Is the effect of postpartum depression on mother-infant bonding universal?

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ABSTRACT

Purpose: Although the negative consequences of maternal depression on infants has been documented in several Western societies, similar studies have not been conducted in Middle-Eastern countries where cultural norms and traditions may differ. The main objective of this study was to determine the risk factors for postpartum depression (PPD) and its relationship to mother–infant bonding in a Lebanese population.

Methods: One hundred and fifty participants were administered the Edinburgh Postpartum Depression Scale (EPDS), and the social support scale at 2–3 days postpartum. At 10–12 weeks mother–infant bonding using the Postpartum Bonding Questionnaire (PBQ) and depression using the Beck Inventory (BDI-II) were assessed during a telephone interview.

Results: The prevalence of depression was 19% with an average score of 10.9 ± 6.02 on the EPDS. At 10–12 weeks 2.7% of the whole sample was depressed with an average score of 18.60 ± 16.87 on the BDI-II. Risk factors of PPD on the EPDS were; history of alcohol use, complications during pregnancy, not a good marital relationship, baby admitted to an intensive care unit, history of depression and low social support. Risk factors for impaired bonding were age, history of depression, BDI-II scores above 20 and low social support. The multiple regression analysis found that impaired bonding was associated with older age, history of depression and low social support, which explained 39% of the variance, F = 7.12, p = 0.02.

Conclusion: The prevalence of PPD was higher than previously reported at day 2–3 post-delivery, but lower at 10–12 weeks postpartum. Impaired mother-infant bonding was associated older mothers, history of depression, low social support and BDI-II scores above 20 which should alert practitioner to assessing these factors in post-partum mothers.

1. Introduction

The effect of maternal depression on infants has been documented for decades in several studies mostly in the Western world (Beeghly et al., 2017; Closa-Monasterolo et al., 2017; Dubber, Reck, Müller, & Gawlik, 2015). Depressed mothers have a difficult time adjusting to motherhood, are less sensitive to their infant cues, resulting in less than optimal attachment to their infants (Miklush & Connelly, 2013; Tietz, Zietlow, & Reck, 2014). Even mild depressive symptoms in the postpartum period can influence mother-infant attachment and child development (Behrendt et al., 2016; Deave, Heron, Evans, & Emond, 2008; Nieto, Lara, & Navarrete, 2017). A negative mother-infant relationship in the early years of the infant’s life has long lasting negative consequences emotionally, socially and cognitively (Abdollahi, Etemadinezhad, & Lye, 2016; Choi, Sikkema, Vythilingum, Geerts, & Watt, 2017; Kerstis et al., 2016).

Abbreviations: CI, confidence interval; EPDS, Edinburgh Postnatal Depression Scale; BDI-II, Beck depression scale; OR, odds ratio; PBQ, postpartum bonding questionnaire; PPD, postpartum depression

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One of the objectives of the Healthy People 2020 is to decrease the number of women who experience postpartum depression (PPD) after delivery. Although some countries have reported a decline in the prevalence of PPD in the past decade (Ko, Rockhill, Tong, Morrow, & Farr, 2017), similar declines have not be universal. Prevalence of PPD varies across and within countries from 0 to 15% in some high income countries to 10–60% in low income countries (Gelaye, Rondon, Araya, & Williams, 2016). Unfortunately, few mothers are diagnosed which may lead to chronic depression and a disturbed mother infant relationship. This is especially true for developing countries where mental health remains a stigma and is not covered by most insurance programs or governmental agencies (Gearing et al., 2015). In the Middle East, Chaaya et al. (2002) found a PPD prevalence of 21.3% among 396 Lebanese women while a recent study from Jordan reported a prevalence of 25% in 315 women (Safadi, Abushaikha, & Ahmad, 2016) and in Qatar the prevalence was 17.6% in 1379 women (Burgut, Bener, Ghuloum, & Sheikh, 2013)

The detection of PPD and its effect on the mother infant relationship may differ among cultures and is of paramount importance to clinicians in order to provide the necessary referrals and sensitive interventions. Factors noted in previous studies to influence PPD and the mother-infant relationship were assessed in this study and included: age, parity, education, type of delivery, complications during pregnancy, happy with pregnancy, infant’s gender, social support, history of alcohol use and depression and having a sick newborn (Dennis & Ross, 2006; Dubber et al., 2015; Ko et al., 2017).

The main objective of this study was to investigate whether postpartum depression has an effect on mother-infant bonding at 10–12 weeks after delivery. The secondary objectives were to assess the effect of potential confounders; age, parity, education, type of delivery, pregnancy complications marital relationship, happy about pregnancy, gender of baby, desired gender, presence of support systems, mother’s history of alcohol use and depression and infant’s admission to the Neonatal Intensive Care Unit (NICU) on PPD and mother-infant bonding. The results may provide information for the development of effective, culturally relevant psychosocial interventions that promote a healthy mother-infant relationship. The research questions were:

1) What is the prevalence of PPD in women delivering at a university hospital in Lebanon?
2) What are the risk factors for developing PPD?
3) What are the associations between the confounding variables, the EPDS, BDI-II scores and mother infant bonding?
4) What are the best predictors for mother infant bonding?

2. Methods & materials

2.1. Design

A prospective longitudinal study using surveys was used with data collected between July 1, 2014 to June 30, 2016.

2.2. Setting

The study was conducted at a tertiary referral 420 bed University Medical Center in Lebanon, a small middle-income country on the Eastern Mediterranean, with an estimated population of 4 million people (Hajj et al., 2015). The hospital provides all kinds of medical, surgical and specialized services to the people of Lebanon and the region with around 30,000 patients a year (Hajj et al., 2015). It is JCI and ACGME-I accredited and Magnet designated. The obstetric unit where the participants were recruited has 24 beds, with around 100 deliveries a month. Outpatient and inpatient management of mental illness is mostly not covered by Ministry of Health or by private insurance companies (Chahine & Chemali, 2010).

2.3. Sample

A convenience sample of 150 women between the ages of 18 and 45 were recruited. Sample size was determined based on a previous study with a prevalence of 21.3% (Chaaya, El Kak, Shaar, & Harb, 2002) a power of 80%, and a 0.05 significance. All women who had recently delivered, were between the ages of 18–45 years, had a live birth during the study period and were willing to participate. Women were excluded if they had severe chronic illnesses such as epilepsy, COPD, Hepatitis C or cancer. From the 200 women approached, 150 (75%) agreed to participate. At 10–12 weeks after delivery, 125 (83%) women were contacted, an attrition rate of 17%. Of the 29 depressed women after delivery, we were able to contact 25, an attrition rate of 9%. Attrition was due to incorrect phone numbers or moving out of the country.

2.4. Instruments

Two instruments were used to assess depression, the Edinburgh Postnatal Depression Scale (EPDS) and the Beck Depression Inventory-II (BDI-II). Although both instruments are highly correlated and accurate in diagnosing PPD, the EPDS has been used mostly in the early post-partum period. Thus, we opted to use the BDI-II at 10–12 weeks which corresponds to the criteria for DSM-IV depressive diagnoses and more likely to be accepted by our psychiatrists for referral (Chaudron et al., 2010; Moraes, Lorenzo, Pontes, Montenegro, & Cantilino, 2017; Sit, & Wisner, 2009)

The Edinburgh Postnatal Depression Scale (EPDS) was used to assess maternal depression. The EPDS is the most commonly used instrument to assess PPD, it is written at a fourth-grade reading level, can be completed in 5–7 min with ten items ranging from zero (no symptom) to three (severe symptoms), with a final score from 0 to 30 points (Cox, Holden, & Sagovsky, 1987; Dennis & Ross,
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