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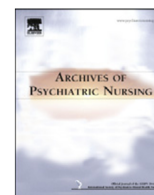

An Integrative Review of Postpartum Depression in Rural U.S. Communities

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ABSTRACT

Aim: This study's aim is to synthesize and summarize the literature on postpartum depression (PPD) in U.S. rural populations.
Background: Internationally, PPD has a high prevalence in rural communities. Although women in rural U.S. communities have higher rates of depression outside of the postpartum time period, little study has been conducted on PPD in U.S. rural populations. It is unknown whether rural women in the United States have high rates of PPD as is common in rural populations internationally.
Design: We used integrative literature review using Whittemore and Knafl's (2005) methodology.
Data Sources and methods: We searched the databases MEDLINE, CINAHL, PsycINFO, and Academic Search Premier with the words “postpartum depression” or “postnatal depression” and the word “rural.”
Results: We found 11 articles with empirical data that met the criteria and thus were included in the review. Seven articles were quantitative, two were qualitative, one was mixed methods, and one was a nonexperimental design. Five foci emerged in the literature including (a) screening and prevalence, (b) demographic factors, (c) program creation and implementation, (d) mental health care seeking, and (e) social support. The results suggest that prevalence of PPD may be higher in rural U.S. areas, that implementing PPD prevention and screening programs for rural women is feasible, and that women in rural areas rely on informal networks and may face a stigma for seeking mental health care.
Conclusions: Further research is needed on PPD in rural U.S. populations. Specifically, this research should focus on the mix of variables found throughout this review such as race and income level. Nurses should lead for changes in clinical practice and policy that increase screening and interventions for PPD in rural communities.
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Postpartum depression (PPD) is a depressive episode in women with onset in the first 4 weeks to 12 months after giving birth and has deleterious effects on both mother and child, and the interactions between them (Centers for Disease Control and Prevention [CDC], 2013; O'Hara & McCabe, 2013). PPD may include symptoms of sadness, anhedonia, weight changes, sleep disturbance, low energy, and thoughts of death with or without suicidal ideation lasting 2 weeks or more (U. S. Department of Health and Human Services, National Institutes of Health, & National Institute of Mental Health, 2013). PPD is not to be confused with the “baby blues” which is a common transient mood disruption experienced within the first 2 weeks postpartum (Buttner, O'Hara, & Watson, 2012; U. S. Department of Health and Human Services et al., 2013), or the extremely rare (<0.5%) incidence of postpartum psychosis, an acute psychotic episode, usually occurring within the first 2–6 weeks postpartum (Jones, Chandra, Dazzan, & Howard, 2014). In the United States, PPD occurs in about 10–15% of childbearing women (Centers for Disease Control and Prevention [CDC], 2013).

In an international systematic review, prevalence of PPD in rural populations was nearly double that of what is accepted as the prevalence rate of PPD in the United States (Villegas, McKay, Dennis, & Ross, 2011). Mental health, including PPD, remains understudied in U.S. rural communities despite that U.S. rural women have higher rates of depression outside of the postpartum time period relative to the general U.S. population (Groh, 2013; Simmons, Huddleston-Casas, & Berry, 2007; Simmons, Yang, Wu, Bush, & Crofford, 2015; U.S. Department of Health and Human Services & Substance Abuse and Mental Health Services Administration, 2014). Taking these factors into account, rural women may be at a greater risk for PPD, with unknown consequence to rural families and communities. This integrative review will synthesize and summarize the available literature on PPD in rural U.S. populations to determine what is known, where further study is needed, and will discuss the implications for nurses who care for rural populations.

BACKGROUND

The effects of PPD are devastating and far-reaching for women, their children, and their communities. PPD causes not only suffering in the

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mothers who experience it, but also serious consequences for their infants. PPD increases the risk of suicide in mothers and is responsible for around 20% of postpartum deaths (Lindahl, Pearson, & Colpe, 2005). Women with postpartum depression are more likely to experience breastfeeding problems and to prematurely discontinue breastfeeding (Dennis & McQueen, 2007; Gagliardi, Petrozzi, & Rusconi, 2012). Depressed women are less likely to take their infants to well child appointments, immunize them, or use appropriate safety practices such as back sleeping (Balbierz, Bodnar-Deren, Wang, & Howell, 2014; Zajicek-Farber, 2009). Postpartum depression predicts poorer cognitive outcomes for offspring, including lower intelligence quotient level and decreased language ability (Brand & Brennan, 2009). These effects carry with them real-life, long-term costs to employers, health care systems, and communities.

Women living in rural communities face the difficulties of PPD in addition to the challenges that all rural dwellers face in staying healthy. Rural individuals are considered health disparities group and are at greater risk for health problems (Meit et al., 2014), due to factors such as low educational attainment (Johnson, Showalter, Klein, & Lester, 2014) and increased rates of poverty (Kusmin, 2013). At the same time, racial and ethnic minorities, another health disparities group, increased in U.S. rural areas by nearly 40% between 1980 and 2009 (Lee, Iceland, & Sharp, 2012). Minorities currently make up 22% of the overall population of rural U.S. communities (Housing Assistance Council (HAC), 2014).

Rural dwellers are less likely to seek health care services if they are unable to pay for them (Deen, Bridges, McGahan, & Andrews, 2012). Yet rural individuals are less likely to be insured, are uninsured for longer periods of time, and often lack comprehensive insurance coverage to pay for their health care needs (Deen et al., 2012). These realities, in addition to rural values of independence, may contribute to rural dwellers' tendency to rely on informal support networks for health advice (Long & Weinert, 1989; Yates et al., 2012) and for mental health support (Blank, Mahmood, Fox, & Guterbock, 2002; Letvak, 2002).

Rural communities have limited availability of health care services and have difficulty recruiting health care providers, especially those who are trained mental health care specialists (National Rural Health Association (NRHA), 2012). Access to health care services is an issue for those rural dwellers who reside in remote and isolated areas that lack public transportation. Women with PPD may feel the need to hide their experiences in order to avoid stigma (Beck, 2002; Mollard, 2014), and the stigma associated with mental health may be amplified in rural communities (Robinson et al., 2012; Smalley et al., 2010). The lack of qualified healthcare providers, and increased potential for stigma, decreases the likelihood that rural women will seek or receive needed care for PPD.

Villegas et al. (2011) conducted an international systematic review of literature on postpartum depression in rural women and found that prevalence rates of PPD were higher in rural women than in nonrural women, and even higher in nonindustrialized (developing) countries compared to industrialized (developed) countries. Overall prevalence of PPD in rural women ranged from 23–57.8% (Villegas et al., 2011). Villegas et al. (2011) calculated the prevalence as 31% in developing countries and 21.5% in developed countries, which are both dramatically higher than the generally accepted rate of 10–15% in the United States (CDC, 2013).

The international rural landscape is culturally and socially diverse, making it difficult to apply the conclusions of Villegas et al. (2011) to the U.S. rural population. After an extensive literature search, we did not find any comprehensive literature reviews on PPD in rural populations focused on the United States.

THE REVIEW

Aim

The aim of this integrative review was to synthesize and summarize the available literature on PPD in U.S. rural populations. By conducting this review, we elucidate what research has been conducted on PPD in rural populations as well as identify gaps in the literature. These findings will aid in the planning of future research and inform nursing care in rural populations.

Search Methods

Based on the low number of articles available for Villegas et al. (2011) international systematic review ($N = 19$), we anticipated that the literature available on PPD in the rural United States would be limited. In response to this concern, we employed Whittemore and Knafl's (2005) integrative review framework. An integrative review serves foremost as a summarization of the available literature to provide a thorough grasp of a topic of study (Broome, 2000). We chose this method as it is the broadest method of literature review, and one that allows for inclusion of all types of methodologies including both experimental and non-experimental research (Whittemore & Knafl, 2005).

We searched the databases MEDLINE, CINAHL, PsycINFO, and Academic Search Premier with the search terms "'postpartum depression' AND 'rural'" as well as "'postnatal depression' AND 'rural.'" To ensure that all available information on PPD in rural U.S. populations was included, there was no date range limit placed on the results. Subsequent to using the database search engines, we hand-searched the reference lists from the selected citations. To be included articles had to be peer reviewed, include empirical data, be written in the English language, include a rural population, and be conducted in the United States. Excluded articles were previous reviews (of which there were none), dissertations, articles exclusively about antepartum depression, and articles about rural mental health issues other than PPD (Fig. 1).

Search Outcome

We found eleven articles that met all of the inclusion criteria for our literature review. Of these articles, two were qualitative studies (Dennis & Moloney, 2009; Gjesfjeld, Weaver, & Schommer, 2012); one was a mixed methods study (Drake, Howard, & Kinsey, 2014); seven were quantitative research studies; and one article was a nonexperimental design that included data related to program creation and implementation (Smith & Kipnis, 2012).

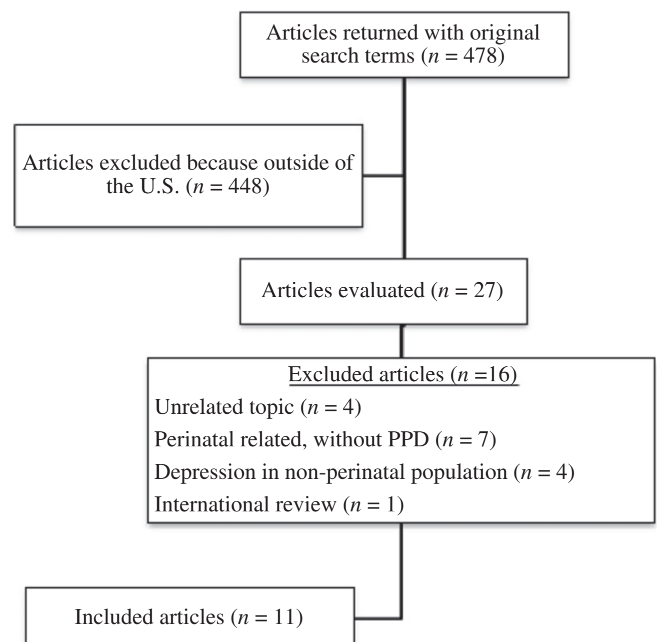

Fig. 1. Flow of review process.

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