Incidence and factors associated with postnatal depression among Jordanian women

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Forward
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Statement of originality

This work has not previously been submitted for a degree or diploma in any university. To the best of my knowledge and belief, the thesis contains no material previously published or written by another person except where due reference is made in the thesis itself.

Khitam Ibrahim Shlash Mohammad
Synopsis

Postnatal depression (PND) is the focus of considerable clinical and research attention however it has been neglected in many developing countries. Using a prospective design with a representative sample of women (n = 353), this longitudinal study aimed to determine the incidence and associated factors in the development of antenatal and postnatal depression in Jordanian women.

There are three Phases of the study. During Phase 1 women in their last trimester of pregnancy and receiving public antenatal clinic care were recruited. In addition to obtaining demographic details, a questionnaire sought information on the antenatal factors commonly associated with depression. These included whether the pregnancy was planned, reproductive history, personal and family history of psychiatric illness including antenatal and postnatal depression, relationship with husband, relationship with mother-in-law, and stressful life events. Standardised measures were used to assess depression, social support, worry, anxiety and stress, preparation for birthing and parenthood, and self-efficacy.

Phase 2 consisted of a telephone or face-to-face interview conducted six to eight weeks postpartum. Participants (n = 353) completed the Postnatal Questionnaire, Edinburgh Postnatal Depression Scale (EPDS), Maternal Social Support Scale (MSSS), and Depression, Anxiety and Stress Scale-21 (DASS-21). In Phase 3 a second telephone or face-to-face interview was conducted at six months postpartum. Participants (n = 353) completed Edinburgh Postnatal Depression Scale, Maternal Social Support Scale, and Depression, Anxiety and Stress Scale-21.

Nineteen percent of participants (n = 67) reported symptoms of probable antenatal depression. Antenatal variables found to contribute to the development of depression were unplanned pregnancy, stressful life events due to financial problems, difficult relationship with husband, difficult relationship with mother-in-law, psychological factors of anxiety; stress; and
worry in general (worry about labour and birth, relationship with husband, and financial problems in particular), low social support, poor general knowledge regarding labour; birth and mothering, and low maternal self-efficacy.

At six to eight weeks postpartum, over twenty percent (22.1%, n = 78) of women scored $\geq 13$ on the EPDS. At six months postpartum, the rate of depression dropped slightly to 21.2% (n = 75). Similar factors were found to contribute to the development of postnatal depression as were associated with the development of antenatal depression with the exception of anxiety.

There was an association between antenatal depression and the development of PND [$\chi^2 (1) = 5.880, p = 0.015$]. Personal and family history of psychiatric illness (including antenatal and postnatal depression) were not associated with development of antenatal depression or postnatal depression. This may be related to a lack of awareness by women that they themselves suffered from any psychiatric illness including depression in past pregnancies or/and after the birth as well as a lack of awareness of mental health problems of relatives and an unwillingness to disclose this information. In Jordan, people in general and women in particular are not aware of the psychiatric illness (including antenatal and postnatal depression) and there is little community knowledge about psychiatric illness (including antenatal and postnatal depression). This may be partly because there is a focus of health services on the provision of physical care and a deficit in provision of health education or psychological care.

Intrapartum factors associated with the development of PND were obstetric events, satisfaction with care during labour and birth, and feelings whilst in labour. Seven obstetric events were consistently associated with the development of PND. These were long and painful labour, increased number of vaginal examinations, lithotomy position during the birth, episiotomy, suturing, use of analgesia (pethidine and nitrous oxide). There was an association between the perception of overall poor quality of care during
childbirth and development of postnatal depression $[\chi^2 (1) 5.880, p = 0.015]$. Satisfaction with emotional care and midwifery and medical care were statistically associated with the development of PND. Women who felt that childbirth was “taken over by strangers and/or machines” were more likely to develop PND. Women who did not talk to any health professional about how they felt about what happened during their labour and birth were more likely to develop PND. Feelings associated with lack of control, helplessness, anxiety, and fear during labour and birth increased women’s risk of developing postnatal depression.

It appears that it is not the pain or process of normal labour and birth that is associated with the development of PND, but rather the experience of intervention and poor care. Despite available information identifying predictors of positive and negative birth experiences and the well-documented overuse of medical intervention in childbirth, birthing services in Jordan have been slow to change and implement this evidence. Birthing services in Jordan still perform many obstetric interventions on labouring women (e.g. excessive vaginal examinations, episiotomy, suturing, ineffective analgesia, and lithotomy position during birth), as well women receive poor care during labour and birth (e.g. not involve in the decision making process, their choices are not respected, and are not routinely given information or explanation regarding their care).

Postnatal factors associated with development of PND were perceived poor social support, and psychological factors of anxiety and stress. There is a high incidence of comorbidity between depression and anxiety. Gender of the baby was also associated with the development of PND with women who gave birth of female babies being more likely to develop PND.

Depression during pregnancy and after childbirth is an under-recognised phenomenon in developing countries and no other similar research has been conducted in Jordan to date. The present study identified a high level of depression suffered by women during pregnancy and after childbirth. This
research is also distinctive in that it identifies the antenatal, obstetric and care factors that contribute to the development of PND. The findings have important implications for maternity practices in Jordan. Recommendations relate to improving antenatal care that recognises and acknowledges the importance of addressing women emotional needs throughout pregnancy and assessing women for depression during pregnancy and postpartum. Maternity service providers need to be cognisant of the incidence of this debilitating condition and be able to identify at risk women for early intervention and referral to a mental health practitioner if appropriate. Staff development activities need to ensure that health care providers are more supportive of women during this important time, to involve women in decision-making processes regarding their care and to respect women’s choices. A final recommendation relates to the need for women to be better supported in labour with the inclusion of women’s family members during labour and birth if she wishes.
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