ORIGINAL ARTICLE

Understanding the Healthcare Practitioners' Experience in Managing Women with Postnatal Depression: A Qualitative Study in Malaysia

Siti R.M. Arifin[a], Khadijah H.A Abdullah[b], Nurul A.H. Abas[c], Rohayah Husain[d], Mohamad C. Man[e]

[a]Department of Special Care Nursing, Kulliyyah of Nursing, International Islamic University Malaysia
[b]Faculty of Medicine and Health Sciences, Universiti Sains Islam Malaysia, Negeri Sembilan
[c]Department of Psychology and Counselling, Faculty of Human Development, Universiti Pendidikan Sultan Idris
[d]Psychological Medicine Unit, Faculty of Medicine, Universiti Sultan Zainal Abidin, Kuala Terengganu, Malaysia.
[e]Department of Family Medicine, Kulliyyah of Medicine, International Islamic University Malaysia

ABSTRACT

INTRODUCTION: Postnatal depression is largely underdiagnosed in many low-and middle -income countries, including Malaysia. Healthcare practitioners' perceptions towards postnatal depression were identified as one of the main barriers to seeking help. Objective: This study aimed to explore the perceptions of healthcare practitioners about postnatal depression, and their experience in managing women with postnatal depression in Malaysia. **MATERIALS AND METHODS**: Eighteen healthcare practitioners (5 head nurses, 9 nurses, and 4 doctors) working in maternal and child health clinics and a female psychiatric ward in Kuala Lumpur were individually interviewed following a generic qualitative research design. Interview data were transcribed verbatim, and the transcripts were analyzed using framework analysis. **RESULTS**: Healthcare practitioners reported that their management of women with postnatal depression was limited by the absence of a specific screening tool, and presence of stigma associated with postnatal depression. **DISCUSSION AND CONCLUSION**: Healthcare practitioners were found to be aware of poor maternal mental health provision within their clinical setting and are ready to contribute to developing protocols to improve maternal mental health. As its diagnosis and treatments vary from general depression, there should be a specific direction addressed in the policy to assist in actions for managing postnatal depression. Professional training and continuous education on postnatal depression are a fundamental component in fostering quality of care, and public awareness as well as improving stigma within the Malaysian healthcare system.

Keywords
Postnatal depression, management, women, healthcare practitioners, experience

Corresponding Author
Dr. Siti Roshaidai Mohd Arifin
Department of Special Care Nursing,
Kulliyyah of Nursing
International Islamic University Malaysia, I
ndera Mahkota Campus
25200 Kuantan Pahang
No Tel : 09-5707296
E-mail: roshaidai@iium.edu.my

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INTRODUCTION

Postnatal depression (PND) is a complex combination of physical, emotional, and behavioural changes that can occur among women after giving birth. In many cases, these changes take place within a few months to a year after birth.[1] A PND prevalence rate of 4.0%-63.9% has been reported in many countries.[2] In Malaysia, about 7-27% of women were reported to suffer from PND.[2] PND has been well-known to cause adverse health impacts to the mother, father, and children. For instance, PND is recognized as one of the causes of suicidal attempts and self-harm thoughts among postpartum women.[3] It also impacts men's roles as a father and partner, mother-child relationships, and children's behavior and emotions.[3-4]

Despite the negative impacts, PND is largely underdiagnosed in many low-and middle-income countries, including Malaysia.[5] Various factors associated with the underdiagnosed of PND have been identified, which include the unavailability of routine and standard screening methods, and healthcare practitioners (HCPs) perceptions towards PND.[6] Routine screening for PND has been acknowledged to increase the identification of at-

risk mothers.[7] In Malaysia, although the Edinburgh Postnatal Depression Scale (EPDS) and Patient Health Questionnaire-2 (PHQ-2) are recommended by the Ministry of Health Malaysia[8] for the detection of depression throughout the perinatal period, it is not equally applied across the country.

HCPs' perceptions towards PND were identified as the barriers to seeking help for women with PND.[9] Notable studies were conducted on the HCPs' perceptions of PND across various countries and cultures.[10-12] While the HCPs were reported to recognise their roles in the care and treatment of women with PND, many agreed that limited resources are available within a healthcare system and a poor understanding of PND among women is present.[12] To illustrate, a qualitative study among postnatal women with PND in Malaysia indicated that the HCPs presented unsatisfying advice, responded in derogatory expressions, and were less attentive to their health complaints.[13] Besides, the nurses in Malaysia were reported to have a lack of knowledge about PND,[14] with 50% of nurse-midwives are confused between PND and postnatal blues.[15]

Within the Malaysian set-up of Maternal and Child Health (MCH) clinics, antenatal and postnatal women together with their children are collaboratively managed by doctors and nurses.[16-17] Services provided in MCH clinics for antenatal women include antenatal booking, health education of fetal movement, urine test for protein and glucose, monitoring blood pressure and body weight, and assessing fetal well-being through abdominal palpation.[18] In general, expecting mothers in Malaysia deliver their babies in government or private hospitals where they will be taken care of during labour by nurse-midwives, a medical doctor and/or obstetrician. Postnatal nursing care for women was provided by community nurses and nurse-midwives who visit new mothers at their homes and provide health education on breastfeeding and family planning.[19] Additionally, community nurses or nurse-midwives also manage child health clinics to provide child immunization, monitor child development and nutrition, and conduct home visits for high-risk babies and malnourished children.[20]

In the management and care for women with PND, HCPs particularly nurses and doctors are expected to act proactively to detect and alleviate symptoms, provide time for the establishment of relationships and trust, encourage the use of available resources for adequate support and motivation, and build awareness regarding different childbearing traditions of diverse cultural backgrounds.[21] Similarly, many efforts have been made to improve the management of PND in Malaysia. For instance, the Ministry of Health[22] has presented three recommendations concerning maternal mental health. First, the promotion of mental health was recommended to be enhanced for both antenatal and postnatal mothers. Second, HCPs should improve their knowledge and skills in perinatal mental health. Third, screening opportunities for postnatal mental illness among women should be available and explored in the healthcare system.

Despite the recommendations, the knowledge and perceptions of HCPs on PND were not extensively studied, and correspondingly, the HCPs' views and management on PND were not explored. The explanations to the nurses' confusion between PND and postnatal blues were described by the quantitative study as unclear.[23] Notably, the understanding of how HCPs perceive and comprehend PND and their functions in handling PND is beneficial to illustrate the details of PND management in clinical practices. Additionally, it was suggested that further research should be performed to examine the literacy, screening, and management of PND among HCPs.[23] Therefore, this study aims to explore the knowledge and perceptions of Malaysian HCPs about PND, and their way of managing women with PND in Malaysia.

MATERIALS AND METHODS

An exploratory qualitative research design was used in this study where the face-to-face semi-structured interview was conducted among 18 HCPs (5 head nurses, 9 nurses, 4 doctors) in six maternal and child health (MCH) clinics and a female psychiatric ward in Kuala Lumpur. The sample size of 18 was selected as there was no additional data found after the analysis of the interview transcripts

which indicated data saturation. Sample inclusion criteria for this study were HCPs working in the clinics or female psychiatric ward and able to converse in Malay or English language. Purposive sampling was employed to collect data from various groups of HCPs with specific characteristics for the understanding of PND in Malaysia and comprehensive exploration of relevant PND constituencies.

The data collection began upon obtaining ethical approval from the Malaysian Medical Research Ethics Committee (MREC). The head nurses in the selected MCH clinics and a female psychiatric hospital were contacted for the first meeting arrangement. The first meeting aimed to allow the engagement between researchers and participants besides the presentation of the study process to the HCPs. The HCPs were given an invitation letter and participant information sheet at the end of the meeting. Eligible HCPs were followed up after at least 24 hours. Upon their agreement, an interview session was arranged, informed consent was sought before the interview session with an option for the participant to withdraw from the study if they wished to do so.

Interviews were conducted in a quiet room at the respective clinic/ward and the conversation was audio recorded with the HCPs permission. Each interview session lasted approximately an hour, and all interviews were conducted by the same researcher. Using a topic guide that was developed from previous research,[24] the HCPs were asked about the following: (i) how would they know that a woman may be experiencing PND, (ii) how would they manage and support the woman, and (iii) what resources related to maternal mental health were available to them or the women they managed. The confidentiality of the research process in the present study was maintained where participants' information was recorded in the recruitment log. The field notes were recorded immediately after each interview session for reflection purposes.[25]

The interview data were transcribed verbatim and were analysed using framework analysis. The analysis involved three inter-related stages which were data management, descriptive accounts, and explanatory accounts.[26] In the first stage, initial themes were developed based on five selected transcripts as these transcripts represent HCPs' views and perceptions towards PND. The themes were generated and grouped based on similar views or perceptions. In the second stage, the relationship and similarities between the themes were identified. In the third stage, the dataset was reviewed to analyse the degree of consistency between the phenomena and the final themes. Both initial and final themes were developed after consensus was achieved among the research team members.

Subsequently, evaluation of trustworthiness that included credibility, consistency and transferability of the findings were verified.[27] Several strategies were applied to perform the evaluation process such as the establishment of engagement with potential participants, recruitment of participants using purposive sampling, verification of participants' profiles and responses, the briefing provided to participants on their rights to withdraw from the study before the commencement of the study, and usage of team analysis (or inter-rater agreement) to confirm codes and themes (validation of qualitative data). Final themes and quotations were presented in the findings section accordingly. The Standards for Reporting Qualitative Research: A Synthesis of Recommendations (SRQR) was used to guide the reporting of this study.[28]

RESULTS

A total of 18 HCPs (5 head nurses, 9 nurses, 4 doctors) from six Maternal and Child Health (MCH) clinics and a female psychiatric ward in Kuala Lumpur were interviewed. Table 1 shows the socio-demographic characteristics of the participants.

The HCPs' experience in managing women with PND were formulated into four themes: understanding postnatal depression, routine care as a preventive strategy, boundaries within the healthcare system, and screening and awareness.

Table 1: Demographic characteristics of healthcare practitioners (n=18) interviewed in this study.

Demographic characteristics	Frequency (Percentage)
Age (years)	
21-30	2 (11%)
31-40	13 (72%)
> 40	3 (17%)
Level of education	
Certificate	3 (17%)
Diploma	1 (5%)
Advanced diploma	10 (56%)
Bachelor's degree	3 (17%)
Master's degree	1 (5%)
Years of service	
0.5 - 5 years	2 (11%)
5.1- 10 years	8 (45%)
10.1-15 years	3 (17%)
15.1- 20 years	4 (22%)
≥ 20 years	1 (5%)
Work setting	
MCH Clinic	15 (83%)
Psychiatric ward	3 (17%)

Understanding Postnatal Depression

This theme addressed two areas explored in the interview which are: the patterns of the HCPs pre-existing knowledge and the cues (symptoms) they perceived to indicate the women are experiencing PND. Analysis of their descriptions indicated that the majority of the HCPs (with an exception of a psychiatrist and a medical officer) appeared to have misconception that the symptoms of postnatal blues were similar to PND and that it is hardly found in Malaysia.

> "They are more or less the same, aren't they? Postnatal blues is also depression after childbirth, isn't it?" (HCP10)
> "This case is very rare, right, rarely seen. No. [It's] very few. [It's] rare." (HCP9)

Nonetheless, almost half of the HCP acknowledged that PND was "underdiagnosed" or "did not represent the true scale of the problem", associating this with the underdeveloped pathway and guidelines that fail to capture women with mild and moderate depressive symptoms at the point of early onset.

> "I don't think it is well proper taken care of or fully developed yet. I don't think so. I don't know, I think it is not properly developed yet." (HCP13)

When asked about how they would know that a woman may be experiencing PND, HCPs discussed two important cues: change in behavior and change in body function. Change in behaviour refers the way that a woman acted or conducted herself, and how she responded to others such as self-isolation, neglecting their baby, responding inappropriately to the baby's crying, refusing to breastfeed, and paying no attention to their baby.

> "She doesn't seem to have interest in her baby, not even looking at the baby, not keen to breastfeed when she was asked to." (HCP9)

Change in body function includes physiological health problems associated with childbirth such as difficulty in sleeping, loss of appetite, loss of body weight, sudden reduction in passing urine and bowel movements, and an increase in blood pressure.

> "When there is increased or decreased in blood pressure, that's the time to ask more. Sometimes that's the stage she'll tell us about her weight loss [was because of] loss of appetite or her busy day." (HCP7)

While the cues shared by a few HCPs' (especially those of medical officers and the psychiatrist) appeared to derive from the standard classification of diagnosing depression (i.e. the Diagnostic and Statistical Manual of Mental Disorders), the cues shared by the nurses were not fully based on the similar classification. Rather, the cues were primarily derived from their personal and intuitive judgment in detecting PND.

Routine Care as a Preventive Strategy

When the HCPs were asked about the available sources and how they manage women with PND within their clinical setting, HCPs mainly shared their routine care. The interview analysis indicated that almost half of them, especially those in MCH clinics believed that existing antenatal care is one of the important elements to prevent maternal distress. The existing antenatal education was described as helpful in preventing PND by addressing the

causes including problems with breastfeeding and perineal pain after childbirth:

> "That is why when they come for a check-up in our clinics, we also check for other issues faced by them in addition to routine maternal and child health care provided. We ask whether they have any other problems." (HCP3)

HCPs reported that they also provide advice on childbirth and postnatal preparation. They felt that PND could be prevented by educating pregnant women on practical aspects such as breastfeeding techniques, adequate rest and sleep, baby's umbilical cord care, neonatal jaundice detection and family planning. Postnatal home visits especially allow nurses to provide professional advice, observe emotional status, recognize any abnormal behaviour and listen to complaints by mothers being examined. The visit was also regarded as a good platform for nurses to provide physical care and professional advice such as breastfeeding practices:

> "During home visits, we guide new mothers on breastfeeding positions such as cradle hold. Once they learn breastfeeding techniques and babies can latch well, mothers no longer feel stressed." (HCP7)

Despite acknowledging their roles and responsibilities in preventing PND, HCPs also discussed the boundaries they had in managing women with PND in the healthcare system.

Boundaries within the Healthcare System

It was evidenced in the HCPs description that there was little attention given in identifying women with PND which was associated with the limited knowledge and a lack of resources within the healthcare system. The HCPs agreed that there is a disparity between physical and emotional care in the healthcare system, with more emphasis given to physical health.

> "It is because we tend to forget and focus more on physical health such as monitoring a mother's blood pressure. Most often, we forget about emotional health." (HCP8)

The focus on physical health in MCH clinics can be related to the availability of a lower number of resources such as screening methods, a guideline for managing PND, and specialists (counsellors or clinical psychologists) to facilitate maternal mental health care.

HCPs reported that there were no specific screening methods for PND in their clinics. The only screening method available is the Depression Anxiety Stress Scale (DASS) but viewed as too general, hence unsuitable for antenatal and postnatal women.

> "We do have a screening tool which is called "DASS- *Minda Sihat*" (*DASS- healthy mind*). We can use the questionnaire which diagnoses depression, anxiety or stress which is very general." (HCP6)

In addition to screening tools, there was a concern about the lack of specialists in the psychological health field, including counsellors and clinical psychologists, making them uncertain about making a referral and has resulted in the overuse of psychiatric units in the hospital.

As reflected in HCPs' descriptions, PND is considered as a domain of psychiatric care, which is mainly delivered by psychiatric units in hospitals. However, the HCPs disclosed that such care is often perceived as less favourable and stigmatized by society. Healthcare practitioners reported that although PND is less severe than psychotic problems, both mental health problems are equally significant. The word 'psychiatric ward' was reported to be misunderstood by some women as they consider only insane people are referred to psychiatric clinic.

> "Some women might consider themselves crazy when she was referred to a counsellor. The stigma of 'being crazy' makes her feel more stressed." (HCP12)

HCPs added that there is also a stigma towards the

'antidepressant' word. This stigma was described as worse than the stigma associated with the 'counselling' word. They believed that the stigma associated with PND could be one of the reasons why hospital admission was not preferred as a treatment option for women with emotional health issues.

> "The family will send the patient to a traditional healer or seek treatment elsewhere. When the treatment failed or is not effective, then they will come and see us. By that time, it is a little bit too late when earlier intervention would have been given to the patients." (HCP18)

It is based on the boundaries they had within the healthcare system that HCPs proposed potential interventions that they perceive would be helpful in the future.

Screening and Awareness

When the HCPs were asked about possible interventions for managing women with PND, most of the HCPs suggested appropriate PND screening measures, public awareness, and supportive strategies to be introduced. The screening method was perceived as useful for PND identification among high-risk women, such as women with a history of mental distress, single mothers, and women who had experienced significant life events during pregnancy. Based on the screening and risk assessment, HCPs can make an immediate referral and provide support for high-risk mothers.

> "If HCPs know that the patient is at high risk, then they can be guided on ways or mechanisms to meet mental health professionals immediately and this will be a good way to assist the affected mothers." (HCP18)

Training and continuous learning for HCPs were viewed as to facilitate their decision-making process in managing women with PND. The HCPs have shown their readiness to enhance their knowledge and are very optimistic about the effectiveness of the PND education program. They suggested a few strategies in creating public awareness to develop the ability to differentiate between normal and abnormal changes among women after childbirth besides assisting the women in managing PND. Accessibility to expert care was described as an added value of supportive strategies. There were also suggestions for collaboration between maternity and psychiatric units, besides upgrading physical facilities in the MCH clinics, establishing relevant policy and fundings, and involvement of other government agencies to strengthen the support for women with PND.

DISCUSSION AND CONCLUSION

It is clear from the findings that majority of the HCPs have some level of misperceptions in understanding the common maternal mental health problems. This was indicated by their uncertainty in differentiating between postnatal blues and PND and adopting intuitive judgment in detecting PND instead of a standard classification system. Due to these misperceptions and uncertainties, the HCPs participating in this study tend to normalise the PND experience and considered that routine antenatal and postnatal care as an effective measure to prevent PND among mothers. Although it cannot be denied that knowledge is to be gained through learning or working experiences,[29] HCPs' knowledge on women's mental health should be developed based on scientific knowledge and professional consensus.[30]

The limitation of PND management were also associated with the lack of a standardized screening tool, availability of mental health specialists within the primary healthcare setting, and standard policy and guideline for managing PND that they could refer to. Although early symptoms were required to be assessed in the primary healthcare setting, HCPs considered physical health to be their priority care. This perception led to a focus on issues that the HCPs felt were relevant and prioritized by the government (i.e., family planning and breastfeeding). Yelland et al.[31] reported that the demand for physical health assessment has made clinical practice a less conducive environment to deal with complex psychosocial issues. Hence, there should be a specific direction addressed in the policy to assist in actions for managing PND, provided that its diagnosis and treatment

vary from general depression issues.[32] Without a clear direction, PND would not be adequately addressed within the healthcare services.[11] Evidence has shown that the availability of guidelines in some countries to facilitate maternal mental health has resulted in high confidence among HCPs in assisting women with PND.[33-34]

Besides, findings from this study also demonstrated the stigma associated with PND, making recommendation andg medical referral and treatment more challenging. HCPs indicated that the word 'counselling', 'psychiatric ward', and 'antidepressants' were related to 'crazy' as reported in previous studies.[35-36] According to Corrigan et al.,[37] stigma can be divided into three different levels namely social, structural and internalized. In the mental health context, social stigma is the discrimination of a person with mental health disorders which caused them to feel isolated in society. Meanwhile, structural stigma is linked to institutional practices, cultural norms, and conditions that are proper to society. Internalized stigma, however, occurs when individuals with mental illness may cognitively or emotionally accept negative messages, societal prejudices and devalue themselves.[38] It was apparent that the stigma highlighted by the HCPs in the present study was more related to internalized stigma. Previous studies have shown that internalized stigma had a stronger association with overall barriers to care in comparison to other levels of stigma.[39-40] Results from the current study suggest the need for community-level interventions to change women's perceptions on PND and assist in tackling societal perspectives relating to mental health stigma[48] which is a barrier for perception change.[41]

Consistent with findings by McCauley et al.,[42] HCPs in the present study were found to be aware of poor maternal mental health provision within their clinical setting and are ready to contribute to developing the necessary protocols to improve maternal mental health care. Suggestions from HCPs to initiate PND screening among the high-risk group of women with a history of mental distress, who are single mothers, and who experienced major life events during pregnancy as part of the interventions for PND management was consistent with that reported by Premji et al.[43] The high-risk groups of women were expected to receive PND diagnosis and had higher PND-related utilization and drugs dispensed compared to those women who were unscreened.[43] Moreover, screening of all postnatal women for PND symptoms is not cost-effective,[44] especially when women were wrongly diagnosed with PND and were being managed in the healthcare system. The establishment of such a screening method requires re-prioritization of workloads, further series of training, and education to change the attitudes and practices of HCPs.[45]

The need for training, scheduled talks or seminars on maternal mental health was also addressed. Noonan et al.[46] reported that public health nurses in their study expressed the need for educational opportunities. The nurses were interested to explore psychological distress across cultures and their attitudes to mental health, systems of clinical supervision, and support pathways. Training on PND screening programs was found to empower HCPs to identify women with PND, increase their confidence level, and improve their sensitivity towards the high-risk group of women who were not identified by any screening tools.[47]

On-site mental health services were identified to boost diversion and bridge the gap between tertiary and primary healthcare settings.[47] Likewise, in this study, the HCPs proposed that a psychological expert should be assigned for duty in a primary healthcare setting as one of the supporting strategies for managing women with PND. It was evidenced that psychological interventions delivered within a primary care setting improved depressive symptomatology.[48]

In conclusion, the lack of information on maternal mental health among HCPs in this study resulted in the normalization of the PND experience. The absence of a reliable screening tool and consistent policy and guidance on PND treatment caused the symptoms to be completely overlooked. Therefore, this study calls for the development of a relevant screening tool to assess PND symptoms among Malaysian women. Professional training and continuous education on PND will be beneficial in

fostering quality maternal mental health care besides creating public awareness within the Malaysian healthcare system on PND among women.

CONFLICT OF INTERESTS

The authors declare there is no conflict of interest.

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