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Women's Decisions about Mental Health Treatment in the Perinatal Period

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Abstract

This study examined a mother's decision-making process in regards to mental health treatment for emotional difficulties during pregnancy and/or in the postpartum period. The literature shows that different factors influence a woman's ability and willingness to seek services, including demographic factors, cultural factors, and interactions with healthcare providers and acquaintances. A sample of women who experienced emotional difficulties in the perinatal period was recruited through social media. Participants answered an anonymous electronic survey; the quantitative data was analyzed through SPSS, and the qualitative data was aggregated by themes. Quantitative findings indicate that age might be an influencing factor for women deciding to speak to a healthcare provider, but the same was not true for socioeconomic status or having already discussed the matter with an acquaintance. Qualitative answers replicate previous findings that embarrassment and confusion about what is "normal" emotional behavior in the perinatal period are deterrents to seeking treatment.

Keywords: pregnancy, perinatal, emotional difficulties, mental health services.

Women's Decisions about Mental Health Treatment in the Perinatal Period

This paper reports on a study that investigated influences on a mother's ability and willingness to seek professional mental health services. The primary research question the study sought to answer was: "What factors (personal, professional, and environmental) impact women's decisions about seeking, initiating, and continuing treatment when experiencing emotional difficulties during pregnancy and/or the postpartum period?" Based on a review of the literature, the study tested the following hypotheses:

1) Younger women, women of color, and women of lower socioeconomic status would be less likely to have discussed symptoms with an acquaintance or a healthcare provider (HCP). These groups would also be less likely of having initiated formal treatment.

2) Women who shared their symptoms with an acquaintance would be more likely to have eventually discussed them with a HCP.

3) Women who received a suggestion for formal treatment from their HCP would be more likely to have followed said suggestion and initiated treatment than women who did not receive a suggestion. Among this group, women of middle or high socioeconomic status would be more likely to have completed treatment.

Literature Review

Even though popular culture regards pregnancy and a woman's transition into motherhood as one of the most joyous events she will experience, this period can also be defined by increased vulnerability to mental illnesses such as major depression and anxiety. The Centers for Disease Control and Prevention (CDC, 2015) estimate that 19% of women will experience depressive symptoms in the period following birth. However, according to Yonkers et al., (2001, as cited in American Psychiatric Association [APA], 2013) an estimated half of episodes of depression for recent mothers actually begin during pregnancy. This led the APA to change its classification from "postpartum" to "peripartum depression" in its most recent edition of the Diagnostic and Statistical Manual of Mental Disorders. The prefix peri- acknowledges that depression might begin "around" pregnancy, as opposed to the previous post-, which limited diagnosable episodes to only after delivery.

Clearly, it is important that women receive adequate and effective treatment, not only for their own wellbeing but also their child's, during and after pregnancy. However, peripartum depression is often left untreated for a variety of reasons. A qualitative systematic review by Dennis and Chung-Lee (2006) examined 40 studies published between 1966 and 2005 which discussed women's help-seeking behavior in the postpartum period. One theme found in several studies was that mothers were not aware that their symptoms were severe enough to be diagnosed as a mental disorder and not simply "baby blues." For those who did know they were suffering from a mental illness, the greatest barriers in seeking treatment were feelings of shame and fears of having their baby taken away by child protective services (CPS). As such, other themes found in the literature regarding barriers and facilitators to service and treatment can be divided into personal and professional categories.

Personal factors such as financial and legal circumstances, as well as misconceptions about the child welfare system can act as deterrents for women in need of mental health services. For example, many participants in the studies surveyed cited lack of transportation and childcare as preventing them from seeking help (Abrams & Curran, 2009; Dennis & Chung-Lee, 2006; Teng et al., 2007). Both native-born Americans and immigrant women said that fears of being reported to CPS prevented them from disclosing their distress to their children's pediatricians (Byatt, Biebel, Friedman, Debordes-Jackson, & Gaydos, 2015; Dennis & Chung-Lee, 2006; Teng et al., 2007).

Cultural circumstances are also relevant in help-seeking behavior. For instance, Hispanic (Abrams & Curran, 2009), middle-eastern, and Asian women (Teng et al., 2007) cited protecting the family's reputation and relying on relatives rather than outsiders as reasons for declining professional help. The desire to "keep things in the family" and deal with their problems without the support of strangers was cited by all of these groups. Asian women, especially, reported familial stigma; a mental health diagnosis would not only tarnish their own reputation but also the reputation of every woman in their family (Teng et al., 2007). For African American women, a barrier in seeking help was the perceived need to be seen as a "strong Black woman," which resulted in silence and dealing with problems by themselves (Abrams & Curran, 2009; Amankwaa, 2003).

Under professional barriers, lack of open communication was reported by both HCPs and women. For example, Price and Bentley (2013) found that both physicians and patients felt the other party regarded medication as the only form of treatment to be considered even though both actually had more comprehensive ideas for treatment. Another important finding about accessing services was found by Song, Sands, and Wong (2004), who reported that, among Medicaid recipients in Philadelphia County, Pa., African American women were only half as likely as White women to seek mental health services at least once during the perinatal period. This difference, the authors argue, shows that equal access does not mean equal utilization when it comes to mental health. An examination of how, and if, services are made available and how HCPs work with women of color might be warranted to find out why, the authors suggest.

Conversely, personal factors identified in the literature as encouraging help-seeking were being White (Alvidrez, 1999; Song et al., 2004) and being older (Song et al., 2004). In regards to healthcare providers, those who were perceived as non-judgmental and provided effective follow-up (Price & Bentley, 2013) and those who offered referrals (Byatt et al., 2013) were the providers who motivated women to seek mental health services. The pediatrician's office, especially, was mentioned by women as the ideal setting for requesting assistance and receiving psychoeducation (Byatt et al., 2013). Empathy and peer support were also important environmental factors that increased the likelihood of a woman getting help. Women cited that having an acquaintance who utilized mental health services in the past (Alvidrez, 1999) and being able to "open up" and normalize feelings (McCarthy & McMahon, 2008) reduced fears about seeking treatment.

Theoretical Framework

The Behavioral Model of Health Services Use (Andersen, 1995), developed originally in the 1960s, served as the framework for the present study. The original model proposes that health service utilization is influenced by three factors: predisposing characteristics, enabling resources, and need. First, "predisposing characteristics" are those inherent to an individual, such as demographic factors (age and gender), "social structure" components like education, occupation, race, and lastly, "health beliefs" that one holds about medical care and services. Second, "enabling resources" are those present in in one's immediate environment and which make using health services possible. In other words, healthcare must be available in one's environment and one must have the ability to physically access such places. Finally, "need" refers to two different dimensions: "perceived need" or someone's own evaluation of symptoms and judgment on whether to seek services, and "evaluated need" or a healthcare professional's opinion on a patient's health and illness. As such, the following survey aimed to assess a mother's personal, environmental, and professional circumstances that encourage or inhibit help-seeking behavior.

Method

Participants

The sample for the study was composed of women who experienced emotional difficulties during pregnancy and/or after giving birth. Participants self-identified as having experienced mood fluctuations during pregnancy and the postpartum period. Thus, an official diagnosis, and disclosure thereof, was not required for a participant to be included in the sample. A purposive sample of participants was recruited through a peer support Facebook group for pregnant women and new mothers, as well as the author's personal profile.

Initially, participants were also going to be recruited through a key informant with access to a postpartum support organization. This strategy was selected because it would have yielded a more diverse sample in terms of race and socioeconomic status, and participants would likely be willing to share their experiences in light of their participation in a postpartum support organization. However, once the survey was shared on Facebook, there was a much faster turnaround for responses than anticipated. After this development, the decision to close the survey before the key informant disseminated it was made because the project had received institutional review board approval for only 30 participants.

Procedure

An online anonymous survey was designed on VCU's Research Electronic Data Capture (REDCap) and its link was disseminated through Facebook. REDCap is secure software available for VCU students and faculty; no personal identifiers, such as IP addresses were recorded from participants, ensuring their data was kept anonymous. The survey contained up to 29 questions, but not all participants answered all of them. The first question triaged women who have experienced emotional difficulties during pregnancy and/or in the postpartum period from those who did not. Women who answered "yes" were prompted to complete a next set of questions, intended for women with self-identified symptoms who discussed them with a non-HCP (spouse/partner, friend, relative, etc.). This batch had up to six questions, and the last question was intended to separate women who discussed their self-identified symptoms with a HCP from those who did not.

The next set of questions was for women who talked to a HCP about their emotional difficulties, and it contained up to nine questions. Participants were screened out of the survey on this round of questions if they did not receive formal treatment for their symptoms, either because their HCP suggested or because they sought it on their own. The final set of questions assessed the type, duration, and helpfulness of treatment and the reasons for stopping it. Every time a participant who answered yes to the first question was screened out of the survey, she was prompted to answer demographic questions such as whether she was currently pregnant or postpartum, age and income at the time of pregnancy, and race. At this time, participants also had the opportunity to share their thoughts on the overall experience of having emotional difficulties during the perinatal period. The complete survey can be seen in the appendix.

Analysis

REDCap was also used to review descriptive trends in the data collected. Once data collection was completed, The Statistical Package for the Social Sciences (SPSS) was used for inferential testing. Chi-square tests were run to assess the relationship between demographic, personal, professional, and environmental factors and a woman's decision to seek, initiate, and continue treatment. Qualitative responses collected from open-ended questions were analyzed by aggregating them into themes. For instance, the answers to "Why did you stop treatment?" were divided into the following categories: changed treatment, treatment wasn't helpful, started feeling better, still in treatment, and no time. Responses that were particularly helpful in illustrating a finding were selected to be included in this report.

Results

A total of 127 complete response sets were collected. Out of these, 110 women

(86.6%) reported having had emotional difficulties in the perinatal period. The vast majority of the sample, 96.4%, identified as White, with only four participants identifying themselves as women of color. Most of the participants were currently postpartum (85.5%), while similar numbers were found in two age brackets: 34.5% were between 26 and 30 while pregnant, and 32.7% were between 31 and 35 years of age at the time. Finally, most women in the sample reported making between US$35,000 and US$99,999 at the time of pregnancy. Only four participants reported being below the poverty level (for a family of three) during pregnancy. Table 1 contains a complete representation of the sample.

A statistically significant relationship was found between the participants' age during pregnancy and choosing to talk to a HCP about their emotional difficulties (p = 0.008). However, the same relationship was not found between participant's age and talking to a non-HCP (p = 0.309). Similarly, socioeconomic status was not correlated with talking to both non-HCPs (p = 0.106) and HCPs (p = 0.618). Regarding initiating treatment, a relationship was found between this factor and age (p = 0.026); but the same was not found in regards to socioeconomic status (p= 0.176). Unfortunately, because only three non-White women responded the survey, the hypotheses related to race could not be tested.

Table 1

Demographics of participants who experienced emotional difficulties

Characteristic	**Frequencies (Percentages)**
Race	
White	106 (96.4%)
Latina	3 (2.7%)
African American	1 (0.9%)
Current Perinatal Status	
Pregnant	16 (14.5%)
Postpartum	94 (85.5%)
Age during Pregnancy	
19-25	16 (14.5%)
26-30	38 (34.5%)
31-35	36 (32.7%)
35+	20 (18.2%)
Household Income during Pregnancy	
Less than 20,000	4 (3.6%)
20,000 to 34,999	12 (10.9%)
35,000 to 49,999	16 (14.5%)
50,000 to 74,999	13 (11.8%)
75,000 to 99,999	23 (20.9%)
100,000 to 149,999	23 (20.9%)
150,000 to 199,999	12 (10.9%)
200,000 or more	7 (6.5%)

Almost the whole group, 90%, reported discussing their emotional difficulties with a non-HCP; partners/spouses were identified as 78.2% of the sample as the main person they talked to, followed by friends, reported by 50.9% of participants. Those who decided not to talk to a non-HCP and answered the optional question on the survey (n= 10) mentioned “embarrassment” and fear of being seen as a “bad mother” as the main reasons for doing so. Similar reasons were given by those who decided not to talk to HCP (48.2%), with more than half who provided an explanation (n = 49) saying they “didn’t think symptoms were severe enough,” and a quarter “did not feel comfortable” bringing the issue up during their appointments.

Fortunately, more than half of the sample, 51.8%, decided to talk to a HCP, and most made that decision when they “couldn’t handle the stress and pressure anymore,” as one participant shared. OBGYNs (31.8%) and family doctors (9.1%) were preferred by most of the sample when they decided to share their concerns with a HCP. However, talking to a non-HCP was not found to be correlated with talking to a HCP (p= 0.086). The majority of HCPs suggested formal treatment to their patients (71.9%), and most participants reported following these suggestions to some extent (85.4%). Medication (79.5%) and individual counseling (48.7%) were the forms of treatment most reported by participants. Almost two thirds of them were in treatment for longer than six weeks, and a majority (86.8%) reported that treatment was “helpful” or “very helpful” (Figure 1).

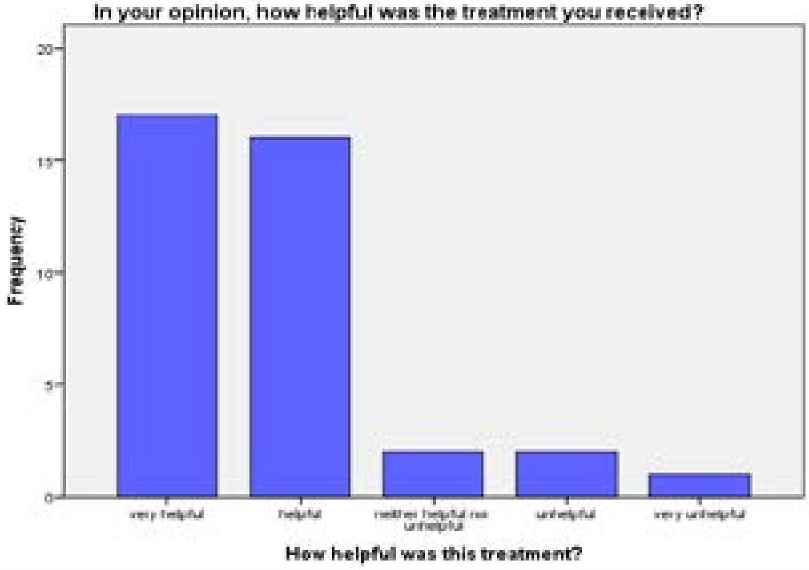

Figure 1: Participants’ perception of treatment helpfulness

Participants who did not receive a suggestion for formal treatment (n = 16) either reported getting no suggestion at all or being told to get more instrumental support to help with their babies. Only three participants who did not receive a suggestion from their HCP decided to seek treatment on their own. Because of this, it was not possible to test the hypothesis that women who received suggestions would be more likely to complete treatment. Some participants, however, provided explanations for not seeking treatment on their own after not receiving a suggestion from their HCP. Those included "not thinking it was bad enough," "waiting for the adjustment period to pass," and lack of time or health insurance. For those who initiated treatment, 59% reported to still being on it at the time of the survey, while 20.5% reported they started feeling better and thus stopped treatment. It was also not possible to test for correlations between demographic factors and completing treatment as the qualitative design of the question did not allow for it.

Discussion

Shame and embarrassment about having emotional difficulties was found to be the main deterrent for participants to talk to both HCPs and non-HCPs. They shared to have "felt pathetic and embarrassed," because "new moms are supposed to be elated and not depressed." One participant wrote she "was embarrassed and thought [her relatives] would think she was silly, pathetic, or looking for attention." Also, many participants mentioned not thinking symptoms were "bad enough," that "it was normal hormonal stuff" or "just baby blues," and so they didn't feel the need to talk to a HCP. As the survey did not ask specifically for a diagnosis for inclusion in the sample, some participants might indeed just have had a case of "baby blues." But for others, the lack of information about what were "normal mommy emotions" and what would have warranted an intervention led them to only seek help when "life was getting almost too much" for them. Many mentioned being asked how they were doing and "losing it" and "bursting into tears" at their appointments.

More than half of the participants were women older than 31 years of age. On one hand, being older while pregnant carries health risks that could contribute to the emotional difficulties experienced by the sample. For example, women who are older perhaps had difficulty getting pregnant, which would have made the process already anxiety-inducing from the beginning. Other women might "have experienced some anxiety because of a previous miscarriage," as one participant shared. However, being older might have equipped this group with more confidence and self-efficacy to advocate for themselves before doctors, as age was found to be correlated with speaking with a HCP and with initiating treatment.

A woman's disclosure to a HCP does not mean they did not feel ashamed anymore. The fact that so many held their emotions in for so long until they could no longer cope indicates that there was something preventing them from speaking up. Also, many participants mentioned they decided to talk to their HCPs because they "felt comfortable" and he or she was "easy to talk to." It is likely they felt their practitioners would not be judgmental, because the participants themselves felt their emotional difficulties were something to be ashamed of. Another indication of participants being embarrassed comes from their choice in people to confide in, mainly their OBGYNs and family doctors. OBGYNs and family doctors are probably the HCPs they have been seeing the longest, contributing to them feeling at ease enough with them to open up. As one participant shared, she "switched OBGYNs late in pregnancy due to [her] husband's duty station changing. [She] wasn't as comfortable with that OBGYN so [she] didn't mention it."

The lack of correlation between talking to a HCP and a non-HCP might be because the circumstances surrounding talking to these two distinct groups of people are different. Some women might have felt more comfortable talking to relatives and friends but not with HCPs because they are seen to be in a position of authority, unlike their acquaintances. Perhaps their acquaintances brought the topic up, but not their HCPs, or they were dismissed when they tried to. For instance, one participant wrote that she "mentioned being 'bummed out' during pregnancy and [the HCP] just said 'well that's normal,'" causing her to decide not to continue the conversation. For other participants, it might have been easier to talk to a HCP because they were perceived as "knowledgeable" and participants were concerned for their babies and how "could depression affect growth/development ." Finally, it might be that participants opened up to their HCPs simply because they asked, as many mentioned, while others in their lives did not.

It is noteworthy that most women who were given a suggestion for formal treatment followed it, and that many who were not given that suggestion did not seek treatment on their own. This shows that HCPs must be proactive in either suggesting treatment themselves or referring patients to other practitioners who can help. At a time when patients' initiative to seek help on their own is likely to be considerably hindered, it is crucial they have someone who encourages them to be treated and provides the tools for doing so. In addition, it is concerning that some participants reported their HCPs suggested “nothing” or even told the patient “they couldn’t help her here” (at the doctor’s office). This is of great concern, be it because these HCPs did not know how to refer the patient or because they did not feel the need to be knowledgeable about issues their patients were likely to face.

The findings of this study replicate many found in the existing literature. The participants’ reflections about not knowing if what they were experiencing was normal or not, along with feelings of shame, were factors found by Dennis and Chung-Lee (2006) as preventing one from seeking professional help during the perinatal period. Song et al. (2004) found that being older was a correlated with seeking professional help, and age is understood as a “predisposing characteristic” for utilizing health services under Andersen’s (1995) Behavioral Model of Health Services Use. Another way in which Andersen’s framework reflects the present study’s findings is under “health beliefs.” In other words, patients’ repeated positive interactions with their HCPs influenced their decision to seek help. Similarly, factors that encouraged the sample women to share their concerns with their HCPs were being treated by what they perceived to be non-judgmental practitioners (similar to Price & Bentley, 2013), and who provided targeted referrals, as discussed in Byatt et al., 2013.

Finally, the literature also provides clues as to why so few women of color participated in the survey even though the sampling method could be considered fairly democratic. As Amankwaa (1993) discussed, African American women might be less willing to discuss emotional difficulties in the perinatal period due to their perceived need to be seen as a “strong Black woman.” Incidentally, the one African American participant provided the following explanation for not talking to her doctor: “I just felt like I should be able to handle it and that I didn’t see how telling my doc would help.” Perhaps, if this group is less willing to seek help, they might be less likely to even admit that they are having challenges, thus not self-selecting to answer the survey. As for Latina women, Abrams and Curran (2009) have described how this group prefers to “keep things in the family” and is less willing to share problems with strangers. This could also have affected participation in the survey. Overall, White women have been found to be more likely to seek professional help (Alvidrez, 1999; Song et al., 2004); this might mean they might be more inclined to answer surveys about their challenges, as they are already equipped with self-awareness about their symptoms just by having gone through treatment.

This study had strengths and limitations. Its main strength was that the survey contained both quantitative and qualitative items, allowing participants to add answers not originally included and/or use that space for explaining or expanding an answer. The qualitative data added depth and nuance to the findings in quantitative data, making the findings more reflective of the participants' experiences than if it had included only multiple-choice questions. The survey also yielded a much larger sample than initially expected, which allowed for statistical testing and significant results. Finally, even though the qualitative design of some questions did not allow for testing, the answers can inform a quantitative design in future studies. The main shortcoming was that only four women of color and four people living in poverty answered the survey. This stopped the data from reflecting culturally diverse experiences, as well as from testing one of the main hypothesis in the study. The homogeneity of the sample in regards of race and socioeconomic status limits the results from being generalizable.

Implications and Future Research

Raising awareness of what is normal and what is not in the perinatal period regarding emotional fluctuations, as well as educating women on the prevalence of perinatal mood and anxiety disorders (PMADs), are the main steps to be considered by HCPs in light of these findings. Many participants expressed how they simply did not know what to expect, as some of them wrote:

> "Looking back I am almost certain I had PPD. I just assumed it was normal to be emotional and distressed at the time."
>
> "It was the worst thing I've ever experienced. I feel like PPD isn't discussed far enough. I think most people brush it off as 'the baby blues'."
>
> "As a first time mom it's very difficult to copy [sic] with everything what was happening, but the most difficult was not knowing if it's normal and what is

normal."

This strategy would also help to normalize the experience and to break the stigma attached to having emotional difficulties during this period. For instance, one participant shared: "I wish I had know [sic] how common it is. I suffered in silence because I felt like people would judge me for it or look at me like I wasn't capable of being a good mom & in all reality seeking help would have been best for all of us." And another woman wrote: "I just wished PPD was something brought up and not deemed a bad thing. I had a wonderful pregnancy and labor and very much wanted my daughter. So when all I did was cry and feel like I was in a fog all I day it threw me off. That was [not] what I had expect [sic] to feel after having this beautiful baby."

It is also vital that HCPs are knowledgeable about recognizing and referring for treatment if their patient is experiencing emotional difficulties. Many participants expressed how they only received treatment because their HCP asked and/or screened them: "My midwife screened me at 6 weeks pp and encouraged me to get treatment. My pediatrician also screened me at my newborn checkups. The screenings were invaluable." In addition, it could be beneficial for HCPs to incorporate frank and open conversations with patients about labor, delivery, and caring for a newborn. Often women's expectations did not match the reality they encountered once their child was born, as "this is 'supposed to be' such a wonderful and special time," as one participant wrote. The need for this intervention is reflected on the quotes below:

> "I was just much more emotional than I ever expected or knew about before. And also, trying to physically heal your body after childbirth, plus the hormones and lack of sleep led to a lot of tears and being upset with family members, my spouse, etc."
>
> "I'm usually a very upbeat, happy, easy going person who can go with the flow. After the baby my anxiety was at its highest. I couldn't figure out how to feed her, bathe her, cloth [sic] her etc. It made it very difficult for me to bond with her."
>
> "Stresses that included breastfeeding (trying to) and being ill after delivering (got mastitis twice in the first month). My husband was slow to catch on to parenthood, and I had little help from family, which put a LOT of stress on me. Plus sleep deprivation."

Future studies should include larger samples and perhaps incorporate strategies to increase participation among women of color. For example, they could rely on key informants to gain access to postpartum peer support groups and purposively seek out experiences of women of color. This strategy might even bring richer data, as these participants are likely to be more self-aware of the challenges they faced and be more willing to discuss them with outsiders. In addition, another questionnaire could be created based on the qualitative responses collected in the present study. For instance, it would be of value to include multiple-choice questions related to concluding treatment, to allow for statistical testing. The qualitative data can also inform future research questions and projects. For example, many participants shared how they struggled with hormonal and physical changes after delivery. A future survey based on their responses could investigate what form of information on the topic, if any, they received from OBGYNs during prenatal care appointments.

This study examined the factors that impacted women's decisions about mental health treatment in the perinatal period. More specifically, the study aimed to discover how personal factors (such as race, socioeconomic status, and age), professional factors, and environmental factors influenced a woman's decision to talk about emotional difficulties and later receive treatment for it. Age was found to be correlated with speaking to a HCP, and shame, embarrassment, and lack of knowledge about PMADs were the most common reasons for participants deciding to not talk to both HCPs and non-HCPs. Those women who did talk to a HCP often received a suggestion for treatment, and the majority who did also received some type of treatment. Most participants found treatment to be helpful. These findings highlight the importance of raising awareness of PMADs, which would help break the stigma associated with them. Another conclusion is that HCPs are often the gatekeepers between women and treatment, and so they must be proactive in screening, referring, and treating patients.

Unfortunately, this study did not yield a culturally-diverse sample as initially expected, which prevented hypotheses from being tested and limits the generalizability of the findings. Nonetheless, previous findings in the literature were replicated, with the added bonus of rich qualitative responses from participants. It was not expected that so many women would expand or explain their answers. The high number of voluntary responses, especially on the last question of the survey ("What would you like to say about your experience with emotional difficulties during pregnancy and in the postpartum period?"), indicate that women very much wanted to share their experiences. Talking about the difficult time they had likely provided catharsis, a way of processing what happened, and even awareness and preparedness for a future pregnancy. Including their responses in this study was important to disseminate these women's thoughts as they were given and to validate their reality, uncensored by statistics. Hopefully future studies will be based on these women's perspectives and further expand this population's voice in the literature.

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Appendix: Survey

Sample: mothers in general

1) Did you experience emotional difficulties during pregnancy and/or the postpartum period?
( ) yes ( ) no
If they answered yes, the next set of questions opened. If they answered no, the survey was completed. Questions marked * were optional.

Sample: Mothers with symptoms (self-identified)

2) Did you discuss your emotional difficulties with a relative, friend, coworker, or any other person other than a healthcare provider?
( ) yes ( ) no

If yes: 3a) Who did you discuss it with (check all that apply)?
    ( ) Partner/Spouse
    ( ) Relative
    ( ) Friend
    ( ) Coworker
    ( ) Other __________________ (option to write in)

If not: 3b) Why did you decide not to discuss it with anyone?* (write in)

4) Did you discuss your symptoms with a healthcare provider (OBGYN, pediatrician, nurse, midwife, doula)?
( ) yes ( ) no

If yes: next set of questions
If not: 5) Why not?* (write in) - Participant was then prompted to answer demographic questions.

Sample: Mothers who talked to a healthcare provider

6) Which healthcare provider did you talk to (check all that apply)?
    ( ) OB-GYN
    ( ) Pediatrician
    ( ) Nurse
    ( ) Midwife
    ( ) Doula
    ( ) Other __________________ (option to write in)

7) What made you decide to talk to said provider?*
(write in)

8) Did your healthcare provider suggest formal treatment (such as counseling, a support group, and/or medication)?
( ) yes ( ) no

If yes: 9a) Did you follow his or her suggestion? ( ) yes ( ) no ( ) somewhat
    If yes or somewhat: next set of questions
    If not: Please explain* (write in) - Participant was then prompted to answer demographic questions.

If not: 9b) What did your healthcare provider suggest instead of formal treatment (if anything)?*
(write in) + Did you seek formal treatment on your own? ( ) yes ( ) no
If yes: next set of questions
If no: Why not?* (write in) - Participant was then prompted to answer demographic questions.

<u>Sample: Mothers who received treatment</u>

10) What type of treatment did you receive?
( ) Individual counseling
( ) Group counseling
( ) Medication
( ) Other ___________________ (option to write in)

11) For how long did you receive treatment?
( ) 1 to 3 weeks
( ) 4 to 6 weeks
( ) More than 6 weeks
( ) Other ___________________ (option to write in)

12) How helpful was this treatment?
( ) Very helpful
( ) Helpful
( ) Neither helpful nor unhelpful
( ) Unhelpful
( ) Very unhelpful
( ) Other ___________________ (option to write in)
13) Why did you stop?
(write in)

14) What would you like to say about your experience with emotional difficulties during pregnancy and in the postpartum period? For example, did encounter any barriers? Or did you receive any advice or support that was particularly helpful?*
(write in)

Demographic info (all participants who answered 'yes' to question #1 will be asked to answer once survey is complete):

1) Are you currently pregnant or postpartum?
( ) pregnant
( ) postpartum

2) What was your age during pregnancy? (check one)
( ) Younger than 18
( ) 19 - 25
( ) 26 - 30
( ) 31 - 35
( ) 35+

3) What is your race or ethnicity? (check all that apply)
( ) White
( ) African American
( ) Asian

( ) Hispanic or Latino
( ) Native American
( ) Other

4) What was your household income at the time of pregnancy? (check one)
( ) Less than $20,000
( ) $20,000 to $34,999
( ) $35,000 to $49,999
( ) $50,000 to $74,999
( ) $75,000 to $99,999
( ) $100,000 to $149,999
( ) $150,000 to $199,999
( ) $200,000 or more
End of survey