What enables or prevents women with depressive symptoms seeking help in the postnatal period?

Abstract

Background **Perinatal mental health problems affect approximately 20% of women. The most common condition is postnatal depression; however, many women do not seek help.**

Aims **To identify and synthesise evidence on factors that enable or prevent help-seeking in women with depressive symptoms in the postnatal period.**

Methods **A qualitative systematic review was conducted using electronic databases and pre-determined eligibility criteria.**

Findings **Thematic synthesis of the included studies (n=4) identified the following themes: the influence of healthcare services, the influence of others and the influence of women themselves. Help-seeking was shaped by women's ability to recognise their symptoms, the reactions (experienced or anticipated) of others and the organisation of services.**

Conclusion **An improved interface between maternity and mental health services and enhanced health professional interactions are needed. However, meaningful change may require empowering women's self-assessment and public health messages to improve understanding of postnatal depression.**

Keywords

Postnatal depression | Maternal mental health | Perinatal mental health | Help-seeking | Systematic review

Up to 20% of women experience a mental health problem in the perinatal period, (the period spanning conception to 1 year after birth) (Bauer et al, 2014). The immediate and long-term costs of perinatal anxiety and depression are estimated at £6.6 billion for each year of births in the UK, equating to approximately £8500 per woman giving birth (Bauer et al, 2014; 2016). The costs reflect the immediate and transgenerational effects of perinatal mental health, which affect the woman, her child and family through, for example, children's emotional and behavioural development and interparent relationships (Letourneau et al, 2013; Norhayati et al, 2015; Oakhill, 2016). In the UK, suicide is the leading direct cause of maternal death in the postnatal year (Knight et al, 2017). Routine assessment of mental health by midwives, including symptoms of depression, was introduced in the UK approximately 10 years ago (National Collaborating Centre for Mental Health, 2007) and remains a key priority for service delivery.

Postnatal depression is the most common perinatal mental health condition, affecting approximately 10-15% of women (Gavin et al, 2005; Dennis and Hodnett, 2007). Many women affected by perinatal mental health problems do not receive the support they require, with less than half seeking help or being identified, even in well-resourced systems (Bauer et al, 2016). Factors that enabled or prevented help-seeking were reviewed by Dennis and Chung-Lee (2006) who, by analysing 40 studies, identified three categories: maternal, family/friend, or health professional. Within these categories the authors identified women's (lack of) knowledge and awareness, shame, stigma, limited social support and understanding among family and friends, rapport with health professionals and the accessibility and availability of services.

The Dennis and Chung-Lee (2006) review predates significant changes to routine perinatal mental health assessment in practice; it was therefore pertinent to conduct a systematic review of more recent literature. Subsequently, other reviews have been published in this area, strengthening the importance of this topic and adding depth to what is known about emerging enabling or preventative factors.

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Table 1. Eligibility criteria

	Inclusion criteria	Exclusion criteria
Population	Participants were required to meet at least one of the following: • Diagnosed with postnatal depression • Above-threshold depressive symptoms, assessed using a validated measure (eg Edinburgh Postnatal Depression Scale)	• Women with mental health conditions other than postnatal depression • Symptoms of any other mood disorders excluding depression
	• Women of any parity or obstetric history • Any women, unrestricted by sociodemographic characteristics	
Timing	During the year after childbirth	Women pregnant at the time of the study
Outcome	Any factor reported by women that helped or hindered seeking help	
Study design	Qualitative design (any)	
Other	• Written in English language • Published since 2006 (ie previous review by Dennis and Chung-Lee, 2006)	

A recent review (Button et al, 2017) explored how women in the UK sought help for perinatal psychological distress more broadly. Key findings included women's ability to identify their 'problem', their experience with healthcare services and the stigma associated with mental health. Hadfield and Wittkowski (2017) reviewed articles relating to women's experience of seeking and receiving interventions for postnatal depression. They reported complex and interconnected themes related to the process of help-seeking, relationships with health professionals and the importance of continuity of care. The author also emphasised the importance of education for health professionals on postnatal depression. Tobin et al's (2018) review investigated refugee and immigrant women's experiences of postnatal depression, with factors that enabled or prevented help-seeking being two of the identified themes.

This systematic review aimed to understand factors that influenced help-seeking in women with depressive symptoms in the postnatal period.

Methods

A systematic search was conducted in 2017 (and updated in 2018) using relevant databases (MEDLINE, MIDIRS, EMBASE, PsycINFO and CINAHL), supplemented by grey literature (OpenSIGLE and the Health Management Information Consortium databases) and checking references. Subject headings and key words were used, including the following: mother, help-seeking behaviour, postnatal depression, barriers, facilitators and experience. These search terms were informed by existing literature. Database-specific truncation was used and terms were combined using Boolean operators. Search results were limited to studies of humans and articles that were written in English. Full details of the review's methods are available on request from the corresponding author.

In total, 810 unique results were identified and screened for inclusion using pre-determined eligibility criteria (*Table 1*). As shown by the flow diagram in *Figure 1*, four studies met criteria for inclusion.

Characteristics of included studies

The four included studies came from the UK (Slade et al, 2010), Canada (Sword et al, 2008; Bell et al, 2016) and Australia (Bilszta et al, 2010). The timing of data collection ranged from 8 weeks to 1 year following birth. Sample sizes in the included studies ranged from 18–40 participants; the total sample being 118. Recruitment varied, including routine appointments in primary care settings and clinics/centres where women were accessing some form of treatment for postnatal depression. Study characteristics are available in *Table 2*.

The studies were critically appraised guided by the Critical Appraisal Skills Programme (2018) with constant assessment of rigour (Lincoln and Guba, 1985). The included studies presented some limitations; such as limited transferability in Sword et al (2008), whose sample consisted mostly of English-speaking women in the same location; insufficient data regarding the participant characteristics (Bilszta et al, 2010; Slade et al, 2010; Bell et al, 2016); or failure to comment on data saturation (Bilszta et al, 2010; Slade et al, 2010).

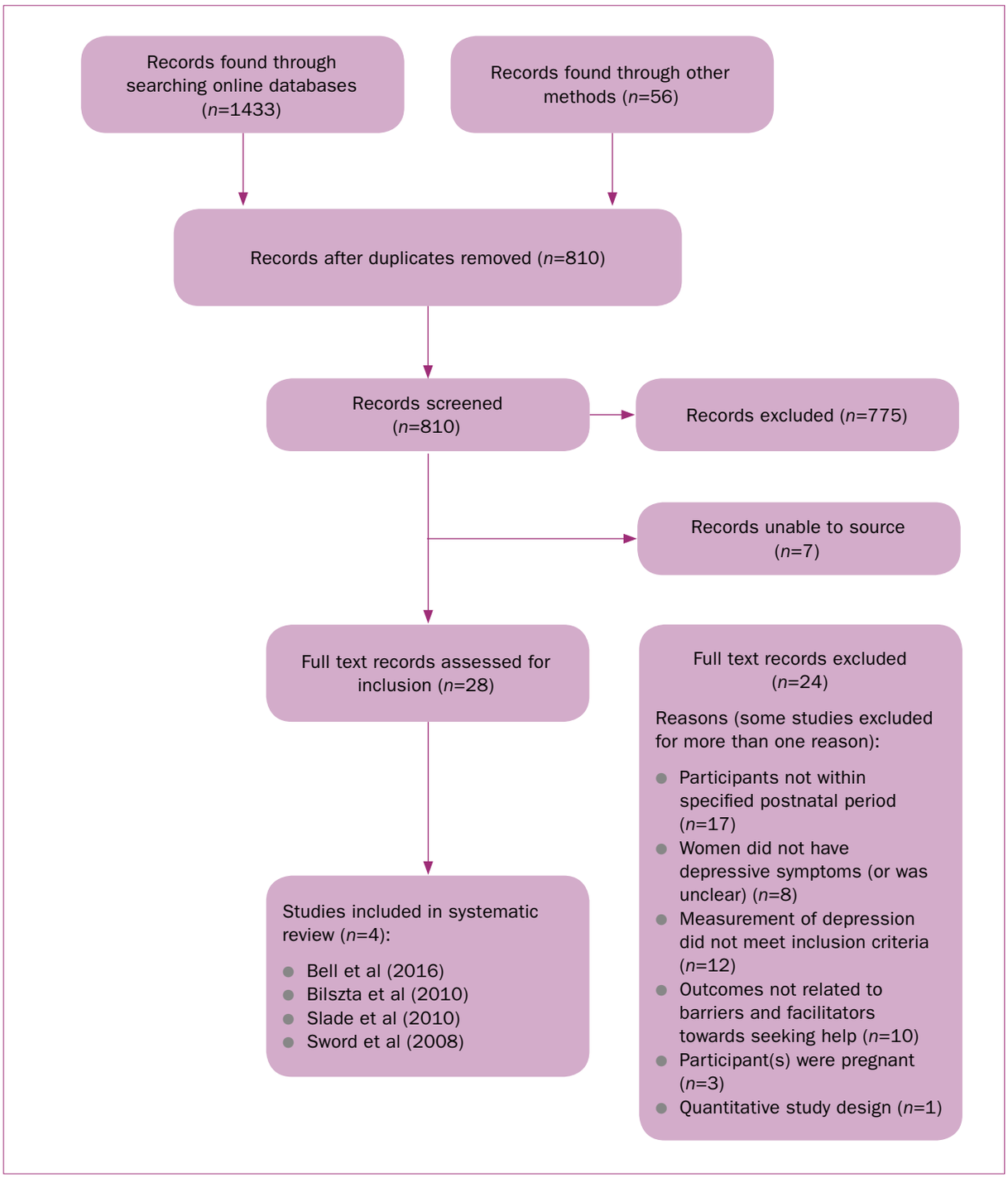

Figure 1. PRISMA flow diagram; full details available on request

Furthermore, two studies did not identify how quotes were selected (Bilszta et al, 2010; Slade et al, 2010) and one of these (Bell et al, 2016) did not identify quotation sources, precluding assessment of representation.

Synthesis

The studies were synthesised using thematic analysis (Braun and Clarke, 2006). The first author independently coded the data, noting issues and emerging themes. A pragmatic approach was used to generate themes from the data, which helped frame the synthesis. All authors then reviewed the emerging themes, scrutinising and providing feedback on alternative interpretations to determine the final three themes and select illustrative quotes. This process identified differences between co-authors, whereby they were more alert to systems

Table 2. Characteristics of included studies

Source	Definition of seeking help	Sample	Recruitment process	Data collection and analysis	Themes
Bell et al (2016) Canada	Accessing mental health services	• *n*=30 heterosexual couples • 19 care acceptors • 11 care decliners • Mean 32.5 years (SD=5.6) Age range n/r • Mean EPDS score 14.8 (SD=2.7) at recruitment • Mean EPDS score 9.6 (SD=4.9) at interview • One-fifth of women had previous mental health disorders • Ethnicity n/r • For the majority of women, this was their first child	Via a perinatal mental health clinic or during a routine visit to the obstetric clinic (in one city) Recruited 1 week–6 months postpartum and interviewed within 1 month	Semi-structured face-to-face interviews with inductive content analysis	• Accessibility and proximity identified as barriers (eg participants reported difficulty of accessing services with young children/long waiting times/not enough HCPs) • Appropriateness and fit (eg a good rapport with the HCP and their approach as well as the environment where services were provided) • Stigma as a barrier (fear of stigma) and a facilitator (knowing that others had experienced it facilitated disclosure) • Others as a barrier (lack of understanding and support from partner/family) and a facilitator (rapport with HCP/support from partner) • Personal characteristics as a barrier (reluctance to seek help because women thought they could manage their symptoms themselves)
Bilszta et al (2010) Australia	Seeking care	• *n*=40 women • Aged 27–47 years; mean 34 years, SD n/r • Mean EPDS 13.9 (SD=6.9); timing n/r • Ethnicity n/r • Average number of children 1.6 (SD=0.9)	Via outpatient depression treatment programmes (in a metropolitan area), mutual support programmes (in cities around the greater metropolitan area) or a large rural centre Time of data collection n/r	Focus groups conducted by two researchers with interpretative phenomenological analysis	• Not coping: women felt they had to appear as though they were coping and did not want to be seen as a failure • Stigma and denial: women reported feeling as though they had to be 'strong and organised' and did not want to be seen as a 'bad mother' • Poor mental health awareness and access: women struggled to recognise being depressed and were not aware of available services • Interpersonal support: women's families affected ability to seek help • Help-seeking experiences: aspects not covered by other themes (difficulty thinking clearly, demotivation, sleep disturbance) • Relationship with HCPs: women reported talking to HCPs when 'the time was right' and acknowledged HCP attitudes that encouraged help-seeking. Normalising of symptoms by HCPs acted as a barrier

n/r: not recorded; EPDS: Edinburgh postnatal depression scale; HCP: health professional

approaches, service perspectives and women's individual influences. This appeared to be influenced by co-authors' previous primary research and professional backgrounds. All perspectives were represented in the final themes. Reflexivity was employed and shared by all authors to help balance interpretation of data.

Findings

Influence of healthcare services

In the majority of studies, the ways in which healthcare services were organised were reported to be both a preventative and an enabling factor for women seeking help for depressive symptoms in the postnatal period.

Table 2. continued

Source	Definition of seeking help	Sample	Recruitment process	Data collection and analysis	Themes
Slade et al (2010) England	Accepting or declining psychological support	• *n*=30 women • Aged 18–45 years; Mean n/r • Mean EPDS n/r; all had EPDS of ≥18 at 6 weeks postpartum • Ethnicity n/r • For the majority of women, this was their first child	Participants recruited from the PoNDER trial into extra training for health visitors to recognise depressive symptoms and use CBT and counselling techniques. Participants recruited for the trial from different GP surgeries (in a former regional health authority) Women 6 months postpartum at time of interview	Semi-structured face-to-face interviews with 'template' approach for analysis	Barriers to help-seeking: • Presenting a coping image: women did not want to be seen as a failure or unable to care for their child • Perception of their health visitor in relation to seeking help: women reported not being able to relate to their health visitor or not knowing them well enough meant that they declined seeing their health visitor
Sword et al (2008) Canada	Seeking care	• *n*=18 women • Mean age 29.4 years, SD n/r; Age range n/r • Mean EPDS n/r; all had EPDS of ≥12 (timing n/r) • Ethnicity n/r • Parity n/r	Participants recruited from the local public health programme to promote child development (in one city) Women 8 weeks postpartum (on average) at time of interview	Semi-structured telephone interviews with content analysis	Individual-level barriers: • Normalising symptoms • Limited understanding • Waiting for symptom improvement • Discomfort discussing mental health • Fears Individual-level facilitators: • Symptom awareness • Not feeling like oneself Social network-level barriers: • Normalising of symptoms • Limited understanding Social network-level facilitators: • Encouragement to seek care • Expressing worry and concern Health system-level barriers: • Normalising symptoms • Disconnected care pathways Health system-level facilitators: • Established and supportive relationships • Legitimisation of postpartum depression • Outreach and follow-up • Timeliness of care

n/r: not recorded; EPDS: Edinburgh postnatal depression scale; CBT: cognitive behavioural therapy

Care that was mostly centred on the physical needs of the woman and her baby created a difficult set-up that limited women from openly discussing mental health. In addition, studies found that mental health services were not well publicised or connected, creating an apparent lack of continuity between services. For some women, services were reported to be inaccessible or posed practical barriers, such as long waiting lists, time of day, limited childcare provision and/or travel costs. In addition, the limited availability of services or an unappealing setting was found to hinder women's motivation to seek help:

'When you go up, especially to where [health professional's] office is, the hallways are so tiny and sterile. I feel like it's not warm and inviting.' (Participant quote; Bell et al, 2016:654)

Responsive staff who were available when needed, enabled women to seek help and to accept support:

'[I] called them and told them I was referred by a public health nurse and she called me back like 10 minutes later and I had an appointment for me for like 3 days after that and I went.' (Participant quote; Sword et al, 2008:1170)

Influence of others

The influence of health professionals, family and others (including wider society) were identified as factors that contributed to women's help-seeking.

Health professionals' attitudes and rapport

Women reported that health professionals' behaviours and attitudes shaped their perceptions of professionals' trustworthiness and influenced their decision to disclose symptoms or access services at all:

'A trustworthy, readily available and culturally sensitive health care professional would facilitate their use of service … a seemingly rushed and uncaring health care professional can deter women from accessing services.' (Author quote; Bell et al, 2016:654)

Some women identified that health professionals' reactions to their disclosures prevented them from feeling able to discuss their mental health further; usually this was where women perceived their symptoms had been minimised or dismissed. Women valued where health professionals 'took it seriously' and asked further questions (Sword et al, 2008).

'My gyne doctor, I thought she would help, she would understand, cause she works in the field. And instead she just like didn't care. I honestly felt that she didn't care and I felt so alone.' (Participant quote; Bell et al, 2016:654)

'If health professionals did not validate the extent of distress but tried to normalise or dismiss it, women felt they were being told to "shut up."' (Author quote; Bilszta et al, 2010:50)

Sword et al (2008) reported that the extent to which women felt comfortable in discussing mental health or 'opening up' with others varied, which heightened the importance placed on interactions with health professionals. While some women found it helpful if they already knew the health professional, others indicated characteristics that were not dependent on the health professional already being known, including offering support and encouraging statements:

'She [nurse] kept saying, you know, if you feel like anything gets worse or your sadness gets worse or anything at all don't hesitate to call … She said that a couple of times: "We don't want postpartum to slip through the cracks" and "Don't suffer without you know telling us" and "Don't be afraid to tell us."' (Participant quote; Sword et al, 2008:1169)

Family

Some women reported family members, including partners, having negative reactions to their disclosures, reflecting interactions with health professionals. In some cases, family members sought to minimise women's distress, which prevented women seeking help elsewhere:

'Yeah, they're trying to normalize it just so that I don't get overstressed about it. But it's a little frustrating because a lot of people are like, "Oh, this is to be expected, and you've been through a lot so give yourself more time to adjust."' (Participant quote; Sword et al, 2008:1167)

In other cases, these reactions appeared to be due to inadequate knowledge among family members:

'Like, I think he [husband] understands it, you know, when you have a baby you're tired and you're up all the time and you're emotional … but I don't think he understands that those can also be symptoms of something else. I think he just thinks it's just what happens when you have a baby… "you'll snap out of it" kind of thing.' (Participant quote; Sword et al, 2008:1167)

Help-seeking behaviour was promoted when family, including partners, gave verbal encouragement to attend appointments or helped to overcome practical barriers. Equally, failure to do so presented barriers:

'My mother doesn't want to look after the baby so I can see my psychologist. She believes I don't need it. I have no support from her for this.' (Participant quote; Bell et al, 2016:656)

Perceptions of others

It was evident that women's help-seeking was shaped by their perceptions of others' views and reactions, including

wider society, their family, colleagues and other mothers. Barriers included fear of negative consequences, such as unwanted social services involvement and implications for employment, as well as a sense of shame, guilt, being judged as a 'bad mother' and being unable to cope.

> ***'I didn't want anyone's help to be honest after I had [my previous child]. I was so frightened that people would think I couldn't cope and take her off me.' (Participant quote; Slade et al, 2010:e443)***

> ***'I remember thinking, "I don't want [health visitor] to think I'm not coping", which is stupid really because I wasn't.' (Participant quote; Slade et al, 2010:e443)***

However, some women in one study reported that they did not fear being judged and this was due to improved societal awareness of postnatal depression, which helped to reduce the stigma:

> ***'I think that postnatal depression is no longer a taboo because so many of us have lived it.' (Participant quote; Bell et al, 2016:655)***

Influence of women themselves

Women's perceptions and self-awareness influenced their help-seeking. Women experienced considerable difficulty in recognising their symptoms and identifying them as indicative of postnatal depression, which hindered their help-seeking; for example:

> ***'Not being able to identify or distinguish between the normal emotional and psychological adjustment associated with parenthood and when they were "depressed" was identified by women as a major barrier to seeking assistance.' (Author quote; Bilszta et al, 2010:48)***

Women held varying expectations and perceptions of depression, sometimes shaped by previous mental health history. Indeed, previous history provided some women with good self-awareness that could encourage help-seeking. If women did not identify their experiences and symptoms as postnatal depression, or resisted identification with postnatal depression (possibly influenced by stigma), this could prevent help-seeking:

> ***'Women believed that PND, and depression in general, "can't happen to me" and, "other people get it."' (Author quote; Bilszta et al, 2010:48)***

> ***'I still don't think that what I was experiencing was postpartum depression. I think it was just an accumulation of not sleeping and being overwhelmed with the job of taking care of him.' (Participant quote; Sword et al, 2008:1165)***

Other women considered that they might have had postnatal depression but chose to delay help-seeking and manage it through watchful waiting:

> ***'I just let the first couple of weeks go and then I figured if it persisted after 3 weeks I'd talk to somebody else about it'. (Participant quote; Sword et al, 2008:1166)***

Discussion

This review identified factors that enabled or prevented help-seeking across three levels: healthcare services, the support of others, and women themselves. The findings are largely consistent with other reviews; this review therefore suggests that changes such as routine assessment have not (yet) fundamentally changed help-seeking.

One of the most consistent findings here and in the wider literature (Dennis and Chung-Lee, 2006; Button et al, 2017; Hadfield and Wittkowski, 2017) was the barriers presented by the (in)accessibility and availability of services, highlighting the need for change. Another common finding was the significance of the environment and its ability to enable women to talk and to help them recognise their symptoms (Button et al, 2017; Hadfield and Wittkowski, 2017; Tobin et al, 2018); referred to by Darwin et al (2016) as the 'context of disclosure'. National investment in maternal mental health services is underway (National Maternity Review, 2016) but it is likely to focus on number of services and geographical location, without addressing factors such as length of appointment and time available to discuss mental health in greater depth (Maternal Mental Health Alliance, 2013).

As this review identifies (along with Dennis and Chung-Lee, 2006; Hadfield and Wittkowski, 2017; Tobin et al, 2018), the attitudes of health professionals and their relationships with women influence a woman's choice to seek help. With health professionals facing pressures from a number of sources in practice, such as time constraints and lack of continuity, it is possible that professionals are struggling to build a relationship with the women they see. However, one memorable conversation, even with an unfamiliar health professional, can still encourage women to seek help. We need to provide health professionals with techniques to have more meaningful conversations; as is relevant for all areas of care (Inspiring Change, 2019).

Consistent with the wider literature (Dennis and Chung-Lee, 2006; Darwin et al, 2016; Button et al, 2017), women's fears of stigma, and of others' perceptions and judgments, prevented women from seeking help for their symptoms of depression. Tackling societal perspectives

Key points

- Perinatal mental health has an effect on the woman, her child and family
- Despite changes to mental health services over the past 10 years, women's help-seeking behaviours relating to depressive symptoms in the postnatal period remain largely unchanged
- Health professionals need to have meaningful conversations with women to facilitate help-seeking for postnatal depression
- Women and their families need further education on postnatal depression

relating to stigmatisation of mental health requires community-level interventions and may take years to come to fruition; however, it is notable that one study (Bell et al, 2016) indicated that stigma may be becoming less of a barrier as perceptions change. Mental health is a topic that requires transparency and honesty in order for women to feel supported to disclose their symptoms, but also for family, friends and other members of the public to understand its nature and support those experiencing mental health problems (NHS Improving Quality, 2015). Some women represented decided not to seek help based on fears that their child would be removed. This indicates the need to improve knowledge regarding the role of social services and for health professionals to ensure that women feel supported to seek help (NHS Improving Quality, 2015).

As has been reported elsewhere (Dennis and Chung-Lee, 2006; Hadfield and Wittkowski, 2017), it appeared that the attitudes of others could both enable and prevent help-seeking. This review identified that women, their partners and family lacked knowledge surrounding postnatal depression and its symptoms. Potentially, partners may be well placed to help women assess their mental health and, where needed, seek help directly. This supports the idea that care should be family-centred to meet the needs of the woman, her partner and their baby (Bateson et al, 2017).

It is important to acknowledge that some factors may be more complex than others. For example, watchful waiting was identified as a barrier to help-seeking (Sword et al, 2008); however, this enables appropriate help-seeking, if women are equipped with self-awareness and cues (such as structurd time frames) to take action.

Implications for practice

Although this review contained only four included studies and one UK study, potentially limiting transferability to UK practice, it nonetheless identified similar themes to those reported elsewhere (Dennis and Chung-Lee, 2006). Such enduring findings suggest that existing strategies (including the introduction of routine assessment) have not yet changed women's help-seeking behaviours related to depressive symptoms in the postnatal period. Women and their families need to be educated on perinatal mental health, to know how and when to seek help. Women also need to be provided with the tools to self-assess their mental health, both by having detailed information on symptoms and having an accessible resource (such as an app) where they can monitor their psychological health. The use of technology is supported by the Maternity Transformation Programme (NHS England, 2017) and is one of nine elements that will help to achieve the vision for maternity care set out in *Better Births* (National Maternity Review, 2016). Any such resource would need to be subjected to research to determine its accessibility, acceptability and effectiveness.

Reflection

The lead author conducted this review as a student learner for a pre-registration undergraduate degree. The review question was chosen having observed the varied ways that health professionals approached mental health with the women in their care, as well as the apparent influence of approaches to 'opening up' or 'shutting down' the conversations. While the review methods were suitable for this level of research, it is recognised that an externally funded review would be expected to demonstrate more exhaustive search strategies and less restrictive eligibility criteria.

Now working as a newly qualified midwife, the author aims to integrate learning from this review, being cognisant that behaviour and attitude can have an influence on whether a woman chooses to seek help.

Conclusion

An improved interface between maternity and mental health services, and better health professional interactions are needed. Meaningful change may require encouraging women's self-assessment and monitoring, and public health messages to improve recognition of symptoms by women and their families. BJM

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CPD reflective questions

- What perinatal mental health services are available in your area?
- What is your understanding of a 'meaningful conversation' and what techniques could you use to encourage this?
- Are you aware of factors that influence women's help-seeking for depressive symptoms in the postnatal period?
- How could you empower women to self-assess their mental health and know how and when to seek help?