Think India (Quarterly Journal)
ISSN: 0971-1260 Vol-22, Special Issue-13
National Conference on
Psychological Contributions in Sustainable Human Development in Sports, Organizations and Community Health
Date of Conference**:** December 20-21, 2019,
Organised by **Department of Psychology, Physical Education & Sports and Home Science V.P.S.P.M.S. Arts, Commerce & Science College, Kannad,** Aurangabad, Maharashtra 431103 India

Prevalence of Maternal Postpartum Depression

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Abstract:

Pregnancy and childbirth are important events in the life of a woman. Giving birth to a child is a life changing and challenging event for every mother. The aim of the present study was to check the prevalence of postpartum depression in semi-urban and rural areas and to see how delivery type and gender of a born child is effective in developing postpartum depression. The study was conducted on 38 postpartum women. Postpartum Depression Screening Scale (Cheryl Tatano Beck and Robert K Gable) was used for determining the postpartum depression. The data was analyzed using descriptive statistics and comparison done with the t-test. The practical implications have been discussed in light of the research findings. This includes a need for a psychological counselor in maternity homes or clinics and beyond that there is a strong need for awareness in families about postpartum depression.

Keywords: Personality Traits, Maternal Postpartum Depression, Descriptive Statistics

Introduction:

Pregnancy and labor are significant occasions in an existence of a lady. Frames of mind toward pregnancy and labor change broadly from culture to culture and furthermore inside a similar culture. Bringing forth a kid is a groundbreaking and testing occasion for each mother. Everything changes and still all ladies should adapt up to every changed thing. Some can't adapt up appropriately and become casualty of depression, called as postpartum depression.

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Postpartum depression is getting regular in Indian ladies however mindfulness and backing for these moms is still low (Panjabi, 2013). India is where the pace of birth is 21 for every 1000 individuals and it is assessed that 9-16% of ladies will encounter postpartum depression after the introduction of kid. Indeed, even among ladies who have just experienced PPD already, commonness is evaluated as 41% and regardless of this it stays undiscovered and along these lines prompts the following stage for example postpartum psychosis. The situation in India is likewise changing with the changing work and family environment. Many research discoveries demonstrated that it is essential to ponder the pervasiveness of Postpartum Depression in Indian populace and different variables associated with it.

Maternal Postpartum depression

Postpartum depression (PPD), additionally called postnatal depression, is a kind of clinical depression which can influence ladies after labor. Manifestations may incorporate misery, absence of vitality, changes in resting and eating designs, and decreased sexual want alongside crying scenes, nervousness, and touchiness. Postpartum blues, generally known as "postnatal depression" is a postpartum state of mind issue. It is portrayed by milder burdensome side effects than postpartum depression. Side effects of these blues regularly get settled inside one - two weeks. On the off chance that the side effects last longer than about fourteen days, at that point there are odds of progressively genuine depression. There is no different conclusion of Postpartum Depression is given in DSM 5, yet it is expressed as specifier of Major Depressive Disorder.

DSM 5 Criteria:

Major Depressive Disorder

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure

Note: Do not include the symptoms that are clearly attributable to another medical condition.

1. Depressed mood most of the day, nearly every day as indicated as either subjective report (eg. Feels sad, empty, hopeless) or observation made by others (e.g. appears tearful or irritable mood)

2. Markedly diminished interest or pleasure in all or almost all activities nearly every day (as indicated by subjective account or observation).

3. Significant weight loss when not dieting or weight gains (e.g. a change of more than 5% of body weight in a month) or decrease or increase in appetite nearly every day.

4. Insomnia or hypersomnia nearly every day.

5. Psychomotor retardation or agitation nearly every day (observable by others not merely subjective feelings of restlessness or being slowed down).

6. Fatigue or loss of energy nearly every day.

7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).

8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).

9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

B. The symptoms cause clinically significant distress or impairment in social, occupational or other important areas of functioning. C. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism)

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In recording the name of a diagnosis, terms should be listed in the following order:

Major depressive disorder, single or recurrent episode, severity/psychotic/remission specifiers/followed by as many of the following specifiers without codes that apply to the current episodes.

With Peripartum Onset:

This specifier can be applied to the current or, if full criteria are not currently met for a major depressive episode, most recent episode of major depression if onset of mood symptoms occurs during pregnancy or in the four weeks following delivery.

Note: Mood episodes can have their onset either during pregnancy or postpartum although the estimate differ according to the period of follow-up after delivery. Between 3&6% of women will experience the onset of a major depressive episode during pregnancy or in weeks or months following delivery. 50% of "postpartum" major depressive episodes actually begin prior to delivery. Thus these episodes are referred to collectively as **Peripartum Episodes.** Women with Peripartum major depressive episodes often have severe anxiety and even panic attacks. Perspective studies have demonstrated that mood and anxiety symptoms during pregnancy, as well as the baby blues increase the risk for postpartum major depressive episode.

Postpartum mood (major depressive or manic) episodes with psychotic features appear to occur in from 1 in 500 to 1 in 1,000 deliveries and may be more common in primiparous women. The risk of postpartum episodes with psychotic feature is particularly increased for women with prior postpartum mood episodes but it also elevated for those with a prior history of a depressive or bipolar disorder (especially Bipolar I disorder) and those with a family history of bipolar disorders.

Once a woman has had a postpartum episode with psychotic features, the risk for recurrence with such subsequent delivery is between 30% and 50%. Postpartum episodes must be differentiated from delirium occurring in the postpartum period, which is distinguished by a fluctuating level of awareness or attention. The postpartum period is unique with respect to the degree of neuro endocrine alterations and psychosocial adjustments, the potential impact of breast-feeding on treatment planning, and the long-term implications of a history of postpartum mood disorder on subsequent family planning.

Risk factors for postpartum depression

Research (Stewart, Robertson, Dennis, Grace & Wallington 2003) have consistently indicated the following predictors of postpartum depression:

1) Strong Predictors - Depression or anxiety during pregnancy, stressful recent life events, poor social support and a previous history of depression
2) Moderate Predictors - childcare stress, low self-esteem, maternal neuroticism and difficult infant temperament
3) Small Predictors - obstetric and pregnancy complications, negative cognitive attributions, single marital status, poor relationship with partner, and lower socioeconomic status

Detection, prevention and treatment

Postpartum depression is a major health issue but most of the times it remains undiagnosed. Even if few measures are made available to detect symptoms of depression among postpartum women, it is necessary to develop postpartum depression screening programs. It is highly needful to look after building the cost-effective mental health care units to screen and provide sensible and specific interpretations along with the proper treatment for postpartum depression. Sessions for awareness of postpartum depression along with knowledge of preventive measures must be provided to the maximum population.

Statement of the problem:

To study the prevalence of maternal postpartum depression

Objectives:

1. To find out if there are significant differences in postpartum depression between mothers with natural delivery and mothers with caesarean delivery.
2. To find out if there are significant differences in postpartum depression between mothers having male child and mothers having female child.

Hypotheses:

1. Postpartum depression would not differ among mothers with natural delivery and mothers with caesarean delivery.
2. Mother having male child and mother having female child would not differ significantly in terms of postpartum depression.

Methodology:

Sample selection is a very important step in any kind of research. Sample is a representation of universe. It is any number of persons selected to represent the population according to the rule or plan. Sample is always smaller representation.

Universe: Mothers with new born babies from Dhule district including rural and urban environments.

Sample:

The simple random sampling technique is used for the present study. There are 16 natural type of delivery and 22 Caesarean type of delivery, which include women having 17 female and 21 male new born babies. Total 38 participants were selected for the present research. The age group between 20–35 years is taken for the research. The area of the research is limited to Dhule district.

Variables under Study:

Independent Variables -

A. Type of delivery

    1. Normal (A1)
    2. Cesarian (A2)

B. Gender of new born baby

    1. Male (B1)

2. Female (B2)

Dependent Variables-

1. Personality traits
2. Postpartum depression

Design:

Based on the nature of the problem and objectives for the present research, two groups design was used.

Research Tools:

1. **Personal Interview Form –**

Personal interviews were taken before solving the questionnaire to gather the related demographic information along with the medical history including pregnancy related questions. Qualitative data was taken with the help of this interview form. Around 10-15 minutes were invested for an interview.

2. **Postpartum depression screening scale (PDSS) –**

The postpartum depression screening scale is developed by Cheryl Tatano Beck and Robert K Gable. The PDSS is a 35 item self report instrument that can be completed by the respondent in 5-10 minutes. There are 7 content scales – Sleeping or eating Disturbances (SLP), Anxiety or Insecurity (ANX), Emotional Lability (ELB), Mental Confusion (MNT), Loss of self (LOS), Guilt or Shame (GLT) and Suicidal Thoughts (SUI). The measure yields the total score, which determines the overall severity of postpartum depressive symptoms and indicated whether the woman needs to be referred for diagnostic evaluation. Cronbach's alpha reliability coefficient of 0.97 is obtained for PDSS total score.

Statistical Analysis:

Hypothesis 1 - Postpartum depression would not differ among mothers with natural delivery and mothers with caesarean delivery.

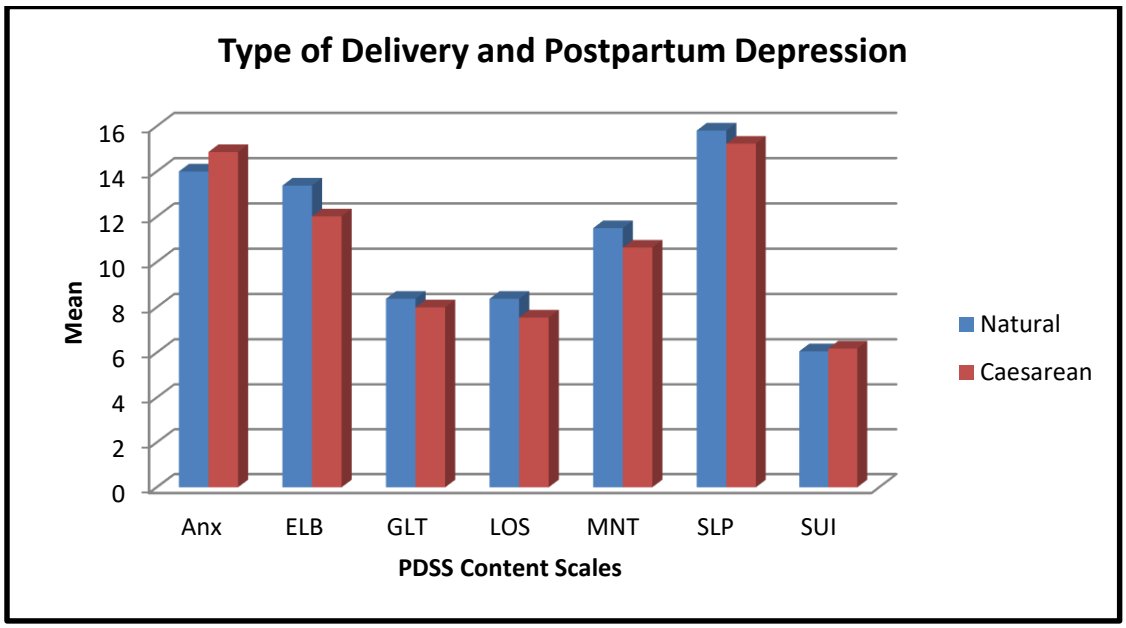
Table No. 1 – Descriptive statistics Type of delivery and Postpartum Depression

PDSS Factors	Delivery Type	N	Mean	S.D.	t
ANX	Natural	16	14.00	4.52	0.62
	Caesarean	22	14.86	3.99	
ELB	Natural	16	13.38	4.49	0.99
	Caesarean	22	12.05	3.76	
GLT	Natural	16	8.38	4.27	0.31
	Caesarean	22	8.00	3.09	
LOS	Natural	16	8.38	3.98	0.79
	Caesarean	22	7.55	2.46	
MNT	Natural	16	11.50	5.07	0.56
	Caesarean	22	10.64	4.32	
SLP	Natural	16	15.81	6.31	0.3
	Caesarean	22	15.23	5.53	
SUI	Natural	16	6.06	3.09	0.13
	Caesarean	22	6.18	2.56	

Table 1 shows the mean and SD between mothers with natural delivery and mothers with caesarean delivery. The mean of mothers with natural delivery and caesarean delivery on content scale for **Anxiety or Insecurity** is 14 and 14.86 respectively. The mean of mothers with natural delivery and caesarean delivery on content scale for **Emotional Lability** is 13.38 and 12.05 respectively. The mean of mothers with natural delivery and caesarean delivery on content scale for **Guilt or Shame** is 8.38 and 8.00 respectively. The mean of mothers with natural delivery and caesarean delivery on content scale for **Loss of Self** is 8.38 and 7.55 respectively. The mean of mothers with natural delivery and caesarean delivery on content scale for **Mental Confusion** is 11.50 and 10.64 respectively. The mean of mothers with natural delivery and caesarean delivery on content scale for **Sleeping or Eating Disturbances** is 15.81 and 15.23 respectively. The mean of mothers with natural delivery and caesarean delivery on content scale for **Suicidal Thoughts** is 6.06 and 6.18 respectively. As seen through table 1, there are no significant

differences found between two groups at the 0.05 and 0.01 levels respectively. Therefore, the hypothesis, postpartum depression would not differ among mothers with natural delivery and mothers with caesarean delivery is accepted. This analysis is shown in following graph clearly.

Graph 1 – Type of Delivery and Postpartum Depression



Hypothesis 2 - Mother having male child and mother having female child would not differ significantly in terms of postpartum depression.

Table 2, drawn below, shows the mean and SD between mothers having male child and mothers having female child. The mean of mothers having male child and mothers having female child on content scale for **Anxiety or Insecurity** is 13.48 and 15.76 respectively. The mean of mothers having male child and mothers having female child on content scale for **Emotional Lability** is 12.24 and 13.06 respectively. The mean of mothers having male child and mothers having female child on content scale for **Guilt or Shame** is 8.43 and 7.82 respectively. The mean of mothers having male child and mothers having female child on content scale for **Loss of Self** is 7.43 and 8.47 respectively. The mean of mothers having male child and mothers having female child on content scale for **Mental Confusion** is 11.33 and 10.59 respectively. The mean of mothers having male child and mothers having female child on content scale for **Sleeping or Eating Disturbances** is 13.71 and 17.65 respectively. The mean of mothers having male child

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and mothers having female child on content scale for **Suicidal Thoughts** is 6.67 and 5.47 respectively. As seen through table 1, there are a significant difference found between two groups on content scale for **Sleeping or Eating Disturbances (SLP)** at the 0.05 levels with df

PDSS Factors	GENDER	N	Mean	SD	t
ANX	Male	17	13.48	4.34	1.72
	Female	21	15.76	3.72	
ELB	Male	17	12.24	4.72	0.61
	Female	21	13.06	3.19	
GLT	Male	17	8.43	3.85	0.51
	Female	21	7.82	3.30	
LOS	Male	17	7.43	3.43	1.08
	Female	21	8.47	2.81	
MNT	Male	17	11.33	5.10	0.49
	Female	21	10.59	4.02	
SLP	Male	17	13.71	6.21	2.18*
	Female	21	17.65	4.50	
SUI	Male	17	6.67	3.48	1.34
	Female	21	5.47	1.23	

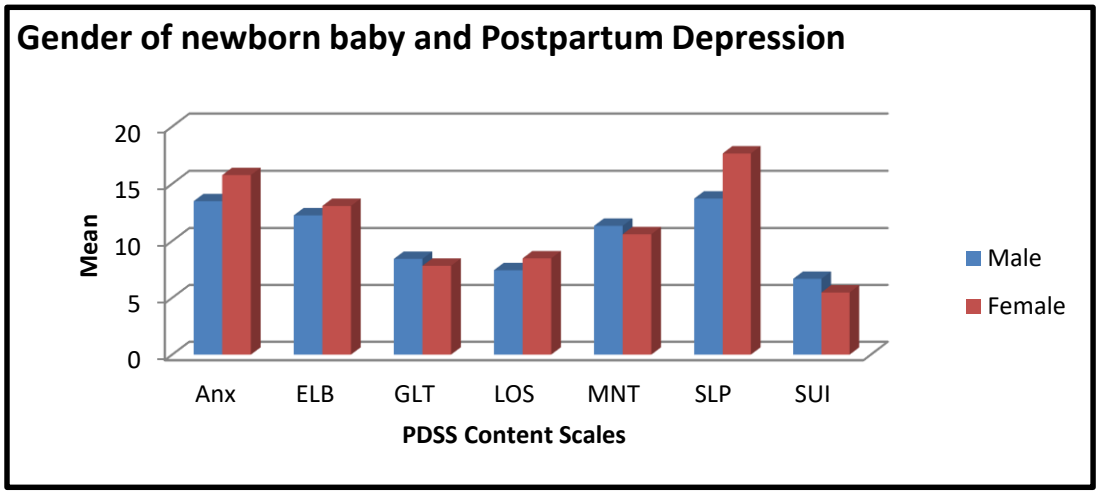
value 2.02. Therefore, the hypothesis, postpartum depression would not differ among mothers with natural delivery and mothers with caesarean delivery is **partially accepted**.

Table No. 2 – Descriptive statistics for Gender of a newborn and Postpartum Depression

* Significant at 0.05 level

The analysis for Table 2 is shown in the following graph clearly.

Graph 2 – Gender of newborn baby and Postpartum Depression



Conclusion:

1. Postpartum depression does not differ among mothers with natural delivery and mothers with caesarean delivery.
2. Mother having male child and mother having female child differs significantly in terms of postpartum depression on content scale for sleeping or eating disturbances; does not differ in terms of postpartum depression on content scales anxiety/insecurity, emotional lability, mental confusion, loss of self, guilt/shame and suicidal thoughts.

Implications

- The study stresses the need for a psychological counselor in maternity homes or clinics for counseling and even screening of postpartum women.
- To create the awareness in the families regarding how it is important to provide support to the postpartum women.

Limtations

1. The present study is limited to Dhule district only.
2. Sample size is very small to generalize results.

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