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Research Paper

Postpartum Depression: Debunking the Idea of a Joyous Motherhood

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ABSTRACT

Postpartum period is a challenging period characterized by overwhelming modifications in biology, physical, social, and emotion. Pregnant women and their families have many postpartum ambitions that are coloured by a little baby's joyful arrival. Unfortunately, during the postpartum period, women may be prone to a multitude of psychiatric disorders like postpartum blues, depression, and psychosis. According to the National Mental Health Survey (2015-2016), 1 in every 20 people in India suffer from depression of which women in their child-bearing age are most prone to it, commonly manifesting as postpartum depression. The voices of these women suffering from postpartum depression are oftentimes silent. Stigma around the idea of mental health and utter lack of awareness are two of the most significant factors behind the silence. The aim of the paper is to understand,

- factors responsible for postpartum depression- hormonal changes vs family settings
- role of a man during postpartum
- healthcare facilities and government policies available

Keywords: *Postpartum Depression, Indian, Medical professionals, Parents, Childbirth*

Depression and Motherhood

Maternal health is an important factor of any country's development. It helps increase equity and reduce poverty. Mother's survival and well-being is not only important in its own right, but also vital to solving larger problems of economic, social and development issues. Maternal mortality ratio is one of the country's major health service quality metrics. India has made tremendous progress over the past two decades in reducing maternal deaths. Remarkable progress in recent years, to 130 per 100000 in 2016 live births from 556 per 100000 live births in 1990, in increasing the maternal mortality ratio (MMR) by 77 percent. Slowly, it is important for India to now start looking at other factors of maternal healthcare- psychological.

Mental disorders affect all, regardless of age, race, location, or living standards. Mental illness is a health issue that causes variations in behaviours, emotions and thoughts eventually leading to changes in relationships. Depression is one such psychological condition which is not only the most prevalent mental health problem faced by women but

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could be more severe in women than men. One of the contributing factors to that could be motherhood. Maternal depression is an all-encompassing term for a spectrum of depressive conditions that can affect mothers (up to 12 months postpartum) and mothers-to-be. These depressive conditions include prenatal depression, postpartum depression, and postpartum psychosis. Symptoms may include fatigue, alter in patterns of sleep and eating, anxiety, withdrawal from society, and sadness. Mothers also tend to develop guilt about their capability to care for their offspring. New mothers have an increased risk of developing PPD because the hormonal fluctuations arising from pregnancy and childbirth are combined with child care.

Postpartum depression:

The postpartum period is characterized by intense emotional and physical adjustments and adaptation to new roles and responsibilities. It does not have a single cause and can affect some women more than other due to various environmental, physical and emotional reasons (Nimh.nih.gov, 2019). PPD is a mood disorder commonly occurring in the first four weeks after birth but may also occur 12 to 18 months after birth (Goodman, 2004). During this time, the focus of the new born frequently overshadows the needs of the women. For most women, having a baby is a very exciting, joyous and sometimes stressful moment. But for women with postpartum depression this can be a very distressing and challenging time. Postpartum depression is a psychological condition that is severe but treatable. It entails extreme sadness, obliviousness and/or anxiety, as well as changes in energy, sleep and appetite. One can find it hard to even go about their daily chores. It is important that a pregnant woman is tested for PPD as it can affect not just her own health but also that of the child (Nimh.nih.gov, 2019). Currently there are two screening tools that can be used to test for PPD, the Edinburgh Postnatal Depression Scale and the Postpartum Depression Screening Scale (2006, Driscoll, Jeanne Watson). There are various treatments available for the treatment of PPD, one of them being talk therapy through CBT and IPT. (Nimh.nih.gov, 2019).

Women are unwilling to reveal to others that they are unhappy after the birth of their children. Much has been written about possible triggers, risk factors and therapies for postpartum depression, but little has been done to examine why it takes so long for women to seek help. Environmental factors also play a very integral role in the understanding of postpartum depression. Depression in pregnant and new mothers is an issue that affects a lot of women but goes un-noticed and un-treated. While there is a good amount of physiological care given to the mother during and after pregnancy, there is little to no emphasis on the mother’s mental health. The World Health Organization advises that after delivery, all women and new-borns receive at least three postnatal contacts — the first between 48 and 72 hours, the second between 7 and 14 days, and the third at six weeks after delivery. Maternal mental health, along with women's health, maternal and child health care, reproductive health care, and other relevant services, can be integrated into general health care.

It is important to make it compulsory to check women with such a condition along with all the other post-natal care that is provided. Early recognition can help reduce the effects of it on the psyche of the mother. Undiagnosed, untreated and prolonged PPD can affect the child’s cognitive development, cause delays in language and also create behavioural problems (2006, Driscoll, Jeanne Watson) (Shashi Rai, Abhishek Pathak, Indira Sharma, 2015).

Risks of postpartum depression in Indian women:

According to a study done by the WHO worldwide about 10% of pregnant women and 13% of women who have just given birth experience a mental disorder, primarily depression (WHO, 2017). In developing countries this is even higher, i.e., 15.6% during pregnancy and 19.8% after child birth (WHO, 2017). In India, 22% of the women suffer from postpartum depression. (WHO, 2017). Maternal depression can affect the mother-child bonding negatively. (WHO, 2017). It is also believed that this can have a negative impact on child's overall development both physical and mental. (WHO, 2017). Some research suggests that treating mother's depression results in improved newborn growth and development and reduces the likelihood of diarrhea and malnutrition in them. (WHO, 2017) PPD appears to have multi-factorial signs and symptoms, environmental, psychosocial, obstetric, and medical risk factors, affecting the population. In resource-rich and resource- limited environments, specific cross-cultural risk determinants for PPD have been reported. Nonetheless, specific factors such as conception of a girl child, traditional ritualistic processes, financial instability, marital violence, lack of social support have emerged as risk factors for PPD in low- and middle-income countries such as India. In a cohort study conducted in low-income countries it was understood that women are at high risk of developing a postnatal mental disorder by the 8th month of their pregnancy (Sekai Nhiwatiwa, Vikram Patel, Wilson Acuda, 1997). In another study researchers use the biopsychosocial model to encapsulate some risk factors, mediators and moderators studied the underlying associations between maternal depression and child outcomes in low-income and middle-income countries (Catherine M Herba, Vivette Glover, Paul G Ramchandani, Marta B Rondon, 2016). Facilities in low-income and middle-income countries are often under-resourced, under-stress and leave most people with mental health problems with little or no care (Kwame McKenzie, Vikram Patel and Ricardo Araya, 2019).

Clinicians in India often believe that the main reason for PPD is hormone imbalance and therefore do not consider the interaction of hormonal and environmental (socioeconomic, cultural and household) factors. Review of research shows that there are a host of reasons for the manifestation of postpartum depression. Women have reported issues such as preference of a son, domestic violence, poverty, the tension in families, lack of support and relationship issues (with spouses and in-laws) as stimuli for their depression. (Dennis 2005; Savarimuthu et al 2010). In spite of this, initiatives are overwhelmingly medical and partners and families are scarcely incorporated in the prevention or any remedial action. India is a collectivist country wherein the influence and importance of family is very heavy and therefore consideration of these factors becomes very crucial to understanding PPD.

Despite having come a long way, misogyny continues to haunt us to this day. Of the many issues, one major issue that mothers in 21st century India continue to suffer with is the pressure to birth a male child. And face a lot of consequences for delivering a female child. The mother faces low self-esteem and detachment from the child and tends to blame the child for the societal disapproval. Gender of the infant has the ability to alter the consequences of other risk factors such as marital abuse. For example, with the birth of a girl child, the risk of PPD among mothers witnessing domestic violence is seen to be higher. Research shows an association between economic poverty, infant gender and marital abuse, affecting PPD, even as the exact mechanisms connecting these risks remains unclear. The joy of a family with the birth of a male child is seen to have helped the mother cope with other pressures (Patel et al 2002).

Another important factor to consider is that of joint families versus nuclear families. There is a lot of mixed research regarding the evidences of PPD in women living in joint families versus nuclear families. Some research suggests that women living in joint families are more prone to PPD, others say it is the nuclear families and lack of support that causes PPD. The risks of PPD attached with joint families is to do with problems with members of the family. Unsupportive partners or relatives often magnify the problems. Disharmony in relationships with the mother-in-law is seen to be a particular stressor for many women living in joint families. Pressures that come with cohabiting family members complying with social norms and traditional practices is also a factor for those living in joint families. In contrast to this, women living in nuclear families may receive limited support in childcare and household tasks, and may feel stressed and frustrated due to the responsibilities of the motherhood and the household, leading to depression (Dubey et al 2012). Furthermore, financial difficulties and low socio-economic status add to the challenges faced by women.

Over recent years, more attention has arisen from men's positions over maintaining maternal health. An integral component of making women feel loved and heard is the supportive mentality of men, especially during pregnancy. However, the role of the husbands in maternal health is often undervalued and disregarded. Enhancing the involvement of men or husbands in maternal mental health care is one of the critical aspects that lead to a woman's stable motherhood. A responsive and sensitive husband with adequate knowledge of maternal health and mental health would assist in providing better financial assistance, aiding in household chores, accompanying the woman for routine care during pregnancy, and contributing towards providing his wife with ample nutritional support.

Many of the Indian families perform obsolete practices and customs post-delivery. Some of those rituals can cause more detriment to the mother than do good. For example, in many areas of northern and western India, the mother and the new-born live in isolation from family and community for forty days after birth. Although this is done in order to protect them from infection, the active isolation leaves the mother lonesome and helpless. Contrary to the perception that such practices are being followed only in villages many women living in the cities follow the procedure in order to follow traditions and admit that the isolation they feel following this tradition has caused ill thinking on their part towards their baby. However, unlike urban women, the women in rural areas neither have access to healthcare for intervention nor have awareness of their situation.

Another issue which is a very important factor to consider is adolescent pregnancies. Pregnancy of a young girl between the age 10 to 19 is considered adolescent pregnancy. In developing countries like India, the accepted cultural norms of our society are early marriages and early pregnancy. According to a study, in India 18.2 percent of women between the ages of 20 and 24 were married at age 15 and 47.4 percent at age 18. 16 percent (Teertha Arora, Nandita Bhan, 2018) of adolescents between 15 and 19 years have begun childbearing. Research done to study adolescent pregnancy shows that young girls are more prone to PPD. Adolescent mothers face multiple psychological issues ranging from low self-esteem to severe depression. This is due to poverty, domestic violence, troubled family relationships, existent psychiatric disorder.

Throughout India, mothers with emotional problems often do not seek help because of the stigmas that accompany them. They may not even be aware in some instances of the fact that there is a diagnosis for their trouble and that it is a matter that requires medical

attention. Consequently, even the mildest type of PPD becomes a challenge for a mother who combines the household with childcare.

Mental health policies for women in India:

The burden of PPD in India must be addressed in the light of women's health policies, particularly mental health policies. Although currently no health policy or initiative explicitly addresses PPD, some laws, as predictors of PPD, make vague or passing references to women's mental health and gender issues. For example, India's Reproductive and Child Health (RCH) program. Reproductive and Child Health (RCH) program is a flagship program under the broader umbrella of the National Rural Health Mission (NRHM) of the Government of India which works towards maternal and infant mortality reduction and total fertility rates. It recognizes the need to expand the scope of postnatal treatment but does not emphasize the psychological well-being of the mother or find it among quality metrics for the programmed care. PPD also finds no mention in National Mental Health Programme of India. NMHP only addresses the need to upgrade the mental health skills of auxiliary nursing midwives, who are a widespread contact point for mothers in rural areas where mental health professionals are in short supply.

DISCUSSION

Research on PPD in India demonstrates that over the last ten years a number of studies have been conducted to calculate the burden of disease and it's risk factors. This knowledge of risk factors needs to be translated into interventions for preventing and managing PPD. Postpartum depression is a growing health concern among women in India and affects both rural and urban women's lives equally. Data suggests that sociocultural determinants contribute to the development of PPD outside hormonal and psychological factors, particularly in relation to a woman's position within families and society.

Most of the studies conducted have been carried out in rural settings of India, indicating a disparity in the data of urban areas. While there is a lot of speculation regarding women in urban areas being more prone to postpartum depression, there is hardly any research that has been done about it. Women in urban areas usually face low social support and are a part of stressful work conditions. Working women are particularly vulnerable to stressors in the workforce due to sleep deprivation, the responsibility of caring for a child, and failure to engage in health promotion activities due to conflicting home and work demands.

Men's awareness of childbirth-related care and a constructive attitude towards gender enhances the use of maternal health care and women's decision-making regarding their health care, while their presence during pre-natal and post-natal care visits significantly increases women's chances of a happier and easier pregnancy. From a policy standpoint, proper propagation of maternal health care information among spouses and compulsory participation of them during postnatal care visits would help primary health care units ensure better engagement of males in maternal health care. Having a sensitive and support spouse can reduce the burden of pregnancy on women and thereby reduce the chances of PPD or at least make it easier to cope with it.

It is also clear that women's reproductive health and mental health strategies and initiatives need to identify and realize the role of these indicators, and develop measures addressing these key structural factors. There is a need for government policies to surround the issue so that the awareness of it reaches a wider public. Given the lack of mental health professionals, midwives, gynaecologists, paediatricians, and community health staff in India

will need to meet service needs related to women's postpartum wellbeing. Also, women's health initiatives need to be established based on cross-sectoral action to address issues related to PPD growth in India.

Many studies conducted around low income countries of South Asia prove that intervention and counselling can help resolve the problem of PPD. "Women to women" initiatives to help increase maternal self-esteem and empowerment may be implemented. Locally trained community health workers can provide the intervention with the goal of offering emotional support and encouragement to mothers in building sensitive responsive experiences with their child. Research suggests intervention could improve the interaction between mother and infant and the growth of infants. Besides, such an action can also help a woman to feel at one with herself again. (Vikram Patel, Atif Rahman, K S Jacob and Marcus Hughes, 2004)

CONCLUSION

Postpartum depression may potentially expose a mother to acute or chronic depression, which may affect the bond between the mother and the infant and ultimately affect the baby's development and growth. Children of postpartum depressive mothers have more emotional, behavioural, and interpersonal difficulties than kids with non-depressed mothers. With 1 in every 20 women in India (WHO, 2017) being affected by it, it becomes important for people of India to start to understand that it is an important aspect to be considered in the area of women's health for the betterment of not just the mother but also for the growth of the baby into a healthy human being. Maternal healthcare cannot be seen in isolation from mental health care and therefore there is a need for us as a country to take steps towards integrating it into our healthcare systems. The paper hopes to create a dialogue that has been hushed due to various societal factors and bring awareness that postpartum depression is easily treatable and if treated early can provide a base for a wholesome growth of a family. Most of the research done before does not cover the integration of the biological, social and psychological factors in the understanding of postpartum depression and the role and importance of the men in postpartum period in a male driven country. The very awareness of this matter amongst people is also a very important factor to be understood because it provides a base for the possible solutions.

To sum up, there are biological, psychological and social manifestations that cause postpartum depression. One of these domains cannot be ignored, and no domain should be asserted at the detriment of the other. Access to maternal mental healthcare needs to be made more accessible and people need to be made aware of PPD.

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Conflict of Interest

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