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The Experiences of Pregnancy and Childbirth in Women with Postpartum Depression: A Qualitative Study

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Abstract

Background: Postpartum depression is a common disease with serious consequences for the mother and child. However, a few qualitative studies have been conducted on the lived experiences of mothers.
Objectives: This study is aimed at exploring the experiences of mothers with the depression from pregnancy and childbirth.
Methods: This qualitative study has been conducted on 16 women with a history of depression after childbirth. To collect data, 16 semi-structured interviews were conducted. The data collected were analyzed using content analysis suggested by Graneheim and Lundman.
Results: The data analysis led to the development of 821 inductive codes categorized into three themes: 'experienced problems', 'unmet expectations', and psychological distresses. The experienced problems comprised socioeconomic factors and complications during pregnancy and childbirth. The unmet expectations comprised conditions and reactions women expected to occur during interactions with others such as social support and marital relationship. Further, psychological distress was the women's reaction to pregnancy-related events and relative interactions, including psychological reactions and inefficiency in playing roles and fulfilling responsibilities.
Conclusions: The findings emphasize the need for exploration of the psychological processes during pregnancy. Women felt they needed support that was not easily available and were worried about lack of privacy and loss of control over their private life, causing psychological distress for women. Couples should receive the education necessary for the risk of post-partum depression.

Keywords: Depression, Postpartum, Qualitative, Research

1. Background

Pregnancy is a transition period (1) when development of a woman's maternal roles (2) is accompanied by dramatic changes in the body and mind (3). The experience of such changes makes her vulnerable during pregnancy (4) to a change in and readiness to accept motherhood roles (5). For some women, it is turned to a crisis, conflict (6), nightmare (7), and may even become a predisposing factor for development of post-partum depression (8). The prevalence of post-partum depression is 0.5% - 60.5% in the world (3) and 25% in Iran (9), a major factor in affecting the health of women and their families (10). Increased prevalence of suicide in mothers (11), separation and divorce (12), and worries about possible harm to the baby (13) indicate the importance of the disorder. Women with postpartum depression have no sense of joy (14). The disease affects women's ability to care for the child (15) and consequently reduces their ability to make emotional ties with the child with consequential negative effects on the behavior, cognition, and emotion of the child (16). Although the association between post-partum depression and biological factors have been explained previously (17), evidence shows that social factors are the experienced problems of the disease (18). It is believed that post-partum depression is not a separate and independent disorder of pregnancy (19) and physiological changes after childbirth and reduction of hormones (20), besides increased motherhood's accountabilities (21), trigger the disease. What connects the events during pregnancy and after childbirth are feelings,

perceptions, and images that affect the mother's readiness to accept their responsibilities after childbirth. Previous studies were focused on the experiences of mothers with pregnancy-related distress and their trigger factors, while in societies undergoing transition from traditional to modern, young women's expectations are affected by modernity. On the other hand, their social interactions are affected by sociocultural and gender roles in the community as well as motherhood's role. Therefore, there are differences between the actual role and role expectations (22). The contrast relationship between expectations and existing conditions may affect the women's emotional experiences during pregnancy (23). This is due to the fact that like many developing countries, Iran is undergoing a transition in the history of civilization (24).

Understanding postpartum depressed women's concerns and cultural-contextual backgrounds helps discover the dimensions of postpartum depression; therefore, the study was intended to explore the lived experiences of mothers with depression due to pregnancy and childbirth.

2. Objectives

The present study has been carried out with an aim to understand the complex phenomenon of postpartum depression, learn more about the dimensions of the phenomenon, and explore the experiences of mothers with postpartum depression.

3. Materials and Methods

This is a qualitative study conducted on a sample of 16 married women aged 25 - 40 with a history of post-partum depression in the previous year. The criteria included in the study were: psychiatrist-detected postpartum depression, treatment received for depression after childbirth, and no history of intrauterine fetal or neonate death.

The data collected were analyzed using qualitative content analysis (25). The sampling process was purposeful with all the participants willingly collaborating through to the end.

Samples were taken of women with a history of postpartum depression and referral to healthcare centers in Isfahan, Iran, between August 2015 and April 2016. As requested by the participants from the healthcare centers, the data collection sites were the participants' places of residence at the time of data gathering, with no one else present except the researcher and participants in a completely private environment. For sampling, maximum variation in terms of age, reproductive characteristics, as well as economic and social conditions were in mind.

Informed consent of the women was obtained for data collection, which continued through to data saturation (26), as no new code was developed to add to the variation of findings completed after 16 interviews. Face-to-face semi-structured interviews were conducted and tape-recorded along with observations and field notes used for data collection. The locations for interviews were decided with the participants' consent. Permission to tape-record the interviews was obtained from the participants. They were informed of the aim and methods of the study, their rights, and the possibility for them to withdraw from the study at any time without being penalized. Further, in the event of psychological distress during interviews lasting 30 - 95 minutes, data collection would be discontinued and appropriate mental support would be provided. The major questions asked during the interviews were as follows: "what important events did you experience after diagnosis of pregnancy?" and "will you share your experiences of the pregnancy period?". Other questions were focused on the women's emotions and perceptions of the pregnancy period.

The interviews were transcribed verbatim and analyzed using contract content analysis suggested by Graneheim and Lundman (26). In the course of data analysis, the researchers avoided any type of prejudgments (27) and allowed for the categories and themes to emerge from the analysis (25). With regard to the rigor of the study, credibility was examined by evaluating the transcriptions, codes, and categories by three members of the research team (26). Further, prolonged engagement with the participants during data collection and obtaining the participants' feedbacks on the findings improved the credibility. The transcripts were returned to the participants for comments and corrections. Where uncertainties occurred about the meanings of the participants' words and codes in the course of data analysis, complementary interviews were held to use their comments in the process of analysis. For dependability, two qualitative research experts were asked to reflect and provide feedbacks on the codes and categories for incorporation in the data analysis.

4. Results

The participants comprised of 16 married women with a mean age of 25 - 40 years with the demographic characteristics presented in Table 1. The data analysis led to the development of 821 inductive codes categorized into three themes: 'experienced problems', 'unmet expectations' and psychological distress'. The experienced problems comprising socio-economic factors and complications during pregnancy led to the creation of experiences

Table 1. The Demographic Characteristics of the Participants

Variable	No. (%)
Age, y	
20 - 30	8 (50)
31 - 40	5 (31.2)
> 40	3 (18.8)
Educational level	
Guidance school	5 (31.2)
Diploma	5 (31.2)
Academic degree	6 (37.6)
Occupation	
House wife	12 (75)
Employed	4 (25)
Pregnancy	
Primiparous	6 (37.6)
Multiparous	10 (62.4)
Economic level	
Good	5 (31.2)
Intermediate	6 (37.6)
Bad	5 (31.2)

and emotional reactions in the participants. The unmet expectations comprised of conditions and reactions that the women were expected to create on interactions with others such as lack of social support and marital relationship. Further, psychological distress was the women's reaction to pregnancy-related events and relative interactions, comprising psychological reactions, and inefficiency in playing roles and fulfilling responsibilities.

4.1. Experienced Problems

4.1.1. Socioeconomic Factors

Socioeconomic factors created bitter experiences for the women, especially, lack of attention to the privacy of the women during pregnancy and after childbirth as well as the husband's job and economic insecurity were subcategories of socioeconomic problems. After childbirth, women needed rest and that lack of respect for their privacy during pregnancy and after childbirth at a time when they needed a break was a common problem for the participants:

"My peace was disturbed because my grandmother-in-law was the owner of our house and was aware of everything I did. Besides, she would tell whatever I did to other relatives. Therefore, my husband's relatives were always in our home. It was agony for me." (P 6).

These conditions along with the cultural obligations for wearing particular clothes made the women feel that they had no privacy. Being forced to wear particular clothing on meeting others was described by the women in the following words:

"My husband was strict with me and I was observant of the religious faith, Besides, he kept grumbling about the way I dressed, which was really upsetting. He did not allow me to wear colorful clothes. He would ask me to cover my body from head to toe by wearing a chador when meeting the relatives." (P 7).

Economic insecurity had caused a participant to think of abortion due to financial difficulties and lack of resources.

"We were in poor economic conditions. I was going to have an abortion in the first trimester of pregnancy. I asked to have an abortion and found that it was a sin and against my religious beliefs." (P 15).

4.1.2. Complications During Pregnancy and Childbirth

Childbirth complications, high risk pregnancy, newborn issues, and unsettled children were the main causes for concern, anxiety, and perception inefficiency in women. A participant advised to have complete rest due to pregnancy complications and high-risk pregnancies expressed her stress about the health of the fetus in the following words:

"I was advised to have complete rest. I had a bleeding in the first three months of pregnancy and was told that the baby I had been expecting so long, in fact any baby in this condition, would die. I had a lot of stress. I got worse in the second month." (P 9).

Crying and feeling anxious due to neonatal icterus, a participant said:

"My baby had neonatal icterus. I was crying in my loneliness. My baby's health was getting worse." (P 1).

4.2. Unmet Expectations

4.2.1. Lack of Social Support

The women expected to receive social support to avoid emotional reactions after childbirth. They expected their family and friends, especially their husband, to understand their conditions after childbirth, meet their expectations and help them with home activities:

"I was in pain all night until morning, and my husband didn't care for me. If I told him about my pain, he would say 'Put up with it until morning'. He was not kind to me and I had so much pain. He took me to the hospital, but the healthcare staff didn't take enough care of me. Some women were visited by their relatives and mothers, but I was visited by none, I was all alone." (P 7).

The women frequently expressed their demand for emotional response to pregnancy and their needs but the negative reactions from the relatives resulted in emotional pain.

"Whenever the child moved, I became so happy that I told my husband to touch my abdomen to feel it, but he didn't show any interest. I grew sad since he was uncaring. He was kind but uncaring and I had gotten used to it." (P 6).

Resenting her husband's unhappiness about her pregnancy and lack of support, participant 2 said:

"My husband was not happy about my pregnancy. He would always say 'I do not like the baby'. I was so scared. He said perhaps he would get to like the baby when it was born. He was busy with his own affairs. He did not support me at all. (P 2).

4.2.2. Marital Relationship

Poor couple relations, domestic violence, and differences in moods were the factors influencing the marital relationship:

"My husband is not an emotional person and has only sexual relationships with me. In the last trimester, he cut his sexual relationships with me, which offended me too much." (P 10).

Believing that her pregnancy did not matter to her husband and resenting her husband's verbal violence, a participant said:

"My husband doesn't care about my pregnancy and is always insulting and shouting at me." (P 2).

Another woman talking about her husband using physical violence on her, said:

"When my husband gets angry, he uses physical violence on me and always insults me verbally." (P 3).

4.3. Psychological Distress

4.3.1. Psychological Reaction

The subcategories of psychological reaction comprised negative body self-image, negative attitudes toward pregnancy, and replacement of love for the child with the love for the husband and emotional distress. The negative body self-image included changes in physical appearance, which made the women sensitive to their own appearance:

"I had gotten fat and was unhappy about it. My husband did not show any tendency towards me. I felt that my husband was getting farther and farther away from me." (P 10).

Negative attitudes towards pregnancy and rejection of psychological responses were the reasons for denial of pregnancy. Negative attitudes toward pregnancy hindered the women's access to life goals for unplanned pregnancy. Following the experienced events during pregnancy, some participants replaced their husband's support with daydreaming and love for children.

"The baby was moving and I told myself that it would support me, because it was a boy. I was expecting a baby boy. He would support me in the face of my husband and relatives." (P 12).

Having experienced loneliness, a woman said: *"I felt lonely. I always thought why I was alone." (P 14).*

4.3.2. Inefficiency in Playing Roles and Meeting Responsibilities

The mothers' experiences, inefficiency in playing roles, and meeting responsibilities were described as rejection of motherhood roles and feeling inefficient in meeting motherhood's responsibilities.

It was described as being unprepared for having a child and feeling indifferent towards the child and unplanned pregnancy. Lack of preparation for having a child was described by a young mother as follows:

"My pregnancy test was positive and I was shocked because I am too young. I wasn't prepared for pregnancy" (P 13).

Feeling indifferent about having a baby, a woman said:

"I did not want a child and it made no difference. I got pregnant though and I had no feeling for it." (P 10).

Failure to play the motherhood roles is described as the inability to raise children, feeling helpless for keeping the children, and feeling inadequate and inefficient in breastfeeding. One mother with the feeling of failure to raise children said:

"I felt unable to take care of my child, staying up all night worrying about being unable to handle it". (P 2).

5. Discussion

The aim of this study has been to explore the lived experiences of mothers with the depression from pregnancy and childbirth. Our findings have been presented on the three themes of 'experienced problems', 'unmet expectations', and psychological distresses. Experienced problems lead to the creation of experiences and emotional reactions in the participants. They comprise socioeconomic factors, complications during pregnancy and childbirth. Unmet expectations comprise conditions and reactions that the women expect to occur on interactions with others including social support and marital relationship. Furthermore, psychological distress has been the women's reaction to pregnancy-related events and relative interactions, comprising psychological reaction and inefficiency in playing roles and meeting responsibilities.

The relationship between low levels of socioeconomic conditions and postpartum depression has been reported by other studies (28). The findings of this study show that socioeconomic conditions affect the women's ability to accept another member of the family, their mental health

during pregnancy, and the ground for postpartum depression (28). Moreover, it disrupts the women's privacy and leads to emotional problems during pregnancy. The privacy of women during pregnancy comprises important factors that affect their mental health (29) and independence. In this study, due to economic or cultural conditions, the women had to live with their husbands' relatives during pregnancy; therefore, they felt that they had lost their control over their private life. Living with the husband's relatives may disrupt the women's privacy due to cultural and social issues. Moreover, the cultural conditions allowed others to interfere with the private lives of the women and affected their mental conditions. Some researchers believed that cultural practices, rituals, and customs could not be perceived as protective mechanisms for postpartum depression in traditional societies (30).

Another finding of the study was that pregnancy complications and lack of attention to women's needs affected their emotions and self-esteem, which lead to dangerous psychological reactions. The relationship between pregnancy complications and postpartum depression has previously been recognized (31). The present study confirmed that lack of social support affected their emotional status.

Lack of attention to women's needs damages their emotions, confidence, and health of the fetus, tripling the risk of postpartum depression in women without a history of post-partum depression (32). The women's awareness and self-efficacy may be associated with reduced risk of postpartum depression (33). Depending on the women's estimation of the social expectations and personal desires (34), the theme of the unmet expectations was an indicator of the conditions and demands of each woman. This study showed that women with postpartum depression expected social support in such different aspects as performance, emotions, information by their spouses, families, and healthcare system. Social support protects individuals against the harmful effects of critical conditions (35).

Although pregnancy is a physiological process, physical changes may increase the need for support felt by women (36). Furthermore, having good relationships with the husband helps women tolerate stressful situations (37). The results of this study showed that women expected their relatives to understand their conditions, help them with their life, have empathy with them, and not to leave them alone. The women reported that their husbands did not devote enough time to listening to them. It is believed that women are more likely to share their worries than men (38) and to receive attention (39). Pregnancy is considered by many women as proof of their womanhood (40). Psychologists believe that women need more emotional support than men in stressful conditions (41) expecting their husbands to understand them in situations like pregnancy. Ignoring the positive emotions for pregnancy by men, may convey the message to women that pregnancy is not an important event. Other studies showed that support by the husband contributes to the woman's mental health during pregnancy, reducing the experience of emotional distress in women (42).

The results of this study showed that women with postpartum depression had experienced a lot of psychological distress. Poor economic conditions and lack of support during pregnancy caused women to perceive pregnancy as an inappropriate event.

All of these issues led to such emotional reactions as fear, indifference towards the health of the fetus, guilt, and self-blame. The bitter experiences during pregnancy (43), the motherhood instinct, and undefined sociocultural responsibilities (28) caused a feeling of guilt in women leading to anxiety and depression (44) during pregnancy and after childbirth. Many women thought that they were not prepared to take on roles and responsibilities damaging to their mental health. Playing a maternal role requires an understanding of self-efficacy, which is influenced by past experiences, incentives, templates, and variables such as stress and anxiety. In addition, lack of perceived self-efficacy in playing the maternal role made women anxious (45). Negative experiences and lack of understanding of women from the unfavorable conditions during pregnancy are due to lack of support from the husband, the family, and the conflict between expectations and current conditions. Provision of emotional and physical support contributes to self-efficacy. The higher the perception of self-sufficiency, the greater the self-sufficiency and psychological adjustment to the maternal role. Women felt vulnerable during pregnancy and expected others to understand their conditions. Failure to fulfill women's expectations imposed psychological distress on women (38).

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Footnotes

Authors' Contribution: Maryam Ghaedrahmati designed the study, collected the data, and drafted the manuscript. Ashraf Kazemi performed the study design, study concepts and supervision design and interpretation of data, drafting the manuscript. Gholam Reza Kheirabadi,

Amrollah Ebrahimi, and Masoud Bahrami in study design, interpretation of data, and drafting the manuscript. All authors read and approved the final manuscript.

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