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Article

Role of the husband's knowledge and behaviour in postnatal depression: a case study of an immigrant Pakistani woman

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ABSTRACT

Objective This study aims to highlight the subjective experience of an immigrant Pakistani woman during postnatal depression (PND), with a special emphasis on the husband's knowledge and behaviour towards PND.
Method A face-to-face interview was conducted with a woman reporting symptoms of depression on the fourth day after delivery. She was evaluated using the *Diagnostic and Statistical Manual of Mental Disorders, fourth edition* (DSM IV)[1] and the *Edinburgh Postnatal Depression Rating Scale* (EPDRS).[2] The evaluations were completed by a qualified psychiatrist. The demographic information, personal and family medical history and attitude towards the child were the principal issues recorded. In addition, five items were used to evaluate the husband's knowledge about PND. The EPDRS differences before and after counselling were evaluated using a student *t*-test.
Results The patient was 32 years old and this was her first experience of delivery by Caesarean section. The evaluation for depression confirmed the diagnosis of PND and she scored 16 on the EPDRS. The husband's knowledge of PND was poor.
Conclusion This case study suggests that lack of social support and understanding appear to play a vital role in the persistence of symptoms of PND among new mothers. Therefore, counselling of couples may be an effective additional tool in treating PND.

Keywords: knowledge, postnatal depression, social support

Introduction

The term PND was used for the first time in 1982 to describe the depressive illness occurring among some women after pregnancy.[3] These emotional changes had previously been identified as the 'baby blues'.[4] Later, it was recognised that a woman can go through baby blues, PND and/or postpartum psychosis. The distinction between these three is based in large part on the duration of symptoms. The baby

blues can happen in the days right after childbirth and normally go away within a few days to a week.[5] However, postpartum depression can happen at any time within the first year after childbirth. A woman may have a number of symptoms such as sadness, lack of energy, difficulty concentrating, anxiety and feelings of guilt and worthlessness. Postpartum depression often keeps a woman from functioning well for a longer period of time than the baby blues.[5] Whilst postpartum psychosis is relatively rare, it still occurs in one or two out of every 1000 births and usually begins in the first six weeks postpartum. Women who have bipolar disorder or schizo-affective disorder have a higher risk for developing postpartum psychosis. Symptoms may include delusions, hallucinations, sleep disturbances and obsessive thoughts about the baby. A woman may have rapid mood swings, from depression to irritability to euphoria.[5] It is estimated that every 10th woman delivering a baby is at the risk of PND.[6,7]

PND involves both physical and psychological signs and symptoms. Among them, excitement, tension, moodiness and self-doubt are commonly observed.[8] Other relatively frequent symptoms are feeling lonely, obsessive thoughts, lack of concentration, changes in sleep pattern, fatigue, tearfulness, loss of interest in routine activities and negative thoughts.[9–11] Sometimes, these feelings fail to subside and augment the severity of the condition.[12] In severe cases, the mother's and child's lives are at risk, with possible attempts at suicide and/or infanticide.[13,14] In general, for the diagnosis of PND to be established, the Edinburgh PND Rating Scale is the gold standard. However, DSM IV is also often concurrently used to enhance the accuracy of the diagnosis.

In terms of the aetiology of PND many theories involve biological causation. Some authors note an association between PND and a deficiency of progesterone.[15,16] However, others have postulated an association with thyroid malfunction,[17,18] and still others believe that a low level of oestrogen is a cause.[19–21] In the context of psychological theories, cognitive theories associate PND with a lack of coping skills in a new mother that can result in lack of confidence in herself and in caring for the baby.[22]

Some researchers have found that those women who have undergone a Caesarean section are at greater risk of PND than those who have delivered the child through the vaginal route.[21] Moreover, generalised anaesthesia during Caesarean section has been found to be significantly associated with PND.[23] However, in the Southeast Asian region (SEAR), PND has been associated with social problems. There has been evidence among Indian women of the association of PND with low socio-economic status, marital violence and a previous history of depression.[24] Though Pakistan is not within the SEAR, there are many similarities with neighbouring countries in terms of socio-cultural aspects. Among native Pakistani women in one study, age and low socio-economic status were the main risk factors for PND.[25] In contrast, a poor relationship with their partner and a previous history of depressive disorder were the main factors observed among immigrant Pakistani women with PND.[26] Overall, a high incidence of depression was also found among those aged 30 and over.[25,26]

A literature search offered no studies regarding the husband's knowledge level of PND and attitude immediately after delivery vis-à-vis PND. This study aims to highlight the subjective experience of an immigrant Pakistani woman during PND. Moreover, this case study will be first to evaluate the role of the husband's knowledge and behaviour after delivery as factors in PND. The findings of this study will help the mental professional to develop a better understanding about the issues associated with the PND among Pakistani women.

Method

A face-to-face interview was conducted with a woman reporting symptoms of depression on the fourth day after delivery. The patient was interviewed at the psychiatry clinic of the public hospital in Penang. Penang is a multicultural state of Malaysia consisting of Malay (42.5%), Chinese (46.5%) and Indian (10.6%) peoples and minorities (0.4%).[27] Among the minorities, the majority are Arab or Pakistani.

Patient information

All demographic information was retrieved from the patient. Information from the patient's medical chart did not disclose any history of current or past medical complications. All the laboratory tests conducted after delivery were normal and no further laboratory tests were advised. A verbal consent was obtained and the patient evaluation was completed using the DSM IV[1] and EPDRS.[2,6,28] Ethical approval was received from the Institutional Research Board, Island College of Technology and the Clinical Research and Ethics Committee. All the evaluations and counselling were done in English by a qualified psychiatrist. The differences in scores were assessed by using the Statistical Package for Social Science (SPSS) ® version 13. A student *t*-test was applied, and a *P*-value of less than 0.05 was considered significant with a confidence interval of 95%.

In addition an interview was conducted with the husband to ascertain his knowledge about PND. The five questions used were:

1 Do you think pregnancy can result in some mood changes in women?
2 Have you ever met someone reporting depression after delivery or during pregnancy?
3 Have you ever heard of postnatal depression (depression after pregnancy)?
4 Are you familiar with the symptoms of depression?
5 What do you think about your wife's situation?

Management of the PND

A 30-minute counselling session was arranged for the couple, with an additional session being arranged for the husband to educate him about the PND. The framework of the patient evaluation and counselling session is described in Figure 1.

Results

The patient's age was 32 years at the time of delivery. This was her first experience of pregnancy and delivery through Caesarean section. She was an immigrant in Malaysia. Immediately after her marriage in Pakistan, she followed her husband to Malaysia. She is a medical doctor by profession and had been working as a medical officer in a cardiology clinic in Pakistan. Currently, she is a housewife. Her husband was 35 years old when she delivered and was a postgraduate student at a Malaysian public university. The sole source of income for this family was a PhD scholarship worth 500 USD monthly. Evaluation results are presented in Tables 1 and 2.

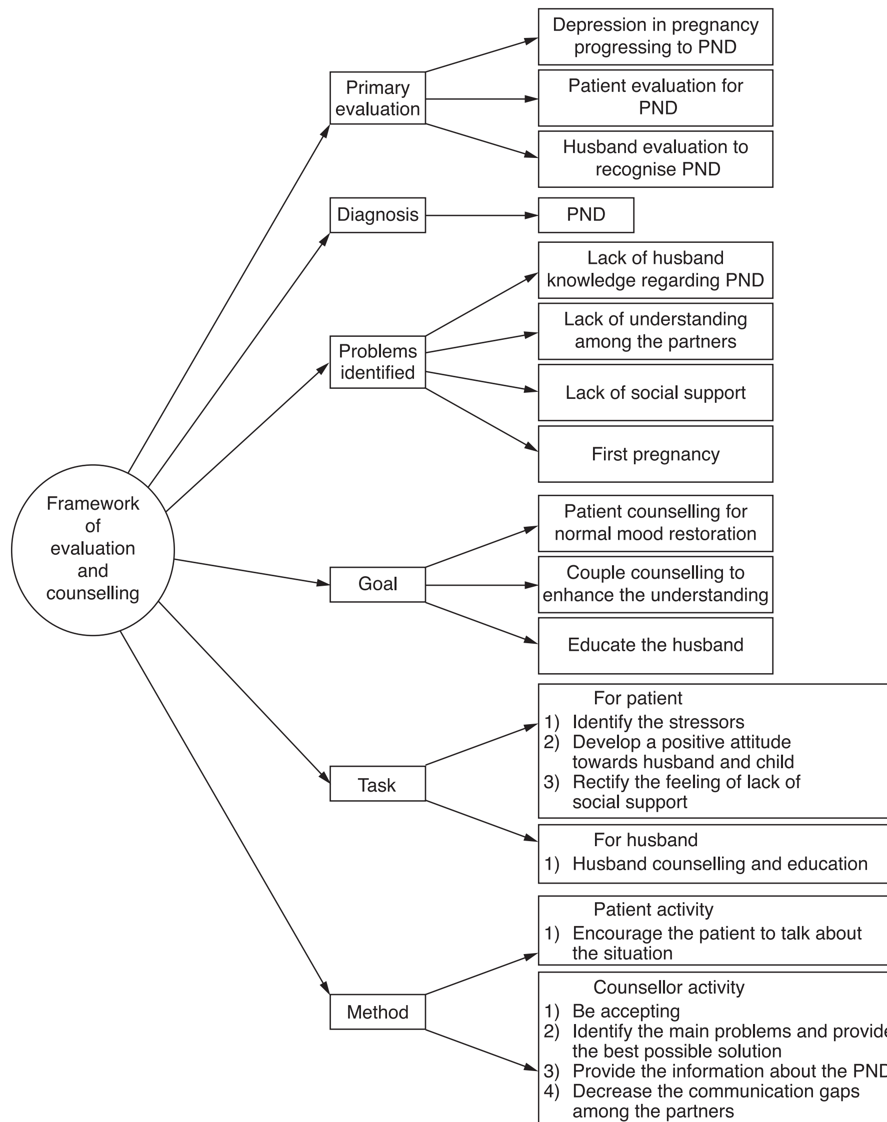

Figure 1 Framework of counselling session

Table 1 Evaluation of depression according to DSM IV TR criteria of depression

Symptoms	Pre-counselling	Post-counselling
Feeling sad or down often	Yes	No
Frequent crying or tearfulness	Yes	No
Loss of interest or pleasure in life	Yes	No
Less energy and motivation to do things	Yes	Yes
Feeling restless, irritable or anxious	Yes	No
Unexplained physical symptoms	Yes	No
Loss of appetite	No	No
Difficulty sleeping, including trouble falling asleep, trouble staying asleep or sleeping more than usual	Yes	No
Marked tiredness on slight effort	Yes	Yes
Reduced concentration and attention on a task	Yes	No
Reduced confidence and self-esteem	No	No
Feeling worthless, hopeless or guilty	No	No
Feeling like life isn't worth living	Yes	No

Table 2 Pre- and post-counselling evaluation on the basis of EPDRS

Questions	Pre-counselling evaluation	Post-counselling evaluation	
	Score	Score	$P = 0.001$* $t = 6.128$ df = 9
1 I have been able to laugh and see the funny side of things	1	0	
2 I have looked forward with enjoyment to things	2	1	
3 I have blamed myself unnecessarily when something went wrong	1	0	
4 I have been anxious and worried for no good reason	2	0	
5 I have felt scared or panicky for no very good reason	1	0	
6 Things have been getting on top of me	2	1	
7 I have been so unhappy that I had difficulty in sleeping	3	0	
8 I have felt sad or miserable	2	0	
9 I have been so unhappy that I have cried	2	0	
10 The thought of harming myself has occurred to me	0	0	
Total	16	2	

Student *t*-test,**P*-value significant at 0.05 at confidence interval 95%

Patient subjective experience of depression

> 'I am so lonely here and there is no one around me. My current situation makes me tearful sometimes. I want to go out for a long drive but I have no car here, back there in Pakistan I have my own car.
>
> In our culture when a woman gives birth to a baby she receives a lot of support from family members who take care of her. But here I have to do all the things on my own. I am so exhausted. I cannot do this alone, my delivery was not a normal one it was through Caesarean and my husband didn't understand my situation. I have requested him for a maid but he is not willing to have one. He says that he has seen his mother doing all this alone, so why can't I do so.'

Patient's attitudes toward child

> 'Initially I was very happy to have a baby boy, but later I started feeling irritated when he cried, sometime it's totally unbearable. At times I feel so disturbed that I want to slap him.'

Husband's knowledge about PND

Evaluation of the husband revealed a poor level of knowledge. He had never heard of PND nor met a person who suffered from it. In terms of recognition of depressive signs and symptoms, only change in behaviour and mood alterations was recognised. While exploring his perception towards pregnancy and PND, he stated that it is possible that these mood changes could occur in a first pregnancy. However, he has described his wife's condition in a very different way:

> 'Her situation is not understandable; I don't know why she is behaving like this. Maybe it is because this is her first time that makes it difficult for her to manage this all. She is not trying to understand the situation, she always complains to me about my behaviour. I am also tired, when she was admitted in hospital I was the one who was taking care of her.'

Follow-up

A follow-up was recommended after one week. Post-counselling evaluation revealed a significant drop in EPDRS score. Evaluation of the patient on the basis of DSM IV reflected a complete remission of symptoms. The couple was happy and the mood state of the patient was improved ($P = 0.001^*$, $t = 6.128$, df = 9). Moreover, the patient reported a positive change in her husband's behaviour.

Discussion

Cultural issues

Cultural issues are one of the vital aspects of PND among new mothers.[5] In Pakistan, the majority of the population is Muslim. In accordance with the principles of pregnancy in Islam, women are prohibited to have sex with their husbands until 40 days after delivery. In addition, the new mother is confined to bed and is prohibited from doing the routine household tasks. In Pakistan, immediately after delivery the mother moves to her parents' house for the duration of the 40 days. This is a time of celebration for every family member. The majority have a strong social network with relatives and neighbours and many still live in traditional joint family systems. On such occasions, neighbours and relatives give special consideration to the mother and newborn. However, in the case reported above, the patient was alone and the traditional care and support from other family members was unavailable. This factor could be one of the possible reasons for the PND.

Lack of social support

Social support – of utmost importance after delivery – was missing in this case. In Asian cultures, new mothers learn child handling from their own mothers, mothers-in-law and elder relatives such as elder sisters or grandmothers. However, in this case no such support was available to the mother, and this could be a possible factor in the resulting PND. The new mother's fear about 'how I would handle this situation alone' could be the result of lack of social support.

Husband's knowledge about PND

The husband's knowledge about PND plays a significant role in understanding the condition of the wife. In this study, the husband was not aware of PND. Regarding this lack of knowledge toward PND, two issues are of great importance. First, the lack of knowledge hinders the ability of the husband to understand his wife's behaviour; and second, the father himself may be suffering from depression, resulting in changes in his attitude towards his wife.[29,30] In this case, education and counselling of the husband proved beneficial in restoring the couple's understanding (see Table 2).

PND among new fathers

Traditionally, to be a male is to be a symbol of physical and emotional strength. For depressed men, this tradition can act as a major barrier to seeking professional advice.[29] New fathers in some cultures are especially reluctant to admit that they are suffering from PND. Women in such cultures more easily discuss and share their problems. However, men typically ease their pain by spending time at the pub and talking about other matters.[30] There is also a widespread belief that only women suffer from PND. This belief creates a scenario in which fathers are hesitant to speak out.[31] In reality, up to one in 14 fathers may suffer from PND. The incidence of PND may be even higher among men but many cases are still unreported because of the reticence of men.[30] Factors such as being a first-time parent; having a small circle of friends; having deprived social interaction; being of limited education; experiencing concurrent stressful life events and having a poor relationship with the partner are the vital factors. Moreover, fatherhood not only adds responsibility but also changes the husband's role in the family, which can affect his mental health.[29] This study lacks an evaluation of the father for the possibility of depression; however, it remains possible that this father may be suffering from PND. According to Kleinman (2001), a stressed father can further exaggerate a mother's compromised mental health.[32]

Conclusion

This case study suggests that a lack of social support from others and a husband's lack of understanding can play a vital role in the persistence of symptoms of depression among postnatal mothers.

Limitations

The findings of this study cannot be generalised because of the small sample size. The hypotheses generated by this study may be supported by interviews with other postnatal couples.

Recommendation

Pre-delivery and post-delivery educational sessions regarding PND can promote better understanding between partners. Maternal clinics and primary healthcare centres can play a vital role in this regard. Furthermore, these findings highlight the need to conduct qualitative interviews with couples coping with mood disorders centred around childbirth. Quantitative research is needed to test the hypotheses generated by the qualitative data reported in this case report.

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CONFLICTS OF INTEREST

None.

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