

Perinatal Mental Health Services: A Preliminary Needs Assessment from the Consumer Perspective

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Keywords: perinatal mood disorders, perinatal assessment, perinatal prevention, perinatal treatment, perinatal mental health services

Abstract: This study is a preliminary community needs assessment of the current status of services for Perinatal Mood Disorders (PMD) including mental health assessment, prevention, and treatment services available to women in Central Washington State. Due to the prevalence rates of PMD and the negative outcomes for women, children and families, it is important that women at risk for PMD be identified and treated. This study surveyed women who gave birth between one to two years ago about their experiences with health care professionals regarding assessment, prevention, and treatment services. Barriers to care were also considered in the assessment. Results indicate a lack of assessment around mental health history, partner relationship, and life stressors; and a lack of prevention services addressing stress management and relationship counseling. The results also showed strengths of the community including breastfeeding support, individual counseling, group counseling, and adjunctive therapies. With a better understanding of service availability and quality from the mother's perspective, future services may be enhanced.

Introduction and Review of Literature

The experience of pregnancy for a woman can be described as a time of growth or a new stage of life (Solchany, 2001), which includes physical, psychological, and emotional change. Certain risk factors such as family violence, unplanned pregnancy, or a lack of social support can make this time more difficult for expectant mothers. Mental health can be affected, which can have harmful effects on the mother, the child, and the family (Stewart, Dean, Gregorich, Brawarsky, & Haas, 2007), and social support can act as a buffer to these stressors (Perrin & McDermott, 1997). This study assessed the availability and quality of maternal mental health services, including interventions aimed at reducing symptoms of

mood disorders, such as anxiety, depression, and posttraumatic stress disorder. The term perinatal mood disorder (PMD) will be used to include all of these disorders and will encompass the time during pregnancy and up to one year postpartum. The majority of the literature to date focuses on perinatal depression, which is defined as depression during pregnancy and up to 1 year postpartum (Austin, 2003). Therefore, much of the following discussion will focus on perinatal depression.

Postpartum depression has recently become more publicized due to heightened awareness of negative outcomes and the vulnerability to depression during the postpartum period (Lusskin, Punsiaak, & Habib, 2007). There has been a push from various organizations in Washington State, such as Postpartum Support International of Washington and Stepping Up, to educate both

women and health care providers about PMD. The need to recognize and treat postpartum depression has been stressed because of the growing amount of research on the negative outcomes for women, children, and their families. More research has been done on postpartum depression than on depression during pregnancy, though pregnancy is beginning to be recognized as a time for assessment and prevention (Austin, 2003; Lusskin et al.; Mian, 2005).

Depression during the perinatal period is related to poor maternal health, negative outcomes for children, and marital dissatisfaction (Stewart et al., 2007). Mothers with depression during pregnancy are less likely to utilize prenatal care and are more likely to use alcohol and drugs (Lusskin et al., 2007). Therefore, the mother-infant bond may be at risk (Moehler, Brunner, Wiebel, Reck, & Resch, 2006), and infant cognitive, behavioral, and social development may be compromised (Milgrom, Ericksen, McCarthy, & Gemmill, 2006). Depressive symptoms in the mother can have negative effects on marital satisfaction for both partners (Zelkowitz & Milet, 1996). Because of the potential negative outcome of perinatal depression on children and families, effective interventions are warranted. Symptoms of depression during the perinatal period should be recognized early so that appropriate prevention and treatment services can be accessed.

Depression during pregnancy and postpartum is not rare. Prevalence rates of major and minor depression at various points during pregnancy range from 8.5% to 11.0% and from 6.5% to 12.9% at various points during the first year postpartum. However, prevalence rates of PMD remain uncertain because of poor screening accuracy and may be higher (Gaynes et al., 2005). Prevalence rates of other mental health concerns during pregnancy are also noted: posttraumatic stress disorder ranges from 3.5% to 7.7% (Twohig & O'Donohue, 2007), and anxiety disorders can be as high as 6.6% (Alder, Fink, Bitzer, Hosli, & Holsgrave, 2007). These are often comorbid with

depression and also have negative outcomes for women and families (Harris-Britt, Martin, Li, Casanueva, & Kupper, 2004; Smith, Poschman, Cavaleri, Howell, & Yonkers, 2006).

Preliminary research suggests that low-income women are at a greater risk for depression (Segre, O'Hara, Arndt, & Stuart, 2007) and that Latina women may have higher rates of depression than non-Latina women (Chaudron et al., 2005). In a study that included 4,332 women, Segre et al. found the prevalence rates of postpartum depression to be as high as 20% among low-income women, which was almost two and a half times higher than the percentage of depression in the highest income group (7.5%). Another study found that 28% of Latinas self-identified as needing help with depression since the birth of their babies, and fewer than half of these women discussed feelings of depression with their health care providers (Chaudron et al., 2005).

Depression during the perinatal period is often under diagnosed. Recognition of this disorder is infrequent, both by the mother and by health care professionals. Studies indicate that as many as half of postpartum depression cases go undiagnosed because of a lack of screening (Chaudron, Szilagyi, Kitzman, Wadkins, & Conwell, 2004; Goldsmith, 2007), and even with identification, few women receive adequate services (Lusskin et al., 2007). Mothers may also be unwilling to acknowledge their depression because of the stigma associated with mental illness, the fear of negative repercussions for their families, and the guilt of feeling depressed during motherhood (Chaudron et al., 2005). Identifying women at risk for depression is the first step to intervention.

Prevention and treatment availability is another component of helping women with PMD. There are a number of identified risk factors that can lead to perinatal depression, such as previous history of depression, lack of social support, and anxiety during pregnancy (Bowen & Muhajarine, 2006; Leigh & Milgrom, 2008; Lusskin et al., 2007; O'Hara & Swain, 1996). With identifiable risk

factors, adequate prevention services can be utilized to decrease depression rates. Treatment of depression during pregnancy has been explored to prevent postpartum depression (Spinelli & Endicott, 2003). Some interventions that have been explored are brief cognitive behavior therapy, building social support networks, and interpersonal therapy. However, there are mixed results on the efficacy of these interventions during pregnancy (Austin, 2003). Treatment interventions for postpartum depression are supported by data (Bledsoe & Grote, 2006), and therefore can be employed to help decrease the negative outcome of postpartum depression. These interventions include medication in combination with cognitive behavior therapy; medication alone; interpersonal therapy; and group therapy that included cognitive behavioral therapy, education, and transactional analysis components (Misri & Kendrick, 2007). Since there may be a large segment of the population that is not receiving adequate screening, it follows that many women are not receiving needed treatment services.

This study looked at Kittitas and Yakima counties in Washington State. There are a high percentage of births paid for by Medicaid in these counties, indicating a high percentage of low-income women. There are also a high percentage of Latina women giving birth, and, in 2005, 53.9% of Latinas were on Medicaid in Yakima County (Cawthon, 2006). Economic status and ethnic variables may impact prevalence rates and access to services (Segre, et al., 2007). Based on this demographic information, it is possible that the incidence of perinatal mood disorders in these counties may be higher than the national prevalence rates previously discussed. In the Washington State Mental Health Resources and Needs Assessment Study (Kohlenberg et al., 2006), consumers and service providers agreed that there is a lack of services in rural areas, transportation is difficult, and services are culturally and linguistically inappropriate. Because low-income and Latina women are at

high risk for depression and may experience barriers to care, community assessment of screening, prevention, and treatment are clearly indicated.

Due to the prevalence of perinatal depression and the negative outcomes for women and their children and families, it is important to know what kinds of services are available to women in order to improve the quality and availability of care. Barriers to care are also considered as part of the assessment. With more information on consumer perspectives of prevention, assessment, treatment services and barriers, areas for improvement can be identified.

Purpose of Study

The purpose of this study was to conduct a needs assessment to determine the consumer perspective of the current status of mental health prevention, assessment, and treatment services available to women during pregnancy and up to one year postpartum in Kittitas and Yakima counties. Specific research questions to be addressed follow.

Prevalence: How often did women feel sad or worried during the perinatal period; how often did they discuss those feelings with a health care professional; and did they receive a diagnosis?

Assessment/Screening: How often were women screened for specific risk factors that indicate depression or anxiety, and how important was it for women to be asked about these risk factors?

Prevention: What prevention services were available to women during the perinatal period?

Treatment: What treatment services were available to women during the perinatal period?

Barriers to Care: What barriers to service did women experience during the perinatal period?

Exploratory Hypothesis 1. Latina women will perceive more barriers to care due to cultural differences, language differences, and not wanting to be labeled depressed than White women.

Methods

Participants

A total of 98 women returned surveys. Of the 95 participants who reported the county that they lived in, 88.4% (n = 84) reported living in Kittitas County and 11.2% (n = 11) in Yakima County. Of the 95 participants who reported their race/ethnicity, 85.3% (n = 81) were White, 12.6% (n = 12) were Latina, 1.1% (n = 1) were Native American, and 1.1% (n = 1) were mixed race. Of the 85 participants who reported their primary language, 84.7% (n = 72) reported English and 15.3% (n = 13) reported Spanish. Of the 86 participants who reported their household yearly income, 24.4% (n = 21) reported an income below \$20,000, 19.8% (n = 17) reported income between \$21,000 and \$39,000, 26.7% (n = 23) reported income between \$40,000 and \$59,000, 20.9% (n = 18) reported income between \$60,000 and \$99,000, and 8.1% (n = 7) reported income of \$100,000 or more. Of the 90 participants who reported their medical coverage, 43.4% (n = 39) reported using Medicaid or basic health, 47.8% (n = 43) reported using private insurance, and 8.9% (n = 8) reported self-pay.

Instrument

The self-report survey contains 16 closed questions with multiple parts, four open-ended questions, and demographic questions. The closed questions are followed by a 4-point Likert-type response scale including wording: never, rarely, sometimes, and always; never, once, a few times, and every time; and strongly disagree, disagree, agree, and strongly agree. The items were created based on recent literature as well as adapted from existing surveys by LaRocco (2001), St. John (1999), and Olsen et al., (2002). After the construction of the survey, expert feedback was obtained and revisions made to the items. The survey addresses assessment, prevention, and treatment service availability and barriers to care. Cronbach's alpha ranged from .777 to .921,

indicating adequate to good internal consistency.

Data Collection

Five hundred and thirty surveys were distributed or mailed out. Each survey sent was in English and Spanish and online in English through mother e-mail groups in the two counties. Women were surveyed through Kittitas Valley Community Hospital in Ellensburg and the Central Washington Perinatal Task Force in Yakima. Kittitas Valley hospital mailed surveys to every woman in the county who had given birth within the previous year and had valid contact information (approximately 300). The Perinatal Task Force, including organizations such as Yakima Valley Memorial Hospital Maternal Services, Yakima Farm Workers Clinic, and Yakima Neighborhood Health, hand distributed surveys in Yakima. It is unknown how many of the 250 packets that were given to providers were delivered to potential participants. Ninety-eight surveys were returned, the majority of which were from the Kittitas county (n = 84) mailing of surveys. Only 4 surveys were returned from the online opportunity. The response rate for Kittitas County was 28%. However, a true response rate could not be calculated because of the availability of surveys online and not knowing how many surveys were delivered to participants in Yakima. All data collection procedures were reviewed and approved by the Human Subjects Review Committee at Central Washington University.

Evaluation of Data

Descriptive statistics were used to characterize the sample and describe self-reported attitudes and experiences related to mental health services for perinatal women. Specifically, women's perceptions of the availability of screening, prevention, and treatment services were determined by looking at the percentages of women who reported availability and use of services. The responses were collapsed into two categories, for example strongly agree and agree

were made into one category for clarity of reporting descriptive statistics. Mann-Whitney U tests were performed to detect exploratory differences in women's responses about barriers to services across ethnicity. A Bonferoni correction was used to adjust for alpha slippage ($p = .017$). The primary researcher analyzed the responses for the open-ended questions and categorized them into first-order themes, based on the language used by the participant. Broader themes or second-order themes were identified by collapsing similar first-order themes. Another researcher acted as an auditor, reviewing the open-ended responses. Feedback was provided to the primary researcher with possible changes to themes. Strengths and areas for improvement in mental health services for perinatal women are described based on the results.

Results

Prevalence

When asked how often they felt sad or worried during the perinatal period, 46.8% ($n = 45$) reported that they sometimes or always did. Of the 14 participants who identified themselves as Latina, Native American, or mixed, 64.2% ($n = 9$) reported sometimes or always feeling sad or

worried. When asked how often they brought up feeling sad or worried with a provider, 82.2% ($n = 79$) of participants reported never or rarely. When asked if they had received a mental health diagnosis (depression or anxiety) from a doctor or other provider, 10.4% ($n = 10$) of the participants reported that they had.

Assessment/Screening

Participants were asked how often they filled out a questionnaire about depression or anxiety during the perinatal period: 78.1% ($n = 75$) reported never and 14.6% ($n = 14$) reported once. Participants were asked how often they were screened for specific risk factors indicated in the literature on depression or anxiety during the perinatal period. Results showed that when participants were asked how often providers inquired about feelings of sadness or worry, 52.1% ($n = 50$) reported never or rarely. When asked how often they were asked about mental health history, 80.3% ($n = 77$) reported never or rarely. When asked how often they were asked about abuse or assault history, 85.4% ($n = 82$) reported never or rarely. Results are reported in Table 1. Participants strongly agreed or agreed (90.3%; $n = 84$) that it was important to them that their health care provider ask about these risk factors.

Table 1. Responses to Frequency of Assessment

Risk Factor	Never/rarely		Sometimes/ always	
	<i>n.</i>	% of total	<i>n</i>	% of total
Feelings of sadness or worry	50	52.1	46	47.9
Pregnancy problems	45	46.9	51	53.1
Mental health history	77	80.3	19	19.8
Abuse history	82	85.4	14	14.6
Partner relationship	56	58.3	40	41.7
Use of drugs/alcohol	54	56.9	41	43.1
Life stress	65	67.7	31	32.3
Social support	47	49.0	49	51.0
Self-care	54	56.8	41	43.2

Prevention

When asked about availability of 11 different prevention services, 92.7% (n = 76) of the participants indicated that childbirth education classes were available, and 51.2% (n = 42) indicated that they had attended these classes. However, of Latinas, 75.0% (n = 6) indicated that childbirth education classes were available to them and only 25.0% (n = 2) attended these

classes. The overall sample of participants indicated that breastfeeding support was available (n = 74, 91.4%), and 39.5% (n = 32) reported that they had used these services. However, 57.6% (n = 49) of participants indicated that stress management classes were not available and 52.3% (n = 45) indicated that relationship counseling was not available. Results are reported in Table 2.

Table 2. Responses to Prevention Service Availability

	Not available		Available, but I did not go		I went	
	<i>n</i>	% of total	<i>n</i>	% of total	<i>n</i>	% of total
Prevention service						
Childbirth classes	6	7.3	34	41.5	42	51.2
Parenting classes	25	30.1	47	56.6	11	11.2
Family planning	25	29.8	47	56.0	12	14.3
Stress management	49	57.6	34	40.0	2	2.4
Home visits	30	36.1	38	45.8	15	18.1
Support group	27	31.0	45	51.7	14	16.1
Nutrition counseling	26	31.0	37	44.0	20	23.8
Breastfeeding support	7	8.6	42	51.9	32	39.5
Individual counseling	36	41.9	44	51.2	6	7.0
Relationship counseling	45	52.3	38	44.2	3	3.5
Educational material	9	13.2	28	41.2	30	44.1

Table 3. Responses to Treatment Service Availability

	Not available		Available, but I did not go		I went	
	<i>n</i>	% of total	<i>n</i>	% of total	<i>n</i>	% of Total
Treatment service						
Individual counseling	28	33.3	51	60.7	5	6.0
Group counseling	37	43.0	49	57.0	0	0.0
Cognitive behavior therapy	44	53.7	36	43.9	2	2.4
Education groups	26	32.5	41	51.2	13	16.2
Adjunctive therapies	32	39.5	37	45.7	12	14.8
Medication	15	21.7	38	55.1	16	23.2
Educational material	28	33.3	51	60.7	5	6.0

Treatment

When asked about availability of six types of treatment services, 78.3% (n = 54) indicated that medication was available and 23.2% (n = 16) indicated that they had taken medication. Individual counseling was reported as being

available by 66.7% (n = 56) of participants and 6.0% (n = 5) reported attending counseling. Finally, 57.0% (n = 49) indicated that group counseling was available, however none reported attending. Among the Latinas, 62.5% (n = 5)

indicated group counseling was not available. Results are reported in Table 3.

Barriers to Care

When participants were asked about what made it hard to get help, 39.6% (n = 36) agreed or strongly agreed that money problems were a barrier, 33.4% (n = 31) agreed or strongly agreed that it was hard to find services, and 29.7% (n = 27) indicated that they did not want to be labeled

depressed. In the overall sample, 93.5% (n = 87) disagreed or strongly disagreed that language differences were a barrier and 89.1% (n = 82) disagreed or strongly disagreed that cultural differences were a barrier. However, among the Latinas, 41.7% (n = 5) agreed or strongly agreed that language differences were a barrier and 50.0% (n = 6) agreed or strongly agreed that cultural differences were a barrier. Results are reported in Table 4.

Table 4. Responses to Barriers to Care

Barrier	Disagreed/ strongly disagreed		Agreed/ strongly disagreed	
	n	% of total	n	% of Total
Not enough time with provider	69	74.2	24	25.8
Hard to find services	62	66.7	31	33.4
Provider didn't know about problem	78	84.8	14	15.2
Money problems	55	60.5	36	39.6
Insurance problems	65	70.7	27	29.4
Other health concerns	73	92.2	7	7.8
Hard to get services	76	82.7	16	17.3
Language differences	87	93.5	6	6.4
Cultural differences	82	89.1	10	10.8
Not wanting to be labeled depressed	64	70.4	27	29.7
Didn't want to discuss with provider	76	83.6	15	16.5
Time of day/year of services	79	86.8	12	13.2

Participants were asked the open question, "What are other problems with services in your community?" Of the 67 responses (one participant may respond with multiple themes), 25.0% indicated not enough services/classes/support, 13.4% indicated not enough information about services was available, and 13.4% indicated services were not personal enough.

Participants were asked the open question, "What services did you use and find helpful?" Of the 100 responses, 22.0% indicated programs such as WIC, First Steps, and Birth to Three, 21.2% indicated providers, and 18.1% indicated childbirth classes.

Participants were asked the open question, "What services do you wish you could have used?" Of the 77 responses, 46.7% indicated prevention such

as: childbirth education classes, support groups, parenting classes (including fathers), nutrition counseling, breastfeeding support, family planning, home visits, and relationship counseling.

Hypothesis 1

To examine the first hypothesis, the differences in participants' responses were analyzed using three nonparametric Mann-Whitney U tests to determine whether there was a significant difference between the White and Latina participants' perceptions of cultural barriers, language barriers, and stigma of being labeled depressed. A Bonferroni correction was used to correct for alpha slippage, and the adjusted significance level was set at .017.

For cultural barriers, the sum of the ranks for the White group ($n = 77$) was 3,267.50, while the sum of ranks for the Latina group that responded ($n = 11$) was 648.50. The mean rank for the Latina group was significantly higher than that of the White group ($z = -2.446$, $p = .014$, $\eta^2 = .26$), indicating that the Latina group perceived more cultural barriers to services during the perinatal period. The effect size was large.

For language barriers, the sum of the ranks for the White group ($n = 76$) was 3,288.0, while the sum of ranks for the Latina group that responded ($n = 11$) was 540.00. The mean rank for the Latina group was significantly higher than that of the White group ($z = -3.324$, $p = .001$, $\eta^2 = .35$), indicating that the Latina group perceived language as a barrier to care. The effect size was large.

For stigma of being labeled depressed the mean ranks showed no significant difference ($z = -.766$, $p = .443$, $\eta^2 = .08$). The hypothesis was partially accepted.

Discussion

The results indicate that 46.8% of participants reported being sad or worried some or all of the time during the perinatal period, while only 10.4% reported that they received a mental health diagnosis of depression or anxiety. This diagnosis rate is consistent with previous research on prevalence rates of major and minor depression which shows that incidences of depression can range from 8.5% to 11.0% during pregnancy and from 6.5% to 12.9% at various points during the first year postpartum (Gaynes et al., 2005). The high percentage of women indicating that they felt sad or worried during this time, along with the low diagnosis rate, may indicate under diagnosis and lack of screening in this community. The results also indicated that a large percentage (46.9% - 85.4% depending on the risk factor) of women perceived providers as not or rarely asking about many of the risk factors,

which may also support a lack of screening. Other research has shown that half of postpartum depression cases go undiagnosed because of a lack of screening (Chaudron et al., 2004; Goldsmith, 2007). The percentage of participants who reported being sad or worried is reminiscent of previous research done on postpartum depression. The Pregnancy Risk Assessment Monitoring System in Washington State found that 53.8% of women self-reported having low to moderate levels of postpartum depression, while 5.1% reported severe levels (Centers for Disease Control and Prevention, 2004).

Over 80% of women also indicated that they did not bring up feelings of sadness or worry with their providers. This may suggest that women are not recognizing symptoms of depression in themselves or that they are not comfortable bringing up these feelings with their providers. Previous research that has explored what kept women from seeking help for perinatal depression found that women chose to keep information to themselves because of lack of understanding and rapport with the health care providers and because of judgment or stigma associated with mental health services (Jesse, Dolbier, & Blanchard, 2008). Over 50% of women indicated that providers never or rarely asked about these feelings of sadness or worry. The results may suggest that providers are not asking about these feelings, or that women are not interpreting the providers' questions as asking about these feelings. Chaudron et al. (2005) suggest that providers may be more willing to discuss feelings of depression with mothers who recognize it in themselves and talk about it. This may mean that women need to advocate more for themselves during their appointments with providers. More education regarding PMD during the perinatal period for women and their partners may increase self-recognition and discussion with providers, thereby improving accurate diagnosis and access to prevention and treatment services. Buist et al. (2007) found that women who received an educational booklet about emotional health

during pregnancy and postpartum were better able to recognize their own emotional state.

The results indicated that 78.1% of women reported not filling out a questionnaire about depression or anxiety which is consistent with previous research indicating providers' lack of screening (Goldsmith, 2007; LaRocco-Cockburn, Melville, Bell, & Katon, 2003; Seehusen, Baldwin, Runkle, & Clark, 2005). Providers have indicated that they use a screening tool 20-32% of the time (Goldsmith; LaRocco-Cockburn et. al.). The results of this needs assessment also indicated that there was a lack of assessment around mental health history, abuse history, and life stressors, all of which are significant risk factors for PMD (Bowen & Muhajarine, 2006; Leigh & Milgrom, 2008; Lusskin et al., 2007; O'Hara & Swain, 1996). This suggests that the use of a formal screening tool is limited and important risk factors are not being assessed. Other research has also suggested that the use of standardized screening tools may improve the detection of depression (Chaudron et al., 2004). It may be beneficial to work with providers to incorporate a standardized screening tool that assesses for important risk factors and is used on a regular basis.

Interestingly, the results for the prevention services indicated that over 80% of women had educational material available to them, but only about half of them used it. Women may have thought they did not need the information, or perhaps it was not comfortable to accept. Stigma associated with perinatal mental health issues may impact women's willingness to both seek and accept information. Utilizing existing community resources may be a way to initiate PMD awareness, education, screening, and advocacy for the general population, for those who are underserved, and for new parents. Other research recommends multiple forms of public education such as television, Internet, newsprint, radio, and face-to-face communication to increase awareness of the mother and her social supports (Sealy, Fraser, Simpson, Evans, & Hartford, 2008). Utilizing groups such as Postpartum Support

International of Washington, Stepping Up, and the Speak Up When You're Down campaign may increase awareness of PMD and, by normalizing mental health concerns, decrease stigma.

The results indicated that over 90% of participants had childbirth education classes available to them, and the results showed that this had the highest attendance rates as well, just over 50%. Given this information, childbirth education classes may be a place to more fully address mental health concerns and provide information on depression and anxiety. Breastfeeding support was also available to most women (91.4%), and this may also be an opportunity to discuss PMD.

The prevention services that appeared to be lacking were stress management classes and relationship counseling. General findings are comparable to the provider needs assessment recently done in Kittitas and Yakima counties. This study found that more than half of providers reported that stress management classes and relationship counseling were not available or had limited availability (Cates, 2009). Relaxation techniques, stress reduction, and strengthening the partner relationship have been indicated in the literature as ways to decrease postpartum distress (Halonen & Passman, 1985; Shapiro & Gottman, 2005; Urizar et al., 2004). Participants indicated in the open question part of the survey that they would like more programs such as support groups, parenting classes (including dads), nutrition counseling, family planning, and relationship counseling. Offering a prevention program in a group format that includes partners could simultaneously address these needs. The prevention program could offer psychoeducation on PMD, stress management techniques, information on parenting, adjustment to parenthood, and strengthening partner relationships. According to Shapiro, Gottman, and Carrere (2000), the quality of the marital friendship acts as either a buffer during stressful times or has an exacerbating effect. Strengthening partner relationships may lessen the risk of PMD.

Though there were only a small percentage of ethnic minority women who returned surveys, culturally relevant services may be indicated. Exploratory results indicated that Latina women perceive cultural and language barriers to care. However, due to the small sample of Latina women, these results should be interpreted with caution. Specifically, Latina women indicated that childbirth education classes were less available to them compared to White women, and only about a quarter of the Latina women attended these classes, compared to half of the White women. This may suggest that Latina women did not want or need childbirth classes, or that they did not feel comfortable attending these classes. Previous research has suggested that Latina women experience more language and communication problems than non-Latina women (Tandon, Parillo, & Keefer, 2005). Addressing these barriers by making prevention services culturally relevant and in Spanish may increase attendance and usefulness of services. Recent studies have suggested that prenatal care in a group format may encourage Latina women to discuss cultural norms and attitudes about pregnancy (Tandon et al.). Grote, Bledsoe, Swartz, and Frank (2004) suggest that culturally sensitive treatment services include psychoeducation about barriers to care, have flexible schedules, and include help finding other social services.

Treatment services such as individual counseling, group counseling, and adjunctive therapies were available more than 50% of the time; however, attendance of these was very low. This may indicate that women have access to these treatments, may even be referred to them, but do not need them, or think they do not need them. Jesse et al. (2008) found that one barrier for women to receiving care was simply not wanting help. It is difficult to draw conclusions about treatment services because of this. It may be more useful at this point to focus on increasing women's awareness of PMD, screening, and prevention services. If women better understand

the symptoms and risk factors for PMD, they may be more willing to attend treatment services.

Money problems and difficulty finding services appeared to be the largest barrier to obtaining mental health services, though this was still a small percentage. Generally most participants indicated that they disagreed with the indicated barriers on the survey. This may suggest that the specific population that returned the surveys did not experience many of these barriers. Most of the women who returned the surveys were White (85.3%), 55.7% had yearly household incomes above \$40,000, and 47.8% had private insurance. Some women indicated that they thought services were great or that they did not need mental health services.

The results indicate that Kittitas and Yakima counties may benefit from using a standardized assessment tool for depression and anxiety on a regular basis. Adequate screening for depression during pregnancy and postpartum can result in early diagnosis and treatment, resulting in a shorter illness and improved outcome (Gjerdingen & Yawn, 2007; Goldsmith, 2007; Pignone et al., 2002). Increasing women's awareness of PMD may also help with early diagnosis and decrease the stigma of mental health issues possibly leading to more women seeking or receiving help. More prevention services could also benefit this community including group counseling addressing stress management and partner relationships.

Limitations

One of the purposes of this needs assessment was to survey the Latina and low income populations. Unfortunately, the percentage of surveys returned from these groups was very small. Only 12.6 % of the participants were Latina. These percentages are not representative of the population in this region. The Washington State Department of Health (2007) showed that 16.3% of mothers were of Latina origin in Kittitas County and 60.6% in Yakima County. Results from the Latina group should be looked at tentatively because of the

small number of participants. Efforts were taken to access Latinas and low-income populations by sending letters and surveys in Spanish and English and having organizations that work with these populations help distribute surveys. By hand delivering surveys, the researchers hoped to personalize the research and increase return rates. More work needs to be done to illicit a greater response from the Latina community, and future assessment of this kind may yield greater return rates if researchers work more closely with particular individuals in these organizations.

Another limitation of this study is that it is based on women's perceptions, and there may be various discrepancies in remembering that period of time. There may also be response bias, especially when looking at sensitive topics such as PMD (Hunt, Auriemma, & Cashaw, 2003).

Future Research

Future research could more closely examine barriers to care in terms of culture and language. More information could be gathered on the specific cultural barriers that keep Latina women from receiving care. Our exploratory results showed language as a perceived barrier for the Latina sample. Future studies may lead to a better understanding of specific cultural barriers between providers and consumers.

This survey did not specifically address when and where women were being assessed for depression and anxiety. Women may only be screened during their first postnatal visit and not during prenatal care or later during their postpartum visits. More information on specific types of providers who do or do not screen may be helpful in targeting areas in the community to increase screening rates. The literature has suggested that screening by a variety of providers is needed, including family physicians, obstetrician-gynecologists, pediatricians during well-baby visits, and other professionals in contact with mothers (Austin, 2003; Chaudron et al., 2005; Heneghan, Mercer, & DeLeone, 2004). Future surveys might include questions targeted to these providers.

Implications for Practitioners

The results of this needs assessment leads to some implications for health care providers. These results and previous research suggest that the consistent use of a standardized screening tool throughout the perinatal period may lessen potential under diagnosis of PMD. Screening by multiple providers may also be helpful, such as family practitioners, nurses, obstetrician-gynecologists, and pediatric doctors at well-child visits.

Increasing awareness of PMD among women and the general population could decrease stigma and increase women's ability to recognize symptoms of anxiety and depression on their own. Including partners and other social supports in awareness education will help support the mother. Increasing awareness may be achieved by talking more about PMD with health care providers or using state and national resources to conduct public health campaigns about PMD. Because of the large percentage of women attending childbirth education classes, this may be an ideal opportunity to teach about PMD. It may be helpful to discuss symptoms, share stories about women to help normalize symptoms, and discuss possible outcomes when not treated. Awareness may lead women to recognize symptoms, seek help, and follow through with prevention and treatment services.

Implementing more prevention services may also be needed. With more availability, access to services will be easier. Again, because of the high percentage of women attending childbirth education classes, there may be an opportunity to expand these types of classes to both increase awareness, but also teach prevention techniques. This may include psychoeducation about stress management, relaxation techniques, child development, and parenting skills. Creating classes that function more as a support group may also benefit women by expanding their support network. Including partners in these classes may also be an important component in

order to address changes in partner relationships during the perinatal period.

Prevention services should be flexible, accommodating cultural differences and family circumstances. This may mean providing

bilingual services, phone consultations, and home visits. Continuous care throughout the perinatal period may keep women accessing needed services and establishing positive relationships with health care providers.

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