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Anonymised manuscript

Title

What are the barriers and facilitators for women with depressive symptoms seeking help in the postnatal period? A qualitative systematic review British Journal of Midwifery

Abstract

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

Aims: To identify and synthesise evidence on the barriers and facilitators to 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 healthcare 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

Key points

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

Reflective questions

- What are the perinatal mental health services in your area?
- What is your understanding of a meaningful conversation and what techniques could you use to facilitate this?
- Are you aware of barriers and facilitators 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?

Introduction

Up to 20% of women experience a mental health problem in the perinatal period, i.e. the period spanning conception to one 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 £8,500 per women giving birth (Bauer et al, 2014; Bauer et al, 2016). The costs reflect the range of immediate and transgenerational impact associated with perinatal mental health affecting the woman, her child and family; for example, children's emotional and behavioural development and inter-parent relationships (Letourneau et al, 2013; Norhayati et al, 2014; 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, including depression symptoms, by midwives 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 (PND) 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). Barriers and facilitators to help-seeking were reviewed previously by Dennis and Chung-Lee (2006) who, via analysis of 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 amongst family and friends, rapport with healthcare professionals (HCPs) and the accessibility and availability of services.

The Dennis and Chung-Lee (2006) review pre-dates significant changes regarding routine perinatal mental health assessment in practice; it was therefore pertinent to review more recent literature. The current systematic review was conducted by the lead author as a final-year BSc (Hons) Midwifery dissertation. Subsequently, other reviews have been published in this area, strengthening the importance of this topic and adding depth to what is known about emerging barriers and facilitators.

A recent review by Button et al (2017) explored how women in a UK context sought help for perinatal psychological distress more broadly. Key findings included women's ability to identify their 'problem', their experience with healthcare services and stigma associated with mental health. Hadfield and Wittkowski (2017) reviewed papers relating to women's experience of seeking and receiving interventions for PND. They reported complex and interrelated themes relating to the process of help, relationships with HCPs and the importance of continuity of care as well as education for HCPs regarding PND. Tobin et al's (2018) review investigated refugee and immigrant women's experiences of PND with barriers and facilitators to help-seeking being two of the identified themes.

This systematic review aimed to understand influences on 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, 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 papers that were written in English. Full details of the review's methods are available on request from the lead author.

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

[Table 1 around here]

[Figure 1 around here]

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). Timing of data collection ranged from 8 weeks to 1 year following birth. Sample sizes ranged from 18-40; 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 PND. Study characteristics are available in Table 2.

[Table 2 around here]

The included studies were critically appraised guided by the Critical Appraisal Skills Programme (CASP, 2017) with constant assessment of the rigour of studies using Lincoln and Guba's (1985) framework. The included studies presented some limitations; for example limited transferability, due to sample characteristics as commented on by Sword et al (2008), whose sample consisted mostly of English-speaking women in the same location, or insufficient data regarding the participant characteristics (Bilszta et al, 2010; Slade et al, 2010; Bell et al, 2016) and not commenting on data saturation (Bilszta et al, 2010; Slade et al, 2010). Furthermore, in two studies, it was not identified how quotes were selected (Bilszta et al, 2010; Slade et al, 2010) and one of these (Bell et al, 2016) did not identify the source of each quotation, precluding assessment of whether various participants were represented across the findings.

Synthesis

The studies were synthesised using thematic analysis, as outlined by 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/candidate 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 respectively more alert to: a systems approach; service perspectives; women's own individual influences. This appeared to be partly

influenced by co-authors' previous primary research and professional/disciplinary backgrounds (Midwifery and Psychology). 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 barrier and a facilitator for women seeking help for depressive symptoms in the postnatal period.

Care being centred on the physical needs of the woman and her baby created a difficult setting, limiting women from openly discussing mental health. In addition, mental health services were not well publicised or connected, creating an apparent lack of continuity between services. For some women, services were inaccessible or posed practical barriers (e.g. long waiting lists, time of day, limited childcare provision, travel costs). In addition, limited availability of services or an unappealing setting hindered women's help-seeking:

> *"When you go up, especially to where her office is, the hallways are so tiny and sterile. I feel like it's not warm and inviting"* (participant quote; Bell et al, 2016, p.654)

Having responsive staff, who were available when needed, facilitated 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, p.1170)

Influence of others

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

HCPs' attitudes and rapport

Women reported that HCPs' 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, p.654)

Some women identified HCPs' reactions to their disclosures as preventing them from feeling able to further discuss their mental health; usually this was where women perceived their symptoms had been minimised or dismissed. Women valued where HCPs '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 al*one"* (participant quote; Bell et al, 2016, p.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, p.50)

Sword et al (2008) reported that women varied regarding the extent to which they felt comfortable in discussing mental health or 'opening up' with others and so this heightened the importance placed on interactions with HCPs.

Whilst some women found it helpful if they already knew the HCP, others indicated HCP characteristics that were not dependent on 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 g*ets 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, p.1169)

Family

Some women reported family members, including partners, having negative reactions to their disclosures, reflecting interactions with HCPs. In some cases, family 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, p.1167)

In other cases, these reactions appeared to be due to inadequate knowledge amongst 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, p.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, p.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 peers (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, p. e443)

> "*I remember thinking "I don't want her to think I'm not coping", which is stupid really because I wasn't*" (participant quote; Slade et al, 2010, p. e443)

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

"I think that [PND] is no longer a taboo because so many of us have lived it."
(participant quote; Bell et al, 2016, p. 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 PND, hindering 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, p.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 be a facilitator for seeking help. If women did not identify their experiences and symptoms as matching their beliefs relating to PND, or resisted identification with PND (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, p.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, p.1165)

For other women, they considered that they may have PND but chose to delay help-seeking and first manage 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, p.1166)

Discussion

This review identified barriers and facilitators to help-seeking across three levels: healthcare services, others, and women themselves. The findings are largely consistent with other reviews; this review therefore suggests that changes such as introduction of routine assessment have not (yet) fundamentally changed barriers and facilitators to 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) is the barriers presented by the (in)accessibility and availability of services, highlighting the need for change. Another common finding is 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 & Wittkowski, 2017; Tobin et al, 2018); referred to elsewhere as the 'context of disclosure' (Darwin et al, 2016). National investment in maternal mental health services is underway (National Maternity Review, 2016) but likely to focus on number of services and geographical location, without addressing factors such as length of appointment and time available for discussing 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 HCPs and their relationship with women influence a woman's choice to seek help. With HCPs 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 HCP, can

still encourage women to seek help. We need to provide HCPs with techniques to have more meaningful conversations; as is relevant for all areas of care (Inspiring Change, 2018).

Consistent with the wider literature (e.g. 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 depressive symptoms. Tackling societal perspectives 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 in this review linked fears of their child being removed with deciding to not seek help. This indicates the need to improve knowledge regarding the role of social services and for HCPs to ensure women feel supported to seek help, as recommended by NHS Improving Quality (2015).

As has been reported elsewhere (Dennis and Chung-Lee, 2006; Hadfield and Wittkowski, 2017), it appeared that others could both enable and prevent help-seeking. This review identified that women, their partners and family lacked knowledge surrounding PND and the signs to look for. 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 is a topic which was identified as a barrier to help-seeking (Sword et al, 2008). However, this could be considered a useful tool in facilitating appropriate help-seeking, provided women are equipped with self-awareness and cues to take action (e.g. structured timeframes).

Implications for practice

Whilst this review contained only four included studies and one UK study, potentially limiting transferability to UK practice, this review nonetheless identified similar themes to those reported elsewhere (e.g. Dennis and Chung-Lee, 2006). Such enduring findings suggest that existing strategies (including introduction of routine assessment) have not yet changed women's help-seeking behaviours relating to depressive symptoms in the postnatal period. Women and their families need to be educated in pregnancy regarding 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 (for example, 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 which 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 as a student midwife the varied ways that health professionals approached mental health with the women that they cared for, as well as the apparent influence of approaches in 'opening up' or 'shutting down' the conversations. Whilst 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, she aims to integrate learning from this review, being cognisant that her behaviour and attitude can have an influence on whether a woman chooses to trust her and seek help.

Conclusion

An improved interface between maternity and mental health services is needed, accompanied by improved HCP interactions. Meaningful change may require empowering women's self-assessment and monitoring, and public health messages to improve recognition of symptoms by women and their families.

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Tables and Figures

Table 1 Eligibility criteria

	Inclusion criteria	**Exclusion criteria**
Population	Participants were required to meet at least one of the following: Diagnosed with PND Above-threshold depressive symptoms, assessed using a validated measure (e.g. Edinburgh Postnatal Depression Scale)	Women with current mental health conditions other than PND 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 currently pregnant
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 (i.e. previous review by Dennis and Chung-Lee, 2006)	

Figure 1 PRISMA flow diagram

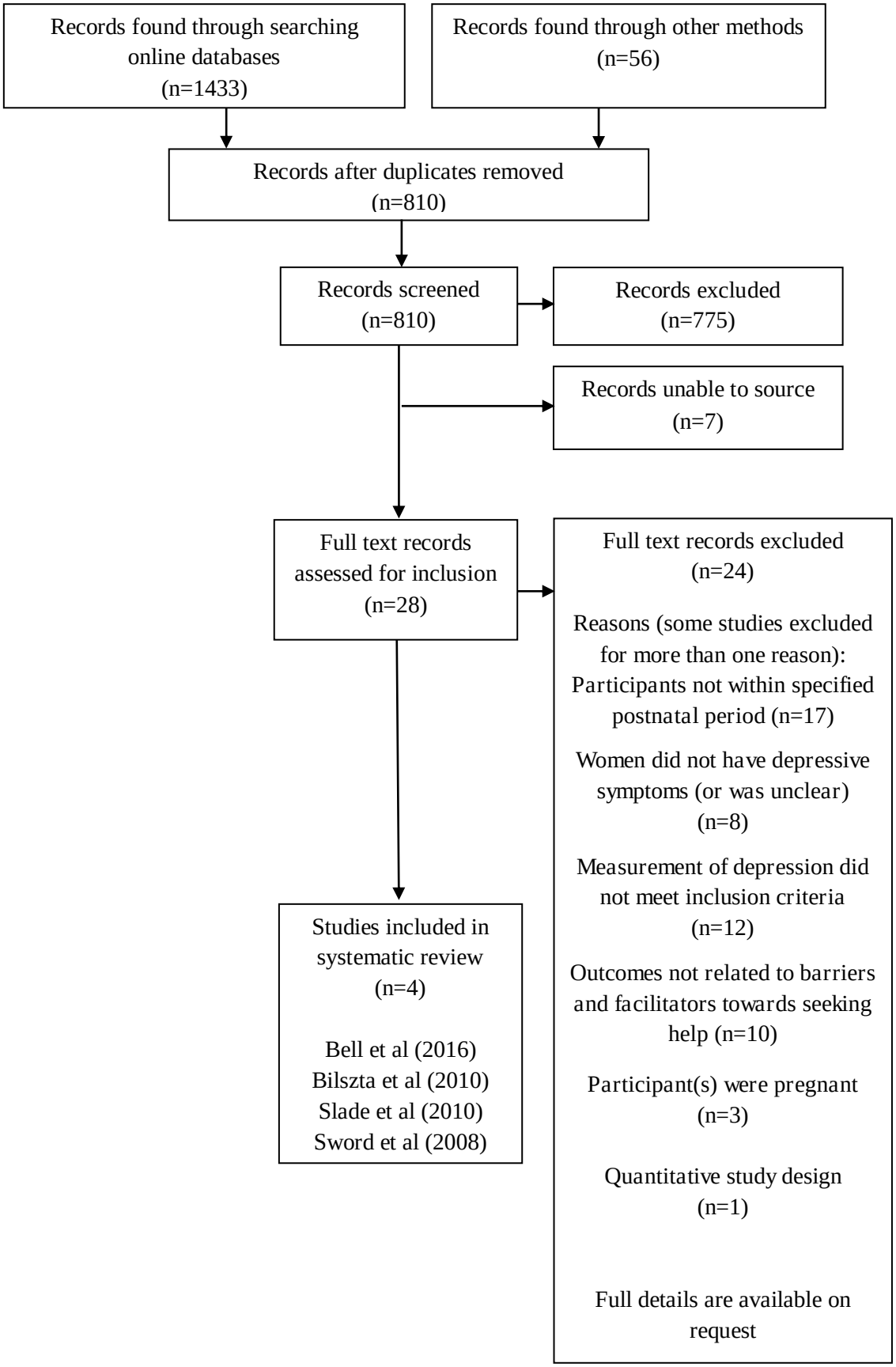

Table 2 Characteristics of included studies

Author, year and country	Definition of seeking help	Sample	Recruitment process	Data collection and analysis methods	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 A 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 were identified as barriers, e.g. participants reported services were difficult to access with young children and had long waiting times with not enough HCPs - Appropriateness and fit, e.g. a good rapport with the HCP and their approach as well as the environment where services were provided - Stigma was identified as a barrier (due to fear of stigma) and a facilitator (as women reported that knowing that people have experienced it facilitated disclosure of own experience) - Others acted as a barrier (due to women's partner and/or family's lack of understanding and support) and a facilitator (if women had a rapport with an HCP or if they had support from their partner) - Personal characteristics acted as a barrier with the main characteristic being reluctance to seek help because women thought they could manage their symptoms themselves
Bilszta et al (2010)	Seeking care	N= 40 women	Via outpatient depression treatment programmes (in	Focus groups conducted by two	- Not coping: women felt they had to appear as though they were coping and did not want to be seen as a failure

Australia		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)	a metropolitan area), mutual support programmes (in cities around the greater metropolitan area) or a large rural centre Time of data collection n/r	facilitators with interpretative phenomenological analysis	- 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 impacted on their ability to seek help - Help-seeking experiences: aspects not covered by other themes including difficulty thinking clearly, demotivation, sleep disturbance - Relationship with HCPs: women reported talking to HCPs when 'the time was right' and acknowledged HCP attitudes which encouraged help-seeking. Normalising of symptoms by HCPs acted as a barrier
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 were recruited from the PoNDER trial which investigated the effectiveness of extra training for health visitors in recognising depressive symptoms and giving sessions using cognitive behavioural therapy and counselling techniques. Participants were recruited for the trial from different GP surgeries (in a former regional health authority) Women were 6 months postpartum at time of interview	Semi-structured face-to-face interviews with 'template' approach for analysis	Barriers to help: - Presenting a coping image: women did not want to be seen as a failure or that they could not 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 were recruited from the local public health program which aims to promote child development (in one city) Women were 8 weeks postpartum (on average) at time of interview	Semi-structured telephone interviews with content analysis	Individual-level barriers: - Normalising of symptoms - Limited understanding - Waiting for symptom improvement - Discomfort discussing mental health concerns - 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 of symptoms - Disconnected care pathways Health system-level facilitators: - Having established and supportive relationships - Legitimisation of postpartum depression - Outreach and follow-up - Timeliness of care

Notes: n/r = not reported; HCP = healthcare professional