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Conceptualisation of postnatal depression in Malaysia: The contribution of critical realism in exploring the understanding of women's and healthcare practitioners' perspectives

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Abstract

This study aimed to explore the perception of PND in women and healthcare practitioners (HCPs) in Malaysia using critical realism. This qualitative study was conducted among 33 Malaysian women attending child or postnatal care and 18 healthcare practitioners (HCPs) using face-to-face semi-structured interviews in six selected maternal and child health clinics and a female psychiatric ward in Kuala Lumpur, Malaysia. The findings suggest that the women's and HCPs' conceptualisations of PND are not entirely established based on either scientific or professional expertise, indicating that there is a lack of systematic awareness of PND within the Malaysian healthcare setting.

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Keywords: Postnatal depression, Women, Healthcare practitioners

Conceptualización de la depresión posnatal en Malasia: la contribución Del realismo crítico en la exploración de la comprensión de las perspectivas de las mujeres y los profesionales de la salud

Resumen

Este estudio tuvo como objetivo explorar la percepción de PND en mujeres y profesionales de la salud (HCP) en Malasia utilizando realismo crítico. Este estudio cualitativo se realizó entre 33 mujeres malasias que asistieron a atención infantil o postnatal y 18 profesionales de la salud (HCP) utilizando entrevistas semiestructuradas cara a cara en seis clínicas de salud materna e infantil seleccionadas y una sala de psiquiatría femenina en Kuala Lumpur, Malasia. Los hallazgos sugieren que las conceptualizaciones de PND de las mujeres y los profesionales de la salud no están completamente establecidas en base a la experiencia científica o profesional, lo que indica que existe una falta de conocimiento sistemático de PND dentro del entorno de atención médica de Malasia.

Palabras clave: Depresión postnatal, mujeres, profesionales de la salud

1. INTRODUCTION

Postnatal depression (PND) is one of the most common maternal mental health problems affecting 4.0%–63.9% postnatal

women worldwide (Arifin, Cheyne, & Maxwell 2018). This non-psychotic depressive disorder develops within 12 months of delivery and affects the woman, her child, and her family. To promote early detection and management of PND, the World Health Organisation (WHO) recommended the integration of perinatal depression in routine perinatal care (WHO 2020). However, misconceptions, misinformation, and a lack of awareness about PND among women and healthcare professionals (HCPs) have been reported (Ransing & Kukreti 2019). Women from different cultures have limited knowledge of postnatal mental well-being, and they could not identify their emotional distress as PND after childbirth (Arifin, Cheyne, & Maxwell 2020).

Despite various evidence suggesting that the experience of PND vary by context and culture, the variation still cannot be explained (Arifin, Cheyne, & Maxwell 2020). Although women across cultures shared some similarities in their PND experiences, there have been some culturally unique experiences that have not been observed in other parts of the world. For instance, Asian women associate their PND experiences with the issue of cultures and traditions during the postnatal period. In addition, the prevalence of PND varies across the countries. For example, in Malaysia, the reported rates of PND ranges from 6.8%–27.3% (Arifin, Cheyne, & Maxwell 2018). Therefore, a qualitative study is needed to explain the nature of PND experience in Malaysia and address reasons for reported variation in the experience as well as prevalence.

In Malaysia, PND was not systematically evaluated and diagnosed in primary health clinics, as there were no clear guidelines for the management of PND. Without credible scientific evidence, it is unknown whether current approaches to PND management have a sense of cultural-based strategies (Arifin, Cheyne, & Maxwell 2018). Therefore, it is essential to explore the perceptions of HCPs on PND and their experience of managing women with PND within the clinical practice. Ransing and Kukreti (2019) also recommended that there should be further research to examine the literacy, screening, and management of PND among HCPs.

PND could not merely be explained by either biomedical or psychosocial research alone (Walsh & Evans 2014). While one can argue that a sociocultural change and stressors across the perinatal period may influence the experience of PND (Sanchez, Urbina, & Hernandez 2020), others may argue that PND is a disease or illness that results from biological changes. Since it is perceived as a complex phenomenon, no single approach could be used to reflect how PND experience can differ by context and culture (Wylie et al. 2011; Sword et al. 2012). Such complexity could be explained by combining both positivism and social constructionism (Pilgrim & Bentall 1999). This approach is known as critical realism. This paper aimed to describe the contribution of critical realism in understanding women's and HCPs' perceptions of PND in Malaysia.

The interpretation of the philosophy of critical realism is primarily related to the British philosopher, Roy Bhaskar. Bhaskar (1998) explained the three features in critical realism, comprising of

firstly, the reality is distinguished by three domains: the 'real', the 'actual', and the 'empirical'. The 'real' acknowledges that reality exists whether or not we experience it or have an understanding of it (Sayer 2000). The 'actual' refers to the manifestations of the fact that occur due to the activation of mechanisms of the real, while the 'empirical' specifically refers to what is directly or indirectly experienced or demonstrated. Secondly, critical realists argue that the causal explanation of a phenomenon can be studied by determining causal mechanisms, how they work, and conditions to activate the mechanism or a specific event. Thirdly, critical realism is aimed at understanding the social world, represented by both intransitive (i.e., scientific knowledge) and transitive (i.e., facts, theories, models, and paradigms) knowledge that cannot be studied separately (Sayer 2000).

2. METHODOLOGY

This was a qualitative study conducted via the critical realist approach. Semi-structured interviews were carried out with 33 women (from three different cultural backgrounds) attending child or postnatal care and 18 HCPs in six purposively selected maternal and child health (MCH) clinics and a female psychiatric ward in Kuala Lumpur, Malaysia. Data were analysed using framework analysis.

An exploratory qualitative design was applied in this study as it is adaptable to change with the presence of new data and insights (Saunders et al. 2012). This design allows the researcher to explore the

experience of PND among postnatal women and the HCPs' perspective of PND and their experience of managing women with PND, as the precise nature of this problem in Malaysia is still ambiguous.

This study was conducted at six purposively selected MCH clinics under the Health Department of Federal Territory Kuala Lumpur and a female psychiatric ward, Hospital Kuala Lumpur. Postnatal mothers attended the MCH clinics for their postnatal visit and child health care and immunization. The HCPs working in these clinics and a female psychiatric ward were also recruited. Both settings were chosen to allow an exploration of the HCPs' experiences of caring for women who already received healthcare treatment for PND and/or those who may not yet be diagnosed as having PND.

The participants of this study were women with PND symptoms and HCPs who work in the selected clinics. The participants came from different cultural backgrounds, including Malay, Chinese, and Indian. Purposive sampling was employed to recruit both the women and HCPs. Data were gathered through semi-structured interviews. Different topic guides were used for the group of women and HCPs. Interviews with the women were conducted either at their homes, or in a private and quiet room at the respective clinic, or at another location of their wish. For HCPs, all interviews were conducted in a private and quiet room at the respective clinic/ward.

Data were analysed using framework analysis to enhance systematic data management and analysis (Ritchie & Lewis 2003). This analysis also allows the researcher to compare and contrast the

themes across cases and provide an accurate and transparent audit trail (Arifin, Cheyne, Maxwell, & Pien 2019). Three interrelated stages were applied in the analysis. Firstly, in data management, transcripts to be reviewed were carefully selected, the initial categories developed, and the initial themes determined. Secondly, in descriptive accounts, the linkage and similarity between one categories to another within the thematic framework were identified. Thirdly, the dataset was reviewed in explanatory accounts to analyse the degree of consistency between the phenomena and the final themes.

All participants involved in this study were required to provide written informed consent and clarified that their participation was voluntary. They were informed that their identity had been maintained by the use of pseudonym during telephone correspondence, interview sessions, data collection, and dissemination of findings (Arifin 2018). The ethical approval was obtained from both the School Research Ethics Committee (SREC), University of Stirling and the Malaysian Medical Research Ethics Committee (MREC).

3. RESULTS and DISCUSSION

The women and the HCPs' experience and perceptions of PND are reflected by three themes: recognising postnatal depression, social circumstance, and tradition-modernity conflict.

The women recounted of recognising the occurrence of "emotional disturbance" after giving birth. Such acknowledgement

was explained through three categories of symptoms or "changes": emotional, behavioural, and physiological changes. Compared across cultural backgrounds, Indian and Chinese women were more likely to address the symptoms of PND based on the changes in their emotional state. In contrast, Malay women described this using a combination of emotional and behavioural changes. While emotional changes were widely discussed by all women in this study, there was no evidence that such changes were discussed by the HCPs. Emotional changes are defined as the feelings experienced by the women when they felt down or depressed. This includes 'loss of excitement', 'getting easily irritated', and 'feeling not being normal'.

Rohana, a first-time mother, reported that she realised something was wrong after her childbirth by noticing "a sudden change" in herself: "After giving birth, I spoke less. I didn't even laugh; I didn't enjoy my life. I didn't feel like talking to others. There was a sudden change. No feeling, nothing, like laughing, not at all" (Rohana, Malay).

Some women's descriptions indicated that they had a lack of knowledge on PND; therefore, were unable to perceive the emotional changes they encountered as problematic. Mira expressed that she became a more sensitive person after giving birth but could not explain the cause of such changes: "I don't know why it happened. After my last childbirth, I felt like I get angry easily, sensitive, and became easily irritated. I easily get stressed while I was working, when I felt stressed, I easily get angry" (Mira, Malay).

From the women's accounts, the feelings of not being their normal self were described as "not normal": "When I felt stressed, I'm not a normal person. Now I'm okay. I was not normal before this, perhaps it was because of the stress" (Siew, Chinese).

Although almost all women appeared to acknowledge emotional changes as one of the primary cues in identifying that something was wrong with their emotional health after giving birth, the HCPs' accounts indicated that behavioural changes are the most critical indicator in detecting PND. Behavioural changes include the way that a woman acted or conducted herself, and how she responded to others. HCPs described the behavioural changes as having a lack of interest in the baby, refusing to breastfeed, and disregarding their baby.

"She doesn't seem to have an interest in her baby, not even looking at the baby, not keen to breastfeed when she was asked to" (Muna, Nurse-midwife). The HCPs also regarded self-isolation as one of the behavioural changes that could be linked to PND. They explained that women with PND might have "uncooperative attitudes", "less focused", "not responding to any conversation" and being "less willing to talk to others". The HCPs, especially the nurses, had observed these changes throughout their professional postnatal home visits.

"She was sad, liked to be alone, and seemed to be dreamy. When we visited her, she wasn't welcoming us" (Alana, Head nurse). "Conforming behaviour" seemed to be an indicator of good maternal mental health. HCPs appeared to surmise that an individual was not affected by PND based on adherence to their health advice, whereas

others who behaved differently from the prescribed "proper behaviour" were labelled as being depressed. Some HCPs acknowledged the women's facial expressions as one of the signs used to distinguish a depressed mother from "normal" mothers:

"She seemed to be very sad. She didn't smile much. It was different from the other patients. She didn't talk much. You can't see a smiling, cheerful smile at their faces. I mean usually patients having twin, they're happy; they're excited with their pregnancy, don't they? But she was not like that" (Chun, Medical officer). Consistent with HCPs' description on behavioural changes, women shared that they begin to notice something was wrong when they had temperamental actions, such as the inability to control their anger, shouting at others, breaking things, and treating the baby harshly.

"I can't control my anger, to the extent that I felt like I'm holding grudges, that's why I become aggressive. This is not who I am before giving birth. After giving birth, I can't hold my emotions; I've to express it out. I always have these emotions, getting angry, if I think I want to fight, I've to. I can't keep it" (Lily, Indian). Another woman noticed the changes she had after giving birth when she had harsh actions towards her baby and tried to make sense of her action: "When I felt disturbed, I'll do everything harshly. I became a harsh person. Then I wonder, why I did so? I changed the nappy harshly, put him down in an improper way like I want to drop him" (Rohana, Malay).

The women repeatedly mentioned uncontrollable crying as one of the indicators of their emotional disturbance or PND. May described this as crying more than usual, "crying all the time":

"I was very emotional throughout my postnatal period. There were so [many] emotional feelings. I was crying all the time. Since I came here [mother in law's house] after the postnatal period, I always cry. I was not the person who [is] always crying" (May, Chinese).

Physiological changes

Physiological changes refer to the alterations in the body function recognised by the women and HCPs as an indication of emotional problems in women following childbirth. Although some have suggested that they somewhat applied the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) in identifying PND, many HCPs (especially nurses) recounted that they used their working experience and intuitive judgment in detecting PND. They considered that women having PND do not follow their healthcare advice and do not meet their expectations in caring for themselves or their baby and family.

In detecting PND, some HCPs reported that they became alert upon sudden reduction in passing urine and bowel movements, or an increase in blood pressure. Hani's description indicated that HCPs tend to associate 'abnormal' bio-physiological changes with PND:

"When there is increased or decreased blood pressure, that's the time to ask more" (Hani, Community nurse).

However, the women accounted for fewer explanations for the physiological changes. While some women associated headache, itchiness, loss of appetite with their PND experience, another woman linked sleep deprivation to other stressors such as family or financial problems:

"I couldn't sleep because I've family problems and financial problems" (Wee, PT14, Chinese).

Social circumstances

When discussing their views on the causes of emotional disturbances after childbirth, all women across different cultures addressed the lack of support, financial constraints, and family problems. The lack of support, especially from their husband, contributed to frustration, creating some level of emotional distress for many women. The women not only longed for practical, but also emotional support from their husbands due to limitations they had during the postnatal period (i.e., not being encouraged to drive, not to have sex, and not to perform heavy work). The women also reported the lack of help from other family members as leaving them without any assistance.

"I was alone; there's nobody to help me. All were depending on me. The pressure was there. I felt like no one cares" (Adlin, Malay).

Almost half of the women (especially among the Chinese) considered financial constraints to be one of the causes of their emotional disturbances. Women associate the constraints with unemployed status, unpaid maternity leave, and family debts. One woman reported: "I always think about that [financial problems]. Those things can make me more emotional" (Neeta, Indian).

Similar to the women's accounts, HCPs also addressed the lack of social support and financial problems as factors leading to PND. Their descriptions indicated that without social support, women were left alone with uncertainty:

"So, no support from anyone, she's on her own without any experience, no knowledge, so these made her stressed" (Hajar, Community nurse). Some of the HCPs perceived that women's financial problems were often due to unstable marital relationships and higher living costs. "And now due to pressures of life, as well as the pressures of life, living cost, isn't it? That's part of the contributing factors for depression. Nowadays, all are advanced. Living cost increased" (Zetti, HCP12, Nurse-midwife).

Tradition-modernity conflict

There was a sense of conflict between the women and their older generation, as presented in both women's and HCPs' descriptions. Traditional postnatal practices are considered as leading to PND by many Malay women, whereas Indian women tend to embrace them as helpful in maternal and baby's health:

"My mother-in-law follows the traditional practices strictly. So, I was stressed. That's why I was stressed. When my baby had jaundice, she [mother in law] showered him with various types of leaves. I'm not that kind of person. I live in the city for quite some times so I can't follow her way" (Rohana, Malay).

"It is definitely very difficult for Indian baby to get flu actually. It's because of the traditional method of handling the baby" (Geeta, Indian). The dispute between the older and younger generations regarding the care of the newborn was primarily addressed by Chinese women:

"My breast milk wasn't coming out for my first baby. Then my mother-in-law said no need to breastfeed. But I wanted to breastfeed" (Siew, Chinese).

While a further explanation of biomedical factors as the causes of PND was anticipated from HCPs, this was not the case. They seemed to discuss more of the postnatal diet, which was seen as limiting the consumption of water, vegetables, and fruits during the postnatal period. Nevertheless, some HCPs agreed that a woman's approach plays a significant role in assessing traditional postnatal practices that may or may not lead to the development of PND. The HCPs indicated that a woman is more likely to be depressed when the practices contradict with their personal preference, and when they believe that they are unable to refuse the rituals.

"I think in other cultures, they have their rules when they are doing their confinement too. I'm not sure how much that would contribute to depression, but in general it may cause added stress to some people, to some people only" (Nur, Psychiatrist). Consistent with the women's descriptions, the HCPs also spoke on breastfeeding practices as the most common conflict arising between the women and their older generation:

"Sometimes we already promoted breastfeeding at our clinic, and some mothers said they were keen to breastfeed. However, their mother-in-law or their mother couldn't stand the baby's crying. They told her: there's no need for breast milk. Yes, the nurses asked you to give it, but it is very slow. Just give bottle feeding. So, the mother was stressed" (Alana, Head nurse).

This study indicated the similarities and differences within and between the women's and HCPs' descriptions of symptoms of PND. From the women's account, emotional changes were mainly discussed by the Chinese and Indian, while the Malays spoke of a combination of emotional and behavioural changes. While the women mentioned more on behavioural and emotional changes, HCPs focussed more on behavioural and physiological changes.

These findings could be connected to critical realism in two ways. First, the women's and the HCPs' recognition of the symptoms of PND, such as loss of excitement and feeling not normal indicates that the experience of PND is real. This reality does not only exist as a socially constructed phenomenon, but it can be experienced by the women and/or observed by the HCPs. Second, the influence of the interpretive lens (Walsh & Evans, 2014) as emphasized by the critical realist, is important in recognising the different perceptions of PND symptoms between individuals of diverse cultural background, as well as between the women and HCPs. For instance, while both women and the HCPs acknowledged a lack of interest in the baby and irritable moods as part of the behavioural changes, the women further explained the changes of their reaction, i.e., shouting at others and harsh actions towards the baby. These findings could mean that HCPs' explanations of behavioural changes were limited to the women's complaints and behaviour, as well as their observation.

The analysis of both women's and HCPs' descriptions suggest that their conceptualisations of the symptoms of PND did not entirely reflect current diagnostic criteria for depressive disorders. For

example, the women reported the symptoms of having headaches, and the HCPs suggested the symptoms of PND include a reduction in passing urine and bowel movements and increase in blood pressure. These manifestations are not included in the DSM-5. This finding is consistent with Place et al. (2015), who reported that HCPs in their study also included other maternal emotional difficulties in explaining PND, such as long-standing distress and postnatal blues.

In his model of health literacy, Jorm (2000) stated that scientific evidence and expert consensus are two primary components for the HCPs in acquiring knowledge about mental disorders. Without such knowledge, HCPs were unable to recognise PND as a serious maternal mental health problem. The majority of HCPs in this study perceived women with excellent physical health, coping well, and conforming to their health advice as having good mental health. In contrast, those who did not adhere to a 'proper norm' were regarded by the HCPs as having PND. Such perceptions imitate the character of acceptable behaviours "for motherhood" as constructed by the media, which were then regulated and shaped by the HCPs through their antenatal and postnatal care (Nicolson et al. 2010; Hollins Martin 2012). Consistent with Nicolson (2010), HCPs in this present study also expected the women to conform to their advice and attempt to "preserve" the standard image and behaviour of a mother, as presented by the media. Such images were then perceived by the HCPs as being the boundary between normal and depressed women.

The findings of this study indicated that while Malay women regarded traditional postnatal practices as contributing factors to PND,

such practices were viewed as supporting good maternal and baby's health by the Indian women. The tradition-modernity conflict, especially newborn care, were spoken more by the Chinese women, and this was seen as factors leading to their PND experience. While women appeared to discuss more on their motherhood experience, HCPs tend to link PND to postnatal diet and traditional postnatal practices. These findings suggest that the women's and the HCP's explanations of the causes of PND were derived from contextual (i.e., lack of social support and financial constraints) and cultural influences (i.e., traditional postnatal practices), and an interplay between the two. Considering the principles of critical realism, PND resulted from the interaction between a right combination underlying causal factors within a specific context (Clark et al. 2008). Without proper circumstance, the combination and interaction remained inactivated; hence, it may not result in PND. This supports the critical realist perspective that individual and social practices should be studied together (Walsh & Evans 2014). Critical realist believed that each individual used their interpretive lens in receiving and responding to certain information accordingly (Easton 2010), and this explains the reasons for variation in the PND experience across diverse cultures. This variation was also discussed in previous studies (Rahman 2007; Edwards & Timmons 2005; Oates et al. 2004; Rodrigues et al. 2003).

4. CONCLUSION

This qualitative study indicates that critical realism is beneficial in understanding the substantial differences within and between women's and HCPs' explanations of the perceived causes of PND. It was evident that the understanding of women and HCPs of PND was not completely established based on either scientific or professional expertise, suggesting that there was a lack of structured knowledge of PND within Malaysia's healthcare setting. Therefore, there is a need for the development of an appropriate screening programme in promoting maternal mental health within the Malaysian healthcare system, as improving the quality of care for new mothers is fundamental for maternal well-being and positive infant development (Coo, García, Awad, Rowe, & Fisher, 2019). The women's beliefs about the perceived causes of PND should be acknowledged in postnatal care, and husband/partner and family should be involved in the professional healthcare interventions. Professional education and training courses should be made available for the HCPs to develop their awareness and expertise on emerging developments in maternal mental health problems. As such, reliable information can be conveyed to women to instil psychological appreciation within clinical practice and society.

Conflict of interests

The authors declare no conflict of interest.

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