

Sociodemographic and Obstetric Factors Related to Symptoms of Postpartum Depression in Hispanic Women in Rural California

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ABSTRACT

Objective: To investigate the relationships among sociodemographic and obstetric factors and symptoms of postpartum depression (PPD) in Hispanic women living in rural California.

Design: Quantitative, cross-sectional, descriptive design.

Setting: Rural southern California communities.

Participants: A convenience sample of 223 Hispanic women, ages 18 to 42 years old, with one living infant younger than 12 months old.

Methods: Interviewer-administered Edinburgh Postnatal Depression Scale and sociodemographic and obstetric history survey (maternal age, marital status, education, annual household income, employment, sex of infant, birth type, and number of children). Chi-square and logistic regression analyses were used to determine associations and predictive relationships among sociodemographic and obstetric factors and symptoms of PPD.

Results: Low education levels, unemployment, cesarean birth, and more than one young child were significantly related to PPD risk (Edinburgh Postnatal Depression Scale scores ≥ 10). Many of the factors associated with PPD symptoms in this sample of Hispanic women were similar to those previously reported in the literature.

Conclusion: Our findings highlighted the need for PPD care among Hispanic women in rural areas. Early assessment and intervention for symptoms of PPD are needed to enhance health equity and promote better health for women who live in rural communities.

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AWHONN

As one of the most critical issues for public health (Fitelson, Kim, Baker, & Leight, 2011; Schiller, Meltzer-Brody, & Rubinow, 2015), postpartum depression (PPD) affects many women, regardless of country of origin or culture (Evagorou, Arvaniti, & Samakouri, 2016). According to the American Psychiatric Association (2013), PPD is defined as major depression, without psychotic features, that begins within 4 weeks after birth and may last up to 1 year (Beck & Driscoll, 2006; Lintner & Gray, 2006). Feelings of depression during the postpartum period can have critical effects on the health of women and their children (Abbasi, Chuang, Dagher, Zhu, & Kjerulff, 2013).

In a meta-analysis of PPD research, Beck (2001) identified 13 risk factors for PPD: prenatal

depression, prenatal anxiety, child care pressure, infant temperament, life stress, lack of social support, single marital status, marital dissatisfaction, history of depression, postpartum blues, low self-esteem, low socioeconomic status, and unwanted pregnancy. Other factors included the mother's employment status (Chatterji, Markowitz, & Brooks-Gunn, 2013; Dagher et al., 2009), living without a partner (Tannous, Gigante, Fuchs, & Busnello, 2008), and breastfeeding (Nishioka et al., 2011). Infant sex has also been associated with maternal feelings of depression during the postpartum period (Sylvén et al., 2011). In two studies, the undesired sex of an infant increased feelings of depression during the postpartum period (Kheirabadi et al., 2009; Lagerberg & Magnusson, 2012).

We examined the sociodemographic and obstetric factors associated with symptoms of postpartum depression in Hispanic women living in rural southern California.

The growth of the Hispanic population has been a significant demographic trend in the United States. Between 2000 and 2010, the number of White Americans living in rural areas increased by 1.8%, but the Hispanic population living in rural areas increased by 46%, faster than any other racial or ethnic minorities: the number of Asian Americans living in rural areas increased by 37.4%, Native Americans by 7.5%, and African Americans by 2.9% (Housing Assistance Council, 2012). This rural growth represented approximately 3.5 million people, 1.9 million of whom identified as Hispanic. Therefore, attention to the health of the Hispanic population is critical to meet the goal of a healthy America (Bellamy, Bolin, & Gamm, 2011; Johnson, 2012).

Although the goal of Healthy People 2020 (HealthyPeople.gov, n.d.) is to promote health equity, individuals who live in rural areas often experience health disparities because of geographic isolation, lack of transportation, lower socioeconomic status, lack of medical insurance coverage, and lack of access to affordable and available health care resources or services (Krothe, 2008). According to Hillemeier, Weisman, Chase, and Dyer (2008), women who live in rural areas are more likely to experience mental stress because of limited employment opportunities, social contacts or services, and health care services compared with women who live in urban communities. Hispanic people in rural areas face challenges to the achievement of a high school diploma because of a lack of social and economic resources and knowledge of the U.S. education system (Schneider, Martinez, & Owens, 2006). Thus, of U.S. adults 25 years and older, 19.2% of Hispanic individuals have less than a ninth grade education, compared with only 2.0% of White individuals (U.S. Census Bureau, 2013). In a study of 1,423 Australian women in the postpartum period, Cooklin, Canerford, Strazdins, and Nicholson (2011) found that low level of education among young mothers could pose a challenge to obtaining and maintaining jobs or finding high-quality jobs.

The Centers for Disease Control and Prevention (2017) reported that the overall rate of PPD was 11.5% in the United States in 2012. The

prevalence of symptoms of PPD varies across racial and ethnic groups (Feinberg, Smith, & Naik, 2009). Authors of a systematic review of studies using a variety of PPD screening tools suggested that the prevalence of PPD symptoms among women in rural communities worldwide ranged from 23% to 58% (Villegas, McKay, Dennis, & Ross, 2011). However, research on symptoms of PPD in rural Hispanic women is lacking (Mollard, Hudson, Ford, & Pullen, 2016). Thus, the purpose of our study was to determine the associations among the sociodemographic factors of maternal age, infant sex, marital status, education, annual household income, employment, and route of birth and symptoms of PPD in Hispanic women in rural areas. The findings will begin to fill the gap in the literature regarding Hispanic women and PPD in the United States.

Methods

Design

We used a cross-sectional design for this descriptive correlational study and conducted structured interviews with a convenience sample of women who identified as Hispanic and spoke English or Spanish. The study was approved by the institutional review board at Azusa Pacific University in California.

Sample

The potential participants were recruited through a rural family health center. Inclusion criteria for women were as follows: (a) self-identified as Hispanic, (b) ages 18 to 47 years, (c) lived in a cluster of rural communities in southern California, (d) had one or two living infant(s) ages 12 months or younger, and (e) spoke English or Spanish. Women with mental disorders diagnosed by a physician and those taking any psychiatric medication were excluded. A priori statistical power for chi-square and logistic regression was determined using G*Power 3.1; at least 175 participants were required for an alpha level of .05 and power level of .80. A total of 251 potential participants were initially recruited; 15 women did not meet the inclusion criteria, and 13 did not complete the study, which yielded a final sample size of 223.

Procedures

We distributed recruitment flyers in English and Spanish at a family health care center that provided postnatal health services in southern California. With assistance from the trained nursing student research assistants who were

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