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A Study on Postpartum Depression in Women of Vadodara Industry

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ABSTRACT

Postpartum depression (PPD) is a type of depressive disorder that affects 9-16% of mothers worldwide and can develop within 4-6 weeks of giving birth and may take several months for symptoms to appear. According to the DSM-IV, symptoms of PPD are decreased interest/enjoyment in activities, weight loss/gain, insomnia/hyper sonic, agitation, fatigue, sadness, and anxiety. "Baby Blues" are often mistaken for PPD and vice versa. Their key difference is that the baby blues only last a few weeks after giving birth, while PPD lasts longer and the symptoms are usually more severe. Some of the causes of a PPD episode are hormonal changes, family history of depression, lack of support from family/friends, expecting a male child, difficulty adapting to changes, stress when dealing with a child, and poor health of the child. Treatment modalities include group therapy, consultation with a psychiatrist, and medication. This research attempts to analyze PPD in working women and the stressors that cause it. The results of this study can be used for policy making in the workplace to promote social and psychological well-being.

1. INTRODUCTION

Depression is a state of mental illness.

Dysthymia (chronic depression) is a less severe form of depression but usually lasts for several years.

Although both diagnoses have overlap in their diagnostic criteria, some of the criteria specific to postpartum depression include intense hopelessness and sadness, excessive worry or anxiety, intrusive thoughts of harm to oneself or harm to the baby, feelings of guilt or thoughts of worthlessness, and a change in appetite which could result in under-eating or overeating.

Depending on one's cultural background, symptoms of postpartum depression may manifest differently, and non-Westerners being screened in Western countries may be misdiagnosed because their screening tools do not account for cultural diversity.

Prevention of postpartum depression If there is a history of depression, it is advisable to inform the doctor as soon as the mother finds out that she is pregnant or if she is planning to become pregnant.

Some studies show that hormone therapy may be effective in women with PPD, which is supported by the idea that the drop in oestrogen and progesterone levels after childbirth contributes to depressive symptoms. However, there is some controversy with this form of treatment because oestrogen should not be given to people who are at higher risk of blood clots, which includes women up to 12 weeks postpartum.

2. REVIEW OF LITERATURE (ROL)

i. **Christa Andrews –Feke, M.D (1999) Feb.:**

Because of the nature of PPD and the tendency for new mothers to ignore their feelings as if they were not a treatable mental illness, family physicians seem to be the key players in diagnosing and treating the disease. The opportunity to educate parents and follow the changes in maternal behaviour is a tool available to the primary care physician. Because of the prevalence of PPD, all obstetricians and gynaecologist should develop a mechanism to diagnose depressive symptoms. Women with significant risk factors will need to be closely monitored in the postpartum period. If a woman experiences a DAM-IV PPD procedure, treatment efforts should begin with psychotherapy and progress to pharmacotherapy if indicated. As with the treatment of other infectious diseases, it is important to use a large enough dose of antidepressants and use them long enough to ensure complete recovery.

ii. **Che Wan Jasimah Bt Wan Mohamed Radzi, Hashem Salarzadeh Jenatabadi & Nadia Samsudin BMC Public Health volume 21, Article number: 27 (2021) Published 27 January 2021**

To conclude, this research examined the effects of depression levels in terms of demographically, lifestyle, healthy food, unhealthy food, and BMI. Besides, the hypothesized model in the present study had been indicated as a suitable model for predicting the depression levels among postpartum women. Subsequently, depression levels affect people's lives (e.g., personal matters, health, eating behavior), and it means clinical intervention is

necessary to prevent depression symptoms from exacerbating. This research is the first study on postpartum women diagnosed with depression symptoms, which were carried out using SEM. The factors associated with depression were presented in the theoretical framework. The associated variables and theories were aligned with the Malaysian culture and the associated environment. Thereby, we believe that this research may be advantageous for future works on the postpartum depression modeling, particularly among public health and life science research scholars.

iii. **Solomon Shitu, Biftu Geda & Merga Dheresa BMC Pregnancy and Childbirth volume 19, Article number: 435 (2019) Published on 21 November 2019**

One in five women in the study area suffers from postpartum depression. This spark's light to health professionals to pay attention to the prevention and treatment of postpartum depression. Marital status, unwanted pregnancy, preferred infant sex by the mother, infant illness and poor social support were independently associated with postpartum depression.

iv. **Original Research article Front. Public Health, 24 October 2019, Sec. Public Mental Health**

In conclusion, we believe that these results could have relevant clinical and social implications. Understanding the most important relevant risk factors for PPD is essential for identifying nulliparous pregnant women at risk and promptly intervening with specific preventive health care programs.

v. **Journal of Affective Disorders Volume 286, 1 May 2021, Pages 158-165Angarath I. Van der Zee-van den Berg**

The shared and separate risk factors for postpartum depression and anxiety may help professionals in identifying mothers at increased risk and provide opportunities for preventive interventions and treatment.

3. RESEARCH-METHODOLOGY

Objective

TO understand the difference between normal “baby blues”, postpartum depression and postpartum psychosis.

To understand the impact of postpartum depression on children and families.

To identify risk and protective factors for maternal depression.

To understand that becomes familiar with maternal depression screening tools.

Research Design

The research design constitutes the blue print for the data collection, measurement and analysis of data. It is the overall operational pattern or the framework of the research that stipulates what information is to be collected from various sources and procedures. The descriptive research design has been employed for the present study.

Sources of Data

Primary and secondary sources

Primary source

Primary data will be collected through a questionnaire containing both closed-ended as well as open-ended questions to identify various parameters.

Secondary source

Information will be collected from secondary. Sources like books, journals, website, sources, research articles etc.

Universe

The universe comprises the employees of

Sampling Method

The sampling method adopted is the simple random sampling method to collect the data for the above-mentioned universe for research.

Data collection tool

A structured questionnaire as a tool for data collection. The questionnaire comprised of both open-ended and close-ended question.

Tool for data analysis

Google forms and Microsoft excel.

DATA ANALYSIS AND INTERPRETATION

ATTRIBUITES	OPTION	FREQUENCY	PERCENTAGE
AGE OF MOTHER	18-22	6	18.8%
	22-24	11	34.4%
	24-28	8	25%
	Above 28	7	21.9%
QUALIFICATION OF MOTHER	12TH Pass	7	23.3%
	Graduate	11	36.7%
	Post graduate	12	40%
Marital status	Married	28	87.9%
	Unmarried	3	9.4%
	Divorced	0	0
	Separated	1	3.1%

The study includes 31 respondents. In the study, age of the respondents is 22-24 years. The average age of respondents is 34.4% and the average (40%) qualification of respondents are post graduated and average (87.9%) married and 9.4% respondents are unmarried.

PHYSICAL: Are you getting proper amount of nutrition? Any deficiencies? And do you have proper appetite?

ATTRIBUITES	OPTION	FREQUENCY	PERCENTAGE
Amount of nutrition	YES	30	93.8%
	NO	2	6.3%
Any deficiencies	YES	7	21.9%
	NO	25	78.1%
Proper appetite	YES	11	67.7%
	NO	10	32.3%

93.8% of the respondents are getting proper amount of nutrition and 78.1% of respondents not having any type of deficiencies and also 67.7% of respondents have proper appetite.

PSYCHOLOGICAL:

ATTRIBUITES	OPTION	FREQUENCY	PERCENTAGE
Desire for male child	Yes	14	43.8%
	No	18	56.3%
Feel stress during child care	Yes	3	9.4%
	No	29	90.6%
Feel sadness during child care	Yes	5	15.6%
	No	27	84.4%
Reduced concentration during work/ child care	Yes	10	31.3%
	No	21	65.6%
Handle the workload after delivery	Yes	21	65.6%
	No	11	34.4%

56.3% of respondents are not desire for male child and 90.6% of respondents are not feel stress during child care and also 84.4% of respondents are not feel sadness during the child care. 65.6% respondents are not reduced concentration during work/ child care.65.6% respondents are not handling the workload after the delivery.

FINANCIAL

ATTRIBUITES	OPTION	FREQUENCY	PERCENTAGE
Financially capable of taking care of child and children	Yes	29	90.6%
	No	3	9.4%
Aware of government schemes	Yes	23	74.2%
	No	8	25.6%

90.6% of respondents are financially capable of taking care of child and children and 74.2% of respondents are aware of government schemes.

FAMILY

ATTRIBUITES	OPTION	FREQUENCY	PERCENTAGE
Pressure for male child	Yes	8	25%
	No	24	75%
Okay with gender of the child	Yes	27	84.4%
	No	5	15.6%
Face physical abuse	Yes	5	15.6%
	No	27	84.4%

75% of respondents are not having a pressure for male child. 84.4% of respondents are okay with the gender of the child (baby). 84.4% of respondents are not face the physical abuse.

SUMMARY OF FINDING

Majority of (11) respondents and age of mother is 22-24.

Majority of (12) respondents and qualification are post-graduate.

Majority of (28) respondents are married.

Majority of (18) respondents having a normal delivery.

Majority of (16) respondents are equal to having a male child and female child.

Majority of (18) respondents having a baby and weight of baby is 2.5kg to 3.5.

Majority of (30) respondents are getting a proper amount of nutrition.

Majority of (25) respondents have not any deficiency.

Majority of (11) respondents have a proper appetite.

Majority of (18) respondents are not desire for male child.

Majority of (29) respondents don't feel stress during child care.

Majority of (27) respondents don't feel sadness during child care.

Majority of (21) respondents don't reduced concentration during work/cildcare.

Majority of (21) respondents are able to handle the workload after delivery.

Majority of (29) respondents are financial capable for taking care of child and children.

Majority of (23) respondents are aware of the government schemes.

Majority of (24) respondents don't have family pressure for male child.

Majority of (27) respondents are okay with gender of the child.

Majority of (28) respondents don't face physical abuse.

CONCLUSION

The prevalence of PPD has been difficult to determine due to several factors. Interventions for PPD include pharmacological interventions, supportive interpersonal and cognitive therapy, psycho social support through support groups, and complementary therapies. This study found that postpartum depression was more prevalent among mothers who were up to 12 months postpartum, although at a lower rate. Some of the respondents had minimal depression, moderate depression, and mild depression, as well as moderate depression and extremely severe depression. The main predisposing factors for the development of PPD are stressful life events, childcare stress and prenatal anxiety, as well as a history of a previous episode of PPD. The most common psycho social and psychological interventions used to manage postpartum depression were psycho social support, professionally supported postpartum home visits, interpersonal psychotherapy, and cognitive therapy. However, among these interventions, psycho social support appeared to be the most effective intervention, as it was reported to influence the reduction of depressive symptoms. Postpartum depression can affect socializing behavior in children and the mother and can lead to thoughts of failure leading to deeper depression.

RECOMMENDATION

Frequent screening exercises for postpartum depression should be organized by Komfo Anokye Teaching Hospital authorities in collaboration with the Ministry of Health, Ghana Health Service and NGOs. The Ministry of Health and the Ghana Health Service should work with the National Commission for Civic Education to undertake public education on the effective use of psycho social support as an intervention against postpartum depression in various health facilities in Ghana. Given the nature of PPD and the tendency of new mothers to deny their feelings as anything other than a treatable psychiatric illness, family physicians appear to be key players in the detection and treatment of this condition. The ability to educate parents and monitor changes in maternal behavior is an available tool for primary care physicians. Given the prevalence of PPD, all physicians caring for obstetric patients and children should develop a method of screening for depressive symptoms. Women who have significant risk factors will need to be monitored more closely in the postpartum period. If a woman meets DSM-IV criteria for PPD, treatment attempts should begin with psychotherapy and progress to pharmacotherapy if necessary. As with the treatment of other affective disorders, it is essential to use a sufficiently high dose of antidepressants and take them for a sufficient period of time to ensure complete recovery.

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