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A qualitative study of the experiences of Hong Kong Chinese women diagnosed with postnatal depression

Key Messages

1. Screening programmes for postnatal depression and depression are useful for early detection, diagnosis, and treatment of the condition.
2. The majority of the women studied perceived marital problems as their major source of unhappiness. They did not take initiatives to seek help for their condition and many were unwilling to receive psychiatric treatment.
3. Screening for both postnatal depression and depression, primary health education, support groups, outreach services, psycho-education, and family services are strategies recommended for helping these women.

Introduction

Postnatal depression (PND) is a destructive condition; marital breakdown and adverse effects upon children's cognitive and emotional functioning have been directly attributed to PND, and women with severe PND may commit suicide and infanticide.¹ The prevalence of major and minor PND is 4% and 10% respectively, which is similar to that found in western countries. Most studies of PND have adopted a quantitative approach focusing on prevalence and the estimation of risk factors. There are very few studies of the experience of PND from women's points of view. This study aimed to examine the experience of PND in Hong Kong Chinese women in order to shed light upon the cultural issues that may contribute to the onset and progress of the condition. The objectives of the study were:

- To examine the experience of depression in Hong Kong Chinese women who are diagnosed as having major or minor degrees of PND.
- To investigate the factors participants perceive as contributors to their depression.
- To identify participants' help-seeking behaviours.
- To compare the experiences of women recently diagnosed with PND, and women recently diagnosed with non-PND.

Methods

This study was conducted from October 1998 to March 2000. A qualitative approach, using in-depth interviews to collect data, was taken to enable a deeper exploration of the experience of PND. All women confined at the Prince of Wales Hospital obstetric unit are screened for depression using the Edinburgh Postnatal Depression Scale, and the General Health Questionnaire. Women with high scores are referred to the psychiatric department where further tests are done. Those diagnosed with PND by a psychiatrist as a result of this screening of the 'normal' childbearing population formed the sampling pool for this study. We recruited a purposive sample of 35 Hong Kong Chinese women who were diagnosed by a psychiatrist as having major or minor PND, as laid out in the Diagnostic and Statistical Manual of Mental Disorders (4th edition) criteria and who were willing and able to describe their experiences. Another 20 women who were recently diagnosed (within 12 months) with non-PND were recruited from the psychiatric out-patient department. Women were referred to this study by a psychiatrist.

Brief demographic data were collected at the initial contact between the participant and interviewer. An in-depth interview was conducted at a mutually convenient place in order to explore the woman's perception of her depression and associated factors. In order to encourage freedom of expression, the interview was semi-structured, guided by a brief interview schedule comprising non-directive open-ended questions.

Results

Women with postnatal depression

Thirty-five women were interviewed. Two were multiparous and the rest were

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Table 1. Themes and subcategories in postnatal depression

Themes	Subcategories
Trapped in the situation	Helplessness and hopelessness Anger Anxious and fearful No way out Suicide or homicide
Ambivalent towards the baby	Both love and hatred towards the baby Cause of their unhappiness Perceived baby as a burden Thought of harming or killing the baby Continue to live for the sake of the baby
Uncaring husband	Shows little concern Unhelpful Controlling
Controlling and powerful in-laws	Gender preference Demand strict obedience Inconsiderate
Regaining control	Attempt to find alternatives to life Seek help from health care professionals Avoid being labelled as mental patient

primiparous. Participants' ages ranged from 20 to 40 years; 31 (89%) of the women had finished secondary school education and 97% were married. The majority had nuclear families. Only 9% of the women were unemployed outside their home. The commonest (29%, n=10) household income range was HK\$11 000 to 30 000. All the women being interviewed were not in acute depression. The time since psychiatric consultation ranged between 6 and 12 months. None of them had been hospitalised for depression.

Themes that emerged from participants' descriptions of their experiences included feeling trapped in their situations, ambivalence towards the baby, that husbands were uncaring, issues with controlling and powerful in-laws, and need to regain control. The women identified their relationships with family members as the source of their unhappiness. Each of these themes had subcategories, as illustrated in Table 1.

Women with depression not associated with the postnatal period

Twenty women who were diagnosed with depression not associated with a postnatal period were interviewed. Participants' ages ranged from 20 to 50 years, 14 (70%) of the women had finished secondary school education; four (20%) were single, eight (40%) married, four (20%) divorced, and four (20%) separated. The majority (55%, n=11) were housewives while the rest had paid employment. Seven (35%) had an average household income of HK\$16 000 to 30 000, which was similar to that of the PND group. Table 2 outlines the themes and subcategories generated by this group of women.

Many of these women had unhappy marriages and marital failure was a major precipitating factor in their depression. They perceived their husbands as uncaring, distant, unhelpful, and abusive. Some perceived their financial burden as their major stress. This group had more

Table 2. Themes and subcategories in non-postnatal depression

Themes	Subcategories
Trapped in the situation	Depressed, angry Anxious and worried Insomnia, weight loss, poor appetite, tired Loss of confidence Helplessness Out of control Suicidal
Sources of unhappiness	Marital problems Financial problems
Regaining control	Find a new life Share feelings with others

severe suicidal ideation than the PND group, and some had been hospitalised for depression. The women did not seek help until symptoms became very severe.

Discussion

Childbirth is an experience that brings many changes and women need support to cope with these changes. A perceived lack of support from husbands and families might contribute to PND. Women might not be able to find help from external sources. People become depressed when they perceive themselves as powerless to control a stressful situation.

Although the family is an important source of social support to individuals in Chinese society, it can also be a burden and source of unhappiness, and is thus a double-edged sword. It is possible that the presence of a family member can induce stress to a new mother, as in this study, where relationships between participants and in-laws were perceived as a major cause of unhappiness.

The majority of the women in this study had received an average education and many had a job. They were financially independent. Although influenced by western culture where assertiveness is valued and encouraged, participants nevertheless found it difficult in reality to be assertive and outspoken. Although Hong Kong women may appear westernised on the surface, they still feel an obligation to obey senior family members and perceive themselves to be powerless to fight back.

The gender of the baby appeared to be a cause of stress for the mother. Although most participants had no personal preference about the gender of the baby, older family members retained a preference for a son to carry the family name.

Problems of dissonance between Chinese and western culture might have a particular impact on adults aged 20 to 40 years, like the participants in this study. Most have been brought up in Hong Kong and received a western education, whereas their parents came from Mainland China and are

considered to be very traditional Chinese. The differences in values and belief systems between the two generations may manifest explicitly around childbirth, such as in the preference for a male baby or the naming of the baby.

Our participants were in a dilemma. On the one hand, they tried to maintain harmonious relationships in the family, but on the other hand, they were unhappy because they had to sacrifice themselves. Kuo and Kavanagh² suggested that depression is usually associated with poor interpersonal relationships in Chinese society. The contribution to PND of poor relationships between mothers and their in-laws as found in our study has not been reported in the literature.

The majority of participants perceived their husbands as uncaring and controlling. In Hong Kong, traditional gender roles continue to prevail in the family: the man is the breadwinner and the woman the caregiver, even if both are employed. The dominant position of the husband might make it difficult for the wife to ask for help. Past studies, such as that by Beck³ and Misri et al⁴ have illustrated that the perceived lack of support from the husband and a poor marital relationship is associated with a high risk of PND. The present study also suggested this association.

The findings of this study shared some similarities with a study by Beck⁵ in which feelings of helplessness and hopelessness, loss of control, ideas of infanticide and self-destruction were common. However, ambivalent feelings toward the baby, which was a common finding in this study, have not been mentioned in other PND studies, such as those of Beck⁵ and Littlewood and McHugh,⁶ and have also not been mentioned in the Chinese literature.

'Phantom crying' was a common phenomenon described by the participants, which has not been reported in the western literature. This phenomenon differs from the common anxiety seen in new parents where, for example, they may get out of bed several times during the night to check on the baby. 'Phantom crying' is worthy of further study as the women who have experienced it often find it disturbing both mentally and physically.

The non-PND group had similar presentations of depression as the PND group. They also perceived themselves to be powerless to control their situations. Both groups of women did not take the initiative to seek medical help for their condition. A woman experiencing PND might see herself as failing at the role of motherhood and consequently suffer loss of face, and shame. Women and their families might not wish to be identified as not coping with motherhood and be perceived as inadequate. They might also worry that they would be labelled as mentally ill, and therefore unfit to be mothers. Women in the non-PND group also worried that they might be perceived as failing to meet their roles in their marriage, homes or work, thus influencing their decision to not seek help at an early stage.

For the PND group, a routine screening programme was in place at the hospital where they delivered the baby so their depressions were detected early and help was given on time. This might be a reason why none of the women in the PND group were hospitalised for depression. In the non-PND group, no easily accessible depression screening mechanisms were available in the community so the diagnosis and treatment might be delayed. Many women in the non-PND group had histories of attempted suicide and some had been hospitalised, indicating that their illnesses were severe by the time they contacted the mental health services.

Possible strategies for managing depression

Early identification of those people who are at high risk of depression could help direct them to appropriate treatment or management as soon as possible. Routine screening for PND by using the Edinburgh Postnatal Depression Scale and the General Health Questionnaire should be established in all obstetric units. Standardised assessment instruments for screening depression, such as Beck's Depression Inventory could be considered for suspected or at-risk individuals. To achieve more accurate and reliable assessments, training on the use of the assessment tools and the relevant assessment skills are important for those health care professionals acting as gatekeepers.

Health care professionals can offer information and psychological support to women through face-to-face individual counselling. Support groups or self-help groups would be useful to mothers, and enable them to offer support and share experiences with each other. Midwives and nurses working in the PND clinic or postnatal out-patient clinics could help clients to set up these groups. Groups could also be organised for husbands so that they could learn how to help their wives through experience sharing and discussion in groups. This intervention can also be applied to the non-PND group.

If women are unwilling to come to the PND/psychiatric clinic, home-based care could be provided. Health care professionals could establish outreach services visiting the women at their homes to gain a better understanding of their lives and give practical support and advice to women in their own environment. Other alternatives, such as tele-support or web-based support groups can make more help available to women at home.

Education programmes on PND can be conducted antenatally as well as at postnatal clinics. Such education programmes should help to diminish the knowledge deficit in mothers and their families.

Health care professionals can assess women's and their family's understanding of illnesses and treatment then provide appropriate psycho-education. This should help improve compliance with treatment.

Health care professionals can assess the family for any

family dysfunction and make appropriate referrals to marital counselling services or family therapy. Family services that are affordable and accessible to all should be made available to women in the community.

Education of the public about mood disorders, their signs and symptoms and potential sources of help is important for clarifying misconceptions about, reducing the stigma of, and raising awareness of, PND and depression.

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