Journal of Advanced Research in Psychology & Psychotherapy
Volume 2, Issue 2 - 2019, Pg. No. 5-8
Peer Reviewed & Open Access Journal

Research Article

Beside Somatization Symptoms Post-Partum Depression Symptoms are Expressed

Faith C Diorgu

Nurse/ Midwife Lecturer, Department of Nursing Science, University of Port Harcourt, Port Harcourt, Rivers, Nigeria.
DOI: https://doi.org/10.24321/2581.5822.201907

I N F O

E-mail Id:
faith.diorgu@uniport.edu.ng
Orcid Id:
https://orcid.org/0000-0003-4521-3571
How to cite this article:
Diorgu FC. Beside Somatization Symptoms Post-Partum Depression Symptoms are Expressed. *J Adv Res Psychol Psychother* 2019; 2(2): 5-8.

Date of Submission: 2019-02-05
Date of Acceptance: 2019-04-25

A B S T R A C T

Post-Partum depression affects majority of women following childbirth. This qualitative study explored the lived experience of post-partum depression among Nigerian women. Rich descriptions of 24 women experience of PPD were collected through individual in-depth interviews. Three themes were identified: 'Missed diagnosis of depression' 'Suffering in silence' and 'Defining depression'. The findings suggested that depressive symptoms were not readily recognized and women suffered delays in accessing prompt medical care. Positive aspect of PPD were highlighted. Implications for nursing practices suggests increased need for re-orientation on the signs and symptoms of depression in relation to African context. Post-partum depression in African women is a disorder that may hide under another tropical ailment. Health care professionals can play a key role in assisting this population of women through proper screening, diagnosis and support for the women, their families and the community.

Keywords: Africa, Depression, Women

Introduction

Post-partum depression is a collection of symptoms that arises after child birth; it is different from major clinical depression.[1,2] Post-partum depression presents with symptoms such as

feelings of sadness, emptiness, excessive crying, inability to fall asleep or wanting to sleep all the time, loss of appetite or overeating. There is lack of concentration and low energy.[1,2]

These symptoms may lead to feelings of worthlessness, feelings of being, lack of interest in normal activities, and in the newborn and preoccupied with worries over the baby's warfare. If untreated, the symptoms may increase leading to thought of harming the baby and or suicide which also occur in major clinical depressive illness.[1,2] Women suffering from post-partum depression usually manifest.

PPD occurs more frequently in individuals who are socially and emotionally disadvantaged.[3] One in four minority low income mothers are likely to develop PPD[4] Post-partum depression poses a medical problem to the mother, baby and family. Post-partum depression meets the criteria of the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) for depression with incidence rate of 11 to 42% varying from one populace to another.[5] Numerous studies exist looking at PPD among women, however, few studies have been committed to the PPD lived experiences of Africa women.[3] Addressing maternal post-partum depression in a timely and proactive fashion is therefore essential. The need for the study therefore cannot be overemphasized especially for its impact on health which had been mentioned above. This study was therefore aimed to explore the experiences of PPD from the account of African women perspectives. It is hoped that an understanding of the experiences may potentially benefit majority of women and families.

Copyright (c) 2019 Journal of Advanced Research in Psychology & Psychotherapy (ISSN: 2581-5822)
https://www.adrpublications.in

Materials and Methods

The qualitative study used exploratory in-depth interview as a means of collecting data from 24 participants. The method facilitated the understanding of Nigerian women's unique experience, the meaning and challenges of PPD from their perspective. This also assisted in the identification of cultural values and disposition regarding PPD.

Sampling Procedure

The group used for the study was Nigerian women who have had clinically diagnosed PPD, and were currently receiving or had received treatment within past five years in either two mental health study hospitals.

Participants were contacted personally, through leaflets, and telephone calls by the researcher. Twelve post-partum women clinically diagnosed with PPD were purposively identified and selected. Their hospital records were sought, through the history and Medical Record Unit of the hospital. Their medical files were identified, their medical diagnosis was confirmed and their contact details obtained. The women were contacted personally through phone calls, but only 22 accepted and participated on a scheduled interview within 1-2 weeks of acceptance.

Ethical approval for the research was obtained from University of Port Harcourt, Nigeria. Also, the study hospital Ethical Research Committees gave approval. The voluntary informed consent, confidentiality and anonymity were explained to the women at the beginning of each interview. They also were informed about their right to withdraw at any point should any discomfort arise. The interviews were conducted in the individual mothers' home. The participants were given a gift voucher as token in appreciation for participating.

Data Analysis

Following each interview, the data were transcribed verbatim using a thematic analysis by Braun and Clarke analysis framework.[6] Interviews were transcribed in full and categorization of the data achieved with several in-depth readings of the transcripts. Data saturation was reached with the facilitation of the eighteen (18th) participant interview as no more new emerging themes were forthcoming. Ten significant statements were extracted and clustered into six themes. Finally, 3 themes emerged that illustrated the Nigerian women's experience of PPD.

Result

The interview questions were developed to understand each participant experience, the meaning and challenges of experiencing PPD. Three themes were identified: Missed diagnosis of depression with sub-theme "Family and friends don't get it", Suffering in silence with the sub-theme 'not mental', and Defining depression with a sub-theme of "dealing with it". The themes were derived across many interviews. Quotations were used to further illustrate the themes.

Missed Diagnosis of Depression

Missed diagnosis was the first theme identified. Depressive episodes were likened to feeling of malaria symptoms in most of the women. Malaria being an endemic tropical African illness, was always the first focus of suspicion. Most participants were first treated for malaria and or typhoid as they were reporting similar symptoms. "Yes, all these experiences started after my last child, headache, night fever and body pains. It will look like I am having malaria……… went to the hospital……. was given malaria drugs, yet within me feels weak and sick".

Sometimes the women felt out of control not coping and even had the feeling of "losing it" absolutely. They also recognized that they were not responding positively to the malaria and typhoid treatment given by the professional health care.

One participant stated: "……I was tired of going to the hospital every time …… the doctors, giving me malaria medication while my condition remained the same".

The women believed that friends, family, even health professionals just 'don't get it'. They felt health professionals failed to help. Doctors minimized their symptoms, and were treating them of malaria as many of them presented with malaria symptoms.

Suffering in Silence

Another theme identified was Suffering in silence. This theme addresses the discovery that the depressive problems of the women were not accepted with sub-theme 'not mental' due to some sociocultural reasons. Being 'insane' was regarded as an unmentionable thus, accessing mental specialist care was unduly delayed.

An example of this sub-theme was when some of the women stated:

"……..you can go to any hospital but not psychiatric" because he [my husband] did not believe I needed such place".

"…… before my husband came to agree that I should be taken to the psychiatric hospital, it was more than 9 months".

Family members failed to admit that the women needed psychiatrist attention as it is forbidden to admit to such. It is also recognized that the women did not speak to appropriate professionals about their true emotional feelings on time for fear of being labelled "insane", which is a stigma.

Defining Depression

When the women were asked: what it was like to be in

ISSN: 2581-5822
DOI: https://doi.org/10.24321/2581.5822.201907

depression after childbirth. Most of the women reported feeling of extremely fearful, loss of sleep, feeling to be left alone, tearful most of the time and loss of identity. However, the women were identified with the theme 'Dealing with it', to live up to being a "good mother" and a "strong woman" in regard to depressive symptoms. In order to "deal with it" the women ignored the daily symptoms and kept their feelings to themselves, increasing their likelihood to develop more depressive symptoms.

Such statements included: ".... I was extremely fearful, I could not be left alone, I was afraid that I would die. ......".

Another woman said: ".... Not having my sleep and losing weight were most disturbing, sometimes I am restless, could not sleep...just like that".

The women's responses identified the description of symptoms of post-partum depression.

Discussion

This study has shown that post-partum depression does exist in our environment but often missed or masked as the symptoms are minimized and masked with malaria symptoms. However, it is the most common complication of childbirth, which have adverse effects on the mother, the newborn, as well as the family unit.[7] In the current study Post-partum depression seems to go undetected and untreated among the women. Women of this category are less likely to undergo PPD screening, and when they experience PPD symptoms, they tend to minimize them or disregard them because of shame, perceived stigma, and/or cultural beliefs. In one study, researchers found that when low-income women were diagnosed with PPD, they were half as likely as their white counterparts to utilize available mental health services.[8]

Multiple barriers to PPD treatment exist, including misperception of the illness as an endemic malaria and or typhoid; a general unwillingness of the sufferer to disclose negative feelings to friends, families, or healthcare providers; and fear of being separated from one's family because of mental instability.[9,10] Cultural and belief system, and stigma have been identified as additional barriers to seeking treatment.[10] Cultural influences can impact an individual's perceptions around mental health and treatment. It could be viewed that women from different cultural backgrounds may likely display different behaviors and actions when suffering from depression. Some cultural differences that have been identified are how one expresses feelings, and how depressive symptoms are reported. However, cultural differences demonstrate variability in relation to what is appropriate when expressing one's feelings and the acceptance of external emotions.[11]

Other major barriers to treatment are lack of prompt identification and acceptance of depressive symptoms on a family member. Cultural norms and beliefs about PPD play a major role in terms of recognition of depressive symptoms.[12] Culturally constructed and sanctioned expressions of language of depression are likely to be overlooked or misidentified by health care professionals trained in mainstream definitions of depression.[12] Somatization of health problems preceded or masked psychological symptoms among the women. In fact, the manifestations and the communication of symptoms vary greatly from members of one culture to those of another culture, and may not be recognizable from the care giver's cultural vantage point.[8] In the present study many had doubts and confusion, and were unwilling to self-identify with having PPD symptoms because of the negative cultural connotations that are associated with this disorder. Research exploring how cultural beliefs affect the experience and manifestation of PPD symptoms among Nigerian women is lacking.

Implication

This awareness will allow the professional to connect with the client as early as possible, establish a relationship of trust, where the professional can educate the client on their diagnosis and assist them in seeking out care to help them manage their symptoms promptly and effectively. This study identified that education of the symptoms was an important step in the identification and healing process. All the women in this study stated that they were being treated of other ailment for a long time before the right diagnosis and treatment were initiated.

An important point for Health care professionals: Many women with depression may not report feeling down or hopeless but, rather, will present as having general symptoms of physical illness and health care professionals may dismiss depressive symptoms as routine stressors, especially if the mothers appear to be physically ill rather than sad and depressed. Health care professionals screening for depression may not recognize that malaria and typhoid can be manifestations of depression.

Conclusion

This study therefore provided insight into what it is like to experience depression and its challenges from the lens of Nigerian women. It also suggests that not all malaria symptoms experienced at post-partum period are factual. Post-partum depression could be masked underneath, thus all post-partum mother presenting with malaria symptoms should be further evaluated for PPD.

Acknowledgement

I thank all mothers who participated in this study. I thank the hospital authorities and my university for giving permission to conduct the study.

Conflict of Interest: None

References

1. Cohen LS, Nonacs RM. *Mood and anxiety disorders during pregnancy and post-partum*. American Psychiatric Pub, Washington, DC. 2005.
2. Stone DS, Menken AE. *Perinatal and post-partum mood disorders: perspectives and treatment guide for the health care practitioner*. Springer, New York. 2008.
3. Luke S, Salihu HM, Alio AP et al. Risk factors for major antenatal depression among low–income African American women. *Journal of Women's Health* 2009; 18(11): 1841-1846.
4. Sampson M, Zayas LH, Seifert SB. Treatment engagement using motivational interviewing for low-income, ethnically diverse mothers with post-partum depression. *Clinical Social Work Journal* 2001; 41: 387-394.
5. Evins GG, Theofrastous JP, Galvin SL. Post-partum depression: a comparison of screening and routine clinical evaluation. *Am J Obstet Gynecol* 2000; 182(5): 1080-1082.
6. Braun V. Clarke V. Using thematic analysis in psychology. *Qual Res Psychol* 2006; 3(2): 77-101.
7. Davidson MR. *A Nurse's Guide to Women's Mental Health.* Springer, New York, NY. 2012; 2.
8. Beck CT. Predictors of post-partum depression: an update. *Nurs Res* 2001; 50(5): 275-285.
9. Dennis CL, Chung-Lee L. Post-partum depression help seeking barriers and maternal treatment preferences: a qualitative systemic review. *Birth* 2006; 33(4): 323-331.
10. Abrams LS, Dornig K, Curran L. Barriers to service use for post-partum depression symptoms among low-income ethnic minority mothers in the United States. *Qual Health Res* 2009; 19(4): 535-551.
11. Amankwaa LC. Post-partum depression among African-American women. *Issues in Mental Health Nursing* 2003; 24(3): 297-316.
12. Goodman JH. Women's attitudes, preferences, and perceived barriers to treatment for perinatal depression. *Birth* 2000; 36: 60-69.

ISSN: 2581-5822
DOI: https://doi.org/10.24321/2581.5822.201907