Nature and Impact of Postpartum Depression on Women's Life

Thesis submitted in partial fulfillment of the requirements for the Degree of M.Phil. in Clinical Psychology awarded by the University of Dhaka

Submitted by

Mumita Jerin Nilav

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Department Of Clinical Psychology

University Of Dhaka

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Approval of the Thesis

This is to certify that the study **"Nature and Impact of Postpartum Depression on Women's Life"** submitted by **Mumita Jerin Nilav** to fulfill the requirements for the degree of M. Phil in Clinical Psychology is an original work. The research was carried out by her under my guidance and supervision. I have read the thesis and believe this to be an important work in the field of clinical psychology.

Date:

(Muhammad Kamruzzaman Mozumder)

Professor

Dept. of Clinical Psychology

University of Dhaka

Abstract

Depression is a common mental health problem among women during the postpartum period, which is generally known as postpartum depression. Postpartum depression negatively affects women, their partners, children and family members. Most of the mothers and their family members are not aware of the consequence and the need for treatment. Literature on the detailed nature and impact of postpartum depression is limited in the world and practically non-existent in Bangladesh. Therefore, the present study was designed to explore the nature of postpartum depression and its impact on woman's life.

This study employed a qualitative research design using phenomenological approach. Purposive sampling with specific inclusion and exclusion criteria was used for the selection of participants, and maximum variation of sampling was kept in consideration while selecting the participants. A two-stage selection process was used with mothers attending maternity unit in a hospital in Dhaka city. The first stage of selection involved screening of the prospective participants with the Edinburgh Postnatal Depression Scale and subsequent diagnostic interviews to identify mothers with postpartum depression. In the second stage, the screened women with postpartum depression were invited to participate in the study. Ten women were interviewed in-person using a topic guide after collecting signed understood consent. The recorded interviews were transcribed for content analysis which was carried out in parallel to ongoing data collection.

Seven broad categories, namely, emotional state, cognitive process, behavior and action, coping, physiological state, impact on relations and impact on self, were identified to organize the themes and subthemes that emerged during the content analysis. The findings indicate that mothers with postpartum depression encounter a wide range of

changes in their emotions, thoughts, behaviors and functioning. These changes adversely affect the women's transition to motherhood and interrupt wellbeing as well as the functioning of the women, their partner, child and other family members.

Various types of emotions such as depressed mood, frustration, guilty feelings, helplessness, hopelessness, anxiety and irritability were found among participants throughout their postpartum period. In the journey of motherhood, many women with postpartum depression perceive almost everything in a negative manner which made them more vulnerable to depression. Mothers reported feelings of losing control over their thoughts, emotions and actions. Aggressive behavior such as hitting self, child and others was also reported by them. Some mothers even tried to attempt suicide which is an alarming concern for the mother, child and family. Physiological troubles such as agitation, exhaustion, pain, sleep disturbances and complications with appetite were reported in relation to psychological state and emotional disturbance.

Growing conflict and emotional isolation with family and friends was another feature of postpartum depression. With limited support and cooperation from family and friends, they became overwhelmed and frustrated with the situation they are in. Due to a lack of understanding of postpartum depression, the women find it challenging to cope with it. They reported the use of helpful and unhelpful coping strategies such as accepting the situation, thinking positively, trying pleasurable and constructive activities, giving up, avoidance, escape, blaming, being aggressive, and having destructive or negative thoughts.

In the context of limited empirical data on the nature and impact of postpartum depression in Bangladesh, the present qualitative research may contribute to reducing the gap by providing a detailed understanding of the phenomenon. The findings on the

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experience of emotion, cognition, behavior, coping, physiological state and interpersonal relations may be useful in developing interventions and strategies for improved wellbeing of mothers with postpartum depression.

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. . . .   Dated

Mumita Jerin Nilav   Dhaka, February, 2022

Dedication

Dedicated to my beloved and respected parents, Mojaffar Hossain and Dipty Kabir who have provided me a secure base and their encouragements, constant support, unconditional love and sacrifices.

CHAPTAR 1

INTRODUCTION

Introduction

Motherhood is often considered the most significant and joyful experience of a women's life. Having a child has been reported as the most fulfilling and satisfying experience for many mothers (Regev, 2001), which is also generally a pleasant event for the entire family. However, depression in the mother, especially when it develops around childbirth (pre or post), can easily turn this joy into despair (Emily C. Clay & Dean A. Seehusen, 2004; Miller, 2002). Pre- or post-partum depression may be manifested in mood swings, crying spells, sleep disturbances, and undefined anxiety. Although twice as common among mothers, such depression can also be seen among fathers (Olshansky, 2003). The commonness of depression among women during prenatal and postnatal periods as reported in the research literature (Stewart, Robertson, Dennis, Grace, & Wallington, 2003) and the limited research on these in Bangladesh urges for an exploration of the phenomenon in this context.

Depression of mothers after giving birth is generally known as postpartum or postnatal depression (O'hara & McCabe, 2013). Childbirth and the contextual process often creates enormous challenges for the mothers in adjusting to their new roles, responsibilities and situational demands. No mother can be fully prepared for these changes in life that follows childbirth. These, in turn, cause fluctuations in mood and can give way to post-partum depression (PPD), i.e., depressive symptoms after the delivery (Terry, Mayocchi, & Hynes, 1996).

Mothers with PPD are at increased risk of social isolation due to lack of energy, fatigue, and feelings of incompetence, worthlessness, and helplessness. Increased need for support from the partner (Holopainen, 2002) to cope with these creates additional strain in

intimate relationships. Thus, PPD has been associated with marital problems such as disagreements, hostility, withdrawal of social support between marital partners (P. T. Davies & Windle, 1997; Leinonen, Solantaus, & Punamäki, 2003) as well as separation and divorce (Meadows, McLanahan, & Brooks- Gunn, 2007). Mother's depression can have a negative impact on the child's early and later development in cognitive, emotional and behavioral domains (Darcy et al., 2011).

Despite the seriousness of the symptoms and impact of PPD, the family and the mothers rarely seek professional support for these (Dennis & Chung- Lee, 2006). It has been reported that less than 40 per cent of depressed mothers seek help (Haynes, 2007). Lack of knowledge and stigma about mental health problems have been suggested as the reason behind not seeking help (Leahy-Warren & McCarthy, 2007). Common symptoms of postpartum depression such as inadequacy, guilt, fatigue, irritability, anxiety, insomnia, changes in appetite and confusion are generally overlooked as a reaction to the physical and contextual changes to childbirth, which are thought as something that would disappear soon and thus ignored by the mothers resulting in lack of treatment-seeking (Chaudron et al., 2005). Furthermore, symptoms of PPD are poorly recognized and often missed by healthcare professionals as well (Gjerdingen & Yawn, 2007). Thus, the majority of PPD incidences remain unrecognized and are left untreated. Due to the wider impacts of PPD on the women, children, partners and other family members, it is important to identify, treat and prevent PPD to ensure the wellbeing of new mothers as well as the family members (Stotland & Stewart, 2008).

1.1 Postpartum Depression

Postpartum depression is a non-psychotic depressive episode that initiates after childbirth (Cox, Murray, & Chapman, 1993; O'hara & Swain, 1996). Globally it affects approximately 10-15 per cent of mothers yearly (C. T. Beck, 2002). Criteria for major depressive episode along with onset specification of postpartum is used for the diagnosis of postpartum depression (American Psychiatric Association, 2013). Postpartum mood disorders can be divided into three different categories according to the severity and termed as baby blues or maternal blues, postnatal depression or postpartum depression and puerperal psychosis or postpartum psychosis (O'Hara, Zekoski, Philipps, & Wright, 1990). Maternal blues or baby blues is considered as a temporary reaction of mood changes such as depressed mood, guilt, fear, anxiety, irritability etc., due to hormonal reasons following childbirth (Robertson, Grace, Wallington, & Stewart, 2004). Baby blues can occur 24 -48 hours after delivery lasting for up to 10 days, and tends to occur in 50-80% of new mothers (C. T. Beck, Reynolds, & Rutowski, 1992; Harding, 1989). If symptoms continue beyond this time period and are severe in their intensity, mothers tend to develop postpartum depression (Harding, 1989). Postpartum depression often occurs between a few months to a year Mauthner (1998). Postpartum psychosis or puerperal psychosis is very rare. Less than 2 in 1,000 mothers may develop postpartum psychosis with the symptoms such as rapid mood swings, delusions, hallucinations, and loss of the sense of reality. Postpartum psychosis generally occurs within the first two weeks to three months after childbirth (Harding, 1989; Leitch, 2002; O'Hara et al., 1990). Some researchers have found biological (multiple hormones), psychological, familial, social, and cultural factors as the causes of postpartum depression (Emily C Clay & Dean A Seehusen, 2004; S. S. Leung, Arthur, & Martinson, 2005; S. S. K. Leung, 2001; O'hara & Swain, 1996).

1.1.1 Diagnosis of postpartum depression.

It has been mentioned in the previous section that the clinical criteria and symptoms of postpartum depression are considered similar to depressive disorder. The classification systems used for diagnosing mental health conditions, namely the Diagnostic & Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association, 2013) and the International Classification of Diseases 10th edition (ICD-10; World Health Organization, 1993) are used for diagnosing postpartum depression. However, none of them recognizes postpartum depression as a separate diagnosis, rather it is considered as part of depressive disorders. The depressive episodes following childbirth are collectively referred to as peripartum episodes. As postpartum depression is diagnosed with the criteria used for major depressive disorder, it requires the presence of five or more symptoms in the area of low mood, loss of interest or pleasure, changes in weight, changes in appetite, insomnia or hypersomnia, psychomotor agitation, feelings of guilt, difficulty in attention, frequent thoughts of demise or suicidal ideation or attempts for a minimum of two weeks to diagnose of postpartum depression. According to DSM-5, a postpartum mood episode onset is within four weeks of birth (American Psychiatric Association, 2013), whereas ICD-10 consider postpartum depression tends to occur 6-weeks after childbirth (World Health Organization, 1993). There are differences in opinion regarding the onset of postpartum depression. Many clinicians, researchers and health professionals reported that the onset of postpartum depression could occur at any time within the first year of childbirth (B. R. Davies, Howells, & Jenkins, 2003; O'hara & Swain, 1996; Perry, Thurston, & Osborn, 2008). However, some others claimed that postpartum depression can occur anytime in the first year and can persist for up to four years following childbirth (Kumar & Robson, 1984; Schott & Henley, 1996).

Apart from diagnostic interviews, different screening and assessment tools are used to aid diagnosis and assess the severity of post-partum depression. The Beck Depression Inventory (BDI; A. T. Beck, Steer, & Carbin, 1988) and the Edinburgh Postnatal Depression Rating Scale (EPDS; Cox, Holden, & Sagovsky, 1987) are the most common globally used tool for screening postpartum depression.

1.1.2 Prevalence of postpartum depression. Different studies have reported different prevalence rates of postpartum depression. Worldwide, the prevalence of PPD among women ranges from 0.5% to 60.8% (Halbreich & Karkun, 2006). Commonly it was found that the prevalence rate of PPD among women is 10-15% (Halbreich & Karkun, 2006; Morse, Buist, & Durkin, 2000; Segre, O'Hara, Arndt, & Stuart, 2007). According to DSM-5 (American Psychiatric Association, 2013), 3% to 6% of women experience major depressive episodes following delivery and 50% of major depressive mood episodes begin prior to childbirth. There are very few studies in Bangladesh on PPD and these studies have some similar and different findings. In Bangladesh, the prevalence of PPD ranged from 18% to 35% among rural mothers has been found (Gausia, Fisher, Ali, & Oosthuizen, 2009; Nasreen, Edhborg, Petzold, Forsell, & Kabir, 2015). A study conducted in the urban slum of Bangladesh found the depressive symptoms among women during their postpartum period was 11% (Azad et al., 2019).

1.1.3 Comorbidity. Post-traumatic stress disorder, postpartum anxiety disorder, obsessive-compulsive disorder and panic disorder are the most common comorbid conditions with postpartum depression (C. T. Beck, 1998; Stuart, Couser, Schilder, O'HARA, & Gorman, 1998; Wisner, Parry, & Piontek, 2002). The anxiety-based disorder has been found to be more commonly associated with postpartum depression than other disorders (Barnett & Parker, 1986). Research in the areas of the different disorders has

been uncommon and contradictory and many of the researches have been formed based on case reports or retroactive study designs (C. T. Beck, 1998; Reynolds, 1997; Stuart et al., 1998). Therefore, more related data are required on PPD.

1.2 Literature on the Nature of PPD

The sign or symptoms of postpartum depression may vary among mothers. Researchers identified different areas and types of troubling experiences the mothers face during postpartum depression. Emotional turmoil, tearfulness, hopelessness, guilty feelings, loss of appetite, and sleep disturbances and also feelings of being incapable and inadequate to take care of the baby, difficulties with concentration and memory, tiredness and irritability among mothers are the most commonly reported complaints in PPD (Leahy-Warren & McCarthy, 2007; Robinson & Stewart, 2001). There are some other symptoms such as fatigue, anxiety, anger, irritability, self-blaming thoughts were found in the research of Pitt (1968).

Symptoms of PPD can be categorized as emotional, behavioral and physical symptoms. Emotional symptoms are sadness, feeling overwhelmed, anxiety, confusion, worry, hopelessness. Behavioral symptoms are oversensitivity, crying, irritability, hostility, panic attacks, and paranoia. Physical symptoms are lack of energy, sleep disturbances, changes in appetite, headaches, chest pains, palpitations, and breathing difficulties (Kruckman & Smith, 2008).

After reviewing some qualitative researches, depressed mood, tiredness, hopelessness, loneliness, guilt, anxiety etc., have been found by Leahy-Warren and McCarthy (2007) as common emotions of mothers with PPD. Most of the mothers feel helpless as they can't cope with their situation and manage their regular activity. They also

feel guilty for their incapability to meet the needs or demands of the child and for failure to perform as an ideal mother during their postpartum period. Mothers also perceive themselves as worthless (Miller, 2002). Some mothers may be extremely anxious about the health or feeding habits of the child and perceive themselves as helpless, worthless, or careless mothers. Mothers feel that everything around them is overwhelming, which makes them scared, anxious and worried. Some mothers develop guilty feelings over their perceived inadequacy as a parent (Verbeek et al., 2012).

Negative thoughts such as avoiding the child, thoughts of harming the child and fear was found as the sign and symptoms of PPD (Cullen- Drill, Smith, & Morris, 2008). Some mother experiences the thoughts of harming their child, but actually materialization of such harms is rare. Though suicidal attempt is rare, some mothers develop destructive or self-damaging thoughts such as hurting or killing themselves (C. T. Beck, 1998; O'hara & Swain, 1996). Many mothers complained about their problems with memory and concentration (C. T. Beck & Indman, 2005; Flynn, 2005; Hanley, 2006). Postpartum psychosis can also occur with the symptoms such as hallucinations, memory loss, confusion, inability to function, incoherence in thought and action and possible harm to the child or self.

Mothers' experiences are different regarding sleep; some mothers experience difficulty with getting sleep, some develop interrupted sleep, mothers also have to frequently wake as the baby wake frequently and ultimately, mothers develop difficulties with sleep even the baby is steady (Verbeek et al., 2012). As mothers need to feed their baby regularly, so their rest is interrupted recurrently and mothers develop sleep disturbances, thus mothers get irritated and tired most of the time. Equally, sometimes mothers feel so sleepy and struggle to get out of bed (B. R. Davies et al., 2003; Flynn,

2005). As a result, simple chore appears too tough for the mother to complete as well as it seems difficult for the mother to take care of the baby (Hanley, 2006; V. Williamson & Mccutcheon, 2007). Changing in appetite is found common among mothers and these changes either led to weight loss following poor appetite or weight gain accompanying overeating (Cullen- Drill et al., 2008; Hanley, 2006).

In a qualitative exploration of experiences of mother with PPD, (J. Green, 2004) found several central themes which were loneliness, social isolation, concern about self in relation to others as the experiences of mothers with PPD. Similarly, it was found that depressed mothers developed difficulties with socialization as they were emotionally so overwhelmed to respond, and they had felt that no one would understand them (Rice, Grealy, Javaid, & Millan Serrano, 2011).

1.3 Literature on the Impact of PPD

The consequences of untreated postpartum depression are numerous and can have long-standing adverse effects. Apart from being a threat to mothers' mental and physical health, PPD creates significant concerns for the wellbeing of the child and the family. The impact of PPD ranges from mildly troublesome to terrifying. Mothers with PPD often lose personal freedom and feel challenged to perform regular activities, social networking, professional activities and personal health care (K. Green, Broome, & Mirabella, 2006; Posmontier, 2008).

Mothers also lose their ability to take care of themselves (Horowitz & Goodman, 2005). Researchers noted that mothers who were highly functioning before childbirth struggled to manage the most mundane tasks after childbirth due to PPD, and therefore, they experienced a loss of capability (C. T. Beck & Indman, 2005). Mothers with

postpartum depression faced problems with basic care of children such as bathing, feeding, and changing diapers and their daily functioning was adversely affected (Edwards & Timmons, 2005). PPD not only impair mothers' daily functioning, but it also creates threats to their survival as suicidal risks of the mother with PPD have been reported in different research (King, Slaytor, & Sullivan, 2004; Ratnaike, 2006). The episode of PPD can be the precursor of chronic recurrent depression for the mother.

Postpartum depression of mothers has an impact on everyone in the house- the infant, other children, the spouse and other family members (Meltz, 2003; Puckering, 2005; Toneguzzi, 2004). Certainly, mothers who suffer from PPD are less capable of doing maternal duties such as taking care of baby, playing and talking with them, which may influence the infant's behavioral, cognitive and socioemotional development as well as the attachment style of the child (S. H. Goodman, Brogan, Lynch, & Fielding, 1993). Similarly, it was found that for the children, mothers' ongoing depression can contribute to emotional, behavioral, cognitive, and interpersonal problems in later life (Miller, 2002). Untreated postpartum depression in the mothers negatively impacts their parental ability and her self-esteem, which negatively affects child's physical and mental development (Perfetti, Clark, & Fillmore, 2004). Mothers with PPD are reluctant to breastfeed their baby, which is required for optimal nutrition as well as immunological and emotional nurturing for normal growth and development of the baby (Hatton et al., 2005). Mothers with PPD exhibit difficulty in interacting and bonding with child, which is connected with the developmental problems of the infants (C. T. Beck, 1995; P. J. Cooper, Murray, Wilson, & Romaniuk, 2003; Dennis & Chung- Lee, 2006; Hanley, 2006; Stanley, Murray, & Stein, 2004). Poor cognitive functioning, behavioral and emotional adjustment problem of the child was also documented in several studies as the impact of mother's postpartum

depression (Horowitz & Cousins, 2006; Stanley et al., 2004). Child can develop poor vocabulary due to maternal depression in their early age (Leitch, 2002). Some studies stated that mother with PPD has poor interaction and bonding with their child (Edhborg, Lundh, Seimyr, & Widström, 2001; McMahon, Barnett, Kowalenko, & Tennant, 2006; Stanley et al., 2004), which can contribute to child's speech development deficits (Meltz, 2003; Puckering, 2005; Toneguzzi, 2004). Mother's postpartum depression has also been associated with child's behavioral problems. Maternal depression is found as a major reason for hyperactivity, aggression, and depression among children (Lusskin, Pundiak, & Habib, 2007). Postpartum depression carriages a risk for mother-child attachment and bonding. Evidence showed that the effect of postpartum depression has long term effects on maternal–infant interaction over 1 year age of children and also the mothers (C. T. Beck, 2002). Children of depressed mothers tend to develop insecure attachments at the age of 18 months (P. J. Cooper et al., 2003). Commonly mothers who are suffering from postpartum depression have thoughts of damaging their children and themselves and they are less emotional and less securely attached with their children, so it's very threatful for the mother and the children (Hagen, 1999). Evidence suggests that depressed mothers are significantly more likely to engage in unhealthy parenting practices (e.g., corporal punishment, reduced home safety practices, non-attendance at child well-health visits); less likely to have knowledge about infant development and age-appropriate nurturing and sensitive parenting; and less likely to perform literacy enrichment activities (Zajicek-Farber, 2010).

The harmful consequences of PPD on wellbeing and family functioning is strongly correlated with PPD. PPD the women can have a dramatic effect on the spouse. As the partner are unable to support each other throughout this stressful period, it creates pressure

on the conjugal relationship (Boath, Pryce, & Cox, 1998). The sudden life changes associated with the transition to parenthood often threaten marital relationships during the early period of postpartum (Anderson, 1996). Indeed, PPD has been associated with decreased relationship satisfaction and marital problems, such as lack of intimacy and sexual issues (Meighan, Davis, Thomas, & Droppleman, 1999), sometimes resulting in separation or divorce (Sayers, Kohn, Fresco, Bellack, & Sarwer, 2001). Maternal mental health problems are also related to family functioning by potentially evoking disagreements and hostility between parents, which frequently result in withdrawal of social support between marital partners (Leinonen et al., 2003). Postpartum depression is associated with impaired interpersonal interactions between partners characterized by anger, hostility, mistrust, emotional detachment, reduced nurturance and affiliation (Feldbau-Kohn, Heyman, & O'Leary, 1998; Kahn, Coyne, & Margolin, 1985) and intimate partner violence (Vaeth, Ramisetty-Mikler, & Caetano, 2010). These interactive characteristics function to further complicate mothers' symptoms of depression (Cohen et al., 2002).

As for the depression of the mother, childcare becomes compromised, intimacy with partners suffers, connection with other family members breaks down and social life may become detaching. The couple's relationship is very much affected, along with the bonding and care of the child. The partner may need to feed, bath, wash, carpool, shop, and pay household bills as well as other countless chores. Spouses and older children may become annoyed, exhausted, angry, upset or hopeless with this type of situation. PPD has not only a harmful effect on the mother and child but also on her spouse. It is found that partners of the mother with PPD are at risk of developing psychiatric disorders (Lovestone

& Kumar, 1993). The incidence of depression in men whose partners have PPD is 24% to 50%, while in general, depression in men is 1.2% to 25.5% (J. H. Goodman, 2004).

Deteriorating and conflicting relationship between women with PPD and their mother-in-law has also been reported (K. Green et al., 2006). Postpartum depression creates a huge burden on the mother, the child and the entire family (S. H. Goodman et al., 1993; Horowitz & Goodman, 2005).

1.4 Gaps in Understanding PPD

There are different types of researches on the topic of postpartum depression. After analyzing previous studies, some major limitations have been found. Over the past two decades amount of research on PPD has been increasing; despite the growing amount of research on PPD, there is a gap of detailed understanding about the nature and impact of PPD have been found (C. Cooper et al., 2007).

Postpartum depression has effects on quality of life, social functioning and economic productivity (Chisholm et al., 2003). Postpartum depression (PPD) negatively affects women's functioning, marital and personal relationships, maternal-infant interaction quality, and children's social and cognitive developmental outcomes (P. J. Cooper & Murray, 1997; P. J. Cooper et al., 2003; Murray et al., 1999). The health consequences could also lead to adverse long-term emotional and physical development of the infant (Boath et al., 1998).

Moreover, failure to diagnose these women often leads to safeguarding concerns for both mothers and infants (Warrington, Wright, & Team, 2001). In our country, we do not have a clear picture of the nature of postpartum depression and its impact on women's

lives, which is needed to develop and implement effective interventions to reduce suffering and enhance the wellbeing of the mothers and the family. The need for research to generate insights on the nature and impact of PPD on women's life is therefore of crucial importance. A deeper understanding of the phenomenon could be useful in increasing awareness among the public and the professionals on PDD and its impact.

1.5 Objectives

The objective of the current study was to improve the understanding of the nature of postpartum depression and its impacts on women's life in Bangladesh. For better understanding, the researcher broke down the main objective into several specific objectives, which are as follows:

- To explore cognitions associated with PPD;
- To explore emotions associated with PPD;
- To explore behaviors associated with PPD;
- To explore physiological states associated with PPD;
- To explore the impact of PPD on women's life;
- To explore the impact of PPD on family members;
- To explore the impact of PPD on social life of the women.

CHAPTAR 2

METHOD

Method

2.1 Research Design

The objective of the present research was to understand the nature and impact of postpartum depression (PPD). Due to limited research and understanding of PPD in Bangladesh context, a qualitative exploration seemed more suitable for attaining the objectives. Qualitative exploration is expected to provide a detailed account on the lived experience as well as the contextual features associated with the women's suffering from PPD.

The phenomenological approach is well suited to grasp the essence of any phenomenon from the lived experience of the participants. The present research is also aimed at exploring women's lived experience of PDD to gain a deeper understanding of PPD in Bangladesh. Therefore, phenomenological approach was selected for the present research. The phenomenological exploration is expected to generate insight regarding women's understanding and experiences of PPD in the context of motherhood, relationship and self-perception.

2.2 Participants

Postpartum women attending maternity unit in a hospital at Dhaka city participated in this study. The inclusion and exclusion criteria used for the selection of suitable participants among the women are presented below.

2.2.1 Inclusion criteria.

- A score above 13 in the Edinburgh Postnatal Depression Scale (Cox et al., 1987).
- Depressive symptoms after four weeks to one year of childbirth were the participants for the present study.
- Persistence of symptoms for at least two weeks at a stretch.

2.2.2 Exclusion criteria.

- Age below 18
- Lack of insight.
- Being intoxicated with drug.
- Inability to communicate or to understand communication.
- Sought care from any healthcare professional for current phase of depression.
- Prior history of depression.

2.2.3 Participant characteristics.

Ten participants were interviewed for the present study. Their age range was between 20 to 36 years. Their socio-economic status ranged from lower to upper class. All of them were literate, married and were occupied either as housewife or as professional. Most of the participants were urban residents, while a couple of them were living in rural or semi-urban areas. Details on the demographic characteristics of the participants are

presented in Table 2.1. Participants were selected from Maternal and Child Health Training Institute, Azimpur, Dhaka.

Table 2.1. *Details of the participants (N=10)*

Participant	Age	Education	Occupation now (Occupation before)	Age of recent child	Socio-economic status
Participant 1	23	HSC	Student	6 months	Middle class
Participant 2	25	Graduate	Student	10 months	Middle class
Participant 3	36	Class 5	Housewife	2 months	Lower class
Participant 4	33	Masters	Housewife (Job)	8 months	Upper middle class
Participant 5	20	SSC	housewife	2 months	Middle class
Participant 6	28	MBA	Housewife (Teacher)	9 months	Middle class
Participant 7	34	Masters	Housewife (Job)	11 months	Middle class
Participant 8	22	HSC	Housewife	11 months	Upper class
Participant 9	24	Graduate	Housewife	4 months	Middle class
Participant 10	32	Masters	Job	10 months	Middle class

2.3 Sampling

Purposive sampling was used for this study. Due to the research's focus on exploration of the nature and impact of postpartum depression, which mandated the recruitment of a specific population i.e., women with postpartum depression, purposive sampling was more suitable than random sampling (K. Williamson, 2002). To ensure maximum variation of the participants, the researcher tried to recruit mothers of different age, education, income, and residential location.

Only those mothers who have postpartum depression were invited to participate in this study. Identification for postpartum depression was made primarily by screening done with a score of 13 on the Edinburgh Postnatal Depression Scale, which was then followed by a diagnostic interview by the researcher. It may be noted here that the researcher had relevant clinical training and practical experience on psychological assessment and diagnosis of mental health conditions using DSM-5 (American Psychiatric Association, 2013).

In line with the tradition of qualitative exploratory research, theoretical sampling and saturation were used to decide the number of interviews to be conducted.

2.3.1 Theoretical sampling. As per the process of theoretical sampling, selection for new participants was made based on evolving themes and hypotheses emerging from the simultaneous data collection and analysis process used in the present study.

2.3.2 Saturation. The researcher continued to interview participants as long as newer information was coming out of the interview. When the interviews reached a point where apparently no new insights were being provided by the participants as reflected by little variation with already gathered data, it is believed a saturation has been reached. No more interview was deemed required when saturation was reached. In this research, the researcher reached the saturation point after interviewing ten participants.

2.4 Data Collection Method

In-depth interview (IDI) along with informal observation was used as the data collection method for the present study.

2.4.1 In-depth interview (IDI). In-depth interview was the main source of data. The researcher conducted in-depth interview using a custom build topic guide suitable for the present research. Questions were mostly open-ended with necessary probes for gaining a deeper understanding.

2.4.2 Observation. The researcher also observed participants' verbal and nonverbal responses and kept memo notes on these observations to aid data analysis which was carried out later.

2.5 Instruments

Interview topic guide, demographic data sheet, explanatory statement form, written consent form, Edinburgh Postnatal Depression Scale (Cox et al., 1987) and voice recorder were used for the present research.

2.5.1 Topic guide. Before data collection, a topic guide was prepared following the objectives of the study (see Appendix A). Initially, the topic guide was developed through brainstorming and mind mapping. It went through several modifications during discussions and role-plays between researcher and supervisor. The revised topic guide was then used for the interview with the first participant. The topic guide contained different exploratory questions to carry out in-depth information from the participants.

2.5.2 Demographic data form. A demographic data form was prepared to collect socio-demographic details of the participant. It contained questions to collect information on age, academic background, occupation, socio-economic status, residence, number of children, and age of the most recent child (see Appendix B).

2.5.3 Explanatory statement form. An explanatory statement form was prepared before starting data collection. The explanatory statement form contained a detailed description of the study, an explanation of its risk and benefits, confidentiality issues, storage of data and the statement that participant can withdraw their consent any time during the research. A written Explanatory statement form was provided to the participants along with verbal explanations before seeking their consent (see Appendix C).

2.5.4 Informed consent form. An informed consent form was used and given to the participant before the interview (see Appendix D). The consent form contained statements and options for participants regarding the understood and voluntary nature of their participation. Participants gave their consent verbally (for screening) and in signed written form (for interview).

2.5.5 Edinburgh Postnatal Depression Scale (Cox et al., 1987). The Bangla translated version (Gausia et al., 2007) of the EPDS (Cox et al., 1987) was used to screen for postpartum depression (see Appendix F). The EPDS (Cox et al., 1987) is a self-report questionnaire with ten statements for assessing depressive symptoms during the postnatal period. Each statement has four possible responses, which are scored from 0 to 3 depending on the severity of the response. With higher scores indicating more severe problems, the maximum total score can be 30. A cutoff score of 13 is used where, any score above 13 on the scale is considered indicative of presence of postpartum depression.

2.5.6 Voice recorder. In the present study, a digital voice recorder (Sony ICD UX-533F) was used for recording the interviews. Later on, all the interviews were transcribed in textual data.

2.5.7 Referral directory. A list of possible sources of support i.e., a referral directory, was provided to the participants (see Appendix G). The referral directory contained the contact details of available and reliable mental health service proving organizations. As participants had depressive symptoms, therefore referral directory was aimed to help them find sources of psychological support to improve their condition and wellbeing.

2.6 Data Collection Procedure

All Participants of the current study were selected from Maternal and Child Health Training Institute, Azimpur, Dhaka and the necessary permission (see Appendix J) was taken from the hospital before data collection. Participants were selected purposively from the hospital using the inclusion and exclusion criteria. At first, participants were approached and verbally explained the purpose and details of the study. All of the participants were given an exploratory statement form. Participants who provided verbal consent for screening were administered the Edinburgh Postnatal Depression Scale for postpartum depression. One hundred and twenty-seven participants filled up the scale and who scored above 13 was considered as having depressive symptoms and they were asked for further in-depth interviews. Few participants refused to give further interviews due to their personal issues. A written consent form was signed by the participants, who agreed for further in-depth interviews. Demographic information of the participants was noted in the demographic information form. The schedule for the interview was set according to the convenience of the participant. Face to face interviews were conducted with all participants. Ten in-depth interviews were conducted following the topic guide. After the interview, a referral directory was provided to the participants. The researcher recorded all interviews with the participants. Both audio recorders and written notes were used to

record information from the participants. The collected data was transcribed later for analysis. The data collection procedure is presented in the flowchart (see figure 2.1).

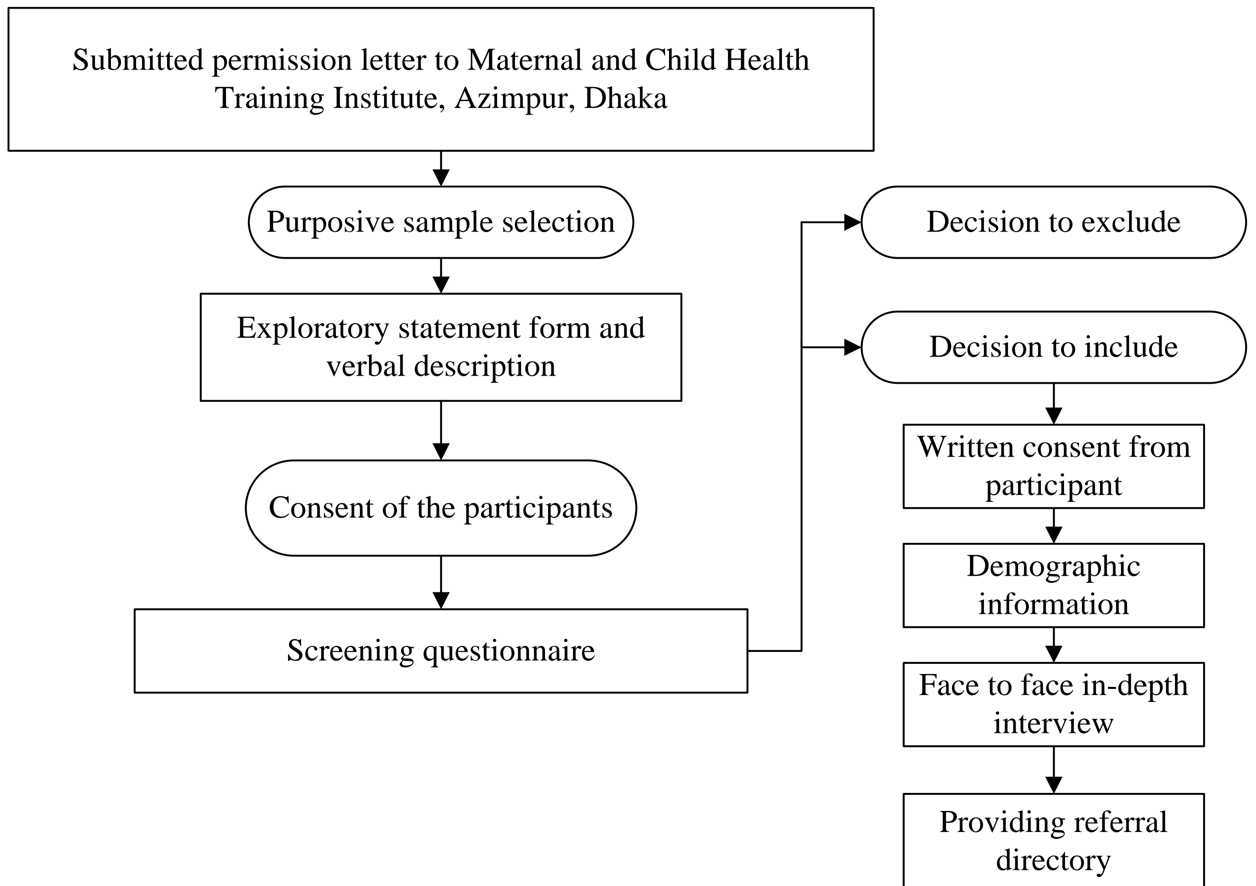

Figure 2.1. Flowchart on data collection procedure.

2.7 Time Frame

Data for the current study were collected from June, 2018 to December 2020.

2.8 Data Analysis Procedure

Data collection and analysis were done simultaneously in the current research. Data were transcribed verbatim from the recorded audio. The Nvivo 10 (QSR International, 2012) software was used to analyze the collected data. The researcher categorized the

initial coding based on similarities. Finally, the researcher formulated some major themes according to the participants meaning. The process of data collection has been detailed out in the following sections.

2.8.1 Transcription. After the interview, recorded data were transcribed verbatim. Transcriptions were done by the researcher and research assistant. The transcription done by the research assistant was thoroughly checked with the original audio by the researcher. All transcription was done in Bangla, which was the original language used in the interviews.

2.8.2 Memo writing. The researcher wrote down significant information as memo notes which helped to understand and gain insight into the data. The memos were noted during the interviews and data analysis.

2.8.3 Data coding. From the transcribed data, the researcher used two levels of data coding, namely open coding and axial coding, which are described below.

***2.8.3.1 Open coding*.** Open coding was done through reading transcribed interviews line by line and assigning codes based on apparent content. In the process of open coding, the researcher tried to break down the data into small meaningful units and identify the core theme that is presented in these units. Then for each unit, code names that reflected the essence of the participants' words were used.

***2.8.3.2 Axial coding*.** After completing open coding, axial coding was done. In axial coding, the researcher began to group the codes into code names and then code names into categories systematically. The researcher examined the categories in terms of characteristics. The researcher attempted to recognize the connection between categories,

generate themes and sub-themes relating to these connections and form broad categories. The theoretical framework continued to grow and become more comprehensive as the categories were identified and defined.

2.9 Ethical Considerations

The present research explored the nature and impact of postpartum depression on women's life. The participating women shared their very personal information. Therefore, it was important to strictly maintain the ethical standards for protecting the safety, rights, self-respect and wellbeing of the research participant. The researcher complied with the principles of human research ethics. The research was approved by the ethics committee of the Department of Clinical Psychology, the University of Dhaka on May 2018 bearing project number MP180501 (see appendix G). As the researcher could not complete the data collection within time, extended approvals till December 2020 was provided by the ethics committee (see appendix G).

The following sections presents a brief summary of the core ethical aspects addressed in the present study.

2.9.1 Informed consent. The participants were clearly informed about the purpose and procedure of the study as well as the utilization of data so that they can make their voluntary decision regarding taking part in this study or not. Detailed explanatory statements were prepared and provided to the participants, which explained the nature, procedure and impact of the study along with their rights and choices. Interviews began after receiving the verbal and written consent of the participants.

2.9.2 Harms and benefits. Before the conduction of the present research, the putative harms and benefits were thought out. No harm other than emotional discomfort arising from sharing of emotional experiences and memories associated with postpartum depression. It was also understood that such discomfort would be transient, and moreover, this sharing may also help them ventilate pent up feelings and thus might be useful for them. Additionally, they were also provided with a list of services where they can seek support if necessary. The harm (transient distress) was thought to outweigh the benefit of carrying out the study.

The possible harms and benefits were also written in the explanatory statement. The researcher kept vigil about the possible discomfort during the interview and asked the participant whether they experienced any distress. Furthermore, if the participant becomes upset during the interview, the researcher was ready to terminate or postpone the interview.

2.9.3 Privacy and confidentiality. Participants shared their very personal information, so it was of utmost importance to maintain privacy and confidentiality. Participants were informed that their privacy and confidentiality would be highly maintained. Interviews were recorded in a secure place. Recordings and transcripts were kept on the researcher's personal computer, which was secured. Personal information identity details of the participants were not recorded. A code number was used to recognize the data, which was only identifiable for the researcher.

2.9.4 Flexibility to withdrawal. The voluntary choice was given priority throughout the research process. Each participant was informed that they could withdraw their participation at any time during the interview if they wished for.

2.9.5 Participants' right to know the findings. Participants have the right to know about the findings of the research. In the initial stage, the score of Postpartum depression and the interpretation of the score was informed to the participant. Email and phone number of the researcher were given to the participant so that they can enquire to know the findings once the study is completed.

CHAPTAR 3

FINDINGS

Findings

The result of this study explains the nature and impact of postpartum depression on woman's life. From each transcribed data, the researcher tried to explore the context, emotional state, cognitive process, behavior, their impact, similarities, dissimilarity and connection. The data analysis procedure has described in the methodology section. Qualitative data analysis software NVivo-10 was used to analyze ten transcribed data from in-depth interviews. From the analysis, seven broad categories have emerged, and these were termed as emotional state, cognitive process, behavior and action, coping, physiological state, impact on relations and impact on self. These broad categories contained themes and sub-themes. The findings of the present study have been presented in Figure 3.1.

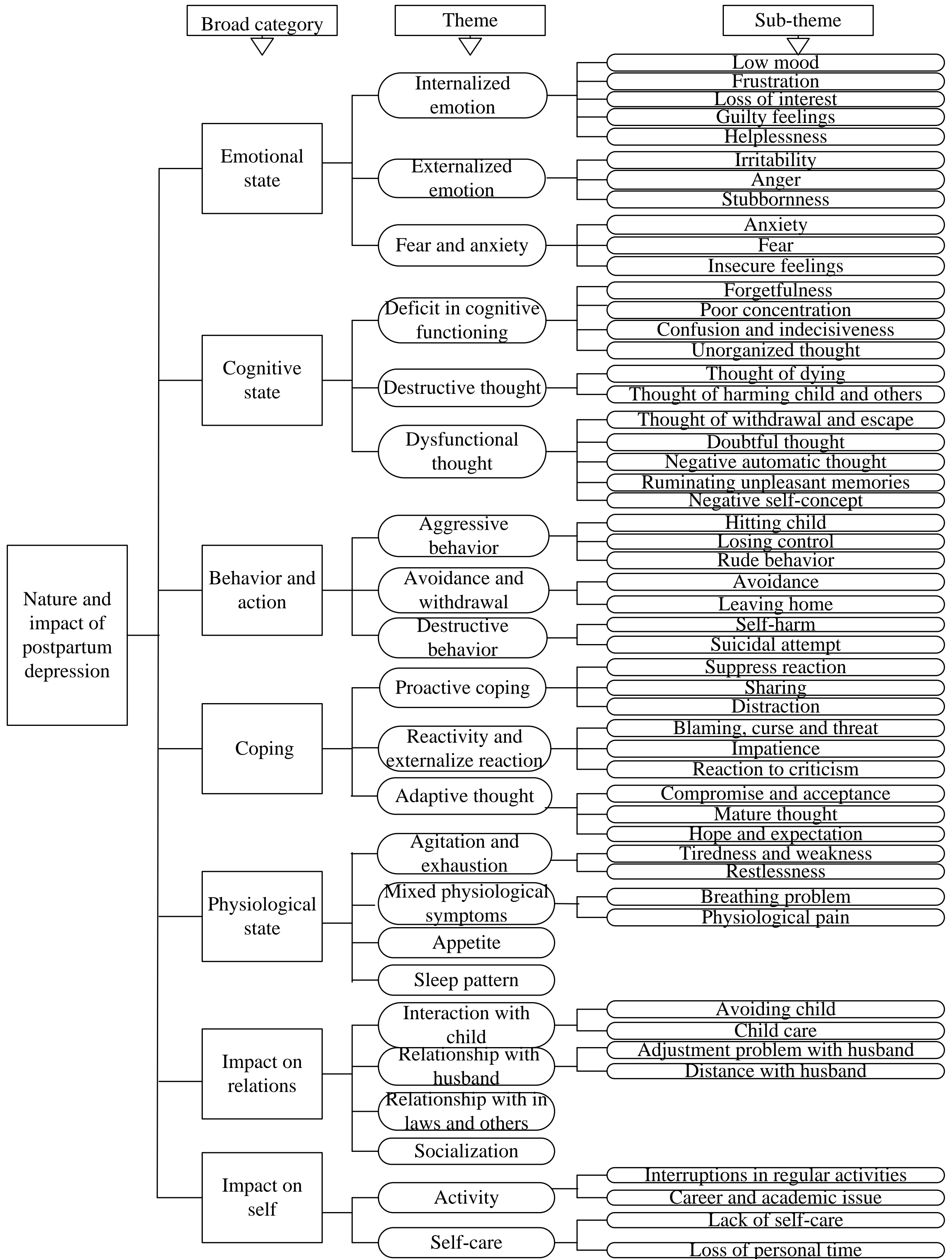

Figure 3.1. Summary of the overall findings

3.1 Emotional State

It was found that participants experienced different types of emotions throughout their postpartum period. It was found that behavior and activities of the participants were influenced by their emotions, and emotions were connected with their cognitive state. Three themes comprised this broad category, which were internalized emotion, externalized emotion and fear and anxiety. Each of these themes included emotions in several sub-themes (see Figure 3.2). The following section presents a brief summary of the themes and sub-themes related to the emotional state category.

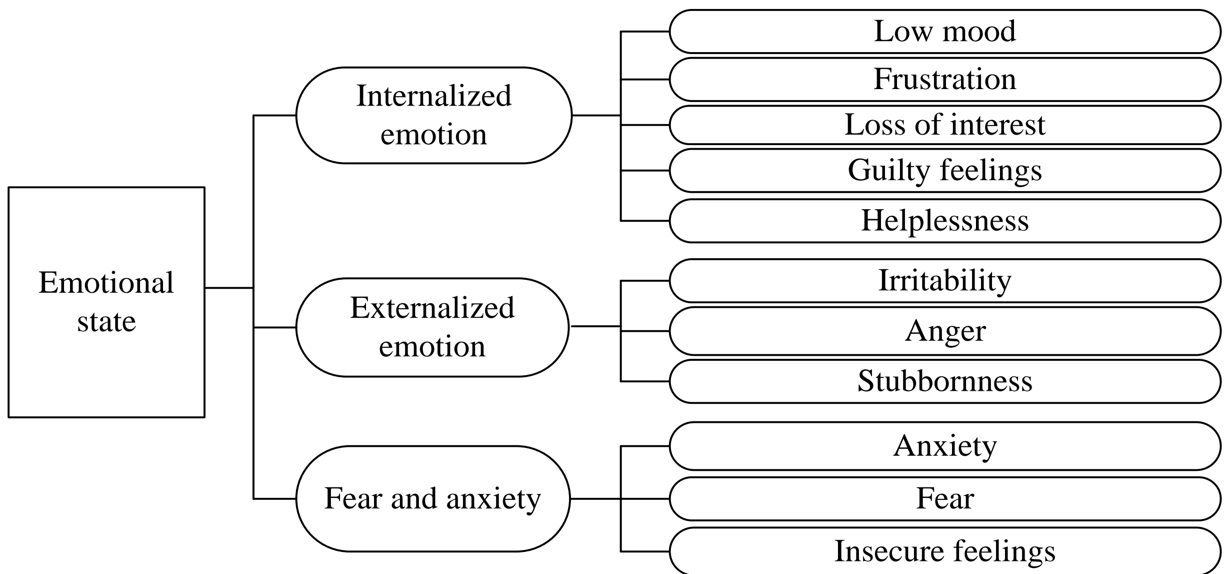

Figure 3.2. The themes and sub-themes related to emotional state.

3.1.1 Internalized emotion. Different types of emotional states were found among the participants. Depressed mood, hopelessness, guilty feelings etc., were the most common internalized emotions found among most of the participants. Five sub-themes named Low mood, Frustration, Guilty feelings, Loss of interest and Helpless comprised this theme.

3.1.1.1 Low mood. Low mood was commonly found among all the mothers with postpartum depression. Most of the time they felt upset, tearful and empty; they perceived themselves as lonely and helpless. Sometimes their sadness made them numb. Some of the participants complained that their life become hopeless and monotonous due to their sadness. Participants expressed themselves as,

> *'I don't feel good, I can't bear it anymore; sometimes I stay alone in the rooftop and cry about my life. I questioned myself that why I can't accept the changes in life."*

> *"All of a sudden, I feel very depressed without any reason, I become tearful. Day by day I'm being more depressed after my delivery. I want to get rid of this sadness."*

3.1.1.2 Frustration. Frustration was a common component found among most of the mothers. Seven participants reported that they were very frustrated about their life, career, academic issues, activity, relationship etc. It was found that they could not manage their life according to their expectation; they could not control themselves and were feeling hopeless. They wanted to escape from life, some wanted to commit suicide due to frustration. A participant expressed as,

> *"I can't do anything; From regular activities to responsibilities, I failed to manage everything. I feel very frustrated with breastfeeding my baby, it's very irritating. I have lost control over myself. I'm a failure; I feel very frustrated."*

3.1.1.3 Loss of interest. Seven participants expressed that they were drowning in depression and losing their interest in everything. They did not find any interest in doing

their daily activities such as household chores, managing baby and maintaining responsivities for husbands and relatives. They also lost their interest in academic activities, career and self-care. Some were not interested in communicating with friends and relatives. Even some participants reported to lost interest in doing sexual activities. A participant stated as,

> *"I don't find any interest in doing anything; most of the time I stay on the bed or sit somewhere. I have no interest in work, I feel very upset. Even I don't like to feed my baby. I don't like to do household chores and don't have interest in cooking. Sometimes I push myself of doing this. I'm not lazy, but I'm helpless."*

***3.1.1.4 Guilty feelings*.** Guilty feelings were commonly found among most (eight) of the mothers. Most of the participants were unable to work efficiently like before, they had difficulties with managing child, household chores, career and academic issues and fulfilling responsibilities with husband and other relatives, therefore they feel guilty. Some participants were unable to control their anger; they shouted or misbehaved with others, sometimes they hit their child, these made them feel guilty. A participant articulated as,

> *"I can't take proper care of my baby; I don't spend that much time with him (baby). I've less connection with him (baby) compared to other mothers. Sometimes I hit him (baby), I feel so guilty that what I'm doing."*

3.1.1.5 Helplessness. Some participants expressed their helplessness. It was found that they had some wish, responsibilities, goals and expectations, but due to depression, they were incapable of performing according to their expectation, it made them helpless. They wanted to manage their child and family properly, achieve career and academic goals; wish to spend quality time with husband and child, but it was difficult for them to

manage due to their low mood and they did not know how to manage. They felt like they are captive and trapped. A participant shared the following,

> *"I feel like I'm the most helpless human in this world. I feel like I'm captive by my depression; it seems that I'm in a prison after the delivery of my baby. I don't have any rest, I don't have time for recreation and self-care, I can't go for traveling. I have gap in physical relation with my husband. I feel that I will turn into a robot for all these and I will lose all my feelings."*

3.1.2 Externalized emotion. Anger, stubbornness, etc., were the most common externalized emotions found among most of the participants. Some mothers could express their externalized emotions throughout their behavior, and some could not. This theme consisted of three sub-themes, namely, irritability, anger and stubbornness and they are described in the following section.

3.1.2.1 Irritability. Irritability was commonly found among all of the participants. It was expressed by the mothers that they got easily irritated with very insignificant issues. When anything happened unexpectedly, if anyone said anything negative, when they felt difficulties with any task such as managing the baby or doing household chores, they became irritated. Sometimes they became very impatient and could not tolerate people; they form reactions or avoid people and situations due to irritability. A participant expressed as,

> *"Most of the time I feel very tired and irritated, especially when I wake up in the morning. I can't sleep properly at night as I have to wake up frequently to feed my baby, to clean his toilet and change diaper. Then I have to wake up early morning, I feel very exhausted and irritated, but I have nothing to do expect doing work. I*

don't know how others manage their child, I can't tolerate anymore, I'm very fed up."

3.1.2.2 Anger. Anger was one of the most common emotions and nine of the participants expressed their anger. It was found that due to anger, they became intolerant to people and situations. Sometimes they showed aggressive behaviors such as using abusive words, shouting, hitting etc., towards self and others. Their anger was caused by their exhaustion, irritability, agitation, uncontrollable negative thoughts and unexpected situations. A participant shared that,

"Maximum time I become angry with my husband and child. If my husband was late to call me, I feel anger. I was not like this before; I don't get angry like this before. I know he (husband) might be busy, but still I feel anger; it seems that he doesn't love me anymore. Everything has become changed after becoming mother."

Another mother expressed as,

"When I feel difficulties in putting my baby to sleep, I feel so angry that sometimes, I hit him. I know that he is a little kid, but I can't control my anger……..When I try to study, he (baby) disturbs me, he destroys my book, it makes me very angry."

3.1.2.3 Stubbornness. Participants of the current study shared about their stubbornness. Participants reported that they became more stubborn than before. They described that they became more impatient and cannot wait for anything. When their needs and expectations were not fulfilled, they became more stubborn and angry.

"Sometimes I became very stubborn that I don't listen to anyone. Though I know I'm wrong and they are right but I don't accept others words or opinion. Sometimes I became so stubborn that they have to accept whatever I say or want, otherwise I refuse to eat and refuse to do anything."

3.1.3 Fear and anxiety. It was found that some participants were very anxious. They developed worry, fear and insecurity about their life. They were tensed about their future. Their fear and anxiety were associated with their negative thoughts. This theme is constituted with three sub-themes, namely, anxiety, fear and insecure feelings.

***3.1.3.1 Anxiety*.** Some participants shared their worries and anxieties. They reported that their life became stressful after having the baby. They had to manage their child, family, career and academic issue simultaneously, and it was stressful for them to manage; they were so worried and tensed that how they would manage all these. They were also worried and tensed about their future. Most of the time they remained worried and tensed, which made them restless, suffocated and agitated. A participant expressed as,

"*I become very tensed and worried with unimportant issues. For example, if my baby suffered from cold, a plenty of negative thoughts come into my mind, I became very anxious and worried, I feel suffocated, can't talk and sleep; whole day I became tensed and negative thoughts run through my head."*

3.1.3.2 Fear. It was found that some participants developed fear about uncertainty, they thought that something wrong was going to happen. They could not sleep and stay alone due to fear.

"…….. I become very fearful, can't breathe properly, it seems that I'm dying. I'm scared all the time. I can't stay alone; I can't sleep alone."

3.1.3.3 Insecure feelings. Some participants reported that they feel insecure. Their insecure feelings came from their negative thoughts.

> *"When I go for sleep at night, I feel very lonely, I feel like crying. It seems to me that no one is beside me, no one loves me like before. I feel very insecure, no one is there to save me."*

3.2 Cognitive State

Mothers with postpartum depression presented a range of cognitive aspects, some of which are common across the respondents while some others were contrasting across them. They have reported changes in their thoughts and cognition after childbirth. Three themes comprised this broad category of cognitive state, which were deficit in cognitive processing, destructive thought and dysfunctional thought. Each theme has been divided into some sub- themes. The summary of cognitive state with its themes and sub-themes are as follows (see Figure 3.3).

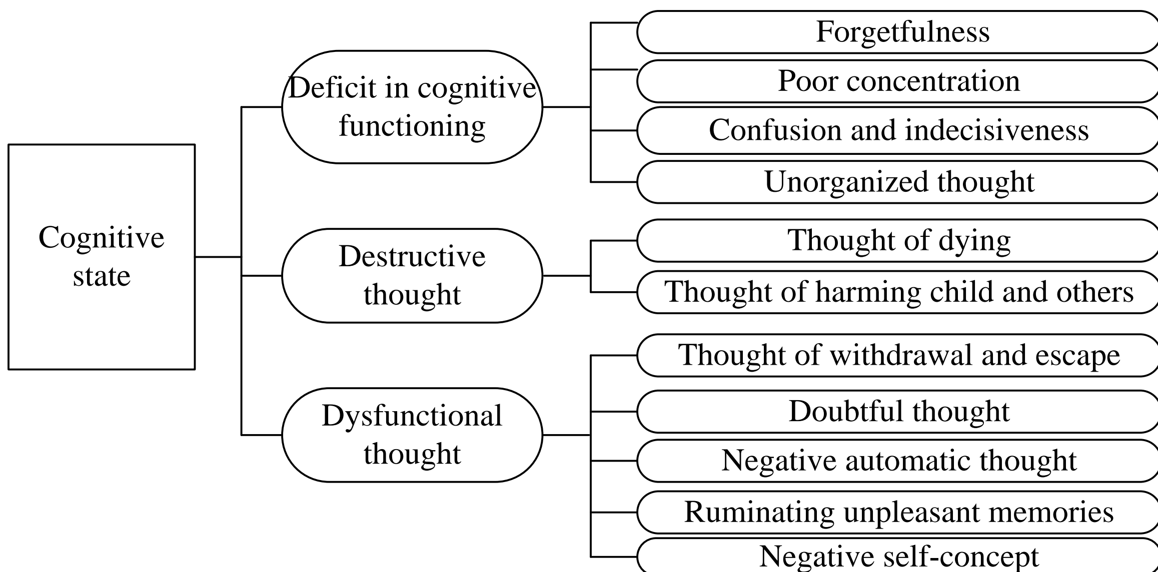

Figure 3.3. The themes and sub-themes related to cognitive state.

3.2.1 Deficit in cognitive processing. Some participants complained that they developed difficulties with memory and concentration. They forgot most of the time and could not concentrate properly. Some participants reported that they could not think clearly like before. Most of the time, they were confused, could not make decision properly and their thoughts were disorganized. Four sub-themes that constituted this theme were forgetfulness, poor concentration, confusion and indecisiveness and unorganized thought.

3.2.1.1 Forgetfulness. Some participants have reported about their forgetfulness. Participants shared that they forgot important tasks and thus find it difficult to manage personal and professional activities. A participant complaint that,

> *"I feel low and forget most of the things. I used to forget what I'm going to do. When I cook, sometimes I forget to add salt, sometimes I forget to add spice in curry. I don't have any interest in cooking like before."*

3.2.1.2 Poor concentration. Some mothers developed concentration problems after their childbirth. Participants shared that they had difficulties in paying attention and could not concentrate properly. A participant expressed as,

> *"I used to write dairy and like to read books, but after my delivery gradually I can't concentrate in reading or writing. Sometimes I try to write, but can't pay attention anymore."*

3.2.1.3 Confusion and indecisiveness. Some mothers were very confused at doing anything, they could not decide what to do or not to do. Participants reported that they were confused and could not make decision properly. A participant articulated as,

> *"I can't decide that what to do. I always remain confused. In anything and everything I can't understand where to go and what to do."*

3.2.1.4 Disorganized thought. Some participants perceived their as life stressful and they had lost their capability of thinking in a systematic way. It was stated by the participants that they were gradually losing their sanity. Some participants shared that they could not think properly and their thoughts became disorganized. A participant expressed as,

> *"…… my head (thought) become messy; I can't maintain time. Sometimes I skip my lunch, I can't manage time for having lunch. Most of the time, I have tea in morning, then starve till evening."*

3.2.2 Destructive thought. Destructive thoughts are one of the troubling and alarming thoughts in the current study. Most of the participants described these thoughts as disturbing and uncontrollable. Two sub-themes comprised this theme, and they are, thought of dying and thought of harming child and others. Some participants stated that when they could not manage their emotions such as sadness, anger, hopelessness, they developed destructive thoughts such as harming self and others and also wanted to die.

3.2.2.1 Thought of dying. Participants who were suffering from depression for many days grew to disown themselves. They often experienced recurrent thoughts of dying. Some participants wanted to die to end their sufferings and get rid of their unbearable miserable situations. Some participants expressed that they were very frustrated, depressed and helpless, that they wanted to die or attempt suicide to end their pain and sufferings. A participant stated as,

> *"…… sometimes I feel very depressed, I cut my hand; I have many spots in my hand. I have thought of suicide. Most of the time I have thought of killing myself, I don't want to live."*

3.2.2.2 Thought of harming child and others. Participants described about their thought of harming the child and others as disturbing and horrifying. These thoughts were causing participants to feel fear and guilty. Some participants shared that when they felt anger or depressed, they had thought to hit their child or husband. Sometimes they had thought of killing their child. A participant articulated as,

> *"Sometimes I feel very angry and helpless, I think to kill my child and then myself. He (child) cries all the time; I can't sleep or eat properly; I can't study also. I feel very irritated. When I'm alone at home, thought of killing my child comes into my mind."*

3.2.3 Dysfunctional thought. Dysfunctional thoughts are commonly found with the participants of the current study. Because of these dysfunctional and negative thoughts, most of the mother experienced emotional turbulences. Five sub-themes comprised this theme, which were thought of withdrawal and escape, doubtful thought, negative automatic thought, recalling unpleasant memories and negative self-concept.

3.2.3.1 Thought of withdrawal and escape. Six participants reported that they had the thought of withdrawal and escaping. They were so stressed and helpless with their life that they wanted to avoid or tried to escape their works and responsibilities. It was found that they were very tired and frustrated and were unable to manage or cope. This led them thinking of giving up, leaving home and avoiding the child. A participant stated as,

> *"I feel lots of stress and pressure with everything especially study, I don't find any meaning of life; I'm tensed, upset and can't bear it anymore, I want to escape to somewhere; neither I can focus on my study and child, nor I can manage my family. My life has become messy. So, I want to leave everything."*

3.2.3.2 Doubtful thought. Some of the participants reported that they developed doubtful thoughts about their husbands and others. Participants shared that they expected to get support and nurture mostly from their partners and relatives, but were extremely disappointed when they perceived that their partners could not provide them enough care and support they needed. They were doubtful that maybe their husbands do not love them anymore.

> *"I can't tolerate my husband and I have doubt on him. I feel that he doesn't love me and care about me like before; even he doesn't call me ……..when he goes to outside, I become very angry. Everything has been changed after the delivery of my child."*

3.2.3.3 Negative automatic thoughts. Negative thoughts were commonly found among most of the participants. Nine participants reported that their thoughts became more negative. Most of the time, they perceived and interpreted their situation negatively. Some were dissatisfied with their life; some were disappointed with others responses, some had negative predictions about the future. It was found that as a result of negative thoughts, mothers became more emotionally vulnerable. A participant shared as,

> *"No one understand me. They blame me always in everything. I'm burden for all. It would be better if I don't exist in this world. I can't take care of my child, I'm not a good mother"*

Another participant expressed that,

> *"I feel like crying in any insignificant issue. It seems to me that no one is accepting me positively. No one loves me, no one cares about me. I'm alone, no one is with me"*

3.2.3.4 Ruminating unpleasant memories. It was found that most of the participants experienced recurrent negative thoughts and unpleasant memories when they had free time. Five participants were found to ruminate their unpleasant memories. Most of the time, they recalled unpleasant events and could not forget. A participant shared that,

> *"I can't forget painful event easily. If I became hurt a long-time ago, most of the time, it comes to my mind and I quarrel with my husband. I ruminate the pain given from my husband and in-laws in past. I can't forget them; these memories provoke me."*

3.2.3.5 Negative self-concept. It was found that most of the participants had negative self-concept. Some participants perceived themselves as a burden, failure and valueless; some blamed themselves and some had a lack of confidence. Seven participants reported that they have negative self-concepts.

> *"I think that I'm the most worthless person in this world. I'm not capable of doing anything. Whatever I do, I always do mistake. I'm good for nothing."*

> *"I always wanted to become an ideal mother, but I can't manage my child properly, I always suffer from inferiority complex. It seems that I failed to become a good mother, it's my limitation. I can't utilize my intelligence and labor. I'm a complete failure."*

3.3 Behavior and Action

The interview identified several patterns of behavior among the mothers with postpartum depressions. Based on similarity, these behaviors and activities were

categorized into three themes, namely, aggressive behavior, avoidance and withdrawal and destructive behavior. Each of these themes included behavior patterns in several sub-themes (see Figure 3.4). The following section presents a brief summary of the behavior and action with its themes and sub-themes.

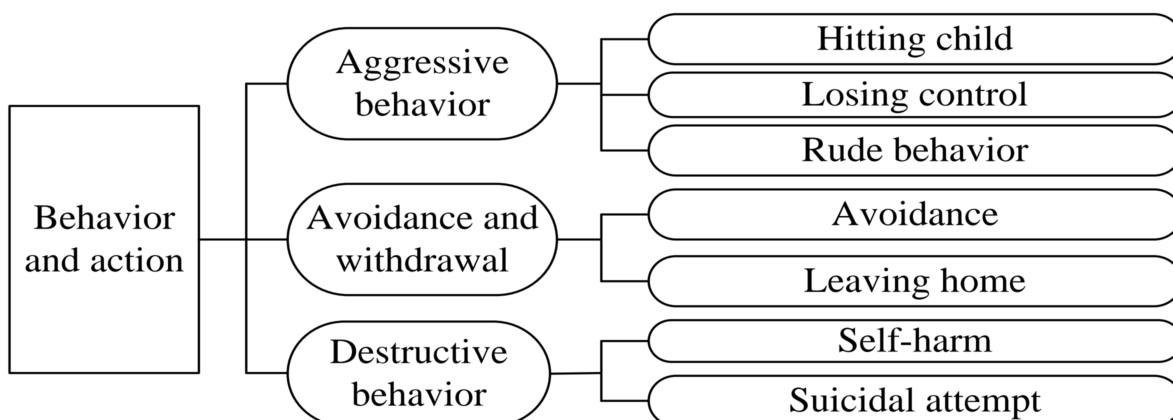

Figure 3.4. The themes and sub-themes related to behavior and action.

3.3.1 Aggressive behavior. Aggressive behavior was commonly found among the participant of the current study. Three sub-themes constituted this theme relating to aggression and related behaviors. Although the sub-themes were very similar and closely linked, they were separated based on the meaning and content.

3.3.1.1 Hitting child. This is commonly found among the mothers with postpartum depression. Most of them (six) mentioned aggression toward the child. The depression and the context created so much distress that the reaction was expressed on the child. All of these mothers also mentioned about subsequent distress they experienced after hitting the child. The following quotation reflects the concern.

> *" .....feel restless, agitated about these issues. My baby is very little – [I often react] and beat him. Later I break into tear. I lose control these days."*

3.3.1.2 Losing control. Some participants reported that they wanted to control their aggressive behavior and activity, but were unable to control themselves. They did not want to express aggression towards self and others and wanted to perform their activities according to their plan, but failed to manage. A participant expressed herself as,

> *"Sometimes I became so irritated that I shout towards my mother and husband, though I know that it's unnecessary, but cannot control myself."*

3.3.1.3 Rude behavior. Behaving rudely was most commonly (nine) reported by the mothers with postpartum depression. They shared that they felt very angry, irritated and stressed and therefore showed rude behave such as shouting, using abusive words, hitting others, and troughing and breaking things. However, they became more distressed about their erratic outburst. A participant reflects her state as,

> *"When I became irritated and angry, I use abusive words and then become surprised that how could I use those slang."*

3.3.2 Avoidance and withdrawal. From the response of the participants, it was found that some participants avoid their child, friends and relatives, withdrawal themselves from different activities. An in-depth look at the content reflected two sub-themes under avoidance and withdrawal, which are discussed below.

3.3.2.1 Avoiding people. Most of the participants of the current study were feeling very down, and they do not like to communicate with others. Therefore, they created distance from people. Some participants reported that they used to avoid people and situations when they became distressed. A participant expressed that,

"When I feel sad, I don't to talk with anyone, I don't like to talk. And when I became hurt or angry by someone's words, I don't talk to him."

Another participant shared that,

"I have made too much distance with him (baby) that now I don't feel anything for him. .... I don't want to have stress for him (baby)."

3.3.2.2 Leaving home. Most of the mothers reported that they felt so much distress that they had thought of leaving home, and some of them actually left their home. Some participants reported that they left home when they became angry or upset.

"I become upset when I feel trouble with my husband, sometimes I leave home with my baby suddenly."

3.3.3 Destructive behavior. Sometimes mothers became very depressed and angry that they harmed themselves and thought of attempting suicide. There are two subthemes under this destructive behavior theme, namely, self-harm and suicidal attempt.

3.3.3.1 Self-harm. Self- harm is one of the most alarming aspects found among some participants. Four participants reported that when they could not control their emotions, sometimes they cut their hands or other parts of the body and pulled off their hair. Most of them reported that they did not have any history of self-harm prior to childbirth. The following quotation reflects the experience of self-ham of a mother.

"..... that day I became very angry and cut my hand as I couldn't express myself. Sometimes I pull off my hair when I become angry and irritated."

"I work for whole day after awaking whole night. No one think about me, no one care about me. Then I become more angry and stubborn and I want to kill the father of my child. When I can't express myself, I cut my hand out of anger."

3.3.3.2 Suicidal attempt. Some participants who were suffering from depression for a long time after childbirth experienced suicidal thoughts. Some were very disappointed about their life and perceived themselves as trapped in the situation, and they thought that killing themselves was the only way to get relief from their misery. Some mothers shared that they attempted to suicide several times when they became sad, frustrated or hopeless as a result of their postpartum depression.

"Often, I want to attempt suicide. Not once, I tried several times."

3.4 Coping

Despite the uncontrolled emotions, most of the mothers wanted to manage their unwanted thoughts, feelings and behavior. They tried different coping strategies to feel better. These coping strategies fall under three themes, namely proactive coping, reactivity and externalize reaction and adaptive thought, which are presented in the following section with sub-themes (see Figure 3.5).

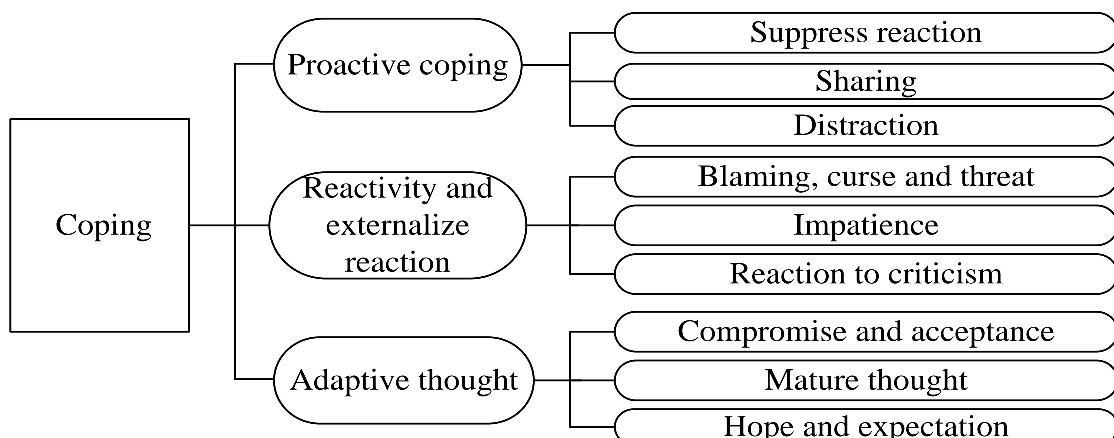

Figure 3.5. The themes and sub-themes related to coping.

3.4.1 Proactive coping. It was found that some of the participants were actively working out to feel better. They tried different approaches to overcome depression and its impact. Proactive coping consisted of three sub-themes are as following,

***3.4.1.1 Suppress reaction*.** It was found that most of the participants experienced anger and sadness, but some participants tried to control their reactions to have peace. Six participants reported that they had difficulties with expressing their feelings and some tried to hide their emotions. They shared as,

> *"I don't react and don't show that I have anger and pain. Try to talk normally or talk with smile."*

3.4.1.2 Sharing. Some participants expressed that they felt relief sometimes when they shared their sorrows, sufferings and problems with others. They tried to share their issues with their partner, friends or close ones. Some participants reported that they often shared their problems with their near ones to reduce their distress. A participant articulated

> *"I try to type (text) message or write dairy or try to distract my mind with pleasant activity, but I fail most of the time. Then I share every detail with my parents to feel better."*

3.4.1.3 Distraction and engagement. To reduce distress and to feel better, some participants tried to do different activities. Six participants shared that they tried to divert mind from negative feelings and attempted to engage in pleasurable activities when they felt distressed. A participant verbalized as,

> *"Whatever I feel, happy or sad, I watch funny videos in YouTube. I try to manage myself. If I feel upset, still try to study yet again."*

3.4.2 Reactivity and externalize reaction. Some participants shared that they became more impatient and reactive after becoming a mother. They expressed that when they became sad or angry, they showed reactions towards others. Under this theme, three sub-themes emerged, they are,

3.4.2.1 Blaming, curse and threat. It was found that some participants did not want to take responsibility for negative consequences. As they were already in distress, they felt relief by blaming, giving curses and threats to others. Some participants shared that they used to blame others in any problematic situation. They also gave curses and threats when they were in distress. A participant stated as,

> *"When I'm surrounded with other people and if my child got wounded in front of them, I blame others instead of myself for not being careful, as I'm the mother of the child, it's my responsibility to take care of my baby, but often I blame others."*

Another participant shared,

> *"When I become frustrated and irritated, I give curse to my child that she would die, so that I can live a good life alone."*

3.4.2.2 Impatience. Some participants shared that they became more impatient after childbirth. They easily got frustrated, irritated and angry, even could not tolerate any minor problem, they became restless. Some participants reported their impatience. A participant uttered as,

> *"He is a little child, but irritated a lot, I can't tolerate, I lose my patience."*

3.4.2.3 Reaction to criticism. Some participants reported that they could not tolerate any comment and criticism after childbirth. Five participants shared that they became more reactive, could not bear criticism and protested if anyone complained or said anything negative. A participant articulated as,

> *"When anyone complaint or say anything negative about my child or my parenting, such as my child is unhealthy, I should be more careful or give advice, I couldn't tolerate, I do react and protest. I became changed and it seems like I'm a different human."*

3.4.3 Adaptive thought. Though most participant shared about their negative feelings and experiences, a few participants shared that they tried to practice some positive and adaptive thoughts as well. It was found that some participants tried to think positively to overcome their suffering. It was comprised of three sub-themes, namely compromise and acceptance, mature thought and hope, and expectation.

3.4.3.1 Compromise and acceptance. Compromise and acceptance were uncommon strategies found in a participant to cope with distress. A participant stated that to maintain peace and harmony in her life and in the family, she was compromising and tried to accept her situation. The statement of the participant was as following,

> *"It seems that I'm becoming a more compromising person. I'm agreeing to compromise to maintain harmony in my family. I think that as a mother I should create a positive environment for my child. So, for the betterment of my children, I should compromise."*

3.4.3.2 Mature thought. Some participants tried to cope with their situation through mature thoughts. Some participants reported that they became more mature after being a mother. They started thinking in more mature ways and could forgive others for maintaining peace in their life.

> *"I think my thoughts are more mature than before. Now I think I'm in a real world, I was in an abstract world before."*

3.4.3.3 Hope and expectation. Hope and expectations made people joyful. Despite having negative thoughts and feelings, some participants shared their hope, dream and expectation, which make them happy sometimes. A participant shared as,

> *"I expect that I will do something when my child will grow up; I want to be financially independent. ……. I don't want my daughter to become a doctor or engineer, I want her to become a good human being."*

3.5 Physiological State

Mothers were found to have different physiological issues during the postpartum period. It was found that their physiological state was connected with their thoughts and emotions. This broad category was made up of four themes, and which were labeled as, agitation and exhaustion, mixed physiological symptoms, appetite and sleep pattern. All themes were constituted with some sub-themes. The physiological state representing these themes and sub-themes are discussed in the following section (see Figure 3.6).

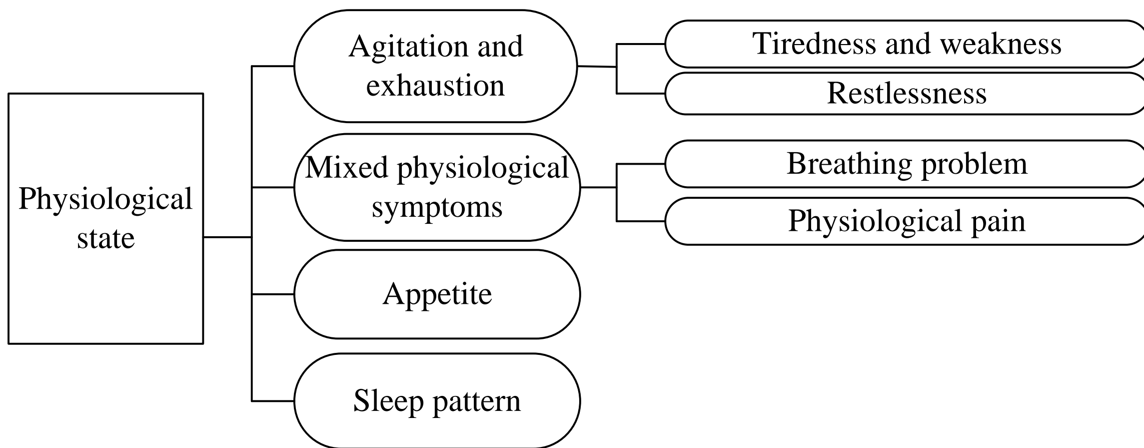

Figure 3.6. The themes and sub-themes related to physiological state.

3.5.1 Agitation and exhaustion. It was found that some mothers felt agitated and exhausted during their postpartum period. They were very weak and tired, which made them drowsy. Some complained about their restlessness. This theme consisted of two sub-themes namely, weakness and tiredness and restlessness.

3.5.1.1 Weakness and tiredness. Weakness and tiredness were found among several (four) mothers with depression. It was found that most of the mothers were so depressed that they could not sleep properly, felt drowsy and weak most of the time. They had to manage household chores and responsibilities associated with the baby, which led them towards tiredness. A participant expressed as,

> *"I feel very tired. I have to work for whole day, after a while I have to feed my baby. It turns out that I have to stay up all night, even I have no scope to sleep at day. …………….. As a whole, I feel very weak."*

3.5.1.2 Restlessness. Some participants complained that sometimes they felt very restless. It was expressed that they became restless when they were anxious and when they felt restless, they had sweat and faster heart rate.

> *"Most of the time I do not feel good, I feel very restless."*

3.5.2 Mixed physiological symptoms. Some participants shared that they developed some physiological symptoms after becoming a mother. They experienced pain in the head and body, dizziness and breathing problems when they were sad, angry or anxious. Mixed physiological symptoms constituted with two sub-themes named breathing problem and physiological pain.

3.5.2.1 Breathing problem. Few participants were found to have breathing problems. Some mothers shared that they had difficulties with breathing when they experienced emotional disturbances such as low mood, fear, anger, tension and stress. A participant shared as,

> *"When I'm become depressed or anxious, I can't breathe, I feel suffocated. It seems like I'm dying. Always I'm scared. I can't stay alone."*

3.5.2.2 Physiological pain. Some participants shared about their physiological pain after childbirth. They reported experiencing occasional headaches and pain in different parts of their body without any physical causes. They observed that their pain became intense when they were in distress.

> *"My mood has become very irritable. I feel headache. I try to find myself."*

3.5.3 Appetite. It was found that mothers experienced changes in their appetite during their postpartum period. Five participants complained that their appetite had become changed after the delivery of the baby. They could not eat like before; their appetite had been decreased. it was found that they could not eat when they were in distress.

> *"Sleep and foods are basic need of human, but when we are deprived from these, it's difficult to survive. I can't eat, I have lost my appetite."*

A participant shared opposite experience regarding increased appetite, she reported that her appetite had been increased.

> *"…………My appetite has been increased and I have gained weight."*

3.5.4 Sleep deprivation. Sleep deprivation was commonly found among most participants. Seven mothers complained that they could not sleep properly, they had to wake up frequently to feed and clean their baby. It was found that some mothers could not sleep due to emotional disturbances and some others due to responsibilities associated with managing their baby. Deprivation of sleep made them feel low and tired. Mothers shared their experiences as,

> *"I'm managing my child alone for ten months and I couldn't sleep for one hour till then. I can't remember that I slept randomly for one hour in these ten months. At night I stay awake with my baby; sometimes he cries for food and sometime he doesn't sleep."*

3.6 Impact on Relations

Mothers who were suffering from postpartum depression experienced different emotional distress, which impacts their life. Most of the mother faced trouble with maintaining the quality of relationships with their husband, baby, in-laws, friends and other relatives. Four themes comprised this broad category, which were impact on child, impact on relationship with husband, impact on relationship with in-laws and others, and impact on socialization (see Figure 3.7). The following section presents a brief summary of the impact on relations.

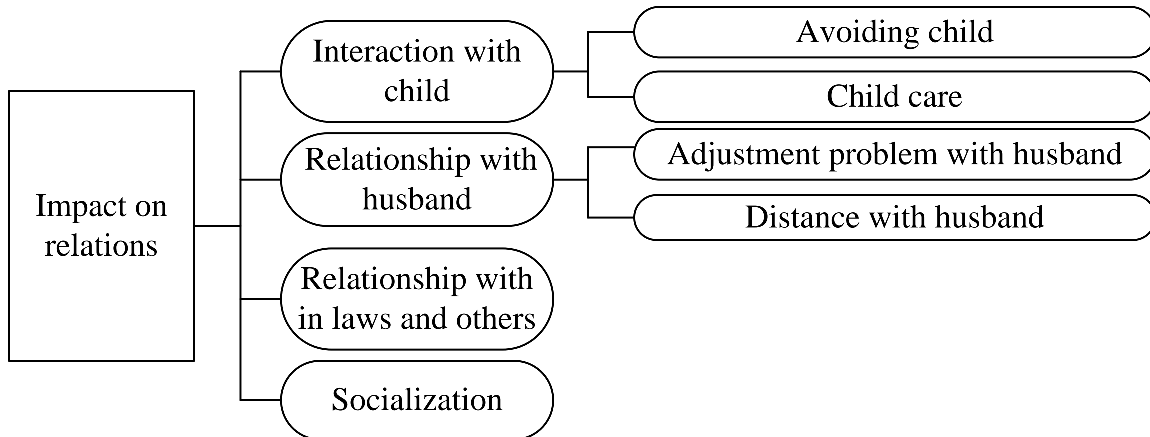

Figure 3.7. The themes and sub-themes related to impact on relations.

3.6.1 Interaction with child. Usually, mother and child share very close bonding, but it was found that due to depression, some mothers could not feel their bond with their baby and they avoid their child. Sometimes despite having positive feelings for the baby, mothers could not take proper care of the baby, they could not manage, some often misbehaved with their child due to their distress. This theme consists of two sub-themes, namely avoiding child and child care. These are presented in the following,

3.6.1.1 Avoiding child. It was found that some mothers were very emotionally disturbed and they could not tolerate their children. Most of the time child wanted to be closed with their mother, but the mother felt irritated and tried to create distance. They did not want to take responsibility of the child; other relatives of the mother took care of the baby. A participant described as,

> *"He (baby) doesn't stay with me all day. I feel very tired after having my classes in university. Rather than feeding him (baby), I don't have any interaction with him (baby). I think he (baby) doesn't love me as well……… when he (baby) comes to me, I hand him over to my brother or mother. I want him (baby) to stay away from me."*

3.6.1.2 Child care. Most of the mothers loved their child and they wanted to take care of the baby, but it was found that due to postpartum depression, mothers could not take proper care of the baby. This resulted in emotional disturbance and poor health among some children. Five of the mothers reported that their child care has been hampered as they could not manage time for the baby and to take care of them in their distress. A participant articulated as,

> *"I feel that I can't take care of my baby according to his need. Sometimes, he feels hungry, but I need rest, so I take rest and feed him later. Very often, he remains dirty with his toilet as I don't feel interest to clean. I don't feel well. Again sometimes, my baby cry for hunger, but I don't want to prepare his food. Sometimes he remains sick as I can't take care of him. His weight is low according to his age as I can't feed him properly."*

3.6.2 Relationship with husband. During the period of postpartum depression, women experienced noticeable emotional distress and negative thought. Due to their distress, they felt very emotionally isolated from their partner. There was a lot of anger, resentment, sadness in the mother which contributed to arise problem in the relationship with their husband. This theme was comprised of two sub-themes, namely adjustment problem with husband and distance with husband.

3.6.2.1 Adjustment problem with husband. Most of the participants (seven) were found to have adjustment problems with their husbands after childbirth. Most of the time, mothers seemed to lose their temperaments and quarreled with their partners on unimportant issues. Some participants were very disappointed with their partner that they wanted to be separated or get divorced from their partner.

> *"I feel that my husband doesn't give me proper attention. We quarrel most of the time. Our relationship has become worse, I don't know why. He doesn't understand me. I can't tolerate him and I can't control myself of being rude."*

3.6.2.2 Distance with husband. Mothers with postpartum depression were emotionally devasted and physically tired, they needed to be supported, appreciated and nurtured. They wanted their partner to understand their pain, support and cooperate them, but most of the time partners failed to fulfil their expectations which led them toward emotional distance with their husband. Some of the participants shared that they did not feel interested in intimate relationship with their partners, which resulted in a gap in sexual relation.

> *"I feel very unhappy that our distance has increased after my childbirth. My husband rarely stays with me, I wanted to be closed with him, but he didn't pay*

attention. I felt ignored, now I don't want him, so we don't have physical and emotional connection like before. I also feel so low and jealous of my child that my husband loves my baby more than me."

3.6.3 Relationship with in-laws and others. It was found that participants developed cold and distant relationships with the in-laws and their family members after childbirth. Women with postpartum depression were emotionally devasted, they did not find interest in communicating and it became difficult for them to behave nicely all the time. They also had negative thoughts about others, which created gaps and adjustment problems with their in-laws and other family members. Some participants reported that they expected supports and care from their in-laws and relatives, but they were always complaining and criticized the mother instead of cooperating, which made the mother more depressed and angrier. Some participants avoid their in-laws and relatives to avoid conflict.

"I have cold relationship with my mother-in-law and her family. I have also distance with my siblings. Our thoughts and perspectives are different, so I made distance with them."

3.6.4 Socialization. It was found that mothers suffering from postpartum depression did not find interest in communicating with others. They were so down in depression that they did not like to attend phone calls and see their friends, neighbors or relatives. Some mothers avoid social programs due to depression. It was found that all of the participants did not like social interaction.

"I don't like to talk with anyone. Sometime it's important to talk, but I don't feel any interest. When my friends or relative call me, I don't receive the call, I just don't want to talk."

3.7 Impact on Self

Mothers with postpartum depression were easily overwhelmed by any smallest chore. It was very difficult for them to manage their personal, professional and regular household chore. Even they did not have interest for self-care. This broad category is constituted of two themes, namely activity and self-care along with several subthemes with these (see Figure 3.8).

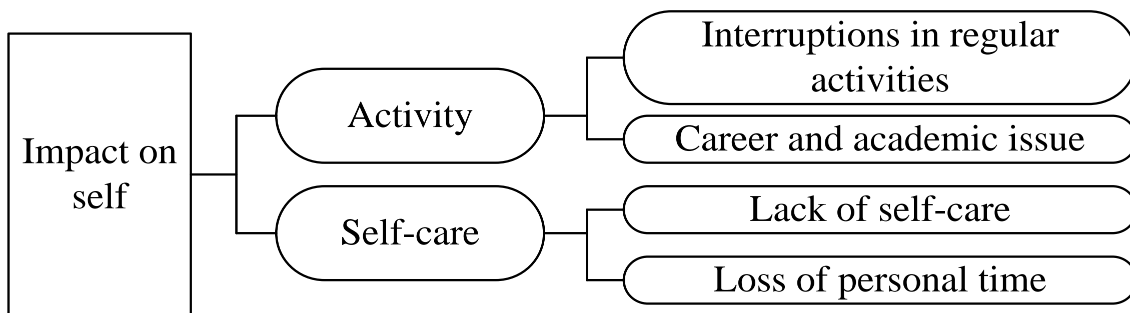

Figure 3.8. The themes and sub-themes related to impact on self.

3.7.1 Activity. It was found that most of the mothers with postpartum depression were unable to function at their usual level. Their personal and professional activities had been hampered due to depression. This theme is formed with two sub-themes, namely, hamper in regular activities and career and academic issue.

3.7.1.1 Interruptions in regular activities. Most of the mothers had to manage their child, husband, household chores and personal activities simultaneously, but it was very challenging to maintain all these for the mother with depression. Six of the mothers

complained that their functional level had decreased after childbirth. They struggled to manage daily household works due to emotional disturbances and lack of energy. It was difficult for them to manage time and everything.

> *"It's being very difficult for me to survive. I don't feel any interest in doing anything. I can't maintain time and manage regular activities. Cooking, cleaning, managing home and taking care of baby has been challenging for me, I don't have any energy. Always I'm late in doing anything."*

3.7.1.2 Career and academic issue. It was found that after childbirth, mothers developed difficulties with managing academic and professional issues. They could not study properly and could not perform in their workplace. Five of the mothers reported that their academic and professional activities had been hampered due to their tiredness and emotional disturbance. Some mothers left their job as it was challenging for them to manage baby, home and professional issues concurrently.

> *"I feel very exhausted and can't work properly. For example, I have attempted to study several times, but couldn't manage. I have lost my control over myself. Sometimes I feel strange about my life. My brain has been disorganized."*

3.7.2 Self-care. Mothers with postpartum depression did not find interest to take care of themselves. Their need for self-care had been decreased after childbirth. They could not manage time and energy to pamper themselves. They did not have any personal time and did not find interest in doing recreational and pleasurable activities. This theme is formed with two sub-themes which are, lack of self-care and loss of personal time.

3.7.2.1 Lack of self-care. It was found that most of the mothers have lost their interest in grooming and nurturing themselves. Some mothers did not maintain their personal hygiene, even they did not wash their face, take showers and brush their teeth regularly. Some mothers complained that they forgot when they last combed their hair. Eight of the mothers reported that they did not have any interest in self-care.

> *"I liked to being presentable before, but now I feel very tired, I don't have any interest. I don't even look into mirror…… I don't wash my face; I found these unnecessary. I'm just passing my life as Robot."*

> *"Sometimes when I see my face, I hate myself; I become very ugly. I can't tolerate myself; I don't like myself. Sometimes I don't brush my teeth, I don't eat properly."*

3.7.2.2 Loss of personal time. It was found that mothers with postpartum depression could not manage any personal time to enjoy. Even if they could hardly manage time, they did not find any interest in doing pleasurable and recreational activities. Six of the mothers stated that they had lost interest or enjoyment in their life. Some mothers shared that they used to watch movies, read books, spend time with social media or friends or travel, but now they did not find interest.

> *"I used to enjoy my life as my requirement. Sometimes I used to read books, watch tv, drama or movie, hang out in outdoor, spend time with friends and can study, but after having baby, I can't manage these; I lost my interest."*

CHAPTAR 4

DISCUSSION

Discussion

The present study was conducted to explore the nature and impact of postpartum depression on women's life in Bangladesh. The findings illustrated that participants experienced changes in their emotions, thoughts, behaviors, and actions because of the transition into motherhood. They were very helpless about their circumstances. Mothers were unaware of the challenges, and adjusting to the new experiences without sufficient practical knowledge became stuck with the crisis. The quality of life of the mothers was hampered due to their postpartum depression. Mothers were dissatisfied with their lives, which created a negative impact on themself, their children, husband, and others family members.

Content analysis of the interview data with postpartum mothers revealed seven broad categories with several themes and sub-themes associated with the nature and impact of postpartum depression. These include emotional state, cognitive process, behavior and action, coping, physiological state, impacts on self and relations. Each category was comprised of multiple themes and sub-themes. Most importantly, the factors were related to each other. A comprehensive discussion of all these aspects is presented in the following section.

4.1 Emotional State

Motherhood is a significant experience for every woman. Despite the joy, some mothers also feel unhappy during their postpartum period. It has been found that there was a various type of emotions experienced by the participants throughout their postpartum period. During the transition into motherhood, there were mixed feelings like sadness, happiness, surprise and worry. Their life had been changed, and it was

very difficult for them to accept the change and cope up with the situation, which made them more emotionally vulnerable. Participants shared about their depressed mood, tearfulness, frustration, guilty feelings, helplessness, hopelessness, anxiety and irritability, which was also reported in other studies by Pitt (1968).

Mothers discovered themselves as lonely and did not have sufficient support from others. Moreover that, they were unable to fulfil their own expectations as well as those from others as a mother. As they could not perform according to their expectations, they perceived themselves as a failure and started to lose meaning in life. They also felt guilty because of their poor functioning, especially when they had difficulties with managing their child. It was found that as they could not perform due to their emotional disturbance; and this failure made them more emotionally vulnerable. Unlike the study of Stewart and Vigod (2016), it was also found in the current study that women with postpartum depression experience emotional impairment such as low mood and loss of interest. Postpartum depression directly impacts the emotional wellbeing of mothers (J. H. Goodman, 2004).

Participants expressed having less control over their emotions. It was found that the greater gap between the pre-birth experience of mothers and the experience of motherhood made them helpless and depressed (Romito, 1990). Similar experiences were also shared by the depressed post-partum mothers in the present study. However, it also raises some questions as similar concerns were also shared by the mothers who were having a baby for the second or third time. Participants also shared that their helplessness and depression was a reaction created by the combination of inability to cope, lack of personal time, fatigue, feeling emotionally unsupported and isolation.

Participants in this study also shared their fear and anxiety. They expressed the fear of losing everything and the unknown threat in the future. They were worried about the negative impact of postpartum depression on their baby, and these feelings are common among mothers with postpartum depression (Chan, Levy, Chung, & Lee, 2002). Mothers with postpartum depression also experience anxiety (Stuart et al., 1998). Mothers found themselves alone and insecure, so they developed worry and felt nervous. Participants had less tolerance for the situation; they became angry easily and showed aggressive behavior towards themselves and others. Most of the time, they were unable to manage their anger. Most of the time, the mothers felt tired and exhausted, which made them intolerant. Mothers expected help, cooperation and emotional support from others, but they were disappointed with the support they received. These made them more irritated, stubborn and angry. Similar experience of anger and irritability among mothers who were suffering from postpartum depression was also found in the study of Vliegen and Luyten (2008). Anger and aggression are considered as vulnerability factors for postpartum mood disorders onset (Bruno et al., 2018).

There are very few qualitative studies on the emotions of women with postpartum depression. As quantitative studies do not explore details of participants' experiences, the researcher could not find that much data to compare and find out similarities and dissimilarities of the outcome. It was found that mass people and family members of the mother are not aware of the emotional vulnerability of the mother; as a result, they failed to understand the emotional suffering of the mother, which led the mother to feel more depressed and helpless.

4.2 Cognitive State

In the journey of motherhood, participants experienced different thoughts and beliefs. Sometimes they had functional thoughts, sometimes dysfunctional. It was found that their thoughts and cognitive impairment were very closely related to depression. Most of the mothers with postpartum depression perceived almost everything in a negative manner. The negative perceptions of motherhood were coming from some specific negative beliefs (Warner, Appleby, Whitton, & Faragher, 1997). Due to their negative and dysfunctional thought and belief, they were very worried and insecure about themselves and their baby. Some studies found both general and maternal-specific negative thoughts and beliefs among mothers with postpartum depression (Church, Brechman-Toussaint, & Hine, 2005; Grazioli & Terry, 2000). Their thoughts and belief made them more emotionally vulnerable, impaired their cognitive functioning and made an impact on their emotion, behavior and action. Participants were not aware that their feelings and behavior was influenced by their thoughts. Mothers with postpartum depression were very helpless as they had trouble with concentration, memory and decision making, their self-confidence became low.

Mothers were unable to manage their misery, so they had thoughts of escape somewhere. Some were very frustrated and found no meaning in life. They thought of their life as a burden and wanted to kill themselves. Some mothers lost their sanity and had thoughts of harming themselves and their children to get relief from their uncontrollable negative thoughts and feelings. Sometimes their thoughts were unorganized and irrational, and they were very confused. They felt messy about what to do and what not to do as they lost their confidence. It was found that these unstable and distressing thoughts contributed to the feeling of losing sanity of the mother with

postpartum depression (C. T. Beck, 1993; Edwards & Timmons, 2005). Some of the mothers wanted to become an ideal mother, but ended up perceiving themselves as a bad mother which made them feel guilty. Similarly, C. T. Beck (1993) also found that mothers with postpartum depression were having thoughts of self-harm, suicidal thoughts and thoughts of harming the baby.

Aggression towards child and thoughts of harming child was found among mothers during their postpartum period (Jennings, Ross, Popper, & Elmore, 1999; Wisner et al., 2002). As mothers were unable to resolve the contradiction between being an ideal mother and the disturbing thoughts of harming the child, so they developed the thought of dying. Mothers also developed guilty feelings, negative self-perception and self-blame for their destructive thoughts. Participants anticipated that their lives would never be normal like before, and they would never be happy again. Negative thoughts among mothers with postpartum depression has also been reported in other studies (O'hara & Swain, 1996).

It was found that mothers who had experienced depression in the postpartum developed dysfunctional thoughts and neuroticism (Jones et al., 2010). Postpartum depression of mothers is triggered and maintained by destructive and dysfunctional thoughts and beliefs. A study by Leigh and Milgrom (2008) also supported that those negative thoughts and beliefs have more of an impact on depressive symptoms during the postpartum period. As mothers were not aware and prepared for the change in their life, it was difficult for them to accept their situation and circumstances. They expected positive changes in their life, but ended up with dissatisfaction. Mothers interpreted all of these experiences in a negative manner and developed negative thoughts and belief about self, others and future, which created emotional vulnerability. As participants

were not aware about that their sufferings were related to their cognition, they could not work on managing their dysfunctional thoughts and belief and their miseries were maintained.

Due to inadequate amount of qualitative research done on this area, a detailed understanding of cognition among mothers with postpartum depression is scarce in the literature. This study would be helpful for the mothers, their family and professional to identify dysfunctional thoughts and beliefs and work on the management.

4.3 Behavior and Action

Depression made significant changes in behavior and action of the mothers during their postpartum period. Most of the time, mothers with depression feel vulnerable, lost, tired and overwhelmed, which affects their behavior and action. They found themselves exhausted and irritated, which led them to a feeling of lost mental peace. Sometimes they were intolerant and sometimes reluctant to respond. It was assumed that their thoughts and emotional turmoil contributed to their behavior and action. When mothers become emotional, they need to control them; avoidances or aggressive outbursts were their way to cope with their emotions. Participants reported losing control over their emotions and actions.

Aggressive behavior such as hitting self, child and others was found among depressive mothers. Sometimes mothers became overwhelmed and hurt themselves, even tried to attempt suicide which was very alarming for the mother, child and others family members. Participants experienced a destructive force that destroyed their sense of self, and they lost control over themselves. After being normal, they felt ashamed and guilt for their unexpected aggressive actions. Loss of control of mothers was very commonly found

in many studies on postpartum depression (C. T. Beck, 1993; Chan et al., 2002; V. Williamson & Mccutcheon, 2007). Mothers were very tired and exhausted with the fact that they did not have control over their feelings and the situation. They felt hopeless and wanted to escape from their distress by trying to avoid their child, work and family members.

4.4 Coping

The emotional, cognitive and behavioral reactions in the women with postpartum depression leads to a sense of disturbance among the women for which they are most often unable to reach out for help especially considering the lack of professional support services in Bangladesh. Participants wanted to feel relief and tried different strategies to cope up with their uncontrollable distressful thoughts, feelings and behavior. They tried both negative and positive strategies to cope. After childbirth, a mother needs to learn to respond to her child's needs, maintain these needs and perform household work and social responsibilities, but it was so difficult for some mothers to manage their child, family and professional activities. They were very frustrated and helpless. They were unaware and had not enough expertise to cope up with their situation. It was very challenging for the mothers to cope and function at their usual level with their depression. Mothers started to perceive themselves as inadequate, which led them to more dissatisfaction with themself and their life. Similar experiences of mothers were found in the study of C. T. Beck (1996).

Sometimes mothers blame themselves and sometimes others to avoid their responsibility so that they can be free from the accusation of any unwanted event as they were already in pain. Some participants gave curses and threats to others in an attempt to

release their anger. However, it brings subsequent feelings of shame and guilt to them. It was threatful for the mother and others' mental peace. Some mothers showed a different response, they were tried passive coping styles by suppressing their emotions to maintain peace and harmony; similar findings have been reported by other researchers as well (Gutiérrez-Zotes et al., 2016). Some mothers tried to engage themselves in recreational and pleasurable activities to manage their distress. After suffering to some extent, some mothers tried to alter their negative thoughts with positive and adaptive thoughts. Self-distraction, substance use and self-blame with some cognitive and behavioral coping strategies among mothers who were suffering from postpartum depression were found in the study of Gutiérrez-Zotes et al. (2016); in the present study, similar coping strategies were found among participants except substance use. It was an important observation that mothers who tried to cope positively such as, accepting their situation, thinking positively, trying pleasurable and constructive activities, were less depressed than the mothers who gave up, tried to avoid and escape or tried in a negative way such as blaming, being aggressive, having destructive or negative thoughts.

This study would be helpful for the mothers, their family and professionals to know about the coping style of mothers and manage their trouble in a healthy way.

4.5 Physiological State

Being constantly busy with household chores and nurturing the baby, the physical need of the mother was pushed aside or completely denied. Despite being drained and exhausted, mothers had no chance to stop for a break. They were desperate for a break from work and child, but mothers were constantly busy with no break or rare break after a long time. Thus, the experiences of denial of physical needs such as

sleeping, eating, taking showers, having rest made mothers foggy, exhausted and drained. Participants shared having physiological symptoms during their postpartum period. It was found that their physiological trouble, such as agitation, exhaustion, pain, sleep disturbances and complications with appetite, was related to their psychological state. When mothers were emotionally disturbed, they developed more physical trouble. Most of the time, mothers were occupied with taking care of the child and household chores. They did not have time for self-care or rest, which made them tired and agitated. As mothers needed some relaxed time and quality time for themselves, but they could not manage everything, these made them helpless, depressed and anxious, and these emotional issues made them tired, exhausted and restless. Due to these emotional troubles, mothers had sleep disturbance and trouble with appetite. Sometimes it was vice versa. Mothers could not take care of themselves and their children due to their fatigue, which made them more helpless and frustrated. Similarly, sleep disturbance, tiredness, exhaustion and fatigue of mother during postpartum are found in several studies (George, 2005; Hanley & Long, 2006; Hoang, Quynh, & Sue, 2009; Parvin, Jones, & Hull, 2004; Rodrigues, Patel, Jaswal, & De Souza, 2003; Tammentie, Paavilainen, Åstedt- Kurki, & Tarkka, 2004). Denial of physical and emotional needs made mothers more tired, and it was found in several studies (Hagen, 1999; Milligan, Lenz, Parks, Pugh, & Kitzman, 1996; Small, Brown, Lumley, & Astbury, 1994).

4.6 Impact on Relations

During the period of postpartum, the relationships of participants with their child, husband and other family members were negatively affected. As participants were not happy and satisfied with their life, they developed conflict and became emotionally isolated from their family and friends. With the deprivation of physical

needs, participants also felt deprivation of emotional needs such as being supported, nurtured and appreciated by husband and other family members. Most of the mothers were emotionally dependent on family members, specifically on their husbands. They expected care and support from their husbands and other family members but were left disappointed. Especially they were emotionally devastated when they realized that their partner was unable to provide sufficient emotional support they expected and needed; this led to distance and conflict in the relationship. Partner was also failed to provide instrumental help. Most of the husbands and family members did not share household works and responsibilities of taking care of the child, which led mothers towards feeling unsupported and frustrated. The lifestyle of mothers became profoundly changed after childbirth, especially those who were first-time mothers. Mothers perceived themselves as alone and lonely where there was no one beside them to share their workloads and responsibilities or help or support them. So, the dynamics of the relationship had also been changed. Participants who felt unsupportive and deprived of physical and emotional needs became frustrated, angry and resentful towards their partner and family members. The unavailability of support and contribution that the mothers needed and expected from their husbands made a negative impact on their relationships. As the partner was emotionally neglectful, unsupportive and unavailable according to the need expectations of the participant, they felt isolated and disconnected from the rest of the world. As a result, they began to emotionally drift apart from their partners and developed conflict with them. Participants felt the loss of closeness and gradual distance from their partners. Studies reported that mothers experience lack of support, conflict and adjustment problem with their partner during postpartum period (Dennis & Ross, 2006; Logsdon, Birkimer, & Barbee, 1997). Less support from the partners affects the mood, and functional level of the mother causes her to feel depressed (Lemola,

Stadlmayr, & Grob, 2007). Most of the mothers were occupied with managing responsibility for the home or children all alone, whereas most of the husbands were not sharing the duties, and it was burdensome for the mother (Razurel, Bruchon-Schweitzer, Dupanloup, Irion, & Epiney, 2011). This ranged from burden to relationship strain. Mothers felt that their partners did not understand their sufferings.

Sometimes it become stressful and irritating for the mother to breastfeed their child as they had to make extra efforts for taking care of the child and managing other responsibilities at the same time (Razurel et al., 2011). It was found that mother's depression negatively affects the child's development and later life functioning (Murray & Cooper, 1996; Righetti-Veltema, Bousquet, & Manzano, 2003). A difficult and unsupportive relationship with in-laws has been found in Asian culture from different studies (Chandran, Tharyan, Muliyil, & Abraham, 2002; Lee, Yip, Leung, & Chung, 2004; Mohammad, Gamble, & Creedy, 2011; Rodrigues et al., 2003; Roomruangwong & Epperson, 2011). Sometimes mother-in-law hold a dominant position in the family and used to criticize the mother, it made her depressed and resentful. It was found that lack of understanding, support and dictatorial behavior from in-laws increase the distress of the mother during the postpartum period (Wittkowski, Zumla, Glendenning, & Fox, 2011).

4.7 Impact on Self

Mothers experienced deprivation of physical and emotional needs during their postpartum period. Specially they missed being nurtured, supported, appreciated, having rest and personal time for self-care. They also experienced loss of freedom, such as going outside when they wished and engaged in pleasurable activities when they needed and thus, they realized of having no charge of their life in their hand, which

made them feel helpless and captive. It was also difficult for them to continue their professional and academic activities. As mothers were emotionally vulnerable and had difficulties with managing child, home and professional works, eventually they became isolated from the outside world and away from family and friends. Denial of physical and emotional needs made the mother feel unimportant and neglected. Mothers experienced a lack of care and nurture, which made them empty, unworthy and drained. There were similar findings in some studies that the role of motherhood includes occupying with multiple tasks and responsibilities were challenging and these also lead them to emotionally and physically exhaustion (Forster et al., 2008; George, 2005; Hanley & Long, 2006; Parvin et al., 2004). Some of the participants in this study expressed about their negative experience of suffering whilst few mothers also shared about some positive aspects such as developing coping strategies, discovering new roles and new self, think in a more mature way; similar outcomes were reported by Khan, Arif, Tahir, and Anwar (2009). Some mothers left their job, and some left their career, so that they could take care of their child properly. However, some mothers experienced the loss of identity as they have shifted from their role as a professional to a mother. Many studies documented similar findings throughout the research about postpartum depression (C. T. Beck, 1993; Berggren-Clive, 1998; Edhborg, Friberg, Lundh, & Widström, 2005; Mauthner, 1999; Nicolson, 1990).

4.8 Strengths of the Study

In Bangladesh, mental health issue has traditionally been given less priority. This is especially true for mothers' mental health who are perceived as the caregivers of others. The present study explored a specific aspect of mental health among new mothers. In-depth information on depression among postpartum mothers is a valuable

offering for broadening understanding of this important area among professionals as well as policymakers. The use of qualitative research design was used was crucial for such in-depth insights. The inclusion of first-hand experience from mothers with post-partum depression is another major strength of this research.

4.9 Limitations of the Study

Beyond the strengths of the study, there are some limitations of this study that should be noted. This study was conducted in urban areas. It would add significant diversity of insights if participants from rural communities could be interviewed. One of the inclusion criteria for this study was that mothers with depressive symptoms after four weeks to one year of childbirth. Inclusion of mothers with longer (more than one year) postpartum depression could also be useful in widening the perspective regarding the nature and impact of PPD. In this study, only mothers were interviewed, additional information from a secondary source such as the spouse and other family members could enrich the data and subsequent insights generated from it. As the study sample was small and had a limited regional diversity, the findings can only be used to generate initial insights and hypotheses regarding women with postpartum depression.

4.10 Implications of the Study

Despite the noted limitations, there are several important implications of this study for the researchers who study maternal health. The implications of this study are as follows.

- There are very few exploratory studies on the area of postpartum depression, which contributed to the existing gap in understanding of PPD, especially in low

resource contexts. The present study, powered by phenomenological exploration, contributed by adding in-depth first-hand insights on the nature and impact of postpartum depression.

- The detailed experience involving emotion, cognition, behavior, coping, physiological state and relationship of mothers with postpartum depression as described in the thesis would be useful for professionals, researchers, and policymakers.

- It was revealed that harmful behavior among the mothers in the form of thought of suicide, self-harm and harming baby, which raised the alarm regarding the importance of treatment of PPD, which is often overlooked. These findings would be helpful to prevent or minimize the risk of harm.

- Different coping strategies used by the women with PPD can be explored further by the clinicians and these can also be used for developing group-based intervention with women suffering from PPD.

- Current research indicates the sufferings and consequences of untreated postpartum depression among mothers. The need for supports, especially from the family, has been clearly exposed, which may help in designing supportive intervention and strategies involving family and relatives for helping these mothers.

- Current research brought forth the picture of the sufferings and impacts of untreated postpartum depression among the mothers and the family members. These findings can be used for awareness campaigns to improve life of the family members and the women with PPD.

CHAPTAR 5

CONCLUSION AND RECOMMENDATIONS

Conclusion and Recommendations

Though maternal mental health is a very important concern as depression after childbirth can affect mothers as well as their families negatively but it is often overlooked in Bangladesh due to lack of awareness and stigma. So, it is very important to understand postpartum depression and its impact on mothers' life to increase responsiveness and to reduce the distress of mothers and their families.

Following the objectives, this study explored the nature and impact of postpartum depression on women's life from a qualitative perspective using phenomenological research approach. Purposive sampling was used for data collection and ten participants were interviewed after screening with Edinburgh Postnatal Depression Scale. Data collection was done through in-depth interviews using a topic guide with the consent of participants.

Content analysis revealed seven broad categories: emotional state, cognitive process, behavior and action, coping, physiological state, impact on relations and impact on self. Findings illustrated that women with postpartum depression experienced changes in their emotions, thoughts, behaviors, actions and physiological state which affects the quality of life of the mothers as well as their partner, children and other family members. Women in this study expressed that in the journey of motherhood they experienced mixed feelings like sadness, frustration, guilty feelings, anxiety and anger. Their negative and dysfunctional thoughts and belief made them more emotionally vulnerable, impaired their cognitive functioning and made impact on their physiological state, behavior and action. Sometimes they lost control over their emotion and action that they behave aggressively and became destructive. Sometimes mothers became so overwhelmed and hurt themselves,

even tried to attempt suicide. Participants tried different strategies to cope up with their uncontrollable distressful thoughts, feelings and behavior. It was very challenging for the mother to cope and function at their usual level with their depression. During the period of postpartum, the relationships of participants with their child, husband and other family members were negatively affected. As the partner and the family were emotionally neglectful, unsupportive and unavailable according to the need expectations of the participant, mothers felt isolated and disconnected from the rest of the world. Participants missed being nurtured, supported, appreciated, having rest and personal time for self-care.

It was mentioned before that in Bangladesh, mental health issue has been given less priority, especially on mothers' mental health. So, the most important strength of the current study was to focus on the mental health issues of mothers. In-depth information about mothers' postpartum depression has been explored in a detailed manner which offered valuable insight for the mothers and professionals to understand and manage postpartum depression.

The present research explored the distress and negative consequences of untreated postpartum depression among mothers and their families. From these findings mothers and their families can understand the miseries of mothers and the possibilities of pursuing mental health treatment for the mothers. This study also indicated self-harm, suicidal attempts, thought of suicide and harming baby, these findings might contribute to prevent or minimize the risk. Throughout the outcome of the current study, effective intervention could be developed.

From the findings of the current study, the following recommendations can be made.

1. The findings of the current study pinpointed the sufferings and negative consequences of PPD among women and their families. So further timely assessment and treatment strategies could be developed to minimize the distress of the women with PPD.

2. Participants shared about the insufficient support and care from their partner and family member during their postpartum period. Further study could be conducted to explore the issues and strategies could be developed to educate the partner and family member about PPD and its consequences.

3. Most of the time PPD is unrecognized by the healthcare professional. From the findings of the current study, health care providers can be aware of the factors that should be considered in the screening and management of PPD.

4. Researchers, practitioners and policymakers should develop strategies to make general people aware of PPD to minimize stigma and ensure support for the mothers with PPD.

5. Present research revealed that mothers with PPD could not take proper care of their children, so further research could be done to explore the consequences of mothers' PPD on their children.

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APPENDICES

<u>**APPENDIX A**</u>

Topic Guide on "Nature and Impact of Postpartum Depression on Women's Life"

Topic guide

Nature of PPD

১। বেশির ভাগ সময় আপনি কেমন অনুভব করেন? আপনার মনটা কেমন থাকে?

- কি কি ধরনের আবেগ বা অনুভূতি আপনি অনুভব করেন?
- কবে থেকে এমন অনুভব করেন?
- কোন সময়ে এমন বেশি অনুভব করেন? কতক্ষণ এমন অনুভূতি থাকে?
- কি কারণে এমন অনুভব করেন?

২। তখন আপনার মনের মধ্যে কি কি ভাবনা/ চিন্তা আসে?

- কি কি ভেবে বা চিন্তা করে এমন অনুভব করেন?
- আপনার সমস্যা বা কষ্টগুলোকে কিভাবে দেখেন বা চিন্তা করেন?
- যখন এমন অনুভব করেন তখন কি করতে ইচ্ছা হয়? মোকাবেলা করার জন্য কি ভাবেন?
- নিজের সম্পর্কে কি মনে হয়/ চিন্তা হয়? নিজেকে কিভাবে দেখেন/ ভাবেন?
- অন্যদের সম্পর্কে কি মনে হয়/ চিন্তা হয় বা অন্যদের কিভাবে দেখেন/ ভাবেন?

৩। আপনার শরীরের মধ্যে কেমন অনুভব করেন? শরীর কেমন লাগে?

- আপনার শরীরে কি কি পরিবর্তন লক্ষ্য করেন?
- কখন এমন পরিবর্তন লক্ষ্য করেন? কতক্ষণ এমন অনুভূতি থাকে?

৪। যেকোন পরিস্থিতিতে নিজের বা অন্যের সাথে আপনার আচরন, ব্যবহার বা প্রতিক্রিয়া কেমন থাকে?

- আপনি যখন খারাপ অনুভব করেন, তখন কি করেন?
- অন্যদের কথা বা কাজে আপনার আচরন, ব্যবহার বা প্রতিক্রিয়া কেমন থাকে?
- নিজের প্রতি আপনার আচরন, ব্যবহার বা প্রতিক্রিয়া কেমন থাকে?
- নিজের প্রতি কেমন যত্ন নেন?

Impact of PPD

আপনার বর্তমান অবস্থা আপনার জীবনে কেমন প্রভাব ফেলছে? কি কি পরিবর্তন অনুভব করছেন?

১। আপনার দৈনন্দিন কাজকর্ম কেমন চলছে?

- আপনার প্রত্যাহিক ব্যক্তিগত কাজকর্ম কিভাবে পরিচালিত করছেন?
- আপনার নিজের প্রতি দ্বায়িত্বগুলো কিভাবে পালন করছেন?
- কাজকর্ম পরিচালনার ক্ষেত্রে কোন বাঁধা/সমস্যা অনুভব করছেন কি? করলে কি ধরনের বাঁধা/সমস্যা? বিস্তাড়িত?
- আপনার বর্তমান অবস্থা আপনার দৈনন্দিন কাজকর্মের উপর কোন প্রভাব ফেলছে? কি ধরনের প্রভাব ফেলছে?

২। আপনার পেশাগত কাজকর্ম কেমন চলছে?

- কিভাবে পরিচালিত করছেন?
- কাজকর্ম পরিচালনার ক্ষেত্রে কোন বাঁধা/সমস্যা অনুভব করছেন কি? করলে কি ধরনের বাঁধা/সমস্যা? বিস্তাড়িত?
- আপনার বর্তমান অবস্থা আপনার পেশাগত কাজকর্মের উপর কোন প্রভাব ফেলছে? কি ধরনের প্রভাব ফেলছে?

৩। আপনার পারিবারিক বা সাংসারিক কাজকর্ম কেমন চলছে?

- আপনার প্রত্যাহিক পারিবারিক কাজকর্ম কিভাবে পরিচালিত করছেন?
- কাজকর্ম পরিচালনার ক্ষেত্রে কোন বাঁধা/ সমস্যা অনুভব করছেন কি? করলে কি ধরনের বাঁধা/ সমস্যা? বিস্তাড়িত?
- আপনার বর্তমান অবস্থা আপনার পারিবারিক বা সাংসারিক কাজকর্মের উপর কোন প্রভাব ফেলছে? কি ধরনের প্রভাব ফেলছে?

৪। সন্তানের লালন-পালন কেমন চলছে?

- সন্তানের কেমন যত্ন নিচ্ছেন? (খাওয়া, ঘুম, গোসল ও অন্যান্য)
- সন্তান প্রতিপালনের ক্ষেত্রে কোন কোন বাঁধা/ সমস্যা অনুভব করছেন কি? করলে কি ধরনের বাঁধা/ সমস্যা? বিস্তাড়িত।

- আপনার বর্তমান অবস্থা আপনার সন্তান প্রতিপালনের উপর কোন প্রভাব ফেলছে? কি ধরনের প্রভাব ফেলছে?

৫। পরিবারের সদস্যদের (স্বামী ও অন্যান্য সদস্য) সাথে আপনার যোগাযোগ কেমন?

- তাদের সাথে আপনার সম্পর্ক কেমন?
- তাদের প্রতি দ্বায়িত্ব কিভাবে পালন করছেন?
- তাদের সাথে কিভাবে যোগাযোগ করেন? যোগাযোগের ধরণ কেমন বা আচরন কেমন?
- এক্ষেত্রে কোন বাঁধা/ সমস্যা অনুভব করছেন কি? করলে কি ধরনের বাঁধা/ সমস্যা? বিস্তারিত?
- তাদের প্রতি কেমন অনুভব করেন?
- আপনার আচরন বা কাজ তাদের উপর কোন প্রভাব ফেলছে? কি ধরনের প্রভাব ফেলছে?
- আপনার প্রতি তাদের আচরন কেমন? তাদের আচরন আপনার উপর কোন প্রভাব ফেলছে? কি ধরনের প্রভাব ফেলে?

৬। আপনার সামাজিক যোগাযোগ কেমন চলছে?

- আত্নীয়, বন্ধু, প্রতিবেশি ও অন্যান্য সামাজিক মাধ্যমগুলোর সাথে আপনার সম্পর্ক কেমন?
- তাদের প্রতি দ্বায়িত্ব কিভাবে পালন করছেন?
- তাদের সাথে কিভাবে যোগাযোগ করেন? যোগাযোগের ধরণ কেমন বা আচরন কেমন?
- এক্ষেত্রে কোন বাঁধা/ সমস্যা অনুভব করছেন কি? করলে কি ধরনের বাঁধা/ সমস্যা? বিস্তারিত?
- তাদের প্রতি কেমন অনুভব করেন?
- আপনার আচরন বা কাজ তাদের উপর কোন প্রভাব ফেলছে? কি ধরনের প্রভাব ফেলছে?
- আপনার প্রতি তাদের আচরন কেমন? তাদের আচরন আপনার উপর কোন প্রভাব ফেলছে? কি ধরনের প্রভাব ফেলছে?

APPENDIX B

Demographic data form

তারিখঃ কোডঃ

ব্যক্তিগত তথ্যঃ

নামঃ	বয়সঃ
ঠিকানাঃ	শিক্ষাগত যোগ্যতাঃ
পেশাঃ	আর্থ-সামাজিক অবস্থানঃ
ধর্মঃ	বৈবাহিক অবস্থাঃ
মাসিক আয়ঃ	ফোন নংঃ
সন্তান জন্মদান পদ্ধতিঃ	পরিবারের সদস্য ও সদস্য সংখাঃ
পরিবারের ধরনঃ একক/ যৌথ	সন্তান জন্মদানে কোন জটিলতা ছিল কি না?
সন্তান মাতৃদুগ্ধ পান করে কি না?	সন্তানের সংখ্যা ঃ
শিশুর ওজনঃ	শিশুর লিঙ্গঃ
শিশুর কোন অসুস্থতা আছে কি না?	কনিষ্ঠ সন্তানের বয়সঃ

APPENDIX C

Explanatory statement form

Explanatory statement (ব্যাখ্যামূলক বিবৃতি)

গবেষণার শিরনামঃ প্রসব পরবর্তী বিষন্নতার প্রকৃতি এবং মহিলাদের জীবনে এর প্রভাব। (Nature and impact of postpartum depression in women's life.)

আমি মুমীতা জেরিন নীলাভ, এম. ফিল. গবেষক, ক্লিনিক্যাল সাইকোলজি বিভাগ, ঢাকা বিশ্ববিদ্যালয়। আমার এম. ফিল. গবেষণার অংশ হিসাবে ডঃ কামরুজ্জামান মজুমদার, সহযোগী অধ্যাপক, ক্লিনিক্যাল সাইকোলজি বিভাগ, ঢাকা বিশ্ববিদ্যালয়- এর তত্ত্বাবধানে একটি গবেষণা করছি।

গবেষণার লক্ষ্য

বর্তমান গবেষণার লক্ষ্য হল মহিলাদের প্রসব পরবর্তীকালীন বিষণ্ণতার প্রকৃতি এবং মহিলাদের জীবনে এর প্রভাব সম্পর্কে জানা।

বর্তমান গবেষণায় অংশ গ্রহন করতে অনুরোধ করার কারণ

প্রসব পরবর্তী সময়ে অনেক মায়েরই বিষন্নতা দেখা যায়। তাদের অবস্থা,অভিজ্ঞতা এবং তাদের জীবনে বিষণ্ণতার প্রভাব জানতে আমি কিছু মায়েদের সাক্ষাৎকার নিতে চাই। আপনার বয়স যদি ১৮ বছরের কম না হয়, আপনি যদি বাংলায় কথা বলতে ও বুঝতে পারেন আপনার শারীরিক অবস্থা ও মানুসিক ভারসাম্য যদি ঠিক থাকে এবং আপনি গবেষণায় অংশ গ্রহণে ইচ্ছুক হলে আমি আপনার কাছ থেকে কিছু তথ্য নিতে চাই। আপনার উত্তর থেকে বোঝা যাবে আপনি এই গবেষণায় অংশ গ্রহণ করতে পারবেন কি না।

গবেষণায় যা করা হবে

প্রথমত, একটি প্রশ্নমালা ব্যবহার করে দেখা হবে যে আপনি এই গবেষণায় অন্তর্ভুক্ত হতে পারবেন কি না। আপনি উপযোগ্য হিসাবে বিবেচিত হলে, আপনার অনুমতি সাপেক্ষে আপনার সাক্ষাৎকার রেকর্ড করা হবে ও লিখিতভাবে সংরক্ষিত হবে।

গবেষণার সময়

গবেষোণার প্রশ্নমালাটি পূরণে ৫-১০ মিনিট এবং একক সাক্ষাৎকারের জন্য ৪০-৬০ মিনিট প্রয়োজন হতে পারে। আপনার দেয়া তথ্যের গুরুত্ব অনুযায়ী পরবর্তীতে আপনার আরোও এক বা একাধিক বার সাক্ষাৎকার দেয়া প্রয়োজন হতে পারে। প্রয়োজন অনুযায়ী আমি আপনার সাথে আলোচনা সাপেক্ষ্যে সময় এবং তারিখ নির্ধারণ করবো।

সম্ভাব্য সুবিধা

বর্তমান গবেষণায় অংশ গ্রহণে আপনার প্রত্যক্ষ সুবিধা না হলেও গবেষণার ফলাফল বিষন্নতায় আক্রান্ত মায়েদের অবস্থা,অভিজ্ঞতা এবং তাদের জীবনে বিষণ্ণতার প্রভাব জানতে সাহায্য করবে যা তাদের অবস্থার উন্নতি এবং সমাজে সচেতনতা তৈরিতে সাহায্য করবে।

সম্ভাব্য অসুবিধা

গবেষণায় যে বিষয়গুলো নিয়ে কথা বলা হবে, তা আপনাকে আবেগতাড়িত করতে পারে বা সাময়িক কষ্ট বা অস্বস্তি তৈরি করতে পাওে কিন্তু তা দীর্ঘস্থায়ী হবে না বলে আশা করা যায়। প্রয়োজন হলে যেখানে মানুসিক স্বাস্থ্য সেবা পাওয়া যায়, সেখানে যোগাযোগ করতে পারেন।

অংশ গ্রহণ প্রত্যাহার

গবেষেণায় অংশ গ্রহন এবং অংশ গ্রহন প্রত্যাহারের উপর আপনার পুর্ণ স্বাধীনতা আছে। গবেষণায় আপনার সাক্ষাৎকার থেকে সংগৃহীত তথ্য লিখিত অনুলিপি অনুমোদনের পূর্বে আপনি যেকোনো মূহুর্তে আপনার অংশ গ্রহন প্রত্যাহার করতে পারেন।

গোপনীয়তা

গবেষণায় আপনার পরিচয় সম্পূর্ণ গোপন রাখা হবে। আপনার এমন কোন তথ্য কারো কাছে বা কোথাও প্রকাশ করা হবে না, যা দ্বারা আপনাকে চিহ্নিত করা যাবে।

সংগৃহীত তথ্যের সংরক্ষণ

গবেষণার তথ্য ঢাকা বিশ্ববিদ্যালয়ের নিয়ম অনুযায়ী সংরক্ষিত থাকবে। এ গবেষণায় প্রাপ্ত তথ্য থেকে একটি থিসিস লেখা হবে। গবেষণাটি রিপোর্ট প্রকাশের জন্য দেয়া হতে পারে এবং এক বা একাধিক মৌখিক উপস্থাপনাও হতে পারে, কিন্তু কোন ক্ষেত্রেই অংশ গ্রহনকারীর পরিচয় প্রকাশ করা হবে না।

গবেষণার ফলাফল

গবেষণার ফলাফল জানতে গবেষকের সাথে (মুমীতা জেরিন নীলাভ) ফোন (০১৫৫৬৩৪৩৬৫২) বা ইমেইল (m.nilav@ymail.com) এর মাধ্যমে যোগাযোগ করতে পারেন।

আপনার সহযোগিতার জন্য ধন্যবাদ।

মুমীতা জেরিন নীলাভ

APPENDIX D

Informed consent form

সম্মতি পত্র

গবেষণার শিরনামঃ প্রসব পরবর্তী বিষন্নতার প্রকৃতি এবং মহিলাদের জীবনে এর প্রভাব। (Nature and impact of postpartum depression in women's life.)

আমি ঢাকা বিশ্ববিদ্যালয়ের উপরোক্ত গবেষণায় অংশ গ্রহণ করার সম্মতি দিচ্ছি। গবেষণা সম্পরকে আমাকে বিস্ত্মরিত বুঝিয়ে বলা হয়েছে এবং আমি এ বিষয়ক ব্যাখ্যামূলক বিবৃতি পড়েছি/ পড়ে শোনানো হয়েছে, যা আমার কাছে রেকর্ড হিসাবে আছে। আমি বুঝতে পারছি যে সম্মতি প্রদানের মানে হচ্ছে -

আমি গবেষকের কাছে সাক্ষাৎকার প্রদানে সম্মতি দিচ্ছি	☐ হ্যাঁ	☐ না
আমি সাক্ষাৎকারটি রেকর্ড করার প্রদানে সম্মতি দিচ্ছি	☐ হ্যাঁ	☐ না
আমি প্রয়োজনে পরবর্তীতে আবার সাক্ষাৎকার প্রদানে সম্মতি দিচ্ছি	☐ হ্যাঁ	☐ না

এবং,

আমি বুঝতে পারছি যে আমার অংশ গ্রহণ স্বেচ্ছামূলক। গবেষেণায় অংশ গ্রহন এবং অংশ গ্রহন প্রত্যাহারের উপর আমার পুর্ণ স্বাধীনতা আছে। গবেষণায় আমার সাক্ষাৎকার থেকে সংগৃহীত তথ্য লিখিত অনুলিপি অনুমোদনের পূর্বে আমি যেকোনো মুহূর্তে আমার অংশ গ্রহন প্রত্যাহার করতে পারি যার জন্য আমি কোনভাবেই ক্ষতিগ্রস্ত্ম হব না।

এবং, আমি বুঝতে পারছি যে গবেষণায় আমার সাক্ষাৎকার থেকে সংগৃহীত তথ্য প্রকাশনায় বা উপস্থাপনায় কোনভাবেই আমার নাম পরিচয় লিপিবদ্ধ থাকবে না বা প্রকাশ করা হবে না।

এবং, আমি বুঝতে পারছি যে গবেষণায় আমার সাক্ষাৎকার থেকে সংগৃহীত তথ্যেও একটি লিখিত অনুলিপি আমাকে দেয়া হবে যা দেখে আমি সেটি গবেষণায় অন্ত্মর্ভুক্ত করার বিষয়ে সিদ্ধান্ত্ম নিতে পারি।

এবং, আমি বুঝতে পারছি যে গবেষণায় আমার সাক্ষাৎকার থেকে সংগৃহীত তথ্যের গোপনীয়তা রক্ষা করা হবে এবং এমন কোন তথ্য কারো কাছে বা রিপোর্টে প্রকাশ করা হবে না যা থেকে আমাকে চেনা যাবে।

এবং, আমি বুঝতে পারছি যে সাক্ষাৎকারের অডিও রেকর্ড থেকে প্রাপ্ত তথ্যের লিখিত অনুলিপি সমূহ একটি নিরাপদ স্থানে সংরক্ষিত থাকবে এবং তা গবেষক ছাড়া অন্য কারো কাছে সহজলভ্য হবে না। এছাড়া এসব তথ্য ৫ বছর সংরক্ষণের পর ধ্বংস করে ফেলা হবে যদি এ তথ্য অন্য কোন গবেষণায় ব্যবহারের জন্য আমার পূর্বানুমতি না নেয়া হয়।

অংশগ্রহণকারীর নামঃ

স্বাক্ষরঃ বা টিপসই ঃ

তারিখঃ

APPENDIX E

Screening Questionnaire: Part I

তারিখঃ কোডঃ

গবেষণায় অন্তর্ভুক্তি বিষয়ক প্রশ্নমালা

প্রাক অংশগ্রহণ প্রশ্নমালা

প্রশ্ন	হ্যাঁ	না
১। আপনার সন্তানের বয়স কি ৪ সপ্তাহ থেকে ১ বছর?		
২। বিগত ২ সপ্তাহ ধরে কি প্রায় আপনার মন খারাপ লাগে?		
৩। আপনার বয়স কি ১৮ এর কম?		
৪। আপনি কি বাংলায় কথা বলতে ও বুঝতে পারেন?		
৫। আপনার কি বর্তমানে এমন কোন শারীরিক বা মানুসিক সমস্যা আছে যা আপনাকে বর্তমান গবেষণায় অংশগ্রহণে বাঁধাগ্রস্থ করতে পারে?		
৬। আপনি কি এই মুহূর্তে মাদকগ্রস্থ অবস্থায় আছেন?		
৭। আপনার কি আগে কখনো বিষন্নতা ছিলো?		
৮। বিষন্নতার জন্য আগে কখনো চিকিৎসা নিয়েছেন?		

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APPENDIX E

Screening Questionnaire: Part II

EPDS - B

Bangla version of the Edinburgh Postnatal Depression Scale
বাংলা- ইডেনবার্গ পোষ্টনেটাল ডিপ্রেশন স্কেল

সম্প্রতি আপনার একটি সন্তান হয়েছে, আমরা জানতে চাচ্ছি আপনার কেমন লাগছে। শুধু আজকে আপনার কেমন লাগছে তা নয় বরং গত এক সপ্তাহ (৭ দিন) ধরে আপনার কেমন অনুভব হচ্ছে তা কি দয়া করে আমাদেরকে বলবেন। এজন্য আপনাকে ১০টি প্রশ্ন করবো। প্রতিটি প্রশ্নের ৪টি করে উত্তর থাকবে, যে উত্তরটা আপনার সঙ্গে মিলে যাবে বা কাছাকাছি হবে সেটাই বলুন।

একটি উদাহরন দিচ্ছি

আপনি আনন্দে ছিলেনঃ

- ○ হ্যাঁ, সব সময়ই
- ● হ্যাঁ, বেশিরভাগ সময়ই
- ○ না, প্রায়ই না
- ○ না, একেবারেই না

( ) এটার অর্থ হচ্ছে 'আপনি গত সপ্তায় বেশিরভাগ সময় আনন্দে ছিলেন', এভাবে নিম্নলিখিত প্রশগুলোর উত্তর দিন।

প্রশ্ন ঃ ১ আপনি হাসতে পেরেছেন এবং হাসি - তামাসা উপভোগ করতে পেরেছেন

- ○ যতটুকু আপনি সব সময় করেছেন
- ○ এখন আগের মত ততটা না
- ○ অবশ্যই এখন ততটা না
- ○ একেবারেই না

প্রশ্ন ঃ ২ আপনি সবকিছু থেকে আনন্দ পাওয়ার আশায় থেকেছেন

- ○ যতটুকু আপনি আগে করতেন
- ○ আগের চেয়ে কিছু কম
- ○ অবশ্যই আগের চেয়ে কম
- ○ বলতে গেলে একেবারেই না

*প্রশ্ন ঃ ৩ কোন কিছু ঠিকমত না হলে আপনি নিজেকে অ-যথাই দোষ দিয়ে থাকেন

- ○ হ্যাঁ, বেশিরভাগ সময়
- ○ হ্যাঁ, মাঝে মাঝে
- ○ খুব বেশি না
- ○ না, কখনোই না

প্রশ্ন ঃ ৪ আপনি এমনিতেই দুশ্চিন্তা করে থাকেন বা ঘাবড়িয়ে যান

- ○ না, কখনোই না
- ○ খুবই কম
- ○ হ্যাঁ, মাঝে মাঝে
- ○ হ্যাঁ, প্রায়ই

*প্রশ্ন ঃ ৫ আপনি এমনিতেই ভয় পেয়েছেন ও আতঙ্কিত হয়েছেন

- হ্যাঁ, খুব বেশি
- হ্যাঁ, মাঝে মাঝে
- না, বেশি না
- না, একেবারেই না

*প্রশ্ন ঃ ৬ সবকিছু আপনার কাছে বোঝা মনে হয়েছে এবং আপনি তা মানিয়ে নিতে পারছেন না

- হ্যাঁ, বেশিরভাগ সময়ই আপনি মানিয়ে নিতে পারছেন না
- হ্যাঁ, মাঝে মাঝে আপনি মানিয়ে নিতে পারছেন না, যেমন আপনি সাধারনতঃ নিয়ে থাকেন
- না, বেশির ভাগ সময়ই আপনি ভালভাবে মানিয়ে নিচ্ছেন
- না, আপনি সব সময় ভালভাবে মানিয়ে নিচ্ছেন

*প্রশ্ন ঃ ৭ আপনার মনটা এতোই খারাপ ছিল যে, আপনার ঘুমের অসুবিধা হয়েছে

- হ্যাঁ, বেশিরভাগ সময়ই
- হ্যাঁ, মাঝে মাঝে
- প্রায়ই না
- না, একেবারেই না

*প্রশ্ন ঃ ৮ আপনার নিজেকে দুঃখী বা অসহায় মনে হয়েছে

- হ্যাঁ, বেশিরভাগ সময়ই
- হ্যাঁ, প্রায় প্রায়ই
- না, প্রায়ই না
- না, একেবারেই না

*প্রশ্ন ঃ ৯ আপনার মনটা এতোই খারাপ ছিল যে আপনি কেঁদেছেন

- হ্যাঁ, বেশিরভাগ সময়ই
- হ্যাঁ, প্রায় প্রায়ই
- কখনো কখনো
- না, কখনোই না

*প্রশ্ন ঃ ১০ আপনি নিজেই নিজের ক্ষতি করার কথা ভেবেছেন

- হ্যাঁ, প্রায়ই
- মাঝে মাঝে
- খুবই কম
- কখনোই না

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APPENDIX F

Referral directory

কোথায় পাবেন মানসিক স্বাস্থ্য সেবা

১। ক্লিনিক্যাল সাইকোলজি বিভাগ, ৫ম তলা, কলা ভবন, ঢাকা বিশ্ববিদ্যালয়।

২। নাসিরুল্লাহ সাইকথেরাপি ইউনিট, ক্লিনিক্যাল সাইকোলজি বিভাগ, চতুর্থ তলা, কলা ভবন, ঢাকা বিশ্ববিদ্যালয়। যোগাযোগঃ ০১৭৫৫৬৫৪৮৩৫

৩। জাতীয় মানসিক স্বাস্থ্য ইন্সটিটিউট ও হাসপাতাল, শেরে বাংলা নগর, ঢাকা।

৪। বঙ্গবন্ধু শেখ মুজিব মেডিকেল ইউনিভারসিটি, শাহবাগ, ঢাকা।

৫। স্যার সলিমুল্লাহ মেডিক্যাল কলেজ, মিডফোর্ড রোড, ঢাকা।

৬। ঢাকা মেডিকেল কলেজ ও হাসপাতাল, বকশী বাজার, ঢাকা।

৫। ন্যাশনাল ট্রমা কাউন্সেলিং সেন্টার, ৩৭/৩, ইস্কাটন গার্ডেন রোড, ঢাকা। ০২-. ৮৩২১৮২৫, ০১৭১৩-১৭৭১৭৫

৬। কান পেতে রই। যোগাযোগঃ ০১৭৭৯৫৫৪৩৯১, ০১৭৭৯৫৫৪৩৯২, ০১৬৮৮৭০৯৯৬৫ ০১৬৮৮৭০৯৯৬৬, ০১৯৮৫২৭৫২৮৬, ০১৮৫২০৩৫৬৩৪।

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APPENDIX G

Ethical Approval Letter Part I: Original

চিকিৎসা মনোবিজ্ঞান বিভাগ
ঢাকা বিশ্ববিদ্যালয়
কলা ভবন (৫ম তলা)
ঢাকা–১০০০, বাংলাদেশ

DEPARTMENT OF CLINICAL PSYCHOLOGY
UNIVERSITY OF DHAKA
Arts Building (4th floor)
Dhaka-1000, Bangladesh

Tel: 9661900-73, Ext. 7801, Fax: 880-2-8615583, E-mail: clinpsy@du.ac.bd

Certificate of Ethical Approval

Project Number : **MP180501**

Project Title : **Nature and Impact of Postpartum Depression on Women's Life**

Investigators : **Mumita Jerin Nilav** and **Dr. Muhammad Kamruzzaman Mozumder**

Approval Period : **14 May 2018** to **13 May 2019**

Terms of Approval

1. Any changes made to the details submitted for ethical approval should be notified and sought approval by the investigator(s) to the Department of Clinical Psychology Ethics Committee before incorporating the change.
2. The investigator(s) should inform the committee immediately in case of occurrence of any adverse unexpected events that hampers wellbeing of the participants or affect the ethical acceptability of the research.
3. The research project is subject to monitoring or audit by the Department of Clinical Psychology Ethics Committee.
4. The committee can cancel approval if ethical conduction of the research is found to be compromised.
5. If the research cannot be completed within the approved period, the investigator must submit application for an extension.
6. The investigator must submit a research completion report.

....
Chairperson
Ethics Committee
Department of Clinical Psychology
University of Dhaka

APPENDIX G

Ethical Approval Letter Part II: 1st Extension

চিকিৎসা মনোবিজ্ঞান বিভাগ
ঢাকা বিশ্ববিদ্যালয়
কলা ভবন (৫ম তলা)
ঢাকা–১০০০, বাংলাদেশ

DEPARTMENT OF CLINICAL PSYCHOLOGY
UNIVERSITY OF DHAKA
Arts Building (4th floor)
Dhaka 1000, Bangladesh

Tel: 9661900-73, Ext. 7801, Fax: 880-2-8615583, E-mail: clinpsy@du.ac.bd

Certificate of Ethical Approval (Extension)

Project Number : **MP180501**

Project Title : **Nature and Impact of Postpartum Depression on Women's Life**

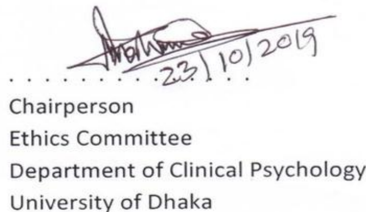
Investigators : **Mumita Jerin Nilav** and **Dr. Muhammad Kamruzzaman Mozumder**

Approval Period : **14 May 2018** to **12 May 2020 (Extended)**

Based on you application dated **13 May 2019** the approval for your research has been extended till **12 May 2020.**

Terms of Approval

1. Any changes made to the details submitted for ethical approval should be notified and sought approval by the investigator(s) to the Department of Clinical Psychology Ethics Committee before incorporating the change.
2. The investigator(s) should inform the committee immediately in case of occurrence of any adverse unexpected events that hampers wellbeing of the participants or affect the ethical acceptability of the research.
3. The research project is subject to monitoring or audit by the Department of Clinical Psychology Ethics Committee.
4. The committee can cancel approval if ethical conduction of the research is found to be compromised.
5. If the research cannot be completed within the approved period, the investigator must submit application for an extension.
6. The investigator must submit a research completion report.



Chairperson
Ethics Committee
Department of Clinical Psychology
University of Dhaka

Dhaka University Institutional Repository

APPENDIX G

Ethical Approval Letter Part III: 2nd Extension

চিকিৎসা মনোবিজ্ঞান বিভাগ
ঢাকা বিশ্ববিদ্যালয়
কলা ভবন (৫ম তলা)
ঢাকা – ১০০০, বাংলাদেশ

DEPARTMENT OF CLINICAL PSYCHOLOGY
UNIVERSITY OF DHAKA
Arts Building (4th Floor)
Dhaka 1000, Bangladesh

Tel: 9661900-73, Ext. 7801, Fax: 880-2-9667222, E-mail: clinpsy@du.ac.bd

Certificate of Ethical Approval (Extension)

Project Number : **MP180501**

Project Title : **Nature and Impact of Postpartum Depression on Women's Life**

Investigators : **Mumita Jerin Nilav** and **Dr. Muhammad Kamruzzaman Mozumder**

Approval Period : **14 May 2018** to **31 December 2020 (Extended)**

Based on you application dated **14 December 2021** the approval for your research has been extended till **31 December 2020.**

Terms of Approval

1. Any changes made to the details submitted for ethical approval should be notified and sought approval by the investigator(s) to the Department of Clinical Psychology Ethics Committee before incorporating the change.
2. The investigator(s) should inform the committee immediately in case of occurrence of any adverse unexpected events that hampers wellbeing of the participants or affect the ethical acceptability of the research.
3. The research project is subject to monitoring or audit by the Department of Clinical Psychology Ethics Committee.
4. The committee can cancel approval if ethical conduction of the research is found to be compromised.
5. If the research cannot be completed within the approved period, the investigator must submit application for an extension.
6. The investigator must submit a research completion report.

. . . .
Chairperson
Ethics Committee
Department of Clinical Psychology
University of Dhaka

APPENDIX H

Permission letter for data collection

চিকিৎসা মনোবিজ্ঞান বিভাগ
ঢাকা বিশ্ববিদ্যালয়
কলা ভবন (৫ম তলা)
ঢাকা–১০০০, বাংলাদেশ

DEPARTMENT OF CLINICAL PSYCHOLOGY
UNIVERSITY OF DHAKA
Arts Building (4th floor)
Dhaka 1000, Bangladesh

Tel: 9661900-73, Ext. 7801, Fax: 880-2-8615583, E-mail: clinpsy@du.ac.bd

Date: 14.10.19

To

Director,

Maternal and Child Health Training Institute,

Azimpur, Dhaka-1207

17/10 Sr. Con (Gynae)

Subject: Application for the permission of collecting research data.

Dear Sir,

With due respect I would like to state that I am doing a research titled "Nature and Impact of Postpartum Depression on Women's Life" under the supervision of Dr. Muhammad Kamruzzaman Mazumder, Associate professor, Department of Clinical Psychology, University of Dhaka as a part of my M.Phil. degree. I need to interview some mothers who are suffering from post partum depression as a part of my research. I would like to screen newly delivered mothers using a questionnaire to find post partum depression and if found I will carry out in-depth interview with them. Therefore, I am seeking permission to conduct interview at your institution.

I am assuring you that I will follow the rules and regulations of your institution during collecting research data. This research will follow principles of research ethics and it has already received ethical approval from the ethics committee of the Department of Clinical Psychology, University of Dhaka (project no. MP180501). I am attaching the questionnaire, demographic data form, explanatory statement and informed consent form along with this application for your consideration.

I therefore, hope that you will be kind enough to consider my application and give me the permission to conduct interview with post partum women at your institution.

With regards

Nilav

Mumita Jerin Nilav
M.Phil. researcher,
Department of Clinical Psychology,
University of Dhaka

Attested

Associate Professor
Clinical Psychology Dept.
Dhaka University