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Prevalence of Marital Conflicts among Women Diagnosed with Postpartum Depression and Non-Depressed

Asghar Ali Shah[1]
International Islamic University, Islamabad

Samia Mazhar[2]
Cambridge College, Sheikhupura

and

Irum Naz Akhter[3]
Preston University Islamabad Campus

The present research was on the prevalence of marital conflicts among women having postpartum depression and from general population. The sample was of 100 women, including 50 women having postpartum depression and 50 from general population. The data was collected after one week of child birth. The hypothesis was "the marital conflicts will be higher in women with postpartum depression than women from general population". The hypothesis was tested by using chi-square test, highly significant results revealed that postpartum depression negatively effect the marital relation. Similarly, women with postpartum depression revealed difficulty in understanding themselves and they blamed themselves comparing them with women without postpartum depression. Women with postpartum depression blamed themselves when things went wrong and created troubles for themselves.

[1] Assistant Professor, Department of Psychology, International Islamic University, Islamabad
[2] Diploma in Clinical Psychology, Department of Psychology, Cambridge College, Sheikhupura
[3] PhD Scholar, Department of Psychology, Preston University Islamabad Campus

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Postpartum depression is a major health concern, produces insidious effects on new mothers, their infant, and family. Postpartum depression is a depressive episode, starting between early four weeks after the childbirth to six months later. It meets criteria for major depressive disorder, without psychotic features. Postpartum depression occurs at a time when heavy demands are placed on a woman's resources and when infant learning and development are occurring (DSM-IV). Postpartum non-psychotic depression is the most common complication of childbearing affecting approximately ten to fifteen percent of women and represents a considerable public health problem affecting women and their families (Warner, Appleby, Whitton, & Faragher, 1996). The effects of postnatal depression on the mother, her marital relationship, and her children make it an important condition to diagnose, treat and prevent (Robinson & Stewart, 2001). Studies provided evidence that during the past decades fifty to seventy percent of mothers go through maternal blues. Postpartum depression is considered to be so common and its occurrence has been estimated as being between ten to fifteen percent in different countries and cultures worldwide (Paulson, 2010; Spinelli, 2009).

Mothers with postpartum depression can unconsciously exhibit fewer positive emotions and more negative emotions toward their children. They are less responsive and less sensitive to infant, less emotionally available and have infants who are less securely attached; and in more extreme cases, some woman may have thoughts of harming their children. On the other hand, children whose mothers are affected by postpartum depression may develop more behavioral, cognitive and emotional difficulties. Furthermore, there is a thirty to fifty percent risk of relapse of depression in subsequent pregnancies. While not all causes of postpartum depression are known, several factors have been identified.

The relationship between postpartum depression and the marital relationship is well examined in the researchers conducted by Para medical field. Numerous studies have consistently associated marital factors such as conflict, dissatisfaction and support with the risk for postpartum depression. More than eighty-five studies were published

during the past decades. Beck (2002) found that marital satisfaction had a moderate predictive relationship with postpartum depression. Earlier meta-analysis conducted by O'Hara and Swain (1996) was supported prior work and emphasized that, for couples with strained relationships; the transition process associated with childbirth is that much more challenging.

The association between depression and marital disharmony has been known for at least three decades (Hollist, Miller, Falceto, & Fernandes, 2007). There is often difficulty ascertaining which came first, disharmony, or depression. Depression may precede the marital problems and be seen as the activator of the conflict (Beach et al., 1990). Moreover, marital distress is a good predictor of depressive relapse. Beach, Katz, Kim, and Brody (2003) found that patients with higher marital satisfaction scores were less likely to suffer a clinically significant return of their depressive symptoms. Those who are dissatisfied with their partners or whose partners are non-communicative are more likely to have a relapse of their depressive illness after childbirth (Coyne, Thompson, & Palmer, 2002).

One research conducted by Dressel and Clark (1990) showed that maternal depression has been commonly associated with negative relational distress such as fear of being rejected by the partner, misdirected anger, withdrawal, marital dissatisfaction as well as poorer communication of needs and expectations. Paley et al. contend that during this period of adjustment it is typical for the developing partners and parent-infant relationships to become stressed. For successful relational adjustments the presence and involvement of both partners was found to be essential. According to Beck (2002) the traditional family care role expectations required readjustments related to men's role as 'career' for their partner (Dressel & Clark, 1990).

Difficulties in the marital relationship can play a major role in the development of depressive illness. Epidemiological data revealed that unhappy marriages were a major risk factor for major depressive disorder, associated with a 25 folds increase relative to untroubled marriages in one major study (Weissman, Bruce, Leaf, Florio, & Holzer, 1999). Another study found a 10-fold increase in risk for depressive symptoms associated with marital discord, a closer look at the link between marital discord and depressive symptomatology (O'Leary, Schlaggar, & Tuttle, 1994). Dennis and Ross (2006) suggested that women were more likely to develop depressive symptoms if they

perceived that their husbands socially excluded them, discouraged them from seeking help, or did not recognize their efforts to nurture the infant at two months postpartum.

Roux, Anderson, and Roan (2002) investigated the association between postpartum depression and marital dysfunction and the impact on infant outcome. Eight of the 12 mothers who were initially identified as breastfeeding nursed their infants for 6–18 months. Regardless of financial and educational advantages, mothers in the study experienced depression and marital dysfunction (Whiffen & Gotlib, 1993). Everingham, Heading and Connor (2006) found that all women identified a priority need to have a partner's understanding of their emotional distress. Women desired that their partners must understand their condition. As a result they feel that understanding will lessen relational conflict and will protect women against being labeled as 'incompetent' mothers. Although husbands recognized their spouses' need for understanding, they found that husbands often misunderstood their partners' intended messages. Expressions of distress were interpreted through a physical, personality, or psychological lens rather than through the wives' frame of being the 'good' mother.

Depressed women have the potential to significantly impact their partners' moods. Depression is often accompanied by relationship difficulties with a high prevalence of marital disharmony (Briscoe & Smith, 1973; Weissman et al. 1991) and divorce (Coyne, 1990). Evidence has shown that harmonious, confiding relationships can protect some people from depression, and improve treatment outcomes (Beach et al., 1990; Brown & Harris, 1978). Whiffen (1992) found the overall rate for postpartum depression of 13.0% to be approximately double the community rate for non-postpartum major and minor depression. The comparison of these rates did not control for marital status. The 1-year prevalence rates of major depression in community samples among married women is much lower (2.1%) than among divorced women (6.3%) which shows that not only depression have the impact on marital relations but marital disharmony or break ups in marital life could also cause the postpartum depression (Weissman et al. 1991).

Marital dissatisfaction or marital conflict was also significantly associated with both depressions during pregnancy and postpartum period. This includes the low level of interaction and companionship experience, the deterioration of social support from partners, and poor intimacy with partners (Roomruangwong & Epperson, 2011). Keller,

Cummings, Peterson, and Davies (2009) Cummings, and Peterson, and Davies (2010) found that fathers' greater covert negativity and mothers' overt destructive conflict behaviors served as intervening variables in the link between fathers' depressive symptoms and child internalizing symptoms, with modest support for the pathway through fathers' covert negativity found even after controlling for earlier levels of constructs. These findings support the role of marital conflict in the impact of fathers' depressive symptoms on child internalizing symptoms.

Some pregnant women feel insecure about bodily changes and regarded themselves as sexually unattractive and need extra support from their partner. They may monitor their partners' affection and task support as indicators of love and acceptance. A lack of these expected supports from the partner could have impact on depressive symptoms. In the other hand, some studies have proposed that antenatal depressive symptoms may precede marital conflict. Their family, partner, as well as friends may try but fail to alleviate their negative emotions, leading others to avoid them. Thus, the relationship between marital conflict and depressive symptoms is considered to be very complicated and depression and marital conflict are likely to influence each other **(**Roomruangwong & Epperson, 2011).

Genetic and biological studies of mood disorders indicate that if an individual has a genetic vulnerability or predisposition to developing depression, there have to be experiential and environmental factors which interact to cause the illness (Dubovsky & Buzan, 1999). Biological perspective suggested that the rapid decline in the levels of reproductive hormones that occur after delivery might be a possible etiology of postpartum affective disorders (Wisner, Parry, & Piontek, 2002). Moreover, Harris (1996) showed a minor association of postpartum depression and thyroid dysfunction in thyroid antibody positive women. Although it has been suggested that postnatal depression is caused by low levels of progesterone or estrogen or high levels of prolactin, no consistent relationships have been found (Hendrick, Altshuler, & Suri, 1998).

O'Hara and Swain (1996) found more life events from the beginning of pregnancy until about eleven weeks postpartum were associated with higher levels of depressive symptomatology and a greater likelihood of being diagnosed with postpartum depression (O'Hara, Schlechte, Lewis, & Varner, 1991a). Hopkins, Campbell and Marcus (1987) found no association between life events and postpartum

depression. At least two other large studies have not found an association between life events and postpartum depression (Dowlatshahi, & Paykel, 1990; Kumar, Marks, Platz, & Yoshida (1995). Many researches have been conducted on postpartum depression with different risk factors in west but a few researches on this topic were conducted in Pakistan. The overall prevalence of postpartum anxiety and depression was found to be 28.8 percent in Pakistan. Domestic violence, difficulty in breast feeding at birth and unplanned current pregnancy were found to be significantly associated with postpartum anxiety and depression (Ali, Ali, & Azam, 2009; Kausar & Kahlid, 2001).

The study was an important effort in a way that postpartum depression affects the whole social occupational and other areas of functioning as well as it can also affect the marital relationships. This study also focused that whether postpartum depression would be a major cause of marital conflicts or marital conflicts plays the role as a predictor to develop postpartum depression. Postpartum depression and its relationship with the marital conflicts is an important issue in Pakistani families which can affect interpersonal and family relationships that would lead to disturbance in whole family life and the growth and development of a child. The present study proved to be a milestone in bringing the very important area to study under psychologist's attention in Pakistan as only some researchers have given their attention to the important issue of women life.

The major objective of present research was to assess the relationship between postpartum depression and marital conflicts among women in Pakistani hospitals. The research was also conducted to explore the prevalence of marital conflicts is more in women who diagnosed as having postpartum depression than women who belongs to general population and was not diagnosed having postpartum depression.

Research design

In the present study 2/2 factorial design was used in the research. Chi square was used for the data evaluation.

Objectives

- To investigate the effects of post-partum depression on marital conflicts among women with postpartum depression and without postpartum depression.
- To study the effect of postpartum depression on understanding one self among women with postpartum depression and without postpartum depression.

Hypotheses

- Women with postpartum depression are more prone to marital conflicts than women than women without postpartum depression.
- Women with postpartum depression will find it more difficult to understand themselves than women without postpartum depression.

Method

Sample

Sample of the study was N=100 women selected from Rawalpindi and Islamabad. Two groups of respondents were participated in the study. The first group included n=50 respondents having postpartum depression from different hospitals of Rawalpindi and Islamabad with the mean age of 20 to 40 years. The second group consisted of n=50 women from general population of same age mean.

Instruments

Edinburgh Postnatal Depression Scale.

The scale was developed by Cox, Holden, and Sagovsky (1987). It is a 10 items self-report measure with four point likert type scale. Responses are scored from 0 to 3 , questions 1 , 2 and 4 are scored 0 , 1 , 2 , or 3 with top box scored as 0 and the bottom box scored as 3, questions number 3, 5 - 10 are reverse scored , with the top box scored as a 3 and the bottom box scored as 0 . The total score is from 0 to 30. Scores of 10 or less are considered normal. Scores of 13 or more suggest significant depression, always looked item 10 (suicidal thoughts). One advantage of

this scale it that it does not include common somatic symptoms such as insomnia and appetite changes, which may occur naturally in postpartum women, but rather only one item addresses a somatic symptom and this relates to mood: I have been so unhappy that I have had difficulty in sleeping (Glaze & Cox, 1991).The EPDS has been reported as a validated measure of depressive symptoms in the antenatal and postnatal period with a coefficient alpha of .82 when used before and after delivery (Deater-Deckard, Pickering, Dunn, & Golding, 1998).

Kansas Marital Satisfaction Scale.

Kansas Marital Conflict Scale was developed by Schumm, Nichols, Schectman, and Grigsby (1983). It consisted of 3 items and is seven point rating scale ranging from extremely dissatisfied) to 7 (extremely satisfied).

Procedure

The Edinburgh Postpartum Depression Scale and the Kansas Marital Conflict Scale were used in the study. The respondents of the present study were contacted by the researcher and were asked for their willingness to participate in the study. They were assured of confidentiality of their responses and were briefed about the scales. They were requested to give as honest answers as possible. Then they were requested to complete the scales. Two groups of respondents were contacted in the study. Group of 50 respondents were contacted from hospitals. The data was collected individually from Capital Hospital Islamabad, Benazir Bhutto Hospital Rawalpindi, PAF hospital Wah Cantt and PIMS Islamabad. Group of 50 respondents were contacted from general population of Islamabad and Rawalpindi. At the end they were thanked for their cooperation. The first group was consisting of diagnosed women of Postpartum Depression; their age range was (20-40). The second group was consisting of women from general population of Rawalpindi and Islamabad which were randomly selected and their age range was (20-40) years. The results of the two scales were analyzed by using statistical package SPSS, according to the scoring directions.

Results

Table 1

Association Between Postpartum Depression and Marital Conflicts (N= 100)

		Group				
Variable		Postpartum depressed women	Normal women	Total	X^2	*p*
Marital conflicts	Low	12	42	54	7.42	.003
	High	38	8	36		
Total		50	50	100		

Table 1 shows association between both husband and wives get their points across to each other without too much trouble and things have been too much for the postpartum depressed women. The hypothesis was tested by using chi-square test at significance level of .003. The value of chi-square i.e. 7.42 at significance level of 0.003 confirmed that husband and wives get their points across to each other without too much trouble but as compared to them women with postpartum depression considered things too much for them and exaggerated things and created troubles among themselves. Hence the hypothesis has been accepted.

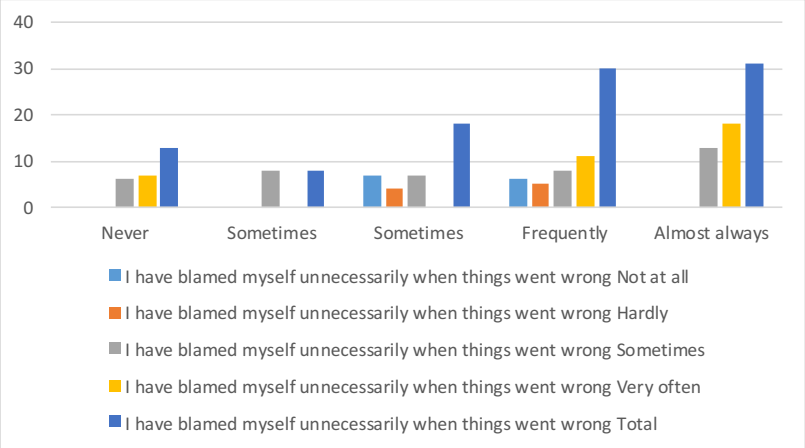

Figure 1 *Coping Mechanism of Women with Postpartum Depression*

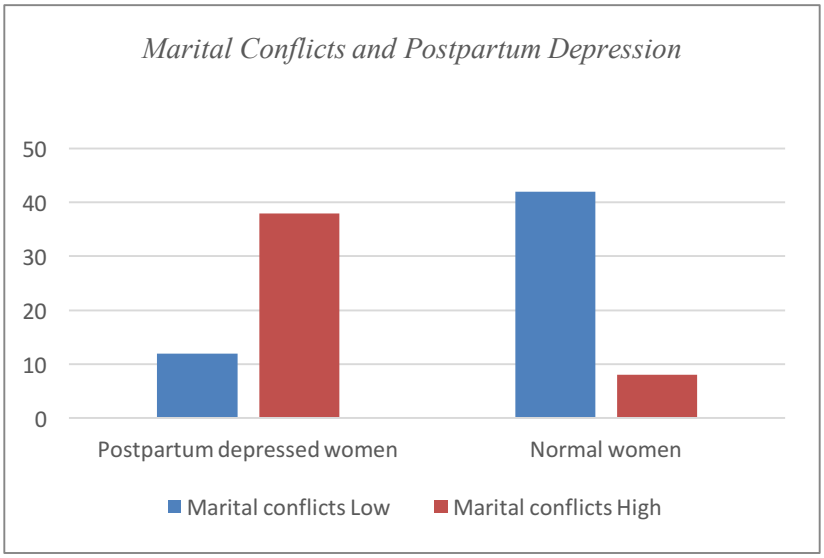

Figure 2

Discussion

The purpose of the present study was to explore that marital conflict will be high in women with the diagnosis of postpartum depression than women of general population. The collection of data from hospitals for the group of 50 diagnosed postpartum depressive women was difficult because of the time factor and because the postpartum depression diagnosis is very rare. So it took much time to find the patients

It was hypothesized that "marital conflicts will be higher in women with postpartum depression than women from general population" was proved according to the results. The hypothesis was tested by using chi-square test at significance level of .002. The results confirmed that husband and wives get their points across to each other without too much trouble but as compared to them women with postpartum depression considered things too much for them and exaggerated things and created troubles among themselves. Hence the first hypothesis has been accepted. The previous research is also evident that marital conflict causes postpartum depression among women (Forman, Videbech, Hedegaard, Salvig, & Secher, 2000).

The second hypothesis "women with postpartum depression have got much difficulty in understanding themselves" was tested by using chi-square test at significance level of .006. The value of chi-square i.e. 0.000 at significance level of .006 confirmed that husbands and wives begin to understand each other's feeling quickly and they can easily cope with their problems. As compared to this women with postpartum depression have got much difficulty in understanding themselves and they blamed themselves unnecessarily when things went wrong. Hence the hypothesis has been accepted. Depression at this critical period of life carries special meanings and risks to the woman and her family. It is possible to identify women with increased risk factors for postpartum depression with the help of marital conflict severity level. Meta-analysis of depression screening programs generally conclude that depression screening must be combined with systemic paths for referral of cases and well defined and implemented care plans to achieve outcome benefits. Unfortunately postpartum depression remains undiagnosed and untreated due to several reasons one of which is lack of knowledge about such emotional and psychological condition after child birth. Prolonged and undiagnosed untreated or recurrent periods of maternal depression appear to be more likely to cause longer term effects on marital relationships (Burt & Stein, 2002; Danaci, Dinc, Deveci, Sen, & Icelli, 2002).

Limitations and Suggestions

Numerous studies have been done on prevalence and determinants of postpartum depression in developed countries, but there was still scarcity of data in our local context which cannot be generalizable. Therefore, the researcher aimed for this study to determine this area of psychology. This research will be helpful for students and researchers who are working in the area of social and clinical psychology in national context.

There were some limitations for further studies in this topic with this sample as one group consisted of patients with postpartum depression have no insight regarding their disorder and they projected their conflicts to some supernatural forces so they didn't respond properly to the marital satisfaction scale. It was also lack of availability of the diagnosed patients of postpartum depression so the data gathering was very difficult. Only one or two patient was coming for the treatment of postpartum depression in outpatient in a day.

Conclusion

The present study aimed at examines the prevalence of marital conflicts among women diagnosed with postpartum depression and women from general population. Two hypotheses were formulated on the basis of past literature. Findings of the study indicated that marital conflicts were more in women with postpartum depression than women from general population.it was also found that women with postpartum depression have got much difficulty in understanding themselves.

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