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Causes of women's postpartum depression symptoms: Men's and women's perceptions

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ABSTRACT

Objectives: To describe men's and women's perceptions of the causes of women's PPD symptoms and to explore similarities and differences between men's and women's perceptions.
Design: Qualitative-descriptive study involving in-depth semi-structured individual interviews and content analysis.
Setting: In-home interviews of participants recruited in two tertiary care hospitals, both in urban centres of the province of Quebec, Canada.
Participants: Both members of 30 heterosexual couples from which women scored at least 12 on the Edinburgh Postnatal Depression Scale.
Findings: Participants described nine causes underlying women's depressive symptoms: societal expectations and pressure on women, physical health problems, transition to parenthood, social connectedness, personality and past psychological history, child health and temperament challenges, unmet care needs, unmet expectations for childbirth, and other life stressors. With one exception, all causes were endorsed by both men and women. Only men mentioned societal pressure on women.
Key conclusions and implications for practice: Men and women mainly perceived similar causes, which could be explained by socio-cultural factors and extended paternal leaves. Understanding men's and women's perceptions could help tailoring health- care professionals' interventions to couples' needs.

Introduction

Postpartum depression

Although the transition to motherhood is usually seen as a positive experience in women's lives, it is also a time of physical, psychological and social adaptation that may leave women in a state of increased vulnerability (Miller, 2002; Wisner, 2006). Postpartum depression (PPD) is a relatively common mental disorder that is estimated to affect 13–19% of women in the first year following childbirth (O'Hara and McCabe, 2013). As per the current versions of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorder (DSM-V) and the International Classification of Mental and Behavioral Disorders (ICD-10), PPD has symptoms, developments and outcomes that are similar to those encountered in non-postpartum-related depressive disorders (World Health Organization, 1992; American Psychiatric Association, 2013). Some of the most commonly reported symptoms include recurrent and impairing feelings of dysphoria, tearfulness, hopelessness, anxiety, guilt and fatigue (Robertson et al., 2004).

While limited to the first year following childbirth, PPD can have long-term implications for women and their family members. Women suffering from PPD are known to be at higher risk for subsequent depressive episodes (Robertson et al., 2004). PPD can

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negatively affect the mother–child relationship (Poobalan et al., 2007; Darcy et al., 2011) and is associated with an increased frequency of cognitive development delays and attachment insecurity (Hipwell et al., 2000), as well as poorer social engagement, in children of women who have suffered from PPD (Feldman et al., 2009).

PPD also affects women's partners. Partners experience a range of negative emotions such as self-doubt, helplessness, anger and fear due to concern and to a perceived inability to help their partner as well as relationship uncertainty (Meighan et al., 1999; Letourneau et al., 2011). Partners of women suffering of PPD have an increased risk of experiencing psychological disturbances (Goodman, 2004, 2008; Roberts et al., 2006). A recent meta-analysis showed that about 10% of fathers experience depressive symptoms and that they are moderately and positively correlated with maternal depressive symptoms (Paulson and Bazemore, 2010).

Perceptions of the causes of PPD symptoms

Despite the efficacy of treatments available for PPD, numerous studies find that women with depressive symptoms are reluctant to seek help and decline a referral for mental healthcare (Callister et al., 2011). A major reason for the poor uptake of healthcare is a lack of fit between the women's perceptions of their needs and the care offered (McIntosh, 1993; O'Mahen et al., 2009). How women and their partners understand women's symptoms may shape their help-seeking behaviour and preferences for care. This knowledge might be an important step in the development of services and intervention programs for PPD that would be more acceptable to women and their partners (Dennis and Chung-Lee, 2006).

There has however been little systematic study of women's understanding of what caused their symptoms. Although many of the causes perceived by women seem to be endorsed worldwide, some are only mentioned in some settings, indicating that women's perceptions are to some extent shaped by cultural influences (Oates et al., 2004). Caribbean women believed that a pile-up of multiple psychosocial stressors or hormonal problems lead to the development of their symptoms (Edge et al., 2004; Edge and Rogers, 2005). Indian women attributed their symptoms to social adversity, poor marital relationships and gender preferences (Rodrigues et al., 2003). Patel and colleagues (Patel et al., 2013) found that British women held a number of different beliefs about their symptoms. Some women attributed symptoms to incongruence between their actual postpartum experience and their idealised expectations. Others considered that a current or previous psychosocial stressor such as a difficult pregnancy or childbirth, relationship problems, financial worries, lack of support, or a change in lifestyle lead to their symptoms. Yet other women considered their symptoms to be due to their personality and blamed themselves for their depressive state. Biomedical factors, such as genetics or hormones, were another category of possible causes for symptoms.

To our knowledge, a single previous study has investigated what women's partners perceive as having caused women's symptoms, and compared men's and women's perceptions. Everingham and colleagues (Everingham et al., 2006) found that the perceptions of men and women differed. Women were anxious about being a "good mother" and preoccupied with how others viewed their mothering abilities. They believed their symptoms were the result of their feelings of inadequacy as a mother. In contrast, their partners attributed symptoms to women's previous history of mental health problems, personality characteristics, or postpartum physical health problems. This study included a small homogenous group of older, well-educated, first-time Australian parents. It is unknown if it achieved saturation. The particular characteristics of this group of older first-time mothers may have shaped their perceptions of the cause of their symptoms. Further exploration of women's and their partners' perceptions is clearly warranted. Thus, the current study examined two questions: 'What are men's and women's perceptions of the causes of women's PPD symptoms?' and 'What are the similarities and the differences between men's and women's perceptions?'

Methods

Design

A primary qualitative descriptive study was undertaken to examine women's and men's preferences for care to manage the women's symptoms (Feeley et al., 2015). The need for the current study emerged as the first interviews from the primary study were analysed. When describing their experience and preferences for care during semi-structured interviews, all participants spontaneously described what they thought caused the women' symptoms. Thus for remaining subsequent interviews, the guide for the primary study was modified to include specific questions to elicit participants' perceptions of the causes of the woman's symptoms. For example, "What does your partner think about your symptoms? 'What does he think would help?' or 'What do you think is the cause of your [or your partner's] symptoms?' were some of the questions asked. The same team of researchers conducted this secondary analysis to describe men's and women's perceptions of what causes the women's symptoms.

The purposive sample consisted of 30 heterosexual couples and included two groups: women with symptoms of depression who accepted a referral for a mental health assessment and their partners, and those who chose not to accept a referral. Couples were included if: (1) both partners agreed to participate and to be audio-taped during the interviews; (2) the women had given birth in the 12 months that preceded the interview; (3) they were able to communicate in English or French; and (4) the women had a score of 12 or more on the Edinburgh Postnatal Depression Scale (EPDS) at the time of enrolment. The EPDS is a validated measure of depressive symptoms in the perinatal period (Cox et al., 1987; Hewitt et al., 2009). In this 10-item self-report questionnaire, respondents report their feelings over the past seven days on 4-point scales. A cut-off point of 12 is used to indicate depression.

Enrolment, setting and data collection

Participants were recruited at two tertiary care hospitals, both in urban centres of the same Canadian province during a routine visit to the obstetrics clinic. Others were recruited at the same study sites from among the participants of a longitudinal study of women's mental health in the postpartum period. The study received approval from the institutional research ethics boards at both centres before initiation. In this province, mothers are entitled to a maximum of 18 weeks of paid maternal leave whereas fathers are entitled to a maximum of five weeks. In addition, both parents can share a maximum of 25 supplemental weeks of paid leave (Gouvernement du Québec, 2015).

In these centres, women who obtained a score of 12 or above on the EPDS were offered a mental health referral and asked if they would be interested in learning about the study. If they agreed, research staff explained that the study's purpose was to understand men's and women's PPD experience and preference for care to manage symptoms. If the woman provided verbal consent, they were asked to provide contact information for their partner, and staff contacted the partners directly to explain the study and to obtain verbal consent. Of those approached, 62%