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Associations of husband/family support and economic status with elevated postpartum depressive symptoms

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Abstract

Background: Postpartum women may experience psychological difficulties during the transition to motherhood, and inadequate social support and socioeconomic conditions may contribute to depressive symptoms. The Edinburgh Postnatal Depression Scale (EPDS) is a screening instrument for postpartum depressive symptoms and should not be used to diagnose postpartum blues.

Purpose: To determine the associations of husband/family support and economic status with elevated postpartum depressive symptoms among postpartum women.

Method: This analytical observational study used a cross-sectional design and was conducted at PMB Lia Maria, Sukarama District, Bandar Lampung, Indonesia. A total of 35 postpartum women were recruited using accidental sampling. Data were collected using a husband/family support questionnaire, economic status data, and the Indonesian version of the EPDS. An EPDS score of ≥ 10 was classified as elevated postpartum depressive symptoms. Bivariate analysis was performed using Fisher's Exact Test, and odds ratios (ORs) with 95% confidence intervals (CIs) were calculated.

Results: The respondents had a mean age of 27.3 ± 4.2 years (range 20–35 years). Most respondents had good husband/family support (28; 80.0%) and an economic status at or above the regional minimum wage (23; 65.7%). Eleven respondents (31.4%) had elevated postpartum depressive symptoms based on an EPDS score of ≥ 10 . Sufficient husband/family support was significantly associated with elevated postpartum depressive symptoms ($p = 0.002$; OR = 27.60; 95% CI: 2.69–282.96). Economic status was also significantly associated with elevated postpartum depressive symptoms ($p = 0.002$; OR = 13.33; 95% CI: 2.42–73.48).

Conclusion: Elevated postpartum depressive symptoms were identified in 31.4% of respondents. Sufficient husband/family support and higher economic status were significantly associated with increased odds of elevated EPDS scores in this sample. These findings should be interpreted cautiously because of the small sample size and cross-sectional design.

Keywords: Economic Status; Edinburgh Postnatal Depression Scale; Husband/Family Support; Postpartum Depressive Symptoms; Postpartum Women.

INTRODUCTION

The postpartum period is the phase following delivery of the baby and placenta, lasting approximately six weeks (42 days), and is characterized by physiological recovery and psychological adaptation to the maternal role. During this period, mothers may experience various physical and psychological problems requiring appropriate

attention from healthcare providers, particularly midwives. The postpartum period is also a critical transition characterized by substantial physiological and emotional changes, during which mothers must adapt to maternal responsibilities, infant care, breastfeeding, and changes in daily routines (Tetik Metin, Gül Can, & Yalçın, 2026). Close monitoring

during the postpartum period is important because inadequate attention to maternal health may contribute to maternal complications and adversely affect the mother's ability to provide optimal neonatal care. Maternal psychological problems may also interfere with infant care and maternal functioning. The World Health Organization reported that approximately 13% of women who have recently given birth experience a mental disorder, primarily depression, with higher proportions reported in developing countries (World Health Organization, 2023). Psychological adaptation during the postpartum period is a complex transition. Responsibilities associated with motherhood can trigger emotional, cognitive, and behavioural changes. Some women adapt successfully to their new role, whereas others experience psychological disturbances, including transient postpartum mood symptoms and postpartum depressive symptoms. Postpartum blues is generally considered a transient psychological condition that develops during the early postpartum period and may be characterized by emotional lability, crying, anxiety, irritability, and mood disturbances. Although postpartum blues is generally mild and temporary, inadequate recognition and support may increase psychological vulnerability and contribute to more persistent depressive symptoms (Hafitasari, 2025; Van Niel & Payne, 2020).

In contrast to postpartum blues, postpartum depressive symptoms represent a more persistent psychological concern. The Edinburgh Postnatal Depression Scale (EPDS) is a 10-item screening instrument designed to identify depressive symptoms during the postnatal period. The Indonesian version has undergone cross-cultural adaptation and demonstrated acceptable internal consistency, with a Cronbach's alpha of 0.75. The adaptation study conducted among postpartum women in Lampung also used an EPDS cut-off score of 10 for postpartum depression screening (Putri, Kartasurya, Nugraheni, & Widjanarko, 2025). Therefore, EPDS scores should be interpreted as screening results rather than as a clinical diagnosis. In Indonesia, postpartum psychological problems remain an important maternal health concern. Previous Indonesian studies have identified postpartum blues and depressive symptoms as being associated with maternal characteristics, psychosocial factors, husband support, and other internal and external factors (Hikmah, Kartikasari, Russiska, & Noviyani, 2021; Febriyanti, 2021; Mones,

Lada, Jutomo, Trisno, & Roga, 2023). Studies conducted in Indonesia have also reported associations between husband support and postpartum blues among postpartum women (Renata & Agus, 2021; Rahayu, Sunanto, & Ekasari, 2023; Anggraini, 2024). National health information also indicates that maternal mental health remains an important public health issue in Indonesia (Ministry of Health of the Republic of Indonesia, 2023). Social support from the immediate environment, particularly from the husband and family, is an important factor in maternal psychological adjustment during the postpartum period. Husband support may include emotional, informational, instrumental, and appraisal support, all of which can help mothers cope with physical recovery, infant care, and the transition to motherhood (Armini, Tristiana, & Tokan, 2017). Previous research has demonstrated that inadequate husband or partner support is associated with postpartum blues and postpartum depressive symptoms (Afrina & Rukiah, 2025; Anggraini, 2024; Eslahi, Bahrami, Allen, & Alimoradi, 2021; Rahayu, Sunanto, & Ekasari, 2023). Spousal relationship quality and husband involvement have also been associated with postpartum depression among postpartum mothers in West Java, Indonesia (Pebryatie, Paek, Sherer, & Meemon, 2022). More recent evidence from Türkiye demonstrated a negative relationship between perceived partner support and maternal blues, indicating that higher partner support was associated with lower maternal blues levels (Tetik Metin, Gül Can, & Yalçın, 2026).

Family support may also contribute to maternal psychological well-being because postpartum women often depend on family members for emotional and practical assistance. Family functioning and relationship satisfaction have been associated with postpartum blues, indicating that interpersonal relationships may influence maternal psychological adjustment (Ayu, Lusiani, Alifiani, Yulidar, & Nurhayati, 2022). Family support may also play an important role in the relationship between socioeconomic status and postpartum depressive symptoms. Lower socioeconomic status has been associated with greater psychological vulnerability, whereas stronger family support may reduce this vulnerability (Xiao, Cui, Li, Zeng, Rozelle, Shi, & Jiang, 2024). Socioeconomic status is another factor that may influence maternal psychological well-being during the postpartum period. Families with limited

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financial resources may experience difficulties meeting nutritional needs, healthcare expenses, infant needs, and household costs, potentially increasing psychological stress. Previous research has demonstrated an association between socioeconomic status and postpartum depressive symptoms, with family support playing an important role in this relationship (Xiao, Cui, Li, Zeng, Rozelle, Shi, & Jiang, 2024). Evidence regarding postpartum psychological disorders also indicates that social and contextual factors should be considered when assessing maternal mental health (Chi, Zhang, Wu, & Wang, 2016; Utami & Nurfita, 2022). A preliminary survey conducted at PMB Lia Maria, Sukarame District, Bandar Lampung, from November to December 2025 found that 6 out of 30 postpartum mothers (20.0%) experienced postpartum psychological symptoms. Preliminary interviews indicated that inadequate husband/family support and low economic status were potential factors contributing to psychological difficulties among postpartum mothers. These mothers reported feeling overwhelmed while caring for their newborns and adapting to their new maternal roles. Based on these findings, this study aimed to determine the associations of husband/family support and economic status with elevated postpartum depressive symptoms among postpartum women.

RESEARCH METHOD

This study employed a quantitative analytical observational design with a cross-sectional approach. The study was conducted at PMB Lia Maria, Gg. Merdeka No. 1, Sukarame Subdistrict, Bandar Lampung, Indonesia. Data collection was conducted from 1 December 2025 to 31 January 2026. PMB Lia Maria is an independent midwifery practice providing maternal and child health services, including antenatal care, normal delivery, postpartum care, newborn care, family planning, immunization, and reproductive health counselling. The population consisted of postpartum women who visited PMB Lia Maria during the data collection period. A total of 35 postpartum women who met the study criteria were recruited as respondents using a non-probability accidental sampling technique. Respondents who were available during the data collection period and

met the inclusion criteria were included in the study. Data were collected directly by the researcher using structured questionnaires. The research instruments consisted of three components: a sociodemographic questionnaire covering maternal age, education level, duration of marriage, and economic status; a husband/family support questionnaire; and the Edinburgh Postnatal Depression Scale (EPDS). The husband/family support questionnaire consisted of 19 Likert-scale items with four response options: Always = 4, Often = 3, Sometimes = 2, and Never = 1. The questionnaire assessed four domains of support: informational, appraisal, instrumental, and emotional support. Total scores ranged from 19 to 76 and were categorized as good support (50–76), sufficient support (25–49), and poor support (19–24).

The EPDS consisted of 10 items scored from 0 to 3, with a maximum total score of 30. Respondents completed the EPDS based on their feelings during the previous seven days. Items 1, 2, and 4 were scored in the forward direction, whereas items 3 and 5–10 were reverse-scored. The Indonesian version of the EPDS has undergone cross-cultural adaptation and demonstrated acceptable internal consistency (Cronbach's $\alpha = 0.75$). A cut-off score of ≥ 10 was used to identify elevated postpartum depressive symptoms (Putri, Kartasurya, Nugraheni, & Widjanarko, 2025). The EPDS was interpreted as a screening instrument and not as a diagnostic instrument for postpartum depression or postpartum blues. Economic status was determined based on the Bandar Lampung Regional Minimum Wage for 2025, as stipulated in Governor of Lampung Decree No. G/850/V.08/HK/2024, which established the minimum wage at IDR 3.305.367 per month. Economic status was categorized as high for monthly income $\geq$ IDR 3.305.367 and low for monthly income $<$ IDR 3.305.367. Data management included editing, coding, cleaning, and data entry. Univariate analysis was performed to describe the frequency distribution of each study variable. Bivariate analysis was performed using Fisher's Exact Test because some cells in the contingency tables had expected counts of less than 5. Odds ratios (ORs) with 95% confidence intervals (CIs) were calculated to estimate the strength of the associations. Statistical significance was determined at $\alpha = 0.05$.

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RESEARCH RESULTS

Table 1. Characteristics of Respondents (N=35)

Variable	Results
Age (Mean±SD)(Range)(Year)	(27.3 ± 4.2)(20-35)
Education (n/%)	
Junior High School	3/8.6
Senior High School	22/62.9
Diploma	6/17.1
Bachelor	4/11.4
Family Income (n/%)	
<UMR	12/34.3
≥UMR	23/65.7
Marital Duration (n/%)	
<10 Years	31/88.6
≥10 Years	4/11.4
Husband/Family Support (n/%)	
Good Support	28/80.0
Sufficient Support	7/20.0
Economic Status (n/%)	
Low	12/34.3
High	23/65.7
Postpartum Blues (n/%)	
Postpartum Blues	11/31.4
No Postpartum Blues	24/68.6

Based on Table 1, the mean age of respondents was 27.3 ± 4.2 years, with an age range of 20–35 years. The majority of respondents had completed senior high school education (22 respondents; 62.9%), had a family income at or above the regional minimum wage (23 respondents; 65.7%), and had been married for less than 10 years (31 respondents; 88.6%). Most respondents received good husband/family support (28 respondents; 80.0%) and had high economic status (23 respondents; 65.7%). Based on the EPDS screening results, 11 respondents (31.4%) had elevated postpartum depressive symptoms with EPDS scores of ≥ 10 , while 24 respondents (68.6%) had scores below 10.

Table 2. Association Analysis to Be Completed After Verification of the Raw Crosstab and SPSS Output

Variable	EPDS ≥ 10 (n= 11)	EPDS <10 (n= 24)	OR	95% CI	P-value
Husband/Family Support (n/%)					
Good Support	5/45.5	23/95.8	1.00	-	-
Sufficient Support	6/54.5	1/4.2	27.60	2.69-282.96	0.002

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Economic Status (n/%)					
Low	3/27.3	20/83.3	1.00	-	-
High	8/72.7	4/16.7	13.33	2.42-73.48	0.002

Based on Table 2, among respondents with elevated postpartum depressive symptoms (EPDS ≥ 10), 6 respondents (54.5%) had sufficient husband/family support and 5 respondents (45.5%) had good husband/family support. Among respondents with EPDS scores < 10 , 23 respondents (95.8%) had good husband/family support and 1 respondent (4.2%) had sufficient support. Fisher's Exact Test showed a significant association between husband/family support and elevated postpartum depressive symptoms ($p = 0.002$). Respondents with sufficient husband/family support had 27.60 times higher odds of having an EPDS score ≥ 10 than those with good support (OR = 27.60; 95% CI: 2.69–282.96). Regarding economic status, 8 respondents (72.7%) with EPDS scores ≥ 10 had high economic status, whereas 3 respondents (27.3%) had low economic status. Among respondents with EPDS scores < 10 , 4 respondents (16.7%) had high economic status and 20 respondents (83.3%) had low economic status. Fisher's Exact Test demonstrated a significant association between economic status and elevated postpartum depressive symptoms ($p = 0.002$). Respondents with high economic status had 13.33 times higher odds of having an EPDS score ≥ 10 than respondents with low economic status (OR = 13.33; 95% CI: 2.42–73.48).

DISCUSSION

The findings showed that 11 of 35 respondents (31.4%) had elevated postpartum depressive symptoms based on an EPDS score of ≥ 10 , while 24 respondents (68.6%) had scores below the screening threshold. These findings represent positive EPDS screening results and should not be interpreted as a diagnosis of postpartum depression or postpartum blues. The EPDS is specifically designed to screen for depressive symptoms during the postnatal period. The Indonesian version used in this study has undergone cross-cultural adaptation and demonstrated acceptable internal consistency, with a Cronbach's alpha of 0.75 (Putri, Kartasurya, Nugraheni, & Widjanarko, 2025). The use of a cut-off score of ≥ 10 is consistent with the screening threshold reported in the Indonesian adaptation study.

The proportion of respondents with elevated EPDS scores in this study indicates that postpartum psychological screening may be important in primary maternal health services. Postpartum women experience substantial physical and psychological changes while adapting to maternal responsibilities. The presence of depressive symptoms during this period may interfere with maternal functioning and infant care. Therefore, screening should be accompanied by appropriate education, psychosocial support, and referral when clinically indicated.

Most respondents in this study received good husband/family support (80.0%), while 20.0% received sufficient support. Husband and family support may involve emotional, informational, instrumental, and appraisal dimensions. These forms of support may assist mothers in coping with physical recovery, infant care, breastfeeding, and changes in daily responsibilities. Previous research has demonstrated that partner and husband support is associated with postpartum psychological outcomes (Armini, Tristiana, & Tokan, 2017; Eslahi, Bahrami, Allen, & Alimoradi, 2021; Pebryatie, Paek, Sherer, & Meemon, 2022).

In this study, husband/family support was significantly associated with elevated postpartum depressive symptoms ($p = 0.002$). Respondents with sufficient support had higher odds of an EPDS score ≥ 10 than respondents with good support (OR = 27.60; 95% CI: 2.69–282.96). The large OR should be interpreted cautiously because of the small sample size and the wide confidence interval. Nevertheless, the finding is consistent with previous evidence indicating that inadequate partner or husband support may be associated with adverse postpartum psychological outcomes (Eslahi, Bahrami, Allen, & Alimoradi, 2021; Pebryatie, Paek, Sherer, & Meemon, 2022).

The association may be explained by the role of husbands and family members in reducing the practical and emotional burden experienced by postpartum mothers. Mothers who receive adequate assistance may have greater opportunities to rest, manage infant-care responsibilities, and cope with emotional changes. Conversely, inadequate support

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may increase perceived burden and psychological vulnerability. Family functioning and marital satisfaction have also been associated with postpartum psychological outcomes (Ayu, Lusiani, Alifiani, Yulidar, & Nurhayati, 2022).

Economic status was also significantly associated with elevated postpartum depressive symptoms in this study ($p = 0.002$). Respondents with high economic status had higher odds of an EPDS score ≥ 10 than respondents with low economic status (OR = 13.33; 95% CI: 2.42–73.48). This finding differs from the commonly expected direction in which lower socioeconomic status is associated with greater psychological vulnerability. Therefore, the result should not be interpreted as evidence that higher economic status causes postpartum depressive symptoms.

The unexpected direction of the association may be related to the characteristics of the sample. The sample consisted of only 35 postpartum women, and most respondents had economic status at or above the regional minimum wage. In addition, economic status was measured using a single income-based categorization rather than a multidimensional socioeconomic index. Other factors, such as parity, employment, household composition, marital satisfaction, obstetric complications, infant health, and perceived financial stress, were not assessed. These factors may influence postpartum depressive symptoms and could contribute to the observed association.

Previous evidence has indicated that socioeconomic conditions may influence postpartum psychological well-being through financial stress, access to healthcare, and the ability to meet maternal and infant needs (Chi, Zhang, Wu, & Wang, 2016; Xiao, Cui, Li, Zeng, Rozelle, Shi, & Jiang, 2024). However, the direction and magnitude of the association in the present study should be interpreted cautiously because of the small sample size and cross-sectional design.

The findings have implications for midwifery and maternal mental health services. Postpartum care should include attention to psychological symptoms in addition to physical recovery. Midwives may involve husbands and family members in postpartum education and psychosocial support. EPDS screening may assist in identifying mothers who require further assessment. However, a positive EPDS screening result should not be considered a clinical diagnosis

and should be followed by appropriate clinical assessment.

This study has several limitations. First, the sample size was small, resulting in wide confidence intervals around the estimated odds ratios. Second, accidental sampling may limit the generalizability of the findings to other postpartum populations. Third, the cross-sectional design does not establish temporal or causal relationships between husband/family support, economic status, and depressive symptoms. Fourth, economic status was categorized according to the regional minimum wage and may not fully represent household socioeconomic conditions. Future studies should use larger samples, probability-based sampling where feasible, and consider additional psychosocial, obstetric, and socioeconomic variables.

CONCLUSION

In this study, 11 of 35 postpartum women (31.4%) had elevated postpartum depressive symptoms based on an EPDS score of ≥ 10 . Most respondents had good husband/family support (80.0%) and high economic status (65.7%). Husband/family support and economic status were significantly associated with elevated postpartum depressive symptoms. Respondents with sufficient husband/family support had higher odds of elevated EPDS scores (OR = 27.60; 95% CI: 2.69–282.96), while those with high economic status also had higher odds (OR = 13.33; 95% CI: 2.42–73.48). These findings should be interpreted cautiously because of the small sample size and cross-sectional design. The EPDS should be used as a screening instrument for postpartum depressive symptoms and not as a diagnostic instrument for postpartum blues or postpartum depression.

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