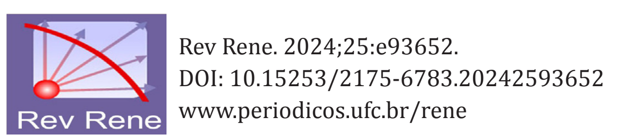
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Original Article

The role of primary care professionals in maternal mental health*

Atuação dos profissionais da atenção primária na saúde mental materna

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ABSTRACT

Objective: to analyze the actions of primary care professionals when faced with situations of psychological distress and/or psychosocial vulnerability among pregnant women and postpartum women. **Methods:** a descriptive and exploratory study was carried out with 78 health professionals working in the family health strategy, who were asked to complete a questionnaire on professional characterization and situational analysis. **Results:** most health professionals see pregnant /postpartum women daily (55.1%). For 66.7% of these professionals, they identify signs /symptoms of emotional, psychological, or mental distress in a minority of their visits to this public. Regarding the training of professionals to act and help pregnant /postpartum women concerning mental health, 76.9% have doubts, 89.7% have not participated in training on the subject, and all agreed with its relevance. The textual analysis of the discursive responses resulted in two categories: Qualified listening as a welcoming tool and shared care and referral to specialized professionals. **Conclusion:** family Health Strategy professionals reported doubts and weaknesses regarding managing the mental health of pregnant and postpartum women. **Contributions to practice:** these professionals experience situations that require them to deal with issues related to perinatal mental health and perceive training to meet this demand as relevant.
Descriptors: Mental Health; Pregnant Women; Postpartum Period; Primary Health Care; Maternal Health.

RESUMO

Objetivo: analisar a atuação dos profissionais da atenção primária ante as situações de sofrimento psíquico e/ou vulnerabilidade psicossocial de gestantes e puérperas. **Métodos:** estudo descritivo e exploratório, realizado com 78 profissionais de saúde atuantes na estratégia de saúde da família, aos quais foi aplicado um questionário de caracterização profissional e análise situacional. **Resultados:** a maioria dos profissionais de saúde atende diariamente gestantes e/ou puérperas (55,1%). Para 66,7% desses profissionais, na minoria dos atendimentos a esse público, eles identificam sinais e/ou sintomas de sofrimento emocional/psíquico/mental. Quanto à capacitação dos profissionais para atuar e ajudar gestantes e/ou puérperas em relação à saúde mental, 76,9% têm dúvidas e 89,7% não participaram de uma capacitação sobre o assunto e todos concordaram com sua relevância. Da análise textual das respostas discursivas resultaram duas categorias: Escuta qualificada como instrumento de acolhimento e Atendimento compartilhado e encaminhamento para profissional especializado. **Conclusão:** os profissionais da Estratégia Saúde da Família relataram ter dúvidas e fragilidades para o manejo da saúde mental de gestantes e puérperas. **Contribuições para a prática:** esses profissionais vivenciam situações que exigem deles o manejo de questões relacionadas à saúde mental perinatal e percebem como relevante uma capacitação para atenderem essa demanda.
Descritores: Saúde Mental; Gestantes; Período Pós-Parto; Atenção Primária à Saúde; Saúde Materna.

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Introduction

Mental health is characterized as a state of well-being in which individuals can realize their potential, cope with the stresses of everyday life, and contribute to their community[1]. Promoting mental health is one of the goals of the 2030 Sustainable Development Goals, which aims to reduce early mortality from non-communicable diseases by one-third through prevention, treatment, and promotion of mental health and well-being[2].

There is a global movement to raise awareness of perinatal mental health, which should include the promotion and prevention of mental disorders during this period[3]. During pregnancy and up to a year after the birth of the baby, one in five women will experience changes in mental health that can negatively affect the well-being of the woman, the family, and the baby[1].

Improving perinatal mental health requires an intersectoral response involving the government, the health sector, social development systems, communities, and families[3]. In the specific context of the health sector, the development of programs to promote, prevent, and treat mental disorders during this period is relevant. However, it was identified that, in the context of mental health, perinatal care was the area with the fewest programs instituted in the member countries of the Pan American Health Organization[4].

To achieve good results from these programs, it is recommended that health professionals be trained to investigate the history of preconception mental disorders[5], detect the disorders, and promote and prevent them with sensitive, individual-focused care. Perinatal mental health is not just an individual issue for women but one that is influenced by society and has repercussions for them, their children, and their families[3].

In this scenario, health professionals are essential in promoting careful and comprehensive care for women, especially during the pregnancy-puerperal cycle. However, in one survey, women described several negative experiences in maternal mental health care, resulting in delays in treatment and missed opportunities for care[6].

There are still stigmas associated with mental health among professionals, and actions continue to focus mainly on the clinical, physical, and biological dimensions of pregnancy and the postpartum period. Research shows that pregnant and postpartum women did not feel open to discussing the emotional, psychological, and social issues they faced[6-7]. They also mention various needs that require spaces for listening and caring for their mental health during prenatal and postnatal care, also carried out within the scope of Primary Health Care (PHC), highlighting the importance of primary humanization actions, welcoming, and qualified listening in PHC[7].

The comprehensive global action plan for mental health 2013-2030 emphasizes the need to decentralize the concentration of care and treatment from secondary and tertiary mental health services to primary health care[2]. However, primary care faces limitations in mental health work, as reported by the lack of structure in the care network and the lack of incentive in policies aimed at reducing the medicalization of problems[8].

However, there is an expectation that primary care through the Family Health Strategy, as the main gateway to the Brazilian Unified Health System, will incorporate promotion into its actions by screening for risk factors for early detection, prevention, and individual and collective mental health care[8].

The need to deal with mental health demands in primary care is an undeniable reality, and this field is up-and-coming for consolidating the Psychosocial Care Network[9]. From this perspective, the Family Health Strategy (FHS) facilitates the establishment of bonds of trust between users and health professionals, personalizing care, as professionals have knowledge of users, the area where they live, and their realities of life[10].

The transition from the traditional to the FHS model was accompanied by re-establishing the Expanded Family Health and Primary Care Center (NASF-AB), ensuring all teams were linked to a cen-

ter[11]. However, the NASF-AB's coverage was still very restricted, covering only 37.17% of the territory, and most of the areas uncovered were precisely those with high levels of social vulnerability[12].

This limitation of the multi-professional team in PHC underscores the urgent need for the emotional and psychological demands of pregnant women and postpartum women cared for by the FHS to be adequately assisted by the health professionals in the primary team. It should be emphasized that all health professionals are also responsible for the emotional well-being of users[13]. Still, they are not always aware of this role and have not received training/sought training for it.

In this context, it became imperative to conduct a situational analysis to understand how this care is provided in PHC. Therefore, this study aimed to analyze the actions of primary care professionals when faced with situations of psychological distress and/or psychosocial vulnerability among pregnant women and postpartum women.

Methods

This is a descriptive and exploratory study. For the qualitative part, the recommendations of the Consolidated Criteria for Reporting Qualitative Research (COREQ) were followed, and for the quantitative part, the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) checklist was used.

The research was carried out in seven of the 10 Basic Health Units in the Central Health Region. The Federal District has seven Health Regions, with the Central Region covering a population of 388,012 inhabitants. The participating units have a total of 36 FHS teams, made up of a doctor, nurse, nursing technician, and community health agent. These professionals provide care for all life cycles, carrying out consultations, including prenatal and postpartum period consultations, vaccinations, minor suturing procedures, dressings, and group activities.

The participants were health professionals from FHS teams working in the health region chosen as the study setting, which covered a population of 193 possible participants. Nurses, nursing technicians, community workers, and doctors carrying out preventive/health promotion actions with pregnant and postpartum women were included. Professionals on leave for any reason during the data collection period and those who did not provide care for the public were excluded. The sample comprised professionals who met the criteria and agreed to take part, totaling 78 participants, representing 40.4% of the population.

Data was collected from September to November 2023 by two previously trained researchers from the research team. A questionnaire created by the authors was used to characterize the professionals, and another was used for situational analysis. The questionnaire developed consisted of eleven objective questions and two guiding and discursive questions about maternal mental health: (1) When pregnant/postpartum women bring psychosocial issues /signs/symptoms of psychological distress to you, how do you approach them? (2) When pregnant/postpartum women bring psychosocial issues/signs/symptoms of psychological distress to you, how do you approach them?

The answers to the questionnaire took an average of 10 minutes. After signing the Free and Informed Consent Form, they were carried out in the participants' work environment, according to their availability. To preserve their identity, participants were given the title "Professional" (P), accompanied by a number.

The data was scanned into a Microsoft Excel document, then transferred to Notepad and organized to be processed by the software Interface de R pour les Analyses Multidimensionnelles de Textes et de Questionnaires (IRaMuTeQ) version 0.7 alpha 2, developed by Pierre Ratinaud in 2009, to constitute the textual corpus.

Among the different features possible with IRaMuTeQ, we used the Descending Hierarchical Classification (DHC), which aims to find classes of text segments (TS) that simultaneously share a similar vocabulary and differ from the vocabulary of TS in other

classes, generating a dendrogram that represents the connections between these classes[14].

We then evaluated the categories, describing the topics covered in the narratives. This made it possible to identify patterns and interpret the data using Content Analysis, which allows quantitative and qualitative approaches. In the quantitative approach, the frequency of words that appear repeatedly in the text is counted, while the qualitative approach examines the characteristics present in a specific piece of content[15].

The project was sent to the Federal District State Health Department Research Ethics Committee and was approved under the Certificate of Presentation for Ethical Appraisal: 69317623.6.0000.5553 and opinion no. 6.174.925/2023.

Results

A total of 78 FHS professionals participated in the study, with a higher prevalence of females (74.4%). In terms of level of education, 15.4% had completed high school, 32.1% had completed higher education, and 52.6% had postgraduate degrees. Among the professions, 35.9% were nursing technicians, 30.8% nurses, 20.5% doctors and 12.8% community health workers.

The average time spent working with pregnant and postpartum women was 9.0 years (standard deviation 7.7 years). Over half of the participants reported caring for pregnant/postpartum women daily. In the minority of cases, they were pregnant or postpartum women at risk or psychosocially vulnerable. Signs/symptoms of emotional/psychic/mental distress in pregnant and postpartum women were identified in a minority of cases (Table 1).

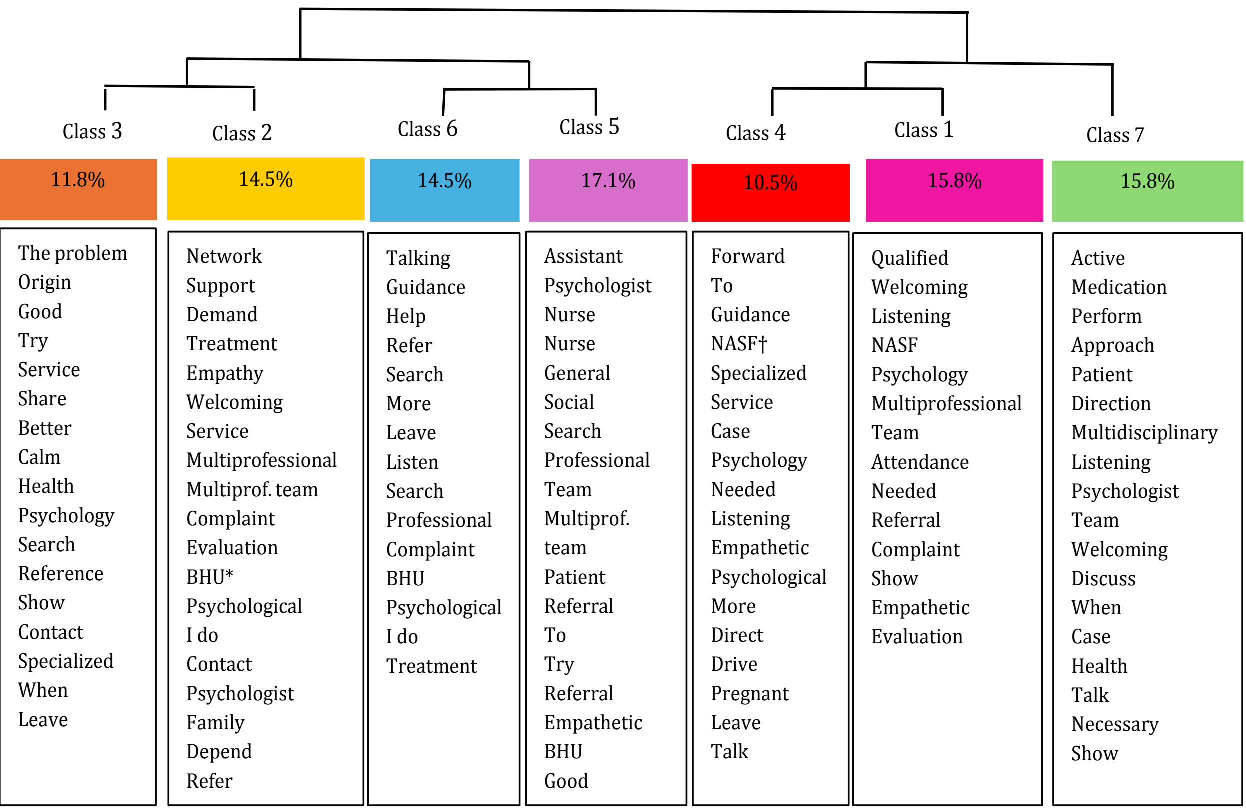
When asked about their capacity/ability to act and help pregnant women with mental health issues, 76.9% said they had doubts about how to approach/deal with this issue. It is noteworthy that 89.7% had not received any training within the scope of the Federal District State Health Department related to the mental health of pregnant women and postpartum women. All of them agreed that it was relevant and that they would like to take part in training on this subject (Table 1).

Table 1 – Profile of care provided to pregnant and postpartum women by Family Health Strategy professionals (n=78). Brasília, DF, Brazil, 2023

Variables	n (%)
How often do you see pregnant/postpartum women?	
Daily	43 (55.1)
Weekly	27 (34.6)
Fortnightly or monthly	8 (10.3)
How often do you see pregnant or postpartum women at risk or psychosocially vulnerable?	
Never	4 (5.1)
In a minority of cases	46 (59.0)
Most of the time	14 (17.9)
Always	14 (17.9)
How often do you identify signs/symptoms of emotional/psychic/mental distress in your care of pregnant/postpartum women?	
Never	2 (2.6)
In a minority of cases	52 (66.7)
Most of the time	21 (26.9)
Always	3 (3.8)
How do you perceive your training to act and help pregnant/ puerperal women about their mental health?	
I have no doubts about how to act in these cases	18 (23.1)
I have doubts about how to act in these cases	60 (76.9)
Have you received any training on mental health for pregnant/postpartum women?	
No	70 (89.7)
Yes	8 (10.3)
Do you think training on maternal mental health is relevant?	
No	–
Yes	78 (100.0)
Would you like to participate in a maternal mental health training course?	
No	–
Yes	78 (100.0)

The textual analysis of the discursive responses obtained a textual corpus consisting of 78 texts. After processing in IRaMuTeQ through DHC, this resulted in 84 TS, distributed in seven classes.

Figure 1 shows the composition of the classes according to semantic relevance, which is the basis for evaluating and understanding the data according to its significance in the context of the classes. The classes were organized into thematic categories, following the structure of the text and the proximity between the classes, resulting in the formation of two thematic categories, detailed below.



*BHU: Basic Health Unit; †NASF (in Portuguese): Family Health Support Center

Figure 1 – Dendogram with the Descending Hierarchical Classification provided by the IRaMuTeQ software. Brasília, DF, Brazil, 2023

Category 1: Qualified listening as a welcoming tool

This category comprises classes 1, 2, 3, and 7, corresponding to 57.9% of the text segments. It expresses the professionals' approach to psychosocial situations involving pregnant women / postpartum women. In these situations, the participants reveal that they welcome the patient in a private setting to make her more comfortable to verbalize the situation, show solidarity, and offer support: *Firstly, I sympathize with her problems, even if they are situations in which I have my restrictions, the important thing is for her to feel that she has support* (P1). *In a welcoming way, from the first contact with the woman, I try to make her feel safe and at ease when talking about problems related to these issues* (P2). *When they arrive at triage, they are nervous; I offer them a glass of water, calm them down, and take them to the reception room. At first, I listen, and then I talk* (P35). *Welcoming the patient, actively listening, advising on mental health care (psychotherapy, routine physical activity, and others), discussing the case in a team meeting with a multidisciplinary approach, and prescribing medication when necessary* (P65).

Qualified listening, which plays a vital role in care, was also mentioned by these professionals to help with decision-making and guidance: *...I welcome the patient with qualified listening to address her issue* (P21). *I am available for qualified listening and welcoming, creating a bond with the patient. Also, I'd like to show the options to provide the necessary support during her follow-up* (P19). *Empathetic care, qualified listening, discussing the case with the team* (P20), *and listening patiently to complaints* (P24).

Category 2: Shared care and referral to a specialized professional

This category comprises classes 4, 5, and 6, which total 42.1% of the text segments. It suggests

that the professionals seek support to qualify the care provided to the women by making referrals to other members of the team, such as nurses or doctors, or by discussing the case with the team: *Through humanized care, discussion of the case with a multi-team, doctor, psychologist, social worker, physiotherapist, nutritionist, welcoming, discussing the case with other professionals, and involving the patient and her family in the construction of the singular therapeutic project* (P70). *I talk to and help them, referring them to social services and advising them to seek help* (P63). *I usually try to calm them down and refer them to the doctor or nurse in charge of the team* (P5). *Furthermore, I called the nurse, called the doctor, and contacted the team* (P56).

The word "refer" frequently appeared in the answers: how to act when identifying signs or symptoms of suffering in pregnant women / postpartum women, highlighting referrals to the Multi-professional Team in Primary Health Care (eMulti), which was previously called the Family Health Support Center (NASF) and the Psychosocial Care Center (CAPS): *Referral to the CAPS, qualified listening, guidance, referral to specialized care, psychological follow-up, referral to the CAPS* (P22). *Listening, referral to pregnancy groups, and NASF* (P32). *For some of them, I provide guidance; in milder cases, and for others, I refer to specialized services* (P2). *I leave the speaking space open for her to vent, provide support and praise for her actions, and provide the guidance necessary for the case. If required, I ask for support from the NASF* (P11).

Discussion

The results indicate that professionals working in the Family Health Strategy have identified that around a third of the pregnant or postpartum women they see show signs or symptoms of emotional, psychological/mental suffering. Most professionals have doubts about how to deal with these signs or symptoms. Few of them have received training to deal with this demand, and all pointed out that training on this subject was relevant and that they would all like to take part. Qualified listening was pointed out as a valuable tool for welcoming these women, and shared care and referrals to specialized professionals were the most important.

Primary health care has expanded its scope of action, especially with strengthening the Family Health Strategy. It has been empowered to act as a protagonist and coordinator of care as the main gateway to health services. In this scenario, it is also pressured to increase its resolvability, which leads to the need to qualify its professionals[10].

To qualify these professionals to care for women in the perinatal period, in addition to the biological aspects, health professionals also need to reflect on and consider the social perspectives of gender and their repercussions on women's mental health. There is a culturally stereotyped expectation that women should have greater domestic responsibilities and care for family members, contributing to a more significant mental workload and mental illness among women, who must accumulate these demands with those of paid work[16].

Motherhood, domestic work, and other care responsibilities, often taken on by women and frequently undervalued or unpaid, take a significant toll on women's mental health, and their importance has not been adequately recognized in understanding illness and, especially, in the treatment of these problems. It is, therefore, considered simplistic and reductionist to attribute women's mental illness solely to natural and individual factors[17].

Feminist movements and the National Mental Health Policy have fostered discussions to encourage recognition of the inequalities faced by women and thus promote alternatives to overcome unequal relationships, gender stereotypes, and predominantly hegemonic health approaches. The aim is to direct health care towards the diversity of society, considering the different contexts in which women live[18].

From this perspective, the intersection between mental health and PHC is crucial for progress in care approaches and essential for developing a public health system that fosters autonomy and emancipation. This was brought about by the psychiatric reform, which favored the decentralization of mental health care, breaking mainly with the culture of insti-

tutionalization and asylum. In this way, PHC has become an essential point of care in the Psychosocial Care Network[19].

Thus, as the participants pointed out, they identify psycho-emotional signs or symptoms in pregnant women and postpartum women in their care. They emphasized that these signs and symptoms are perceived in a minority of cases. This can be explained by the fact that the emotional and psychological aspects of pregnant women involve various factors and manifest themselves through multiple signs and symptoms, which are sometimes confused with the emotions typical of this time or with gender stereotypes related to motherhood (for example: to be a mother is to suffer in paradise), making it difficult for health professionals to identify these aspects at an early stage[20]. The lack of training to track and identify the symptoms gives the impression that they are found in "small" numbers, which is not true since they affect up to ¼ of the cases seen, both during pregnancy and postpartum.

In addition, many revealed that they had doubts when dealing with the mental health situations of pregnant women and postpartum women. This result corroborates another study, which indicated that PHC professionals often face difficulties in knowing how to act when identifying cases of psychological distress, attributing this hesitation to a lack of appropriate training[21].

This reinforces the results of the present study, in which few participants reported having been trained on the subject, and all indicated that it would be relevant for them to take part in training on the subject. In another study, health professionals also perceived some difficulties in providing care around perinatal mental health, such as lack of time, limited human resources, lack of trained professionals to analyze and solve maternal mental health problems, the cultural stigma surrounding the subject, poor teaching on the topic at the undergraduate level and low promotion of specialization in mental health, compared to other areas[22].

Regarding the way they approach pregnant/postpartum women with signs and symptoms of psychological distress, the participants strive to be empathetic, listening, and showing support for the women, transmitting security and providing a bond that will favor the management of care. The process of welcoming occurs by understanding the needs of the individual, listening attentively, offering support and solidarity, not judging others, recognizing that there is no universal approach to care, and establishing excellent proximity between the professional and the patient. Health needs cannot be adequately met Without a welcoming environment and a meaningful connection[23].

As an integral part of welcoming, qualified listening is essential for understanding the health demands of the population served. The professionals in this study frequently mentioned this conduct. In a survey carried out in the United Kingdom, women with mental health problems reported feeling that health professionals, especially doctors, were less willing to talk to them so that they could understand them, listen to them, be attentive, or treat them as individuals[24-25].

In another analysis, in which 31 puerperal women were interviewed, 21 reported not having been asked about mental health nor given guidance on what postpartum depression might be. It was also observed that the professionals only raised these issues with those women who showed some sign of postpartum sadness, so many women with emotional changes were not entirely welcomed by the professionals[26]. This highlights the importance of health professionals investigating these aspects during care due to a barrier on the part of the woman herself, who is afraid of being judged as "out of her mind" when diagnosed with a mental disorder[22]. Or even being considered an incompetent/"unnatural" mother when she shows any sign or feeling that is different from what is socially expected, according to the stereotype of perfect, romanticized motherhood[13].

It is understood that welcoming people and listening to them can build a bond closely linked to the longitudinal nature of care, an essential attribute of

PHC. This continuity in care is vital to building trust and affection, which strengthen over time. Reciprocity in this relationship of trust and affection with users facilitates the approach and enhances care, even in complex cases[25].

Regarding the conduct of the participants when faced with psychosocial issues/signs/symptoms of psychological distress in pregnant/puerperal women, there was an inclination to refer the pregnant/puerperal woman to the psychologist of the multi-professional team or Psychosocial Care Centers, and in some situations to share and discuss within the essential team itself, also involving the family as a support network for this woman.

Including family and friends in the woman's care is essential. However, it should be noted that there is still social stigma related to mental health and that some women report that the lack of recognition and understanding of this aspect in their communities makes it difficult to seek help. Added to this, the expectations associated with naturalized and idealized motherhood, such as breastfeeding, continuing to do household chores, as well as looking after the children, and the cultural influence that they should be firm, often lead them to minimize their symptoms and delay seeking help[6].

Referrals to the psychologist of the multi-professional team should be emphasized as expected from the perspective of primary care[27]. This articulation with other professionals in the team is relevant to achieving better-quality mental health care in primary care, integrating efforts, and using a collaborative care model. This is achieved through interdisciplinary initiatives that increase the effectiveness of primary care, providing satisfactory responses to patients' needs[28].

However, it is important to emphasize once again that all health professionals must also take responsibility for the emotional well-being of their patients, seeking training courses and strategies to deal more and better with maternal mental health demands without restricting themselves to referrals to perinatal psychologists and psychiatrists. Professionals mustn't have a limited perception of care and an expectant and passive attitude, making the presence of psychologists and psychiatrists, who are scarce and overworked professionals in PHC[13] indispensable for dealing with psychological and emotional issues[27]. Referrals within the Health Care Network are common but not restricted to specialized care[9]. Another difficulty is establishing the flow of care and the delimitation of care in each service, leading to referrals of mild cases, which overloads the CAPS[29].

The National Program for Improving Primary Care Access and Quality has shown a shortage of NASF and CAPS teams to cover primary care needs. These deficiencies create challenges for making universal access and responsiveness to mental health practical in the Unified Health System[30], so reducing these referrals and resolving mental health demands in the Basic Health Unit itself is important when possible.

Study limitations

A limitation to the selection by the convenience of the health region was the limited number of health professionals who agreed to participate. In addition, data collection using a questionnaire may have restricted the depth of the participants' responses.

Contributions to practice

The study provided insight into the fragility of maternal mental health care within PHC and encouraged the need to train these professionals to improve their knowledge on the subject and make the service more resolute.

Conclusion

Health professionals working in the Family Health Strategy frequently see pregnant women or women who have recently given birth. Around a third of these visits to pregnant women or women who have

recently given birth, the health professionals identify signs or symptoms of emotional, psychological /mental suffering/situations of psychosocial risk or vulnerability. Most professionals reported having doubts about how to deal with these signs or symptoms and these situations. Most of them have not received any training to deal with issues related to the mental health of pregnant/postpartum women. They all stressed the importance of training and showed interest in participating.

In terms of behavior, there was an emphasis on reception, qualified listening, and frequent referrals to other professionals and services in the Psychosocial Care Network. This situational analysis identified that the professionals' lack of training on the subject may have weakened the identification of signs and symptoms and care procedures.

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Authors' contribution

Conception and design or analysis and interpretation of data and writing of the manuscript or relevant critical review of the intellectual content: Rocha FR, Arrais AR, Barros AF. Final approval of the version to be published and responsibility for all aspects of the text to ensure the accuracy and integrity of any part of the manuscript: Rocha FR, Fernandes BBO, Andrade YVS, Arrais AR, Barros AF.

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