Pregnant women's mental health literacy and perceptions of perinatal mental disorders in the Western Cape, South Africa ☆

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ABSTRACT

Introduction: Low levels of mental health literacy (MHL) have been identified as a significant treatment barrier. However, little is known about how pregnant women perceive mental disorders during this time, particularly in low- and middle-income countries such as South Africa.
Materials and methods: 262 pregnant women attending antenatal care at a Midwife and Obstetrics Unit (MOU) were recruited to participate. Participants were presented with one of five vignettes, depicting a perinatal woman with a DSM-5 defined mental disorder, including ante- and postnatal depression, panic disorder, substance dependence and schizophrenia. Participants were asked to provide a diagnosis and completed two scales assessing aspects of MHL.
Results: Three quarters of respondents (77.4%) did not identify the signs and symptoms described in the vignettes as those consistent with a mental disorder. More than half (57.5%) viewed the conditions as "typical of a weak character", while stress was the most widely held explanation for symptoms. Postnatal depression appeared to be perceived as more pathological than antenatal depression. Ability to name mental disorders' appeared to have little bearing on treatment preference for psychological services as participants were most confident in the therapeutic benefits of consulting with a counsellor or social worker. Notably, seeking help from a spiritual or religious advisor was comparably as popular as seeking help from a psychologist or social worker.
Discussion: Given the elevated prevalence of perinatal mental disorders, these findings are concerning. Developing socio-culturally nuanced understandings of how perinatal mental disorders are perceived is central to the development of successful interventions.

1. Introduction

The prevalence of perinatal common mental disorders (CMD) in low- and middle-income (LMI) countries is high, with one systematic review finding weighted mean prevalence rates of 15.6% during pregnancy, and 19.8% postnatally (Fisher et al., 2012). Untreated CMDs have been shown to be associated with a range of adverse outcomes for both mothers and their infants. For infants, these include preterm delivery (Diego et al., 2008; Grigoriadis et al., 2013; Vythilingum, 2011), low birth weight and adverse foetal growth (Brittain et al., 2015; Grote et al., 2010), poor physical and cognitive development (Patel, Rodrigues, & DeSouza, 2002; Talge, Neal, & Glover, 2007), and

emotional and behavioural problems (Judd, Stafford, Gibson, & Ahrens, 2011; Pawlby, Hay, Sharp, Waters, & O'Keane, 2009). For mothers, CMDs are associated with increased substance abuse (Tomlinson et al., 2014; Vythilingum & Roos, 2012), social isolation (Almond, 2009), reduced caregiving capacity (Fisher et al., 2010), subsequent parenting stress (Leigh & Milgrom, 2008; Misri et al., 2010), and suicide (Almond, 2009; Oates, 2003).

Despite these potentially severe outcomes, it has been estimated that fewer than one in six pregnant women in who screen positive for depressive symptoms receive any treatment even in high income (HI) contexts (Fonseca, Gorayeb, & Canavarro, 2015; Marcus, Flynn, Blow, & Barry, 2003). Few such perinatal data are available in South Africa as

yet, however results from the South African Stress and Health (SASH) study indicated that only about a quarter of people with mental disorders received any treatment within a twelve-month period (Williams et al., 2008). A low perceived need for treatment (93%) was found to be the single most influential factor for not seeking treatment among South Africans, along with the belief that symptoms would spontaneously resolve (Bruwer et al., 2011). These findings suggest that conceptualisations of mental disorders may be preventing help-seeking behaviour.

In addition to being able to recognise mental disorders, the construct of mental health literacy (MHL) includes knowledge of risk factors, causes, treatments, and perceived effectiveness of professional services (Jorm et al., 1997). Research suggests that poor MHL serves as a barrier to appropriate help-seeking, as well as contributing to patients' failure to adhere to recommended treatments once a diagnosis is received (Bruwer et al., 2011; Jorm et al., 2006; Trump & Hugo, 2006). To date, most research has focused on depression and schizophrenia, with almost no attention given to other disorders, including CMDs such as anxiety or substance use disorders (Furnham & Hamid, 2014; Hugo, Boshoff, Traut, Zungu-Dirwayi, & Stein, 2003; Mbanga et al., 2002; Schomerus et al., 2012; Sorsdahl & Stein, 2010; Sorsdahl, Mall, Stein, & Joska, 2010). Data from LMI countries are even less readily available (Atilola, 2015; Furnham & Hamid, 2014; Jorm, 2012). Atilola's (2015) systematic review of levels of community MHL in sub-Saharan Africa found that the limited available data were primarily concerned with mood and psychotic symptoms, and reflected poor knowledge of the names of psychiatric syndromes. Supernatural explanations for symptoms were predominant, with alternative mental health services identified as the preferred treatment option (Atilola, 2015).

Internationally, research investigating the MHL of women in the perinatal period is limited and is primarily focused on depression (Furnham & Hamid, 2014). A small body of data has been gathered from HI countries, showing that women in the perinatal period often fail to recognise depression in themselves (Dennis & Chung-Lee, 2006; Fonseca et al., 2015), while the signs and symptoms frequently also go undetected by their healthcare providers (Goodman & Tyer-Viola, 2010). Research has shown that pregnant women often have difficulty differentiating between the experience of being pregnant and the symptoms associated with depression, more so than in the postnatal period (Henshaw, Sabourin, & Warning, 2013; Highet, Gemmill, & Milgrom, 2011; Hübner-Liebermann, Hausner, & Wittmann, 2012). Difficulties distinguishing between the emotional adjustments to pregnancy or parenthood and depression have been found to be a barrier to help-seeking (Bilszta, Ericksen, Buist, & Milgrom, 2010;Fonseca et al., 2015; Goodman, 2009). One study found that women who are pregnant and screen positive for depression have the most confidence in psychotherapy and support from friends and family, and the least in medications and case management as treatment options (O'Mahen & Flynn, 2008).

The adverse outcomes associated with perinatal mental illness make the early recognition of symptoms and uptake of treatment particularly critical (Freed, Chan, Boger, & Tompson, 2012). Given the high prevalence rates, understanding how women view mental disorders during pregnancy is essential to the development of appropriate interventions aimed at the prevention and treatment of perinatal CMDs. However, MHL research with perinatal women in LMI countries, including South Africa, is absent. The aim of this study was to investigate the MHL of South African women who are pregnant and receive antenatal care at a primary health care facility in one peri-urban community in the Western Cape province of South Africa. Focusing on depression (antenatal and postnatal), anxiety (panic disorder), substance dependence (alcohol), and psychosis (schizophrenia), the study sought to understand more about women's perceptions of perinatal mental disorders, particularly beliefs about causes of mental disorders, and views on the most effective treatments.

2. Materials and methods

2.1. Study setting and population

Data were collected at a Midwife and Obstetrics Unit (MOU) that serves a large district in the Western Cape province of South Africa, with a primarily low-income population of approximately 500 000 people (Peton, 2012). According to a report published by the Department of Local and Provincial Government (2011), the district has a population density of 3618 people per km^2, where more than one fifth of households live in informal housing and almost half live in poverty. Just more than 60% of the population are under the age of 29 years and 48% of employable adults are unemployed (Department of Local and Provincial Government, 2011).

2.2. Participants

A convenience sample of 262 pregnant women attending antenatal appointments at the MOU were recruited to participate in the study. Due to limited resources and time constraints, convenience sampling was deemed the most appropriate sampling method. Women had to be pregnant, registered for perinatal care at the MOU, and at least 18 years of age in order to qualify for inclusion in the study.

2.3. Study procedure

Over a three week period in 2014, a member of the research team made announcements to the women in the waiting area of the MOU, explaining the purpose, nature, requirements, inclusion criteria, and voluntary nature of the study. Women who indicated interest in participating were each taken to a private area, where a research assistant would provide further information and obtain the participant's written informed consent. Thereafter, each participant was randomly presented with one of five possible vignettes. The vignettes portrayed a fictitious woman with signs and symptoms that fulfil the DSM 5 criteria for a mental disorder. These included antenatal depression ($n = 51$), postnatal depression ($n = 48$), panic disorder ($n = 53$), alcohol dependence ($n = 51$), and schizophrenia ($n = 56$). Thereafter, participants were asked to complete the study questionnaire, which included two scales that were adapted for this population. Both the vignette and the measures were read aloud by the research assistants while the participants read along, if they were able to. The materials were available in English, Afrikaans or Xhosa, with research assistants fluent in all three languages.

Ethics approval for the study, including all procedures and materials, was obtained from the University of Cape Town's Human Research Ethics Committee. Permission to conduct the study was also obtained from the Western Cape Department of Health, as well as facility management. All participants were required to provide written informed consent forms prior participation. Any participant who reported psychological distress was offered a referral to a qualified counsellor on site.

2.4. Measures

In addition to a number of socio-demographic variables, the following measures were included in the survey:

2.4.1. Socio-economic status

Participants were asked whether or not they had electricity, as well as certain household items such as a radio, television, telephone, fridge, computer, washing machine, and cell phone. Those who had four or less of these items were grouped into a low socio-economic status (SES) group and those who had five or more were grouped into a high SES group (Morojele et al., 2010).