



The relationship of postpartum negative affects with marital satisfaction in parents referred to healthcare centers

Amin Asghari¹, Sara Shirdelzade², Masoumeh Saadati^{3*}, Alireza Ghodsi⁴,
Raziyeh Bayat⁵, Elahe Ramezanzadeh Tabrize⁶ and Batoul Alizadeh⁶

¹Student of Nursing, Students Research Committee, Neyshabur University of Medical Sciences, Neyshabur, Iran

²Msc of Pediatric Nursing, Department of Nursing, Neyshabur University of Medical Sciences, Neyshabur, Iran

³Msc. Nursing, Department of Operation room, Neyshabur University of Medical Sciences, Neyshabur, Iran

⁴Phd, Department of Statistics, Hakim Sabzevari University, Sabzevar, Iran

⁵Nursing, CCU ward, 22 Bahman Hospital, Neyshabur, Iran

⁶Msc. Nursing, Department of Nursing, Neyshabur University of Medical Sciences, Neyshabur, Iran

Corresponding Email: saadati.ms nursing@gmail.com

ABSTRACT

Sexual satisfaction is a key factor in strengthening and preserving marriage. This study aimed to investigate the relationship between negative emotions and sexual satisfaction in couples is done. This study was a correlation-analytic study. That 189 couples were referred to health centers of neyshbure & eligible were participated. Data by Inrich Sexual satisfaction questionnaire , DASS questionnaire was collected.

INTRODUCTION

Pregnancy, delivery, and coping with newborn may be the most sensitive stage of a woman's growth. A physiological, emotional, and spiritual crisis is taken place in this time which results in disorientation and individuality change (Ehati shafie,2009). Postpartum period is an important time for parents. In most of women anxiety, stress, and negative thoughts increase (Akbarzadeh,2009). Child birth, in many women, is a stressor which is the initiative stimulus for depression disorders (Rahmani.2011).postpartum psychological disorders divided into grief, depression and psychosis (Fatemeh,2011).postpartum depression signs include depressive mood, sleep disorder, anxiety, lack of interest, guilty feelings, suicide thoughts, disappointment, hopelessness, lack of appetite, eroticism decrease, irritability (Cornish,2005). Although, approximately half of women with postpartum depression dismiss; the reported incidence of it, in studies, is 10-20% and 25-39% in Iran (Davies2003, Verkerk2004). Mothers' depression begins in 3rd trimester and may be continuing one year after birth (Gjerdingen2007, shahmiri2007). Postpartum depression affects the quality of mother-child relationship and hurt the child's cognitional development; also this can effect on the partners relationship and partners depressed, too (Josefsson2005, Cox2005). Men's depression due to becoming a father begins days to weeks after child birth and may be continue to one year. Studies have shown 10% of new fathers experience postpartum depression, and American fathers with 14.1% are the most depressive ones. The most experienced depression occurs in 3-4 months after childbirth in men and women(eshtianer 2005). Beck illustrated 13 risk factors for postpartum depression including: depression history before pregnancy, newborn care stress, life tensions, social; support, marital relationship, past history of depression, newborn mood, maternal grief, socioeconomic status of mother, parents' anxiety, self-esteem, marital satisfaction, and unplanned pregnancy (Beach1992). Postpartum depressions can effects on marital satisfaction very much (ahmadi2011, Josefsson2002). Marital inconsistency in 50% of depressed women and depression in 50% of women with marital inconsistency is seen (Beach1992). Studies have revealed persons with appropriate marital satisfaction have healthy ad proper nutrition, and less develops depression and other psychological problems (vagheiy2010). Cornelia et al (2005) had shown marital satisfaction has a significant relationship with postpartum depression (Cornelia 2005). Greef defines marital satisfaction as coping partner are those having many agreements with each other, satisfied with the type and level of their relations, satisfied with the

type and quality of leisure times, and have good management of their financial and time (Greef2000). According to mutual effect of psychological disorders such as postpartum depression, anxiety, and stress on marital satisfaction and the noticeable role of them in family's psychological health and consequently child's development and personality, measuring these disorders in parents, and giving supportive and consultation service to them in this period can have considerable role in children's appropriate social personality formation. Therefore, this study was designed to assess the postpartum negative affects (depression, anxiety and stress) and its relationship with satisfaction of parents referring to Neyshabur's healthcare centers.

MATERIALS AND METHODS

This is a cross-sectional (descriptive-analytical) study; statistical population consisted of all parents referring to 9 healthcare centers of Neyshabur, 4 of these centers were selected by random sampling and then 189 referring couples who had inclusion criteria were entered based on purposive sampling. Inclusion criteria were: having 3-6 months old baby, both parents participation, no assisted reproductive technique were used, not having a disable child, interested to participation and no history of psychological disorder. Data were gathered by demographic, 47-items ENRICH marital satisfaction, and DASS questionnaires. All participants fulfilled study's questionnaires in one session. Demographic questionnaire assessed variables like age, gender, education, residence place (city or village), delivery type, child's gender, and etc. ENRICH scale (Enriching and Nurturing Relationship Issues, Communicating and Happiness) consisted of 47 questions in 9 subscales including: personality compatibility, communication, conflict resolution, financial management, leisure time activities, sexual relationship, parenting, relationship with friends and relatives, and religious orientation; each questions was 5 items scored from zero to four. This is a reliable and validate questionnaire. The reliability and validity of scale were measured by Vaghei et al (2010). Alpha Cronbach's coefficient was calculated 0.92. DASS questionnaire (Depression Anxiety Stress Scale) have 3 subscale of depression, anxiety and stress evaluation which their 4 items questions scored from zero to three. This is also a reliable and validate scale. The reliability and validity were measured by Naebinia et al (2011)(20).Data were analyzed by SPSS 16 by descriptive (frequency, mean, SD) and analytical tests (ANOVA, Pearson correlation, chi-square, Mann-Whitney-U, Fisher's exact test, Kolmogrov-Smirnov, paired t-test, and independent t-test).

RESULTS

Most of male participants were educated less than diploma (43.4%), and female participants had diploma (47.1%). The mean ages of women were 26.68 ± 5.51 and men were 31.07 ± 6.85 years old and their marriage duration was 7.24 ± 4.51 years. Other demographic data are shown in table 1.

Evaluation of main variables, depression, anxiety, stress, and marital satisfaction, revealed most of women hadn't depression (65.6%), and their anxiety and stress were in normal level (61.4%, and 67.2%, respectively). Also, most of their partners' depression (78.3%), anxiety (69.8%), and stress (78.8%) were in normal or mild levels. The most observed marital satisfaction in women and men was moderate (61.4% and 63.5%, respectively)(table 2).

Pearson correlation showed there is negative significant relationship between marital satisfaction and depression, anxiety, and stress of men and women ($p < 0.05$); it means increase in level of depression, anxiety, and stress cause decrease in marital satisfaction. Also, there is positive significant correlation between women's and their partners' depression, anxiety, and stress ($p < 0.001$, $r = 0.341$); the more women's depression, anxiety, and stress level, the more men's ones (table 3).

Positive significant relationship was found between women and men marital satisfaction by Pearson correlation ($p < 0.001$, $r = 0.964$). For analyzing main variable relationships with other variables, different tests were used. Kruskal-Wallis test found significant difference in level of women depression and anxiety by their education, women anxiety by their partners' education, and men anxiety by their education ($p < 0.05$). One way ANOVA showed men marital satisfaction level differs by their education ($p < 0.041$) and Dunken's post hoc test specifies the difference is between diploma and under diploma groups with others(table 4).

Independent t-test showed stress in women having son ($p < 0.04$) and abortion history ($p < 0.024$) is higher than others. There was no significant relationship between the main variables and other variables such as marriage duration, intercourse frequency, delivery type, and etc.

DISCUSSION

Results showed depression incidence was 34.4% in women and 21.7% in men. But other studies reported less. Veskma et al had shown postpartum depression incidence 10% in women and 4% in men. Also, teng et al reported

10.3% and other studies had a 10-20% range (Tannous 2006, Moraes 2006). This difference is due to the effect of social, cultural, and racial factors on depression. One of most effective factors in our study was the low level of perceived perinatal socialsupport.

Another important effective factor on depression is education; with increased level of education, the depression levels decrease. A recent study in 17 states of US (CDC 2008) and a study by Chaaya et al (2002) also confirmed this. Increased education results in more men and women awareness of each other rights and needs, elevation of mutual understanding and collaboration and may be more family income, which all play roles in forming a family's healthy atmosphere.

Marital satisfaction in our study was moderate; but another study in Iran by Bakhshayesh et al (2011) had reported it low, that might be due to different culture and lifestyle in different parts of Iran.

Also, results showed there is negative correlation between women and men negative affects and marital satisfaction, which is consistent with previous studies (Kaplan2003,Clisson 2004, Twenge 2003).

Figueiredo et al (2010) showed depression and anxiety of women effect more on quality of mutual relationship rather than men; the men relationship score in their study hadn't differed as a function of their anxiety or depression .

Postpartum anxiety and depression can also effect on child-parent developmental activities (Paulson). Britton et al (2011) had shown positive significant relationship between postpartum anxiety and depression and infant mobility, temperament, adaptability, and sensibility .

Other effective factors on negative affects we found were abortion history, and child's gender. Joseffson et al also had shown significant relationship between abortion history and postpartum depression; it seems mothers with abortion history had more failure feeling, disappointment, and incompetence. Lee et al had reported significant relationship with the child's gender and postpartum depression which is consistent with our findings.

Table1: Demographic information of couple participation in research

Variables	Frequency		Percent		Cumulative Percent	
	Men	Women	Men	Women	Men	Women
Education						
illiterate	13	5	6.9	2.6	6.9	2.7
High school	69	53	36.5	28.0	43.4	30.9
Diploma	66	89	34.9	47.1	78.3	78.2
Bachlare	17	15	9.0	7.9	87.3	86.2
master	24	26	12.7	14.3	100.0	100.0
Participations age	Frequency	Minimum	Maximum	Mean	Std. Deviation	
Men	189	16	43	26.68	5.519	
Women	189	19	75	31.07	6.857	
Years of marriage	186	1	25	7.24	4.519	
Living place	Frequency	Percent		Cumulative Percent		
City	176	93.1		93.1		
village	13	6.9		100.0		
Abortion						
Yes	30	15.9		15.9		
no	159	84.1		100.0		
Wanted pregnancy						
Want	147	77.8		83.1		
Don't want	30	15.9		100.0		
Sex fetal						
Boy	108	57.1		57.4		
girl	80	42.3		100.0		
Type of childbirth						
Natural	98	51.9		52.1		
cesarean	90	47.6		100.0		

Table 2: Mean main variables(depression, anxiety, stress, and marital satisfaction) in women and MEN

Variables	N	Minimum	Maximum	Mean	Std. Deviation
	Statistic	Statistic	Statistic	Statistic	Statistic
Depression in women	189	.00	38.00	8.0756	8.12233
Anxiety in women	189	.00	34.00	8.2758	7.25114
Stress women	189	.00	37.00	11.8818	8.70588
Depression in men	189	.00	39.00	5.7720	7.62589
Anxiety in men	189	.00	39.00	6.5518	6.98214
Stress men	189	.00	42.00	9.1891	8.30680
Marital Satisfaction in women	189	113.00	230.00	170.64	25.45209
Marital Satisfaction in men	189	109.99	235.00	177.59	26.04551
Valid N (listwise)	189				

Table 3: correlation between women’s and their partners’ depression, anxiety, and stress

Paired Samples T –Test

pairs	t	df	Sig. (2-tailed)
Depression in men-in women	3.526	188	0.001
Anxiety in men-in women	3.021	188	0.003
stresse in men-in women	3.769	188	0.000

Table 4: correlation between men’s educational. With main variables

Chi-Square Tests						
Education men	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)	Point Probability
High school	3.036	2	0.219	0.262		
Likelihood Ratio	4.911	2	0.086	0.135		
Fisher's Exact Test	2.920			0.241		
Linear-by-Linear Association	2.336	1	0.124	0.156	0.095	0.059
N of Valid Cases	82					
Diploma	19.491	2	0.000	0.000		
Likelihood Ratio	21.197	2	0.000	0.000		
Fisher's Exact Test	18.222			0.000		
Linear-by-Linear Association	17.441	1	0.000	0.000	0.000	0.000
N of Valid Cases	66					
Graduated in university	22.216	2	0.000	0.000		
Likelihood Ratio	18.481	2	0.000	0.000		
Fisher's Exact Test	15.742			0.000		
Linear-by-Linear Association	41.606	1	0.000	0.000	0.000	0.000
N of Valid Cases	41					

- a. 2 cells (33.3%) have expected count less than 5. The minimum expected count is 1.95.
- b. The standardized statistic is -1.537.
- c. 2 cells (33.3%) have expected count less than 5. The minimum expected count is 3.27.
- d. The standardized statistic is -4.176.
- e. 4 cells (66.7%) have expected count less than 5. The minimum expected count is 1.02.
- f. The standardized statistic is -3.822.

CONCLUSION

According to our results and previous studies, poor marital relationship and insufficient perceived support from each other is one of important risk factor in inducing postpartum depression (Bjerke 2008, Anna 2008). Due to the effects of postpartum depression on mothers and whole family, it is important to determine its risk factors and high risk women and use prenatal and postnatal interventions to prevent this disorder and consequently improve psychological health of mother, children and society.

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REFERENCES

- [1] Ahmadi Z, MolaieYarandi E, Malekzadegan A, Hosseini AF. Sexual Satisfaction and its Related Factors in Primigravidas. *Iran Journal of Nursing*. 2011; 24 (71) :54-62
- [2] Akbarzadeh M, Sharif F, Zare N, Ghodrati F. Prevalence of Symptoms Post-Partum Anxiety and Baby Blues and Factors Effective Upon it in Women With High Risk Pregnancies. *Journal of Family Research*. 2009.5(17):57-71
- [3] Ana MPF, Claudio ES, Claudia GP, Gauldadela M, Tamara HO, Claudia PH. Prevalence and risk factors associated with postpartum depression in puerperal women consulting in primary care, *RevistaMedica De Chile*. 2008;136(1):44-52
- [4] Bakhshayesh A, Mortazavi M, The relationship between sexual satisfaction, general health and marital satisfaction in couples. *Journal of applied Psychology*. 2011; 4(12): 73-85.
- [5] Beach, S. H., & O'Leary, K. D. Treating depression in context of marital discord: Outcome and predictor of response for marital therapy vs. cognitive therapy. *Behavior Therapy*.(1992), 23, 507-528.
- [6] Bjerke SEY, Vangen S, Nord hagen R, Yeterdahi T, Magnus P, Stray-pedersen B. Postpartum depression among pakistani women in norway: Prevalence and risk factors. *Maternal-fetal and neonatal medicine*. 2008; 21(12): 889-94
- [7] Britton JR. Infant temperament and maternal anxiety and depressed mood in the early postpartum period. *Women & Health*. 2011;51(1):5.71-5
- [8] Chaaya M, Campbell OM, Elkak F, Shaar D, Harb H, Kaddour A. Postpartum depression: prevalence and determinants in labanon. *Arch Women Health*. 2002; 5(2): 65-72
- [9] Centers for disease control and prevention. Prevalence of self reported post partum depressive syndrome- 17 state, 2004-2005. *MMWR Morbidity and mortality weekly report*. 2008; 57(14): 361-366
- [10] Clisson C, Melton SC, Roggow L. The effect of separation on marital satisfaction, depression and self esteem. *J SocServ Res*. 2004; 4(1): 21-8
- [11] Cornish AM, McMhon CA, Ungerer JA, Barnett B, Kowalenko N, Tennant C. Postnatal depression and infant cognitive and motor development in the second postnatal year: the impact of depression chronicity and infant gender. *Infant Behavdev* 2005;28(4):4077.
- [12] Cornelia y. Chee, Dominic T.S. Lee, YS. Chong, L.K. Tan, T. P. Ng, Calvin S.L. Fontes. "Confinement and other psychosocial factors in perinatal depression: A transcultural study in Singapore". *J Affective Disorders* 2005 Dec; 89 (1-3): 157-66