BARRIERS TO CARE FOR WOMEN WITH POSTPARTUM DEPRESSION: AN INTEGRATIVE REVIEW OF THE QUALITATIVE LITERATURE

by

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March 2013

DEDICATION

This project is dedicated to my family. You raised us to have a love of education and an appreciation for hard work. Everything that I am is because of the home I was raised in.

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ABSTRACT

The purpose of this qualitative literature review is to examine barriers to care for women with postpartum depression in order to provide a better understanding of ways that healthcare providers can help patients overcome these barriers. Postpartum depression has been identified as the "most common complication of childbearing" (Teng, Blackmore, & Stewart, 2007, pg. 93). It is estimated that between 10% and 20% of all childbearing women will be affected by postpartum depression (PPD) (McCarthy & McMahon, 2008).

This disorder not only affects the well-being of the mother, but of the infant as well. As many as 50% of all cases may go unrecognized and untreated. Barriers to care that have been identified include stigma, lack of child care, finances, poor past experiences with healthcare providers, language barriers, failure to recognize own symptoms as PPD, and providers' lack of understanding of the condition (McCarthy & McMahon, 2008). Increasing awareness of these common barriers among primary care providers may enable them to assist patients in a way that will improve health outcomes for both the mother and the infant.

CHAPTER ONE

RESEARCH PROBLEM

Introduction

A serious health issue that is likely to be encountered by all advanced practice nurses at some point in their career, whether in a rural clinic or an emergency department setting, is postpartum depression (PPD). Postpartum depression has been identified as the "most common complication of childbearing" (Teng, Blackmore, & Stewart, 2007, pg. 93). PPD often goes unrecognized and therefore untreated by primary care providers simply because of a lack of awareness and understanding of the problem. As many as 50% of women with PPD are not treated simply because healthcare providers fail to detect this condition (McCarthy & McMahon, 2008).

It is estimated that between 10% and 20% of all childbearing women will be affected by PPD (McCarthy & McMahon, 2008). Although the disorder affects women of all ethnicities, ages, socioeconomic statuses, and parities, certain risk factors such as "stressful life events and poor social support" have been identified (Teng, Blackmore, & Stewart, 2007, pg. 94). Research suggests that the prevalence may be higher among lower income and ethnic minority mothers as well (Abrams, Dornig, & Curran, 2009). Despite these findings, lower income and/or ethnic minority mothers have very low rates of utilization of mental health services (Anderson et al, 2006). In a retrospective study examining utilization of mental health services by low income Caucasian, African American, and Latina mothers with PPD, 9% of Caucasian mothers received treatment

compared to 4% of African American and 5% of Latina mothers (Kozhimannil et al, 2011).

The vast majority of women with PPD do not seek treatment, and as many as half do not ask for help from family or friends either (McCarthy & McMahon, 2008). Healthcare providers need to explore the barriers to treatment so that once the disorder is recognized women can be appropriately treated. It is important to note, however, that some identified barriers such as child care and finances are beyond the providers' control. Once PPD is recognized and diagnosed, treatment approaches usually include a combination of pharmacological and non-pharmacological methods. Many women have shown reluctance to using pharmacological methods of treatment such as antidepressants because of fear of side effects, breast feeding, and fear of addiction (Fitelson et al, 2011). Non-pharmacological methods like group therapy may be more widely accepted however there are barriers to these treatment approaches as well. Some of the more commonly mentioned barriers to treatment include stigma, restraints of child care, finances, poor past experiences with healthcare providers, and failure to recognize own symptoms as PPD (McCarthy & McMahon, 2008). Unique barriers for low income mothers, ethnic minority mothers, and foreign immigrant mothers may include issues with cost, transportation, language barriers, and knowledge gap (Abrams, Dornig, & Curran, 2009).

Background and Significance

Postpartum Depression

Postpartum affective disorders are often separated into three categories based on severity; these include postpartum blues, postpartum depression, and postpartum psychosis. Postpartum blues, or the "baby blues", is a period of emotional vulnerability that is self-limiting and experienced by many new mothers, most often this is considered a normal part of transition into motherhood. Postpartum psychosis is a severe psychological disorder characterized by episodes of psychosis and psychotic symptoms such as delusions, and most often requires hospitalization as treatment (Ugarrriza, 2004). Postpartum depression is defined as major or severe depression occurring anytime within the first four weeks of the postnatal period. Although this disorder is not recognized as a separate disorder by the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV), providers can use the criteria for "major depressive episode" with a postpartum onset specifier (American Psychiatric Association, 2000).

According to the DSM-IV, the criteria for a major depressive episode includes five or more of the following symptoms within the same two week time frame: depressed mood, diminished interest or pleasure in everyday activities, weight loss or decreased appetite, insomnia or hypersomnia, psychomotor agitation or retardation, fatigue, feelings of worthlessness or guilt, inability to concentrate or make decisions, and thoughts of death or suicide. At least one of the first two symptoms must be present, and in order to meet the postpartum onset qualifier the onset of symptoms must be within the first four weeks of the postnatal period (American Psychiatric Association, 2000). However, it is

important to note that although most of the time symptom onset is between two weeks to three months, it can be as late as one year after giving birth.

Effects on the Mother and Infant

Postpartum depression can be debilitating for the mother and causes feelings of hopelessness and sadness in a time that is widely accepted as a joyful one. Typical symptoms include social withdrawal, loss of appetite, fatigue, loss of interest, and somatic symptoms (Ugarriza, 2004). It can affect self-esteem and relationships with the new infant, spouse/partner, and other children. Women who have PPD are also more likely to have reoccurrence of depressive episodes, whether postnatally or otherwise. Many women with untreated PPD suffer from suicidal thoughts and physical illness such as nausea and headaches (Tsivos et al, 2011). Women with PPD are also more likely to abuse tobacco, alcohol, and illegal drugs and they are more likely to be abused by others (physical, emotional, and sexual) than non-depressed women (Fitelson et al, 2011). "A recent World Health Organization report on women's health identifies self-inflicted injury as the second leading cause of maternal mortality in high-income countries; suicide remains an important cause of maternal deaths in moderate and low-income countries" (Fitelson et al, 2011, p.2).

PPD not only affects the well-being of the mother, but of the infant as well. Studies have found that infants of mothers with PPD have diminished maternal-infant interactions, delayed cognitive development, and issues with attachment (McCarthy & McMahon, 2008). Children of mothers with PPD may also suffer from behavior problems such as sleep disturbances, hyperactivity, and aggression, cognitive

developmental delays, difficulty with relationships, social withdrawal, low self-esteem, anxiety, and depression (Smith & Segal, 2012). In lower income, developing countries infants of mothers with PPD have been found to have higher rates of malnutrition and diarrheal illnesses (Fitelson et al, 2011).

Affordable Care Act Legislation

The Affordable Care Act (ACA) refers to the new legislation and laws for federal healthcare under the Obama Administration which will have implications for women with postpartum depression. In Montana there will be increased funding for programs like Maternal, Infant, and Early Childhood Home Visits and the Pregnancy Assistance Fund. The home visit program allows healthcare workers to meet with high risk families in their homes to provide education and identify problems such as postpartum depression and then make appropriate referrals. Hopefully, this will reduce the number of unidentified cases of PPD and also eliminate the problem of women not knowing where treatment is available. The Pregnancy Assistance Fund helps pregnant and parenting women finish high school and post-secondary education, as well as provides money for healthcare, childcare, and other social services (US Department of Health & Human Services, 2012).

Important legislation under the Affordable Care Act for women with postpartum depression is going to include increased health insurance coverage for prenatal and postnatal visits, coverage for mental health care services, educational resources to increase awareness of PPD and the treatment options available, reduced drug costs for women who choose pharmacological treatment approaches, and resources like reduced

cost childcare for women who are attending appointments with providers or therapy sessions (US Department of Health & Human Services, 2012). However, without an understanding of barriers to treatment and a collaborative effort to try to increase the number of women with PPD getting treatment, these new initiatives will likely not be successful.

Postpartum Depression Screening

In order for providers to more successfully recognize and treat postpartum depression, it is essential to have awareness of the different screening tools that are available. These tools are designed to be a starting point for discussion and teaching, as well as a universal measurement device of PPD symptoms. Many of the research studies done on postpartum depression have inclusion/exclusion criteria that are directly related to scores on certain screening scales. This allows the researcher to include or exclude participants based on the presence of or the severity of depression symptoms in the postpartum period. The three most common screening tools, frequently mentioned in the literature, are the Edinburgh Postnatal Depression Scale (EPDS), the Postpartum Depression Screening Scale (PDSS), and the Beck Depression Inventory-II (BDI-II).

Edinburgh Postnatal Depression Scale

The Edinburgh Postnatal Depression Scale was designed at health clinics in the United Kingdom to be a quick and easy assessment tool for providers to detect postpartum depression. The scale consists of ten statements such as, “I have been anxious or worried for no reason”, and the mother underlines which of the four responses

are closest to how she has been feeling in the past seven days (Cox, Holden, & Savosky, 1987). Responses are scored zero, one, two, or three, depending on the severity of the symptom and then totaled (see Appendix A). A score of twelve or more would indicate a high likelihood of depression. Mothers should complete the tool on their own unless language or education barriers exist. It is most often used at the six week postpartum office visit (Cox, Holden, & Savosky, 1987).

Postpartum Depression Screening Scale

This tool, developed by Cheryl Beck, is a 35 item, self-reporting instrument used to identify women who are at high risk of developing PPD. The scale only takes about five to ten minutes to complete and is accurate in gauging seven different symptom areas including: sleeping and eating disturbances, anxiety, emotional liability, mental confusion, loss of self, guilt or shame, and suicidal thoughts (Beck & Gable, 2000). The instrument is written at a third grade level and uses short, simple sentences that are easy to understand (see Appendix B). The PDSS can be administered as early as two weeks postpartum, and has been shown to be an effective way of addressing PPD (Beck & Gable, 2000).

Beck Depression Inventory-II

The Beck Depression Inventory-II (BDI-II) is a twenty-one item, self-reporting tool used to assess the presence of depression symptoms as listed in the DSM-IV (see Appendix C). This screening tool can be used to assess depression symptoms of all severities in patients of nearly age. It is used in many mental health settings, and is not

specific to postpartum depression. Some studies have found that the use of generic depression screening tools such as this in postpartum women may over exaggerate the level of depression symptoms and may not be as useful as those designed specifically for use in the postpartum period (Curzik & Begic, 2012).

Summary

These tools are not meant to take the place of clinical judgment. They only identify symptoms of depression, and do not recognize symptoms of other psychiatric conditions. Although they can indicate the likelihood of depression being present they are not an accurate representation of severity or to be used to direct treatment approaches. They are also limiting in that the responses are dependent on how the woman has been feeling short term, rather than long term. Tools such as the EPDS and PDSS that are specifically designed for women in the postpartum period may be more sensitive than those for generalized depression, such as the BDI-II. Another available screening tool not mentioned here is the Physician's Health Questionnaire (PHQ-9), which is also for general depression and not specific to PPD.

Available Treatments

Treatments for postpartum depression include both pharmacological methods and non-pharmacological methods. Pharmacological approaches include the use of antidepressant medications. Most recommended are the selective serotonin reuptake inhibitors (SSRIs) and serotonin-norepinephrine reuptake inhibitors (SNRIs) because of their low detectability in infant plasma and rare adverse reactions which make them the

safest for breastfeeding mothers. Research on the long term effects of SSRIs in breastfed infants is not available at this point. There is also very little research on the effectiveness of one class of antidepressant versus the other, however the research that has been done comparing the effectiveness of antidepressant medications to non-pharmacological treatment modalities has shown medication to be just as effective. There are still many mothers who are very reluctant to use medication, especially those who breastfeed, because of fear of side effects and addiction (Fitelson et al, 2011).

Non-pharmacological treatments include interpersonal therapy, cognitive behavioral therapy, non-directive counseling, and peer and partner support. These methods have all been found to be equally effective in the treatment of PPD without the risk of adverse side effects. However, there are barriers to these types of treatment as well such as stigma, cost, and ability to find childcare to attend appointments. Participants in peer support specifically have reported relief of negative feelings associated with stigma when they are surrounded by others going through a similar situation (Fitelson et al, 2011).

Theoretical Framework

The theoretical framework chosen for this professional project is Beck's midrange nursing theory of postpartum depression. This theory was chosen because it examines the different stages that women with postpartum depression go through, and how each stage affects emotions and decision making such as the decision to seek treatment. Beck's theory was published in 1993, "Teetering on the edge: A substantive theory of

postpartum depression", and included a four stage process that women go through when they have PPD. The four stages include, "encountering terror, dying of the self, struggling to survive, and regaining control" (Beck, 1993).

"Encountering terror" includes a sudden, blindsiding onset of feelings of anxiety, fear, panic, obsession, and inability to focus. This initial stage can be very scary and confusing for women. There is a rollercoaster of emotion with anxiety and panic attacks, followed by obsessive thoughts such as wondering if they are going crazy. The inability to focus leads to the depressive symptoms of loss of interest and pleasure, which eventually turns into isolation. The second stage, "dying of the self", is hallmarked by severe depressive symptoms, complete isolation, loneliness, and hopelessness. Women often feel a loss of sense of self, like they are not the same person they were before they had their baby. This stage is critical in regards to help seeking behavior because this is the stage when suicidal type thoughts can become increasingly prevalent (Beck, 1993).

"Struggling to survive" comes with the desire to become healthy again. If women are going to seek help this stage is the beginning of their journey. Beck describes many of the barriers that women in this stage face including "patronizing, minimizing their symptoms, frequent referral to other physicians, lack of knowledgeable providers, limited treatment options, and financial hardship" (Beck, 1993). The final stage is "regaining control", a gradual period of recovery (Beck, 1993).

Definition of Terms

Postpartum depression (PPD) – Defined by Medline as "moderate to severe depression in a woman after she has given birth. It may occur soon after delivery or up to a year later. Most of the time, it occurs within the first 3 months after delivery" (Zieve, 2012, pg. 1). The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) defines postpartum depression as:

Criteria for Postpartum Onset Specifier: Onset of major depressive episode must be within 4 weeks after delivery.

Criteria for Major Depressive Episode:

Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least 1 of the symptoms is either 1) depressed mood or 2) loss of interest or pleasure. (Not including symptoms that are clearly due to a general medical condition, or mood-incongruent delusions or hallucinations.)

Depressed mood most of the day, nearly every day, as indicated by either subjective report or observation made by others

Markedly diminished interest in pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)

Significant weight loss when not dieting or weight gain, or decrease or increase in appetite nearly every day

Insomnia or hypersomnia nearly every day

Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)

Fatigue or loss of energy nearly every day

Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)

Diminished ability to think or concentrate, or indecisiveness, nearly every day (either subjective account or as observed by others)

Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

The symptoms do not meet the criteria for mixed depressive episode

The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning

The symptoms are not due to the direct physiological effects of a substance or a general medical condition

The symptoms are not better accounted for by bereavement, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation (American Psychiatric Association, 2000).

Barrier – Defined by Webster's as "something immaterial that impedes or separates" (Merriam-Webster, 2013, pg. 1).

Problem Statement

Postpartum depression has been identified as the "most common complication of childbearing" (Teng, Blackmore, & Stewart, 2007, pg. 93). It affects 10-20% of all childbearing women. Successful treatment methods have been identified, including antidepressants and various specialties of therapy. Much of the literature available focuses on different treatment options that are available and the effectiveness of each. There is much less research available that specifically examines the barriers to receiving these treatments. These barriers are significant in that as many as 50% of women with postpartum depression do not get treatment (McCarthy & McMahon, 2008).

Purpose of Professional Project

The purpose of this integrative, qualitative literature review is to explore the barriers to treatment for women with postpartum depression. Qualitative literature examines the lived experience of women and allows the researchers to obtain narratives from participants by using open ended questions. This approach, unlike quantitative, focuses on feelings and experiences, rather than statistics and outcomes. A better understanding of barriers to treatment and exploration of ways to break down these barriers may ultimately result in more women getting successful treatment for their PPD symptoms, which would result in better health outcomes for the mother and the infant.

Summary

Postpartum depression affects 10-20% of all childbearing women (McCarthy & McMahon, 2008). A report from the World Health Organization found that self-inflicted injury was the second leading cause of maternal mortality, and the disorder not only affects the health of the mother, but of the infant as well (Fitelson et al, 2011). Studies have found that infants of mothers with PPD have diminished maternal-infant interactions, delayed cognitive development, and issues with attachment. Although there are screening tools available that are widely used at routine postpartum office visits, half of all cases still go undiagnosed and untreated (McCarthy & McMahon, 2008). Successful treatment options are available once women make the decision to seek help, but factors that influence help seeking behavior and barriers to getting treatment are areas for clinicians to focus on to improve overall health outcomes for postpartum women.

CHAPTER TWO

REVIEW OF LITERATURE

Literature Search

One of the earliest steps in this literature review was to devise a plan for locating relevant research. Electronic bibliographic databases were the primary source of finding literature. According to Polit and Beck (2012, p.98), "rapid technological changes have made manual methods of finding information obsolete". Online databases have thousands of journal articles from all time periods and disciplines available. The most important aspect of using these databases to find relevant data is searching a variety of key words. Important databases for nursing research include CINAHL and MEDLINE (Polit & Beck, 2012).

Inclusion/Exclusion Criteria

The primary inclusion criterion for this literature review was to find qualitative research that focused primarily on barriers to treatment or help seeking for women with postpartum depression. Literature focusing on different treatment options or their effectiveness, risk factors or causes of postpartum depression, and any quantitative studies were not included. Studies were included as far back as ten years (1992-2012) in order to have enough relevant material to review. Only peer reviewed, primary source research articles were used.

Search Methods

Databases. The electronic databases used included CINAHL (Cumulative Index to Nursing and Allied Health Literature), MEDLINE (Medical Literature Online), and Cochrane Library.

Search Terms. Search terms used included: *postpartum depression, postnatal depression, barriers, help seeking, attitudes, preferences, mothers, treatment,* and *experience.*

Findings

CINAHL. A search using the terms *barriers* and *postpartum depression* yielded five studies, of which one (Abrams, Dornig, & Curran, 2009) was used. A second search using the term *barriers* and *postnatal depression* yielded two results, none were used. A third search of *help seeking* and *postpartum depression* had nine results, one (McIntosh, 1993) was used. Two studies used in this literature review were found with CINAHL (see Table 1).

MEDLINE. A search using the terms *barriers* and *postpartum depression* yielded sixty-eight results, of which one (Teng, Blackmore, & Stewart, 2007) was used. A second search using the term *attitudes* and *postnatal depression* yielded sixty-eight results, of which one (Whitton, Warner, & Appleby, 1996) was used. A third search of *experience, treatment,* and *postpartum depression* had fifty-five results, one (McCarthy & McMahon, 2008) was used. A fourth search using the terms *barriers, care,* and

mothers yielded eight results, of which one (Anderson et al, 2006) was used. A total of four studies were used from MEDLINE (see Table 2).

Table 1. CINAHL: Studies Meeting Inclusion Criteria

Citation	**Purpose**	**Method**	**Participants**	**Conclusions**
Abrams, Dornig, & Curran, 2009	Explore barriers to services used for postpartum depression by low-income, ethnic minority mothers	5 focus groups and 10 individual interviews	Mothers with PPD symptoms in the past year, an infant under 12 months old, 18 years of age or older, current WIC recipient, and English or Spanish language.	Themes identified in process of help seeking and their barriers
McIntosh, 1993	Explore women's own perceptions of PPD and implications on help seeking behavior	Six individual interviews conducted with each woman, once prenatally and five times postnatally at 2 month intervals.	First time mothers.	Identified most frequent symptoms of depression, perceptions of causes of depression, and where women sought help.

2. MEDLINE: Studies Meeting Inclusion Criteria

Citation	**Purpose**	**Method**	**Participants**	**Conclusions**
Teng, Blackmore, & Stewart, 2007	Explore healthcare workers' perceptions of barriers to care for immigrant women with PPD	16 key informant interviews with healthcare workers working at agencies that provide care to postpartum immigrant women.	Social workers, public health nurses, registered nurses, practical nurses, home visitors, psychologists, family doctors, and psychiatrists that worked with immigrant women with PPD.	Practical barriers and cultural barriers identified, as well as challenges for healthcare workers.

2. MEDLINE: Studies Meeting Inclusion Criteria Continued

Whitton, Warner, & Appleby, 1996	Investigate women's attitudes towards PPD that influence whether or not they seek treatment.	Participants that were identified as being depressed were asked questions regarding their current symptoms and attitudes towards treatment	Scored greater than a 10 on the EPDS, were 6-8 weeks postpartum, and agreed to participate	Higher social class and primiparous women were less likely to identify PPD and seek treatment.
McCarthy & McMahon, 2008	Investigate the factors that influence the decision to seek and accept treatment for PPD.	Interviews on factors influencing the decision to accept treatment, understanding of PPD, and experience of the treatment	Women who had been diagnosed with PPD by clinical interview and had received treatment in a community mental health setting in New Zealand.	Identification of five stages of PPD.
Anderson et al, 2006	To explore barriers to formal mental health care in lower income mothers	One on one ethnographic interviews	Women between the ages of 18 and 55, were biological, step-, or adoptive mother living with the child being presented for care.	Four key themes identified related to mother's reluctance or refusal to seek mental health treatment

Cochrane Library. The same terms searched in CINAHL and MEDLINE were used in this data base as well. All of the research found had either been used already, or did not meet inclusion criteria. No studies used in this literature review were found in the Cochrane Library.

Summary

A total of six articles were utilized in this literature review. The literature search was conducted using electronic bibliographic databases including: CINAHL, MEDLINE, and Cochrane Library. Search terms used included: *postpartum depression, postnatal depression, barriers, help seeking, attitudes, preferences, mothers, treatment,* and *experience.* Only peer reviewed, primary source research articles were used.

CHAPTER THREE

DATA ANALYSIS

Overview

Studies used in this literature review were analyzed and critiqued using the guidelines in the text, Nursing Research: Generating and Assessing Evidence for Nursing Practice (Polit & Beck, 2012). Polit and Beck list specific areas that need to be addressed when critiquing qualitative studies. These areas include:

1. Title: Suggests the key phenomenon and the group being studied.
2. Abstract: Clearly summarizes key features of the study.
3. Introduction: Statement of problem is easily identified, builds a persuasive argument, has significance for nursing, and matches the paradigm, method, or tradition being used. Research questions are clearly stated or absence is justified, and questions are consistent with philosophical basis or tradition being used in the study. Literature review is nicely summarized and correlates with the phenomenon of interest, and provides a solid base for the new research. Key concepts are defined conceptually and the philosophy, tradition, or conceptual framework is clearly stated and appropriate.
4. Method: Protects participants, minimizes risk and maximizes benefits, and completed necessary IRB approval. Methods of gathering and analyzing data are consistent with the research tradition, sufficient time was spent with participants, and there were a sufficient number of participants. Setting and sample are clearly

described, recruitment of participants was appropriate, best possible sampling method was used, and the sample size was sufficient. Data collection was appropriate, right questions and observations were made, and adequate time was spent collecting data. Procedures were clearly defined and bias was minimized. Researchers did everything possible to enhance the integrity of the research, methods were trustworthy, and description of methods was sufficient to support transferability.

5. Results: Data analysis was clearly described, analysis methods were consistent with tradition being used, analysis yields an appropriate "product", and procedures used do not suggest bias. Findings are clearly summarized, themes are defined, and findings produce a clear picture of the phenomenon being studied. Themes are logically connected, figures and models are used if necessary, and the themes are linked to the conceptual framework being used.
6. Discussion: Findings are interpreted in the correct social context, major findings are discussed within the context of previous research, and interpretation is congruent with researches limitations. Researchers discuss clinical implications.
7. Global Issues: The study is well written and organized. Description of findings builds a clear picture. Researchers express confidence in their findings and findings appear trustworthy. Overall the research contributes in a meaningful way to nursing discipline (Polit & Beck, 2012, p. 115-117).

Quality of the Literature

Quality was assessed using Polit and Beck's guidelines listed above. The literature was also summarized into a clear, meaningful chart using the Joanna Briggs Institute Qualitative Appraisal and Review Instrument Data Extraction Form (see Appendix D). This form includes the study's methodology, method, setting and context, geographical context, participants, data analysis, author's conclusions, and reviewer's comments.

Data Reduction

During this literature review it was not necessary to find ways of reducing data, as the number of studies meeting all inclusion criteria was very small.

Identification of Themes

Once all of the studies and been critiqued and then analyzed again in chart form, clear themes emerged. In most cases these themes were consistent with the theoretical framework that the researchers were using, and also with Beck's theoretical framework that was used for this literature review. Themes that were identified are discussed in detail in Chapter Four, presentation of findings. Charts constructed with the Joanna Briggs form are listed in Appendix E.

CHAPTER FOUR

PRESENTATION OF FINDINGS

Overview

Six studies met the inclusion criteria of focusing on barriers to care in postpartum depression, being all qualitative research, peer reviewed, and primary source (see Table 3). The selected literature was critiqued using Polit and Beck's guidelines and organized using the Joanna Briggs chart.

3: Qualitative Studies in Literature Review

Citation	**Purpose**	**Method**	**Participants**	**Conclusions**
Abrams, Dornig, & Curran, 2009	Explore barriers to services used for postpartum depression by low-income, ethnic minority mothers	5 focus groups and 10 individual interviews	Mothers with PPD symptoms in the past year, an infant under 12 months old, 18 years of age or older, current WIC recipient, and English or Spanish language.	Themes identified in process of help seeking and their barriers
McIntosh, 1993	Explore women's own perceptions of PPD and implications on help seeking behavior	Six individual interviews conducted with each woman, once prenatally and five times postnatally at 2 month intervals.	First time mothers.	Identified most frequent symptoms of depression, perceptions of causes of depression, and where women sought help.

3: Qualitative Studies in Literature Review Continued

Teng, Blackmore, & Stewart, 2007	Explore healthcare workers' perceptions of barriers to care for immigrant women with PPD	16 key informant interviews with healthcare workers working at agencies that provide care to postpartum immigrant women.	Social workers, public health nurses, registered nurses, practical nurses, home visitors, psychologists, family doctors, and psychiatrists that worked with immigrant women with PPD.	Practical barriers and cultural barriers identified, as well as challenges for healthcare workers.
Whitton, Warner, & Appleby, 1996	Investigate women's attitudes towards PPD that influence whether or not they seek treatment.	Participants that were identified as being depressed were asked questions regarding their current symptoms and attitudes towards treatment	Scored greater than a 10 on the EPDS, were 6-8 weeks postpartum, and agreed to participate	Higher social class and primiparous women were less likely to identify PPD and seek treatment.
McCarthy & McMahon, 2008	Investigate the factors that influence the decision to seek and accept treatment for PPD.	Interviews on factors influencing the decision to accept treatment, understanding of PPD, and experience of the treatment	Women who had been diagnosed with PPD by clinical interview and had received treatment in a community mental health setting in New Zealand.	Identification of five stages of PPD.
Anderson et al, 2006	To explore barriers to formal mental health care in lower income mothers	One on one ethnographic interviews	Women between the ages of 18 and 55, were biological, step-, or adoptive mother living with the child being presented for care.	Four key themes identified related to mother's reluctance or refusal to seek mental health treatment

Summary of Literature

Quality

Overall quality of the six studies was assessed using Polit and Beck's guidelines. All studies found that met inclusion criteria were included, and were considered to be of high quality based on those guidelines.

Study Location

Study locations varied greatly, from rural to urban, and various different international locations. Locations within the United States were Los Angeles (Abrams, Dornig, & Curran, 2009) and Pittsburgh (Anderson et al, 2006). International locations included Toronto, Canada (Teng, Blackmore, & Stewart, 2006), Glasgow, Scotland (McIntosh, 1993), rural New Zealand (McCarthy & McMahon, 2008), and Southern Manchester, Great Britain (Whitton, Warner, & Appleby, 1996). This great variation in study locations can be viewed as a weakness because things like universal healthcare and distance to a mental health facility will impact which barriers affect receiving treatment. However, because of the limited amount of research available in this area it was not possible to only include studies from one country or even all rural or all urban settings.

Study Design

All six studies were qualitative in design. All studies utilized grounded theory, except Anderson et al (2006) who utilized ethnography by conducting one on one "ethnographic interviews" with each participant (Anderson et al, 2006).

Data Collection

Abrams, Dornig, and Curran (2009) conducted five focus group interviews as well as ten individual, in-depth interviews with each participant. McIntosh (1993) conducted six individual interviews with each participant, once prenatally and then at 2 month intervals. Teng, Blackmore, and Stewart (2006), McCarthy and McMahon (2008), Anderson et al (2006), and Whitton, Warner, and Appleby (1996) all conducted one in-depth individual interview with each of the participants lasting anywhere from one to three hours.

Sample Size and Description

Anderson et al (2006) had 127 participants, the largest sample size in this literature review. Abrams, Dorning, and Curran (2009), McCarthy and McMahon (2008), and Teng, Blackmore, and Stewart (2007) were all smaller studies with fewer than 20 participants. McIntosh (1993) and Whitton, Warner, and Appleby (1996) were moderately sized studies with 60 to 78 participants.

Abrams, Dornig, and Curran (2009) included mothers reporting PPD symptoms in the past year who were recruited from WIC sites, and female service providers (nurse-midwives, counselors, and social workers) who had experience working with low-income ethnic minority mothers. All mothers were considered low income, and ethnic minorities (Latina and African American). They were eligible for the study if they had symptoms of PPD in the past year, an infant under twelve months old and maternal age greater than eighteen years.

The participants in the study by McIntosh (1993) were first time mothers recruited from Glasgow antenatal clinics that were all were considered "working class". Races and cultures were not disclosed. This study was unique in that half of the participants were less than twenty years of age, giving a unique perspective of motherhood and PPD in younger mothers.

Teng, Blackmore, and Stewart (2006) did not use mothers with PPD as their participants. Rather, participants were healthcare workers at multidisciplinary provider groups. There were fifteen women participants and one male participant. Occupations included: social workers, public health nurses, registered nurses, practical nurses, home visitors, psychologists, family doctors, and psychiatrists. All had spent an average of fifteen years working with immigrant women with PPD. Seven participants were immigrants and four of the women had suffered from PPD in the past themselves.

Participants in the study by Whitton, Warner, and Appleby (1996) included new mothers who had given birth at one of two large maternity wards in Glasgow. Women were eligible for the study if they scored greater than a ten on the EPDS, were six to eight weeks postpartum, and agreed to participate. Culture and race of participants not disclosed, however they were described as socially diverse and were separated into five social classes by income and also an unemployed class.

McCarthy and McMahon (2008) included women who were discharged from mental health services in the past 18 months. All of the women had been diagnosed with PPD by clinical interview and had received treatment in a community mental health setting in rural New Zealand. Ages ranged from 27 to 41 years, and education ranged

from completing high school to finishing an undergraduate degree. All were in long term relationships with the father of their children, and parity ranged from one to four children.

Anderson et al (2006) recruited women who presented at community mental health centers in disadvantaged communities in urban United States to get services for their children. Communities were characterized by high unemployment rates, poverty, mental illness, substance abuse, and frequent family crises. All of the women were considered low income, and were either Caucasian or African American. Women were eligible for the study if they were between the ages of 18 and 55, were biological, step-, or adoptive mother living with the child being presented for care, and had no mental or physical condition that precluded understanding of study procedures. This study was unique because participants were not recruited because of PPD, but rather to gain insight into their feelings about overall mental health services in disadvantaged communities.

Themes

Stigma. Some of the most commonly cited reasons for not seeking help for PPD were stigma, embarrassment, and shame (McIntosh, 1993). A participant in one study stated, "I thought at a moment that I might have postpartum depression, but I jumped back into place because I don't want anyone thinking I'm crazy or I'm incapable of raising my child" (Abrams, Dornig, & Curran, 2009, pg. 541). In a study focusing specifically on cultural barriers for immigrant women, participants stated that barriers to care included stigma and fear that their illness would alienate them or cause distress

within the family (Teng, Blackmore, & Stewart, 2006). One healthcare provider for immigrant women at an OB/GYN clinic stated,

> "Some cultures tend to believe that depression of any kind is a form of madness. Those who admit to suffering from depression after the joyous birth of a baby – especially of a boy – are labeled 'crazy'" (Teng, Blackmore, & Stewart, 2006, pg. 96).

McCarthy and McMahon (2008) also described how gradual breakdown of stigma through discovering other women going through the same thing was an important part of recovery. One woman stated,

> "It wasn't probably the advice that she (mental health nurse) gave me, it was just knowing that someone else had been through what I had been through. I wasn't a weirdo, I wasn't a nutter, I wasn't a freak, I was just a normal person suffering from what mums, some mums, suffer" (McCarthy & McMahon, 2008, pg. 630).

Lack of Knowledge. Teng, Blackmore, and Stewart (2006) described the most common practical barriers to receiving care for immigrant women as lack of knowledge as to where to get assistance and being unsure of healthcare provider's role in mental health. Primiparous women were also identified as being less likely to recognize PPD, and therefore not seek treatment (Whitton, Warner, & Appleby, 1996). One new mother stated,

> "The intense emotions were overwhelming. I couldn't understand and I wasn't handling it. You know, being a mother comes naturally. I always thought before having children that it was going to come naturally" (McCarthy & McMahon, 2008, pg. 624).

Even women who were very accepting of the diagnosis of depression, attributed their feelings and symptoms to external stressors, most commonly identified were poverty, abuse, and the stress of raising a child. These external stressors were seen as

either transient, so the depression would resolve on its own, or beyond help from outside sources. This explains why referrals to mental health were viewed as not helpful (Anderson et al, 2006).

Rejection of Medications. For women who attributed their depression to external stressors, they felt medication would not help or relieve their depression, but rather a dramatic change in life circumstances (Anderson et al, 2006). One participant said, "What upset me was the response that it was recommended that I go to counseling…I joked with my friend, I said, you know, if they really wanted to make a difference here, throw $10,000 at me" (Anderson et al, 2006, pg. 935).

Abrams, Dornig, and Curran (2009) described rejection of formal care due to bad past experiences with mental health services, such as being offered medication first, which in turn caused mental health care providers to be viewed as uncaring. Many women expressed concern over taking medications and made statements such as, "What could the doctor do? He can't sort out my man or any of my other problems. They only give you pills" (McIntosh, 1993, pg. 182), and "I went to the doctor and he gave me Xanax, I said "I'm not going to take it", and they said to just take it when [I] feel like I can help things and just to relax. I got it but I threw it away in the toilet" (Abrams, Dornig, & Curran, 2009, pg. 542).

Lack of Support . Once women began to think about their symptoms and seek advice, barriers to care included people saying the symptoms are normal, support persons like family and spouses thinking that the mother just needs more help with the infant, and

being told to wait and see if symptoms resolve on their own (Abrams, Dornig, & Curran, 2009). "I'd like more time and help. This is where your man should come in. You're like the forgotten tribe – you're just left" (McIntosh, 1993, pg. 180). McIntosh (1993) identified problems with a spouse/partner as a significant barrier to care. One woman stated, "I keep it to myself. I've given up saying to him [husband]. He thinks I'm making a fuss about nothing. I'd rather go into my room and sit and cry myself" (McIntosh, 1993, pg. 181).

Barriers identified by immigrant women included external conflicts such as when the woman's needs conflict with other peoples' expectations, lack of family and friend support, and lack of spouse support (Teng, Blackmore, & Stewart, 2006). One provider said, "Immigrant women need a lot of help…if you're new to the country, most of your family is probably not here, and you probably haven't had enough time to make friends who will help you out much" (Teng, Blackmore, & Stewart, 2006, pg. 97).

Minimization of Symptoms or Failure to Diagnose. For women who did accept a mental health referral, the experience was most often viewed as negative. Women attributed the negative experience to the feeling that the provider did not take their symptoms seriously, or treated them like they were not intelligent enough to understand their own condition (Anderson et al, 2006). "I asked the healthcare visitor about it and she just said, 'Oh that's normal – it'll go away on its own'" (McIntosh, 1993, pg. 183).

Abrams, Dornig, and Curran (2009) discussed women's rejection of formal care due to bad past experiences with mental health services, being offered medication first, and seeing mental health care as uncaring. "It's like oh I'm having really bad thoughts,

the doctor said to wait until I come back for my six week, and if I continue to feel that way, he'll prescribe something for me" (Abrams, Dornig, & Curran, 2009, pg. 542). Another woman stated, "The problem I'm having right now is the doctor doesn't listen" (Anderson et al, 2006, pg. 937).

Cost and Childcare. McIntosh (1993) identified housing issues, unemployment, and financial problems as women's perceptions of what was causing their depression and also as barriers to seeking help. "I'm stressed because I worry…about everything. You know, your job, your home, your finances. It's everything, you feel very stressed" (Anderson et al, 2006, pg. 930). Teng, Blackmore, and Stewart (2006) described the most common practical barriers to receiving care for immigrant women as transportation to and from appointments and finding child care. In the study by Anderson et al (2006) all of the women attributed their depression to external stressors, one of the most commonly identified was poverty. One woman said, "I had no home to go to, no money, he [partner] had gone off and I felt alone and isolated…and I had to cope with the baby all on my own" (McIntosh, 1993, pg. 181). Another participant stated, "If somebody could give us a house and a job that's all we need, that's why I'm depressed" (McIntosh, 1993, pg. 180).

Theoretical Framework

All of the studies included in this literature review used grounded theory as the basis for their research, so other theoretical frameworks were not mentioned. However, the studies that involved mothers with postpartum depression often described feelings,

stages, or themes that are consistent with Beck's theory of postpartum depression. The four stages of Beck's model include, "encountering terror, dying of the self, struggling to survive, and regaining control" (Beck, 1993). Many of the themes identified above describe the initial shock and feelings fear, followed by a worsening depression, then the decision to seek help or not, and subsequently a period of recovery.

4: Quotes from Literature for the Stages of Beck's Model

Four Stages of Beck's Model	**Direct Quote from Qualitative Literature**
Encountering Terror	"I started to fall to pieces and think I am not coping as a mum or I am not doing things right as a mum and that I am failing as a mother" (McCarthey & McMahon, 2006, pg. 625).
Dying of the Self	"I felt depressed, fed up and tired. I just couldn't stop crying. I couldn't be bothered with anybody or anything and I couldn't be bothered with the baby" (McIntosh, 1993, pg. 179).
Struggling to Survive	"You know, I get through life managing…I'm depressed but I manage, I'm not one of those women who falls apart" (Anderson et al, 2006, pg. 934).
Regaining Control	"The best thing you can do to deal with depression is to talk about it. Find someone you can trust or seek professional help because it will help. Depression is really, really something that is difficult to deal with" (Abrams, Dornig, & Curran, 2009, pg. 544).

Gaps in Literature

With all of the available research on postpartum depression, possible causes, risk factors, epidemiology, diagnosing and screening, and treatment, there is very little

available on the lived experience and women's perceptions of barriers to getting help and treatment. Only six studies met the inclusion criteria for this review, and of those two were not the perspective of mothers with PPD specifically. More research needs to be done on barriers to care, and that can be followed up with research on ways to overcome these barriers to improve health outcomes.

Conclusions

Although there were a small number of studies that met the inclusion criteria, these six studies were very diverse. Locations were both urban and rural and included cities all over the world. Participants varied greatly in age, race, culture, socioeconomic status, education level, and parity. Women with postpartum depression were included, as well as healthcare workers, and community members who had utilized mental health services in the areas. Overall these six studies were a good representation of the whole of women with postpartum depression all over the world.

The most common themes identified for specific barriers to care for postpartum depression included: stigma, lack of knowledge regarding PPD or where to get treatment, fear that medication is the only treatment, lack of support, minimization of symptoms by healthcare providers or failure to diagnose, cost, and childcare. These identified barriers all need to be researched further, and also ways to overcome these barriers needs to be explored.

CHAPTER FIVE

DISCUSSION AND SUMMARY

Discussion

The purpose of this integrative literature review was to explore the barriers to treatment for women with postpartum depression, with the idea that if specific barriers could be identified perhaps further research would yield ways of overcoming these barriers and result in better overall health outcomes for mothers with PPD and their infants. After exhaustive searches of available online data bases, only six studies were found that met all of the inclusion criteria. This small number only further indicates the need for more research in this area. Common themes identified for barriers to care included: stigma, lack of knowledge regarding PPD or where to get treatment, fear that medication is the only treatment, lack of support, minimization of symptoms by healthcare providers or failure to diagnose, cost, and childcare.

Strengths

Although there were a small number of studies to be reviewed, one of the strengths was that the research that was done was of high quality. The studies were thorough, examined the lived experience of women with PPD, and successfully identified themes for barriers to treatment. Overall quality of all of the studies, as determined by Polit and Beck's criteria, was good and the data could be viewed as trustworthy.

Limitations

The obvious limitation for this review was the lack of available research. While there is a lot of available research on postpartum depression, there is very little available on the lived experience and women's perceptions of barriers to getting help and treatment. Only six studies met the inclusion criteria for this review, and of those two were not the perspective of mothers with PPD specifically.

Another limitation was that data was only gathered from online databases that were available through Montana State University's library. Perhaps if there had been access to a larger library, or a location where hand searches could be done, there would have been more useful research found.

Implications for Clinical Practice

Postpartum depression has been identified as the "most common complication of childbearing", affecting as much as ten to twenty percent of all childbearing women at some point (Teng, Blackmore, & Stewart, 2007, pg. 93). This means that whether providers are working in an outpatient clinic, inpatient setting, emergency department, or community health center, more than likely it is an issue that all will encounter at some point in their career.

The purpose of this integrative literature review was to explore the barriers to treatment for women with PPD. After review of the literature, common themes were identified for barriers to care and included: stigma, lack of knowledge regarding PPD or where to get treatment, fear that medication is the only treatment, lack of support,

minimization of symptoms by healthcare providers or failure to diagnose, cost, and childcare. Providers can use knowledge of these common barriers to help their patients by explaining how common PPD is, that it does not mean that they are "crazy" or "bad mothers", and that there are many women just like them going through similar situations and feelings. Making referrals to support groups can also help with stigma, lack of support, and feelings of loneliness. A thorough explanation of exactly what PPD is and all available treatments, pharmacological and non-pharmacological, should be discussed in detail, on more than one occasion, with each patient. Using available screening tools can help providers make more accurate diagnoses, and by using them as a routine part of postpartum care PPD is less likely to go unrecognized. Patients need to feel that they can have an open, honest relationship with their provider. When feelings of PPD are discussed it is important for the provider to be empathetic and understanding. Issues with finances, cost of healthcare, and cost of childcare need to be discussed with each patient and if necessary referrals can be made to social workers that can assist with government programs and financial assistance. Many community health offices have mental health services that are either free of charge or fees are on a sliding scale based on income and family size. Women in the literature also described how non-health related finances were a burden and often increased their feelings of depression. If there are issues with paying for housing, utilities, food, etc. social services can also help with this. A better understanding of these barriers to treatment and exploration of ways to break down these barriers may ultimately result in more women getting successful treatment for their PPD symptoms, which would result in better health outcomes for the mother and the infant.

Implications for Research

Although there were common identifiable themes in this review, there were only six studies available that met inclusion criteria. This is a clear indicator that more qualitative research needs to be done on barriers to care for women with PPD. The research that was reviewed for this project indicated a strong correlation between low income and ethnic minority mothers with PPD that do not seek treatment. Only two qualitative studies were found that focused on this specifically. This is definitely an area where more research is needed.

Further research is also needed on specific barriers to treatment and help seeking. For example, a single research study could be done on the topic of stigma related to PPD or on women's feelings regarding taking an anti-depressant for treating PPD. Once more research is accomplished in this area, further research can be done on ways of overcoming these barriers to see if the number of untreated PPD cases is reduced.

Summary

Although more research needs to be done in this area, the review of literature that was available did yield specific results for barriers to treatment for women with postpartum depression. These barriers included: stigma, lack of knowledge regarding PPD or where to get treatment, fear that medication is the only treatment, lack of support, minimization of symptoms by healthcare providers or failure to diagnose, cost, and childcare. Participants in the study cited these specific factors as reasons for not seeking help or getting treatment for their postpartum depression symptoms.

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APPENDICES

APPENDIX A

EDINBURGH POSTNATAL DEPRESSION SCREENING SCALE (EPDS)

Name: _____ Address: _____

Your Date of Birth: _____ _____

Baby's Date of Birth: _____ Phone: _____

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

Here is an example, already completed.

I have felt happy:

- ☐ Yes, all the time
- ☒ Yes, most of the time — This would mean: "I have felt happy most of the time" during the past week.
- ☐ No, not very often — Please complete the other questions in the same way.
- ☐ No, not at all

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   - ☐ As much as I always could
   - ☐ Not quite so much now
   - ☐ Definitely not so much now
   - ☐ Not at all

2. I have looked forward with enjoyment to things
   - ☐ As much as I ever did
   - ☐ Rather less than I used to
   - ☐ Definitely less than I used to
   - ☐ Hardly at all

*3. I have blamed myself unnecessarily when things went wrong
   - ☐ Yes, most of the time
   - ☐ Yes, some of the time
   - ☐ Not very often
   - ☐ No, never

4. I have been anxious or worried for no good reason
   - ☐ No, not at all
   - ☐ Hardly ever
   - ☐ Yes, sometimes
   - ☐ Yes, very often

*5 I have felt scared or panicky for no very good reason
   - ☐ Yes, quite a lot
   - ☐ Yes, sometimes
   - ☐ No, not much
   - ☐ No, not at all

*6. Things have been getting on top of me
   - ☐ Yes, most of the time I haven't been able to cope at all
   - ☐ Yes, sometimes I haven't been coping as well as usual
   - ☐ No, most of the time I have coped quite well
   - ☐ No, I have been coping as well as ever

*7 I have been so unhappy that I have had difficulty sleeping
   - ☐ Yes, most of the time
   - ☐ Yes, sometimes
   - ☐ Not very often
   - ☐ No, not at all

*8 I have felt sad or miserable
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Not very often
   - ☐ No, not at all

*9 I have been so unhappy that I have been crying
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Only occasionally

*10 The thought of harming myself has occurred to me
   - ☐ Yes, quite often
   - ☐ Sometimes
   - ☐ Hardly ever
   - ☐ Never

Administered/Reviewed by _____ Date _____

SCORING

QUESTIONS 1, 2, & 4 (without an *)
Are scored 0, 1, 2 or 3 with top box scored as 0 and the bottom box scored as 3.

QUESTIONS 3, 5-10 (marked with an *)
Are reverse scored, with the top box scored as a 3 and the bottom box scored as 0.

Maximum score: 30
Possible Depression: 10 or greater
Always look at item 10 (suicidal thoughts)

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Instructions for using the Edinburgh Postnatal Depression Scale:

1. The mother is asked to check the response that comes closest to how she has been feeling in the previous 7 days.

2. All the items must be completed.

3. Care should be taken to avoid the possibility of the mother discussing her answers with others. (Answers come from the mother or pregnant woman.)

4. The mother should complete the scale herself, unless she has limited English or has difficulty with reading.

APPENDIX B

POSTNATAL DEPRESSION SCREENING SCALE (PDSS)

Below is a list of statements describing how a mother may be feeling after the birth of her baby. Please indicate how much you agree or disagree with each statement. In completing the questionnaire, please circle the answer that best describes how you have felt over the past 2 weeks. Read each item carefully. Then circle the number that best fits your answer. Please give only one response for each statement, using the following scale:

1	2	3	4	5
Strongly Disagree	**Disagree**	**Neither Agree nor Disagree**	**Agree**	**Strongly Agree**

If you wish to change your response, completely mark through your first response with an "**X**." Then circle the response that best fits your new choice.

Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree	
					During the past 2 weeks,
1	2	3	4	5	**1.** I had trouble sleeping even when my baby was asleep.
1	2	3	4	5	**2.** I got anxious over even the littlest things that concerned my baby.
1	2	3	4	5	**3.** I felt like my emotions were on a roller coaster.

APPENDIX C

BECK DEPRESSION INVENTORY – II (BDI-II)

BECK DEPRESSION INVENTORY - ADULT

This questionnaire consists of 21 groups of statements. After reading each group of statements carefully, circle the number (0,1,2 or 3) next to the one statement in each group which best describes the way you have been feeling the past week, including today. If several statements within a group seem to apply equally well, circle each one. **Be sure to read all the statements in each group before making your choice.**

1
0 I do not feel sad.
1 I feel sad.
2 I am sad all the time and I can't snap out of it.
3 I am so sad or unhappy that I can't stand it.

2
0 I am not particularly discouraged about the future.
1 I feel discouraged about the future.
2 I feel I have nothing to look forward to.
3 I feel that the future is hopeless and that things cannot improve.

3
0 I do not feel like a failure.
1 I feel I have failed more than the average person.
2 As I look back on my life, all I can see is a lot of failures.
3 I feel I am a complete failure as a person.

4
0 I get as much satisfaction out of things as I use to.
1 I don't enjoy things the way I used to.
2 I don't get real satisfaction out of anything anymore.
3 I am dissatisfied or bored with everything.

5
0 I don't feel particularly guilty.
1 I feel guilty a good part of the time.
2 I feel quite guilty most of the time.
3 I feel guilty all of the time.

6
0 I don't feel I am being punished.
1 I feel I may be punished.
2 I expect to be punished.
3 I feel I am being punished.

_____**Subtotal**

7
0 I don't feel disappointed in myself.
1 I am disappointed in myself.
2 I am disgusted with myself.
3 I hate myself.

8
0 I don't feel I am any worse than anybody else.
1 I am critical of myself for my weaknesses or mistakes.
2 I blame myself all the time for my faults.
3 I blame myself for everything bad that happens.

9
0 I don't have any thoughts of killing myself
1 I have thoughts of killing myself, but I would not carry them out.
2 I would like to kill myself.
3 I would kill myself if I had the chance.

10
0 I don't cry any more than usual.
1 I cry more now than I used to.
2 I cry all the time now.
3 I used to be able to cry, but now I can't cry even though I want to.

11
0 I am no more irritated now than I ever am.
1 I get annoyed or irritated more easily than I used to.
2 I feel irritated all the time now.
3 I don't get irritated at all by the things that used to irritate me.

_____**Subtotal**

(OVER)

APPENDIX D

JOANNA BRIGGS INSTITUTE APPRAISAL AND REVIEW INSTRUMENT

DATA EXTRACTION FORM FOR INTERPRETIVE

AND CRITICAL RESEARCH

Methodology	Identify the research methodology used in the study.
Method	The way in which the data is collected.
Setting and Context	Provide the specific location of the research in terms of local environment. Be as descriptive as possible because this is a component in assessing transferability.
Geographical Context	Location of the research: country, urban/rural/suburban
Cultural Context	Cultural features in the study setting such as period, ethnic groupings, age-specific groupings, socioeconomic characteristics, employment, lifestyle, and so forth, which are associated with distinct values and beliefs.
Participants	Information related to inclusion and exclusion criteria. Should provide sample size and a description of the sample to include but not to be limited to description of age, gender, sample size, participation rate, and ethnicity.
Data Analysis	The specific method used for data analysis.
Author's Conclusions	
Reviewer's Comments	