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Why women do not seek professional help for anxiety and depression symptoms during pregnancy or throughout the postpartum period? Barriers and facilitators of the help-seeking process

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Abstract

Goals: This study examined Portuguese women's help-seeking intentions to address their emotional problems during pregnancy and the first 12 months after childbirth, and the relative influence of main attitudinal and knowledge barriers and facilitators (prior experience and encouragement from the partner).
Methods: Pregnant women or women within the first 12 months postpartum answered to a cross-sectional online survey that included self-reported questionnaires to assess depressive and anxiety symptoms, depression literacy, attitudes towards help-seeking and intentions to seek professional help.
Results: Women's (N = 243) have a greater intention to resort to informal sources of help than to formal sources of help. Women with clinically relevant psychopathological symptoms reported less positive attitudes towards help-seeking and a poorer perception of their partner's support in seeking professional help. Both stigma and the perceived encouragement from the partner to seek professional help were strong predictors of formal help-seeking intentions.
Discussion: These results elucidate the importance of including the partner in the women´s help-seeking process and recovery, as well as the important role of the media and health professionals in reducing the stigma about perinatal depression.

Keywords: Perinatal Depression; Stigma; Help-seeking intentions; Literacy.

Introduction

Perinatal depression, defined as depression in pregnancy, around childbirth or within the first year postpartum, is a relevant public health problem, and often occurs comorbidly with other mental health illnesses such as anxiety disorders (Muzik & Borovska, 2010). Incidence estimates show that 14.5% of women develop depressive symptomatology during pregnancy, and this number rises to 49% if we consider the first year postpartum (Gavin et al., 2005). Perinatal depression not only impairs the functional capacity of mothers (Bonari et al., 2004; Field, 2011) but also has a negative impact on the mother-infant

relationship and on the cognitive, behavioral and socio-emotional development of the child (Letourneau et al., 2012) as well as on the partner's emotional well-being (Burke, 2003; Goodman, 2008; Letourneau et al., 2012). Psychological interventions were found to be effective in addressing women's perinatal depressive symptoms (Sockol, 2015; Stuart, O'Hara, & Gorman, 2003).

However, few women seek professional help to deal with mental health problems in this period (Fonseca, Gorayeb, & Canavarro, 2015; McGarry, Kim, Sheng, Egger, & Baksh, 2009) or are proactively involved in treatments (Dennis & Chung-Lee, 2006; Sharma & Sharma, 2012), making the consequences of depression even more adverse (Righetti-Veltema, Bousquet, & Manzano, 2003). Henshaw, Sabourine and Warning (2013) found that less than half of women with symptoms of depression in the perinatal period received some form of treatment from formal sources (e.g. mental health professionals), and similar results were found in other studies (Mayberry, Horowitz, & Declercq, 2007; McGarry et al., 2009). In a recent study in Portugal, only 13.6% of women with a positive screen for depression in the perinatal period sought professional help for their emotional problems (Fonseca et al., 2015). In fact, research has consistently reported women's preference for informal sources of help (e.g. seeking advice and support from family and friends or printed material) as opposed to seeking professional help (Henshaw et al., 2013; O´Mahen, & Flynn, 2008; Scholle, & Kelleher, 2003).

The literature has identified a set of attitudinal (e.g., stigma) and knowledge barriers (e.g. mental health literacy) for seeking professional treatment, that are beyond existing structural barriers (e.g. financial constraints and lack of time) (Bilszta, Ericksen, Buist, & Milgrom, 2010; Callister, Beckstrand, & Corbett, 2011; Dennis & Chung-Lee, 2006; Mayberry et al., 2007; O´Mahen, & Flynn, 2008; Sword, et al., 2008). Regarding attitudinal barriers, given that the infant's birth has a positive emotional connotation, depressive symptoms tend to be understood by women as signs of failure and incapacity (Abrams, Dornig, & Curran, 2009; Callister et al., 2011). These symptoms are associated with feelings of shame (Abrams et al., 2009; Letourneau et al., 2007) and fear of disapproval by the social network (Callister et al., 2011). Therefore, the perceived stigma in relation to postpartum depression and other emotional difficulties during the perinatal period seem to compromise women's recognition of the presence of symptoms. Women attempt to deal with their symptoms alone and are reluctant to share them with family and friends (Abrams et al., 2009; Callister, et al., 2011; Goodman, 2009) or with health professionals (Woolhouse, Brown, Krastev, Perlen, & Gunn, 2009). This reluctance to seek help may also be related to the fear of the implications of a diagnosis of mental health problems (e.g., loss of custody) (Dennis & Chung-Lee, 2006; Goodman, 2009; Letourneau et al., 2007).

Knowledge barriers , that is, poor depression literacy (defined as the individual's ability to recognize depression and make informed decisions about depression treatments) (Deen & Bridges, 2011) include failure to recognize the signs and symptoms of depression (Dennis & Chung-Lee, 2006; Mayberry et al., 2007), namely difficulty in distinguishing between the normative emotional reactions of the transition to parenthood and the symptoms of depression (Abrams et al., 2009; Bilszta, et al., 2010; McCarthy & McMahon, 2008; Sword, et al., 2008; Whitton,Warner, & Appleby, 1996) and the tendency to attribute the origin of symptoms to environmental changes (e.g., fatigue, problems with other family members) (Callister, et al., 2011; Whitton, et al., 1996) or to normal postpartum stress (Abrams et al., 2009). Similarly, women report a lack of knowledge regarding mental health services, particularly with regard to appropriate health professionals and types of treatments available (Fonseca, Silva, & Canavarro, 2017; Gulliver, Griffiths, & Christensen, 2010; O´Mahen, & Flynn, 2008).

Although the literature also notes the existence of facilitators for women's help-seeking process, facilitators have been considerably less investigated than barriers, and there are no specific data on how these facilitators may influence the help-seeking process during the perinatal period. On the one hand, research in the general population highlights the role of previous positive experiences with mental health

professionals, which contribute to an increase in mental health literacy (Gulliver et al., 2010). Thus, women's familiarity with mental health treatments (Alvidrez & Azocar, 1999) and their prior positive experiences with mental health professionals (Thome, 2003) may positively influence their intentions to resort on formal sources of help to deal with their mental health problems.

On the other hand, the literature has emphasized the facilitating role of social support and of the encouragement of others (Gulliver et al., 2010) in the process of professional help-seeking. In fact, there is some evidence that women who have experienced symptoms of postpartum depression reported that they were advised by friends and family to seek professional help (Abrams et al., 2009; Sword, et al., 2008). In particular, women's male partners have been mentioned as the individuals who express the most concerns about their female partner's emotional experience during the perinatal period (Henshaw et al., 2013). Thus, in addition to emotional and instrumental support (Pilkington, Milne, Cairns, Lewis, & Whelan, 2015), male partners may play an important role in preventing postpartum depression by encouraging women to seek professional help when they experience the first symptoms of this clinical condition (Dennis & Ross, 2006; Fonseca & Canavarro, 2017). However, it is important to understand whether women's prior experiences with mental health services and women's perceived encouragement from their partner to seek professional help may buffer the impact of attitudinal and knowledge barriers in the help-seeking process to address women's emotional problems during the perinatal period. In addition, some studies have shown the role of cultural differences that can influence women´s formal help-seeking, translated into cultural beliefs about motherhood and about the women's role, cultural attitudes toward mental health professionals (Abrams et al., 2009; Callister et al., Dennis & Chung-lee, 2006) and about the perception of support (Dennis & Chung-lee, 2006), suggesting the need to explore women's help-seeking intentions within different sociocultural contexts.

To our knowledge, most studies conducted on this topic have used qualitative and descriptive methodologies and have separately addressed the role of barriers and facilitators for professional help-seeking (Bilszta et al., 2010; Abrams et al., 2009; Dennis & Chung-Lee, 2006, Sword et al., 2008). That approach prevents us from understanding the relative influence of different barriers and facilitators in women's intentions to seek professional help to address their emotional problems during the perinatal period. Furthermore, although some of these studies have been conducted with the perinatal population (e.g. Callister et al., 2011; Sword et al., 2008), they do not yet allow a systematic understanding of how barriers and facilitators concurrently contribute to influence the process of help-seeking, and whether it is similar to that of the general population (e.g., Gulliver et al., 2010). Therefore, it is important to better understand how different barriers and facilitators influence women's professional help-seeking process during pregnancy or throughout the first childbearing year, in order to develop effective campaigns aimed to change women's intentions to seek professional help that take into account those barriers and facilitators. Moreover, it is important to examine if the relative influence of barriers and facilitators on women's help-seeking intentions may differ when an effective need for help (that is, the presence of clinically relevant psychopathological symptoms) is present, as this may influence the design of more universal or selective/indicative campaigns. Although prior evidence suggests that psychological distress is positively associated with the intentions to seek professional help (Vogel & Wei, 2005), other studies provide contradicting findings (Manos, Rusch, Kanter, & Clifford, 2009).

This study had the following aims: 1) to characterize women's intentions of seeking help from different sources to address their emotional problems during pregnancy and the first postpartum year and to compare intentions of help-seeking in women presenting and not presenting clinically relevant psychopathological symptoms; 2) to evaluate the relative influence of main barriers (attitudes towards help-seeking, depression literacy) and facilitators (perceived usefulness of previous treatment experiences, perceived encouragement from the partner) in women's intentions of seeking professional help to address emotional difficulties occurring within pregnancy and the first postpartum year; and 3) to evaluate whether

the relative influence of the main barriers and facilitators in women's intentions of seeking professional help depends on the presence/absence of clinically relevant psychopathological symptoms.

Methods

Design

A cross-sectional study was conducted using an online survey that aimed to characterize the help-seeking intentions of Portuguese women during pregnancy and the first postpartum year, as well as the barriers and facilitators of the help-seeking process. The participants of this study were recruited between November 2014 and March 2015 through advertisements published on social networks and on websites related to pregnancy and maternity. The advertisements contained information about the study goals and the researchers' and participants' roles as well as the weblink for the online survey (hosted on the Limesurvey ® platform). Participants were selected according to the following inclusion criteria: (1) being a pregnant woman or a woman who had a baby in the last 12 months); (2) being 18 years old or older; and (3) having a level of understanding of the Portuguese language that would enable the completion of the assessment protocol.

Instruments

Sociodemographic (age, marital status, educational level, professional status, urban vs. rural residence) and clinical information (pregnancy vs. postpartum period, gestational age if pregnant, infant's age if postpartum, parity, history of psychiatric, neurological or psychological problems) was collected through a self-report questionnaire.

Depressive symptomatology was evaluated through the Portuguese version of the Edinburgh Postnatal Depression Scale (EPDS, Cox et al., 1987; Augusto, Kumar, Calheiros, Matos & Figueiredo, 1996), a self-administered screening scale that assesses the intensity of depressive symptoms in the last seven days in pregnant or postpartum women. The EPDS consists of 10 items (e.g., *"I've been nervous or worried for no reason"*) answered on a 4-point response scale. Higher scores indicate a greater intensity of depressive symptoms. A score of 9 or higher is indicative of the possible presence of a major depressive episode (Areias, Kumar, Barros & Figueiredo, 1996). In this study, Cronbach's alpha was .91.

Anxiety symptoms were measured through the Portuguese version of the Hospital Anxiety and Depression Scale (Escala de Ansiedade e Depressão Hospitalar (EADH); Zigmond & Snaith, 1994; Pais-Ribeiro et al., 2007), a self-administered questionnaire that evaluates the levels of anxiety and depression felt in the last week. The EADH is a widely-used scale composed of 14 items, with a response scale of 4 points (0-3). It is organized into two subscales: the Anxiety subscale, composed of 7 items (e.g., *"I have a feeling of fear, as if something terrible is going to happen"*), and the Depression subscale, composed of the remaining 7 items (e.g. *"I lost interest in looking after my physical appearance"*). In both subscales, the scores can vary between 0 and 21 points. A score higher than 8 on each subscale is considered by the authors to be indicative of clinically relevant symptoms. In this study, only the Anxiety subscale was used, with a Cronbach's alpha of .87.

Depression literacy was measured with the Depression Literacy Questionnaire (D-Lit; Griffiths, Christensen, Jorm, Evans, & Gorves, 2004; Portuguese version: Fonseca & Canavarro, in preparation), which assessed the individual's knowledge of depression symptoms and treatment options. The D-Lit consists of 22 items that may be true (e.g., *"Loss of confidence and low self-esteem may be a symptom of depression"*) or false (e.g., *"Not stepping on the blue stones of the sidewalk may be a sign of depression"*). Each item comprises three alternative responses: *"True"*, *"False"*, and *"I do not know"*. Each correct answer is scored with one point, and the total score ranges from 0 to 22 points. Higher scores are indicative of higher depression literacy.

Attitudes towards help-seeking were measured with the Portuguese version of the Inventory of Attitudes Toward Seeking Mental Health Services (IAPSSM;

Mackenzie, Knox, Gekoski, & Macaulay, 2004; Portuguese version: Fonseca, Silva, & Canavarro, 2017), which assesses attitudes towards help-seeking for mental health problems. The IAPSSM is a self-report questionnaire composed of 24 items answered on a Likert scale, ranging from 0 (*"Disagree"*) to 4 (*"Agree"*). It includes three factors, each consisting of eight items: Psychological Openness (e.g., *"There are certain issues that should not be discussed with people outside the immediate family"*), Propensity to Seek Help (e.g., *"I would know what to do and with whom to speak if I decided to seek professional help because of psychological problems"*) and Indifference to Stigma (e.g., *"Having a mental illness carries a burden of shame"*). Higher scores are indicative of the presence of more positive attitudes towards professional help-seeking. In the present study, only the Psychological Openness and Indifference to Stigma dimensions were used, with Cronbach's alphas of .63 and .84, respectively.

Help-seeking intentions were measured with the General Help-seeking Questionnaire (GHSQ; Wilson, Deane, Ciarrochi, & Rickwood, 2005; Portuguese version: Fonseca & Canavarro, in preparation) which assesses the individual's intentions to seek help from different sources to address emotional problems. Participants were asked to state their intention to seek help from different sources to deal with personal/emotional problems on a 7-point Likert scale, ranging from 1 (*"Extremely Unlikely"*) to 7 (*"Extremely Likely"*). It is possible to compute the individual's intentions of help-seeking from different types of sources: Formal (e.g., mental health professional, general practitioner); Semiformal (e.g., telephone help line, priest); Informal (e.g., partner, friend, parent, other relative/family) and Self-help (e.g., Internet) (Rickwood & Thomas, 2012). Higher scores are indicative of higher intentions of seeking help from each source.

The GHSQ also includes two questions to evaluate previous experiences with mental health professionals: *"Have you ever consulted a mental health professional (e.g., psychologist, psychiatrist) for help with personal or emotional problems?"* (Dichotomous response scale: *"Yes"/"No"*); and *"How useful was/were the consultation(s) with the mental health professional?"*, answered on a 5-point Likert scale ranging from 1 (*"Extremely Useless"*) to 5 (*"Extremely Helpful"*). The participant's answers were recoded into two categories: did not have previous contacts with health professionals or did not consider them useful vs. had previous contacts with health professionals and considered them useful.

Finally, given the lack of specific instruments validated for the Portuguese population, the partner's perception of encouragement and support in help-seeking to address emotional problems during the perinatal period was assessed through a questionnaire specifically developed by the authors. The questionnaire included a set of four questions (e.g., *"My partner would encourage me to seek professional help"*) answered on a 4-point Likert scale according to the degree of agreement (from 1 = *"Strongly Disagree"* to 4 = *"Strongly Agree"*). For this sample, Cronbach's alpha was .83.

Data Analysis

Data analysis was performed with IBM SPSS, version 20.0. Descriptive statistics were calculated to characterize the sample. First, a mixed ANOVA was performed to characterize women's help-seeking intentions, with the types of sources as within-subjects factor (formal, semiformal, informal, and self-help) and the presence/absence of clinical psychopathological symptoms as between-subjects factor (group presenting clinically relevant psychopathological symptoms, group not presenting clinically relevant symptoms), followed by post-hoc tests to clarify the nature of the differences found. Moreover, the descriptive statistics of the barriers (Depression Literacy, Attitudinal Barriers – Indifference to Stigma and Psychological Openness) and facilitators (Partner's Encouragement of Help-seeking, Usefulness of prior treatment experiences) of professional help-seeking were calculated. To compare the barriers and facilitators as a function of the presence/absence of clinical psychopathological symptoms, comparison tests were used, including MANOVA (Attitudinal Barriers), t-student tests (Depression Literacy, Partner's Encouragement of Help-seeking) and chi-square tests (Usefulness of prior treatment experiences). Effect size measures were presented for the comparative

analyses (small: η2 ≥ .01, d ≥ .01; medium: η2 ≥ .06, d ≥ .20; large: η2 ≥ .14, d ≥ .80).

A multiple linear regression was performed to evaluate the main and interaction effects of the barriers and facilitators in the women's intentions to seek professional help to address their emotional problems. The moderating analyses were conducted according to the procedures of Aiken and West (1991). Specifically, after centering the continuous variables, the help-seeking barriers (Indifference to Stigma, Psychological Openness, Depression Literacy) were introduced in the first step of the model, the help-seeking facilitators (Perceived Usefulness of Prior Treatment Experiences, Perceived Encouragement from the Partner) were introduced in the second step of the regression model, and the interaction terms (Stigma x Usefulness, Stigma x Encouragement, Openness x Usefulness, Openness x Encouragement, Literacy x Usefulness, Literacy x Encouragement) were introduced in the third step of the model. Significant interactions were analysed using Modgraph (Jose, 2008).

Ethical Issues

The study followed the ethical procedures for research with humans (Helsinki Declaration, American Psychiatric Association) and was approved by the Ethics and Deontology Commission of Blind for Review. After accessing the weblink, the participants gave their consent to participate in the study (answering the question *"Do you agree to participate in this study?"*) and then answered a set of self-response questionnaires.

Results

The sample consisted of 243 women in the perinatal period, aged between 18 and 41 (*M* = 30.08; *SD* = 4.09), most of whom were married or cohabiting (*n* = 202, 83.1%). More than half of the sample had higher education (*n* = 150, 61.7%), lived in urban areas (*n* = 192, 79.0%), was currently employed (*n* = 176, 72.4%) and had a monthly income of 1000 € or more (*n* = 158, 65.0%). Of the total participants, 28.8% of the women were pregnant (*n* = 70, *M* = 24.49 weeks of gestation, *SD* = 11.02) and 70.4% of the women were in the postpartum period (*n* = 172, *M* = 5.60 months postpartum, *SD* = 3.50). Most of the women were primiparous (n = 164, 67.5%). For multiparous women (*n* = 79, 32.5%), the mean number of children was 1.21 (*SD* = 0.59). Only 30.0% (*n* = 73) of women have a prior history of professional help-seeking for mental health problems. Of these, 12 (16.4%) women have received both psychiatric and psychologic treatment, 18 (24.7%) have received only psychiatric treatment, and 43 (58.9%) have received only psychological treatment. In this study, 39.5% (*n* = 96) of the women had scores representing clinically relevant anxious and/or depressive symptomatology (women who scored on the EADH> 8 and / or the EPDS> 9, according to the authors of the Portuguese version of the scales; Augusto et al.,1996; Pais-Ribeiro et al., 2007).

Help-seeking intentions

Table 1 presents the women's intentions of seeking help from different types of sources (e.g., formal, informal) as a function of the presence of clinically relevant psychopathological symptoms. No significant differences in women's help-seeking intentions were found due to the presence/absence of clinically relevant psychopathological symptoms. However, there was a significant effect of the type of help-seeking source as well as a significant interaction effect between type of source and the presence/absence of clinically relevant symptoms. Specifically, concerning the type of help-seeking sources, post-hoc analyses showed that compared with the intention to seek formal help, women had a significantly lower intention of using semiformal sources of help (p <.001) and self-help (p <.001) but a significantly higher intention to resort to informal sources of help (p <.001) regardless of the presence of clinically relevant psychopathological symptoms. Moreover, concerning the interaction effect, differences between the women presenting and not presenting clinically relevant psychopathological symptoms were only found with regard to women's intentions to seek informal help (t_{241} = -2.29, p = .023, d = 0.29), with women who did not present clinically relevant psychopathological symptoms showing a greater intention to resort to this type of source of help.

Barriers and facilitators of the help-seeking process

A significant multivariate effect on attitudinal barriers was found for the presence of clinically relevant psychopathological symptoms (Pillai's Trace = .10, $F_{2,239}$ = 13.14, p <.001, η^2 = .10). The univariate tests showed that significant differences were found in the Psychological Openness (group not presenting clinically relevant psychopathological symptoms: M = 2.76, SD = 0.66 vs. group presenting clinically relevant psychopathological symptoms: M = 2.46, SD = 0.72, F = 11.96, p = .001, η^2 = .47) and Indifference to Stigma (group not presenting clinically relevant psychopathological symptoms: M = 3.46, SD = 0.58 vs. group presenting clinically relevant psychopathological symptoms: M = 3.01, SD = 0.91, F = 22.71, p < .001, η^2 =. 86) dimensions. Women presenting clinically relevant psychopathological symptoms reported less psychological openness and less indifference to stigma; that is, they presented less positive attitudes towards professional help-seeking. However, no significant differences were found regarding knowledge barriers (Depression Literacy levels; group not presenting clinically relevant psychopathological symptoms: M = 12.82, SD = 3.71 vs. group presenting clinically relevant psychopathological symptoms: M = 12.22, SD = 3.57, t_{241} = 1.25, p = .214, d = 0.16).

Table 1. *Help-seeking intention: help-seeking sources as a function of the presence of clinically relevant psychopathological symptoms*

	Without psychopathological symptoms (n = 147)	With clinically relevant psychopathological symptoms (n = 96)	Source Effect		Group effect		Source effect X Group	
	M (DP)	*M (DP)*	*F*	η ²	*F*	η ²	*F*	η ²
Formal help	4.65 (1.57)	4.30 (1.61)	345.12***	.59	1.59	.01	2.94*	.01
Semiformal help	2.13 (1.32)	1.97 (1.17)						
Informal help	5.41 (0.92)	5.10 (1.20)						
Self-help	2.93 (1.47)	3.17 (1.57)						

* p < .05. ** p < .01. *** p < .001

Concerning help-seeking facilitators, significant differences were found concerning women's Perceptions of Encouragement from the Partner in the help-seeking process (group not presenting clinically relevant psychopathological symptoms: M = 3.65, SD = 0.41 vs. group presenting clinically relevant psychopathological symptoms: M = 3.21, SD = 0.70, t_{241} = 6.22, p <.001, d = 0.77). Women presenting clinically relevant psychopathological symptoms perceived less support and encouragement from the partner to seek professional help to address their mental health problems. Concerning the Usefulness of Prior Experiences with mental healthcare, 23.1% (n = 34) of women who did not present clinically relevant psychopathological symptoms and 32.3% (n = 31) of women who presented clinically relevant psychopathological symptoms reported prior use of mental healthcare, and found it useful. However, no significant differences in perceived usefulness of prior mental healthcare were found as a function of the presence of clinically relevant psychopathological symptoms (χ^2 = 2.49, p = .115).

Barriers and facilitators as predictors of women's help-seeking intentions: main and interaction effects

Table 2 shows the regression model predicting the women's intentions to seek formal help to address their emotional problems during the perinatal period. Help-seeking barriers were introduced in the first step of the model. Indifference to stigma (B = 0.44, SE = .14, t = 3.06, p = .003) was the only barrier that significantly predicted women's intentions to seek professional

help, with higher indifference to stigma predicting a higher intention to seek professional help (ΔR^2 = 5.3%). The introduction of the facilitators added a significant contribution to the model (ΔR^2 = 5.3%; F = 5.46, p = .005); higher perceived encouragement from the partner was a significant predictor of women's higher intentions to seek professional help (B = .58, SE = .19, t = 3.09, p = .002).

Table 2. *Barriers and facilitators as predictors of women's intentions of seeking professional help: Main and interaction effects*

	Professional Help-seeking Intentions		
	Step 1: ΔR^2 = .53 ; $F_{3,238}$ = 4.48*** ; *B (SE)*	**Step 2:** ΔR^2 = .042 ; $F_{2,236}$ = 5.46*** ; *B (SE)*	**Step 3:** ΔR^2 = .028 ; $F_{6,230}$ = 1.23 ; *B (SE)*
Indifference to Stigma	0.44 (0.14)**	0.30 (0.15)*	0.40 (0.20)$^{+}$
Psychological Openness	0.11 (0.17)	0.04 (0.16)	0.05 (.19)
Depression Literacy	-0.02 (0.03)	-0.02 (0.03)	-0.02 (0.03)
Usefulness of prior experiences		0.18 (0.23)	0.24 (0.25)
Encouragement from the partner		0.58 (0.19)**	0.68 (0.20)***
Stigma x Usefulness			-0.22 (0.31)
Stigma x Encouragment			0.07 (0.22)
Openness x Usefulness			0.04 (0.40)
Openness x Encouragement			0.49 (0.26)$^{+}$
Literacy x Usefulness			-0.01 (0.08)
Literacy x Encouragement			-0.10 (0.06)

$^{+}p < .10$. $^{*}p < .05$. $^{**}p < .01$. $^{***}p < .001$.

The interaction between barriers and facilitators did not significantly contribute to the explained variance of the women's intentions to seek professional help (ΔR^2 = 2.8%; F = 1.23, p = .293), suggesting that stigma (barrier) and perceived encouragement from the partner (facilitator) independently contribute to the women's intentions to seek professional help.

Barriers and facilitators as predictors of women's help-seeking intentions: the moderating role of clinically relevant symptoms

In the first step of the model, Indifference to Stigma (B = 0.30, SE = 0.15, t = 1.99, p = .047) and Perceived Encouragement from the partner (B = 0.58, SE = 0.19, t = 3.09, p = .002) acted as significant predictors of women's intentions to seek professional help, explaining 9.5% of the variable's variance ($F_{5,236}$ = 4.97, p < .001). The second (moderator variable: clinically relevant psychopathological symptoms) and the third (interaction terms) steps of the model did not significantly add explained variance (step 2: ΔR^2 = 0.0%; F = 0.02, p = .880; step 3: ΔR^2 = 0.01%; F = 0.69, p = .632).

Discussion

This study has three main results: 1) Women showed a significantly higher intention to resort to sources of informal help than to seek formal help, regardless of the presence of clinically relevant psychopathological symptoms; 2) Women with clinically relevant psychopathological symptoms reported more attitudinal barriers (less psychological openness and less indifference to stigma) and perceived less encouragement

from the partner to seek professional help, although they did not differ in their perceived usefulness of prior treatment experiences or in their knowledge about depression (depression literacy); 3) Both barriers (stigma) and facilitators (perceived encouragement from the partner) significantly and independently predicted women's intentions to seek professional help, regardless of the presence of clinically relevant psychopathological symptoms.

First, consistent with previous studies (O´Mahen, & Flynn, 2008; Scholle, & Kelleher, 2003), women reported a significantly higher intention to seek help from informal sources to address their emotional problems in the perinatal period compared to formal sources of help, supporting the idea that women prefer to discuss their emotional difficulties with their social network (family and friends) (Fonseca et al., 2015; Henshaw et al., 2013). Moreover, women who presented clinically relevant psychopathological symptoms reported a lower intention to seek informal help from their family and friends compared to women who did not present clinically relevant symptoms. This result may be explained by the fact that women's awareness of the presence of depressive/anxiety symptoms may translate into feelings of stigma, shame, and fear that their social network will not understand their symptoms and, consequently, into greater reluctance to share their symptoms and needs with family and friends (Abrams et al., 2009; Goodman, 2009; Letourneau et al., 2007).

Second, the presence of an effective need for help (that is, clinically relevant psychopathological symptoms) appears to be itself a barrier in the process of seeking professional help to address emotional problems because it seems to accentuate the barriers and to minimize the facilitators towards professional help-seeking. In fact, in our study, women with clinically relevant psychopathological symptoms reported less psychological openness and less indifference to stigma. They revealed less positive attitudes toward seeking formal/professional help, and perceived less encouragement from the partner to seek professional help to address their mental health problems. One possible explanation for these results may be the fact that depressive symptoms are associated with a more negative interpretation of events, which can negatively influence women's perceptions of their partner's support and the negative consequences that may result from seeking professional help to address their emotional problems during the perinatal period.

Contrary to expectations (Dennis & Chung-Lee, 2006), there were no differences in women's levels of depression literacy, as a function of the presence/absence of clinically relevant psychopathological symptoms, and this variable did not constitute a significant predictor of women's intentions to seek professional help. This finding suggests that knowledge limitations regarding depression symptoms and treatment options may not be a significant barrier to the women's help-seeking process. However, this result may be due to the fact that, in our sample, most of the women had higher education levels. Previous studies (Abrams et al., 2009; Bilszta et al., 2010; Dennis & Chung-Lee, 2006; Mayberry, 2007; McCarthy & McMahon, 2008) have reported that knowledge barriers play an important role in the process of symptom recognitions and of seeking professional help. Therefore, further studies are needed to investigate the role of depression literacy among a more sociodemographically diverse Portuguese sample.

Similar results were found in relation to the perceived usefulness of prior experiences with mental health professionals, with no effect of this variable in women's intentions to seek professional help. One possible explanation for this result may be the fact that, in our sample, the majority of women with clinically relevant psychopathological symptoms had no prior experiences with mental health professionals or did not consider these experiences helpful, which may have contributed to the development of negative attitudes towards mental health professionals and reluctance to consider this type of help (Abrams et al., 2009; Guy, Sterling, Walker, & Harrison, 2014). However, even when women perceive their prior experiences with mental health professionals as useful, this may not be synonymous with anticipating the establishment of a trusting and non-judgmental relationship with health professionals in case of need.

Therefore, women may continue to fear the implications of being assigned a diagnosis of a mental health problem (Dennis & Chung-Lee, 2006; Goodman, 2009; Letourneau et al., 2007).

Third, women's perceptions of stigma and perceived encouragement from the partner seem to independently act as a barrier and as a facilitator, respectively, of the women's professional help-seeking intentions. Globally, these results seem to corroborate the importance of social influences in women's help-seeking process (Rickwood, Deane, Wilson, & Ciarrochi, 2005). On the one hand, the results highlight the important role of stigma with regard to mental illness, which translates into women's feelings of shame and fear of not being understood by their social network and by health professionals (Abrams et al., 2009; Woolhouse et al., 2009). Therefore, women may be more prone to seek professional help in case of need if they feel that their social network does not have stigmatizing attitudes towards mental health and illness. On the other hand, these results underscore the important role of the social network, particularly of the woman's male partner, in encouraging women to seek professional help when they experience the first symptoms of a clinical condition (Dennis & Chung-Lee, 2006). In fact, the partner can provide not only emotional and instrumental support in the transition to parenthood (Pilkington et al., 2015) but can also be an essential element in detecting a woman's symptoms by being available to listen to her difficulties and encouraging her to share them with health professionals. This joint and comprehensive management of depressive symptoms is essential to prevent the development of even more adverse outcomes since depressive symptoms are associated with marital conflicts and an increased likelihood of depression in the male partner (Burke, 2003; Letourneau et al., 2012).

Moreover, the influence of barriers (stigma) and facilitators (perceived encouragement from the partner) in the help-seeking process seems to occur regardless of the presence of an effective need for help (the presence of clinically relevant psychopathological symptoms). This finding supports the development of universal media campaigns (Bilszta et al., 2010; McCarthy, & McMahon, 2008; McGarry et al., 2009) that aim to improve women's professional help-seeking to address mental health problems during the perinatal period.

Despite its important contribution, this study has some limitations that need to be acknowledged. First, our sample consists mainly of married women with higher education levels and high income. Although this sociodemographic pattern is similar to other studies of the perinatal period, it may not be representative of the entire female Portuguese population in the perinatal period, and future studies should use a more sociodemographically diversified sample. In addition, the conclusions from this study should be carefully interpreted given the self-selected nature of the participants' and, consequently, to the possibility of an overrepresentation of more concerned participants with the topic of help-seeking. Second, this is a cross-sectional study based on self-administered questionnaires. It does not allow for a clinical diagnosis of perinatal depression and does not evaluate the impact of barriers and facilitators on women's help-seeking intentions over time and depending on the degree of the severity of anxiety/depression symptoms. Third, this study provides insight only into women's barriers and facilitators to their intentions of professional help-seeking. Future studies should include other sources of information (e.g., the male partner) in an attempt to better understand the male partner's role (e.g., attitudes towards professional help-seeking) in women's intentions to seek professional help. In addition, this study does not characterize in detail the women´s previous experiences with mental health professionals (e.g., psychiatrists vs. psychologists) nor the reasons behind these previous experiences. Future studies should explore these variables to better understand their influence in women's intentions to seek professional help.

Finally, several clinical implications may be drawn from our results. Firstly, given women's higher intentions to resort to informal sources of help when confronted with an emotional problem during the perinatal period and the role of social influences (stigma and encouragement from the partner) in predicting

women's intentions to seek professional help, education about perinatal depression, its symptoms and available treatments, as well as campaigns to raise individual awareness of the importance of seeking formal help should address not only women in the perinatal period, but also the people from the women's social network (e.g., family members, close friends) (Henshaw et al. 2013, O'Mahony, Donnelly, Bouchal, & Este, 2012). Second, it is important that male partners in particular may be made aware of the adverse consequences of perinatal distress (anxiety/depression) as well as their important role in supporting and encouraging women's professional help-seeking process (Bilszta et al., 2010; Fonseca & Canavarro, 2017; O'Mahony et al., 2012). Third, given that stigma was found to be a significant barrier in women's intentions to resort to professional help, awareness-raising campaigns are needed that focus on motherhood-related myths (e.g., discussing motherhood idealization and myths of perfect motherhood) (Bilszta et al., 2010), the prevalence of women who experience perinatal distress symptoms during the perinatal period, and the risks of not seeking treatment.

Because pregnant and postpartum women have increased contact with health professionals (Battle & Zlotnick, 2005), the obstetrical follow-up should include the monitoring of women's perinatal distress symptoms by health professionals as well as continuous information about the symptoms of perinatal distress and treatment options (Goodman, 2009; O'Mahony et al., 2012). Finally, in an attempt to normalize the occurrence of these symptoms during the perinatal period and to reduce the stigma related to perinatal mental health problems, health professionals can systematically include an assessment of women's emotional state (e.g., openly questioning them about the difficulties experienced in this period, emotional changes) during their obstetric and/or neonatal follow-up appointments.

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