

Relationship between Perceived Social Support and Depression Before and After Cesarean in the Pregnant Women

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Abstract

Introduction: Depression can have unfavorable complications for the mother and the baby. Given the probable relationship of social support with the amount of depression, the present study aimed to determine the relationship between perceived social support and depression, before and after cesarean in the pregnant women referring to Besat Hospital in Sanandaj in 2018.

Materials and methods: The present study is descriptive co-relational and cross-sectional, and was conducted on 180 pregnant women enrolled for the cesarean section referring to Besat hospital in 2018 who were selected according to available sampling method. The demographic information questionnaire, the perceived social support of MOS-SSS, and the depression, questionnaires Dass 21 were used to collect data. Using the SPSS 16 software, the data was analyzed through descriptive statistics, Pearson co-relation.

Results : Results indicated that the degree of the overall rate of depression, before cesarean was 35.5% and in the post operation stage 21.7% respectively. In addition, there was a negative significant difference between social support and depression, before the operation ($p < 0.05$, $r = -0.816$), and depression, after cesarean ($P < 0.05$, $r = -0.788$).

Conclusion: The results of the study showed that there is a negative and significant relationship between perceived social support and depression, before and after cesarean section. Hence it is advised that interventions be designed to identify and promote the level of social support in the pregnant women enrolled for Cesarean.

Key words: Perceived social support, Depression, Cesarean

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I. INTRODUCTION

Today, depression is considered as one of the most common psychiatric disorders and a general problem in human life and is seen in all countries and cultures [1]. The World Health Organization estimates that by 2020, depression will be the second most common illness worldwide [2]. Pregnancy and the subsequent period are associated with very important psychological and physiological changes that may sometimes lead to pathological changes and psychological disorders [1]. The prevalence of depression in women during pregnancy is 10-15% [3] And in the postpartum period is between 5 and 40%. Depression accounts for more than 12.5 percent of women's admissions due to psychological problems [4]. Maternal depression is one of the most serious mental health problems in women due to its side effects [5]. Postpartum depression is more common in women who have given birth by cesarean section [1].

The progression of postpartum depression is often gradual and usually begins 2 to 3 weeks after delivery. General symptoms of depression is: include fatigue, depressed mood, marked change in appetite or weight, loss of interest in most activities, insomnia or oversleeping, feelings of worthlessness or guilt, decreased concentration, death or suicide scars [6], agitation Acceptability, fear, lack of confidence, anger [7]. Maternal depression leads to: Decreased maternal self-care, inadequate nutrition during pregnancy, substance abuse, use of harmful substances to the fetus, spontaneous abortion, preeclampsia and postpartum depression [8], prematurity, low birth weight and infant death [9], the child's cognitive disorders (10), mother-infant relationship disorder [11], suicide [12] and parenting become dysfunctional [13]. Depressed women are unable to meet their social and emotional needs and their children are more prone to anxiety disorders and depression [14].

According to theories, factors such as biological causes (such as hormonal causes, genetic theories), psychosocial factors (personality traits, coping styles, stressful life events, dissatisfaction with marriage and low

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levels of social support) and And cultural factors play a role in depression [15]. Strong social support acts as a safeguard against pregnancy and postpartum depression, and lack of social support has been suggested as an important risk factor for postpartum depression [7]. Social support means receiving health information, material and psychological assistance provided by loved ones such as spouse, relatives, friends or a social network such as health care providers [15]. Social support is classified into two subgroups perceived and received [16]. Perceived social support is an individual's assessment of the availability of support when necessary. In fact, it refers to the idea that the sufferer has effective people who are potentially able to help him in times of need [17]. According to researchers, perceived social support is more important than received support for health behaviors. This conclusion is based on the argument that if sources of support are not perceived by a person, he/she will not use them [18].

The study of MasoudNia et al. (2011) showed that social support and postpartum depression have a negative and significant relationship with each other[19].The results of Pourkhaleghi et al. (2016) also showed that social support plays an important role in reducing postpartum depression [7]. while in the study of Abedian et al. (2014) with the increase of social support, the rate of postpartum depression also increased [15] and And the study of Lumley et al. (2001) also reported little effect of social support on depression during pregnancy and postpartum [20]. Therefore, due to the complications of depression, contradictory results in the relationship between perceived social support and depression and due to lack of knowledge in this field among women undergoing cesarean section, this study aimed to determine the relationship between perceived support and depression before and after the cesarean section between Pregnant women referred to Besat Hospital in Sanandaj were performed.

II. METHODOLOGY

This cross-sectional, descriptive-correlational study was conducted on 180 pregnant women referring to Besat Hospital in Sanandaj to undergo cesarean section. The inclusion criteria included willingness to participate in the study, being at the age of 18 to 45, having full consciousness, planned pregnancy, having a natural course of pregnancy, being healthy in terms of hearing and speech, lack of mental retardation in the mother, lack of history of infertility, lack of education in medicine and paramedics, lack of history of known mental illness, and other illnesses affecting the psychological state and surgical outcomes, having no significant event other than pregnancy in the past 9 months, no having a disable spouse or child, non-use of tobacco and drugs, and for the post-cesarean section, in addition to the above, the birth of a seemingly healthy child was also a criterion for entering the study. The exclusion criteria were the unwillingness to continue cooperation, tubectomy or hysterectomy during surgery, the death of the baby after birth, and the baby's hospitalization in the neonatal intensive care unit.

After obtaining permission from the Ethics Committee of Kurdistan University of Medical Sciences and obtaining a letter of introduction from the research deputy of the Faculty of Nursing and Midwifery and presenting it to the head of Besat Hospital, the researcher recoured for collecting information on consecutive days in the morning to the postpartum section of Besat Hospital And presented to pregnant women who were referred for preparation for cesarean section and had criteria for entering the study, provided an explanation of the purpose of the study.Pregnant women willing to participate in the study using the available sampling method were selected and after signing the consent form, questionnaire for demographic and midwifery information, social support perception, and depression DASS 21³ in the pre-cesarean section and the DASS 21 depression questionnaire in the post-cesarean section were completed by the researcher for the selected samples.

The demographic information questionnaire including questions about age, level of education, and occupation of the women and her husband, family income level, and midwifery characteristics such as questions about marital satisfaction, number of parity, history of surgery and cesarean section and satisfaction with the baby's gender. To measure social support in this study, the Social Support Survey Scale (MOS-SSS)⁴ developed by Sherbourne and Stewart (1991) for use in medical outcomes, was administered to the respondents. The scale measures the respondents' social support using 19 statements and 5 sub-scales. These sub-scales include tangible support including material and behavioral support (items 9 to 12), emotional support that evaluates positive emotions, sympathy, and encouragement to express feelings (items 1-8), Information support that measures guidance, information or feedback (items 1-8), kindness that measures love and affection (items 16 to 18), positive social interaction that measures the existence of individuals to engage in recreational activities (items 13, 14, 15, and 19). This scale is a self-report questionnaire that asks the participants to express the degree of their opposition or agreement with each of the statements based on a five-point Likert scale (never = 1, rarely = 2, sometimes = 3 points, often = 4, and always = 5 points). The lowest and the highest scores one may obtain on this scale are 19 and 95, respectively. To get the overall score, the sum of all scores is calculated.

¹Depression,Anxiety,Stress Scale (DASS)

²Social Support Survey Scale (MOS-SSS)

A higher score on this scale indicates that the person receives a higher level of social support. The reliability of this scale was reported using the Cronbach's alpha coefficient in the range of 74% to 93% [21]. Temanaifar and Mansurininik (2014) confirmed the face and content validity of the scale from the point of view of psychologists and estimated its reliability through the Cronbach's alpha coefficient as equal to 97% [22]. Then, based on their perceived social support scores, the respondents were placed into three groups (low social support: scores 19 to 44), (average social support: scores 44 to 69), and (high social support: scores: 69 to 95: high social support) [23].

To assess the respondents' Depression, the Depression, Anxiety, and Stress Scale (DASS 21) was administered. The scale consists of 21 items that measure depression, stress and anxiety, each by 7 items. The final score of each of the three scales is calculated as the sum of scores gained on that scale. The respondents' depression levels were assessed using items 3, 5, 10, 13, 16,17 and 21. The questions in this questionnaire are based on Likert and have four chances at all (none = 0, low = 1, average = 2, and high =3). After calculating the sum of the scores of the seven items, the final score obtained on the depression subscale was multiplied by 2 in order to match the 42-item scale. The final score obtained shows the severity of the symptoms (0-9: normal depression, 10-13: low depression, 14-20: average depression, 21-27: severe depression, and ≤ 28 : very severe depression). The reliability and validity of the scale have been confirmed in various studies in Iran [24] and abroad [25]. After completing DASS 21 in the pre-cesarean section, respondents completed the scale again at least 35 days after cesarean section. The collected data were analyzed using descriptive statistics and Pearson correlation test using SPSS software (version 16).

III. RESULTS

The mean age of the respondents was 30.51 ± 6.32 and that of their husbands was 34.87 ± 6.78 . Most of the respondents (85.6%) were housewives and 92.8% of their husbands were employed. 73.3% of them had a sufficient level of income and the majority of the respondents and their husbands held a high school diploma (37%). Most of the respondents (86.7%) Satisfied with their marital life. Besides, 16.6% of mothers did not have a history of delivery. Only 24.4% of mothers had a history of surgery and the majority of the respondents (83.9%) were satisfied with their baby's gender.

Table 1 shows the frequency and level of perceived social support in the respondents. As it can be seen, the percentage of perceived social support in the majority of respondents (63.3%) is within the score range of 44-69, indicating an average social support level.

Table 1: The frequency and level of perceived social support

Variable	Level	Frequency	Percentage
Perceived Social Support	19-44	4	2.2%
	44-69	114	63.3%
	69-95	62	34.5
	Total	180	100

The results showed the depression level in the majority of respondents before the cesarean section (64.5%) and after cesarean section (78.3%) is within the ange of 0-7, indicating a normal level of depression. The overall depression levels before and after the cesarean sections were 35.5% and 21.7%, respectively.

Table 2 shows the correlation between perceived social support and depression before and after cesarean section. The results of the Pearson correlation test showed a significant negative correlation between perceived social support and depression before and after cesarean section (p-value = 0.0001). The correlation coefficient values indicate the intensity and direction of this relationship. According to the obtained values, there a negative and strong correlation between the two variables, indicating that by increasing the level of perceived social support, the level of depression decreased before and after cesarean section.

Table 2: Correlation between perceived social support and depression before and after cesarean section

Variable	Statistics	Depression before cesarean section	Depression after cesarean section	Perceived social support
Perceived social support	Correlation	-0.816	-0.788	1
	P-value	0.0001	0.0001	-----
Depression before cesarean	Correlation	1	0.899	-0.816

section	P-value	-----	0.0001	0.0001
Depression after cesarean section	Correlation	0.899	1	-0.788
	P-value	0.0001	-----	0.0001

IV. Discussion

The results of the study showed that the majority of the respondents experienced an average level of perceived social support. These results are consistent with a study conducted by Faramarzi and Pasha. (2015) who reported the average social support among pregnant women [26], but contrary to the results of a study by SadeghiAvalshahr et al. (2014), who reported high social support among mother [18]. The reason for the inconsistency between the two studies can be due to differences in the studied populations. The participants in Sadeghi et al.'s study were primiparous women, and such women are more likely to be supported by their relatives.

According to the results of this study, the overall rate of depression before cesarean section was 35.5% (21.1% mild depression, 3.9% moderate depression, 9.4% severe depression and 1.1% very severe depression), after cesarean section. 21.7% (11.7% mild depression, 6.6% moderate depression and 3.4% severe depression). These results are consistent with the study of moshki et al. (27) and Baghi et al. (28).

Social support is a protective factor against depression and anxiety in pregnant women, which improves mental health through psychological mechanisms or the endocrine system. Social support in women is associated with positive mood, self-efficacy, self-worth, good self-esteem, good quality of life and a sense of positive interpersonal communication (29). When a person comes to believe that there are those who can help her when needed, her ability to overcome psychological pressures increases. In fact, perceived social support plays a moderating role in stressful life situations and has a positive role in the physical and psychological health of individuals [30]. Perceived social support can help a person who needs effective psychological help to cope with the pressures and problems of life because such a person has a clear perception in all the moment in life that there are some who help him/her when needed. Therefore, he/she stands more powerfully against difficulties [17]. Social support helps maintain the mother's mood and prevents postpartum depression (31).

The limitations of this study include the cross-sectional nature of the study, the limited access to Besat Hospital, the relatively low number of respondents (despite the calculation of the sample size based on previous studies), the use of availability sampling technique and the possibility that the respondents' may have not provided honest responses in the presence of the researcher.

V. CONCLUSION

Considering the prevalence of depression before and after cesarean section and Given the multiple complications of depression on mothers and infants and the relationship between social support and depression in the pre and post-cesarean section, health managers and health care practitioners are recommended to design some interventions to identify and promote the level of social support for pregnant women who are volunteers for cesarean section. Mental health and its related factors in pregnant women and patients undergoing surgical procedures should be placed on the top of the research list of the university.

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