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ABSTRACT

Objective: To explore the recognition and management of postpartum depression (PPD) by the obstetric team in a maternity hospital concomitantly, was to find the rate of PPD in the centre.

Design: A descriptive cross-sectional study.

Setting: Island Maternity Hospital, Lagos, Nigeria; a moderately large obstetric facility with 68 beds and 42 paediatric cots.

Subjects: The medical staff including doctors and nurse midwives in the study centre. Concomitantly, a sample of women that delivered in the hospital during the study period.

Results: Seventy two (65.5%) of the total 110 obstetric staff in the hospital consented to the study; made up of 10 doctors and 62 midwives of varying cadres. 43.1% of them admitted their difficulty to recognise PPD with X^2 of 25.8, while 19.4% expressed doubt in the obstetric team's ability to manage PPD. 86.1% would rather refer PPD cases to the psychiatrists, but saw stigma as a militating factor. Hence 77.8% with X^2 of 65.3 would want consultation-liaison psychiatric services established in the centre. Concomitantly, of the 252 women assessed with EPDS, 23% were depressed with scores >12.

Conclusion: It is concluded that there is need to update the obstetric team's knowledge on the management of PPD through Continuous Medical Education (CME) to which 97.2% of them agreed.

INTRODUCTION

Many studies from the western world have found an increased rate of depressive illness following childbirth(1,2,3), with 10-15% of postpartum women so effected(4). A review of the relatively few studies from developing countries on the transcultural aspects of postpartum depression (PPD) show similar rates compared to Western Europe and North America(5). In a very recent transcultural study, including Uganda in Africa; PPD, described as "morbid unhappiness" in some centres was recognised as a common phenomenon following childbirth. The study further revealed that unlike biological causation (e.g hormonal changes) of PPD in most advanced nations, psychosocial factors of poverty, lack of social support, sleeplessness etc. were the major causes of PPD in developing countries(6). PPD is a serious and challenging illness on the woman and her family(7); most especially in Africans nations where mental illnesses are still highly stigmatised(8). Despite the enormity of this problem, available specialised care is far from being sufficient in Africa; as most African nations have no mental health policy and 96% of them have less than one psychiatrist per 100,000 population(9,10). For instance, in Nigeria which is among the African nations with relatively developed psychiatric care; there are slightly over 150

registered qualified practicing psychiatrists to a population of 120 million people. Therefore, early recognition, diagnosis and treatment of the problem (PPD) by the general practitioners and obstetric team is highly essential so as to be less dependent on psychiatric specialists(11). However, past studies from developed countries have shown that these non-psychiatric medical practitioners often find themselves in a dilemma when it comes to the diagnosis and treatment of the illness(7). More recent studies still indicate persistent low levels of case recognition and management by the general practitioners and obstetricians(12). Hence, the advocacy for mother and baby units with mental health specialist services to take care of the PPD cases(6). The difficulty at recognising cases of PPD becomes more pronounced among non-psychiatric practitioners in Africa where psychiatric illnesses especially depression are often masked by physical symptoms(13,14). As part of the measures to overcome these problems over patient-care in Nigeria, continuous medical education (CME) was in the last few years made a pre-requisite to renew the practicing license for doctors yearly. Thus, this study set out to assess the extent to which medical practitioners in a maternity hospital were able to recognise and manage PPD in their patients.

MATERIALS AND METHODS

Study setting: The study took place in Lagos Island Maternity hospital, a health institution owned by the Lagos State Government of Nigeria. It is a moderately large obstetric facility with 68 beds, 42 paediatric cots and staffed by six consultant obstetricians, and varying grades of 11 medical officers and 93 midwives. It serves as both primary and secondary obstetric healthcare facility for the teeming population of Lagos Island and its environment with an average number of four deliveries per day. The services in the hospital include antenatal care for expectant mothers and medical care for mothers and newborn babies up to six weeks after childbirth.

Subjects: The study population was 110 medical personnel as outlined above; but only 72 of them gave their consent to participate in the study. Approval to carry out the study was earlier given by the Lagos State Hospitals Management Board. Additionally, a total of 252 postpartum women who delivered consecutively over a four month period and consented to be evaluated were concomitantly assessed with Edinburgh Postnatal Depression Scales (EPDS) so as to obtain the prevalence of postpartum depression in the study centre.

Procedure: (a) The researchers developed a special interview questionnaire based on areas of inquiry informed by the aims of the study. The questionnaire was broadly divided into two parts. The first part was to explore the socio-demographic variables of the subjects (medical staff). The variables included the age, sex, religion, marital status and educational/ professional training; their understanding or knowledge of PPD to include the recognition, causes as well as to what extent they can manage the problem: and when to refer such cases for further specialist psychiatric treatment. The questionnaire was thereafter administered on the 72 consenting health professionals to complete. Furthermore, the case notes of some PPD patients that were previously

managed by the medical staff in the hospital were studied. For such cases, the nature of the treatment given (if any) and cases of those referred for psychiatric evaluation by the obstetric team were noted.

(b) Concomitantly, during the study period, 252 post partum women who gave their consent were evaluated with EPDS in order to obtain the prevalence of PPD in the study centre. EPDS has been the most frequently used instrument for research into PPD across various countries and cultures of the world (15,16). It was recently validated in Nigeria by Uwakwe(17) who submitted that the instrument (EPDS) clearly distinguished between depressed and non-depressed postpartum women and finally recommended that being a simple and easy to use instrument, it should be administered in routine postnatal screening(17). EPDS being a simple and short instrument was administered for the subjects to complete. In some cases, there was need to assist few of the subjects to complete the instrument as earlier noted by Uwakwe in his validation study(17).

RESULTS

Of the 110 obstetric medical staff in the study centre, a total of 72 (65.5%) consented to participating in the study. Of these 72 subjects, ten (13.9%) were doctors including two consultant obstetricians and five senior medical officers (5). Sixty two (86.1%) were varying cadres of midwife nursing staff i.e. thirteen chief nursing officers, eighteen principal nursing officers and thirty one nurse midwives. The age range of the subjects was 28-50 years with mean age of 38.6 ± 5.9 years. Only one (1.4%) of the subjects had no psychiatric clerkship while in training; but the others had average duration of 8.4 weeks in psychiatric clerkship during their student days.

Table 1

The knowledge, attitude and practice of the medical personnel's in the management of PPD in the study centre

Factor	Percentage of medical personnel	Degree of freedom (df)	Chi Square (X^2)	P-value
Adequacy of training and knowledge in psychiatry for clinical practice	31.9	2	17.58	0.00
Difficulty at recognising PPD	43.1	2	25.75	0.00
Believes PPD is not a big problem	87.5	3	150.44	0.00
Admits there is need for CME in mental health	97.2	1	64.22	0.00
There is need for quick intervention in PPD cases	97.2	2	132.25	0.00
Doubt in ability to manage PPD by the obstetric team	19.4	2	36.33	0.00
There is need to refer PPD cases to the psychiatrist	86.1	2	90.33	0.00
Stigma is a militating factor against psychiatric referral	86.1	2	90.33	0.00
Psychiatric referral cannot cause adverse doctor-patient relationship	80.6	2	72.25	0.00
There is need for consultation-liaison psychiatric service in the maternity hospital	77.8	2	65.33	0.00

PPP= Postpartum Depression, CME= Continuing Medical Education

Over half of the subjects (54.2%) considered their psychiatric clerkship as inadequate and 31.9% felt the clerkship they had was adequate for their clinical practice with chi-square (χ^2) of 17.6. 43.1% of the subjects had difficulty at recognising PPD with χ^2 of 25.8, while 19.4% expressed doubt in their ability to manage it. 86.1% felt it is of necessity to refer PPD cases to psychiatrists; but also believed stigma is a militating factor against such referral. Hence, 77.8% advocated the establishment of consultation-liaison psychiatric services in the maternity hospital (Table 1).

Concomitantly of the 252 women screened for PPD with EPDS in the study centre, 58 (23%) were depressed with scores of ≥ 12 , the cut-off value with the instrument (EPDS); thereby showing PPD to be a significant problem in the study centre. The retrospective analysis of the case notes of patient suspected to have had PPD in the study centre showed evidence of indiscriminate prescription of benzodiazepines, analgesics and vitamin supplements for symptomatic treatment of insomnia, body pains, loss of appetite and sadness with no definitive diagnosis made on any of them.

DISCUSSION

Our study showed the difficulty of the obstetric health care workers to recognise and manage PPD in the study centre. In this regard, close to 90% of them believed PPD was not a significant problem; when on the contrary from EPDS assessment up to 23% of their postpartum patients suffered from PPD. Furthermore, over 40% expressed difficulty at recognising PPD; and this is similar to findings in earlier studies even from developed nations of the world where it has been shown that non-psychiatry physicians often misdiagnosed depression as an adjustment problem during pregnancy and postpartum period(7,18). Perhaps, perceived inadequacy of training in psychiatry by majority of the respondents (close to 70%) during their student days might partly be responsible for this problem of recognising and managing PPD. Studies from Britain and Canada indicated that psychiatric clerkship is associated not only with positive attitudes towards mentally ill patients but also at improvement of knowledge of psychopathology(19,20). This factor of psychiatric clerkship might partly explain an outcome of some recent transcultural researches into PPD where it was found that when compared with the lay informants, non-psychiatric health professionals are increasingly able to recognise morbid unhappiness/ depression in new mothers and the predominant aetiological role of psychosocial factors in such PPD cases (6,21).

Majority of the subjects (86.1%) recognised the need for psychiatric referral for these patients. However, they saw stigma for psychiatric consultation as a militating factor against such referrals. Similar finding was reported earlier by Aghanwa *et al* (22) in the country over the stigmatisation of psychiatrically ill

patients, and the reservation of some clinicians to refer them for consultation-liaison psychiatric service(22). In an earlier study from Britain, Maguire *et al* (23) also noted that only a small proportion of patients in a general hospital setting with psychological morbidity were referred for psychiatric assessment(23); but on their part blamed this low rate of referral on the psychiatrists whom they viewed as been "alienated" from other physicians. In our study, it is a welcome development that over 80% of the staff respondents did not think psychiatric referral could cause adverse doctor-patient relationship. This is contrary to earlier findings in Europe where some authors noted that the doctors hesitated to refer their patients to psychiatrists so as not to upset them (patients) and the belief that patient-doctor relationship would be destroyed(24,25). However, some of the authors noted that patients who have cause to see a psychiatrist would not mind been referred to one irrespective of the attached stigma(25). Similar to our findings an earlier study also in Nigeria by Adeyemi *et al*(26) pointed out that the non-psychiatric physicians did not mind to refer their patients for psychiatric evaluation as the effect of stigma is much reduced when patients are managed within general hospital setting, and there was a similarity in attendance between psychiatric clinics and the non-psychiatric ones among referred patients. With stigma seen in our study as a militating factor against the desired referral of the PPD cases to psychiatric facilities nearly four-fifth (77.8%) of the respondents would want an alternative arrangement of consultation-liaison psychiatric services being established in the centre. Results from some PPD studies among which was the transcultural one involving various countries including Uganda in Africa strongly support our findings. Firstly, they observed the predominance of psychosocial factors of poverty, differing social roles, sex discrimination (against the female), more negative life events and physical emotional/ sexual abuse against women especially in developing countries(27,28). Thus, because of these predominant psychosocial aetiologies, the non-psychiatric health professionals saw the increased need for "talking therapies" i.e psychotherapies for those patients; but then noted this solution lays outside their own professional skill(12). Therefore, across various cultures, there is support for such consultation-liaison psychiatric services to be established as typified by the English general practitioners as well the obstetricians and paediatricians in Japan and Italy(6).

Finally, it is gratifying to note that nearly all the respondents admitted there is need for continuing medical education (CME) in mental health. Holden *et al*(29) laid similar emphasis on the need for the education of obstetric staff and public health nurses in the psychosocial care of postnatal depressed women(29). The CME in mental health would most probably increase their skill in the management of PPD as against what obtained in the indiscriminate prescription of hypno-sedatives and

analgesics. Such CME is also urgently required due to the inadequate number of psychiatrists the country needed to staff the desired establishment of consultation liaison psychiatric services.

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