Identifying Risk Factors and Role of Counselling on Psychological Well-being of Mothers with Postpartum Depression

A Dissertation

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List of Abbreviation

PPD	Postpartum Depression
EPDS	Edinburgh Postnatal Depression Scale
GHQ	General Health Questionnaire
TA	Transactional Analysis

Declaration

I declare that the work on "Identifying Risk Factors and Role of Counselling on Psychological Well-being of Mothers with Postpartum Depression" is my own work both in conception and execution and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references. I also declare that no portion of the work referred to in the thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institute of learning.

Signature of the Author

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Certificate of Supervisor

This is to certify that I have read the dissertation entitled "Identifying Risk Factors and Role of Counselling on Psychological Well-being of Mothers with Postpartum Depression" "submitted by Anne Anthonia Baroi for the degree of Master of Philosophy in Educational and Counselling Psychology and this is a record of authentic/original research carried out by her under my supervision and guidance.

Professor Dr. Mahjabeen Haque

Supervisor's signature and date:

Acknowledgment

I want to express my heartiest gratitude and sincere thanks to my supervisor Professor Dr. Mahjabeen Haque, Department of Educational and Counselling Psychology, University of Dhaka, for her extraordinary cooperation, invaluable guidance and supervision. Her patience, motivation and immense knowledge helped me all the research and writing of this thesis.

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Lastly, I sincerely acknowledge the efforts of all those who have directly or indirectly helped me in completing my thesis successfully.

I submit my thesis of mine with great humility and utmost regard.

Anne Anthonia Baroi

Abstract

This study aims to identify the cause of postpartum depression and see the effect of counseling on mothers suffering from postpartum depression (PPD). A total of 91 women were assessed during the first seven months of their babies. The validated Bangla version of Edinburgh Postnatal Depression Scale (EPDS) was used to measure PPD. To identify the cause of the PPD, some information was collected online. It has found that 46.2% of the mother was suffering from postpartum depression. Marital status, depression, unplanned pregnancy, mental stress during pregnancy, and physical complications significantly correlate with postpartum depression. Individual counselling session were provided to mothers with PPD. Counselling session was provided for five consecutive weeks, and feedbacks were taken after that. The session was designed by the researcher based on Transactional Analysis, Person-Centered Therapy, and relaxation techniques. The effect of counselling was measured with the comparison of pretest and posttest of postpartum depression and general health questionnaire score. These two scales assessed the maternal and overall health of the mother. After providing the session, it has found that the mean difference of PPD was 5.211 and GHQ became 4.053 which showed significant improvement. The result of the study showed that the role of counselling is essential for the psychological well-being of the mother.

Introduction

Identifying Risk Factors and Role of Counselling on Psychological Well-being of Mothers with Postpartum Depression

Introduction

Pregnancy and childbirth are generally viewed as a time of joy and pleasure in most families, but sometimes for different factors make it stressful for the mother. After giving birth, sometimes a mother might go through a phase of depression called postpartum affective illness. Mainly this postpartum affective illness has three types: baby blues, postpartum depression, and postpartum psychosis. Among them, maternity blues are relatively common, and postpartum psychosis is rare. Still, postpartum depression is developed in as many as 20% of women, which may develop into mild to moderate levels (Hopkins et al., 1984). The symptoms of baby blues usually start 3 to 4 days after the baby is born. The signs have some similarities with postpartum depression like irritability, anxiety, sleep disturbance, changing mood, but the difference is that these symptoms remain for few days. It does not need any treatment except some reassurance for the mother in this stage (Kennerly & Gath, 1989). Postpartum depression exhibits uneasiness, anxiety, and guilt, inability to focus and cope with the new situation. Also, forgetfulness, fatigue with the symptoms of low self-esteem, lack of confidence are other symptoms within the mother. They also have high, unrealistic expectations of motherhood (Cox 1983).

On the other hand, postpartum psychosis is very rare, with the rate of 1-2 episodes per 1000 deliveries. It has the psychotic feature with very severe depressive episodes (Kendell et al., 1987). It can occur within the first two weeks after the delivery. Symptoms are like depressive mood, which can fluctuate rapidly; the patient may develop disorganized behavior, cognitive impairment, hallucination, and delusion with a high incidence of suicidal or homicidal ideation.

In this stage, it needs psychiatric emergency that requires immediate treatment of the mother. Mother's behavior has changed, and sometimes it can cause both mother and child's safety and well-being issues (Sit et al., 2006).

The present study focuses on postpartum depression because this phase might have a significant impact on the mother, which needs to be discussed and identified. According to American Psychological Association (2015), "Post-Partum Depression is a serious mental health problem characterized by a prolonged period of emotional disturbance, occurring at a time of major life change and increased responsibilities in the care of the newborn." It is a unique state of mental health disorder and a variant of depression- defined by the World Health Organization (2011). When a mother is going through post- partum depression, she faces some symptoms like low mood, tearfulness, hopelessness, emotional liability, and feelings of guilt, loss of appetite, and sleep disturbances. In addition, feelings of inadequacy and inability to cope with a child, poor concentration and memory, fatigue, and irritability. They may worry excessively about the health of the baby and their feeding habits. They perceive themselves as insufficient, inadequate, or unloving mothers (Stewart et al., 2003).

The signs and symptoms of postpartum depression are generally the same as those associated with major depression. (Nonacs & Cohen, 1998). Another reason to focus on postpartum depression is the rate and impact on mother and child. Data showed that10-15% of women after delivery develop postpartum depression (Mehta & Mehta 2014). Though there are different studies about the onset of postpartum depression, data showed the rate of postpartum depression is high among four weeks to thirty weeks of the baby (Andrews-Fike, C.1999).

Postpartum depression has a significant impact on the mother-child relationship and the child's growth and development. Studies show that depressed women have been found not aware of

their infant's needs. They find it difficult to follow cues of their infant's requirements and sometimes become aggressive when taking care of their infant (Murray et al., 1996). If left untreated, the children may have a long-term effect on their cognitive, behavioral, and interpersonal levels (Stewart et al., 2003). It can also create insecurity among children with cognitive impairments, vulnerabilities, and depression. Because of the depression of the mother, there might be disruption in mother-child communication for which the child may have an adverse emotional effect. For that reason, they might have found it challenging to communicate with others later in life. Attachment issues are also found among the child and also have a relational problem. Besides that, though the mother is going through mood disturbance and irritability, it also affects her marital relationship. Hence, postnatal depression is an essential condition to diagnose, treat and prevent because of its effect on both mother and her children (Stewart et al., 2003).

If we analyze the cause of postpartum depression, we can see several associated factors related to developing postpartum depression. According to O' Hara & Swain (1996) and Beck (2001), some variables are reasoned behind this depression. Most importantly, clinical, obstetric & infant, psychological, and social factors are behind this. O' Hara & Swain (1996) divided these clinical factors into depression during pregnancy, prenatal anxiety, previous history of depression, and family history of depression. All of it has a medium level of connection of having PPD except the family history of depression. No link has been found between these two variables. Obstetric & infant-related factors have a remote connection for having PPD. Psychological aspects of cognitive attributions have small, and neuroticism has a moderate relationship with it.

On the other hand, under the term of social factors, it has been found out that life events and social support have a moderate impact on having PPD among mothers. Marital relationships and income have a small association with PPD, but marital status has no connection. Besides that, analysis from Beck (2001) said that if the mother has depression during pregnancy, prenatal anxiety, and previous history of depression, childcare stress, infant temperament, self-esteem, life stress, and social support, then it can have a moderate impact on postpartum depression. On the other hand, maternity blues, unwanted pregnancy, and marital and socioeconomic status have a minor influence.

Another research study showed that unplanned pregnancy is significantly more common in depressed mothers. In addition, a comparison between depressed and with no psychological disorder mother has found that mental symptoms like fear and depression during pregnancy can lead to postpartum depression. Along with it, factors like adverse life events and complicated relationships were found more common in postpartum depressed mothers (Kettunen et al., 2016). In addition, a low level of support from others and a poor socioeconomic status is associated with PPD (Kettunen and Hintikka, 2017).

Very few studies have been found in the context of Bangladesh. One study examined the impact of depressive and anxiety symptoms on maternal bonding among mothers from rural Bangladesh. Mothers with depressive symptoms were more from low socioeconomic backgrounds and less educated than mothers who were mentally well and had no anxiety issues. They also reported more intimate partner violence and showed more inadequate emotional bonding to their infants (Edhborg et al., 2011). Poor socioeconomic status, physical violence from a partner during pregnancy, anxiety symptoms during pregnancy, and previous depressive symptoms were identified as risk factors in the context of Bangladesh (Nasreen et al., 2015). In

the study of Asia, it has been seen that age is a factor. In addition, low socioeconomic background and if the father is the only earning then it causes burden on the mother which a can be a risk factor of having PPD among mothers. Besides that, unwanted pregnancy or having a child without marriage is taboo in many Asian countries which can lead to PPD. The level of education in Asian countries can also lead to this depression. In addition, psychological factors like lack of social support or friend, stressful life events, and abuse by in-laws are the reason behind this postpartum depression (Mehta & Mehta 2014). Hence analyzing all these studies, we can say that there is no single cause for developing postpartum depression. All women tend to develop depression after childbirth but who have one or more than the factors mentioned above are at high risk of experiencing the PPD (Robertson et al., 2004).

In Bangladesh, no reliable estimated study has been found, but it has been assumed that postnatal depression is high in this hugely populated country (Gausia et al., 2007). The incidence proportion of PDS from the third trimester of pregnancy to 2-3 months postpartum was 8.0%, and from 2-3 to 6-8 months postpartum, 18.4% (Nasreen et al., 2011).

Henceforth identification and treatment need to address importance for the well-being of mother and child. To screen the PPD, Edinburgh Postnatal Depression (EPD) Scale is used. It is a 10-items scale, and each item is scored on a 4-point scale (from0-3) with a total score rating from 0 to 30. This is the self-report scale, and the participant expressed her last 7days feelings. This scale is widely accepted for the identification of postpartum depression among mothers.

For the treatment of postpartum depressive mothers, pharmacological treatment is less chosen by mothers because it may directly or indirectly impact children. Mother feared that this medication might have a negative impact on breastfeeding of the child (Fitelson et al., 2010). Psychological

treatments are preferred because they effectively treat depressive symptoms and do not involve the risks of exposure to medications. Though relatively very few studies have been conducted, research supports both psychotherapy and other psychosocial interventions as effective in mitigating symptoms of PPD (Fitelson et al., 2010). Stuart (2012) found Interpersonal Psychotherapy is one of the practical tools to address Postpartum Depression. These treatments target to address the interpersonal distress that the mother is going through. It works with the individual's disputes, the grief and loss they are going through, and, most importantly, their role transition. Also, they focus on the attachment issue of the mother. This Interpersonal Psychotherapy model is a specific and problem-focused therapy that is very useful for the mother. This time-limited and empirically validated treatment for PPD make it reliable to use. Besides interpersonal psychotherapy, cognitive behavioral therapy and psychodynamic psychotherapy were also helpful to address this condition (Fitelson et al., 2010). Psychosocial interventions are also beneficial techniques to deal with it. This psychosocial intervention is based on person-centered therapy, which is a nondirective counseling process. Empathetic understanding and non-judgmental listening help the client to recover from PPD. Other studies showed that nondirective counselling sessions to the mother showed significant recovery than those who did not receive sessions (Holden et al., 1989). According to new research (Buckley & Brownridge, 2020), this therapy is the most effective tool for people experiencing depression. The environment of unconditional positive regard and empathetic listening help the client to talk openly and thus move to the self-healing process. Supportive interventions can also be given, such as telephone-based peer support and counseling by a health visitor (Fitelson et al., 2010). Dennis and colleagues (2009) demonstrated telephone-based peer support for the high-risk of

postpartum depressed mothers. They found that they are at a lower risk of developing PPD after receiving this telephone-based peer support.

In this study, tools from Transactional Analysis is also used because it helps the person know about self and foster personal growth. Ego State from this therapy also lets us know how we structure psychologically (Bianchini and de Nitto, 2019). It was found that mothers feel "bad" or inadequate about themselves. Hence tools of stroke from TA are used to motivate the client and have a positive vibe about self and others. Stroke also help a client to talk about positive aspect rather than a negative one and help to move forward (Stewart and Joines, 1987).

Besides that, psycho-educate about some self-help techniques might help a mother. For example, taking adequate sleep, exercising and eating properly, and a balanced diet help boost up a mother. Talking with a friend can help the mother relieve stress rather than isolating from everyone (Marcin, 2020). Moreover, breathing and meditation can also help to reduce depression and focus on the present. It helps to reduce negative thinking about self. It helps pay attention to someone's thoughts and emotions and thus increases awareness (Raypole. 2020). Finally, a mother and family member need to address this problem before it's too late and take help from the professional.

1.1 Objective of the Study

The present study aims to create awareness about identifying the cause of postpartum depression and how counselling can help a mother come out from this condition. Following are the specific objectives of the study:

1. To identify the causes of the postpartum depression
2. To see the role of counselling on mothers with postpartum depression

3. To know the role of counselling on the overall well-being of the mother

Methods

Method

2.1 Sample

The sample of this research was the mother who was suffering from Postpartum Depression. Data were collected online by google Docs because many people can be reached in different areas and Covid-19 condition. A total of 91 participants have taken part in this research and age group of 18 to 40 years was taken as it is the most reproductive year (Steiner & Jukic, 2016).. Hence this age group was taken for the survey.

Inclusion Criteria of the sample were

1. The mother who has a baby of one month to seven months old
2. The data were collected after four weeks to avoid baby blue
3. The age limit is 18 to 40 year
4. Mothers who were willing to participate
5. Educated and have internet facilities

Exclusion Criteria of the sample were

6. The mother who is suffering from Baby blue and Postpartum Psychosis
7. Who already started taking counseling/ psychotherapy sessions

2.2 Demographic information

Demographic information was taken to see whether these factors are associated with having postpartum depression. Before collecting data, a literature review has been done. Then expert opinion was taken from the psychologist, counselor, and psychiatrist—demographic questionnaire was prepared based on their feedback. Data was collected on sex, age, marital

status, gender, and age of the last children. Moreover, some other variables that can be possible risk factors for the PPD were also taken to see whether those have an effect was asked whether they faced the following situation:

(i)pregnancy was wanted or unwanted (ii) their marital relationship is going well or not (iii) any physical complicacy during pregnancy (iv) mental stress during this time (v) negative life experience events during this time (vi) social support (vii)close friend whom she can share her experience (viii) relationship with in-laws (ix) previous history of depression (x) previous counseling help. All that information was taken to see the impact on postpartum depression.

2.3 Types of Study

An online survey design was used for this study.

2.4 Data Collection Procedure

Data was collected online by google form. It was circulated through different Facebook pages. Besides that, counselors and psychiatrists distributed the form for their respective Social Media Pages, such as Facebook and Whatsapp. The online form was circulated as much as possible to reach the population. Data was collected for almost six months from December 2019 to the end of May 2021.

2.5 Instruments

Edinburgh Postnatal Depression Scale is a valuable and efficient way of identifying patients at risk for depression. It has been widely used for identifying postpartum depression among mothers. This scale has 10-items, and each item is on a 4-point scale (from0-3). Total score rating from 0 to 30. A participant expressed her last 7days feelings. A score higher than 13

indicates that the mother has postpartum depression (Cox et al., 1983). The last item of this scale is suicidal ideation. EPD is a self-reported scale. For measuring postpartum depression, it was translated to the Bengali version of the Edinburgh Postnatal Depression Rating Scale (EPDS), which was validated by Gausia et al., 2007.

General Health Questionnaire (GHQ) developed by Goldberg (1978) and translated and adapted by Ilyas and Ayesha (2001). This scale is used to measure the mental health of the participant. It is also a self-administered scale. It is a 12 item scale where six are positive items, and six are negative items. The items were answered on a four-point scale. Positive items were scored from 3 to 0, and the negative is in reverse order. A high score indicates the increased mental health problems.

2.6 Procedure

The research has been done in three phases:

i. Collecting the demographic information
ii. Assessing the data for identifying postpartum depression
iii. Providing counseling service

In the first phase, demographic information was taken. It was given to find the risk factors of postpartum depression among mothers. Edinburgh Postnatal Depression Rating Scale was also provided with the demographic questions for assessing the level of PPD. Next, participants were asked whether they are willing to take the counseling service or not. If participants accept that condition, they give their name and contact info so that the counselor can contact them later if they have postpartum depression. Finally, those willing to take the counseling session General Health Questionnaire were given to assess their present condition. After taking five consecutive

sessions, they were again provided both EDPS and GHQ scale to compare after counseling effect. In figure 1, the whole process of the sampling technique is presented in short.

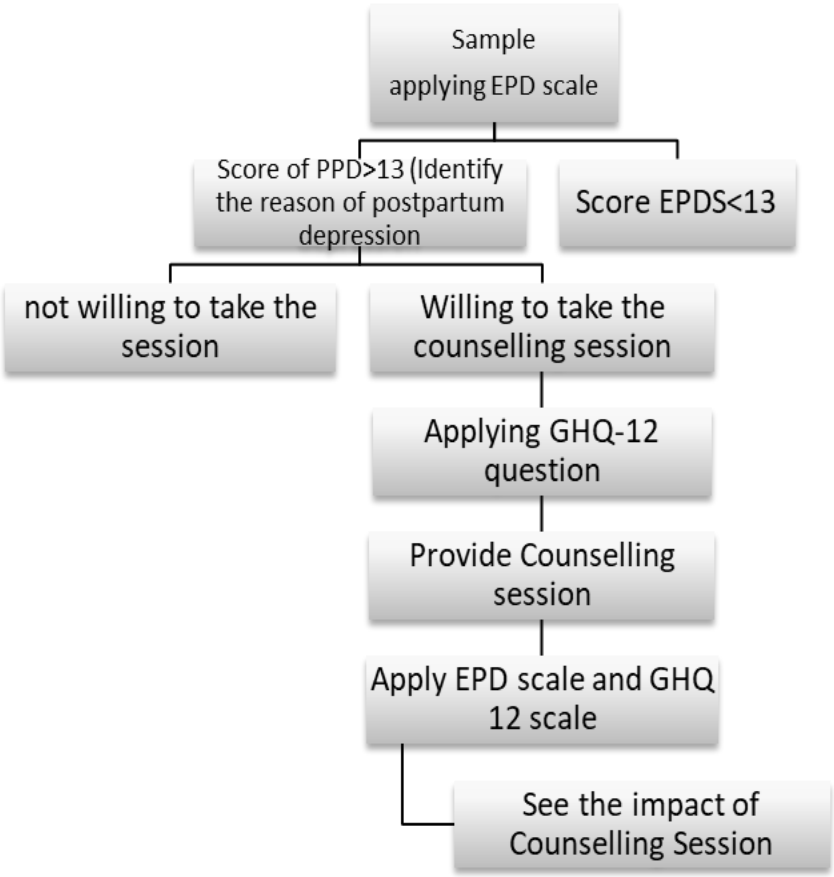


Figure 1: The process of sampling technique

Total of 91 participants took part in this research. Among them, 32 participants were willing to take to the session. Eleven had less than 13 scores on the EPD scale; therefore, counseling

sessions were not provided to them. Finally, counselling session was provided to 21 participants. Among them, two has dropped out in the middle of the session.

2.7 Counselling Service

As a part of this research, counselling session was provided to see the impact of well-being on the mother. Three trainee counselors provided the session. The researcher designed the sessions with the combination of Person-Centered Therapy, Transactional Analysis, and some relaxation techniques. Lots of validation and positive affirmation were given to them to help them come out from their situation. The ego state model from Transactional Analysis was used to see which ego state they were functioning. Family counselling was also provided if necessary. Participants were provided EPD and GHG-12 for pretest and posttest to see the effect. Participants need a different number of sessions, but the impact has been seen after five sessions. Each session was a one-hour session and provided session on a weekly basis. The session was conducted through online video calls.

Table 1

Summary of the counselling session

Number of sessions	Summary of the session	Objectives
1st session	History taking Psychoeducation about Postpartum Relaxation technique	The objective of the session was to take history and build rapport with the client. Here, the model of person-centered approach was followed to help the client ventilation. Some

		relaxation method was used to make the client calm.
2nd session	History taking and emotional ventilation Giving stroke Setting Goal	Worked on rapport with the client and create emotional ventilation for the client. Stroke helped her to see the positive aspect of her life. Through goal setting, which was helping her to focus on the present and the area she would like to improve.
3rd session	Work on goal Introduce with Ego state model Give the homework of exercise of Ego gram Finding the strength of life Tips on self-care Exercise on positive affirmation	How the person is structured psychologically was introduced through Ego state and Ego-gram. Moreover, self-care and positive affirmation is a crucial part of a mother's well-being. How the mother can take care of herself and appreciate self which will be helpful to increase her energy level, was discussed.
4th session	Work on Goal Practicing two chair or empty chair technique Exercise from safe place	For emotional ventilation or finding the inner strength of self was the goal of this session. Practicing two chair or empty-chair technique and empty chair technique in this session was helpful to ventilate the mother and find the strength. Moreover, exercise of safe place help

		to calm her mind and body.
5th session	Feedback from the last session Discuss with any pending issue Discussion from stroke to build up the positive self-image	Feedback and the pending issue were discussed in the session. The discussion was made on whether she faces any barrier with it and how she can resolve this.

2.8 Data Analysis Plan

Appropriate Statistical analysis was used by using SPSS.

2.9 Ethical Consideration

This research was ethically approved by the Department of Educational and Counselling Psychology, University of Dhaka. Written consent was taken from each participant regarding their participation. They were assured that their information would be kept confidential and only be used for research purposes. It was made sure that the participants understood the concept of the research and they have no obligation to participate and can withdraw at any point during the working period without any negative consequences

Result

Result

Descriptive statistics and tests of significance were computed by using IBM SPSS 20. The correlation was calculated to find the relationship of different variables with postpartum depression. For example age, sex of the child, marital relationship, mental stress and physical complicacy during the pregnancy, relationship with in-laws, depression, etc. In addition, t-tests were done to see the effect of counseling in reducing PPD.

Table 2

Percentage of the postpartum depression

N=91	Frequency	Percent
Having Postpartum Depression	42	46.2
Found no Postpartum Depression	49	53.8
Total	91	100.0

From table 2, it was found that 46.2% were suffering from PPD.

Table 3

Correlation between PPD with martial life and depression

	Postpartum Depression
Marital life	r =.455**
	P= .0001
History of Depression	r =.522*
	P= .012

The marital life of the mother is significantly related to the postpartum depression score, r =.455, p<0.01. Mothers who are not on good terms with their partners showed a significantly correlated with postpartum depression as well as a history of depression r=.522, p<.005 has found correlation with depression.

Table 4

Correlation between PPD with unplanned child, stressful life event during pregnancy, and physical complicacy

	Postpartum Depression
Planned or Unplanned Child	r =.263*
	P = .01
Stressful life event during pregnancy	r= .338**
	P= .0001
Physical complicacy	r= .194**
	P= .04

The planning of a child has a significant impact on PPD score. There is a positive correlation between unplanned children and PPD score, r =.263, $p<0.05$. Therefore, it was found unplanned child leads to the developing PPD. Also, the correlation has been found in the stressful life event r =.338, $p<0.0001$ and physical stress r= .194, $p< 0.01$during the time of pregnancy.

Table 5

Correlation between PPD with age, sex of the child, and relationship with in-laws

	Postpartum Depression
Age of the mother	r = .035
	P = .743
Sex of the child	r = .137
	P= .197
Relationship with in laws	r = .117
	P= .270

The rest of the variables are not significantly correlated with having PPD. It has been found that mother's age is not significant factor of having PPD. As well as sex of the child is not an important factor. Relationship with in laws r =.117, p=.270 are not also an important factor.

Table 6

Correlation between PPD with helping hand in raising child, opportunity to share with friends and previously taking mental health support

	Postpartum Depression
Helping hand in raising children	r = .184* P = .081
Opportunity to share	r =.409** P = .081
Previously taking mental health support	r =.051 P = .629

If the mother does not have helping in children r=.184, p<.081 and a friend with whom she can share r=.409, p<.001 has no significant correlation. Previously taking mental health support does not have also r=.051, p<.629 significant correlation.

From the tables mentioned above, we have found that marital status and depression have significant correlation with postpartum depression of the mother. However, other factors like whether the baby is planned or unplanned, mental stress during pregnancy and physical complications have also significant correlation. Though the mother's age, sex of the child,

whether the mother got helping hand, previously taken session and relationship with laws have not significantly correlated with PPD score.

Effect of Counselling

After the effect of counselling we can see the difference of PPD and GHQ in following way

Table 7

Number of Cases of PPD before and after Counseling Session

	Number of cases	*Frequency*	*Percent*
Pretest	Yes (greater than 13)	*19*	*100*
Posttest	Yes (greater than 13)	*6*	*31.6*

From the table, it is observed that, after five counseling sessions, PPD became less for 13 participants among 19 participants.

Table 8

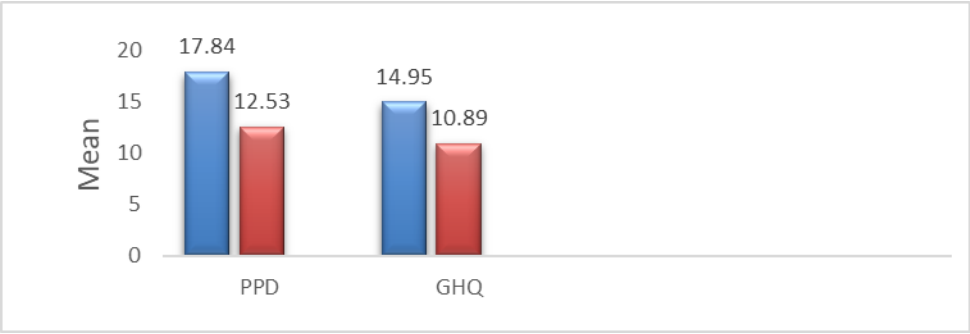
Mean and standard deviation of pretest and posttest of PPD and GHQ scales

	PPD_Pretest	PPD_Postest	GHQ_Pretest	GHQ_posttest
N	19	19	19	19
Mean	**17.84**	**12.53**	**14.95**	**10.89**
SD	2.433	2.736	3.734	2.885

From the comparison, it has been found that both scales' scores have reduced after the counseling session.

Figure 2

Mean score of pretest and posttest of PPD and GHQ



The mean score for PPD has decreased from 17.84 to 12.53. GHQ mean scores also reduced from 14.95 to 10.85 after the counselling session.

Table 9

Paired Sample t-Test of Pretest and Posttest of PPD and GHQ score

		Mean Difference	Std. Deviation	Std. Error Mean	t	df	Sig. (2-tailed)
Pair 1	PPD_pretest - PPD_Postest	5.211	2.859	.656	7.943	18	.0001
Pair 1	GHQ_Pretest - GHQ_posttest	4.053	1.508	.346	11.712	18	.0001

From the table mentioned, we can say that there is a significant change after counseling session. This also proves that counseling session has significantly impact on the well-being of the mother.

3.1 Qualitative Assessment of the Intervention Progress

The effectiveness of the intervention was also examined by taking verbal feedback from the participants. Some questions were asked to the mother to know about their feedback regarding the counseling sessions. Questions were asked on how it was helpful to them and what types of changes it was bringing to their lives.

Following are some of the verbal comments of the mother.

"*I feel light. It feels good that someone listened to me, and I can share my emotions."*

"Now I can relax. I can give attention to my child and smile at him."

Few reported that it helped them develop an interest in their activities and enjoy their daily activities more.

"*Before the session, I felt like everything is coming to an end. I did not know how to focus on my work. I could not eat and sleep properly. Now I am enjoying my everyday activities. It does not feel burdened anymore".*

"It helps me to focus on my well-being. Whenever I feel sad, I remind myself about my resources, it makes me strong and happy again".

Discussion

Discussion

This study provides information on identifying risk factors for developing postpartum depressive symptoms amongst mothers and sees the role of counseling for their psychological well-being. For this study, some demographic information was taken to find the possible risk factors for mothers. First, EPD scale was applied to identify the mother with postpartum depression. Next, the mothers who had PPD and were willing to take the counselling session were included in the session. Three trainee counselors provided counselling sessions. Then the effect of counselling was then measured by comparing with the pretest and posttest of EPDS and GHQ scale after five consecutive counseling sessions.

Our findings identified that 46.2% of women are suffering from postpartum depression. A study found that postpartum depression rates in Asian countries could be at 65% among new mothers. (Carberg, 2019). Another research from Azad et al. (2019) showed that the prevalence of PPD was 39.4% within the first 12 months following childbirth. The women's change into motherhood is a period that involves changes in another aspect of life like psychological, social, and physiological aspects, which often led to the development of a mental illness called postpartum depression (Chowdhary et al., 2014). Hence this study also aims to find the risk factors of PPD. From the result, it has been found that marital status and depression have a significant correlation with the postpartum depression of the mother. Other factors like whether the baby is planned or unplanned, mental stress during pregnancy, physical complications had correlate with PPD. Though the mother's age, sex of the child, whether the mother got helping hand, relationship with laws and previously taken session also has correlation but not found significant.

Hence this aim to find the risk factors of PPDIt can be seen that most of the factors studied in this research were associated with having postpartum depression. Correlation has been found among marital status r =.455, p<0.01, and whether the baby is planned or unplanned r=.263, p<.005. The study also found that the prevalence of PPD is associated with the marital relationship, especially which has more than five years of married life. Increasing day-to-day responsibilities creates a burden for the mother, and hence mother becomes predisposed to have PPD (Guin & Rawat, 2018). In addition, Warner et al. (1996) found a significant relationship between unplanned pregnancy and depression, which supported our study that postpartum depression is also correlated with unexpected babies.

Also, the relation has been found in the level of mental stress r =.338, p<0.01 and physical stress r= .194, p< 0.05 during pregnancy. If the mother is facing any pressure and also if there is any physical complicacy, then the chance of getting PPD is much higher. PPD was significantly higher in mothers who reported stressful life events (18.9 %) than those who said no stressful life events (Qobadi 2016). It has studied the effects of additional stressful life events that women experience during pregnancy. These events can be differ from the death of a loved one or the loss of a job. Studies said that women tend to be more vulnerable, become stressed, and play a causal role in postpartum depression (Robertson et al., 2004).

In addition, this research shows postpartum depression is also significantly related to previous history of depression r=.522*, p<0.05 (Table 3). Subsequent studies also found that prior history of depression has a moderate to strong relationship with postpartum depression. (Johnstone et al., 2001). For example, mothers who had a previous history of depression were 3.7 times more likely to be depressed than those who had postpartum (Shitu et al., 2019). In addition, if the mother has a partner with whom she can share or support hand work as a protecting factor

against PPD (Robertson et al., 2004). This research also proves that if the mother has a supporting hand for raising their child r=.184, p<.005 or finding someone who can share r=.409, p<.001 have less postpartum depression.

The rest of the variables are not significantly correlated with having PPD. Relationship with in-laws r =.117, p=.270, previously taking mental health support r =.051, p=.629 is not particularly related with postpartum depression. Besides that, the mother's age and sex of the children are not highly correlated with having PPD. A study from Cohen (1977) also showed that the maternal age and gender of the child have no effect on it.

Counselling impact was measured through pretest and posttest of EPD and GHQ scale. Scales was applied before the counseling session and after the session, and the score was recorded. Consecutive five sessions was provided online. It has been observed that the mean score of PPD and GHQ has both been reduced. The mean score of PPD came down from 17.84 to 12.53, and GHQ score is from 14.95 to 10.89. This proves that counselling session effects on the mother. A combination of Person-Centered therapy, Transactional Analysis and some relaxation techniques was used in the session. In the theory of Person-centered, it has been found out that if the person gets a non-judgmental attitude, it becomes helpful for them to talk about their guilt, shame, and other emotions. It becomes a useful release for them (Buckley & Brownridge, 2020). Our present study also proves (Table 9) positive impact of the counselling session. In addition, research from Good Therapy Editor Team (2016), also confirms that TA works better when the person is suffering from emotional difficulties.

For providing counselling session, consecutive five sessions were given. Counselling session was given to 21participants and among them19 continued their sessions. Each client was

provided the pretest scale after five sessions. Among them, 13 recovered from postpartum depression, and the rest 6 showed improvement, though the PPD score was still greater than 13. Though it was not part of the research but counselor continued their session. The participants' progress can say that the role of counseling sessions is essential for the well-being of the mother. However, the score of both scale was reduced after the counselling session than it can be said that counselling session significantly (Table 09) help them for the well-being of the mother. Mothers also share some feedbacks where they showed great deal of satisfaction after the counselling session.

4.1 Limitation and Recommendation of the Study

For the study's recommendation, more data can be taken to validate the risk factors for postpartum depression. Though the data was taken from online, women who took part in the research are primarily from educated backgrounds. Those who have data connection excess can take part in this research. This is the primary limitation of this research because of not possible to reach all cohorts of women. This model of counseling can apply more women to all affiliates so that valid conclusions can be taken.

4.2 Conclusion

This study showed us the risk factors of mothers suffering from postpartum depression and how the counselling session can positively contribute to a mother's psychological health. People can get the aware of the risk factors and help the mother accordingly. Besides that, people generally tend to focus on maintaining the mother's good health of the mother but this study also shows that mental health support is also necessary. It can ultimately keep both mother and child happy and healthy.

References

References

American Psychological Association, Postpartum depression. Available from: http://www.apa.org/pi/women/resource s/reports/postpartum-dep.aspx.[accessed on 21 July 2015].

Andrews-Fike C. (1999). A Review of Postpartum Depression. *Primary care companion to the Journal of clinical psychiatry, 1*(1), 9–14. https://doi.org/10.4088/pcc.v01n0103

Azad, R., Fahmi, R., Shrestha, S., Joshi, H., Hasan, M., Khan, A. N. S., Chowdhury, M. A. K., Arifeen, S. E., & Billah, S. M. (2019). Prevalence and risk factors of postpartum depression within one year after birth in urban slums of Dhaka, Bangladesh. *PLOS ONE*, 14(5), e0215735. https://doi.org/10.1371/journal.pone.0215735

Beck, C. T. (2001). A meta-analysis of predictors of postpartum depression. *Nursing Research*, 45, 297- 303.

Bianchini S, de Nitto C (2019). The Parent Ego State as a Developmental Achievement: A View from Social-Cognitive Transactional Analysis. Transactional Analysis Journal 49(1):14-31.

Buckley, D. (2017, April 14). *Client Centered Therapy: Why It Works.* Better Help. https://www.betterhelp.com/advice/therapy/client-centered-therapy-why-it-works/

Carberg, J. (2019, May 3). Postpartum Depression Statistics. Postpartum Depression. https://www.postpartumdepression.org/resources/statistics/

Chowdhary, N., Sikander, S., Atif, N., Singh, N., Ahmad, I., Fuhr, D. C., Rahman, A., & Patel, V. (2014). The content and delivery of psychological interventions for perinatal depression by non-specialist health workers in low and middle income countries: A systematic review. *Best Practice & Research Clinical Obstetrics & Gynaecology*, *28*(1), 113–133. https://doi.org/10.1016/j.bpobgyn.2013.08.013

Cohen, J. (1977). Statistical Power Analysis for the Behavioural Sciences. Revised edition New York: Academic Press.

Cox, J. L. (1983). Postnatal depression: a comparison of African and Scottish women. Social Psychiatry, 18, 25-28.

Dennis, C. L., Hodnett, E., Kenton, L., Weston, J., Zupancic, J., Stewart, D. E., & Kiss, A. (2009). Effect of peer support on prevention of postnatal depression among high risk women: multisite randomised controlled trial. *BMJ*, 338, a3064. https://doi.org/10.1136/bmj.a3064

Edhborg, M., Nasreen, H. & Kabir, Z.N. (2011). Impact of postpartum depressive and anxiety symptoms on mothers' emotional tie to their infants 2–3 months postpartum: a population-based study from rural Bangladesh. *Arch Womens Ment Health* 14, 307. https://doi.org/10.1007/s00737-011-0221-7

Fitelson, E., Kim, S., Baker, A. S., & Leight, K. (2010). Treatment of postpartum depression: clinical, psychological and pharmacological options. *International journal of women's health*, 3, 1–14. https://doi.org/10.2147/IJWH.S6938

Gausia, K., Fisher, C., Algin, S., & Oosthuizen, J. (2007). Validation of the Bangla version of the Edinburgh Postnatal Depression Scale for a Bangladeshi sample. *Journal of Reproductive and Infant Psychology*, *25*(4), 308–315. https://doi.org/10.1080/02646830701644896

Goleberg, D. (1978). Manual of the General Health Questionnaire. Windsor: NFER.

Guin, G., & Rawat, S. (2018). Prevalence of postpartum depression and association with risk factors in a tertiary care hospital. *International Journal of Reproduction, Contraception, Obstetrics and Gynecology*, 7(3), 1094. https://doi.org/10.18203/2320-1770.ijrcog20180899

Holden, J. M., Sagovsky, R., & Cox, J. L. (1989). Counselling in a general practice setting: controlled study of health visitor intervention in treatment of postnatal depression. *BMJ (Clinical research ed.)*, 298(6668), 223–226. https://doi.org/10.1136/bmj.298.6668.223

Hopkins, J., Marcus, M., & Campbell, S. B. (1984). Postpartum depression: A critical review. *Psychological Bulletin*, 95(3), 498–515. https://doi.org/10.1037/0033-2909.95.3.498

Ilyas, Q. S. M., & Aeysha, M. (2001). Bengali version of Goldberg General Health Questionnaire (GHQ). Ubpublished Manuscript, Department of Psychology, Dhaka University, Dhaka.

Johnstone, S. J., Boyce, P. M., Hickey, A. R., Morris-Yatees, A. D., & Harris, M. G. (2001). Obstetric risk factors for postnatal depression in urban and rural community samples. Australian and New Zealand Journal of Psychiatry, 35, 69-74.

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

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

Kettunen, P., & Hintikka, J. (2017). Psychosocial risk factors and treatment of new onset and recurrent depression during the postpartum period. *Nordic journal of psychiatry,* 71(5), 355–361. https://doi.org/10.1080/08039488.2017.1300324

Kettunen, P., Koistinen, E., & Hintikka, J. (2016). The Connections of Pregnancy-, Delivery-, and Infant-Related Risk Factors and Negative Life Events on Postpartum Depression and Their Role in First and Recurrent Depression. *Depression research and treatment,* 2016, 2514317. 96https://doi.org/10.1155/2016/251864317

Marcin, A. (2020, February 11). 7 Ways to Cope with Postpartum Depression. *Healthline.* https://www.healthline.com/health/depression/how-to-deal-with-postpartum-depression

Mehta, S. and Mehta, N. (2014), "An overview of risk factors associated to postpartum depression in Asia", *Mental Illness,* Vol. 6 No. 1, pp. 14-17. https://doi.org/10.1108/mi.2014.5370

Murray L., Fiori-Cowley A., Hooper R., Cooper PJ. (1996). the impact of postnatal depression and associated adversity on early mother infant interactions and later infant outcome. Child Dev. 67, 2512–2526.

Nasreen, H. E., Kabir, Z. N., Forsell, Y., & Edhborg, M. (2011). Prevalence and associated factors of depressive and anxiety symptoms during pregnancy: a population based study in rural Bangladesh. *BMC women's health*, *11*, 22. https://doi.org/10.1186/1472-6874-11-22

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

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

Qobadi, M., Collier, C., & Zhang, L. (2016). The Effect of Stressful Life Events on Postpartum Depression: Findings from the 2009-2011 Mississippi Pregnancy Risk Assessment Monitoring System. *Maternal and child health journal*, *20*(Suppl 1), 164–172. https://doi.org/10.1007/s10995-016-2028-7

Raypole, C., & Raypole, C. (2020, January 30). Meditation Won't Cure Your Depression, but It Can Be a Big Help. *Healthline*. https://www.healthline.com/health/meditation-for-depression

Robertson, E., Grace, S., Wallington, T., & Stewart, D. E. (2004). Antenatal risk factors for postpartum depression: a synthesis of recent literature. *General hospital psychiatry*, *26*(4), 289–295. https://doi.org/10.1016/j.genhosppsych.2004.02.006

Shitu, S., Geda, B., & Dheresa, M. (2019). Postpartum depression and associated factors among mothers who gave birth in the last twelve months in Ankesha district, Awi zone, North

West Ethiopia. *BMC Pregnancy and Childbirth*, *19*(1), 435. https://doi.org/10.1186/s12884-019-2594-y

Steiner, A. Z., & Jukic, A. M. (2016). Impact of female age and nulligravidity on fecundity in an older reproductive age cohort. *Fertility and sterility*, 105(6), 1584–1588.e1. https://doi.org/10.1016/j.fertnstert.2016.02.028

Stewart, D.E., Robertson, E., Dennis, C-L., Grace, S.L., & Wallington, T. (2003). Postpartum depression: Literature review of risk factors and interventions

Stewart I, Joines V (1987). TA today: A new introduction to transactional analysis. Life space Publ.

Stuart S. (2012). Interpersonal psychotherapy for postpartum depression. Clinical psychology & psychotherapy, 19(2), 134–140.

Warner, R., Appleby, L., Whitton, A., & Faragher, B. (1996). Demographic and obstetric risk factors for postnatal psychiatric morbidity. *British Journal of Psychiatry*, 168, 607-611.

World Health Organization 2011, Postpartum Depression: An Overview of [1] Treatment and Prevention. Available from: http://www.gfmer.ch/SRH-Course-2011/maternalhealth/pdf/Postpartum-depression-Corey-2011.pdf [accessed on 12 December 2015].

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Appendices