Pregnant women's experience of depression care

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Abstract

Purpose – *Up to 25 per cent of women will experience depression during their pregnancy. Perinatal mental health problems are a leading cause of maternal morbidity and mortality, however care provided to women is often a low priority. The purpose of this paper is to explore women's perspective of care from GPs and midwives, when they experience symptoms of depression during pregnancy.*

Design/methodology/approach – *Women, with self-reported symptoms of depression, were invited to post comments in response to a series of on-line questions posted on two discussion forums over a nine month period. The questions were related to the care women received from GPs and midwives. Data were analysed using thematic analysis.*

Findings – *In total, 22 women responded to the on-line questions. A number of themes were identified from the data including women's disclosure of symptoms to GPs and midwives; lack of knowledge of perinatal mental health among health providers; attitudes of staff and systemic issues as barriers to good care; anti-depressant therapy and care that women found helpful.*

Research limitations/implications – *Women often face significant emotional and psychological health issues in the transition to motherhood. This small study indicates women often experience difficulties in interacting with their GP and midwife in seeking help. This research has identified some contributing factors, however more rigorous research is needed to explore these complex issues.*

Originality/value – *This paper highlights service provision in the care of women with depression in pregnancy.*

Keywords *GPs, Antenatal depression, Internet discussion groups, Midwives, Perinatal mental health, Women's experience*

Paper type *Research paper*

Introduction

While a number of studies have focused on women's experience of postnatal depression (Cox 1983; Chan *et al.*, 2002) in comparison, little research has explored the experiences of women with depression during pregnancy. When it does occur, research on antenatal depression tends to centre on the aetiology of the illness (O'Keane and Marsh, 2007), pre-disposing factors (Kitamura *et al.*, 1996) and risk factors only (Field *et al.*, 2006). There remains an absence of research on the help-seeking experiences of women with pregnancy-related depression.

This paper presents findings from a study exploring the experiences of pregnant women, with self-reported depressive illness, when they seek help from their GPs and midwives. The findings form phase one of a larger project, the aims of which were to examine women's experience of mild to moderate mental health problems during pregnancy and identify ways in which midwives could be helped to manage the care of such women. Findings from phase two of the project are reported elsewhere Jarrett (2010). The overall objective of the project was to improve the care pregnant women receive when they experience perinatal mental health problems.

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Background

A literature search was conducted to identify previous research on women's experience of care when depressed during pregnancy. The search terms depression, antenatal, prenatal care, pregnancy, patient experiences, GPs, midwives were used to search the Cochrane, Medline, PsycINFO and CINAHL databases.

A review of the literature identified a number of studies which address women's perspective of care, when depressed and pregnant.

In a study by Stanley *et al.* (2006) barriers to disclosure of mental health problems were explored with women. Women perceived the preoccupation with checklists and procedures by midwives prevented good communication and disclosure of mental health problems (Stanley *et al.*, 2006). Additionally, women from non-English speaking groups felt differences in language between patients and health providers created a barrier to effective discussion of mental health problems. Women believed their care would improve if they had a relationship with a professional that was continuous throughout their pregnancy. Women also wanted to be given time and space and the opportunity to develop a trusting relationship with their health professional and for professionals to make them feel more comfortable (Stanley *et al.*, 2006).

Some of these themes were repeated in a more recent study which investigated the experiences of women with perinatal mental health problems (Boots Family Health Alliance, 2013). Using a questionnaire survey, the researchers found that women often do not recognize the symptoms they were experiencing during pregnancy, however later realized that they had been depressed. A number of women had not remembered being asked about their mental health by a midwife during their pregnancy. Some women believed that expressing mental health problems was a sign of failure and this prevented them from disclosing their symptoms. Further to this when women did disclose symptoms of depression they tended to choose a middle ground when describing these, for example women would disclose some, but not all or of the symptoms they were experiencing. Women often felt embarrassed and were terrified that their child would be taken into care (Boots Family Health Alliance, 2013). Other barriers to disclosing mental health problems were that "the timing was wrong" and many women were not ready to admit that they were experiencing mental health problems. In total, 23 per cent of women in the study believed that health professionals were not friendly and "could not help them" with the problems they were experiencing (Boots Family Health Alliance, 2013).

A review of the literature shows that previous studies which comment on women's experience of antenatal depression either explore the views of women who did not have depression (Stanley *et al.*, 2006) or do not distinguish between women's experience of antenatal and postnatal depression (Boots Family Health Alliance, 2013). To the author's knowledge, no research has been conducted on the views of women who use internet discussion groups and self-report symptoms of antenatal depression. The aims of this paper, therefore, are to explore the experiences of women in seeking help from GPs and midwives when experiencing depression during pregnancy.

Project design

Qualitative description (QD)

This study uses a qualitative descriptive design (Neergaard *et al.*, 2009). QD is not informed by any theoretical or methodological premise, however does offer a rich description of participants experience in a language similar to those of the participant (Neergaard *et al.*, 2009). The design specifics of QD suggest data collection be through minimally structured open ended questions using one-to-one or focus group discussions. Analysis of QD is through a system of coding and thematic grouping.

Use of internet discussion groups in research. The original study aimed to conduct face to face interviews with pregnant and depressed women. However, interviewing depressed women during their pregnancy was thought to risk an intervention whose effects may not be benign. As a result alternate routes of exploring women's experiences of care were sought.

The discovery of a series of internet discussion groups or "chat rooms" dedicated to women's experience of mental health problems in pregnancy appeared an alternate data source. The internet contains a large number of electronic discussion groups many of which enable discussion of health-related problems, provide help and access to support. Individuals who participate in discussion groups post messages which are disseminated to all internet sites which comprise the discussion group. The advantages of using internet generated data over more traditional methods include reduced time for data collection, through counteracting the need for transcription of interviews and by providing cheap and easy access to the views of a wide range of people (Eysenbach and Till, 2001).

PNI-UK.com and mothersvoice.org.uk. A search of the internet, using www.google.co.uk, was conducted to identify internet forums which might contain discussion of perinatal depression. A total of nine discussion boards were identified and each differed in terms of background, structure and purpose.

Two internet discussion forums were selected as data sources, PNI-UK.com and mothersvoice.org.uk. PNI-UK was selected because of their previous collaboration with MIND (mental health charity) on a survey of women's mental health during pregnancy and postpartum. This collaboration suggested PNI-UK might have a positive attitude and be more open to research involvement, than other discussion groups. Mothervoice.org.uk was chosen as this forum was dedicated solely to the discussion of perinatal mental health problems.

PNI-UK.com are described on their website as "a registered charity for women and their families who think they have any type of perinatal illness […] incorporates any distressing psychological and emotional condition which has developed during pregnancy".

Mothersvoice.org.uk describe themselves as a "not for profit" organization providing support and information to women and families affected by perinatal mental illness. Perinatal mental illness is described as those conditions which include postnatal depression, puerperal psychosis, birth trauma and pregnancy-related anxiety.

Advertisement of banner on www.PNI-UK.com and mothersvoice.org.uk. A banner[1] inviting women who have experienced depression in pregnancy was posted on both internet websites. When women "clicked" on the banner they were directed to a series of questions asking about their experiences of care from midwives and GPs in relation to pregnancy-related depression (see Figure 1, Banner and questions posted on internet discussion boards).

Women were asked to post their responses directly onto the discussion thread or send a private e-mail to the site administrators at PNI-UK.com and mothersvoice.org.uk which were then automatically forwarded onto the research team. The banner was advertised on the www.PNI-UK.com internet discussion board website for a total of nine months and on the mothersvoice.com website for a total of eight months.

Access and ethics approval. Permission to access the discussion forums and invite women to make postings to the study banner were obtained from the executive team at both mothersvoice.org.uk and PNi-UK.com. Approval to conduct the study was granted by the Research Governance Committee at the host institute.

Ethical considerations in using internet generated data. Maintaining the confidentiality and anonymity of the women whose postings were being used was an issue of concern. It was recognized that an internet search of direct quotes might identify participants. Therefore in order to prevent identification of women it was decided that only paraphrases or short quotes, not easily traceable, would be used in the write up and analysis.

Furthermore, although not planned, some direct communication with women was unavoidable. For example there were occasions when, due to the sensitivity of e-mail content provided by one woman, it was necessary for a member of the research team to respond directly. Women sometimes requested clarification of their eligibility to participate in the study, asked for advice, feedback, requested collaboration on other projects or made offers to provide more information on the experience of their illness. In these instances it was felt necessary to respond to women directly and an e-mail response was made by the researcher.

Figure 1 Banner and questions posted on internet discussion boards

"Banner" and Questions for "invited" postings

Do you have experience of feeling depressed during pregnancy?

An ongoing study at the Mother & Infant Research Unit, University of York is aiming to improve the care of pregnant women who feel depressed during pregnancy.

We particularly want to hear women's experiences of the ways in which midwives and GPs have or have not been helpful.

We would be most grateful for your postings on this site telling us about your experiences. Maybe you did not want to talk to your midwife or GP. If so, we'd be interested to know why not. If you did talk to them, was it easy to do? Was there anything that they did which made it easier or more difficult? Were they able to help?

We look forward to your postings. Anything around this topic will be potentially useful to us in helping to improve women's care.

The study is funded an independent charity, the Burdett Trust and has been approved by the Health Sciences Research Governance Committee at the University of York. If you would like to know more about the Mother & Infant Research Unit, please see www.york.ac.uk/healthsciences/research/miru.htm.

Thank you, in advance for your help which is much appreciated.

Please note that we will not be responding to postings here other than to say thank you. Please continue to use the antenatal message board if you are seeking advice and support.

Data analysis of e-mails and internet postings. Preliminary analyses of the postings indicate that women did not always address the questions that were asked of them. This was not entirely surprising given that internet mediated data often allows little researcher control over data collected. For example the researcher is unable to clarify with respondents the meaning of the questions being asked or to probe responses from the respondent for further details (Eysenbach and Till, 2001).

Inclusion and exclusion criteria. A total of 26 women forwarded e-mails or made postings to the two discussion boards, in response to questions about the care they received from midwives and GPs when experiencing depression in pregnancy. The purpose of the study was to investigate care delivered to pregnant women living in the UK. When women did disclose that their care was non-UK based, their postings or e-mails were excluded from the analysis. Postings and e-mails

were also excluded from analysis if they did not contain discussion relevant to the study. For example, those postings and e-mails which exclusively contained advice, support or encouragement, a request to sign a petition or for clarification of eligibility to participate in the study, were excluded from the analysis.

One woman, whose discussion was included in the study, made contributions using both postings and e-mail. Both these data sources contained different aspects of her experience of care in relation to antenatal depression and therefore were counted as two separate contributions.

From a total of 35 postings and e-mails, sent in response to a banner posted on two discussion boards over a nine month period, 24 postings and e-mails were included in the analysis (12 postings from PNI-UK.com, six postings from mothersvoice.org.uk and six private e-mails from users of mothersvoice.org.uk and PNI-UK.com). From a total of 26 participants who made postings or sent e-mails, discussions from 22 participants were included in the analysis. Four participants who responded to the banner were excluded from the analysis.

Findings

Analysis of data

Data were analysed using thematic analysis (Braun and Clarke, 2006). Data were searched to find repeated patterns of meaning and issues of potential interest in the postings and e-mails. This involved repeated reading of the 24 postings and e-mails in an active way to gain familiarity. After familiarization with the postings, a list of codes was generated. Codes can be defined as elements of raw data which have a meaningful relationship and inform the topic under investigation (Braun and Clarke, 2006). Two academic members of staff from the university where the study was hosted, conducted an independent analysis of internet posting and e-mails. After discussion with the author a consensus was reached regarding interpretation of the data.

Women's discussion of the care they received during pregnancy could be classified under the following themes: reasons for non-disclosure of symptoms; midwives and GPs ability to help (see Table I, Midwives and GPs knowledge & Systematic barriers and attitudes of professionals); care received from mental health services (see Table I, Systemic barriers and attitudes of professionals); use of antidepressant medication; and what care did women find helpful? (Table I). Women also discussed the type of care that they would liked to have received from GPs and midwives.

Reasons for non-disclosure of symptoms. While one woman did report that she had spoken to her GP who was "lovely" other women did not find disclosure easy. Five women reported not having spoken to a midwife or GP about their depressive symptoms – "never said anything", while other women reported "trying" or having "tried hard" to get help from their midwives and GPs.

One reason for women's failure to disclose appeared to be a perceived lack of confidence in the response they would receive from GPs and midwives. Women believed either, that effective care could not be provided – "Did not want to talk to my GP, nothing they could do for me", or that disclosure would result in them losing custody of their child; women were frightened and therefore did not say anything. One woman believed she would be criticized if she disclosed her feelings:

> put on a brave face when I see midwife […] don't want people judging me […].

Other women reported their depressive symptoms were dismissed by GPs and midwives as normal for pregnancy or due to pregnancy "hormones".

Some women did not want to discuss the feelings they were experiencing because they "felt ungrateful not to be ecstatic I was finally pregnant", while other women did not disclose their symptoms until after they had given birth.

Midwives and GPs ability to help. Women's responses to whether health professionals were able to help them after disclosure of their symptoms can be categorized under two sub-themes:

- GPs and midwives knowledge of perinatal mental health problems; and
- attitudes of midwives and GPs.

Table I Findings from analysis of internet postings from women

Non-disclosure of symptoms	Did not want to talk to my GP, nothing they could do for me Never said anything, thought someone would take children away Scared Dr would think I did not love baby and they would take him away Tried hard to speak to GPs but they would not help unless I gave up breast feeding Put on a brave face when I see the midwife. Do not want people judging me and not believing me
Midwives and GPs knowledge	GP well informed on perinatal mental health Put down to hormones in pregnancy Doctor told me I had anxiety which I had worked out for myself All doctor did was give me a leaflet on depression Midwife and doctor were understanding but that was about it Mostly they were out of their depth and decided they would ignore it Medics and midwives understand body mechanisms but not mind
Systematic barriers and attitudes of professionals	Not understood, emotional needs are not being met GP treated me as an intelligent human being Wish I had got the help I needed Seen six midwives during pregnancy, never see the same midwife My mw (midwife) appointments were quick and rushed and I did not have time to complain about my feelings Felt antenatal care was a low priority as it was my 4th baby Midwife and doctor were sympathetic but that was about it
Antidepressant medication	Stopped ant-depressants before pregnancy – no information on the side effects of them Doctor refused medication if I intended to breast feed Came off anti-depressants to become pregnant Periodically taken SSRI's – came off them when found I was pregnant Came off all prescribed meds when pregnant
What helped?	Depression lifted when my baby was born With the help of meds and the discussion board slowly becoming the person I used to be Discussion board website and medication Sertraline – now fine postnatally Still struggling despite the baby being 15 months old Not only person who feels like this, feelings do not mean you are a failure, there are people who understand – can give you a sense of relief. Did not want conventional meds – meditation, relaxation and reading – understanding and explanation from obstetrician

GPs and midwives knowledge of perinatal mental health problems. While one woman believed that her "GP was well informed on perinatal mental health", the majority of women were critical of the knowledge and understanding of GPs and midwives and their access to resources. One woman described her health providers as being "out of their depth" in their management of her depression while another reported she would have liked her doctor or midwife "to have been more informed" or to have had more experience in caring for women with mental health problems. Doctors and midwives were reported as being sympathetic to women's problems of depression, but lacking in specialist skills:

> […] Drs and midwives were sympathetic, but that's about it […].

Three women reported doctors explained the symptoms they were experiencing as a result of "hormones" while another woman reported doctors had "normalized" her symptoms. This resulted in women believing their symptoms had "not [been] taken seriously".

There was a perception among women that midwives and doctors had not received sufficient training in perinatal mental health. Women believed there to be more emphasis on the physical aspects of pregnancy and childbirth, with less emphasis on women's emotional needs. One woman wrote:

> Medics and midwives understand body mechanisms but not mind.

Women perceived education and training related to perinatal mental health to be a neglected area of care. Another woman wrote:

> […] .don't think medical profession trained enough […].

The severity of women's depression was often not picked up by health providers with women describing midwives and GPs as "understanding, but that was about it", Women reported being offered written information from doctors (leaflets) when they needed practical help and support. Women believed doctors patronized their illness "told me I had anxiety, which I worked out for myself" or alternatively, ignored them. Advice, when it was provided, was sometimes dubious. For example one woman was advised that it was "normal not to feel anything for her unborn baby".

Attitudes of health professionals. Three women reported the attitudes and response from health professionals positively, with one woman commenting that she believed her GP and consultant were "very, very worried" and another described her doctor as "understanding and caring". One woman felt it important to report that her GP had treated her as "an intelligent human being" Some women reported being happy with their care, "when I hit rock bottom, doctor very caring and understanding".

However these experiences were not shared by all women. Women reported suffering considerably when symptoms they disclosed to the midwife or doctor were not taken seriously. For example one woman wrote:

> I went in needing some help and support but came out being told some people have real problems.

Some women felt undermined by the responses they received from doctors and midwives and another reported being laughed at by her consultant when she told him she was depressed. One woman wrote:

> […] hospital told me to stop being irrational […] told some people have real problems […].

Not being listened and not being helped were dominant themes in the postings from women.

Another woman was left feeling "not understood" and commented that her emotional needs had not being met. Other women felt that their experience of depression was a low priority for health professionals; this was especially true for those women in their second or subsequent pregnancy.

Care from mental health services. Six women reported having been referred to mental health services for depressive illness and again women were often unhappy with their care. For example, women reported delays with gaining access to services – "mental health services taking their time, so gave up". Frequent cancellation of appointments and long waiting lists to receive counselling were described by women:

> […] so pressed for time […] never got any counseling or CBT as requested, so had to opt for medication as no other alternative […].

Due to the lack of urgency with which referrals to mental health services were made led some women to believe their symptoms had not been taken seriously. One woman reported not being given a referral to mental health services despite experiencing suicidal ideation. When they did receive a referral to mental health services this was not always considered a positive experience for women. One woman described her experience of care from the community psychiatric nurse as "horrible". Mental health services appeared to provide the "cheapest, easiest option" in the care women were offered with one woman feeling like a "second class citizen" when accessing mental health services.

Use of antidepressant medication. Women described antidepressant medication as the main treatment option. However women were uneasy and concerned about the safety of antidepressant medication during pregnancy. Consequently, women reported stopping their medication, without medical advice, either when they were planning a pregnancy or when they became pregnant. Other women were advised to stop antidepressant medication by their doctor if they intended to breast feed. Women felt ill-informed and wanted more information on the side effects of antidepressant medication. The perception from one woman was that anti-depressants were the only option available and that they were an inferior treatment option.

What care women did women want?. Women wanted more support and help from health professionals:

> I think more understanding and genuine concern would have helped.

One woman recognized the stigma surrounding mental health issues and regretted her own lack of understanding and awareness of depression in pregnancy. This, she felt, made it difficult to for her cope with her depression.

What care did women find helpful?. Women reported that being listened to, especially by someone who understood the problems they were experiencing was paramount in helping them cope with mental health problems:

> […] understanding that you are not the only person to feel like this […] that there are people who understand […].can give you a sense of relief/comfort.

Women found the support they received from other women who participated in the internet discussion groups helped them cope with the symptoms they were experiencing. One woman found antidepressant medication helpful in overcoming her depression, but alternative therapies such as meditation, relaxation and counselling were also found to be helpful by another woman. Although only one woman reported that her mental health problems had lifted after the birth of her baby, another woman reported that she was still struggling with depression several months after having given birth.

Discussion

Up to 25 per cent of women will experience some form of mental health problem during pregnancy (O'Keane and Marsh, 2007). Antenatal depression if unresolved can have severe consequences not only for those women affected (Bansil *et al.*, 2010) but for the unborn child (Grote *et al.*, 2010; Kim *et al.*, 2013) the infant (Bauer *et al.*, 2014b; Glover, 2014) and also for partners and families. A confidential report on the causes of maternal mortality has identified mental health problems as a leading indirect cause of maternal morbidity and mortality. Provision of perinatal and perinatal mental health services was identified as a contributory factor (MBRRACE, 2014).

Women in the current study had difficulty disclosing the symptoms they were experiencing due to the perceived and actual responses they received from health professionals. Women felt they would not be believed, their symptoms dismissed as normal or their competency as a parent questioned. Lack of knowledge among GPs and midwives on perinatal mental health issues contributed to women's failure to disclose and women believed there was less emphasis on emotional well-being of pregnancy in contrast to the physical aspects of their care.

When women did manage to access treatment the response from mental health services was believed to be slow and poorly timed. Women often disliked pharmacological treatments, often preferring alternative therapies. Having contact with another person who understood their experiences was found to be most helpful to women. Women wanted more understanding and genuine concern from GPs and midwives.

Findings from this study are consistent with those from other studies which examine provision of care for women with perinatal mental health problems.

Disclosure of symptoms

Up to 33 per cent of pregnant women do not disclose symptoms of depressive illness to their health provider (Boots Family Health Alliance, 2013) and a significant contributing factor is the shame and guilt of having a mental illness (Raymond, 2009; Byatt *et al.*, 2013; Foulkes, 2011; Lara-Cinisomo *et al.*, 2014; Koppleman *et al.*, 2008). Mothering and nurturing are central to many women's lives and the pressure to be a "good mother" is considerable. As a result any association with being labelled a "bad mother" is a major barrier to women's disclosure of depressive illness. Depression or sadness during pregnancy or around the time of birth can be seen, by women and by others, as a sign of failure and of woman's inability to be a "good mother" (Raymond, 2009; Byatt *et al.*, 2013).

Antidepressant medication

Use of antidepressant medication during pregnancy and while breast feeding continues to be a divisive issue (Hackley, 2010; Koppleman *et al.*, 2008; Zuckerman *et al.*, 1989). One of the major concerns among both women and health care providers are the teratogenic effects of antidepressant medication on the fetus and infant. Although limited and often inconclusive evidence exists on the safety of drugs during pregnancy (Hackley, 2010) some drugs have been deemed safe, for example Sertaline (Zolqit) and Paroxetine (Paxit) have been shown to be safe for breast feeding women (Hackley, 2010) and Sertaline (Zolgit) during pregnancy (Hackley, 2010).Untreated depression is not without risks to the mother, fetus and infant (Hackley, 2010). As previously discussed, pregnant women and new mothers affected by depression are at risk of suicide (Appleby, 1991) poor self-care (Hackley, 2010) pre-term birth (Grote *et al.*, 2010), behavioural and mental health outcomes for the child (Bauer *et al.*, 2014a; Graignic-Phillipe *et al.*, 2014; Glover, 2014). Additionally, although relapse of depression increases in women during pregnancy, it is much higher in women who discontinue their antidepressant medication (Hackley, 2010). Treatment of depression during pregnancy involves balancing the risk of adverse effects of antidepressant medication on the mother and foetus with the adverse effects on the mother and infant of leaving depression untreated (Hackley, 2010). Every woman's circumstances should be assessed and treated individually.

Women in this study perceived antidepressant medication to be the "cheapest, easiest option" available. This is consistent with other studies where women viewed doctors as "pushing meds" (Byatt *et al.*, 2012)' and medication as a "quick fix" or "band aid" to the reality of their illness (Foulkes, 2011).

There are times when women undoubtedly do need and benefit from antidepressant medication as women in this study and other studies, clearly testify (Dennis and Chung-Lee, 2006; Foulkes, 2011). However consistent with the findings in this study, many women have been shown to have a "strong distaste" for pharmacological interventions (Foulkes, 2011) and prefer non-pharmacological treatments for depressive symptoms (Dennis and Chung-Lee, 2006). There is often a stigma associated with taking antidepressant medication and for women, resorting to this form of treatment can "solidify the depth of their illness" (Foulkes, 2011, p. 455).

The belief that pharmacological therapies are the only treatment on offer can affect a woman's decision to seek treatment, for example, women will not go to their doctor with depressive symptoms if they feel antidepressant medication is the only treatment option available (Foulkes, 2011).

Again, consistent with other studies, women in the current study did not feel they were provided with enough information about the side effects of antidepressant medication (Dennis and Chung-Lee, 2006). As a result women found decisions about whether or not to take antidepressant medication difficult because they were uncertain about the impact this might have on the fetus (Walton *et al.*, 2014). More rigorous research to provide clear answers to pregnant women about the risks and benefits of antidepressant medication are needed (Walton *et al.*, 2014). Additionally, the perceived lack of knowledge among health professionals of the safety of antidepressant medication often prevents women from discussing these issues with their carer (Byatt *et al.*, 2013).

Interactions with health providers

Individual's interactions with health providers play a key role in influencing patient decisions about treatment utilization. A critical component of women's accounts of successful connection with mental health treatment involves making a connection with an empathetic and knowledgeable health care provider (Henshaw *et al.*, 2011, p. 938). Women in the current study often described interactions with doctors and midwives where they felt undermined, not listened to and not helped.

The responses that women received and the attitudes of GPs and midwives when caring for women in this study often prevented good interactions. This is consistent with other findings, for example Byatt *et al.* (2012) found that when women attempt to seek help for mental health problems they perceive avoidance among health professionals (Byatt *et al.*, 2012, 2013).

McCauley *et al.* (2011) also found that midwives tended to avoid those women with serious mental health problems (McCauley *et al.*, 2011). As a result of poor interactions with health providers women with perinatal mental health problems felt ignored, traumatized, disregarded and uncomfortable when accessing care (Byatt *et al.*, 2013).

Being listened to and treated in a respectful, non-judgemental way with the practitioner displaying interest and enabling women to have control over treatment decision is an important element in women engaging with advice and the treatment options that are being recommended (Henshaw *et al.*, 2011). When this does not happen women are left feeling patronised, exacerbating their feelings of low self-worth and guilt at being unable to cope and lack of appreciation of their experience as a real illness (Holopainen, 2002). Evidence would suggest that women who experience perinatal mental health problems want genuine, warm and optimist care which facilitates development of a trusting relationship with their health provider (Henshaw *et al.*, 2011).

GPs and midwives knowledge of perinatal mental health

Lack of knowledge of perinatal mental health among health professionals has been highlighted as a major barrier to care (Byatt *et al.*, 2012, 2013; Jarrett, 2014, 2015; McCauley *et al.*, 2011; Dennis and Chung-Lee, 2006). Lack of knowledge and skills (Byatt *et al.*, 2012; McCauley *et al.*, 2011) inability to identify risk factors (Jarrett, 2015), and inability to identity symptoms of perinatal mental illness (McCauley *et al.*, 2011) have all been highlighted as problematic in the care of women with perinatal mental health problems. In a survey assessing midwives attitudes Jones *et al.* found that midwives perceived lack of competency in perinatal mental health issues influenced their motivation and engagement with women thereby compromising care. Inadequate mental health training combined with lack of resources can affect the confidence and motivation of those providing care (Byatt *et al.*, 2012).

Consistent with this study, other researchers have commented on the apparent low priority among health providers regarding perinatal mental health care. For example, McCauley *et al.* (2011) found mental health assessment was considered the least important skill among midwives in their care of women (McCauley *et al.*, 2011). Midwives have described themselves as "out of their depth" (McCauley *et al.*, 2011) while other health professionals believed they were "not qualified" (Byatt *et al.*, 2013) to provide care for women with serious mental health problems. Those caring for pregnant women with mental health problems recognize how deficiencies in their own knowledge and confidence often impact on quality of care (Byatt *et al.*, 2013). While also acknowledging that they often hoped women did not disclose depression symptoms because they lacked confidence in providing offering care and support to women (Byatt *et al.*, 2013).

Professional and systemic barriers

The perinatal care environment has often been identified as not designed or equipped to provide mental health support to women and not an appropriate place to address mental health problems (Byatt *et al.*, 2013). Consistent with other studies, women often report appointments as quick and rushed, giving them little time to discuss depressive symptoms (Boots Family Health Alliance, 2013; Edge, 2011; Raymond, 2009). Often Women see several midwives and doctors during their pregnancy which further prevents them from disclosing symptoms.

The perception of "busyness" can have a detrimental effect on women's ability or willingness to disclose mental health problems (Boots Family Health Alliance, 2013; Edge, 2011). Health professionals "busyness" often invalidates a woman's needs, making her feel like an "irritant" and reluctant to disclose problems (Edge, 2011).

Fragmentation of care, especially when women see multiple health professionals during pregnancy can add to a women's emotional isolation (Boots Family Health Alliance, 2013; Raymond, 2009). Additionally, women do not want to tell "ten different people [their] story" (Raymond, 2009, p. 46). Those women who receive one-to-one care, although depressed, are shown to have a more positive experience of pregnancy than those women receiving care from multiple health providers (Raymond, 2009).

What helped?

When women were asked to identify what helped them in their recovery two women suggested that antidepressant medication had helped them. One woman suggested that private counselling was beneficial. However, the majority of women suggested that discussion and dialogue with others who were going through the same thing, for example, those using the discussion boards, was helpful. Understanding and explanation from health professionals also helped women feel more hopeful.

Peer-to-peer relationship support and peer support has been shown to be beneficial to women experiencing perinatal mental health problems (Byatt *et al.*, 2012; Seefat-van Teefflen *et al.*, 2011). Other research suggests that women experiencing perinatal mental health problems do benefit from having contact with women who have made a successful recovery (Byatt *et al.*, 2012). Raymond (2009) also found that women benefitted from meeting other women and accessing community services during pregnancy. In this study pregnant women with depression had used the term "safety net" to describe the support they had received. Connection with other women who were experiencing or who had experienced similar difficulties during pregnancy either via the internet or face to face was seen as helpful by the majority of women that were interviewed (Raymond, 2009).

What did women want?

It is interesting that women did not offer or suggest types of treatment or medication, but the attitude of the health provider was believed important. Genuine concern, warmth and optimism, were attributes that women sought in their health perinatal health providers (Henshaw *et al.*, 2011). Consistent with the findings presented here, women wanted clinicians with expertise but who also demonstrated a style of interaction which communicated authenticity and concern. This might enable women to develop a relationship of trust with their clinician (Henshaw *et al.*, 2011).

Limitations

A number of limitations were identified in the study. Although many women provided information that was relevant and despite asking specific questions about care when depressed, some women gave information on the symptoms they were experiencing, the causes of their depression or relationship problems they were experiencing. One of the difficulties of using internet generated research, over more traditional methods of enquiry, is the lack of researcher control over the research environment. Researchers are often unable to exert any control over the reactions of the participants to the research questions posed, the environmental conditions in which they were responding under or who the participants are (The British Psychological Society, 2006).

Those who post to internet discussion groups generally expect their postings to be private and not accessed by those outside of the group. Researchers "lurking" or using internet sites as a data source can be seen as intrusive and damaging to the level of trust which exists within the discussion group community. For these reasons, it was believed some women in the current study might have been reluctant to participate in an internet-based research project.

Although some biographical information was available on women who posted on the one of the internet forum website, it was not enough to establish the background or the diversity of the sample. There is some evidence there is self-selection bias inherent in research using internet discussion groups (Bordia, 1996) and although large numbers of people now have internet access there are segments of the community who do not and therefore would have potentially been excluded from this study.

A further limitation was that no clinical judgement was made as to whether or not participants were suffering from antenatal depression. However, the underlying belief of the author is that mental health and well-being is often a realization made by the individual and consequently often cannot be assigned by others. Mental health is often a personal and subjective experience and each individual has a sense

of their own mental health and well-being. On this premise an individual experiencing mild to moderate depression would know whether they are mentally well or otherwise (Tenoweth *et al.*, 2011).

Finally, in order to protect the confidentiality and anonymity of the respondents, it was agreed to use paraphrases or short quotes in the analysis of postings. This may have led to a less than rich and illustrative account of the analysis presented (Ritchie *et al.*, 2013). However, many of these limitations were compensated by the much wider access and lack of censored responses provided by women that only internet generated data are able to provide (Chen *et al.*, 2004).

Conclusion

Depression during pregnancy is a significant cause of maternal mortality and morbidity. Inadequate service provision has been highlighted as a contributing factor. This study aims to better understand the perspectives of women who seek help from their GPs and midwives when they experience symptoms of depression during pregnancy. Although some women found the response of health providers helpful, the majority of women did not. Women's perceived responses from GPs and midwives often prevented them from disclosing symptoms. When women did disclose symptoms they found responses and treatment options below par and below their expectations.

User perspectives are often a good indicator of quality and standards of health service provision. On this premise, findings from this study imply improvements to those services caring for women with pregnancy related depression are needed. Primarily, there should be adequate training among GPs, midwives and obstetricians on the emotional needs of women during pregnancy. Mental health of women during pregnancy should have parity with physical well-being. Midwives and GPs should understand the difficulties prevent women may experience in disclosing symptoms of depression and facilitate disclosure by offering an informed but genuine and empathic manner. A relationship offering continuity and built on trust appears important for women to disclose depressive symptoms. Women often perceive appointments as rushed indicating. GPs and midwives require adequate time to support and counsel women effectively. Finally, pharmacological therapies are often preferred by women, especially during pregnancy and therefore improved access and increased availability is required.

Note

1. Banners are interactive online advertisements in the form of a graphic image that typically runs across the top or bottom of a web page. When a user clicks on the banner they are sent through to the advertiser's website or an advertisers landing page.

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