THE PSYCHOSOCIAL FACTORS RELATED TO POST-PARTUM DEPRESSION AMONG MOTHERS IN THE POST-PARTUM PERIOD AT THE DE SOYZA MATERNITY HOSPITAL FOR WOMEN IN SRI LANKA

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INTRODUCTION

Post-partum depression (PPD) is an episode of non-psychotic depression according to standardised diagnostic criteria, with onset within one year of childbirth (Stewart et al., 2003). PPD can be considered a significant public health problem and a mental health problem because it causes maternal suicides and affects the well-being of the mother as well as the cognitive and social development of the infant and the family. In developing countries, the rate of PPD is around 19.8% and the prevalence of PPD in Sri Lanka is around 27% (Isuru, Gunathillaka, & Kathriarachchi, 2016). Specifically, in Sri Lanka, for the year 2010, out of 206 reported maternal deaths, 31 were due to suicide, which is an alarming rate (Rishard, Ranaweera, & Senanayake, 2012). But still, maternal mental health problems remain underdiagnosed and understudied in Sri Lanka (Isuru, Gunathillaka, & Kathriarachchi, 2016). Therefore, it is paramount to diagnose, treat and prevent PPD. Identifying the different influencing and risk factors will be beneficial to diagnose, treat and prevent PPD. Previous literature evidenced that there is a vast range of factors that can lead mothers to develop PPD (Ayoub, Shaheen & Hajat, 2017; Mehta & Mehta, 2017). Hence, this study aimed to determine the psychosocial factors that can affect PPD among mothers in the postpartum period in the Sri Lankan context.

METHODOLOGY

In this quantitative descriptive study, 103 mothers in the postpartum period were recruited conveniently from the postnatal wards, postnatal well-baby clinic and '*MithuruPiyasa'* at the De Soyza Maternity Hospital for Women in Colombo, Sri Lanka. This study was carried out in two stages. In the first stage, the Edinburgh Postnatal Depression Scale (EPDS) was used to identify mothers with depressive symptoms. All mothers identified to have depressive symptoms were included in the study and mothers who were in critical condition who were unable to answer the questions were excluded. In the second stage, an interviewer-administered questionnaire was used to identify the factors influencing PPD. The questionnaire was developed using an extensive review of literature under the guidance of a supervisor and pre-tested with 10 postnatal mothers before the study. Data collection was conducted by midwifery-qualified nurses who have basic knowledge in Psychology and work in an obstetric clinical setting. The descriptive and inferential data analysis was performed using SPSS software. Ethical approval for conducting the study was obtained from the Ethics Review Committee of the De Soyza Maternity Hospital for Women.

RESULTS AND DISCUSSION

In the first stage of data collection, EPDS was used and 113 mothers with depressive symptoms were identified. Out of them, 10 participants refused to participate and only 103 participants were assessed in the study. Of the 103 participants, the demographic data of the sample is presented in Table 01. The majority (94%) of participants were married. This result evidences that marital status does not directly impact PPD. Kosi*ƒ*ska-Kaczy*ƒ*ska et al (2008) found that marital status has no relationship with the depressive symptoms experienced by mothers suffering from PPD. But some studies concluded that single motherhood to be a factor that affects PPD among mothers (Wubetu, Engidaw & Gizachew, 2018; Anuradha & Sebanti, 2011). In the current study, only 6% of unmarried mothers were found to have PPD. The reason for that could be the unavailability of emotional and physical support of the husband. Social stigma also can directly affect this.

In line with previous studies, the majority (67%) of the participants had not expected to have a child or, on the other hand, it had been an unexpected pregnancy. Abbasi and Chuang (2013)

highlighted that the prevalence of postpartum depression was higher in women with unintended pregnancies compared to women with intended pregnancies. An unexpected pregnancy can increase stress during the pregnancy, which may lead to PPD. Further, results of a meta-analysis suggest that the association of unintended pregnancy with PPD may be possibly due to seeking prenatal care later and experiencing the conflict between keeping or terminating the pregnancy (Qiu *et al*., 2020).

Table 01: Demographic Data

Characteristics	Frequency (N)	Percentage
15 - 20	12	12%
21 - 30	31	30%
31 - 40	42	40%
Above 41	18	18%
Religion		
Buddhist	56	54%
Catholic	31	30%
Muslim	12	12%
Hindu	4	4%
Marital status		
Married	97	94%
Unmarried	6	6%
Education		
Up to Grade 8	14	14%
Up to O/L	32	31%
Up to A/L	33	32%
Graduate	24	23%
Type of Delivery		
Normal delivery	57	55.3 %
Caesarean surgery	28	27.2 %
Forceps delivery	10	9.7 %
Vacuum delivery	8	7.8 %

The fear of delivery affects the psychological status of the mother during delivery, which can lead to a prolonged labour and cause PPD (Fazraningtyas, 2020). Many studies evidence that the fear of delivery was higher in mothers diagnosed with PPD (Räisänen *et al*., 2013; Fazraningtyas, 2020). The results of the current study, which are consistent with previous literature show that 45% of the participants had some fear when they admitted to the hospital for delivery, which is usual. However, 36% of mothers had excessive fear. Therefore, developing coping mechanisms and teaching relaxation techniques for and to mothers is essential to reduce fear of delivery, which could prevent PPD.

The results of the current study demonstrated that more than half (59.22%) of the participants experienced unbearable pain during the delivery. Kwok *et al*., (2015) suggests that there may be a positive association between labour pain and PPD. Further, they suggest that effective and timely pain management can reduce the occurrence of PPD in post-partum mothers.

The majority (67%) of the participants have stated that they were not being harassed by husbands. But 25% stated that they have been harassed by scolding while 6% stated they are been physically harassed. There were no sexual issues faced by the participants as it accounts for 79% of the total mothers. A prospective cohort study conducted to assess the association between violence against women and PPD also concluded that sexual, physical or psychological violence have no association with PPD (Budhathoki *et al.*, 2012). However, Tho Nhi *et al.*, (2019) evidenced that physical and

sexual violence by a partner was significantly associated with PPD among mothers while no association was found between emotional violence and PPD in their study.

When considering the assistance to look after the new-born baby, 39% of the participants said that they do not have anybody form whom to seek assistance to care for the baby while 38% depend on their parents and 17% rely on hired carers (servants). Further, 41% of the participants stated that they receive little support to look after the child from their husband and 30% believed that the role of the husband in helping to look after the child is at a satisfactory level. However, 29% stated that there is no support from the husband in this context. A larger portion of these participants is looking after their children without any assistance. Wubetu, Engidaw and Gizachew, (2018) found that mothers who have poor social support are more likely to develop PPD. The authors further discussed that having poor social support is one of the major factors in poor mental health (Wubetu, Engidaw & Gizachew, 2018).

Table 02: Psych-social Factors

Characteristics	**Frequency**	**Percentage (%)**
Did you expect a child?		
No, an unexpected pregnancy	69	66.99
Yes. Expected a child	34	33.01
How you felt when you see the child for the first time		
Delighted	65	63.11
Had no special feeling	22	21.36
Felt sad	16	15.53
How you prepared to welcome the child		
Happily	71	68.93
No special preparation, but ready to welcome the child	28	27.18
No need for a child	4	3.88
Were you frightened when admitting for delivery?		
Had little fear	20	19.42
Had somewhat fear	46	44.66
Had excessive fear	37	35.92
How emotionally you felt the delivery pain?		
Had no pain. Controlled by painkillers	28	27.18
Had a mild pain. It was bearable	14	13.59
Had mild pain. It was unbearable	12	11.65
Had excessive pain. It was unbearable	49	47.57
How do you take assistance to look after the new-born?		
Parents from both sides	39	37.86
Other relations and neighbours	6	5.83
Servants	18	17.48
Nobody is there for assistance	40	38.83
Does your husband assist to take care of children?		
Support satisfactory	31	30.10
Gets little support	42	40.78
No support at all	30	29.13
Do you experience any harassments of your husband?		
No. does not harass	69	66.99
Yes. Does physical harassments such as hitting	6	5.83
Yes. Do harassments such as scolding	26	25.24
Yes. Does both Physical and mental harassments	2	1.94
Did you suffer from any mental disease before delivery		
Yes	16	15.53
No	87	54.47

CONCLUSIONS/RECOMMENDATIONS

The results of this study concluded that unexpected pregnancies, the fear of delivery, lack of social support, acceptance of the pregnancy and caring for the child could influence the occurrence of PPD. By knowing the influencing factors, healthcare professionals can identify such factors when indicated among mothers in the community. The early detection of contributing factors and modifying such factors will be beneficial to reducing the occurrence of PPD. Therefore, urgent attention must be paid to this problem, so that maternal morbidity could be reduced. Further, the general public does not know about postpartum depression. The general public should be knowledgeable on PPD and the influencing factors to identify mothers with depressive symptoms and refer them to proper medical care. Health education programmes could exhibit relevant notices and posters in the maternity hospitals, maternity unit/ ward and clinics, and encourage midwives and nursing officers to identify this condition. Finally, conducting educational programmes for the general public in the hospital and community are further recommended.

REFERENCES

Abbasi, S., Chuang, C. H., Dagher, R., Zhu, J., & Kjerulff, K. (2013). Unintended pregnancy and postpartum depression among first-time mothers. *Journal of Women's Health*, *22*(5), 412- 416.

Ayoub, K., Shaheen, A., & Hajat, S. (2017). Prevalence and associated factors of postpartum depression in Palestinian mothers: a cross-sectional study. *The Lancet*, *390*, S31.

Budhathoki, N., dahal, M., Bhusal, S., Ojha, H., pandey, S., & Basnet, S. (2013). Violence against Women by their Husband and Postpartum Depression. *Journal of Nepal Health Research Council*. https://doi.org/10.33314/jnhrc.v0i0.327

Fazraningtyas, W. A. (2020). Psychological Factors in Postpartum Depression: A study at General Hospitals of Banjarmasin.

Ghosh, A., & Goswami, S. (2011). Evaluation of postpartum depression in a tertiary hospital. *The Journal of Obstetrics and Gynecology of India*, *61*(5), 528-530.

Kwok, S. C., Moo, D., Sia, S. T., Razak, A. S., & Sng, B. L. (2015). Childbirth pain and postpartum depression. *Trends in Anaesthesia and Critical Care*, *5*(4), 95-100.

Isuru, L. L. A., Gunathillaka, K. D. K., & Kathriarachchi, S. T. (2016). Reducing maternal suicide in Sri Lanka: closing the gap. *Sri Lanka journal of psychiatry*, *7*(1).

Mehta, S. and Mehta, N. (2014), "An overview of risk factors associated to post- partum depression in Asia", *Mental Illness*, Vol. 6 No. 1, pp. 14-17.

Qiu, X., Zhang, S., Sun, X., Li, H., & Wang, D. (2020). Unintended pregnancy and postpartum depression: A meta-analysis of cohort and case-control studies. *Journal of Psychosomatic Research*, 110259.

Räisänen, S., Lehto, S. M., Nielsen, H. S., Gissler, M., Kramer, M. R., & Heinonen, S. (2013). Fear of childbirth predicts postpartum depression: a population-based analysis of 511 422 singleton births in Finland. *BMJ Open*, *3*(11).

Rishard, M. R. M., Ranaweera, A. K. P., & Senanayake, H. M. (2012). Can we reduce maternal suicides?. *Sri Lanka Journal of Obstetrics and Gynaecology*, *34*(3).

Stewart, D. E., Robertson, E., Dennis, C. L., Grace, S. L., & Wallington, T. (2003). Postpartum depression: Literature review of risk factors and interventions. *Toronto: University Health Network Women's Health Program for Toronto Public Health*, 1-289.

Szymusik, I., Wielgoś, M., Horosz, E., & Kosińska-Kaczyńska, K. (2008). Affective disorders in the first week after the delivery: prevalence and risk factors. *Ginekologia polska*, *79*(3).

Tho Nhi, T., Hanh, N. T. T., Hinh, N. D., Toan, N. V., Gammeltoft, T., Rasch, V., & Meyrowitsch, D. W. (2019). Intimate Partner Violence among Pregnant Women and Postpartum Depression in Vietnam: A Longitudinal Study. *BioMed Research International*, *2019*.

Wubetu, A. D., Engidaw, N. A., & Gizachew, K. D. (2020). Prevalence of postpartum depression and associated factors among postnatal care attendees in Debre Berhan, Ethiopia, 2018. *BMC pregnancy and childbirth*, *20*, 1-9.