Chapter One

Introduction

1.1 Background to the study

Pregnancy and delivery are two significant events for women. A woman's tasks and obligations automatically change with the birth of a child. As a result the Post-Natal period is associated with an increased risk of Maternal Post-Partum Depression (MPPD). Post- Natal Depression is a debilitating mental illness. It is an indicator for major depressive illness in the Diagnostic and Statistical Manual of Mental Disorders (5th edition; DSM-V) (MDD). PPD can alternatively be described as surpassing a certain level on a set mark, such as the Edinburgh Postnatal Depression Scale (EPDS) [1]. Sad demeanour, lack of interest or pleasure, insomnia, food disorder, fatigue, hopelessness or regret, poor focus, impatience, fear, and suicidal thoughts are common symptoms of Post- Natal Depression, which can start within 2 to 6 weeks after delivery or birth of the baby and last for over a year[2].

Post- Natal Depression is one of the most frequent but often under-diagnosed complications of delivery worldwide, affecting 10–15% of postnatal mothers yearly[3]. Although to mothers childbirth is seen as a beautiful experience, it can also be exhausting, tasking, and unpleasant, resulting in a low mood that impairs a woman's well-being, emotional stability, and productive capacity[4]. Post- Natal Depression has been dubbed "the parenthood thief" because it deprives some mothers of the pleasure of welcoming a new baby into their lives[5]. As already indicated, while this condition can evolve into severe depression and poses a significant risk of sickness and mortality, it is well acknowledged that it is highly under recognized and undervalued in many other nations. Also, reports state that the prevalence of PPD is 70 % greater in underdeveloped nations than in industrialised ones, with a variety of variables that contribute to the deterioration of the illness[6].

Various elements in Nigeria may act as repellants to Post-Natal Depression. The collective lifestyle, which is particularly prevalent in rural areas, allows community members to provide assistance. This provides pregnant women and new mothers with a sense of relaxation and calm while they face challenges. Furthermore, in certain African cultures, the customary naming ritual, which is usually held on the baby's eighth day of life, allows mothers to look forward to an exciting event during the first few days following birth. In addition, the traditional practice of "omugwo," in which a woman's mother and/or mother-in-law lives with her for up to 6 months following her delivery to care for both mother and baby . This ritual helps the new mother adjust accordingly. However, anecdotal observations show that while rural women enjoy communal support, the urban women including female primary school teachers may not enjoy the same type of communal help. Some may succumb to postnatal depression[7].

Post- Natal Depression (PPD) is a type of mood disorder or mental illness that brings about a complex blend of physical, emotional and behavioural changes that happen after giving birth. It can develop at any point during the first year of postpartum, with a peak of incidents in the first 4 months of postnatal[8]. The mother might feel she is not capable of taking care of the child which might lead to having a feeling of worthlessness. It should be pointed out that the emotions projected out by the mother will have effect on the father which may also adversely affect the marital relationship. It is somewhat difficult to attain marital satisfaction when PND is in place. It takes a great deal of effort to sustain the relationship between couples if there is the issue of Post- Natal Depression. One very sensitive part of married life is that when a baby comes into the picture, the relationship between the couple is put to the test. In the first year following the birth of a new child, marital issues are frequently encountered by couples. It may be much more challenging to adjust your lifestyle if you have Post- Natal Depression. A relationship can be severely strained by depression of

any type. However, there is a direct correlation between post-natal depression and an increase in marital issues. Marriage issues might arise after Post-Natal Depression for a number of different reasons; just dealing with post-natal depression may be tough. Relationship stress together with persistent melancholy and anxiety might exacerbate the issue. These emotions might cause recurring issues that make being a parent more challenging[9].

A woman's body and mind go through many changes during and after pregnancy. There are some cases where the feeling of emptiness, lack of emotion and sadness comes with childbirth[10]. Some would-be mothers accommodate fear as a result of internal and external forces. Some of those internal forces can be feeling of fear for lack of readiness in giving birth and raising the child; some individuals as a result of what they've heard and seen are afraid of the whole process of bringing a child into the world. There is also the fear of death during child birth. External forces that might result in Post-Natal Depression can be pressure from spouse and also in-laws. Mostly common in the eastern and part of western Nigeria is the importance of having a male child. Some cultures in this part do not regard female offspring as children because they believe male children are assets to carrying over the family name, the pressure and stress of this can result in the new mother developing Post-Natal Depression. This proves that the cause of PPD can be social as well as psychological.

Social support has been demonstrated to be useful in assisting women in coping with postnatal depression, despite the fact that the cause of Post-Natal Depression is still unknown[11]. Women report feeling lonely during the transition to parenthood, and it has been discovered that women's support networks shrink and become more consistent after having a baby[12]. According to several researches, a significant risk factor for Post-Natal Depression is a lack of perceived social support[13]. Social support is the ability to reach out for and receive assistance from others when necessary. When assistance is most needed, social support refers

to the back-up provided by family members, friends, coworkers, neighbors, professionals, organizations, and the spouse. Severe stress that results in Post-Natal Depression can be brought on by a lack of social support, along with discontent, issues in marital relationships, and financial constraints[14].

Social connections are usually linked to improved health outcomes, particularly for moms with Post-Natal Depression. Our health and well-being may be significantly impacted by the interactions we have with our family, friends, colleagues and community at large. People are more likely to make good decisions and experience better mental and physical health benefits when they are in stable, supportive relationships. Additionally, they are better equipped to handle difficult situations, stress, worry, and depression[15]. Studies confirm the claim that social support and post-natal depression have a strong inverse relationship, showing that the absence of a reliable support system can be detrimental to the mother[16]. It includes all forms of emotional support, informational support (such as seeking advice or venting), physical or material aid (someone to assist with basic requirements), and interaction support (someone to engage in enjoyable activities with) [17]. In this study, Social support will be viewed in three parts namely; emotional support, esteem support and network support.

An essential component of emotional support is empathy, putting oneself in another's shoes and letting the person know that their sentiments are normal and acceptable, validating their feelings goes one step further[18]. Emotional support may take many different forms, such as active listening, emotional validation, and reassurance. However, each situation and individual requires different strategies. People who wish to provide emotional support need to take into account all they know about that person, including their needs and feelings. Depending on the circumstance, the persons involved, and cultural or societal conventions, emotional support may take on numerous forms. There are, however, some characteristics of effective emotional support that hold true in every circumstance which include respect, no-

judgment, understanding, and compassion[18]. The degree of emotional support provided to the new mother is one of the most crucial aspects to take into account in post-natal depression. Having emotional support can enhance the quality of life and perhaps prolong it for those with mental health disorders[19].

Support at an emotional level can come in a variety of forms. It is critical to comprehend not just the kind of emotional support you can provide, but also the kind of help the other person needs or desires. Receiving emotional support makes us feel better and more equipped to handle life's challenges and helps us deal with day-to-day issues, stress, disappointments, or suffering[20]. Having emotional support in a relationship fosters emotional closeness and trust. It should not be a surprise that emotional support and marital satisfaction are related. The future of the partnership may be at risk due to a lack of emotional support[21]. It is well recognized that emotional support may enhance both physical and mental health. Anxiety, sadness, mental and physical health concerns are more likely to be avoided with a spouse's emotional support. For instance, the woman needs support more than anything else while she is dealing with the psychological stress brought on by pregnancy[22].

Esteem social support has been seen as a way of relieving stress, it is often given to those going through a trying time that might be damaging to their self-esteem. It serves as signals that serve to boost one's talents, abilities, and inherent value[23]. Receiving esteem support has been linked to a positive increase in self esteem in the moment as well as self-efficacy and relationship satisfaction while low self-esteem has been linked to a variety of negative relationship outcomes [24, 25]. A new mother with Post-Natal Depression can be helped with the right measure of esteem support because giving birth to a child comes with a number of changes; weight gain, change in shoe size and also flabby skin depending on the woman's genes. Such changes can lead to the new mother feeling depressed, disgusted and she might lose confidence in herself. Esteem support is a tactic that can be used to help the

new mother by her spouse to regain confidence, but it is regrettably lacking in several families, particularly in this region of the world[26].

The father and the entire family are urged to assist new mom, particularly with household chores and child care while they observe adequate rest in order to care for the baby and themselves. In this region of the world (Nigeria), the mother-in-law is expected to visit the home and assist with caring for the infant for at least three months after child birth. Observations show that although many new mothers enjoy network support, however in some cases it is a major stimulant for Post-Natal Depression in the new mother[27].

Post-Natal Depression has been linked to low network support all around the world[28]. Previous qualitative research have also shown that excessive intervention from the mother-in-law, arguments over the finer points of baby care, and lifestyle disparities between a woman and her mother-in-law contributed to postpnatal women's poor emotions[29]. Consequently, it is projected that the mother's connection with her mother-in-law would influence how she feels after giving birth. One of the most significant personal life objectives has been determined to be having fulfilling long-term love relationships. A variety of favorable personal outcomes, such as better health and well being, are linked to having a healthy relationship, while interpersonal conflict is linked to a higher risk of psychopathology[30]. Due to its connection to the happiness and mental health of partners, the children, and the family as a whole, the couple relationships is especially crucial throughout the transition to motherhood and in the early years of childhood [31]. However, for women and their partners, the adjustment to motherhood is connected with several psychological, social, and biological changes that may jeopardize marital pleasure. Additionally, the baby's health and sleeping habits may make this era difficult[32].

These changes might cause parents to feel overburdened and unable to handle the added expectations and obligations. As a result, parental stress is common among parents.

Many couples may feel that their expectations and the realities of post-natal care, along with loss of sleep and less opportunity for quality time together, are not aligned[33]. Research has demonstrated that following the birth of the first child, pleasant interactions decrease such as sexual intimacy between couples, couple conflict increases, and couple relationship satisfaction decreases[34]. A rise in marital issues is closely related to post-natal depression although any form of depression may significantly affect a relationship. It's challenging enough to manage with post-natal depression alone, let alone additional marital problems. Couples Relationship tension might get worse when it coexists with ongoing unhappiness and worry[35]. The sexual connection is one aspect of a couple's relationship that is frequently impacted by PPD. Women's sexual health is in danger throughout critical life transitional stages like pregnancy and post-natal[36].

The time after childbirth is a crucial time in the lives of women, newborn babies, and fathers. For parents and their families, it is a time of excitement and tremendous anticipation as they look forward to getting to know and love a new, healthy baby. Indeed, the post-natal sexual health and well-being of mothers undergoes various changes as a result of pregnancy/delivery[37]. Although it is a prevalent worry, postpartum sexual activity has gotten little from researchers, developmental psychologists, and therapists. As a result, there are little opportunities for health promotion and education about post-natal sexual health in existing maternity care, particularly in developing nations[38, 39]. Observations reveal that in marriage Detachment does not occur randomly. Post-Natal Depression is a reliable factor in psychological separation. Couples who have gone through painful experiences frequently react by suppressing their feelings. This may have helped them at the moment of the shock, enabling them to carry on in a very stressful environment. In that situation, it may be a legitimate kind of self-preservation, although some continue to avoid their emotions for years after the stressful period has passed. This may cause issues in many marital relationships, but

particularly in their romantic relationships. Researchers examined this issue and came to the conclusion that emotional awareness often decreases as a result of past trauma [40].

There is more to emotions than just how we feel. They have an impact on social interaction, affect how we respond to circumstances, and promote human connection. The emotions of others have both pleasant and unpleasant impact on us. Healthy emotional control in marriages enables couples to process feelings without becoming overwhelmed by them[41]. Disconnects between partners are frequent in relationships and often end when both parties are in a position to reconnect. The relationship may suffer if the separation persists or becomes prevalent. After having giving birth, a woman may have post-natal depression, which can progress to other mental illnesses such post-traumatic stress disorder (PTSD). PSTD is a disorder that can appear after experiencing a terrifying, potentially fatal incident or being exposed to trauma. Majority of the time, both women who have traumatic childbirth and troops who have been in battle are found to have this illness. One way PPD might show up is through emotional detachment, Poor communication, less love, as well as being unavailable physically and emotionally[42]. This might greatly impact on couples' relationship.

In Nigeria, it has been observed that depression is mainly an underlining psychological disorder that affects most of her citizens[43]. However; this is weighed in more on new mothers because in as much childbirth is a thing of joy, it takes physical, emotional and psychological toll on the women. In most cultural practices, it is the sole responsibility of the woman to care for the newborn[44]. The presence or absence of some factors has been stipulated to make coping with PPD among new mothers easier or harder. The factors stipulated are; the woman and her self-image, the relationship between the new mother and her spouse, family, both extended and nuclear[45]. Hence, this study is motivated by the relationship between Social Support, Couples Relationships and Post-Natal Depression

among Public Primary School Teachers in Ibadan North Local Government Area and the roles of Educational and developmental Counselling Psychologists.

1.2 Statement of the Problem

The role change from wife to mother and from husband to father changes the whole dynamic of the couple and their relationship which also include their new sets of responsibilities. Africa, like all other parts of the world struggles with a burden of post-natal depression. A review in sub-Saharan Africa reported 18.6% postpartum depression, with a range from 7% to 50.3%[46]. Post-Natal Depression in Nigeria is gradually increasing, specifically western Nigeria, the lowest and highest prevalence of PPD reported were 14.6% and 23.0% respectively[47]. This demonstrates the gravity of this problem, and the need for post-natal depression to be taken seriously as a public mental health concern in the country and among elites such as primary school teachers.

Unfortunately for some families, the new mother develops post-natal depression. Although the causes have been said to be psychological, physical and genetically, the necessary steps needed to be taken to avoid this mental illness have been overlooked. Social support which should be highly encouraged has been disregarded in this part of the world. Support from spouse, family members and in-laws is not majorly practiced as highlighted in literature. Furthermore, the lack of social support in the post-natal period can cause a breach in the couple's relationship bringing about more underlying problems. In this part of the world- Africa especially Nigeria, post-natal depression is a mental disorder that is not regarded as something worth giving attention to because it is not believed to be found here. Surprisingly it is more rampant among us than in other nations because of some our barbaric cultures, values and norms.

This proposed research aspires to explore the relationship between Social Support, Couples Relationship and Post-Natal Depression among Public Primary School Teachers in Ibadan North Local Government Area, Oyo State

1.3 Aim and Objectives of the Study

This study's primary aim is to investigate the relationship among variables: Social Support, Couples Relationship and Post-Natal Depression among public primary school teachers in Ibadan North local Government of Oyo State. The objectives are to:

i. evaluate the level of knowledge of post-natal depression among Public Primary School Teachers in Ibadan North Local Government Area, Oyo State.
ii. investigate the contribution of Social Support during the post-natal period among Public Primary School Teachers in Ibadan North Local Government Area, Oyo State.
iii. examine the relationship between Social Support and Post-natal depression among Public Primary School Teachers in Ibadan North Local Government Area, Oyo State.
iv. examine the relationship between couples relationship and prevention of perceived post-natal depression among public primary school teachers in Ibadan North Local Government Area, Oyo State

1.4 Research Questions

1. What is the level of knowledge of Post- Natal Depression among Public Primary School Teachers in Ibadan North Local Government Area, Oyo State?
2. What is the contribution of Social Support to Post- Natal Depression among Public Primary School Teachers in Ibadan North Local Government Area, Oyo State

1.5 Hypotheses

H01 There will be significant relationship between Social Support and Post- Natal Depression among Public Primary School Teachers in Ibadan North Local Government Area, Oyo State.

H02 There will be significant relationship between Couples Relationship and Post- Natal Depression among public primary school teachers in Ibadan North Local Government Area, Oyo State.

1.6 Significance of the Study

This study's findings when published will be of immense benefit to the following groups; married couples, counselors and psychologists. This study can be considered significant as presented below. The study results will be beneficial to female and male primary school teachers; this will help identify mothers with post-natal depression and get them concerned with possible ways of managing the issue, preventing it from arising in the future and also maintaining the relationship with spouses. This study can help create awareness on the possible problem that might arise in the post-natal period and also help manage it. This study can also be of help in handling post-natal depression cases that are concerned with couples relationships and the kind of support system they have. Finally this study will also be of great advantage for intending couples, they will receive necessary psycho-education on PND and how to develop emotional, network and esteem support for strengthening family interface in their relationship.

1.7 Scope of the Study

The study examined Social Support, Couples Relationships and Post-Natal Depression among Public Primary School Teachers. The geographical area was in Ibadan North Local Government Area, Oyo State. The respondents in this study were both male and female primary school teachers. Adapted standardised Questionnaire was used for collection of data.

1.8 Limitation of the Study

The study was limited to female and male teachers in Ibadan north local Government public primary, secondary schools could have been included. One major factor was the fact that 13

questionnaires went missing from the possession of some of respondents. Lastly financial constraints delayed the work.

1.9 Operational Definition of Terms

Social support: This is the belief and experience that one is taken care of and has access to help from others. According to study they include: Emotional, Esteem and Network support

Emotional support: This is a purposeful verbal and nonverbal technique to express care and compassion for an expectant or nursing mother.

Esteem support: This is a form of social support displayed via words of encouragement or assurance to an expectant or nursing mother.

Network support: This is the type of support gotten from extended family members such as relatives, in-laws and friends.

Couples Relationships: In this study *couples relationships* is defined as the intimacy and close interaction during the arrival of a new baby in the family. This is examined under; Sexual Relationship and Detachment.

Sexual Relationship: Sexual relationship is an intimate relationship that involves sexual intercourse which is both physical and emotional.

Detachment: Detachment is a feeling of emotional freedom resulting from a lack of involvement in a problem or situation or with a person.

Post-Natal Depression: Postpartum depression is a complex mix of physical, emotional, and behavioral changes that happen in some women after giving birth.

Perceived Post-Natal Depression: this is finding out views or perceptions of respondents on after birth experience.

Endnotes

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Chapter Two

Literature Review

The chapter shall be discussed under the following sub-headings

2.1 Conceptual Review

2.1.1 Concept of Post-Natal Depression

Birth-Related/Post-Natal Post-traumatic stress disorder

2.1.2 Concept of Social Support

Perceived support and Received support

Social Support and Mental Health

Social support and Self-Esteem

2.1.3 Post-Natal Depression and Couples Relationship

2.2 Theoretical Framework

2.2.1 Beck's middle-range Biological Theory

2.2.2 Social capital theory

2.2.3 Skinners Operant Conditioning theory

2.3 Review of Empirical Study

2.3.1 Young women's experiences of support networks on pregnancy care and wellbeing

2.3.2 Postpartum Depression and its Relation to Social Support and Marital Satisfaction

2.3.3 Postpartum Depression and Maternal Well-Being among Postnatal Women

2.3.4 Perceived social support and depression levels of women in the postpartum period

2.3.5 spousal relationship, husband involvement, and postpartum depression

2.3.6 Social Support Satisfaction as a Protective Factor for Postpartum Maternal Distress

2.3.7 Prevalence, associated factors and perinatal outcomes of antepartum depression

2.4 Conceptual Model

2.5 Summary of the Reviewed Literature

Endnotes

2.1 Conceptual Review

2.1.1 Concept of Post-Natal Depression

According to the World Health Organization (WHO), the post-natal period is the most crucial but also the most ignored time of a mother's and baby's life; during this time, the majority of maternal and infant fatalities occur[1]. Following the post-partum, the Post-Natal phase starts and is normally thought to last six weeks[2]. At specific points throughout the postpartum period, a number of organizations advise routine post-natal assessment[3].Appropriate therapy and early detection are necessary. The "baby blues" affect 70–80% of women who give birth within a few days. Ten to twenty percent of women will have depression; women who have previously had post-natal depression, clinical depression, anxiety, or other mood disorders[4].

Post-Natal Depression (PPD also known as Peripartum Depression, or Major Depressive Disorder with peripartum onset in the DSM-5) is a sub-type of depression that occurs during pregnancy or in the first 4 weeks after delivery. However, women remain at risk of developing depression up to several months following delivery. PND is the most common psychiatric complication related to child-bearing[5]. Post-natal depression is not classified as a separate condition in the current classification schemes; however, the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR) permits the documentation of the onset of a depressive episode within 4 weeks after childbirth[6].

PND, according to the US National Library of Medicine, is a mild to severe depression that develops within the first year of life, usually within the first three months. PND affects an estimated 13 to 19 percent of pregnant women, making it one of the most frequent post-natal morbidness[7]. PND is expected to affect 18.4 percent of Africans. However, other nations have recorded greater percentages, such as Uganda (43.1%) and Cameroun (23.4%), as compared to Ethiopia (13.1%), Ghana (3.8%), and Morocco (3.8%). (11.6%). (Using the Edinburgh Postnatal Depression Scale, different research has been undertaken in Nigeria to estimate the prevalence of PPD (EPDS). The lowest and greatest prevalence of PND are observed in western Nigeria, at 14.6 percent and 23.0 percent, respectively[3]. In two separate investigations in southern Nigeria, a low incidence of 10.7% was found in one and a high prevalence of 30.0 percent was found in the other. In Northern Nigeria, prevalence rates of 44.5 percent and 21.8 percent, respectively[8]. According to studies conducted in Nigeria, about 10–30% of women attending primary care have PPD[9].

Both sexes are susceptible to post-natal depression (PND), which is a form of mood disorder connected to delivery [10]. Extreme melancholy, poor energy, anxiety, weeping spells, impatience, and changes in sleeping or eating routines are only a few symptoms [11].

Symptoms normally occurs a week to a month after delivery, even though majority of women only feel anxious or unhappy for a short while after giving birth, post-natal depression should be recognized when symptoms are severe and persist for more than two weeks[12].

PPD has been seen as a severe mental disorder that affects the brain, new mothers behavior, and physical health. Three fMRI studies show that moms with post-natal depression and those without had different patterns of brain activity. When compared to healthy controls, mothers with PPD often have decreased left frontal lobe activity and higher right frontal lobe activity. Additionally, they show less connection between key brain regions, such as the hippocampus, amygdala, dorsal lateral prefrontal cortex, and anterior cingulate cortex. When triggered by emotional signals other than those related to a baby, variations in brain activity between sad and non-depressed women are more evident. Right amygdala activity toward emotional cues from sources other than babies is higher in depressed moms, and there is less connection between the amygdala and right insular cortex. Recent research has also shown that mothers with PPD exhibit reduced activity in the striatum, orbitofrontal cortex, anterior cingulate cortex, and insula while seeing photos of their own babies[13].

Some emotional indications of depression are feelings of sadness and emptiness which affect an individual's daily life, these emotions range from moderate to high. If a pregnant woman has the following symptoms she might be more susceptible to Post-Natal Depression, they include; personal history of mental illness, history of bipolar illness or depression in your family, lack of family and friend support, depression during pregnancy, difficulties with a prior pregnancy or birth, troubles in a relationship, financial issues, having a child at a very young age, substance use disorder such as alcoholism or addiction, having a child that need special care, unintended pregnancy or having trouble nursing[8]. Post-Natal Depression may be brought on by hormonal and physical changes, a personal or family

history of sadness, and the strain of caring for a new infant. While the actual cause of PND has not been clearly defined, the cause has been believed to be biological, psychological, genetical and also social[14].

There may be a neuroendocrine etiology for PND given the significance of reproductive hormones in depressed behavior. There is substantial evidence to support the theory that in sensitive women, alterations in the reproductive hormones induce their dysregulation. Changes in a variety of biological and endocrine systems, including the immune system, the hypothalamic-pituitary-adrenal axis (HPA), and lactogenic hormones, might contribute to the pathophysiology of PPD. The illness process of post-partum depression is known to include the Hypothalamic-Pituitary-Adrenal Axis (HPA). In times of trauma and stress, the HPA axis releases cortisol; if the HPA axis function is abnormal, the reaction inhibits the production of catecholamines, which results in a subpar stress response. Hormones that release HPA rise throughout pregnancy and continue to rise for up to 12 weeks after delivery[15].

In women who are vulnerable, the fast changes in reproductive hormones like estradiol and progesterone after birth may be a potential stressor and these changes may trigger the start of depressive symptoms. Prolactin and oxytocin are crucial players in the etiology of PPD. These hormones control both the production of breast milk and the milk let-down reflex. It is frequently noted that the beginning of PND and inability to lactate occur together. Low oxytocin levels are particularly common in PND and unwelcome early weaning. Reduced oxytocin levels in the third trimester are linked to an increase in depression symptoms throughout pregnancy and after birth[15].

Evidence suggests that hormonal alterations may be involved in the emergence of after birth depression[16]. Given the unpredictability of changes to the brain and other bodily systems during pregnancy and post-natal, it has been particularly challenging to comprehend

the neuroendocrinology typical of PND. A review of exploratory studies found that women with PND show more substantial changes in HPA axis activity, albeit the directionality of specific hormone increases or reductions is still unclear[17]. Among the hormones that have been studied include estrogen, progesterone, thyroid hormone, testosterone, corticotropin-releasing hormone, endorphins, and cortisol[18]. Oestrogen and progesterone levels revert to pre-pregnancy levels within 24 hours of giving birth, which might be the reason[19]. Abnormal steroid hormone-dependent regulation of neuronal calcium influx via extracellular matrix proteins and membrane receptors involved in responding to the cell's environment may be a source of biological risk [20].A greater prevalence of postpartum psychological discomfort has been linked to synthetic oxytocin, a drug used to induce labor[21].

General causes of Post-Natal Depression include; Family history of depression, stressful life events during pregnancy, birth related trauma, past experience of sexual abuse and also physical abuse, traumatic events like miscarriages, inadequate support, single parenting, marital stress, financial instability, problem of age, lack of emotional support from significant other and unplanned pregnancy[22]. PND is commonly thought to result from significant lifestyle adjustments brought on by caring for the baby. However, there is not much evidence to back up this claim. Even mothers who have had numerous children in the past without suffering PND might get it with their most recent kid[23]. Most women do not receive a PND diagnosis, despite the physologic and behavioral changes that may occur throughout pregnancy and the post-natal period[24]. Many moms struggle to obtain the sleep they require to heal from giving birth completely. Physical discomfort and weariness brought on by lack of sleep might worsen post-natal depression symptoms[25].

Birth-Related/Post-Natal Post-traumatic Stress Disorder

After giving birth, parents may have symptoms of Post-Traumatic Stress Disorder (PTSD) or develop PTSD itself[26]. Although there has been disagreement in the medical world over the

classification of delivery as a traumatic experience, it is currently agreed upon that it may be. Although they both permit childbirth to be taken into consideration as a potential cause of PTSD, the DSM-IV and DSM-5, the standard classifications of mental illnesses used by medical practitioners, do not specifically acknowledge PTSD connected to delivery[27]. Post-Natal Depression and Post-Traumatic Stress Disorder connected to childbirth are closely associated. Research shows that Post-Natal Depression is frequently experienced by women with PTSD connected to delivery[26]. Recent studies have shown similarities between the symptoms of Post-Natal Depression and Post-Traumatic Stress Disorder. The diagnostic criteria for the two diagnoses overlap, but some of the Post-Natal Depression-specific criteria include extreme sadness and hopelessness, excessive worry or anxiety, intrusive thoughts of harming oneself or the baby, feelings of guilt or thoughts of worthlessness, and a change in appetite that could lead to under-eating or overeating. On the other side, aggressiveness, irritability, panic attacks, easily startled, recurrent nightmares, flashbacks, avoiding the infant or anything that reminds one of delivery, are all diagnostic criteria unique to Post-Natal post-traumatic stress disorder[28].

Three to six percent of Post-Natal moms experience PTSD connected to delivery[29]. In high-risk samples (women who have a history of physical or sexual abuse, have experienced serious delivery problems, or have other risk factors), the percentage of people with PTSD connected to childbirth is between 15–18%[26]. Numerous variables have been linked to an increased risk of developing Post-Natal Depression after delivery. These include a poor subjective experience of childbirth, a history of trauma, problems with the baby's delivery (such as an emergency cesarean section or admission to the NICU), a mother's mental health (prenatal depression, perinatal anxiety, acute postpartum depression, and history of psychological issues) and inadequate social support[30].

A particularly bad psychological result for women is the development of post-natal PTSD, which has been shown to affect 1.7-9% of Post-Natal women[31]. It has been demonstrated that Post-Natal PTSD symptoms negatively affect women's lives as well as the development of their children in terms of mental health outcomes, nursing, and mother-infant attachment[32]. Furthermore, PTSD may negatively affect women's relationships with their spouses[33].

2.1.2 Concept Social support

Strong relationships and psychological well-being are frequently linked to social support, but what does it really mean? In essence, social support is having a support system of friends and family that you can rely on when things go tough. These connections are essential to your daily functioning, whether you're in the midst of a personal crisis and need help right away or you just want to spend time with the people you care about. People are strengthened by social support during stressful situations and are frequently given the willpower to persevere and even thrive. Experts in mental health, including psychologists, frequently stress the need of having a robust social support system. Experts usually advise people to rely on their friends and family for help when attempting to achieve their objectives or navigate a crisis. Studies have further indicated the connection between social connections and other facets of health and well-being. It has been demonstrated that a lack of social support can change brain chemistry and raise the risk of depression and loneliness.[34]

Social support is described as verbal and nonverbal interactions between those receiving and giving it that serve to lessen confusion about the circumstances, oneself, the other, or the relationship and to increase one's sense of personal control over their experiences[35]. It is noted that while social assistance is beneficial under stressful circumstances, support-giving is a regular occurrence in interpersonal interactions and does

not simply occur in times of crisis[36]. There are several ways to classify and quantify social support; they include:

Emotional support- The provision of empathy, concern, love, trust, acceptance, closeness, encouragement, or care is referred to as emotional support. It is the warmth and nurturing offered by social support systems. Giving the person emotional support might help them feel appreciated[37]. Providing emotional support might make someone feel less alone and more connected. Providing emotional support is not always simple, and various circumstances necessitate different kinds of assistance. In order to offer emotional support, one must listen without passing judgment and demonstrate their understanding by answering with empathy. This might imply that one must fight the need to attempt to make things right or persuade someone out of their feelings[38]. The first step in providing emotional support is to listen to other people's experiences with empathy. Compassionate behavior promotes relationship trust. Since vulnerability necessitates trust, the partnership is permitted to develop. Emotional support is highly considered as a sign of trust and support, whether it involves secrets revealed or grievances expressed[39].

Affirmational support- The kind of support that fosters a sense of social integration is known as affirmational support (and is also called belonging). This could be interpreted as the presence of company for joint social activities. It was formerly known as "esteem support" or "appraisal support," but these terms, along with normative and instrumental support, have since evolved into alternative forms of support[40]. Expressions of confidence or encouragement are examples of this kind of social assistance. Someone who is offering you esteem support might draw your attention to qualities you've forgotten you possess or just express their confidence in you. This kind of support is provided by many therapists and life coaches to show their patients that they have their backs. This frequently inspires the patients to have greater self-confidence[41]. Esteem support is different from similar ideas like broad

emotional support, which focuses more on easing overall emotional suffering than specifically addressing how it affects the recipient's sense of self[42]. When we are involved in something where we feel appreciated, this happens. Perhaps you fill this function as part of your job, through volunteer activities, or as a result of your obligations to your family. It's important to draw attention to this kind of support, acknowledge our successes, and compliment others if we want to stay motivated[43].

Tangible support- The offer of financial aid, tangible products, or services are all examples of tangible support[44]. This type of social assistance, also known as instrumental support, includes the practical, overt ways people help others[45]. Doing up someone else's responsibilities so they can handle a problem themselves or taking other concrete actions to actively support someone in managing a situation they're facing are examples of tangible support. In contrast to informational assistance, which merely provides advice, someone who provides you with tangible support may bring you food when you're ill, assist you in coming up with solutions, or otherwise assist you in taking action to address the problem at hand[46]. This kind of request is comparable to the idiom "Can I borrow a pen?" This is a concrete service—or perhaps a favor—that someone is rendering to you[32]. Perhaps a coworker is giving you a ride, or someone is carrying your belongings. This kind of assistance is useful. But acknowledging when you receive helpful assistance might promote the belief that "I am not alone, and I can ask for aid when I need it"[43].

Informational support- Giving someone advice, direction, suggestions, or beneficial knowledge is referred to as informational support[40]. Others may benefit from this kind of information by using it to address their problems[45]. Individuals that provide informational support do so by giving guidance, acquiring and sharing information that can advise people of possible next steps that may be successful, or both[41]. You get informative support when

you read an article, watch videos on social media, or get an update from different sites. This is a great example of how you may still be of assistance to someone even if you don't have an emotional bond with them. Only positive, uplifting material can promote thoughtful or intellectual growth[43].

Perceived Support and Received Support

Researchers frequently distinguish between received and perceived support[47]. The term "perceived support" refers to a recipient's subjective assessment that providers will give (or have provided) efficient assistance when necessary. Received support, often referred to as enacted support, describes particular supporting activities (such as counsel or reassurance) provided by providers during critical periods[48]. Additionally, structural support or functional support can be used to quantify social support. The level of a recipient's social network connections, such as the number of social relationships or how integrated they are, are referred to as structural support (also known as social integration) [40, 47]. Friendships, family ties, and participation in clubs and groups all help people integrate into society[49]. Functional support examines the particular services that individuals within this social network may offer, such as the aforementioned emotional, esteem, tangible and information support[50]. According to data, emotional support may be more important than structural forms of support, such social engagement or exercise, in shielding people from the harmful consequences of stress[51].

The patterns of associations between these various forms of social support and health, personality, and interpersonal interactions vary. As an illustration, social integration and received assistance are not consistently associated with improved mental health, but perceived support is[47]. In fact, studies show that perceived social support that remains untapped might be more efficient and helpful than social support that is used[52]. Some have argued that the most helpful type of support may be invisible support, which involves

providing assistance to a person without that person being aware of it[53]. However, more recent research contradicts this idea, arguing that the effects of invisible social support, like visible assistance, are tempered by contextual factors, such as receivers' views of providers' attentiveness to their needs or the strength of the bond between the one providing the assistance and the person receiving it[54].

Family, friends, love partners, pets, links to the community, and coworkers are just a few examples of the many people who may provide social support[55]. Support might come from natural sources (such family and friends) or more official ones (e.g., mental health specialists or community organizations) [56]. An essential factor affecting how successful social support is as a coping mechanism is where it comes from. Support from a love relationship is linked to advantages for health, especially for males[57]. Nevertheless, a research indicated that although spouses' support mitigated the harmful impacts of professional stress, it did not mitigate the connection between marital and parenting stress since the spouses were involved in these circumstances. Support tailored specifically for working families, however, was more effective in reducing the work-family stress that contributes to marital and parental stress. Employee levity is favorably correlated with stress, health, and stress coping efficiency and adversely correlated with burnout[58]. Because they were less involved in the marital dynamic, social support from friends did act as a buffer in reaction to marital stress[59].

Studies have indicated that having social support during difficult times may significantly impact people's lives. People can benefit from social assistance in two ways. In the first place, it makes people see things more favorably. How useful this may be is understood by everyone who has a buddy who can make them laugh even in the most trying circumstances. People can also benefit from social support by using it to help them find coping mechanisms. They can support you if you know someone who has experienced the same thing as you during a difficult period. Later on, you'll be able to assist others in going

through the same experience[39]. Compared to those with great social support, those with low social support exhibit more subclinical symptoms of anxiety and sadness. Furthermore, significant mental disorders are more common in those with little social support than in those with great support[60].

Everybody experiences stress occasionally throughout their lives. Excessive stress has several detrimental impacts on health, such as heart disease and a compromised immune system. Thus, for many people, learning how to manage stress is a crucial subject. Psychologists have studied stress management in great detail, and they have discovered that seeking and accepting social support is one of the most effective coping mechanisms. The following are some of the benefits of social support: Improved General health, Reduction in stress and anxiety, reduced indicators of depression, increased self-esteem. The direct effect (also known as the main effects) hypothesis of social support suggests that those who experience a high system of social support will fare better in terms of health and have more positive outcomes in good and in difficult times than those who otherwise do not have these supports in place, whether actual or perceived[39].

Social Support and Mental Health

Increased psychological well-being is linked to social support and occurs in reaction to significant life events[61]. There is a wealth of data demonstrating how social support helps to reduce issues with one's mental health. Social support assists individuals in minimizing psychological suffering (such as anxiety or depression) during stressful periods[62]. Social support may serve as both an emotion-focused and a problem-focused coping mechanism (e.g., obtaining concrete knowledge that aids in resolving a problem) (e.g. used to regulate emotional responses that arise from the stressful event) [63]. It has been discovered that social support fosters psychological adjustment in situations of significant chronic stress. While a person's mental health has been linked to a likelihood of social isolation, this study also

demonstrates how social support functions as a buffer to shield people from various threats to their physical and mental health, including protection from certain life stresses[64].

Social support has also been linked to a number of factors that affect both acute and chronic pain. Compared to those with high social support, those with poor social support show higher sub-clinical signs of anxiety and sadness[47]. Psychological discomfort is affected by social support, string of mid-1970s studies analyzing the research on the relationship between mental diseases and elements including marital status change, relocation, and social breakdown sparked interest in the implications of social support[65]. Researchers discovered that the theme prevalent in each of these circumstances is the breakdown of social networks and the lack of sufficient social support. Numerous researches have been done on the impact of social support on mental health in response to this identified association.

To further comprehend the connection between social support and depression, theoretical studies have also been done. According to the stress-mobilizing theory, stress motivates people to look for social assistance. The substantial co-occurrence between stress and depression, in particular, and the high association between stress and psychological suffering should be noted. This significant factor might be the cause of the erroneous correlation between depression and social support perception[66].

Perceived Social Support and Self-Esteem

According to the socio-cognitive approach, self-esteem is promoted by perceived social support, which ultimately results in better mental health outcomes. Positive ideas about oneself are assumed to be related to perceived social support, which explains the direct and indirect effects on mental health outcomes through self-esteem. However, the way that young adults view their social connections and support systems may prompt various self-evaluations[66]. Self-esteem and social support have been shown to be inversely correlated in the past. Social support influences both the association between depression and self-esteem

as well as the relationship between depression and social support. Through its impact on self-worth, sense of security, and belonging—elements of better self-esteem—perceived social support may enhance psychological health. Social support creates the impression that one is respected and accepted by others, which gives one a sense of self-worth. However, there's a chance that the connection between social support and self-esteem is reciprocal. For instance, poor self-esteem may influence how people perceive social support, restrict efforts to seek help, or encourage people to recall the bad parts of previous social contacts[66].

Social support protects against stressful life events and supports mental health. A network of individuals drawn from family, friends, and the community provides social support. Students' quality of life is negatively impacted by a lack of social support, which is a factor in mental health issues, such as depressive symptoms, among university students. There is a strong inverse correlation between social support and psychological diseases including stress and depression[67]. Even among those who are under a lot of stress, social support is thought to be an important aspect that promotes well-being. Lack of social support can contribute to feelings of isolation and sadness, which can make it difficult to sustain connections and cause people to stay away from social events out of fear of being excluded[68].

Emotional Support: Emotional support is the process of showing care and compassion for another person verbally or non-verbally[69]. Although emotional support gotten from anyone is a good thing, it is even better when gotten from a close acquaintance. Being emotionally supportive is to show concern and genuine care, being supportive doesn't just entail giving out monetary gifts. For instance, For instance, someone small can be carrying a big bag, helping such a person shows emotional support.

Esteem Support: Esteem support is showing support by promoting an individual's aptitudes, qualities, and innate principles[69]. This is mostly seen in therapy sessions and sports agencies. Sometimes the solution to a depressed individual can be as simple as saying "you've got

this". Words of encouragement and words that boost self esteem are attributes of esteem support. It helps people gain confidence in their ideas and beliefs. For instance it is well known that new mothers can be stressed, words of confidence can boost her self-worth and may even prevent Post-Natal Depression.

Network Support: Friends, family, and peers are the primary support groups. To show how important a network support group is some counselling centres have a different room set aside for it. It involves who share the same or similar issues coming together to talk about their issues. In this study the network support focused ion is the husband, family and in-laws. Having someone to call on can help in the prevention of Post-Natal Depression. Past studies have shown that having people around especially family reduces both risk of poor mental and physical health.

Social support may be very helpful to someone going through a challenging circumstance, an illness, or just having a terrible day. Living alone increases the chance of developing mental health issues and addiction issues in a person. A support system lessens their struggles, which frequently result from a lack of companionship, and helps them cope with their situation better. An important component of a peaceful society is social support[34]. The relationships and social networks that provide support, friendship, love, and hope, is one of four primary dimensions of recovery and is addressed in three of the ten guiding recovery principles[70].

2.1.3 Post-Natal Depression and Couples Relationships

There is a link between PPD, the strength of a couple's relationship, and mental-health[71].Previous studies have found that anxiety disorders are linked with marital adjustment simultaneously and that stressful situations can indicate a reduction in marital adjustment ov er time[72].The first four months after giving birth are when the incidence of post-partum

depression peaks, although it can occur at any time throughout the first year of life. The mother may experience physical or emotional difficulties in caring for her newborn, which can hinder the early bonding and attachment process between the mother and child. It can also impede the development of effective infant care skills. If left untreated, this can negatively impact the mother-child relationship and have an adverse effect on the child's cognitive, psychosocial, and physical development. PND may have a negative impact on a married couple's relationship. As much as PND affects the mother and the new born child it also affects the father[73].

Most studies examine the effect of PND on the mother-infant relationship not bothering with the effect it has on the couples' relationship. PND is a mental illness that if not taken note of early can destroy a relationship. As mentioned earlier some depressed mothers feel too insecure to talk about how they feel will begin to frustrate their spouses. In this part of the world depression it is seen as an "ALIEN" word. Most Nigerians feel they have no luxury of the time to be depressed. We call depression "OYINBO MAN'S ILLNESS". Unfortunately that's not true, depression is an illness that can affect anybody irrespective of colour, race or tribe. If depression is seen as strange illness, imagine what post-partum depression would be seen as.

Despite this notion it is a common type of mental illness found in this part of the world. Most depressed mothers often place their total focus on the infant as a result of the feeling of guilt thereby abandoning their spouses. Those that don't focus on the new baby often abandon their responsibilities to both child and spouse and prefer to mope around in self pity. Either way it affects the couple's relationship. This kind of attitude often has negative impact on relationships. The first effect is the breach of communication which leads to widening the gap in couple's bond and relationship strength; PND causes new mothers to feel a range of emotions which leads them to getting confused and helpless. Most women are

not able to explain this feeling to their partners and it begins to tamper with the communication system between the couple. The second effect is separation. The separation can be physical and emotional. The effect of PND is a process; it starts from communication issues which lead to misunderstandings and the next is separation. It starts from emotional separation and if care is not taken can lead to physical separation. The last effect PND has couples relationship is divorce. Post-Natal Depression can lead to divorce. It can lead to couples misunderstanding each other and then having irreconcilable differences resulting in divorce.

Sexual Relationship among Couples

A sexual relationship creates a bond between married couples. Both parties in a close relationship are conscious of their own physical and emotional sensitivities. An avenue for expressing emotions is sex. There is a link between regular sex and general well-being. Additionally, it demonstrates how sex predicts affection, which in turn predicts the frequency of sexual behaviour. There are many reasons why sex might be an important part of your relationship[51]. For example: It could be an opportunity to bond with your partner, It could be an opportunity to show your partner love and affection, you might feel more secure in your relationship if you're having sex often, it could simply be pleasurable and fun, while providing psychological balance for your spouse at the same time. Furthermore, frequent sexual engagement has a lot of advantages. There are numerous reasons why having sex is excellent for your brain, body, and relationship in addition to the pleasure it brings[74].

Emotional: Many individuals have sex for emotional reasons. Sex has a number of emotional advantages: it could boost your self-confidence, it might make it easier for you to develop a satisfying connection with your body, It could strengthen your relationship with your lover and serve as a means of showing them your affection, It can help you relax.

Physical- Sex may also be beneficial to your body and physical well-being. For instance, some studies indicate that regular sexual activity may boost a stronger immune systems[74].

Having sex isn't the only way to feel close to your spouse. We frequently mistake closeness for sex. Although having sex with someone can be a great way to be intimate, it's not the only option. For instance, affectionate touch can be a great way to get close. Non-sexual physical closeness examples include: massages, kissing, cuddling, holding hands[75].

In addition to physical intimacy, many people may place value on emotional intimacy in relationships, including candid, frank talks. There is no denying the significance of sexual compatibility. When one partner believes that having sex is necessary for a healthy relationship but the other does not, dealing with this scenario can be challenging. In a same vein, it could be challenging if one individual has a high libido while the other has a low one. It is feasible to manage, though. Communication may be quite beneficial[53]. Experiencing certain changes over time is typical. Your libido may fluctuate over time due to a variety of factors. Here are a few possible causes of decreased libido: Relationship difficulties **(**Arguments, dishonesty, and a lack of trust could lead to a lower libido),Stress (Stressful events, and stressful lifestyles, might dampen your sex drive), age **(**Your libido might change as you age), hormonal changes **(**Menopause, pregnancy, and other events cause hormonal changes, which can in turn affect your libido), medication **(**Many medications list changes in libido as a side effect), **c**ertain medical conditions (Arthritis and coronary artery disease, for

example, are linked to a low sex drive), trauma (Traumatic experiences cause psychological stress, which can lead to difficulties with libido)[76].

Unless it's giving you stress, not desiring sex doesn't always indicate that you have an issue that needs to be fixed. It's crucial to discuss closeness in communication. It's crucial to discuss any changes in your sexual preferences with your spouse. Some individuals do, but not everyone requires sex to be in a happy and healthy relationship. A couple's relationship should have a healthy sexual component. When post-natal depression enters the scene, the couple's relationship is typically the one that is most negatively impacted. In a committed relationship, having sex may deepen intimacy and increase love, PND may sour a relationship between two sexually active people, and when that happens, alienation sets in[75].

Emotional detachment

A person with emotional detachment is psychologically unable to completely interact with their own or other people's feelings. It may be constant, as it is in those who have attachment problems, or it may be a brief reaction to a dire circumstance. Many different manifestations of emotional detachment exist. Also known as attachment anxiety it is characterized by: difficulty opening up, challenging intimate relationships, poor listening skills, a lack of physical, verbal, or sexual contact, poor self-esteem, substance abuse, ambivalence, avoiding people, situations, or activities, difficulty empathizing with others, feeling disconnected from other people, losing interest in people and activities, losing touch with people, not paying attention to other people, preferring to be alone , problems forming and maintaining relationships, problems expressing emotions, struggling to feel positive emotions. Being emotionally distant is an attribute of detachment; this may entail an inability or reluctance to become engaged in other people's emotional life. This detachment may shield individuals from strain, harm, and anxiety, but it can also harm one's psychological, social, and

emotional health. When people are put in stressful or challenging situations, emotional detachment can occasionally happen as a coping technique. In other instances, it could be a sign of a mental health issue[77, 78].

What causes emotional detachment?

The causes of emotional detachment can depend on whether it is part of a larger attachment disorder or a temporary response to a specific situation: experiencing significant loss, such as the death of a parent or separation from a caregiver, having traumatic experiences, experiencing emotional abuse, experiencing physical abuse, experiencing neglect[77]. It's possible that emotional detachment is less visible than other mental symptoms. Patients with an emotional detachment diagnosis are less likely to communicate their emotions, sympathize with others, or develop strong emotional bonds. Numerous anxiety and stress problems are more common in patients, increasing their risk. This may make it challenging to establish and sustain intimate relationships. When this happens, the individual may look distracted or "not quite there," or they may appear fully present yet behave only intellectually when emotional conduct would be more appropriate. They could struggle to be a devoted family member, or they might steer clear of things, people, and situations that bring up painful memories. Their separation can result in a loss of focus, which then causes memory issues and, in severe cases, forgetfulness. They can exhibit a severe lack of empathy in particular situations, which is connected to the spectrum of narcissistic personality disorder[79]. Emotional blunting is also associated with worse remission quality. When a patient is suffering emotional blunting, the unfavorable symptoms are far less likely to go away. Male patients receiving treatment for depression who scored higher on the Hospital Anxiety and Depression (HAD) scale also had greater levels of emotional blunting (though the frequency difference was slight). When emotional detachment interferes with a person's capacity to

perform, it becomes a problem[80]. It is important to remember that emotional detachment is not a mental health condition, but it might be a symptom of some mental disorders[78].

Emotional Detachment in PTSD

After experiencing or witnessing a traumatic event, some personas develop post-traumatic thereby escaping the reality of thee unpleasant or negative emotion and pain the situation has caused. Emotional detachment is part of the signs of PTSD as victims unknowingly use it as a response to trauma. At the moment of the trauma, emotional detachment may be adaptive (helpful), since it might shield you from unpleasant thoughts or emotions. However, because it impedes the processing of emotions, it might actually prevent healing. Research suggests that suppressing or denying sensations may not only make some PTSD symptoms worse but also may be a factor in the emergence of PTSD symptoms following a stressful experience. In PTSD patients, emotional detachment is also associated with PTSD severity. Take note that some symptoms of PTSD can also found in PPD[81].

Emotional Detachment in Relationships

Being in a happy and committed relationship requires emotional connection on both sides. However, emotional detachment might make you feel as though you're the only person on a boat that needs two people to move it along. This can be extremely difficult and stressful at times, but it can also cause misunderstandings about the relationship and eventually breed hatred[82]. Some indications of emotional separation in a romantic partnership include:

1. Being unavailable: Bids for connections (such as pleas for things or emergency assistance) may go unanswered by your partner. While there may be times when a spouse is less available due to personal, professional, or stress-related reasons, persistently being emotionally unavailable or turning down offers of connection might be signs of emotional detachment.

2. Poor communication: Not all communication is verbal, yet it is still a crucial ability that needs continual practice. Poor communication simply refers to one partner's inability to explain themselves in a way that the other can understand, or to that partner's use of body language to convey rejection or disdain.

3. Reduced affection**:** There are several methods to express love. Understanding each other's love languages is a crucial first step in creating a solid connection. For instance, emotionally distant spouses could find it difficult to show affection or declare their love for one another, which could be detrimental to the relationship**.**

Stonewalling, a type of emotional distance that frequently appears during disagreement. One of Dr. John Gottman's four criteria for determining whether a marriage will end in divorce is stonewalling. He refers to the four reasons for divorce as "The Four Horseman of the Apocalypse," a New Testament allegory for the end of the world. A couple needs to invest in their union and build "an emotional bank account" in order for it to last. This account has "deposits" from flatteries, dates, and physical affection as well as "withdrawals" from unpleasant experiences[83].

Interventions for Post-Natal Depression

Pharmacological treatments for post-partum depression

1. **Antidepressant medication**- It is possible to think of post-natal depression as a kind of severe depression that responds similarly to antidepressant drugs[84]. The post-natal period's metabolic changes, the infant's exposure to medication through breast milk, the impact of depression and treatment on the depressed mother's ability to care for a newborn, and the stigma associated with taking medication all pertain specifically to the pharmacologic treatment of PPD. The decision of the patient and her caregiver on the selection of pharmacologic and non-pharmacologic therapies for PND may be influenced by these

additional elements; woman's level of suffering, access to care, and experience with prior therapy[85].

Sertraline, venlafaxine, nefazodone, fluvoxamine, and bupropion have all been shown to be successful in treating post-natal depression in a number of open trials. Together, data from both the controlled and open studies suggest that antidepressants typically used to treat major depression are equally effective in treating post-natal depression, with no obvious differences between medications in efficacy and side effect burden. This is true even though there is little data comparing medications to placebo in the perinatal population. Therefore, some professionals advise that if a woman has previously reacted to a particular antidepressant, that drug should be among the first to be tried in treating her post-natal depression.[86].

2. **Breastfeeding considerations**- The advantages of breastfeeding have been thoroughly explained. The World Health Organization, the American Academy of Pediatrics, and the American Academy of Family Physicians all advise breastfeeding during at least the first six months for the majority of mothers in light of studies[87]. Many women and medical professionals are concerned about the potential negative effects of antidepressant medication on breastfeeding[88]. Due to their developing neurological systems, immature blood-brain barriers, and immature hepatic and renal systems, newborns and early infants are particularly susceptible to possible medication side effects. Since little is known about how antidepressants behave in breast milk, several professionals advise using nonpharmacologic therapy options wherever possible, especially for mild to severe depression[89]. However, some women do not respond well to non-pharmacologic therapies, and many women may not have access to them.

The use of citalopram, escitalopram, fluoxetine, doxepin, and bupropion by mothers has been associated with adverse outcomes; however, rates and causality cannot be

determined from case reports, and other studies have shown no negative effects when the same drugs were used[90]. Paroxetine or sertraline may be the best option for a patient who has never used antidepressant medication before the post-natal phase because to the lower newborn blood levels and fewer adverse reactions. Although the results are positive, it is uncertain if the absence of an impact on peripheral transporters can be extended to indicate a lack of impacts on newborns' developing central nervous systems[91]. Nortriptyline, a tricyclic antidepressant, has the most evidence to support its safety during nursing, although doxepin is generally thought to be inappropriate. There is a lack of information on the newer antidepressants, yet minimal side effects have been observed[92].

3. **Hormone therapy**- It has been suggested that one trigger for the onset of PPD in some women is the substantial decline in maternal levels of estrogen and progesterone at the time of birth. The stimulation of neuronal development and survival, augmentation of neurotransmitter activity, reduction of oxidative stress, and manipulation of the hypophyseal-pituitary axis are only a few of estrogen's effects on the brain[93]. When subjected to a decline in estradiol and progesterone, women with a history of post-natal depression developed mood symptoms, although individuals without a history of PND did not. This was discovered in a research intended to mimic the hormonal changes occurring around the time of childbirth[94]. This discovery increases the idea of hormonal intervention as a therapeutic or prevention measure for PND by indicating susceptibility to hormone alterations in a portion of the population.

Due to worries about passing the medicine to their infants through breast milk or worries about potential adverse effects, many post-natal moms chose psychological therapy instead of antidepressants[95]. The use of psychological treatments, particularly interpersonal therapy, cognitive-behavioral therapy, and psycho-dynamic psychotherapy, as well as psycho-social interventions like non-directive counseling is supported by current research, despite the fact

that relatively few studies have comprehensively examined non-pharmacologic treatments for PPD. Both psycho-social and psychological therapies are successful in reducing depression and are valid therapy choices for post-natal depression, according to a Cochrane meta-analysis of 10 randomized controlled trials of psycho-social and psychological treatments for the condition[96].

Psychological and psychosocial treatments

1. Interpersonal therapy (IPT) - Interpersonal therapy (IPT), which views depression as a medical condition that occurs in a social setting, is a time-limited treatment for serious depression that focuses on resolving the link between interpersonal difficulties and mood[97,98]. Role transition, role dispute, bereavement, or interpersonal deficits are the four interpersonal issue areas that the patient and clinician choose as the therapy emphasis in IPT. Strategies are followed throughout treatment (usually 12–20 weeks) to help individuals change harmful relationship behaviors and strengthen their social networks. IPT has been modified to address issues related to post-natal depression, such as the mother-infant bond, the mother-partner relationship, and the transition back to work[99]. IPT matches the needs of the postpartum mother well since it is problem-focused and time-limited.

IPT has been shown to be successful in treating post-natal depression in several investigations, including one large-scale randomized controlled experiment. 120 women with post-natal depression were randomly assigned by O'Hara and colleagues to undergo 12 weekly, 60-minute individual sessions of manualised IPT from a qualified therapist as opposed to the wait-list control condition[100]. When compared to the wait-list group, the women who got IPT had significantly less depressed symptomatology (as determined by the Hamilton Depression Rating Scale and Beck Depression Inventory) and significantly higher social adjustment scores[101].

2. Cognitive behavioral therapy (CBT) - The foundation of cognitive behavioral therapy (CBT), a well-researched and successful treatment for severe depression, is the idea that perceptions and behaviors are closely related to mood. The main goal of CBT is to assist depressed individuals in altering erroneous thought patterns and changing their behavior to improve coping and lessen misery[102]. There have been several trials evaluating CBT either by itself or in combination with other PND therapies. In a factorial design, 87 women with PPD were randomly assigned to one of four conditions in a randomized controlled psychotherapy-pharmacotherapy study. The conditions varied based on treatment with either one or six sessions of CBT-based counseling, and treatment with fluoxetine or placebo[103]. Depressive symptoms significantly decreased in all four therapy groups. Six CBT sessions instead of one resulted in a larger reduction in depression symptoms in women. Treatment with fluoxetine with one session of CBT was as beneficial as six sessions of CBT plus a placebo tablet[104].

3. Non-directive counseling- Psycho-social interventions, which also include non-directive counseling and peer support, are unstructured and nonmanualized in contrast to IPT or CBT. Non-directive counseling, commonly referred to as "person-centered" counseling, is focused on the use of supportive and empathetic listening[105].

4. Peer and partner support- Few studies have looked at the function of the partner or other family members in recovery from PND, despite the fact that poor partner support has been recognized as a key risk factor for PND. According to one survey research, a mother's chance of experiencing depression symptoms at 8 weeks after giving birth was reduced by shared activities, problem-focused information and support, and positive comments from the spouse[106]. "Emotional support from spouse," "better communication with partner," "practical help from partner," and "emotional support from friends and family" were all regarded as "critical" to recovery in a qualitative assessment of the elements most significant to women who had recovered from PND[107].

Other treatment options

1. **Electroconvulsive therapy**- Electroconvulsive therapy (ECT) is a therapeutic option for depressed post-natal women who do not react to antidepressant medication or who have severe or psychotic symptoms, similar to treatment-refractory major depression in the general population. Under general anesthesia, electroconvulsive treatment (ECT) is a process in which tiny electric currents are purposely used to cause a short seizure in the brain. There are extremely few data that are particular to this group. There was a 100 percent remission rate in one small trial of 5 women who had ECT for refractory post-natal depression[108]. The use of ECT for postpartum depression is similar to that for severe depression except from issues with anesthesia and breast-feeding. By timing breast feeding appropriately, the danger of transmission in breast milk can be reduced. Anesthesia used in ECT is often quickly metabolized[109].

2. **Bright light therapy**- Bright light therapy was first used to treat seasonal affective disorder, but research has shown that it is also useful in treating nonseasonal depression[110]. A treatment that involves exposure to an artificial light source is called light therapy, sometimes referred to as photo-therapy. Given that there are no known dangers to the fetus or nursing newborn, light therapy offers a promising alternative for the treatment of perinatal depression[111].

3. **Omega-3 fatty acids**- Because of the well-known health advantages of these substances for pregnant and post-natal women as well as some evidence indicating good effects on mood in the general population, omega-3 fatty acids have garnered particular interest in the treatment of perinatal depression[112]. A class of polyunsaturated fatty acids known as omega-3 fatty acids are crucial for many bodily processes. EPA and DHA, two types of omega-3 fatty acids, are present in seafood including fatty fish (such as salmon, tuna, and trout) and shellfish (e.g., crab, mussels, and oysters). Depletion of maternal omega-3 fatty acids occurs

during pregnancy to facilitate this process. Omega-3 fatty acids, such as the eicosapentaenoic acid (EPA) and docosa-hexaenoic acid (DHA) found in fish oils, are the key building blocks for the development of a baby's central nervous system while in utero[113]. According to a well referenced international study that examined major depression in the general population, there was a negative correlation between per-capita fish intake and the likelihood of experiencing major depression[114].

4. **Acupuncture and massage**- The practice of putting and manipulating needles into different spots on the body to cure pathological processes and relieve pain is known as acupuncture. It dates back to ancient China. It has been studied as an adjuvant treatment for nausea, discomfort, breech presentation, and inducement of labor in pregnancy, with varying degrees of success[115]. It has also been studied for the treatment of depression in the general population. In terms of lowering the depressive symptom rating scales in depressed pregnant women, 8 weeks of active acupuncture (treatments were standardized but individually individualized) performed considerably better than a massage intervention[116]. Independent studies have also looked at massage therapy as a post-natal depression treatment, and techniques include therapeutic massage, partner-delivered massage, and post-natal teaching in baby massage[117].

5. **Exercise**- Numerous researches have looked into how exercise might help with post-natal depression symptoms[118]. In a research by Da Costa et al., 88 PPD-afflicted women were randomly assigned to receive standard treatment or a 12-week home exercise program. Post-treatment, but not at the 3-month follow-up, there was a decline in depression rating scales in the intervention group as compared to the usual care group[119]. The UK's National Institute for Health and Clinical Excellence (NICE) has advised that health practitioners explore exercise as a management approach in women having mild-to-moderate depression despite the paucity of data supporting its use in the treatment of PPD[120]. The definition of "feasible and

effective" exercise in a study of the benefits of exercise on PPD was moderate-intensity exercises lasting at least 30 minutes per day, five days per week, including walking with "pram pushing"[121].

2.2 Theoretical Review

2.2.1 Beck's middle-range Biological Theory

Cheryl Tatano Beck, a nursing theorist who has been active since 1949, created a middle-range theory with an emphasis on Post-Natal Depression (PPD). What has not been given comparable importance in postpartum follow-up treatment, however, is the mother's psychological health, more especially, the problem of maternity blues, which Beck recognized as a serious deficit in maternal care. The first week following birth is when the blues typically strike early discharge moms at home. Beck began defining the distinctions between the notions of Post-Partum psychosis, Post-Natal Depression, and maternity blues after studying studies on the subject. Beck discovered 11 themes that explain the basic components of PND and 45 major assertions concerning how PND affects women. In the year after that (1993), Beck expanded on those discoveries and developed Teetering on the Edge, a grounded theory of PND. Since the Beck Depression Inventory (BDI), a commonly used tool to diagnose depression, failed to adequately reflect the horrible events she observed in her therapeutic practice, Beck opted for a qualitative approach to the subject[122].

This hypothesis was created in order to comprehend PND better and to communicate it in a way that both specialists and the general public could grasp. This was accomplished by creating screening instruments, encouraging PND acceptance, and pushing interventions and treatments. Although this grounded theory was first categorized as a middle-range theory, it was later reclassified as a substantive theory, or SST, since it is updated over time to account for changing circumstances in order to strengthen the theory's predictive power[122].

The SST is a branch of middle-range theory that was created to address a particular societal issue, in this instance, PND in women. Participant observation provided the data for this theory, and analysis of the data identified loss of control as the fundamental social psychological issue and served as the basis for the construction of her theory. Regarding the nursing meta-paradigm, Beck's theory was created for PND-affected women and as a teaching tool for nursing students, medical professionals (such as nurses, physicians, and mental health care providers), and social workers. Beck did not provide a precise definition of health, but since PPD is a mental health disease, she concentrated on that. Her idea placed a strong emphasis on holistic health, which she defined as a person's "wholeness," or their connection to their environment on all levels, including physically, emotionally, and mentally. Beck came to the conclusion that a woman's interpersonal environment, if it's unstable, affects both her and her family outside[122].

Support from medical experts, as well as from friends and family, is essential to helping the mother manage. This may be achieved by ensuring that everyone involved is educated on PND. Aspects of the Beck Theory In studying Beck's theory of postpartum depression, it is assumed that she holds that nursing involves professional relationships with others in order to promote an individual's utmost health[122]. A holistic approach to treatment should be used to treat each individual as a whole including biological, social, and psychological components. Beck stated that a woman's health is a reaction to the substance of her life and that all factors, including her surroundings, should be recognized. While maintaining physical and mental health requires internal homeostasis or balance within the environment, one's shelter, culture, situations, events, family, and friends may also have a significant impact on one's health. At least 19 percent of all pregnant women have postpartum depression in the first three months following delivery. Untreated PND may

make moms feel hopeless, leave her incapable of caring for her child, and put both of them in danger; at the least, it will strain the bond between the mother and child[122].

If left untreated, PND can endure for years and create unneeded suffering for women and their families. From identifying a clinical issue, Beck moved on to investigating descriptive research, concept analysis, and middle-range theory formulation. The final phase included putting her idea to the test in a clinical environment. The use of Beck's theory can help enhance the training of nurses and other healthcare workers[122]. There is clear value placed on understanding pregnancy, delivery, and motherhood through "the eyes of women" throughout all of Beck's work, which is in line with feminist philosophy. In addition, Beck recognizes that there are several concurrent settings (medical, social, and economic) in which delivery happens and that women' responses to labor and motherhood are influenced by their responses to these contexts[123]. The theoretical claims made by Beck in her theory are well-represented in all of her publications. In making the following claims, she recognizes the significance of the research on the biochemical elements contributing to postpartum depression[124].

Whether brought on by internal biological processes or outside events, the brain may biochemically adapt to a variety of stresses. Events that are stressful (internal or external) especially when they last a long time impair the brain's biochemical balance. The brain gets more chronically deregulated as more injuries are inflicted upon it. It is conceivable that major mood and mental problems will develop as a result of the brain's existing disturbed regulation being put under further stress from new stressors (internal or external). At pivotal points in their lives, notably after giving birth, women are more susceptible to mood problems due to the distinctive and typical brain and hormonal chemistry of women[125].

Post-Natal Depression is caused by a combination of biological (including genetic), psychological, social, relational, economic, and situational life stressors. Post-Natal

Depression is not a homogeneous disorder. Women may express Post-Partum Depression with a single symptom but are more likely to have a constellation of varying symptoms. This is related to varying life histories of internal and external stressors. Culturally, women are expected to feel happy, look happy, act happy, understand how to be a mother naturally, and experience motherhood with a sense of fulfillment. These expectations make it difficult for women to express genuine feelings of distress[125].

All pregnancies come with a variety of biological, social, and psychological problems and difficulties that are completely natural. These could include feeling worn out, having trouble sleeping, doubting one's skills, and similar things. Comprehensive prenatal and post-natal treatment can help women normalize anticipated symptoms and get rid of bothersome pathological symptoms, which will lessen the stress they really feel throughout pregnancy. Numerous researches have widened the scope of the areas where Beck felt that greater conceptual clarity was required. For instance, baby temperament was found to be a distinct risk factor and predictor for post-natal depression through her own study and meta-analysis of previous studies[125].

Marriage is a significant shift as well. It was discovered via future study that there were two marriage elements to be aware of: married status and the satisfaction level of the marital relationship's nature. Socioeconomic status and problems with unintended and undesired births were two additional risk variables that were found[123]. Over the course of years of research on post-natal depression, Beck's key ideas have been improved and clarified. Beck conceptualized them into;

1. Post-Natal Mood Disorders- Over time, the definitions of Post-Natal Depression, the "maternity blues," and Post-Partum psychosis have improved. Post-Natal obsessive-compulsive disorder and Post-Natal -onset panic disorder are two more perinatal mood disorders that have been found, along with how they differ from one another and how they

are connected. They include: Post-Natal Depression, Maternity Blues, Post-Partum Psychosis, Post-Natal Obsessive-Compulsive Disorder and Post-Natal -Onset Panic Disorder[126].

2. Loss of Control- In the 1993 substantive theory of Beck's early work, it was recognized as the fundamental psychological issue. This descriptive theory accurately described the Post-Natal Depression process that women go through. Women reported feeling out of control in every aspect of their life, despite the fact that the specifics of each situation could have varied. The idea of losing control was consistent with existing literature and left women feeling as though they were "teetering on the brink". The method was divided into the following four steps:

1. Stage 1 Encountering Terror: horrifying anxiety attacks, relentless obsessive thinking, enveloping fogginess
2. Stage 2 Dying To Self: alarming unrealness, isolating oneself, contemplating and attempting self destruction.
3. Stage 3 struggling to survive: battling the system, praying for relief, seeking solace at support groups.
4. Stage 4 Regaining Control: unpredictable transitioning, mourning lost times, guarded recovery[126].

The development of particular testing focuses was based on the conceptual notions and definitions mentioned above. Eight characteristics were initially identified as being at risk for Post-Natal Depression. Numerous researches have widened the scope of the areas where Beck felt that greater conceptual clarity was required. For instance, baby temperament was found to be a distinct risk factor and predictor for Post-Natal Depression through her own study and meta-analysis of previous studies[126]. These key ideas have been identified as important risk factors or predictors of Post-Natal Depression. Each concept definition

concludes with the most recent interpretation of impact size, which was determined using a meta-analysis of 138 published research.

1. Prenatal Depression
2. Child Care Stress
3. Life Stress
4. Social Support- network support (e.g., babysitting, help with household chores) and emotional support. Structural features of a woman's social network (husband or mate, family, and friends) include proximity of its members, frequency of contact, and number of confidants with whom the woman can share personal matters. Lack of social support is when a woman perceives she is not receiving the amount of instrumental or emotional support she expects.[E](Effect size = Medium)
5. Prenatal Anxiety
6. Marital Satisfaction
7. History of Depression
8. Infant Temperament
9. Maternity Blues
10. Self-Esteem
11. Socioeconomic Status
12. Marital Status
13. Unplanned or Unwanted Pregnancy

These final concepts represent the distillation of all predictor and risk factors that are used to screen women for symptoms of Post-Natal Depression in the PDSS[126].

a. Sleeping and Eating Disturbances
b. Anxiety and Insecurity

c. Emotional Liability

d. Mental Confusion

e. Loss of Self

f. Guilt and Shame

g. Suicidal Thoughts

When a mental condition is linked to the birth of a child, the stigma associated with it soars, forcing women to suffer in silence. Post-Natal Depression can be avoided within a level of preventive framework by identifying and reducing risk factors before to delivery and experiences during the prenatal period. The negative impacts on mothers, their infants, and their families can be threatening to the relationship. This theory (though founded by a nurse) talks about the biological and psychological causes of Post-Natal Depression and also how it can be heightened by social factors and the lack of social support from spouse and family[126]. The substantive theory contributes greatly to this study because it opens our eyes to the various stages of the post-natal period. This theory believes that the mothers social environment greatly affects her physical, mental and emotional state after having a baby. Though it was founded by a nurse, the theory does not limit the treatment of PND to just biological but it recognises the social and the psychological[126].

2.2.2 Social capital theory

Mothers were shown to be protected against Post-Natal Depression by their social, emotional, and practical support networks. In the individual level qualitative research and the subsequent group level qualitative study, the idea of "support and nurturing" of mothers emerged as a potential generative mechanism of the phenomena of Post- Partum Depression. "Support for moms" was recognised as a mechanism that might shield mothers from stress and despair. Support from partners, families, "mum type" people, social networks, and

mothers' groups were also noted [127]. Social capital was a prominent theme in the group-level qualitative study, and the situational analysis supported the significance of the connected notions of social support networks, social cohesiveness, and social capital in shielding mothers from depression. The idea of social support has several different aspects. Support may come from your spouse, your family, friends, or colleagues. The central purpose in this section is to ascribe meaning to the phenomenon of post-natal depression within a social capital conceptual framework[128].

Social capital can be thought of as both resources embedded in networks and as having both individual and group characteristics. It is indicated that network-based resources are significant at both the person and group levels, are consistent with the notion that social capital has both individual and group characteristics. Additionally, the authors point out that there is presently debate over whether social capital should be defined as social cohesion or as resources embedded in social networks[129]. Network approaches to social capital were lost when the idea was applied to public health. According to the authors, social capital was initially thought of as a psychosocial mechanism working at an ecological level that could regulate the relationship between wealth disparity and health. As a result, the "communitarian" approach to social capital with "disproportionate emphasis to normative and associational qualities of locations" came to dominate[130].In researches done, three dimensions of social cohesion were identified[131]:

1. Social relations of everyday life, family and social relationships, networks, and voluntary social processes (social capital)

2. Reduction of differences, cleavages and inequalities between groups of people and people living in different geographical areas (social exclusion)

3. A distinct cultural dimension referring to “ties that bond people together with a sense of common purpose, shared identity and common values (social cohesion)”.

According to numerous studies, social support and its opposite, a lack of social support, are both linked to Post-Natal Depression. A moderate effect size was seen in the association between social support and Post-Natal Depression. Other researchers have consistently demonstrated a negative connection between Post-Natal Depression and social support during pregnancy. With regard to the pressures faced by couples, social assistance may be very important[132]. In a multi-ethnic sample of new mothers, it was discovered that social support and social networks were independently connected to depression symptoms[133]. It was also noted that "social support may have a stronger favorable direct influence on health than stress has a negative one”. They also point out that research has shown that social support can reduce the detrimental psychological impacts of long-term stress. Social support has been demonstrated to improve psychological well-being in connection to pregnancy, especially in low-income women. Low-income pregnant women "may be more dependent on social support because of the relative lack of financial resources, since they may become less likely to work and have increased demands for emotional and emotional aid[134].

The social capital theory emphasises on the support system the mother has during the Post-Natal which contributes greatly to this study. The theory claims that a strong network support group can positively affect the health of a mother thereby alleviating the stress that comes during the post-natal period.

2.2.3 Skinners Operant conditioning theory

According to operant conditioning, depression is brought on by a lack of environmental positive reinforcement because they decrease the positive reinforcement from others. Some occurrences, like losing your job or in this case, going through a difficult

delivery, can create sadness [42]. People who are depressed typically engage in substantially less social activity. Inadvertent encouragement of depressive behavior by others might also contribute to Post-Natal Depression. For instance, when there is little to no support from a spouse or family members, an essential source of encouragement has also been gone. This results in inaction. However, this frequently reinforces maladaptive behavior, such as crying, whining, and discussing suicide. Over time, this alienates even close friends, which results in even less support, growing social isolation, and rising unhappiness. In other words, post-partum depression is a downward spiral in which the sufferer is continually pushed[135].

B.F Skinner distinguished between two different types of behaviours

1. Respondent behaviors such as jerking your leg when the doctor taps on your knee or moving your hand away from a hot stove are those that happen spontaneously and reflexively. These habits do not need to be learned. They just take place without conscious thought or intention[136].

2. Operant behavior- on the other side, there are some that we can consciously influence. The results of these activities then determine whether or not they recur in the future. Some acts may happen accidentally, while others are done on purpose. Our interactions with the environment and the results of those interactions have a significant role in how we live[136]. The components of operant conditioning include:

Reinforcement in Operant Conditioning

Any occurrence that enhances or improves the behaviour it leads to is referred to as reinforcement. The reinforcers come in two varieties. The behaviour advances in both of these reinforcement scenarios.

- Positive reinforcers are rewarding experiences or results that follow a behavior. A reaction or behavior is strengthened in conditions involving positive reinforcement by the addition of compliments or an outright payment. Support in terms of self-esteem is required at this time. The birthing process is challenging, stressful, and often traumatizing, yet it is also incredibly rewarding. Words of support and phrases that foster self-worth, confidence, and self-esteem can help new moms who have gone through this process.
- Negative reinforcers entail the elimination of undesirable circumstances or results following the manifestation of a behavior. In these circumstances, the elimination of anything deemed unpleasant strengthens a reaction. For instance, in the case of a depressed mother who has just had her first child, avoidance of hurtful words, discouraging words and social support will cause an improvement in emotional stability[136].

The theory of operant condition paradigm claims that depression is a consequence of a decrease in the positive efficient reinforced behavior and could be a sign of obvious punishment for nonconforming behaviour. It is also the result of a decrease in the accessibility of reinforcement events, personal ability to maneuver the environment, the impact of variety of events, or a combination of the above. Moreover, a negative feedback of social reinforcement behaviors may result from unavailability of support from family and other social networks such as social withdrawal. However, a low rate of positive reinforcement for mood-enhancing behavior and high rate of positive reinforcement for depressive behavior may be experienced by people who experience major stress originating from unexpected events. People with traumatic delivery, abusive pasts and faced other traumatic past events can be susceptible to PND. This theory of operant conditioning claims

using social support as a positive reinforcement decreases the possible occurrence of depressive behaviour[137].

The theory of operant conditioning believes that reinforcement plays an important role during the Post-Natal period which is n important component of his study. As earlier said this theory claims that depression is a consequence of a decrease in the positive efficient reinforced behaviour, which in turn means that support can be used as a technique of positive reinforcement to avoid depressive behaviour.

2.3 Review of Empirical Studies

The first study's objective was to explore the experiences of young females, in particular, receipt of social support, and its effect on pregnancy care and wellbeing during the prenatal period, through a phenomenological approach, in the context of Soweto, South Africa. An interpretive phenomenological approach was employed to understand and interpret pregnant young women's lived experiences of support networks on their pregnancy care and wellbeing. Data was collected conducting 18 in-depth interviews with young pregnant women. Analysis of the data resulted in the development of two super ordinate themes: (1) relationships during pregnancy and (2) network involvement. Each super ordinate theme was linked to subthemes that helped explain whether young women had positive or negative experiences of social support during their pregnancy care, and their wellbeing. The sub-themes emanating from the super ordinate theme 'relationships during pregnancy' were (a) behavioural response of partner following disclosure of pregnancy, (b) behavioural response of family following disclosure of pregnancy, and (c) sense of emotional security. Accompanying subthemes of the super ordinate theme 'network involvement' were (a) emotional and instrumental support, and (b) information support. An interpretation of the young women's experiences has revealed that young women's satisfaction with existing support networks and involvement of the various social networks contributed greatly to the participants having a greater sense of

potential parental efficacy and increased acceptance of their pregnancies. Pregnant women who receive sufficient social support from immediate networks have increased potential to embrace and give attention to pregnancy-related changes. This could, in turn, foster positive behavioural outcomes that encourage engaging in good pregnancy care practices and acceptance of motherhood.

The study took place at the Chris Hani Baragwanath Academic Hospital located in Soweto, Johannesburg, South Africa. It is nested in the Healthy Life Trajectories Initiative (HeLTI), and specifically the "*Bukhali"* randomised control trial that examines the effects of a complex intervention aimed at optimizing the health of young women preconception, during pregnancy, and postnatally. Interview guide questions were developed by the study team and used for prompting where necessary. Interview questions focused on young women's pregnancy experiences, support structures, health behaviours (antenatal care visits) and sources of information on pregnancy. Colaizzi's seven-step method was used to analyze the data with the aid of MAXQDA software version 2020 which assisted in recording and coding the interview transcripts. However, only six steps were employed in this study given that follow-up interviews did not take place in the seventh stage in order to validate our findings from the study participants. An exploration of the participants' narratives showed that both partners and families of the pregnant young women are a key pillar in supporting the young women during their pregnancy and helping them navigate through challenges associated with pregnancy. An interpretation of their narratives shows that although the participants received financial support from their families and partners, participants mostly received emotional support which contributed significantly to their emotional wellbeing. The narratives also showed that some participants received most support from their partners, some from their families and some had an equal balance of support from both networks. In addition, partner and family engagements included provision of funds to meet healthcare

needs, food security, and provision of a conducive living environment. Focusing on previously unexamined factors that could improve maternal health, such as social support, could improve maternal mortality rates and help achieve reproductive health accessibility universally.

The findings demonstrate that support from members of their various relationship networks contributed greatly to the young women's pregnancy care and emotional wellbeing. Such support was found to be available to most participants of the study, even though the support that they received either from their partner or family, and the type of support that they received (instrumental, emotional and informational support) somewhat varied. This contributes greatly to young mothers having increased acceptance of their pregnancies and a greater sense of potential parental efficacy. The existence of social support has a major influence on pregnancy care and wellbeing and a lack thereof can pose significant risks on both maternal and child health. Focusing on social support could help contribute to reducing maternal mortality rates and achieving reproductive health accessibility universally. Pregnant women who receive sufficient social support from immediate networks have increased potential to embrace and give attention to pregnancy-related changes. These findings address a critical gap in the literature, since the nature of social support has not previously been explored from a qualitative perspective in South Africa[138].

Another study aim was to assess the relationship between postpartum depression and social support and marital satisfaction and found a significant proportion of mothers, in the early childbirth period, experience PPD and this is correlated with lower levels of social support and marital relation satisfaction. The prevalence of PPD varies significantly depending on the description of the disorder, country, diagnostic tools used, and period that the prevalence is determined, and the threshold of discrimination chosen for the screening measure. Nevertheless, the prevalence of PPD in Saudi Arabia in Saudi study was 23.9% .

Moreover, the prevalence of PPD in Egypt is estimated between 10% and 20%, with an average prevalence of 13% . In developing countries, the prevalence has been determined to range between 5.2% and 74.0%, with the highest prevalence reported in Turkey and lowest prevalence in Pakistan. The significant variation in the prevalence of PPD can be attributed to the use of different diagnostic tools as well as a heterogeneous study designs. For example, the research used tools such as the EPDS, MSPSS, BDI, and CSI . As demonstrated by the outcomes of the research, the prevalence of PPD was 33.3%. On the other hand, marital dissatisfaction was reported to be 39.5% of 22 mothers (participants). Additionally, 22.0% had co-morbid depression and anxiety as well as worse marital dissatisfaction.

Focusing on the results of investigating the correlation between social supports and developing the PPD, proved that both teen and adult mothers were about five times likelier to experience PPD. This is evident if they did not receive support or minimal support after the birth of a baby. Furthermore, research shows that that social support during prepartum and postpartum periods has significant implications on depression. The mean scores were significantly declined among women who are suffering from worse levels of PPD. Additionally, a statistically significant negative association was found between social support and the development of PPD.This explains the current study findings that a statistically strong negative significant association between PPD among the study women was interviewed 2- 16 weeks post-delivery and their scores for couple satisfaction.

As demonstrated by the findings of the research, it is evident that there is a significant and inverse correlation between marital satisfaction and PPD. Additionally, research shows that couples with effective marital communication and understanding enjoy a better health status. Additionally, women who reported higher levels of social support had fewer symptoms of depression during the postpartum period in comparison to women with less supportive networks. From clinical application, practical PPD intervention approaches should

incorporate amenable factors. However, the type and timing of the intervention are still clearly outlined[139].

This next study investigated the Psycho-social Determinants of Postpartum Depression and Maternal Well-Being among Postnatal Women in Accra Metropolis. Collection and analysis of quantitative data on psycho-social variables preceded a qualitative process of data collection. The qualitative data was to explain in-depth, the identified variables that determine PPD among postnatal women in the Accra Metropolis. The descriptive survey method was adopted for the quantitative responses while interviews were conducted to collect qualitative data. Simply, the study used a sequential explanatory mixed-method design.

The purposive sampling procedure was used to sample 205 postnatal women accessing postnatal care services at the obstetrics and gynecology, and public health departments of 37 Military Hospital. This number was obtained as women who met the inclusion criteria and agreed, to participate in the study. Ten out of the 205 women were further selected for the qualitative study because these were women who had been identified through the EPDS as those at risk of PPD based on their scores. Postnatal mothers aged 15 to 39 years, who are at least 4 weeks old and at most 12 weeks old and had no history of major or endogenous or bipolar depression were used for the study. Mothers who had lost their babies but are accessing postnatal care at the hospital and those who were unwilling to participate or demonstrated signs of being in a hurry were excluded from the study.

A five-section questionnaire to obtain socio-demographic information, DASS-21, EPDS, MSPSS, and the MAT were adapted and used to obtain data for the study. A self-prepared semi-structured interview guide was also used to elicit information for the qualitative study.Biodata such as age, baby's age, educational level, marital status, and

occupational status was collected. The actual age of mothers and that of their babies were obtained on a continuous level of measurement.

Although not reported in previous studies, the current study found that single parenting affected maternal well-being. Partner neglect and limited support especially in the postpartum period increased low mood and suicidal thoughts in single mothers and mothers who were married but were single- handedly taking care of their babies. It is recommended that the Ghana Health Service (GHS) under the auspices of the Ministry of Health (MOH) should include mental health screening section in the antenatal care book to monitor mental health and well-being among mothers during the antenatal period. This will help identify women who are at risk of developing pregnancy-related or other mental illnesses, rather than focusing on those women already diagnosed with existing mental illnesses. Again, screening mothers in the antenatal period will also prevent the progression of mood disorders to the postpartum period. This will also help GHS build a good database of sufferers for monitoring and evaluation purposes[140].

In another study, perceived social support and depression levels of women in the postpartum period in Hatay, Turkey were designed as a cross sectional study. The research was conducted in Narlıca No. 2 family health center located in the city center of Hatay. The universe of this study was formed by the women who have given birth in the last 1 year in Narlıca. The annual number of births was determined as 375 according to 2012 statistical reports of Narlıca area. The research was conducted with 177 women who have given birth at least 2–4 months ago and agreed to participate in the study [102]. The research was applied between the dates of 01 December 2013 and 01 September 2014 until sample number has completed. The study data were collected by face-to-face interview method at 2 days of the week (Tuesdays and Thursdays) when women came for their infants' vaccinations.

The average age of women who attend this research is 25.30 ± 5.59 and 35.0% are

between the age of 21 and 25 years, whereas the average age of the partners is 30.28 ± 5.89 and 38.4% are between the age of 26 and 30 years. Marrige age of 61.0% was 18 and over (X— = 18.57 ± 2.52), 41.2% were married for 1–4 years (X— = 6.76 ± 5.09), 23.7% had two previous pregnancies, 28.2% had one alive child, and 76.3% gave birth to a child 3 months ago. Overall, 72.9% of women stated that they got pregnant intentionally, 81.9% stated that the gender of their babies is as they expected, 78.8% of them got support from infant care, 32.6% got support from their own families, and 47.6% from the partner. The questionnaires took nearly 15–20 minutes to be completed. An official permission from the institution and informed written consent of mothers were obtained.

Edinburgh Postpartum Depression Scale (EPDS), Multidimensional Scale of Perceived Social Support (MSPSS), and Sociodemographic Information Form was utilized for data collection. The information form consists of 16 questions about introductory properties of mothers.It is detected that the social support grades of mothers varies between 12 and 84, the postpartum depression grades varies between 0 and 26 and 34.5% of mothers are under the risk of postpartum depression in this study. Average scores of mothers who intended to this study for the subfields were found as the following: EPDS average score was 10.30 ± 5.70, MSPSS total average score was 57.36 ± 24.66, family support subfield average score was 21.75 ± 8.56, friend support subfield average score was 17.31 ± 9.86, and partner's support subfield average score was 18.29 ± 9.28 .

This study concludes that as social support levels increase there is a decrease at postpartum depression risk. It is recommended that planning of interventions should be in accordance with the factors affecting the social support and depression levels at women in the postpartum period[141].

Likewise another study examined the Associations between Spousal Relationship, Husband Involvement, and Postpartum Depression among Postpartum Mothers in West Java, Indonesia. A survey was carried out among 336 postpartum mothers who received maternal care in 27 independent midwifery clinics in 7 regions of West Java Province, Indonesia. The measurement model of husband involvement comprising 4 dimensions, namely maternity care engagement, instrumental support, emotional support, and informational support were developed and validated using confirmatory factor analysis. The Quality of Marriage Index (QMI) and the Edinburgh Postnatal Depression Scale (EPDS) were also validated and used to measure spousal relationship and postpartum depressive symptoms. A structural equation model was specified to examine the association between spousal relationship, husband involvement, maternal healthy behavior, and postpartum depression**.**

The study confirms the assumption that the quality of the spousal relationship could determine husband's involvement during pregnancy, childbirth, and postpartum ($\gamma = .60$, $P < .001$), eventually leading to better maternal healthy behavior ($\gamma = .015$, $P < .001$) and a decrease in postpartum depressive symptoms among mothers ($\gamma = -.21$, $P < .001$). The study results suggest the needs to promote comprehensive husband involvement to enhance the well-being of mothers. This can be achieved through couple interventions at the community level and the inclusion of a supportive role for husbands in the maternal and childcare guidebook offered during ANC visits[142].

Conversely another study determined Social Support Satisfaction as a protective Factor for Postpartum Maternal Distress. In this study, many dimensions of social support and a large range of alternative factors such as SES, maternal employment status, and marital status were asessed. However, consideration of other mediating or risk factors may be important to elaborate influences of postpartum maternal distress. Prior studies provided compelling evidence for maternal personality characteristics as moderating the association

between social support and maternal distress. For instance, it was found that women with high neuroticism were unable to benefit from high levels of social support, and still exhibited high levels of postpartum depression. Additionally, other studies founded neuroticism to be an independently strong risk factor for postpartum distress. Thus, future studies, which are larger and prospective, should consider exploring maternal personality characteristics such as neuroticism.

Considering the risk that poor maternal mental health poses for mother-child bonding, child development, and well-being, it is important to understand the factors that may help women cope with this transition. Prior works on protective factors for postpartum maternal distress have presented an unclear picture. Findings from the current study fill a gap by providing a more nuanced understanding of the aspects of social support mothers find most helpful in the postpartum period, beyond receiving adequate amounts. Improved understanding of the multidimensional aspects of social support that buffer against postpartum maternal distress could improve preventions, interventions, and treatment. Continued attention is needed regarding specific protective factors such as social support for postpartum mothers' needs in order to strengthen outcomes for mothers and children[143].

Conclusively, this particular study examines we determined the prevalence, associated factors and perinatal outcomes of ante partum depression among pregnant women in Ibadan, Nigeria. A prospective cohort study was conducted among 1745 pregnant women enrolled early in pregnancy ($\leq$20 weeks) at four comprehensive obstetric facilities within Ibadan metropolis. Antepartum depression was ascertained during the third trimester using the Edinburg Postpartum Depression Scale $\geq$ 12. The primary exposure was antepartum depression and the outcome variables were the perinatal outcomes. The associated factors assessed included sociodemographic, obstetric, psychological, and lifestyle characteristics.

Bi-variate logistic and Poisson regression analyses were used to assess the factors and relative risk for perinatal outcomes of antepartum depression.

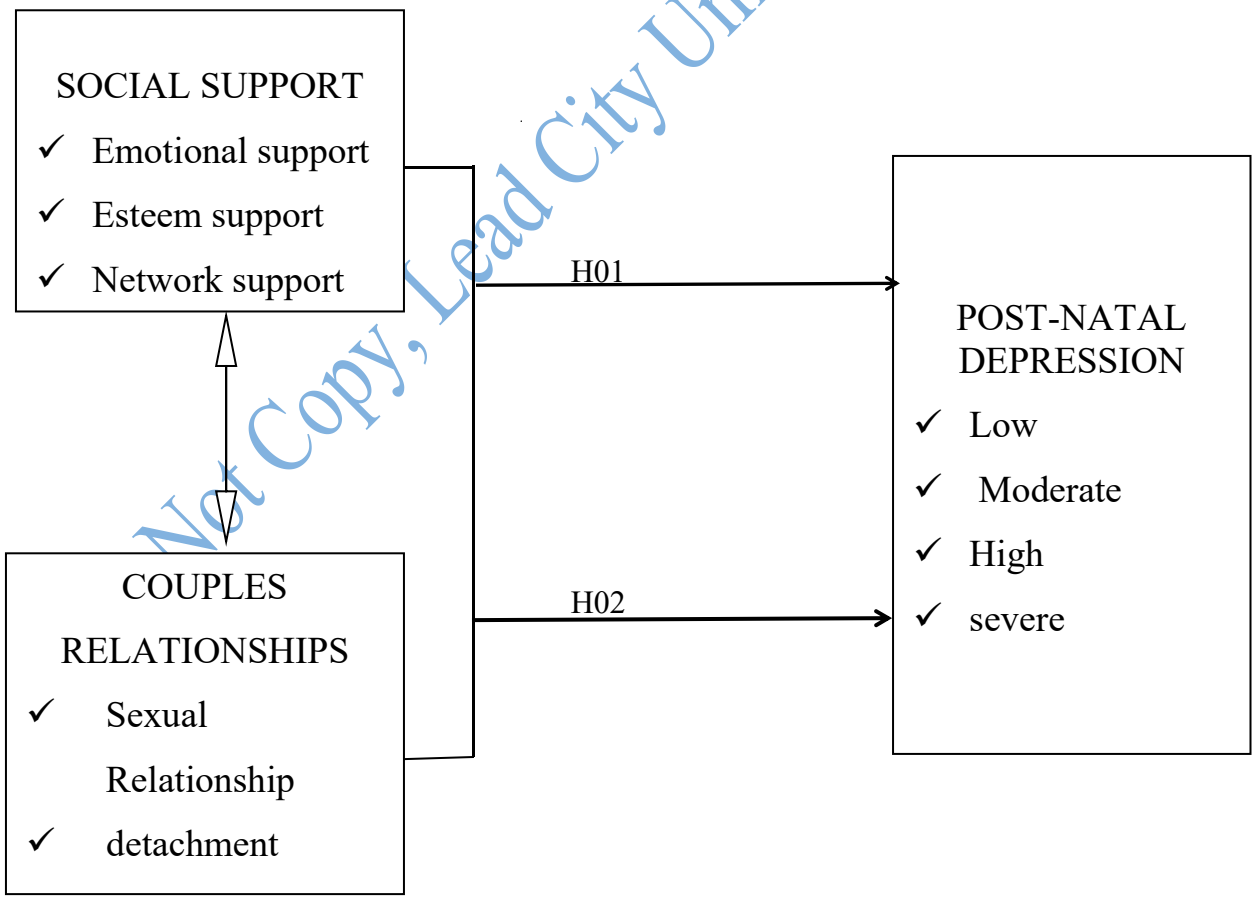
The prevalence of antepartum depression was 14.1%. This fall within the range of antepartum depression reported for Nigeria and sub-Saharan Africa. It is however lower than the prevalence rate reported by a similar study in Ogun State in a cross-sectional study conducted among antenatal care attendees in Ogun state which comprised a population of women with a lower level of education and income The prospective design enabled us to investigate perinatal outcomes among our study population. Previous studies have been limited in investigating the perinatal outcomes associated with maternal mental concerns because of the study design that was utilized, mostly cross-sectional. Multivariate analysis showed high income and perceived stress as significant factors associated with APD, after adjusting for confounders. Actually, perceived stress had a dose–response association with APD which suggests causality. The causal relationship between stress and depression has been reported by researchers. Perceived stress during pregnancy could result from low socio-economic status, financial distress particularly the difficulty with meeting basic needs such as food and shelter, lack of social and family support, marital dysfunction and conflict. These factors, together with other early life stressors as physical, sexual and psychological maltreatment could contribute to maternal depression during pregnancy.

APD was prevalent among our study population. The significant factors identified in this study can be targeted to reduce the occurrence of APD among pregnant women in Nigeria through appropriate social and public health interventions which include APD screening, counselling, and the provision of emotional support for pregnant women during antenatal care[144].

Independent variables

Dependent variable

2.4 Conceptual Model



The conceptual model is an expression of how the variables interact. The two independent variables are linked to the dependent variable. The independent variables are going to be

examined in relation to how they influence the dependent variable- post-natal depression. Social support and couples relationships could interact with one another to determine whether or post-natal depression is avoidable.

Source: Researcher's Fieldwork, 2023

2.5 Summary of Gap in of the Reviewed Literature

The relevant literature on Social Support, Couples Relationships and Post-Natal Depression has been reviewed. The conceptual, theoretical and empirical review was done where the theoretical review was carried out on social support, couples relationships and post-natal depression. The study reviewed how social support can determine the appearance of post-natal depression; how couples relationship can also determine the appearance of post-natal depression.

The study looked into post-natal depression which mostly focused on the mother and child neglecting the couple's relationship. Although a considerable amount of research has demonstrated interrelations between social support and post-natal relationship, few studies have investigated the combined relationship between couples relationship and PPD. It has been identified that emotional support, esteem support, tangible support and informational support as the four main types of support needed when facing a mental challenge. Where post-natal depression is concerned, emotional support and esteem support has been seen to be very important because it determines the mental health status of the mother and in turn has an effect on the couple's relationship. The social network group of the new mother also plays a major role in the postpartum period. In this part of the world the social network support

group includes the husband, the relatives and also the in-laws and each have their specific roles to carry out.

The couple's relationship has been seen to be a major determinant of whether or PND might appear or not. The level of intimacy present in the relationship and how healthy the sex life is also included. Post-Natal Depression is a mental illness that affects not just the mother but her social network group. It is also identified that PND can lead to emotional detachment from the closest relationship the mother has which is her spouse. This leads to deterioration in the condition.

Based on the above review, there hasn't been enough studies carried out on the relationship between social support, couples relationship and post-natal relationship and how the condition can be managed with the appropriate measures, this study tends to cover this gap.

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Chapter Three
Methodology

This chapter describes the procedures that was adopted in carrying out the study under the following subheadings: design of the study, area of study, population of study, sample and sampling technique, research instrument for data collection, validation of the instrument, reliability of the instrument, method, of data collection , method of data analysis and decision rule.

3.1 Research Design

The descriptive survey research design was adopted in this study. It was adopted because the researcher is geared towards finding opinion of teachers concerning social support, couples relationship and post-natal depression in primary school female teachers in Ibadan north local government area of Oyo state**.** A survey design was used to access and predict the views, reactions or standings of a large number of people on a limited topic like social support, couples relationship and post-natal depression.

3.2 Population of the Study

The area of study is Ibadan North Local Government Area of Ibadan. It is located in the capital city of Oyo State. The sample will be selected from the population of the study which consists of 600 teachers in the Seventy-three (73) government primary schools within Ibadan North Local Government area of Oyo state.

Name of Public Primary Schools in Ibadan North Local Government

S/N	Name of Schools in Ibadan North Local Government	No of Teachers
1	ST. Johns Agodi N5	11
2	C.A.C School I Oniyarin	9
3	C.A.C School II Oniyarin	8
4	C.A.C School I Special Sango	8
5	C.A.C Primary School II Sango	7
6	C.A.C Basic School III Sango	13
7	C.A.C School IV Special Elewure Sango	7
8	C.A.C Primary School Oje Igosun	7
9	C.A.C SP. School ONIYANRIN	3
10	Salvation Army Basic School Nalende	4
11	St. Brigids Boys Mokola	7
12	Methodist School II Bodija	9
13	St. Mary Convent School I Oke-are	9
14	St. Mary Basic School II Oke-are	5
15	St. Paul's Basic School I Yemetu	9
16	St. Paul's Basic School II Yemetu	9
17	St. Paul's Basic School III Yemetu	9
18	St. Paul's Anglican Basic School IV Yemetu	7

19	St. Thomas School I Agbowo	8
20	St. Thomas School II Agbowo	5
21	ST. Thomas School III Agbowo	9
22	Immanuel Primary School I Orita U.I	13
23	Immanuel College Primary School II U.I	10
24	C & S New Eden Basic School 1 Mokola	9
25	C & S New Eden School 1I Mokola	9
26	C & S New Eden Basic School 1 Bodija	10
27	C & S New Eden Basic School 1I Bodija	13
28	Abadina School I U.I	13
29	Abadina School II U.I	12
30	Abadina School III U.I	9
31	Oluyole Cheshire Home School	10
32	Poly Staff School I Ijokodo	7
33	Poly Staff School II Ijokodo	7
34	Poly Staff School III Ijokodo	4
35	Community School I Ojokodo	10
36	Community Basic School II Ojokodo	6
37	Community Basic School III Ojokodo	8
38	United Brothers School Nalende	4
39	U.N.A Mission School Nalende	9
40	Home School For The Handicapped Ijokodo	5
41	St Peters Catholic School I Oke-are	6
42	St Peters Catholic School II Oke-are	7
43	St John's RCM School nalende	6
44	Islamic Mission School I Odoye Ibadan	9
45	Islamic Mission School II Odoye Ibadan	8
46	Islamic Mission School III Odoye Ibadan	7

47	Islamic Mission School IV Odoye Ibadan	8
48	Salvation Army Basic School I Kube	9
49	Salvation Army Basic School II Kube	9
50	Salvation Army School I Yemetu	6
51	Salvation Army School II Yemetu	11
52	Salvation Army School III Yemetu	9
53	I.M.G School I Oniyanrin	7
54	I.M.G School II Oniyanrin	7
55	I.M.G Adeoyo N4 Yemetu	9
56	I.M.G Basic School I Ije-igosun	10
57	I.M.G Basic School II Ije-igosun	8
58	I.M.G School I Mokola	8
59	I.M.G School II Mokola	4
60	I.M.G School III Mokola	6
61	St Micheal's Basic School I Yemetu	6
62	St Micheal's School II Yemetu	7
63	St Stephen's Anglican School I Nalende	7
64	St Stephen's Anglican Primary School II Nalende	9
65	St Brigid's Convent Mokola	8
66	Ebenezer A\C Basic School Nalende	5
67	Methodist N5 Basic School Agodi	8
68	Methodist Basic School I Bodija	12
69	Community Primary School Ikoloba	14
70	Alafia (Free) Primary School Mokola	9
71	Ibadan School OF Deaf Ijokodo	13
72	Olive Primary School I Bodija	9
73	Olive Primary School II Bodija- Isopako	8
	Total	600

Field Source: SUBEB Report 2022

3.3 Sample and Sampling Techniques

The researcher used the total population from each school. All the Government Primary schools in Ibadan North Local Government area were sampled to give a fair representation of schools in the area. All the schools were used for this study which included all teachers, male and female from each of the primary schools making a total population of six hundred (600) respondents for this study. Although only 587 questionnaires were returned.

3.4 Research Instrument

The research instruments used were adapted questionnaires on Post-Natal Depression, Social Support and Couples Relationship, it had five sub- scales which included the bio-data, the knowledge of post-partum depression, the Edinburgh Post-Natal Depression Scale (EPDS), Multidimensional Scale of perceived social support tool (MSPSS) and the couple satisfactory index (CSI).

3.5 Description of the Research Instrument

Three instruments were be adapted for this research work. They are all questionnaires. (1. Edinburgh Post-natal Depression Scale (EDPS) 2. Multidimensional Scale of perceived social support (MSPSS), and 3. The Couples Satisfaction Index (CSI). Edinburgh Postnatal Depression Scale by Cox et al (1987) is used to determine the levels of depression among respondents based on the descriptions of their symptoms. The tool has 10 self-reports based on a four-point Likert scale score that ranges from 0 (no symptoms) to 3 (very intense symptoms). The 10-question Edinburgh Postnatal Depression Scale (EPDS) is a valuable and efficient way of identifying patients at risk for “perinatal” depression. The EPDS is easy to administer and has proven to be an effective screening tool. The scale indicates how the mother has felt after delivery. Women with postpartum depression need not feel alone. This is evident that higher total scores indicate severe depressive symptoms.

Multidimensional Scale of perceived social support MSPSS tool by Zimet, Dalhem, and Farley (1988) has the benefit of being free of social desirability bias. The MSPSS tool had 12-items. The tool will be used to assess three sources of support including friends support, family support, and significant others support. The participants using the MSPSS are required to indicate their agreement that is represented on a 4 point Likert - type structure. In the Likert scale, 1 means "strongly disagree" and 4 implies "strongly agree." The tool was modified from a 7 point Likert-type to 4 point since the differences between adjacent categories is minor. The internal consistencies of the Cronbach"s alpha (subscales) are 0.76, 0.78 and 0.70 for friends support, family support, and significant other support, respectively. The highest mean score represents outstanding social support.

The Couples Satisfaction Index (CSI) was developed by Funk and Rogge (2007) using item response theory, to measure individuals' satisfaction in their relationship. The CSI is a self-report questionnaire that can be used as a 32, 16, or 4-item scale. The participants using the CSI are required to indicate the frequency of action that is represented on a 4 point Likert - type structure. In the Likert scale, 1 means "rarely" and 4 implies "always". Relationship satisfaction has been associated with personal well-being, overall happiness, mental health, physical health and intimacy, emotional intimacy, commitment, trust, safety, cohesion, acceptance, conflict and longer lifespan. The researcher adapted and adopted these instruments to better suit the requirements of the study.

3.6 Validation of the Research Instrument

The scales were validated and their psychometric properties were established. The face, content and construct validity were ascertained. They were established through the jugdement of experts in psychometrics, test and measurement with inputs from the researcher's supervisor. It was ensured that items on the instruments were suitable to elicit needed information from respondents. The researcher's instruments were subjected to proper

validation with the assistance of the supervisor in order to ensure that the instruments sub sales actually measured what they were expected to measure.

3.7 Reliability of the Research Instrument

Reliability of the instruments was determined with the use of Cronbachs alpha in SPSS software. Reliability of the instrument refers to the level of consistency, stability and accuracy of the instrument in measuring what it is expected to measure. A pilot study was conducted; the questionnaires were field tested on 10% of the population (60 respondents) in different locations and the data were analyzed to establish the reliability of the instrument. The values are as follows: The knowledge about post-natal depression= 0.80, EDPS= 0.94, MSPSS= 0.87 and CSI= 0.84.

3.8 Procedure for Administration of the instrument and data collection

Permission was taken from each schools' principals by the researcher also consent was sought from the respondents. The researcher administered the questionnaires to the respondents alongside with research assistants within a specific time frame. The research assistants were properly guided on the method of administration and they were sent to the selected public primary schools under the Ibadan North local government area in Oyo state, Nigeria which was the area of study. However instructions on how the questionnaires were to be filled were made known and also the respondents were notified that their responses and feedback were for research purposes and the researcher would treat it confidentially. Therefore questionnaires were administered in some minutes and retrieved back for scoring. Scores obtained from the data were analysed to determine the influence of the independent variables on the dependent variables.

3.9 Method of Data Analysis:

Data collection from the respondent were analysed with the aid of questionnaire. This was done through the use of descriptive statistical measure such as the demographic characteristics of the respondents used for the study and was analysed using sample percentage and frequency counts and was represented on charts. The research questions were analysed using descriptive statistics employing measures such as frequency, percentage and mean scores while research hypotheses were tested using inferential statistics such as Pearson's correlation analysis which was used to test the hypotheses at 0.05 alpha level of significance.

Chapter Four

Results and Discussion of Findings

Introduction

This chapter presents the analysis and in-depth discussion of the data derived from the survey conducted among Public Primary School Teachers in Ibadan North Local Government Area, Oyo State. To investigate Social Support, Couple's Relationship and Perceived Post-Natal Depression among the respondents, the study adopted descriptive statistics methods and correlation analysis. The data is presented in pie charts, bar charts and tables using measures such as frequency, percentage, and mean.

Descriptive statistics was employed to measure the demographic characteristics of the respondents. The research questions were also analysed descriptive statistics while the research hypotheses were tested using inferential statistics such as Pearson's correlation analysis. The findings have been presented according to research question and research hypothesis.

4.1 Demographic Data Analysis

This section highlights demographic features of the respondents namely sex, age, religion, ethnicity, number of children, means of delivery and family income.

Table 4.1. Overview of Demographic Information

		Frequency	Percentage
Sex	Male	200	34.1
	Female	387	65.9
Religion	Christianity	462	78.7
	Muslim	110	18.7
	Traditional	6	1.0
Age range	Less than 20	28	4.8
	21-25	74	12.6
	26-30	154	26.2
	31-40	158	26.9
	41 – above	172	29.3
Ethnicity	Yoruba	465	79.2

	Igbo	57	9.7
	Hausa	29	4.9
	Others	16	2.7
Number of children	1 – 2	311	52.9
	3 – 4	181	30.9
	5 – 6	43	7.4
	7 – 8	3	0.5
Means of delivery	Normal	429	73.1
	Caesarian	92	15.7
	Both	33	5.6
Family income range	Below 50,000	47	8
	51,000 - 100,000	275	46.6
	101,000 - 200,000	51	8.7
	200,000 - 500,000	30	5.2
	Above 500,000	4	0.6
Education status	NCE	140	24
	Polytechnic	140	24
	PGDE	42	7
	B.Ed	130	22
	M.Ed	32	5.3
	Others:		
	ACA	1	0.2
	B.A	7	1.2
	B.Agric	1	0.2
	B.Eng	1	0.2
	B.Sc	51	8.7
	B.Tech	5	0.9
	FCIA	1	0.2
	FNIMN	1	0.2
	HND	4	0.7
	M.A	2	0.3
	M.BA	1	0.2
	M.Sc	4	0.7
	M.Tech	2	0.3
	PHD	2	0.3
	Sch. Cert	10	1.7
	Missing	9	1.4

Table 4.1. presents the demographic features of the respondents. According to Table 4.1., majority of the respondents, 65.9% of them, are females while 34.1% are males. Regarding the distribution of respondents according to religion, 78.7% are of the Christian faith, 18.7% are Muslims, only 1% are traditional worshipers, while 1.6% did not indicate any religion. Also, majority of the respondents (29.3%) are above 41 years of age, 26.9% are within the age range of 31 and 40, 26.2% are within 26 and 30 years, 12.6% are within 21 and 25 while

only 4.8% are below 20 years of age. Table 4.1. also reveals that members of the Yoruba tribe constitute a majority of the respondents (79.2%), 9.7% are Igbo, 4.9% are Hausas while 2.7% belong to other tribes. This can be attributed to the higher population of Yoruba indigenes in the area of study. Furthermore, most of the participants in this study (52.9%) have between 1 or 2 children, 30.9% have 3 to 4, 7.4% have 5 to 6 while only 0.5% have 7 to 8. Regarding the means of delivery, 73.1% of the respondents reported normal delivery, 15.7% reported giving birth to their children through Caesarian surgery, while 5.6% delivered their children through both means. Evaluating the economic conditions of the respondents, Table 4.1. shows that most of the respondents earn between #51,000 and #100,000, 8.7% earn between 101,000 and 200,000, 8% earn below 50,000, 5.2% earn between 200,000 and 500,000 while only 0.6% earn above 500,000. Table 4.1. also reveals equal representation of NCE and Diploma holders among the respondents as both categories have 24% each, constituting a majority of the respondents. About 22% of the respondents hold Bachelors degree in Education, 5.3% Masters holders, while 7% hold post graduate diplomas in education. The respondents also reported other educational degrees such as the ACA (0.2%), B.A (1.2%), B.Agric and B.Eng (0.2 each), B.Sc (8.7%), School Certificate (1.7%).

Presentation of Data

The findings of this study are presented below according to each research question.

4.2 Research Questions

Research Question 1: What is the Perception of Post-Natal Depression among Male and Female Public Primary School Teachers in Ibadan North Local Government Area, Oyo State?

This section evaluates the knowledge of post-natal depression among male and female Public Primary School Teachers in Ibadan North Local Government Area, Oyo State using the 22-item PND awareness scale. The perception of male and female respondents have been presented below.

Table 4.2. Male Respondents' Knowledge of Post-Natal Depression

Items	Yes	%	No	%
I was aware of PPD before now	127	63.2%	70	34.8%
I do not know much about PPD	99	49.3%	97	48.3%
PPD is a health problem	153	76.1%	43	21.4%
PPD is a Mental Health Disorder	149	74.1%	43	21.4%
PPD is a weakness of character	129	64.2%	63	31.3%
Family History of PPD is a risk factor for PPD	136	67.7%	54	36.9%
Financial problem is a risk factor for PPD	135	67.2%	57	28.4%
Stressful Life Events is a risk factor for PPD	155	77.1%	33	16.4%
Poor Marital Relationships is a risk factor for PPD	155	77.1%	38	18.9%
Depressed mood is a symptom of PPD	150	74.6%	41	20.4%
Feeling sad, hopeless or empty are symptoms of PPD	157	78.1%	34	16.9%
Poor sleep or oversleeping are symptoms of PPD	133	66.2%	58	28.9%
Crying more often than usual is a symptom of PPD	139	69.2%	51	25.4%
Having trouble concentrating, remembering details or making decisions are symptoms of PPD	146	72.6%	46	22.9%
PPD can be detected early	147	73.1%	44	21.9%
PPD can be treated when detected	168	83.6%	26	12.9%
Rendering physical help or assistance can help reduce symptoms of PPD	166	82.6%	25	12.4%
PPD can be prevented through support	162	80.6%	27	13.4%
Reduced stress can help prevent PPD	166	82.6%	27	13.4%

A good marital relationship can help prevent PPD	162	80.6%	29	14.4%
Good social support can help prevent PPD	165	82.1%	29	14.4%
Family history of mental illness can trigger PPD	129	64.2%	61	30.0%

Table 4.2. measures the knowledge of post-natal depression among male Public Primary School Teachers in Ibadan North Local Government Area, Oyo State. According to Table 4.2. 63.2% of respondents were aware of post-natal depression prior to the survey, while 34.8% were not. Regarding knowledge of post-natal depression, almost half of the participants (49.3%) denied knowing much about PND, while 48.3% agreed. Also, significant majority (76.1%) recognize post-natal depression as a health problem, while 21.4% do not. Additionally, 74.1% of the respondents' view PND as a mental health disorder, and 64.2% disagreed with the notion that PND is a weakness of character. Identifying risk factors of post-natal depression, majority of respondents acknowledged risk factors such as; family history (67.7%), financial problems (67.2%), stressful life events (77.1%), and poor marital relationships (77.1%). Stressful life events and poor marital relationships were identified as the highest risk factors of post-natal depression. Furthermore, most of the respondents were able to identify symptoms of PND, such as depressed mood (74.6%), feelings of sadness, hopelessness, or emptiness (78.1%), poor sleep or oversleeping (66.2%), crying more often than usual (69.2%), and having trouble concentrating, remembering details or making decisions (72.6%). A significant majority believed that PND can be detected early (73.1%) and treated once detected (83.6%). Most respondents agreed that rendering physical help or assistance can help reduce symptoms of PND (82.6%), and that PND can be prevented through support (80.6%). Also, 82.6% agreed that reduced stress can help prevent PND, 80.6% believe a good marital relationship can help prevent PPD, and 82.1% think good social support can help prevent PND. Lastly, 64.2% of respondents believed that a family history of mental illness can trigger PND.

Overall, while a majority of respondents were aware of PND, there's still a lack of detailed knowledge, as almost half admitted to not knowing much about it.

Table 4.3. Female Respondents' Knowledge of Post-Natal Depression

Items	Yes	%	No	%
I was aware of PND before now	208	68.0%	85	27.8%
I do not know much about PND	147	48.0%	146	47.7%
PND is a health problem	244	79.7%	48	15.7%
PND is a Mental Health Disorder	230	75.2%	59	19.3%
PND is a weakness of character	209	68.3%	77	25.2%
Family History of PND is a risk factor for PND	227	74.2%	63	20.6%
Financial problem is a risk factor for PND	235	76.8%	56	18.3%
Stressful Life Events is a risk factor for PND	243	79.4%	47	15.4%
Poor Marital Relationships is a risk factor for PND	239	78.1%	54	17.6%
Depressed mood is a symptom of PND	238	77.8%	54	17.6%
Feeling sad, hopeless or empty are symptoms of PND	228	74.5%	60	19.6%
Poor sleep or oversleeping are symptoms of PND	207	67.6%	80	26.1%
Crying more often than usual is a symptom of PND	213	69.6%	74	24.2%
Having trouble concentrating, remembering details or making decisions are symptoms of PND	175	57.2%	112	36.6%
PND can be detected early	232	75.8%	59	19.3%
PND can be treated when detected	256	83.7%	34	11.1%
Rendering physical help or assistance can help reduce symptoms of PND	206	67.3%	82	26.8%
PND can be prevented through support	253	82.7%	38	12.4%
Reduced stress can help prevent PND	242	79.1%	50	16.3%
A good marital relationship can help prevent PND	253	82.7%	39	12.7%
Good social support can help prevent PND	240	78.4%	52	14.4%
Family history of mental illness can trigger PND	180	58.8%	110	37.8%

Table 4.3. evaluates the perception of post-natal depression among female Public Primary School Teachers in Ibadan North Local Government Area, Oyo State. Table 4.3 reveals that

about 68.0% of respondents were aware of post-natal depression before the survey, while 27.8% were not. This is a slightly higher percentage compared to male respondents, indicating higher awareness of post-natal depression among female public primary school teachers than males. However, similar to male respondents, nearly half of the participants (48.0%) indicated that they do not know much about PND, while 47.7% disagreed. Also, significant majority (79.7%) recognized PND as a health problem, while 15.7% did not. Additionally, 75.2% of respondents considered PPD a mental health disorder, and 68.3% disagreed with the notion that PND is a weakness of character. Most respondents acknowledged various risk factors for PND: family history (74.2%), financial problems (76.8%), stressful life events (79.4%), and poor marital relationships (78.1%). The majority of participants were able to identify symptoms of PPD, such as a depressed mood (77.8%), feelings of sadness, hopelessness, or emptiness (74.5%), poor sleep or oversleeping (67.6%), crying more often than usual (69.6%), and having trouble concentrating, remembering details or making decisions (57.2%). A significant majority believed that PND can be detected early (75.8%) and treated once detected (83.7%). Most respondents agreed that rendering physical help or assistance can help reduce symptoms of PND (67.3%), and that PND can be prevented through support (82.7%). Also, 79.1% agreed that reduced stress can help prevent PND, 82.7% believe a good marital relationship can help prevent PND, and 78.4% think good social support can help prevent PND. 58.8% of respondents believed that a family history of mental illness can trigger PND.

Overall, although more females claim to be aware of post-natal depression than males, there is no significant difference in perception of post-natal depression among male and female respondents.

Research Question 2 - What is the contribution of Social Support to Post-Natal Depression among Public Primary School Teachers in Ibadan North Local Government Area, Oyo State?

This section answers research question two by evaluating the contributions of social support to the development of post-natal depression. It measures social support using the Multidimensional Scale of perceived social support (**MSPSS**) by Zimet Et al. 1988. It also presents a Pearson's correlation to show the relationship between Social Support and Post-Natal Depression.

Table 4.4. Respondents' Knowledge of Social Support during the Post-Natal Period.

Items	Never	Rarely	Sometimes	Always	Mean
There is a special person who is always around when I need help as a nursing mother.	18 (5.9%)	35 11.4%)	146 (47.7%)	103 (33.7%)	2.106
I have a special person with whom I can share my joys and sorrows during the birth of my baby	23 (7.5%)	62 (20.3%)	120 (39.2%)	97 (31.7%)	1.9636
My family and friends always help me cook, wash and take care of my baby and I.	21 (6.9%)	52 (17.0%)	162 (52.9%)	67 (21.9%)	1.9106
I get the emotional help and support I need from my husband\family.	24 (7.8%)	48 (15.7%)	129 (42.2%)	101 (33.0%)	2.0166
My husband is a real source of comfort to me. He helps make the nursing period smooth and easy	18 (5.9%)	32 (10.5%)	107 (35.0%)	145 (47.4%)	2.255
I can talk about my problems with my husband/family.	27 (8.8%)	36 (11.8%)	111 (36.3%)	125 (40.8%)	2.1171
My family is willing to help me make decisions to make me comfortable during the nursing period.	15 (4.9%)	73 (23.9%)	125 (40.8%)	88 (28.8%)	1.9502
I have friends with whom I can	21	69	143	69	1.8609

share my joys and sorrows during the birth and nursing experience	(6.9%)	(22.5%)	(46.7%)	(22.5%)	
There are many family members in my life who care about my feelings and welfare as a nursing mother.	11 (36%)	50 (16.3%)	140 (45.8%)	100 (32.7%)	2.1887
I can count on my family for help when things go difficult during the nursing period.	13 (4.2%)	37 (12.1%)	139 (45.4%)	111 (36.3%)	2.16
Average Mean = 2.05					

Table 4.4 measures the respondents' perception of social support during the post-natal period. Findings from this study revealed that about majority of the respondents sometimes (47.7%) or always (33.7%) had a special person around when they needed help as nursing mothers. Similarly, more than 70% of respondents had someone with whom they shared their joys and sorrows during the birth of their baby. However only about 20% of respondents reported that their family and friends always helped with cooking, washing, and taking care of them and their baby while majority (52.9%) indicated that this help was sometimes available. Also, 75% of respondents received emotional help and support from their husband or family, either sometimes or always. About 85% of respondents indicated that their husband is a real source of comfort to them during the nursing period. This suggests that husbands play a significant role in providing support and comfort, which can contribute to a smoother and more manageable nursing experience. Over 80% of respondents reported being able to talk about their problems with their husband or family members. Around 70% of respondents reported that their family is willing to help them make decisions to make them comfortable during the nursing period. This indicates a level of support in ensuring the mother's comfort and well-being. Approximately 70% of respondents indicated having friends with whom they can share their joys and sorrows during the birth and nursing experience.

Overall, the data reflects a positive perception of support during the nursing period, with many respondents reporting having access to emotional, practical, and relational support

from family, friends, and spouses. However, there are areas where support may not be as consistently available, such as in cooking, washing, and taking care of the baby and the mother. The overall average mean for all the statements is 2.05, which suggests that, on average, respondents tend to agree more often with the statements related to support during the post-natal period.

To further address the research question, a corresponding hypothesis was postulated in hypothesis 1.

4.3 Hypotheses

Ho1: There is no significant relationship between Social Support and Post-Natal Depression among Public Primary School Teachers in Ibadan North Local Government Area, Oyo State.

Table 4.5. Relationship between Social Support and Post-Partum Depression

		Social Support	*PPD*
Social Support	Pearson Correlation	1	-.141*
	Sig. (2-tailed)		.014
	N	305	305
PND	Pearson Correlation	-.141*	1
	Sig. (2-tailed)	.014	
	N	305	305

*. Correlation is significant at the 0.05 level (2-tailed).

Table 4.5. measures the relationship between social support and post-natal depression. The Pearson's correlation coefficient obtained is -0.141, suggesting a weak negative correlation between social support and post-natal depression. This indicates that as social support increases, post-natal depression tends to decrease, and vice versa. However, the coefficient also reveals a weak correlation implying that the relationship between these variables is not highly pronounced. Furthermore, the p-value of 0.014, is less than the significance level of

0.05 suggesting that the correlation between social support and post-natal depression is statistically significant. In other words, the observed relationship between social support and post-partum depression is unlikely to be due to random chance and is likely to exist in the broader population.

These findings suggest that there is a weak negative correlation between social support and post-natal depression. This means that women who perceive higher levels of social support are more likely to experience lower levels of post-natal depression, and those with lower levels of social support may be more prone to experiencing higher levels of post-natal depression.

H02: There is no significant relationship between Couples Relationship and Post-Natal Depression among public primary school teachers in Ibadan North Local Government Area, Oyo State.

Table 4.6. Relationship between Couples Relationship and Post-Natal Depression

		Couples Relationship	Post-Natal Depression
Couples Relationship	Pearson Correlation	1	-.149*
	Sig. (2-tailed)		.012
	N	286	286
Post-natal Depression	Pearson Correlation	-.149*	1
	Sig. (2-tailed)	.012	
	N	286	305

*. Correlation is significant at the 0.05 level (2-tailed).

Table 4.8. measures the relationship between spousal role and post-natal depression. The Pearson's correlation coefficient obtained is -0.149, suggesting a weak negative correlation between couples realtionship and post-natal depression. This indicates that as couples relationship increases, post-natal depression tends to decrease, and vice versa. However, the

coefficient also reveals a weak correlation implying the influence of other variables on post-natal depression. Furthermore, the p-value of 0.012, is less than the significance level of 0.05 suggesting that the correlation between couples relationship and post-natal depression is statistically significant. In other words, the observed relationship between couples relationship and post-natal depression is unlikely to be due to random chance.

These findings rejects Hypothesis 1, by establishing a significant relationship between couples relationship and post-natal depression. By implication, women who have a strong relationship are more likely to experience lower levels of post-natal depression, and those with lower levels of spousal role may be more prone to experiencing higher levels of post-natal depression.

Discussion of Findings

From the findings of the research, it is evident that majorities of both male and female of the respondents were aware of PND; the results however still showed a lack of detailed knowledge, as almost half admitted to not knowing much about it. This lack of detailed knowledge has the potential to impact their response in a case of post-natal depression. According to Beck's theory, support from medical experts, as well as from friends and family, is essential to helping the mother manage during post-natal depression. This can be achieved by ensuring that everyone involved is educated on PND[1]. Also the theory assesses that while maintaining physical and mental health requires internal homeostasis or balance within the environment, one's shelter, culture, situations, events, family, and friends may also have a significant impact on one's health[2]. Based on this factors it can be said that a lack a of in-depth details or inaccurate perception of Post-partum Depression can result in an inability to support mothers experiencing PND and can lead to a prolonged experience of PND due to lack of treatment. Studies have shown that untreated PND may make moms feel hopeless, leave her incapable of caring for her child, and put both of them in danger; at the least, it will

strain the bond between the mother and child[1]. This is also supported by the social capital theory. The social capital theory emphasises on the support system the mother has during the post-natal period and posits that it has the ability to contribute greatly to the recovery of the mother. The theory claims that a strong network support group can positively affect the health of a mother thereby alleviating the stress that comes during the post-natal period. Schaefer et al., also found that the perception of social support showed a stronger association with depression than the social network. Stemp et al found that the cognitive experience of social support contributed to changes in psychological distress post-natal, rather than the social supportive network. Inadequate awareness of PND by study population therefore would imply that mothers who experience PND are likely to not receive adequate support and treatment which can result in prolonged PND and other related symptoms.

The findings of the study show that husbands play a significant role in providing support and comfort, which can contribute to a smoother and more manageable nursing experience. Over 80% of respondents reported being able to talk about their problems with their husband or family members. This is an indication a tangible level of social support for post-natal mothers. The social capital theory finds its applications in this regards as a presence of contribution and social support is an indication of a higher tendency to over PND. The findings from the study also revealed a weak negative correlation between social support and post-natal depression. This implies that mothers who benefit from a perceive higher levels of social support are more likely to experience lower levels of post-nataldepression, and those with lower levels of social support may be more prone to experiencing higher levels of post-natal depression. This is also in tandem with the theory of operant conditioning, which asserts that depression is brought on by a lack of environmental positive reinforcement. The assertion of this theory is that depression is a consequence of a decrease in the positive

efficient reinforced behaviour, which in turn means that support can be used as a technique of positive reinforcement to avoid depressive behaviour.

The findings of this study corroborate the findings of a previous study, which revealed that single parenting affected maternal well-being. The study further states that partner neglect and limited support especially in the post-natal period increased low mood and suicidal thoughts in single mothers and mothers who were married but were single- handedly taking care of their babies. It can therefore be implied that the presence of absence of social support played an active role in alleviating or increasing the occurrence of post-natal depression in mothers.

The analysis revealed a Pearson's correlation coefficient of -0.141, indicating a weak negative correlation between social support and post-natal depression. This result suggests that as the level of social support increases, there tends to be a reduction in post-natal depression among our study participants. To determine whether to accept or reject the hypothesis, we considered the statistical significance of the correlation. The p-value associated with the correlation was found to be below the chosen alpha level of 0.05, indicating statistical significance. Therefore, we reject the null hypothesis (H0) and conclude that there is indeed a significant relationship between social support and post-natal depression among public primary school teachers in Ibadan North Local Government Area, Oyo State. The negative correlation observed suggests that increasing social support can act as a protective factor against postpartum depression. This finding aligns with existing theoretical expectations, which posit that strong support systems can mitigate the risk of post-natal depression. This finding is supported by the Social capital theory whose application posits that a presence of contribution and social support has the potential to help overcome PND.

Our analysis revealed a Pearson's correlation coefficient of -0.149, indicating a weak negative correlation between spousal role and post-natal depression. Additionally, the p-value associated with this correlation was found to be 0.012, which is less than the chosen alpha level of 0.05, indicating statistical significance. Based on the observed correlation and its statistical significance, we must reject the null hypothesis (H02). This indicates that there is indeed a significant relationship between couples relationship and post-natal depression among public primary school teachers in Ibadan North Local Government Area, Oyo State. The negative correlation coefficient suggests that an active and positive couples relationship is associated with a reduction in post-natal depression among the study participants. In other words, as the level of couples relationship and involvement increases, there tends to be a decrease in post-natal depression. The practical implications of this finding are significant. It underscores the importance of couples relationship and involvement during the post-natal period for public primary school teachers in Ibadan North Local Government Area. Encouraging and facilitating active couples relationship may be an effective strategy for preventing post-natal depression in this population.

Endnotes

1. C.T Beck, *Postnatal depression: a metasynthesis.* **Qual Health Res** 2002 12(4):453–472
2. C.T Beck, *Predictors of postpartum depression: an update*. **Nurses** 2013 50(5):275–285

Chapter Five

Conclusion

This section includes the summary of the findings, conclusion and recommendation based on the findings, contribution to knowledge and suggestions for further studies.

5.1. Summary of Findings

The post-natal period is characterized by a many experiences. The ability to scale through that particular period unscathed is almost impossible. Several factors contribute greatly to the outcome of the post-natal period. Such factors can be financial status, past experiences, mental status history, couples relationship, level and type of support gotten during the pre and postpartum period. In this part of the world, post-natal is just recently being recognized because of the notion most families have of it. Most women and their spouses live with it because it is seen as a normal or rather a necessary experience to go through. In some cultures it seen more as a rite of passage for every woman rather than a mental illness which has contributed greatly in the increase in population of families that experience PND. Not all individuals are aware of the term PND also known as afterbirth depression and also, only a smaller part of the population recognises the danger it poses on the life of those involved and their relationship. In some cases post-natal depression can be regarded as a post traumatic stress disorder especially for those who had challenging birth

experiences. In cases where the mother alone survives the mental condition can deteriorate making the mother have a feeling called Survivors Guilt (feeling guilty for being the only one that survived).

Teachers at the Ibadan north local government who were perceived to be parents were surveyed to determine the relationship between Couples relationship, social support and post-natal depression.

This study's findings are summed up as follows:

At the Ibadan north local government public schools female teachers claim to be aware of post-natal depression than males, although there is no significant difference in knowledge of post-natal depression among male and female respondents. A table measures the first independent variable with the dependent variable; the relationship between couples relationship and post-natal depression. The Pearson's correlation coefficient obtained is -0.149, suggesting a weak negative correlation between couples relationship and post-natal depression. This indicates that as couples relationship increases, post-natal depression tends to decrease, and vice versa. However, the coefficient also reveals a weak correlation implying the influence of other variables on post-natal depression. Furthermore, the p-value of 0.012, is less than the significance level of 0.05 suggesting that the correlation between couples relationship and post-natal depression is statistically significant. In other words, the observed relationship between couples relationship and post-natal depression is unlikely to be due to random chance. Another table measures the second independent variable with the dependent variable; it is observed that the relationship between social support and post-natal depression is unlikely to be due to random chance and is likely to exist in the broader population. The Pearson's correlation coefficient obtained is -0.141, suggesting a weak negative correlation between social support and post-natal depression. This indicates that as social support increases, post-natal depression tends to decrease, and vice versa. However,

the coefficient also reveals a weak correlation implying that the relationship between these variables is not highly pronounced. Furthermore, the p-value of 0.014, is less than the significance level of 0.05 suggesting that the correlation between social support and post-natal depression is statistically significant.

5.2 Conclusion

Based on the findings of this investigation, the following conclusions were drawn out**:** overall more females than males at the public primary schools of Ibadan North Local Government area claim to be aware of post-natal depression, the contribution of social support to the development of post-natal depression was high, strong connections, open communication, commitment and physical affection indicated a strong couples relationship among the teachers of public primary schools of Ibadan North Local Government area in Ibadan and their spouses, the most practiced social support type during the post-natal period of the teachers at the public primary schools of Ibadan North Local Government area was emotional support. Both social support and quality of couples relationship have a strong relationship with post-natal depression in the lives of the teachers of public primary schools of Ibadan North Local Government area, Ibadan.

5.3 Recommendations

Based on the findings of the study, the following recommendations are made:

1. Awareness should be created in schools all over the nation about PND, is effects and its preventive measures.
2. There should be a module dedicated to handling the possibility of post-natal depression for about to wed couples by the counselling psychologist or therapist. It is the job of the counsellor to let the couple know the possibility of the occurrence of PND and how to handle it. This could be incorporated into premarital counselling.

3. During the pregnancy period, relatives and spouses should be advised to render support in any form necessary form necessary so as to prevent the occurrence of PND.
4. All health care personnels and counselling psychologists should undergo training as regards to post-natal depression and its preventive measures. This is to handle the situation physiologically and psychologically

5.4 Contribution to Knowledge

This study has contributed to knowledge in the following areas:

1. Couples relationship and social support have significant joint and relative relationship with post-natal depression among public primary school teachers in Ibadan north local government. Oyo state, with social support relating more.
2. There is an established conceptual model of couples relationship, social support and post-natal depression among married public primary school teachers.
3. This study has implications for counselling psychologists' and health care personnels in identifying areas of need for psychological and physiological remedies to post-natal depression among public primary school teachers in Ibadan north local government.

5.5 Suggested Areas for Further Researches

1) Research Design: This study employed the descriptive survey, future studies can use other designs like quasi experimental designs to evaluate post-natal depression among married couples.

2) Methodology: The methodology used in this study was quantitative (the use of questionnaires) method of research. Qualitative or mixed method can be used by researchers in future studies.

3) Population: The researcher is suggesting that further researches be carried out using individuals of other professions.

4) Variables: Other variables such as socio-demographics (age, gender, socio-economic status, marital status) can be used by other researchers in relation to post-natal depression (after birth depression)

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Appendix I

Social Support, Couples Relationship and Post-Natal Depression Questionnaire

Lead City University, Ibadan
Department of Arts and Social Science Education, (Guidance & Counselling)
Faculty of Arts and Education

Dear respondent,

This questionnaire is designed to elicit information about the relationship among variables: social support, couples relationship and perceived post-natal depression
(After birth depression) in primary schools in Ibadan North local Government, Ibadan **(SSCRPNDQI&2)** for male and female teachers.
Please note that this research is mainly for academic purpose and any information received from you will be treated with utmost confidentiality.

Thank you.

Toluwalope Olivia, KING
Researcher

Instruction

You are kindly required to carefully read through and respond to each statement. Indicate your response opinion by ticking (√) appropriate option and fill in your information where necessary.

For section B-D, tick the option (√) that best suits your opinion from the options available in Likert format of **Strongly Agree** (SA), **Agree** (A), **Strongly Disagree** (SD) and **Disagree** (D)

Section A

Demographic Data

Religion: Christianity ( ) Muslim ( ) Traditional ( )

Age: Less than 20 ( ) 21-25 ( ) 26-30 ( ) 30-40 ( ) 40- above ( )

Ethnicity: Yoruba ( ) Igbo ( ) Hausa ( ) Others ( )

Number of children: ( )

Means of delivery: Normal ( ) Caesarian

Family income: _____

Education NCE( ) Polytechnic( ) PGDE( ) B.Ed( ) M.Ed( ) Others(specify)

Obstetric History: It concerned with data regarding gravidity, parity, type of delivery, new-born's sex , number of children, history of post-natal depression, mental illness and prenatal depression.

KNOWLEDGE OF AFTER BIRTH DEPRESSION (PPD)

To be considered by both male and female teachers

S/N	ITEMS	YES	NO
1	I am aware of PND before now		
2	I do not know much about PND		
3	PND is a health problem		
4	PND is a Mental Health Disorder		
5	PND is a weakness of character		
6	Family History of PND is a risk factor for PND		
7	Financial problem is a risk factor for PND		
8	Stressful Life Events is a risk factor for PND		
9	Poor Marital Relationships is a risk factor for PND		
10	Depressed mood is a symptom of PND		

11	Feeling sad, hopeless or empty are symptoms of PND		
12	Poor sleep or oversleeping are symptoms of PND		
13	Crying more often than usual is a symptom of PND		
14	Having trouble concentrating, remembering details or making decisions are symptoms of PND		
15	PND can be detected early		
16	PND can be treated when detected		
17	Rendering physical help or assistance can help reduce symptoms of PND		
18	PND can be prevented		
19	Reduced stress can help prevent PND		
20	A good marital relationship can help prevent PND		
21	Good social support can help prevent PND		
22	Family history of mental illness		

Section B (1)

Adapted Edinburgh Postnatal Depression Scale (EPDS) 1987

This questionnaire measures post-natal depression to be answered by male teachers.

1 = Strongly disagree

2 = Disagree

3 = Agree

4 = Strongly Agree

S/N	ITEMS	Strongly disagree	Disagree	Agree	Strongly agree
1	My wife had been able to laugh and see the funny side of things after the birth of our baby.				
2	Many things become tough for I and my wife since the birth of our baby				
3	My wife had everything easy with enjoyment after the birth of our baby				
4	My wife had been so unhappy that she had difficulty sleeping since the birth of our baby				
5	My wife had blamed herself unnecessarily since she gave birth to our baby				
6	My wife had felt sad or miserable since she gave birth to our baby				

7	My wife had been anxious or worried for no good reason				
8	My wife had been so unhappy that I have been crying since I gave birth to my baby				
9	My wife had felt scared or panicky for no very good reason since she gave birth to our baby				
10	The thought of harming herself has occurred to my wife since she gave birth to our baby				

Section B (2)

Adapted Edinburgh Postnatal Depression Scale (EPDS) 1987

This questionnaire measures post-natal depression to be answered by female teachers.

1 = Strongly disagree
2 = Disagree
3 = Agree
4 = Strongly Agree

S/N	ITEMS	Strongly disagree	Disagree	Agree	Strongly agree
1	I have been able to laugh and see the funny side of things after the birth of my baby.				
2	Many things become tough for me since the birth of my baby				
3	I have everything easy with enjoyment after the birth of my baby				
4	I have been so unhappy that I have had difficulty sleeping since the birth of my baby				
5	I have blamed myself unnecessarily since I gave birth to my baby				
6	I have felt sad or miserable since I gave birth to my baby for no reason				
7	I have been anxious or worried for no good reason after the birth of my baby				
8	I have been so unhappy that I have been crying since I gave birth to my baby				
9	I have felt scared or panicky for no very good reason since I gave birth to my baby				

10	The thought of harming myself has occurred to me since I gave birth to my baby				

Section C

Adapted Multidimensional Scale of perceived social support (**MSPSS**) by Zimet Et al. 1988 (for mothers only)

There is no right or wrong answers.

1 = Never
2 = Rarely
3 = Sometimes
4 = Always

S/N	ITEMS	Never	Rarely	Sometimes	Always
1	There is a special person who is always around when I need help as a nursing mother.				
2	I have a special person with whom I can share my joys and sorrows during the birth of my baby				
3	My family and friends always help me cook, wash and take care of my baby and I.				
4	I get the emotional help and support I need from my husband\family.				
5	My husband is a real source of comfort to me. He helps make the nursing period smooth and easy				
6	I can talk about my problems with my husband/family.				
7	My family is willing to help me to make decisions to make me comfortable during the nursing period.				
8	I have friends with whom I can share my joys and sorrows during the birth and nursing experience				
9	There are many family members in my life that cares about my feelings and welfare as a nursing mother.				
10	I can count on my family for help when things go difficult during the nursing period.				

Section D (1&2)

Adapted Couples Satisfaction Index **(CSI)** by Funk and Rogge (2007)

1= Strongly Disagree

2= Disagree
3= Agree
4= Strongly Agree

S/N	ITEMS	Strongly Disagree	Disagree	Agree	Strongly Agree
1	I still feel a strong connection with my spouse				
2	If I had my life to live over, I would marry (or live with/date) the same person				
3	Our relationship is strong				
4	My relationship with my spouse makes me happy				
5	I feel that I can confide in my spouse about virtually anything				
6	For me, my spouse is the perfect romantic partner				
7	I and my spouse are very intimate				
8	I and my spouse spend a lot of time together				
9	I am still very much attracted to my spouse				
10	I and my spouse express ourselves freely to each other (hugging, kissing, holding hands) and intimacy				

Appendix II

Table 4.1. Overview of Demographic information

		Frequency	Percentage
Sex	Male	200	34.1
	Female	387	65.9
Religion	Christianity	462	78.7
	Muslim	110	18.7
	Traditional	6	1.0
Age range	Less than 20	28	4.8
	21-25	74	12.6
	26-30	154	26.2
	31-40	158	26.9
	41 – above	172	29.3
Ethnicity	Yoruba	465	79.2
	Igbo	57	9.7
	Hausa	29	4.9

	Others	16	2.7
Number of children	1 – 2	311	52.9
	3 – 4	181	30.9
	5 – 6	43	7.4
	7 – 8	3	0.5
Means of delivery	Normal	429	73.1
	Caesarian	92	15.7
	Both	33	5.6
Family income range	Below 50,000	47	8
	51,000 - 100,000	275	46.6
	101,000 - 200,000	51	8.7
	200,000 - 500,000	30	5.2
	Above 500,000	4	0.6
Education status	NCE	140	24
	Polytechnic	140	24
	PGDE	42	7
	B.Ed	130	22
	M.Ed	32	5.3
	Others:		
	ACA	1	0.2
	B.A	7	1.2
	B.Agric	1	0.2
	B.Eng	1	0.2
	B.Sc	51	8.7
	B.Tech	5	0.9
	FCIA	1	0.2
	FNIMN	1	0.2
	HND	4	0.7
	M.A	2	0.3
	M.BA	1	0.2
	M.Sc	4	0.7
	M.Tech	2	0.3
	PHD	2	0.3
	Sch. Cert	10	1.7
	Missing	9	1.4

Source; fieldwork

Table 4.2. Male Respondents' Perception of Post-Natal depression

ITEMS	YES	%	NO	%
I was aware of PND before now	127	63.2%	70	34.8%
I do not know much about PND	99	49.3%	97	48.3%
PND is a health problem	153	76.1%	43	21.4%
PND is a Mental Health Disorder	149	74.1%	43	21.4%

PND is a weakness of character	129	64.2%	63	31.3%
Family History of PND is a risk factor for PND	136	67.7%	54	36.9%
Financial problem is a risk factor for PND	135	67.2%	57	28.4%
Stressful Life Events is a risk factor for PND	155	77.1%	33	16.4%
Poor Marital Relationships is a risk factor for PND	155	77.1%	38	18.9%
Depressed mood is a symptom of PND	150	74.6%	41	20.4%
Feeling sad, hopeless or empty are symptoms of PND	157	78.1%	34	16.9%
Poor sleep or oversleeping are symptoms of PND	133	66.2%	58	28.9%
Crying more often than usual is a symptom of PND	139	69.2%	51	25.4%
Having trouble concentrating, remembering details or making decisions are symptoms of PND	146	72.6%	46	22.9%
PND can be detected early	147	73.1%	44	21.9%
PND can be treated when detected	168	83.6%	26	12.9%
Rendering physical help or assistance can help reduce symptoms of PND	166	82.6%	25	12.4%
PND can be prevented through support	162	80.6%	27	13.4%
Reduced stress can help prevent PND	166	82.6%	27	13.4%
A good marital relationship can help prevent PND	162	80.6%	29	14.4%
Good social support can help prevent PND	165	82.1%	29	14.4%
Family history of mental illness can trigger PND	129	64.2%	61	30.0%

Source; fieldwork

Table 4.3. Female Respondents' Perception of Post-Natal depression

ITEMS	YES	%	NO	%
I was aware of PND before now	208	68.0%	85	27.8%
I do not know much about PND	147	48.0%	146	47.7%
PND is a health problem	244	79.7%	48	15.7%
PND is a Mental Health Disorder	230	75.2%	59	19.3%
PND is a weakness of character	209	68.3%	77	25.2%

Family History of PND is a risk factor for PND	227	74.2%	63	20.6%
Financial problem is a risk factor for PND	235	76.8%	56	18.3%
Stressful Life Events is a risk factor for PND	243	79.4%	47	15.4%
Poor Marital Relationships is a risk factor for PND	239	78.1%	54	17.6%
Depressed mood is a symptom of PND	238	77.8%	54	17.6%
Feeling sad, hopeless or empty are symptoms of PND	228	74.5%	60	19.6%
Poor sleep or oversleeping are symptoms of PND	207	67.6%	80	26.1%
Crying more often than usual is a symptom of PND	213	69.6%	74	24.2%
Having trouble concentrating, remembering details or making decisions are symptoms of PND	175	57.2%	112	36.6%
PND can be detected early	232	75.8%	59	19.3%
PND can be treated when detected	256	83.7%	34	11.1%
Rendering physical help or assistance can help reduce symptoms of PND	206	67.3%	82	26.8%
PND can be prevented through support	253	82.7%	38	12.4%
Reduced stress can help prevent PND	242	79.1%	50	16.3%
A good marital relationship can help prevent PND	253	82.7%	39	12.7%
Good social support can help prevent PND	240	78.4%	52	14.4%
Family history of mental illness can trigger PND	180	58.8%	110	37.8%

Source; fieldwork

Table 4.4. Respondents' Perception of Social support during the Post-natal period.

Items	Never	Rarely	Sometimes	Always	Mean
There is a special person who is always around when I need help as a nursing mother.	18 (5.9%)	35 11.4%)	146 (47.7%)	103 (33.7%)	2.106
I have a special person with whom I can share my joys and sorrows during the birth of my baby	23 (7.5%)	62 (20.3%)	120 (39.2%)	97 (31.7%)	1.9636
My family and friends always help me cook, wash and take care of my baby and I.	21 (6.9%)	52 (17.0%)	162 (52.9%)	67 (21.9%)	1.9106

I get the emotional help and support I need from my husband\family.	24 (7.8%)	48 (15.7%)	129 (42.2%)	101 (33.0%)	2.0166
My husband is a real source of comfort to me. He helps make the nursing period smooth and easy	18 (5.9%)	32 (10.5%)	107 (35.0%)	145 (47.4%)	2.255
I can talk about my problems with my husband/family.	27 (8.8%)	36 (11.8%)	111 (36.3%)	125 (40.8%)	2.1171
My family is willing to help me make decisions to make me comfortable during the nursing period.	15 (4.9%)	73 (23.9%)	125 (40.8%)	88 (28.8%)	1.9502
I have friends with whom I can share my joys and sorrows during the birth and nursing experience	21 (6.9%)	69 (22.5%)	143 (46.7%)	69 (22.5%)	1.8609
There are many family members in my life who care about my feelings and welfare as a nursing mother.	11 (36%)	50 (16.3%)	140 (45.8%)	100 (32.7%)	2.1887
I can count on my family for help when things go difficult during the nursing period.	13 (4.2%)	37 (12.1%)	139 (45.4%)	111 (36.3%)	2.16
Average Mean = 2.05					

Source; fieldwork

Table 4.5. Relationship between Social Support and Post-Natal Depression

		Social Support	***PPD***
Social Support	Pearson Correlation	1	-.141*
	Sig. (2-tailed)		.014
	N	305	305
PND	Pearson Correlation	-.141*	1
	Sig. (2-tailed)	.014	
	N	305	305

*. Correlation is significant at the 0.05 level (2-tailed).

Source; fieldwork

4.8. Relationship between Spousal role and Perceived Postpartum depression

		Couples Relationship	Post-Natal Depression
Spousal Role	Pearson Correlation	1	-.149*
	Sig. (2-tailed)		.012
	N	286	286
Post-Natal	Pearson Correlation	-.149*	1
Depression	Sig. (2-tailed)	.012	
	N	286	305

*. Correlation is significant at the 0.05 level (2-tailed).

Source; fieldwork

Table 4.7. Multidimensional Scale of perceived social support (MSPSS)

ITEMS	Never	Rarely	Sometimes	Always	Mean
There is a special person who is always around when I need help as a nursing mother.	18 (5.9%)	35 11.4%)	146 (47.7%)	103 (33.7%)	2.106
I have a special person with whom I can share my joys and sorrows during the birth of my baby	23 (7.5%)	62 (20.3%)	120 (39.2%)	97 (31.7%)	1.9636
My family and friends always help me cook, wash and take care of my baby and I.	21 (6.9%)	52 (17.0%)	162 (52.9%)	67 (21.9%)	1.9106
I get the emotional help and support I need from my husband\family.	24 (7.8%)	48 (15.7%)	129 (42.2%)	101 (33.0%)	2.0166
My husband is a real source of comfort to me. He helps make the nursing period smooth and easy	18 (5.9%)	32 (10.5%)	107 (35.0%)	145 (47.4%)	2.255
I can talk about my problems with my husband/family.	27 (8.8%)	36 (11.8%)	111 (36.3%)	125 (40.8%)	2.1171
My family is willing to help me make decisions to make me comfortable during the nursing period.	15 (4.9%)	73 (23.9%)	125 (40.8%)	88 (28.8%)	1.9502
I have friends with whom I can share my joys and sorrows during	21 (6.9%)	69 (22.5%)	143 (46.7%)	69 (22.5%)	1.8609

the birth and nursing experience					
There are many family members in my life who care about my feelings and welfare as a nursing mother.	11 (36%)	50 (16.3%)	140 (45.8%)	100 (32.7%)	2.1887
I can count on my family for help when things go difficult during the nursing period.	13 (4.2%)	37 (12.1%)	139 (45.4%)	111 (36.3%)	2.16
Average Mean = 2.05					

Source; fieldwork

PILOT TEST

SECTION A

Case Processing Summary			
		N	%
Cases	Valid	58	96.7
	Excluded[a]	2	3.3
	Total	60	100.0
a. Listwise deletion based on all variables in the procedure.			

Reliability Statistics		
Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.893	.901	22

SECTION B

Case Processing Summary			
		N	%
Cases	Valid	58	96.7
	Excluded[a]	2	3.3
	Total	60	100.0
a. Listwise deletion based on all variables in the procedure.			

Reliability Statistics		
Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.879	.871	10

SECTION C

Case Processing Summary			
		N	%
Cases	Valid	55	91.7
	Excluded[a]	5	8.3
	Total	60	100.0
a. Listwise deletion based on all variables in the procedure.			

Reliability Statistics		
Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.942	.942	10

SECTION D

Case Processing Summary			
		N	%
Cases	Valid	59	99.7
	Excluded[a]	1	0.3
	Total	60	100.0
a. Listwise deletion based on all variables in the procedure.			

Reliability Statistics		
Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.842	.842	10

RELIABILITY TEST RESULT – MALE

SECTION A

Case Processing Summary			
		N	%
Cases	Valid	38	82.1
	Excluded[a]	2	17.9
	Total	40	100.0
a. Listwise deletion based on all variables in the procedure.			

Reliability Statistics		
Cronbach's	Cronbach's Alpha Based on	N of Items

Alpha	Standardized Items	
.804	.831	22

SECTION B

Case Processing Summary			
		N	%
Cases	Valid	39	94.0
	Excluded[a]	1	6.0
	Total	40	100.0
a. Listwise deletion based on all variables in the procedure.			

Reliability Statistics		
Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.877	.873	10

SECTION C

Case Processing Summary			
		N	%
Cases	Valid	36	93.0
	Excluded[a]	4	7.0
	Total	40	100.0
a. Listwise deletion based on all variables in the procedure.			

Reliability Statistics		
Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.957	.957	10

Source: Fieldwork

BIODATA

PERSONAL INFORMATION

Full name: KING, Toluwalope Olivia

Email:	Toluoliviaking@gmail.com
Phone number:	+2348142708805
Address:	Akoto Elebu Area Ibadan
Date of birth:	20th February 1997
Nationality:	Nigerian
State of origin:	Oyo state
Marital status:	Single
Sex:	Female
Language:	English and Yoruba

EDUCATION

Leadcity University, Oyo state. 2021- Till present

a. M.Ed Guidance and Counselling

National Youth Service Corps, Ogun State. 2018-2019

b. NYSC Certificate

Pinnacle Project Managers. 2018

c. Human Resource Management Program

Ahmadu Bello University Zaria, Kaduna State. 2013-2017

d. B.Ed Guidance and Counseling

e. Graduated Second Class Lower Division

Vital Years School Zaria, Kaduna State. 2001-2012

f. Junior Secondary School Certificate

g. First School leaving Certificate

WORK EXPERIENCES

TEACHER

Vital year's sec. school Zaria and Methodist comprehensive college Sagamu.

September 2016- December 2016 (Teaching practice)

May 2018- March 2019 (National Youth Service Corps)

RESPONSIBILITIES

5. Writing lesson plan and notes

6. Teaching students

7. Administering tests, marking and recording them.

COUNSELLOR

Government secondary school kwangila, zaria.

January 2017- April 2017

RESPONSIBILITIES

14. Counseling students on educational, personal-social and career matters
15. Keeping record of students counseling sessions
16. Organizing educational seminars and talk

ELECTORAL OFFICIAL

Ibido and latawa, sagamu.

6th December 2018- 12th December 2018 (Distribution of permanent voters' cards)

23rd February 2019 & 9th March 2019 (Presidential and Governorship election)

RESPONSIBILITIES

- ✓ Performing the duties of an assistant revision officer by properly distributing Permanent Voters Cards to registered persons.
- ✓ Performing the duties of a polling officer thereby signing and stamping of ballot papers and ensuring that all voters are registered and accredited
- ✓ Overseeing the collection and return of sensitive and non-sensitive election materials
- ✓ Recording the correct result

TUTOR
Zaria, Kaduna state.
May 2020 - April 2021

RESPONSIBILITIES
Teaching nursery, primary and junior secondary school students Mathematics and English language

PERSONAL ASSISTANT
Delcoms enterprise
2021-2022

RESPONSIBILITIES
Administrative duties

MEDIATOR (INTERN)
Citizens Mediation Centre Agege, Lagos state.
May-June 2022

RESPONSIBILITIES
- Registering candidates for mediation and setting appointments
- Assisting head mediator during mediation which involved landlord-tenant dispute, Marital dispute and Work place dispute

SKILLS
- Good personal and social skills
- Time management skills
- Good communication and writing skills
- Good organisational skills
- Dedication to responsibility
- Always ensure continuous self-improvement
- Teachable
- Ability to work independently
- Microsoft office tools

PUBLICATIONS, RESEARCH AND COMMUNITY SERVICE EXPERIENCES
- 6 months teaching and counseling practicum in Kaduna state
- 6 weeks as mediator at the citizens mediation centre Agege, Lgos state

- Research on "Social Support, Couples Relationship and Perceived Post-Partum Depression among Public Primary School Teachers in Ibadan North Local Government Area, Oyo State"

PROFESSIONAL TRAINING AND CERTIFICATE

Human Resources management (envirofly), Pinnacle Project Managers

ACADEMIC CONFERENCE

Nigeria Association Of Pastoral Counselling

2nd International Academic Conference- Chattered Institute Of Personnel Management

REFERENCES

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The University Compliance Form

This is to certify that the thesis by Toluwalope Olivia KING in the Department of Guidance and Counseling, Faculty of Arts and Education Lead City University, Ibadan, Oyo State is in full compliance with the approved University Format and Style.

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Name/Signature Date