Determination of Severity of Postpartum Depression in Bangladeshi Women

A project submitted

by

Shanta Islam

ID: 13346001

Session: Summer 2013

to

The Department of Pharmacy

In partial fulfillment of the requirements for the degree of

Bachelor of Pharmacy (Hons.)

Dhaka, Bangladesh

September, 2018

Dedicated to my parents

Certification Statement

This is to certify that the project titled "Determination of severity of Postpartum Depression among women in Bangladesh" submitted for the partial fulfillment of the requirements for the degree of Bachelor of Pharmacy from the Department of Pharmacy, BRAC University constitutes my own work under the supervision of **Dr. Mesbah Talukder**, Associate Professor, Department of Pharmacy, BRAC University that appropriate credit is given where I have used the language, ideas or writings of another.

Signed,

_____

Countersigned by the Supervisor

_____

Acknowledgment

In the accomplishment of this project successfully, many people have best owned upon me their blessings and the heart pledged support, this time I am utilizing to thank all the people who have been concerned with this project.

I would like to thank the Almighty Allah for the completion of this project with success. My special thanks to the most helpful supervisor **Dr. Mesbah Talukder** (Associate Professor, Department of Pharmacy, BRAC University) whose inspiration and valuable guidance showed me the way to complete this project. Without his constant encouragement and suggestions, it would not be possible to shape the present work. I am really grateful to our honorable chairperson, **Dr. Eva Rahman Kabir** (Chairperson, Department of Pharmacy, BRAC University) for her enormous support throughout the project.

Then I would like to express my gratitude towards my parents, family and friends who willingly helped me out with their abilities in various phase of the completion of this project.

Finally, I would like to thank all the women who participated and shared their experience for this research. Their experience enriched my knowledge and extended my range of vision.

Abstract

Postpartum depression is one of the major categories of maternal disorder right after the delivery process. Women experience a serious phase of vulnerability during that period. Though postpartum depression has been found to have an effect on a large number of women after child delivery in developing countries, no authentic estimation to understand the immensity of this disorder in Bangladesh. Women in our country might not speak out but this does not excuse the actual fact that the surrounding system is not ready to concentrate on this matter yet. Additionally, most of us do not acknowledge the symptoms and ignore it as a negligible matter. The aim of this study was to elucidate the current scenario of this disorder in Bangladesh, compare the severity of postpartum depression among housewives and working women while determining the existence of different support groups that might play a significant role to overcome this issue.

Table of Contents

Contents

List of Tables

List of Figures

List of Acronyms

PPD = Postpartum Depression

WHO = World Health Organization

DSM IV-TR = Diagnostic and Statistical Manual of Mental Disorders - Fourth Edition (Text Revision)

APA = American Psychiatric Association

NIMH = National Institute of Mental Health

US = United States

EPDS = Edinburgh Postnatal Depression Scale

1 Introduction

Depression is one of the major contributors that might lead to suicide, with an estimation of quite three hundred million folks of all ages who are suffering globally. Postpartum depression, also known as postnatal depression, is one kind of clinical depression. Besides, it is the most frequent complication after childbirth. Postpartum depression may be outlined as an episode of non-psychotic depression that usually strikes within one year after the birth of a child (Cox et al., 1993; O'Hara, 1994; Watson et al.,1984). According to DSM IV-TR (APA, 2000), postpartum disorder is not characterized by their occurrence but by the timeline of its onset, which is within four weeks following the delivery. Moreover, it involves physical, behavioral and emotional changes following the delivery process. It is associated with psychological signs and the severity of this disorder vary from mild to psychotic (Brockington, 2004; Geller, 2004). This post pregnancy disorder can appear anytime within one year of birthing. However, this is not a women's issue anymore, it exerts its negative influence on everybody including their marriage partner, children, family, friends, and colleagues. Recent studies indicate that the frequency of PPD in developing countries is higher compared to the developed countries (Patel, Rodrigues, & DeSouza., 2002; Rahman, Iqbal, & Harrington, 2003). According to a report of WHO, countries with higher income have 10-15% prevalence of perinatal disorder whereas, countries with low and middle income have 10-41%. Another study shows that the postpartum depression prevalence rate of Asian countries ranges from 3.5% to 63.3% (Klainin & Arthur, 2009). Maternal disorder, especially postpartum depression is overlooked largely due to various reasons. One study shows that the reasons are twofold. Firstly, women often feel hesitant to look for professional assistance (Small, Brown, Lumley, & Astbury, 1994). Secondly, despite being in constant contact with healthcare professionals, they usually cannot share their problems regarding emotional health, precisely depression (Brown & Lumley, 2000). If postpartum depression is not treated properly, it can generate harmful chronic effects. Consequently, it may cause long-term depression for mothers and a mother‟s persistent depression may affect children‟s emotive, behavioral, physical and interpersonal areas in future (Jacobsen, 1999). Additionally, postpartum depression may have an impact on new fathers as well. The first year following the childbirth, around 3.56% of fathers go through depression (Davé, Petersen, Sherr, & Nazareth, 2010). The prevalence rate of PPD varies from culture to culture over the world

(Rahman et al., 2003). Here is a small illustration of this fact.

Table 1.1: Varying rate of PPD in different cultures

Reference	Country	Prevalence of PPD
(Ghubash & Abou-Saleh, 1997)	Middle East	15.8%
(Cooper, et al., 1999)	South Africa	34.7%
(Klainin & Arthur, 2009)	Asia	3.5-63.3%

1.1 Types of Postpartum Depression

Postpartum depression is categorized into three types. Each of these types has its distinct set of timing, signs and symptoms, duration, development, and treatment. Depending on the intensity of symptoms from mild to severe, short term to long term, PPD has been classified into these categories. The types are:

1. Postpartum blues
2. Nonpsychotic postpartum depression and
3. Puerperal psychosis

Table 1.2: Postpartum Depression Types with an overview of Onset, Duration & Treatment

Source: (Nonacs & Cohen, 1998)

Disorder	Prevalence	Onset	Duration	Treatment
Postpartum Blues	30 – 75%	Day 3 or 4	From hours to days	No treatment is required except support

Postpartum Depression	10 – 15%	Within 12 months	From weeks to months	Treatment is mostly required
Puerperal Psychosis	0.1 – 0.2 %	Within 2 weeks	From weeks to months	Hospitalization is generally required

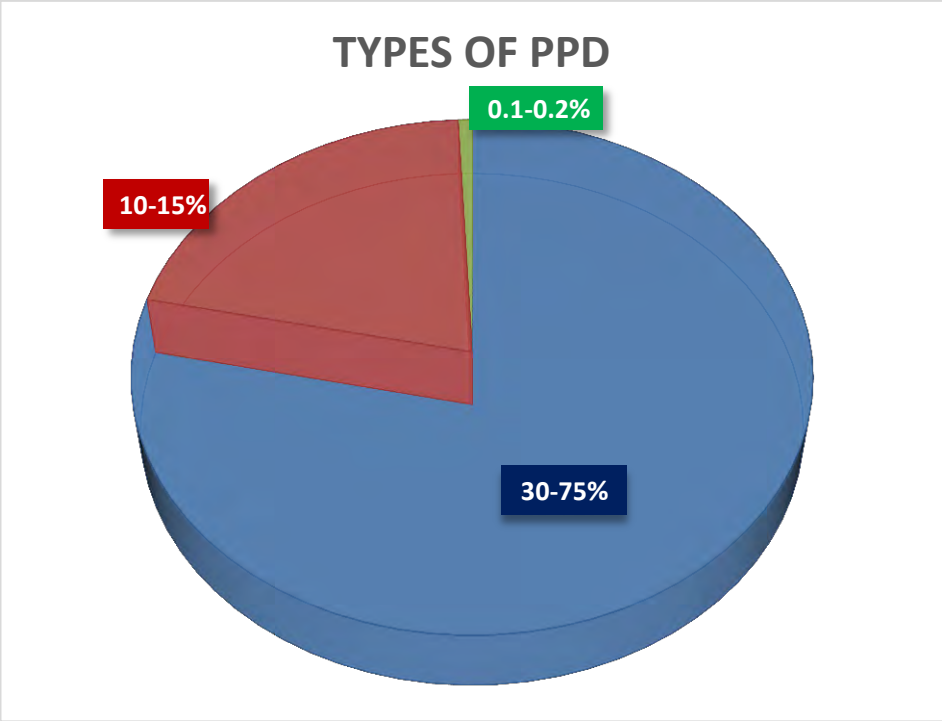

Figure 1.1: Types of PPD

1.1.1 Postpartum Blues

The first type is postpartum blues, which is observed mostly among post-pregnancy mood disorders. The prevalence rate ranges from 30-75% for this (O'Hara et al., 1984). Possible symptoms are mood swing, irritation, weepiness, anxiety, trouble in sleeping and loss of appetite. Moreover, the symptoms arise right after the delivery, generally within 3 to 4

days after birthing and last from hours to several days. This class of PPD is a short-term depression and do not need any treatment due to its mild effects, the symptoms disappear within a few days (Kennerly & Gath, 1989; Pitt, 1973). Around 20% of women having postpartum blues are susceptible to significant depression during their first year postpartum (Campbell et al., 1992; O'Hara et al., 1991b).

1.1.2 Postpartum Depression

This type is the complicated and difficult part after childbirth affecting around 10-15% of women (O'Hara & Swain, 1996). The symptoms include a gloomy mood, sadness, feeling less energetic. Most of the symptoms are similar to the symptoms of major depression. The onset of action starts within the first six weeks after delivery. Generally, treatment from the health experts is required for this type.

1.1.3 Puerperal Psychosis

Puerperal psychosis, also known as postpartum psychosis is the rare one among these. Women undergoing this disorder face serious depressive events and severe psychotic characteristics. Only 0.1% to 0.2% among 1000 deliveries has to suffer from this condition (Kendell et al., 1987). This class has a fast onset of action and shows up within the first 48 to 72 hours after birthing. Moreover, rapid mood fluctuations, misconception, unorganized behavior and hallucinations (Brockington et al., 1981). Psychological and demographic features have been found to be the less important element in developing puerperal psychosis (Brockington et al., 1990; Dowlatshahi & Paykel, 1990). This disorder may require hospitalization for the purpose of treatment (Nonacs & Cohen, 1998).

1.2 Signs and symptoms of PPD

Postpartum depression has broad signs and symptoms that vary from one to another. The same set of depressive symptoms is not going to fit everyone. But most usual ones include:

- Change in eating habit
- Trouble in sleeping
- Mood fluctuations
- Feeling miserable
- Poor self-confidence
- Feeling anxious, scared, guilt and shame
- Fatigue
- Detachment with family and friends
- Less interest in activities inclusive sex
- Trouble in focusing and remembering things
- Feeling less attached to the baby
- Having an idea of self-harming and harming the baby

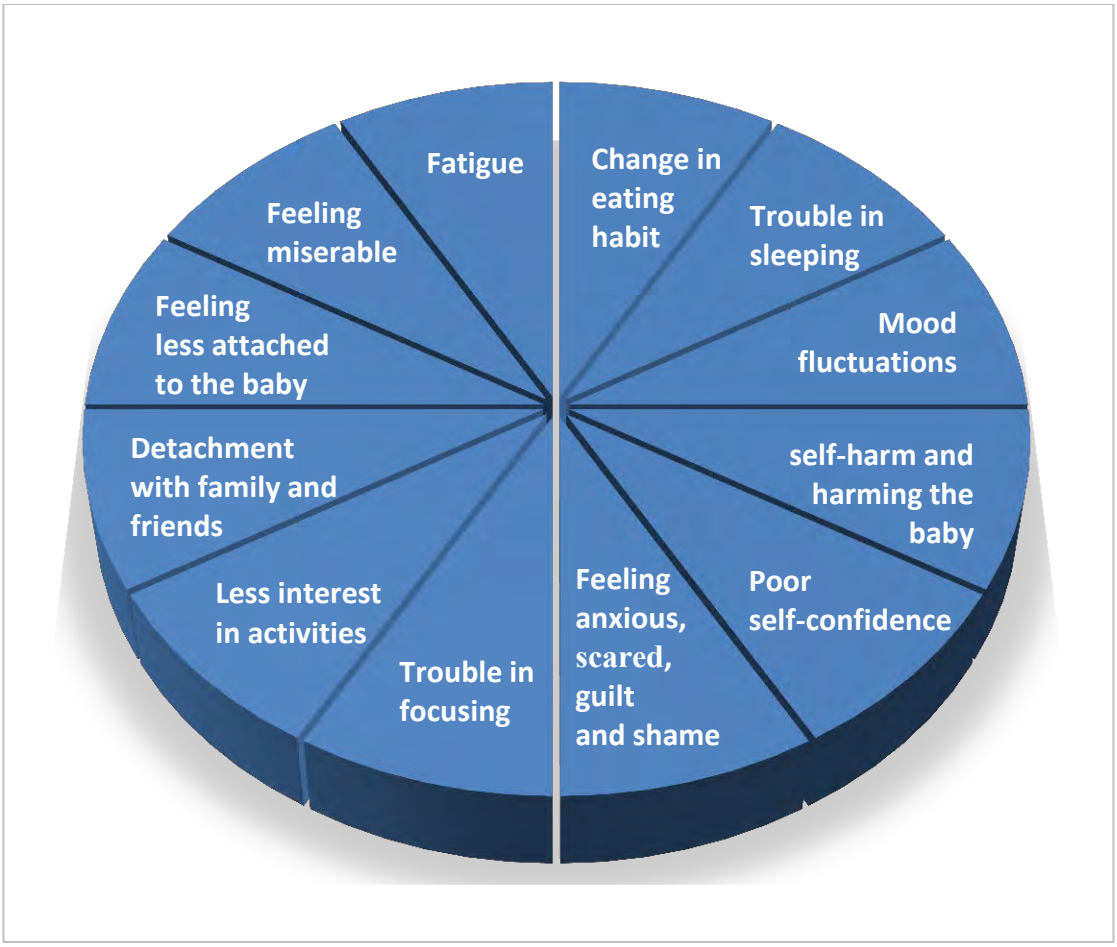

Figure 1.2: Signs and symptoms of PPD

1.3 Causes of PPD

According to NIMH, the causes behind PPD are not specific. It is a mixture of physical and emotional aspects that usually takes place after the childbirth. The underlying fact is postpartum depression is not the reflection of any positive or negative activities of the mothers. Following the delivery process, women‟s hormonal levels (estrogen and progesterone) fall rapidly, though there is no clear connection between this drop and postpartum depression. During pregnancy, the mentioned reproductive hormones multiply ten times compared to the previous level. So, after delivery when the hormones fall back to its former status, the change may stimulate mood swings. Besides, after nine months of pregnancy, women try to get back to their earlier position within weeks. Thus, they do not receive the proper relaxation time needed to recover from birthing issues. Throughout this

stage, physical weakness and uneasiness may occur due to persistent difficulty in sleeping and this can induce the possibility of PPD.

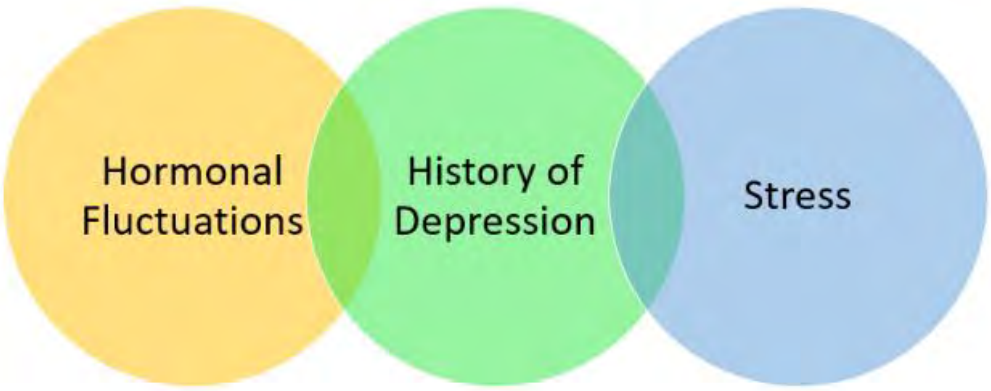

Figure 1.3: Causes of PPD

1.4 Diagnosis and Treatment

For a better physical and mental health of the mother and baby, prior diagnosis and treatment of postnatal disorders are very essential (Attia et al., 1999). There are numbers of screening tests that may include filling out of a questionnaire to evaluate the depression condition. Depending on the result of the evaluation, effective measures are taken.

Treatment of postpartum depression is a challenging issue requiring proper knowledge and skill. It involves taking medication and psychotherapy or a compounding of both. From a review, different strategies and approaches to treatment have been recorded and enlisted in the table.

Table 1.3: Different treatment approaches based on a literature review (Stewart, Robertson, Dennis, Grace & Wallington, 2003).

Strategy	Treatment
Pharmacological	- Antidepressant Medication
Psychological	- Interpersonal Psychotherapy - Cognitive Behavioral Therapy
Psychosocial	- Peer Support - Partner Support - Non-Directive Counselling
Hormonal	- Oestrogen Therapy
Others	- Relaxation/Massage Therapy - Bright Light Therapy - Sleep Interventions

Source: (Stewart, Robertson, Dennis, Grace & Wallington, 2003).

Through proper investigation, structuring the attributes of postpartum women and their choice of treatment would be a great help for the healthcare professionals. Moreover, there are no particular treatment instructions available due to insufficient research. In addition to that, PPD is treated with less significance than normal depression (Jermain, 1995; Nonacs & Cohen, 1998, 2002).

1.5 PPD Support Group status in Bangladesh

Women who suffer from PPD always find themselves alone and suppressed. They hardly can share their feeling with others. In these cases, support groups can play a vital role in improving their experience during this transition period. Attending the support groups can create hopes inside women as they find other women going through the similar situation as them. Then, they do not find themselves abnormal and alone anymore (Berggren-Clive, 1998). But surprisingly, there are no support groups for PPD in Bangladesh. There are some counselling and therapy

centers for general depression only, though most of the women show unwillingness to visit there. Some social media support groups have been found that are created to discuss issues regarding pregnancy. In United States and Canada, numbers of PPD support groups are available to help the mothers. Here is a map showing the locations of PPD support group in USA.

(Source: "When Motherhood Meets Mental Health," 2018)

Figure 1.4: PPD Support groups of USA

1.6 Scenario of PPD in Bangladesh

Bangladesh is one of the highest populated countries in the world with 160 million people (United Nations 2016). Bangladesh has done an excellent job in health advancements with a significant decrease in maternal mortality (Arifeen et al. 2014). On the other hand, mental health is not being prioritized as other diseases. Merely 0.5% of the health cost is allocated for mental health in Bangladesh. There is no proper national mental health guideline. On top of that, we are lacking mental health human personnel and other facilities (Islam and Biswas 2015). In every

aspect, this issue of depression, especially postpartum depression remains overlooked here. The condition of the mothers with low income includes inferior companionship, illiteracy, gender discrimination and past history of depression which induces the formation of the postpartum depression in Bangladesh (Nasreen et al. 2011). Women got frustrated for not meeting the socially demonstrated image of a good mother (Beck 1992, 2002). In Bangladesh, childbirth has been established as women‟s most triumphal achievement. Women are forced into emotional constraints due to huge social pressure. Numerous research results have promoted the idea that depression is caused by inadequate emotional involvement (Brown et al. 1986; O‟Hara 1986; George et al. 1989; Stice, Ragan, and Randall 2004). Due to these social and cultural perspectives, women are afraid to discuss, diagnose and take treatment for their PPD in Dhaka.

2 Methodology

2.1 Research goals and objectives

The goal of this study was to demonstrate the current scenario of postpartum depression in Bangladesh and investigate people‟s perception about it. Therefore, the main objectives of the research were to compare the severity of PPD between housewives and working women and figure out the existence of social support group for PPD.

2.2 Research design and methods

A literature search was conducted first to collect required information about postpartum depression. Then the design of the study was accordingly done along with other necessary steps. The subsequent flowchart illustrates the entire methodology of this research.

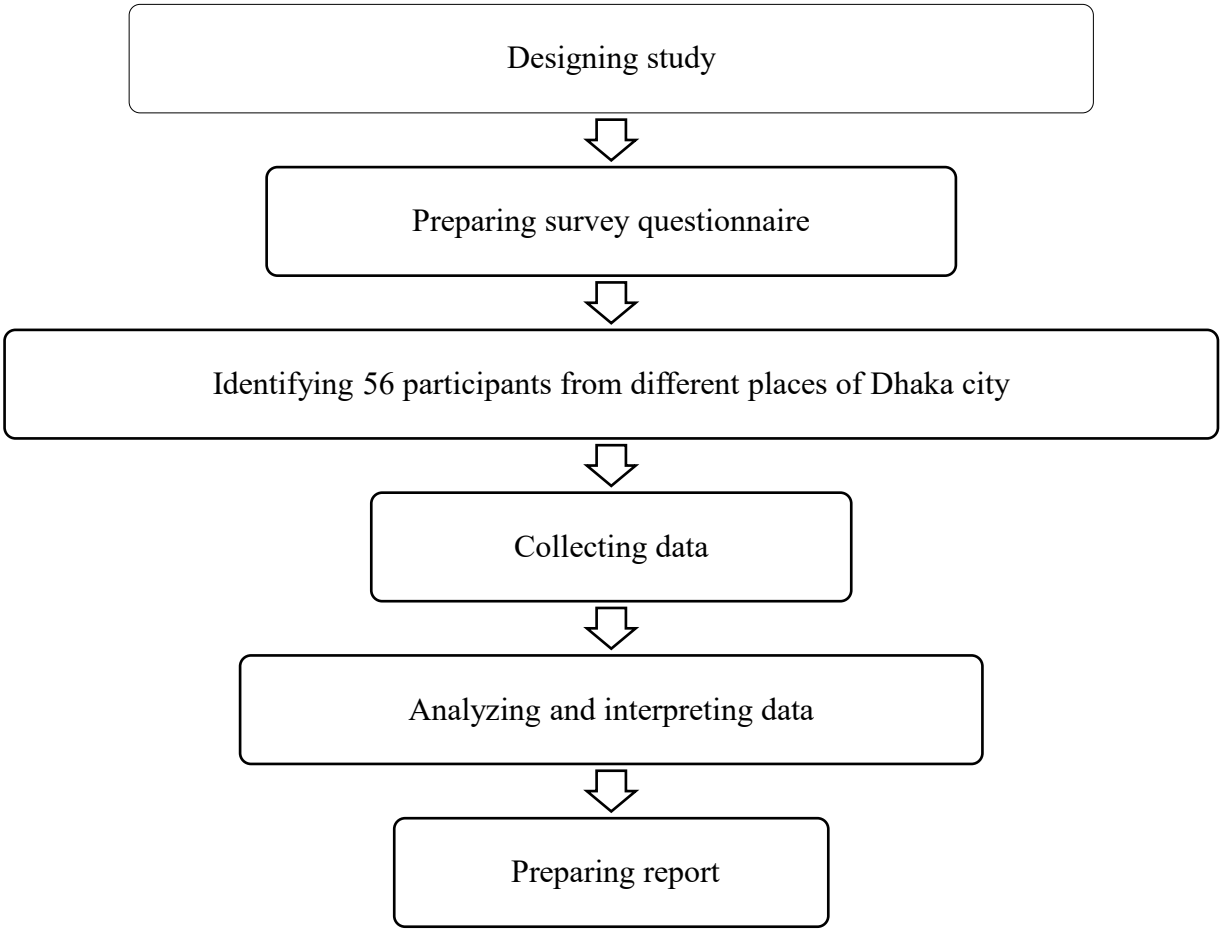

Figure 2.1: Overview of methodology of the study

2.2.1 Designing study

The first approach of this research was a cross sectional study to determine the intensity of PPD among housewives and working women in Bangladesh, compare their condition, defining existence of social support groups and elucidate people‟s attitude towards this maternal disorder.

2.2.2 Preparing questionnaire

After designing the study, two questionnaires were selected for the research purpose. One of them was being used globally for screening PPD (EPDS) and another one was developed following the collected information related to PPD.

EPDS (Edinburgh Postnatal Depression Scale) is the most extensive psychological tool for the screening of PPD globally. This is a 10-item self-assessing scale precisely schemed to screen the depression in postpartum period (Cox, Holden, & Sagovsky, 1987). Every item has been assigned a score of 4-point scale (from 0 to 3), with a maximum score of 30. The question consists of the relevant answers about how mothers have felt during past seven days (Glaze & Cox, 1991).

Another questionnaire was an 8-item questionnaire with few sub sections, including participants demographic information as well. This was used to illustrate the actual image of a depressed mother. Only the mothers who scored more than 13 in the previous questionnaire, was selected for the second stage.

2.2.3 Identifying participants and pre-testing

This study was conducted only by the mothers with first child. When the questionnaires were ready, 10 participants of the mention category were identified to assess first for pre-testing. After that, their valuable suggestions were recorded to modify it. Before finalizing the questionnaire, it was reviewed multiple times.

2.2.4 Collecting data

Pre-testing and modification process of questionnaire was followed by data collection. Total 60 participants were assessed after giving proper instructions. The participants were ensured that their shared information would be used for research purpose only. Mothers were given the EPDS questionnaire first and after calculating their scores, mothers scoring 13 or more than that were given the second questionnaire. After completion of filling up the questionnaires, 4 of them were eliminated for containing errors. Then, the rest of the questionnaires were forwarded for data

analysis.

2.2.5 Analyzing data

The collected data was then divided according to their score group and analyzed using Microsoft Excel 2016.

3. Results and Discussion:

3.1 Edinburgh Postnatal Depression Scale (EPDS) Result:

After evaluating the Edinburgh Postnatal Depression Scale quiz, 66.07% of 56 women participants had high probability of postpartum depression. Moreover, 7.14% of them were leading to PPD. Besides, 21.43% and 5.36% of women had been found to deal with baby blues and low probability of depression respectively.

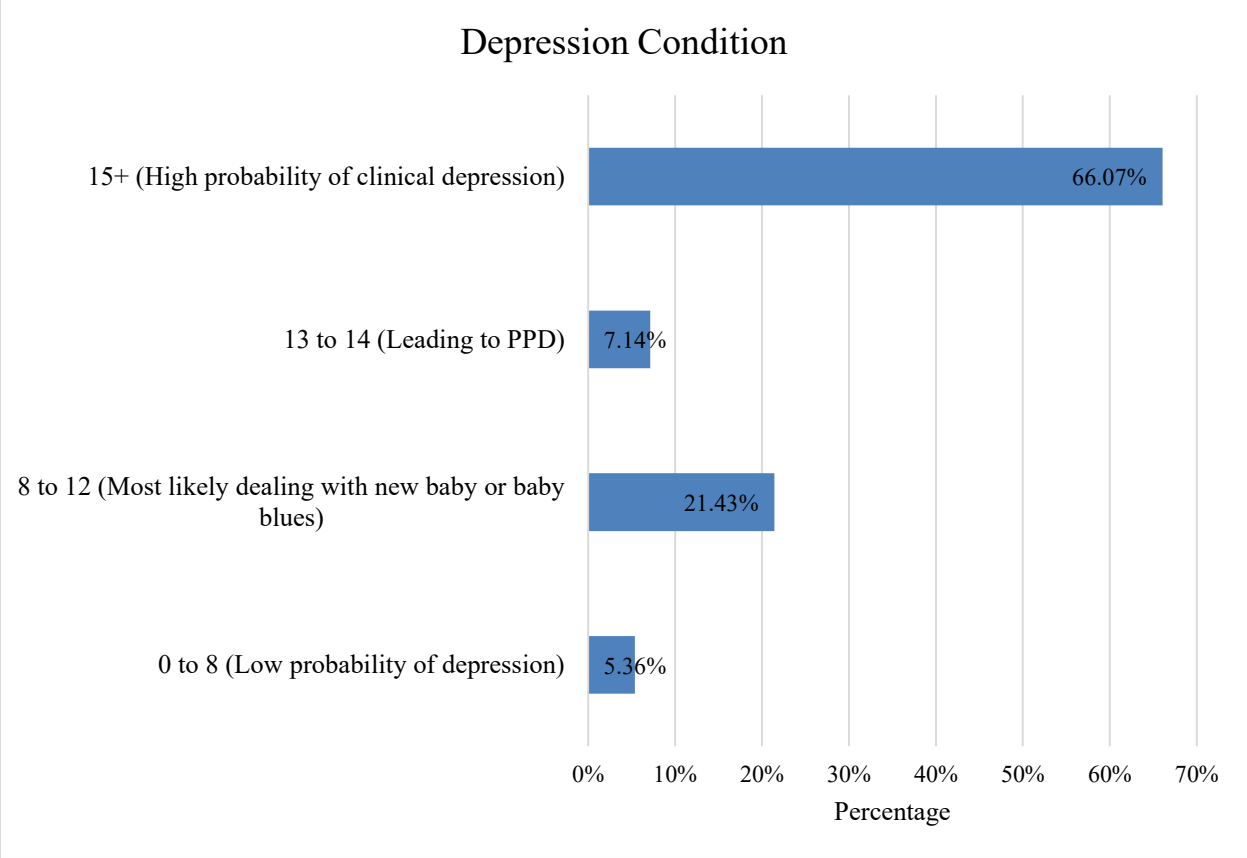

Figure 3.1: Percentage of participants at a different level of PPD

This 10-item standard questionnaire was used for the screening test of PPD on the basis of their last 7 days postpartum experience before filling it out. Now the individual items will be discussed.

3.1.1 Ability to laugh and see the funny side of things

Among the 56 participants, only 17.86% of women were able to laugh and find funny things as much as they always could. Moreover, 35.71% and 37.50% of women were not finding it funny quite so much now and definitely not so much now respectively. Furthermore, A percentage of 8.93 of total participants were not at all able to laugh and see the funny side of things.

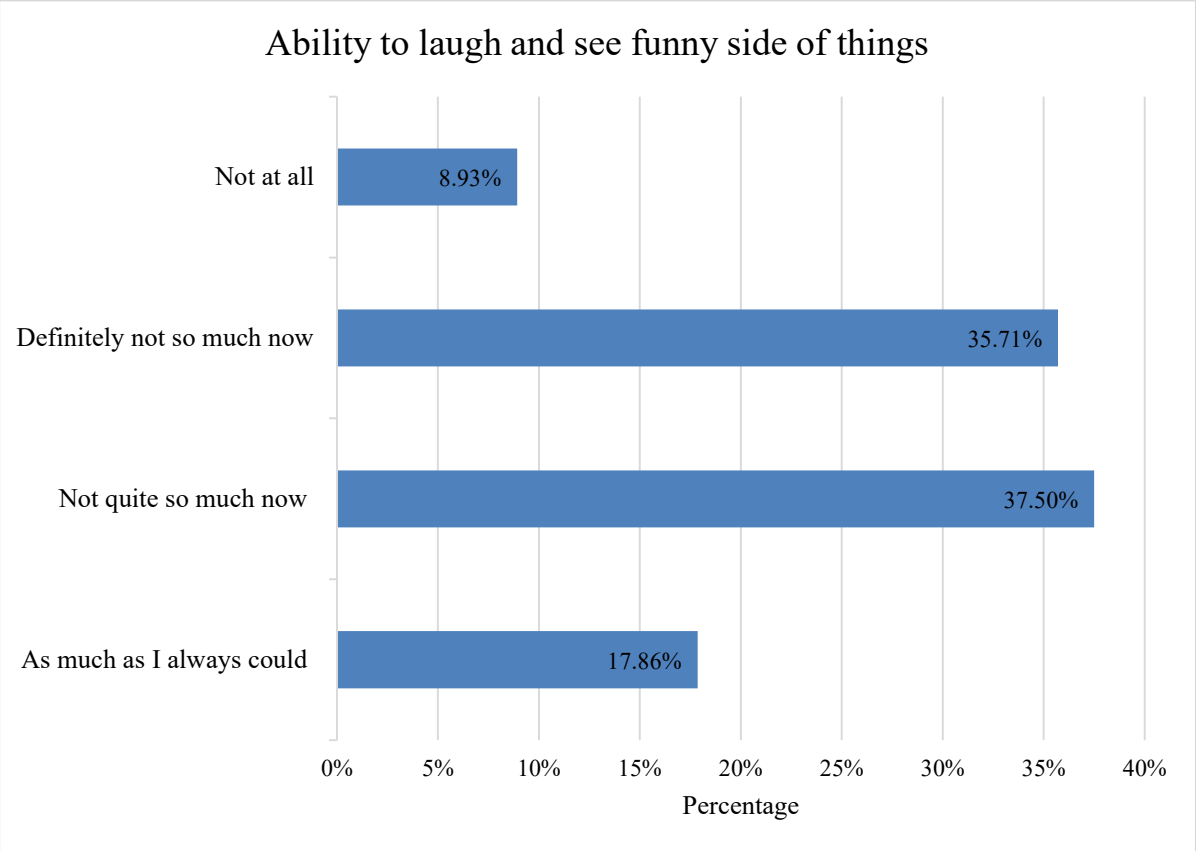

Figure 3.2: Participant's responses about their ability to laugh and see the funny side of things

3.1.2 Looking forward with enjoyment to things

An amount of 12.50% women were looking forward to things with enjoyment as much as they ever did. On the other hand, 37.50% and 33.93% of women were enjoying things rather less than they used to and definitely less than they used to respectively. Besides, 16.07% of participants were finding the same enjoyment hardly at all.

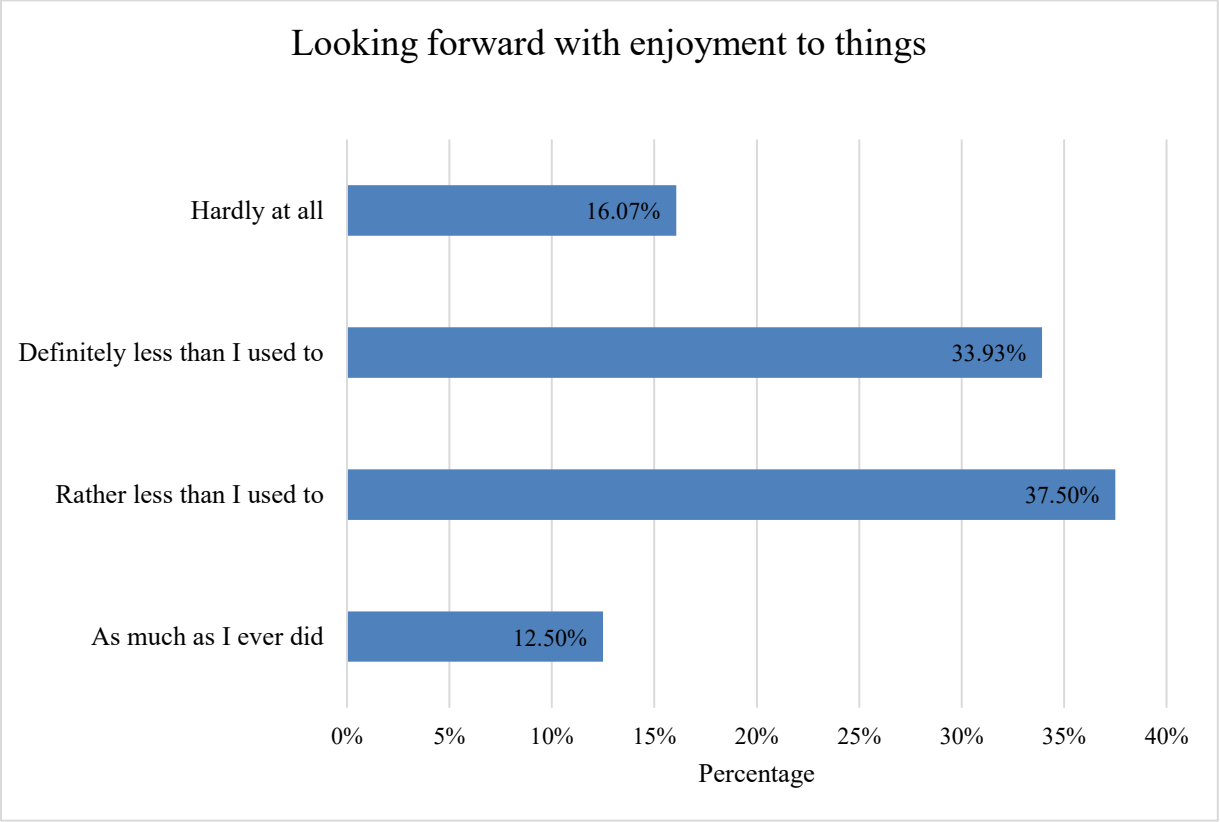

Figure 3.3: Participant's responses about their ability to look forward with enjoyment to things

3.1.3 Unnecessary self-blaming

Women having postpartum depressive symptoms had been observed to make self-blame unnecessarily when things went wrong. Additionally, 35.71% of participants had agreed to do this most of the time. Around 32.14% of them were found to it some of the time. Besides, 26.79% and 5.36% of these 56 women were blaming them not very often and never doing self-blaming at all.

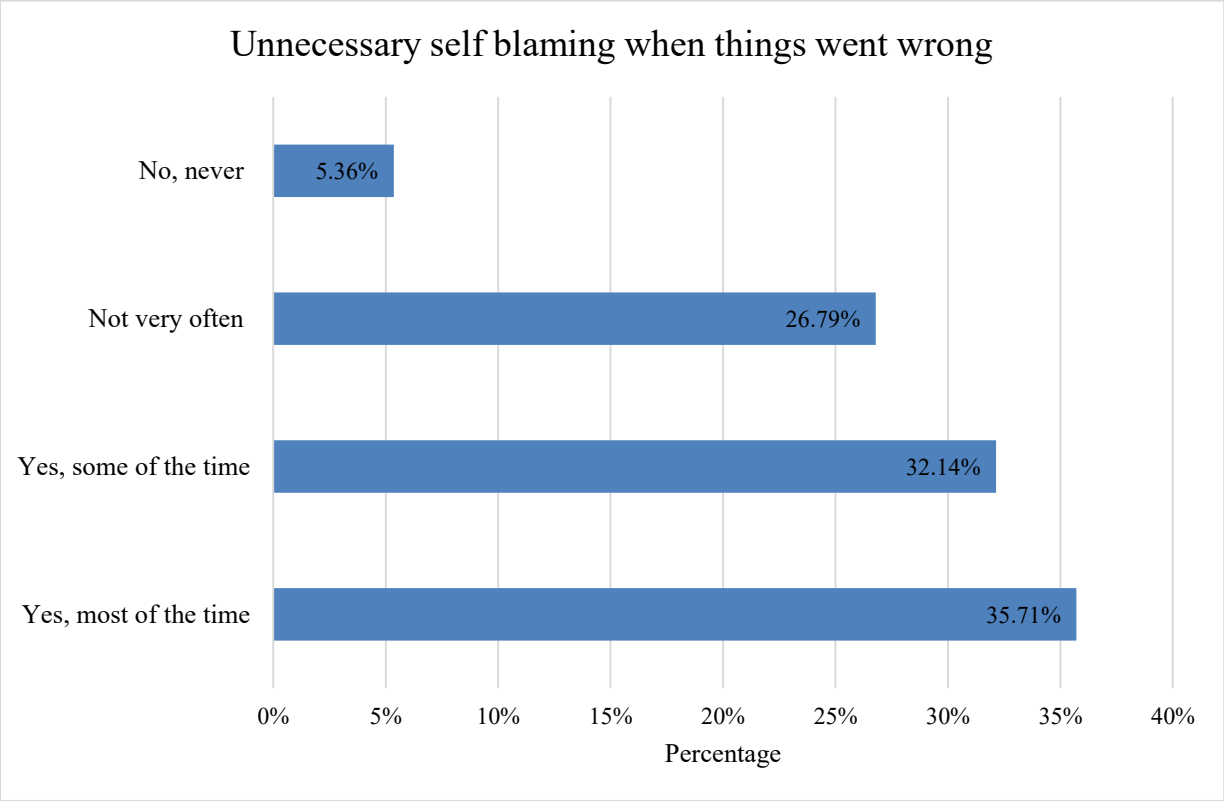

Figure 3.4: Participant's responses to unnecessary self-blaming

3.1.4 Being anxious or worried for no reason

Around 51.79% of participants, which is more than half of the total number, had responded to get anxious very often for no good reason. Additionally, 32.14% of them also got worried sometimes. But only 10.71% and 5.36% hardly ever got anxious and not at all worried respectively.

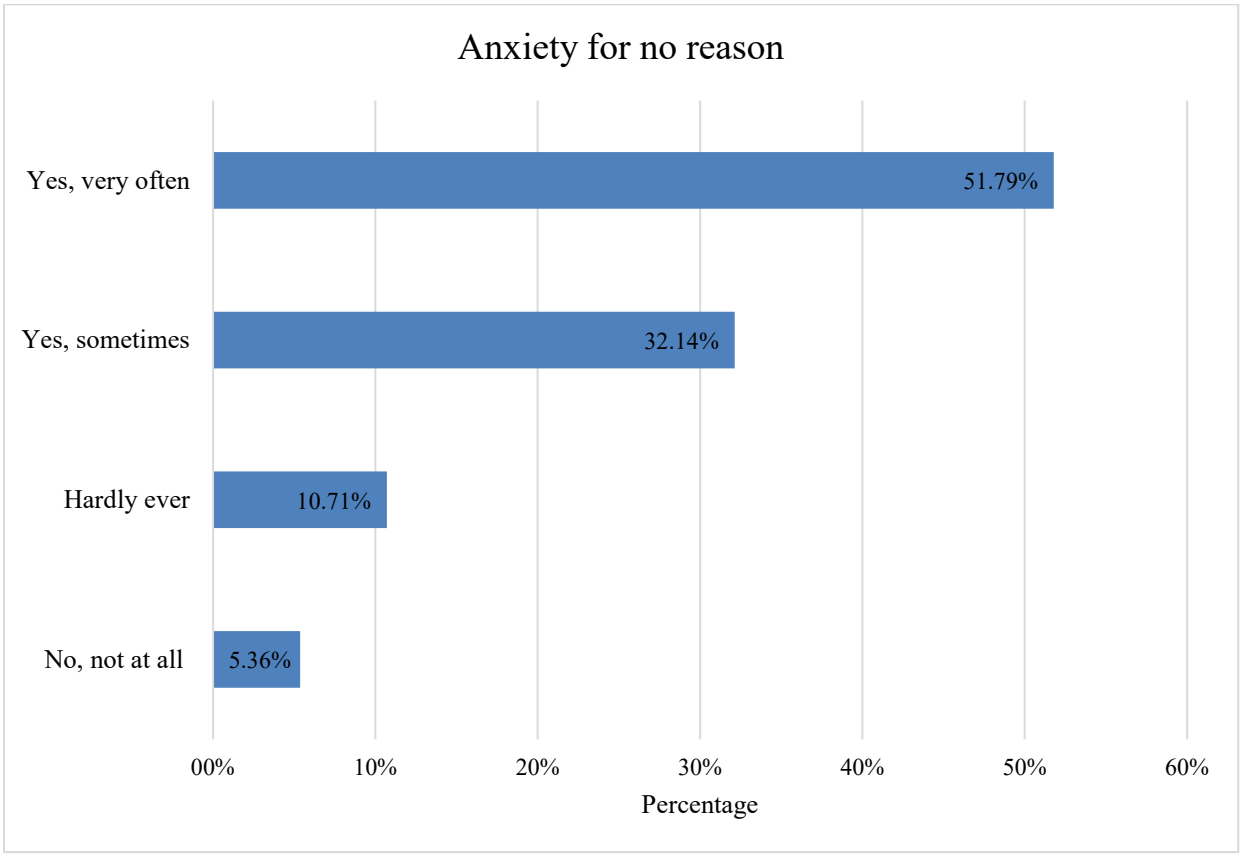

Figure 3.5: Participant's responses about their anxiety for no reason

3.1.5 Feeling scared or panicky for no good reason

Among the 56 participants who filled out the questionnaire, 32.14% of them had experienced it quite a lot. Around 37.50%, which was more than one-third of the participants, went through this sometimes during this period. Furthermore, 21.43% and 8.93% of women responded to feel scared not much and not at all respectively.

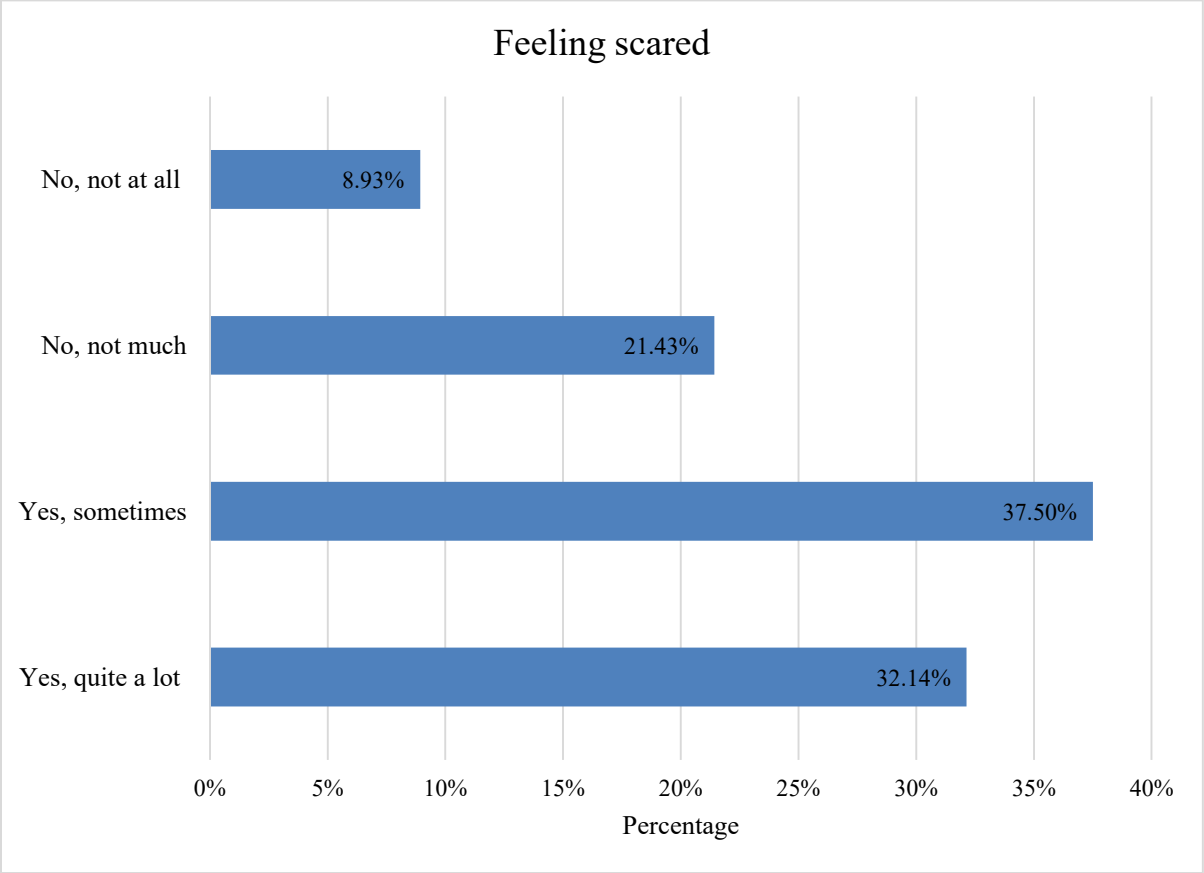

Figure 3.6: Participant's responses about feeling scared for no good reason

3.1.6 Adjustment

Due to the postpartum depressive symptoms, 30.36% of women were unable to cope up with things around them most of the time. Besides, 37.50% of them found this situation is not as well as ever sometimes. On the other hand, 21.43% and 10.71% were detected to find things most of the time quite well and as well as ever respectively.

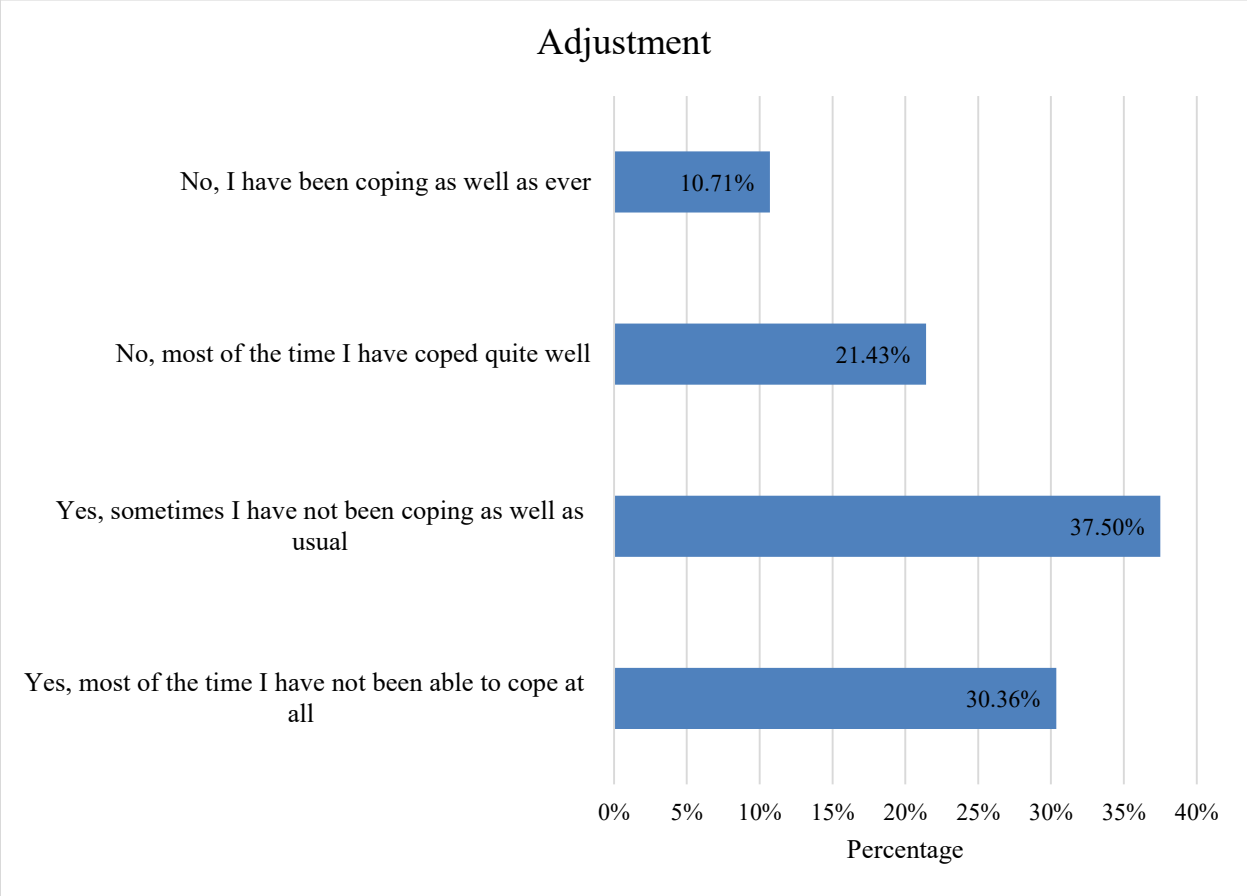

Figure 3.7: Participant's responses about their ability to adjust to their surroundings

3.1.7 Difficulty in sleeping

Women participating in this study found it difficult to sleep as they were going through low to high probability of PPD. Additionally, 33.93% of women responded to face this difficulty most of the time and sometimes each. Moreover, 21.43% and10.71% had been found to endure this problem not very often and not at all respectively.

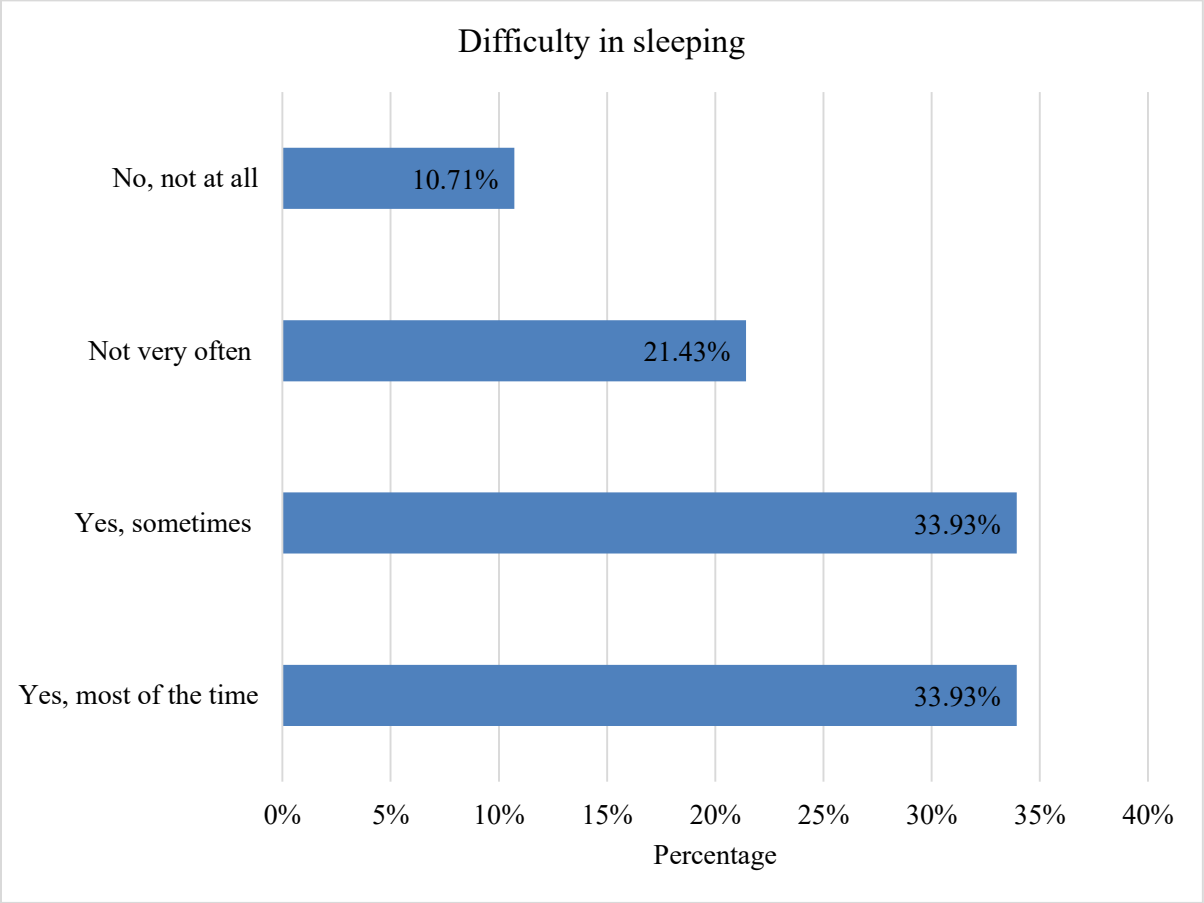

Figure 3.8: Participant's responses to difficulty in sleeping

3.1.8 Feeling sad or miserable

More than one-third of the total participants, which was 37.50%, had experienced to feel sad or miserable most of the time after childbirth. Besides, 35.71%, another large portion, had to go through this quite often. Among 56 participants, 23.22% and 3.57% endured this feeling not very often and not at all respectively.

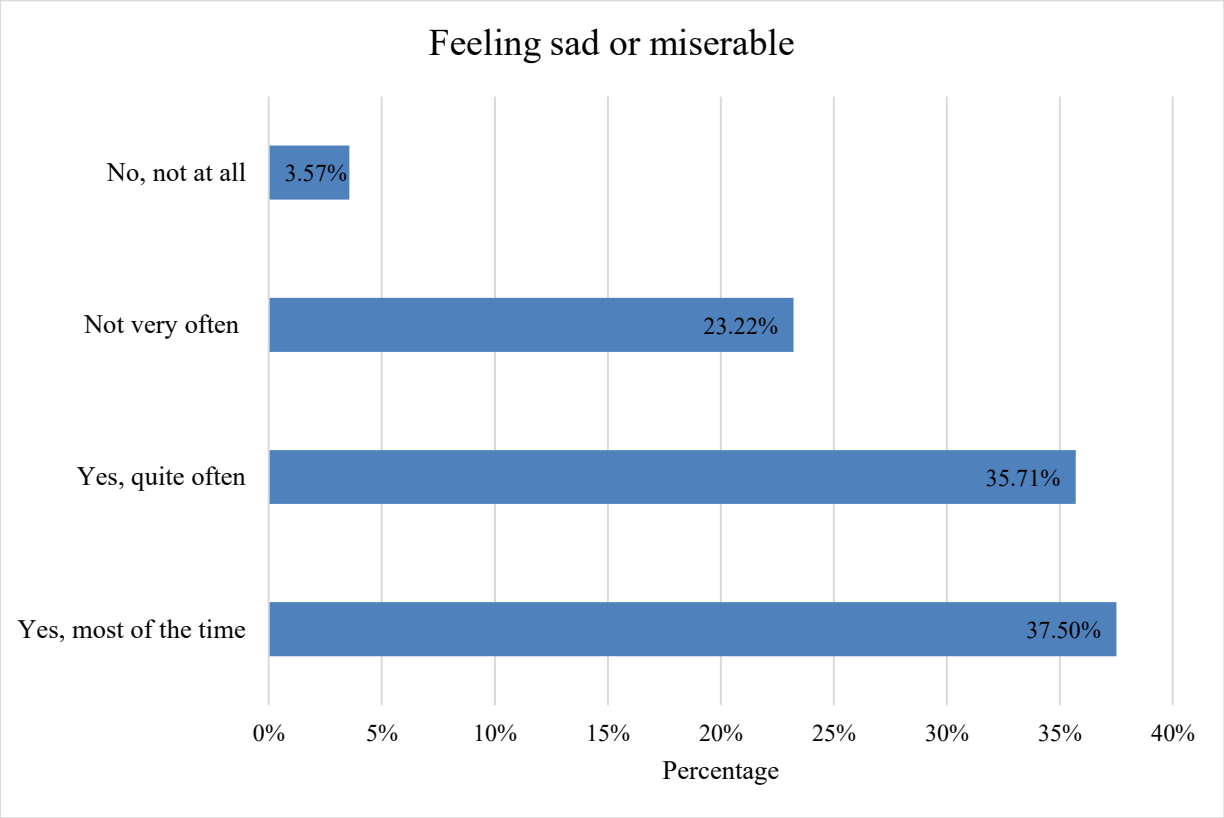

Figure 3.9: Participant's responses to feeling sad or miserable

3.1.9 Unnecessary crying

Unnecessary crying being unhappy, was one of the symptoms of PPD. Interestingly, 28.57% of women had responded to cry most of the time, quite often and only occasionally in each section separately. Besides, 14.29% of total participants had never faced this.

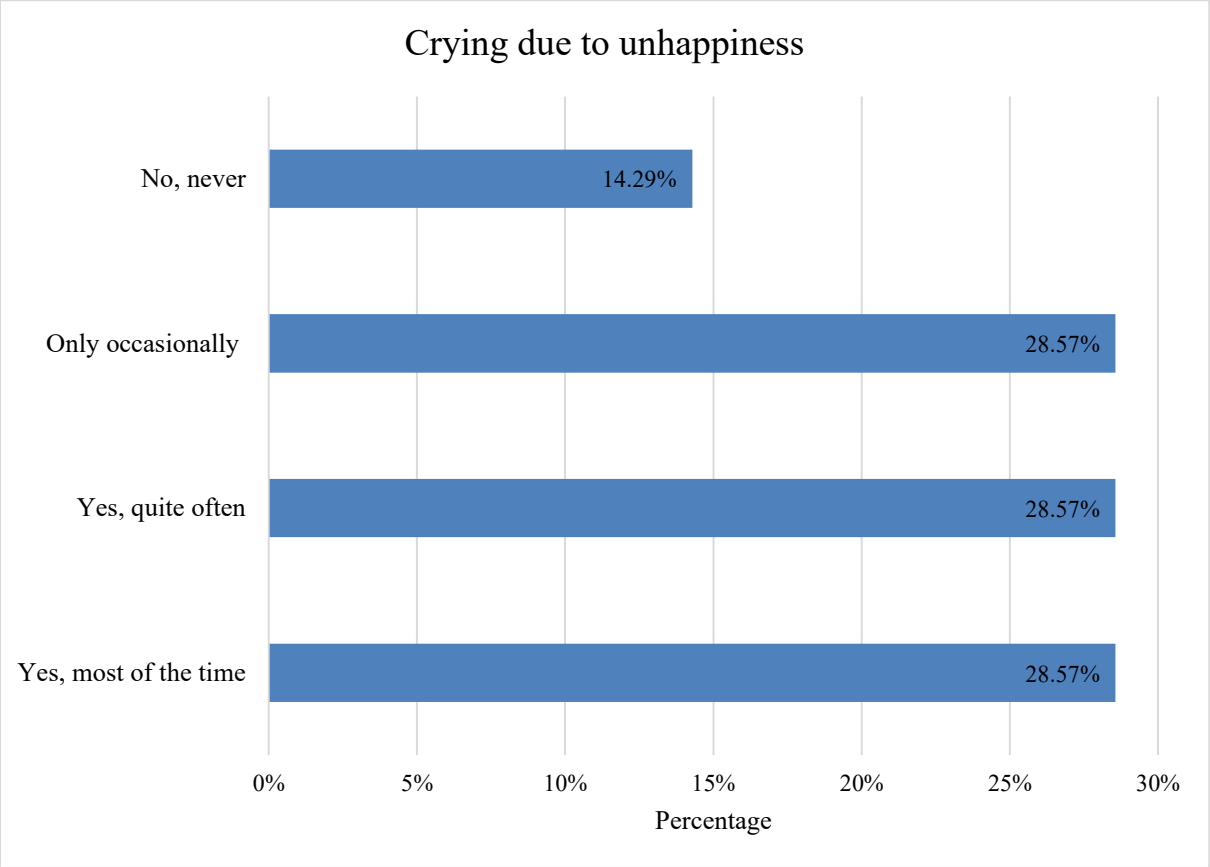

Figure 3.10: Participant's responses to unnecessary crying due to unhappiness

3.1.10 Suicidal tendency

Self-harming and having suicidal thought had been found to be one important aspect of this questionnaire. This was instructed to observe very carefully. Additionally, 10.71% of 56 women had a tendency of committing suicide quite often. Besides, 30.36% were thinking about self-harming sometimes. 16.07% of the participants were having suicidal thought hardly ever. On the other hand, almost half of the women participants never went through this condition.

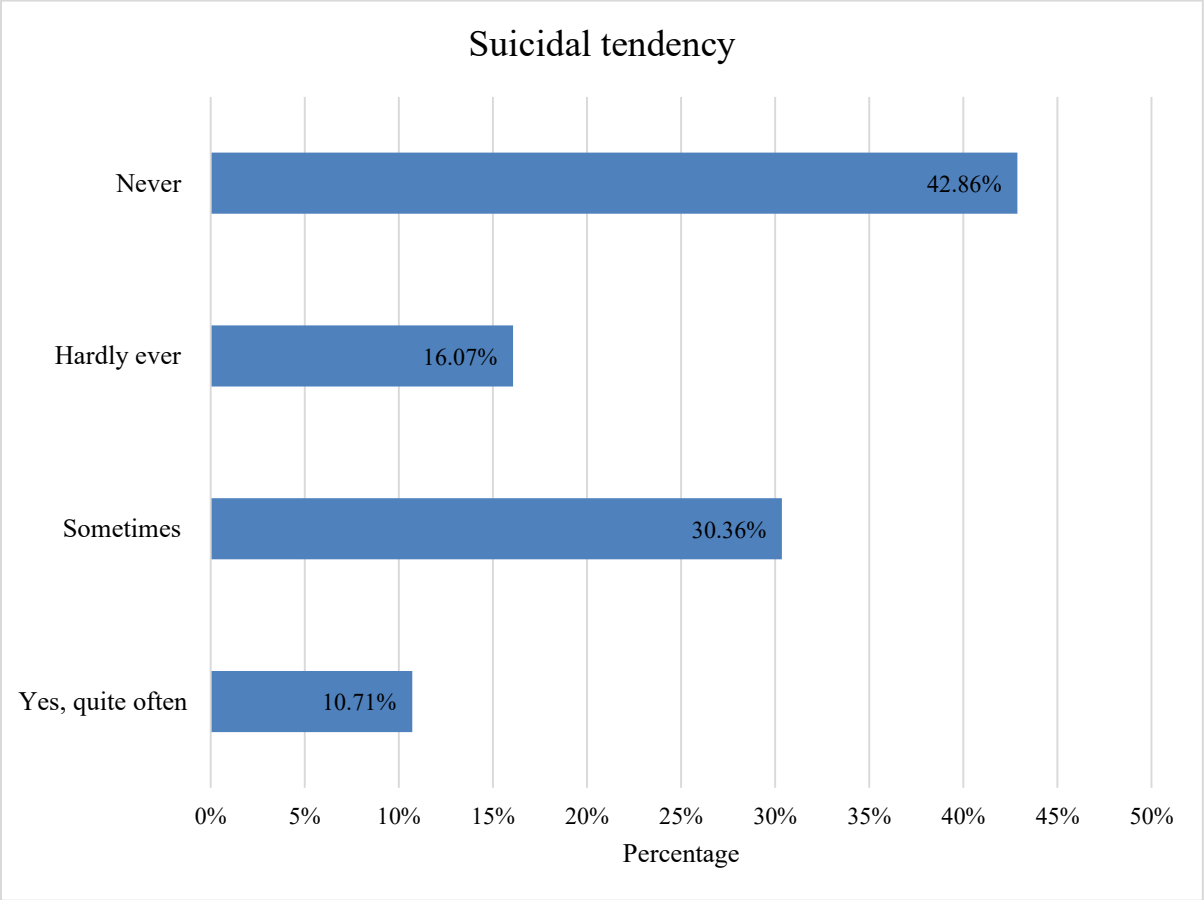

Figure 3.11: Participant's responses about their suicidal tendency

3.2 Determination of severity of PPD in Bangladeshi Women

After filling the first questionnaire, women scoring 13 or above were marked to have possible postpartum depression or leading towards this. Subsequently, they had to fill out another research questionnaire for more information and better understanding. Participants from different age group and occupation cooperated in this research

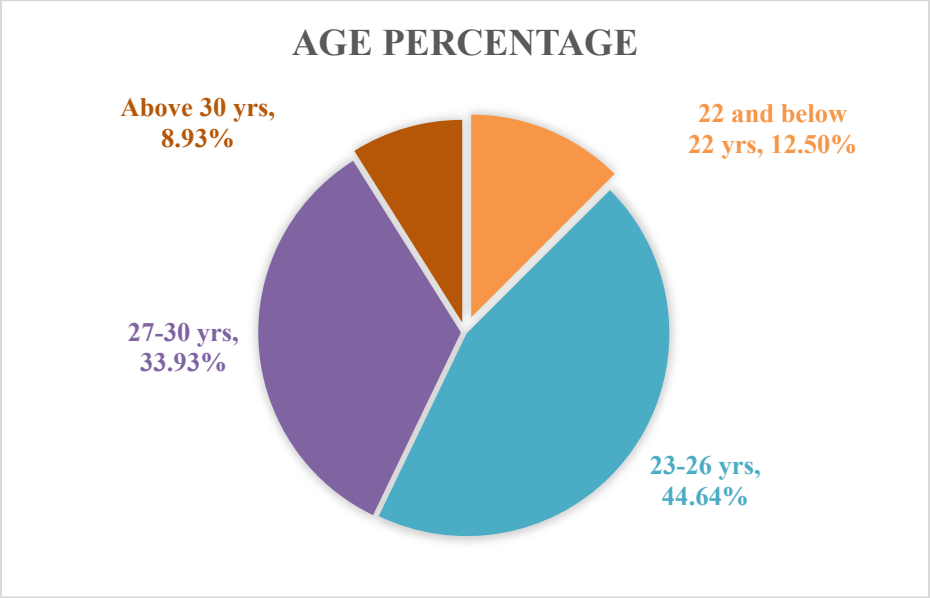

Figure 3.12: Participant's responses about their age

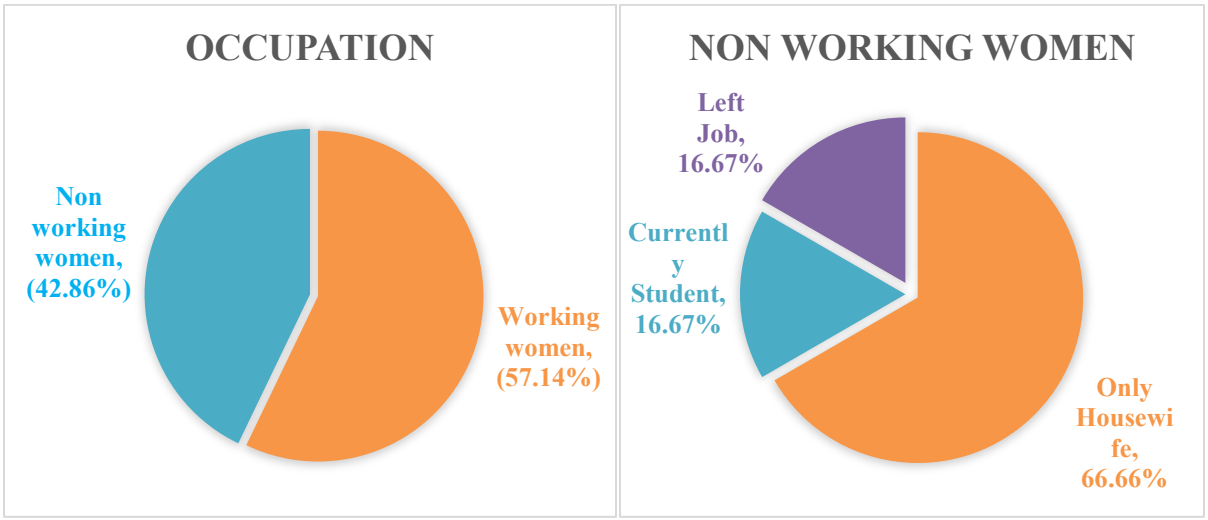

Figure 3.13: Participant's responses about their occupation

This questionnaire had 8 sections with some subsections. Each section will be discussed separately.

3.2.1 Prevalence of Postpartum Depression among women in Bangladesh

After assessing a sample of 56 participants, 73.21% of participants had been found to have postpartum depression. Another 26.79% were just dealing with baby blues and low depression.

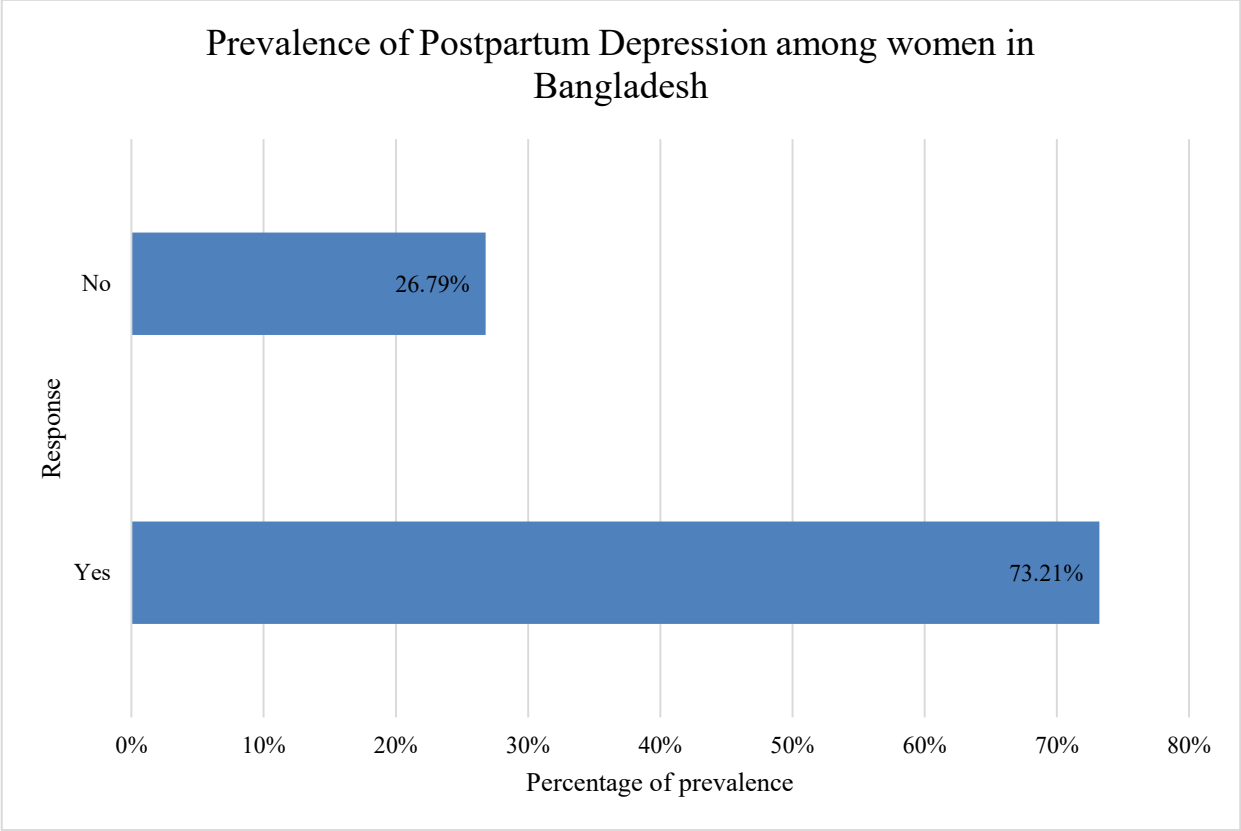

Figure 3.14: Prevalence of PPD among Bangladeshi women

3.2.2 Postpartum depression timeline

Out of 56 participants, 41 participants had been marked to have postpartum depression. While doing the assessment, 17.07% of 41 participants had gone through different depressive symptoms during 48 hours to 4 weeks following childbirth. More than half of them faced this during 1 to 6 months after childbirth. Another 17.07% were found to endure this situation during 6 months to 1 year after childbirth. Only 2.44% of the total participants experienced this from 48 hours to 1 year after childbirth, which was rare. Moreover, a percentage of 7.32 did not have to bear this until one year following childbirth. They suffered from the depression "after 1 year of childbirth".

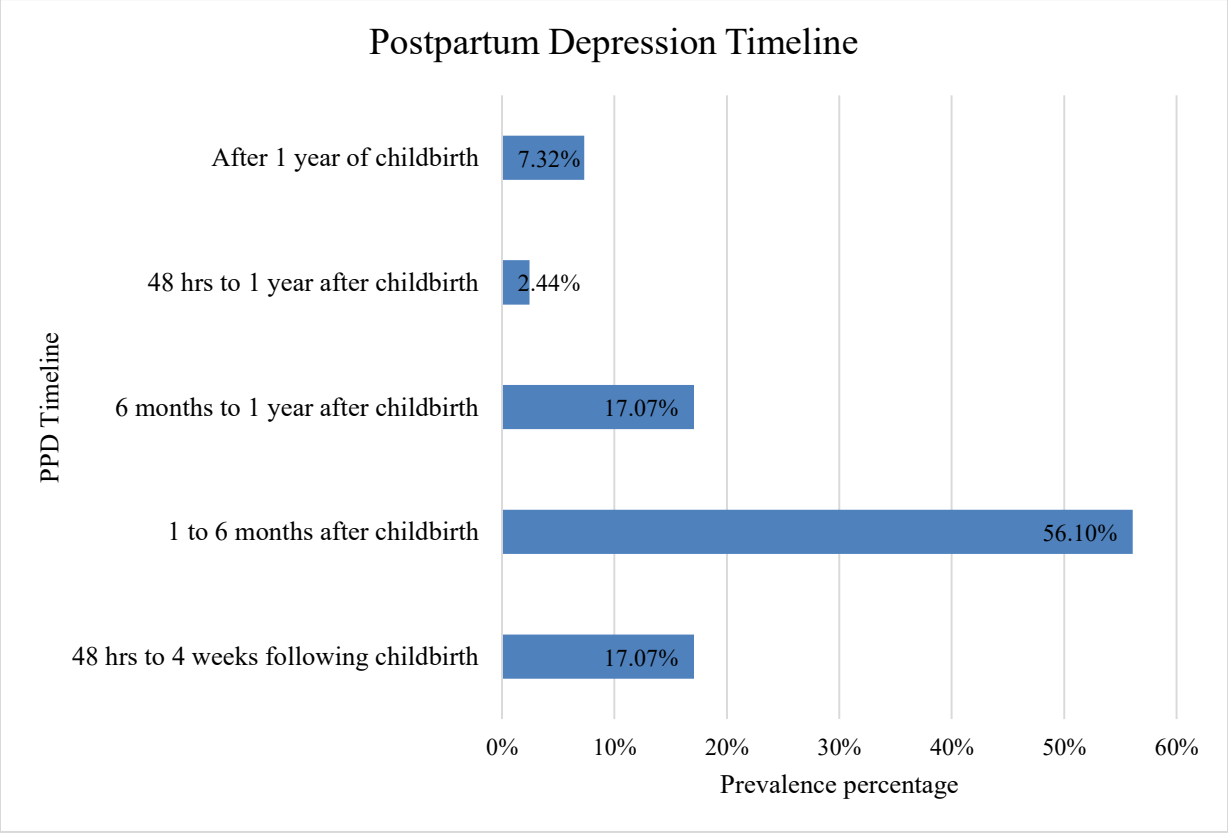

Figure 3.15: Participant's responses about their PPD timeline

3.2.3 Psychological changes during PPD

Women having PPD are susceptible to various psychological changes like periodic mood swing, trouble in sleeping, fatigue, feeling anxious or sad and having suicidal thought. Over two-thirds of the participants, which was 73.17%, experienced all of these emotional changes. Around 14.63% of these 41 women were going through two or three mixed physiological changes. Very few of the participants were undergoing single psychosomatic changes, which were 2.44%, 2.44% and 7.32% for suicidal thought, fatigue and frequent mood changes respectively.

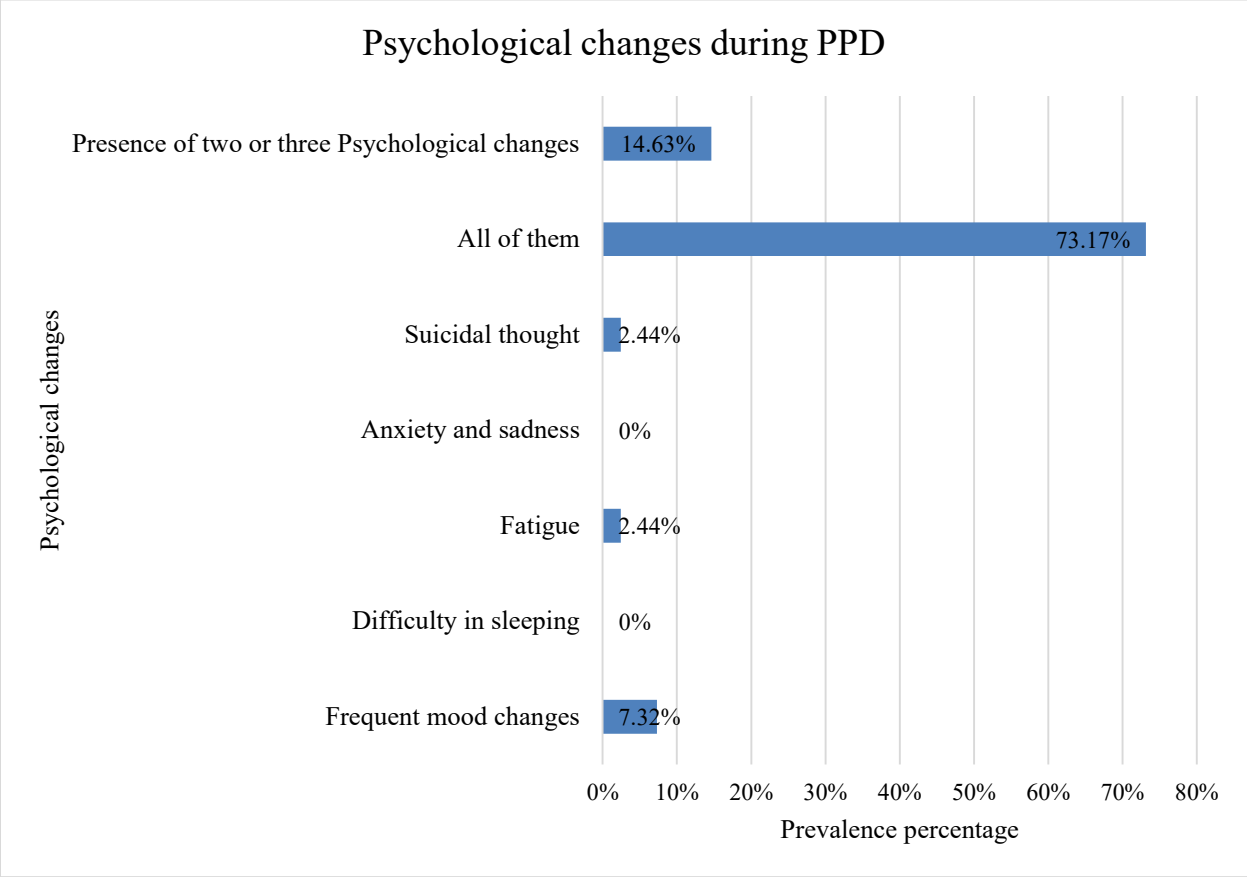

Figure 3.16: Participant's responses about their psychological changes

3.2.4 Impact of PPD on the bonding between mother and baby

Out of 41 participants, 29.27% felt detached with the baby. On the other hand, 70.73% responded that PPD did not affect their relationship with their baby.

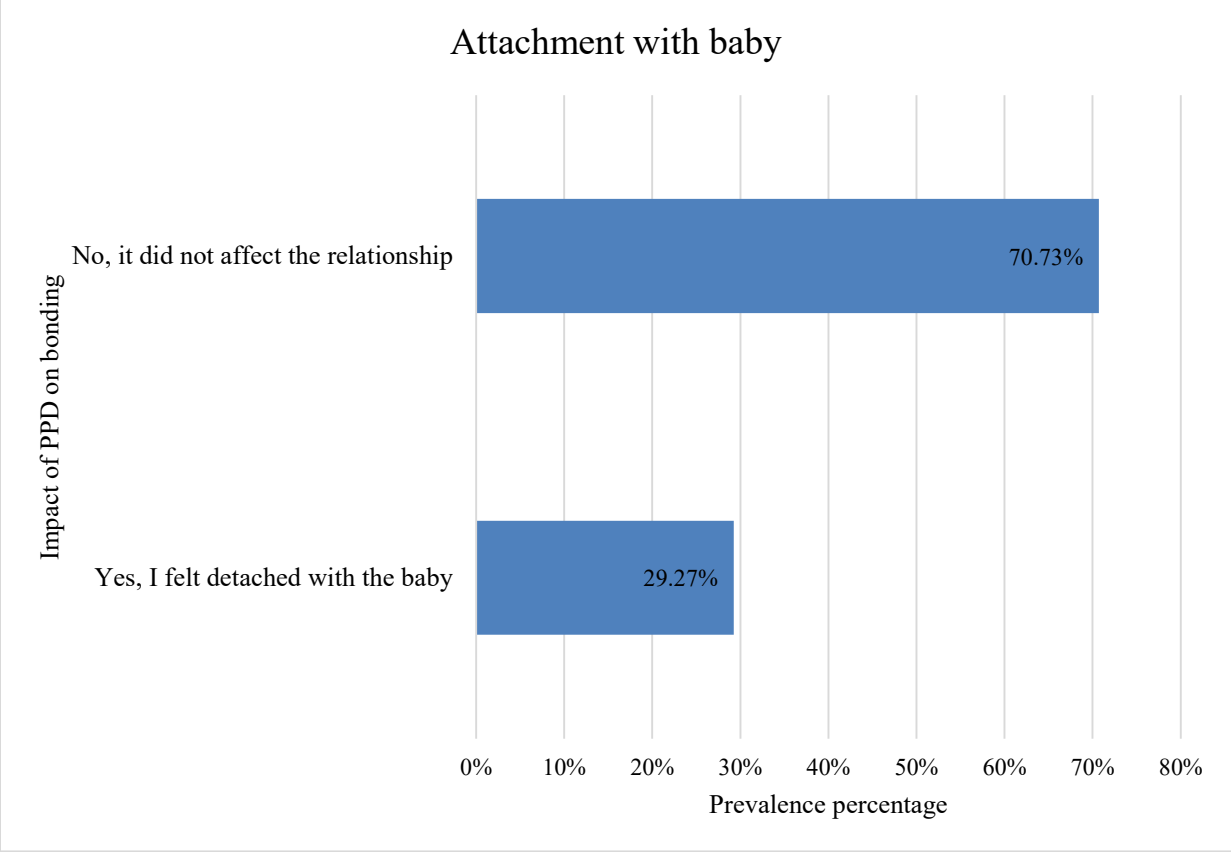

Figure 3.17: Participant's responses about the impact of PPD on the bonding with baby

3.2.5 Sharing problem and expressing feeling with others

For women passing through the postpartum depressive symptoms, it was difficult to share their feelings with others. Still, 51.22% of them responded to yes. Around 48.78% were not able to express their thought and responded to no.

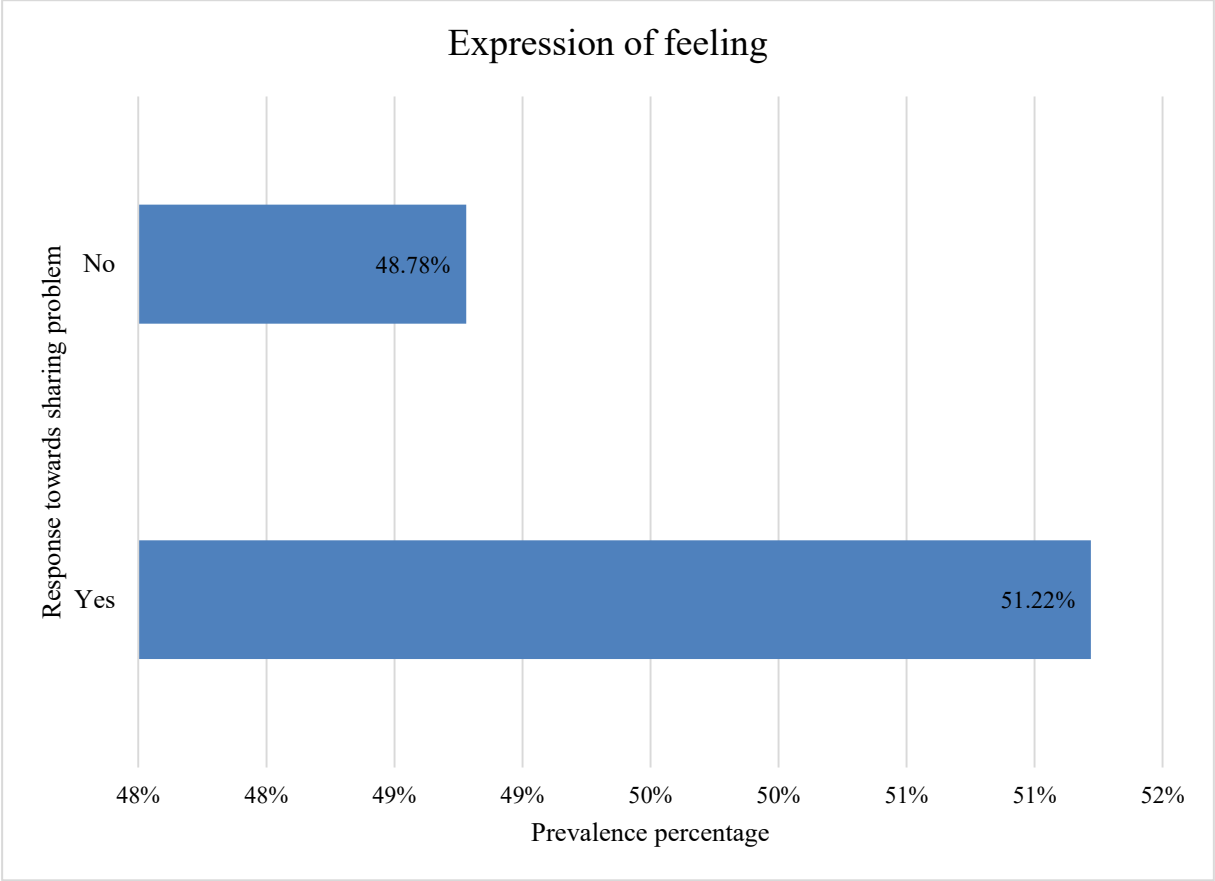

Figure 3.18: Participant's responses about their problem sharing

3.2.5A Support from family and friends

Among 41 participants, 21 of them responded positively and shared their problems with family and friends. One-third of them, which was 33.34%, got an understanding ear to listen. Additionally, 4.76%, 28.57% and again 4.76% responded to made me feel valued, helped me with the baby and household chores and encouraged me to take medical help respectively. Interestingly, 28.57% experienced all of them.

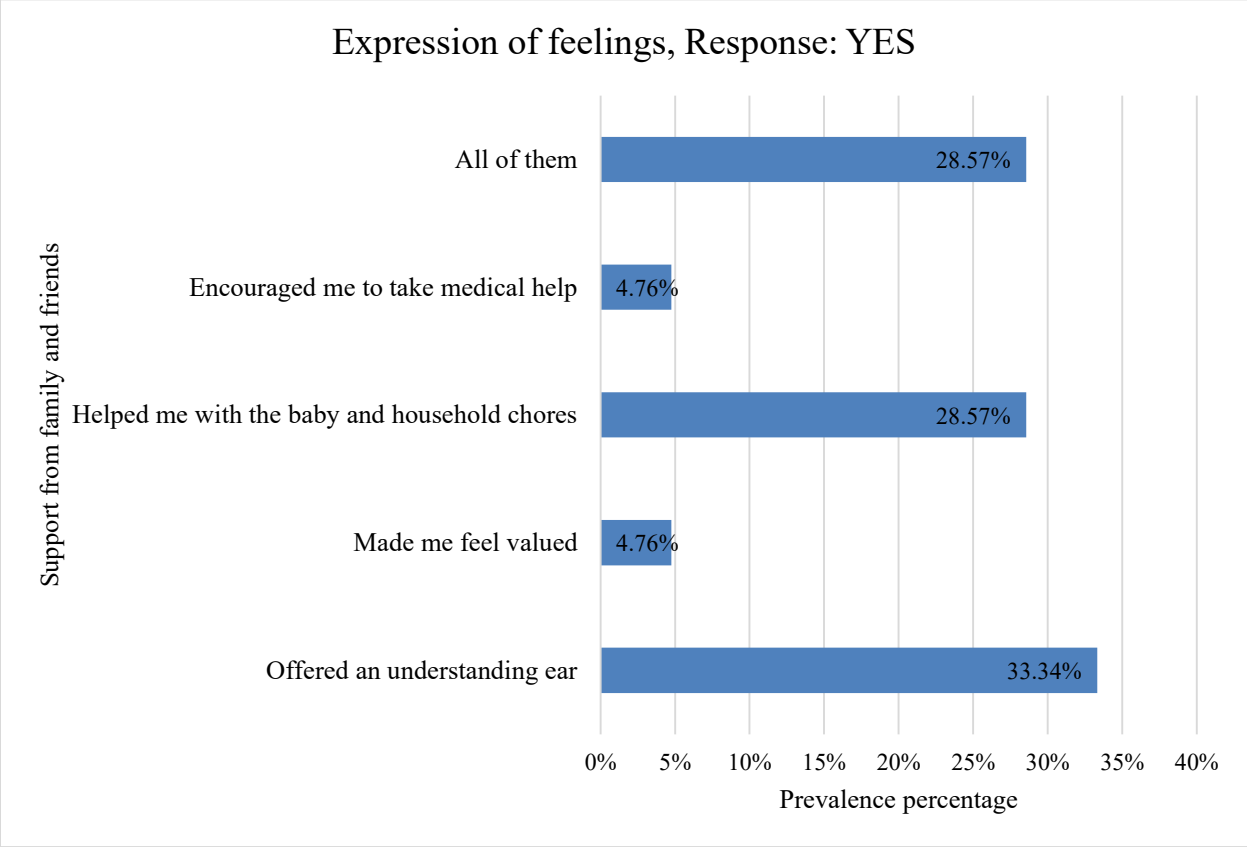

Figure 3.19: Participant's responses to support from family and friends

3.2.5B The reason for the influenced decision

Among the 41 participants, 20 women did not share their problem with anyone and marked no. In their response to the reason for the influenced decision, 10% of women said that they felt guilty thinking about being a bad mother. Around 30% of them was afraid of being judged by the society. Besides, 25% of women responded to did not want to be labeled as mental patient. On the other hand, 35% of total 20 participants were influenced by all of them.

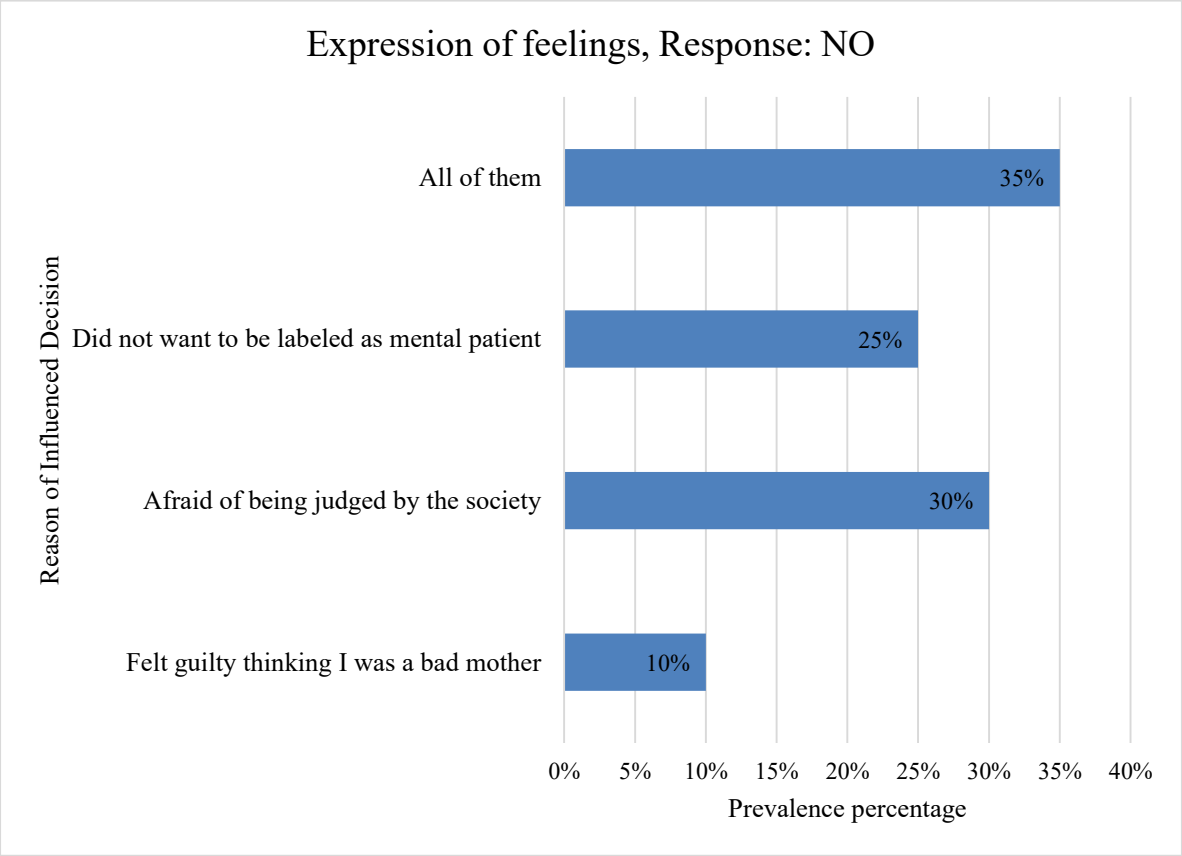

Figure 3.20: Participant's responses about their influenced decision for not sharing problems

3.2.6A Treatment

Total 41 women answered this question about whether they took treatment or not, but only 2 women responded to yes, I did. This was 4.88% of the participants. Rest 95.12% of them did not take any treatment for the depression they were experiencing.

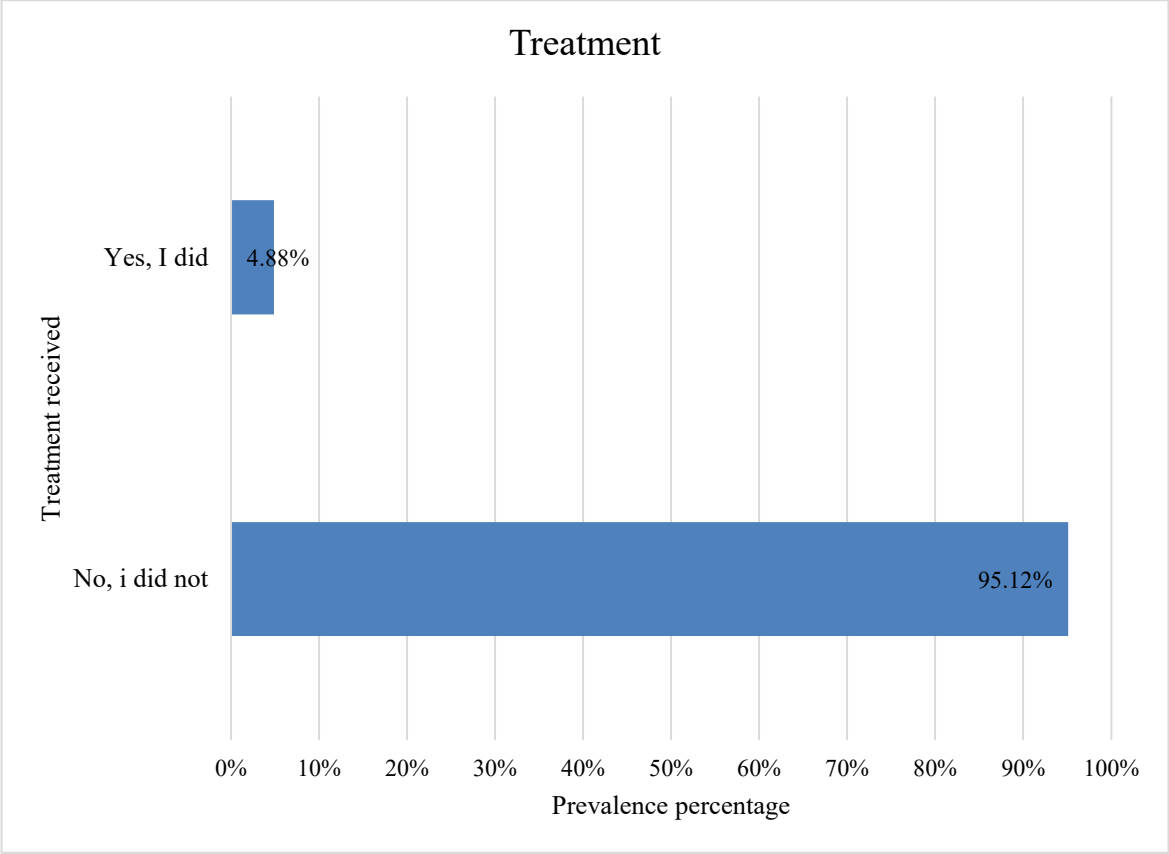

Figure 3.21: Participant's responses about the treatment they received

3.2.6B Type of treatment

Among the 2 participants who responded yes to the previous question, one of them took medication only and another one received both medication and therapy.

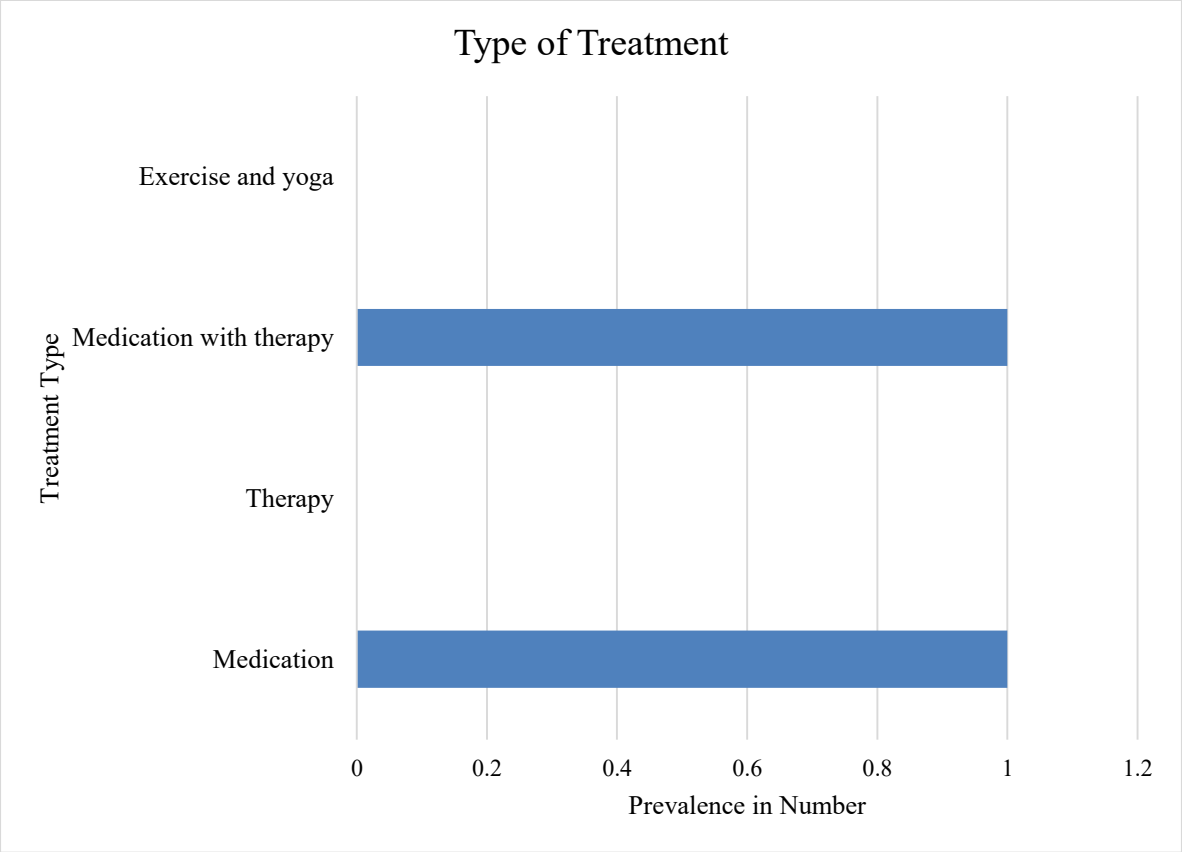

Figure 3.22: Participant's responses about the treatment type

3.2.6C Recovery process

Surprisingly, out of 41 participants, 78.05% of women chose myself as their recovery option. Because PPD is not so highlighted topic in an Asian country like Bangladesh. Most of the time women overlooked the symptoms and healed by themselves. Additionally, 4.88% of these participants took medication as discussed previously. Along with that, 17.07% women had responded to receive family and social support.

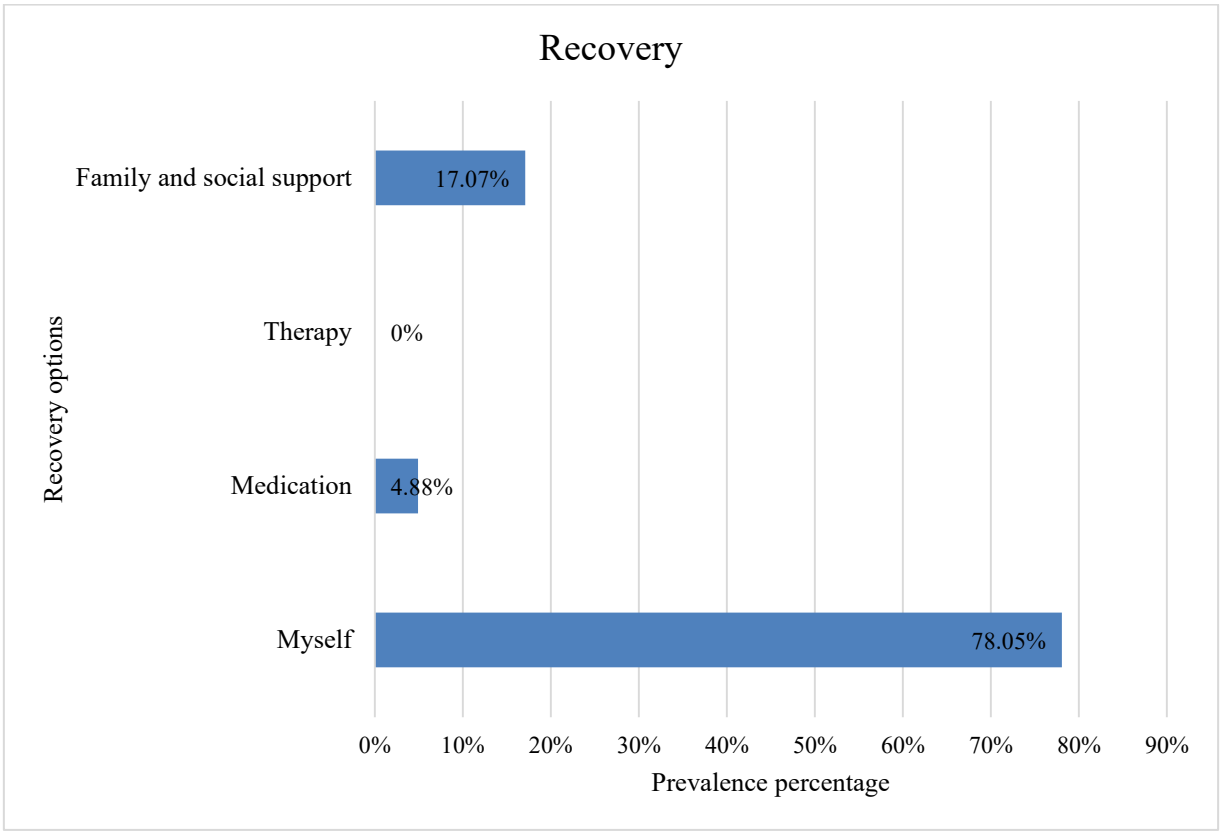

Figure 3.23: Participant's responses about their recovery process

3.2.7A Life maintenance ways of housewives

41 women were found to have PPD, among them 24 were housewives. In a response to the question of how actually they maintained housework's during this period, 8.33% of women chose faced different problems due to compartmentalized focus. Over one-third of the participants responded to had to balance housework with the parenting of baby. Rest 25% and 29.17% of 24 participants had preferred household works actually helped me to recover this disorder and others respectively.

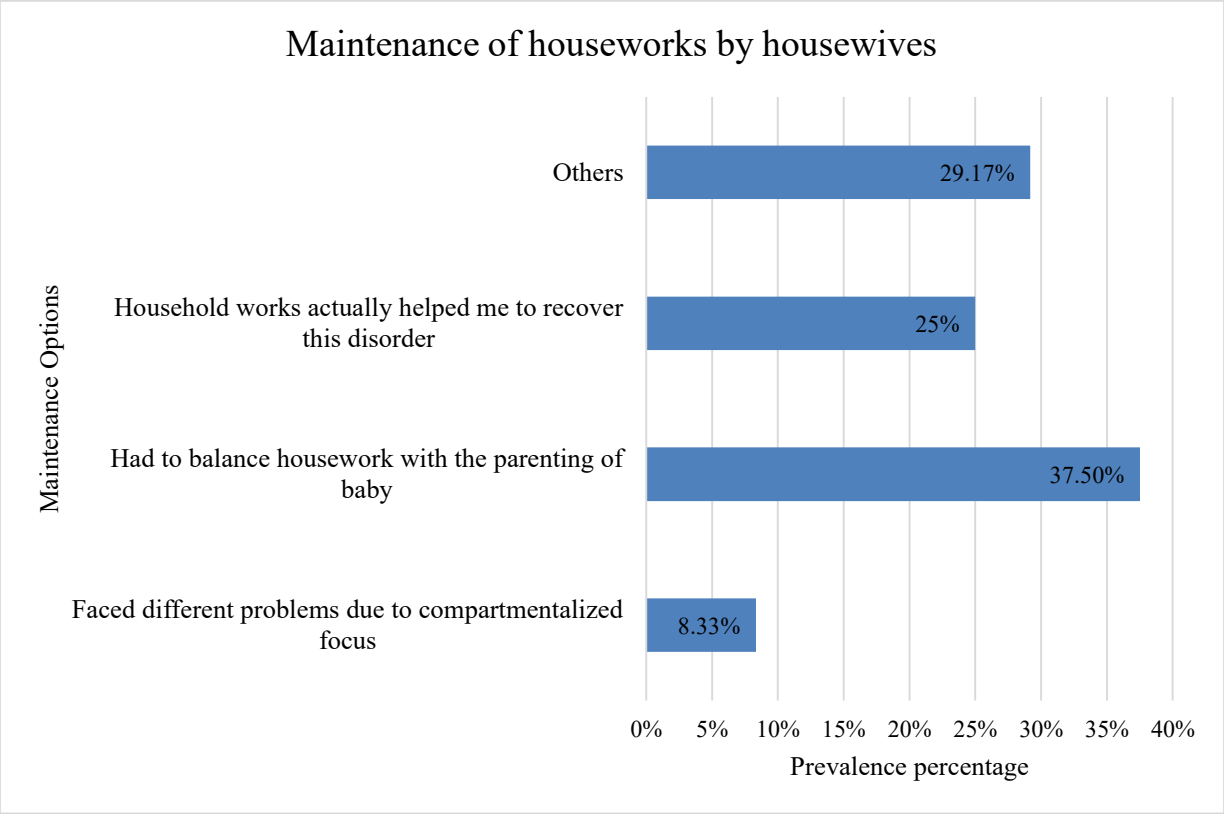

Figure 3.24: Participant's responses about how housewives maintaining life during PPD

3.2.7B Balance in professional life for working women

Nowadays, a large number of women are working outside and creating their own source of income. 17 women out of 41, were found to be in the corporate field. A percentage of 17.65 had chosen faced different problems due to compartmentalized focus as their option. Almost half of the participants, around 41.18% said that they had to balance between personal and professional life. Furthermore, 17.65% and 23.52% responded to office environment actually helped me to recover the disorder and others respectively.

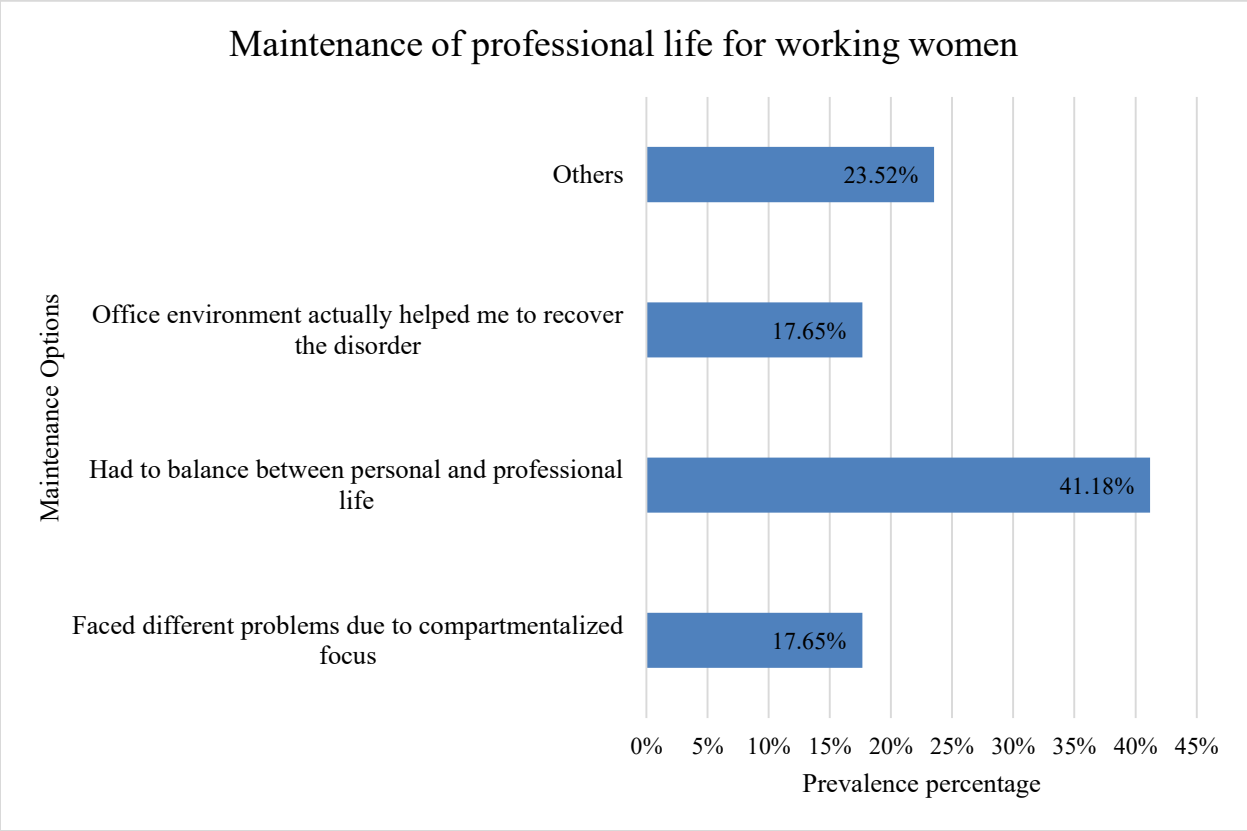

Figure 3.25: Participant's responses about how working women balanced life during PPD

3.2.7C Family/office working environment for PPD affected mothers

Women undergoing PPD need a considering and helpful working environment whether at home or office. 41 women participating in this study shared their response about their working environment condition. 21.95% of them responded to yes having a concerned workplace. 36.59% chose to say no and rest 41.46% went for moderate as their option.

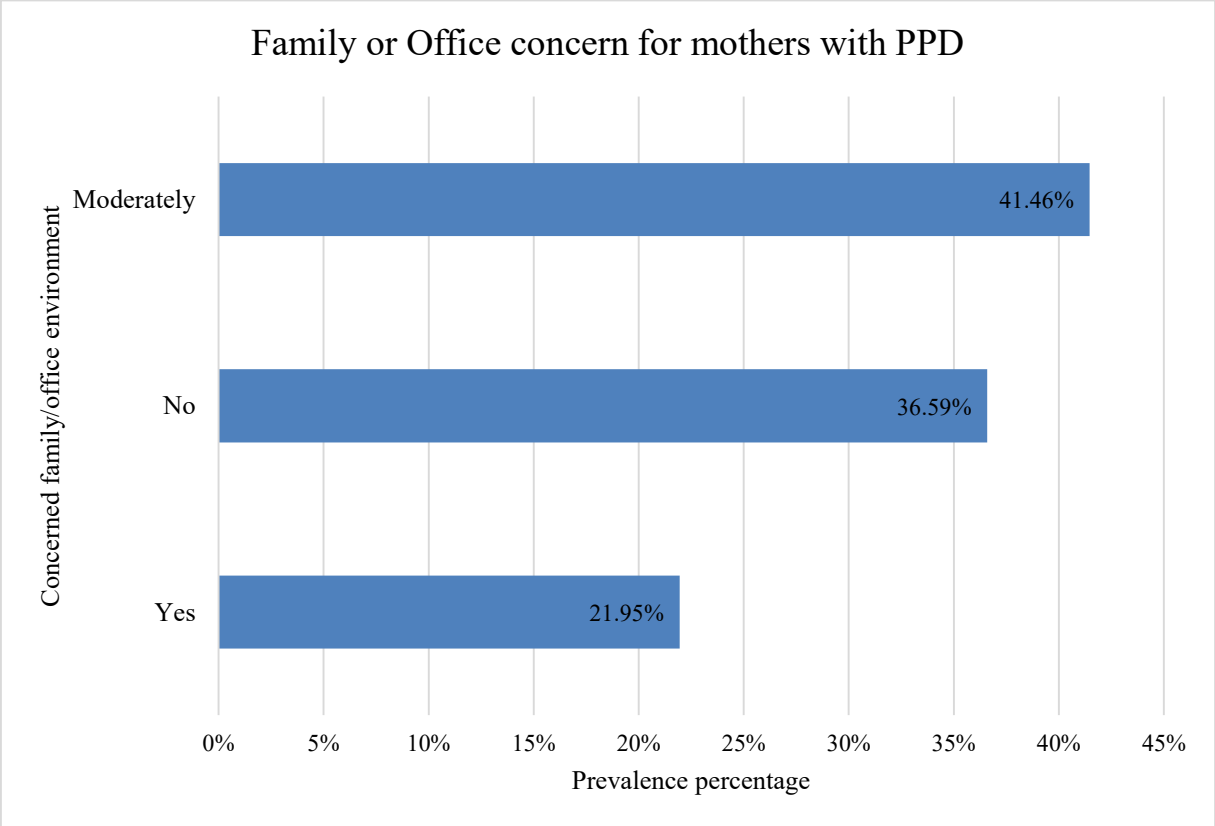

Figure 3.26: Participant's responses to their family/office working environment

3.2.8 Knowledge about PPD support group

In developed countries, large numbers of social support groups are available to normalize PPD affected mothers and to support general mothering matters. These groups usually render a secure place to disclose all the problems and experiences. While answering about the social support group, 37.71% of the total 41 participants replied that they do not have any idea about the social support group and their role. Surprisingly, only 4.88% of them responded to yes, I know as their option. More than 63.41% of participants knew about this but unfortunately, they did not find any social support group.

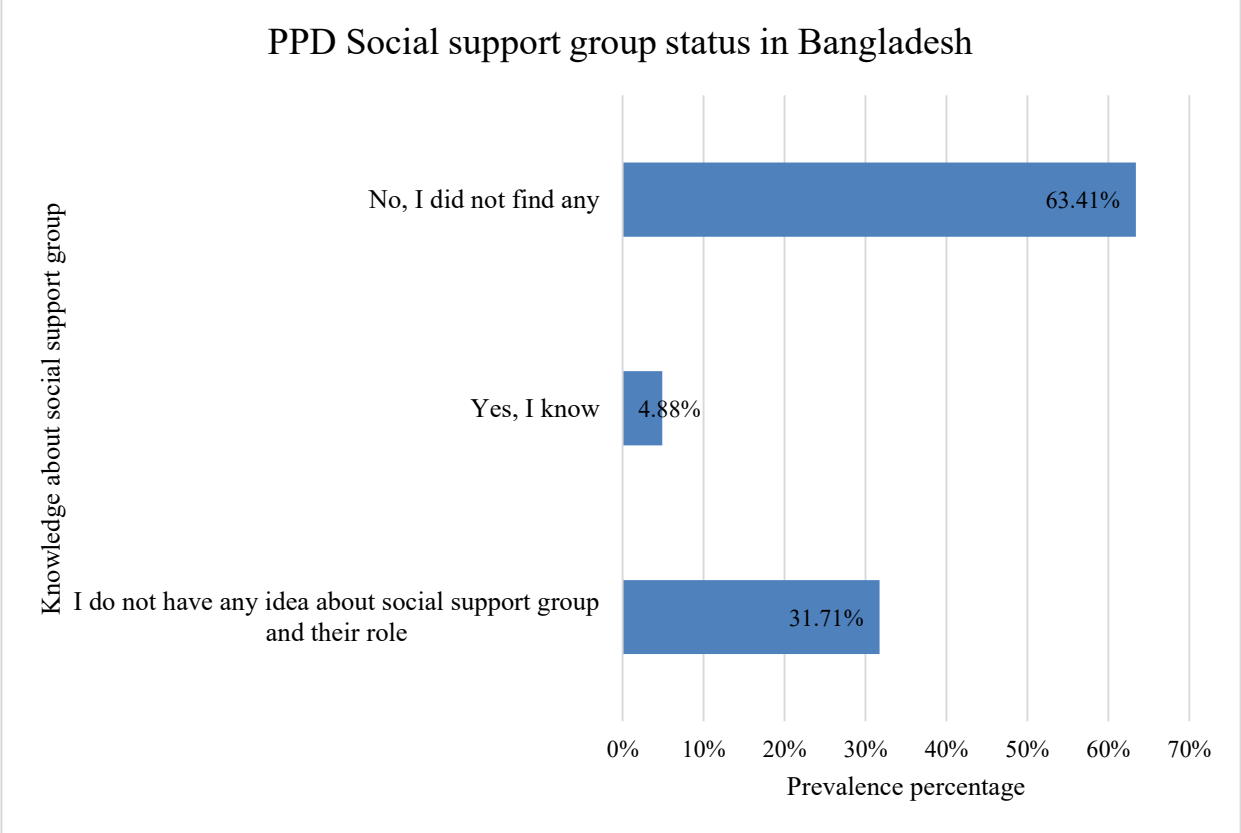

Figure 3.27: Participant's responses about their knowledge of PPD social support groups

Only 2 participants who responded yes to this question, suggested about some Facebook support groups namely „Mommy Talk Bangladesh", „Pregnancy, Birth, Motherhood BD" etc. No suggestions of any physical counseling or therapy center were found.

3.3 Comparison of PPD severity between housewives and working women

While assessing the information provided by the participants, 24 women were found to be housewives and 32 of them were working women. After analyzing their data, it was observed that 79.16% of housewives and 68.75% of working women were suffering from PPD respectively. It clearly shows that housewives are more affected with PPD than working women. According to a study, working women scored less in depression scale than the housewives, as profession might have worked as a substitute to alleviate depression (Mohammadi, Aghdam & Ranji, 2011)

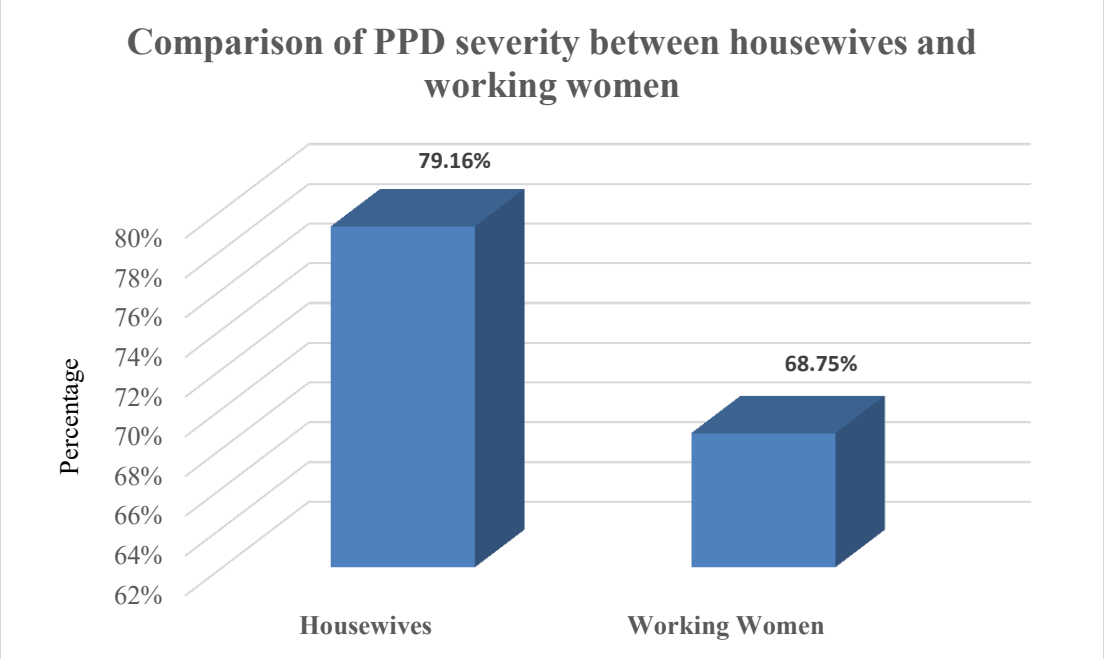

Figure 3.28: Comparison of PPD severity between housewives and working women

4 Conclusion

The primary aims of this study were to put spotlight on the updated facts of PPD in Bangladesh. The study reveals that approximately 66.07% of women have high probability of depression and 7.14 % are leading towards PPD. Besides, the study also shows that housewives are more clinically depressed than working women. A large portion of these women are not sharing about their problem with anyone as they do not want to be judged. Most of the time, these women do not understand their symptoms of depression or overlook those. Around 95% of women do not take any treatment for this disorder and almost 78% of them retrieve by themselves. The present scenario of PPD suggests that very few women actually have knowledge about social support centers but do not find any in Bangladesh. In reference to our findings, it is recommended to introduce this maternal disorder properly and create awareness among everyone including maternal health professionals. Moreover, a proper PPD screening program should be inaugurated to find out the depression condition and reducing the risks during postnatal period. Additionally, different social support groups should be set up to demonstrate a new picture of women sharing problems regarding their maternal mental health with others and taking proper advice to diminish it. They need to understand that taking mental health service is one of their rights and nobody should judge it. Furthermore, maternal healthcare professionals have to be more helpful and encouraging in this period. If these measures are taken, the maternal health condition of mothers can be improved and a new frame work for postpartum depression can be set up in Bangladesh.

5. References

Cox, J. L., Murray, D., & Chapman, G. (1993). A controlled study of the onset, duration and prevalence of postnatal depression. British Journal of Psychiatry, 163, 27-31.

O'Hara, M. W. (1994). Postpartum depression:Causes and Consequences. New York: Springer-Verlag.

Watson, J. P., Elliott, S. A., Rugg, A. J., & Brough, D. I. (1984). Psychiatric disorder in pregnancy and the first postnatal year. British Journal of Psychiatry, 144, 453-462.

American Psychiatric Association, 2000. Diagnostic and Statistical Manual of Mental Disorders, Text Revision, DSM-IV-TR™4th ed. American Psychiatric Press, Inc., Washington D.C.

Brockington, I. (2004). Post partum psychiatric disorders. Lancet 363 (9405), 303–310.

Geller, P.A. (2004). Pregnancy as a stressful life event. CNS Spectr. 9 (3), 188–197.

Patel, V., Rodrigues, M. & Desouza, N. (2002). Gender, poverty, and postnatal depression: A study of mothers in Goa, India. American Journal of Psychiatry, 159, 43–47.

Rahman, A., Iqbal, Z. & Harrington, R. (2003). Life events, social support and depression in childbirth: Perspectives from a rural community in the developing world. Psychological Medicine, 33, 1161–1167.

The World Health Report 2008 – Maternal mental health and child health and development in low and middle income countries. Geneva, World Health Organization, 2008.

Postpartum depression in Asian cultures: A literature review. (2009, March 26). Retrieved from https://www.sciencedirect.com/science/article/pii/S0020748909000704.

Small, R., Brown, S., Lumley, J., & Astbury, J. (1994). Missing voices: what women say and do about depression after childbirth. Journal of Reproductive & Infant Psychology, 12, 19-22.

Brown, S., & Lumley, J. (2000). Physical health problems after childbirth and maternal depression at six to seven months postpartum. British Journal of Obstetrics & Gynaecology, 107(10), 1194-1201.

Jacobsen, T. (1999). Effects of postpartum disorders on parenting and on offspring. In L.J.Miller (Ed.), Postpartum Mood Disorders (pp. 119-139). Washington, DC.: American Psychiatric Press.

Davé, S., Petersen, I., Sherr, L., & Nazareth, I. (2010). Incidence of Maternal and Paternal Depression in Primary Care. Archives of Pediatrics & Adolescent Medicine, 164(11). doi:10.1001/archpediatrics.2010.184

O'Hara, M. W., Neunaber, D. J., & Zekoski, E. M. (1984). Prospective study of postpartum depression: prevalence, course, and predictive factors. Journal of Abnormal Psychology, 93, 158-171.

Kennerly, H. & Gath, D. (1989). Maternity blues. I. Detection and measurement by questionnaire. British Journal of Psychiatry, 155, 356-362.

Pitt, B. (1973). 'Maternity blues'. Br.J Psychiatry, 122, 431-433.

O'Hara, M. W., Schlechte, J. A., Lewis, D. A., & Wright, E. J. (1991b). Prospective study of postpartum blues. Biologic and psychosocial factors. Arch.Gen.Psychiatry, 48, 801-806.

Campbell, S. B., Cohn, J. F., Flanagan, C., Popper, S., & Meyers, T. (1992). Course and correlates of postpartum depression during the transition to parenthood. Development and Psychopathology, 4, 2947.

Kendell, R. E., Chalmers, J. C., & Platz, C. (1987). Epidemiology of puerperal psychoses. Br.J Psychiatry, 150, 662-673.

O'Hara, M. W. & Swain, A. M. (1996). Rates and risk of postpartum depression-a meta-analysis. International Review of Psychiatry, 8, 37-54.

Brockington, I. F., Martin, C., Brown, G. W., Goldberg, D., & Margison, F. (1990). Stress and puerperal psychosis. Br.J Psychiatry, 157, 331-334.

Dowlatshahi, D. & Paykel, E. S. (1990). Life events and social stress in puerperal psychoses: absence of effect. Psychological Medicine, 20, 655-662.

Nonacs, R. & Cohen, L. S. (1998). Postpartum mood disorders: diagnosis and treatment guidelines. Journal of Clinical Psychiatry, 59 Suppl 2, 34-40.

Postpartum Depression Facts. (n.d.). Retrieved fromhttps://www.nimh.nihgov/health/ Publications/postpartum-depression-facts/index.shtml

Rahman, A., Iqbal, Z., Harrington, R., 2003. Life events, social support and depression in childbirth: perspectives from a rural community in the developing world. Psychol. Med. 33 (7), 1161–1167.

Ghubash, R., Abou-Saleh, M.T., 1997. Postpartum psychiatric illness in Arab culture: prevalence and psychosocial correlates. Br. J. Psychiatry 171, 65–68.

Cooper, P.J., Tomlinson, M., Swartz, L., Woolgar, M., Murray, L., Molteno, C., 1999. Postpartum depression and the mother–infant relationship in a South African peri-urban settlement. Br. J. Psychiatry 175, 554–558.

Attia, E., Downey, J., & Oberman, M. (1999). Postpartum Psychoses. In L.J.Miller (Ed.), Postpartum Mood Disorders London, England: American Psychiatric Press.

Jermain, D. M. (1995). Treatment of postpartum depression. American Pharmacy, NS35(1), 33-38.

Berggren-Clive, K. (1998). Out of the Darkness and Into the Light: Womens Experiences With Depression After Childbirth. Canadian Journal of Community Mental Health, 17(1), 103-120. doi:10.7870/cjcmh-1998-0006

When Motherhood Meets Mental Health, (2018), Retrieved from http://darksideofthefullmoon.com

Cox, J.L., Holden, J.M., Sagovsky, R. (1987). Detection of postnatal depression. Development of the 10-item Edinburgh Postnatal Depression Scale. Br. J. Psychiatry 150, 782–786

Glaze, R., & Cox, J. L. (1991). Validation of a computerised version of the 10-item (self-rating) Edinburgh Postnatal Depression Scale. Journal of Affective Disorders, 22(1-2), 73-77.

Mohammadi, A., Aghdam, G. A., & Ranji, S. (2011). Comparison of Postpartum Depression of Working Women and Housewives and its Relationship with Social Support and Marital Adjustment. Procedia - Social and Behavioral Sciences, 30, 1837-1839. doi:10.1016/j.sbspro.2011.10.354

Arifeen, S. E., Hill, K., Ahsan, K. Z., Jamil, K., Nahar, Q., & Streatfield, P. K. (2014). Maternal mortality in Bangladesh: A Countdown to 2015 country case study. The Lancet, 384(9951), 1366-1374. doi:10.1016/s0140-6736(14)60955-7

Islam, A. (2015). Mental Health and the Health System in Bangladesh: Situation Analysis of a Neglected Domain. American Journal of Psychiatry and Neuroscience, 3(4), 57. doi:10.11648/j.ajpn.20150304.11

Beck, C. T. (1992). The lived experience of postpartum depression: a phenomenological study. Nursing Research, 41(3), 166-170.