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BARRIERS TO THE ASSESSMENT AND TREATMENT OF POSTNATAL DEPRESSION AMONG WOMEN. REVIEW

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Abstract

Introduction: Postpartum depression (here in after PDD) is an important public health problem. According to WHO reports, this nosology has about 10-15% of the prevalence worldwide. Any woman in the postpartum period is susceptible to PDD. This nosology does not look at culture, country and nationality.

Purpose of the work: to identify barriers to assessment and treatment of postpartum depression among women based on international experience.

Search strategy: literature search was carried out manually using the keywords postpartum depression, postnatal depression, puerperal depression, predictors AND risk factors, help-seeking barriers, maternal treatment preference in the PubMed, Web of science, CyberLeninka databases, "E-library", using the specialized search engine "Google Scholar". The depth of research is 10 years. Only those literatures that considered barriers to the assessment and treatment of postpartum depression were reviewed.

Results: Based on the results of the review, three main categories of barriers were identified: individual, organizational and socio-cultural. Individual barriers to women in childbirth constitute the main percentage of all barriers. There are 3 main components of individual barriers: lack of information, stigma and fear for the child's life.

Conclusions: The acceptability of treatment approaches for postpartum depression and maternal preference should be the main indicators for the treatment of PDD.

Every woman needs to be provided with high quality and culturally sensitive information about the symptoms of PDD to highlight the differences between perceived normal changes in pregnancy and symptoms of PDD. Similar information should also be provided to family members of the woman, and in particular to medical workers and students in medical institutions. Such resources should be available in multiple languages and culturally appropriate.

Keywords: *postpartum depression, postnatal depression, puerperal depression, predictors AND risk factors, help-seeking barriers, maternal treatment preference.*

Резюме

БАРЬЕРЫ ДЛЯ ОЦЕНКИ И ЛЕЧЕНИЯ ПОСЛЕРОДОВОЙ ДЕПРЕССИИ СРЕДИ ЖЕНЩИН. ОБЗОР ЛИТЕРАТУРЫ

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Введение. Послеродовая депрессия (далее ПРД) является одной из важных проблем общественного здравоохранения. По отчетам ВОЗ данная нозология насчитывает около 10-15% распространённости по всему миру. Любая женщина в послеродовом периоде восприимчива к ПРД. Данная нозология не смотрит на культуру, страну и национальность.

Цель работы: выявить барьеры оценки и лечения послеродовой депрессии среди женщин на основе мирового опыта.

Стратегия поиска: поиск литературы был осуществлен ручным методом по ключевым словам postpartum depression, postnatal depression, puerperal depression, predictors AND risk factors, help-seeking barriers, maternal treatment preference в базах данных «PubMed», «Web of science», «CyberLeninka», «e-library», с помощью

специализированной поисковой системы «Google Scholar». Глубина исследования 10 лет. Изучению подлежали только те литературные источники, которые рассматривали барьеры оценки и лечения послеродовой депрессии.

Результаты: По итогам обзора было выявлено три основных категории барьеров: индивидуальные, организационные и социокультурные. Индивидуальные барьеры роженицы составляют основную долю среди всех барьеров. Существуют 3 основные составляющие индивидуальных барьеров: неинформированность, стигма и боязнь за жизнь ребенка.

Выводы: Приемлемость подходов к лечению послеродовой депрессии и предпочтения матерей должно быть основными показателями для лечения ПРД.

Каждой женщине необходимо предоставить высококачественную и культурно чувствительную информацию о симптомах ПРД, чтобы подчеркнуть различия между воспринимаемыми нормальными изменениями беременности и симптомами ПРД. Аналогичную информацию также необходимо предоставлять и членам семьи женщины, и в особенности медицинским работникам и студентам, обучающимся медицинских учреждениях. Такие ресурсы должны быть доступны на нескольких языках и адаптированы с учетом культурных особенностей

Ключевые слова: *postpartum depression, postnatal depression, puerperal depression, predictors AND risk factors, help-seeking barriers, maternal treatment preference*

Түйіндеме

БОСАНҒАННАН КЕЙІНГІ ДЕПРЕССИЯНЫ БАҒАЛАУ МЕН ЕМДЕУДЕГІ КЕДЕРГІЛЕР: ӘДЕБИЕТТІК ШОЛУ

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Кіріспе. Постнатальды депрессия (бұдан әрі - ПД) денсаулық сақтаудың маңызды проблемасы болып табылады. ДДҰ есептеріне сәйкес, бұл нозология бүкіл әлемде шамамен 10-15% таралған. Босанғаннан кейінгі кез-келген әйел ПД-ге сезімтал. Бұл нозология мәдениетке, елге және ұлтқа қарамайды.

Жұмыстың мақсаты: халықаралық тәжірибеге сүйене отырып, әйелдер арасындағы босанғаннан кейінгі депрессияны бағалау мен емдеудегі кедергілерді анықтау.

Іздеу стратегиясы: әдебиеттерді іздеу қолмен босанғаннан кейінгі депрессия, постнатальды депрессия, перуальды депрессия, болжаушылар мен қауіп факторлары, көмек іздейтін кедергілер, PubMed, Web of Science, CyberLeninka мәліметтер базаларында, «Электрондық кітапхана» кілт сөздерін қолдану арқылы жүзеге асырылды. , «Google Scholar» мамандандырылған іздеу жүйесін қолдану. Зерттеу тереңдігі - 10 жыл. Босанғаннан кейінгі депрессияны бағалау мен емдеудегі кедергілерді қарастырған әдебиеттерге ғана шолу жасалды.

Нәтижелер: Қарау нәтижелері бойынша кедергілердің негізгі үш категориясы анықталды: жеке, ұйымдастырушылық және әлеуметтік-мәдени. Босану кезіндегі әйелдер үшін жеке кедергілер барлық кедергілердің басым бөлігін құрайды. Жеке кедергілердің негізгі 3 компоненті бар: ақпараттың жеткіліксіздігі, стигма және баланың өмірі үшін қорқыныш.

Қорытынды: босанғаннан кейінгі депрессияға және ананың қалауына байланысты емдеу тәсілдерінің қолайлылығы ПДД емдеудің негізгі көрсеткіштері болуы керек.

Жүктіліктің қалыпты өзгеруі мен ПД белгілері арасындағы айырмашылықты көрсету үшін әр әйелге ПД белгілері туралы жоғары сапалы және мәдени тұрғыдан сезімтал ақпарат беру керек. Осындай ақпарат әйелдің отбасы мүшелеріне, атап айтқанда медициналық қызметкерлер мен медициналық мекемелердегі студенттерге берілуі керек. Мұндай ресурстар бірнеше тілде қол жетімді және мәдени тұрғыдан сәйкес болуы керек.

Түйінді сөздер: *postpartum depression, postnatal depression, puerperal depression, predictors AND risk factors, help-seeking barriers, maternal treatment preference.*

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Relevance

Postpartum depression (hereinafter PDD) is an important public health problem. According to WHO reports, this nosology has about 10-15% of the prevalence worldwide [27].

According to the ICD-10, the PDD has the code F53 "Mental and behavioral disorders associated with the puerperium, not elsewhere classified" and belongs to the category "Mental and behavioral disorders" (F00-F99) [28].

Any woman in the postpartum period is susceptible to PDD. This nosology does not look at culture, country and nationality [5, 12]. Primary screening helps to eliminate the signs of this disease [13]. There are various emotionally unstable transient states of PDD: baby blues / postpartum blues, perinatal depression, anxiety disorder, puerperal or postpartum psychosis, and bipolar disorder (manic-depressive disorder). Depending on the degree, psychotherapy or pharmacotherapy is used. The etiology of PDD is still controversial among researchers, since PDD is a complex of their psychological, physical and endocrine causes. Reveals the genetic, biological and environmental factors of the onset of PDD [24]. Due to various etiological factors, there is a need to use specialized tools and measures to detect PDD depression among pregnant women and women in labor. The search results revealed the following main questionnaires: the Edinburgh Postpartum Depression Assessment Scale, the WHO self-completion questionnaire SRQ-20, DASS-42, DASS-21, the Beck Depression Scale, the Center for Epidemiological Studies Depression Scale (CES-D), the Tsung Depression Self-Assessment Scale, and the Bromley Postpartum Depression Scale. According to various analytical publications of the PRD rating scales, the Edinburgh scale is the most common and more sensitive [25]. Nevertheless, this scale is only used to diagnose and identify primary symptoms. The main conclusion is given by practicing psychologists [14].

In the course of the search, articles were found concerning factors, etiology, diagnosis of PDD among women of reproductive age. But there are very few publications pointing to barriers to evaluating and treating postpartum depression in women. Identifying the main barriers to the assessment and treatment of postpartum depression among women helps to develop the most optimal algorithms and tools for treatment, taking into account the interests and preferences of women in the prenatal and postnatal periods [18].

For this reason, the main goal of the literature search is to identify barriers to the assessment and treatment of postpartum depression among women based on global experience.

Search strategy

To achieve this goal, a literature search was conducted by keywords (Postpartum depression, postnatal depression, puerperal depression, predictors AND risk factors, help-seeking barriers, maternal treatment preference) and literature sources from the databases "PubMed", "Web of science", "CyberLeninka", "e-library", using a specialized search engine "Google Scholar". The research depth is 10 years. The study included only those literature sources that considered the barriers to the assessment and treatment of postpartum depression.

Inclusion criteria: publications with clearly formulated and statistically proven conclusions, high-quality systematic reviews.

Exclusion criteria: summaries of reports, personal messages, advertising articles, reviews, articles with an analysis of the measurement properties of the PRD assessment scales, articles prohibited from downloading, protocols of working with the questionnaire.

The strategy of searching and selecting literary sources is described in Table 1.

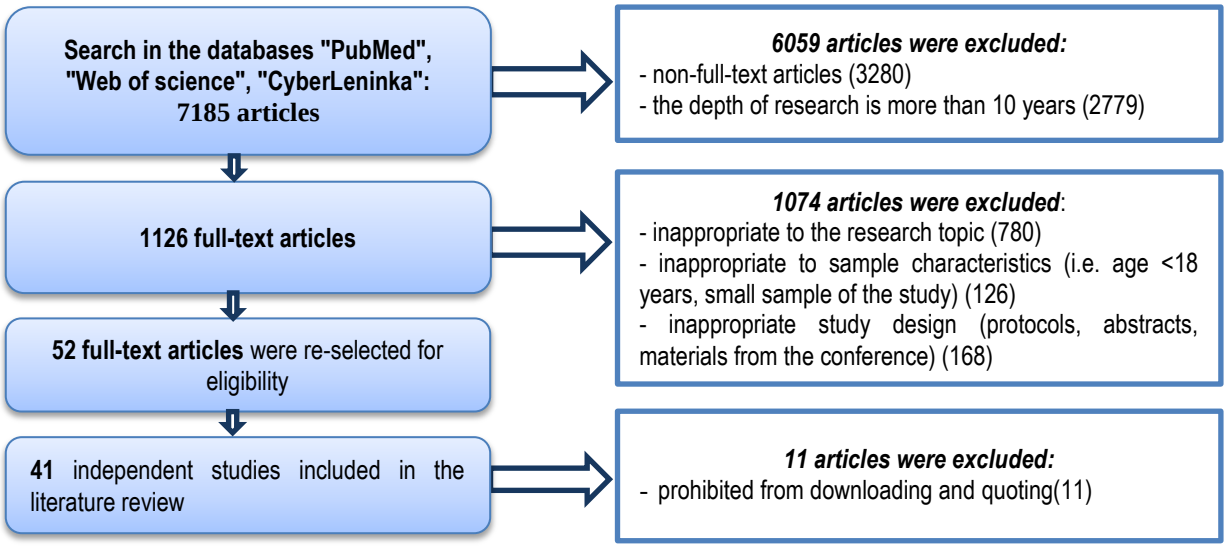

Table 1. Search and selection strategy.

Results

The first symptoms of PDD appear during the first 12 weeks after delivery. Baby blues lasts from 5-10 days and is accompanied by mood disorders, constant crying. Fluctuation of hormones, metabolic disorders in the thyroid gland, irregularities, in some cases adherence to a strict

diet provoke the occurrence of maternal blues. These symptoms are easily and favorably prevented in the proper care and environment of the mother in labor [22].

PDD is observed within one year after childbirth among women in labor. Anhedonia (lack of interest and pleasure) is one of the important symptoms of PDD [19].

Recurrence of PDD is quite expected after delayed detection and treatment of PDD. Compliance or the implementation of all the recommendations of specialists by women in labor is another pressing issue. Existing fears about the fear of pharmacotherapy and mistrust of their feelings in specialists cause complications of the course of PDD and leads to more severe forms of PDD [16].

Postpartum psychosis, as well as PDD, appears after 2 weeks after delivery. Despite its low incidence, postpartum psychosis is a serious mental illness that can threaten the life of both mother and child. At this level of depression, only pharmacotherapy is indicated or the use of 2 types of treatment at once [16]. The main flows and characteristics of the PDD are shown in Table 2.

At the level of the Republic of Kazakhstan, UNICEF conducts training in module No. 7 "Parental well-being". The training is mainly carried out by foster nurses, who are the main key link for detecting of PDD in parents [21]. According to the informative bulletins, foster nurses are required to assess the psychological health of parents on the Edinburgh scale and continue to refer them to a psychologist, if necessary. Despite the relevance of the study and the availability of certain algorithms for diagnosing PDD, there are no general statistics of PDD in our country.

Understanding the severity and consequences of this disease and interest in research is only now coming. Only one study was identified in Kazakhstan, considering the prevalence and possible factors for the development of PDD in the city of Nursultan [23] and 3 articles with a similar topic[20, 26]. However, no analytical publications were found to identify barriers to the assessment and diagnosis of PDD at the CIS and national levels.

Table 2.

Main currents and characteristics of PDD.

	Baby blues	Postpartum depression	Postpartum psychosis
Duration	Within 1-3 weeks after giving birth	2 weeks after childbirth up to a year	2 weeks after delivery
Morbidity	Up to 80%	Up to 25%	Up to 0.2 %
Symptoms	- Changeable mood - Hypersensitivity - Tearfulness - Concern - Poor concentration - Anxiety and irritability - Disturbed sleep	- Constant fatigue - Sleep problems that are not related to the child's sleep mode - Lack of energy, - Crying - Melancholy - Weight loss or gain - Irritability -Feeling physically and emotionally depressed - Pessimism - Suicidal thoughts -Lack of interest and motivation - Poor concentration	- Symptoms occur abruptly - Unnatural behavior - Quick change of mood - Thought disorder - Delusional ideas - Hallucinations - Disturbed behavior - Confusion, lack of understanding of their own behavior

Source: "Information Card-Symptoms and conditions" from the Booklet of Information cards for Nursing nurses, compiled on the basis of UNICEF modules.

Since it is not possible to prevent PD in all women, it is necessary to focus on identifying the barriers that prevent women from seeking psychological help for the treatment of PDD.

The development of optimal algorithms and tools for the treatment and evaluation of the PDD will help to consider the interests of women in the prenatal and postnatal periods and facilitates the work of all stakeholders (practice nurse, psychologist, physician, obstetrician-gynecologist, etc.).

The review identified three main categories of barriers: individual, organizational and socio-cultural (see Figure 1).

Individual barriers of woman in postnatal period makes up the main share among all barriers. We identified 3 main components of individual barriers: lack of information, stigma, and fear for the child's life (Figure 2). Next, we will try to reveal all the components.

Poor awareness of PDD and the signs and symptoms of PDD by women in labor and family members were highlighted as the most common causes reported across studies. [11, 12, 18].

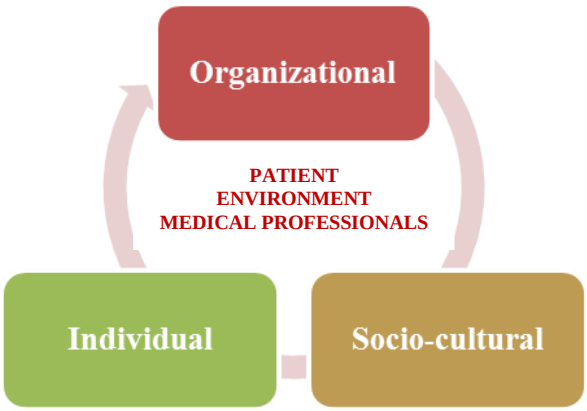

Figure 1. Barriers to the assessment and treatment of postpartum depression.

Figure 2. Individual barriers.

Many women in labor perceive the nursing service as a service that provides assistance only to children, but not to parents, especially in case of depression. Physical symptoms (back pain, problems with breastfeeding, the consequences of a difficult birth, cesarean section, etc.) are perceived as the main indicator when referring to specialists. Indecisiveness in parturient women in recognizing depression and a tendency to minimize symptoms is the main barrier to identifying PDD. Also, studies by *Kim J, Buist A.* indicate that women take psychological fluctuations for granted. Most believe that this is a normal body reaction after childbirth [22].

According to a study by *Megan Sambrook Smith, Vanessa Lawrence, et al*., it was found that women do not have sufficient knowledge about the main symptoms of PDD [18].

The focus on the health and condition of the child after childbirth is the main reason when women in labor are left without attention and supervision [9].

Family members also said that they felt unable to recognize the signs and symptoms of PRD, and for this reason could not provide any effective support. Fluctuations in behavior (bad mood and irritability) of women were usually associated with fatigue or hormonal fluctuations [10].

Fear of judgment and fear for the life of the child were also one important reason for hiding emotions by women in labor. Many had a fear of judgment of not being able to fulfill the social expectations of the environment, family, friends in relation to motherhood[10].

Sometimes women felt guilty for all their negative emotions, for instead of the expected feelings of happiness [18].

As mentioned earlier, there are two ways to treat PDD: psychotherapy and pharmacotherapy. The treatment algorithm depends on the course and level of the disease. Sometimes two methods are used at once. As a result of studies and reviews, it turned out that many mothers prefer non-pharmacological treatment options. Important concerns relate to the teratogenicity of psychotropic drugs and possible side effects for mother and child and drug dependence [24].

Also, women are reluctant to seek professional help because of negative experiences in the past when contacting specialists. It is difficult for women in labor to disclose their feelings and experiences to strangers due to the lack of open discussion with medical professionals and family members [7].

Because of the widespread stigma surrounding psychological illnesses, women are afraid of being treated as patients with psychiatric disorders. They are afraid that because of this, their child may be taken away from them [7].

Despite all of the above, it should be pointed out that many women who have symptoms of PRD wait for a critical point to seek psychological help, or decide not to seek help at all. Women hope for the self-treatment.

Organizational barriers are the second most significant of the barriers listed above. Organizational barriers include the following: high workload, limited time for visits, unqualified specialists, inconsistent work of specialists among themselves, lack of specialists and incomplete curriculum in higher and specialized educational institutions.

Previous reviews highlight that the lack of prenatal care focused on women in labor, the stigmatization of mental health and limited time for counseling, the workload and lack of awareness of medical professionals also increase distrust on the part of women [9].

Negative experiences of attending PHC in the past and feelings of frustration, anger, humiliation and anger drained women after interacting with medical professionals increased distrust of specialists [6].

In a cross-cultural study, *Oates M.R., Cox J.L. et al.* found out that for many women the most desirable treatment was simply the opportunity to talk about their feelings with a responsive and understanding listener who has sufficient knowledge about this[8].

An example of such a study is the study of *Samuel Adjorlolo and Lydia Aziato*, which reported a lack of knowledge of health professionals about how to help women with PDD [3].

Medical professionals point out that they do not have enough time to establish mutual understanding with women with PRD, and some of them were criticized as slow by other colleagues if they felt that they needed more time to communicate with women in labor[6].

The lack of nursing and midwifery staff, as well as long waiting lists for specialists, lack of interest from medical staff, and integrated check-ups with the child also limit women's access to the health system. The *ACOG study* recommends screening after 3 weeks and 12 weeks after delivery. Screening for women's health needs to be done separately from the reception of children [14].

Young professionals, in a qualitative study by *Honda C. Boyd, Marjie Mogul* pointed to gaps in the curriculum, where there is very little information about maternal mental health and practical training.

Women in rural areas are less likely to seek help and have problems due to access to health facilities [17].

The lack of consistency among specialists plays an important role. Women with PDD symptoms expressed uncertainty about knowing which health care provider is best to contact for access to proper consultation [18].

In an analytical study by *Donna E. Stewart, E. Robertson, et al.* health professionals were often negative about the use of existing assessment tools (such as the Edinburgh Postpartum Depression Scale). Midwives, general practitioners and therapists agreed that such

screening tools are currently unsatisfactory and increase the risks of women dropping out of the study [1, 19].

It is worth noting that issues related to the physical and mental health of women in the reproductive period require a lot of attention from the government, as this can have long-term consequences for the development of the child and social and economic consequences for the entire society. Therefore, the well-coordinated work of an obstetrician-gynecologist, psychologist, therapist, pediatrician and a nursing nurse plays an important role in the process of identifying and treating PDD.

Also, proper care, environment, and the presence of maternal support groups and interpersonal relationships help mothers understand that they are not alone with their problems. [16].

The last type of barriers, socio-cultural barriers, are described in many foreign studies, which consider the cultural characteristics of different nationalities and language barriers when applying for help. It would be good if such parameters would be taken into account in our multinational country when developing preventive measures for PDD.

The elimination of this barrier will help to develop measures for the prevention of PDD, taking into account socio-cultural barriers.

In the study of *Titilayo Babatunde and Carlos Julio Moreno-Leguizamon*, the cultural characteristics of the peoples also play an important role. These researchers developed practical recommendations for health professionals, taking into account the everyday and cultural problems of postpartum depression in African immigrant women in south-east London[5].

According to a review of 106 articles by *Olympia Evagorou, Aikaterini Arvaniti and Maria Samakouri* the cultural beliefs and customs of different peoples regarding the conditions of women in the postpartum period should be taken with due seriousness when detecting PDD, as well as when assessing the needs of women who have recently given birth to a child[8].

Fatemeh Abdollahi, Moon-San Lee, et al. point out that the signs of PDD are present in both Asian and European cultures. However, there are differences in detection rates. Researchers attribute this primarily to cultural beliefs in Asian countries[2].

Problems related to language barriers were mainly identified among immigrant women who moved from other countries. According to research, language barriers have shackled women when seeking psychological help[4, 15].

Discussion.

If we summarize all the research data, the role of the importance of prevention and timely detection of PDD is undeniable.

Training and awareness of the symptoms of PDD to all stakeholders and close relationships with practical health professionals (nursing nurse, obstetrician-gynecologist, general practitioner) reduce the risk of occurrence and complications of the course of PDD.

Earlier discussion about the problems and awareness of family members about the symptoms and levels of PDD reduces the incidence of PDD.

Ignorance about the high susceptibility to the disease, leads to a frivolous attitude to the disease.

Educating women in the prenatal period about the potential susceptibility to PDD and the long-term complications in women and children that can occur without PDD treatment is a top priority to raise awareness of the importance of seeking care.

The training should indicate the perceived benefits that will outweigh the potential barriers to recourse.

When developing preventive measures for the elimination of PDD, it is necessary to take into account not only the quality of the tools and algorithms used for detecting, but also it is necessary to take into account the interests of women in the prenatal and postnatal periods.

Conclusion

This review found that the barriers to diagnosing PDD among women are related to several factors: the individual preferences and fears of the woman and her family about the stigmatization of psychological illnesses, gaps in health care delivery, and sociocultural characteristics.

The acceptability of treatment approaches for postpartum depression and maternal preference should be the main indicators for the treatment of PDD.

Every woman needs to be provided with high quality and culturally sensitive information about the symptoms of PDD to highlight the differences between perceived normal pregnancy changes and symptoms of PDD. Similar information should also be provided to family members of the woman, and in particular to medical workers and students in medical institutions. Such resources should be available in multiple languages and culturally appropriate.

Research limitations:

Lack of research and publications on the Republic of Kazakhstan and the CIS and paid access to centralized publications describing barriers.

Conflict of interest.

The authors declare that they have no conflicts of interest.

Authors' contributions:

Abenova M.B. - literature search, idea of LR, writing an article, correspondence with the editorial office of the journal

Myssayev A.O. - scientific advice, making comments in the draft version, approval of the final version

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