Interfering Barriers to Postpartum Depression Screening among women in Saudi Arabia: A Phenomenological Study

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Abstract

Background: During the postpartum period women are at critical risk for postpartum depression. However, with the continuous development of maternal health services this maternal mental health issue remains underdiagnosed.

Aim: This study aimed to explore the barriers interfering with postpartum depression screening among postpartum women in the context of Saudi Arabia.
Method: An interpretive phenomenological qualitative approach was conducted in a tertiary hospital in Saudi Arabia. A convenience sample of 10 nurses who work in postpartum units were interviewed face-to-face. Semi-structured interviews were employed, recorded and transcribed.

Findings: Two main themes and sub-themes were derived from the data analysis of the interviews: personal barriers and fragmented care.

Conclusion: The findings may aid in improving maternity health services in Saudi Arabia by establishing a postpartum depression screening programme and enhancing awareness among postpartum women so they can maintain their mental health.

Keywords: Postpartum, depression, barriers, women, nurse

Introduction

The postpartum period is associated with mental health problems, such as postpartum depression (PPD); it was reported that depression can occur anywhere between a few days and a few weeks after childbirth (Rai et al., 2015). According to Rezaie-Keikhaie et al. (2020), the prevalence of what is known as the baby blues ranges from 13.7% to 76.0%.

Unfortunately, the mental health of postpartum women has traditionally been neglected in women and child healthcare programmes, particularly in low- and middle-income nations (Atif et al., 2015). Consequently, the World Health Organization (2019) launched a unique initiative concerning mental health (to run from 2019–2023) as an aspect of universal health coverage, with the aim of achieving the highest standards of mental health and well-being. Moreover, PPD remains underdiagnosed because women may not show any signs of depression or they may fail to initiate a discussion about their mood with their healthcare providers (Falana et al., 2019).

Maternity research in the Middle East has tended to focus on maternal and perinatal mortality and morbidity as well as prevalent birthing techniques, which is in line with the medicalisation of birth and the desire to enhance the quality of maternity services in these countries (Jahlan et al., 2016). Relatedly, a number of studies conducted in Saudi Arabia have reported the prevalence of PPD, its risk factors and its predictors (Al asoom & Koura, 2014; Al marzouki et al., 2014; Al Nasser et al., 2020; Al sayed et al., 2021).

In terms of maternal health in Saudi Arabia, the services typically provided to women include premarital screening, which aims to identify any hereditary or infectious diseases; periodic maternal screening for breast cancer; and the creation of a mother and child passport system, which is used as a record of the woman's health status and her child's health status (Ministry of Health, 2021).

Maternity care is also provided in Saudi Arabia. Women with straightforward pregnancies are offered at least eight consultations starting in their first trimester, although low attendance of these consultations represents a serious problem (Alanazy & Brown, 2016). Moreover, initiatives designed to promote breastfeeding have been introduced, including mother–child passports and baby-friendly hospitals (Ministry of Health, 2021). Other initiatives have been introduced in an attempt to improve the health of mothers and children by tracking the mother's health throughout pregnancy and the child's health until the age of five (Ministry of Health, 2019). However, the effectiveness of these initiatives still needs to be evaluated (Raheel & Tharkar, 2018).

While the continuous improvement in the healthcare services provided to women during their perinatal period has been a priority, the clinical pathway for addressing maternal mental health problems, including PPD, remains unclear (Saleh et al., 2020). There is a lack of studies about the challenges that interfere with screening for postpartum depression among women in Saudi Arabia in order to provide maternal mental healthcare. Thus, the present study aimed to explore postpartum nurses' perceptions about the barriers to screening for depression among postpartum women in the context of Saudi Arabia.

Theoretical considerations

Kristen Swanson (1991) developed the theory of caring, which has subsequently been validated for utilisation in research, education and clinical practice. The theory of caring involves five steps: knowing, being with, acting for, enabling and maintaining belief. When used in nursing practice, each of these five steps enhances the caregiver's attitude and promotes the patient's total well-being (Lillykutty et al., 2018). Nurses who work in the maternity field come into direct contact with women during the pregnancy, labour and postpartum periods; thus, they can assess, educate and provide suitable interventions for women who are at risk of, or have, developed mental health problems, such as PPD (Segre et al., 2010). If PPD is identified, nurses must conduct an immediate assessment to detect any risk for the mother and/or baby and provide appropriate management (Mughal et al., 2021). Furthermore, nurses should look to facilitate and encourage the involvement of peer support, partners and families in the provision of care for depressed postpartum women (Bolton, 2005; Lowdermilk et al., 2016).

Methodology

Research Design

This study is an interpretive phenomenological qualitative inquiry. Interpretive phenomenology is dedicated to understanding and uncovering the experiences of individuals in constant relation with others (Frechette et al., 2020). In the study discussed in this paper, we attempted to understand the factors that inhibit nurses from screening for postpartum depression based on the interpretation of their experience in caring for postpartum women (Neubauer et al., 2019).

Participants

In interpretative phenomenology, an average of 10 phenomenon-rich participants is appropriate (Frechette et al., 2020). A convenience sample of 10 nurses who worked in the postpartum department in a tertiary maternal hospital participated in this study. All the participants were female. Their ages ranged from 27 to 52 years; their professional experience ranged from 3 to 19 years. To develop a thorough understanding of the phenomenon of interest, a study must be credible, which requires interviewing a sufficient number of people to gain a good understanding of the subject (Ellis, 2016). Unlike a statistical study, phenomenological studies strive to illuminate the lived experience in depth, as much as possible, rather than generalising it.

Data Collection
An interview protocol enables the interviewer to take notes on the interviewees' responses. Additionally, it assists researchers in organising their thoughts on the topics, such as headings, how to begin the interview, concluding ideas, how to conclude the interview and thanking the interviewees (Cresswell & Poth, 2016). In this study, Bevan's (2014) phenomenological interview structure was applied. The interview structure provides researchers with an explicit approach because it enables the use of phenomenology as a comprehensive method of research that contributes to the clarity of the overall study (Bevan, 2014). The data required for this study were collected through individual face-to-face interviews that were conducted over the course of two days. Six participants were interviewed on the first day and four were interviewed on the second day. The durations of the interviews ranged from 30 to 45 minutes. Data saturation was recognised by the absence of the emergence of new data, thus indicating suitability of the termination of the session.

Data tabulation and analysis
The interviews were recorded, transcribed and stored until they were analysed. Colaizzi's (1978) data analysis method was used as a straightforward and logical procedure for delving into the meanings of the nurses' experience (Wirihana et al., 2018). Additionally, the findings were sent to the participants via a link for the purpose of validation (Polit & Beck, 2017).

Rigor
Credibility was attained by intensive listening during the interviews. Careful probing to obtain rich and comprehensive data, audio-recording the interviews for the purpose of transcription and monitoring the transcription accuracy are all strategies for enhancing the quality of data (Polit & Beck, 2017). Moreover, dependability was ensured by introducing the data to the participants after the analysis to determine the truthfulness of the results. Confirmability was demonstrated by an audit trail through the digital recording, and field notes assisted with confirmability. Transferability was presented by detailed information to allow for judgements concerning the setting, the participants and their experience.

Ethical issues
The participants were informed about the study, asked to participate on a voluntary basis and were reminded of their right to withdraw from the study at any time. Prior to the interview, the interviewer informed the participants that their participation was voluntary, anonymous and would not affect their employment status. This study was approved by the review board of King Saud University with log No.KSU-HE-21-617.

Results

Two main themes were derived from the data analysis of the interviews: personal barriers and fragmented care. Communication barriers, cultural issues, lack of education and stigma were sub-themes for the personal barriers theme. Missed care, resources and workload were sub-themes for the fragmented care theme.

Theme 1: Personal Barriers
Sub-theme 1: Communication Barriers.
Participants highlighted language barriers as a major difficulty within the hospital due to the resultant limitations on their ability to express what they want to say to postpartum women in Arabic. As one participant noted: *"Here, the barrier is the language and understanding of the postpartum women."*

The participants also explained that most nurses who work at the hospital are expatriates who are prevented from understanding postpartum women due to language: *Language is an issue because most of the staff are Indian and Filipino, so that is the thing, the postpartum woman can't express their feelings and the staff can't express how they will educate them and extract those emotions of the women in order to understand postpartum women.*

The nurses also reflected on how communication barriers negatively affect postpartum women's care because they cannot verbalise their feelings, which limits the nurses' ability to understand what the women are going through after delivery and provide the care they need. Here, the nurses stated they were unsure about how to ask postpartum women to express their feelings. One of the participants said: *"First for most is the language barrier, because I am not an expert in Arabic, and if a postpartum woman can't express herself, I can't help."*

Sub-theme 2: Cultural Issues.
Cultural differences can result in miscommunication between nurses and postpartum women, which can negatively impact care. For instance, the participants mentioned that when attempting to educate postpartum women to do something, some will refuse because the relevant practice is not allowed in their culture. For example, one of the participants said: "*When we ask postpartum women to do something, they will say it is prohibited, like that."*

The nurses also believed that, due to cultural differences, they feared breaching the postpartum women's privacy by asking them about their mental health status, as mental health issues are not discussed in several cultures. One participant said: *"We have some reservations or hesitations if we feel like we're invading their privacy or culture. Although it is confidential between you and the patient, I hesitate in asking."*

Sub-theme 3: Lack of Education.
The nurses reported that health education programmes are provided to postpartum women to enable them to care for themselves and their newborn. However, such maternal education tends to focus on the women's physical needs, such as exercise, diet and breastfeeding. They felt that postpartum women also need to be educated about PPD so that they can recognise the signs of depression and seek help when required. According to one participant: *"Other barriers would be education. They need to educate the postpartum women; they should have something to educate them."*

The nurses clarified that PPD is not covered in the education provided to postpartum women. As one of the nurses noted, they typically refer these issues to other healthcare providers, such as social workers: *"Education about postpartum depression not covered, but if she needs support, we will make referrals."*

Sub-theme 4: Stigma.
In this context, stigma refers to a negative attitude toward persons with mental health problems. The nurses explained that cultural stigmatisation prevents some postpartum women from reporting their depression and seeking proper treatment. Indeed, the participants stated that postpartum women often fear reporting what they feel because doing so is prohibited in their culture. One of the participants said: "*Postpartum women are afraid to verbalise what they think is a taboo, especially for their cultures."*

The nurses reflected on the fact that depression might occur after a woman is discharged from the hospital, and she might not have someone to trust to whom she can report her depression. As one of the participants noted: *"Sometimes postpartum depression occurs late, and they don't like to tell it to somebody unless trusted."*

The nurses suggested that because postpartum women with depression often feel guilty, awareness is needed to overcome this misconception. One participant said: "Some feel guilty because '*I am like this, so they feel bad about it. That is the main thing I felt personally."*

Theme 2: Fragmented Care
Sub-theme 1: Missed Care.
The nurses sadly acknowledged that care is sometimes omitted, delayed or not completed. In particular, they reflected on how and why PPD is not detected or managed. After delivery, a woman who delivered normally or via Caesarean section spends a short amount of time in hospital, and depression may not occur within that time. Once postpartum women are discharged home, they may start to experience depression without being aware of the condition. The nurses highlighted the possibility of depression not manifesting until a postpartum woman returns home. One participant said: "*Actually, postpartum depression may happen at their home; in 24 hours, we can't identify postpartum depression."* Another participant added: "Here, postnatal cases we can assess for 24 hours and caesarean cases we have only 72 hours, maybe after that *it will happen. Within one week, maybe after two to three days, postpartum depression can develop suddenly."*

The nurses noted that data should be collected during admission to help identify the risk of depression, although this is not always done, suggesting that more effort should be dedicated to detecting PPD. A participant said:

On admission, we have to collect data from postpartum women so we can find out [about PPD], but this is not always done. Sometimes it is missed, so we have to inform nurses to do more about screening postpartum women's mental status, especially in terms of postpartum depression.

The nurses suggested that mental health assessments are not always performed for postpartum women because mental health is not a focus of the maternity services provided to postpartum women. Another participant said: *"In our maternity hospital, we don't do this assessment to determine who will develop this depression. It is not the focus; it is not routinely done."*

The nurses revealed that the priority with maternity care services is to ensure a healthy mother and baby, although maternity mental well-being is not part of the provided care services from the beginning. Another participant said: "*The active problem for us is to help them give birth and deliver a healthy baby. Postpartum woman's depression is not part of our admission assessment."*

The nurses added that the main focus of maternity services is conducting maternal programmes, such as breastfeeding promotion, and there is no available program for PPD. According to one participant: *"We are focusing more on breastfeeding, but for postpartum depression, I am not aware if there is a programme."*

Sub-theme 2: Resource Barriers.
The participants elucidated their perceptions of how resources within maternity health services impact the care for postpartum women. Here, most of the nurses mentioned that there are no specific assessment guidelines for PPD. They suggested that increasing the availability of screening tools for PPD would help nurses promptly identify postpartum women who are at risk of depression and refer them to a social worker. One of the participants said: *"If there were depression screening papers, we could easily do the referral to a social worker."*

The nurses indicated that postpartum women are not usually assessed for PPD because there are no screening tools available for depression in maternity health services. Another participant said: *"We don't have a screening tool, and it is not routinely done. I think this is the only thing we need."*

The nurses stated that if they knew a postpartum woman to have depression, they inquired about how to confirm a diagnosis of PPD. They mentioned that the signs of depression were generally confirmed without the use of

assessment tools, such as those used for pressure injury and fall risk assessment. One of the participants said: "*How will I know if she has signs of depression when we don't have assessment and screening tools in this hospital? This screening focuses more on pressure injury and fall risk assessment than on postpartum depression."*

Moreover, the nurses noted that they depend on the postpartum women's history to determine if they are at risk of PPD. One participant said: *"There is no tool for assessing postpartum depression, but we take a history."*

The availability of policies and procedures to guide nurses in how to handle a postpartum woman with depression was identified as another issue. The nurses linked their role in detecting and managing PPD to the availability of policies and clinical pathways to guide them in doing so. They mentioned that policies could guide them in caring for postpartum women. One participant said: *"If there is a policy for depressed postpartum women, it would be easy for us to follow it."*

Unfortunately, PPD is not covered in any of the hospital's current policies. Moreover, the participants noted that clinical pathways explaining the process of detection and recommending intervention measures are not available. According to one of the participants: "*We don't have a clinical pathway when it comes to postpartum depression. We are not detecting it. This is a big issue or problem because there is no clinical pathway for PPD."*

Sub-theme 3: Workload.

Most of the nurses mentioned that caring for postpartum women takes a lot of time and effort. However, the pressure associated with a heavy workload may affect nurses' concentration during the provision of care. A heavy workload may also result in delays in assisting postpartum women. The signs of depression could be missed or ignored due to workload issues, as nurses are typically assigned to more than four postpartum women and their newborn.

The participants explained that postpartum women have to be assisted in attending to their daily needs, for example, ambulation following a Caesarean section. According to one participant:

Sometimes we are handling more than four postpartum women with four babies, or five postpartum women with four babies. Sometimes it is difficult to be with the postpartum women. Due to our workload, we may not notice that a postpartum woman has depression. Even if a postpartum woman is expressing concerns about depression, things are sometimes ignored.

Spending sufficient time with postpartum women so as to detect the signs of depression is difficult for nurses because their heavy work load means that they typically have to focus on physical rather than psychological aspects. As one participant noted: *"We need to spend more time, but maybe because of some other work, we tend to neglect that part; we are more focused on medical nursing care, but as a whole in mental issues not so much."*

The participants explained that the high admission rate of postpartum women results in nurses only having a limited amount of time to spend with individual postpartum women, although they would have a better chance of determining the women's psychological status if they had fewer patients. According to one of the participants:

We can't control the census of the hospital. If the census is high and we are taking more than our allowed number of postpartum women, it will be a barrier. We usually handle three to four postpartum women; usually, there is time then.

Discussion

The main aim of this study was to explore nurses' experience regarding the barriers to screening for postpartum depression among women. The findings from the data analysis of the interviews revealed two main themes: personal barriers and fragmented care. Communication barriers, cultural issues, lack of education and stigma were sub-themes for the personal barriers theme. Missed care, resources and workload were sub-themes for the fragmented care theme.

In general, Sofronas et al. (2011) identified the following barriers to caring for postpartum women: a lack of time, training and language, as well as patient and family beliefs. Among the organisational factors considered to be important barriers are a lack of maternal mental health services, lack of care pathways, heavy workload, lack of time, lack of privacy and inability to see women frequently enough to develop relationships with them (Higgins et al., 2018).

Smith et al. (2019) described the barriers that affected relevant actors, such as the barriers related to a woman's knowledge, attitudes and individual characteristics, her family's knowledge, attitudes and individual characteristics and her healthcare providers' knowledge, attitudes and individual characteristics; organisational characteristics, such as service access and resource inadequacy; sociocultural barriers, such as family support, wider social support networks and cultural attitudes; and structural barriers, such as undefined policy.

The communication barrier sub-theme was indicated by the nurses in this study when they reported that language differences make it difficult to understand postpartum women's feelings, limit postpartum women's ability to be open with nurses and prevent nurses from providing psychological care for mothers. Language barriers have been frequently reported as a limitation in caring for postpartum women (Loudon et al., 2016; Sofronas et al., 2011; Teng et al., 2007). Thus, investing in language support, whether in the form of a broad linguistic team or interpreters, is critical to effectively offering PPD services to women (Ganann et al., 2019).

In this study, the cultural issues sub-theme was raised by the nurses when they related their fear about saying something that may breach a woman's privacy or providing care that is prohibited in a woman's culture. Saleh et al. (2020) stated that most international midwives and nurses are unfamiliar with the Kingdom of Saudi Arabia's culture and needs and cannot communicate in Arabic, which complicates efforts to improve maternal healthcare.

In this regard, the common obstacles are related to the influence of women's partners, friends and family members rather than the healthcare system. This is a notable finding, because if a woman's relatives or friends have incorrectly normalised her symptoms, she may choose not to share them with healthcare professionals (Kingston et al., 2015).

In this study, the lack of education sub-theme was found to relate to both nurses and postpartum women. The nurses reported the existence of educational programmes for postpartum women within maternity services, although such programmes mainly focused on the physical needs of postpartum women and their new-borns, such as nutrition, breastfeeding and exercise. Education regarding mental health issues was absent.

A review study revealed that women and their families lacked basic knowledge of maternal mental health, which highlighted the importance of a broader approach to increasing knowledge (Smith, 2019). Moreover, Kingston et al. (2015) emphasised the need to educate women's friends and family members about the importance of maternal mental health education. Women are not always confident about determining if their emotional status is clinically relevant, which validates the significance of the perspectives of their family or friends.

The nurses who participated in this study highlighted the stigma sub-theme as one of the barriers to the detection of PPD. Here, stigma involves a negative attitude toward mental health problems and impacts the mother by preventing her from seeking help. The mother may fear reporting PPD and seeking help from a psychologist due to the dominant views in her society. In fact, postpartum women may not report their symptoms of depression for a variety of reasons, including a desire to avoid questioning or experiencing the shame or stigma connected with their feelings; a lack of understanding of depression as a serious issue; and a lack of symptoms within the period in which professional interactions occurred (Place et al., 2015).

In terms of the fear of social stigma, a woman's spouse may discourage her from seeking care or exposing her symptoms, even to her relatives. There may also be concerns about confidentiality and whether other people will be aware that the mother is receiving mental health treatment. Negative attitudes toward the diagnosis and treatment of psychological health issues can result in women avoiding getting help and reinforce their feelings of stigma and guilt (Smith et al., 2019).

Ordan et al. (2018) reported that nurses who care for postpartum woman with mental illness and their new-borns might provide fewer conventional postpartum interventions due to professional stigma and negative views. Professional stigma can also impact the therapeutic relationship with postpartum women who are experiencing psychological issues (Ordan et al., 2018).

With regard to the missed or delayed care sub-theme, this study found that psychological problems may be missed or a diagnosis may be delayed due to a postpartum woman's short length of stay in the hospital, the means of collecting data about mental health status during admission or the lack of focus on maternal health services. Smith et al. (2019) reported that a lack of awareness of psychological issues, such as PPD, among healthcare providers, women and their families could result in delayed diagnosis, delayed referrals and confusion about the healthcare provider's role.

The timing and methods of any PPD screening may also impede the identification of women at risk of or with PPD. For example, evaluations conducted prior to hospital discharge following the birth, or even at the six-week postpartum check-up, may miss many women who develop symptoms later in the postpartum period (Smith et al., 2019). Moreover, due to the sensitivity associated with the perinatal period, the waiting periods for mental healthcare were considered a major concern, as women may become discouraged from seeking treatment if they are faced with long wait times or have the impression that the professionals are unwilling to assist them (Ganann et al., 2019).

In the present study, the identified barriers related to resources include a lack of policies, guidelines and screening tools, in addition to a shortage of healthcare providers. According to Saleh et al. (2020), no standardised techniques for screening for PPD have been developed, and there are no clinical guidelines for assessing and managing PPD in most healthcare settings in the Kingdom of Saudi Arabia. Furthermore, there are no job descriptions or standards governing the roles of nurses and midwives in assessing and managing PPD. Smith et al. (2019) reported that structural barriers, such as weak policy implementation, interfere with providing access to healthcare for postpartum women with mental illness.

The nurses in the present study reported adhering to clinical practice guidelines, although they noted that there are none available for PPD. Indeed, PPD screening is not widespread, which may contribute to the low prevalence estimates (Goldsmith, 2007). Physicians, nurses and social workers have reported being unable to use screening tools due to a lack of official hospital guidelines on PPD, which gives rise to a sense of powerlessness (Place et al., 2017). It must also be acknowledged that existing validated PPD instruments lack cultural sensitivity and terminology and do not resonate with cross-cultural manifestations of PPD (Ganann et al., 2019).

Place et al. (2016) presented three significant findings regarding whether and how postnatal depression is addressed in healthcare policies: 46% of policies address postnatal depression in ways that may improve the quality of the care for women experiencing, or at risk of developing postnatal depression through statements of intent or actions; 15% of policies acknowledge postnatal depression but do not address it in a way that might impact postnatal depression care and management and 38% of policies do not address postnatal depression at all.

In the present study, the workload sub-theme was highlighted by the participants as another factor that limits the amount of time a nurse has to provide care for postpartum women. According to Place et al. (2017), the failure of health personnel to detect and care for women with PPD symptoms represents a failure to care for the patient in an integrated or holistic manner. This failure was largely attributed to overly heavy work schedules and "practices" in healthcare settings, which do not allow for adequate patient interaction time (Place et al., 2017). Kebede et al. (2021) reported that healthcare providers may be unable to correctly follow the standards due to their workload or they may choose to ignore them entirely. In this regard, the availability of enough sufficiently skilled birth attendants in the maternity unit would enable providers to comply with recommendations, reduce their task overload and promote teamwork, thereby facilitating the early detection and treatment of PPD.

Conclusions and Recommendations

The study's findings indicate that maternal mental health is challenging in both Saudi Arabia and worldwide due to several barriers. The current regulations regarding maternal healthcare services should also be evaluated to help maintain the mental health of postpartum women. Screening for PPD needs to be added to the package of services provided to women in Saudi Arabia, as the ongoing development of the healthcare system is part of the Saudi Vision 2030.

Limitations

Since this study used qualitative research methods, it has some limitations. Because only 10 participants were interviewed from one maternity hospital, the study was not entirely representative of all postpartum nurses in Saudi Arabia. However, since the study participants varied in age and length of work experience, the results are applicable to a wider audience.

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