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Relation of Postpartum Depression and Health Care Climate with Type of Delivery

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ABSTRACT

The present study was conducted to investigate the relation of postpartum depression and health care climate to type of delivery. It was hypothesized that postpartum depression is positively correlated with type of delivery, birth order of the child, social support and health care climate. Sample was consisted on 200 females from which 100 were with normal delivery and 100 were with cesarean delivery. Data was collected from Nishtar Hospital Multan and DHQ Muzaffar Garh. Edinburg Postnatal Depression Scale (EPDS) Sagovsky in 1987 and Health Care Climate Questionnaire developed by Williams, G. C., & Deci, E. L. (2001) were used as research instruments. Results indicate that postpartum depression is positively correlated with 1st child birth, cesarean delivery and poor health care climate.

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1 Introduction

Postpartum Depression

Child birth is considered as happy and exciting experience for females. \But for 10 to 30 percent females this experience of child birth cause clinical depression (Rubertsson et al., 2005; Grace et al., 2003; O'Hara, 2003). This depression starts within four weeks after birth of a child known as peripartum depression (APA, 2013), which is different in severity and pattern from normal "baby blues". It is also different from postpartum psychosis. 80 percent of women experience peripartum depression after the child birth due to changes in life routine such as changes in sleep and emotions which cause crying spells, fatigue, anxiety, insomnia and sadness (Horowitz et al., 2005).

Depressive symptoms may continue after the years of child birth. These cause disturbance in mother child relationships. One a women suffer from peripartum depression it has 25 to 50 percent chances to suffer from it again (Beautrais, 2005; Krol, 2016). Peripartum depression is a serious mother- child health issue. Parry (1999) called it a thief which robe the valued time of mother which she could spent with her child, as well as it affects

the marital relationships. Children of depress mothers have to face problems in cognitive and emotional development, low IQ, attention problems and violent behavior (Goodman, 2002; Field, 2005).

Symptoms of Postpartum Depression

Symptoms of postpartum depression include high level of "sadness, despair, tearfulness, insomnia, anxiety, intrusive thoughts, compulsions, panic attack, feelings of inability to cope and suicidal ideation" (Beautrais, 2005). These symptoms may last up to a year (Terry, 1996), and 25 to 50 percent women have chances to suffer from it again with a subsequent child birth (Stevens, 2010).

Postpartum depression has drastic effects on health of both mother and child as Parry (1999) describes them as "a dangerous thief that, after delivery, robs a mother of precious time spent with the infant she has anticipated throughout her pregnancy" (p.1). Besides directly impacting the emotional wellbeing of mothers, postpartum depression (PPD) affects marital relationships (Goodman, 2002), mother-infant interaction infant behavior (Field, 2005) and cognitive and emotional development of children. Children of depressed mothers have significantly lower intelligence quotient (IQ) scores, attention problems, violent behavior related to attention-deficit/hyperactivity disorder and problems with anger management that endure into childhood (Haynes, 2001).

Cultural Effects of Postpartum Depression

The hot-cold beliefs in non-western cultures stated that hot and cold balance should be maintain within the mother's body and the environment after child birth. This belief is centuries old in non-western cultures (2010). In India and Middle East such as Jordan, Lebanon, Egypt and Palestine the period of postpartum confinement usually lasts up to 40 days. This shelter or seclusion is made to protect mother and infant from evil spirits and illness. Both mother and child are considered vulnerable to such states after the birth (American Public Health Association, 2001). All women experience a kind of hormone " withdrawal" after delivery, as estrogen and progesterone levels, which rise as much as 50 times above normal during pregnancy, now drop sharply below normal (Horowitz et al., 2005).

Psychological Factors of Postpartum Depression

Psychological and socio-cultural factors are also considered as the casual factors of postpartum depression because baby's birth cause many psychological and social transformations (Gjerdingen & Center, 2005). "A woman typically faces changes in her marital relationship, daily routines, and social roles. Sleep and relaxation are likely to decrease and financial pressures may increase. Perhaps she feels the added stress of giving up a career or to trying to maintain one. This pileup of stress may heighten the risk of depression" (Horowitz et al., 2005).

Postpartum depression is commonly observed and its prevalence is 30 to 75% (O'Hara et al., 2003). Symptoms appear soon after or within few days of birth of a child. These symptoms last for hours till many days. Irritability, sleep problem crying, irritable mood are the symptoms which are associated with postpartum depression (Kennerly& Gath, 1989).

Tendency to develop the depression or blues is not related with the environmental stress, cultural perspective, breastfeeding, and psychotic history, but all these factors might bring the major depression (Miller, 2002). Women up to 20% may lead to major depression within the first year of postpartum (Gardner, & Campbell, 1992) study from large data shows that non psychotic postnatal depression brings difficulty in. Symptoms of major depression and sign of postnatal depression are similar. Postnatal depression usually require treatment from the health professionals. Somatic symptoms are different from the signs of postnatal or postpartum depression. (O'Hara, 2003).

O'Ha:ra & Swain (1996) found in the analysis of 59 researches from Europe, Japan, North America and Australia 13% ratio of post-partum. This study consisted of 12, 810 subjects. Study was conducted on the women from the age of 14 to 18. And it was approved in the study that depressive symptoms were found higher in this particular age group of mothers. it was also showed in the study that pregnancy in this age not only produces postpartum depression but also other problems as well. (Troutman & Cutrona, 1990).

When studying the other factors like genetic and biological, it becomes clear that this is not an easy to understand this. In fact, this is complex. those who are genetically vulnerable may become easy prey of these disorders. That's why many factors may play the role in developing the postpartum depression (Dubovsky& Buzan, 1999).

Objectives of the Study

1. To study the relationship of postpartum depression with type of delivery.
2. To study the relationship of postpartum depression with health care climate.
3. To study the relationship of postpartum depression with various demographic variables.

Hypotheses of the Study

1. Postpartum depression is significantly correlated with the type of delivery.
2. Females with cesarean delivery have more postpartum depression as compared to females with normal delivery.
3. Postpartum depression is positively correlated with social support to the mothers.
4. Postpartum depression is significantly correlated with the health care climate.

2 Methodology

Correlative and comparative research design was used in this study. The sample consists of 200 females from which 100 were with normal delivery and 100 were with cesarean delivery. The sample was selected with purposive and snow ball sampling from Nishtar Hospital Multan, Fatima Jinnah Hospital, and DHQ Muzaffargarh and from general population.

Edinburgh Postnatal Depression Scale (EPDS) developed by Sagovsky in 1987 and Health Care Climate Questionnaire developed by Williams, G. C., & Deci, E. L. (2001) to study the level of autonomy and

supportiveness by health care providers and the perception of patients about their doctor. It is a 15 item 7-point Likert scale, were used.

3 RESULTS

Table 1

Mean, Standard deviation, t and p-value on the score of postpartum depression among 1st child birth and 2nd child birth

Ppd	N	Mean	S.D	T	p
1st child	100	12.33	2.808	9.960	.000
2nd child	100	9.37	2.606		

Note. N=200.*df =58, p<0.05*

Above mentioned table shows Means, Standard Deviations and t-value for the Scores of postpartum depressions on 1st and 2nd child birth (t= 9.960, df= 58, p <0.05). It shows that there is significant difference among the 1st child birth and 2nd child birth on postpartum depression. The results indicated that after 1st child birth females have more postpartum depression as compared to 2nd child birth.

Table 2

Mean, Standard deviation, t value of postpartum depression, with the type of delivery

Type of delivery	N	Mean	S.D	T	p
Normal	100	11.76	6.420	-7.091	.000
Cesarean	100	16.40	6.117		

Note. N=200.*df =98, p<0.05*

Above mentioned table shows Means, Standard Deviations and t-value for the Scores of postpartum depressions with the type of delivery. Values shows that females with cesarean delivery have much postpartum depression as compared to females with normal delivery.

Table 3

Mean, Standard Deviation, and t-value of social support with the type of delivery

Type of delivery	N	Mean	S.D	T	p
Normal	100	27.60	4.049	3.904	.000
Cesarean	100	25.14	5.033		

Note. N=200.*df =98, p<0.05*

The above table shows the mean, S.D and T-value of social support with the type of delivery. Values shows that there is no significant difference between the type of delivery and social support to young mothers.

Table 4

Mean, S.D and T-values of Autonomy of mothers with type of delivery

Type of delivery	N	Mean	S.D	T	p
Normal	100	30.70	6.075	-1.464	.000
Cesarean	100	32.36	5.232		

Note. N=200.*df =98, p<0.05*

The above table shows the mean, S.D and T-value of temperament with the type of delivery. Values shows that there is no significant difference between the type of delivery and level of temperament to young mothers.

Table 5

Mean S.D and T-values of postpartum depression, with the family type

Type of family	N	Mean	S.D	T	p
Joint family	130	14.14	4.068		
Nuclear Family	70	13.85	3.829	0.286	.000

Note. N=200.*df =98, p<0.05*

The above table shows the mean, S.D and T-value of postpartum depression with the type of delivery. Values shows that there is no significant difference between the type of family and level of postpartum depression.

Table 6

Mean S.D and T-values of health care climate, with the type of delivery

Type of delivery	N	Mean	S.D	T	p
Normal	100	45.66	8.676	-.404	.000
Cesarean	100	54.70	10.317		

Note. N=200.*df =98, p<0.05*

The above table shows the mean, S.D and T-value of health care climate with the type of delivery. Values shows that there is significant difference between the type of delivery and satisfaction with health care climate. Females with cesarean delivery have much dissatisfaction with health care climate as compared to females with normal delivery.

Table 7

Mean, S.D and T-value of postpartum depression with gender of the child

Gender	N	Mean	S.D	T	p
Male	80	61.76	5.666	.814	.000
Female	120	60.60	5.879		

Note. N=200.*df =98, p<0.05*

Above table shows the mean, S.D and the t value of the postpartum depression among the females with the gender of children. According to the results there is no significant difference between the gender of the child and the postpartum depression.

4 Discussion

In the light of above mention results and discussion on effect of postpartum depression social support and temperament of mothers the findings reveal that the postpartum depression is positively correlated with temperament and negatively correlated with social support which means that low social support causes high postpartum depression. Similarly, the postpartum depression is highly correlated with the cesarean delivery as compared to normal delivery. The postpartum depression is not significantly correlated with the family type and the social support and temperament of mothers because social support exists in any shape in all family types either joint or nuclear. It is also shown in the results that health care climate for females with cesarean delivery is very dissatisfactory. There may be different reasons for this such as usually the females for normal delivery goes to the local maternity homes or daies who are usually the known and familiar person in the community and for cesarean delivery in the hospitals doctors do not give much attention and care to patients which may cause the dissatisfaction among females.

Limitations

1. The data was taken from only two cities Multan and Muzaffargar therefore nationwide generalization was not possible for this research.
2. The time limit was very short for this research. For this type of sensitive topic more time would be given.
3. This study can be conducted on different age group and on different sample.

Suggestions

1. Sample used in the present study was small. It should be representative and large enough to generalize the other cities and areas of Pakistan.
2. Further research should do on the sex of the child, mother's age and mother's education or in rural and urban areas.

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