Post natal depression case study

The Experience of Health & Illness Level 2 Assessment Client Study – Culture and the ‘ service user’ experience

This essay details the experiences that I had in dealing with and observing a Mrs. N, a 28 yr old lady who safely delivered a baby girl in December of last year. Her major problem was the development of post natal depression, but there were a number of contributory factors which were relevant in her case, one of which was her culture and ethnic background which coloured both her expectations and her reactions to the various landmarks which punctuated her illness trajectory.

1. Identify a specific client/user and provide a vivid but non-judgemental description of his or her personality, family, cultural and social background (include employment, education, housing etc).

Mrs. N is a Bangladeshi lady who has been married for seven years. It was an arranged marriage. She is 28 yrs old which means that she was married comparatively late for her culture. Her husband, (Mr. N) is a year older than her and has been living and working in the UK for 8 years as a London Transport bus driver. He has been working to set up a home in the UK and it was always the intention that Mrs. N would come to the UK when conditions were stable for them.

Mrs. N has lived in her in-laws home in Bangladesh until last year when she was granted permission to enter the UK and live with her husband. The seven years that she spent with her husband’s family were very difficult for her. She had a great deal of difficulty in coping with her mother-in-law’s (Mrs S.) overbearing and dictatorial manner. Mrs S felt that it was her place to “

mould and shape” her daughter-in-law’s life and manners to suit what she considered to be her place in society.

Mrs. N had only a limited education and would be considered to be less well educated than her husband. This was a major issue for the husband’s family and there was the underlying feeling that he “ could have done better” for himself. Mrs S appeared never to miss an opportunity to remind Mrs. N of this fact. (Tseng, W et al. 2001)

An additional factor was that both Mr. & Mrs. N were intensely aware of the cultural and family expectations on them to have children. Although Mr. N frequently visited his wife in Bangladesh, she had not conceived for 6 years, which led to anxiety between the couple and friction between Mrs. N and Mrs S.

When Mrs. N eventually became pregnant, she came to the UK to live with her husband in a culture that she was unfamiliar with and could only speak rudimentary English. She felt very isolated and had difficulty in coping with the day to day problems of living.

2. Provide a brief outline (no more than 200 300 words) of the basis of their need for health care (i. e. pregnancy or other specific physiological condition) highlighting only those aspects that may have implications for their cultural and social health and well-being.

Mrs. N had a relatively uneventful pregnancy and a normal delivery. Routine midwife post delivery checks were normal, but it was noticed buy the health visitor that Mrs. N was becoming progressively more withdrawn, tearful and

unable to cope with the new baby at about the 3 month period. This was difficult to assess as Mrs. N had difficulty in expressing herself and also was reluctant to involve the healthcare professionals in what she saw as “ her problem”. There was some debate amongst members of the primary healthcare team as to whether these changes were indicative of post natal depression or whether they were due to social isolation or perhaps a combination of both factors.

Post natal depression and culture

A number of studies have shown that post natal depression occurs with a similar incidence across virtually all cultures and civilisations. (viz. Marks, M. N. et al. 1992). It is known that perinatal psychoses are a leading cause of maternal morbidity and suicide related to such morbidity is the major cause of maternal mortality in both the UK and in Northern Europe. (CEMD 2001). There is no good quality published work detailing the prevalence of such mortality in Asian countries, but there is no evidence to suggest that it is in any way significantly different from the European figures. In any event, one can clearly deduce that post natal depression (and the other perinatal psychoses) are a major cause of debility.

Post natal depression is also known to be associated with longer term consequences for maternal mental health, marital problems and also the psychological health of the marital partner. (Asten P et al. 2004). It is also known to be associated with a number of adverse effects on the social and cognitive development of the infant and other siblings in the family. (Murray, J et al. 2003)

A brief overview of the literature on the subject however, shows that the great majority of the studies conducted into the subject of post natal depression has been undertaken in Western societies (viz. Kumar, R. 2004). The consequence of this observation is that such research generally does not take into account the range of psychosocial experiences that are associated with other cultures and civilisations where there are differing rates of lone motherhood, differing degrees of social support and family bonding, quite apart from the different emphasis placed on relationships within marriage, kinship and family. All of these factors will intuitively impact on the incidence and nature (and possibly the clinical presentation) of post natal depression.

3. Define how you are using the notion of ‘ culture’ for the purposes of the assignment. Try to make explicit answers to the following questions: What evidence and research did you use to describe and analyse the client’s/user’s cultural perspectives, needs and any other factors that might influence their understanding and interpretation of health, illness and treatments? How did you gather the evidence? ‘ Evidence’ here must include the client/user’s own narratives. What were your findings? For example, how did the user/client describe their experience and how did their story ‘ fit’ with what you observed in practice? How did it ‘ fit’ with theory you have read? Were they seen as ‘ difficult’ or ‘ good’ clients by practitioners – if so on what grounds and how might this be explained?

Culture is a complex concept. Most definitions refer to various patterns of human activity and the symbolic structures that give such activities significance and importance. Cultures can be “ understood as systems of symbols and meanings that even their creators contest, that lack fixed

boundaries, that are constantly in flux, and that interact and compete with one another” (Findley A et al. 2006)

Mrs. N’s culture was a central consideration in this case. Unlike many of her countrywomen, she had not become in any way anglicised and was, to a large extent, completely unprepared for the enormous cultural changes that she experienced between her lifetime home in rural Bangladesh and her new home in suburban London. If one adds to this the inevitable stresses of her first pregnancy, the loss of support of her (albeit critical) family and the advent of post natal depression.

Bangladeshi culture regards childbirth as a major life event, generally with a greater significance than in western civilisations. (Cox, J. L. 2006). It is specifically considered to be one of the major “ rites of passage” of a woman, not only from childhood to adulthood, but also into social respectability. (Gautam, S et al. 1992). Bangladeshi society has a number of specific rituals, prohibitions and proscriptions which typically accompany the passage of the woman into motherhood which are generally not found in western societies. These rituals both aid and guide the new mother, as well as providing the social support networks, to help the new mother adapt to her newly acquired role. It has been suggested that these rituals may assist in protecting new mothers from becoming depressed. (Seel, R. M. 1996)

In the case of Mrs. N however, it is clear that she had no back up of such rituals or social network support, as she found herself being suddenly removed from her familiar society and being suddenly transported (at a very critical and emotionally charged time in her life) into an alien an unknown

culture where she could not easily communicate with the healthcare professionals who were trying to help her.

In a landmark study of transcultural birthing practices in 1983, Stern & Kruckman found “ surprisingly little evidence of the phenomenon identified in Western diagnoses… as postnatal depression and suggested that the lack of post-partum rituals in Western society might be a cause of postnatal depression.” (Stern, G et al. 1983). The authors support this finding with the comment that “ The effectiveness of counselling in treating the condition may be through its re-creation of post-partum ‘ structure’ and the provision of social support which might formerly have been provided by the extended family (in Asian societies) and public recognition of the new role.”

An additional feature which was not immediately apparent, but only came to light later in the trajectory of the management of the illness, was the fact that Mrs. N felt ashamed that she had given birth to a baby girl. In Bangladeshi culture it is considered a sign of cultural status to have boys, particularly the first child. Shaheen R et al. 2006). The fact that Mrs. N had a girl reduced her own self esteem enormously.

4. You should develop a discussion of the assessment of the person’s actual and potential cultural needs, with reference to a specific theoretical perspective that has been introduced in the module e. g. social class and effects on health or the impact of illness on the family. As far as possible, use the evidence of the client/user’s own words to provide a more vivid insight of the client/user’s view and to give a robust basis for your own analysis and discussion.

Studies which have considered the cultural implications of post natal depression point to a number of factors which can be considered “ independent risk factors” for the development of post natal depression. (Kit, L. K et al. 1997). In specific regard to the case of Mrs. N , one can identify many of these as being relevant to her case.

We shall consider each factor in turn.

Many studies point to a number of factors that are a cause of happiness in pregnancy (which reduce the incidence of post natal depression) and these include discovery of pregnancy and the awareness of foetal movement. There is no doubt that Mrs. N was delighted to find that she was pregnant, not only because it pleased Mrs S, but also it meant that she would join her husband in the UK. This has to be contrasted with the negative factors including the initial difficulty in conception in Asian families as being a factor which increases the likelihood of post natal depression. (Mari, J et al. 1999)

Further negative associations were physical illness and discomfort, nausea, tiredness and a lack of sleep, (O’Hara, M. W et al. 1996) all of which were relevant to Mrs. N as she had bad back pain from about 18 weeks onwards which limited both her mobility and her ability to sleep comfortably. This pain did not resolve quickly after delivery and the lack of sleep persisted as she tried to establish breast feeding and experienced great difficulty as the baby did not feed well and therefore would not sleep well.

The role of healthcare professionals is often cited as a cause of postnatal unhappiness in studies that involve Asian women (viz. Pillsbury, B. L. K. (1998)

Maternity staff who are unsympathetic, and little time to talk (or difficulty in talking) are the commonest negative associations. Mrs. N certainly experienced both of these factors with some of the hospital staff and found her hospital visits very difficult.

Fortunately Mrs. N has a normal, relatively atraumatic delivery which therefore spared her another independent risk factor for post natal depression.

5. How were these cultural needs addressed? If they were not, or only partially met, say so and describe in what way you feel they might have been better achieved.

Mrs. N’s cultural needs were not met in a number of ways. Clearly the family support that she would normally expect to count upon was limited to her husband. This comment has to be seen in the context that her husband was a man, although she had known him for several years she had never lived in close dependent proximity to him before she was pregnant. In the same way, Mr. N was also a comparative stranger to this situation and he did not have other members of his family group to advise and support him. In the context of this small nuclear family unit (which clearly is not the cultural “ norm” in Bangladesh) it was not surprising that tempers were frayed and that Mr. N did not always support his wife. It is possible that he did not even recognise the signs of the pathophysiology of the post natal depression.

The language difficulty persisted. The hospital services provided a translator, but this lady was not present at every occasion that Mrs. N attended the

hospital and therefore she sometimes had to rely on other Bangladeshi women to translate and to help her. Clearly this was far from satisfactory.

6. Offer a conclusion with some indication of how your experience of this particular person’s needs have informed your practice and evaluate your own interactions and experience with the client/user/patient and their carers. For further details on submitting assessments, pass requirements and other information please refer to the separate assessment pack.

I have considered the case of Mrs. N at great length and reflected on its implications for my personal practice. (Palmer 2005). It is with some sadness that I look back. It seems clear that Mrs. N had a number of circumstances relevant to her post natal depression which were largely beyond her control. The fact that her “ world” was uprooted while she was in the early stages of pregnancy and she was transported to a culture that was alien to anything that she had previously known, clearly was a major de-stabilising factor for her. The factors which could have been changed would have to be the fact that an empathetic translator could have been present at every interaction with the healthcare professionals and this might have not only eased her problems but might have given the healthcare professionals a reciprocal insight into her predicament.

With her past history, one might reasonably deduce that she had a number of major risk factors for post natal depression and therefore it should have been actively considered from the point of delivery. There is a considerable body of evidence which suggests that the earlier post natal depression is positively diagnosed and aggressively treated, the less severe its eventual

trajectory becomes. (Dennis C L 2005). The language difficulties, inexperience of cultural difficulties and a reluctance on the part of Mrs. N to seek help all contributed to her post natal depression reaching quite a severe level before it was finally recognised.

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