

1-1-2013

The Relationship of Shame in the Treatment of Antepartum Depression

Pennie F. Wilson

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Recommended Citation

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The Relationship of Shame in the Treatment of Antepartum Depression

by

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Presented to the Faculty of the
Graduate Department of Clinical Psychology

George Fox University

in partial fulfillment

of the requirements for the degree of

Doctor of Psychology

in Clinical Psychology

Newberg, Oregon

May, 2013

The Relationship of Shame in the Treatment of Antepartum Depression

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has been approved

at the

Graduate School of Clinical Psychology

George Fox University

As a Dissertation for the Psy.D. degree

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Abstract

The purpose of this pilot study was to determine the relationship between shame, Antepartum Depression, and treatment seeking. Research shows that shame plays a role in Major Depression and other disorders. For the present study, the first hypothesis was that shame is positively correlated with Antepartum Depression as measured by the Edinburgh Postnatal Depression Scale. The second hypothesis was that shame would be negatively correlated with treatment seeking behaviors. The third hypothesis was that psychoeducation about Antepartum Depression could lower the level of shame and increase treatment seeking behavior. This study consisted of using the Edinburgh Postnatal Depression Scale to determine depression in pregnant women; a measure to determine risk of prenatal depression; the Internalized Shame Scale and 2 questions intended to determine motivation for seeking treatment and an opportunity to a comments for a qualitative portion of the study. Participants were solicited through ads placed on Craigslist. After completing the preliminary survey, women were directed to either view a psychoeducation webcast about Antepartum Depression, or to a consumer information website.

Participants completed a posttest to determine if a significant level of change occurred in degree of shame and receptivity toward treatment in relation to action taking participants compared to those who took no action. Fifty-five participants between the ages of 19 and 42, who were located in 31 states, completed both parts of the study. A T-test, ANOVA and a qualitative analysis were run to determine the results of the study. The first hypothesis was found true: Shame and Depression, as determined by the EPDS are positively correlated. Because of the lack of participation in watching the psychoeducation video, the second hypothesis was inconclusive and due to an unintentional flaw in the research design, hypothesis 3 was also inconclusive. Of interest is that while only a few women watched the video this study was able to discover that women who sought support following the pretest showed greater lessening of shame and depression levels in the posttest. Qualitative information was gathered and indicates many of the stressors and treatments available to women.

Acknowledgments

The dissertation could not have been completed without the help and support of many people. A world of thanks goes to Wendy Davis, PhD, Executive Director of Postpartum Support International who took the time to work with me on this and agreed to be filmed for a segment of the video intervention. Additional thanks to Aaron Sparks who built and manages my website without charge. He has been an excellent resource. My husband and family deserve recognition for the support they have given me throughout this process. My husband's patience with me has been immeasurable. Others who deserve recognition for support and aid are my committee members, Drs. Thurston, Gathercoal and Peterson, editors Kimberly Snow and Kimberly Kunze and statistics wizard Luann Foster. Countless others have voiced interest and support through this process and they have my eternal thanks.

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Chapter 1

Introduction

Depression

Pregnancy is expected to be the happiest time in a woman's life. A pregnant woman is often described as glowing and envisioned as brimming with optimism and joy in blissful anticipation of the birth of her child. Women often idealize what pregnancy is like. Research and reality shows us that happiness is not always the case for women. Some women become depressed and anxious. Depression during pregnancy is known as Antepartum Depression, Antenatal Depression and Perinatal Depression. For the purposes of this study, we will refer to it as Antepartum Depression. There are no unique criteria for Antepartum Depression in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV-TR)* as compared to Major Depressive Disorder (American Psychiatric Association, 2000). The only salient difference is in the timing of the depression, during pregnancy (Luskin, Punkiak, & Habib, 2007). In this author's experience, women may experience ambivalence about the pregnancy, or feelings of resentment surrounding it. There may be fears of the woman's ability as a parent, or about financial strains.

Unfortunately, diagnosis of depression in pregnancy is often confounded by the fact that many symptoms of depression are similar to those of pregnant women who may or may not be depressed. These symptoms include a change in weight, appetite and sleep behavior as well as reduced energy. However, symptoms of loss in pleasure, depressed mood, hopelessness and guilt, among other symptoms, continue to be strong indicators of depression in pregnancy as well

as outside of pregnancy (Manber, Blasey, & Allen, 2008). Common symptoms of depressed women with Antepartum Depression may present predominantly with negative cognitions in relation to oneself and the pregnancy, suicidal ideations, which leads to interference with self-care, support seeking behaviors and the motivation to bond with their child. (Muzik & Borovska, 2010). Both men and women have been found to have an increase in anxiety and depression during pregnancy that follows a U shaped curve, that is, higher in the first and third trimesters. Still, research shows that women have higher degrees of depression than do men in all three trimesters of pregnancy (Teixeira, Figueirdo, Conde, Pacheco, & Costa, 2009). Other research has observed slightly higher rates of depression during pregnancy than in the postpartum period (Manber et al., 2008). Research has been inconclusive as to why some women are more susceptible to Antepartum Depression than other women (Faisal-Cury, Menezes, Araya, & Zugaib, 2009) and much more research needs to be done to shed light on this. Physiologically, researchers have noted that plasma cortisol and other hormones rise over the course of pregnancy and peak just before labor (Bonari et al., 2004). Risk factors for Antepartum Depression include a family history of depression, personal history of depression, unplanned pregnancy, lack of social support, marital discord, and history of sexual abuse, miscarriages, abortions and stillbirth as well as chronic life stressors such as financial strains (Luskin et al., 2007).

Prevalence

The *DSM-IV-TR* states that Major Depressive Disorder is most predominant in women during their reproductive years (Perlstein, 2008). Nonetheless, some research shows that prevalence of depression is higher in pregnant women as compared to non-pregnant women. A study by Ryding (2008), informs that the prevalence of depression of nonpregnant women during

their reproductive years is between 1.4% and 3.5%; pregnant women have a prevalence of depression of 7.4% to 12.8%, a 4% to 5% increase. Other studies suggest a prevalence of depression during pregnancy as high as 7% - 20% and because Antepartum Depression appears to be under reported there is potential for a much higher percentage of women being effected (Goodman & Tyer-Viola, 2010; Muzik & Borovska, 2010). One large study found a 9% prevalence of Antepartum Depression, which is lower than other studies; however, they found that studies of women in lower income levels show a higher rate of prevalence of Antepartum Depression, which can be as high as 50%. The rates appear to drop significantly in middle class populations. They found 30% increase in the prevalence of “symptoms among women with household incomes below \$40,000.00” (Rich-Edwards et al., 2006, p. 225). Minority women also have a higher prevalence of Antepartum Depression; this may be due to a large number of minority women experiencing lower SES, living in dangerous conditions and their inaccessibility to mental and medical healthcare (Davis & Dimidjian, 2012). Rich-Edwards et al. (2006) also found that of the 1,278 women in their study only 6% who did not experience Antepartum Depression later developed postpartum depression whereas 31% of the women with Antepartum Depression also experienced postpartum depression (p. 224). This is supported by Goodman & Tyer-Viola (2010) who stated in their study that Antepartum Depression is “the greatest risk factor for postnatal depression” (p. 477). Rich-Edwards, et al. (2006) found a twofold increase in prevalence among women with unwanted pregnancy and a fourfold increase in women who have a history of depression (p. 225).

Treatment

Research has shown that women who are depressed during pregnancy are often depressed before and after pregnancy as well. Unfortunately, women who are depressed before pregnancy often discontinue treatment of depression when they become pregnant, especially if the treatment includes medication. Women might be concerned that if they take medication they may harm their child if used during pregnancy. The use of antidepressants during pregnancy continues to remain controversial yet they are widely prescribed for depression, even during pregnancy. Some research shows that use of medication during pregnancy may not be as dangerous as previously believed (Davis & Dimidjian, 2012). Bonari et al. (2004) found that over half of the women in a study discontinued taking antidepressants for their preexisting depression once they discovered they were pregnant. This same study found that over 21% of women from a random sample who were found to be depressed during pregnancy were not receiving any type of treatment. It is vital to participate in some manner of treatment and several alternatives to medication are available, if desired.

Continuum of care. The types of treatment useful to pregnant women can be viewed as a continuum of care. There may be a variety of methods that are effective for one woman and not effective for another; the following is a list of methods that are proven to be effective. Cognitive Behavioral Therapy and Interpersonal Therapy have both been found to be highly effective methods of treating pregnant women who are depressed (Manber et al., 2008). An Australian study by Hight, Gimmell, & Milgrom (2011), shows that while men were more likely to suggest seeking treatment first from a General Practitioner, women were significantly more likely to seek treatment from friends and family first. Very few of those surveyed in that study indicated a

preference for support groups, counseling or other healthcare professionals. This same study suggested that many of those surveyed did not understand the seriousness of Antepartum Depression (p. 228). A study by Muzik and Borovska (2010) suggests not only is individual therapy effective but marital therapies, parenting classes and other such treatments as well as Electroconvulsive Therapy have been effective in the treatment of Antepartum Depression. Natural medicines such as acupuncture and homeopathic herbs have also been used in treatments, but the benefits are yet to be proven conclusively. Overall, this study suggests that treatment of Antepartum Depression is complex and often involves several different modalities that should be monitored by a physician. All care is recommended to be coordinated through providers to ensure the safety of the patient. A study by Davis & Dimidjian (2012) explored the relationship of increased physical activity and the effects on mood during pregnancy. Results were encouraging and indicated that exercise or increased activities may significantly reduce symptoms of Antepartum Depression. Because lack of social support is a risk factor in developing Antepartum Depression, it is important to look at it as a treatment factor as well. Blanchard, Hodgson, Gunn, Jesse, & White (2009) investigated social support in terms of the partnership. They interviewed seven couples to explore their perception of support in during the pregnancy. They discovered that when a woman perceived her partner as understanding her needs by listening, helping, and respecting barriers, the participants reported feeling better. Conversely, when the participants experienced arguments and felt intruded upon, they felt worse. A study by Ugarriza (2006) looked at unique social support factors among African American women during the postpartum period. She found that of the women she interviewed regardless of acculturation status, those who perceived that they were highly supported by their families had

lower occurrences of postpartum depression. Education can play a role in helping women become more receptive to treatment, including the use of antidepressants. Turner, Sharp, Folkes, & Chew-Graham (2008) found that even when women started out with negative views of antidepressants their perspective of many women changed after listening to health professionals and others about their views on this form of treatment. A large study by Buist et al. (2007) found that an increase of public awareness of maternal mental health issues increased the likelihood of women receiving treatment. Because a variety of methods are available and useful for pregnant women to reduce their symptoms of depression, we can view care as a type of continuum. Care can be as simple as talking to a friend or loved one or more involved care, such as receiving medication while under the supervision of a doctor or therapist.

Impact

The importance of receiving treatment for Antepartum Depression becomes apparent when we look at the impact it has on mother and child. There appears to be a genetic link to affective disorders and behavioral problems in the children of women who are depressed during pregnancy (Bonari et al., 2004; Hay, Pawlby, Waters, & Sharp, 2008). Research shows that treating Antepartum Depression is essential; not only to the mother, but also to the child she is bearing. For the pregnant woman experiencing depression, there are links to preeclampsia, pregnancy induced hypertension, bleeding during gestation, and increased uterine artery resistance as well as risks of suicide and drug use (Blanchard et al., 2009; Bonari, et al., 2004;). Untreated Antepartum Depression has been linked to harmful effects to the offspring of these women resulting in spontaneous abortion, low Apgar scores, fetal death, preterm deliveries, and admission to a neonatal care unit (Bonari et al. 2004). Depression, stress, and anxiety during

pregnancy can be linked to low birth rate, smallness for gestational age, premature labor, poor sleep patterns, and other physiological problems in children; the comorbidity of depression and anxiety is very common during pregnancy and seems to have the worst outcomes in many of these areas, including higher levels of cortisol and norepinephrine in neonates (Bonari et al., 2004; Field et al., 2010; Yonkers et al., 2009). Research shows that affective disorders in pregnant mothers can be passed on to their offspring. For instance, prenatal anxiety has been linked to colic and having children with a more difficult temperament in babies as well as behavior problems as late as four years old (Field et al., 2010). There is some indication that self-perceived distress is the best indicator for transmission of anxiety disorders from mother to offspring (Martini, Knappe, Beesdo-baum, Lieb, & Wittchen, 2010).

Shame

When a person is facing depression they may develop shame about the symptoms of this disorder. Shame is described as striking at “the core of a person’s identity, and as a result, forces the individual to contemplate the possibility of a defective, unworthy, or damaged self” (Kim, Thibodeau, & Jorgensen, 2011, p. 70). Shame, or stigma, has been studied primarily in regards to major depressive disorder, outside of the realm of pregnancy. What has been discovered is that it is both a factor in not seeking treatment and in not being truthful about their symptoms while in treatment for regular depression. Nearly a quarter of all participants in one study were against seeking treatment for depression due to the stigma attached to it (Schomerus, Matschinger, & Angermeyer, 2009). Another study showed that the predominant reason for not disclosing all of their symptoms to their therapist was feeling too ashamed (Hook & Andrews, 2005). One study found that stigma plays a part in the acceptability of treatment of Antepartum Depression. That

is, women were less likely to seek treatment in settings in which they may be more at risk of being shamed, such as group settings (Goodman, 2009).

In theory, stigma and shame should be reduced if information is given to normalize the disorder. There is some support for this based on how Postpartum Depression has become much more accepted since actress Brooke Shields first publicized her experience with the disorder, and after the very public case of Andrea Yates who drowned her five children in 2001 (Luskin et al., 2007). Research on Chinese women who were first time mothers found that psychoeducation about childbirth was effective in reducing depressive symptoms in the postpartum period (Ngai, Chan, & Yim, 2009). While this study focused on learned resourcefulness, it stands to reason that similar programs that focus on understanding depression during pregnancy can reduce depression symptoms in pregnant women in the United States. Interestingly, research conducted in 2006 found that psychoeducation focused on destigmatization alone did not motivate depressed individuals to seek professional help as much as did information about the biological causes of depression. This research indicated that having depression legitimized by biological frameworks did more to motivate people to seek help because of the fact that they could look at depression as an affliction, or disease, which needed professional attention (Han, Chen, Hwang, & Wei, 2006). This, in effect, seems to allow for destigmatization of the disorder. Though there is little research available on the shame involved in Antepartum Depression, it is easy to identify areas which may lead to stigmatization of this depression. As previously outlined, pregnancy is looked upon as a happy time in a woman's life, therefore, if a woman is depressed an unhappy, she could be perceived as being different, or flawed in her nature as a woman. Additionally, there is an apparent finite time span of Antepartum Depression and women may believe that

once the pregnancy is complete, the depression will end. However, women with Antepartum Depression often develop postpartum depression as well. These things may reduce the likelihood of women seeking treatment for this condition.

For the present pilot study, the first hypothesis was that shame is positively correlated with Antepartum Depression as measured by the Edinburgh Postnatal Depression Scale. The second hypothesis was that shame would be negatively correlated with treatment seeking behaviors. The third hypothesis was that psychoeducation about Antepartum Depression could lower the level of shame and increase treatment seeking behavior.

Chapter 2

Method

Participants

Participants were solicited through ads placed on Craigslist. All of the women participating in the quantitative portion of the study scored above 10 or above on the Edinburgh Postnatal Depression Screener (EPDS, Appendix A), indicating possible depression. In the pretest there were 164 subjects who completed the surveys and 78 participants who completed the posttest. Participants who did not complete the posttest were automatically removed from the study quantitative portion of the study. Of the 78 remaining participants, 65 women completed both the EPDS and the Internalized Shame Scale (ISS, Appendix B) portion of the test. Those who did not complete both of these tests were removed from the quantitative portion of the study. Three participants were removed due to the loss of their baby. Seven were removed because they did not meet the criteria for depression on the EPDS. The total number of qualified participants was 47. The participants were then divided into three groups depending on their answer to the question “Following the survey I ...” on the follow-up survey and posttest. The three groups were labeled *Talk Only* for those who did not watch the video, but talked to their partner or sought support somewhere; *Video plus Talk*, for those who did watch the video and sought support; and *Did Nothing* for those who did not watch the video or seek support of any kind. There were 47 participants in all, 32 of the participants were placed in the *Talk Only* group, 5 participants in the *Video plus* group, and 10 in the *Did Nothing* group.

Participants were between the ages of 19 and 42. All participants were from 31 States in the United States. 10 (18.1%) participants came from the Eastern States; 18 (32.7%) participants came from Midwestern states; 13 (23.5%) participants came from Southern States; and 15 (25.4%) of participants came from Western states including Hawaii and Alaska. Eight (14.8%) participants described themselves as Catholic; 19 (35.3%) as Protestant; 18 (33%) as not religious; and 9 (16.8%) as following another religion. For 30 (54%) of the participants, this was their first pregnancy. Ten (18.2%) were in their first trimester of pregnancy; 19 (34.5%) were in their second trimester; and 26 (47.3%) were in their third trimester. Thirty-eight (69.1%) of participants were Caucasian; 5 (9.1%) were Latino; 8 (14.5%) were Black or African American; and 1 (1.9) was Asian or Asian American. Three participants did not report their ethnicity. Thirty (54.5%) of participants were married; 2 (3.6%) were divorced; and 23 (41.8%) had never been married, or were members of an unmarried couple. One (1.8%) participant had less than a high school degree; 11 (20%) had a High School Degree or equivalent; and 43 (78.1%) had a least some college experience or degree, including 1 participant with a graduate degree. Twenty-eight (50.9%) participants described themselves as employed part time, a student, self-employed or as a homemaker; 19 (34.5%) as unemployed or unable to work; and 8 (14.5%) as working 40 or more hours per week.

Participants were entered in a drawing for a \$100.00 gift certificate to Babies R US or a prepaid Visa Card. A winner was selected by using the online software Random Picker. She was contacted via email and per her choice, mailed a prepaid Visa Card in the amount of \$100.00.

For the qualitative portion, all women who commented in the open dialogue box on the pretest and posttest were included. In the pretest, there were 164 subjects. Of these, 87 (53%)

wrote comments. In the post-test, there were 78 respondents. Of these, 39 (50%) wrote comments.

Instruments

The Edinburgh Postnatal Depression Scale (EPDS) is a 10-question, self-report measure designed to measure depression in women in the postpartum period (Cox, Holden, & Sagovsky, 1987). A Score of 30 is the highest possible score on the EPDS, with a score of 10 indicating possible depression. Scores of 10 or higher indicate a strong likelihood of depression. The EPDS consists of 10 items scored from 0 to 3 (resulting range 0–30). Scores above 12 may be referred to as indicating *probable depression*; scores above 9 as *possible depression* (Cox et al., 1987). According to Ganiy (2011) “The sensitivity of EPDS was 73% and specificity was 90%. However, by using a cut-off score of 10, the sensitivity significantly increased to 91%, without much reduction in specificity (84%)” (p. 2)

The Internalized Shame Scale (ISS) is focused on evaluating the extent to which the negative affect of shame becomes magnified and internalized (Cook, 1994, 1996). It reflects feelings of inferiority, worthlessness, inadequacy, and alienation so that one can isolate an individual’s specific feelings of shame involved in a presenting problem (Cook, 1994, 1996). Reliability tests demonstrate Cronbach’s alphas at approximately 0.95, and test–retest correlations of 0.94 (Cook, 1994; Rybak & Brown, 1996).

The author created two questions intended to measure attitudes about receiving treatment (Appendix C). These questions were developed in a session with the authors committee members. They consisted of a story followed by a question asking the woman if she agreed or

disagreed with the character in the story by using a likert-like scale of five possible responses:

Not Likely to Very Likely.

At the end of the surveys, participants were invited to “Share your own thoughts and feelings about your pregnancy if you would like” on the pretest and to “Share your own thoughts and feelings about your pregnancy, if you would like. You may also comment on this study.”

Procedure

Participants were originally solicited using babycenter.com, and thebump.com, through the use of posts in forums for women due to give birth in a six month time frame. Prior to soliciting participants, this author tried to contact forum managers to discuss the appropriateness of using their forums to obtain participants. No responses were received from these enquiries. Unfortunately, even though a few women did complete the survey through the use of these forums, the posts were reported as spam mail and removed from these sites. Babycenter.com sent an email stating that they would allow recruitment of women from their website, if the author allowed the website full access to results. It was determined that these were unacceptable terms. Therefore, the researcher then posted advertisements for participants on Craigslist. The ads were placed in the Community Volunteer section in 78 regions on Craigslist. This included 50 states and two United States territories. Women were asked to participate in a survey if they were feeling sad or depressed and told they would have the opportunity to win a \$100.00 gift certificate to Babies R Us. A web link for the Survey Monkey site was also given. This link allowed all participants to view and agree to the informed consent (Appendix D). Clicking that they read and agreed to the informed consent was required for continuing with the survey. Following the informed consent, the participants completed a section on demographics, which

asked about their age, pregnancy and family information as well as region and religious information. After this, participants completed the EDPS to confirm depression, the ISS to establish a baseline level of shame experienced during this depression and two questions intended to assess treatment receptivity. After these questions, women were allowed space to comment on their pregnancy and then were provided with a link to the researchers' website, www.pregnancydepressionstudy.com. The women were asked to click on a button for having an even or odd birthday. Those who clicked on the EVEN button were directed to a webcast, which provided psychoeducation about Antepartum Depression. Those who selected the ODD button were directed to a consumer reports website on baby products. After clicking these buttons, a screen opened allowing the women to input their name and email address in order to enter to win the gift certificate. Email was sent to participants at intervals of approximately two weeks after participation in the original survey. This email requested them to complete a repeated measure of the EDPS, ISS and treatment receptivity on another web link. All participants were reminded that they could drop out of the study at any time. A link was provided explaining how all participants could view the webcast on the researchers' website. Additionally, participants were informed that when the study was completed the results would be posted on the website for one year. The winner of the gift certificate was notified via email and arrangements were made for delivery.

Data Analysis

Means and standard deviations for the ISS and EPDS subscores and total scores were reported. A repeated measures ANOVA was used to compare the ISS and EPDS scores across the two groups while also reporting the age, ethnicity, number of previous pregnancies and children of the participants involved in the study. The qualitative data was analyzed for themes

within the responses and the responses were categorized into categories of Emotional, Shame, Stressors, Support and Effects of the Study.

Chapter 3

Results

Quantitative

The mean values of the Edinburgh pretest, post-test and difference scores, and the ISS pretest and post-test are shown for women in the three intervention groups are shown in Table 1. It should be noted that higher scores on the Edinburgh test indicate more depression and higher scores on the ISS indicate more shame. In the present study, the clinical cutoff for depression was an EPDS score of 10 or more on the pretest. Shame was determined by an ISS score of 50 or more, while a score of 60 or higher indicates a high level of shame. The reader should note that 55 participants met the criteria for depression in the pretest and 43 met the criteria in the posttest. 36 participants met criteria for shame with 28 of those meeting the criteria for a higher level of shame in the pretest.

The first hypothesis, that shame is positively correlated with Antepartum Depression as measured by the EPDS was tested by comparing the EPDS pretest and posttest scores to the total score of the ISS pretest and post test scores using a T-Test. As predicted, the test showed that the EPDS and ISS scores in the pre and post-tests were positively correlated. Correlations are shown in Table 2. When the depression scores are higher, shame scores are also higher. All of these correlations represent large effects, according to Cohen (1992).

A repeated measures ANOVA revealed that women had significantly less depression at the post-test, $F(1, 52) = 12.84, p = .001$, but there was no main effect of the intervention, $F(2, 52) = .01, p = .98$, and no interaction of intervention and time of depression assessment, $F(2, 52)$

Table 1

Descriptive Statistics on the Edinburgh and ISS Before and After the Intervention for Women in the Three Intervention Groups

Group	Edinburgh Pretest	Edinburgh Post-test	Edinburgh Change	Shame (ISS) Pretest	Shame (ISS) Post-test
Video Plus (<i>n</i> = 7)	18.71 (2.81)	15.14 (6.41)	-3.57 (4.89)	64.20 (11.94)	54.14 (18.70)
Talk Only (<i>n</i> = 37)	19.30 (4.95)	14.62 (6.44)	-4.68 (4.73)	61.41 (22.73)	53.63 (25.02)
Did nothing (<i>n</i> = 11)	17.18 (4.29)	16.18 (4.98)	-1.00 (6.15)	68.90 (14.47)	64.73 (19.30)
Total Sample	18.80 (4.62)	15.00 (6.10)	-3.80 (5.17)	63.26 (20.20)	55.91 (23.34)

Table 2

The Correlations of the Edinburgh and the ISS at the Pretest and Post-Test Periods

	Edinburgh Posttest	ISS Pretest	ISS Posttest
Edinburgh Pretest Total Scores	.57**	.69**	.57**
Edinburgh Posttest total scores		.65**	.74**

= 2.25, $p = .12$. The results for shame show the same pattern. A repeated measures ANOVA revealed that women had significantly less shame at the post-test, $F(1, 52) = 8.11, p = .006$, but there was no main effect of the intervention, $F(2, 52) = .87, p = .43$, and no interaction of intervention and time of shame assessment, $F(2, 52) = .37, p = .69$. Post hoc Power analyses for both ANOVAs reveal that the power for the main effect of time (i.e., depression or shame at time one versus time two) was adequate, but the Power for test of the main effect of intervention and the interaction of intervention and time were too low. The low Power was due to the small sample sizes in the three intervention groups. These results suggest that depression and shame were decreased at the post-test relative to the pretest, but that the sample sizes were too small to assess the effects of the intervention.

Qualitative Data

Many women took the time to express some of the emotions they were feeling and their experiences during their pregnancy. These comments became a powerful tool to understand the feelings and events in the lives of pregnant women.

Depression and anxiety. Several women complained of emotional symptoms, such as anxiety, fear, sadness, depression, stress, anger, regret, feeling overwhelmed or, and feeling detached. Others expressed feelings of happiness, gratefulness and excitement. One woman wrote, “I often feel disconnected to my body or like I am wearing a costume that hides the real me. I also don't feel sexually appealing and I get uncomfortable around women that aren't pregnant.” Another woman helps us understand some of the physical things that can affect our emotions,

I'm very happy about my pregnancy and excited to meet my son, but I do panic almost constantly about all the things that can go wrong with my pregnancy and birth. All the worrying and lack of sleep wears my nerves and emotions so thin and makes me grouchy and depressed a lot.

A 32-year-old woman wrote this about her first pregnancy,

I feel like I am being held hostage in my body. I am constantly in pain or nauseated, and regularly depressed and anxious, yet the anxiety keeps me from wanting to take any drugs. The weight of making a tiny person and the potential negative repercussions of my behavior on that tiny person overwhelms me. I know I will but don't know how I will make it through these next 26 weeks.

Another woman indicates that timing can sometimes make a difference in the way a woman feels, "As my pregnancy has progressed and the chance of miscarriage has passed, I feel much more relaxed and confident about the future." However, for some women, timing doesn't seem to make a difference at all, "I'm at the end of the pregnancy and getting my tubes tied after this one." For this woman, it seems that the experience of pregnancy has been so overwhelming that she doesn't wish to experience it again.

Shame. Some women talked about what are potentially shaming themes that could affect many women. They described feelings of guilt, failure, feeling like a burden to others and insecurity. One woman said, "I feel like I am not ready and that people will constantly judge my every move with this baby." Another said, "I have worries and concerns about what people would think because it will be my sixth child." For these women, what they believe other people may be thinking causes them significant distress. Another woman seems to take responsibility

for something that she must have had little control over. She simply wrote, “Unplanned C-section I have lots of Guilt over this.”

Stressors. Several women talked about how finances, unemployment, money, school, unplanned or unwanted pregnancy and other situational stressors can play a large role in the way they are feeling. One woman explained her stressors and what happened following the recent death of her mother,

Within a week of her passing I found out I was pregnant. I also have been having a hard time with my husband and our relationship. Finances are a huge issue. I am high risk and supposed to be on bed rest but am unable to due to having a 5-year-old and 2-year-old.

Another woman spoke of similar pregnancy issues, “Since I was put on maternity leave early with two young children I feel very overwhelmed like we will never have what we need nor will we ever catch up on things.” A young mother faced with an unexpected pregnancy while in college said,

It’s taking a toll on my life. I had dreams to get my life started the right way, now I have to wait once again. I just feel if I somehow lose the baby or something else remarkable happens, I’ll probably smile again like I use to.

Support. Support was an important issue for many women. Women talked about experiencing discord or lack of support by their partner, family or friends and feeling abandoned. Regarding the effects of the lack of support, one woman said, “I’ve never felt more ignored or overlooked by my significant other than after I became pregnant ... but now I am too far in to get myself out.” A 42-year-old woman with older children said, “I wish my spouse was here to support me and my kids. He ran off with another woman.” These women need support during

their pregnancy, but they are unable to find that support from the father of the baby and this appears to be devastating to them both.

This 21-year-old addresses many of the issues mentioned above when she wrote, Getting pregnant was the one of the dumbest decisions I have ever made. I am in college for Christ sake! I had so much going for me, only to be knocked up by a no good bum of a man. He isn't around to comfort me or help me through this pregnancy! Matter of fact no one is, I am alone in this journey and I hate it. I have lost friends because of this; my family isn't speaking to me, just a complete disgrace. I don't know what happened to me, I used to be beautiful, now I have stretch marks, a bowling ball for a stomach, feet that leave me in excruciating pain daily. I could just scream to the top of my lungs!

For her, this pregnancy has left her completely isolated and she feels that she has no one to blame except herself for her decision to become sexually involved with a man who has abandoned her. What a difference support could make for her.

Others wrote about the positive aspects of support. One woman wrote, "Taking the time to talk with family about my pregnancy has helped me." A 23-year-old single woman, who had a very difficult time throughout her pregnancy, wrote this after watching the psychoeducation video associated with this study, "now I am very confident in my abilities to be a good mother and have a lot of good support from my Mother and my good friends of which are very big help to me." All of these statements and many more, show that a lack of support is a detriment to a woman's emotional wellbeing, while those with the support of family and friends find it beneficial.

Effects of the study. Four of the responses speak to the possibility of a therapeutic effect from this study. One woman wrote, “This study has made me realize I do have depression thank you.” And another said,

Glad I did this study – before participating in the survey I was really unaware of my changing emotions and it made me look into a support group and now I realize I need more emotional support and reaching out for help really lifted my mood and feelings of happiness about the pregnancy.

Another woman, a widow, who watched the video said, “Thanks for offering the study. It had helped me take the time to put my thoughts and feelings into words ... this, in and of itself, is therapeutic.” And another said, “This was good for me thank you for allowing me to participate.”

Chapter 4

Discussion

The present study posed three hypotheses. The first hypothesis was that shame is positively correlated with Antepartum Depression as measured by the Edinburgh Postnatal Depression Scale. The second hypothesis was that shame would be negatively correlated with treatment seeking behaviors. The third hypothesis was that psychoeducation about Antepartum Depression could lower the level of shame and increase treatment seeking behavior.

The first hypothesis was supported; Antepartum Depression and shame are positively correlated. When depression is high, shame is high. When depression is low, shame is low. This validates pregnant women the prior research, mentioned above, which found that shame and depression are positively correlated.

There appears to be a significant reduction in depressive symptoms from women who participated in the study. This could be related to the psychoeducation portions effects on the study. Several participants sought help or support following the original survey and a decrease in both depression and shame were seen in these women. This shows that helping women understand that they are not alone in their depression may be enough to encourage them to get the support they need.

This appears to be directly supported in the qualitative portion of the study. As shown in the results, four women commented directly on the benefits they felt they received, just from doing the study. Only one of the women watched the psychoeducational video meant as an

intervention. The other three, even without this specific intervention, felt educated and more informed about Antepartum Depression and this appears to have helped them to feel better or understand their condition in way that allowed them to seek support. This was an unforeseen result of this study; however, it is very informative in that it shows that merely allowing women the process to think about their feelings and a way to express them, in and of itself can be greatly beneficial to some women.

The qualitative portion of the analysis also shows us that receiving support is extremely essential to the emotional wellbeing of women during pregnancy; without it the pressures that accompany pregnancy can become too much for women to bear. This also speaks to the continuum of care that needs to be available to women during pregnancy. Many doctors' offices routinely screen pregnant women for depression; however, many of these women continue to struggle with depression without receiving care. If doctors talk to the women about the importance of receiving support in addition to screening for the support that women are receiving, this may assist women in soliciting support either from friends and family, or through support groups available in the United States and around the world. A doctor's office is an ideal location for providing at least a minimal amount of psychoeducation, which, as this study shows, has the potential of motivating women to get the help they need. This help can be informal as in talking with partners, friends, family and community leaders, or more formally as in making an appointment with a doctor, getting a referral or calling a support line.

Even though literature doesn't support it, there is a high likelihood that pregnant women who are depressed during pregnancy will experience more stigma due to the pressure that is

often applied to women by the commonly held belief that pregnancy is the happiest, most natural time of a woman's life.

Complications with women receiving treatment or seeking treatment may lie in the finite amount of time that is associated with pregnancy. Women may believe that as soon as the pregnancy is over, these feelings of discomfort, sadness and anxiety will end and they do not need to receive treatment.

Limitations

It is important to recognize some of the limitations of this study. Unfortunately, a flaw in the design was not discovered until the final results were collected. The questions regarding treatment seeking behavior appear to have been too face valid, allowing participants to anticipate the correct answer rendering the results unusable.

The sample was obtained over the internet using Craigslist. It is very likely that this created a biased population, one that is composed mainly of women who look for surveys to complete on the internet. This may limit the generalizability of the study. Due to the design of the study, the participants were directed to a website and in an effort to randomize the results they were asked to click on two innocuous appearing buttons that would send them to either the intervention or to another website. These instructions were a part of the informed consent and its importance stressed. However, the participants appear not to have understood the directions to get to the websites. Only about five participants watched the video and none went to the second site. A study by Carter, Carter, Luty, Wilson, & Frampton (2006), found that there appears to be a recruitment problem with pregnant women in that they are usually willing to take the first steps in assessments and are either unwilling or unable to take further steps. They referenced studies

by other researchers that were more successful because of a low burden placed on the women. Therefore, it stands to reason that research conducted on pregnant women needs to be stress-free and plainly communicated and easily accessible in order to achieve maximum results.

Due to the attrition mentioned in the methods section, the sample became too small to infer conclusions. Therefore results are inconclusive at this time. Additionally, the groups were very disparate in size, which will cause an imbalance in the data set and limits the researchers' ability to make any conclusions from the data set.

Because it appears that participation in this study inspires women to talk more about their feelings or even seek help for their problems, there is the potential for these activities to confound the posttest data despite the authors best effort to screen for this possibility.

Finally, there may be a limitation due to the use of the Internalized Shame Scale. This test measures the trait of shame, rather than a state, which may indicate a smaller amount of movement possible within the testing time frame.

Future Directions

For future research it is believed that gaining access to an OB/GYN office or to pregnancy groups such as Mothers and Babies or other such groups for pregnant women will allow for more generalizable results. This would likely increase the participation of women in further steps of the study, especially if the researcher is willing to meet women where they are most comfortable. For research done online, it is recommended that online participants be solicited through separate ads placed in the same area with links to two separate surveys. Each survey will forward participants to a different webpage, one with the video link to the psychoeducation video so that it minimizes the steps that women have to take to get in the intervention. This should allow for

more direct participation in facets of the study and leave less to chance. Additionally, for researchers using a program such as Survey Monkey, take the extra step to make all questions on survey required so that it is ensured that all women answer all of the questions. It is impossible to know why some women chose to seek support and others did not despite participation in the intended intervention, or not. If we can discover why the women in these groups, and others like them, are different, be it personality style, self-efficacy or some other reason, we can then figure out how we can help those women in the *Do Nothing* group become more like the women who sought help and support.

An interesting way of pursuing the shame portion of this study would be to analyze the questions on the EPDS, such as Question 3 which states, “I have blamed myself unnecessarily when things went wrong.” This question and perhaps others, may tap into shame and it may be interesting to correlate them to the ISS to see if any relationship exists.

Finally, it is recommended to use a pre-established test of treatment receptivity, or attitudes about receiving treatment rather than creating a new scale to ensure an accurate measurement in this area.

Conclusion

Understanding the emotions and stressors that women experience while pregnant helps us to understand them better and gives us a glimpse of the continuum of care that can help them through their pregnancy. This study has shown us that depression and shame are linked and that educating women about Antepartum depression can have a positive effect toward motivating women to seek help within the continuum of care. Support has been shown to be a key factor influencing the direction of a woman’s emotions. Great care needs to be taken to educate women

from the beginning of their pregnancy about the myriad of emotions they may experience and how important support can be for them. Any interventions directed toward pregnant women needs to be simple to complete and understand.

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Appendix A

The Edinburgh Postnatal Depression Scale

The Edinburgh Postnatal Depression Scale

- | | |
|--|--|
| <p>1. I have been able to laugh and see the funny side of things:</p> <ul style="list-style-type: none"> <input type="radio"/> As much as I always could <input type="radio"/> Not quite so much now <input type="radio"/> Definitely not so much now <input type="radio"/> Not at all <p>2. I have looked forward with enjoyment to things:</p> <ul style="list-style-type: none"> <input type="radio"/> As much as I ever did <input type="radio"/> Rather less than I used to <input type="radio"/> Definitely less than I used to <input type="radio"/> Hardly at all <p>3. I have blamed myself unnecessarily when things went wrong:*</p> <ul style="list-style-type: none"> <input type="radio"/> Yes, most of the time <input type="radio"/> Yes, some of the time <input type="radio"/> Not very often <input type="radio"/> No, never <p>4. I have been anxious or worried for no good reason:</p> <ul style="list-style-type: none"> <input type="radio"/> No, not at all <input type="radio"/> Hardly ever <input type="radio"/> Yes, sometimes <input type="radio"/> Yes, very often <p>5. I have felt scared or panicky for no very good reason:*</p> <ul style="list-style-type: none"> <input type="radio"/> Yes, quite a lot <input type="radio"/> Yes, sometimes <input type="radio"/> No, not much <input type="radio"/> No, not at all | <p>6. Things have been getting on top of me:*</p> <ul style="list-style-type: none"> <input type="radio"/> Yes, most of the time I have not been able to cope at all <input type="radio"/> Yes, sometimes I have not been coping as well as usual <input type="radio"/> No, most of the time I have coped quite well <input type="radio"/> No, I have been coping as well as ever <p>7. I have been so unhappy that I have had difficulty sleeping:*</p> <ul style="list-style-type: none"> <input type="radio"/> Yes, most of the time <input type="radio"/> Yes, sometimes <input type="radio"/> Not very often <input type="radio"/> No, not at all <p>8. I have felt sad or miserable:*</p> <ul style="list-style-type: none"> <input type="radio"/> Yes, most of the time <input type="radio"/> Yes, quite often <input type="radio"/> Not very often <input type="radio"/> No, not at all <p>9. I have been so unhappy that I have been crying:*</p> <ul style="list-style-type: none"> <input type="radio"/> Yes, most of the time <input type="radio"/> Yes, quite often <input type="radio"/> Only occasionally <input type="radio"/> No, never <p>10. The thought of harming myself has occurred to me:*</p> <ul style="list-style-type: none"> <input type="radio"/> Yes, quite often <input type="radio"/> Sometimes <input type="radio"/> Hardly ever <input type="radio"/> Never |
|--|--|

Response categories are scored 0, 1, 2, and 3 according to increased severity of the symptom. Items marked with an asterisk () are reverse scored (i.e., 3, 2, 1, and 0). The total score is calculated by adding together the scores for each of the 10 items. Women with scores above 12 likely have depression.*

Appendix B

The Internalized Shame Scale

The Internalized Shame Scale

Below is a list of statements describing feelings or experiences that you may have. Read each statement carefully and circle the number to the right of each item that indicates the frequency with which you find yourself feeling or experiencing what is described in the statement. Use the scale below. Try to be as honest as you can when responding. Please answer all of the items.

Never	Seldom	Sometimes	Often	Almost Always
0	1	2	3	4

1. I feel like I am never quite good enough.
2. I feel somehow left out.
3. I think that people look down on me.
4. All in all, I am inclined to feel that I am a success.
5. I scold myself and put myself down.
6. I feel insecure about others' opinions of me.
7. Compared to other people, I feel like I somehow never measure up.
8. I see myself as being very small and insignificant.
9. I feel I have much to be proud of.
10. I feel intensely inadequate and full of self-doubt.
11. I feel as if I am somehow defective as a person, like there is something basically wrong with me.
12. When I compare myself to others, I am just not as important.
13. I have an overpowering dread that my faults will be revealed in front of others.
14. I feel I have a number of good qualities.
15. I see myself striving for perfection only to continually fall short.
16. I think others are able to see my defects.
17. I could bet myself over the head with a club when I make a mistake.
18. On the whole, I am satisfied with myself.
19. I would like to shrink away when I make a mistake.
20. I replay painful events over and over in my mind until I am overwhelmed.
21. I feel I am a person of worth at least on an equal plane with others.
22. At times I feel like I will break into a thousand pieces.
23. I feel as if I have lost control over my body functions and my feelings.
24. Sometimes I feel no bigger than a pea.
25. At times I feel so exposed that I wish the earth would open up and swallow me.
26. I have this painful gap within me that I have not been able to fill.
27. I feel empty and unfulfilled.
28. I take a positive attitude toward myself.
29. My loneliness is more like emptiness.
30. I feel like there is something missing.

Appendix C

Treatment Resistance Questions

Treatment Resistance Questions

1. Sally is 7 months pregnant and is feeling apprehensive toward giving birth, she is tired of being pregnant. She's not ready to have the baby. She is scared and sad. Her husband tells her, "Sally, this is just pregnancy hormones and all in your head, you just need to get over it."

How likely are you to agree with this statement?

Not Likely

Very Likely

2. Jennifer is 3 months pregnant, she is tired and sad most of the day. She mentions this to her doctor and he gives her the number of a counselor and suggests more frequent check-ups.

As her friend, how likely are you to recommend she follows her doctor's suggestion?

Not Likely

Very Likely

Appendix D
Informed Consent

Informed Consent

Principal Investigator: Pennie F. Wilson, M.A., George Fox University, Newberg, OR.

Study Purpose: The primary purpose of this study is to understand the relationship between depression during pregnancy and pregnant women's attitudes about seeking professional help.

Study Procedures: Participation in this study will require approximately 40 minutes. You will be asked to complete an online questionnaire. Each questionnaire will be securely stored online and randomly assigned a number by a computer program. Identifying information will only be maintained in order to contact you about completing the same questionnaire that you completed at the beginning of this study (posttest). Either before or after the post test, you will be asked to view a webcast. Total commitment time is approximately two hours over a period of one or two months.

Risks: Whenever someone is questioned about their feelings or attitudes, these same emotions can surface for them. If this happens, please let the researchers know and information will be provided for you to help you seek treatment for any disturbances in your emotional well-being.

Confidentiality: All information obtained is strictly confidential. Only the Primary Investigator and the research assistants will have access to identifying information (name, age, email address, etc.). This information will be kept only for contact purposes. All responses to questionnaires will be assigned a random number and separated from identifying information.

Compensation: You will have an opportunity to view a webcast that provides you with information about the causes of depression during pregnancy as well as the risks of not treating

depression during this time. Information about treatment options and providers will be available during all phases of the study. You will also be entered to win a gift certificate to Babies R Us in the amount of \$100.00.

Contact: If you have any questions or desire further information with respect to the study, you may contact Pennie Wilson at pewilson@georgefox.edu or faculty advisor Nancy Thurston, PsyD at nthurston@georgefox.edu

Consent: I am aware that I have the right to ask questions and receive answers on any questions related to this study. I am aware that I have the right to refuse to participate or may withdraw from the study at any time. I also realize that all information is strictly confidential. I understand the risks involved with this study and that help will be provided if further symptoms of depression and/or anxiety develop.

1. I have read and agree to the above terms of participation

Yes

2. Please enter your name and email address below. This information will be kept separately from your survey responses.

Name _____

Email address _____

Appendix E
Curriculum Vitae

PENNIE F. WILSON
6985 SW Nyberg Street. · Tualatin, Oregon 97062
971-282-6621 · pewilson@georgefox.edu

EDUCATION

George Fox University
Graduate Department of Clinical Psychology: APA Accredited
Anticipated Degree: Doctorate of Psychology in Clinical Psychology
Anticipated Commencement Date: April 2014
Cumulative GPA: 3.519
Newberg, Oregon

George Fox University
Graduate Department of Clinical Psychology: APA Accredited
Master of Arts in Clinical Psychology
Commencement Date: May 2011
Cumulative GPA: 3.528
Newberg, Oregon

George Fox University
Bachelor of Science in Psychology
Spanish Minor
Commencement Date: April 2007
Cumulative GPA: 3.505 Cum Laude
Newberg, Oregon

Universal, Centre De Lenguas
Spanish culture and language training (August - December 2006)
GPA: 3.225
Cuernavaca, Morelos, México

SUPERVISED CLINICAL EXPERIENCE

Lutheran Community Services, Northwest
Supervisor: Joshua Payton, PsyD, Licensed Psychologist
Community Mental Health
August 2012 – current
McMinnville, OR

Position: Clinical Intern

Responsibilities:

- Psychotherapy for children and their families
- Co-teaching Mothers and Babies Class
- Co-facilitating anger management class
- Evaluations for anger management
- Cognitive Behavioral Therapy
- Modified play therapy

- Emotion Focused Therapy with appropriate clients.
- Weekly individual supervision with a licensed clinical psychologist
- Weekly staff meetings (interdisciplinary)

Salem Veteran's Center

September 2011 – May 2012

Supervisor: David Collier, PsyD, Licensed Psychologist

Salem, OR

Veterans Center

Position: Clinical Intern

Responsibilities:

- Readjustment counseling for individual combat veterans and families
- PTSD screening and assessment
- Cognitive Behavioral Therapy
- Emotion Focused Therapy
- Weekly group supervision
- Monthly training

George Fox Behavioral Health Clinic

October 2010 – August 2011

Supervisor: Joel Gregor, PsyD, Licensed Psychologist

Newberg, OR

Behavioral Health Clinic

Position: Practicum II Therapist

Responsibilities:

- Individual and couples psychotherapy and
- Psychological assessment rotation
- Serving underinsured or uninsured
- Cognitive Behavioral Therapy
- Brief therapy
- Co-led parenting class
- Co-manage the office independently by communicating with referral sources, organizing finances, and developing the client caseload
- Weekly individual and group supervision
- Weekly group trainings

Multnomah County Corrections

July 2008 – March 2009

Supervisor: Stephen Huggins, PsyD, Licensed Psychologist

Portland, OR

County Jail Facility

Position: Therapist in training

Responsibilities:

- Psychotherapy services for incarcerated males and females
- Primarily working with anxiety and depression.
- Rotating group therapy for life skills in two dorms.
- Weekly individual and group supervision and
- Multidisciplinary treatment team meetings.

George Fox University

September 2007 – April 2008

Supervisor: Susan Dutcher, MS, MA
Licensed Supervisor, Mary Peterson, PhD
Position: Analog Therapist

Newberg, OR

Responsibilities:

- Psychotherapy to two undergraduate students
- Client Centered Therapy
- Weekly group supervision with an advanced graduate student Supervised by a licensed clinical psychologist
- Videotaped sessions and presented cases

OTHER WORK EXPERIENCE

Cehalem Youth and Family Services,
Residential Treatment Center for adolescents
Position: Relief Youth Treatment Specialist

May – August 2007
Newberg, OR

Responsibilities:

- Supervision and guidance in residential, school and recreational settings.

Department of Human Services
On Site Supervisor: Cecily Hoffman, MSW
Faculty Supervisor: Kristina Kays, PsyD
Addiction Recovery Team
Position: Intern (Undergraduate Field Experience)

January 2006 – April 2006
Hillsboro, OR

Responsibilities:

- Working with parents who lost children due to substance abuse issues
- Observed treatment assessment interviews
- Home visits
- Scheduling inpatient and outpatient appointments.

George Fox University, Department of Psychology
Supervisor: Sally Hopkins, PsyD
Position: Peer Mentor

September 2005 – April 2006
Newberg, OR

Responsibilities:

- Helping adjust to college life at George Fox University

RESEARCH

Dissertation: George Fox University
Supervisor: Nancy Thurston, PsyD
Title: The Relationship of Shame in the Treatment of Antepartum Depression

2010- Present

- Original data collection study
- Online recruitment
- Pre and Post tests
- Video intervention applied at random
- Data analysis completed February 2013

- Preliminary defense: November 2011.
- Final defense: May 2013

TEACHING EXPERIENCE

George Fox University Fall 2012

Graduate Assistant for Kristina Kays, PsyD

Course: Advanced Counseling

Responsibilities:

- Facilitate group discussions
- Support student development of basic counseling skills
- Teaching & modeling skills
- Viewing videos
- Role Play
- Providing feedback

George Fox University June, 2012

Graduate Assistant for Mary Peterson, PhD

Course: Family and Couples Therapy

Responsibilities.

- Provided administrative support
- Grading tests
- Evaluating presentations.
- Lecture on Emotion Focused couples therapy.

Behavioral Health Clinic February, 2011

George Fox University

Topic: Understanding and Treating Grief

George Fox University October, 2009, September, 2010 & September 2012

Graduate Assistant for Elizabeth Hamilton, PhD

Course: Lifespan Development

Topic: Maternal Mental Health Disorders

PROFESSIONAL PRESENTATIONS

DePierre, L.M., Jenkins, D., Wilson, P., Ulmer, J., & Thurston, N. (2011). Major life events and antenatal depression. *Poster presented at 2011 American Psychological Association annual conference*

DePierre, L.M., Jenkins, D., Wilson, P., & Thurston, N. (2011). Factor analysis of postpartum depression measures for identifying antenatal depression. *Poster presented at 2011 Oregon Psychological Association annual conference*

Jenkins, D., DePierre, L.M., Wilson, P., & Thurston, N. (2011). Factor analysis of protective factors in antenatal depression. *Poster presented at 2011 Western Psychological Association annual conference*

APPLICABLE SERVICE WORK

Psi Chi, GFU Chapter
Vice President 2006-2007
Treasurer 2005-2006

PROFESSIONAL DEVELOPMENT TRAINING

Motivational Interviewing Introduction Workshop February 1 & 2, 2013
Michael Fulop, PsyD
George Fox University, Newberg, Oregon

Working with Transgender Issue October 10, 2012
Erica Tan, PsyD
George Fox University, Newberg, Oregon

Mindfulness March 7, 2012
Erica Tan, PsyD
George Fox University, Newberg, Oregon

Cross-Cultural Psychological Assessment November 2, 2011
Tedd Judd, PhD
George Fox University, Newberg, Oregon

Motivational Interviewing & A Work in Progress October 4, 2011
What it is & Why to use it
Michael Fulop, PsyD
George Fox University, Newberg, Oregon

Neurobiological effects of trauma March 16, 2011
Anna Berardi, PhD
George Fox University, Newberg, Oregon

Best practices in Multi-cultural assessment October 27, 2010
Eleanor Gil-Kashiwabara, PhD
George Fox University, Newberg, Oregon

Education and Engagement: Learning about Diversity January 2008
Jessica Henderson Daniel, PhD, ABPP
Oregon Psychological Association, Portland, Oregon

HONORS

George Fox University Undergraduate Dean's List: Four Semesters
PSI CHI National Psychology Honor Society, 2005-Present
George Fox University Undergraduate Studies: Cum Laude

PROFESSIONAL AFFILIATIONS AND MEMBERSHIPS

American Psychological Association, Student Affiliate, 2007 – Present
Oregon Psychological Association, Student Affiliate, 2007 – 2008, 2011 – Present
Western Psychological Association, Student Affiliate, 2011 – Present
Psi Chi, 2005 – Present