Published in final edited form as:
Womens Health Issues. 2018 ; 28(3): 201–204. doi:10.1016/j.whi.2018.01.003.

Increasing Diagnosis and Treatment of Perinatal Depression in Latinas and African American Women: Addressing Stigma Is Not Enough

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Perinatal depression (PND), a major depressive episode during pregnancy and the first postpartum year (American Psychiatric Association, 2013; Gavin et al., 2005), is estimated to occur in 12% to 19% of the general U.S. population (Gavin et al., 2005; O’Hara & McCabe, 2013). However, rates of PND are substantially higher among immigrant and U.S.-born Latinas living in the United States at 11% to 50% (Kuo et al., 2004; Lara, Le, Letechipia, & Hochhausen, 2009). Latinas are an important group because of their high fertility rates (Passel, Livingston, & D’Vera, 2013) and high psychosocial risk factors, such as high rates of poverty (Lara-Cinisomo, Girdler, Grewen, & Meltzer-Brody, 2016). Another vulnerable group is African American women, whose estimates of PND range between 7% and 28% (Beeghly et al., 2003; Melville, Gavin, Guo, Fan, & Katon, 2010; Rich-Edwards et al., 2006). Much like Latinas, African American women experience increased rates of economic hardship and other psychosocial stressors that increase their risk of PND (O’Hara & McCabe, 2013). Given the complex psychosocial risk factors among these groups, increased efforts to diagnose and treat Latinas and African American women are needed.

Despite the number of reliable screening tools and national efforts at increasing detection of PND (Siu et al., 2016), rates of diagnosis and treatment continue to be low among Latinas and African American women (Das, Olfson, McCurtis, & Weissman, 2006; Geier, Hills, Gonzales, Tum, & Finley, 2015; Lara-Cinisomo, Griffin, & Daugherty, 2009). Stigma and limited access to psychoeducation about PND might help to explain these disparities. Although these factors have been explored individually, they have not been examined simultaneously, limiting our understanding of their effect.

Stigma and Cultural Factors

It is well-understood that stigma negatively impacts treatment-seeking behaviors in Latinas and African American women (Nadeem et al., 2007). Many pregnant women with mental health concerns fear being perceived as “crazy” and worry about losing their child should

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Conflicts of Interest: No conflicts of interest to report.

they disclose depressive symptoms to health care professionals (Nadeem et al., 2007). The fear of losing their child is exacerbated by poverty and immigration status (Chaudron et al., 2005). Among Latinas, concerns about stigma might be further complicated by the practice of *Marianismo* — the notion that a mother must put her children and family first and sacrifice herself for the well-being of her family — which has been shown to limit treatment-seeking behaviors (Callister, Beckstrand, & Corbett, 2011; Sirulnik, Lara-Cinisomo, Wisner, & Meltzer-Brody, 2014). However, this "giving mother" attitude or belief is less explored and should be examined further in the context of diagnosis and treatment. Among African American women, there is evidence to suggest that the need to "tough it out" or be a strong Black woman discourages treatment-seeking behaviors (Amankwaa, 2003) outside the postpartum period (Amankwaa, 2003), and reflects cultural beliefs that depression is preventable and resolvable through strength and religious faith (Nicolaidis et al., 2010). Understanding the notion of the "strong woman/mother" can provide insight on approaches that will increase diagnosis and treatment.

Other aspects of stigma that reduce diagnosis and treatment are differences in the description of depressive symptoms. There is evidence to suggest that Latinas and African American women are more likely to report somatic symptoms (e.g., head and stomach pain) than mood symptoms (e.g., sadness), likely because they are more culturally acceptable (Lewis-Fernandez, Das, Alfonso, Weissman, & Olfson, 2005; Nadeem, Lange, & Miranda, 2009). Fears of stigma among Latinas and African American mothers is further complicated by negative perceptions of mental health professionals and psychotherapy, as well as the belief that medication is not an effective treatment for depression (Interian, Martinez, Guarnaccia, Vega, & Escobar, 2007; Lara-Cinisomo, Wisner, Burns, & Chaves-Gnecco, 2014; Leis, Mendelson, Perry, & Tandon, 2011; Nadeem, Lange, & Miranda, 2008).

Strategies to Optimize Diagnosis and Treatment

The recommended treatment for PND is psychotherapy and/or pharmacotherapy, and the choice to obtain treatment should be based on a discussion between the patient and her health care provider. The patient's diagnosis (e.g., major depression) is also critical to determining an optimal treatment plan. To increase diagnosis and treatment, providers at all levels must build patient trust, an important factor in women's help-seeking behaviors (O'Mahony, Donnelly, Bouchal, & Este, 2012). Health care professionals can increase patient trust by providing psychoeducation about PND, which includes describing the symptoms, normalizing the condition by sharing statistics on the high prevalence of PND, and informing patients that it is treatable. Reminding women that PND is not their fault and can be treated will also reduce shame and stigma, especially given the increased risk that Latinas and African American women will blame themselves when diagnosed. To further minimize the effects of stigma, it is recommended that practitioners be aware of these cultural differences and ask about mood symptoms that patients might not initially disclose. Additionally, practitioners and health educators can increase women's health literacy about PND.

Numerous strategies have been developed to reduce mental health stigma and increase education about PND, namely, contact and education (Rüsch, Angermeyer, & Corrigan, 2005). Although public campaigns are designed to increase contact, they do not provide the trusting interaction women seek. Therefore, psychoeducation by a trusted health care professional can be effective at reducing stigma, increasing diagnosis, and promoting the use of effective treatments. Factors to consider are who should provide this education, where should it be delivered, and when should it be provided. Health care settings and public health agencies that serve high-risk women (e.g., low income, marginalized) are ideal. Given that PND can occur at any point during the perinatal period, all health care providers have an opportunity to inform and act. Practitioners with frequent contact with perinatal women (e.g., obstetricians, family physicians, nurse practitioners, midwives) are especially well-positioned to educate women about PND. For example, in a qualitative study with Latinas, nurses were identified as practitioners trusted to deliver brief, targeted information to women because of their level of contact with patients (Lara-Cinisomo et al., 2014).

To ensure the success of psychoeducation programs designed to increase screening and treatment of PND in Latinas and African American women, obstetricians, gynecologists, family medicine providers, physician assistants, and nurses, as well as mental health providers, must be trained and equipped to provide the necessary referrals and resources. Patient education should also be delivered in an active manner (e.g., via conversation versus handing a brochure). It is recommended that such information be provided before delivery, when PND education seems to be the most effective, particularly among depressed women (Clatworthy, 2012). Antenatal education must be emphasized, given the priority mothers give infant wellness checks over their own health visits. However, infant wellness checks are also prime opportunities for providers to reinforce or introduce key information about PND. Frequency of the psychoeducation matters. One survey of postpartum women found that psychoeducation about PND was “passive” and patients recommended information be provided at all points of contact (Garg, Morton, & Heneghan, 2005).

Although perinatal psychoeducation initiatives delivered by nurses have been shown to be effective at reducing the risk of PND (Ngai, Chan, & Ip, 2009), other studies have found that nurses and other frontline staff did not have the necessary sources to guide women who requested additional information (Horowitz & Goodman, 2005). Therefore, health care providers who treat perinatal women must be equipped with tools that will allow them to provide women with the necessary resources and information they need, such as the effectiveness of various interventions or treatments, cost, and privacy. Providing Latinas and African American women with accurate information and directing them to useful resources can also positively impact treatment adherence. Websites such as mothertobaby.org and womensmentalhealth.org use accessible and supportive language to provide information on the symptoms and treatment options for PND. A major barrier to adhering to pharmacotherapy for many Latinas and African American women is limited information about the safety and efficacy of psychotropic medications (Leis et al., 2011). Thus, consistent, clear, and concise information about the side effects, effectiveness, and safety of medications for mother and baby, as well as time commitments involved in psychotherapy/interventions and benefits of such treatments, is needed in English and Spanish so mothers can discern their preferred treatment approach. Related, providers should be trained to have objective conversations with patients regarding the risks and benefits of medications such as antidepressants or the efficacy of psychotherapy to avoid bias toward a particular treatment.

Similarly, information about the various forms of treatments and interventions available, their effectiveness, number of required or target sessions, and level of privacy can counter bias and stigma among Latinas and African American women. A trusted and educated health care provider should deliver this information at the time of referral, when risk for depression is expected, or when the woman expresses an interest.

Providing treatment options that are affordable and culturally appropriate is equally important given the evidence that Latinas and African American women experience remission when the treatment takes into account their cultural and linguistic needs (Tandon, Leis, Mendelson, Perry, & Kemp, 2014). To optimize treatment engagement and adherence, services/programs must be sensitive to cultural beliefs and systemic barriers must be addressed. For example, many African American women believe that they are personally responsible for healing oneself and that mental health problems will resolve on their own, which might reduce the use of mental health services or adherence to recommended treatments (Anglin, Alberti, Link, & Phelan, 2008). Health-seeking behaviors are further complicated by religious beliefs. Although religious faith has been associated with positive mental health (Guinn & Vincent, 2002; Koenig, 2009; Mann, McKeown, Bacon, Vesselinov, & Bush, 2008), it has also been associated with poorer outcomes and less help-seeking behaviors (Mann, Mannan, Quiñones, Palmer, & Torres, 2010). For example, there is evidence to suggest that African Americans who are spiritual or religious are less likely to seek mental health treatment (Colbert, Jefferson, Gallo, & Davis, 2009). Latinas’ religious beliefs might be associated with self-blame for the depression or a belief that they are being punished for a previous wrongdoing (Sirulnik et al., 2014), although this area requires further investigation.

Given the need for more psychoeducation and training of key health care providers, we call to action policymakers and recommend they direct funds to build capacity among health care providers via the training described herein. To increase diagnosis, we urge policymakers to invest in training providers to use reliable screening tools with all perinatal women. The shortage of mental health providers skilled in caring for perinatal women in underserved areas must be improved to increase appropriate diagnosis and treatment adherence. Additionally, federal, state, and local funding should be directed at building capacity by providing funding for education and training of perinatal health professionals at all levels. We also recommend the development of culturally and linguistically appropriate resources that better inform women about treatment options. Strategies that include early and frequent psychoeducation in primary care settings for perinatal Latinas and African American women are likely to increase diagnosis. Finally, access to culturally acceptable and evidenced-based treatments is important for treatment adherence. Therefore, federal funding should be allocated for the development and assessment of such interventions.

Acknowledgments

Funding: Crystal T. Clark received funding from the National Institute of Child Health and Human Development (1K23HD087529-01A1). The funders were not involved in the development of this project and did not contribute to any portion of the writing.

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