Barriers in Seeking Treatment for Perinatal Depression in Low-Income African Americans: A Systematic Review

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Abstract

Introduction: Perinatal depression is a mood disorder that can occur during pregnancy and within four weeks of childbirth. Individuals at the greatest risk for perinatal depression include low-income African American and Hispanic women. African American women are least likely to seek psychiatric treatments for perinatal depression. Current literature presents conflicting findings as to the existence of racial and ethnic differences in screening and treatment for perinatal depression. This systematic review aimed to summarize and categorize the barriers faced by low-income, pregnant Black/African American women that discourages treatment engagement for depression. ***Methods*:** The author abstracted evidence from articles published between 2008 and 2021 from CINAHL, PubMed, and ScienceDirect electronic databases and ancestry search strategy. Papers eligible for inclusion included: full-text, peer-reviewed studies, and a focus on the barriers for low-income, pregnant African Americans in seeking treatment for depression. Quality assessment was conducted, using Melnyk and Fineout-Overholt's Rapid Critical Appraisal Checklists. ***Results:*** Of 8,715 papers identified, 7 studies met the inclusion criteria. Common themes were 1) avoidance of psychiatric medications with greater preference for faith-based interventions and 2) time constraints and costs as significant barriers to treatment for perinatal depression in this population. ***Discussion:*** The results suggest the need to include faith-based approaches to appeal more to African American women, ask more culturally sensitive questions, integrate mental health services in obstetric clinics, and offer virtual appointments and/or options for mothers to bring their children for easier convenience.

Keywords: perinatal depression, African American, low-income, pregnant, barriers, and treatment.

Barriers in Seeking Treatment for Perinatal Depression in Low-Income African Americans: A Systematic Review

Low-income, African American women are approximately five times more likely to experience perinatal depression than Hispanic, Caucasian, and Asian women (Cruser et al., 2012). Perinatal depression, as defined by the American Psychiatric Association (2013), is characterized as an affective disorder that can occur during pregnancy and within four weeks of childbirth. Within the general population, this mood disorder can occur at rates between approximately 6.5% to 12.9% (Sidebottom et al., 2021; Wenzel et al., 2021). Individuals at greatest risk for perinatal depression include low-income African American and Hispanic women (Wenzel et al., 2021). Among African Americans, the prevalence of antenatal depression was found to be 15.3%, significantly higher than their White counterparts, 3.6% (Gavin et al., 2011). Unfortunately, these populations are also least likely to seek psychosocial treatments and psychiatric medications to help manage this complication (Salameh et al., 2019).

Before we can treat individuals, we must identify they need treatment, accomplished through screening for signs and symptoms. Although there is an existing recommendation to implement universal screening for perinatal depression across the United States at least once during pregnancy, disparities in the screening and rendering of psychiatric services are observed in low-income African American women (Powers et al., 2020). This gap in practice suggests there could be racial and sociocultural factors, such as exposure to interpersonal trauma, presenting barriers for this at-risk group in seeking mental health treatments (Powers et al., 2020). Current literature presents conflicting findings as to the existence of racial and ethnic differences in screening and treatment and describes several other possible barriers faced by this population. This systematic review aimed to summarize and categorize the many barriers

encountered by pregnant low-income Black/African American women in seeking screening and treatment for perinatal depression.

Background & Significance

Low-income African American women have been observed to be at elevated risk for antenatal depression, specifically in the third trimester, as well as postpartum depression (Cruser et al., 2012; Wenzel et al., 2021). This disparity poses an important concern to our society, as untreated prenatal and postpartum depression can lead to adverse birth outcomes, such as preterm deliveries and low birthweight. It can also negatively impact the mother-infant bond and lead to developmental and behavioral issues for the child later in life (Sidebottom et al., 2021). Potential factors that could explain this disparity involve sociocultural factors for African Americans in low-income areas, including greater exposure to traumatic events, such as interpersonal violence (Powers et al., 2020). Exposure to adverse events can not only increase the risk for post-traumatic stress disorder (PTSD), but also for comorbid psychiatric conditions such as depression (Powers et al., 2020). Thirty to fifty-percent of African American women in low-income, at-risk communities have experienced PTSD and depressive symptoms (Powers et al., 2020). Furthermore, the lack of spousal/partner support for pregnancy is also noted to be another risk factor for socioeconomically disadvantaged African Americans to experience perinatal depression (Mukherjee et al., 2018). In addition to this significant barrier of trauma, Powers et al. (2020) and Hsieh et al. (2021) state other barriers, such as stigma of receiving mental health treatment, racial discrimination, and lack of culturally sensitive resources, come into play in these at-risk communities. It is important that health care providers clearly understand these barriers so they may address them in a culturally sensitive manner, helping patients to feel supported and empowered to seek help for depression (Cruser et al., 2012).

Review of the Literature

Several studies have assessed perinatal depression screening and treatment rates, risk factors, and barriers for low-income African Americans. Sidebottom et al. (2021) studied the number of perinatal and postpartum depression screenings within a large healthcare organization to determine if any disparities existed. The sample of 7,548 women was mostly Caucasian, married, and had private insurance. Only 11.5% were African Americans. This study found no evidence of inequitable care regarding prenatal screening; however, they did find women who were less than 24 years old, non-English speaking, African American, Asian, or not Caucasian, and/or on Medicaid/Medicare were less likely to be screened for perinatal depression during postpartum. In addition, they found infrequent screenings and a lack of understanding or motivation to return for postpartum visits were also barriers to care for perinatal depression. Cruser et al. (2012) conducted a systematic review of 16 articles that explored risk factors that predisposed African American women to perinatal depression. Key findings from this review demonstrated there were multiple risk factors including impoverished living conditions, lack of a spouse or partner, and history of interpersonal trauma and violence (Cruser et al., 2012).

A qualitative study by Hsieh et al. (2021) explored the perspectives of 29 pregnant or postpartum women (51.7% African American) regarding perinatal depression screening and how their experiences influenced their decisions about mental health care. Three major themes found from these mothers' experiences were: perceived ineffectiveness of screening, providers' disengagement, and macro-level barriers, such as racism and stigma towards disclosing honestly about depressive symptoms (Hsieh et al., 2021). The extant literature addressing perinatal depression screening and treatment in low-income African American women describes many barriers for this population, but also demonstrates conflicting findings as to whether racial and

ethnic differences exist as obstacles (Salameh et al., 2019). This review summarized and categorized these barriers to assist providers in applying culturally appropriate screening and treatment measures for this population.

Purpose & Clinical Question

Low-income pregnant African American women are one of the minority groups who are at increased risk for perinatal depression and yet, are the least likely to seek psychiatric treatments. Because of the existing conflicting findings in the literature, the aim of this present study was to systematically summarize and categorize the barriers for low-income African Americans in seeking treatment for perinatal depression. The clinical question guiding this review was: What are the major barriers faced by low-income African American women, pregnant to 3 months postpartum, to seeking treatment for perinatal depression?

Conceptual Framework

The conceptual framework that guided this systematic review was the Neuman's Systems Model (Petiprin, 2020). This established nursing theory discussed the concepts that every person has unique characteristics that interact with his/her environment and can influence his/her wellness (Petiprin, 2020). Betty Neuman, the author of this conceptual framework, described that every individual is complex, and considerations should be made towards their multidimensional aspects, including physiological, psychological, socio-cultural, spiritual, and developmental, all which can impacted from the stressors within the patient and from the external environment (Petiprin, 2020).

Specifically for this current study, this conceptual framework has been integrated with the understanding that while pregnant African American women in low-income, high-risk

communities have been observed at greater risk for perinatal depression, it is important to initially identify any risk factors that could act as stressors and lead to adverse outcomes in pregnancy and postpartum (Petiprin, 2020). With awareness of the potential barriers to treatment for depression, it is also important as advanced nurse practitioners to recognize the present signs and symptoms of perinatal depression within this vulnerable population, following exposure to these stressors and aim to prioritize appropriate interventions to restore wellness (Petiprin, 2020).

Methods

Project Design

This systematic review of the literature followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines and was guided by Neuman's Systems Model.

Search Strategy

An electronic database search was conducted from September to November 2022 with use of search terms: perinatal depression, African American, low-income, pregnant, barriers, and treatment. Databases searched included: CINAHL, PubMed, and ScienceDirect. This systematic review was population specific. Specific inclusion criteria used to screen the studies included: full-text, peer-reviewed studies, English, date range of publication within 15 years (2007-2022), and relevant articles that addressed the main topic of the barriers for low-income, pregnant African Americans in seeking treatment for depression. To obtain additional articles, ancestry searching was used. Ancestry searching is an excellent search strategy that involves reviewing the list of references from currently used articles that are relevant in addressing the clinical question or topic of interest (Melnyk & Fineout-Overholt, 2019). Since this systematic review

consisted of studies with multiple research designs, Melnyk and Fineout-Overholt (2019)'s Rapid Critical Appraisal Checklists were the quality appraisal tools that were used to evaluate the validity, reliability, and applicability for each study. The cut-off score for inclusion in the study was 3 out of 10.

Selection Process

The PRISMA flow-diagram of study selection and screening can be seen in Figure 1. Research articles were primarily located through the online database searching in Texas State University Library. Additional articles were identified through Zotero reference management tool and ancestry searching. One reviewer (J.B.) independently read the titles, abstracts, and full-texts of the articles, using the inclusion criteria (peer-reviewed, English, date range of publication within 15 years [2007-2022], and directly addressed main topic of barriers for low-income, pregnant African Americans in seeking treatment for depression. Additionally, since this systematic review consisted of studies with various study designs, Melnyk and Fineout-Overholt (2019)'s Rapid Critical Appraisal checklists were the specific quality appraisal tools that I used to evaluate the validity, reliability, and applicability for each study. These assessment tools also allowed analytical reflection as to how results from each individual study can be used to develop final clinical recommendations (Melnyk & Fineout-Overholt, 2019).

Synthesis Method

An evidence synthesis table was created to review and contrast the studies used for this systematic review (see Table 1). This step in the systematic review process rendered insight into the level of evidence, strengths, and limitations of each study and allowed me to objectively compare findings and observe patterns between the studies (Melnyk & Fineout-Overholt, 2019). This evidence synthesis table also demonstrated inconsistencies in some studies that indicated

weaknesses in the evidence and areas in which future research could improve upon to address the clinical question (Melnyk & Fineout-Overholt, 2019). Through this overview of information, common themes of potential barriers for low-income, pregnant African American women in seeking treatment for depression were sought. Furthermore, this data analysis enabled me to make final recommendations for a systematic strategy to eliminate this health disparity and improve healthcare outcomes (Melnyk & Fineout-Overholt, 2019).

Results

Search Results

In total, 8,715 articles were identified (see Figure 1). After removing 2,179 duplicates and 6,358 screened out by title, 178 studies were included in the initial screening stage. Several full-text articles were excluded either because of incorrect study population, incorrect study designs, and they did not appropriately address the aim of this systematic review. Seven articles met all inclusion criteria.

Characteristics of Studies

This sample consisted of 1 qualitative study (Iturralde et al., 2021), 1 cross-sectional study (Chang et al., 2016), 1 mixed-methods study (Sacks et al., 2015), and 4 descriptive survey studies (Goodman et al., 2013; Liu & Tronick, 2012; O'Mahen & Flynn, 2008; Salameh et al., 2019). Their purposes ranged from examining various factors that influence low-income mothers from seeking treatment for perinatal depression (Goodman et al., 2013; Sacks et al., 2015) to examining social determinants such as race, socioeconomic status, and health characteristics as barriers for treatment engagement for perinatal depression (Chang et al., 2016; Liu & Tronick,

2012). Their sample sizes ranged from 30 females (Iturralde et al., 2021) to 81,910 females (Chang et al., 2016) with a total sample size across studies of 87,318 females.

Treatment barriers of perinatal depression was the most studied topic (Chang et al., 2016; Iturralde et al., 2021; O'Mahen & Flynn, 2008; Sacks et al., 2015; Salameh et al., 2019). Four studies examined the race/ethnicity differences between treatment engagement for perinatal depression (Chang et al., 2016; Iturralde et al., 2021; O'Mahen & Flynn, 2008; Salameh et al., 2019). Other studies commented on pregnant, low-income African Americans' perceptions of preventive treatment options for perinatal depression and patient and health characteristics influencing the provider-patient conversation about mood (Goodman et al., 2013; Liu & Tronick, 2012). Data collection was mostly through surveys (Goodman et al., 2013; Liu & Tronick, 2012; O'Mahen & Flynn, 2008; Salameh et al., 2019). In 5 articles, most of the study population was pregnant women (Chang et al., 2016; Goodman et al., 2013; O'Mahen & Flynn, 2008; Sacks et al., 2015; Salameh et al., 2019) with two studies including postpartum women (Iturralde et al., 2021; Liu & Tronick, 2012). One study involved clinicians' perspectives (Iturralde et al., 2021).

Synthesis Across Studies

Using the thematic analysis methods by Whittemore and Knafl (2005), two major themes describing the barriers faced by African Americans when seeking treatment for perinatal depression were generated across studies.

Theme 1: Avoidance of Psychiatric Medications

A common finding in most of the studies was that among pregnant African American women, there was a greater preference for prayer or psychosocial interventions over pharmacotherapy in treating perinatal depression (Goodman et al., 2013; Iturralde et al., 2021; O'Mahen & Flynn, 2008; Sacks et al., 2015; Salameh et al., 2019). Among this minority

population, the commonly shared cultural belief was that depression was perceived as a weakness and could be overcome by prayer and faith alone. Even in cases in which Black women previously experienced a depressive episode, antidepressants were considered less favorable than psychosocial interventions such as IPT or MCBT and faith-based approaches (Goodman et al., 2013; Iturralde et al., 2021). For example, Iturralde et al. (2021)'s study participants stated, "You have to stay strong," (people say)…Whatever emotions you have, you push them away because you don't want to seem weak. And just pray about it." --Black patient (Iturralde et al., 2021)

Theme 2: Time and Resources

In four out of the seven studies, researchers found that time constraints and costs were barriers to treatment engagement for perinatal depression for this population (Goodman et al., 2013; Iturralde et al., 2021; Sacks et al., 2015; Salameh et al., 2019). Both clinicians and participants stated that inflexible work schedules and the responsibilities of taking care of a child conflicted in their ability to follow up and see a mental health provider (Iturralde et al., 2021; Sacks et al., 2015). Another barrier for depression treatment engagement among pregnant, low-income African American women was the costs of treatment (Chang et al., 2016; Goodman et al., 2013; Iturralde et al., 2021; Sacks et al., 2015; Salameh et al., 2019). Higher co-pays and deductibles and lack of low cost, accessible treatment options were described as barriers by participants in most studies (Chang et al., 2016; Goodman et al., 2013; Iturralde et al., 2021; Sacks et al., 2015; Salameh et al., 2019).

Other Findings

Two studies found there were no racial/ethnic disparities noted in the perceived barriers of treatment for perinatal depression (Liu & Tronick, 2012; Salameh et al., 2019). One

descriptive survey study, in fact, stated that its findings showed that no differences were shown between White and non-White patients in having a conversation about mood with their obstetric providers, indicating that providers may be especially sensitive about discussing depression treatment with their at-risk populations (Liu & Tronick, 2012). This finding differed from most studies in this systematic review, as time constraints, lack of transportation, treatment costs, stigma, and cultural beliefs influencing use of faith-based interventions over psychiatric interventions were common barriers faced in this population in treatment engagement for perinatal depression.

Neuman's Systems Model has guided and has been integrated with this systematic review's themes and sub-themes. Particularly for low-income, pregnant African American women, most studies in this systematic review revealed that sociocultural and spiritual aspects of their environment were the most influential in whether this population chose to seek mental health treatment for perinatal depression.

Discussion

This systematic review aimed to summarize and categorize the barriers encountered by pregnant, low-income Black/African American women in seeking treatment for perinatal depression. Overall, the studies' findings revealed that AA women may avoid depression treatment because their cultural beliefs see depression as a human weakness, not treatable by medication, and because of socioeconomic concerns. Across the studies, African American women predominantly preferred psychosocial or faith-based treatment approaches over antidepressant therapy. This could likely arise from the overriding cultural perspective that depression is a human flaw that cannot be cured with medication and should be approached through prayer and faith alone (Goodman et al., 2013; Iturralde et al., 2021). The second theme

found across studies was that time constraints and costs were treatment barriers to seeking mental health services for AA's. The responsibilities of working and child-rearing made it difficult for these socioeconomically disadvantaged women to make their own psychiatric care a top priority.

Neuman's Systems Model supports these findings in that it states that every patient should be approached with the understanding that he/she is an individual with unique characteristics that interact with his/her environment and can influence his/her wellness (Petiprin, 2020). No individual has identical responses to similar stressors (Petiprin, 2020). It is important to consider that social determinants such as race/ethnicity and socioeconomic status influence how an individual copes with stress, such as perinatal depression. Nurse practitioners should maintain a balanced, objective, and culturally sensitive approach with pregnant, low-income Black/African American women. Understanding the major treatment barriers to perinatal depression, providers must evaluate for a history of or current symptoms of depression, assess the patient's knowledge and perceptions about this mental health condition, inquire about personal preferences for prophylactic and ongoing treatments, and evaluate for reasons limiting their ability to seek out mental health services.

Recommendations from Findings

In a systematic review by Cruser et al. (2012), the authors described that the best approach to help socioeconomically disadvantaged, pregnant Black women is to include culturally sensitive questions when depressive symptoms are in question. Due to the influence of their environment, Holzman et al. (2006) explained that this population may be less likely to be knowledgeable about the various aspects of maternal and infant health. Advanced practice nurses must understand the importance to maintain an objective, yet culturally sensitive attitude when

assessing for risk factors in this vulnerable population (Petiprin, 2020). Culturally sensitive questions such as asking about the presence of social and emotional support may be helpful (Cruser et al. 2012). Furthermore, encouraging autonomy in decision making in these individuals has also been shown to help lead them to become more open in choosing mental health options if needed. In another study, integrating psychiatric care with primary care has been helpful in responding to the mental health needs of at-risk Black women (Ley et al., 2009). Based on these findings, to improve mental health treatment for pregnant Black women, providers should include culturally sensitive questions in screening this population for depression, including inquiries about perceptions regarding depression as a disease and its treatment, and socioeconomic barriers to treatment. Additionally, providers should encourage autonomy in decision-making, and advocate for the development of more integrated care clinics.

Limitations

This present study's findings should be considered in the context of several limitations. First, most of these studies, four out of seven, have small samples, indicating that the findings of these individual primary studies cannot be generalized and may not accurately reflect the range of perspectives of the stakeholders on this topic. To confirm the findings of this systematic review, future studies need to have larger samples. Second, four out of the seven studies may have introduced bias into the findings from self-reporting. Inaccuracies can result from self-reporting if participants are not fully disclosing the truth or cannot recall what happened. Future studies should use provider-patient clinical interviews or computer-assisted interviews to reduce this bias. Third, unfortunately, research studies specifically addressing the topic of barriers in low-income, pregnant African American women in seeking perinatal depression treatment are

limited. More studies regarding racial/ethnic differences in depression treatment engagement need to be completed.

Conclusions and Implications

Despite these limitations, the overall findings from this present study reflect a need to raise more awareness and education within at-risk communities about perinatal depression and its associated treatment modalities. Including faith-based approaches which may appeal to more African American women, integrating mental health services in obstetrics clinics, offering virtual appointments and/or the option for mothers to bring their children to the appointments for easier convenience, and considering hiring psychiatric providers from diverse backgrounds to decrease cultural stigma in seeking assistance, are all recommended options for health care providers. In the context of future research and policy changes, the current findings implicate a need to do more research to assess the barriers and facilitators for low-income African American women in seeking treatment for perinatal depression. Specific to policy changes, they should increase funding towards improving access to mental health services in at-risk communities where low-income African American women live. Lastly, there is also a need for more research into the effectiveness of different interventions for pregnant, low-income Black women to prevent depression. While the implementation of universal screening across the United States has increased rates of detection for perinatal depression, low-income African American women remain the least likely minority group to seek mental health treatment for this condition. We must strive to reduce this racial disparity in maternal health care.

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Figure 1

Flow Diagram of Systematic Review Process

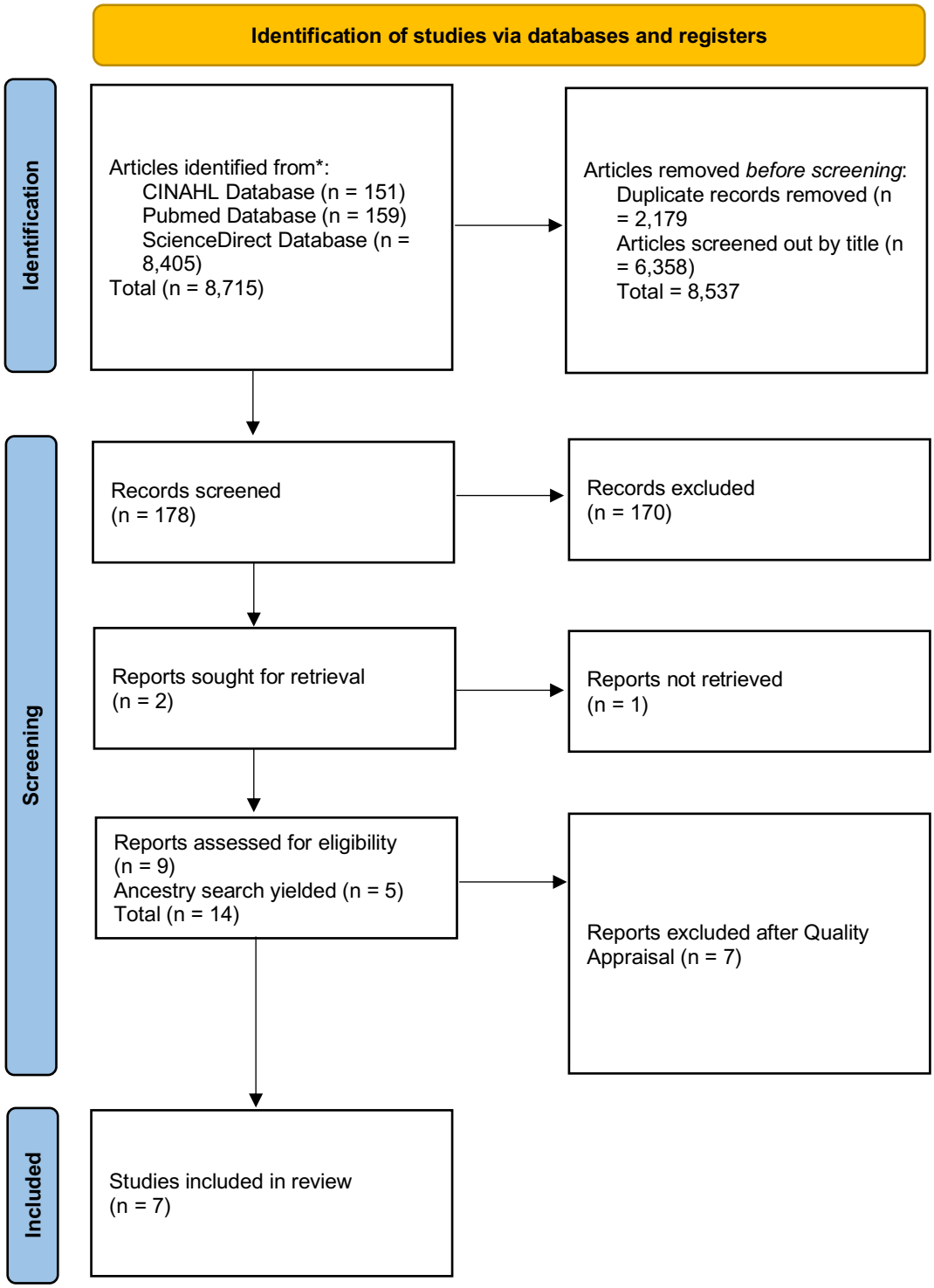

Table 1

Evidence Synthesis Table

Author	Purpose	Frame-work	Design	Sample/ Setting	Methods	Findings	Quality Appraisal/ Limitations	Conclusions/ Application
Chang, 2016	To identify factors that predict use of mental health services among pregnant women from various racial/ethnic backgrounds in Florida.	Andersen Behavioral Model of Health Services Use	Cross-sectional population-based study	81,910 pregnant women (27,936 White, 21,425 AA, 1,477 American Indian, 1,109 API, 29,963 Hispanics) from Florida with self-reported depressive symptoms	Specific measures used: Florida's Healthy Start program prenatal risk screening	Treatment barriers among pregnant AA women include: 1) being unmarried, indicating lack of time and resources as part of single parenthood and less financial support and 2) lack of insurance coverage.	Quality Appraisal Rating 3/10 Causal associations cannot be established; inaccuracies from self-report of lifetime use of mental health txts and covariate data from prenatal screening; bias from self-report of symptoms; sample characteristics are generalizable only to pregnant women in Florida and pregnant women in U.S. with similar characteristics.	Supports need for healthcare providers to be culturally competent & sensitive and for development of mental health services for racial/ethnic minorities to avoid disparities in care.
Goodman, 2013	To examine perceived barriers	None	Descriptive Survey	60 pregnant, low-income AA women; DeKalb	Specific measures used:	Primary perceived barriers in preventative txt	Quality Appraisal Rating 7/10	Supports need for further community education about mental health txts,

Author	Purpose	Frame-work	Design	Sample/ Setting	Methods	Findings	Quality Appraisal/ Limitations	Conclusions/ Application
	and influence of past depressive episodes in pregnant, low-income AA women in selecting preventive txt options for perinatal depression.			County, Georgia, mean age 25 years, majority <$10,000/yr income, single, already with 1 child; almost 50% with HS education.	Credibility scale, Personal Reactions Scale, EPDS depression scale.	include lack of affordability & cultural beliefs to use faith-based interventions instead.	Small sample limits generalization of findings; psychosocial txt options (MCBT & IPT) not usually accessible in obstetrical or behavioral settings; survey about hypothetical selection of preventive depression txt; no inquiry about CBT treatment preference.	including psychosocial options for perinatal depression, affordable and easily accessible txts, and incorporating txt as adjunct to faith-based approaches to depression.
Iturralde, 2021	To examine factors that influence treatment engagement in perinatal depression within each race/ethnicity among	None	Qualitative	30 females (10 Asian, 5 AA, 9 White) with PHQ-9 scores ≥10 from EHR, mean age 34 years, 10 pregnant & 20 postpartum, Northern	Focus groups and interviews conducted to explore participants' perinatal depression episodes, preferred treatment options,	Treatment barriers exist on individual, social, & clinician levels, including time constraints, fears of documented treatment affecting occupation or	Quality Appraisal Rating 5/10 Small sample not reflective of range of perspectives within each racial/ethnic group & findings not transferable to women uninsured,	Treatment barriers exist on individual, social, & clinician levels, including time constraints, fears of documented treatment affecting occupation or immigration status, cultural messages that depression can

Author	Purpose	Frame-work	Design	Sample/ Setting	Methods	Findings	Quality Appraisal/ Limitations	Conclusions/ Application
	diverse sample of insured women in healthcare system and from providers' perspectives.			California region	factors influencing engagement for mental health txt, including race/ethnicity, and thoughts to improve treatment engagement.	immigration status, cultural messages that depression can be overcome by prayer alone, clinicians' insensitivity to social determinants and fears of racial profiling.	speak English as 2nd language, or receive care in non-integrated clinics; potential inaccuracies due to women not disclosing truth on depressive screening tool.	be overcome by prayer alone, clinicians' insensitivity to social determinants and fears of racial profiling. Supports need for integration of mental health txt with obstetric care, virtual psychiatric appointments for convenience, and more community education & resources about perinatal depression to improve access.
Liu, 2012	To examine patient & health characteristics that influence health providers in	None	Descriptive Survey using the New York City Pregnancy	3,597 NYC mothers (1,023 White, 971 AA, 1,204 Hispanic, & 399 API)	NYC PRAMS survey given to postpartum women to evaluate maternal experiences before, during, and	Social factors and forms of prenatal care payment have influence in provider-patient conversations about mood.	Quality Appraisal Rating 4/10 Causal associations cannot be established; inaccuracies from self-report with conversations with	No racial/ethnic differences noted in provider-patient conversations about mood. Lack of treatment engagement in pregnant, low-income AA women

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	discussing about mood in perinatal period with diverse sample of NYC postpartum mothers		Risk Assessment Monitoring System (PRAMS)		after pregnancy.	AA are likely as White pregnant women to have conversations with provider about mood.	providers last year; other social factors like social support and race-related stressors not addressed.	could arise from other factors.
O'Mahen, 2008	To examine perceived barriers and factors influencing treatment engagement for perinatal depression within each racial/ethnicity.	None	Descriptive Survey	447 women (86% white from suburban clinic, 57% AA in urban clinics), 4 Midwestern area OB-GYN clinics in 2004-2007	Specific measures used: EPDS depression scale, 5-point Likert scale. Interviews conducted to explore participants' severity of depressive symptoms, history of depression txts, perceptions towards mental health	Treatment barriers include cultural beliefs to use faith-based interventions (eg. Seeking help from a religious leader) and negative attitudes towards depression treatment.	Quality Appraisal Tool 5/10 Low rates of depression treatment indicating suboptimal treatments received; lack of longitudinal data; small sample; differences in how interviews were conducted could have introduced bias;	Supports need for increased access to mental health professionals, training religious leaders in psychotherapies for depression, need for further community education about perinatal depression treatments, such as affordable and easily accessible telehealth options.

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					txts, and barriers in seeking txt.		high rates of attrition.	
Sacks, 2015	To examine barriers and facilitating factors for low-income women with perinatal depression in seeking mental health txt; assess if financial rewards can increase use of psychiatric services.	None	Mixed-method	42 (7.9% non-White) low-income pregnant women, aged 18 & older, Lane County, positive for depression on EPDS or PHQ-2 scales	Random assignment into control or intervention groups. Both groups informed of Medicaid-covered resources for psychiatric care. Women in intervention group informed each time psychiatric visit was completed, $10 gift card given. Semi-structured interviews completed at baseline and 6-8 weeks postpartum. EPDS	External & internal barriers exist within low-income pregnant women in seeking mental health txt for perinatal depression. External barriers included: time and lack of transportation. Internal barriers included: negative attitudes towards mental health treatment and not feeling healthy to seek services. Financial incentives not effective in increasing use	Quality Appraisal Tool 4/10 Small sample, mostly Caucasian, not representative of usual Medicaid patients, not able to determine differences between control & intervention groups; potential selection bias from loss in follow-up	External & internal barriers exist within low-income pregnant women in seeking mental health txt for perinatal depression. Financial incentives not effective in increasing use of psychiatric services. Supports need to offer phone or virtual counseling for low-income patients to facilitate mental health tx & need to provide education to obstetricians on efficacy of psychiatric services

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					completed to assess depressive symptoms postpartum.	of psychiatric services.		
Salameh, 2019	To explore racial/ethnic differences in mental health treatment of pregnant women with psychiatric illnesses and/or comorbid substance use disorder in United States	Behavioral Model of Health Service Use	Descriptive survey; secondary analysis of National Survey on Drug Use and Health (NSDUH)	N=1232 pregnant women with psychiatric and/or substance use disorder (14.4% AA), 18-44 years old, live in urban areas of USA from NSDUH 2008-2014	Evaluated depressive symptoms with K6 scale, substance abuse disorder & mental health txt with questions from NSDUH.	Although there were no significant differences between white and nonwhite women on perceived barriers, cost was a barrier for 35.6% of nonwhite women, opposition to treatment was a barrier for 39.8% of nonwhites, Stigma was perceived as a greater barrier to nonwhites (26.6%) when compared to whites	Quality Appraisal 5/10 Psychiatric & substance use disorders not assessed as problems during pregnancy; bias from DSM-IV self-report of symptoms; small sample size leading to categories Non-white vs. White.	Even after controlling multiple variables, pregnant AA women significantly less likely to receive mental health txt or prescription drugs. No racial/ethnic differences in perceived barriers in txt for perinatal depression. Hire psychiatric providers from diverse backgrounds to improve access & retention; offer options of counseling services sensitive to minorities' needs & make them active participants in care.

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						(22.5%), same with time/transport ation, whites (17.6%), non whites (19.1%), and not knowing where to go.		

Legend:
AA = African American; DSM-IV = Diagnostic & Statistical Manual of Mental Disorders; EPDS = Edinburgh Postnatal Depression Scale; K6 Scale = Kessler Psychological Distress Scale; OB-GYN = obstetrics-gynecology; NSDUH = National Survey on Drug Use & Health; PHQ-2 = Patient Health Questionnaire-2; txt = treatment