

Postpartum Depression in Working and Non-Working Women

Neha Gurudatt ⁺

School of Liberal Studies, Pandit Deendayal Petroleum University (PDPU)

Abstract. Objective: A comparative analysis on susceptibility of postpartum depression in working women and non-working women.

Postpartum depression (PPD), a type of depression that affects 9-16% of women around the world after conceiving a baby can develop within 4-6 weeks after giving birth, but can sometimes take several months to appear. According to the DSM-IV the symptoms of PPD are diminished interest/pleasure in activities, weight loss/gain, Insomnia /Hypersomnia, agitation, fatigue, sadness & anxiety. “Baby Blues” are often confused as PPD and vice-versa but there is a distinct difference amidst the two; Baby blues last maximum till a week whereas PPD lasts for a longer duration and usually the symptoms are more severe in nature. Some of the causal reasons of PPD are hormonal changes, depression in the family history, lack of support from family/friends, trouble in adapting to changes, stress while dealing with the child and poor health of the child. Treatment methods vary from joining social groups, consulting a psychologist, taking medication to therapies. This research attempts to analyze the susceptibility of PPD in working & non-working women as their duties and roles vary and also the environment in which they function is different due to which the stressors are different in working and non-working women.

Conclusion: Susceptibility for Postpartum Depression higher in Non-working Women in comparison with Working Women.

Value/Implementation: Policy Making, Psychological Well Being, Social Development

Keywords: Postpartum Depression, Working Women, Gender & Health

1. Introduction

The purpose of this study was to determine the susceptibility of postpartum depression affecting working and non-working women. Postpartum depression (PPD) is a non-psychotic depressive episode of mild to moderate severity, beginning in or extending into the first postnatal year.[1] Postpartum depression not only has a negative effect on mother-infant and marital relationship, but also causes depression in the husbands,[2] causes or aggravates marital problems, and even leads to separation or divorce.[3] A depressed mother cannot have a suitable emotional connection with her child, and this leads to negative impact on mother-infant relationship, and child’s cognitive development.[4] Statistics from large sample studies have placed postpartum depression at about 20–40% in mothers and a somewhat lower percentage in fathers [5]. The consequences of postnatal depression to the child, mother, and family may include neglect of the child, family breakdown, self harm, and suicide. However, the more common consequences include emotional and behavioral problems, and cognitive delay in the children of depressed mothers.[6], [7] The aim of the study was to understand the probability of postpartum depression affecting working-women and non-working women, so a sample of 80 women was chosen. And also, this study has taken place in a set geographical location, the sample was collected from Hospitals and Nursing Homes.

Inclusion criterions: Well being of the child, the mother’s previous health history & marital status

Exclusion criterions: Age, financial stability/ socio-economic factors and the sex of the infant

Hypothesis 1: Post Partum Depression affects non-working women

Hypothesis 2: Level of depression and the age of the infant have no relation

2. Methodology

Sample selection has been done through stratified sampling and the selected sample section included post-natal women who have recently delivered to who have infant the age of 1 year. The sample size was 80

⁺ Corresponding author. Tel.: +91 9586845844, +91 7925625990
E-mail address: nehagurudatt@gmail.com.

people (40 working and 40 non-working women). The scales used in the research are: *Edinburgh Postnatal Depression Scale (EPDS)*: The 10-item Edinburgh Postnatal Depression Scale (EPDS) is a valuable and efficient way of identifying patients at risk for “prenatal” depression. The EPDS is easy to administer and has proven to be an effective screening tool. [8] It consists of likert style answering system. The maximum score is 30 and possible depression can be suspected when the score is 10 or higher, wherein, 10-20 scores can indicate mild to moderate level of postnatal depression and 22 and above show high levels of postpartum depression. The overall reliability (Cronbach's alpha) of EPDS was 0.79. There was a significant correlation ($r^2=0.60$, P value <0.01) between EPDS and HDRS [9]. The validity level was satisfactory as well. (Developer: Cox, J.L., Holden, J.M., & Sagovsky, R.1987) [10]

Hamilton Depression Rating Scale (HAM-D): One of the most widely used scale to measure depression; It is a 17-item scale which consumes around 12-15 minutes per interview. The total score can be obtained by adding the score of each item, 0-4 (absent, mild, moderate, severe) or 0-2 (absent, slight /trivial, clearly present). The scores can range from 0-54 [11]. The inter-rater reliability for the total scores is 0.80-0.98 which is very high and test-retest reliability is as high as 0.81. The validity for this scale can range from 0.65 to 0.90. Scoring can be indicated by the following key, 0-6 indicates no presence of depression, scores ranging from 7-17 indicate mild depression and scores between 18 and 24 indicate moderate level of depression and scores above 24 shows high level of depression. Some of the parameters that the HAM-D scale measures are Suicidal impulses, agitation, insomnia and anxiety [12]. These 2 scales have been selected as HAM-D is a standardized, well-accepted scale universally and the EPDS scale has been one of the very frequently used scale regarding studies related to postnatal depression. Hence, by using these two scales the validity of the study increases.

Data Collection Method: 4 General and Women’s Hospital were selected and 5 Nursing Homes and clinics were selected. The data was collected from the post-natal delivery wards in the hospitals and nursing homes, also data was collected from the pediatric sections of the general and women’s hospitals and clinics where mothers frequently visit for the administration of vaccinations and other consultations. All the participants were briefed about the research and its objective and with their consent; the data collection process took place. The patient filled both the EPDS and the HAM-D scale and the whole process took 15-20 minutes per patient. It was seen to it, that the patient was relaxed and comfortable before taking the interview so as to eliminate errors. Also, the family members were asked to wait outside, so the patient could comfortably and truthfully fill the questionnaires.

Any kind of help that was necessary was given to facilitate the patient. After the collection of data, the patient was once again briefed about the purpose and usage of data and also regarding the confidentiality of the collected sample. Also the scales were converted to Hindi to facilitate better understanding for the subjects as the language would pose to be a barrier otherwise and also to reduce bias.

3. Results and Discussion

Age of Infant	Level of Depression in Mothers
0-2 months	33.95%
3-5 months	20.00%
6-8 months	14.88%
9 months & above	28.76%

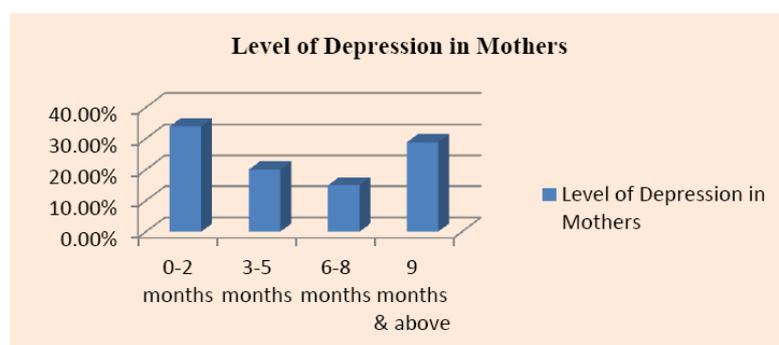


Fig. 1: Relationship between the age of the infants and the level of probable depression in mothers

The Highest level of susceptible depression is during the first 2 months of the baby’s birth. Preceding it is during when the baby is 9 months and above. [13]

During the initial years the infant is completely dependent on the mother for the fulfillment of all its basic & developmental needs and to nurture the infant; the physical, mental and psychological well being of the mother becomes extremely important. The postpartum depression levels peak due to the initial, unaccustomed stress of motherhood which might act as a trigger for depression. A study indicated that mothers with high postpartum depression scores were significantly more likely to discontinue breastfeeding at 4–16 weeks postpartum and were giving the infant water, juice or cereal during that time.[16] Similarly, another study indicated problematic sleep patterns such as: (1) parental disagreement regarding managing the infants’ sleep; (2) the infant sleeping in the parents’ room; (3) the mothers nursing the infants to sleep at the beginning of the night; and (4) the infants waking 7 nights per week.[17] Also, there is the initial discomfort of surgery (natural/caesarian) and sometimes the mothers suffer from body image issues. According to the research, the highest rate of depression in mothers are whose infants are 0-2 months old i.e., 33.95%. In a meta-analysis of studies on the early interactions of postpartum depressed mothers, the mothers who were depressed across their infants’ first 3 months of life were noted to be more irritable and hostile, to be less engaged, to exhibit less emotion and warmth and to have lower rates of play with their 3-month-old infants.[18] The next highest level of depression is during the infant’s 9th month or above, which indicates that in working women, this is the approximate time around which the mothers resume their respective jobs leading to multitasking between the domestic chores, the maintenance of the baby and handling the career; Similarly, for non-working women around this duration they resume their domestic work, handling the chores of the household and taking care of the baby, sparing no time for recreational activities.

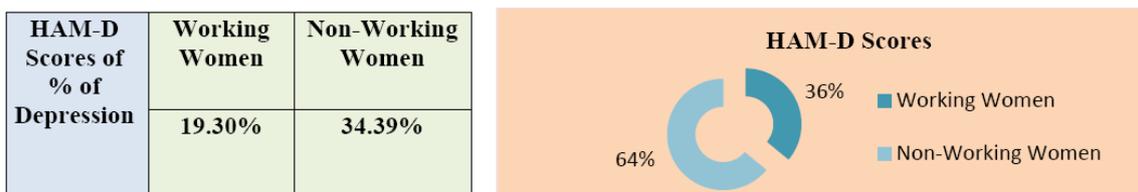


Fig. 2: Scores of the Hamilton depression Rating Scale (HAM-D) in working and non-working women

Again, in this table Non-working women have higher levels of depression when compared to working women.[14] We used the HAM-D as a gold standard of depression diagnosis in this study, because of its acceptability for this application.[19] Scores of the HAM-D rating scales depict a higher percentage of depression in non-working women. Almost 60% of non-working women have probable depression ranging from moderate to high. This level of depression in non-working women must have some common factors like lack of education & awareness, turbulent marital life and unavailability of a support system (friends, family etc). Many of the subjects reported a decreasing interest in work and other interests. In working and non-working women, family structure played an important role, according to some of the subject’s opinion; a joint family provided the necessary support system while some subjects confided that it was a causal factor regarding excessive stress and also strain on the financial status. 80% of the working women have a nuclear family and according to them the structure is very beneficial to them as there is less work, double income and more emotionally closer bonds as there is a lack of fear, another determining factor is that education, job satisfaction plays a crucial role in the study, this strata of people are more aware and open to accept psychological problems as needing professional care whereas the non-working women attach stereotypical value to psychological issues and tend to avoid seeking professional care even when necessary.

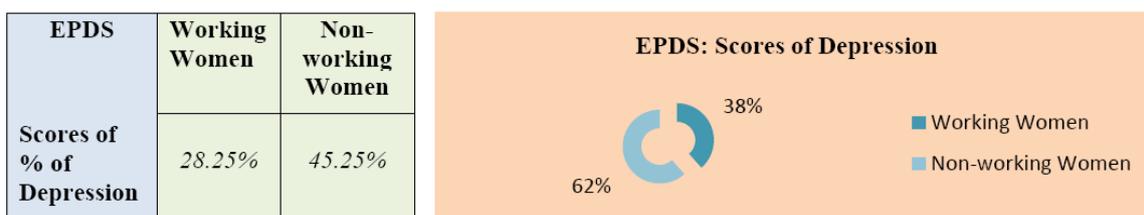


Fig. 3: Scores of the Edinburgh Postnatal Depression Scale (EPDS) between working and non-working women

This table depicts the percentage of depression of working women in comparison to non working women in the Edinburgh Postnatal Depression Rating Scale (EPDS), where the non-working women have 42.25% of depression compared to the working women who have 28.25% of depression.[15] Similarly in this scale too there is a higher level of depression in non-working women when compared to working women. There are lesser levels of depression in working mothers, this may point towards career being a boost to the mother and fulfilling her social needs as well, also working mothers have an alternative other than the routine domestic household work and also there is a feeling of mutual equality between the spouses leading to a more harmonious relationship and a lack of fear is present strengthening the bond between the partners. Even though stress levels are present for the working mothers as well, they are able to balance their work life and their personal lives in a better manner. The financial stability proves to be an important factor, more number of children and lesser income levels lead to an elevation in stress levels when compared to the working mothers where both the partners are earning and have a planned family.

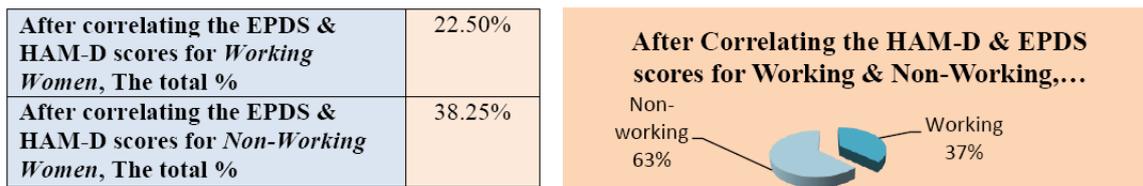


Fig. 4: Combined percentage of EPDS and HAM-D scores between working and non-working women

After combining the individual values between the EPDS scale and the HAM-D scale, the total percentage of depression Working Women was derived i.e., 22.5% and in Non-working Women 38.25%. The significant difference can indicate working mothers perceived less infant distress at separation, were less anxious about separation, and were less apprehensive about other care-givers. Career orientation and maternal satisfaction were related to beliefs about infant needs in both working and nonworking groups. [20]This study highlights the fact that participation in the social sphere, education, career, income needs, awareness these are some of the pivotal factors in decreasing the levels of depression in women. Postpartum depression's symptoms can be traced back to the time during the pregnancy, proper care, necessary rest and exercise becomes very essential in keeping negative thoughts and depression at bay. Constant support and motivation from spouse and family becomes very essential as the woman undergoes a myriad of hormonal, emotional, physical & psychological changes in her body and mind and help and care becomes a very necessary part. Also, for the well-being of the infant this becomes a crucial factor as the child too is affected when the mother suffers. The infant's developmental needs when not met, leads to slower development in cognitive abilities etc.

4. Conclusions

The study showed higher levels of Postpartum Depression in Non-Working Women (38.27%) in comparison to Working Women (22.5%). The study was conducted with the usage of two instruments, Hamilton Depression Rating Scale (HAM-D) and Edinburgh Postnatal Depression Scale (EPDS). The study also indicated towards a higher level of depression in the initial months after the delivery both in working and non-working women.

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6. References

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