

Acceptability and barriers to treatment for perinatal depression. An exploratory study in Mexican women

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Artículo original

SUMMARY

Background

Depression is frequently experienced during the perinatal period. In Mexico, it has received very little attention from researchers and health service providers. It is well known that untreated depression is one of the leading causes of disability in women.

Objective

This study seeks to explore: 1. the recognition of perinatal depression among pregnant and postpartum women; 2. the acceptance of various modalities of treatment for depression, and 3. the perception of the barriers to receive treatment.

Material and methods

For this descriptive, exploratory study, 41 women in the third trimester of pregnancy and 30 women between the fourth and sixth postpartum weeks were interviewed. The study was conducted at a health center and a general hospital. The interview included demographic and obstetric data; depressive symptomatology (PHQ-2); open questions on the recognition of perinatal depression and scales relating to the acceptance of treatment modalities and barriers to access health services.

Results

Almost all the women had heard of the term postpartum depression, while one quarter did not know the causes of this disorder, which was attributed to an inability to face new challenges, emotional and hormonal changes, and lack of social support. The majority considered that it is not easy to speak about their unhappiness or discomfort, and that people would not understand if pre- or post-partum women felt sad or depressed in this period. Individual psychotherapy was the treatment with the highest level of acceptance, while medication, during pregnancy or breastfeeding, was the least accepted. The main barriers to treatment were: lack of time; institutional procedures; being unable to afford care and not having anyone to look after the children.

Conclusions

These results constitute a preliminary approach to the care needs for depression during the perinatal period. Women's awareness that help is required may not suffice to encourage them to seek assistance due to instrumental barriers and attitudes to treatment. In order to ensure effective care, it is necessary for the official norms regulating the health care for women and babies in this period to include treatment for mental disorders.

Key words: Post-partum depression, health care services, barriers to treatment, pregnancy.

RESUMEN

Antecedentes

La depresión es un estado frecuente en el periodo perinatal. En México ha recibido muy poca atención por parte de investigadores y prestadores de servicios. Se sabe que la depresión no tratada es una de las causas más importantes de discapacidad en las mujeres.

Objetivo

Explorar: 1. el reconocimiento de la depresión perinatal en embarazadas y púerperas, 2. la aceptación de diferentes modalidades de atención para la depresión y 3. la percepción de las barreras para asistir a tratamiento.

Material y métodos

En este estudio descriptivo y exploratorio se entrevistó a 41 mujeres en el tercer trimestre del embarazo y a 30 entre la cuarta y sexta semanas del posparto. El estudio se llevó a cabo en un centro de salud y en un hospital general. La entrevista incluyó: datos demográficos y obstétricos; sintomatología depresiva (PHQ-2); preguntas abiertas sobre el reconocimiento de la depresión perinatal y escalas relativas a la aceptación de diversas modalidades de tratamiento y barreras para acudir a servicios de salud.

Resultados

Casi todas habían escuchado el término depresión posparto; una cuarta parte desconocía las causas de este trastorno, el cual fue atribuido a no saber enfrentar los nuevos retos, cambios emocionales, cambios hormonales y falta de apoyo social. La mayoría consideró que no es fácil hablar de tristeza o malestar en este periodo y que la gente tampoco lo entendería. La psicoterapia individual fue el tratamiento con mayor aceptación; los medicamentos, durante el embarazo o lactancia, los menos aceptados. Las principales barreras al tratamiento fueron: la falta de tiempo, los trámites institucionales, la imposibilidad de pagarlo y la carencia de cuidado para los hijos.

Conclusiones

Estos resultados constituyen una primera aproximación a los requisitos de atención de la depresión en el periodo perinatal. El reconocimiento de la necesidad de ayuda por parte de las mujeres puede no ser motivo suficiente para que acudan a buscarla debido a las barreras instrumentales y las actitudes hacia el tratamiento. Para poder brindar una atención efectiva es necesario que las normas oficiales, que regulan el cuidado de la salud de mujeres e infantes en este periodo, incluyan una atención a los trastornos mentales.

Palabras clave: Depresión posparto, servicios de salud, barreras para el tratamiento, embarazo.

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INTRODUCTION

Perinatal depression refers to the presence of this disorder during pregnancy and the first six months post-partum. Prevalence of post-partum major depression (PPD) varies across countries, with rates typically ranging from 6.5% to 12.9% in developed countries.¹ In Mexico, reported prevalence varies from 6.66% to 24.6%.²⁻⁴ Prenatal depression is also fairly common worldwide, affecting approximately 2% to 21% of women.⁵ In Mexico, prenatal major depression is found in 12.3% to 14% of pregnant women.^{2,6}

Some of the psychosocial factors associated with PPD depression in Mexican women include history of depression,^{2,4,7} fear of being unable to care for the baby,⁷ a difficult relationship with the partner, family problems and being unpartnered.⁴ These risk factors are similar to those found in international studies.⁸ Risk factors associated with major depression in pregnancy include a history of depression, unplanned pregnancy, lack of social support, and previous miscarriages.^{2,9} Several of these risk factors have been observed in pregnant women in other countries.¹⁰

Maternal PPD may be detrimental to infants, affecting their cognitive and language development.¹¹ Babies of mothers with PPD have a higher risk of deficits in their early interactions with their mothers and an increased rate of insecure attachment.¹² These effects can last for years.¹³ Prenatal depression may also result in significant short- and long-term negative effects on the mother and child. It affects eating habits that may be problematic in women with low socioeconomic status; it leads to poor prenatal care, and may increase the potential for substance abuse.⁵ Prenatal depression has also been associated with premature births, low birth weight,⁵ and an increased risk for PPD.¹⁴

Despite the well-documented risk factors and health consequences of pre- and post-partum depression, only a minority of mothers affected by this disorder are detected and treated, even in countries where perinatal depression is more widely recognized and more treatment options are available.^{15,16} In this respect, the study of barriers to formal help seeking for pre- and post-partum depression has increased in the past decade, particularly through qualitative methods, contributing to understanding how to improve early detection and intervention in this population.

Recognition of depressive symptoms has been considered a prerequisite for seeking mental health care. In this respect, Abrams et al.¹⁷ found that, among low-income ethnic minority mothers in the United States (U.S.), lack of recognition of depressive symptoms was an important barrier to treatment. In this study, mothers tended to normalize or minimize their stress experiences in order to preserve an image of themselves as "good mothers". In a cross-cultural qualitative study of eleven Western and non-Western countries, Oats et al.¹⁸ found that, although perinatal women were able to identify morbid unhappiness after childbirth,

they did not see it as an illness that could be cured by health interventions. Mothers across all countries identified very similar factors that contributed to happiness and unhappiness in pregnancy and the post-partum. Physical illness and discomfort were a cause of unhappiness in the former, and lack of social support, family conflict, sleeplessness, and problems with the infant, in the latter.

Personal values and preferences have a significant influence on decision-making about treatment.¹⁹ In a large, ethnically diverse sample in the U.S. to study women's preferences and attitudes regarding treatment for depression, Goodman²⁰ found that a high percentage of pregnant women would agree to receive psychotherapy (92% individual; 14% group) and would agree to take medication (35%) if they suffered from depression.

Other perceived barriers to seeking professional treatment for depression and anxiety in the perinatal period that have been identified are: shortage of time, stigma, lack of child care, not knowing where to go, lack of transportation, cost, absence of interpersonal support, help-seeking and treatment experiences, and relationship with health professionals.^{17,20-22} A systematic review to identify barriers to seeking help for post-partum depression reported women's inability to disclose feelings, often reinforced by family members; and health professionals' reluctance to respond to the mothers' emotional and practical needs, as common barriers to treatment.²³

Post-partum depression has received scant attention in Mexico, resulting in a complete lack of published studies on barriers to mental health care among perinatal women. In its absence, data from epidemiological studies in the general population can shed light on the problem. In a literature review of the reasons given by Mexican women for failing to seek help for psychological problems, Berenzon and Medina-Mora²⁴ found: thinking that no one can help, feelings of guilt and shame, not knowing where to go, lack of child care, reluctance on the part of the family, cost of treatment, lack of transportation and cumbersome procedures by health institutions. In addition, it should be mentioned that Mexico has one of the highest rates of people with untreated psychiatric disorders, and the lowest use of services for mental health problems in the Americas.²⁵

In short, there is evidence that a considerable percentage of Mexican women suffer from perinatal depression,^{2,4} which may potentially result in adverse consequences for the mother and the baby,^{5,11-14} pointing to an important public mental health problem that requires attention. There is no estimate of the proportion of perinatal Mexican women affected by this disorder who are detected and treated. However, considering the international trend,^{15,16} the high number of people with untreated psychiatric disorders in Mexico,²⁵ and the lack of specific official norms regulating the mental health care of women during pregnancy and the post-partum, it is possible that very few in fact receive proper care.

In this context, there is a shortage of information on what prevents perinatal women from seeking care in the event of perinatal depression. Understanding the barriers pre- and post-natal women face to seeking treatment may constitute a first step to planning mental health services for this population to respond to their needs. This study is relevant because of the negative consequences of perinatal depression for women, their children and families. The aims of this study were, therefore, to explore: 1. pregnant and post-partum women's recognition of perinatal depression, 2. their acceptance of different treatment modalities, and 3. perceived barriers to treatment.

MATERIAL AND METHODS

This descriptive investigation was part of the exploratory phase of a prevalence study to explore various psychological measurements –not all of which are reported here– related to perinatal depression. For the purposes of this paper, the following scales were included: Patient Health Questionnaire (PHQ-2),²⁶ Mother's Awareness of Perinatal Depression, Acceptability of Different Treatment Modalities and Perceived Barriers to Treatment for Perinatal Depression.

Participants

A convenience sampling strategy was used (N=71) to recruit: a) women in the third trimester of pregnancy who were receiving prenatal care at a community health care center providing prenatal care and other comprehensive medical care (N=41), and b) women in the fourth to sixth post-partum weeks (N=30) in a general hospital setting that provides obstetric and gynecological services in Mexico City. All participants were ≥ 20 years. Questions on the acceptability of different treatment modalities and perceived barriers to treatment scales were only answered by 27 pregnant and 27 post-partum women.

Instruments

Data were collected through an interview that included the following areas:

Demographic and obstetric data, comprising: age, educational attainment, family income, marital status, and occupation in the previous six months.

Depressive symptoms were measured to estimate the level of risk for depression of the sample using the Patient Health Questionnaire (PHQ-2).²⁶ This consists of the first two items of the PHQ-9,²⁷ developed as a self-report scale to screen for depression symptoms in primary care settings. The items assess 1) depressed mood and 2) diminished interest or pleasure in all, or nearly all, activities (anhedonia), the two distinctive symptoms for major depressive disorder (Diagnostic and Sta-

tistical Manual of Mental Disorders) (DSM-IV).²⁸ A positive response to either of the two questions indicates that depression is highly likely.²⁹ This two-question screening instrument has similar test characteristics to other case-finding instruments and is less time-consuming, with acceptable sensitivity and specificity.³⁰ The PHQ-9 has been used in Mexico.³¹

Mother's recognition of perinatal depression. Seven open-ended questions were translated from Oats et al.,¹⁸ who proposed these measures for the use in an international cross-cultural study. The questions explore women's beliefs about the factors contributing to happiness/unhappiness during pregnancy and the post-partum; their understanding about feeling emotionally unwell during this period and the causes of these feelings at this time; and their views on what could be done to help them. Two questions were added on their knowledge of PPD and what they thought were the causes for it. The responses to each question were categorized by themes, taking care to ensure that the categories were homogeneous, inclusive of all responses and exclusive of other categories. This was performed by two team members and subsequently discussed with a third team member (not involved in the original categorization) to reach a consensus.

Acceptability of different treatment modalities was assessed with five questions developed in English and Spanish by Goodman²⁰ in the United States and used in a sample that included Hispanic women. The questionnaire seeks to explore women's treatment preferences for perinatal depression and the acceptability of certain specific treatments (individual counseling, group counseling, and antidepressant medication) for perinatal depression to women. They are answered on a 1 to 4 scale (1=Definitely; 2=Probably; 3=Probably Not; 4=Definitely Not), which indicates the modality in which they are more likely to participate if they seek help for depression.

Perceived barriers to treatment for perinatal depression were assessed by a questionnaire comprising ten possible barriers answered on a 1 to 3 Likert-type scale (1=Not difficult; 2=Difficult; 3=Very difficult).²⁰ The items included six developed by Goodman²⁰ in perinatal women including Latinas: lack of time; lack of child care, not knowing where to go for treatment; being unable to afford treatment; lack of transportation; and family might not approve. The other four items were developed by Berenson and Medina-Mora²⁴ in Mexican non-perinatal women: being ashamed to talk to others about the problem; being worried about what others might think; cumbersome procedures by health institutions; and lack of interest.

Procedure

All participation was contingent on standard informed consent procedures obtained from women receiving routine perinatal care for examining how women feel during pregnancy and the post-partum, their mood and the sort of things that worry them. Pregnant women were invited to

Table 1. Sociodemographic data (N= 71)

	Pregnant n=41		Postpartum ^a n=30		Total N=71	
	\bar{x} (SD)		\bar{x} (SD)		\bar{x} (SD)	
Age	29.5 (5.7)		30.0 (6.6)		29.7 (6.1)	
Years of schooling	12.6 (3.2)		13.7 (3.8)		13.1 (3.5)	
	f	%	f	%	f	%
Monthly family income						
• ≤ \$5,246 ^b	28	68.3	19	63.8	47	62.2
• > \$5,246	13	31.7	11	36.7	24	33.8
Marital status						
• Partnered	29	70.7	26	86.7	55	77.5
• Single	12	29.3	4	13.3	16	22.5
Occupation						
• Employed	25	61.0	20	66.7	45	63.4
• Unemployed	16	39.0	10	33.3	26	36.6
Depressive symptoms (PHQ-2)						
• Endorsed one of the items	24	58.6	17	56.7	41	57.7

^a No statistical differences were found between the groups.

^b This corresponds to the 1-3 deciles, comprising families with the highest poverty rate in Mexico (INEGI, 2013).

participate and interviewed in the waiting room of the health center service. Fieldwork was conducted in two settings: a) in the general hospital in the hospitalization area, between three and 48 hours after delivery, and b) at the health center in the vaccination area. In the first setting, mothers were asked to provide information to arrange for an appointment (date and place) in order to conduct an interview before the 6th week post-partum. Women at the health center were usually interviewed on the same day they were invited. In both settings, before the interview, the objectives of the research and the confidentiality of information were explained and written informed consent was requested.

All the interviews were conducted by trained psychologists from the research team. The study was approved by the Institutional Review Board (IRB) of the Ramón de la Fuente Muñiz National Institute of Psychiatry.

Data analyses

For the analyses of the acceptability of different treatment modalities and perceived barriers to treatment for perinatal depression, descriptive statistics (frequencies, percentages, means, and standard deviations) were used. χ^2 and *t* tests were used for comparing sociodemographic characteristics between pregnant and post-partum women. Analyses were performed using the SPSS 19 Windows statistical package.³²

Responses to the open questions about mothers' recognition of perinatal depression were analyzed, as previously mentioned, on the basis of constructed categories, through the "categorization of meanings" technique proposed by Kvale.³³

RESULTS

Sociodemographic characteristics

The women in the study were approximately thirty years old, had completed thirteen years of education and about two thirds were within the highest poverty level bracket³⁴ (table 1). Most of them were partnered (77.5%) and had a paid job (63.4%).

On the PHQ-2, 57.7% endorsed at least one of the two items indicating that they were at risk of perinatal depression. There were no statistical differences in these variables between pre- and post-natal women ($\chi^2=0.02$; $p=0.87$) (table 1).

Mothers' recognition of perinatal depression

As shown in table 2, pregnancy itself, giving birth to a new life and awareness of fetal movements were contributors to happiness in pregnancy. Receiving support from family and partner, having emotional and economic stability, and a planned pregnancy were also reasons for happiness, while the absence of these factors constituted reasons for unhappiness. Frequent causes of unhappiness included concerns over the babies' health, pregnancy complications, changes in physical appearance and conflicts with the partner, family or at work.

Following delivery, having a healthy baby, holding the baby, the mother's health and having a new family member contributed to happiness. Conversely, concern for the baby's health, complications during delivery and lack of support

Table 2. Mothers' recognition of perinatal depression

	Pregnant (n=41)		Postpartum (n=30)	
	f	%	f	%
What do you think brings happiness to women during pregnancy?				
• Giving birth to a new life	21	35.5	20	44.4
• Awareness of fetal movements	13	22.0	5	11.1
• Receiving support from family	6	10.1	10	22.2
• Receiving support from partner	7	11.8	7	15.5
• Economic stability	5	8.4	1	2.2
• Being emotionally stable	5	8.4	2	4.4
• Planned pregnancy	2	3.3	–	–
• Total	59		45	
What do you think brings unhappiness to women during pregnancy?				
• Concern about babies' health	12	19.0	12	26.6
• Pregnancy complications	10	15.8	6	13.3
• Conflict with partner	8	12.6	7	15.5
• Conflicts with family or at work	8	12.6	5	11.1
• Financial problems	8	12.6	3	6.6
• Emotional changes	5	7.9	6	13.3
• Lack of family support	5	7.9	5	11.1
• Unexpected pregnancy	5	7.9	1	2.2
• Changes in physical appearance	2	3.1	–	–
• Total	63		45	
What do you think bring happiness to women after childbirth?				
• Having a healthy baby	14	25.4	8	20.0
• Holding the baby	21	38.1	14	35.0
• The mother's health	12	21.8	8	20.0
• Having a new family member	4	7.2	4	10.0
• Receiving support from family	3	5.4	3	7.5
• Receiving support from partner	1	1.8	3	7.5
• Total	55		40	

contributed to unhappiness. Other causes of unhappiness included financial problems, conflict with the partner, being unable to cope with new challenges, hormonal changes, changes in physical appearance, and unexpected pregnancy. Six of the pregnant and one of the post-partum women could find no reason for their unhappiness.

In relation to their knowledge about morbid depression, most of the respondents said that they had heard the term PPD, although nearly a quarter of the sample did not know why women could have this disorder. The remaining answers regarding the causes attributed to PPD were similar to those they mentioned as causing unhappiness after birth such as: being unable to cope with new challenges, hormonal changes, no family support, financial problems, and unexpected pregnancy. Lack of partner support and emotional changes were also frequently mentioned.

Table 2. Continued

	Pregnant (n=41)		Postpartum (n=30)	
	f	%	f	%
Difficulty talking about DPP				
Do you think that is easy for women who are pregnant to say they feel very sad or worried?				
• Yes	14	34.1	–	–
• No	27	65.9	–	–
Do you think it is easy for women who are postpartum to say they feel very sad or worried?				
• Yes	–	–	9	30.0
• No	–	–	21	70.0
What do you think people (you) know/understand about being emotionally unwell following birth (postpartum depression)?				
• People don't understand women who experience PPD	30	73.2	20	66.7
When a woman is emotionally unwell during the postpartum period, what do you think can be done to help her?				
• Psychological help	23	50.0	18	47.3
• Listen and give them emotional support	19	41.3	15	39.4
• Ensure they get support from the family	4	8.6	5	13.1
• Total	46		38	

Over half the pregnant women perceived that it was not easy during pregnancy to talk about feeling blue or depressed, while almost three quarters of the post-partum women thought that this was also not easy after giving birth. Many thought that people did not understand women who felt emotionally unwell during the post-partum. Approximately half of them suggested that receiving psychological assistance when emotionally unwell during the post-partum period, as well as listening and giving them support, would be useful (table 2).

Acceptability of different treatment modalities

As one can see from table 3, 70.4% of pregnant and 66.7% of post-partum women said that they would definitely accept one-on-one therapy from a professional if they suffered from depression or anxiety. Conversely, only half of the pregnant women and a third of the post-partum mothers said that they would seek group treatment. Taking medication while pregnant or breastfeeding was definitely not accepted by half the pregnant and the post-partum participants. This contrasts with the high proportion who said that they would definitely accept medication for depression or anxiety when neither pregnant nor breastfeeding (55.6% and 66.7%) (table 3).

Table 3. Acceptability of different treatment modalities (Pregnant=27; Postpartum=27)

	Definitely %	Probably %	Probably not %	Definitely not %
How acceptable is it to you to seek one-on-one counseling from a mental health professional for depression or anxiety?				
• Pregnant	70.4	29.6	0	0
• Postpartum	66.7	33.3	0	0
How acceptable is it for you to seek group counseling for depression or anxiety?				
• Pregnant	51.9	18.5	14.8	14.8
• Postpartum	29.6	33.3	7.5	29.6
How acceptable is it for you take medication for depression or anxiety when pregnant?				
• Pregnant	7.4	22.2	18.5	51.9
• Postpartum	0	22.2	25.9	51.9
How acceptable is it to you take medication for depression or anxiety when breastfeeding?				
• Pregnant	7.4	18.5	22.2	51.9
• Postpartum	3.8	33.3	18.5	44.4
How acceptable is it to you take medication for depression or anxiety when neither pregnant nor breastfeeding?				
• Pregnant	55.6	37.0	7.4	0
• Postpartum	66.7	25.9	0	27.4

Perceived barriers to treatment

Lack of time was perceived as an important barrier to treatment for emotional problems or nerves; predictably, this was more salient in the post-partum sample, 88.9% of whom perceived it as very difficult or difficult in comparison to 70.4% of the pregnant sample (table 4). Similarly, child care availability was difficult or very difficult for 40.7% of pregnant and for 66.7% of post-partum women. Most of the participants found it difficult or very difficult to know where to go for treatment (pregnant: 66.7%; post-partum: 54.8%) and nearly two thirds found it difficult or very difficult to afford it (70.4% and 74.1%, respectively). Lack of transport was not seen as difficult by the majority (74.1% and 77.8%), while dealing with cumbersome procedures at health institutions was more difficult for post-partum (77.8%) than for pregnant women (59.2%).

Pregnant women found little difficulty in the items assessing possible stigma (family may not approve, ashamed to talk to others about problems and worried about what others may think) (7.4%-14%). Nevertheless, around a quarter of the postnatal group reported experiencing a considerable degree of difficulty in these items (29.6%, 22.2% and 22.2%, respectively). Lastly, 22.2% of the pregnant and 16.7% of the post-partum women reported that they would not be interested in seeking treatment in the event of emotional problems.

DISCUSSION

To our knowledge, this study is the first in Mexico to explore the awareness of perinatal depression, acceptability of different treatment modalities and perception of barriers to treatment in pregnant and post-partum women. While some of our findings are consistent with international research, new considerations and questions also emerged.

Being pregnant and having a baby were found to be sources of happiness for most mothers. In their international study, Oats et al.¹⁸ also found that there was a physical and emotional delight at being pregnant and a mother which contributed to their happiness, suggesting that in most cultures, being a mother is highly valued. Unique to this study, and not reported in Oats et al.¹⁸ was the importance given to the baby's and mother's health and to pregnancy outcome, as major reasons for happiness when present and for unhappiness when absent. Further research is required to explore why perinatal Mexican women are so anxious about their health and that of their babies', whether this constitutes a risk factor for depression, and its potential for health promotion and prevention programs. Conversely, Oats et al.¹⁸ found that the quality of health care was an important contributor to unhappiness in most of the countries they studied, an issue which was not mentioned by the women in our

Table 4. Perceived barriers to treatment in pregnant (n=27) and postpartum women (n=27)

	Not difficult %	Difficult %	Very difficult %	Difficult & very difficult %
Lack of time				
• Pregnant	29.6	51.9	18.5	70.4
• Postpartum	11.1	66.7	22.2	88.9
No child care available				
• Pregnant	59.3	14.8	25.9	40.7
• Postpartum	33.3	37.0	29.7	66.7
Not knowing where to go for treatment				
• Pregnant	33.3	44.5	22.2	66.7
• Postpartum	44.5	40.7	14.8	55.5
Not being able to afford treatment				
• Pregnant	29.6	55.6	14.8	70.4
• Postpartum	25.9	40.8	33.3	74.1
Lack of transportation				
• Pregnant	74.1	25.9	0.0	25.9
• Postpartum	77.8	14.8	7.4	22.2
Cumbersome procedures at health institution				
• Pregnant	40.8	40.8	18.4	59.2
• Postpartum	22.2	51.9	25.9	77.8
Family might not approve				
• Pregnant	85.2	11.1	3.7	14.8
• Postpartum	70.4	22.2	7.4	29.6
Ashamed to talk to others about problem				
• Pregnant	85.2	14.8	0.0	14.8
• Postpartum	77.8	14.8	7.4	22.2
Worried about what others may think				
• Pregnant	95.6	7.4	0.0	7.4
• Postpartum	77.8	14.8	7.4	22.2
Interested in seeking treatment	Interested		Not interested	
• Pregnant	77.8		22.2	
• Postpartum	83.3		16.7	

study. The fact that women were contacted at the health institutions and some were interviewed in the waiting rooms may have discouraged them from mentioning these aspects, or it may be that they were satisfied with the quality of the care they were receiving. Nevertheless, future investigation is needed to confirm this finding as there is evidence about the poor quality of Mexican perinatal services.³⁵

Other factors contributing to happiness when present and/or unhappiness when absent were related to family/partner support, being able to cope with new demands, emotional and economic stability, and having a planned

pregnancy, among others. These results closely replicate international ones.¹⁸ Similarly, studies in Mexico have demonstrated the importance of social support in postpartum depression.^{36,37} Changes in physical appearance were consistently mentioned, a factor not often mentioned in the literature.¹⁸ Because of the relation between physical appearance and eating habits that affect fetal growth, this aspect warrants further study.

It was interesting that the majority of the women interviewed had heard about PPD given the low institutional consideration of this problem. It remains to be studied whether women who have heard about PPD are also able to recognize it if they suffer from it. Conversely, nearly a quarter of the sample did not know what caused postpartum depression. The ones that, did know, attributed PPD to very similar causes to unhappiness after delivery (such family/partner support, ability to cope with new demands, emotional and economic stability). Many of these issues were found in the international study,¹⁸ and are also well established risk factors for PPD.^{8,38,39} Together, these data support the notion of a certain degree of universality regarding the causes of unhappiness and postpartum depression.¹⁸

Women perceived that it was not easy for a new mother to talk about feeling blue or depressed and thought that people did not understand a mother who expressed such feelings in the postpartum. These findings are consistent with previous studies that have observed that women fear acknowledging their emotional problems and repeatedly speak of being scared of being depressed.²¹ According to Knudson-Martin and Silverstein,⁴⁰ PPD is experienced as a cumulative struggle in which expressing negative feelings is not congruent with the social construction of motherhood, and as a result of this silencing process, women become overwhelmed by feelings of incompetence.

Regarding the perception of what could be done to help a woman if she was feeling emotionally unwell, in keeping with their view of the causes of unhappiness and of PPD as being predominantly psychosocial, they suggested psychological help, listening to them and providing them with emotional and family support. Women's recognition that help is needed may not be sufficient to encourage them to seek help, as attitudinal and instrumental barriers may lead them to choose self-help practices, as has been previously noted.¹⁷

Individual psychotherapy was highly accepted, consistent with previous findings for perinatal women.²⁰ It has been suggested that for many mothers, the best treatment would simply be to have the opportunity to talk about their feelings with a sympathetic, empathetic listener.²³ Group therapy was less accepted. Goodman²⁰ has suggested that having to attend regular meetings, on the one hand, and having to disclose feelings that do not fit the stereotype of the "happy mother" to other women, on the other, may constitute barriers to group psychotherapy. As with other

women,²⁰ for the majority of the participants it was unacceptable to take medication for depression during pregnancy or while breastfeeding. Women's deep concern about baby's health and pregnancy outcome, as previously mentioned, may weigh heavily when it comes to medication. According to O'Mahen et al.,⁴¹ women may find it extremely difficult to gauge the risk and/or benefits of medication in relation to the severity of their symptoms and the potential side effects to their infant. This may be particularly true of this sample considering women's limited educational attainment. The stigma associated with medication use may also account for its unacceptability.²¹

Lack of time and child care, not knowing where to go for treatment, being unable to afford treatment and cumbersome procedures at health institutions were perceived as the most important barriers to treatment for depression in perinatal women. These barriers to mental health services are widely reported in different contexts and populations.^{17,20-23}

When participants were asked about barriers in relation to stigma (family might disapprove, ashamed to talk to others about problems, worried what others may think), few of them thought that these constituted a problem: between 7.4%-14.8% in pregnancy and 22.2%-29.8% after giving birth. The differences between pregnant and postpartum women in relation to these barriers may be linked to the degree of emotional distress experienced between the groups, with postnatal women being more aware of distress and the difficulties of expressing it. In this respect, other barriers were also perceived as more of a problem in the postpartum group (lack of time and child care, being unable to afford treatment, cumbersome health procedures).

In sum, this study presents preliminary data on a key issue for women's mental health that has received scant attention in Mexico. The findings are a first step towards defining perinatal women's needs regarding services for depression during this already vulnerable period. However, they are only tentative because of the small size of the sample and its descriptive exploratory nature. Future studies are required to address these issues with larger samples, particularly cultural aspects related to stigma that prevent the expression of feelings of sadness and depression and treatment seeking. Institutional and professional barriers to mental health care for perinatal women also remain an important aspect to be studied. Nevertheless, as we have previously emphasized in order to bring effective care to Mexican women, it is necessary for the official norms regulating the health care of women and babies during pregnancy, delivery, and postpartum to include care for mental disorders.

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