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Women' and midwives' experiences of perinatal mental health care: A qualitative study

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ABSTRACT

Background: Perinatal mental health problems affect one in five women during pregnancy and the first postpartum year, negatively impacting maternal and infant health. Despite its importance, healthcare remains focused on physical aspects, whereas mental health is neglected, highlighting the need for comprehensive and effective approaches.
Aim: To explore the current status of perinatal mental healthcare from the perspective of women and midwives, and to identify needs, challenges, and potential solutions to improve comprehensive care during pregnancy and the postpartum period.
Methods: An exploratory qualitative study in which 20 midwives from different care settings and 30 women at different stages of pregnancy and postpartum participated in individual semi-structured interviews. Reflexive thematic analysis assisted by Nvivo12 was used for data analysis.
Results: Four main themes emerged from the data analysis: (I) Challenges in Emotional Care: Cultural stigma identified as a significant barrier. Culturally sensitive care and strong therapeutic relationships highlighted as essential for emotional support. Need for dedicated time and safe spaces to facilitate emotional openness. (II) Significance of Perinatal Mental Health: Importance widely recognized but rarely addressed effectively. Mental health closely linked to emotional well-being, yet often neglected in daily practice. (III) Training-related challenges: Midwives report feeling unprepared. Need for ongoing, specific mental health training and standardized assessment tools. (IV) Challenges in Clinical Practice: Absence of clear protocols. High workloads hinder emotional care. Inconsistent approaches contribute to fragmented care.
Conclusions: This study highlights key priorities to improve perinatal mental healthcare: including culturally sensitive training, validated and standardised assessment tools, clear clinical protocols, and sufficient time for emotional support. Strengthening therapeutic relationships between midwives and pregnant and postpartum women emerged as essential for effective care. Findings support implementing structured support groups, multidisciplinary collaboration, and a more responsive, holistic care model.

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What is already known

- Perinatal mental health is critical to maternal–infant outcomes yet remains under-prioritised in routine practice.
- Midwives frequently report limited training, time, and resources to address emotional needs effectively.
- Fragmented services and stigma reduce disclosure and impede timely referral and follow-up.
- Structural barriers hinder emotional care and the development of therapeutic relationships in maternity services.

What this paper adds

- Highlights from midwives' and women's perspectives, how workload, protocol gaps and stigma combine to produce variability in emotional care and missed opportunities for early support.
- Identifies the therapeutic relationship (time, continuity, safe spaces) as a modifiable lever for better outcomes and experience of care.
- Specifies actionable improvements: culturally sensitive training and strategies to enhance midwifery roles, validated screening/assessment, explicit referral pathways, and structured support groups embedded in midwifery-led care.

1. Introduction

Perinatal mental health conditions are those that may arise during pregnancy and the first year after the birth of a child (World Health Organization, 2022). During this period, women experience multiple physical, emotional and social changes that can increase their vulnerability to experiencing mental health conditions (Howard and Khalifeh, 2020). It is estimated that one in five women develop a mental health illness in the perinatal period (Hahn-Holbrook et al., 2018; World Health Organization, 2022), with depression and anxiety among the most prevalent (Shorey et al., 2018). Sociodemographic characteristics, particularly low socioeconomic status, have been identified as significant risk factors for perinatal depression in systematic reviews and population-based studies (Yang et al., 2022; Pan et al., 2024).

Perinatal mental health conditions not only affect the mother, as they can also have long-term adverse effects, impacting the infant's physical, emotional and social development (Rogers et al., 2023). Maternal depression can hinder a mother's ability to care for and connect emotionally with her child, which is crucial to establishing a secure and healthy bond, as the lack of this bond can have long-term consequences for the child's cognitive and social development (Madigan et al., 2018; von Olberg et al., 2025). For instance, recent systematic reviews and prospective studies have shown that maternal depression and anxiety during the perinatal period are associated with long-term adverse outcomes, including an increased risk of persistent psychiatric difficulties in mothers and a higher likelihood that children will experience socioemotional, cognitive, and behavioural challenges later in life (Morales et al., 2023; Severo et al., 2023). The presence of the mental health conditions described above is also associated with an increased risk of obstetric complications during pregnancy particularly preterm birth and low birth weight, underscoring the need for comprehensive care that addresses both physical and emotional aspects of prenatal and postpartum care (Fekadu Dadi et al., 2020; Simonovich et al., 2021; Su et al., 2023).

Although awareness of the relevance of perinatal mental health has increased, healthcare services continue to focus primarily on the physical aspects of pregnancy and childbirth, and mental health remains insufficiently integrated into routine care (Harrison, 2024). Prenatal visits often prioritize physical health monitoring, such as weight checks, blood pressure and laboratory tests, while women's emotional well-being receives less attention. A lack of integration of mental health into perinatal care can lead to mental health conditions not being identified early, perpetuating the stigma associated with mental disorders and deterring many women from seeking needed help (Webb et al., 2023; World Health Organization, 2022).

In many healthcare systems, midwives serve as a primary point of contact during the perinatal period and are therefore well positioned to provide mental health support to women. However, their role varies across countries and clinical settings depending on how maternity care is organised. Despite being well placed to address women's mental health needs, many midwives report limited capacity, lack of confidence, and insufficient access to training and information. These gaps in skills and formal preparation remain significant barriers to providing comprehensive and effective support (Higgins et al., 2018; Bayrampour et al., 2018; Savory et al., 2022; Johnson et al., 2023). While some midwifery training programmes incorporate mental health components, many still prioritize clinical competencies and the physiological aspects of pregnancy and childbirth, leaving important gaps in preparation to adequately address women's mental health needs (Karalia et al., 2024).

Perinatal mental healthcare faces significant systemic barriers. Variability in mental health services and lack of specialized resources limit access to needed care for many women (Sidebottom et al., 2021). In addition, the fragmentation of services, where physical and mental healthcare are managed separately, can lead to a lack of continuity of care and communication problems among health professionals (Moran et al., 2023; DeRoche et al., 2023). This lack of coordination affects the quality of care and can be especially detrimental to pregnant or postpartum women with complex perinatal mental health needs (Dossett et al., 2024).

The fragmentation of perinatal health services where physical and mental healthcare are managed separately can contribute to reduced continuity of care and communication gaps among providers. This lack of integration may reinforce stigma around mental

health conditions by minimizing their visibility within routine care, ultimately deterring individuals from seeking support (Asefa et al., 2024; Feyissa et al., 2025). In health systems where midwives have a sustained and trust-based relationship with pregnant and postpartum individuals, they can play a key role in mitigating these barriers (Cibralic et al., 2023; Barr et al., 2024; Andersen et al., 2023). Although this is not universally the case, midwives can be well-positioned to offer early emotional support and facilitate access to specialized services when care structures and training enable them to do so (Cummins et al., 2025).

Recent research highlights the importance for midwives to inquire about women's emotional well-being in order to identify possible concerns, address them appropriately and provide timely support (Harrison et al., 2023). It is therefore essential to create an environment where birthing individuals feel comfortable expressing emotional concerns, and where maternity care systems actively work to reduce the stigma associated with mental health conditions (Webb et al., 2023; Savory et al., 2022). Improving care for pregnant women therefore requires paying more attention to the needs of women in relation to all the symptoms, physical and mental, that can arise during pregnancy (Dubreucq et al., 2024)

Improving maternal health should include measures to prevent and address mental health conditions integrated into routine obstetric care during pregnancy and after childbirth (Manolova et al., 2023; Prom et al., 2022). Authors such as Evans et al. (2022), state that there is an urgent need to improve the training of midwives so that they can identify opportunities for earlier interventions. In addition, they argue that the organization of health systems should be made simpler and more efficient, so that the midwife is the central figure with whom the pregnant woman relates, and who is responsible for referral to other specialists when required (Johnson et al., 2023). To achieve this, a collaborative approach is needed, integrating midwives with other professionals, such as psychiatrists and psychologists, thus offering multidisciplinary care focused on the woman's needs (Singla et al., 2021; Le et al., 2022).

Given the importance of perinatal mental health for the well-being of mothers and their babies, it is essential to address the barriers to providing adequate care in this area (Dossett et al., 2024). This study aims to investigate the current situation and aspects of care practice in perinatal mental health care from the perspective of women and midwives, with the objective of exploring needs, challenges, and potential solutions to improve comprehensive care during pregnancy and the postpartum period.

2. Methods

2.1 Study design

This study adopted an exploratory qualitative design using thematic analysis to explore the experiences and perceptions of women during the perinatal period and the midwives in charge of their mental healthcare. This approach was selected for its theoretical flexibility and suitability to examine patterns of meaning across a dataset, with particular attention to emotional needs and how they unfold within the healthcare system (Braun and Clarke, 2022).

2.2 Participants and sampling

The participants were selected by purposive sampling, including women at different stages of pregnancy and postpartum (excluding those in labour) and midwives with at least two years of experience working in health centers and/or hospitals in the Health Area of Ibiza and Formentera of the Balearic Islands (Spain). This strategy allowed us to identify cases that were truly representative of the study objectives and to offer a rich, contextualized view of the phenomenon under investigation (Otzen and Manterola, 2017). Specifically, for the women's group, the inclusion criteria required that participants be pregnant or in the postpartum period and have attended the Maternal-Infant Unit at Hospital Can Misses or the Primary Care Centers in the area, in addition to being over 18 years of age. Women were excluded if they did not provide or sign informed consent, presented language barriers, were underage, or had a prior diagnosis of mental health problems. For midwives, the inclusion criterion was that they be actively working in the aforementioned centers with at least two years of experience in their current position. Midwives on short-term contracts or with an impending contract end date near the study's commencement, as well as those who did not provide or sign informed consent, were excluded. This sampling made it possible to identify participants whose experiences were representative of the objectives of the study, thus offering a rich and contextualized view of the phenomenon under study.

2.3 Recruitment of midwives

The midwife recruitment process was carried out with the collaboration of the service supervisor, who acted as an intermediary for the study. This supervisor facilitated the contacts and was responsible for inviting the midwives to participate. The principal investigator made face-to-face visits to the services at different times to expand the information and clarify doubts. Those professionals who agreed to participate and met the inclusion criteria were interviewed after signing the informed consent form.

2.4 Recruitment of pregnant and postpartum women

The women were recruited through the appointment schedules of Primary Care and the Hospital, selecting both those who were in prenatal follow-up and those in the postpartum stage either prior to hospital discharge or already in the postpartum follow-up by the primary care midwife. Access to these participants was managed with the collaboration of those responsible for the Gynecology and Obstetrics Service of the Hospital Can Misses and the Primary Care Area. Each woman was invited to an initial interview in which the purpose of the study was explained in detail, their doubts were clarified, and they were asked to sign the informed consent form.

2.5 Data collection

The data were collected between 2022 and 2023, and the authors used individual semi-structured interviews with a question guide adapted to each group of participants (Supplementary file 1). The development of the interview guide was grounded in the lead researcher's expertise in perinatal care and followed a structured yet flexible process consistent with best practices in qualitative instrument design. As noted by DeJonckheere and Vaughn (2019), semi-structured interviews enable a dynamic balance between rapport-building and methodological rigour, an essential feature when exploring sensitive topics such as maternal mental health.

The main researcher conducted the interviews, which had an average duration of between 45 and 90 min, adapting to the availability and participation of each interviewee, either in person or via Zoom. The interviews were recorded after obtaining consent and transcribed verbatim to ensure the accuracy of the information.

Data saturation was reached after the twentieth interview with the midwives and the thirtieth with the women. Data saturation was systematically monitored throughout data collection and analysis. In line with the framework proposed by Saunders et al. (2018), saturation was conceptualised as an inductive and iterative process encompassing both code saturation, the point at which no new codes emerged, and meaning saturation, when no further insights or nuances were identified within existing codes. Data collection and analysis were conducted concurrently, enabling the research team to observe the progressive consolidation of the codebook and the refinement of thematic patterns. Saturation was deemed to have been reached once consecutive interviews produced only repetitive information without adding conceptual depth. To confirm thematic redundancy, recruitment continued for two additional interviews in each participant group. The principal investigator conducted all interviews, ensuring an unbiased and professional approach. In addition, she was supported by the collaborating researchers, experts in qualitative research who supervised the entire process to ensure the quality and integrity of the data collected.

2.6 Data analysis

Data analysis followed a reflexive thematic approach combining the classic inductive logic of Taylor and Bogdan (1998) with its sequential phases of discovery, coding, and relativization, and the contemporary framework of Braun and Clarke (2022), which emphasises reflexivity, transparency, and the active role of the researcher in theme development. NVivo 12 software supported data management.

Throughout the study, regular meetings were held among team members where themes were reviewed and discussed by various team members to ensure consistency and reduce possible biases, reflecting on possible preconceptions and how they might affect the interpretation of the results. Collaboration between researchers from different specialties helped to approach the analysis from a broad and diverse perspective, minimizing the influence of individual opinions. This ensured that the voices of the participants were faithfully captured, offering a complete and respectful view of their experiences.

3. Results

The study was conducted involving 20 midwives and 30 women who were at different stages of pregnancy and postpartum. The mean age of the participating midwives was 40 years, ranging from 25 to 60 years. The mean age of the women was 32 years, with a range of 24 to 40 years. The mean age of the women was 32 years, with a range of 24 to 40 years. Table 1 provides comprehensive sociodemographic data for the 20 midwives and Table 2 provides data for the 30 perinatal women. Notably, although 60 % of midwives reported receiving mental health training, many still expressed feelings of unpreparedness. This discrepancy likely reflects the limited depth of current training programs, which tend to focus on theoretical knowledge rather than practical application, as well as the absence of continuous professional development. Moreover, the diversity in age, experience, and other sociodemographic factors

Table 1
Sociodemographic characteristics of the participating midwives ($N = 20$).

Variable	Category	n (%)
Age (years)	25–30	3 (15.0)
	31–35	3 (15.0)
	36–40	3 (15.0)
	41–45	4 (20.0)
	46–50	3 (15.0)
	51–55	2 (10.0)
	56–60	2 (10.0)
Professional experience (years)	1–5	2 (10.0)
	6–10	3 (15.0)
	11–15	3 (15.0)
	16–20	4 (20.0)
	21–25	3 (15.0)
	26–30	2 (10.0)
	31–35	3 (15.0)
Mental health training	Yes	12 (60.0)
	No	8 (40.0)

among both midwives and women underscores the challenge of standardizing perinatal care in a heterogeneous clinical environment.

Thematic analysis of the interviews with midwives and women revealed a range of complex experiences and perceptions of mental health care during the perinatal period. The results were organised into four main themes: (1) Challenges in Emotional Care, (2) Significance of Perinatal Mental Health, (3) Training-related challenges, and (4) Challenges in Clinical Practice. Findings from both groups of participants are detailed below.

3.1 Challenges in emotional care

The emotional support offered by the midwives ranged from active listening to more structured attempts at emotional support. However, they recognized the need for improvement in this area.

"We strive to be empathetic and listen, but I feel that we need to learn more specific techniques to really help women." (Midwife 20).

The women valued the moments of listening, although they also noted limitations in the interventions.

"When they really listened to me, I noticed a big difference, but there were also times when I needed a little more support and I didn't get it as I would have expected." (Woman 9). "I felt like some midwives really wanted to help me, but perhaps because of their age or whatever, I felt like they didn't always know how to do it," (Woman 7).

These perspectives highlight a recurring tension between intention and capacity, where midwives' willingness to offer support may be constrained by limited practical tools or confidence in addressing emotional needs.

Cultural barriers and stigma around mental health were identified as major challenges in both groups of participants.

"The cultural stigma around mental health is a big barrier. Many women don't feel comfortable talking about their emotional problems or we have a big language barrier with them." (Midwife 8). "I grew up in an environment where when you are going to become a mother you have to be strong." (Woman 1).

The influence of sociocultural norms appears to shape both the provision and reception of emotional care, suggesting that interventions must be sensitive not only to individual needs but also to broader community beliefs

Both groups also stressed the importance of a personalized approach in the therapeutic relationship and again suggested that more time should be available for each consultation.

"Time is crucial to build a trusting relationship and offer support that goes beyond the physical." (Midwife 16). "It is essential to feel that you are not just a number, but that they really care about how you feel and what you want on the day of your delivery." (Woman 6).

Time constraints were perceived as structural barriers to effective emotional support, limiting opportunities for relational depth and continuity of care.

The creation of support groups was also suggested as a way to improve care. Women who participated in support groups reported a positive experience.

"Support groups are an excellent way to provide a space where women feel understood and accompanied" (Midwife 7). "The support groups helped me to feel less alone and to understand that I wasn't going through this alone." (Woman 19).

Support groups emerged as a key facilitator, offering a collective space that fosters belonging and shared emotional processing, thereby complementing individual care.

3.2 Significance of perinatal mental health

The midwives considered mental health a key component of perinatal wellbeing, closely linked to physical health. They acknowledged that, although they understand that addressing mental health is fundamental, it is not effectively addressed in daily practice, attributing it to time constraints in care practice and specific resources.

"You can't separate how a woman feels mentally from her physical health. If she's emotionally OK, everything else flows more smoothly, but

Table 2
. Sociodemographic characteristics of the participating perinatal women ($N = 30$).

Variable	Category	n (%)
Age (years)	24–30	10(33.3)
	31–35	8 (26.7)
	36–40	12(40.0)
Stage of pregnancy	1st trimester	8 (26.7)
	2nd trimester	8 (26.7)
	3rd trimester	7 (23.3)
	Postpartum	7 (23.3)
Conception with assisted reproductive technology (ART)	Yes	12(40.0)
	No	18(60.0)
Previous abortions	None	15(50.0)
	One	10(33.3)
	Two or more	5 (16.7)
High-risk pregnancy	Yes	12(40.0)
	No	18(60.0)
Partner	With a partner	25(83.3)
	Without a partner	5 (16.7)

sometimes our questions are too superficial." (Midwife 14). "We know for a fact that mental health is key, but with the current pace of work, it's hard to give it the space it needs." (Midwife 3). "There is a disconnect between what we know is important and what we can actually do on a day-to-day basis, but we don't have any more time." (Midwife 12).

These observations suggests that overlooking mental health concerns may adversely affect both emotional well-being and physical health outcomes. Women's accounts reinforced this view, emphasizing that the absence of emotional assessment during clinical encounters may contribute to negative health trajectories. These findings highlight the critical need to embed mental health evaluations within standard perinatal care protocols.

Women also emphasized the importance of mental health during the perinatal period and noted that, in many cases, their emotional well-being was not addressed in consultations, with little or no questions being asked about their emotions or mental health.

"At each visit, it was all about the baby and my physical condition, but I was almost never asked how I was feeling emotionally" (Woman 5). "I felt like I had disappeared, it was very overwhelming to go into the operating room for the emergency cesarean section and I never had a chance to talk about it" (Woman 11).

In cases of women with a history of perinatal loss, both midwives and women indicated that anxiety levels were not always recognized or adequately addressed.

" I have seen women who have gone through losses and their anxiety levels are extremely high, but we lack the preparation and time to support them as we should" (Midwife 1). "With cases of previous losses, I feel we fall short, we need a more conscious approach" (Midwife 9). " We want to be more helpful, but without clear actions, more time and with so many limitations, we are not always able to offer the support that these women really need." (Midwife 17).

Women with perinatal loss experiences felt that their anxiety was not always recognized or addressed.

"I lost my baby in my last pregnancy and now I'm really scared, but they don't seem to have time to address or work through these fears in public health." (Woman 16). "After losing my baby, I expected more emotional support in this pregnancy, but it was like it didn't matter." (Woman 4). "I felt that the death of my baby was not considered and that made me very anxious on the day of delivery and suffer it more, I believe." (Woman 22).

These perspectives underscore the importance of integrating mental health screening into routine perinatal care. Both midwives and women consistently acknowledged mental health as a critical component of perinatal well-being.

3.3 Training-related challenges

The midwives acknowledged that their training in perinatal mental health was limited or insufficient and that training in their specialty focused more on the physical aspects of care. All the midwives agreed on the urgent need to improve continuing education in perinatal mental health and to develop clear protocols to guide emotional care.

"We were trained extensively in the physical aspect for two years and the resolution of emergencies, but in terms of mental health, there is a huge gap, we hardly go beyond the baby blues, and we touch on postpartum depression at most." (Midwife 4). "Mental health in pregnancy and the puerperium requires specific skills that we have not been taught in the specialty of midwifery, but even in mental health specialty it isn't really addressed. "(Midwife 14). "With clear protocols, we would be able to offer better quality care to our patients." (Midwife 11).

The lack of structured guidance may perpetuate variability in practice and leave midwives underprepared to address mental health concerns with confidence and clinical coherence. The perceived absence of clear protocols not only limits clinical actionability but may also exacerbate emotional burdens among professionals facing uncertainty in patient interactions.

Women also indirectly noted this lack of training, which was reflected in their perception of the emotional support received.

"When I spoke of my concerns during consultations, I felt that they didn't really know what to tell me or how to help me" (Woman 18). "I expected to receive more guidance, but the answers were brief." (Woman 10).

Women's testimonies reveal a disconnect between expectations of emotional support and the professionals' preparedness, indicating that training gaps are both perceptible and impactful at the patient level. Bridging this training gap is therefore not only a matter of professional development, but a determinant of person-centred, high-quality care.

3.4 Challenges in clinical practice

The midwives mentioned that the lack of specific mental health protocols hinders adequate care. The emotional care they provide, they described, varies significantly among professionals, depending on their personal style and available resources.

"We know that we have to be aware of how each woman's mental health is going, but without a specific protocol, each woman handles it however she can" (Midwife 6). "Without clear guidance, it's complicated to do anything or to know if we are doing the right thing" (Midwife 10). "We strive to be there for them, but many times we feel like we are only scratching the surface of what they really need." (Midwife 18).

Subjective interpretation, as reported by several midwives, appears insufficient to ensure consistent quality in emotional support. These narratives illustrate how the absence of formalized assessment frameworks may lead to disparities in the identification and management of mental health conditions.

Women described both positive and negative experiences regarding the emotional support received from the midwives. Some felt they were listened to, while others perceived a lack of interest.

"There were midwives who really took the time to listen to me, and that made me feel very supported." (Woman 11). "I feel it was a matter of luck during labour. Some midwives were very sweet, while others failed to convey a sense of calm." (Woman 8).

The lack of standardization in mental health assessments was another issue mentioned by the midwives, who noted that in many cases they relied on subjective observation.

"I think we do try to evaluate the emotional state through observation, but without a specific guide, it is probably totally useless" (Midwife 6). "Each of us has our own style, and that can lead to differences in the care women receive." (Midwife 7). "We would really need standardized tools to assess emotional health effectively" (Midwife 14).

These responses reveal that inconsistent practices hinder the delivery of effective care. Accounts of variability in care reinforce concerns about inequity in the emotional dimensions of maternity services.

Women noted this variability in emotional assessment. Some noted that, in certain consultations, they were asked about their emotional state, while, in others, the topic was not addressed.

"Some midwives would ask me how I was or how my mood was, but others would not even touch the subject, which made me feel that my emotions were not important" (Woman 13). "I expected my emotional state to be taken into account, but many times it wasn't the case and whatever I asked, the response was always that it was normal for pregnancy.." (Woman 22).

Women's testimonies point to a mismatch between their expectations and the emotional care delivered, possibly contributing to a sense of invisibility or unmet needs. *Inadequate integration of emotional care into routine practice may inadvertently perpetuate a biomedical model that marginalizes psychosocial dimensions of maternity.*

The lack of time and resources were mentioned as a significant constraint for midwives in their ability to provide adequate emotional care. Women also perceived this lack of time as an obstacle to receiving the emotional support they needed.

"We are very limited by time and the number of patients we see. The reality is that we cannot dedicate the necessary time to each woman" (Midwife 2). "Clearly the work burden forces us to prioritize the physical over the emotional." (Midwife 13).

Time constraints and workload pressures, consistently highlighted across interviews, emerge as key structural barriers to comprehensive emotional care.

"You can tell they have a lot of work, and that affects the time they can dedicate to you at each consultation." (Woman 5). "I felt that my midwife was rushing around, the whole time she was in and out of the ED and it was clear to us that there was no time to address what was bothering me." (Woman 3).

The findings reveal a tension between professional intention and systemic limitations, whereby midwives strive to offer support but lack the tools and conditions to do so effectively.

4. Discussion

This study explored midwives' and women's experiences and perceptions of perinatal mental healthcare, identifying needs, challenges, and potential solutions to improve comprehensive care during pregnancy and the postpartum period. The results provide a detailed perspective on both structural and personal difficulties in both groups of participants that affect emotional and mental support during pregnancy and postpartum.

Perinatal mental health is a fundamental pillar for the wellbeing of mothers and their infants, as has been highlighted globally. Nonetheless, the findings of this study reveal a specific, dual-perspective account of how protocol gaps, workload, and stigma interact to limit the enactment of emotional care in routine midwifery practice, despite widespread recognition of its importance. Although midwives understand the importance of mental health, they face limitations such as lack of time, insufficient resources, and the absence of clear protocols, evidencing a disconnect between theoretical knowledge and its practical application, a problem previously documented in other research (Howard and Khalifeh, 2020; Sidebottom et al., 2021).

These findings align with Cummins et al. (2025); Sandall et al. (2024), who demonstrated that continuity of care models not only strengthen therapeutic relationships but also lead to measurable improvements in perinatal mental health outcomes, especially in settings where system-level fragmentation is present.

The value of this study lies in showing how these barriers directly affect women, who feel that their emotional needs are relegated to their physical needs. This dynamic perpetuates a fragmented model of care, making emotional concerns during pregnancy and postpartum invisible. Previous studies have shown that comprehensive, woman-centred care significantly improves mental health outcomes (Nagle et al., 2018; Barr et al., 2024). However, the findings presented here suggest that it will continue to be difficult without a profound transformation in the paradigm of perinatal care.

The midwives highlighted the lack of specific training in perinatal mental health, which they felt affects their ability to provide comprehensive, quality care. Although they feel prepared to manage the physical aspects of pregnancy, mental health training was said to be insufficient, which limits their ability to provide comprehensive support to women with perinatal mental health disorders (Coates and Foureur, 2019; Noonan et al., 2017). The findings of this study add a new perspective by highlighting how this lack of training also negatively impacts professional confidence, resulting in inconsistent care. In addition to clinical knowledge, participants emphasized the need for specific training in cultural sensitivity and communication strategies tailored to diverse populations.

Although the literature argues that continuous training can improve the quality of care (Sidebottom et al., 2021; Dubreucq et al., 2024). The results suggest that training alone is not enough. Policy recommendations emerging from this study include the creation of targeted funding schemes for perinatal mental health education, the inclusion of cultural competency modules in midwifery education programs. A broader approach is needed, including structural changes in the work environment to facilitate the effective application of acquired competencies and to prioritize mental health in daily clinical practice.

The women interviewed described inconsistent emotional care, which varied according to the midwife and the workload of the day. Highlighting the importance of individualization in care and adequate time to build meaningful therapeutic relationships, something that has been well documented in the literature (Cibralic, et al., 2023; Cummins et al., 2023). However, this study provides concrete examples of how current perinatal care structures limit these critical interactions. The mental health assessment remains subjective and dependent on individual midwives' intuition or knowledge, which creates variability in the quality of care. It also adds pressure on

midwives, who often feel unprepared to address mental health issues effectively or insecure about their interventions. Although other studies have highlighted the need for the development of standardized assessment tools (Blackmore et al., 2022), this study highlights that such tools will not solve the existing barriers without an adequate support system for midwives to carry out specific interventions within the framework of their competence.

Another critical aspect identified was the lack of continuous follow-up after the detection of risk factors for perinatal mental health problems such as previous perinatal loss. Women expressed feeling neglected and disconnected from the healthcare system, which not only aggravated their emotional problems, but also affected their confidence in perinatal care. This reinforces the importance of a woman-centred, continuum of care approach, a perspective that has received less attention in previous studies, where screening or treatment are often the main focus (Fisher et al., 2024).

The study also highlights how cultural stigma and lack of specific resources represent significant barriers to perinatal mental healthcare. Both midwives and women noted that stigma inhibits the expression of emotional needs and complicates the ability to provide appropriate care. The lack of cultural competency training and the absence of resources tailored to different communities perpetuate inequities in perinatal care, as shown in recent evidence from equity-focused and qualitative studies (Prady et al., 2021; Conneely et al., 2023). This study offers a critical perspective on how to overcome these barriers, suggesting the need for a broader approach that includes cultural mediators and the adaptation of policies that foster inclusion and respect for cultural diversity.

The transferability of our findings is shaped by the Spanish National Health System, a universally covered and predominantly publicly funded, decentralized model that differs from many global settings. In low- and middle-income countries (LMICs), limited specialist capacity, weaker referral systems, and resource scarcity contribute to substantially higher burdens of perinatal mental disorders. Meta-analyses estimate that about one in four women in LMICs experience perinatal depression (Mitchell et al., 2023), with global mapping also confirming higher postpartum depression rates in lower-income regions (Wang et al., 2021). Similar patterns are observed for anxiety, with prevalence around one in four women in LMICs (Nielsen-Scott et al., 2022; Mitchell et al., 2023). Evidence for severe conditions such as postpartum psychosis remains scarce and heterogeneous in LMICs (Kalra et al., 2022). By contrast, European longitudinal studies, including a recent Spanish cohort, show that major depressive symptoms can persist beyond the first postpartum year (Míguez and Vázquez, 2023). These contrasts highlight the influence of systemic and cultural contexts and caution against direct extrapolation of our results beyond Spain.

Finally, the results underscore the need for a transformative and adaptive approach to perinatal care. Improving continuing education in mental health and developing clear and standardized protocols are essential steps to close the gap between theoretical knowledge and clinical practice (Viveiros and Darling, 2019). However, it is also crucial to review the working conditions of midwives, reducing their workload and allowing them the time needed to make meaningful connections with women. Restructuring the previously identified barriers would not only optimize and improve the quality of care but would also benefit midwives' well-being and professional satisfaction.

Likewise, the creation of safe and accessible spaces, such as support groups that address the emotional dimension and perinatal mental health, along with the availability of ongoing resources, is highlighted as essential to improving women's emotional experience during pregnancy and postpartum. Participants valued these spaces, indicating that they must be part of a broader systemic change. A truly comprehensive and culturally sensitive approach to perinatal care would not only improve outcomes for women and their babies but also strengthen the health system's ability to respond to challenges in diverse and changing contexts.

4.1 Strengths and limitations

This qualitative study stands out for the depth and richness of the data obtained, providing a detailed insight into the experiences and perceptions of midwives and women in relation to perinatal mental health. The diversity of the sample in terms of age, professional experience, and cultural context adds significant value, allowing us to capture a variety of perspectives that enrich the understanding of this phenomenon. This breadth of experience highlights the different challenges and needs in perinatal care, which represents one of the main strengths of the study.

Nonetheless, there are some limitations that should be considered when interpreting the results. First, the study was conducted in a specific geographical context, focused on the islands of Ibiza and Formentera, which could limit the applicability of the findings to other settings, especially those with different cultural characteristics, resources and care systems. In addition, the purposive selection of the sample, based on the availability and willingness of the participants, may have introduced a bias in the representativeness of the experiences captured, something that is often a challenge in qualitative research.

It would be valuable for future studies to recruit a greater number of women from diverse ethnic groups and socioeconomic backgrounds, as their perspectives may offer greater depth and differ from those reflected in this study, as the literature notes that minority women face unique inequalities and barriers to accessing perinatal mental healthcare. In addition, it would be useful to explore the experiences of women with specific health conditions, those with neurodiversity, and those already diagnosed with a perinatal mental health problem. Delving deeper into their needs could provide a more complete understanding and help design more inclusive approaches for those in need of additional support.

4.2 Implications

The study findings reveal that it is essential to implement specific continuing education in mental health and cultural competencies for midwives, and the implementation of standardized tools for mental health assessment is essential to ensure systematic, equitable, and high-quality care. Restructuring midwives' working conditions to facilitate meaningful therapeutic relationships is also crucial,

including the allocation of adequate time and the reduction of workloads.

Women highlighted the need for continuous and personalized emotional support, especially in cases of perinatal loss. Creating safe spaces, such as support groups that address this phenomenon, can improve their emotional well-being during pregnancy and postpartum.

5. Conclusions

This qualitative study offers an in-depth understanding of perinatal mental healthcare based on the perspectives of both midwives and women. The findings reveal persistent structural barriers, such as time constraints, lack of protocols, and insufficient training, that hinder midwives' ability to provide consistent emotional support. Women reported fragmented care and unmet emotional needs, further compounded by sociocultural stigma and limited follow-up after risk identification. The study also underscores the centrality of the therapeutic relationship and the importance of personalized, culturally sensitive care models.

Based on these findings, several recommendations emerge for nursing practice and policy. First, midwifery training curricula should be expanded to include comprehensive modules on perinatal mental health and cultural competence. Second, healthcare systems must prioritize the development and implementation of standardized protocols and screening tools, accompanied by the necessary institutional support for their use in daily practice. Third, policies should address workload distribution and time allocation to facilitate relational continuity and therapeutic engagement. Finally, the promotion of support groups and culturally adapted interventions can play a crucial role in improving emotional wellbeing during the perinatal period and advancing equity in care delivery.

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Ethical considerations

The study was approved by the "**anonymized** for **review"** prior to the start of the study. All participants signed an informed consent form before beginning the interviews, with the guarantee that they could withdraw from the study at any time without repercussions. The confidentiality of the information was protected by anonymizing the data and storing them in secure, password-protected devices. Participants had the flexibility to decide when and how to participate, with a time frame ranging from one day to months to arrange interviews. The procedures followed were aligned with international ethical guidelines for research involving human subjects, protecting the rights and welfare of the participants at all times.

CRediT authorship contribution statement

Raquel Navarro Maldonado: Writing – review & editing, Writing – original draft, Software, Resources, Funding acquisition, Formal analysis. **Antonio R. Moreno-Poyato:** Writing – review & editing, Writing – original draft, Supervision, Methodology, Formal analysis, Conceptualization. **Nuria María Albacar Rioboó:** Writing – review & editing, Writing – original draft, Supervision, Methodology, Formal analysis, Conceptualization.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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