Clinical and Experimental Health Sciences

The Effect of Spousal Support on Postpartum Depression and Quality of Life

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ABSTRACT

Objective: The study was conducted to determine the effect of spousal support on postpartum depression and quality of life.

Method: The descriptive and correlational study was conducted with 201 mothers between the 4th and 12th week postpartum in a Lokman Hekim Hospital of Ankara. The data were collected with the Personal Information Form, the Spouse Support Scale, the Edinburg Postpartum Depression Scale, and the World Health Organization Quality of Life Scale-Short Form. The data were evaluated using the SPSS 22.0 program, parametric methods, correlation and regression analyses and descriptive statistics.

Results: The mean scores of the participants were 66.23±18.19 on the Spouse Support Scale, 6.14±7.90 on the Edinburg Postpartum Depression Scale and 15.09±3.72 on the World Health Organization Quality of Life Scale. The postpartum depression rate was 25.4%. There was a negative and high correlation between the Spouse Support Scale and the Edinburgh Postpartum Depression Scale (r=-.84, p<.05), and a positive and high correlation between the Spouse Support Scale and the World Health Organization Quality of Life Scale (r=.82, p<.05).

Conclusion: The support women receive from their husbands reduces the risk of postpartum depression and enhances their quality of life in the postpartum period. It is recommended that fathers be included in training during pregnancy and birth to prevent postpartum depression.
Keywords: Postpartum, depression, spousal support, quality of life

1. INTRODUCTION

Pregnancy, also known as the antepartum period, lasts for around nine months and ten days and plays a significant role in a woman's life. The period following the birth event is called postpartum (1). The mother goes through several physiological, psychological, and social changes during the postpartum period (2). She is also going through a time of psychological distress as she attempts to adjust to her new tasks and obligations. Postpartum depression may develop at this time due to depression symptoms, including mood swings and a lack of enjoyment in life, which may progress to postpartum depression (3). A psychiatric condition called as postpartum depression often starts 2–6 weeks after delivery and can persist for up to a year (4). The prevalence of postpartum depression is reported to be 5-20%, but the baseline frequency is estimated to be 10% (5). Several factors can contribute to postpartum depression, such as underlying unhappiness and anxiety, difficulty caring for children, harsh living conditions, an unhappy marriage, an unplanned or unexpected pregnancy, socioeconomic status, and a lack of social support (6). The absence of social support is one of the most potent causes of the formation of negative psychotic states in the postpartum period (7). The most significant form of social support for a woman is marital support, which she receives from her spouse with whom she shares parental responsibilities. The husband is the one with whom the mother shares the same social environment, has the same issues, spends the most time in the same location, and shares parenthood duties. Accordingly, the mother's receiving both social, physical, and mental support from her partner, such as baby care, housework, and communication support, will enable her to carry out the postpartum period in a healthy way. When the literature is examined, it is reported that the support a woman receives from her husband during the postpartum period has a reducing effect on postpartum depression (8-10).

Another important issue in the postpartum period is quality of life. Quality of life is a broad concept that can be affected by many factors. The quality of life can be favorably or adversely influenced by a person's physical and mental health, emotional state, amount of independence, social connections, and environmental factors. By identifying uncomfortable circumstances and acting, people's quality of life can be

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enhanced, and their level of happiness raised (11). In addition to postpartum depression, the mother's quality of life may be significantly impacted, particularly during the postpartum period when women are emotionally sensitive. The maternal quality of life may be significantly influenced by insomnia, adjusting to new responsibilities, caring for the newborn, and hormonal, physical, emotional, and social changes encountered during the postpartum period (12). The spouse's support during these procedures may have a favorable effect on the maternal quality of life. This support can be given through participating in infant care, helping with housework, supporting the mother emotionally, and sharing, thus contributing positively to the improvement of the maternal quality of life (9,13-16).

According to the relevant literature, the postpartum period is a significant issue that affects the mother, the infant, the family, and even society as a whole. Spouse support is believed to have a significant role in this crucial process that affects postpartum depression and quality of life. Studies on the postpartum period are generally related to social support and adjustment to motherhood. Especially the spousal support provided in the postpartum period has not been covered much in the literature we examined. Field research findings highlight the significance of looking at these interactions (17,18). For this reason, this descriptive and correlational study in nature was conducted to determine the effect of spousal support on postpartum depression and quality of life.

1.2. Research Questions

1.Does the spousal support women receive affect the risk of postpartum depression?

2.Does the spousal support women receive affect their quality of life?

3.Is there a relationship between spousal support received by women and postpartum depression and quality of life?

2. METHODS

2.1. Design and Sample

This descriptive and correlational study was conducted in Lokman Hekim Hospital of Ankara between February and May 2022. The population of the study consisted of mothers who were admitted to this hospital between the 4th and 12th week after delivery. The sample size calculate formula for unknown population was used to calculate the sample size of the study ($n=t^2.[p*q]/d^2$). Using the sampling formula, the sample size for this non-homogeneous universe was calculated as $n = (1.96)^2(0.15)(0.85)/(0.05)^2 = 196$. Considering case losses, 201 women who met the inclusion criteria were recruited for the study.

Inclusion criteria of the study; were being at the age of 18-45 years of age, being between 4 and 12 weeks postpartum, having an alive and healthy fetus, having no communication problems, and not having any previously diagnosed psychological disorder in herself or her partner and volunteering to participate in the study. Foreign national women were excluded from the study. The women included in the sample were selected using the random sampling method.

2.2. Data Collection Process

The data were collected through face-to-face interviews between February 2022 and May 2022. The Personal Information Form, postpartum the Spouse Support Scale (SSS), the Edinburg Postpartum Depression Scale (EPSDS), and the World Health Organization Quality of Life Scale-Short Form (WHOQOL-SF) were used for data collection.

The Personal Information Form: Prepared by the researcher (in line with the literature), the form consists of 10 questions about personal characteristics, pregnancy, and the health status of the woman (6,8,10,13).

The Spouse Support Scale (SSS): The Spousal Support Scale was developed by Yıldırım (2004) to determine the level of perceived spousal support. It consists of 27 items and has a 3-point Likert type. The maximum score that can be obtained from this scale is 81, and a high score refers to high perceived spousal support. The SSS has 4 sub-dimensions: emotional support, instrumental and information support, appraisal support, and social support. Cronbach's alpha coefficient of the Spouse Support Scale was found to be.95 (19) in the original study and.98 in our study.

The Edinburg Postpartum Depression Scale (EPDS): It was developed by Cox and Holden in 1987 and adapted into Turkish by Engindeniz (1996). The 10-item scale is a 4-point Likert-type and is based on self-report. Responses with four options are scored between 0 and 3. The minimum and maximum scores to be obtained from the scale are 0 and 30. Cronbach's Alpha was found to be.79 in the validity and reliability study conducted by Engindeniz and.96 in our study. The cut-off point of the EPDS is 13, and those with a score of 13 or more were considered the risk group (20).

The World Health Organization Quality of Life Scale-Short Form (WHOQOL-SF): Turkish adaptation study of the scale was conducted by Eser et al. (1999), and there are 27 questions in total in the Turkish version of the scale. In the Turkish version, unlike the original 26-question short form, the 27th question is not included in the scoring and is evaluated separately. The WHOQOL-SF has 4 sub-dimensions: physical, mental, social, and environmental quality of life. The scale does not have a total score, and each domain is evaluated over 20 or 100 points. The Cronbach's alpha internal consistency coefficients of the scale were.76 for the physical quality of life,.67 for the mental quality of life,.56 for the social quality of life, and.74 for the environmental quality of life. In the study conducted by Eser et al., Cronbach's alpha internal consistency coefficient was found to be.86 (21). In our study, the reliability of the WHOQOL-SF was found to be Cronbach's Alpha=.98.

2.3. Data Assessment

Data evaluated with SPSS 22.0 statistical program. Frequency and percentage analyses were used to determine the descriptive characteristics of the women, and mean, and standard deviation statistics were used to analyze the scale. Kurtosis and Skewness values were analyzed to determine whether the research variables were normally distributed. In the relevant literature, results regarding kurtosis and skewness values of variables between +1.5 and – 1.5 (22), +2.0 and – 2.0 (23) are considered normal distribution. Parametric methods were used to analyze the data. The relationships between the dimensions that determine the scale levels of women were examined through correlation and regression analyses.

2.4. Ethical Approval

Ethical permission was obtained from the Health Sciences University Hamidiye Scientific Research Ethics Committee on 05.11.2021(number of approval:3/18). Institutional permission was obtained from Lokman Hekim Hospital of Ankara (date:23.02.2022; number:260). In addition, all the participants gave written and verbal informed consent to participate in the study. Necessary permissions were obtained for the use of the scales.

3. RESULTS

The mean age of the women was 26.13±4.26 years, 50.2% were university graduates, and 52.2% had income equal to their expenses. Most of the women (72.1%) spent most of their lives in metropolitan cities, 62.7% got along well with their husbands, 43.3% gave birth 4 weeks ago, 78.6% had planned pregnancies, 41.8% had two children, 62.7% had cesarean sections. 51 (25.4%) of the participants who scored 13 and above on the EPDS were considered at risk for postpartum depression (Table 1).

The analyses showed that the mean total score was 66.23±18.19 for the Spouse Support Scale, 22.04±5 for the emotional support, 16.92±4.95 for the instrumental and information support, 19.71±5.47 for the appraisal support, and 7.54±2.22 for the social support sub-dimensions. The mean score of the WHOQOL-SF was 15.09±3.72. The mean scores for the sub-dimensions were 15.25±3.78 for the physical quality of life, 15.13±3.75 for the mental quality of life, 14.62±4.61 for the social quality of life, and 15.38±3.33 for the environmental quality of life (Table 2).

As seen, a high level of negative correlation was found between the total score of the EPDS and the total and sub-dimensions of the SSS (p<.001). A positive and high correlation was found between the total score of the WHOQOL-SF and the total and sub-dimensions of the SSS (p<.001). Physical quality of life, mental quality of life, social quality of life and environmental quality of life scores, the sub-dimensions of WHOQOL-SF, were found to be positively and highly correlated with the total and sub-dimensions of the SSS (p<.001)(Table 3).

Table 1. *Descriptive, Obstetric Characteristics and Postpartum Depression Status of Women*

Characteristics	N=201	
	n	%
Age		
20-25 ages	41	20.4
26-30 ages	98	48.8
30 + ages	62	30.8
Education level		
High school and below	58	28.9
University	101	50.2
Postgraduate	42	20.9
Income level		
Income less than expenses	50	24.9
Income equal to expenses	105	52.2
Income more than expenses	46	22.9
Place of residence		
Metropol	145	72.1
City – Province	56	27.9
Relationships with spouse		
Good	126	62.7
Moderate	49	24.4
Bad	26	12.9
Time of the last birth		
4 weeks ago	87	43.3
5-8 weeks ago	55	27.4
9-12 weeks ago	59	29.3
Planning status of the last pregnancy		
Planned	158	78.6
Unplanned	43	21.4
Number of children		
1	71	35.3
2	84	41.8
3 and over	46	22.9
Mode of delivery		
Vaginal Birth	75	37.3
Cesarean Birth	126	62.7
Risk of postpartum depression		
In the risk group (13 and over)	51	25.4
Not in the risk group (under 13)	150	74.6

Table 2. *Total and Sub-dimension Scores of the Scales.*

Scales	N=201		
	Mean ±SD	Min.	Max.
Spouse Support Scale total	66.23±18.19	27.00	81.00
Emotional support subscale	22.04±5.91	9.00	27.00
Instrumental and information support subscale	16.92±4.95	7.00	21.00
Appraisal support subscale	19.71±5.47	8.00	24.00
Social support subscale	7.54±2.22	3.00	9.00
Postpartum Depression Scale total	6.14±7.90	0.00	29.00
Overall Quality of Life Scale total	15.09±3.72	6.06	19.83
Physical quality of – life subscale	15.25±3.78	4.00	20.00
Mental quality of life subscale	15.13±3.75	6.67	20.00
Social quality of life subscale	14.62±4.61	4.00	20.00
Environmental quality of life subscale	15.38±3.33	7.56	20.00

Mean: Average SD: Standard deviation, Min: Minimum, Max: Maximum, SD: Standard deviation

Table 3. *Correlation Between Spouse Support, Postpartum Depression, and Quality of Life*

		Spouse support	Emotional Support	Instrumental and Information Support	Appraisal Support	Social Support
Postpartum Depression	r	-.84*	-.81*	-.81*	-.83*	-.84*
Overall Quality of Life	r	.82*	.79*	.79*	.81*	.79*
Physical Quality of Life	r	.73*	.71*	.71*	.73*	.70*
Mental Quality of Life	r	.81*	.79*	.78*	.82*	.79*
Social Quality of Life	r	.81*	.79*	.80*	.80*	.79*
Environmental Quality of Life	r	.78*	.76*	.76*	.79*	.75*

**p<.001; Pearson correlation analysis was used*

Table 4. *The Effect of Spouse Support on Postpartum Depression and Quality of Life*

Dependent Variable	Independent Variable	ß	t	p	F	Model [p]	R^2
Postpartum Depression	**Constant**	**30.32**	**26.43**	**.000**	**477.56**	**.000**	**.70**
	Spouse Support Total	-0.36	-21.85	.000			
Overall Quality of Life	**Constant**	**3.96**	**6.94**	**.000**	**408.41**	**.000**	**.67**
	Spouse Support Total	0.16	20.20	.000			
The physical quality of life	**Constant**	**5.15**	**7.48**	**.000**	**230.87**	**.000**	**.53**
	Spouse Support Total	0.15	15.19	.000			
The mental quality of life	**Constant**	**3.96**	**6.83**	**.000**	**398.17**	**.000**	**.66**
	Spouse Support Total	0.16	19.95	.000			
The social quality of life	**Constant**	**0.91**	**1.27**	**.200**	**395.40**	**.000**	**.66**
	Spouse Support Total	0.20	19.88	.000			
The environmental quality of life	**Constant**	**5.82**	**10.60**	**000**	**325.19**	**.000**	**.61**
	Spouse Support Total	0.14	18.03	.000			

Linear Regression Analysis was used

ß: Coefficient of expansion, t, p, F: Test significance values, R^2: Explanation variance ratio

The linear regression analysis conducted to determine the cause-and-effect relationship between the SSS and the EPDS was found to be significant. The regression analysis between the SSS and the total and sub-dimensions of the WHOQOL-SF was found to be significant (p<.001). Spousal support explained 70% of the total change in the level of postpartum depression, and spousal support decreased the level of postpartum depression. 67% of the total change in the overall level of quality of life was explained by spousal support, and spousal support increased the level of quality of life Spousal support affected the physical quality of life by 53%, the mental quality of life by 66%, the social quality of life by 66%, and the environmental quality of life by 61%, and it was concluded that spousal support increased the level of physical, mental, social, and environmental quality of life of women (Table 4).

4. DISCUSSION

Postpartum depression is a problem that cannot be ignored in women, both in terms of its effects and frequency. Studies can offer us an indication, even if it is impossible to declare that the prevalence of postpartum depression reveals the precise rates owing to various factors. In a study conducted in Israel with 280 women in the postpartum period, the prevalence of PPD was reported as 22.6% (24). In a study conducted with 1584 women in Sweden, a scale to determine the prevalence of PPD was applied at the 8th and 12th weeks postpartum, and the rates were found to be 12.5% and 8.3% in these weeks, respectively (25). When the prevalence of PPD was examined in studies conducted in our country, it was found to be 33.3% in the study of Dağlar et al (2018) (26). The prevalence of PPD was determined to be 23.8% in a meta-analysis research that included 52 publications published between 1999 and 2015 to explore its prevalence and the variables influencing it in our country (27). In the current study, PPD was found to be 25.4%, close to the rates in our country (Table 1). These differences may be related to the structure of the society in which the study was conducted, the differences in diagnostic measurements, the time of application of the measurements, and the way the scales were applied.

Spousal support is an integral element of social support systems. The need for spousal support increases even more in the postpartum period. As seen in Table 2, the mean score of SSS was found to be 66.23±18.19. This value can be interpreted as the women participating in the study receiving moderate spousal support (19). In the literature, like the current study, Yüksekal et al (2021) found the mean total score of the SSS to be 68.99±10.8 (28). It was observed that the subscale scores of the relevant studies were similar to our study. There are a limited number of studies in the literature examining spousal support in the postpartum period. In addition, there are a few studies conducted with the "Spouse Support Scale" in the postpartum period. In the literature, it

is emphasized that women need spousal support in postnatal processes and that these critical processes become less stressful in this way and lack of spousal support at the time of need may cause irreparable problems (29).

Postpartum depression is a mood disorder that mothers may encounter after giving birth. In the present study, the mean score of EPDS was found to be 6.14±7.90 (Min=0; Max=29) (Table 2). This score can be interpreted as the average scale score of the women participating in the study being below average. In parallel with the current study, the mean score of EPDS was found to be 5.61±4.51 (Min=0; Max=24) by Özşahin et al. (2020), and 5.66±4.72 (Min=0; Max=29) by Sunay et al. (2021) (30,31). The current study is similar to the literature in this regard, but small differences are thought to be due to measurement time, personal and cultural factors.

The quality of life of women in the postpartum period can sometimes be ignored. The mean overall score of WHOQOL-SF scale, which we applied to measure the quality of life of women in the postpartum period who participated in our study, was found to be 15.09±3.72 (Min = 6.06; Max: 19.83). These values and subscale scores are listed in Table 2. This score can be interpreted as the general quality of life of the women participating in the study being at a medium level. When the literature was examined, other studies evaluating postpartum quality of life found studies in which the postpartum quality of life of mothers was at a moderate level, similar to our study (32,33). Some studies have also reported that postpartum quality of life is at good levels (34,35). These differences are thought to result from differences in time, group, culture and measurement tool.

Social support appears to have a direct impact on PPD risk (36). Here, we took the spouse as the primary source of support for the woman in the postpartum period, and the highly negatively correlated correlation between spousal support and PPD has demonstrated that as spousal support increased, PPD risk decreased (Table 3). This result can be interpreted as the incidence of postpartum depression decreases as spousal support (all support including emotional, instrumental and informational, assessment and social support) increases. In a study, it was reported that 14.7% of women who received support from their spouses were diagnosed with PPD, while 42.9% of women who did not receive support from their spouses were diagnosed with PPD (37). Similarly, there are other studies with similar findings stating that the risk of PPD is higher in women who cannot receive support from their husbands in the postpartum period (38,39). Although the results in the literature are similar to our results, it can be said that regardless of place, time and culture, it is important for women to receive support from their husbands, especially in the postpartum period. In our study, the relationship of spousal support with quality of life, as well as its relationship with PPD, was examined. A high positive correlation was determined between the total score of the WHOQOL-SF and the total and sub-dimensions of the SSS, namely ''emotional support'', ''instrumental and information support'', ''appraisal support'', and ''social support'' (Table 3). Consistent with our results, noted that spouse support has a major impact on quality of life, so it can be concluded that as spousal support grows, so does quality of life. In a similar study, a moderately strong and positive relationship was found between spousal support and all its sub-dimensions and general quality of life and its sub-dimensions (40). Similar to our study, it has been observed in the literature that spousal support increases the quality of life.

Current study results revealed that spousal support reduces the level of postpartum depression and increases the quality of life (Table 4). Although there are no studies in the literature that examine both the relationship between spousal support and postpartum depression and quality of life simultaneously, there are studies that examine this relationship separately. It has been observed that the results in the literature and our study results are generally similar (39-41). Regardless of the place, time, culture and measurement tool where the study was conducted, it is an expected result that spousal support reduces depression and increases the quality of life during this important and difficult period for women.

5. CONCLUSION

Postpartum depression poses a risk to one-fourth of women. Spousal support is a powerful tool in lowering the prevalence of postpartum depression, and women's perceptions of spousal support improve their quality of life. Considering these results, health professionals working in the relevant units of hospitals can be trained on the prevention, diagnosis, and treatment of postpartum depression and the importance of including the woman's partner in the whole process during pregnancy, birth, and the postpartum period. PPD screening might also be included in standard postpartum examinations.

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