

Perinatal Depression Triggered by Gender Expectation in a Roma Woman: A Case Report

Depressão Perinatal Desencadeada pela Expectativa de Género numa Mulher de Etnia Cigana: Um Relato de Caso

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ABSTRACT

Perinatal depression is a challenging condition, associated with multiple risk factors: personal, sociocultural, pregnancy-related and perinatal experience. A 29-year-old Roma woman, married and with a daughter, started the pregnancy surveillance with her family doctor for a desired low-risk pregnancy. During the second trimester ultrasound a female fetus was identified. The patient repeatedly expressed a belief and hope that “it can be a baby boy” sic. In subsequent visits, she expressed sadness, loss of appetite and significant weight loss, though she never perceived these symptoms as pathological.

Cultural dimensions play a significant role in shaping the perception and experience of motherhood. In this case, the mother’s gender expectation appeared to be a major risk factor for the development of perinatal depression, within a community where traditional patriarchal gender roles are deeply valued.

KEYWORDS: Culture; Depression, Postpartum; Mother-Child Relations; Romani People

RESUMO

A depressão perinatal é uma condição desafiante, associada a múltiplos fatores de risco: pessoais, socioculturais, relacionados com a gravidez e experiência perinatal. Uma mulher de 29 anos, etnia cigana, casada e com uma filha, iniciou a vigilância da gravidez com a sua médica de família por uma gravidez de baixo risco desejada. A ecografia obstétrica do segundo trimestre identificou um feto feminino. A utente expressava repetidamente a crença e desejo de que “pode ser um rapaz” sic. Nas consultas seguintes, a utente apresentava tristeza, perda

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de apetite e de peso significativa, apesar de não considerar estes sintomas patológicos. As dimensões culturais desempenham um papel preponderante na percepção e experiência da maternidade. No presente caso, a expectativa de gênero por parte da mãe foi considerada como um fator de risco *major* no desenvolvimento da depressão perinatal, considerando a comunidade na qual está inserida, onde os papéis de gênero patriarcais são valorizados.

PALAVRAS-CHAVE: Cultura; Depressão Pós-Parto; Povo Cigano; Relação Mãe-Criança

INTRODUCTION

Perinatal depression is defined by depression occurring during pregnancy or within 12 months after childbirth, recognizing that depression associated with having a baby may often begin during pregnancy.

It is a challenging condition, associated with a complex interplay of multiple risk factors: biological, pregnancy-related, peri-partum experience or social and cultural.^{1,2} Its consequences extend beyond maternal emotional and behavioural symptoms and include neuroendocrine, inflammatory, and stress-related physiological alterations that may influence maternal health and infant outcomes.³ Difficulties in mother-infant interaction, caregiving and family dynamics may occur as clinical manifestations of the disorder, and long-term developmental vulnerability in the child has been described.^{1,2}

The female gender, in certain cultural contexts, has been a source of social stigma and discrimination, particularly in patriarchal societies where the birth of a male child is culturally valued. Gender preference has been extensively documented in Asian and Middle Eastern contexts, sometimes resulting in gender-selective practices, such as gendercide.^{4,5} Nevertheless, little has been documented regarding these dynamics in European minority groups.

Particularly in the Roma community, cultural traditions and family structures often emphasize patriarchal norms, early motherhood and the symbolic value of bearing a male child who is perceived as the family's heir and protector.^{6,7} These cultural dimensions may increase psychological vulnerability when maternal gender expectations are unmet.

In this paper, the authors describe a case of perinatal depression in a Roma woman, triggered by the unmet maternal expectations regarding the child's gender.

This case also highlights the importance and impact that cultural dimensions have in health and how Family

Medicine played a sensitive approach to identify and manage perinatal depression.

CASE REPORT

MEDICAL HISTORY: The present clinical case describes a 29-year-old Roma woman, unemployed, married and mother of a daughter (Duvall's Family life cycle stage III), settled in a community family type. Her past medical history included an episode of anxiety and depressive symptoms in 2016, after a cousin's death. She had no history of chronic illness, psychiatric medication or substance use. Her past pregnancy occurred without complications, with an eutocic delivery in 2018, and breastfeeding was successful.

PREGNANCY SURVEILLANCE: The patient started the pregnancy surveillance with the family doctor at nine weeks of gestation for a desired, but unplanned, low-risk pregnancy.

At twenty-two weeks gestation, the patient expressed the hope that the fetus might be male, although the second trimester obstetric ultrasound described a female fetus, without anatomical malformations and adequate development (estimated fetal weight at 61st percentile).

During the subsequent visits, she reported loss of appetite and an unintentional weight loss of 4 kg (when compared with the weight before pregnancy), without an identifiable cause. Although she denied sadness, anxiety or insomnia, she presented objectively depressed mood. By the third trimester ultrasound, signs of fetal growth restriction were noted, with the fetal weight of 1606 g (9th percentile). Perinatal depression diagnosis was formalized due to the presence of depressed mood, anhedonia, fatigue, significant weight loss and feelings of inappropriate guilt.⁸ The patient received structured education regarding her condition, including its potential maternal and child risks associated with untreated perinatal depression. Both psycho-

logical support and pharmacological treatment were proposed. Despite repeated counselling, the patient refused all therapeutic proposals, including referral to specialized care. The patient consistently attended the consultations alone; involvement of family members was suggested but could not be implemented due to the patient's declination.

Delivery occurred at the gestational age of 40 weeks and 2 days, with a female healthy newborn (Apgar 10/10/10) – it was eutocic with a mild vaginal laceration (grade I). Breastfeeding was successful. The patient had a vasovagal syncope while admitted to the hospital, due to a mild and limited post-partum hemorrhage, being discharged two days after delivery.

POSTPARTUM FOLLOW-UP: Four days later, she came alone to an acute disease appointment in the health centre, reporting headache, dizziness and fear of staying alone at home. She expressed no concern for the newborn and denied psychotic symptoms or suicidal thoughts. At the puerperium appointment (six weeks post-partum), she complained of fatigue and palpitations and was found to have iron deficiency, for which supplementation was started. Despite denying emotional lability, depressive or anxious symptoms, her weight loss had progressed to 6 kg when compared with her pre-pregnancy status. The surveillance of the mother-newborn relationship was closely maintained during her child's programmed appointments, as well as the child's health status. At the child's six-month appointment, the patient was accompanied by her husband for the first time. She left the room when the baby started to cry and the husband expressed concern then with the worsening of the patient's anxiety since childbirth, and even a certain disconnection with the newborn, although breastfeeding was unaffected. He also described that the infant's care was mostly under the maternal grandparent's supervision. Screening and clinical reasoning revealed moderate to severe depression and anxiety (Patient Health Questionnaire-9: 18 points, moderate to severe depression; General Anxiety Disorder-7: 19 points, severe anxiety; Sheehan Disability scale: 23 points, moderate to severe impairment in social and family life). A shared-decision plan was made with the patient and her husband to start sertraline 50 mg daily, together with urgent referral to psychology and psychiatry for further evaluation and support.⁹

CURRENT STATUS: Nowadays, following a therapeutic review, due to confusion and suboptimal response to

sertraline, and after the patient ceased breastfeeding at her child's 18 months, her medication regimen was adjusted to escitalopram 10 mg id, trazodone 150 mg at night and lorazepam 1 mg as needed, under psychiatry supervision, alongside cognitive-behavioural therapy. The patient currently recognizes that her emotional investment in the expectation of having a male baby, and the subsequent birth of a female, was the trigger for feelings of guilt, sadness and frustration.

Ongoing follow-up indicates an adequate mother-infant relationship, without observable impairment in bonding or caregiving. The child demonstrates age-appropriate psychomotor development, with no apparent adverse developmental impact identified to date. Family involvement has increased over time, with the father becoming more actively engaged in caregiving and regularly accompanying the mother and children to medical appointments.

The authors understand that gender expectation was a major contributing factor for the onset of perinatal depression, which subsequently evolved to a chronic pattern of depression and anxiety.

DISCUSSION

This case illustrates the intersection of cultural gender expectations and perinatal mental health in a Roma woman, emphasizing the impact of these determinants on maternal mental health status, particularly in the perinatal period.

Gender disappointment has already been recognized as a trigger for emotional distress, depressive symptoms and even grief.¹⁰ In patriarchal societies that value patriarchy, female offspring may be less valued, contributing to maternal feelings of failure or guilt, and ultimately a risk factor for depression.¹¹

Within the Roma community, the concept of the family is the central pillar of their lives and children are paramount. Traditional norms often associate male children with social and familial prestige. Women may internalize these expectations, perceiving the birth of a daughter as a failure to fulfil the maternal role and the family desires.⁵ These factors associated with limited mental health literacy and stigma towards psychiatric disorders may lead to a delay in the diagnosis, proper treatment and management. This was recognized when the patient accepted the diagnosis and treatment, once her husband was included and participated in the shared-decision plan.

From the Family Medicine perspective, this case reinforces the importance of a continuous and holistic medical approach. Primary care physicians are in a unique position to detect early signs, foster a trustful relationship and adapt their clinical reasoning, to respect patient's expectations and beliefs. Active family involvement should also be emphasized, as it can significantly enhance adherence, support, and clinical outcomes, particularly in the perinatal context. Interdisciplinary collaboration is also fundamental to optimize patient-centred care, particularly when it occurs in the community setting. Furthermore, moderate to severe cases should be promptly referred to specialized mental health care to ensure appropriate evaluation and management.⁹ To the authors' knowledge, this is the first documented case of perinatal depression in a Roma woman directly associated with gender expectation. It underscores the necessity of recognizing sociocultural determinants of mental health within vulnerable populations.

Perinatal depression is a complex biopsychosocial disorder that requires early detection and culturally sensitive management. Gender expectations, particularly in communities where the male role is considered to be superior, may act as a significant psychological stress factor. Family Medicine plays a pivotal role in understanding the different health determinants, providing continuous care and coordinating with the multidisciplinary care, aimed both for the individual and its family.

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AC, SM – Bibliographic search, study design, data collection, drafting of the article, and critical review of the content.

AMP, CN – Critical review of the content.

DD – Technical and textual review of the content.

All authors approved the final version to be published.

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