Published in final edited form as:
Gen Hosp Psychiatry. 2013 ; 35(6): 598–604. doi:10.1016/j.genhosppsych.2013.07.011.

Patient's views on depression care in obstetric settings: how do they compare to the views of perinatal health care professionals?☆

Nancy Byatt, D.O., M.B.A.[a,*], **Kathleen Biebel, Ph.D.**[b], **Liz Friedman, M.F.A.**[c], **Gifty Debordes-Jackson, M.A.**[d], **Douglas Ziedonis, M.D., M.P.H.**[d], and **Lori Pbert, Ph.D.**[e]

[a]Department of Psychiatry and Obstetrics and Gynecology, University of Massachusetts Medical School, Worcester, MA 01655

[b]Department of Psychiatry, University of Massachusetts Medical School, Worcester, MA

[c]MotherWoman, Inc., Hadley, MA

[d]Department of Psychiatry, University of Massachusetts Medical School, Worcester, MA

[e]Department of Medicine, University of Massachusetts Medical School, Worcester, MA

Abstract

Objectives—The objectives were to examine patients' perspectives on patient-, provider- and systems-level barriers and facilitators to addressing perinatal depression in outpatient obstetric settings. We also compare the views of patients and perinatal health care professionals.

Method—Four 90-min focus groups were conducted with women 3–36 months after delivery (*n*=27) who experienced symptoms of perinatal depression, anxiety or emotional distress. Focus groups were transcribed, and resulting data were analyzed using a grounded theory approach.

Results—Barriers to addressing perinatal depression included fear of stigma and loss of parental rights, negative experiences with perinatal health care providers and lack of depression management knowledge/skills among professionals. Facilitators included psychoeducation, peer support and training for professionals.

Conclusions—Patients perceive many multilevel barriers to treatment that are similar to those found in our previous similar study of perinatal health care professionals' perspectives. However, patients and professionals do differ in their perceptions of one another. Interventions would need to close these gaps and include an empathic screening and referral process that facilitates discussion of mental health concerns. Interventions should leverage strategies identified by both

☆Disclosures: Dr. Byatt received funding for this study from the Faculty Scholar Award at the University of Massachusetts Medical School. Dr. Byatt has also received research funding from the Meyers Primary Care Institute/Rosalie Wolf Interdisciplinary Geriatric Healthcare Research Center Small Grants Initiative and the National Institutes of Heath (NIH). Dr. Biebel does not have any relevant disclosures. Ms. Friedman is on the governor-appointed Massachusetts Postpartum Depression Commission. Dr. Ziedonis has received research funding support from the NIH, Legacy Foundation, Massachusetts Department of Mental Health, Connecticut Department of Public Health and Substance Abuse and Mental Health Services Administration. Dr. Pbert does not have any relevant disclosures.

*Corresponding author. Department of Psychiatry and Obstetrics and Gynecology, University of Massachusetts Medical School, Worcester, MA 01655. Tel.: +1 508 334 7839; fax: +1 508 856 6426., nancy.byatt@umassmemorial.org (N. Byatt).

patients and professionals, including empowering both via education, resources and access to varied mental health care options.

Keywords

Depression; Barriers; Facilitators; Perinatal; Treatment

1. Introduction

Perinatal depression refers to minor or major episodes of depression occurring during pregnancy or the first postpartum year [1–3]. Up to 18.4% of women experience depression during pregnancy, and as many as 19.2% of mothers experience depression within 3 months of delivery [1]. Perinatal depression has been associated with deleterious effects on mother–child dyad and family [4–6]; it can have a negative effect on birth outcomes [7] and on infant attachment, behavior and development [4,5]. Twenty percent of postpartum deaths in depressed women result from maternal suicide [6].

The perinatal period is viewed as a time that may be ideal to screen, diagnose and treat depression because women have frequent and regular contact with perinatal health care professionals. Because perinatal depression is a critical public health issue, several guidelines have been developed to help providers address perinatal mood disorders [8–10]. Despite high acceptance of depression screening by perinatal women, screening for perinatal depression remains controversial because many women are not amenable to contact with a mental health provider [11–14]. Less than 30% of women who screen positive for depression attend an initial or subsequent mental health visit [11–14], and as few as 0%–6% [11,14] adhere to a full treatment course. This lack of adherence may be due to unengaged providers and staff [15] and limited resources to ensure depression evaluation, treatment and follow-up [16,17].

Why is it so difficult for perinatal women to access and engage in depression treatment? Perinatal women and their obstetric providers find screening a futile exercise when done in the absence of trained providers with access to mental health resources/referrals. In our recent literature review [18], we identified patient-, provider- and systems-level barriers and facilitators to the treatment of perinatal depression and reviewed clinical-, program- and systems-level interventions. Identified provider- and systems-level barriers included: (a) lack of obstetric provider training in technical aspects of depression care [17,19,20] and communication skills in this context [21], (b) absence of standardized processes and procedures for depression care [22,23], (c) lack of mental health providers willing to treat pregnant women [23], (d) lack of referral networks [22–26] and (e) inadequate capacity for follow-up and care coordination [22–26]. These barriers are exacerbated by patient-level barriers. Perinatal women report that they are afraid to disclose mental health concerns due to fears of stigma, losing parental rights and being judged as an unfit mother [27–48]. Many women perceive obstetric providers and staff as unsupportive, unavailable [30,32,33,40,41,44,49–51] and inadequately trained in depression assessment and treatment [49,50].

Our previously published qualitative study with perinatal health care professionals [52] also suggests that complex interactions between patients and perinatal health care professionals contribute to untreated perinatal depression. In our previous study, we conducted four focus groups with perinatal health care professionals (*n*=28) including obstetric resident and attending physicians, licensed independent practitioners, nurses, patient care assistants, social workers and administrative support staff. We identified patient-, provider- and systems-level barriers that prevent perinatal women and perinatal health care professionals from addressing depression [52,53]. We found that perinatal health care professionals perceived that shame, stigma and fear of negative consequences contributed to women's reluctance to discuss and seek mental health treatment. Provider-level barriers included lack of resources and knowledge needed to educate women, refer them for treatment, assess their safety and/or discuss or prescribe medications. Limited access to mental health care and resources was identified as a system-level barrier [52,53].

Patient-level facilitators reported by perinatal health care professionals included empowering women via awareness of perinatal depression and access to flexible treatment options. Training in perinatal depression, colocated mental health and obstetric care, care coordination, increased support from mental health and social care professionals, and increased communication among mental health and perinatal health care professionals were identified as provider-level facilitators. System-level facilitators included integration of obstetric and depression care and enhanced collaborations among mental health and perinatal health care professionals [52,53].

The goal of this exploratory qualitative study was to address a gap in the literature by (a) identifying patient's perspectives on patient-, provider- and systems-level barriers and facilitators to addressing perinatal depression in outpatient obstetric settings and (b) comparing patient's views with our previous findings on the views of perinatal health care professionals [52] to determine areas of concordance and discordance. Comparing the perceptions of patients and perinatal health care professionals provides a unique and understudied perspective on perinatal depression that can inform interventions aimed to close gaps perceived by women and perinatal health care professionals.

2. Methods

Four focus groups were conducted with a purposeful sample of women(*n*=27) who had previously been obstetrical patients and self-reported anxiety, depression and other intense emotions during pregnancy and/or the postpartum period. This cross-sectional qualitative design reflects the experiences of women who ranged from 3 to 36 months postpartum. Three focus groups with 7–11 participants each were conducted in locations convenient to participants. A fourth focus group (*n*=4) with prior participants was conducted to review and refine initial themes and findings.

Participants were recruited through a midsize community organization that provides education and advocacy for perinatal women. Participants were recruited by a Co-Investigator (L.F.) through fliers and direct contact at community organization meetings, informational sessions and personal communications. Written informed consent was

obtained from all participants. Demographic data were collected from individual participants before the focus groups. Participants received a $30 gift card. The study protocol was approved by the Institutional Review Board.

Each 90-min focus group was conducted by a seasoned and experienced qualitative researcher (Co-I: K.B.). Open-ended study probes, informed by the literature and our previous research, were used to elicit participants' opinions regarding barriers and facilitators to addressing perinatal depression and other mental health concerns in obstetric settings. The researcher asked a series of open-ended questions about women's experiences with depression screening, identification and management in obstetric settings and their opinions on strategies that could optimize depression care in obstetric settings. After each focus group, the research team (Co-I: K.B.; RC: G.D.J.) debriefed to identify immediate impressions and general themes. Focus groups were audio recorded, transcribed and checked for accuracy. Transcripts were imported into NVivo, a code and retrieve software program, to facilitate analysis of focus group transcripts (NVivo, 2008).

A grounded theory approach, a commonly used strategy for examining exploratory and pilot research data, was employed. Focus group data were reviewed, segmented and coded by the research team. They began with open coding to identify and name the occurring phenomenon described by participants and then moved to nonhierarchical axial coding where codes are grouped to generate themes and categories and make connections between ideas [54]. Given the pilot nature of the study, themes and categories were not ranked for frequency or impact. To identify recurrent patterns and emerging themes, an iterative, constant-comparative process was used [55]. Codes were added until new themes no longer emerged, and initial sections were categorized using reformulated codes. All transcripts were coded independently. A rate of agreement of at least 90% was achieved. Investigators then met to review disputed coding segments and recoded to achieve a 100% agreement rate.

3. Results

Participants were a diverse and representative sample of women (Tables 1 and 2). While focus group probes asked questions about barriers and facilitators to identifying and engaging women in depression care and mental health treatment in general, women's responses focused mainly on depression. Below we present women's perceptions of patient-, provider- and systems-level barriers and facilitators to addressing perinatal depression in obstetric settings.

3.1. Patient-level barriers

3.1.1. Complex psychosocial factors result in low rates of treatment seeking and participation—Participants were reluctant or "terrified" to acknowledge mental health concerns to family, friends or health care professionals due to shame, guilt and pressure to be a "super-mother" who can "do it all."

> "I'm not really depressed. I'm just being a baby; I'm being a whiner. And I never came back, 'cause I felt so guilty about showing up and complaining about the fact that I…was severely depressed and crying all day long.…I felt like I was whining."

Many feared being labeled as a bad mother, and several felt further stigmatized for having a criminal record, having a low income or being a young parent. Women were scared to report their authentic experiences to providers because of the real fear of custody loss and losing contact with their children.

Limited access to transportation, child care and financial resources made it even more difficult for participants to access mental health care. Several participants that were able to find a mental health provider were unable to access treatment due to prohibitive co-pays or health insurance issues. Lack of partner support and judgmental comments by partners, friends or family also decreased participants' likelihood of seeking help.

3.2. Provider-level barriers

3.2.1. Feeling invalidated, disrespected and/or judged by perinatal health care professionals—Attempts to seek mental health treatment were felt to be of no help due to perceived avoidance of mothers' mental health concerns among perinatal health care professionals. One participant noted:

> "The only other thing I could have done was dressed in neon lights…it was pooh-poohed…I couldn't have been more upfront…"

Such interactions left participants feeling ignored, disregarded, traumatized and uncomfortable accessing care. One mother relayed a disappointing conversation with her provider:

> "I'm telling you the god's honest truth, the person who screened me said, 'Well, you have a happy, healthy baby. What else do you want?'…That's inexcusable…"

3.2.2. Reluctance to seek mental health care due to fear of negative consequences—Participants were less likely to seek help or disclose depression symptoms and/or intrusive thoughts due to the looming threat of child protective services and/or involuntary psychiatric hospitalization.

> "I might say…'I am so stressed out. My baby has not stopped crying. I want to throw him out the window,' which, immediately, red flag, red flag, red flag, red flag…Call the cops, call the people. She's a horrible mother. Lock her up," versus…what I really mean is, 'I'm really stressed out. I can't handle it right now.'"

Participants reported feeling accused, unsupported and judged during interactions with child protective services. Several mothers noted that that they did not trust child protective services, perceiving them as unhelpful and working against them.

3.2.3. Perception that perinatal health care professionals lack mental health training, skills and confidence—Inadequate knowledge and skills regarding depression among perinatal health care professionals was noted to be a major barrier to accessing mental health treatment. Mothers felt that professionals did not know how to discuss or manage depression and thus avoided it. One mother suggested that, "part of the reason…

why OBs and even midwives aren't asking is they're not really prepared to deal with the answers."

Several participants avoided discussing thoughts of harming themselves or others because they felt that perinatal health care professionals were not prepared to assess and/or manage safety concerns.

> "I could not tell them my specific symptoms…in terms of throwing your kid against the wall or stabbing them or whatever. Even though I knew I wasn't gonna do it, I had these images of it."

3.2.4. Lack of resources/knowledge to prepare for the possibility of depression—The lack of education about depression during outpatient perinatal care and/or childbirth education classes was noted as a major omission.

> "During the birthing class…it was all about pregnancy and the birth…there was no mention of emotional stuff…it just needed to be mentioned…so we could have had a conversation."

Several women noted how their partner/primary support was not educated or prepared for the possibility of depression. As one mother noted, "It would have been nice if somebody had taken my husband aside and been like '…you need to look for this… Here are some warning signs.'"

3.2.5. Depression not addressed by perinatal health care professionals—Participants felt isolated and discouraged when their efforts to seek help were not acted upon by perinatal health care professionals. One mother shared her experience reaching out:

> "When I then called back for help, all I got was, 'Well, call these people.'… Nobody really took the time to see me or…try and find out what was going on.… they basically wrote me a prescription… and said…'Go find a therapist.'"

Multiple participants felt they were offered very narrow treatment options. Several women that had postpartum depression noted, "Every answer I got was Zoloft," and there were limited alternatives to traditional medication treatment. Several noted that the conversation about care for mental health issues ended once they declined medication treatment or that medications were offered to the exclusion of other options.

3.2.6. Lack of information regarding the risks and benefits of psychotropic medications during pregnancy—Several participants discontinued their psychiatric medications and wished that somebody had warned them about the risks of discontinuing antidepressants in pregnancy. One participant described a long history of treatment with antidepressants that she stopped before she became pregnant:

> "I thought everything was gonna be smooth sailing. I was…feeling great that I was finally off these meds. Nobody talked to me about…the fact that that might not be the case…I assumed I would continue to do really well, and I didn't."

Some participants suspected that lack of knowledge regarding safety of medications during pregnancy deterred perinatal health care professionals from offering or discussing the risks

and benefits of medication treatment during pregnancy. Several participants were told by health professionals to discontinue psychiatric medications due to pregnancy.

3.3. System-level barriers

3.3.1. Perinatal care environment is not designed or equipped to provide mental health support—Participants noted that while the obstetric setting is an obvious place to detect and address depression, depression is often not detected and/or well managed. They also perceived a narrow focus on women's physical health in the OB setting. Women noted a precipitous drop in the focus on mothers' emotional health in the postpartum period, leaving many women feeling unsupported and unsure who to call for help.

> "I had more than enough attention before the birth, all this support… then afterwards, just 'Boop! Hot potato…' if I could just redesign the whole system…I would make all of those appointments afterwards… in retrospect, what I needed was a SWAT team."

Participants that were screened for depression felt it had limited utility and did not encourage engagement in treatment.

3.3.2. Limited access to providers and mental health resources—Barriers to accessing mental health care included participants' limited knowledge regarding available providers, unresponsive providers and long wait times for appointments, all especially difficult for women experiencing emotional crises.

> As one woman noted, "I can't take care of myself. I can't take care of my baby. I need help. I'm homicidal. I'm suicidal. Help me. And it was, 'We'll call you back.' …it just doesn't fly for me."

Participants described "the hoops you have to jump through to get help" including leaving "message after message after message" for providers without any response.

> "I fell through every single layer, where I could have been caught…I literally was screaming for help calling every person in, that I could find in the phonebook, every psychiatrist, bawling on the phone, 'I think I have postpartum depression. I'm not okay. I need help.' And I couldn't find anybody."

Several women felt that mental health providers were reluctant or declined to treat them due to their pregnancy. A lack of collaboration and communication among mental health and perinatal health care professionals was also noted by several participants.

3.4. Patient-level facilitators

3.4.1. Feeling empowered by having a voice—Woman felt empowered by the opportunity to share their experiences and feel heard. Discussing and processing the birth and transition to the postpartum period with a perinatal health care professional were valued greatly by many participants.

> "There's this step, this critical step that's skipped…acknowledging the experience that you went through is so important…validating, as you move forward to…caring

> for a new beating heart…that check-in of that experience would have been really helpful for me…"

Empathy, support and concern from partners, family, friends and trusted perinatal health care professionals helped participants feel strong, gave them a sense of relief and, particularly in response to traumatic and difficult birth experiences, allowed for healing and closure.

Women felt heard and validated via support from peers. Participants described their positive experiences in psychoeducational support groups, noting the "powerful," "supportive" and "nonjudgmental atmosphere." Several commented on the value of having a "caring" place to go in which they could "talk about the bad stuff…and not feel judged."

> "We just wanna be heard, and it gives us a place where we can speak and hear our own wisdom without other people giving us advice."

3.5. Provider-level facilitators

3.5.1. Perinatal health care professional training in how to detect, manage and discuss depression—Participants suggested perinatal health care professionals use their limited time wisely by framing interactions with women in such a way to encourage women to disclose concerns and seek help. Women wanted to be validated rather than being told that, "everything falls within the normal range."

> "It would have been important for somebody to just listen to my concerns…even just reassure me that…it's okay that that's happening and it's not your fault."

Women wanted to be reassured that struggling with depression did not mean they were "incompetent" or "bad moms" or "not enough of a person." Probing questions and empathic and destigmatizing statements were suggested. As one mother noted, "It had never been normalized for me…having a care provider…say to me. 'You might feel disconnected from your baby. You might feel not overwhelmed with joy,'…would have been…amazing."

Participants felt that more sophisticated assessment and management of safety concerns would allow for more comfortable, productive and empathic safety discussions. Participants wanted to trust their providers and seek help and not be scared of disclosing thoughts of harming themselves or others.

3.5.2. Screening, education and treatment and/or referral for treatment—Participants found that depression screening, psychoeducation and provision of mental health care encouraged help seeking. Preparing women and partners/primary supports for the postpartum transition was identified as key to appropriate and effective perinatal care. Participants suggested that perinatal health care professionals discuss depression and the emotional distress that can occur before, during and after birth with women and their primary supports. They felt this would help women and their supports recognize and act on depression if and when it occurs.

Participants also found it helpful when their obstetrician was proactive and detected depression, and began a conversation about treatment, which may sometimes include medication.

> "I went back to my OB…and [said] 'Well, I have a problem,' and they put me on Prozac…the day after I felt so much better, and I've been on it for a year now, and I feel so much better — no issues, nothing."

Participants reported feeling empowered by discussions of resources and treatment options. Participants recommended perinatal health care professionals distribute and review perinatal depression resource and referral guides and educational materials to help women and their supports recognize and seek help for depression. They suggested placing such educational material and posters in providers' waiting rooms and offices.

3.6. System-level facilitators

3.6.1. Improved coordination and follow-up of perinatal depression care—In order to engage and support women in the postpartum period, participants suggested 2-, 6-, 12-week and 6-month postpartum check-ins and/or follow-up phone calls. Multiple participants felt that "having the doctor's office reach out to you" would ease what seemed like a precipitous drop in contact with perinatal care providers after delivery.

> "I love the idea…of having a social worker on staff, or somebody who's, who's just in charge of giving you a phone call — you don't even have to go in, just check in with me on the phone…I need to know somebody's there. It would have been great to not have to find all that on my own…somebody should be calling you and checking in with you…"

A point-person such as a care coordinator or social worker was suggested to help women navigate the mental health system. Colocated mental health and perinatal care and improved communication among mental health and perinatal health care professionals were also recommended. One mother described a "perfect world: a building where you had you, your therapist, and your OB and pediatrician."

3.6.2. Supportive screening and referral protocols that engage women in treatment—Participants wanted effective screening and referral procedures and protocols that encourage and support women to seek help. Participants suggested that providers develop a standard interview to ensure an empathic screening process in which mental health care was discussed and resources and treatment are offered.

> "Actually having a conversation about those as opposed to…'You're gonna fill out some form and we're never gonna talk about it…'"

A comprehensive screening process that offered varied and flexible mental health treatment options via a website with resources, simplified referral processes, centralized telephone referral systems and resource guides were recommended. Participants also suggested that professionals offer nonmedication treatment options including peer support, psychosocial support groups, yoga, lactation consultation, meditation, light therapy and interactive online resources such as a chat room.

4. Discussion

Our findings echo those of previous studies detailing that perinatal women are afraid to disclose mental health concerns due to fears of stigma, losing parental rights and being judged as unfit mothers [27–48]. Our findings are also consistent with prior studies which illustrate that many women perceive their obstetric providers and staff as unsupportive, unavailable [30,32,33,40,41,44,49–51] and inadequately trained in depression assessment and treatment [49,50].

In our current study with patients and previous study [52,53] with perinatal health care professionals, both groups valued perinatal depression care yet noted that most perinatal settings are not designed to address and/or provide these services (Table 4). Barriers to help seeking identified in both studies included complex psychosocial factors and fear of negatives consequences (Table 3). Lack of access to perinatal mental health care, training, resources and skills in regards to mental health among perinatal health or allied health professionals were also noted in both studies.

Both studies identified disconnected pathways to care, lack of depression detection and management, and limited collaboration among obstetric and mental health providers as barriers to addressing depression in obstetric settings. Both women and professionals recommended that depression care become a routine part of perinatal care via training perinatal health care providers in mental health and improved collaborations. Both groups suggested empowering women to seek help through psychoeducation, provision of resources, validation of women's experiences, and attention to language and interactions that could be interpreted as stigmatizing.

Perinatal health care professionals and women differed in their perceptions of one another. Women reported that they desired treatment, yet were less likely to seek help because they felt judged, invalidated and even traumatized during mental health discussions with perinatal health care/allied health professionals. In contrast, perinatal health care professionals perceived women as reticent to disclose mental health concerns. Perinatal health care professionals also felt frustrated that women did not follow through with recommendations, which contributed to an avoidance of discussing mental health concerns.

Women perceived screening as unempathic and ineffective due to lack of follow-up and offering of resources and psychoeducation regarding treatment options, yet perinatal health care professionals did not report this. More specifically, women perceived that medications were often recommended at the exclusion of other treatment options and recommended that providers also encourage nonmedication treatments. Women also expressed concern about a precipitous drop in the focus on mothers during the postpartum period, another finding not reported by perinatal health care professionals.

The present study has a number of limitations. The first limitation is the broad inclusion criteria; women ranged from 3 to 36 months postdelivery, which may have impacted their reporting or recollection of their perinatal experience. The generalizability of our findings is limited by responder bias and our purposeful and nonrepresentative sample. We did not limit our sample to depressed women and did not measure depression severity. Our inclusion

criteria, however, allowed us to elicit the experiences of a broad array of women, with multiple mental health concerns, over a longer timeframe, all of which are appropriate for exploratory research.

This is the first study to compare the perspectives of women and perinatal healthcare professionals regarding barriers and facilitators to perinatal depression treatment. Our findings build on previous findings by shedding light on the complex patient-, provider- and systems-level factors that lead to untreated perinatal depression and inform the development and testing of interventions. For example, interventions can be built to leverage strategies identified by both women and professionals including integration of perinatal mental health care via professional training, improved collaboration and coordination of care.

Other interventions can be designed to close the gaps in the perceptions of women and providers. For example, women want to seek treatment yet may not do so because they feel judged by professionals. Meanwhile, professionals avoid discussing depression because they perceive that women do not want help. Developing an empathic screening process that facilitates discussion of mental health concerns and help seeking is critical to address their respective perceptions and concerns. Strategies may include training providers in motivational interviewing and empowering both with education, resources and access to varied mental health care options.

In summary, to be effective in addressing perinatal depression, it is critical that interventions are designed to overcome patient-, provider- and systems-level barriers to treatment experienced by both women and perinatal health care professionals.

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Table 1

Demographic data of women participants (*N*=27)

Characteristic	Percent
Age[a]	
≤24	15%
25–34	33%
≥35	48%
Race	
White	100%
Number of children	
1 child	42%
2 children	38%
3 or more children	20%
Household income	
≤20,000	22%
20,000–40, 000	19%
40,000–60,000	18%
60,000–80,000	26%
≥80,000	15%
Parenting with	
Spouse/partner	85%
Other	15%
County	
Berkshire	33%
Franklin	22%
Hampden	11%
Hampshire	11%
Northampton	4%

[a]Missing data.

Table 2

Mental health treatment reported by participant

Mental Health Treatment	Yes	No
Diagnosed by provider	59%	41%
Treatment: pre-pregnancy	70%	26%
Treatment: during pregnancy	22%	78%
Treatment: postpartum	67%	33%

Table 3

Concordance of perceived barriers among perinatal health care providers and postpartum women

Barriers
Patient level
Complex psychosocial factors result in low rates of treatment seeking and participation
• Economic barriers
• Shame and stigma inhibit help seeking
• Lack of psychosocial support
Provider level
Feeling invalidated, disrespected and/or judged by perinatal health care or allied health professionals
• Avoidance and/or minimization of mental health concerns among professionals
Perception that perinatal health care professionals lack mental health training and skills, and confidence
• Lack of knowledge regarding safety of medications during pregnancy or lactation
• Lack of training in safety assessment
Lack of resources and knowledge to prepare women for the possibility of postpartum depression
• Lack of education about depression
Lack of information regarding the risk and benefits of psychotropic medications during pregnancy
• Lack of knowledge among perinatal health care professionals deterred them from discussing risks and benefits of medications during pregnancy.
• Lack of education and/or referrals among perinatal health care professionals
Systems level
Perinatal care environment is not designed or equipped to support mental health
• Depression often not detected and/or managed in perinatal setting
Limited access to providers and mental health resources
• Women get lost in the system due to disconnected pathways to mental health care
• Lack of collaboration and communication between mental health and perinatal health care professionals

Table 4

Concordance of perceived facilitators among perinatal health care providers and postpartum women

Facilitators
Patient level
Feeling empowered and supported by interactions with perinatal health care professionals
• Destigmatization of depression
• Being prepared for possible depression and emotional distress that can occur during and after birth
Provider level
Perinatal health care professional training in how to detect, manage and discuss depression
• Training in assessment, diagnosis and treatment of depression Screening, education and treatment and/or referral for treatment
• Perinatal health care professionals provide psychoeducation by distributing and reviewing resource and referral guide and educational material on perinatal depression
• Simplified referral process
• Utilizing a multidisciplinary approach which includes improved communication among mental health and perinatal health care professionals
• Obstetricians start medications if depression is detected
• Perinatal health care professionals use their limited time wisely by asking the probing questions and making empathic and destigmatizing statements
Systems level
Improved coordination and follow-up of perinatal depression care
• Communication between providers of different disciplines so they work together as a team
• Care coordinator
• Colocation of mental health and medical care
• More visits in order to allow for ample opportunities to discuss depression and prepare and support women into postpartum period