Towards a Better Understanding of Postpartum Depression: The Professionals’ Perspectives

Sarah Vella 362391M
B.Psy (Hons)
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Abstract

The relationship between mother and baby has been and remains one of the most basic and important relationships throughout the ages. However, not all relationships between mother and baby or father and baby are a bed of roses. With mental health problems on the rise it is no surprise that many parents are finding themselves affected negatively by the birth of their new-born. This study aims to improve the understanding of Postpartum Depression (PPD) whilst also delving into the various associated factors, issues relating to awareness, referral, treatment modalities, and outcomes through the perceptions of professionals in the field. The consequences of, and degree of societal awareness about the illness as well as strategies to assist sufferers are also considered. The study is done through a qualitative methodology with convergent and divergent themes. Our society has become somewhat more sensitive about this condition, allowing mothers and fathers to better understand the illness whilst being aware of the symptoms and warning signs. Unfortunately, more needs to be done, at various levels, to reduce the burden of this disease particularly on those directly affected and their relatives. “I confirm that this is my own work and that all material attributed to others (whether published or unpublished) has been clearly identified and fully acknowledged and referred to the original sources. I agree that the University has the right to submit my work for originality checks.”

Keywords: PND, PPD, Mothers, Depression, Mental Health.
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Chapter 1: Introduction

1.1 Background of the Study

As a general rule, the arrival of a baby is looked forward to with a mixture of trepidation, excitement, and joy. The parents will usually have had a long period to try to come to terms with the fact that their responsibilities are going to increase and that life as they had known it will change forever. The parents’ expectations gradually build up, reaching their maximum on the day when the new arrival makes its entry into the world. What may not be readily apparent is that although the birth of a baby usually brings with it novelty, joy, and relief, the couple might not be prepared for the emotional impact that this life event will have on them as individuals or a couple or both. This emotional impact may also have a significant effect on single mothers, especially those without adequate family or social support. In Malta, a quarter of all babies are born to unmarried mothers and of these 37% are births where the father is unknown (NSO, 2011).

In a world where demands on an individual are always on the rise and people struggle to juggle their time between various responsibilities, the addition of another human being who is totally dependent on them can have a negative, possibly devastating effect on lives which are already under considerable pressures. A certain degree of stress and anxiety, both before and after a birth, is quite normal and is to be expected. These emotions may result in the baby blues which have a tendency to affect the mother, father, or both in the first few days after the birth of the baby. However, this can turn into depression which renders the mother or father incapable of continuing with their “normal” existence and one may then enter into the realm of Postnatal or Postpartum Depression. Postpartum depression (PPD) can affect the parent/s at any time during the first year after the birth. Single mothers may face the
additional strain of finances and stigmatisation which, inter alia, may contribute to an increase in the incidence of PPD in this subgroup.

Postpartum Depression is defined by the American Psychological Association (APA) as “a serious mental health problem characterized by a prolonged period of emotional disturbance, occurring at a time of major life change and increased responsibilities in the care of a new-born infant. PPD can have significant consequences for both the new mother and family.” (APA, 2013). The Diagnostics and Statistical Manual (DSM-IV), which is published by the American Psychiatric Association, outlines the diagnostic criteria for PPD. It defines the condition as a clinical depression which tends to affect mothers within six months after the birth of their child. It is a condition which disables the mother and affects her life and mental health significantly, sometimes leading to suicide or suicidal thoughts (Regus, 2012).

Although not discussed as much as it should be, there is increasing awareness of this condition. This increased recognition may help mothers and fathers to recognise the symptoms of baby blues and seek out help before the symptoms become more intense and interfere with their daily lives. The prevalence of Postpartum Depression varies, affecting 1 in 10 women who can be treated with the use of therapy, counselling and medication (Massa, 2005), whilst others quote a figure between 15 and 20% of mothers who have recently given birth (KidsMalta, n.d). The APA quotes figures between 9-16% of women who will experience PPD after birth. Also, women who have already experienced PPD after a previous pregnancy are subject to an increase in prevalence by 41% (APA, 2013).

As surprising as it may seem to some, research has shown that fathers also suffer from PPD, although most experiencing PPD go undiagnosed. In the United States over 1,000 new fathers experience depression every day, and some studies show that that number has escalated to 2,700. This means that 1 in 10 new fathers experience PPD (PostpartumMen,
2008). Even though research has shown that fathers are prone to suffering from PPD, less attention is focused on the mental state and coping strategies of these men. This depression may manifest differently to that of the mother, says Dr. Susan Nolen-Hoeksema, an expert in depression and professor of psychology at Yale University. Men are more likely to express feelings of hostility, aggression and anger, unlike their female counterparts who tend to exhibit emotions of sadness during their depression. Dr. James Paulson, a clinical child psychologist and professor of paediatrics at Eastern Virginia was quoted stating that the cause of PPD in fathers is most likely similar to those which affect the mother; sleep deprivation, isolation from social interactions and friends, and stress in the relationship between the parents (Wang, 2010).

1.2 Aims of the Study

The research question adopted for this study was: ‘Towards a Better Understanding of Postpartum Depression: The Professional’s Perspectives’. The aim of this study is to analyse the perceptions of professionals involved in the care of individuals suffering from PPD, through the use of in-depth interviews. This was done to consider the various components causing and leading to this disorder, to examine how professionals diagnose and treat women and men with PPD, which type of care or therapy is more effective in treating this condition, the ways this condition changes the lives of those who suffer from it and whether there is enough awareness about PPD in Malta.

1.3 Motivation for studying PPD

This study enabled the researcher to make use of her interest in Clinical Psychology. Despite the fact that I did not have an abundance of knowledge on the subject, I was interested in discovering how PPD is diagnosed, treated and how it affects mothers, fathers
and their families. While carrying out this research, it became apparent that many stressors in our daily lives are increasingly affecting individuals, causing anxiety, depression and other mental health issues, conditions which could all benefit from and be controlled with proper treatment. It was therefore decided that the study would focus on the awareness of the illness, and treatment given to those suffering from PPD.

1.4 Outline of the Study.

Following this introduction, I shall proceed to Chapter 2 which reviews the relevant research on PPD whilst Chapter 3 outlines the qualitative methodology adopted to collect and analyse the data. It also provides a brief description of the participants and the interview procedure. Chapter 4 highlights the main themes obtained subsequent to the analysis. Chapter 5 discusses the results in light of the literature obtained in Chapter 2, as well as outlining the study’s limitations. Finally, Chapter 6 presents the conclusions, the implications of the study as well as recommendations for future research.

1.5 Conclusion.

This chapter introduced PPD, the aim of this particular study and what motivated me to research such a topic. It also gave a brief description of how the next chapters will be divided. Chapter 2 will focus on the relevant literature available on PPD.
Chapter 2: Literature Review

2.1 Introduction

This chapter discusses PPD in relation to mental health and addresses the issues such as awareness of the illness, diagnosis, treatment and education. To conclude, I will discuss the importance of educating individuals on PPD even at earlier ages in secondary schools since awareness seems to be lacking, causing many parents to remain undiagnosed and untreated.

2.2 Definition and Diagnosis of PPD

Postpartum Depression is a disorder comprised of a mix of emotional, behavioural and physical changes which affect a woman after giving birth. The National Women’s Health Information Center (2002) divides PPD into three different categories: the baby blues (occurring soon after childbirth for a period of one to two weeks); postpartum depression (starting from soon after birth to a few months after, even continuing for as long as one year); and postpartum psychosis (the extreme form of PPD which usually occurs within three months after giving birth).

The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV TR) does not consider postpartum depression as being a separate diagnosis; instead patients who have been diagnosed with PPD are required to meet the criteria for major depressive episodes as well as for the postpartum onset specifier. These criteria state that the onset of a major depressive episode must occur within 4 weeks after the delivery of the baby. The criteria for Major Depressive Episode are listed in five sections as follows:

A. Five (or more) of the following must have been present during a period of two weeks, representing change and inability to function as the patient did before. One of the
symptoms must at least be depressed mood or a loss of pleasure or interest. (NB: Symptoms which are due to a general medical condition, hallucinations or mood-incongruent delusions are not to be included.)

i) Experiencing a depressed mood during most of the day, and almost every day, as reported by either observations made by others (eg. Appearance of tearfulness) or by subjective report (eg. Statements of feeling sadness or emptiness).

ii) A significant decrease in experiencing pleasure or interest in all, or almost all, activities during most of the day, almost every day as stated by either subjective report or the observations made by others.

iii) A significant amount of weight loss (not due to dieting) or weight gain (changes of more than 5% of the body weight in the space of a month); or a marked increase or decrease in appetite almost every day.

iv) Hypersomnia or Insomnia almost every day.

v) Psychomotor agitation or retardation almost every day (which is mostly observed by others, not just based on the subject’s feelings of apathy or restlessness).

vi) Loss of energy and feeling fatigued almost every day.

vii) Feelings or inappropriate and excessive guilt (may be delusional) and worthlessness almost every day (not just feeling guilty for being sick or self-reproach).

viii) Decreased ability to concentrate or think, or feeling indecisive, almost every day (as observed by others or by subjective account).

ix) Recurrent suicidal ideation without a plan or suicide attempt, and recurrent thought of death (not just the fear of it).

B. The symptoms do not make part of the criteria for Mixed Episode (p.365 DSM-IV)
C. The symptoms cause impairments in social and occupational areas, as well as daily functioning and cause clinically significant distress.

D. The symptoms do not occur because of the direct physiological effects of a general medical condition (e.g. Hypothyroidism) or substance (e.g. Drug or alcohol abuse, medication).

E. The symptoms are not due to bereavement, persist for more than two months or are characterised by an increase in morbid preoccupation with worthlessness, symptoms of psychosis, psychomotor retardation, functional impairment or suicidal thoughts.

The Edinburgh Postnatal Depression Scale (EPDS) is a screening tool based on a questionnaire designed by Cox et al. (1987). The questionnaire analyses the answers to ten standard questions asked at regular intervals during the postpartum period. It is a self-report tool based on analysis of emotional and functional factors rather than somatic symptoms. Replies may indicate the development of PPD and the need for further intervention and observation. Garcia-Esteve (2003) validated the use of EPDS as a means of detecting PPD in Spain. Similarly, Torelli (2012) uses EPDS as an instrument for the screening of PPD and depressive disorders among women in Hungary. The rate for seeking help and assistance for PPD are generally found to be low, but population screening may help to raise the rates of diagnosis. Milgrom (2010) proved that using EPDS as a screening tool always increased identification rates and therefore rates of treatment. Comparisons with the use and results from physical health screening programs seem favourable. Therefore appropriate training for health and medical professionals is imperative to minimize the potential dangers or harms and following up the positive screening results with a diagnostic procedure is very likely to be considered useful both in clinical and health system settings. Other screening tools include the Postpartum Depression Screening Scale and the Physician’s Health Questionnaire. As with screening
tools, there will be a degree of false positives – their usefulness is to identify individuals for clinical assessment.

Some psychologists believe that the cause of PPD is in the psychological make-up of the individual. The Cognitive Model states that if a mother suffers from a negative view of herself and the world around her then she will fall into depression due to low self-esteem and conflicts in her relationships. It explains that patients who have an abnormal attitude towards self-control may in time develop a learned helplessness which in turn leads to depression. On the other hand, there are some biological theorists who believe that the main cause of PPD may most likely be due to the hormonal changes which come into effect during pregnancy and childbirth (Massa, 2007).

Between 8 to 15% of women suffer from postpartum depression. As with any condition, certain groups are found to be more at risk: adolescents, single mothers and women with a history of depressive illness (Cunningham, Leveno, Hauth, Gilstrap, and Westrom, 2001). Being primiparous and unemployed also causes greater risk of succumbing to PPD (Felice, Saliba, Grech and Cox, 2006). They therefore recommended screening the mother-to-be for mental illness during her first prenatal examination, including her mental history or previous use of psychoactive medication. This is also necessary and extremely important in cases of sexual abuse, violence or substance abuse because these could lead to an increased risk of depression in the pregnant or postpartum woman.

The Postpartum Education for Parents (PEP) quotes Logan (1989) as stating that PPD is a real condition and disorder with social and physical causes which is not just “in her head”.

“Our society does not currently accept brain disease as it accepts physical illness. There is a stigma about depressive disorders. The illness is difficult to explain. Those closest to a depressed mother need to understand that while
psychological and environmental stress may play a role, depression is basically a physical and chemical disorder. Give support, encouragement and hope. Your assistance during this time of crisis is invaluable” (Logan, 1989).

Experts believe that a certain degree of postpartum distress can be considered normal. Each postpartum reaction, mild or severe, in most cases is treatable and temporary. Therefore in the case of women who are considered to be at a higher risk of succumbing to this distress, starting anti-depressants during or right-after pregnancy may be beneficial.

Self-help books that women and men can find in libraries or support groups suggest that if the mother feels good or well after the delivery of the baby, then the father is most likely to be at an increased risk of succumbing to postpartum depression. In their book *Great Expectations: Your All-in-One Resource for Pregnancy and Childbirth,* Jones and Jones describe male postpartum depression, they state that fathers too have to recover from the shock of their new family situation, and this overwhelming feeling of responsibility and care may lead to PPD. For mothers suffering from PPD, antidepressants are recommended, however fathers are told that the remedy for their distress is rest and time to take in the birth of the baby; the wife’s encouragement to help him create a relationship with the baby; and exploring new ways of affection towards the mother when she feels uninterested in sex (Jones & Jones, 2004).

2.3 Symptoms and Management of PPD

Kruckman and Smith (2000) state that symptoms of PPD fall into three categories: physical, behavioural and emotional; and that these symptoms vary with the severity of PPD. The physical symptoms include lack of sleep, loss of energy, changes in appetite and weight, headaches, chest pains, hyperventilation and heart palpitations to name a few. Behavioural
symptoms range from oversensitivity, crying, paranoia, irritability to panic attacks and hostility. Emotional symptoms include anxiety, sadness, confusion, suicidal ideation and thoughts, guilt feelings and helplessness. The most severe form of PPD is postpartum psychosis and symptoms include loss of memory, confusion, lack of functioning as before and a risk of possible harm to self or to the infant (Kruckman and Smith, 2000).

Management of PPD involves clinical, psychological, pharmacologic options and other options. These include antidepressant treatment, hormone therapy, interpersonal therapy (IPT), Cognitive Behaviour Therapy (CBT), psychosocial interventions such as non-directive counselling, peer and partner support, and other therapy such as electroconvulsive therapy, bright light therapy, omega-3-fatty acids, acupuncture and massage and exercise. Whilst not underestimating the value of antidepressant medication, psychological treatments are often the treatment of choice as they avoid exposure to medications. Telephone based peer support and health visitor counselling and partner support are also of benefit. (Fitelson et al, 2011). For each type of treatment, patients require frequent monitoring and observation for side effects and response to treatment; monitoring of their compliance and response to medication; and re-evaluation in the case where dosage might be increased or changed along with the treatment. In breastfeeding women, special attention is given when medication is prescribed (Massa, 2007).

In the US, every year 400,000 infants are born to depressed mothers making perinatal depression the most underdiagnosed obstetric complication in America (Earls, 2010). A new report by the National Health Services (NHS) by 4Children suggests that up to 35,000 mothers face PPD without diagnosis or treatment every year (BabyMed, 2011). The 4Children survey states in most cases of PPD, GPs prescribe antidepressants; of the women who were treated by professionals 70% were prescribed antidepressant medication and 41%
were guided into seeking talking therapies. Of the women who feel that they suffered from PPD and went undiagnosed or did not seek help; almost one-third expressed their anxiety over the circumstances which could affect them or their children. Mothers with and older child are more likely to seek professional help and guidance for PPD.

In a study on the efficacy of Interpersonal Psychotherapy (IPT) for PPD; O’Hara, Stuart, Gorman and Wezel (2000) found that IPT is in fact an effective form of treatment for PPD. This type of therapy reduced depressive symptoms, improved adjustment to social situations and was an efficacious alternative for women who were breastfeeding who could not take certain medication. Antidepressant medication, CBT and IPT have been established and validated as treatments which are effective for those suffering from PPD. In breastfeeding pregnant and postpartum women, concerns about the side-effects that may occur on the foetus due to the antidepressant medication administered have led to the exclusion of these women from treatment trials for depression.

The efficacy, however, of all these methods of treatment is difficult to determine because of the flaws in research designs, especially those involving small sample sizes and exclusive samples which fail to identify the outcomes of the intervention (Dennis, 2004).

2.4 Social considerations

Literature suggests that women are expected by society to place their life and well-being secondary to that of the child. This view of women goes as far as being expected to sacrifice their lives in cases recommended by doctors, such as foetal surgery (Casper, 1998). Regus (2012) has suggested that the greater number of women than men being diagnosed with depression is a direct result of the medicalization of a woman’s emotionality. Stoppard (2000) states that women rather than men are taught and expected by society to use
forbearance and negation as a means of coping. In the eyes of psychiatrists these strategies are seen as “passive, problem-avoidant, emotion-focused, and viewed as deficit” (Regus, 2012). It is suggested that hormonal factors are the reason behind the increased rate of depression amongst women, which is double the rate of that in men (Bilirakis, 2004). Stoppard and McMullen (2003) and Mauthner (2002) state that the way culture depicts women and stresses the image of the “good mother” puts extra pressure on women, who feel the need to abide by these proscriptions and refrain from expressing any negative thoughts or emotions about motherhood.

“Mothers themselves, anxious to live a Gerber commercial, may feel ashamed or guilty about having any negative thoughts. Antidotes for postpartum depression begin with an awareness of symptoms: excessive worry about caring for the baby; teariness; anxiety or panic; inability to sleep when the baby sleeps; difficulty doing regular tasks; inability to take pleasure in the baby” (Meltz, 2003).

This shows that depression in fact, results due to the fact that the reality of mothering and motherhood is very different from the perfect picture of motherhood painted by society (Mauthner, 2002).

The WHO (2008) states that: “Mental health problems are often undiagnosed, because many of its core features such as fatigue and poor sleep are also commonly associated with motherhood itself and/or part of the gender stereotype of what motherhood should include. These symptoms and signs are not trivial conditions. Pregnant women or mothers with mental health problems often have poor physical health and also have persistent high-risk behaviours including alcohol and substance abuse. They have increased risk of obstetric complications and preterm labour. Pregnant women or mothers with mental health problems are much more
disabled and less likely to care adequately for their own needs. These women are less likely to seek and receive antenatal or postnatal care or adhere to prescribed health regimens.’’

PPD does not just cause emotional suffering; it strains marriages, causes the mother to undermine her self-confidence, impairs her ability to function in social situations, impairs her quality of life and in very dramatic cases, contributes to infanticide, abuse of the infant and suicidal behaviour. Recent studies have also shown that PPD has an adverse and drastic effect on emotional, behavioural and the cognitive development of the new-born child. Offspring of mothers suffering from PPD are at an increased risk of succumbing to depression by the age of sixteen. This may be explained due to the vulnerability of the child during infancy and the early years, and its exposure to adversity in the family. A routine screening for PPD and support for parents suffering from PPD may in fact, reduce the chances of the development of clinical depression in their offspring during childhood and adolescence (Murray, 2011).

There is also growing awareness that shows that depression can in fact occur during the pregnancy itself, and this antenatal depression can have drastic effects on obstetric and neonatal outcomes. Antenatal depressive symptoms are also the greatest and strongest predictor for PPD (Lee, 2007). Antenatal risk factors include: problems in relationships, antenatal depression, domestic violence and limited support. Perinatal factors which are associated with PPD are: highs/lows, lack of support or no partner during the birth of the child and dissatisfaction with the care and guidance offered during labour (Willink, 2004).

Oates (2003) referring to the Confidential Enquiry into Maternal Deaths 1997 to 1999 stated that “psychiatric disorder, and suicide in particular, is the leading cause of maternal death. Suicide accounted for 28% of maternal deaths. Women also died from other complications of psychiatric disorder and a significant minority from substance misuse”. The
need for medical professionals to acknowledge the substantial risk that women with a previous psychiatric history of serious mental illness face following delivery was highlighted.

Coast (2012) reviewed a list of forty-seven articles which relate to PPD and poverty across low and middle income countries. Although the basis of the research on the relationship between poverty and PPD is limited, it has recently been expanded to help understand PPD in poor countries, taking into account neighbourhoods, communities and localities.

Wan (2009), showed that PPD was associated with lower income, difficult pregnancy experience, poor health status of the infant, lack of childbirth classes, and low involvement of the spouse before and after delivery. Among the 96% of women who practiced Zuoyuezi, a traditional Chinese custom where new mothers rest for a month at home, those for whom the caregiver was her mother-in-law or who perceived Zuoyuezi as unhelpful had twice the odds of PPD.

Buist 2007, reported on the introduction of a routine screening program across 43 health services in Australia in which over 40,000 women participated directly in this program. It was found that screening is acceptable and feasible as part of the mental-health management of perinatal women, but needed to be supplemented with information for women and education and support for staff.

In a study of 138 nurses and midwives by Skocir, 2006, on whether Slovenian Nurses and midwives were ready to take on a greater role in the care of women with postnatal depression, it was noted that participants lacked knowledge of postnatal mental health, and 99% of them expressed the need for more information. They considered the woman's partner to be the most appropriate person to detect postnatal depression, and doctors to be the key people involved in the treatment. In order to take over the role of prevention, detection and
management of postnatal depression, midwives and nurses felt that they would need more knowledge and more continuous contact with women. However, Jardri, 2010, reported that qualitative and qualitative PND screening by midwives improved significantly following training.

PPD may have sequelae beyond the family. In the workplace, especially in larger ones, Employee Assistance Programs may be available as a tool to sufferers with mental problems. In order to have a truly effective and beneficial program, a holistic approach must be adopted, addressing not only occupational health but also personal issues. It must be noted that EAP’s alone are not enough to completely eliminate withstanding mental health problems (Arthur, 2000). This highlights the importance of the way in which they are promoted to create a de-stigmatizing environment encouraging employees to make use of services before it is too late. When used appropriately and implemented correctly, EAPs can be extremely beneficial to one’s mental health creating a more positive lifestyle in general.

2.5 PPD across the globe

A review of 30 articles on male PPD showed that the scientific study of predictors of men’s symptoms of depression pre and post birth remains in its infancy. Given the implications of clinical depression in men which occur both during the gestational and postnatal periods, additional systematic examination of direct and indirect predictors of depressive symptoms in men during this time is warranted (Wee, 2011).

In a study on PPD in Chinese men, Lai (2010) found that around 3.1% met the DSM-IV criteria for depression at 8 weeks post birth. The incidence rate of postnatal depression in Chinese men was found to be comparable to that of their Western counterparts. A study in Sweden found that women who deliver their new-borns during the last quartile of the year
had a significantly higher risk for depressive symptoms during the 6 weeks and 6 months postpartum. This group would benefit from a closer support network and frequent follow-ups after delivery (Sylven, 2008).

Melo (2012), considered the situation of PPD in Brazil, noting that it was prevalent in about 10% of the women. It was closely linked with unfavourable socio-demographic conditions, which included the use of alcohol and the occurrence of violence, both physical and psychological. In a study featuring 1,109 women, it was found that the prevalence of meaningful depressive symptoms during pregnancy was 20.5% and postpartum was 16.5%. Women suffering from prenatal depression were at higher risk of developing postpartum depression. The findings suggested that the mother’s financial situation, psychiatric history, partner absence and stressful lifestyle should be considered significant risk factors for relevant symptoms of Postpartum depression (Silva et al, 2012).

Zubaran (2011), presented findings of a study involving 101 volunteers in Brazil. The study confirmed that low quality of life and socio-economic deficiencies can indeed enable the expression of depressive symptomatology during the postpartum period. The findings stress the prominence of psychosocial risk factors towards the predisposition of developing postnatal depression.

A study was created to investigate the role of “personality and parental relationships as risk factors in the course of postnatal depression in first-time mothers and fathers” (Matthey, 2000). Whilst there was some consistency for mothers and fathers in the variables of antenatal mood and partner relationship, there was also evidence that adjustment to parenthood was clearly related to different variables at different periods of time. Early postpartum adjustment was found to be related to the couple’s personality as well as their
relationship with their own parents. Later adjustment was related to the couple’s relationship and functioning (Matthey, 2000).

2.6 Conclusion

Throughout my research I discovered that there is a considerable body of work on this subject, though considerably less on the local situation. The multiple factors affecting development, diagnosis and management of this condition were instrumental in preparing the questionnaire to see the respondents’ perceptions on the various issues related to PPD which were considered interesting to survey in the Maltese setting.
Chapter 3: Methodology

3.1 Introduction

This chapter provides an overview of the procedures undertaken in carrying out the study, the reasons why the theoretical frameworks were chosen and how the data was gathered and analysed, staying true to the technique that was chosen. I will then explain how I tried to ensure that the study was accurate and ethically correct.

3.2 Qualitative Methodology

This study aims to explore qualitatively the perspectives of professionals on PPD. A qualitative method was chosen to provide the researcher with an in-depth, subjective understanding of PPD and how professionals diagnose and treat it. This research involved the collection of data through semi-structured interviews forming the basis for the analysis. (Langridge & Hagger-Johnson, 2009).

3.3 Participant Recruitment & Selection

It was important for my participants to either have experience in diagnosing and treating people suffering from PPD or working with parents and families suffering from the effects of PPD. Four participants who met the above criteria were contacted; a psychiatrist with a special interest in PPD, a psychologist, an obstetrician/gynaecologist, and a family doctor working in private practice. Unfortunately, those suffering from PPD could not be interviewed due to ethical considerations. Convenience sampling was adopted and participants were selected through word of mouth. All participants were contacted via email or telephone and voluntarily agreed to being interviewed.
3.4 Interview Procedure - Interview Guide

For the purpose of this study, 4 semi-structured interviews were carried out which lasted between 45 minutes to 60 minutes each. All interviews were carried out with the aforementioned professionals; the interview guide was tailored accordingly (see Appendix A). The questions within the interview guide are based on literature and are also queries about awareness and services provided in Malta in order to elicit the different perspectives of the participants more effectively, therefore, their role was critical to the way in which the interview guide was initially formed (Lyons et al, 2007). The respondents were asked various questions about PPD and their encounters with the illness; the first questions started out as being very broad with questions such as ‘What is the difference between baby blues and PPD?’ and got more specific as the interview progressed. The questions mainly focused on the types of services provided as well as the awareness and literature available in Malta, and on the relevance of economic and psychosocial factors.

3.5 Data Analysis - Thematic Analysis

Analysis did not begin until all the interviews were carried out and transcribed verbatim. Although various qualitative methods could have been selected for this study, thematic analysis through convergent and divergent themes was deemed best as it provides a flexible and accessible approach to analysing qualitatively. Thematic analysis is not limited to a specific theoretical framework this allows for greater freedom to identify, analyse and report patterns of data found to be relevant to the research question (Fereday & Muir-Cochrane, 2006).

After familiarizing myself with the data, I then proceeded to generate codes by extracting data from each interview which I felt would be most relevant to the study. I then proceeded to analyse the individual codes by sorting the different codes and combining them
to form potential themes.

The convergent and divergent themes were identified from my interviews. I then continued to organize and condense the information, grouping relevant themes together and making sure all themes were connected to more than one interview, which showcased patterns in the data. In the end I came up with five major themes, and a total of 10 sub-themes varying between two to three sub-themes for each major theme. A thematic network was then developed to illustrate the complexity of the study and to show how each theme is inter-related to each other.

3.6 Ethical Considerations

In order to keep in line with ethical procedures, the interview guide was approved by my tutor Dr. Sandra Scicluna Calleja. Furthermore, the names of the respondents have not been mentioned, instead they are referred to by their profession. This was done in order to safeguard their anonymity and ensure that nothing could be traced back to them. Moreover, prior to the interview, the participants were provided with an information sheet (see Appendix B) giving a detailed understanding of the study at hand, as well as a consent form (see Appendix C); this stated the purpose for the interview, that their identity will be protected, that at any stage in the interview they could decline to answer any questions at their own discretion and that the interview was going to be recorded.

3.7 Reliability and Validity

In order to maximize the validity of my research all the interviews were carried out in a location suggested by the respondent, thus ensuring that they were in a setting where they felt comfortable. The participants were also given a copy of the questionnaire during the
interview, ensuring that they understood what was being asked of them, thus producing the best possible responses.

3.8 Conclusion

In this chapter all the measures which were taken to produce a carefully planned, correct and substantial study have been highlighted; always taking into consideration the research question at hand and what I aim to bring out from this study. In the next chapter the data elicited from the interviews will be evaluated and analyzed following the analytical methodologies described above.
Chapter 4: Results

4.1 Introduction

This chapter gives an account of the overall findings of the study. These were grouped in five main themes which were then developed into ten sub-themes.

4.2. Epidemiology of PPD

4.2.1 Incidence

There was broad agreement that baby blues is common, in fact described as ‘normal’ by both the obstetrician/gynaecologist (obs/gyn) and the psychologist reflecting the large incidence quoted by the psychiatrist (50-70%). The Family Doctor (FD) and obs/gyn considered that there is a degree of transition and possibly overlap in the two conditions, but the psychiatrist feels that they are two separate conditions due to the different prognosis. In fact, the treatment for the conditions is considerably different; whereas reassurance and ensuring adequate support to mothers with baby blues usually has good outcomes especially since it usually develops and is over within the first two weeks after birth, if the condition develops into more serious PPD treatment and therapy are required.
With regards to incidence of PPD, different professionals gave different figures, doubtless based on their direct experiences. The FD thought this was around 10% with less than 1% being serious cases, the obs/gyn gave a figure of 10-15% and thought that it was getting commoner, possibly due to lack of family support, the psychiatrist quoted an incidence of 8-10%, whilst the psychologist mentioned a figure of 20%.

4.2.2 Influencing factors

There was broad agreement that low financial and social status, single parenthood and marital or relationship problems, all could have a negative effect on the mental health of the mother. Age was not considered to have any particular impact, although certain situations which may be more likely to affect teenage mothers such as difficult financial situations, insufficient support and education problems could contribute to the development or exacerbation of the condition. It was also agreed that personal factors, both with regards to character traits like anxious personalities, and personal experiences such as a difficult pregnancy or delivery history e.g difficult or prolonged labour, Caesarean Section could also contribute to the aetiology of the illness. Similarly a history of PPD in the past was also, in the views of the respondents, associated with increased likelihood of development of PPD in subsequent pregnancies.

Employment was considered to have an effect on development of PPD. The psychiatrist specified that if employment is a career decision where the mother is happy in her job, having a baby might provoke a sense of isolation as she would be expected to focus her attentions on the child. On the other hand, when employment is solely undertaken for financial gain as a means to make ends meet for the family, and she has to return whether she wants to or not to work, then this could make matters difficult. This would be worse in the
case of single unsupported mother. The psychologist echoed this view and pointed out that returning to work after maternity leave is in itself stressful as the mother is constrained to leave the child with carers, whether family or at a child care centre with worries ensuing that the child will not be taken care of as well as the mother would have. The psychologist remarked that grandparents taking care of the child usually results in less stress to the mother than leaving the child in a care centre.

4.3. Awareness

One of the main aims of this research was to find out whether there is a significant amount of awareness in Malta or not. When asked about awareness the professionals had varying answers, some believed that more awareness is needed, whereas others did not see the need for it; “there’s a lot that can increase awareness, it’s whether they’re necessary, whether we need an information programme about PPD” (FD).

4.3.1 Individual/Family Awareness

It appears from the perceptions of all the respondents, that in a substantial number of cases, sufferers of PPD are either unaware that there is something wrong with them or do not link their feelings with the birth of the child, although previous sufferers of PPD know about it and seek help (Psychiatrist). “Sometimes they’re not aware that there is something wrong
with them. It is the family who remark and who would bring them because there is something wrong. And obviously there are some who know about depression because they’ve been through a depressive illness and know about it so they come for treatment.” (Psychiatrist).

Awareness is important not only for the mother and the partner, but also for the in-laws/grandparents who may be reluctant to admit that a relative of theirs who has given birth to a healthy child can be unhappy, especially since there is a degree of stigma attached to mental health disorders which may affect recognition of the condition by the mother as well as uptake of available services.

In the psychiatrist’s own words ‘If there is more awareness you are more educated about the condition. If you’re more aware it becomes more acceptable and you don’t blame yourself for being a bad mother or you don’t blame yourself for doing something wrong and accepting the condition creates hope that once you’re aware of it you seek treatment and get better. So the sooner they approach the GP or a professional for treatment you can shorten the length of the depressive illness and that is very important postpartum because we know that the first year of development of the child has a lot of behavioural, emotional maturity in the baby. And the first year is a very important growth spurt or phase for the child and we know there is the Attachment Theory and these are very important for the development of the child. There is research showing that having no bond, no attachment with the child in the first year has an effect on the behavioural, emotional and cognitive function of the child. So having awareness can create a better approach to treatment.’

There was agreement that there is little awareness in Malta of the possibility that PPD could leave a toll on the father. This is considered to be the domain of mothers. Although the
condition exists, there are no services for fathers with PPD at MDH. The FD went on to explain that he felt that male PPD “is even rarer than in females. I think it’s such an uncommon condition, I don’t see the need for some national program in raising awareness”. The psychiatrist stated that even though there is not enough recognition about male PPD, it does in fact occur and more needs to be said about it.

The psychologist felt that even the extended family of the mother or father need to be made aware of the “needs of the sufferer”. She went on to mention that because there is in fact an increase in awareness, husbands and the extended family members do recognise the symptoms in certain cases and take the mother to see a professional for help. However she also stressed that she did not think there was “enough awareness about PPD because not all people with PPD are aware of the services that one can make use of”.

4.3.2 Awareness campaigns

All four professionals stated that an increase in education and research would prove to be beneficial for Malta since there is not enough Maltese research or literature available. “Yes, new strategies are needed, more care, more education, more community awareness as the infant is growing and preventive, such as parental skills, classes where mothers are taught how to care for the children” (Psychiatrist).

The importance of awareness was highlighted by the psychiatrist when she stated that if there is more education about PPD, mothers and future mothers and their families may become more aware about the illness and therefore it “becomes more acceptable and you don’t blame yourself for being a bad mother or you don’t blame yourself for doing something wrong and accepting the condition creates hope that once you’re aware of it and see treatment
you will get better”. She goes on to mention that having no bond or attachment with the child in the first year can have a significant impact on the behavioural, emotional and cognitive function of the child. “There needs to be more research done locally. It’s always good to do more research. If there is a local guideline or a local information leaflet to be produced, I think that would be good.” (FD).

There was general agreement that there is insufficient awareness of such conditions amongst women and their partners. Nurses and midwives mention PPD in prenatal classes, describing the symptoms and services available, including the perinatal mental health clinic, and gynaecologists and doctors see the pregnant mother on a regular basis. However, whilst agreeing that prenatal classes do help raise awareness these “can be improved upon” (Obs/Gyn). The FD however, felt that “there are so many other things such as raising children, the delivery, the first few months, the moment of development, siblings, there’s so much more that needs to be imparted in these classes” in order for treatment to be more effective. The psychologist felt that these classes are not “catered for by mental health professionals, they are done by midwives who themselves do not know enough about PPD”. The psychologist went on to mention that if mental health nurses, psychologists and psychiatrists gave talks at these classes, it would be beneficial for the mothers and treatment will be more effective.

With regards to availability of literature on the condition, there was agreement that although there were some educational materials, this was not enough. The Obs/gyn commented that these should also be in the Maltese language. The point was made by the FD that there was a lot of literature available on the internet, although it may not be locally oriented. This was echoed by the psychologist who mentioned resources available on the internet but that there is no literature or educational material available at Mater Dei hospital.
4.4 Seeking help and treatment modalities

4.4.1 Referral

Sufferers are mostly taken to professionals by relatives but sometimes mothers are aware and seek help (obs/gyn, FD). This was echoed by other respondents. Treatment should first involve counselling by psychiatrist, psychologist or social worker before drug therapy is considered (Obs/gyn). The psychiatrist referred to psychological therapy in the form of CBT or IBT as well as antidepressants, though care has to be taken to avoid drugs which interfere with breastfeeding or which sedate the mother compounding already existing problems with taking care of the baby. For severe cases there is also the possibility of ECT (Psychiatrist).

4.4.2 Treatment Modalities

The psychiatrist mentions that treatment available to these mothers includes “Cognitive Behaviour Therapy, Interpersonal therapy together with anti-depressant treatment”. Both the psychiatrist and the psychologist work at Mater Dei and are in touch with mothers suffering from PPD who are referred to hospital by their Family Doctor (FD), “I’ve had a few cases of people with PPD who needed professional attention and when I was in antenatal gynae I remember one particular case which needed attention in hospital” (FD).
“Sometimes also what happens in delivery has a big impact on the mother, the type of delivery she had. With some people that did not deliver normally, they feel guilty that they didn’t deliver normally and then develop PPD. Even the midwives’ reaction and attitude can impinge, even on the baby’s physical health” (Psychologist). The psychologist, having said this, also mentioned that she felt that there is no real understanding among midwives of what PPD really entails and how it affects the mother. “Even here at Mater Dei, they should mark it much more, the services to mothers with PPD. And also as I said before, there is no aftercare for such people when they need hospitalisation for them and the baby, there is no place where they can stay and keep their baby when they are diagnosed with PPD and need to stay in hospital” (Psychologist).

The psychiatrist noted that it was rare for a suicidal mother to have her child taken into custody as usually there is considerable family support and the child is well taken care of by in-laws. Usually when care orders are given there are other complicating factors like severe child neglect, personality problems etc. The psychologist agreed with this stating that as far as she recalls there was never a care order simply because of severe PPD but these involve other issues such as substance abuse. The psychologist highlighted her opposition to care orders in the PPD setting stating that taking a child, from a mother in that situation would make the situation worse.

The psychologist referred to the Perinatal Mental Health Clinic as a reference point for such sufferers and stated that the combination of pharmacologic treatment with therapy is usually effective. “There is the perinatal mental health clinic and some are referred to therapy. Obviously there is a lot to be improved, there should be a place where people suffering from PPD can stay at hospital and be with their child....Another thing is midwives
should be aware much more if the patient has a family history of PPD. Even after delivery they should check with the mother if the mother is attending some form of assistance regarding the pregnancy besides the gynaecological services. Also I think that there needs to be a lot of improvement on the aftercare of childbirth so there will be a follow-up to ensure that everything is all right.” (Psychologist).

4.5. Consequences of PPD on the individual and the family

4.5.1 Sufferer

All participants agreed that the persons suffering from PPD are more likely to have mental health sequelae and that the consequences on the family both during and after an eventual cure may be serious.

The obstetrician/gynaecologist and the psychiatrist agreed that a stigma surrounds PPD in Maltese society, although this is decreasing and that PPD sufferers may find it more difficult to re-enter or remain in the labour market and that there is a significant economic and social cost in Malta as a result of PPD. The FD disagreed with this whilst the psychologist stated that there is not a huge stigma anymore. With regards to remaining or re-entering in the labour market, the psychologist conceded that if the PPD sufferer requires
admission to a psychiatric hospital, this does carry a stigma whereas this is much less so if the person is treated at home, the length of stay away from work was also considered to be an influencing factor.

When asked if stigma still surrounded sufferers of PPD in Malta, the professionals’ opinions varied. Both the psychologist and the FD felt that the stigma surrounding PPD has decreased over the years. The FD also stated that “there will be a tendency, like in other mental health problems, for people to say “It’s not so bad” and they make people feel worse. However, the psychiatrist and gynaecologist believe that there is still a significant amount of stigma in Malta. “Sometimes some women do not link this depression to the birth of the child because they don’t get enough support, people will comment “You have a healthy baby, why are you feeling low?” so they feel guilty for feeling so low and they say “What can I do better?” and actually do not approach any doctors for help.” (Psychiatrist).

4.5.2 Family

The psychiatrist noted that apart from the personal suffering of the ill mother, there may also be effects on the family relationship, both on the husband/partner and on the child. The husband may be negatively affected, inter alia, by the increasing responsibility of taking care of the child and being supportive to the mother as well as the possibility that a decreased libido consequent to the PPD may give rise to suspicions of infidelity. There is also the effect on the child with regard to attachment and bonding with the mother and also the decreased maternal attention resulting in less stimuli to the child. Other children in the family unit will also suffer from this situation. The psychologist agreed with this and also referred to a negative effect on the extended family. The FD also noted that this condition may also lead to suicide or harm to the baby.
4.6. Support to sufferers

Support is a major aspect of PPD and its importance was highlighted in most of the interviews.

4.6.1 National and Professional Support

When talking about national and professional support, the psychologist mentioned how important supporting the family of the sufferer is. She also felt that the husband or partner should be allowed to have extended leave to support and care for the mother. “Even the children, if they go to school they must be supported and what they are passing through should be taken into consideration by the teachers who should be made aware” (Psychologist).

“With professional support usually GPs can provide very good support, if not, they can refer to psychiatrists. There is room for improvement and one of the improvements which could be done is setting a community team where the team consists of a social worker, a psychiatric nurse and a psychologist that can be there and available to provide this service
and if financially possible, to have a mother-baby unit at Mater Dei.” (Psychiatrist). From the interview with the FD, this view was also expressed. The FD stated that “we have competent health care professionals who are capable of helping these mothers but these can be improved.”

### 4.6.2 Family Support

From the interviews, the topic of family support was stressed by all the professionals and they all felt that family support was extremely important and lack of it could prove to be detrimental to the health of the mother or father suffering from PPD. The marital relationship was also highlighted by most of the professionals and the psychologist also referred to the health of the baby, “If the child is normal the mother is supported by the partner but if there are also problems like marital problems, and especially if the child is sick and needs more treatment of if the child has some abnormalities, these circumstances have a great toll on the relationship”. This was parallel to what the psychiatrist said also; “it can have an effect on the infant regarding attachment, the relationship and the bonding with the mother not giving enough stimuli to the child because she is depressed and obviously as well on the other children if they’re not care for or getting the attention required”.

The FD interviewed also stated that lack of family support could raise the risk of development of PPD and that a lot of family support could be protective. However he also stated that not all families provide adequate support and this view was expressed by the other professionals also, the gynaecologist stated that he did not believe that there is enough family support and that this is effecting the incidence of PPD in Malta.
“Sometimes not all families can provide that support to the mother and understanding because it’s difficult to see someone who has a baby and she’s asleep and she’s not able to do the housework and to care. How can a husband understand that the baby they’ve been waiting for, the mother has no interest in this baby? So sometimes, unless someone explains, there won’t be family support and it’s not easy when it happens” (Psychiatrist). The psychiatrist went on to explain that sometimes the husband can also suffer from depression when the wife is depressed, but most of the time “if the father is well he is very supportive” (Psychiatrist).

With regards to whether there is adequate family support and understanding of the PPD sufferer the answer was in the negative (obstetrician/gynaecologist). The psychologist felt that there is a lot of material support offered by the family, be it in the taking care of the child or carrying out household chores. However there remains a lack of understanding of the condition of PPD sufferers. The psychiatrist felt that a lack of understanding of the condition by the family may result in inadequate support. The psychiatrist noted that the need for support depends to a certain extent on the particular individual’s condition and severity – in mild cases there may be insufficient symptoms and some support may be adequate but with serious cases, it would be obvious to the family that something is wrong. The problem is with cases in between the two extremes.

The level of support varies between couples (obs/gyn). The psychiatrist noted that in a considerable proportion of mothers with PPD, the father will also be suffering from the condition, so both parents need assistance. However, in the psychiatrist’s experience, in most cases, fathers were very supportive of their wives/partners suffering from PPD.

It was felt that there are competent professionals in the field who can assist sufferers but that this can always be improved (obs/gyn). The FD said that there is adequate support in
the private health setting with referrals to health professionals as required. The psychiatrist felt that there was good support for FD but if a FD cannot provide adequate support, there is the possibility of referral to psychiatrists. However the psychiatrist felt that a community team, composed of a nurse, psychologist and social worker should be available to assist sufferers directly in the community. It was also opined that a day Family or Mother and Child Unit should be set up to allow the child to be taken care of whilst the mother undergoes treatment. This was echoed by the psychologist. “There should be a mother-child unit here, where the mother is observed constantly, helped with the caring of the child” (Psychologist).

The psychiatrist felt that the fact that FDs are aware of this condition and that there are some good medications available for treatment and usually know the family’s situation helps a lot. There is also an increased awareness amongst midwives and obstetricians to consider the emotional aspect of the patient as well as the purely physical. New strategies are needed, and as she put it ‘more care, more education, more community awareness as the infant is growing and preventive measures, such as parental skills, classes where mothers are taught how to care for the children, these are all preventive means for the mother to take care of the children.’ The psychologist also agreed that more needs to be done, both as regards assisting the partner of the PPD sufferer, possibly through extended leave, or some form of financial benefits if they are off work for long periods, as well as the child or other children. In this regard, if children are attending school their teachers should be made aware of the family situation to understand what the child may be passing through. The extended family also need to be kept up to speed with developments. It was also suggested that information about this condition is given at school by nurses/midwives familiar with this illness.
4.6.3 Financial Support

Support is also to be considered in terms of finances; this aspect came through in all the interviews. “We definitely know that people with low socioeconomic status, low social status and single parents are at a higher risk of developing PPD.” (Psychologist). The psychologist went on to say that the economic and social costs of PPD in Malta could be considered to be huge. “Imagine if each person had to take 6 months sick leave from the labour market, it would cost a lot” (Psychologist). In order to minimize the cost, the psychologist suggested that a national protocol should be created for PPD so that people would be treated earlier, thus decreasing the length of the illness as also stated by the psychiatrist “the earlier that professional help is sought, the less suffering because we can start treatment immediately”.

“What I find in my practice is that mothers who have a career and always have been in employment and always had job satisfaction that could have an effect on the way the mother feels after giving birth. If employment status is for financial gain and the mother has to go out to work because they have loans and it depends on her income to maintain the family then yes, this could affect how the mother feels, it could be a cause of depression.” (Psychiatrist). This highlights the fact that being in a secure financial situation could be protective for both fathers and mothers.

4.6 Conclusion

This chapter attempted to describe the themes that were found in the participants' responses through networks of sub-themes around three global themes. The next chapter will discuss these results in comparison with the literature previously reviewed.
Chapter 5: Discussion

5.1 Introduction.

This chapter discusses the results obtained in light of the relevant literature presented in Chapter 2. The discussion will therefore focus on the main themes which emerged during the participants’ interviews, as well as highlight the limitations of the study.

PPD is a relatively common illness with multiple contributory causes which may have a substantial impact not only on the mother, but also on the whole family. Last year, there were 4,231 births in Malta (NSO 2013). Based on the incidence as reported by the respondents which mirror those in various international studies, a reasonable estimate of the numbers of mothers suffering from baby blues would be of between 2100 and 2900 (50-70%) whilst those suffering from PPD would be around 400 (10%). There is also the likelihood of an equal number of males suffering PPD, which in most cases probably go unreported. Based on these admittedly rough estimates, there are about 800 persons suffering from various degrees of PPD in Malta every year. This is not an inconsiderable figure. Of more concern is that if the situation in Malta mirrors that in other countries, a considerable proportion remains undiagnosed and unassisted.

The NHS states that about 35,000 mothers face PPD without treatment or diagnosis every year. This suggests that there is a significant lack of awareness in the United Kingdom. The professionals felt that there is also not enough awareness in Malta. Whilst there is no doubt that there is a pressing need to raise awareness levels, the most cost-effective methods need to be kept in mind due to the considerable constraints on financial resources in these cash-strapped times. Such a national campaign to improve awareness could contain all or a number of the following:
5.2 Media and Education

It is better to adopt a strategy that imparts information about this condition from an early age. Including modules about PPD in Secondary School Personal and Social Development (PSD) classes would be an effective and beneficial method of educating younger generations about PPD. This could prove to be beneficial as part of their sex education, especially if younger people are engaging in unprotected sex leading to teenage pregnancies.

The production and inclusion of educational spots on television or radio programmes about PPD and the use of billboards or articles focusing on this issue in the media to highlight the existence of PPD and to provide information on seeking help could be very beneficial on a national level. An important component would be to introduce the idea that this illness is not the exclusive domain of mothers but can also affect fathers. Such a campaign would also help address the issue of stigma associated with mental disease which has decreased somewhat over the past decade but which still exists, including with regards to PPD. However, even though professionals are recognising that men may also suffer from PPD, research concerning men’s symptoms of depression during and after the birth of their child is still uncommon as stated by Wee (2011) in the literature review. “I don’t think that there is sufficient recognition in Malta because we talk about post natal depression with mother...and also we don’t hear about it much even if there are talks about depression and PPD, we focus mainly on the mother. Fathers do suffer from it, there has to be more said about it and recognised” (Psychiatrist). Therefore education about PPD is also an important aspect which needs to be recognised and worked on. Failure to mention this side of PPD can only result in more undiagnosed cases of PPD in men.
5.3 Information

“If there is a local guideline or a local information leaflet to be produced, I think that’s a good idea” (FD); producing a leaflet or booklet about PPD which would then be distributed in schools, places of work and clinics in Malta could increase awareness of the condition.

Another area where information on this condition may be highlighted more is during antenatal classes which could serve to provide educational material and information regarding self-referral. Equally important is to encourage would-be mothers to discuss such issues with their partners who may not be inclined to attend antenatal classes.

5.4 Increasing awareness amongst carers

Equally important to awareness campaigns is to ensure that caring professionals, especially those coming into direct content with this subgroup, are routinely updated on developments in this field to be able to recognise the early signs of the condition and provide the necessary support or treatment as necessary. This could be done through relevant professional societies. It is important to stress the need for consideration of the client’s mental health, as well as any other relevant issues, by the caring professional as part of the clinical evaluation if the needs of the pregnant mother are to be considered holistically. Advantage should also be taken of the possible presence of the father attending antenatal visits with the expectant mother to consider his mental health.

Apart from nurses and midwives, both in the secondary as well as the primary health sector and obstetricians and family doctors who all have a role to play in following up a mother who has given birth, paediatricians should also play a role as apart from looking after
the infant, they will be in a very good position to check on the parents’ mental health during the first year and may then refer any cases of minor/major depression encountered.

5.5 Intervention

Early intervention and specialist referral of symptomatic patients/partners as necessary, together with closer follow up of those at higher risk would facilitate improved outcomes. The importance of early intervention cannot be overstressed.

The use of routine antenatal screening tools to identify higher risk subjects through e.g. the Edinburgh Postnatal Depression scale should be considered during both antenatal and postnatal periods. In itself, this will heighten the awareness of the pregnant mother about this condition.

The suggestion that a small dedicated community team is available to monitor and support cases of PPD merits a lot of attention. This could help in decreasing the progression of disease if intervention occurs at earlier stages as well as facilitating recovery and keeping a close watch on clients whose PPD has warranted institutionalisation. It could also liaise with the education authorities in cases where there are other children in the family who may be negatively affected by the mother’s condition. The support that such professionals may provide to these clients, in conjunction with other treatment modalities, should prove very useful and a pilot project should be considered to evaluate effectiveness and sustainability.
5.6 Services

A dedicated Mother and Child unit involving a multidisciplinary team to take care of severe cases of mothers with PPD in an institutional setting which allows them to remain in contact with their child and family apart from the service provided by the Psychiatric Unit at Mater Dei or at the facilities within Mount Carmel Hospital has been recommended by the psychiatrist and psychologist. This would address the special needs of these clients.

AA style classes for mothers or fathers who are going through or went through PPD would also be useful since they will be in an environment surrounded by people who have been through or are going through the same condition and who can understand and relate to them. It will also be therapeutic and act as part of aftercare. Opening a family unit at Mater Dei as mentioned by both the psychiatrist and the psychologist should also be looked into as it provides an environment which caters for the immediate needs of the mother and her baby and possibly also the family.

5.7 Other measures

Other supportive measures which warrant further study are whether the statutory paternity leave which ranges from 2 -3 days in various industrial sectors should be extended to a more reasonable period, given the upheaval brought about by the new-born child. The presence of the father in the first week of birth would help to assist the mother to adapt to the new reality. Obviously this measure would come at a cost. Another measure which may be considered is an extension of the statutory parental leave from the current maximum of 4 months to each parent. Given that this is unpaid leave, it is doubtful whether there would be any increased uptake and the effectiveness of such a measure in assisting the family is doubtful.
A measure which is also aimed at facilitating work-life balance is the statutory right of a pregnant woman or mother to choose to refuse to work overtime during pregnancy and for a year after birth. Consideration could be given to extending the right to refuse overtime for a year after birth of the child to the father. Apart from providing for equal treatment, this could have an impact both on the father’s ability to support his partner as well as help reduce a factor which might help in development of male PPD.

5.8 Limitations of the study.

The findings of this study reflect the experiences and perceptions of four participants and it must be noted that these are perceptions and hence subjective and may not reflect either the reality on the ground or that of the professions they come from. However care was taken to ensure that the individuals who were asked to participate were ideally placed through their direct involvement in management of persons with these conditions to give as valid a contribution as possible. Again any observations on the services provided for PPD sufferers in Malta are also subject to bias.

5.9 Conclusion.

In this chapter, the main issues found in the results were discussed in light of the relevant literature presented in Chapter 2, as well as outlining the limitations of the study. The next concluding chapter will present the implications of the study as well as the recommendations for future research.
Chapter 6: Conclusion

6.1 Introduction

This chapter concludes the study by bringing together the knowledge gained from reviewing the relevant literature and conducting research. It also includes a list of recommendations for future research.

6.2 Implications of this Study

Due to the lack of PPD research in Malta, the interviews provided the researcher with more sufficient results related to the local context. By interviewing four professionals each with different professional backgrounds and knowledge, I was able to elicit separate perspectives, subsequently resulting in more of a holistic approach.

The main outcomes of this study have been to illustrate the need for more awareness and for different services to be created for mother or fathers who suffer from PPD. It also highlights that with adequate support and treatment, both families and sufferers have better chances of overcoming the illness and its effects.

6.3. Recommendations for Future Research

all of the participants felt that there is not enough research and literature concerning PPD in Malta. If, to a certain extent, maternal PPD has been studied, there is no doubt that more research is required both on PPD in the local setting as well as on the quantum of male sufferers of PPD and how they are coping with this burden. This would serve to increase awareness and referral for this condition.
Additionally a study on the financial impact of PPD to the economy would help justify any financial outlay which would be necessary to implement new and broader initiatives to mitigate the effects of PPD on the individual and the family.

6.4. Conclusion

After delving into literature and the results of the interviews, the researcher now has a better understanding of PPD, especially the way it affects people in Maltese society. This study has been an eye opener on how PPD affects mother and their families. It has also helped to provide various suggestions for improvement in the services present in Malta.
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Appendix A: Interview Guide for Professionals

1. Do you feel there is a difference in the presentation, treatment and sequelae between baby blues and Postpartum Depression [PPD]? Are they two separate conditions or can one consider one as a milder form of the other? When do they usually develop?

2. What is the incidence of PPD in Malta? Do you think this has changed over the past decade? If yes, is there a trend and is there a particular reason for this?

3. Do you think that there is an association between financial, social or marital status and PPD?

4. Do you think that there is a particular age group which is more vulnerable?

5. Do you think that employment status has an effect on the incidence of PPD?

6. Is it more common in primagravida or in multigravida?

7. Do you think that there are personal or other factors which raise the risk of development of PPD? Are there any factors which protect against the development of PPD in men and mothers?

8. Is there sufficient awareness of such conditions amongst women and their partners? What factors have an impact on levels of awareness?

9. Do you think that pre-natal classes help raise awareness about PPD? How effective do you think these classes are in this respect? Are there any other strategies both on a personal as well as on a national level which could increase awareness about this condition?
10. Do you feel that there is sufficient literature / educational material available for parents to be made aware of the symptoms and warning signs of PPD?

11. Do you think that sufferers themselves are usually aware that this is a specific condition related to childbirth or do they feel that they are suffering from depression not linked to the birth of the child?

12. Do you feel that in most cases there is adequate family support and understanding of the condition of the PPD sufferer? If yes, do you think that this is usually enough to address the condition or should sufferers seek professional help at the earliest symptoms?

13. Do sufferers of PPD usually self-refer, or are they taken to professionals in the field by concerned relatives?

14. What modalities of treatment are available? Which treatment or combination do you consider more effective in most cases?

15. Is the spouse/partner/family of the sufferer usually supportive or do they themselves also need assistance and if yes, how are they assisted in these cases?

16. Is the spouse/partner/family of the sufferer usually supportive or do they themselves also need assistance and if yes, how are they assisted in these cases?

17. Do you think that if the father is the sufferer, there is sufficient recognition in Malta that males can also be suffering from PPD or is this illness considered to be solely a domain of the mother? (both by the caring professions and by society in general)

18. In the case of suicidal parents, do you think that they understand and appreciate the reasons behind removing their baby from their custody? Is this primarily done
19. If a parent has suffered from PPD, is there an increased risk that the condition will recur if another child is born?

20. Do you feel that a person suffering from PPD is more likely to have mental health sequelae as a result of the condition?

21. How serious can the consequences of having a person suffering from PPD be on the family both during the illness and after its eventual cure?

22. Do you think that there is a stigma in Maltese society surrounding sufferers of PPD?

23. What do you think are the main strategies which may be or are already in place which are most effective in helping the PPD sufferer and his/her family? Are new strategies needed?

24. Do you think that sufferers of PPD find it more difficult to re-enter and stay in the labour market after an episode of PPD? If yes, is this because of how the disease affects the sufferer or because of other factors external to the sufferer, such as negative perceptions relating to mental illness?

25. Do you feel that there are significant economic and social costs in Malta as a result of PPD?
Appendix B: Information Sheet

Dear Participant,

I am a student at the University of Malta, currently reading for an undergraduate degree in Psychology. In part-fulfilment of my course, I am undertaking a dissertation concerning Postpartum Depression (PPD), under the supervision of Dr. Sandra Scicluna Calleja. The aim of this study is to evaluate whether specialists in the field consider that there is sufficient awareness in Maltese society about the prevalence, risk factors, symptomatology, modalities of treatment and consequences to sufferers of PPD, as well as whether the current infrastructure to deal with this illness are adequate.

The data that is needed for this study is being collected through semi-structured interviews. The interviews will last approximately 45 minutes to 1 hour. All information obtained will be analysed using thematic analysis. After all the information is analysed, the voice recordings will be destroyed.

Please note that participation in this study is entirely voluntary and you are free to decline from participating. Should you agree to participate in this study, please be aware that all information that is collected will be held as strictly confidential and your identity will not be disclosed. Moreover, you have the right to decline questions you would not like to answer, as well as to withdraw from the study at any time without the need to provide a reason for your withdrawal.

I would like to take the opportunity to thank you for your time. If you kindly agree to participate in this research project, please sign the consent form attached. Should you have any queries, please do not hesitate to contact me at sarah.k.vella@gmail.com and I will be very happy to answer any questions that you may have.
Yours truly,

Sarah Vella
Appendix C: Consent Form

I, the undersigned, am willing to participate in Sarah Vella’s research project entitled ‘Towards a Better Understanding of Postpartum Depression: The Professionals’ Perspectives’. I am aware that the interview will be recorded and that any relevant information shall be used solely for academic reasons. I understand that no personal information shall be disclosed and that all recorded material shall be destroyed after completion of the project. I understand that I am allowed to withdraw from the project at any time and without having to provide a reason. I have been briefed about the nature and aim of the study, and have had the opportunity to ask further questions and seek clarifications. I am satisfied by these conditions and consent to participation in this study.

__________________
Participant’s Signature

Name:
Date:
**Psychologist Transcript**

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<thead>
<tr>
<th>Interview Transcript</th>
<th>Line by line coding</th>
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<tbody>
<tr>
<td>1 INT: Do you feel there is a difference in the presentation, treatment and sequelae between baby blues and Postpartum Depression [PPD]? Are they two separate conditions or can one consider one as a milder form of the other? When do they usually develop?</td>
<td>Baby blues= normal reaction</td>
<td>Baby blues= normal reaction</td>
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<td>Result of changes in hormones</td>
<td>Result of changes in hormones</td>
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<td>9 RES: Baby blues is a normal reaction, usually it happens on the 3rd-4th day after delivery. It is the result of changes in hormones when there will be an increase in progesterone because of the breastfeeding and the increase in oestrogen. So that switch produces side-effects which are usually the baby blues. With PPD the presentation can be longer, usually it</td>
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<td>Presentation of PPD = longer</td>
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Psychiatrist Transcript

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<tr>
<td>1 INT: Do you feel there is a difference in the presentation, treatment and sequelae between baby blues and Postpartum Depression [PPD]? Are they two separate conditions or can one consider one as a milder form of the other? When do they usually develop?</td>
<td>Baby blues = very common</td>
<td>Diagnosis of Baby blues</td>
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<td>9 RES: Yes there is a difference. Baby blues are very common it occurs in 50-70% of women it is a very short episode which usually lasts between 3 to 10 days. It starts on the 3rd day and usually lasts for 10 days. It presents with inability, mother doesn’t think she’s confident enough, these insecurities, but usually within 10 days they pass. And the only thing that you can do as treatment is support the mother</td>
<td>Mother is unconfident</td>
<td>Treatment</td>
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### Family Doctor Transcript

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<tr>
<td>1 INT: Do you feel there is a</td>
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<td>Diagnosis of Baby blues vs. PPD</td>
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<td>2 difference in the presentation,</td>
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<td>3 treatment and sequelae between baby</td>
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<td>4 blues and Postpartum Depression</td>
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<td>5 [PPD]? Are they two separate conditions or can one consider one as a milder form of the other? When do they usually develop?</td>
<td>Baby blues= sadness, disillusioned</td>
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<td>8 RES: Yes and no, I mean there’s a grey area, baby blues can simply be a person feels sad or disillusioned after delivery, PPD goes all the way to more severe cases, complete detachment from the baby etc. So I do think there’s a difference. There’s a spectrum but there’s a lot of overlap.</td>
<td>PPD= more severe</td>
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**Interview Transcript**

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<td><strong>INT:</strong></td>
<td>Do you feel there is a difference in the presentation, treatment and sequelae between baby blues and Postpartum Depression (PPD)? Are they two separate conditions or can one consider one as a milder form of the other? When do they usually develop?</td>
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<td><strong>RES:</strong></td>
<td>I believe that baby blues can be considered as “normal” after delivery but if they last longer than about 2 weeks then the possibility that PPD is present should be considered.</td>
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<td>Baby blues= normal</td>
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<td>If longer than 2 weeks= possibility of PPD</td>
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<td>Difference between severity of baby blues vs. PPD</td>
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