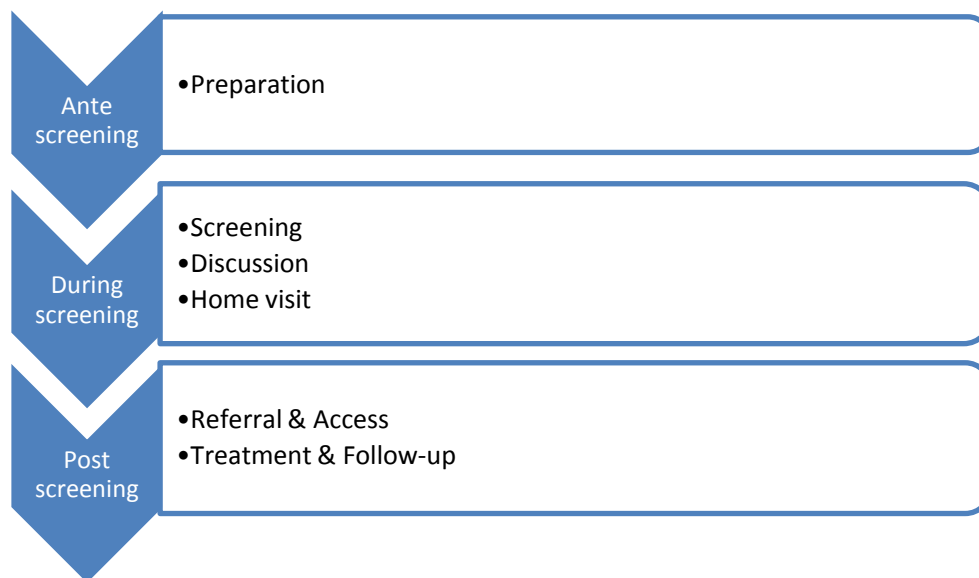


Figure 1. Phases in the screening trajectory divided in three categories.

1.4 Quality of care

Preparatory to the possible implementation of the screening trajectory for PPD, its quality needs to be determined. In general, quality relates to the properties of a product that meet the expectations of this product (29). According to the Institute of Medicine, the definition of quality of care is: “The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge” (30). With regard to this definition, the Institute of Medicine set up six domains of quality that may lead to an improvement of quality of care if these are pursued. These are the following domains (31, 32):

- Safety: avoiding injuries to patients from the care that is intended to help them.
- Effectiveness: providing services based on scientific knowledge to all who could benefit, and refraining from providing services to those not likely to benefit.
- Patient-centeredness: providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions.
- Timeliness: reducing waits and sometimes harmful delays for both those who receive and those who give care.
- Efficiency: avoiding waste, including waste of equipment, supplies, ideas, and energy.
- Equitability: providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location and socioeconomic status.

According to the Institute of Medicine (31), health care systems that gain in these six areas are likely to improve themselves in meeting patients’ needs. The determination of the quality of care in a health system, is dependent on the perspective of the relevant actor (29). This, because different actors attach a

different importance to each of the six areas of quality of care. From the perspective of the professional, the effectiveness is an important area of quality of care. However, from the perspective of the patient it is mainly about the safety, effectiveness, patient-centeredness and timeliness and from the perspective of the organization it is mainly about the efficiency and safety.

In order to make a statement on the quality of care, the quality of a health system needs to be measured by the use of indicators (29). An indicator is "a measurable aspect of care that functions as a possible indicator of quality of care" (33). Indicators can be characterized as structural, process or outcome indicators (34, 35). The following characterization refers to the different aspects of health care where the indicator is related to (29, 36, 37):

- Structural indicators: are related to human, physical and financial resources to provide good care, such as staff training or the presence of a quality certificate.
- Process indicators: provide information about the actual care, such as the performance of health care providers and the number of deployed interventions.
- Outcome indicators: provide insight into the effect of care. These indicators show how the provider performs and what the added value is for the patients.

In determining the quality of care from the patients' perspective, process indicators are most relevant as these provide information about the actual care.

1.4.1 Facilitators and barriers in health care

As mentioned in the above, the quality domains that are relevant from the perspective of the patient are the safety, effectiveness, patient-centeredness and timeliness. In these areas, good communication between the doctor and patient is indispensable (38). Effective communication between the doctor and patient and also good communication skills of the professional can be seen as a source of motivation, incentive, reassurance and support; when the relationship between the doctor and patient is good, this may increase doctors' job satisfaction, the patient's self-confidence, motivation and it may strengthen the view on his health which may react on his health outcomes (38-40). However, in reported cases, doctors seem to avoid discussion regarding to the emotional and social impact of the patients' problems. Reasons for this behavior were the feeling of being distressed when they did not know how to solve the problem or because they did not have the time for it. This may lead to an unwillingness of the patient to elicit his problems which could result in a delay and an adverse effect in his recovery (38, 41). Reports showed that doctors may discourage the patient from sharing his concerns, expectations and making requests to obtain more information (38, 42). This makes the patient to feel deterred to pronounce his need for obtaining explanations and information which results in insufficient adequate explanation. When a patient does not receive sufficient adequate explanation, his lack of understanding may turn into a lack of consensus between him and the doctor which according to DiMatteo (42) may lead to therapeutic failure. Patients seem to consider their doctors as a meaningful source of support in their mental and emotional

state (43). Concernment of the doctor is, according to Baile et al. (43), a vigorous way of supporting the patient in reducing his feelings of isolation and confirming their feelings or mind as usual or typical. If patients perceive their feelings or mind as usual and typical, the undesirable effect of for example a social stigma also reduces.

Screening for PPD is likely to improve the quality of care since it may, as seen in the above chapters, lead to early detection and better health outcomes for both the mother and child. However, according to the literature, there seem to be several barriers that mothers experience in mental health. Regarding to mental health treatment, O'Mahen & Flynn (10) described these in structural, knowledge and attitudinal barriers. Structural barriers existed in insurance, inability to pay, transportation and inadequate child care. Knowledge barriers existed in women being least sure whom to contact and not knowing the best treatment for the depression. Furthermore, attitudinal barriers existed in mothers that have a lack of expressed motivation for treatment and that are hopeless about treatment working.

Barriers regarding to the screening, diagnosis and treatment of PPD that were reported by other studies consist of a lack of insurance coverage, no adherence to depression treatment, time constraints, social stigma, lack of follow-through with mental health referrals and lack of access to care (44-48). In a study conducted by Shakespeare et al. (9) women were interviewed at 11-19 months after giving birth about the completion of the EPDS-10 in the first three months post-partum. The study showed that for 54% of the women screening for PPD was unacceptable. Reasons for unacceptability were that the process of screening was seen as simplistic, anxiety about the consequences, insufficient time and privacy, not seeing a medical solution to their complaints and not wanting to admit to their diagnosis (9, 49). Another study that examined the acceptability of the EPDS-10 showed that 81.2% of the women indicated that they were (very) comfortable with the instrument and that for 97% of the women the screening was desirable (50). However, discomfort in screening is higher in women with more severe depression (51). Among the women with high EPDS-10 scores, 64% were uncomfortable with the screening process. The same study showed that of the 216 women that were told they might be depressed, only 154 made further contact after referral and of them 18% disagreed they were depressed (49).

Screening and treatment of depressive disorders benefits potentially in reduced morbidity and mortality and in an improvement in the functioning of quality of life and employment (52). However, the potential harm of screening exists of the consequences of false-positive screening results whereby screened people are told they might have a depressive disorder according to their screening results, but where diagnostic examination shows this is incorrect (53). This may lead to suffer from the adverse effects in costs and treatment and the potential adverse effects of labeling (52, 54). False-positive screened people have been worried unnecessary (53). While most of them are relieved when further examination shows incorrect results, a small group remains worried which may result in not coming back for another screening.

1.5 Framework of factors assigned to phases and domains of quality of care

The barriers that mothers seem to experience in the screening trajectory and in mental health care as described in the above, are listed with their references in table 1. Several factors can be derived from these barriers. Since the Netherlands includes the care for PPD in the 'basic insurance package for YHC', the structural barriers except for the access to care and time constraints do not fit in the Dutch situation of quality of care (55). The other barriers can be combined and/or set up as the following factors: Knowledge, Attitude, Time available, Privacy available, Social stigma, Access to care, Agreement, Anxiety and Adverse effects.

As mentioned in the previous chapters, the course of action of screening for PPD in Twente can be divided in six phases and three categories: ante screening, during screening and post screening (figure 1). However, the aim is to get insight in the experiences and priorities of mothers in the process of screening for PPD, referral and follow-up, which makes the category ante screening not relevant for this present research. The five relevant phases are the Screening, Discussion, Home visit, Referral & Access and Treatment & Follow-up.

Table 1. Barriers in mental health care and references.

Barriers	References
Structural barriers: Insurance, inability to pay, transportation, inadequate child care, lack of insurance coverage, lack of access to care and time constraints.	O'Mahen & Flynn ⁽¹⁰⁾ (2008); Katon & Ludman ⁽⁴⁶⁾ (2003); LaRocco-Cockburn et al. ⁽⁴⁵⁾ (2003); Gjerdingen & Yawn ⁽⁴⁴⁾ (2007); Scholle et al. ⁽⁴⁷⁾ (2003); Williams et al. ⁽⁴⁸⁾ (1999)
Knowledge barriers: Being least sure whom to contact and not knowing the best treatment for the depression	O'Mahen & Flynn ⁽¹⁰⁾ (2008)
Attitudinal barriers: Lack of expressed motivation, hopelessness about treatment working, lack of follow-through with mental health referrals, no adherence to depression treatment, process of screening seen as simplistic, anxiety about the consequences, not seeing a medical solution to the complaints and not wanting to acknowledge to one's own diagnosis.	O'Mahen & Flynn ⁽¹⁰⁾ (2008); Katon & Ludman ⁽⁴⁶⁾ (2003); Gjerdingen & Yawn ⁽⁴⁴⁾ (2007); LaRocco-Cockburn et al. ⁽⁴⁵⁾ (2003); Scholle et al. ⁽⁴⁷⁾ (2003); Shakespeare et al. ⁽⁹⁾ (2003)
Insufficient time and privacy	Mitchell & Coyne ⁽⁴⁹⁾ (2009); Shakespeare et al. ⁽⁹⁾ (2003)
Social stigma	Katon & Ludman ⁽⁴⁶⁾ (2003); Gjerdingen & Yawn ⁽⁴⁴⁾ (2007); Scholle et al. ⁽⁴⁷⁾ (2003)
Comfort ability with the EPDS-10	Gemmill et al. ⁽⁵⁰⁾ (2006); Buist et al. ⁽⁵¹⁾ (2007)
Adverse effects of false-positive screening results	Dennis & Ross ⁽⁵⁴⁾ (2006); Pignone et al. ⁽⁵²⁾ (2002)

According to the areas of quality of care, a framework can be set up where the factors will be assigned to the five phases of screening and quality of care domains in order to obtain an overview of the phase and

quality area a certain factor belongs (table 2). In determining the actual care and the experiences and priorities of mothers herein, only process indicators are relevant.

Table 2. Factors assigned to phases and domains of quality of care.

	Quality of care domains					
	<i>Safety</i>	<i>Timeliness</i>	<i>Effectiveness</i>	<i>Efficiency</i>	<i>Equitability</i>	<i>Patient-centeredness</i>
During screening						
<i>Screening</i>		Time available	Agreement	-	-	Privacy available
<i>Discussion</i>	Anxiety Adverse effects	Time available	Knowledge	-	-	Attitude
<i>Home visit</i>			Knowledge	-	-	Attitude
Post screening						
<i>Referral & Access</i>		Access to care	Knowledge	-	-	
<i>Treatment & Follow-up</i>	Anxiety Social stigma	Time available	Knowledge	-	-	Attitude
			Knowledge			Attitude

1.6 Research question

Previous studies showed that mothers experienced several barriers in the screening trajectory of PPD. Because evaluating patients' experiences and priorities is a part in determining the quality of care of the complete screening trajectory, this study has the aim to gain insight in the experiences and priorities of mothers in the process of screening for PPD, referral and follow-up. Therefore, the following research question will be answered:

What are the experiences and priorities of mothers in the process of screening for PPD, referral and follow-up in the YHC setting?

This research focuses on the factors that can be assigned to the phases of screening and the areas of quality of healthcare as shown in table 2. The results of this study are to contribute to an improvement in the care of PPD in YHC.

2. Methodology

The current study is part of the 'Post-Up Study', a larger study that investigated the effectiveness of screening for PPD in YHC settings and that was conducted by the 'Academische Werkplaats Jeugd Twente (AWJT)'. Since the participants of this current study were studied at one point in time, this is a cross-sectional study. Data was collected through a questionnaire that was completed by mothers.

2.1 Participants

In total, 265 mothers were approached and invited to take part in this study. These are mothers that already participated in the Post-Up Study and who have indicated that they were willing to participate in follow-up studies concerning PPD. The inclusion criteria for this study existed of mothers who had given birth in the period of January 2013 to May 2014 in the region of Twente. The exclusion criteria existed of mothers who had not completed the questionnaire and mothers who were not screened for PPD (who did not complete the EPDS-10).

2.2 Measurement instrument

Data were collected through an online patient questionnaire that was completed by mothers. The questionnaire started with an introduction providing information on the research and duration of the survey. In the first part of the questionnaire mothers were asked to agree with participation in this study. In the second part, five questions were asked about mothers' demographics. These included questions about the age of the mother, the highest education the mother completed, the mother country, current health status perceived by the mother and whether or not the mother had a depression within one year after child-birth. The third and fourth part consisted of questions about the period during screening and the period post screening. The questions in these two parts were assigned to the factors shown in table 2. There were two kinds of questions for each factor; experience questions and priority questions. The experience of the mothers with the screening trajectory is measured by giving a (positive or negative) statement about the performance of the aspect of care. The mothers were asked to state their agreement with the statement on a 5-point Likert scale ranging from 'totally agree' to 'totally disagree'. Afterwards, the mother is asked to state the priority of the aspect of care on a 5-point Likert scale ranging from 'totally important' to 'totally not important'. The questionnaire can be found in appendix C.

The factors and the amount of items these factors measured are shown in table 3. Here it can be seen that some of the factors measured more than one item. For the period during screening these were the following factors: *Attitude*, *Knowledge* and *Time available*. For the period post screening these were: *Attitude* and *Knowledge*. To separate these items, new and different final names were given to them.

Table 3. Item names for the items that measure the same factor and corresponding questions in questionnaire.

Factors	Sample questions (experience)	Factors (final names)
During screening		
Privacy available	'The clinic was suitable for completing the EPDS-10.'	Privacy available
Agreement	'The outcome of the EPDS-10 corresponded with my feelings at that moment'	Agreement
Time available	'I had enough time to complete the questionnaire at the clinic.'	Time available Screening
	'The doctor at the clinic took enough time listening to how I felt.'	Time available Clinic
Anxiety	'During the conversation at the clinic I had enough confidence in the doctor to tell how I felt at that moment.'	Anxiety
Attitude	'The doctor at the clinic responded involved and made sure I felt supported to take further steps.'	Attitude Clinic
	'The YHC nurse at home responded involved and made sure I felt supported to take further steps.'	Attitude Home
Knowledge	'I received sufficient explanation from the doctor at the clinic to select the right next step.'	Knowledge Clinic
	'I received sufficient explanation from the YHC nurse at home to select the right next step.'	Knowledge Home
Adverse effects	'I found it annoying that there was according to the questionnaire a possibility of having a depression while I did not have a depression.'	Adverse effects
Post screening		
Time available	'The family doctor took enough time listening to how I felt.'	Time available
Anxiety	'During the conversation I had enough confidence in the family doctor to tell how I felt at that moment.'	Anxiety
Social stigma	'During the conversation the family doctor explained that a depression after giving birth can happen to any mother.'	Stigma
Attitude	'The family doctor responded involved and made me feel motivated to address myself to the depression.'	Attitude Family doctor
	'I felt supported when the YHC nurse/YHC physician contacted me to ask how I and my baby were doing at the time.'	Attitude Follow-up
Knowledge	'I received adequate explanation from the YHC nurse/YHC physician why it took me a referral and with whom I had to take further contact.'	Knowledge Referral
	'I received sufficient explanation from the doctor to make the right next step in treatment.'	Knowledge Family doctor
	'The doctor has given me enough information and explanation about the 'mother-baby intervention' to decide if I wanted to use this.'	Knowledge Project
Access to care	'The time between the discussion of a possible PPD until the start of treatment was acceptable.'	Access to care

The period during screening included the following topics: screening, discussion with the physician and the home visit by the YHC nurse. *Privacy available* measured if the clinic was suitable for completing the EPDS-10. Mothers that reported that the clinic was not suitable for completing the EPDS-10 were asked to elucidate this in an open question. The answers on this open question will be divided into categories to determine what the most common reasons are why mothers reported that the clinic is not suitable. *Agreement* measured whether the outcome of the EPDS-10 corresponded with mothers' feelings at that moment. *Time available* measured if mothers had enough time to complete the EPDS-10 and if the YHC physician spent enough time on listening to their feelings at the clinic and so these two items were named *Time available Screening* and *Time available Clinic*. *Anxiety* related to mothers' confidence in the YHC physician that made them talk about their feelings and thoughts. *Attitude* measured the involvement of the YHC physician at the clinic and of the YHC nurse at home in supporting and motivating mothers, and therefore these two items were given the final names *Attitude Clinic* and *Attitude Home*. *Knowledge* measured if mothers received sufficient explanation from the YHC physician at the clinic and from the YHC nurse at home to select the right next step so these items were called *Knowledge Clinic* and *Knowledge Home*. *Adverse effects* related to the question wherein mothers with false-positive results on the screening were asked if these false results bothered them.

The period post screening included the topics referral & access and treatment & follow-up. *Time available* measured if the family doctor spent enough time on listening to mothers' feelings. *Anxiety* related to mothers' confidence in the family doctor that made them talk about their feelings and thoughts. *Social stigma* measured if the family doctor explained that PPD may happen to any mother. Because *Attitude* related to the involvement of the family doctor and of the YHC physician/YHC nurse during the follow-up in supporting and motivating mothers, these items were named *Attitude Family doctor* and *Attitude Follow-up*. *Knowledge* measured if mothers received sufficient explanation from the YHC physician/YHC nurse and family doctor about the reason for a referral and to select the right next step in treatment and in 'mother-baby intervention', therefore these three items were named *Knowledge Referral*, *Knowledge Family doctor* and *Knowledge Project*. *Access to care* measured if the time between the discussion of a possible PPD until the start of treatment was acceptable for mothers.

2.3 Procedure

The researcher of the Post-Up Study approached and invited mothers who already existed in the Post-Up database to participate in this study. Mothers who were approached, met the inclusion criteria of this study. The approached mothers consisted of two groups; mothers with and mothers without a depression within one year after child-birth. They received an invitation by email starting with a text containing information about the aim of the study, anonymity, voluntariness and confidentiality. The web link leading to the online questionnaire was included at the end of the email, giving the mothers who agreed to participate a direct opportunity to complete the questionnaire. To comply with ethical considerations, mothers were asked at the beginning of the online questionnaire, to give their consent for participation in

this study in form of a checkbox. A reminder was sent one week after the initial mailing in order to obtain a sufficient number of respondents.

2.4 Ethical approval

According to the *Medical Research Involving Human Subjects Act* (WMO), medical research is research that includes subjecting persons to treatment or requiring persons to behave in a certain way (56). Since this study includes collecting data of the participants, it is not WMO complicit. However, in order to guarantee scientific integrity, approval of the Ethics Committee of the Faculty of Behavioral Sciences of the University of Twente was requested. This Ethics Committee confirmed that this study satisfied the standards for ethical conduct of scientific research.

2.5 Analysis

Data was stored in a database and analyzed in SPSS version 22. The data-analysis contained a descriptive statistical analysis. At first, a descriptive statistical analysis including frequencies, means and standard deviations of the demographics was conducted to explore the sample. An independent samples t-test and a Pearson's chi-squared test were conducted to compare the demographics in both mothers with and without PPD and to determine if there were any significant differences between these two groups wherein p-values of $<.05$ were considered as statistically significant.

Hereafter, a descriptive statistical analysis was conducted for each factor separately. Meaning that means, standard deviations and ranges were computed for both the experience and the importance questions and the extent to which the means of these two outcomes differ. The descriptive analysis was conducted for the period during screening and the period post screening. However, since (only) the period during screening included both mothers with and without PPD, only for this period a Pearson's chi-squared test was conducted wherein these two groups of mothers were compared in their experiences and priorities regarding the measured factors. Also for this analysis the used level of significance was $p<.05$.

3. Results

3.1 Participants' characteristics

Of the 265 mothers that were invited to participate in this study, 213 responded. Of these 213 mothers 16 mothers did not complete the questionnaire and 21 mothers were not screened and were therefore excluded which makes a total final of 176 mothers participated in this study. The excluded 21 mothers who reported not to be screened existed of 5 (23.8%) mothers with PPD and 16 (76.2%) mothers without PPD. The included 176 mothers existed of 28 (15.9%) mothers with PPD and 148 (84.1%) mothers without PPD. The average age of the mothers was 32.3 years (range 22-44). An independent-samples t-test that was conducted to determine if there was a statistically significant difference between mothers with PPD who had an average age of 31.2 years (range 25-42) and mothers without PPD who had an average age of 32.3 years (range 22-44), showed that there was no significant difference, conditions; $t(174) = -.467$, $p = .641$. In table 4, that presents the mothers' highest education completed, mother country and perceived current health status, there can be seen that the level of education that mothers completed was higher in the group of mothers without PPD than in the group of mothers with PPD. According to the mother country, there can be seen in both groups, that most of the mothers were born in the Netherlands.

Table 4. Characteristics of the participants, specified for those with PPD (N=28) and for those without PPD (N=148) and chi-squared test results with chi-square(χ^2), degrees of freedom (df) and p-value (p).

Description	Mothers with PPD N=28 (15.9%)		Mothers without PPD N=148 (84.1%)		χ^2	df	p
	Frequency	Percent	Frequency	Percent			
Highest education completed (N=176)					1.58	3	.665
- Low ¹	3	10.7%	11	7.5%			
- Middle ²	12	42.9%	53	35.8%			
- High ³	13	46.4%	84	56.8%			
Mother country (N=176)					-	-	-
- Netherlands	26	92.9%	144	97.3%			
- Country within Europe	1	3.6%	1	.7%			
- Country outside Europe	1	3.6%	3	2.0%			
Current health status (N=176)					12.27	3	.007
- Excellent/Very good	3	10.7%	51	34.5%			
- Good	19	67.9%	87	58.8%			
- Moderate	5	17.9%	10	6.8%			
- Bad	1	3.6%	0	0%			

High School (low). In the Netherlands: VMBO/LWO/MAVO.

² High School (high)/General Education Development (GED)/Some college. In the Netherlands: HAVO/VWO/MBO.

³ Bachelor's Degree/Master's Degree. In the Netherlands: HBO/University.

p < .05 (two-tailed)

Because the characteristics were measured on an ordinal scale, a Pearson's chi-squared test was conducted to determine if there were any significant differences between mothers with PPD and mothers

without PPD. Since in both groups most of the mothers were born in the Netherlands, the mother country was not included in this test. No significant difference was found in the level of highest education completed between mothers with PPD and mothers without PPD ($p=.665$). In mothers' current health status there was found a significant difference ($P=.007$) meaning that mothers without PPD perceived their own current health status as more positively than mothers with PPD did.

3.2 Experiences and priorities measured in the period during screening

The questions about the screening itself were answered by mothers with PPD ($N=28$) as well as mothers without PPD ($N=148$). Table 5 presents the descriptive data of the measured factors.

If we look at the factor *Time available screening*, which measured the time mothers had for completing the EPDS-10 at the clinic, the left column of the table shows that on average mothers perceived their experience as $M=4.0$ and the right column of the table shows that mothers reported the priority regarding to this factor as $M=3.9$. Additionally, figure 2 presents through dots the corresponding position of the factors in a four planed figure. In this figure, *Time available screening* is located upper right in the plane where we can see that both the priority and the experience with regard to this aspect of care were reported by mothers as high, which means that mothers reported that it was important that they had sufficient time for completing the EPDS-10 at the clinic and that they had a good experience with this aspect. Mothers also reported the suitability of the clinic for completing the EPDS-10 (*Privacy available*) as important but regarding to the experience, 82 of the 176 mothers did not agree with the clinic being suitable for completing the EPDS-10 and were therefore asked to elucidate this in an open question. The answers could be divided into three categories where most of the mothers indicated there was too less privacy at the clinic and that it would be more suitable to complete the EPDS-10 at home. Most of the mothers also indicated there was too much fuss at the clinic and that they rather complete the EPDS-10 at home. Some of the mothers indicated that their baby and/or child needed attention when they were completing the EPDS-10 at the clinic which caused them not being able to complete the EPDS-10 with their fully attention. Most of these mothers indicated also that it is more suitable to complete the EPDS-10 at home.

Of the 176 mothers that were screened, 164 mothers discussed their feelings/results of the instrument with the YHC physician. These mothers reported that it was important that the YHC physician spent sufficient time on listening to the their feelings at the clinic (*Time available Clinic*) and that they had confidence in the YHC physician which made them talk about their feelings and thoughts (*Anxiety*); with regard to both aspects of care, mothers had good experiences. Of these 164 mothers, 126 mothers discussed the results of the instrument with the YHC physician and reported that it was important that the outcome of the EPDS-10 corresponded with their feelings at that moment (*Agreement*) which they also had a good experience with.

Twenty-two of the 28 mothers with PPD, indicated that they discussed the outcome of the instrument with the YHC physician and three mothers indicated they discussed only their depressive

feelings with the YHC physician. The other three of the 28 mothers indicated they did not discuss their outcome or depressive feelings with the YHC physician at all. The 25 mothers that had a discussion with the YHC physician reported it was important that the YHC physician at the clinic responded involved which supported and motivated them (*Attitude Clinic*) and that they also had a good experience with regard to this aspect. These mothers also reported it was important that they received sufficient explanation of the YHC physician at the clinic to select the right next step (*Knowledge Clinic*), they however did not have a good experience with regard to this aspect. Notable for these two aspects as can be seen in table 5 is that that the range of the scores on the priority was smaller than the range of the scores on the experience, meaning there was more variation in the experience mothers reported than there was in the priority with regard to these aspects.

Nine of the 25 mothers that had a discussion with the YHC physician, indicated the YHC nurse had visited them at home. The mothers reported that it was (very) important that the YHC nurse at home responded involved which supported and motivated them (*Attitude Home*) and also with regard to this aspect they had a good experience. The same applies for the amount of explanation the mother received from the YHC nurse at home to select the right next step (*Knowledge Home*). Mothers reported it was important that the explanation of the YHC nurse was sufficient, and they also had a good experience with the amount of explanation they received.

Four of the 148 mothers without PPD, had indicated that their results from the screening were false-positive (*Adverse effects*). While they reported it was important that the results from the screening would be correct positive, they however had a neutral opinion regarding to their perceived experience with regard to this aspect.

Table 5. Descriptive data on the experiences of respondents and their priorities specified for the individual quality of care items in means (M), standard deviations (SD), ranges (R) and number (N).

Factor	Experience (5-point Likert scale)			Priority (5-point Likert scale)			N
	M	SD	R	M	SD	R	
Time available Screening	4.0	.9	1.00-5.00	3.9	.8	1.00-5.00	176
Privacy available	2.8	1.0	1.00-5.00	4.0	.6	1.00-5.00	176
Time available Clinic	3.8	.9	1.00-5.00	4.1	.7	2.00-5.00	164
Anxiety	3.6	1.0	1.00-5.00	4.4	.6	2.00-5.00	164
Agreement	4.1	.8	2.00-5.00	4.3	.7	2.00-5.00	126
Attitude Clinic	3.6	1.2	2.00-5.00	4.4	.5	4.00-5.00	25
Knowledge Clinic	2.9	.9	1.00-5.00	4.2	.5	3.00-5.00	25
Attitude Home	4.4	.5	4.00-5.00	5.0	.0	5.00-5.00	9
Knowledge Home	4.0	.7	3.00-5.00	4.6	.5	4.00-5.00	9
Adverse effects	3.0	1.6	2.00-4.00	4.0	.8	3.00-5.00	4

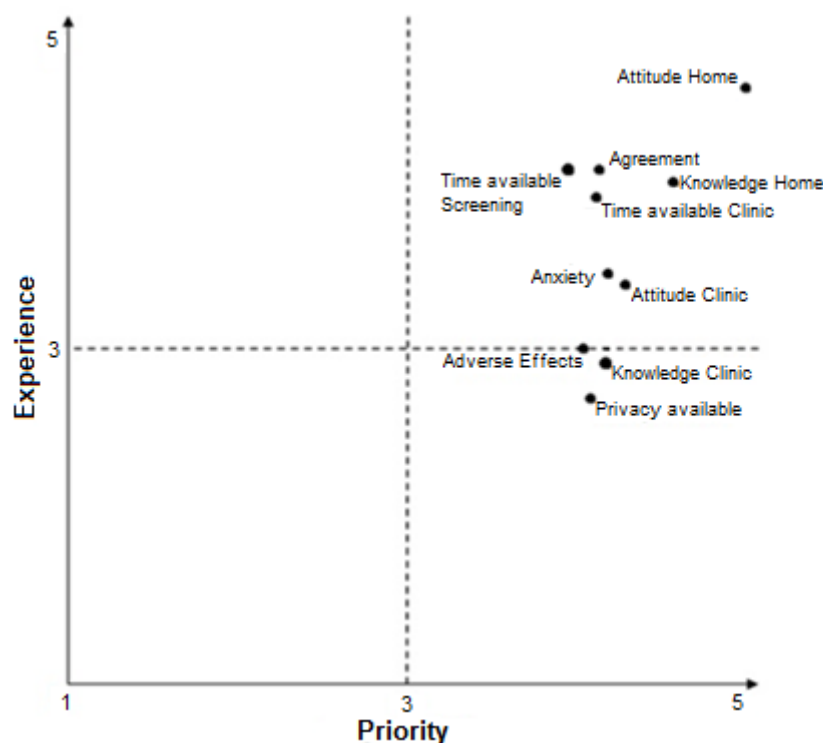


Figure 2. Positions of the experiences and priorities with regard to the individual quality of care items in a four planed figure where the vertical line relates to the experience and the horizontal line to the priority of mothers.

3.2.1 Experiences and priorities of both mothers with and without PPD

Since the during screening period consisted of participation of both mothers with PPD (N=28) and mothers without PPD (N=148), these two groups were compared in the factors answered by both of them in order to determine if there existed any significant differences between them. The following five factors were answered by both mothers with PPD and mothers without PPD: the time mothers had for completing the EPDS-10 at the clinic (*Time available Screening*); the suitability of the clinic for completing the EPDS-10 (*Privacy available*); the time the YHC physician spent on listening to mothers' feelings at the clinic (*Time available Clinic*); the confidence mothers had in the YHC physician which made them talk about their feelings and thoughts (*Anxiety*) and the outcome of the EPDS-10 that corresponded with mothers' feelings at that moment (*Agreement*). While the results on the experiences and priorities are presented in means, they were however measured on an ordinal scale and therefore a Pearson's chi-squared test was conducted to determine if there were any significant differences with regard to the measured aspects between mothers with PPD and mothers without PPD (table 6).

Table 6. Descriptive data and chi-squared test results of the experiences and priorities of the respondents and their priorities individualized for mothers with and without PPD in means (M), standard deviations (SD, number (N), chi-square(χ^2), degrees of freedom (df) and p-value (p).

	Mothers with PPD			Mothers without PPD					
Factor	M	SD	N	M	SD	N	χ^2	df	p
<i>Experience</i>									
Time available	3.7	.9	28	4.0	.9	148	5.98	4	.201
<i>Screening</i>									
Privacy available	2.4	.9	28	2.8	1.0	148	4.59	4	.333
Time available Clinic	3.6	1.1	25	3.8	.9	139	8.39	5	.136
Anxiety	3.3	1.2	25	3.6	1.0	139	11.20	5	.048
Agreement	3.4	.9	22	4.2	.7	104	24.99	4	.000
<i>Priority</i>									
Time available	4.3	.7	28	3.9	.8	148	6.10	4	.192
<i>Screening</i>									
Privacy available	4.1	.6	28	4.0	.7	148	1.33	4	.857
Time available Clinic	4.1	.9	25	4.2	.7	139	14.47	4	.006
Anxiety	4.4	.5	25	4.3	.6	139	4.52	4	.340
Agreement	4.3	.6	22	4.3	.7	104	2.22	4	.695

p <.05 (two-tailed)

Here can be seen that with regard to the experience, *Anxiety* showed a significant difference (p=.048) meaning that mothers with PPD perceived in their experience that they had less confidence in the YHC physician which made them talk about their feelings and thoughts than mothers without PPD had. Also *Agreement* showed a significant difference (p=.000) meaning that mothers with PPD perceived that the outcome of the EPDS-10 corresponded less with their feelings than mothers without PPD perceived.

With regard to the priority *Time available Clinic* showed a significant difference (p=.006) which means that mothers with PPD reported it was less important that the YHC physician spent sufficient time on listening to their feelings at the clinic than mothers without PPD reported.

3.3 Experiences and priorities measured in the period post screening

The questions in the period post screening were answered only by mothers with PPD (N=28). Table 7 that presents the descriptive data of the measured factors shows that 4 of the 28 mothers indicated they were referred to the family doctor by the clinic. These mothers reported a neutral opinion on the statement of how important it is that the YHC physician/YHC nurse gives them sufficient explanation about the reason for a referral (*Knowledge Referral*), they however reported they had a good experience with it. Notable for this aspect is that the range of the score on the priority was much larger than the range of the scores on the experience, meaning there was more variation in the priority mothers reported than was in the experience.

Twenty-one of the 28 mothers had indicated they went to the family doctor for their depression. The other 7 mothers indicated they had not gone to the family doctor. The 21 mothers that had gone to the family doctor reported that it was important that the time the family doctor spent on listening to their feelings was sufficient (*Time available*) and that they had confidence in the YHC physician which made

them talk about their feelings and thoughts (*Anxiety*). For these two aspects it was notable that the range of the scores on the priority was much smaller than the range of the scores on the experience. The mothers reported also that it was important that the family doctor explained to them that PPD may happen to every mother (*Social stigma*) and that the family doctor responded involved which supported and motivated them (*Attitude Family doctor*). With the four latter aspects, mothers had a good experience. Furthermore, mothers did report that it was not important that they received sufficient explanation from the family doctor to select the right next step in treatment (*Knowledge Family doctor*) but they however reported they had a good experience with it. The mothers reported it was not important to them that they received sufficient explanation from the family doctor to select the right next step in the 'mother-baby intervention' (*Knowledge project*) and that they did not have a good experience with this aspect. With regard to *Knowledge Family doctor*, the range of the score on the priority was smaller than the range of the score on the experience.

A total of 16 of the 28 mothers indicated they had been treated for their depression and fourteen of these mothers had gone to the family doctor while 2 of these treated women did not. Of the other 12 mothers with a depression, 7 mothers indicated that they had gone to the family doctor but were not treated and 5 indicate they had not gone to the family doctor and were not treated either. The 16 mothers that had been treated for the depression reported it was important that the time between the discussion of a possible PPD until the start of treatment was acceptable (*Access to care*) and that they had a good experience with it. Ten mothers indicated that the YHC nurse/YHC physician contacted them at a later moment to ask how they and their babies were doing at the time, what they reported it was important that the YHC physician/YHC nurse responded involved which supported and motivated the mother (*Attitude Follow-up*) and that they had a good experience with it.

Table 7. Descriptive data on the experiences of respondents and their priorities specified for the individual quality of care items in means (M), standard deviations (SD), ranges (R) and number (N).

Factor	Experience (5-point Likert scale)			Priority (5-point Likert scale)			N
	M	SD	R	M	SD	R	
Knowledge Referral	4.3	.5	4.00-5.00	3.0	2.3	1.00-5.00	4
Time available	4.1	.9	2.00-5.00	4.7	.5	4.00-5.00	21
Anxiety	4.0	1.0	2.00-5.00	4.7	.5	4.00-5.00	21
Social stigma	3.8	1.0	1.00-5.00	4.0	.9	2.00-5.00	21
Attitude Family doctor	3.9	.9	2.00-5.00	4.3	.6	3.00-5.00	21
Knowledge Family doctor	3.9	1.0	2.00-5.00	1.5	.5	1.00-2.00	21
Knowledge Project	2.0	.9	1.00-4.00	2.3	.7	1.00-3.00	21
Access to care	3.8	.9	1.00-3.00	4.6	.5	2.00-5.00	16
Attitude Follow-up	4.2	.4	4.00-5.00	4.5	.5	4.00-5.00	10

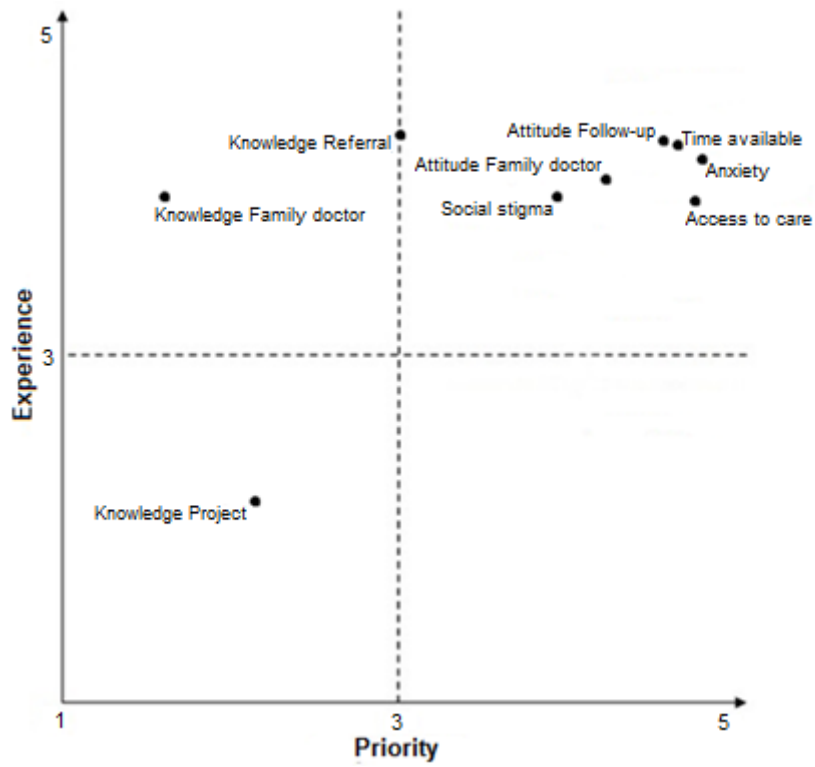


Figure 3. Positions of the experiences and priorities with regard to the individual quality of care items in a four planed figure where the vertical line relates to the experience and the horizontal line to the priority of mothers.

4. Discussion

The objective of this research was to gain insight in the experiences and priorities of mothers in the process of screening for PPD, referral and follow-up in the YHC setting. This was measured through a questionnaire that measured two periods: the period during the screening that consisted of the process of screening where mothers with and without PPD took part, and the period after the screening that consisted of the process of referral and follow-up wherein only mothers with PPD took part.

Process of screening for PPD

This study found that mothers were of the opinion that all aspect of care in the process of screening were important to them. However, where they had a good experience with most aspects of care, there were certain aspects which they perceived as a bad experience. One of these bad experiences was the suitability of the clinic for completing the EPDS-10. Where mothers were asked to elucidate this in an open question, most of them explained it would be more suitable if they would have the possibility to complete the EPDS-10 at home because there was too much fuss at the clinic and their attention was needed to their baby or child which caused them not being able to focus on completing the EPDS-10. Most of the mothers reported also insufficient privacy at the clinic which is consistent with Mitchell & Coyne (49) and Shakespeare et al. (9) who reported lack of privacy as a barrier to mothers.

Another aspect of care which mothers perceived as a bad experience is the sufficiency of explanation of the YHC physician at the clinic to select the right next step. This is consistent with O'Mahen & Flynn (10) who stated in their study that mothers seemed to have experienced knowledge barriers such as not knowing the best treatment for their depression. Peculiar for this aspect of care was that there was more variation in the experiences mothers had than there was in the priorities. This might be explained by the case that not all mothers were informed by the same YHC physician which might have caused differences in the explanations that were giving to them.

Mothers with a false-positive result on screening for PPD had a neutral opinion in the experience regarding to if they suffered from the false-positive screening results, which can be interpreted as that they did not suffer from it but that they were not pleased with it either. This is inconsistent with the report that false-positive screening results might lead to potential harm as in adverse effects (52-54). However, our study's result with regard to this aspect of care is based on the statement of 4 mothers, it might be possible that mothers would possibly have experienced harm from the false-positive results on the screening if the response rate of this question was higher.

Mothers with PPD and mothers without PPD showed some significant differences in their experiences and priorities. Mothers with PPD perceived in their experience that they had less confidence in the YHC physician which made them talk about their feelings and thoughts than mothers without PPD had, which might be explained by the case that mothers with a depression are less open about their feelings that are probably more negative than the feelings of mothers without PPD. Mothers with PPD

also perceived that that the outcome of the EPDS-10 corresponded less with their feelings than mothers without PPD. This might be explained by the fact that mothers with PPD are not having a realistic view to their situation anymore and by the fact that that mothers with a raised score do not want to acknowledge their (possible) diagnosis where mothers with a low score do not mind talking about feelings or thoughts since there are no signs of a possible depression. This is consistent with Mitchell & Coyne (49) who reported women not wanting to acknowledge their own diagnosis as a reason for unacceptability of screening for PPD.

The significant difference that was found in the priority showed that to mothers without PPD it was more important that the YHC physician spent sufficient time on listening to their feelings at the clinic than it was to mothers with PPD. Since little scientific articles were available on the priorities of mothers in the screening trajectory for PPD, the results regarding to mothers' priorities could not be compared to the literature. This may indicate however that still little is known about this on (inter)national level which could potentially generate interest among researchers to study upon this.

Process of referral and follow-up

The results of this study showed that mothers were of the opinion that all aspect of care in the process of referral and follow-up were important, there were however certain aspects of care which were not important to them. The same applies to the experiences where they had a good experience with most aspects of care, but where there still was a certain aspect which they perceived as a bad experience. Peculiar for this period is that the aspects reported as not important and/or that mothers had a bad experience with are all aspects concerning knowledge. One of these knowledge aspects that was a neutral priority to mothers is the sufficiency of explanation about a reason for a referral given by the YHC physician/YHC nurse, meaning that it was not important to mothers that they received sufficient explanation of the YHC physician/YHC nurse but that it was not non-important to them either. This might be explained by the possibility that some of the mothers reported this aspect as non-important because they might be of the opinion that they do not need a sufficient explanation about the reason for a referral while other mothers reported this aspect as important because they would have liked to have given to them sufficient explanation. Peculiar for this aspect was that there was more variation in the priorities of mothers than there was in the experiences. This might be explained by some of the mothers not exactly knowing what the explanation about the reason for a referral should contain and therefore reported it as not important.

Another knowledge aspect of care that was not important to mothers was the sufficiency of explanation of the family doctor to select the right next step in treatment. This might be explained by mothers already knowing sufficient about the treatment for PPD and therefore do not need sufficient explanation about the treatment. Peculiar for this aspect of care was that there was more variation in the experiences mothers had than there was in the priorities. This also might be explained by the case that

mothers go to different family doctors which might have caused differences in the explanations that were giving to them. Also the sufficiency of explanation of the family doctor to select the right next step in the 'mother-baby intervention' was not important to mothers and with regard to this knowledge aspect they also did not have a good experience. This might be explained by the possibility that mothers did not receive any explanation about this 'mother-baby intervention' and that they therefore stated it was not important either. According to DiMatteo (42), patients who do not receive sufficient adequate explanation, lack of understanding may turn into a lack of consensus between them and the doctor which may lead to therapeutic failure.

4.1 Strengths and limitations

This study knows several strengths and limitations. Since only mothers from the region of Twente participated in this study, the results are generalizable for only this part of YHC in the Netherlands. Although a total of 176 mothers participated in this study, not all mothers experienced every aspect of care, which caused large differences in response rates. For example, 176 mothers answered the question about the suitability of the clinic for completing the EPDS-10 and only 9 mothers answered the questions concerning the YHC nurse's home visit. These low response rates lead to greater uncertainty (variation) in the responses and so may have affected the reliability of this study. This affection of the reliability of this study may also have been caused by the fact that in some aspects of care in the process of screening, only mothers with PPD or mothers without PPD participated. This means that not for all aspects in the process of screening there was data available of both groups of mothers.

That some of the mothers did not complete the questionnaire and so were excluded from this study can be seen as a limitation. The reason these mothers did not completed the questionnaire might have been because of a lack of interest. Therefore it is possible that these mothers might had reported the priority much lower than mothers in this current study did.

Since the questionnaire was completed individually, clear results of the mothers could be obtained. A limitation of this study is that the questionnaire consisted mainly of closed questions. This could possibly have led to socially desirable answers, yet this is to a great extent avoided since the questionnaire was answered individually and anonymously and of the possibility for the mothers to explain, if needed, their answers in an open field. If the same questions would be asked in interviews or focus groups, mothers would probably feel inhibited to give honest answers about the professionals they might are involved with.

The use of the 5-point Likert scale in order to measure the experiences and priorities of mothers in this study is, on the one hand, a strength since the use of a scale did not forced mothers to choose as in yes or no answers, but provided them the possibility to respond on a level of agreement. On the other hand the use of the Likert scale is a limitation since this study only contained five options to choose wherein the distance between each of these options possibly was not equidistant leading to not being able to determine the truly agreement mothers had on the measured statements.

Since this study determined both the experiences and priorities of mothers, more information could be obtained than when only the experiences, as in most studies, would be focused on. A limitation of this study is that the experiences that were measured took place approximately six months to two years before this study was conducted. Recall bias may have influenced the reliability since mothers could have given other answers if their experiences and priorities would be measured directly after the moment they had their experience with the aspects of care.

Relevant in this study were the following four quality of care domains: timeliness, safety, patient-centeredness and effectiveness. If we look at table 2 with the observed results of this study, we see that the quality of care was most satisfying concerning the timeliness domain. While the neutral opinion of false-positive screened mothers towards experiencing harm from the false-positive result may have reduced the quality of care in the safety domain, further research could show why mothers had a neutral opinion in the experience and if there might be any reasons why false-positive results could possibly harm them.

The same applies for the quality of care concerning the patient-centeredness, which was reduced since mothers reported the clinic as not being suitable for completing the EPDS-10. Further research could bring more distinctness into why they did not perceive the clinic as suitable and if any interventions could lead to an improvement in this aspect.

Regarding to the effectiveness domain, the knowledge aspect did not show satisfying results both for the experience mothers had as for their priority. As already mentioned in the above, not receiving sufficient adequate explanation, can lead into a lack of consensus between patient and doctor which may lead to therapeutic failure (42). Therefore further research could elucidate why these knowledge aspects were not important to mothers and why they reported they did not receive sufficient explanation in one of these certain aspects.

5. Conclusion and recommendations

5.1 Conclusion

According to the experiences of the mothers in the process of screening for PPD, the clinic is not suitable for completing the EPDS-10 and the explanation of the YHC physician at the clinic to select the right next step is not sufficient. False-positive screened mothers did not suffer from the harms false-positive screening results can bring, but were not pleased with it either.

Mothers with PPD had less confidence in the YHC physician which made them talk about their feelings and thoughts than mothers without PPD. The outcome of the EPDS-10 corresponded less with the feelings of mothers with PPD than of mothers without PPD. For mothers with PPD it was less important that the YHC physician spent sufficient time on listening to their feelings at the clinic than it was to mothers without PPD.

In the process of referral and follow-up, the knowledge aspects called for our attention. According to the mothers, receiving sufficient explanation of the YHC physician/YHC nurse about the reason for a referral was not important but not non-important either. Receiving sufficient explanation of the family doctor to select the right next step in treatment was not important. Receiving sufficient explanation of the family doctor to select the right next step in the 'mother-baby intervention' was not important also and the explanation of the family doctor was not sufficient.

5.2 Recommendations

Regarding to the discussion and conclusion the following recommendations can be derived by which the quality of YHC in terms of the complete screening trajectory can be improved.

Recommendations for further research

Recommended is to conduct further research regarding to why the clinic was not suitable for completing the EPDS-10 and why the explanation of the YHC physician at the clinic to select the right next step was not sufficient, and to thereon develop interventions for improvement.

Moreover there is a need for further research in the knowledge aspects to determine why the explanation of the family doctor for both to select the right next step in treatment and to select the right next step in the 'mother-baby intervention' was not important and why the explanation in the last aspect was not sufficient. This, in order to develop interventions that improve the care for PPD regarding to these knowledge aspects.

There is need for further research on the significant differences between mothers with PPD and mothers without PPD, where the development of interventions specified on mothers with PPD could improve the care for PPD. Since in the literature little is known about the priorities of mothers in the screening trajectory, further research on this is also recommended.

Recommendations for YHC

By gaining more clarity from further research, YHC can where necessary set up interventions. Since mothers had a bad experience with the suitability of the clinic for completing the EPDS-10 and most of them thought it would be better for them to complete the EPDS-10 at home, it is recommended to create a possibility for mothers to choose between completing the EPDS-10 at the clinic or at home.

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Appendices

Appendix A. The Edinburgh Postnatal Depression Scale (EPDS)

Please select the answer that comes closest to how you have felt in the past 7 days:

1. I have been able to laugh and see the funny side of things.
<ul style="list-style-type: none"><input type="radio"/> As much as I always could<input type="radio"/> Not quite so much now<input type="radio"/> Definitely not so much now<input type="radio"/> Not at all
2. I have looked forward with enjoyment to things.
<ul style="list-style-type: none"><input type="radio"/> As much as I ever did<input type="radio"/> Rather less than I used to<input type="radio"/> Definitely less than I used to<input type="radio"/> Hardly at all
3. I have blamed myself unnecessarily when things went wrong.
<ul style="list-style-type: none"><input type="radio"/> Yes, most of the time<input type="radio"/> Yes, some of the time<input type="radio"/> Not very often<input type="radio"/> No, never
4. I have been anxious or worried for no good reason.
<ul style="list-style-type: none"><input type="radio"/> No not at all<input type="radio"/> Hardly ever<input type="radio"/> Yes, sometimes<input type="radio"/> Yes, very often
5. I have felt scared or panicky for no very good reason.
<ul style="list-style-type: none"><input type="radio"/> Yes, quite a lot<input type="radio"/> Yes, sometimes<input type="radio"/> No, not much<input type="radio"/> No, not at all
6. Things have been getting on top of me.
<ul style="list-style-type: none"><input type="radio"/> Yes, most of the time I haven't been able to cope at all<input type="radio"/> Yes, sometimes I haven't been coping as well as usual<input type="radio"/> No, most of the time I have coped quite well

	<input type="radio"/> No, I have been coping as well as ever
7. I have been so unhappy that I have had difficulty sleeping.	<input type="radio"/> Yes, most of the time <input type="radio"/> Yes, sometimes <input type="radio"/> Not very often <input type="radio"/> No, not at all
8. I have felt sad or miserable.	<input type="radio"/> Yes, most of the time <input type="radio"/> Yes, sometimes <input type="radio"/> Not very often <input type="radio"/> No, not at all
9. I have been so unhappy that I have been crying.	<input type="radio"/> Yes, most of the time <input type="radio"/> Yes, quite often <input type="radio"/> Only occasionally <input type="radio"/> No, never
10. The thought of harming myself has occurred to me.	<input type="radio"/> Yes, quite often <input type="radio"/> Sometimes <input type="radio"/> Hardly ever <input type="radio"/> Never

Sources:

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Appendix B. Manual for EPDS-10

Het gevalideerde EPDS-screeningsinstrument wordt gebruikt tijdens de artsconsulten van 1, 3 en 6 maanden.

Werkwijze

1. De verpleegkundige JGZ informeert ouders tijdens het postnatale huisbezoek dat de JGZ werkt met de EPDS, wanneer en waarom we dit doen.
2. De CB-assistente JGZ deelt de vragenlijst, behorend bij de EPDS, uit aan ouders die komen voorafgaand aan het consult van 1, 3 en 6 maand. De vragenlijst wordt door de moeder ingevuld.
3. De arts JGZ bespreekt de vragenlijst met de moeder en noteert de score in het DD JGZ onder het kopje 'Hoe gaat het met ouder(s)'
4. De arts JGZ bespreekt tijdens de nabespreking CB met de verpleegkundige JGZ welke actie er ondernomen is of dient te worden.
5. De ingevulde vragenlijst wordt vernietigd.

Afhankelijk van de score kunnen de volgende acties plaats vinden:

0-8 punten: Geen of vrijwel geen aanwijzing dat er een PPD aanwezig is.

9-12 punten: Waarschijnlijk wat aanpassingsproblemen aan een leven met baby. Eventueel huisbezoek door verpleegkundige JGZ .

13-14 punten: Er zijn signalen die lijken op PPD. Verpleegkundige JGZ brengt huisbezoek en er vindt indien nodig een verwijzing plaats.

15 + punten: PPD is waarschijnlijk. Indien overeenstemming met klinische indruk, verwijzen naar de huisarts of de GGZ.

Verwijzing

Moeders, bij wie de diagnose PPD is gesteld, door de huisarts of de GGZ, kunnen zich aanmelden bij een KOPP project. De aanmelding kan ook plaats vinden door de arts JGZ of de verpleegkundige JGZ.

KOPP staat voor 'Kinderen van ouders met psychiatrische problematiek'. Binnen het KOPP-project zijn tal van activiteiten ontwikkeld, die ouders ondersteunen in hun rol als opvoeder.

Voor ouders met baby's is er de 'moeder-baby' interventie, namelijk 'Contact met je baby'.

Informatie voor ouder(s)/ verzorger(s) over 'Contact met je baby'

Extra steun voor ouders psychische problemen en een baby tot 12 maanden.

Voor mensen met psychische problemen en hun partners bieden Mediant en Dimence 'Contact met je baby'. In maximaal 10 huisbezoeken is er aandacht en tijd voor vragen over opvoeding, verzorging en de omgang tussen jou en je baby. Doel is telkens het verbeteren van het contact met je baby. Hierdoor zal niet alleen jouw zelfvertrouwen groeien, ook je baby zal zich steeds beter ontwikkelen.

Een moeder: 'Na de bevalling was ik zo moe. Ik moest herstellen. Ik kon mijn kind er eenvoudig niet bij hebben...'

Een vader: 'Voor vaders is het anders, dacht ik altijd. Maar dat is dus niet waar.'

Een moeder: 'ik was opeens zelf moeder en ik kon alleen maar denken aan wat ik zelf als kind allemaal gemist had.'

Je hebt een kindje gekregen. Misschien kort geleden, misschien kennen jullie elkaar al weer een poosje. En, hoe is dat? Heeft het je leven erg veranderd? Had je je hierop voorbereid? Of is het allemaal anders dan je verwachtte. Is die roze wolk in geen velden of wegen te bekennen en vraag je je soms wel eens af hoe het verder moet?

Ondersteuning

Zelf zorgen voor je baby. Het leren begrijpen en er een band mee opbouwen. Voelen dat je het kunt! Allemaal zaken die belangrijk zijn voor de ontwikkeling van je kindje en de ontwikkeling van je gevoel als ouder. Wat kun je doen als dat niet lukt? Als je het gevoel hebt dat je tekort schiet? Als je al zenuwachtig wordt bij de gedachte dat je baby straks weer gaat huilen. De afdelingen van Mediant en Dimence hebben oog voor jou en je baby. Zij bieden ondersteuning, geen therapie, in de eerste 12 maanden van jouw nieuwe leven samen met je baby.

Meer informatie te vinden: **www.mediant.nl** en **www.dimence.nl**

Source:

1. GGD Twente (2008). *Manual EPDS-10*.

Appendix C. Questionnaire

Onderzoek Ervaringen Moeders

Onderzoek naar de ervaringen van moeders met het gebruik van de depressievragenlijst op het consultatiebureau, en met het vervolgtraject

Dank u wel dat u mee wilt doen aan ons onderzoek. Het invullen van deze vragenlijst duurt ongeveer 5-10 minuten. Bij het beantwoorden van een vraag of stelling vinkt u het antwoord aan dat het beste bij u past.

Na elke stelling komt er een bijhorende vraag waarin er wordt gevraagd hoe belangrijk u iets vindt. Dit wordt gevraagd om uw wensen te kunnen bepalen waarmee de zorg voor depressieve moeders in de toekomst verbeterd kan worden.

Er zijn 58 vragen in deze enquête

Instemming met het onderzoek

Voordat u met de vragenlijst begint wordt er van u gevraagd om akkoord te gaan met uw deelname aan het onderzoek. U gaat akkoord door 'ja' aan te vinken.

☐

Ik heb de informatie in de uitnodigingsmail gelezen. Hierbij ga ik akkoord met deelname aan dit onderzoek.

*

Kies a.u.b. een van de volgende mogelijkheden:

☐ Ja

☐ Nee

Persoonlijke kenmerken

[] Wat is uw leeftijd? *

Vul uw antwoord hier in:

Jaar

[] Wat is de hoogste opleiding die u met een diploma heeft afgesloten? *

Kies a.u.b. een van de volgende mogelijkheden:

☐ Geen opleiding

☐ Lagere school/basisonderwijs

☐ VMBO/LBO/MAVO

☐ HAVO/VWO/MBO

☐ HBO/Universiteit

☐ Anders

[] Wat is uw geboorteland? *

Kies a.u.b. een van de volgende mogelijkheden:

☐ Nederland

☐ Suriname

☐ Nederlandse Antillen/Aruba

☐ Marokko

☐ Turkije

☐ Een ander land *binnen* Europa

☐ Een ander land *buiten* Europa

[]Hoe zou u op dit moment uw gezondheid beschrijven? *

Kies a.u.b. een van de volgende mogelijkheden:

- ☐ Uitstekend/heel goed
☐ Goed
☐ Matig
☐ Slecht

Depressie na de bevalling

[]

Tijdens de onderzoeksperiode van januari 2013 tot mei 2014 bent u bevallen van een kind.

Hebt u in het eerste jaar na deze bevalling een depressie gehad?

Toelichting: met depressie wordt bedoeld: periode van somberheid en/of lusteloos zijn, die langer duurde dan 2 weken, en die duidelijk invloed had op uw dagelijks functioneren. Als de depressieve klachten vóór de bevalling zijn begonnen, maar ook na de bevalling nog aanwezig waren, kunt u deze vraag met 'ja' beantwoorden.

Kies a.u.b. een van de volgende mogelijkheden:

- ☐ Ja
☐ Nee

Depressievragenlijst op het consultatiebureau

De volgende vragen gaan over het gebruik van de depressievragenlijst.

[]

Om depressieve klachten op tijd te kunnen herkennen, wordt er op de consultatiebureaus in Twente een korte depressievragenlijst gebruikt van 10 vragen. De moeder wordt bij het bezoek aan het consultatiebureau gevraagd om deze in te vullen. Dit gebeurt maximaal 3 keer, op de leeftijd van 1, 3 en 6 maanden van de baby.

Heeft u op het consultatiebureau de vragenlijst waarmee depressieve klachten te herkennen zijn ingevuld?

Kies a.u.b. een van de volgende mogelijkheden:

- ☐ Nee
☐ Ja, 1 of meer keer

Depressievragenlijst op het consultatiebureau - vervolg

[]De volgende vragen gaan over het gebruik van de korte depressievragenlijst. Als u deze lijst meerdere keren op het consultatiebureau heeft ingevuld, wilt u dan een antwoord geven dat uw gemiddelde ervaring weergeeft?

[]Ik had op het consultatiebureau genoeg tijd om de vragenlijst in te vullen. *

Kies het toepasselijk antwoord voor elk onderdeel:

- Helemaal mee oneens Mee oneens Neutraal Mee eens Helemaal mee eens
- ☐ ☐ ☐ ☐ ☐

[]Hoe belangrijk vindt u het dat er op het consultatiebureau genoeg tijd is voor het invullen van de vragenlijst? *

Kies het toepasselijk antwoord voor elk onderdeel:

- Helemaal niet belangrijk Niet belangrijk Neutraal Belangrijk Erg belangrijk
- ☐ ☐ ☐ ☐ ☐

Geschiktheid consultatiebureau

[]Ik vind het consultatiebureau een geschikte plek om de depressievragenlijst in te vullen. *

Kies het toepasselijk antwoord voor elk onderdeel:

- Helemaal mee oneens Mee oneens Neutraal Mee eens Helemaal mee eens
- ☐ ☐ ☐ ☐ ☐

[] Licht hieronder toe waarom u vindt dat het consultatiebureau geen geschikte plek is voor het invullen van de depressievragenlijst. *

Vul uw antwoord hier in:

[] Hoe belangrijk vindt u het dat u de depressievragenlijst kunt invullen op een plek die daarvoor geschikt is? *

Kies het toepasselijk antwoord voor elk onderdeel:

Helemaal niet belangrijk
☐

Niet belangrijk
☐

Neutraal
☐

Belangrijk
☐

Erg belangrijk
☐

Bespreken depressievragenlijst

[] Heeft de arts op het consultatiebureau de uitkomst van de depressievragenlijst met u besproken bij uw bezoek met 1, 3 en/of 6 maanden? *

Kies a.u.b. een van de volgende mogelijkheden:

☐ Nee

☐ Ja, één of meer keer

[] De uitkomst van de vragenlijst kwam overeen met hoe ik me op dat moment voelde. *

Kies het toepasselijk antwoord voor elk onderdeel:

Helemaal mee oneens
☐

Mee oneens
☐

Neutraal
☐

Mee eens
☐

Helemaal mee eens
☐

[] Hoe belangrijk vindt u het dat de uitkomst van de vragenlijst overeen komt met hoe u zich voelt? *

Kies het toepasselijk antwoord voor elk onderdeel:

Helemaal niet belangrijk
☐

Niet belangrijk
☐

Neutraal
☐

Belangrijk
☐

Erg belangrijk
☐

Bespreken depressievragenlijst - vervolg

[] U geeft aan dat u op het consultatiebureau geen depressievragenlijst heeft ingevuld. Heeft de arts of verpleegkundige wel met u besproken hoe u zich voelde tijdens 1 of meerdere bezoeken in de eerste 6 maanden na de bevalling? *

Kies a.u.b. een van de volgende mogelijkheden:

☐ Ja

☐ Nee

[]

U geeft aan dat de arts de uitkomst van de depressievragenlijst niet met u besproken heeft.

Heeft de arts wel met u gesproken over hoe u zich op dat moment voelde?

Kies a.u.b. een van de volgende mogelijkheden:

☐ Ja

☐ Nee

Tijd voor het bespreken

[]De arts op het consultatiebureau nam voldoende tijd om te luisteren naar hoe ik mij voelde. *

Kies het toepasselijk antwoord voor elk onderdeel:

Helemaal mee oneens

Mee oneens

Neutraal

Mee eens

Helemaal mee eens

[]Hoe belangrijk vindt u het dat de arts op het consultatiebureau voldoende tijd neemt om te luisteren naar hoe u zich voelt? *

Kies het toepasselijk antwoord voor elk onderdeel:

Helemaal niet belangrijk

Niet belangrijk

Neutraal

Belangrijk

Erg belangrijk

Vertrouwen in de arts van het consultatiebureau

[]Tijdens het gesprek had ik voldoende vertrouwen in de arts om te kunnen vertellen hoe ik mij op dat moment voelde. *

Kies het toepasselijk antwoord voor elk onderdeel:

Helemaal mee oneens

Mee oneens

Neutraal

Mee eens

Helemaal mee eens

[]Hoe belangrijk vindt u het dat u voldoende vertrouwen in de arts heeft om om te kunnen vertellen hoe u zich voelt? *

Kies het toepasselijk antwoord voor elk onderdeel:

Helemaal niet belangrijk

Niet belangrijk

Neutraal

Belangrijk

Erg belangrijk

Betrokkenheid en steun

[]De arts op het consultatiebureau reageerde betrokken en zorgde dat ik me gesteund voelde om verdere stappen te ondernemen. *

Kies het toepasselijk antwoord voor elk onderdeel:

Helemaal mee oneens

Mee oneens

Neutraal

Mee eens

Helemaal mee eens

[]Hoe belangrijk vindt u het dat de arts op het consultatiebureau betrokken reageert en ervoor zorgt dat u zich gesteund en gemotiveerd voelt om verdere stappen te kunnen ondernemen? *

Kies het toepasselijk antwoord voor elk onderdeel:

Helemaal niet belangrijk

Niet belangrijk

Neutraal

Belangrijk

Erg belangrijk

Uitleg van de arts op het consultatiebureau

[]Ik kreeg voldoende uitleg van de arts op het consultatiebureau om zelf de juiste vervolgstap te kunnen kiezen. *

Kies het toepasselijk antwoord voor elk onderdeel:

Helemaal mee oneens

Mee oneens

Neutraal

Mee eens

Helemaal mee eens

[]Hoe belangrijk vindt u het dat u voldoende uitleg krijgt van de arts op het consultatiebureau om de juiste vervolgstap te kunnen kiezen? *

Kies het toepasselijk antwoord voor elk onderdeel:

Helemaal niet belangrijk

Niet belangrijk

Neutraal

Belangrijk

Erg belangrijk

Onjuiste uitkomst van de vragenlijst

[]Soms kan het voorkomen dat uw antwoorden op de depressievragenlijst wijzen op een mogelijke depressie, terwijl u geen depressie heeft. Is dit bij u het geval geweest? *

Kies a.u.b. een van de volgende mogelijkheden:

☐ Ja

☐ Nee

[]

Ik vond het vervelend dat er bij mij volgens de vragenlijst mogelijk sprake zou zijn van een depressie terwijl ik geen depressie had.

*

Kies het toepasselijk antwoord voor elk onderdeel:

Helemaal mee oneens

Mee oneens

Neutraal

Mee eens

Helemaal mee eens

[]

Hoe belangrijk vindt u het dat uw ingevulde vragenlijst juist aangeeft of er bij u sprake is van een mogelijke depressie?

*

Kies het toepasselijk antwoord voor elk onderdeel:

Helemaal niet belangrijk

Niet belangrijk

Neutraal

Belangrijk

Erg belangrijk

Huisbezoek jeugdverpleegkundige

[]Is de jeugdverpleegkundige bij u thuis langs geweest om verder met u te praten over hoe het op dat moment met u ging? *

Kies a.u.b. een van de volgende mogelijkheden:

☐ Ja

☐ Nee

[]De jeugdverpleegkundige thuis reageerde betrokken en zorgde dat ik me gesteund voelde om verdere stappen te ondernemen. *

Kies het toepasselijk antwoord voor elk onderdeel:

Helemaal mee oneens

Mee oneens

Neutraal

Mee eens

Helemaal mee eens

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[]Hoe belangrijk vindt u het dat de jeugdverpleegkundige betrokken reageert en ervoor zorgt dat u zich gesteund voelt om verdere stappen te kunnen ondernemen? *

Kies het toepasselijk antwoord voor elk onderdeel:

Helemaal niet belangrijk

Niet belangrijk

Neutraal

Belangrijk

Erg belangrijk

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Uitleg van de jeugdverpleegkundige

[]Ik kreeg tijdens het huisbezoek voldoende uitleg van de jeugdverpleegkundige om zelf de juiste vervolgstap te kunnen kiezen. *

Kies het toepasselijk antwoord voor elk onderdeel:

Helemaal mee oneens

Mee oneens

Neutraal

Mee eens

Helemaal mee eens

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☐

[]Hoe belangrijk vindt u het dat u voldoende uitleg krijgt van de jeugdverpleegkundige om de juiste vervolgstap te kunnen kiezen? *

Kies het toepasselijk antwoord voor elk onderdeel:

Helemaal niet belangrijk

Niet belangrijk

Neutraal

Belangrijk

Erg belangrijk

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Vervolgtraject

[]Moeders met een mogelijke depressie kunnen door de arts of verpleegkundige van het consultatiebureau verwezen worden voor verdere hulp, bijvoorbeeld naar de huisarts.

Bent u door het consultatiebureau naar de huisarts doorverwezen? *

Kies a.u.b. een van de volgende mogelijkheden:

☐ Ja

☐ Nee

[]Ik kreeg van de arts of verpleegkundige voldoende uitleg over waarom er bij mij een verwijzing nodig was en met wie ik verder contact op moest nemen. *

Kies het toepasselijk antwoord voor elk onderdeel:

Helemaal mee oneens

Mee oneens

Neutraal

Mee eens

Helemaal mee eens

☐

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☐

[] Hoe belangrijk vindt u het dat er op het consultatiebureau voldoende uitleg wordt gegeven over waarom er bij u een verwijzing nodig is en met wie u verder contact moet opnemen? *

Kies het toepasselijk antwoord voor elk onderdeel:

Helemaal niet belangrijk

Niet belangrijk

Neutraal

Belangrijk

Erg belangrijk

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Bezoek aan de huisarts

[]Bent u bij de huisarts geweest vanwege uw depressieve klachten? *

Kies a.u.b. een van de volgende mogelijkheden:

☐ Ja

☐ Nee

[]De huisarts had genoeg tijd om naar mij te luisteren en mijn vragen te beantwoorden. *

Kies het toepasselijk antwoord voor elk onderdeel:

Helemaal mee oneens

Mee oneens

Neutraal

Mee eens

Helemaal mee eens

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[]

Hoe belangrijk vindt u het dat de huisarts voldoende informatie en uitleg geeft over de "moeder-baby interventie" zodat u kunt beslissen of u hier van gebruik wilt maken?

*

Kies het toepasselijk antwoord voor elk onderdeel:

Helemaal niet belangrijk

☐

Niet belangrijk

☐

Neutraal

☐

Belangrijk

☐

Erg belangrijk

☐

Toegang tot zorg

[]Bent u behandeld voor uw depressieve klachten? *

Kies a.u.b. een van de volgende mogelijkheden:

☐ Ja

☐ Nee

[]De tijd tussen het moment dat ik depressief werd en de start van mijn behandeling was acceptabel. *

Kies het toepasselijk antwoord voor elk onderdeel:

Helemaal mee oneens

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Mee oneens

☐

Neutraal

☐

Mee eens

☐

Helemaal mee eens

☐

[]Hoe belangrijk vindt u het dat de tijd tussen het moment dat u depressief werd en de start van uw behandeling acceptabel is? *

Kies het toepasselijk antwoord voor elk onderdeel:

Helemaal niet belangrijk

☐

Niet belangrijk

☐

Neutraal

☐

Belangrijk

☐

Erg belangrijk

☐

Vervolgcontact door het consultatiebureau

[]

Heeft de arts of jeugdverpleegkundige van het consultatiebureau op een later moment nog weer contact met u opgenomen om te vragen hoe het met u en uw baby ging?

*

Kies a.u.b. een van de volgende mogelijkheden:

☐ Ja

☐ Nee

[]Ik voelde me gesteund toen de jeugdarts of jeugdverpleegkundige contact met mij opnam om te vragen hoe het op dat moment met mij en mijn baby ging. *

Kies het toepasselijk antwoord voor elk onderdeel:

Helemaal mee oneens

☐

Mee oneens

☐

Neutraal

☐

Mee eens

☐

Helemaal mee eens

☐

[]Hoe belangrijk vindt u het dat de jeugdarts of jeugdverpleegkundige contact met u opneemt om te vragen hoe het op dat moment met u en uw baby gaat? *

Kies het toepasselijk antwoord voor elk onderdeel:

Helemaal niet belangrijk

☐

Niet belangrijk

☐

Neutraal

☐

Belangrijk

☐

Erg belangrijk

☐

Afsluiting

[]

Dit is het einde van de vragenlijst.

Mocht u nog opmerkingen hebben over de vragenlijst dan kunt u dat hieronder aangeven. Klik vervolgens op "Versturen" om de vragenlijst af te sluiten.

Hartelijk dank voor uw medewerking.

Vul uw antwoord hier in:

Verstuur uw enquête

Bedankt voor uw deelname aan deze enquête.

