

Postpartum Depression and the Role of Midwives in Its Early Detection

Shqipe Tahiri^{1*}, Idriz Sopjani¹, Vlora Ejupi², Lirije Beqiri³, Afërdita Berisha³

¹Faculty of Nursing, AAB College, Pristina, Kosovo

²Clinic of Hematology, University Clinical Center of Kosovo, Pristina, Kosovo

³Nursing Service, University Clinical Center of Kosovo, Pristina, Kosovo

Email: *shqipe1.tahiri@universitetiaab.com

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Abstract

Transition to being a parent is a stress-producing process that involves adapting both parents and their families even in the most favorable circumstances. Information on the level of psychological adaptation of women and family before and during pregnancy is very important as anxiety and the effects of accumulated life stress can directly affect individual and family well-being in the postnatal period. Especially for women or families facing multiple stresses and limited resources, ensuring security, understanding, compassion and direction may have a significant positive effect during this phase. A sample of 91 women immediately after birth at the Obstetrics-Gynecology Clinic (KOGJ) at the University Clinical Center of Kosovo (UCCCK) completed two self-administered questionnaires. Initially, literature on postpartum depression was investigated. Two instruments for this paper have been selected from the range of instruments available for postnatal depression research literature: Patient health questionnaire (PHQ-9) and Postpartum Depression Screening Scale (PDSS). The introduction and analysis of data is done with the Statistical Package of Social Sciences (SPSS), Version 21 (Statistical Package for the Social Sciences—SPSS). Failure or frustration and sleep problems are the highest mean postnatal depression indicators 1.8. Then there is fatigue or lack of energy, increased appetite or anorexia and suicidal thoughts and self-esteem with a mean attendance of 1.7 in the post-depression indicator group. Depression or loss of hope and dissatisfaction or interest in activities are in the group of indicators with an average of 1.6. Movement or speech problems and concentration problems are the least affected indicators in the post-depression indicator group, with only 1.5. Our statistics show a relatively high level of postpartum depression, which includes women of all categories without taking into account the economic situation, the level of education or the number of births, the results derived

from the correlation analysis which is non-aligning during the comparison of these categories. Involvement of nurses/midwives at a time setting of this phenomenon is a necessity for which to invest?

Keywords

Postpartum Depression, Midwives

1. Introduction

1.1. Postpartum Mood Disorders

Today, in the reality of a shorter rest after childbirth, the new mother has to pass quickly from concern for herself to concern for her new-born [1]. It is important that the physical and psychological needs of the mother must be met so that she is able to focus on the care of her new-born. The new mother can experience various emotions, such as: crying, happiness, irritation, anxiety, confusion, and fear [2]. There are physical symptoms as well, such as fatigue and headaches. If the mood does not stabilize within 21 days or if severe symptoms occur, the patient should be referred to a mental health professional. Pregnancy affects the entire family; therefore, assessment and intervention should be considered from a perspective that includes the family.

1.2. Postpartum Depression

It is a clinical term referring to a depressive episode associated with childbirth [3]. Postpartum depression is a mood disorder that may begin in the first 24 hours after birth or a few months after delivery, but usually occurs two to six weeks after birth [4]. Postpartum depression is worse than “Baby Blues” and may occur at any time in the first year after birth, which occurs in 10% to 20% of mothers [5]. Initially, it can be fast or gradual with two main signs, constant sadness and lack of motherly joy. Behavioral symptoms include a state of despair or uncontrolled humorous fluctuations, lack of hope, a flat face no expression of any emotion, a sense of constant guilt (Bennett & Indman, 1966), perceptions of defect in itself or in her baby, indecision, lack of concentration or excessive focus, nervousness, social withdrawal, and loss of interest in self-care [6].

1.3. Postpartum Psychosis

The most serious condition, postpartum psychosis occurs 1 - 2 cases per 1000 women postpartum. The start may change from 2 to 3 days to 3 months after childbirth. Symptoms include severe insomnia, indifference to food, extreme anxiety and agitation. Visual hallucinations, illusions denying the child's birth or death, and suicidal thoughts or gestures can occur along with delusions. Postpartum psychosis requires immediate assessment by a medical

practitioner and hospitalization for medical treatment and psychiatric care. This condition is considered as a serious medical emergency because without treatment it may have tragic results for the mother and baby or other children.

1.4. Postpartum Depression Risk Factors

Risk factors for postpartum depression include stress, low socioeconomic status, low social support, a history of depression, and complications during birth, such as premature birth or as a result of mother-to-child partition. Before the symptoms are identifiable by healthcare professionals, the first signs of postpartum depression may be present in mothers earlier in the postpartum period. Medical check-up is used for early detection of postpartum depression, and is not considered a diagnosis. A positive result during medical examination does not always mean that it shows the current state. The value of the nurse's intuition that "something is wrong" can be taken as a starting point to assess the mother's condition regarding postpartum depression.

2. Purpose of the Research

Nurses and midwives in contact with birthing women were responsible for early detection of possible symptoms of postpartum depression.

The purpose of the research was:

- 1) Measurement of postpartum depression with relevant instruments;
- 2) Detection of the symptoms of postpartum depression;
- 3) Provide information in the most appropriate form based on the results of the research by making a literature analysis correlated with our findings.

3. Methodology

3.1. Samples

A sample of 91 women immediately after giving birth at the Clinical Obstetrics and Gynaecology Clinic (KOGJ) at the University Clinical Centre of Kosovo (UCCCK) completed two self-administered questionnaires. The average sample size was 27.6 ± 6.1 years, where 40 women (44%) reside in villages, while 51 women (56%) in cities. Their levels of formal education were, 21 (23.3%) at an Elementary level, with High School education 45 women (49%), 21 women (23.3%) had College educations, and at the Postgraduate level were 4 women (4.4%). In regards to their economic conditions, 11 women (12.4%) had poor economic conditions, 67 (75.3%) were at the average level, and 13 (12.3%) were at a high economic level. In the sample, 33 families (36.3%) had up to 5 members, 40 families (44%) of 6 - 10 members, 12 families (13.2%) with 11 - 15 members and 6 families (6.5%) with 16 - 20 members. The sample selection was random.

3.2. Instruments

Two instruments have been used in this research: Patient health questionnaire

(PHQ-9) and Postpartum Depression Screening Scale (PDSS) scaling.

3.3. Patient Health Questionnaire (PHQ-9)

The PHQ-9 instrument is a self-administered questionnaire, consisting of 9 questions that assess the degree of depression in the patient. The PHQ-9 has two components:

- Assess the symptoms and their functions to make a preliminary diagnosis for depression;
- Based on the results, help to select and monitor the treatment of depression.

The instrument is designed to measure the patient's mood over a period of two weeks. They are required to provide one of the four possible answers:

- Never 0 points;
- Some days 1 point;
- More than half of the day 2 points;
- Almost every day 3 points.

Patients are asked whether they have been disturbed by the following actions over the two-week period:

- Low satisfaction or diminishing interest in doing things or activities;
- Bad feelings, depression or loss of hope;
- Sleep problems;
- Decrease or increase in appetite;
- Low self-esteem, feelings of failure, or disappointment with yourself or your family;
- Difficulty concentrating;
- Moving or speaking too slowly;
- Thoughts that death or self-injury would be a solution.

Form PHQ-9 is available in the following languages: English, Greek, Croatian, Arabic, Bengali, Bulgarian, Czech, French, German, Hebrew, Hindi, etc.

PHQ-9 has been tested for validity and reliability in a number of languages. It has also been available for use in a variety of afflictions, such as sclerosis, depression in HIV/AIDS patients, and depression in diabetes patients.

3.4. Postpartum Depression Screening Scale (PDSS)

The PDSS has been developed to evaluate a woman's emotional state in the postpartum period. It consists of 35 questions grouped into 7 dimensions.

Responses are evaluated with the degree of 1 - 5: 1) completely disagree, 2) disagree, 3) neutral, 4) agree, and 5) completely agree. See **Table 1**.

3.5. Procedures

Initially, literature on postpartum depression was researched. During the months of April-May 2014, a list of 50 scientific articles dealing with the post-natal depression problem was consulted. Two instruments for this paper have been selected from the range of instruments available for postnatal depression

Table 1. Dimensions of the Postpartum Depression Screening scale (PDSS).

Dimensions	Questions
Sleep and Food Disorders	1, 8, 15, 22, 29
Anxiety and insecurity	2, 9, 16, 23, 30
Emotional lability	3, 10, 17, 24, 31
Mental Confusion	4, 11, 18, 25, 32
Loss of self	5, 12, 19, 26, 33
Blame and shame	6, 13, 20, 27, 34
Suicidal thoughts	7, 14, 21, 28, 35

research literature: Patient health questionnaire (PHQ-9) and Postpartum Depression Screening Scale (PDSS). Translation and adaptation of instruments from English into Albanian language has been done. The questionnaires were implemented in June 2014. The KOGJ chief of staff was informed about the implementation of the questionnaires. Respondents were also informed about the purpose of the research and the possibility of volunteer participation and withdrawal.

Both questionnaires were self-administered and their completion required a time of 15 minutes. The introduction and analysis of the messages is done with the Statistical Package of Social Sciences, version 21 (Statistical Package for the Social Sciences—SPSS).

4. Results

4.1. Results of the Questionnaire on Patient Health (PHQ-9)

See **Table 2** for degree of postnatal depression according to **PHQ-9**.

The average value of each of the PHQ-9 indicators in postpartum depression ranges from 1.5 to 1.8, the standard deviation of $\pm 0.6 - 0.86$. Feeling of failure or disappointment and sleep problems are the indicators of postmenopausal depression with the highest median of 1.8. Then there is fatigue or lack of energy, increased appetite or anorexia, suicidal thoughts and self-injury with an average attendance of 1.7 in the group of postpartum depression indicators. Depression or loss of hope and dissatisfaction or interest in activities are in the group of indicators with an average of 1.6. Movement or speech problems and concentration problems are the least affected indicators in the post-depression indicator group, with only 1.5. See **Table 3** for postpartum depression indicators (PHQ-9).

The impact of postnatal depression, on work, home care or social care has been measured at an unprecedented rate. These indicators are without any impact on 27.5% of post-natal women. 49.5% of postpartum women declare that these indicators to some extent have an impact on their lives. For 17.6% of women, the indicators are very positive for the post-birth. While at 7.7% of women, postpartum depression indicators have an enormous impact on their daily lives.

Table 2. Degree of postnatal depression according to PHQ-9.

Point	Description	Frequency	Percentage (%)
0 - 4	No Depression	23	25.3
5 - 9	Slight Depression	29	31.9
10 - 14	Moderate Depression	17	18.7
15 - 19	Moderate to severe Depression	13	14.3
20 - 27	Severe Postpartum Depression	9	9.9

Table 3. Postpartum depression indicators (PHQ-9).

Problems	Average	Standard deviation
Failure or disappointment	1.8	0.6
Sleep problems	1.8	0.69
Tired or with little energy	1.7	0.86
With little or too much appetite	1.7	0.76
Thoughts of suicide or self-injury	1.7	0.77
Depressed or hopeless	1.6	0.78
Low level of satisfaction or interest in doing things	1.6	0.69
Problems with motion or speaking	1.5	0.7
Problems with concentration	1.5	0.82

4.2. Results of the Postpartum Depression Screening Scale (PDSS)

Results of the postpartum depression screening scale.

4.3. Sleep and Food Disorders

In the category of sleep and food disorder see **Table 4**, 75.8% of women disagree or completely disagree with having sleep problems even when their child is sleeping, 11% are neutral, and 13.2% agree or fully agree that have sleep problems. There is no appetite loss in 56% of the women, neutral is 23.1%, and agree completely to agree that they have loss of appetite are 20.9% of the women. Sleep overnight due to insomnia was present in 61.6% of the women, neutral at 15.4%, and 23.1% of women were awoken at night due to insomnia. Movement during sleep did not occur in 58.2% of the women, 15.4% were neutral, and 26.4% of women admitted that they were rotating overnight at night due to insomnia. The women suffering from anorexia who were aware that they should receive nutrition were at 22%, despite 67% of them who did not agree that they had anorexia, neutral were 11%.

Overall, in the sleep and food category, 43.7% of women completely disagree with having sleeping or eating disorders, 20% disagree with having these disord-

ers, 15.2% are neutral, 12.7% of them agreed to have a food and sleep disorder, and 8.4% completely agree that they have sleep and food disorders. Anxiety even for the smallest things see **Table 5**, was present in 24.2% of the women, 15.4% were neutral, and 60.4% of women did not feel that they were anxious. No emotional burden is stated by 59.8% of the women, neutral 24.9%, and emotionally charged 15.4%. Also, 15.4% of women felt as if they were having an out of the body experience, 12.1% were neutral, and 72.5% of them did not have that feeling.

Loneliness occurred in 11% of the women, 14.3% were neutral, and 74.7% disagreed that they were feeling lonely. Women that moved and walked made up the 16.7% of women, 22.9% were neutral and 60.4% of women did not move and walk regularly. Finally, in the category of anxiety and insecurity, 47.3% of women completely disagree, 18.3% disagree, 17.9% are neutral, 10.6% agree, and 6% fully agree that their life after childbirth the child is causing them anxiety and insecurity.

Emotional lability see **Table 6**, manifests itself in the form of dizziness in 23.1% of the women, neutral is 11%, and in 66% of women, it did not affect them at all. Women that suffered from fear of loss of happiness were at 14.3%, 6.6% were neutral, and 79.1% of women were not afraid of loss of happiness. Unwanted crying was not present in 69.2% of the women, 11% of were neutral, and 19.8%

Table 4. Results in dimension: Sleep disorder and food.

Nr.	Problem	I completely disagree (%)	I do not agree (%)	Neutral (%)	Subscribe (%)	I completely agree (%)
1	Problems sleeping even with the baby asleep	50.5	25.3	11	7.7	5.5
8	[Text Wrapping Break] Loss of appetite	39.6	16.5	23.1	12.1	8.8
15	Awakening at night due to insomnia	39.6	22	15.4	13.2	9.9
22	[Text Wrapping Break] Bed rotations overnight	41.8	16.5	15.4	15.4	11
29	[Text Wrapping Break] Anorexia despite being aware of the need for food	47.3	19.8	11	15.4	6.6

Table 5. Results in dimension: Anxiety and insecurity.

Nr.	Problem	I completely disagree (%)	I do not agree (%)	Neutral (%)	Subscribe (%)	I completely agree (%)
2	Anxiety about the little things that have to do with the baby	35.2	25.3	15.4	16.5	7.7
9	Feeling an emotional load	38.5	21.3	24.9	11	4.4
16	Out of body experiences	57.1	15.4	12.1	8.8	6.6
23	Feeling loneliness	57.1	17.6	14.3	3.3	7.7
30	Moving and walking	38.4	12.1	22.9	13.2	3.5

Table 6. Dimension results: Emotional likelihood.

Nr.	Problem	I completely disagree (%)	I do not agree (%)	Neutral (%)	Subscribe (%)	I completely agree (%)
3	Emotional mix of emotions	44	22	11	16.5	6.6
10	Afraid she would never be happy	61.5	17.6	6.6	12.1	2.2
17	Crying without reason	50.5	18.7	11	13.2	6.6
24	Irritation	57.1	15.4	12.1	11	4.4
31	Feeling anger	48.4	31.9	7.7	8.8	3.3

of women did not suffer from crying without reason. Women who did not feel irritated were at 72.5%, neutral were 12.1%, and to some extent were 15.4% of the women. Feeling of anger was present in 12.1% of women, neutral 7.7%, and did not feel angry 80.3%.

The overall score of the emotional lability shows that only a very small number of women of 4.6% fully agree that they have an emotional lability, 12.3% agree with such a finding, 9.7% are neutral, 21.1% do not agree that they have emotional lability, and 52.3% of women say they are completely stable.

Loss of mind as a manifestation of mental confusion is present in 12.1% of women, neutral is 8.8%, while 79.1% of them do not have this problem. Loss of concentration is expressed in 15.4% of the women, neutral is 13.2%, and there is no issue in 71.4% of the women. Another problem with postpartum depression is the feeling of dementia at 11% in women, compared to 83.5% of women who are not excluded from this feeling, neutral ones are 5.5%.

Difficulties in making even the simplest decisions are present in 12.1% of the women, 16.5% of those difficulties are not reported, and 71.4% of women have no difficulty in making different decisions. The loss of focus in activities is present in 9.9% of the women, 17.6% are neutral, and 72.5% of women are not affected by non-concentration in activities.

In conclusion, the results of the category of mental confusion go in favour of its non-influencing in women's life: 55.4% of women fully agree that they are not confused, 20.2% of women only agree with this finding, 12.3% are neutral in their responses, 6.6% of women agree to have a degree of mental confusion, and 5.5% of them fully agree that they are confused in their lives.

5. Discussion

From our sample, the degree of depression from easy to severe postpartum depression is at relatively worrisome levels. Out of 91 respondents, 68 reported signs of postpartum depression, with 29 of them reporting signs of severe depression. The Center for Disease Control and Prevention reports that 12% of women are in moderate depression and 6% in deep depression after childbirth. Four million births in the United States represent 480,000 cases, or 1 in every 8

women after birth. From these studies, we see that postpartum depression is present and includes all the different categories and cultures in the world. From the measured dimensions to the research, the most affected areas in mother's life are: feeling of failure, sleep problems, fatigue, lack of energy, increased appetite or anorexia. Then feelings of suicide and self-injury. All these problems are associated with anxiety, failure or frustration, loss of hope, dissatisfaction or lack of interest in activities, problems in movement, speech or concentration. According to the Texas Birthplace Resource Center (PRCT), at least 36,500 mothers in Texas suffer from postpartum mood disorder each year. Episodes of this paralyzing mood disorder last six months to more than 25% - 50% of mothers.

Present is the fear of losing oneself, strong emotional changes, the feeling of guilt that she can not feel so much love for the child, the feeling of guilt and shame that they are not the mothers they should be, feeling that the child would live better without the mother, the desire to escape this world, and the sense of death as the only solution.

The correlation results between the two variables show a $p < 0.01$ and $p < 0.05$ significance. Problems with postpartum depression at work, at home and in society are associated with a low level of satisfaction or low interest in doing things or activities ($r = 0.398$; $p < 0.01$). Depression or hopeless feeling in the woman who gave birth to her baby comes from a variety of symptoms of depression, and in relation to the baby make her feel she was not the mother she should be ($r = 0.517$; $p < 0.01$). The feelings of fatigue or lack of energy lies in a correlation with many emotional burdens that worsen even more mom's health immediately after the baby's birth ($r = 0.408$; $p < 0.01$). Failure and frustration come as a result of having the feeling that many other mothers were better mothers than her ($r = 0.363$; $p < 0.05$).

The sense of a mix of emotions with respect to an unstable emotional state is caused precisely by the fear that it would never be herself ($r = 0.539$; $p < 0.01$).

The presence of anxiety in the life of a woman who has just given birth to her baby is due to the feeling of loneliness she should have because of different experiences not so pleasing to her life ($r = 0.427$; $p < 0.01$). Loss of mind due to even simple things causes her to think it would be best if she was dead ($r = 0.475$; $p < 0.01$).

The more she feared that she would never be herself, the more she imprints the feeling wanting to leave this world ($r = 0.577$; $p < 0.01$).

That she was not the mother that she thought she would be, contribute to make her feel like a failure ($r = 0.715$; $p < 0.01$). With the growth of fear that she would never be happier, then the desire to hurt herself increases ($r = 0.528$; $p < 0.01$). The feeling of failure as a mother in the face of the newborn baby made her feel guilty that she could not have as much love as the baby needed ($r = 0.469$; $p < 0.01$). The manner of the child's birth, especially a Cesarean birth, is followed by increased anxiety caused by even the smallest of things ($r = 0.276$; $p < 0.01$).

Yonkers (2003) states that 80% of women who experience postpartum mood disorder will have another episode later in their lives [7]. More than half of women identified by postpartum mood disorder were not identified with depression by their healthcare provider [8].

Postpartum depression affects the quality of a mother's life in all categories. The timely identification of postpartum depression is a necessity, as the presence of this phenomenon, results in the mistreatment of the condition. The instruments used in the research give us a clear picture of the degree of depression among our respondents. These figures are alarming and require immediate treatment and interventions. In England, the program used by nurses/midwives to assist postpartum women is divided into two parts.

The first part is screening and the second part is home treatment.

Although in England this is a practice established in nursing processes there is no published report, which has directly examined how well this health practitioner adopts this practice. In Scandinavia, a focus group survey interviewed health workers who conducted these visits and found that using the Edinburgh Postnatal Depression Scale (EPDS) made them feel safer in postpartum depression. Prior to using this instrument, they felt that there was no reliable way to determine the degree of depression of their patients. With involvement in the EPDG daily routine, nurses felt safer and did not need to speculate on the emotional state of the patients [9]. In the context of Australia's national control over screening and implementation of post-ophthalmic depression measuring instruments. 16 It appeared that 83% of 230 nursing respondents believed that EPDS was easy to use, 85% felt it was easy to explain to patients, 75% believed that the instrument was indispensable or very necessary, and 99% reported that they would continue to use it, indicating they had confidence in the instruments.

In the USA, screening for postpartum depression by midwives is supported by the US nursing organization, which has shown efficacy in primary care [10]. The American system does not apply the second part of the English system because they have a different healthcare system from England, where nurses come from a different education and training system [10]. Acceptance of screening for postpartum depression is necessary, but it is not enough. Preparing and implementing screening programs requires the completion of many steps: including staff training, the design of a screening instrument, and the formulation and implementation of protocols for postpartum depression screening [11]. Identifying treatment resources also poses a challenge on its own.

6. Conclusion

This phenomenon is multi-dimensional and touches on the nucleus of society, the young family. Apart from the direct impact of mother's emotional well-being, postpartum disorders also affect spousal relationships [10] [12] [13] [14] [15]. Depressed mothers have lower intelligence, attention deficit [10] [14] [16], violent behaviours related to attention deficit disorder, and long-term anger man-

agement problems [10] [14] [15]. Postpartum depression is a serious public health problem that can lead to ongoing mental health problems for many new mothers [16]. Approximately 15% of 669,000 UK-born mothers have developed postpartum depression, referring to one non-psychotic depressive illness which may last for several weeks, months or even a year after the child's birth [17]. Bringing a home child is a major event for the new mother and for the family, but the negative impact of postpartum depression on all its levels. Our statistics show a relatively high level of postpartum depression, which includes women of all categories without taking into account their economic situation, the level of education, or the number of births. These results derive from the correlation analysis which is non-aligning during the comparison of these categories. Involving of nurses/midwives in a timely determination of this phenomenon is a must. Based on the different health systems in the world that apply this practice, it should focus on the implementation of well-defined protocols and the implementation of tools that help health workers do their job more effectively.

7. Recommendations

Timely intervention of medical, nursing, midwife staff is crucial in the clinical course of this phenomenon. Pregnancy affects the whole family and therefore, assessment and intervention should be considered in a perspective with the family at the center.

Transition to being a parent is a stress-producing process that involves adapting both parents and their families even in the most favorable circumstances. Information on the level of psychological adaptation of women and family before and during pregnancy is very important as anxiety and the effects of accumulated life stress can directly affect individual and family well-being in the post-natal period. Especially for women or families facing multiple stresses and limited resources, ensuring security, understanding, compassion and direction may have a significant positive effect during this phase.

However, women and their families often have other needs and concerns beyond the perinatal nursing sphere. These issues may require cooperation with members of specialties such as psychiatry, mental health, nutrition services, social services or community agencies. If the mood does not stabilize within 21 days or if severe symptoms occur, reference should be made to the relevant mental health specialist and postnatal depression. The role of nurse/midwives is very important in timely capture and proper treatment of this phenomenon. Implementing well-established protocols, testing and supplementing these sourcing instruments should be compulsory for women in post-control checks.

Reliable instruments that help determine postpartum depression signs should be accessible to any counseling. Training of nursing staff/midwives for the implementation and interpretation of these instruments should be a priority of hospital maternity policies and counseling centers. Nowadays, many women

prefer to receive their information via the internet, the provision of official websites of hospital institutions, maternity and counseling centers should create a window of information for accurate information of women and family where it is possible to fill these instruments online with the possibility of automatically extracting the results and showing exactly where to turn for help.

Mothers' education and counseling by midwives, midwives/midwives should be part of everyday procedures, including education for a healthy life with a focus on:

- Food—a diet rich in multivitamins and juices.
- Staying away from alcohol consumption.
- Understanding and acceptance by family and friends is a very important factor in recovering the mental and emotional health of a woman suffering from postnatal depression.
- Quietness and Relationship.
- Physical exercises.
- Information flyer equipment for the symptoms and importance of handling these at any counseling centers and maternity clinics.
- Creating multidisciplinary support groups not only for the mother but also for the family members who are facing this concern.

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Ethical

At the moment that this topic was approved, by the Administration of University of Vlora, I have signed the declaration of academic honesty. I have stated and have always adhered to the principle that I will correctly and accurately refer to all the sources of literature used in this topic.

Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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