

# Social Support among Mothers with Spouse Postpartum Depression

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## Abstract

**Introduction:** Social support is one of the important things that affect factor for postpartum depression. Social support after childbirth is essential to reduce postpartum depression. Support from a spouse reduces psychological disorders among mothers. **Objective:** This study was to determine the social support among mothers with postpartum depression. **Method:** This study used a survey design. This research was conducted at Community Health Centers in Yogyakarta with 102 sample postpartum women. The study used the Edinburg Postpartum Depression Scale (EPDS), social support questionnaire, and demographic data questionnaires. The descriptive statistic uses percentage, mean, and standard deviation. **Results:** The results revealed that the mean score on the EPDS was 15.89 ( $SD \pm 2.47$ ). Generally, postpartum mothers showed moderate postpartum depression. Postpartum mother got high social support from their partner on average for the four subscales were respectively: emotional support 56.9%, household support 52%, babysitting support 51%, and help support 52.9%. **Recommendation:** Social support has an essential role in minimizing postpartum depression. Strategies to decrease postpartum depression should focus on increasing social support for postpartum mothers. The indicators of postpartum depression should be screened for and closely monitored by healthcare professionals. Additionally, healthcare professionals should provide sufficient assistance that is customized to the mother's needs through her spouse and family.

**Keywords:** postpartum, depression, social support



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## INTRODUCTION

Postpartum moms undergo several physical, emotional, and social changes that might be detrimental to their health. However, not all women can adjust to manage these pressures effectively, leading to anxiety and depression (1). This negative coping behavior will have a detrimental impact on their mood, causing them to feel unable to adapt to their dual duties as mother and wife. They anticipate playing both roles. After realizing their various roles are complex, they are disappointed that they cannot live up to their standards (2). In a vicious loop, this difference between reality and anticipation leads to additional negative coping strategies, increasing stress and sadness.

The following symptoms characterize postpartum depression (PPD), according to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) and the American Psychiatric Association (APA) (2013): loss of pleasure, insomnia, weight loss or gain, fatigue, feelings of worthlessness, impaired concentration, and suicidal ideation (3).

These conditions can hinder children's physical, mental, and emotional development, resulting in developmental delays. According to the World Health Organization (WHO), depression reduces productivity. It has a negative economic impact on society due to the high cost of treatment in nations where it is offered(4). Postpartum depression influences the social and personal lives of postpartum moms in various ways, affecting both mother-child and marital relationships (5).

WHO (2018) states that 13 percent of mothers worldwide have a postpartum mental condition, predominantly depression. In underdeveloped countries, 19.8 percent of mothers experience a postpartum mental condition, with

depression being the most prevalent(4). In one study, the prevalence of postpartum depression in Indonesia in the first, second, and third months following childbirth was 18.37 percent, 15.19 percent, and 26.15 percent, respectively (6).

The cause of postpartum depression is still debated; however, hormone imbalance is one of the predictors(7). Other characteristics include depression history, unplanned pregnancy, self-esteem(6)(8), and social support(8)(9).

Many studies have demonstrated that the presence of a husband, partner, or other family member who assisted with childrearing is connected with a reduced risk of postpartum depression(10)(11)(12). This is comprehensible because a woman who does not receive childcare assistance from her partner may experience problems if she or her partner lacks interpersonal skills. It may be difficult for her to request support from her relationship, or her partner may be unwilling or unavailable. In addition, a mother may believe that her partner is the only person who can comprehend the situation and aid her at home(13).

Social support is a primary concern within the domain of mental health and psychiatry. It protects a wide range of mental and psychological ailments. Several ailments are more likely to be survived due to the presence of social support. Social support exerts numerous beneficial impacts on the psychological, physical, and financial dimensions of human existence. However, there are also negative consequences for interpersonal relationships and the financial burdens associated with social support due to discrepancies between those who require assistance and those capable of offering it (14).

Despite the substantial evidence linking social support to the onset of

postpartum depression, this aspect is not frequently assessed by healthcare professionals during this time in Indonesia. To enhance comprehension of social support for women during postpartum, it could be beneficial to conduct additional research on how mothers of newborns feel about their level of social support.

## **OBJECTIVE**

This study aims to determine the social support among mothers with postpartum depression.

## **METHOD**

### **Design**

This study uses a survey design to understand better individual or group perspectives relative to social support.

### **Sample size and sampling technique**

The sample size calculation using G-power and postulating that there is at least a medium effect size of .25 with 80% power and .05 level of significance, approximately 86 subjects are required. Factoring in an attrition rate of 20%, a total of 104 subjects were recruited. This study uses convenience sampling; all eligible respondents are included in the study. Two respondents were excluded from this study due to an incomplete filling questionnaire.

This study includes respondent postpartum mothers who have an Edinburgh Postnatal Depression Scale (EPDS) score  $\geq 13$ , who can read, all types of delivery, full-term gestation, and healthy infants. Exclusion criteria include postpartum women with depression who have a drug abuse history, bipolar, and schizophrenia history.

### **The instrument of data collection**

This study instrument used demographic data characteristics included (age, occupation, number of children, and pregnancy planning), depression score by

the Edinburg Postpartum Depression Scale questionnaire, and social support use the part of the Postpartum Depression Predictors Inventory.

### **a. *Edinburg Postpartum Depression Scale (EPDS)***

The EPDS was developed to assist health care professionals in identifying mothers with depressive symptoms following childbirth, it was developed by Cox in English version (15). It is a 10-statement self-report questionnaire; each item has four possible answers with scores ranging from 0 to 3. Total possible scores range from 0 to 30 with higher scores showing a more elevated risk for postpartum depression (15). This study used The Indonesian version translated by the researcher, the validity used content validity by expert review the CVI result was 1.00, and the reliability obtained a Cronbach alpha of 0.869.

### **b. *Social support questionnaire***

The social support questionnaire is part of the Postpartum Depression Predictors Inventory Revise (PDPI-R) a medium effect size .36-.41. The social support part of PDPI-R is a 4-question questionnaire developed by Beck (8). The reliability was .83, the validity used content validity by expert review and the CVI result was 1.00; construct validity with factor analysis showed all items were valid .70 (16).

### **Data collection process**

Before conducting this research, the researcher applied to the Institutional Review Board (IRB); after getting the IRB approval, the researcher contacted the heads of the community health centers and the midwife manager as a key person to explain the purposes of the study.

The data collection period for this research was three months. The researcher used four settings in the community health

center in Sleman Yogyakarta (Kalasan, Pakem, Ngemplak 1, Ngemplak 2).

Firstly, the researcher assessed the postpartum mother using an EPDS questionnaire to screen for depression; the postpartum mother, who has an EPDS score  $\geq$  of 13 and eligible criteria, was asked as a respondent if they agreed to join the study, then the researcher explained the purpose and procedure of this study to the respondent; before the respondent started to fill in the questionnaire (demographic data, EPDS, Social support), they signed the consent form on the same day. The research checks the questionnaire's completeness after the respondent returns it and asks the respondent to complete it, write the respondent code, and keep it in the file holder.

### Data Analysis

To determine percentage, mean, and standard deviation using descriptive analysis.

### Ethical consideration

The researcher got ethical clearance from the Research Ethics Committee at the RESPATI University Yogyakarta Indonesia (registration number 107.3/FIKES/PL/VI/2021). Researchers endeavor to respect respondent privacy and ensure that the data collected remains confidential. Records are kept confidential for five years after the research is completed and destroyed. It will not have the respondent's name or personal information if published at any time. The original author permits all the questionnaires

## RESULT

### Characteristic of respondents

Table 1 describes respondent demographic data, the respondent's ( $n=102$ ) age mean was 28.47 years old, and the standard deviation was 6.16.

All respondents show that 53.92% ( $n = 55$ ) were unemployed, and 46.08% ( $n = 47$ ) were employed.

About 46.08% of respondents ( $n = 47$ ) in both groups have 1-2 children and 53.92% ( $n = 55$ ) have three or more children. All respondents with unplanned pregnancies, about 56.86% ( $n = 58$ ) and 43.14% ( $n = 44$ )

### Social support and Depression score

Table 2 describes that mother with postpartum depression has high emotional support, household support, babysitting support, and help support, around 56.9% ( $n=58$ ), 52% ( $n=53$ ), 51% ( $n=52$ ), and 52.9% ( $n=54$ ), respectively. Besides that, two respondents had no emotional support 2% ( $n=2$ ), low household support 16.7% ( $n=3$ ), low babysitting support 8.8% ( $n=9$ ), and no help support 4.9% ( $n=5$ ).

Each variable shows mean and SD for emotional support  $7.56 \pm 2.35$ ; household support  $8.12 \pm 2.06$ ; babysitting  $7.62 \pm 2.38$ ; help support  $7.28 \pm 2.55$ .

All respondents had moderate EPDS scores of 75.5% ( $n=77$ ) and severe EPDS scores of 7.8% ( $n=8$ ), with a mean of 15.89 and SD 2.47

**Table 1. Demographic Data (n=102)**

Characteristics		<i>n</i>	%
Age ( <i>M</i> ± <i>SD</i> )	28.47±6.16		
Work status			
Unemployed		55	53.92
Employed		47	46.08
Number of children		47	46.08
1-2		55	53.92
≥ 3			
Pregnancy planning			
Unplanned		58	56.86
Planned		44	43.14

**Table 2. Social support and Depression score**

Variable	(n=102)			
	<i>n</i>	%	<i>M</i>	<i>SD</i>
Emotional support			7.56	2.35
No emotional support	2	2		
Low emotional support	4	3.9		
Moderate emotional support	19	18.6		
High emotional support	58	56.9		
Very High emotional support	19	18.6		
Household support			8.12	2.06
No household support	0	0		
Low household support	3	2.9		
Moderate household support	17	16.7		
High household support	53	52		
Very High household support	29	28.4		
Babysitting support			7.62	2.38
No babysitting support	0	0		
Low babysitting support	9	8.8		
Moderate babysitting support	17	16.7		
High babysitting support	52	51		
Very High babysitting support	24	23.5		
Help support			7.28	2.55
No help support	5	4.9		
Low help support	2	2		
Moderate help support	21	20.6		
High help support	54	52.9		
Very High help support	20	19.6		
EPDS			15.89	2.47
Mild	17	16.7		
Moderate	77	75.5		

Variable	(n=102)			
	n	%	M	SD
Severe	8	7.8		

## DISCUSSION

The age mean across all respondents (n=102) was 28.47 years old, with a 6.16 standard deviation. Another research states that the best age for pregnancy depends on the spouse's readiness to have a baby but the healthy pregnancy with less risk and complication was 20-30 years old (17).

This study's findings were consistent with other studies' findings that the number of children did not affect postpartum depression (18)(19). However, a different investigation discovered that the number of children associated with postpartum depression (20)(21). As a result, bearing children is a blessing and a sign of good fortune in Indonesia. The continuation of the lineage and the nurturing and raising of offspring are two biological roles of the family (22)(23).

According to one study, the type of childbirth had no bearing on postpartum depression (19). In contrast to earlier studies, this one linked that sort of labor to postpartum depression (21)(24). Due to the community's conviction that childbirth is a natural process that the mother must confront, whether it is a normal or medical birth, postpartum depression was not associated with the type of birth in Indonesia. Instead, the mother simply needs to surrender herself to God and believe that childbirth is a natural process (25)(26)(27).

According to findings from other studies, pregnancy planning has no connection to postpartum depression (18)(19). Contradictory research indicates a link between pregnancy planning and postpartum depression (20)(28)(29). Pregnancy is seen to be a predetermined event in Indonesia. If it is God's plan, pregnancy will happen whether or not you

are ready. Additionally, carrying on the family line is the objective of marriage. This belief is in line with the findings of other studies (30)(31).

In this survey, all respondents felt they received high social support from their spouse in all four categories (emotional, household, babysitting, and help), in defiance of several respondents stating they have no and low emotional and helpful support. Despite having high social support, the respondents still had an EPDS score at a moderate level, around 75.5% (n=77), with a mean±SD of 15.89±2.47.

Postpartum depression is considerably affected by emotional support (32). Emotional support protects against clinically significant depressed symptoms and weakened bonding attachment to the newborn (33). Emotional support is a deliberate verbal and nonverbal demonstration of caring and affection. By providing emotional support to another person, you provide them with comfort, acceptance, encouragement, and compassion, so making them feel valued and significant (34).

Household support also plays a role in preventing postpartum depression (10)(11)(12); a mother may have a strong expectation that her spouse would be active and may believe that her spouse is the only person who can comprehend the situation and assist her at home (13).

Prior research has shown that the presence of a husband, partner, or other family member who helped with childrearing is associated with a decreased risk of postpartum depression. A woman who does not receive childcare assistance from her spouse may encounter difficulties if

she or her spouse lacks social support. It may be challenging for her to obtain assistance from her spouse, or her partner may be hesitant or unavailable. A mother may also assume that her spouse can only comprehend the situation and help her at home. A study found that a partner's help in child care was useful for mothers although in a small portion (35).

Lower support from the husband will increase the length of physical and emotional recovery after childbirth and could cause depression the worst (36). Recent studies found that partner involvement was related to the mother's depression level although the involvement could not fulfill the mother's expectation. Partner's involvement could be in the form of any help that assists mothers in filling their needs from the childbirth until postpartum period. Mothers with a partner's help in assisting with household chores and infant care have a lower risk of developing depression (35).

Our study showed that although mothers had a variety of social support which included no social support, and low or high social support from their spouse, on average, the EPDS score was moderate. Social support is the most critical factor in the fight against postpartum depression. Social support is one of the postpartum depression-predicting factors; several studies mention that social support is the crucial factor that enhances postpartum depression. One study showed how crucial social support is in lowering the incidence of postpartum depression, particularly from spouses (37). A study in Russia also found that social support from a partner was negatively associated with postpartum depression levels. A bigger involvement will be better to fill in the mother's expectations and indirectly could lessen the mother's depression level (35).

People with strong social support will have fewer physical and mental health

problems than those with poor social support. Therefore, the importance lies in the quality of the social support network (38-39). This study limitation cannot reveal how their interpersonal communication delivered their social support and how tight their relationship was. For future research, it is essential to investigate how close spouse/family relationships and interpersonal communication contribute to social support. To improve the quality of care, we suggest improvement by healthcare institutions to develop supportive care from spouses and family.

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