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SERVICE PROVIDERS' PERCEPTIONS OF BARRIERS TO SERVICES FOR WOMEN WITH POSTPARTUM DEPRESSION IN SAN BERNARDINO AND RIVERSIDE COUNTIES

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SERVICE PROVIDERS' PERCEPTIONS OF BARRIERS TO SERVICES FOR
WOMEN WITH POSTPARTUM DEPRESSION IN SAN BERNARDINO
AND RIVERSIDE COUNTIES

A Project
Presented to the
Faculty of
California State University,
San Bernardino

In Partial Fulfillment
of the Requirements for the Degree
Master of Social Work

by
Bertha Ayala Reeves
Hana Gen Swenson-Coon

June 2018

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ABSTRACT

The purpose of this study was to identify barriers to receiving services for women suffering with Postpartum Depression (PPD) in the San Bernardino and Riverside County areas. 11 - 20% of mothers experience symptoms of PPD, which if left untreated can negatively impact the mother-infant relationship, ultimately affecting the entire family unit. Past studies have identified a variety of barriers to receiving treatment for PPD. However, research has not focused specifically on the obstacles mothers face in these two neighboring counties.

The study utilized an online self-administered questionnaire developed by the researchers to identify barriers to treatment for PPD. There were 41 participants from San Bernardino and Riverside Counties. The questionnaire was intended to be distributed to service providers that come into contact with this vulnerable population; primarily social workers, licensed therapists, masters of social work (MSW) students student interns, physicians, registered nurses, and midwives. However, because a snowball sampling technique was used, it was possibly sent to other professionals who come into contact with this population.

Our study found that most of the barriers identified in previous studies also applied to our participants. The barriers rated highest in terms of limiting access to PPD services were a physician's lack of time with patients, knowledge of PPD symptoms, the patient's relationship to physician, and limits in coverage, as well as knowledge of services covered, lack of emotional support from significant

other and/or family members, and transportation challenges including distance from providers. Additional barriers that were recognized in the literature and in our research, were education barriers, cultural barriers, stigma associated with postpartum depression, fear of child welfare officials, lack of culturally sensitive screening tools, and fears surrounding the use of medication.

The results from this study may help practitioners and researchers better understand the barriers women with PPD face in accessing services, and may help service providers tailor their treatments and services accordingly. Additionally, the knowledge gained from the research may also inspire policy changes to improve women's access to PPD services.

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-Bertha Ayala Reeves

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-Hana Gen Swenson-Coon

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CHAPTER ONE

INTRODUCTION

Problem Formulation

The social problem this research project addresses is identifying barriers to service access for women experiencing postpartum depression (PPD). The study identifies barriers perceived by human service providers who regularly encounter pre-natal and postpartum women in San Bernardino and Riverside Counties in California.

According to the National Institutes of Mental Health (NIMH) in 2012, PPD is an extreme fluctuation of moods resulting after childbirth; symptoms include sadness, anxiety, fatigue, and the inability to graciously take care of one's self and others. PPD should not be confused with the "baby blues", which is more commonly experienced by 80% of women, whom only identify symptoms of sadness within the first two weeks of delivery; however these symptoms soon dissipate (NIMH, 2012). PPD is consistent for longer than two weeks and continues to affect the mother and her newborn, as well as the entire family unit. PPD has been described as a "dangerous grief" that interferes with the crucial bonding time between mother and her infant (Beck, 2001, p. 275). A disruption in this mother-infant bonding time may hinder normal childhood development, resulting in future relationship challenges among children, adolescents, and adults (Katon, Russo, & Gavin, 2014). In addition to impeding the mother-infant

relationship, PPD may also generate intense pressure on parental relationships (Werner, et al., 2016). Furthermore, mothers experiencing PPD tend to isolate themselves, disconnecting from available and helpful social support systems (Werner, et al.). Most disturbingly, PPD continues to take the lives of women all around the world. Suicide has been reported to be lower during pregnancy; however, it still accounts for 20% of deaths by suicide and it is the second leading cause of death among pregnant and postpartum women (Lindahl, Pearson, & Colpe, 2005). Lastly, the stigma surrounding PPD can discourage new mothers and their families from seeking or receiving treatment.

Abrams, Dornig and Curran, (2009) estimate that 13-16% of women will suffer from PPD each year in the United States, and also postulate that PPD is vastly under-reported and undertreated. In fact, according to the Centers for Disease Control and Prevention (CDC), PPD is more common among women in the U.S. than diseases such as tuberculosis, leukemia, multiple sclerosis, Parkinson's disease, Alzheimer's disease, lupus, and epilepsy (CDC, 2016). This is alarming because, despite the previously mentioned statistics, there is so much more outreach and awareness of the illnesses listed above than there is of PPD.

Social workers have an ethical responsibility to understand and recognize the symptoms of PPD in their clients. Social workers are required to protect and to empower the vulnerable populations, including women experiencing PPD, as a means of addressing their overall wellbeing (Grinnel & Unrau, 2014). Thus, in order to make the right referral, it is imperative that social workers be

appropriately educated to best assist women suffering from this disorder. This knowledge can strengthen the whole family unit as well as preventing further emotional damage to the child.

Purpose of the Study

The purpose of this study is to identify the barriers women with PPD experience in accessing services in two Southern California counties. The study used a quantitative approach; researchers surveyed human service providers from various agencies that serve pre- and post-natal women. The survey asked these providers to identify the barriers women encounter in accessing services. Participants included social workers, licensed therapists, MSW student interns, physicians, registered nurses, midwives, and other professionals who come into contact with this population. This study fills a gap in our understanding of service barriers for women with PPD in two specific counties. By more clearly defining the barriers that limit access to services, we can create policies and implement programs to better serve this population.

Significance of the Project for Social Work Practice

The results from the research have implications for research and policy. The study's findings suggest areas in need of additional funding and programming to minimize these barriers, ultimately influencing the planning and implementing phases of the generalist intervention process. The planning phase

entails formulating a plan based on an in-depth assessment and the availability of resources, while the implementing phase administers the interventions. For both phases to be completed, service providers must be aware of the services available, potential barriers to receiving services, and how to assist clients in accessing these services.

The findings of the study are important to social work practitioners, since social workers are likely to meet women suffering from PPD in both their careers and personal lives. Social workers have an ethical responsibility to learn how to appropriately assist women suffering from PPD. Possessing the knowledge and skills to assess for signs and symptoms PPD, will assist providers in making the the right referral. Understanding the service gaps associated with services will aid social workers in being more efficient in their support to these women.

This study is relevant to child welfare practice because PPD is a problem that transcends racial/ethnic, economic, and geographic groups. PPD is a mental illness that can negatively impact the entire family unit, including children. Identifying and properly addressing PPD in mothers is especially important to child welfare agencies to preserve the health and safety of minor children. Child welfare workers may be better able to provide referrals and to engage in appropriate case planning for the families they serve, if they understand PPD and the barriers to service access for families affected by this condition. This research study identifies the barriers to PPD services from the service provider's perspective.

CHAPTER TWO

LITERATURE REVIEW

Introduction

In the following chapter, we review the research on barriers to PPD services from the perspective of both women and providers. Second, we discuss the gaps in the literature. Third, we describe the Andersen Health Care Utilization Model (Aday & Andersen, 1974), which serves as the theoretical framework for this study.

Barriers to Accessing Mental Health Services

According to Cunningham (2009) only 33% of individuals diagnosed with a mental illness access and receive services. Poor or lack of healthcare coverage was reported as a significant barrier to attaining mental health services, as well as a low number of service providers. Other challenges identified were geographic locations, public policies, practicing physicians, and the overarching health care system (Cunningham, 2009). In addition, Sareen, et al. (2007) noted that individuals with a lower socioeconomic status were more likely to report financial concerns as the predominant barrier for seeking professional assistance for mental health services. Social factors can present boundaries to services as well. For example, Ostrow, Manderscheid, and Mojtabai (2014) found that the stigma surrounding mental illness was also a strong contributing factor.

Barriers to Accessing Postpartum Depression Services

An ample amount of literature has honed in on postpartum depression. Barriers to PPD services have been identified to mirror those of overall mental health services. In the previous section, we briefly presented barriers to accessing mental health services in general. Next, we will focus on the literature surrounding PPD barriers specifically. The following barriers will be reviewed; economic, physician, knowledge, emotional, geographical, education, cultural, stigma, fear of Child Family Service (CFS) referrals, fears surrounding the use of medication, and lastly, culturally sensitive screening tools.

Economic Barriers

Socioeconomic status affects PPD in multiple ways. First, low-income mothers are at greater risk for PPD (Robertson, Grace, Wallington, & Stewart, 2004). Limited education, unemployment, and lower income all combine to increase the odds that mothers will experience PPD. According to Abrams, et.al (2009), this increased risk can be found across low-income communities. Second, low-income mothers are less likely to be able to afford treatment. Especially among African-American mothers, the costs of such treatment may seem like a waste of already scarce resources, particularly when women are uncertain about whether treatments are covered by insurance. Rather, African-American women were more likely to engage in self-care as an alternative to professional PPD treatment. African-American women were also more likely to engage in free, religious practice as a form of treatment for PPD (Abrams, et al.).

Physician Barriers

According to Abrams, et al., physicians report feeling unprepared when specifically working with the low-income communities, since the physicians state they had difficulties identifying and separating normal life stressors and postpartum depression. They further cited an ongoing lack of economic support in patient's lives as casting a shadow over any new feelings of depression, which prevented them from accurately identifying when the depression started or the actual cause of it.

Additionally, cultural barriers were the biggest concern among providers (Abrams, et al.). The inability to be culturally sensitive in conducting the appropriate screening tool or simply talking to the patient about her feelings and possible treatments was seen as challenging by the physicians interviewed. For example, in some cultures, the presentation of symptoms may appear or are seen differently by the women, such as body aches or ascertaining PPD as just sadness, and in some cultures talking with a physician about one's problems can be challenging since they are seen as outsiders (Abrams, et al.). The cultural challenges for the physicians to gain the mother's trust becomes more complicated by providers' lack of time available per patient. They reported not being allowed the quality time that is needed to spend with a mother to truly dissect the mother's verbal and nonverbal cues. This consequently leaves the mother feeling unattended to, since insufficient time was given to her feelings

and concerns. Because of this, the important component of trust, as well as the bond between the patient and physician, can become obsolete.

Gjerdingen and Yawn (2007) suggested that physicians could possibly conduct a postpartum analysis with the new mother at the newborn's well-baby visit since they are more frequent, and mothers typically do not miss these visits. However, according to pediatricians interviewed in this study, the time taken away to do a postpartum checkup is simply not feasible because there are particular time constraints per patient which varies by employer. Another problem is the lack of knowledge in treating adults since pediatricians specialize in children's care (Gjerdingen & Yawn, 2007; Heneghan, Mercer, & Deleone, 2004). They are simply not trained or required to diagnose PPD.

These same studies also found a problem with the physician lacking the ability to build trusting relationships with the postpartum mothers (Abrams, et al., 2009; Gjerdingen & Yawn, 2007). The researchers clearly made the correlation between mothers who felt comfortable talking to a doctor about their feelings and the level of rapport they actually had with the health care provider. It was recognized that a positive relationship with a health care provider can by far insure an open dialog in regards to a mother's true feelings.

The lack of resources is another barrier physicians cannot control. It has been documented by Kornelsen and Grzybowski (2006) that there has been a great decline in available maternity clinics. This study was conducted by interviewing Canadian women whom lived in rural areas. They discovered that

several maternity clinics were closing in their communities, thus forcing the women to resort to unhealthy measures to resolve the problem. Kornelsen and Grzybowski (2006), as well as Abrams et al., document this barrier faced by both the women and the health care providers because they cannot provide these services or make adequate referrals if the resources are not available.

Knowledge Barriers

Many mothers simply do not know where to go for help (Abrams, et al.). Several studies suggest that women are often unsure if one's general doctor, an OBGYN, or her child's pediatrician is the proper professional to ask about PPD and to conduct a PPD screening (Gjerdingen & Yawn, 2007; Heneghan, et al., 2004). This is all very confusing for the mother and unfortunately this is not completely clear among all health care providers. Abrams, et al. discovered that it was up to the physician's discretion to ask or screen for PPD. Providing PPD screening is a global failure among physicians and the health insurance providers. Physicians should be educating all of their patients on PPD, and the importance of PPD screening, while the healthcare insurance providers should be making it a point to inform all of their clients that PPD screening is covered, and where to seek assistance under their insurance plans.

Access to medical care is vital for humanity, especially those suffering with mental illnesses (Ostrow, et al., 2014). Having services available for PPD women that are also accessible is important. Women will often find alternative ways of resolving the issue of inaccessibility to services on their own (Kornelsen

& Grzybowski, 2006). Unfortunately, the alternatives may be hazardous, and can potentially endanger both the mother and her new born. However, for women who live in rural areas that do not have access to health care, sometimes alternative care is the only viable option they have.

This goes along with clearly understanding the limitations in health care coverage for PPD. Abrams, et al. identified that there is a lot of confusion as to what insurance covers. This concern is important; however is not researched or addressed enough. When a mother is already having socioeconomic problems, then seeking additional services is not going to be either a priority or a possibility (Dennis & Chung-Lee, 2006). Two studies acknowledged participants' sentiments that clearly stated they did not know who to contact in order to find out information about their insurance coverage (Abrams, et al.; Dennis & Chung-Lee, 2006). That is a double barrier in services. For example, Dennis and Chung-Lee's study of 37 postpartum participants found that only three participants were aware of the mental health services available from their health care provider.

Emotional Barriers

Emotional support is defined as actions of love, understanding, respect and the sense of inspiration (Thoits, 2011). By allowing that person to feel loved, valued and understood unconditionally, they are more likely to have an open dialog without fear of repercussions or judgments. Robertson, et al. (2004) found

that healthy relationships with friends and family are very important during stressful circumstances and are a key shield against PPD.

Family and friends play an important role in a postpartum mother's life. A new mother needs to feel comfortable and able to express her feelings with a trustworthy person. Research found that despite some hesitation on behalf of the mother, she will ultimately seek help. Once this occurs and she thinks the symptoms could potentially be PPD, validating her feelings is key. The findings of Abrams, et al. suggest that when women are open about their emotional concerns, loved ones generally advise them to give it time and that the symptoms are normal. Advice like this can be detrimental to a new mother since it does not validate their true feelings and places them in an awkward position to second guess their own emotions. Teng, Blackmore, and Stewart (2007) also pointed out women who are not in their original country or community lack emotional support in a large way, since their family is not close by to assist. This results in a lack of emotional support.

The lack of support from a spouse/partner is also problematic, and is particularly apparent in Latino culture (Abrams, et al.). They discovered that the husband/partners' ideology of PPD were impeded by a barrier against emotional support. For PPD treatment or medication to take place, the husband/partner had to agree, thus stripping the mother of her own autonomy regarding her feelings of PPD. However, lack of support is apparent in all social economic circles. Robertson, et al. (2004) also pointed out that marital problems go hand-

in-hand with feelings of loneliness due to the lack of support. Beck (2006) suggests assistance from the husband/partner such as validating her feelings, assisting with household responsibilities, attending physician appointments with her, and getting education on PPD can be very beneficial. Beck (2006) also states that sitting with her is the most important thing a husband/partner can do, thus validating her feelings without judgment or unsolicited advice.

Geographic Barriers

Historically individuals living in rural areas struggle with several specific barriers in comparison to their urban counterparts (Gjesfjeld & Jung, 2011); sadly PPD access is no different. An exploratory qualitative study conducted by Kornelsen & Grzybowski (2006) interviewed 44 women living in British Columbia, Canada. Women in these focus groups reported that due to the difficulties associated with their geographic locations, the limited health services available in their own community and the monetary burden of traveling to deliver were all barriers to treatment. Thus, they attempted to alleviate these barriers by opting for induced labor, timing pregnancies to avoid having to travel during winter, and delivering at home. If the mother delivered in a hospital she would ask to be discharged sooner to avoid adding to the already exacerbated expense and emotional burden. Many of the women reported having breastfeeding difficulties, severe stress, anxiety and exhaustion which are all red flags for postpartum depression (Beck, 2006). Many of the women who were interviewed reported

stress and fear of traveling with a new infant, thus considering obtaining PPD services as a luxury they would do without (Kornelsen & Grzybowski, 2006).

Education Barriers

According to Shi and Altshuler (2004), the lack of programs to educate pregnant women and new mothers about the possible symptoms contributing to PPD is a considerable risk factor for the under-recognizing and under-treatment of PPD. The lack of knowledge can leave a mother to suffer with this illness alone and/or to minimize the clear signs that encompass the illness (Dennis & Chung-Lee, 2006). Some new mothers have difficulties seeing PPD symptoms as problematic. They have been generationally educated that a new mother will be challenged, thus feelings of depression should be normal (Dennis & Chung-Lee). This is where educating the new mothers about all the different PPD symptoms come into play. They would be able to identify the common symptoms, and know that some symptoms are not normal. Abrams, et al. (2009) identified that lack of education or exposure to the topic can lead to the woman not knowing who to call, where to go or how to seek help. Lack of education is linked to several other barriers postpartum mothers have to deal with, such as knowledge of available services, transportation, available support groups, and assistance with childcare (Abrams, et al.; Dennis & Chung-Lee).

According to Dennis and Chung-Lee, education can also reduce stigma in the PPD community. They also pointed out that having access to an open and safe forum and normalizing consistent stressors with other women is helpful.

PPD education was also found to be immensely important for the whole family so they can understand what the mother is dealing with and how to accurately support her. This barrier is linked with family support. Finally, another barrier in education is linked to the physician's knowledge of PPD. Dennis and Chung-Lee note that it is important to be up-to-date in new research, and possess knowledge of new resources available in the area they service.

Cultural Barriers

Cultural understanding is very important when one is in the helping profession (Dennis & Chung-Lee). Cultural barriers can be as simple as using the correct verbiage when asking the mother about her symptoms. Asking if the mother is depressed can potentially cause her to withdraw and not be completely honest about her symptoms, since the terminology is not accepted in certain cultures and labels them as weak or unfit mothers. Some women will minimize their symptoms to avoid additional questions or future problems with CFS. Thus, learning how to approach the problem in a unique way for each person's culture is significant. Dennis and Chung-Lee noted that in African American culture, women acknowledged that they would rather "deal with it" than be labeled a bad mom by getting professional assistance.

Another significant problem faced by minority women in the health care field is obtaining crucial information in their own language (Templeton, Velleman, Persaud, & Milner, 2003). The inability to communicate how clients feel in their own language is a barrier. Having an available interpreter or a health care

provider who speaks their language is vitally important (Dennis & Chung-Lee). In Templeton, et al.'s (2003) study, women interviewed indicated that they simply did not talk to the provider. This is a disservice since it is the physician's job to ask questions, educate and inform them about their illnesses and treatment options.

Physical appearance of PPD varies among cultures. This barrier is clearly demonstrated by two studies in which the mother did not identify the illness as depression, rather she would report feelings of aches in her body such as stomach pain or chest pain (Abrams, et al.; Templeton, et al.). According to Templeton, women interviewed described their illnesses as fibromyalgia or rheumatism instead of depression, since having PPD is considered taboo in some cultures.

Stigma Associated with Postpartum Depression

Abrams, et al. found that African American and Latina women are more likely to feel embarrassed about seeking help for PPD. Having a diagnosis of PPD can be seen as a failure to be a good mother or lack of being a strong woman. They could be viewed as not being able to handle a natural situation such as giving birth and taking care of a new baby. This embarrassment related to PPD is supported by Shi, et al.'s (2004) study which also recognizes that the women who feel ashamed or embarrassed will not seek help for PPD. Some women with PPD view their symptoms as a sign of being "crazy [or] schizo" (Abrams, et al., p. 541). Consequently, this may encourage women to minimize

their true feelings and not get the help they need. This stigma or feeling of being judged has been found to be present with both friends and family, as well as physicians, leaving the new mother feeling alone with PPD.

Fear of Child Family Services Referrals

Reluctance to disclose depression symptoms to a mandated reporter is a true reality, according to Abrams, et al.. The new mother may not be forthcoming about her emotional stability, in order to avoid a referral to child protective services. Anderson, et al. (2006) interviewed 127 women who identified the same fear of being labeled an unhealthy parent by the health care provider.

An innovative qualitative study was conducted by Heneghan, et al. (2004), which involved a total of seven focus groups with ethnically diverse women. They asked the mothers about their thoughts and feelings behind disclosing prenatal depression with their child's pediatrician. They were all uncomfortable with the idea, because they stated that the pediatrician was the baby's doctor, not theirs. In addition, a large percentage of minority women disclosed that they were afraid to divulge such sensitive information out of fear that the pediatrician would initiate a child protection referral. The fear of being judged and misunderstood by the pediatrician was found in each one of the focus groups. It was also discovered that women in the lower economic groups feared the medical social workers too. They viewed them as threatening since they are predominantly known for removing children from their homes. Thus, being able to disclose PPD to a professional medical person is vastly feared and sadly underutilized.

Fears Surrounding the Use of Medication

In the United States, mental illness is often treated, at least in part, using medication. Unfortunately, this is not always the type of help postpartum mothers are seeking. Many women fear that talking to a physician about depression will lead the physician to prescribe medication (Abrams, et al.). Some new mothers do not want to be on medication, especially those who are breastfeeding, due to the possibility of transferring the medication into their breast milk (Dennis & Chung-Lee, 2006). This same study also found that women fear the side effects of the medication and becoming addicted to them. Dennis and Chung-Lee point out that most of the time they are not fully educated on what the medication is and the potential side effects, along with the major concern of stigma associated with taking daily medication for a mental illness. Some mothers also disclosed that if medication was prescribed, they would either not be truthful about taking it, or they would take it inconsistently. This resulted in the mother not obtaining the actual help she truly needed. Our current system sometimes fails to address social economic and other potential contributing factors to the current symptoms of the mother. The need to be heard from a non-judgmental, trustworthy party is what postpartum mothers are seeking (Abrams, et al.).

Culturally Sensitive Screening Tools

The importance of postpartum depression screening conducted in a timely manner has been widely studied (Beck, 2006). There are several different tools

created with the hopes of being able to detect PPD in postpartum mothers. For the purpose of this paper we will look at the Beck Depression Inventory (BDI-II), Center for Epidemiological Studies-Depression Scale (CES-D), Edinburgh Postnatal Depression Scale (EPDS), and Postpartum Depression Screening Scale (PDSS). All four screening tools require a fifth-grade reading level. They are all self-administered questionnaires. BDI-II, CED and EPDS have under 21 variables; they all range on a four-point scale. However, PDSS has a total of 35 variables and uses a five-point scale. BBDI-II and PDSS both measure levels of depression within the past two weeks, however CES and EPDS measures PPD in the past seven days (King, 2012).

Scholars and practitioners disagree about which tool is most useful. Roberson, et al. (2004) recommend the Edinburgh Postnatal Depression Scale because it is a questionnaire that entails only ten simple scoring questions. However, the cultural aspect of the questions is problematic since different cultures perceive certain verbiage differently. In fact, Abrams, et al. found that PPD symptom screening varies based on the provider's knowledge, interest and time allowed per patient by the clinic or hospital.

An innovative study was conducted by King (2012) which analyzed existing literature evaluating screening tools for PPD. The goal was to identify the potential bias in PPD screening tools directly affecting women living in low socioeconomic areas. Out of 20 articles, only eight were comprised of women with a lower economic status, and out of that only three tested the validity of PPD

in low income women. The lack of a culturally diverse screening tool was apparent. King (2012) indicated that the current screening tools do not evaluate the effects of the women's current environment which are potentially influencing PPD symptoms.

Theory Guiding Conceptualization

The theoretical perspective used to guide this study is the Andersen Health Care Utilization Model, also known as the Behavioral Model of Health Services (Aday & Andersen, 1974). This model was first introduced by Dr. Ronald Andersen in 1968 due to his interest in the accessibility of health care services particularly among the homeless, the elderly, children, women, low income and minority groups (UCLA Fielding School of Public Health, n.d.). This theoretical framework is primarily focused on access to health care services.

According to Anderson's theory, access is evaluated in two different ways: an individual's insurance coverage, and the effectiveness of navigating through the system. Some researchers define access as insurance coverage, attitudes regarding medical care, income, or health organizational systems, while other researchers suggest that access is an individual's successful navigation through the system, experienced outcomes, and satisfaction (Aday & Andersen, 1974). Additionally, the theoretical framework assumes that there are three conditions that heavily influence an individual's use of health care services. These three conditions include an individual's predisposition towards the use of medical

services, availability and accessibility of health care services known as enabling, and degree of illness (Andersen & Newman, 2005). Predisposing factors are explained as an individual's inclination towards the utilization of health care services. These characteristics are present before the onset of illness. Social, structural, demographic, and attitudinal-beliefs all assist in determining these propensities. The enabling condition is described as the availability and accessibility of resources. Factors that influence enabling include level of health care coverage, income, third-party payment source, and the quality and consistency of health care. Finally, illness severity determines the need and immediacy of health care services. This entails an individual's ability to appropriately evaluate the level of illness as well as potential risks for illness (Andersen & Newman, 2005).

Andersen's Health Care Utilization Model strives to conceptualize the factors that either inhibit or encourage access to health care services (Aday & Andersen, 1974). Utilizing this theoretical framework will assist in expanding our knowledge of the underlying causes that may lead to both. The aim of the study is to more precisely identify barriers to receiving services for women afflicted with PPD, hopefully contributing to the existing research, and offering solutions that can better assist this population.

Gaps in the Literature

Our study builds on established research, as well as filling in gaps in the literature. First, the study provides current data on perceived barriers to PPD treatment focusing on two neighboring counties in California, to identify the specific need in PPD services. Second, this study includes important insight to a variety of providers (such as social workers, licensed therapists, MSW student interns, physicians, registered nurses, and midwives) in order to identify the barriers that different types of service providers recognize. Currently PPD research has methodological limitations such as patients' cultural influences, economic barriers, knowledge of health care access, emotional support, geographical barriers in accessing medical assistance, education, stigma, fear of Child Family Service referrals, the lack of culturally sensitive screening tools, and fears surrounding prescription medications. Current research also suffers from several gaps that are affecting postpartum mothers and their support systems.

Summary

This chapter presented research that investigated barriers to accessing services for PPD. The proposed underlying causes of these barriers were explored from the perspective of both clients and service providers. Additionally, methodological limitations along with gaps in the research were revealed, suggesting possible avenues for further research. Lastly, the justification for the application of the Andersen Health Care Utilization Model was articulated.

CHAPTER THREE

METHODS

Introduction

In this section, we describe the study's design and elaborate on the research methods. First, we identify the sampling procedure and participants. Second, we describe the data collection instruments and procedures that were utilized. Third, we detail the data analysis techniques. Finally, we address the steps taken to protect the human subjects.

Study Design

The purpose of this study was to identify the barriers to services for women suffering from postpartum depression (PPD). We approached this study from the perspective of the service providers working directly with this population in the San Bernardino and Riverside County areas. Although the literature describes general barriers to services for women with PPD, this study addressed barriers in a particular geographic region – Southern California. The goal was to conduct a primarily quantitative research study, which can ultimately build upon the data already in existence, and broaden our awareness of this issue.

The study is limited in that it may not be generalizable to service providers in other communities. However, this study contributes to the existing research by examining the views of providers. The study aims to answer one specific and

important question regarding postpartum depression services: What do the service providers perceive as barriers for PPD?

Sampling

This study used purposive and snowball sampling techniques to generate a sample of service providers who are actively working with this population. These providers were appropriate study participants because of their regular interactions with postpartum women making them essential informants to the study (Grinnel & Unrau, 2014). First, we recruited participants from their personal and professional networks. Second, we asked participants to nominate other practitioners to participate in the study. We sought out a total of 40 participants presently working in the field, including: social workers, licensed therapists, MSW student interns, physicians, registered nurses, midwives and other service providers that were over the age of 21, representative of diverse ethnic backgrounds and including both genders.

Data Collection and Instruments

Data were collected using a self-administered, online questionnaire we developed (See Appendix A). We used a review of the literature, along with our personal experiences living in the communities of study, to determine the questionnaire design. The questionnaire began with information regarding informed consent which described the purpose of the study, the risks and

benefits to the participants, and whom to contact in case participants had questions (See Appendix B). Next the participants were asked to answer questions about their demographics such as gender, age and marital status. Last, the questionnaire presented a series of multiple choice and open-ended questions. These questions pertained to barriers that providers believed their clients with PPD experienced. They included questions regarding economic, physician, emotional, and health insurance barriers that might interfere with PPD treatment.

Limitations

The study has several limitations. First, the study includes a rather small sample size, so it may not be generalizable to other communities or to women with PPD across the country. However, the trade-off was that the study attempted to address the specific barriers to service access in this particular region. Second, because a snowball study was utilized, once a participant completed it, the researchers were not privy to other participants it may have been sent to. Third, an additional limitation was the lack of motivation for a respondent to contribute to an online survey. Furthermore, our survey instrument is of unknown reliability and validity. This was necessary, as we were unaware of any reliable, valid, and widely accepted instrument used to measure barriers to service access for PPD clients. An advantage to using this type of survey was

that we would have the availability to cover a larger geographical area, since the accessibility to access the questionnaire was online.

Procedure

An online survey was created utilizing Qualtrics survey system. Participants were recruited using a snowball sampling technique. The questionnaire was distributed via email to various service providers. The questionnaire duration was based on the participants' own preference, which ranged from 5 to 10 minutes depending on how much detailed information was provided.

We utilized a self-administered, online questionnaire. The multiple-choice, open-ended and scaling questions were created to examine barriers to receiving treatment, specific to women suffering from PPD, from the perspective of the service providers. This included professionals who come into contact with women experiencing PPD such as social workers, licensed therapists, MSW student interns, physicians, registered nurses, and midwives from a variety of facilities within San Bernardino and Riverside Counties. A purposive snowball sampling technique was employed. We made contact with service professionals and explained in detail the procedures, expectations, and the purpose of the study. Anticipating their willingness, we also inquired if other professionals within their field of expertise would be willing to participate. Once the participants expressed an interest, we proceeded to send an email with the Qualtrics survey

link. A brief explanation of the purpose of the study, along with contact information was provided in the email. The survey was available to participants beginning in September 2017, and ending in January 2018. Data was gathered and analyzed using the SPSS program for statistical analysis.

Protection of Human Subjects

The study presented minimal risk to the participants, and did not ask them to provide any identifying information. Protocol was compliant and in accordance with all IRB standards. Prior to beginning the survey, participants were required to read the informed consent, and certify that they were 18 years or older before proceeding. The informed consent explained that all necessary precautions would be taken in order to maintain confidentiality and anonymity. If the participants had any questions or concerns regarding the study, our contact information was provided. Additionally, it was noted that the results of the study would be made available after July 2018.

Data Analysis

This study aimed to identify the barriers to PPD services from the direct perspective of service providers. By employing the Qualtrics system, we could electronically retrieve and analyze the responses, and could also use the system to transfer the data directly to an SPSS program for precise data analysis. We

used descriptive statistics to describe the participants' demographic characteristics, as well as their overall responses to the questions.

Summary

In the above section, we presented how this study was carried out. Study design, sample methods, data collection, and the procedures of the study were described. Lastly, we articulated how we complied with the IRB standards and maintain confidentiality and anonymity of the participants.

CHAPTER FOUR

RESULTS

Introduction

The purpose of this study was to identify barriers to receiving services for women suffering with Postpartum Depression (PPD) in the San Bernardino and Riverside County areas. The study identified barriers perceived by human service providers who regularly treat pre-natal and postpartum women. In this chapter we will explain the data gathered from the surveys. First, we will describe the demographics characteristics of the participants. Second, we will discuss the results for each barrier specifically addressed in the survey.

Data Results

Our sample consisted of 41 participants. The majority of participants identified as female (n=37; 88.9%), with the remaining identifying as male (n=4; 8.9%). The age group 41-50 years old had the largest number of participants (n=13; 28.9%); the 31-40 years old and 51-60 years old groups both contained the same amount of participants (n=11; 24.4%), followed by 21-30 years (n=4; 8.9%) and then 61-70 years (n=2; 4.4%). The majority of participants (n=29; 64.4%) identified as being married, followed by divorced (n=9; 20%), cohabitating (n=2; 4%) and single (n=1; 2.2%). The minimum number of years reported as working in healthcare was one year with the maximum number being 41 years (M

= 15.96, SD = 10.644). The minimum number of years reported as working with postpartum patients is less than year with the maximum number being 38 years (M = 9.72, SD = 9.310), as can be seen in Table 1.

Table 1

Demographics of the Participants

| | N | % | M | SD |
|---------------------------------------|----|-------|-------|-------|
| Gender | | | | |
| Female | 37 | 88.9 | | |
| Male | 4 | 8.9 | | |
| Age | | | | |
| 21-30 | 4 | 8.9 | | |
| 31-40 | 11 | 24.4 | | |
| 41-50 | 13 | 28.9 | | |
| 51-60 | 11 | 24.4 | | |
| 61-70 | 2 | 4.4 | | |
| Marital Status | | | | |
| Single | 1 | 2.2 | | |
| Cohabiting | 2 | 4.4 | | |
| Married | 29 | 64.4 | | |
| Divorced | 9 | 20.01 | | |
| Years in Healthcare | | | 15.96 | 10.64 |
| | | | | 4 |
| Years working with PPD clients | | | 9.72 | 9.310 |

Regarding economic barriers, most of the participants (n=9; 22.0%) selected none of the provided barriers as being appropriate. Of the provided barriers, insurance coverage was chosen by 21 (51.2%) participants; the ability to pay was selected by 13 (31.7%); the cost of additional services was selected by 11 (26.8%). Approximately 15% of participants selected “other” (n=6) and five (12.2%) participants stated that they “did not know” (See Table 2).

Participants were able to provide “other” barriers not listed. The other barriers identified included, access and knowledge of services; asking for help, not feeling understood, and finding trained specialists; access to childcare; the stigma of postpartum depression and transportation.

Table 2

| <i>Economic Barriers</i> | N | % |
|-----------------------------|----|------|
| Insurance Coverage | 21 | 51.2 |
| Ability to Pay | 13 | 31.7 |
| Cost of Additional Services | 11 | 26.8 |
| Other | 6 | 14.6 |
| None of These | 9 | 22.0 |
| Do Not Know | 5 | 12.2 |

Note: Percentages do not add up to one hundred because participants could select more than one choice.

Regarding physician barriers, the largest number of participants (n=20; 48.8%) identified lack of time with patients, while 15 (36.6%) indicated lack of knowledge in identifying postpartum depression symptoms as a barrier. Relationship with physician was indicated by 14 (34.1%) and 14.6% (n= 6) indicated inability to identify normal stressors of everyday life. One participant (2%) selected “do not know” and five (12.2%) selected “other” as an option (See Table 3).

Table 3

Physician Barriers

| | N | % |
|---|----|------|
| Physician’s Lack of Time with Patients | 20 | 48.8 |
| Physician’s Inability to Identify Normal Stressors of Everyday Life | 6 | 14.6 |
| Lack of Knowledge in Identifying Postpartum Depression Symptoms | 15 | 36.6 |
| Relationship with Physician | 14 | 34.1 |
| Other | 5 | 12.2 |
| Four or More Reasons | 1 | 2.2 |
| None of These | 2 | 4.9 |
| Do Not Know | 5 | 12.2 |

The other stated reasons which were each identified by one participant, include: culture in which people are supposed to “get over it”; physicians not making referrals to mental health services; physicians not understanding the

culture of their patients; physicians using only the option of medication as a treatment, and long wait for appointments.

Regarding knowledge barriers, most of the participants (n=22; 53.7%) chose access to services, followed by 18 (43.9%) selecting limitations in health care coverage. Knowledge of health care coverage was selected by 16 (39.0%); followed by “none of these” (n=5; 12.2%) and “do not know” (n=4 (9.8%). Lastly, 7.3% of participants (n=3) selected “other” (See Table 4).

Table 4

Knowledge Barriers

| | N | % |
|-------------------------------------|----|------|
| Access to Services | 22 | 53.7 |
| Knowledge of Health Care Coverage | 16 | 39.0 |
| Limitations in Health Care Coverage | 18 | 43.9 |
| Other | 3 | 7.3 |
| None of These | 5 | 12.2 |
| Do Not Know | 4 | 9.8 |

The other stated reasons include: many insurance companies do not provide additional services for postpartum support; many mental health services, such as prevention, are not covered by insurance; only given short term sessions; patients may not feel comfortable sharing pregnancy related concerns

and only may disclosed if they feel sad or worried; screener may not ask if symptoms are related to PPD.

Regarding emotional barriers, most of the participants (n=26; 63.4%) selected lack of emotional support from significant others as being appropriate. Lack of emotional support from family members was chosen by 24 (58.5%) participants; “other” was selected by four (9.8%). Approximately five (12%) participants selected “none of these”, and lastly six (14.6%) indicated “do not know” (See Table 5).

Table 5

| <i>Emotional Barriers</i> | N | % |
|---|----|------|
| Lack of Emotional Support from Significant Others | 26 | 63.4 |
| Lack of Emotional Support from Family Members | 24 | 58.5 |
| Other | 4 | 9.8 |
| None of These | 5 | 12.2 |
| Do Not Know | 6 | 14.6 |

The other stated reasons include: Clientele varies covers all three of my selections; Knowing that there are options, and lack of education.

For geographic barriers, most of the participants (n=27; 65.9%) selected transportation as the main barrier; others (n=20; 48.8%) indicated distance from

providers. “Other” was selected by five (12.2%) along with “none of these” and “do not know” (See Table 6).

The other stated reasons include; patients are homeless and don’t have an address to be assigned to a provider close to them, clientele covers all three of those options, cost of the transportation, more public transportation needs to be utilized, there are no crisis intervention services available in our rural town.

Table 6

Geographic Barriers

| | N | % |
|-------------------------|----|------|
| Transportation | 27 | 65.9 |
| Distance from Providers | 20 | 48.8 |
| Other | 5 | 12.2 |
| None of These | 5 | 12.2 |
| Do Not Know | 5 | 12.2 |

The next six questions examined participants’ level of agreement with specifically identified barriers using a five point Likert-type scale.

In examining participants’ perceptions of education as a barrier the following responses were collected: no participants chose education as never being a barrier; four (10.3%) participants identified that education is seldom a barrier. Sixteen (41.0%) participants identified education as being a barrier

sometimes and often, and finally, three participants (7.7%) identified education as always being a barrier (See Table 7).

Table 7

How Often is Education a Barrier to Accessing Services?

| | N | % |
|-----------|----|------|
| Never | 0 | 0.0 |
| Seldom | 4 | 10.3 |
| Sometimes | 16 | 41.0 |
| Often | 16 | 41.0 |
| Always | 3 | 7.7 |

In examining participants' perception of culture as a barrier the following responses were collected: No participants chose culture as never being a barrier; two participants (n=2; 4.4%) identified that culture is seldom a barrier. Sixteen participants (35.6%) identified culture as being a barrier sometimes and often, and finally, five participants (11.1%) identified education as always being a barrier (See Table 8).

In examining participants' perception of stigma as a barrier the following responses were collected: One participant (2.2%) chose stigma as never being a barrier; three participants (6.7%) identified that stigma is seldom a barrier. Eight participants (17.8%) identified stigma as being a barrier sometimes, and sixteen

(35.6%) identified stigma as being a barrier often. Finally, eleven participants (24.4%) identified stigma as always being a barrier (See Table 9).

Table 8

How Often is Culture a Barrier to Accessing Services?

| | N | % |
|-----------|----|------|
| Never | 0 | 0.0 |
| Seldom | 2 | 4.4 |
| Sometimes | 16 | 35.6 |
| Often | 16 | 35.6 |
| Always | 5 | 11.1 |

Table 9

How Often is Stigma a Barrier to Accessing Services?

| | N | % |
|-----------|----|------|
| Never | 1 | 2.2 |
| Seldom | 3 | 6.7 |
| Sometimes | 8 | 17.8 |
| Often | 16 | 35.6 |
| Always | 11 | 24.4 |

In examining participants' perception of fear of Children and Family Services (CFS) as a barrier the following responses were collected: No participants chose fear of CFS as never being a barrier; nine participants (20.0%) identified that fear of CFS is seldom a barrier. Eleven participants (24.4%) identified fear of being CFS as being a barrier sometimes and often. Finally, eight participants (17.8%) identified fear of CFS as always being a barrier (See Table 10).

Table 10

How Often is the Fear of Child and Family Services a Barrier to Accessing Services?

| | N | % |
|-----------|----|------|
| Never | 0 | 0.0 |
| Seldom | 9 | 20.0 |
| Sometimes | 11 | 24.4 |
| Often | 11 | 24.4 |
| Always | 8 | 17.8 |

In examining participants' perception of lack of tools as a barrier the following responses were collected: Two participants (4.4%) chose lack of tools as never being a barrier; five participants (11.1%) identified that lack of tools is seldom a barrier. Sixteen participants (35.6%) identified lack of tools as being a barrier sometimes and fourteen participants (31.1%) identified lack of tools as

being a barrier often. Finally, two participants (4.4%) identified lack of tools as always being a barrier (See Table 11).

Table 11

How Often is Lack of Culturally Sensitive Screening Tools a Barrier to Accessing Services?

| | N | % |
|-----------|----|------|
| Never | 2 | 4.4 |
| Seldom | 5 | 11.1 |
| Sometimes | 16 | 35.6 |
| Often | 14 | 31.1 |
| Always | 2 | 4.4 |

In examining participants' perception of fear of medication as a barrier the following responses were collected: One participant (2.2%) chose fear of medication as never being a barrier; seven participants (15.6%) identified that fear of medication is seldom a barrier. Fourteen participants (31.1%) identified fear of medication as being a barrier sometimes and nine participants (20.0%) identified fear of medication as being a barrier often. Finally, eight participants (17.8%) identified fear of medication as always being a barrier (See Table 12).

Summary

In this chapter we illustrated the data gathered in connection to our survey. We described the demographic characteristics of the survey's

participants such as gender, age and marital status. Finally, we articulated the results for each of the questions regarding potential barriers addressed in the survey.

Table 12

How Often is Fear of Taking Medications While Breastfeeding a Barrier to Accessing Services?

| | N | % |
|-----------|----|------|
| Never | 1 | 2.2 |
| Seldom | 7 | 15.6 |
| Sometimes | 14 | 31.1 |
| Often | 9 | 20.0 |
| Always | 8 | 17.8 |

CHAPTER FIVE

DISCUSSION

Introduction

In this final chapter, we discuss the findings of our research and explain how it applies to social work practice. The limitations of our study are presented as well as suggestions for future research. Recommendations for changes in social work practice and policy will be articulated. The theory guiding conceptualization throughout this study is explained. Lastly, we will briefly summarize the study.

Discussion

The study's objective was to examine the barriers to treatment and services for women with PPD in the San Bernardino and Riverside County areas, specifically from the perspective of the service providers. There were 41 participants surveyed in the study. These individuals were presumed to include social workers, licensed therapists, MSW student interns, physicians, registered nurses and midwives. It is important to note that because we employed a snowball sampling technique, other professionals who come into contact with this population may have participated as well. However, we were not able to identify their professional titles or areas of specialization.

The results from this study suggest that the most significant barriers to treatment are: physician's lack of time with patients and knowledge of PPD symptoms, patient's relationship to physician, limits in insurance coverage as well as knowledge of services covered, lack of emotional support from significant other and/or family members and lastly, transportation barriers and distance from providers. Barriers related to the physician's lack of time, understanding of PPD symptoms, and the inability to build rapport with patients is consistent with research conducted by Abrams, et al. (2009). Interestingly, they found that providers reported that these barriers were more prominent when working with lower-income populations, something our study did not address.

The literature suggests that physicians had a difficult time discerning between PPD symptoms and normal life stressors due to the persistent economic hardships their patients faced. Furthermore, physicians reported the time constraints per patient as being an obstacle to building rapport and maintaining cultural competency (Abrams, et al.). However, our participants suggested that these barriers applied more generally to patients, without regard to the patients' socio-economic characteristics. Therefore, it may be fair to say that these issues are not, in all cases, due to physician's unwillingness or lack of compassion when dealing with this population, but rather may result from more complex interactions between service providers' skills and protocols as well as from patient socio-economic characteristics.

Other significant barriers to services highlighted in the literature and presented in our data were inadequate health insurance as well as lack of knowledge of health services covered. The literature notes that many women were not aware of the services available to them, and who or where to go to access these services (Abrams, et. al.; Gjerdingen & Yawn, 2007; Heneghan, et al., 2004). A fairly high number of participants rated knowledge of health care coverage as a barrier to accessing services under the category of knowledge barriers. According to Abrams, et al. this may be a source of confusion not only for recipients of services, but for providers as well. Therefore, this may indicate a large disconnect among service providers, insurance agencies, and mothers experiencing PPD. Furthermore, the literature, along with the results of our survey, confirmed that lack of healthcare coverage, and limits in coverage to be major deterrents in accessing services; not only for PPD, but for mental health services in general (Cunningham, 2009).

Lack of emotional support from significant others and/or family members were also identified as common barriers to accessing services in both previous studies, and in our findings. Significant others, family members and friends all become important members of a new mother's social support system (Beck 2006; Robertson, et al., 2004). A breakdown of emotional support, especially in relation to partner support may exacerbate already existing symptoms of PPD. Additionally, the lack of emotional support from loved ones as well as providers may be linked to the differences in cultural views and knowledge surrounding

PPD (Abrams, et al.; Templeton, et al., 2003). Lack of emotional support from significant others and family members were rated very high as barriers by the participants in our study.

Transportation barriers and distance from providers were also mentioned in previous studies, and rated vary high as barriers from our participants. Though this is seen more predominantly in rural areas, it must present as a challenge in these locations as well (Kornelsen & Grzybowski, 2006). Further research may be needed in order to distinguish between transportation barriers as being the result of geographical locations, or of income restraints; for example, distance from providers or the inability to pay for transportation services, or having access to a vehicle. Our survey did not provide questions that would enable participants to address these issues.

Other barriers identified in our research and also found in the literature included education barriers, cultural barriers, stigma associated with postpartum depression, fear of CFS, fears surrounding the use of medications and lack of culturally sensitive screening tools (Abrams et al.; Dennis & Chung-Lee, 2006; Heneghan, et al., 2004; King, 2012; Sri, et al., 2004). Our participants, in particular, noted a lack of patient education as a barrier to services. This is consistent with prior findings. Educational programs help new mothers as well as service provides to identify contributing factors, and symptoms of PPD helping to reduce the risk of symptoms worsening (Dennis & Chung-Lee; Sri, et al.). Our participants noted that cultural barriers were sometimes or often barriers to

services. This is consistent with King's (2012) study which found that culturally sensitive screening tools were lacking. Culturally appropriate screening tools along with addressing language barriers may assist in minimizing this barrier.

Our study also found that stigma associated with PPD was often a barrier to PPD services. Abrams et al. discovered that Latina and African American women were more likely to feel uncomfortable inquiring about and seeking services due to the stigma related to having PPD. Further, participants in our study reported mixed responses to the impact of fear of child protection referrals as a barrier to PPD services. Research suggests that this is a real concern for new mothers, and may inhibit them from initiating treatment (Abrams et al.; Anderson, et al., 2006; Heneghan, et al.). Therefore, our study suggests that perhaps providers may lack awareness of this particular fear.

Lastly, our participants suggested that fear of taking medications was only sometimes a barrier. According to the literature, new mothers are reluctant to inform physicians about their symptoms fearing that they will be prescribed medications. Breastfeeding concerns, side effects of the medication, and addiction were all reported to be common fears surrounding medications (Abrams, et al.; Dennis & Chung-Lee). Again, these findings suggest that our participants may have underestimated their clients' concerns about medications.

The survey was set up to allow participants to present additional information in response to five of the questions. We found that participants provided more detailed information in regards to each question. We were made

aware of other barriers not addressed in the survey or found in past literature. The items brought to our attention included; lack of access to childcare, lack of trained specialists and service providers, preventative services not being covered by insurance, physicians' simply not making referrals for mental health services, long wait times for appointments, and that homeless mothers who do not possess an address are assigned to providers that are not easily accessible. These additional barriers should be explored and examined more thoroughly. This information is testament to the fact that this is a very complex issue and more research is necessary.

Limitations

There were several limitations associated with this study. First, the instrument utilized for data collection was an online self-administered survey. A disadvantage to using this type of survey is the inability for researchers to follow up with the participants to inquire about any additional information, or to ask any clarifying questions. Second, our sample size was small, limiting the study's generalizability in relation to both counties and to the population of providers across the state and beyond. Third, we did not inquire specifically about the type of professionals participating in the survey. We intended to send the survey primarily to social workers, licensed therapists, MSW student interns, physicians, registered nurses and midwives. However, we had no means of verifying this information, and the survey may have been sent to other professionals who work

with this population. Lastly, we developed the survey tool without vigorously testing its reliability or validity. Additionally, the survey may not have captured the overall complexity of the problem.

Recommendations for Social Work Practice, Policy, and Research

Despite all of the research surrounding the topic of PPD and the barriers to accessing services, it is necessary to continue research in this area. However, the study did present relevant findings that will assist professionals in both micro- and macro-practice. In relation to micro-level practice, service providers who are more acutely aware of the identified barriers may be better equipped to properly assess, engage, advocate, empower and implement individualized services. Educational seminars, workshops and trainings on how to appropriately intervene with this population while maintaining cultural competency would also assist service providers. On a macro-level, services for this population may be improved through policy change. This might include funding for programs that provide education to the public about PPD, which may help reduce the stigma associated with the illness. Changes in policy and procedures associated with physicians and their ability to spend more time with their patients may enable them to better address language and/or cultural barriers. Additionally, policy and practice changes to improve communication among patients, physicians, and insurance agencies might also improve access to services. Furthermore, it has

been firmly established that women who live in rural areas have a more difficult time accessing services (Gjesfjeld & Jung, 2011). Research also suggests that individuals who fall into a lower socioeconomic status are more at-risk for PPD (Robertson, 2004). Therefore, policy and practice changes designed to address the PPD population in general should also pay special attention to the unique challenges rural women face.

It is recommended that future studies employ both quantitative and qualitative methods. The research might begin with focus groups in order to obtain more detailed feedback from professionals who come into contact with this population. A more thorough survey may be formulated as a result. Hand delivering paper surveys may be more time consuming, however researchers may be able to gather more information such as the participants' professional titles, their roles, and the settings in which they service this population. Another suggestion for future research might be to survey women who have experienced, or who are experiencing PPD. The knowledge gained from acquiring their perspective on the barriers to accessing services may provide invaluable insight to better understanding the nature and complexity of this problem.

As presented earlier, the theoretical perspective utilized to guide this study was the Andersen Health Care Utilization Model, which is also known as the Behavioral Model of Health Services (Aday & Andersen, 1974). This model primarily focuses on access to health care services by exploring the relationship between the health service system, societal determinants, and three individual

conditions such as an individual's predisposing factors, enabling factors, and degrees of illness (Aday & Andersen; Andersen & Newman, 2005). The health service system includes the volume and distribution of resources, and organizations, which entails structure and accessibility. Societal determinants are defined as technology and social norms. Finally, an individual's predisposing factors are explained as the level of inclination to utilize medical services, availability and accessibility to services known as enabling, and one's own perspective on illness determining the need for care (Andersen & Newman). This theoretical framework aligns well with our results, and the results of former research.

Conclusion

This study examined barriers to services and treatments for women who experience PPD, specifically from the perspective of the service providers in the San Bernardino and Riverside Counties. It is estimated that between 11 and 20% of new mothers experience symptoms of PPD. Without interventions or timely services, the mother-infant relationship may be hindered, potentially resulting in lifelong relationship challenges for the child. Additionally, the whole family may be negatively impacted further exacerbating symptoms of PPD.

The study results aligned with former literature on barriers to treatments. However, additional issues were brought forward confirming the complexity and

enormity of the problem. This issue needs to be addressed holistically; both in micro- and macro-practice to more successfully and fully assist this population.

APPENDIX A
DEMOGRAPHICS AND RESPONSE QUESTIONNAIRE

QUESTIONNAIRE

1. I have read and understand the above Informed Consent document and agree to participate in the study. I understand that I must be 18 years of age or older in order to participate in the study.

Yes/ No

2. What is your gender?

Male / Female / Other, please specify

3. How old are you?

18-20

21-30

31-40

41-51

51-60

61-70

70 +

4. What is your marital status?

-Single

-Cohabiting

-Married

-Divorced

-Separated

-Widowed

-Other, please specify

5. How many years have you worked within the healthcare field? _____

6. How many years have you worked with the postpartum population? _____

*Enter zero if you have not worked with the postpartum population _____

7. If you entered zero in response to the above question, please share with us how you were informed about this study and any experience or specific knowledge of postpartum depression you possess. For example, perhaps you or a loved one experienced postpartum depression, or you worked in a clinic that treated postpartum clients, but you did not see patients directly.

**For questions 8 through 12 please choose one or more of the following answers

8. Which economic barriers do your postpartum clients encounter in trying to access care?

- Insurance coverage
- Ability to pay the co-pay
- Cost of additional services
- None of these options
- Do not know

9. Which physician barriers do your clients encounter in trying to access care?

- Physician's lack of time with patients
- Physician's inability to identify normal stressors of everyday life
- Physician's lack of knowledge in identifying postpartum depression symptoms
- Relationship with physician
- None of these options
- Do not know

10. Which health insurance coverage barriers do your clients encounter in trying to access care?

- Access to services
- Knowledge of health care coverage
- Limitations in health care coverage
- None of these options
- Do not know

11. Which emotional barriers do your clients encounter in trying to access care?

- Lack of emotional support from significant other
- Lack of emotional support from family members
- None of these options
- Do not know

12. Which geographic barriers do your clients encounter in trying to access care?

- Transportation
- Distance from providers
- None of these options
- Do not know

**For the remaining questions please choose either always, often, sometimes, seldom or never.

13. How often is education a barrier to accessing services?

Always / Often / Sometimes / Seldom / Never

14. How often is culture a barrier to accessing services?

Always / Often / Sometimes / Seldom / Never

15. How often is stigma a barrier to accessing services?

Always / Often / Sometimes / Seldom / Never

16. How often is fear of Child and Family Services a barrier to accessing services?

Always / Often / Sometimes / Seldom / Never

17. How often is lack of culturally sensitive screening tools a barrier to accessing services?

Always / Often / Sometimes / Seldom / Never

18. How often is fear of taking medications while breastfeeding a barrier to accessing services?

Always / Often / Sometimes / Seldom / Never

Developed by Bertha Ayala Reeves and Hana Gen Swenson-Coon (2017)

APPENDIX B
INFORMED CONSENT



California State University, San Bernardino
Social Work Institutional Review Board Sub-Committee
APPROVED 5/12/17 VOID AFTER 5/23/2018
IRB# SW1753 CHAIR [Signature]

College of Social and Behavioral Sciences
School of Social Work

INFORMED CONSENT

The study in which you are asked to participate is designed to examine the barriers to services for women suffering with Postpartum Depression in the San Bernardino and Riverside County areas. The study is being conducted by Bertha Reeves and Hana Swenson- Coon, graduate students, under the supervision of Dr. Deirdre Lanesskog, Assistant Professor in the School of Social Work at California State University, San Bernardino (CSUSB). The study has been approved by the Institutional Review Board Social Work Sub-committee at CSUSB.

PURPOSE: The purpose of the study is to examine the barriers to services for women suffering with Postpartum Depression.

DESCRIPTION: Participants will be asked a few questions regarding their demographics, and questions regarding barriers to receiving services.

PARTICIPATION: Your participation in the study is totally voluntary. You can refuse to participate in the study or discontinue your participation at any time without consequences.

CONFIDENTIALITY OR ANONYMITY: Your responses will remain anonymous and data will be reported in group form only

DURATION: It will take 5 to 10 minutes to complete the survey.

RISKS: There are not foreseeable risks to the participants.

BENEFITS: There will not be any direct benefits to the participants.

CONTACT: If you have any questions about this study, please feel free to contact Dr. Lanesskog at (909) 537-7222.

RESULTS: Results of the study can be obtained from the Pfau Library ScholarWorks database (<http://scholarworks.lib.csusb.edu/>) at California State University, San Bernardino after July 2018.

This is to certify that I read the above and I am 18 years or older.

Place an X mark here

Date

909.537.5501

5500 UNIVERSITY PARKWAY, SAN BERNARDINO, CA 92407-2393

The California State University • Bakersfield • Channel Islands • Chico • Dominguez Hills • East Bay • Fresno • Fullerton • Humboldt • Long Beach • Los Angeles
Maritime Academy • Monterey Bay • Northridge • Pomona • Sacramento • San Bernardino • San Diego • San Francisco • San Jose • San Luis Obispo • San Marcos • Sonoma • Stanislaus

APPENDIX C
INSTITUTIONAL REVIEW BOARD APPROVAL

CALIFORNIA STATE UNIVERSITY, SAN BERNARDINO
SCHOOL OF SOCIAL WORK
Institutional Review Board Sub-Committee

Researcher(s) Bertina Reeves & Hana Swenson-Coon
Proposal Title What do service providers perceive barriers to services for women with post-partum depression (PPD) in San Bernardino and Riverside Counties
5011753

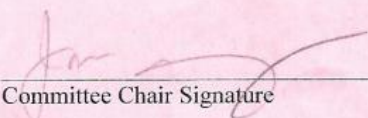
Your proposal has been reviewed by the School of Social Work Sub-Committee of the Institutional Review Board. The decisions and advice of those faculty are given below.

Proposal is:

- approved
- to be resubmitted with revisions listed below
- to be forwarded to the campus IRB for review

Revisions that must be made before proposal can be approved:

- faculty signature missing
- missing informed consent debriefing statement
- revisions needed in informed consent debriefing
- data collection instruments missing
- agency approval letter missing
- CITI missing
- revisions in design needed (specified below)



Committee Chair Signature

5/24/2019

Date

Distribution: White-Coordinator; Yellow-Supervisor; Pink-Student

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ASSIGNED RESPONSIBILITIES

This was a two-person project where authors; Hana Gen Swenson-Coon and Bertha Ayala Reeves collaborated. Throughout the project, particular sections were assigned to each author. Listed below is the breakdown on how the responsibilities were divided. Each of the author's skillsets played a significant role in complimenting the other.

1. Introduction:

a. Problem Formulation

Team effort: Hana Gen Swenson-Coon and Bertha Ayala Reeves

b. Purpose of the study

Team effort: Hana Gen Swenson-Coon and Bertha Ayala Reeves

c. Significance of the Project for Social Work Practice

Team effort: Hana Gen Swenson-Coon and Bertha Ayala Reeves

2. Literature Review:

a. Introduction

Hana Gen Swenson-Coon

b. Literature Subsection

Team Effort: Hana Gen Swenson-Coon and Bertha Ayala Reeves

c. Theories Guiding Conceptualization

Hana Gen Swenson-Coon

3. Methods:

a. Introduction

Bertha Ayala Reeves

b. Study Design

Bertha Ayala Reeves

c. Sampling

Bertha Ayala Reeves

d. Data Collection and Instruments

Team Effort: Hana Gen Swenson-Coon and Bertha Ayala Reeves

e. Limitations

Team Effort: Hana Gen Swenson-Coon and Bertha Ayala Reeves

f. Procedures

Hana Gen Swenson-Coon

g. Protection of Human Subjects

Hana Gen Swenson-Coon

h. Data Analysis

Team Effort: Hana Gen Swenson-Coon and Bertha Ayala Reeves

i. Summary

Team Effort: Hana Gen Swenson-Coon and Bertha Ayala Reeves

4. Results:

a. Introduction

Bertha Ayala Reeves

b. Data Results

Bertha Ayala Reeves

c. Summary

5. Discussion:

a. Introduction

Hana Gen Swenson-Coon

b. Discussion

Hana Gen Swenson-Coon

c. Limitations

Hana Gen Swenson-Coon

d. Recommendations for Social Work Practice, Policy and Research

Hana Gen Swenson-Coon

e. Conclusion

Hana Gen Swenson-Coon