Proceedings of ICBioMed 2024 Workshop: Workshop on Intelligent Medical Data Analysis for Precision Medicine
DOI: 10.54254/2753-8818/50/2024AU0101

Nursing care for women with perinatal depression

Liangzhen Ma

School of Nursing, Binzhou Medical University, Shandong, China

1801040330 @stu.hrbust.edu.cn

Abstract. The perinatal period can be a challenging and difficult time for many women, during which they experience a shift in their social roles and a gradual transition to motherhood. Perinatal depression (PND) is one of the most common perinatal mental health conditions that jeopardizes mental health. health. Electronic database searches were conducted to find suitable papers; these publications included risk factors for perinatal depression, interventions, limitations and perspectives of interventions, and finally the information was extracted for narrative synthesis. Personal psychiatric history and addictive behaviors, mother-infant and husband conflicts in the family, economic and employment in the society and teenage pregnancy were associated with the risk of developing the disease. Medication and psychotherapy, providing professional help and family-centered care, improving the health care system and psychological screening and education, and providing social support were effective solutions. Perinatal depression is an important global public health problem that deserves some attention from individuals, families, and societies.

Keywords: perinatal depression; risk factors; intervention measures; synthesis

1. Introduction

PND is not just a women's issue, it's a global problem that affects the wellbeing of society. The most marginalized women without access to proper sanitation or social support have a higher prevalence of PND, and that poverty, gender dysphoria, and partner violence all contribute to the onset of the disease [1]. In China, the prevalence of PND has increased over the past decade, with a prevalence of 19.7% for AND, 14.8% for PPD, and 16.3% for comorbidities [2].

In early screening for depression using the 9-item Patient Health Questionnaire (PHQ-9), scores of 5 to 9 were considered mild depression, 10 to 14 were considered severe depression, 15 to 19 were considered moderately severe depression, and >19 were considered severe depression. Although the exact mechanisms of PND are unknown, biological factors such as neuroendocrine, genetic, and pregnancy may have an impact on perinatal mood. Perinatal depression is often under-recognized and may even be underestimated due to the lack of timely and effective diagnosis and treatment for women who silently endure the silent burden. PND may trigger symptoms such as depressed mood, loss of interest and pleasure, lack of energy for activities of daily living, sleep disturbances, poor concentration, anxiety in mothers, and even increase the risk of maternal suicide or infanticide [3]. PND can also have a negative impact on children, increasing the risk of developmental delays, such as reduced activity levels and attention levels, affecting children's cognitive, emotional and social development. PND, especially AND, increased the risk of depression in adolescence or adulthood in their children, with a

DOI: 10.54254/2753-8818/50/2024AU0101

70% increase in their children's chances of developing depression [4].PND significantly increases the burden on families and society by increasing the risk of physical and mental health problems for both the woman and her children.

Many scholars are aware of the dangers of perinatal depression, and they have studied the risk factors and treatments for perinatal depression. However, only a few studies have been able to propose corresponding solutions for specific high-risk factors. The purpose of this review is to describe the individual, familial, and societal factors influencing perinatal depression, and to propose effective nursing interventions aimed at enhancing their mental health.

2. Influencing factors

2.1. Individual psychological and psychiatric risk factors

2.1.1. Previous psychiatric history. In a study of PND among women with major depression, the prevalence of PND was found to be very high among women with lifelong depression. The prevalence of PND was 70.4% in menstruating women, with 77% of women who had a depressive episode prior to pregnancy screening positive for PND; 67% of those with a history of major depression experienced depression during pregnancy and after delivery; 37% of women with PND who had no history of depression experienced symptoms postpartum, and were more likely to experience postpartum depression compared to women with a previous history of the disorder (26%); with 47.3% of women with PND who had no history of depression had episodes lasting longer than 6 months, and were more likely to have postnatal depression lasting longer than women with a previous history (42.3%) [5]. A systematic review, which included 97 papers, showed that a history of prior psychiatric illness, particularly anxiety and depression, and a history of prior psychiatric treatment at any time during the lifetime, are recognized risk factors for the development of prenatal anxiety and depression [6].

2.1.2. Addictive Behaviour. Smoking may be a way for pregnant women to relieve stress. One study showed that women who smoked during pregnancy had an odds ratio of 4.01 (95% CI 2.23-7.20) for postpartum depression compared to nonsmokers, and that smoking during pregnancy can even increase suicidal ideation[7]. Smoking during pregnancy may affect several neurological systems, including altered levels of dopamine and GABA neurotransmitters, and altered nicotinic acetylcholine receptors affecting the hypothalamic-pituitary-adrenal axis [8]. These effects may contribute to the development of postpartum depression. In addition, quitting smoking is a difficult task, and pregnant smokers who have to quit smoking trigger a series of withdrawal reactions, mood changes. They recognize the consequences of smoking during pregnancy for their children, but the difficulty of quitting triggers feelings of guilt that become another emotional burden that triggers postpartum depression.

Although it is generally recommended that alcohol be prohibited during pregnancy. Among women who consumed alcohol during pregnancy, 23% experienced postpartum depression [7]. Alcohol has been shown to be cytotoxic, directly inhibiting the normal function of the thyroid gland. Secondly, alcohol also inhibits the secretion of thyrotropin-releasing hormone (TRH) from the hypothalamus, which indirectly inhibits the activity of the thyroid gland, and reduced levels of thyroid hormones may trigger symptoms such as low mood and depression [9]. Previous studies have shown that neither non-drinking nor heavy drinking is associated with an increased risk of postpartum depression, but low or moderate drinking is associated with less severe depressive symptoms [10].

2.2. Family relationship risk factors

2.2.1. Relationship between pregnant women and their babies. The perinatal period brings many physical and emotional changes for mothers, causing dramatic shifts in women's roles and responsibilities. With regard to mother-infant interaction, difficult parenting experiences and the mother's own emotional distress can lead to an inability to cope with the infant's negative emotions,

DOI: 10.54254/2753-8818/50/2024AU0101

thus reducing the quality of parenting. At the same time, sleep deprivation or disruption due to infant care and night feedings can cause hormonal changes and altered neurotransmitter function in mothers, thus increasing their risk of postpartum depression [11].

2.2.2. Relationship between pregnant women and their partners. Women are often seen as the emotional bridge that builds the family, taking on the responsibility of caring for children in the home, while fathers are seen as equal partners involved in caregiving. However, one study showed that although many fathers want to support their partners, they generally lack support and do not know how to help their partners [12]. Some fathers may even be "macho" and believe that it is not their responsibility to take care of their children. These ideas have been embedded in historical and cultural contexts for many years, putting pressure on women and their families, and these pressures may cause family members to conflict with each other. Perinatal depression and anxiety can be worsened and prolonged by various factors, such as interpersonal conflicts, ineffective communication, and insufficient support from loved ones. These issues not only make the symptoms more severe and long-lasting but also impede recovery, heighten the chances of relapse, and potentially give rise to additional mental health concerns during the perinatal period [13].

2.3. Social risk factors

2.3.1. Economy and employment. Difficulties in life and high unemployment are factors associated with postpartum depression. Although women have made significant progress in terms of gender equality in the workplace, stability of employment often depends on their ability to demonstrate competence in the workplace. A family has to address the issue of work even more because of the financial burdens of health care, education, housing, etc., that come with having and raising children. In many low-income countries, unaffordable high costs of care and inadequate human resources and health system equipment and infrastructure make timely diagnosis of perinatal depression difficult. A cohort study that recruited 77,999 employed women across 9 years (1999-2008) noted that prenatal work stress was associated with 30 weeks of gestation (OR=1.33,95% CI: 1.19-1.49) and 6 months postpartum (OR=1.44,95% CI: 1.28-1.61) Work-related stress during pregnancy increased the likelihood of postpartum depression, which was linked to both depression and anxiety in mothers [14].

2.3.2. Adolescent pregnancy. Pregnancy among minors is a global phenomenon, and the age at which it occurs tends to be younger, with serious health and economic consequences for individuals, families and society. The absence or low quality of sex education in schools and the inability of adolescents to receive timely information on access to and proper use of contraceptives lead adolescents to engage in risky sexual behaviors. Poor adolescents have low self-esteem due to their economic situation and may face social stigmatization when seeking contraceptive services, further hindering their willingness to use contraceptives. At the same time, prejudice and neglect of adolescents' sexual health needs by some health-care workers is another important barrier to adolescents' access to contraceptive services.

Pregnancy requires psychological, physical and material preparation. Whereas puberty itself is a period of rapid metabolism and complex physical and psychological changes in the body, which in itself is stressful for girls, the physiological and developmental changes brought about by pregnancy and the shift in social roles and discomfort with motherhood can be an additional stressor for adolescent girls. This may affect the way they receive treatment and care, leading to the onset or progression of perinatal depression.

DOI: 10.54254/2753-8818/50/2024AU0101

3. Alternative

3.1. Individual

3.1.1. Drug therapy. Medications such as antidepressants and estrogen patches are commonly used to treat perinatal depression. In mild depression people usually cope with it through psychotherapy. However, for moderate to severe perinatal depression, selective 5-hydroxytryptamine reuptake inhibitors should be used, and the drugs of choice are sertraline, escitalopram, or citalopram; It is generally not advisable to use paroxetine or clomipramine while pregnant, nor is it recommended to take fluoxetine or doxepin during the breastfeeding period. [15].

More caution is needed in treating perinatal depression if the patient has a history of previous psychiatric illness. For postpartum depression with psychotic symptoms or with postpartum psychosis or suicidal behavior, additional antipsychotic medications or electroconvulsive therapy (ECT) may be needed in addition to conventional antidepressants and mood stabilizers, and the specific treatment plan will be determined according to the severity of the patient's condition and individualized needs.

3.1.2. Psychological therapy

3.1.2.1. Mindfulness-based therapy. In recent years, mindfulness-based therapy, often described as focusing attention on the present moment in a conscious, non-judgmental way, has been one of the more widely used interventions in the management of perinatal depression. Positive thinking therapy can increase women's awareness of their physical condition, leading to reduced smoking and drinking behaviors and improved mental health. In a four-week randomized controlled trial in China, women in the intervention group were taught face-to-face classes on Positive Thinking Therapy and practiced it informally in their daily lives, while in the control group, which was provided with a 5-10-minute video perinatal literacy education program every day, the intervention group also received the same health education as the control group. The results showed that anxiety and depression levels were significantly lower in the intervention group than in the control group from 3 days postpartum, and such differences continued up to 6 weeks postpartum. Positive thinking training for pregnant women can reduce the incidence of depression at 3 days postpartum (depression score decreased by 2.67), increase life satisfaction during pregnancy and postpartum, and reduce perinatal depression and anxiety [16].

3.1.2.2. Cognitive behavioral therapy. Cognitive behavioral therapy (CBT) is an evidence-based therapy that combines cognitive and behavioral psychotherapy. It emphasizes the determining influence of cognitive processes on behavior, and how changes in behavior can in turn affect cognition. This therapy is based on the theory of human cognitive processes and positive psychology, and corrects patients' adverse cognitions and negative emotions and behaviors by changing their thinking patterns, belief systems, and behaviors [17]. Through gradual communication, healthcare professionals enable perinatal women to recognize and gradually correct their maladaptive behaviors and establish new perceptions to improve their mental health. Some studies have shown that receiving cognitive behavioral therapy can help pregnant women to comprehensively understand perinatal delivery knowledge and possible complications during delivery, thus improving their knowledge and coping ability, and at the same time, it can target strategies to help pregnant women to identify and drink away negative thoughts, so that pregnant women can master methods of emotion regulation, thus relieving maternal anxiety, promoting emotional stability and improving the quality of delivery [17].

3.1.2.3. Interpersonal relationship therapy. Interpersonal relationship therapy (IPT) is a dynamic and informed approach to psychological intervention, with role transitions, role disputes, and grief as the three interpersonal themes on which it focuses. During the course of treatment, IPT helps patients to identify and cope with these interpersonal issues, to improve interpersonal relationships, and to address social support issues in order to alleviate symptoms of depression, which are important in the

DOI: 10.54254/2753-8818/50/2024AU0101

challenging post-partum period, and are therefore particularly suitable for women suffering from Postpartum depression [18]. In addition, research has found that IPT can help women cope with changes in "motherhood" and interpersonal challenges [18]. IPT has now been shown to be a safe and effective treatment for depression. One study found that culturally relevant enhancements to IPT-B demonstrated significant effects in improving depressive symptoms in pregnant women, preventing recurrence of depression, and facilitating recovery of social functioning during the six months postpartum. IPT-B can help to close the gaps in health care treatment due to race and economic status, and the vulnerable and at-risk group of socio-economically disadvantaged pregnant women with depression are able to accept and persist in Participate in brief, evidence-supported psychotherapy and achieve positive treatment outcomes before and six months after delivery [19].

3.2. Family

3.2.1. Specialized staff to provide perinatal depression care. Women in the perinatal period feel that the care and treatment they receive is not adequately adapted to their specific needs, and they would like to have more contact with professionals to provide information on medication and perinatal parenting [20]. The study showed that group-based perinatal parenting and childbirth education for mothers, led by various healthcare professionals, significantly focused on perinatal and infant mental health. Consequently, mothers experienced improved mental well-being, with notable reductions in depression and anxiety and overwhelm, increased parenting self-confidence and efficacy, and improved mother-infant interaction Quality [21].

3.2.2. Family-based collaborative care model. For women with perinatal depression due to lack of support from fathers and conflict among family members, the family-centered care model is crucial in preventing and intervening in perinatal depression. Educational materials and classes on perinatal mental health, newborn care, and family relationships are provided to families to help equip them with relevant knowledge and skills. A study of a collaborative family-based model of care provided easily accessible training for these families, with 10 weekly 30-minute interactive sessions provided to families and a 1-hour video course provided to infant care providers, which demonstrated decreased maternal depressive symptoms and notably reduced family conflict [22]. Both the mother's and father's mental health should be assessed perinatally. Medical professionals consider the entire family when preventing and treating depression throughout the perinatal period.

3.3. Society

3.3.1. Integrate perinatal mental health care into routine maternal care. A study in rural India demonstrated the association between socioeconomic factors and depression, highlighting existing treatment gaps, and realizing the aim of comprehensive health coverage for all requires integrating mental health services into the overall healthcare system[23]. Policymakers should ensure that primary care doctors and other healthcare providers are adequately trained. With proper training, they will be able to recognize symptoms, offer initial drug therapies and psychological support, and make referrals to specialists for severe cases. At the same time, community health workers can raise public awareness and encourage those in need to seek timely professional help.

3.3.2. For adolescent perinatal depression

3.3.2.1. Mental health screening and education. Mental health screening and education for adolescents in settings frequented by adolescents, such as hospitals and schools, and mental health screening can provide useful approaches to improving adolescents' help-seeking behaviors. The screening process itself is an opportunity for mental health education that can reduce adolescents' misconceptions and prejudices about mental illness and treatment and remove barriers to help-seeking. In addition, screening

DOI: 10.54254/2753-8818/50/2024AU0101

can facilitate communication and collaboration among schools, parents and students, and increase understanding and appreciation of mental health issues among all parties. At the same time, in promoting universal screening, it is also necessary to pay attention to the protection of adolescents' privacy, so as to avoid stigmatization of adolescents or other negative impacts that may lead to reduced willingness to be screened. In response to the inability of adolescents to obtain timely access to contraceptives, school-enterprise cooperation can be used to set up condom dispensers in school hospitals, paying attention to the quality of the condoms and the privacy of the students when they receive them.

3.3.2.2. Social support. The protective role of social support may be particularly prominent in low-income countries, where enhanced social support can buffer risk factors such as poverty and reduce the prevalence of perinatal depression. A study in Ngozi province, Burundi, found that antenatal care services for adolescent pregnancies is a highly effective intervention that provides access to detection and treatment of abnormal pregnancies and improves adolescent pregnancy outcomes, but locally more than one-third of mothers enrolled in antenatal care services late due to lack of information about the correct timing and fear that their parents would know about the pregnancy, but Their utilization of the service was high [24].

4. Limitations and prospect

4.1. Individual

With regard to medication, some physicians believe that patients may be less willing to accept antidepressant medication for perinatal depression, and many women show strong concerns about antidepressant medication. Indeed, some patients prefer prefer non-pharmacological treatments, such as psychotherapy or social support, to minimize the potential risks associated with medication side effects. However, other patients believe that medication is the key to their recovery, and that the use of appropriate medication under a doctor's supervision carries fewer potential risks than the health risks associated with depression itself [25]. In addition, women who use antidepressants during pregnancy or breastfeeding exhibit strong feelings of guilt, shame, and confusion, which makes it difficult to openly communicate about depressive symptoms, and even sometimes, fearing that they will not be understood or supported, they are reluctant to discuss their depressive symptoms with their physicians [25].

A study found that patient participation in decision-making improves satisfaction and health outcomes by improving patients' knowledge and preventing them from being assigned to treatment regimens they don't like, and that depressed patients who participated in medical decision-making had significantly higher rates of symptom remission and improved quality of life during an 18-month follow-up period [26]. Patient-centered communication strategies can be used in future studies to ask about their understanding of the disease and treatment preferences and to help them participate in their care.

The coverage of psychological treatment is still small compared to medication. Although the enactment of the bill supports universal access to psychological services, the fact that it reduces the likelihood that women will delay seeking psychological services due to financial burdens does not increase the likelihood of actually using mental health services [27]. What factors actually constrain patients' utilization of mental health services, and is simply reducing financial burdens sufficient to promote service utilization? Medicaid expansion, according to another study, may have increased the care received by existing mental health service users without leading to a rise in the utilization of new providers [28]. This means that improving the utilization of mental health services cannot rely solely on the strategy of reducing the financial burden, but also requires attention to racial/ethnic differences such as cultural perceptions and social prejudices. There is also a need to strengthen the identification and intervention of those in potential need through increased screening and referral measures to bring more people in need of help into the service area.

DOI: 10.54254/2753-8818/50/2024AU0101

4.2. Family

Compared to the general community mental health team, women evidently appreciate the knowledge and views of service staff during the specific perinatal period, but professionals seem to be more concerned with needs during pregnancy, they rarely seem to identify unmet needs in the postnatal period, and postnatal care is often focused on the baby rather than the mother, who tends to feel neglected during this period [20].

Professionals in perinatal depression care need to be trained in specialized knowledge in order to better assist women. To properly address women's needs during the postpartum transition, which go beyond physical healing, care providers must identify strategies that help women acquire necessary skills.

In modern, diverse societies, the promotion and popularization of family-centered models of care are challenged by differences in racial and cultural backgrounds. One study emphasized the value of "cultural similarity" between mothers and the professionals they see if they are from minority backgrounds, and possible barriers to transracial health care include: difficulty for health care workers in accurately identifying the severity of a patient's depressive symptoms due to differences in cultural background and expression; communication barriers between doctors and patients; and the lack of understanding of mental health issues. Communication barriers or differences in perceptions of mental health issues may make it difficult for patients to understand medical advice and treatment plans, affecting adherence and treatment outcomes; time constraints may make it difficult for professionals to fully understand the patient's condition and needs in the limited time available for consultation [29].

Due to ideological and cultural differences resulting from ethnic diversity, the family-centered care model is difficult to promote widely across all populations. To better meet maternal physical and mental health needs, this requires healthcare professionals to adopt flexible, individualized care plans, respect the needs and values of patients and families in different cultures, and understand how perinatal depression is expressed in different cultures.

4.3. Society

While the integration of mental health services into the health-care system is a key step towards achieving the goal of universal health coverage, the sustainability of health-care delivery still faces serious challenges. In Nigeria, the accessibility and quality of health resources remains a pressing issue, with a significant portion of the population not receiving adequate health care services, mainly due to deficiencies in the public health system, such as inadequate staffing, shortage of obsolete equipment, and limited access to treatment services [30].

The health care system needs to be more proactive in the future. Training for health care providers should be strengthened to increase their awareness and sensitivity to women's mental health needs. Secondly, cooperation with community organizations should be strengthened to carry out targeted health education and publicity to de-stigmatize mental health problems and encourage women to take the initiative to seek help. At the same time, more attention and support should be given by the community. Increase investment in perinatal mental health services, improve relevant policies and regulations, and create a caring and inclusive social environment.

Mental health screening and education for minors is a useful approach, but the fact is that while there are already some forms and channels of education on topics such as reproductive health education and sex education, this is only a formality in schools and families, and many parents and teachers intentionally avoid ignoring or even prohibiting this issue out of traditional attitudes or taboos, resulting in many students still lacking access to authoritative and correct sexual health information.

Teenage pregnancy is a problem that is easily overlooked by society, yet it is closely related to adolescent mental health. Adolescent pregnancy prevention requires a multilevel, multidimensional approach, and policymakers and program officials need to plan pregnancy prevention programs that take into account risk factors at all levels.

DOI: 10.54254/2753-8818/50/2024AU0101

5. Conclusion

Perinatal depression is a global public health problem that affects the well-being of society. Personal psychiatric history and addictive behaviors, conflicts in the family between mother and baby and husband, economic and employment in society and teenage pregnancy are associated with the risk of developing the disease. Pharmacological and psychotherapeutic treatment, providing professional help and family-centered care, improving the health care system and psychological screening and education, and providing social support are effective solutions. However, these methods still face some limitations and challenges in their practical application, and there is a need to use a combination of methods and to strengthen screening, referral and other measures to improve the utilization and coverage of mental health services.

References

[1] McNab, S., et al., Comment: silent burden no more: a global call to action to prioritize perinatal mental health. BMC Pregnancy Childbirth, 2022. 22(1): p. 308.

[2] Nisar, A., et al., Prevalence of perinatal depression and its determinants in Mainland China: A systematic review and meta-analysis. J Affect Disord, 2020. 277: pp 1022-1037.

[3] Huang, S., et al., Help-Seeking Intentions for Depression and Associated Factors among Chinese Perinatal Women: A Cross-Sectional Study. Int J Environ Res Public Health, 2023. 20(3).

[4] Tirumalaraju, V., et al., Risk of Depression in the Adolescent and Adult Offspring of Mothers With Perinatal Depression: A Systematic Review and Meta-analysis. JAMA Netw Open, 2020. 3(6): p. e208783.

[5] Kiewa, J., et al., Lifetime prevalence and correlates of perinatal depression in a case-cohort study of depression. BMJ Open, 2022. 12(8): p. e059300.

[6] Biaggi, A., et al., Identifying the women at risk of antenatal anxiety and depression: A systematic review. J Affect Disord, 2016. 191: pp 62-77.

[7] Pacho, M., et al., Substance use during pregnancy and risk of postpartum depression: a systematic review and meta-analysis. Front Psychiatry, 2023. 14: p. 1264998.

[8] Philip, N.S., et al., Nicotinic acetylcholine receptors and depression: a review of the preclinical and clinical literature. Psychopharmacology (Berl), 2010. 212(1): pp 1-12.

[9] Zeng, Wan-Ting et al. Analysis of the risk of perinatal depression and its influencing factors. Zhejiang Medicine, 2021. 43(13): pp. 1409-1414.

[10] Gea, A., et al., Alcohol intake, wine consumption and the development of depression: the PREDIMED study. BMC Med, 2013. 11: p. 192.

[11] Saharoy, R., et al., Postpartum Depression and Maternal Care: Exploring the Complex Effects on Mothers and Infants. Cureus, 2023. 15(7): p. e41381.

[12] Mayers, A., et al., Supporting women who develop poor postnatal mental health: what support do fathers receive to support their partner and their own mental health? BMC Pregnancy Childbirth, 2020. 20(1): p. 359.

[13] Noonan, M., J. Jomeen and O. Doody, A Review of the Involvement of Partners and Family Members in Psychosocial Interventions for Supporting Women at Risk of or Experiencing Perinatal Depression and Anxiety. Int J Environ Res Public Health, 2021. 18(10).

[14] Clayborne, Z.M., et al., Prenatal work stress is associated with prenatal and postnatal depression and anxiety: Findings from the Norwegian Mother, Father and Child Cohort Study (MoBa). J Affect Disord, 2022. 298(Pt A): pp 548-554.

[15] Dama, M.H. and R.J. Van Lieshout, Perinatal Depression: A Guide to Detection and Management in Primary Care. J Am Board Fam Med, 2024. 36(6): pp 1071-1086.

[16] Wang, S.L., et al., Benefits of Mindfulness Training on the Mental Health of Women During Pregnancy and Early Motherhood: A Randomized Controlled Trial. Biomed Environ Sci, 2023. 36(4): pp 353-366.

DOI: 10.54254/2753-8818/50/2024AU0101

[17] Guo, X., et al., Effects of Perinatal Cognitive Behavioral Therapy on Delivery Mode, Fetal Outcome, and Postpartum Depression and Anxiety in Women. Comput Math Methods Med, 2022. 2022: p. 8304405.
[18] Jiang, X., et al., Efficacy of nondrug interventions in perinatal depression: A meta-analysis. Psychiatry Res, 2022. 317: p. 114916.
[19] Grote, N.K., et al., A randomized controlled trial of culturally relevant, brief interpersonal psychotherapy for perinatal depression. Psychiatr Serv, 2009. 60(3): p. 313-21.
[20] Westgate, V., T. Manchanda and M. Maxwell, Women's experiences of care and treatment preferences for perinatal depression: a systematic review. Arch Womens Ment Health, 2023. 26(3): pp 311-319.
[21] Baldwin, A., et al., Transition to Parenthood: Antenatal Education Promotes Perinatal Mental Health When Collaboratively Delivered by Midwives, Mental Health Peer Workers and Perinatal and Infant Mental Health Professionals. J Perinat Educ, 2022. 31(2): pp 104-110.
[22] Cluxton-Keller, F. and A. Olson, A Family-Based Collaborative Care Model for Treatment of Depressive and Anxiety Symptoms in Perinatal Women: Results From a Pilot Study. JMIR Pediatr Parent, 2023. 6: p. e45616.
[23] Shidhaye, R., et al., Predictors, help-seeking behaviour and treatment coverage for depression in adults in Sehore district, India. BJPsych Open, 2017. 3(5): p. 212-222.
[24] Iradukunda, L.I., O.O. Ogunbode and O.S. Arulogun, Antenatal Care Utilisation among Adolescent Mothers in Ngozi Province, Burundi. J West Afr Coll Surg, 2024. 14(2): p. 174-179.
[25] Battle, C.L., et al., Perinatal antidepressant use: understanding women's preferences and concerns. J Psychiatr Pract, 2013. 19(6): p. 443-53.
[26] Clever, S.L., et al., Primary care patients' involvement in decision-making is associated with improvement in depression. Med Care, 2006. 44(5): p. 398-405.
[27] Hall, S.V., et al., The impact of the affordable care act on perinatal mood and anxiety disorder diagnosis and treatment rates among Michigan Medicaid enrollees 2012-2018. BMC Health Serv Res, 2024. 24(1): p. 149.
[28] Breslau, J., et al., Impact of the Affordable Care Act Medicaid Expansion on Utilization of Mental Health Care. Med Care, 2020. 58(9): p. 757-762.
[29] Iturralde, E., et al., Engagement in perinatal depression treatment: a qualitative study of barriers across and within racial/ethnic groups. BMC Pregnancy Childbirth, 2021. 21(1): p. 512.
[30] Uguru, N., et al., Is the national health insurance scheme a pathway to sustained access to medicines in Nigeria? BMC Health Serv Res, 2024. 24(1): p. 403.