POSTPARTUM DEPRESSION: A COMPARISON OF KNOWLEDGE AND ATTITUDE BETWEEN THE FAMILY MEMBERS OF POSTPARTUM WOMEN

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Abstract

Postpartum Depression (PPD) is a common complication that mostly occurs during the postpartum period with the consequence of negative health outcomes for women and infants as well as other family members. The relatives of women are the first group that can notice abnormal signs and symptoms of PPD after discharge from the hospital. This study was a cross-sectional survey, aiming to explore knowledge and attitudes of 400 postpartum women's family members regarding PPD. A self-administered survey questionnaire was used for data collection. Data were analyzed using descriptive statistic. The findings show that family members, both husbands and female relatives, had positive attitudes and good knowledge about causes and risks of PPD. However, misunderstanding and wrong beliefs with regard to PPD were addressed. Therefore, health education on PPD should be provided for family members of postpartum women throughout pregnancy and postpartum periods.

Keywords: maternal care, mental health literacy, postpartum depression, family intervention

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INTRODUCTION

Postpartum Depression (PPD) is a mental health problem commonly found amongst postpartum females. Its prevalence has been reported both nationally and internationally. Many countries around the world reported the prevalence rate of postpartum depression as ranging from 4- 29% (Ghorbanshiroudi, Azari, Khalatbari, Charmchi, & Keikhayfarzaneh, 2011). In Thailand, Limlomwonse & Liabseutrakul (2006) report about 20% of postpartum women developing depressive mood. Postpartum women with depression will present constant sadness, fatigue, irritability, sleep disturbances, poor appetite, separateness, offensive thoughts and feeling guilt during their postpartum period (Lucero N, Beckstrand, Calliser, & Sanchez Birkhead, 2012). The symptoms of depression lead postpartum women to negative consequences that affect their role adaptation, baby health and the family.

Research pointed out that postpartum women need early detection and appropriate care. Ghorbanshirodi et al. (2011) mentioned that PPD usually occurs within 4-6 weeks after delivery of the baby. Also, a study by Liabsuetrakul & Pitanupong (2006), points out that those postpartum women can develop a depressive state and some of those can further develop onto postpartum psychosis. Noticeably, most postpartum women developed depression while staying at home, under the care of their husbands and other relatives (Jorm, 2006; Chongpanish, Kaewprom, Pisaipan, & Pratoom, 2014). Therefore, husband and relatives possibly play an important role and should be able to take care of postpartum mothers during this critical period.

Knowledge and attitudes regarding PPD should be promoted among family members of postpartum women because they are the potential persons who stay close to women after discharge from the hospital. Some studies suggest that women should have good social support during pregnancy and the postpartum period to move along and get through the stress situation to prevent PPD (Borra, Iacovou, & Sevilla, 2015; Kruse, Low, & Seng, 2013). Dayan et al. (2010) pointed out that problems at the work place, family problems, a past history of congenital baby abnormality and neglect from the family members or husbands are associated with PPD (Dayan, et al., 2010). Therefore, mental health literacy regarding PPD among family members of postpartum women should be a concern.

As previously mentioned, family members of postpartum women are an important group to have knowledge and a good attitude toward PPD in order to detect abnormal signs and symptoms. However, there is limited research that illustrates knowledge and attitude toward PPD between husbands and female relatives. Thus, this study aimed to illustrate the differences of knowledge and attitudes toward PPD. The research findings can be used as data for healthcare providers to design appropriate health service delivery to postpartum women and their families and to gain more knowledge and good attitudes toward PPD as well as to promote the well-being of women after delivery in the near future.

STUDY PURPOSE

This research aimed to survey knowledge and attitudes regarding PPD among husbands and female relatives of postpartum women.

METHODOLOGY

Research Design

This study was a cross-sectional survey, using self-reported questionnaires, conducted among postpartum women's relatives. Ethical consideration of the study was approved by the Institutional Review Board Committee of Assumption University (AUIRB no. 0001-2014) and Nopparatrajathanee Hospital (IRB no. 9/2559 project code no. 59-2-002-0). Research participants were informed that their participation in this study was voluntary and could be withdrawn at any time without any effect. Participant information sheets were distributed to the participants to read, and consent was obtained before the completion of the questionnaires. Participants were informed that their information would be kept confidential and data would be analyzed and presented as overall results without personal identification.

Population and Subjects

The research population involved relatives of postpartum women who gave birth at Nopparatrajathanee Hospital, Bangkok. The number of women who delivered in the hospital per year was approximately 3,500 to 4,000. Therefore, 400 subjects were recruited for the study because this number is big enough to represent the mass population as suggested by Yamane (Israel, 1992).

Samples were 400 family members of postpartum women who gave birth at Nopparatrajathanee Hospital, Bangkok, in the period of February- December, 2016. Systematic random sampling was used; the last number of admission to the postpartum ward included 2, 4, 6, and 8, and were chosen for data collection. Then, the family members who came to visit postpartum women were approached to participate in the study. The family members of women who had complications after delivery were excluded from this study. Finally, 238 husbands and 162 female relatives were willing to participate in the study.

Research Instrument

The research instrument was a self-reported questionnaire developed by Chongpanish et al. (2014). The questionnaire had two parts; 9 items about the causes and risks and 15 items about attitudes toward postpartum depression. Each item consisted of a brief statement with a 3-category Likert scale format, ranging from 1(disagree), 2 (partly agree) and 3 (strongly agree). The research instruments were evaluated for content validity by giving the questionnaires to five experts, including three nurses who have experience in midwifery and two experts from the psychology field. The questionnaire had a content validity index (CVI) of .90. After revising the questionnaires according to the suggestion from experts, the research instrument was tested with 40 subjects with the same characteristics as the target population of the research study (the family members who came to visit postpartum women in the hospital). Then, the questionnaires were calculated for reliability utilizing Cronbach's Alpha Coefficient, which was 0.80 (Chongpanish, et al., 2014).

Data Analysis

The descriptive statistics included frequency, percentage, and means for each variable were used to analyze the participants' characteristics, knowledge, and attitudes toward PPD.

FINDINGS

1. Demographic Data

The age of the majority of the participants, both husbands and female relatives, ranged between 21 to 30 years. The educational background levels, of the majority of husbands and female relatives were primary school and secondary school and 0.8% and 0.6% graduated higher than the bachelor's degree, respectively. About one half of the participants had monthly incomes ranging between 5,001-10,000 Thai baht. More details are shown in Table 1.

Table 1 Demographic characteristics of the participants (N =400)

Variables	Husbands (n=238)	%	Female relatives (n= 162)	%
Age				
= 20	20	8.4	16	9.9
21 – 30	121	50.8	72	44.4
31 – 40	71	29.8	39	24.1
41 – 50	24	10.1	27	16.7
>51	2	0.8	8	4.9
Educational level				
Primary school	68	28.6	49	30.2
Secondary school	88	37	40	24.7
High school/Vocational certificate	60	25.2	42	25.9
Diploma degree	12	5	11	6.8
Bachelor degree	8	3.4	19	11.7
Higher than Bachelor degree	2	0.8	1	0.6
Monthly income				
< 5,000	41	17.2	22	15.8
5,001 – 10,000	107	45	81	47
10,001 – 20,000	59	24.8	41	25
20,001 – 30,000	23	9.7	10	8.2
30,001 – 40,000	6	2.5	4	2.5
> 40,000	2	0.8	4	1.5

2. Knowledge about Causes and Risks of PPD

Regarding knowledge of the causes and risks of PPD, perspectives of husbands and female relatives were separately analyzed, as shown in Table 2. It is more likely that female relatives have a better overall understanding about the causes and risks of PPD than husbands. Husbands perceived that the 3 main causes of PPD were poor relationship within the family, life crisis, and history of depression; while female relatives considered unplanned pregnancy, life crisis, and history of depression as the main causes. Interestingly, 42.02% of husbands and 38.27% of female relatives misunderstood postpartum depression as caused by ghost possession or committing sin.

Table 2 Knowledge about causes of postpartum depression

Items	Husbands (N = 238)		Female relatives (N = 162)	
	Agree (%)	Disagree (%)	Agree (%)	Disagree (%)
1. Postpartum depression is genetic disease.	55.04	44.96	54.32	45.68
2. Woman who has unplanned pregnancy is risk to have postpartum depression.	84.45	15.55	91.98	8.02
3. Crisis situation in life can cause postpartum depression.	87.82	12.18	94.44	5.56
4. Poor relationship among family members can cause postpartum depression.	88.66	11.34	90.74	9.26
5. Woman who has history of depression is high risk to have postpartum depression.	87.39	12.61	91.98	8.02
6. Woman who is rearing the child alone is risk to have postpartum depression.	85.29	14.71	86.42	13.58
7. Postpartum depression is caused by ghost possessed or doing sin.	42.02	57.98	38.27	61.73
8. Postpartum woman who lack of confidence in taking care of baby is risk to have postpartum depression.	80.25	19.75	80.86	19.14
9. Health problem/sickness of baby may cause postpartum depression.	85.71	14.29	90.12	9.88

3. Attitudes toward Postpartum Depression

Overall, there was an ambivalent perspective with regard to postpartum depression. Seemingly, both husbands and female relatives had positive attitudes toward the treatment of PPD and would send patients to hospital. 89.08 – 90.76 % of the husbands and 89.51 – 91.36 % of the female relatives thought that depressive postpartum women were pitiable persons with whom they sympathize and would be patient in dealing with. Also, 92.02 % of the husbands and 93.21 % of the female relatives agreed that depression was a signal calling for help to postpartum women, and 91.98 – 92.02 % of them would be willing to help if any of their wives or relatives were diagnosed with postpartum depression. However, there were some negative views toward depressive postpartum women too. For example, about one half of the husbands perceived postpartum women who have depression as being weak and annoying persons and a burden to the family; they felt shame and would not tell anyone that their wife or relative had this depression.

Moreover, the findings also reflect that both husbands and female relatives considered depressive postpartum women as a low-potential persons. To illustrate this, about 70% of husbands and of relatives assumed that postpartum women with depression could not make decisions at all. About 60% of both groups considered postpartum women with depression unable to take care of their own child.

The details on attitudes towards postpartum depression perceived by husbands and female relatives are presented in Table 3.

DISCUSSION

The numbers of participants in this study were 400 relatives of postpartum women, including 238 husbands and 162 female relatives. All participants identified themselves as primary caregivers for postpartum women at home. The previous research studies pointed out that if caregivers have more knowledge in detecting signs and symptoms of PPD early, it can prevent severe complications that might happen to postpartum women (Farr et al., 2014; Jorm, et al., 2006). However, this research study demonstrated that some of the participants still lacked the knowledge to detect signs and symptoms of PPD, which can increase the risks for postpartum women to face this health problem (Farr et al., 2014; Lucero et al., 2012). The study of Limlomwonse & Liabsuetrakul (2006) supported that depressive condition was found both in pregnancy and the postpartum periods, which are mostly under the care of husbands. If they lack knowledge and have a negative attitude toward PPD, negative consequences or problems will affected people on both the individual and the family levels (Pei-Jung, Jen-Jiuan, & Chin-Mi, 2015). Therefore, family members including both husbands and female relatives should be educated and given sufficient knowledge and ability to care for women, even regardless of depression.

The study results showed that husbands and female relatives had similar levels of knowledge regarding the causes and significant risk factors of PPD, such as life crisis, unplanned pregnancy, history of depression, and poor relationship within the family. However, some participants still misunderstood PPD as being caused by ghost possession or sin. These research findings were

Table 3 Comparison of attitudes between husband and female relatives toward postpartum depression

Items	Husbands (N = 238)		Female relatives (N = 162)	
	Agree (%)	Disagree (%)	Agree (%)	Disagree (%)
1. I feel shame and do not tell anyone that my relative has postpartum depression.	42.02	57.98	40.12	59.88
2. Postpartum women who have postpartum depression cannot be good mothers.	46.64	53.36	56.79	43.21
3. Postpartum women who have postpartum depression should stay home.	37.40	62.60	42.59	57.41
4. Postpartum women who have postpartum depression are weak and annoying persons.	46.22	53.78	40.74	59.26
5. We should be patient and have empathy with the women who have postpartum depression.	89.08	10.92	91.36	8.64
6. Postpartum women who have postpartum depression cannot take care of her own children.	61.35	38.65	60.49	39.51
7. Postpartum depression is an uncured disease and will continue increasing in severity.	47.06	52.94	58.03	41.97
8. Postpartum women who have postpartum depression are a pitiable persons.	90.76	9.24	89.51	10.49
9. I feel it oppressive to take care of a woman who has postpartum depression.	57.56	42.44	54.32	45.68
10. Postpartum women who have postpartum depression cannot make decisions at all.	72.27	27.73	67.90	32.10
11. Postpartum women who have postpartum depression should not have another child.	69.75	30.25	77.78	22.22
12. I am ready to help if my relative has postpartum depression.	92.02	7.98	91.98	8.02
13. Postpartum women who have postpartum depression is a burden to the family.	51.68	48.32	56.17	43.83
14. Postpartum women who have postpartum depression should be treated in hospital.	84.03	15.97	80.86	19.14
15. Postpartum depression is an alert sign that a postpartum woman needs help from a caregiver.	92.02	7.98	93.21	6.79

consistent with the study by Chongpanish et al. (2014), which supported life crisis situations, unplanned pregnancy, depression history, and especially poor relationship within the family as the main risk factors for PPD. Also, the finding was confirmed by the previous studies that women who lack social support revealed signs of PPD (Ganann, Sword, Thabane, Newbold, & Black, 2016; Leung, Letourneau, Giesbrecht, Ntanda, & Hart, 2017). According to the literature reviews, several studies conclude that depressive mood is complex and influenced by multifactors, including biological and psychosocial factors (Lee, Yip, Leung, & Chung, 2000; Mehta & Mehta, 2014).

Interestingly, nearly half of the participants believed that ghost possession or committing sin were causes of PPD. This finding reflects some wrong beliefs in Thai society about the causes of PPD. In a study by Burnard et al. (2006), there is evidence that some Thais considered doing bad or sin as cause of mental illness. This implies that Thai people still need more information and knowledge about PPD.

Regarding the attitudes, the results demonstrated positive attitudes towards PPD, among family members of postpartum women. In detail, it is more likely that husbands have positive attitudes and intentions to help depressive postpartum women than female relatives. This reflects that husbands had more acceptance and sympathy towards their wives, which promotes good relationship, love and care between couples. Traditionally, although the husband is not directly involved in the stage of childbirth, he is supportive and offers helps with love and care to his spouse, especially when his wife has health problems (Lewis, Lee, & Simkhada, 2015). Literature review demonstrated that a husband's competency in caring for women with PPD can contribute to good a health outcome in postpartum women and the baby (Farr, Denk, Dahms, & Dietz, 2014; Lucero NB, Beckstrand, Callister, & Sanchez Birkhead, 2012).

However, the research findings pointed out that nearly half of the family members reported they would feel shame and not tell anyone if their relatives were diagnosed with PPD. It is important for health care providers to explain the risks and nursing management in PPD for patients and family members in order to promote good health outcomes and emotional support for them (El-Ibiary et al., 2013).

RECOMMENDATIONS

The findings of the study illustrate the understanding and attitudes towards postpartum depression among relatives of postpartum women. Also, they reflect the need to improve mental health literacy related to postpartum depression among relatives of postnatal women, as they play key roles in maternal mental health care during the period of pregnancy and the postpartum state.

According to the findings, nurses who work at antenatal care units (ANC) and postpartum units (PP) should provide information about causes and risk factors of postpartum depression and care strategies for postpartum women who had depressions. Psychological education related to postpartum depression should be provided for postpartum women's relatives, especially husbands, throughout the periods of pregnancy and postpartum in order to increase the relatives' potential for mental health care. It will help them to deal with maternally emotional distress along the journey

of maternal care at home (Chongpanish, et al., 2014; Corrigan, Kwasky, & Groh, 2015; Khalifa, Glavin, Bjertness, & Lien, 2015).

Furthermore, healthcare professionals who work in communities should be trained to improve knowledge and competence regarding care for postpartum depression. In fact, the state of a depressive mood can occurr during both pregnancy and the postpartum period (Ghorbanshiroudi, et al., 2011). Accordingly, continuous home health care for pregnant and postpartum women should be conducted by healthcare professionals who have sufficient understanding and competence to deliver mental health care. The research findings pointed out that giving birth alone may cause PPD so that the women need mental support from family members. Therefore, healthcare providers should be concerned about the feasibility to allow family members to stay with the women during the intrapartum period.

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