Pakistan Journal of Psychological Research Vol. 4, Nos. 3-4, Winter 1989, 71-80

* MATERNITY BLUES AND PUERPERAL DEPRESSION IN PAKISTANI WOMEN

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This study examines the prevalence of maternity blues and puerperal depression in a heterogeneous sample of 202 Pakistani women. Mothers were assessed for maternity blues two to three days after delivery. As reported by the mothers, 68.31% of them experienced maternity blues and were placed in the experimental group. The remaining 31.68% of mothers who did not suffer from maternity blues formed the control group. Mothers in both the groups were administered the Morsbach and Gordon's Maternity Blues Questionnaire (MBQ) (1984) to determine the intensity of maternity blues. The mothers in both the groups were re-examined seven to eight weeks later on Pitt's Questionnaire (1968) for puerperal depression. It was found that there was positive correlation between the scores of MBQ and the Pitt's Questionnaire for the experimental group only. It was also found that mothers in the experimental group had significantly higher scores for depression and were more likely to experience puerperal depression than the mothers in the control group. The importance of these results for identifying women who are at risk for developing depression are discussed.

'Maternity Blues' characterized by transitory depression in mothers generally occurs during the first week after childbirth (Ballinger, Buckley, Naylor, & Stanfield, 1979; Cox, Connor, & Kendell, 1982; Nott, Franklin, Armitage, & Gelder, 1976; Pitt, 1973). The maternity blues syndrome consist of sporadic, often unexplicable crying, sadness, fatigue, irritability, mild confusion, anxiety and insomnia. These symptoms last only for a short time and requires no psychiatric treatment (Yalom, Lundee, Moos, & Hamburg, 1968). For some women maternity

* The researcher is grateful to the students of Applied Psychology Department, Punjab University, Lahore, for assisting in data collection. Thanks are also due to the anonymous reviewers for helpful comments on an earlier version of this article.

blues symptoms come to a peak on fifth day postpartum and then decline gradually (Kendell, Rennie, Clarke, & Dean, 1981). In the case of others, these symptoms persist even after the mothers return home from the hospital. If left unchecked, symptoms of maternity blues may lead on to puerperal depression characterized by a state of prevailing despondency lasting a month or more (Pitt, 1973). While there are many factors that are associated with puerperal depression, literature seems to suggest that there is a possible link between maternity blues and puerperal depression in the first year following childbirth (Dalton, 1980; Morsbach & Gordon, 1984; Paykel, Emms, Fletcher, & Rassaby, 1980; Stein, 1980). The symptoms of puerperal depression are not very different from those of maternity blues, but they last longer and are very likely to effect the interaction between the mother and her infant. Women suffering from puerperal depression need medical or psychological help to alleviate these symptoms (Rees & Lutkins, 1971).

Most of the studies on the occurrence of maternity blues are based on Western cultures, hence their relevance for Pakistani women is not known. It is generally held that the phenomenon of maternity blues is universal (Davidson, 1972; Pitt, 1968). If that is so, it should be experienced by the Pakistani mothers also. However, the experience of pregnancy and child birth for the Pakistani women are known to be very different from the western women. First of all, there is the fundamental difference in medical philosophy; while child birth in the west is regarded a high risk activity which needs careful medical monitoring, childbirth in Pakistan is generally considered a natural phenomena, often characterized by irregular attendance of clinics, insufficient health care, home deliveries, avoidance of induction of labour and pain killers, resulting in high mortality among mothers and infants. Moreover, there is passive acceptance of child bearing, unplanned pregnancies and high incidence of multiparity among majority of Pakistani women (Anwar & Ijaz, 1985). These conditions can lead to altogether different experiences for Pakistani mothers compared to the Western mothers.

So far there is no published research available on maternity blues in Pakistani women. However, midwives and obstetricians do mention its occurrence in some mothers. Although the medical professionals are aware of this problem,

it has not been scientifically studied and the prevalence of maternity blues among Pakistani women is still not known. Neither is there any research available on the relationship between maternity blues and puerperal depression in Pakistani mothers. Thus the phenomena of maternity blues among Pakistani mothers calls for a detailed examination.

The study aims at (1) measuring the occurrence of maternity blues in Pakistani mothers; (2) determining the relationship between maternity blues and puerperal depression.

METHOD

Subjects

Two hundred and twenty-five mothers who had normal deliveries were approached during their stay in the maternity wards of four hospitals. These hospitals were randomly selected from the hospitals in the city of Lahore. Six mothers refused to take part in the study, five mothers expired, eight lost their babies and four were not available at the addresses given by them. Of the 202 remaining mothers, 72 were primigravidae, while 130 were multi-gravidae. The mean age of the mothers was 24 years. Our sample was restricted by the mothers present in the maternity wards at the time of the study. The demographic data of the sample are presented in table – 1.

Table 1
Demographic Characteristics of the Sample

Variable	Range	Sub-category	%
Age	18-34 years	Below 24 years	57
		24 Years & above	43
Education		Illiterate	28
		Primary	50
		Secondary	22
Income p.m.	Rs. 2000-3500	Below Rs. 2000/-	75
		Rs. 2000/- & above	25
Parity		Primiparous	36
		Multiparous	64

Instruments

Morsbach and Gordon's Maternity Blues Questionnaire (MBQ)(1984) was used to determine the intensity of maternity blues.

Pitt's Questionnaire (1968) was used to determine puerperal depression.

Procedure

The data were collected in three stages.

First Stage: Two or three days after delivery, the mothers participating in the study were interviewed. Demographic data were collected from them and the mothers were probed as to how they generally felt after childbirth. After this interview the mothers were categorized into two main groups: (1) the control group consisting of mothers who felt good, were happy or cheerful; (2) the experimental group included mothers who felt depressed, tense, irritable, worried and/or experienced episodes of crying.

Second Stage: The next day the mothers in both the control and experimental groups responded to Maternity Blues Questionnaire (Morsbach & Gordon, 1984). The questionnaire comprises of a list of eighteen blues-symptoms which are most commonly mentioned in the literature. Each symptom was rated on a three-point scale, i.e., whether the mothers had experienced it continuously (two), some times (one), or, never (zero), after the birth of the baby. Thus the maximum total score on the blues-symptoms a mother could obtain was 36 and a minimum of zero.

Third Stage: Seven to eight weeks after the delivery of the baby, the mothers were interviewed at home for the second time. To assess the occurrence of puerperal depression, the mothers' responses to a Urdu version of Pitt's Questionnaire were noted. This questionnaire consists of twenty-four items; the total score ranging between zero and forty-eight. The higher the score, the more it is interpreted as a sign of puerperal depression.

Regular procedure of translation and retranslation in Urdu was followed. Pitt's Questionnaire was selected because it claims good test-retest reliability and validity correlations and has been claimed to be successful in finding cases of puerperal depression (Pitt, 1968). Further, it allowed us to relate our data to Pitt's findings.

RESULTS

The results of the general mood of the mothers during the immediate postnatal period are summarized in table–2. As reported, 68.31 percent of mothers experienced maternity blues and were placed in the experimental group. On the other hand, 31.68 percent of mothers reported to have no symptoms of maternity blues and formed the control group. The means of these two groups on the MBQ are also shown in table–2.

Table 2

The percentages of mothers forming the experimental and control groups at the time of the first interview and their Means on MBQ

	f	$\bar{X}$	%
Experimental Group	138	19.89	68.31
Control Group	64	2.56	31.68

Table 3

Percentages of depressed mothers in the experimental and control group at the time of the second interview

	Depressed	Non-depressed
Experimental Group N= 138	20.29%	79.71%
Control Group N= 64	61.56%4	98.43%

The results of the second interview are presented in table– 3. As shown in table– 3, in the experimental group, 28 mothers, i.e., 20.29% of the mothers in the experimental group were suffering from depression at the time of the second interview. In the control group, one woman, i.e., 1.56% of the mothers in the control group complained of depression.

Table 4

Means, standard deviations, and t-test scores for the Experimental & Control groups on Pitt's scale

Experimental group			Control group		
N	$\bar{X}$	*SD*	*N*	$\bar{X}$	*SD*
138	9.17	6.01	64	6.09	3.21

t= 7.33 *p*<0.05

Table 5

Correlation between MBQ and Pitt's Questionnaire

Group	*r*	*p*
Experimental group	0.43	0.05
Control group	0.02	n.s.

The means and t-test results of the Pitt's Questionnaire for both the groups are presented in table– 4. The mean score for the experimental group was 9.17, whereas for the control group it was 3.21. Comparison between the means of the two groups using t-test showed significant difference ($t = 7.33$, $p < 0.05$).

In order to determine the relationship between maternity blues and puerperal depression for both the groups, product moment correlation was calculated. As shown in table– 5, the correlation coefficient for MBQ with Pitt's Questionnaire for the experimental group was significant ($r = 0.43$, $p < 0.05$), and for the control group it was not significant ($r = 0.02$).

DISCUSSION

The results of the present study establish high rate of maternity blues incidence (68.31%) among Pakistani women. The percentage of maternity blues observed in our Pakistani sample is comparable with the data on Western women. In the West, the maternity blues prevalence estimates range between 50% to 80% (Pitt, 1973; Robin, 1962; Yalom et al., 1968). Like the Western women, the maternity blues symptoms overshadow the immediate postnatal period of a majority of Pakistani women. Thus, it seems reasonable to consider such a transient mood disturbance as a normal concomitant of postpartum adjustment. Mothers experiencing maternity blues are troubled by worries, anxiety, tearfulness, irritability, insomnia, insecurity and tension. These women do not conform to the general picture of a happy mother who feels fulfilled after giving birth to a child and cheerfully cares for her baby. Their unpleasant experiences in this state are further aggravated by a particular set of socio-cultural factors, lack of medical facilities and above all, ignorance.

By comparison, the Western women are far more aware of the occurrence of maternity blues in postnatal period. Besides, the medical staff in the hospitals is generally more conscious of its presence and is trained to handle maternity blues symptoms among child bearing mothers. They are generally more supportive and show sympathy to the suffering mothers. At present, Pakistani women do not receive this kind of help. The maternity blues, though a transient disorder, is at any rate disturbing. The public in general, and obstetricians in particular, need to be made aware of its prevalence in mothers. Without adequate knowledge about the occurrence of maternity blues, the diagnosis and treatment of postpartum problems can be misdirected.

The results also reveal the nature of relationship between maternity blues and puerperal depression. For the experimental group, the correlation between MBQ and Pitt's Questionnaire administered six weeks after the delivery of the baby was $r = 0.43$. This correlation, though significant, is not all that striking, hence, one can conclude that though the relationship between maternity blues and puerperal depression is not "overwhelming", it is certainly too strong to be disregarded. We also found that women experiencing

maternity blues were more likely to develop puerperal depression than woman who did not experience maternity blues. 28 mothers (i..e., 20.29%) in the experimental group were depressed, while only one woman in the control group reported to be depressed. Similar evidence has been reported by earlier studies which report depressed and anxious mood to presage puerperal depression (Atkinson & Rickel, 1984; Cox et al., 1982; Paykel et al., 1980; Rees & Lutkins, 1971; Saks et al., 1985).

Cases of severe puerperal depression need medication and relief to the suffering mothers. Our sample included 28 women who needed psychiatric attention, although none of the mothers in our sample had received any special treatment at the time of the second interview. Most of them were shy of discussing their condition with others. They thought that no one could understand the suffering that they were going through and that no one could help. The implications of this continuing disability for the mother, the baby, and indeed the whole family could be serious. It is important that all workers in the obstetric field be made aware of the problems of maternity blues and puerperal depression so that early help can be provided to the suffering women.

CONCLUSION

To sum up, the present results have important implications for the identification of women who are at risk of developing depression after childbirth and for the diagnosis and treatment of puerperal depression. First, maternity blues are experienced by a considerable number of Pakistani women, and practitioners should be aware of this fact. Second, clinicians must be cognizant of the significant relationship between maternity blues and puerperal depression; women who experience maternity blues are at risk for puerperal depression. The occurrence of maternity blues may represent the onset of a clinical depression in a subgroup of women. However, additional research is needed to identify the women who are at risk and to clarify the etiology of the blues. To corroborate that it is a transient phenomenon distinct from a prexisting depression, or from an ongoing clinical depression, it will be worthwhile to study mothers more directly and intensively from an early stage in pregnancy. It is also

important to find out the relevance of place of delivery, constitution, personality, attitude and support at home and the sex of the child for the incidence of maternity blues and puerperal depression. The effects of such depression on the family, and the effectiveness of early treatment with psychotherapy and/or antidepressive drugs also need further investigations.

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