The Nature And Associates Of "Maternity Blues" In An Egyptian Culture

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ABSTRACT

This work was conducted on 94 delivered women in the General Hospital of Ismailia in Egypt during January (1987). All delivered women included in this study were interviewed at their homes on the 4th day and the 15th day of puerperium.The results revealed that most of them were illiterate. 36 had experienced the "maternity blues"(38.3%), the remaining 58 delivered women (61.7%) were considered as controls.We found highly statistical significant difference between the "blues" and "non blues" groups as regard the somatic symptoms, depression, phobia and anxiety at P<0.05, and statistically significant differences between both groups regarding premenstrual tension syndrome, pregnancy worsening the mother's figure and mother health problems at P<.05. On the other hand, there were no differences between the two studied groups regarding the biological changes, newborn wanting, obsession and hysterical traits.

INTRODUCTION

"The maternity blues" is an American term which has been widely adopted and the appellation "maternity blues" was accepted by Stein (1980)who reviewed the condition (Snaith, 1983). The word"blues" is also an American expression used as the meaning of "not O.K", "not in the mood", "psychologically tired" or "psychologically not feeling well".

Maternity blues disorder, illness or syndrome (Brudenell and Wilds, 1984) is a dysphoric mood state (Snaith, 1983 and Brudenell and Wilds, 1984) occurring between the third and the tenth days and up to two weeks after

delivery (Harris,1981). It often commences abruptly (Snaith, 1983) on the third, fourth (Brandon, 1982 and Robinson and Stewart, 1986) or fifth day (Snaith, 1983 and Kendell, 1985), is too ephemeral (Kendell, 1985), characterized by tearfulness and mild depression (Pill, 1973 Paykel et al,1980, Stein, 1980, Yalom et al.,1968 and Trethowan and Sims, 1983) of unknown etiology (Stein, 1980). Maternity blues is highly significantly correlated to anxiety (Harris, 1980, Harris, 1981 and Stein, 1980) and somatization symptoms (Harris, 1980 and Harris, 1981). A weak but significant correlation was found with hysteria (Haris, 1980 and Harris,1981) , phobic (Harris, 1981) and depressive symptoms (Harris, 1986, Harris, 1981 and Stein, 1980). There is a correlation with emotional distress during pregnancy (Carnes, 1983), marital problems (Paybel et al., 1980), previous history of psychiatric disorder (Harris, 1980 and Stein, 1980). There is seasonal variation; blues increases in winter (Snaith, 1983). Maternity blues was also correlated with hormonal disturbances as low tryptophan level in plasma (Harris, 1980, Stein et al., 1981 and Yalon et al., 1968), raised plasma cortisol in late pregnancy (Handley et al., 1986 and Robinson and Stewart, 1986). Menstrual irregularities, premenstrual tension syndrome, level of sex hormones, high parity and weeping third trimester of pregnancy were found to be correlated by some investigators (Robinson and Stewart, 1986, and Carues, 1983 and many others).

Maternity blues may be presented with depression (Metz et al., 1983). This usually occurs as acute bouts which last one or two days; at the most between fourth and sixth days postpartum.

Transient negative feelings towards the new-born baby are not uncommon as well as towards the husband , but their cause is unclear (Stein et al., 1981).Crying, weeping or tearfulness occurs in 66.6% of women in blues after delivery (Metz et al., 1983). Elation shows the converse pattern to depression on the first day, in 80% of the women (Stein et al., 1981). Irritability was frequently met with in maternity blues (Metz et al., 1983). Anxiety occurs in 51% of women in blues after delivery (Robinson and Stewart, 1986).Confusion was met with in 20% of women in blues (Metz, 1983). Insomnia occurs in 70% of women in blues after delivery (Robinson

and Stewart, 1986). Headache occurs in 23% to 30% of women in blues reaching the peak at 4^{th} and 6^{th} days post partum and also dreaming, (Stein et al., 1981), emotional lability (Snaith, 1983), restlessness (Yalon et al., 1968). Anorexia, thirst, ankle edema, breast changes and body weight changes (Stein et al., 1981) may occur in women with blues.

Maternity blues should not be confused with atypical or neurotic form of depression occurring after delivery in 7 to 10% of mothers which lasts for weeks or months (Pill, 1973 and Handley et al., 1981) . It is not a low level depression but it is an emotional lability (Macy, 1983). But still there is uncertainty about the differences between the phenomena seen in the blues and prodromata of post partum psychosis (Brudenell and Wilds, 1984) . The aim of this study is to determine the psychiatric nature of such a syndrome as well as the possible associates of such a disorder, in a sample from a state hospital.

SUBJECTS AND METHOD

Ninety - four women delivering a living child in the General Hospital of Ismailia during the month of January (1987) were included in this study and divided into two groups:

1. The first group comprised 36 women with blues taken as the "blues sample".
2. The second group comprised 58 women not in blues who were taken as a control.

Both groups were matched as regards age, marital status, duration of marriage, education and socio-economic standard. Both groups were subjected to the following:

1 .Psychiatric interview to collect the data through the classical sheet, as well as modified rating scale of Moos for diagnosis of premenstrual tension syndrome. Each symptom was rated for presence and severity, we considered (0) as absence of the symptom,(1) as a mild symptom,(2) as a moderate symptom and (3) as a severe symptom. Diagnosis of premenstrual tension syndrome was given for those who scored one moderate mental symptom (2) and one moderate physical symptom (2) (Gain and Hudson, 1973).

2. Middlesex Hospital Questionnaire; the sum of 9 scores or more on each scale was considered to be diagnostic for morbidity (Crown and Crisp, 1966).
3. Each member of both groups was interviewed at her own home, if she was discharged on the 4th and 15 th day of puerperium, using Stein questionnaire to diagnose maternity blues.
4. The scores were calculated as follows; we took the scores of mother response and this was consensually validated whenever necessary by some member of the family living with her. We added the scores of each symptom together. The sum of 8 or more was considered to be the diagnostic level for maternity blues (Stein, 1980). All data were analysed calculating rate of maternity blues and correlating factors related to its occurrence.

RESULTS :

Table (1) showing the incidence of maternity blues among all woman who delivered in January 1987.

Item Mothers	Number	Percent
Maternity blues	36	38.3%
Maternity non blues	58	61.7%
Total	64	100%

From table (1) we can see that 36 out of 94 women who delivered manifested the blues with a percentage of 38.3.

Table (2) showing the rate of maternity blues in 94 women who were interviewed after delivery on day (4) and day (15) using Stein questionnaire (1980). The 94 women are taken from General Hospital of Ismalia.

Delivered women Day	Maternity blues in 28 Primigravida		Maternity blues in 66 Multigravida		Maternity blues in Both of them			
	No	%	No	%	No	%	t	P
4 th	8	28.5	23	35	31	33	± 1.33	>0.1
15th	4	14	14	21	18	19	± 1.12	>0.1
4th or 15 th	11	39	25	38	36	38		
4th + still in 15th	1	3.5	12	18	13	14	±2.94	<0.01*

* P<0.01 significant

From Table (2) we can see that the highest rate of maternity blues in both primigravida and multigravida occurred in the 4th or 15th day, 38% followed by the 4th day, 33% - the rate of maternity blues in primigravida is near that of multigravida in the 4th day as well as the 4th or 5th days.(28.5%,35%) repectively in the 4th and (39%, 38%) respectively in the 4th and 15th days.While they differ from each other in manifesting the blues in the 15th day and 4th day and still 15th (14%,21%) in respectively in the first and (3.5%,18%) in the second.

Table (3) showing the age distribution of both the maternity blues group and the non blues group.

Age Mothers	15 - 20 No	%	21 - 25 No	%	26 - 30 No	%	31 - 35 No	%	36 - 40 No	%	Total
Mothers in blues	5	13.8	15	41.6	9	25	3	8.3	4	11.11	36
Mothers not in blues	6	10.3	24	41.3	9	15.5	16	27.5	3	5.17	58

t 0.285 N.S.

Table (4) The marital status in both groups the blues and non blues

Blues	Married	Not Married	Total
Blues	36	0	36
Total	58	0	58
Total	94	0	94

$X^2 = 0$ N.S.

Table (5) showing the duration (years of marriage) in both the blues and non blues maternity.

Mothers	1 - 5	6 - 10y	11 - 5y	16 - 20y	21 - 25y	Total
Blues	21		10	1	3	1	36
Non blues	30		14	10	4	0	58

t = 0.586 N.S.

ıble (6) showing the education level of blues group and non ılues.

Mothers	University Degree No	%	Educated No	%	Illiterate No	%	Total
Blues	1	2.8	9	25	26	72.2	36
Non blues	3	5.2	24	41.4	31	53.4	58
Total	4	4.3	33	35.1	57	60.6	94

$X^2 = 3.29$ N.S.

Table (7) showing the Anxiety Scale of Middlesex Hospital Questionnaire in both the Blues and Non Blues Mothers.(Morbidity Scale started from 9 - 16).

Mothers	Blues	Non blues	Total	x^2	1
0 - 8	18	46	64		
9 - 16	18	12	30		8.79 P<0.005
Total	36	58	94		

* P<0.005 highly significant

From table (7) we can see that blues mothers showed significant difference on anxiety scale at P<0.005 than the non blues mothers.

Table (8): showing the phobia scale of (M.H.Q.) in both th blues and non blues mothers.

Mothers	Blues	Non blues	Total	x^2	
0 - 8	17	45	62		
9 - 16	19	13	32	9.12	P<0.005*
Total	36	58	94		

* P<0.005 highly significant

Table (8) showed that there is a statistical difference between the blues and non blues mothers on phobia scales at P<0.005.

Table (9) showing the obsession scale of (M.H.Q.) in both the blues and non blues mothers.

Mothers	Blues	Non blues	Total
0 - 8	12	27	39
9 - 16	24	31	55
Total	36	58	94

From Table (9) we can see that blues mothers did not differ from the non blues mothers on obsession scale. The results between both were non significant.

Table (10): showing the Somatic scale of (M.H.Q.) in both the blues and non blues mothers

Mothers	Blues	Non blues	Total	x^2	P
0 - 8	13	42	55		
9 - 16	23	16	39	12.06	P<0.005*
Total	36	58	94		

P<0.005 highly significant

From table (10) we can see that the difference between the blues and non blues mothers on somatic scale in highly statistically significant.

Table (11): showing the depression scale of (M.H.Q.) in both the blues and non blues

Mothers	Blues	Non blues	Total	x^2	1
0 - 8	14	44	58		
9 - 16	22	14	36	12.86	P<0.005*
Total	36	58	94		

P<0.005 highly significant

From table (11) we can see that the difference between both groups (the blues and non blues) on depression scale is statistically significant at P<0.001.

Table (12) : showing hysterical scale of (M.H.Q.) in both the blues and non blues mothers.

Mothers	Blues	Non blues	Total
0 - 8	33	57	90
9 - 16	3	1	4
Total	36	58	94

$X^2 = 2.37$ N.S.

From table (12) we can see that there was no difference between blues and non blues hysterical scale.

Table (13) : Moos Rating Scale for diagnosis of premenstrual tension

Mothers	Trual Premenstural tension Syndrome	Trual No Premenstural tension Syndrome	Total	X^2
Blues:	20	16	36	
Non blues	16	39	58	4.75*
Total	39	55	94	

* P<0.05 significant

From table (13) we can observe that the blue mothers manifest more premenstrual tension syndrome than the non blues mothers, this result was statistically significant at P<0.05.

Biological Changes Study :

Table (14) : showing that menstrual regularity in both the blues and non blues

Mothers	Irregular menstruation	Non Irregular menstruation	Total	x^2
Blues:	9	27	36	
Non blues	6	51	57	3.42
	N.S			
Total	15	78	93	

From table (14),we can see that there was no statistical difference between the blues and non blues mothers regarding the menstrual regularity.

Table (15) : showing the effect of pregnancy complications on blues and non blues mothers.

Mothers	Complication of pregnancy	No Complication of pregnancy	Total	x^2
Blues:	26	10	36	
Non blues	32	261	58	3.56
	N.S			
Total	58	36	96	

From table (15) we can see that there was no difference between the blues and non blues regarding the complications of pregnancy.The result was statistically non significant.

Maternal and newly born psychological and physical health problems and its possible etiological factors and background of the mother.

Table (16) : showing the effect of pregnancy on the feeling of worsening of the mother figure in blues and non blues.

Mothers	Pregnancy worsened her figure	Pregnancy did not worsen her figure	Total	x^2
Blues:	20	16	36	
Non blues	19 P<0.05*	39	58	4.75
Total	39	55	94	

From table (16) we can see that the number of blues mothers showing that pregnancy worsened their figure is higher than that of non blues, a result which is statistically significant at P<0.05.

Table (17) : showing the mother health problems in blues and non blues.

Mothers	Mother health problem	No Mother health problem	Total	x^2
Blues:	17	19	36	
Non blues	15 P*<0.05	43	58	4.51
Total	32	62	94	

P<0.05 significant.

From table (17) we can observe that blues mothers suffered health problems more than non blues mothers, in a statistically significant result at P<0.05.

Table (18) : showing the new born health problems of the blues and non blues mothers

Mothers	New born health problems	No New born health problems	Total	x^2	
Blues:	23	13	36		
Non blues	31	27	58	0.98	N.S
Total	54	40	94		

From table (18) we can see that the new born sleeping problems in blues did not show any statistically significant difference.

Table(19) : showing the new born sleeping problems in blues and non blues mothers

Mothers	New born sleeping problems	No New born sleeping problems	Total	x^2	
Blues:	16	20	36		
Non blues	16	42	58	2.81	N.S
Total	32	62	94		

From table 919) we can see that the new born sleeping problems in blues did not show any statistically significant difference.

The next two tables demonstrated the effect of new born wanted or not and the sex desired.

Table (20) : showing the wanted and unwanted pregnancy in blues and non blues.

Mothers	Unwanted pregnancy	Wanted pregnancy	Total	x^2	
Blues:	11	25	36		
Non blues	20	38	58	0.16	N.S
Total	31	63	94		

Table (20) demonstrated that there is no statistical difference between blues and non blues mothers regarding wanted pregnancy or not.

Table (21): showing the new born desired sex in blues and non blues mothers.

Mothers	New born desired sex	New born undesired sex	Total	x^2	
Blues:	33	3	36		
Non blues	55	3	58	0.37	N.S
Total	88	6	94		

Table (21) demonstrated that there is no statistical difference between blues and non blues mothers regarding the desired or undesired sex.

Table (22) : showing the number of the primi and multigravida in blues and non blues.

Mothers	Primigravida	Multigravida	Total	x^2	
Blues:	11	3	36		
Non blues	17	41	58	0.01	N.S
Total	28	66	94		

From table (22) we can see that there is no statistical significant difference in the prevalence of blues or non blues in primi and multigravida.

DISCUSSION

The word blues is an American expression used for indicating some sort of psychological upset or as if the mood is covered by a tinge of depression together with some sort of pessimism, e.g."I have the blues today". However, the same corresponding expressions are popular in our country specially in rural areas indicating more or less that something is not going well, e.g., "what a blue day!!![1]" "It is a blue day and like the Nila[2]". Moreover, the word "blue " is also used with some other connotation meaning crooked or tricked behavior e.g."you are going to work for me in the blues3" (Meaning : your behavior with me is getting to be dishonest and not authentic).

The first meaning is more related to the American term used here in this work. This would let us welcome adopting the term"maternity blues" in our current psychiatric language.

Our result has shown that the incidence of blues in our recently delivered mothers was 36.6%. To compare this result with similar results in the

1 "يادى النهار الأزرق"

2 دانهار أزرق وزى النيلة.

3 أنت ها تشتغللى فى الأزرق.

literature is rather challenging since the sample and method of study varies enormously from one another. In general our results lie on the lower side (for instance Hamilton (1962) 80%, Robin (1962) 80%, Harris (1981) 76%, Metz (1983) 68% and Yalem(1968) 66%).We come nearer to Pitt(1973) 50% and Ballinger et al. (1982) 29% . We are inclined to interpret our results at least partly in terms of cultural differences, considering our result obtained by our structured research tool as well as consensually validated over a larger period, as the more valid results describing our culture.

However, there is another available figure from our culture also and almost at the same time (1987). This is Youssef's survey (Youssef, 1987) who found that the incidence in his sample is only 7.5. We can easily exclude this figure as representing our culture in comparison with ours. He relied on a poor definition for the blues "tears without sad feelings "in the first day interview without resorting to any reliable questionnaire as Stein for instance.

Our relatively lower results can be explained by the fact that the traditions related to child birth in our country permits more familial and social support warmth and acceptance. Also, such a mild ailment (the blues) could pass unnoticed as a result of being diluted by the overwhelming crowd of visitors , ceremonies and traditional rituals related to the occasion. Children in our society, in spite of all family planning, propaganda and over crowding , are still as welcomed as they have ever been. They still represent the real family binding measure particularly in this socio - economic level (our sample). Comparing between primigravida and multigravida, our results showed that the blues are met with more or less near to each other on the fourth day (28.5% primi.,35% multi.) and the 15^{th} day although difference are more (raw score) in the latter (statistically unsignificant). However, the maternity blues in the primigravida has a different causation from than of multigravida. In the primigravida, it could be some sort of astonishment and reaction to the ill defined new experience and heavy coming responsibilities and once the mother settles in, atte a very short time it may have disappeared or her happiness by being a mother for her first time may cover this blues coming to her, whereas the blues in the multigravida could be some sort of conditioning related to certain stressful experiences in the previous delivery

whether the previous reaction has been conscious or unconscious. This may explain the significant difference, showing higher representation in the multigravida for those having the blues in the 4^{th} day and persisted up till the 15^{th}. In other words, it seems that such multigravida are conditioned to the whole situation rather than the act of labour itself. Moreover, blues should be taken more seriously as it may prove to be the prodroma of more prolonged depressive syndrome.

As regard the psychiatric symptoms related to the mother's condition particularly the affective aspects, we have found that somatic symptoms (M.H.Q.), depression (M.H.Q.)and anxieties (M.H.Q.) have been shown statistically significant different from the non blues control sample. All goes with other researches (Harris, 1980 and 1981, Stein , 1980 and Carnes,1983).

The maternity blues, being a mild state of depression and anxiety, we would have expected to find these two symptoms sited at the top of the list which was not the case. However, in our culture particularly in this socio-economic stratum, somatization of both depression and anxiety is very common, replacing directly expressed depression and anxiety. The somatic symptoms here whether they are due to autonomic imbalance or preoccupation with the body structure and possible dysfunction i.e. hypochondriasis, could not be disentangled from both depression and anxiety. We can look to the three items depression, anxiety and somatic symptoms as the main symptoms expected from the mothers presenting with the blues with no necessity to delineate one from the other. As regards phobias, we prefer to consider it here as an independent item although it is, after all, a type of objectified fear (anxiety) symptoms.

In the MHQ obsession scale, we found that it was represented more or less equally in both the test and the control group. This finding is available in the literature "correlation of the maternity blues with the obsession (MHQ) was not significant "(Harris, 1980). Whether the obsession traits is protective against declaring an awareness about the affective dysthmia or it is simply a casually equally represented trait could not to be finally reported upon within our limitations here.

The Middlesex results on the hysterical trait also showed insignificant difference while Harris 1980 and 1981 reported that hysteria represented higher with the blues. However, having a look at the raw score, we find that the hysterical trait has been represented more in the blues group although statistically insignificant. This may indicate that in a larger sample we may approach the finding of Harris (1980).

As regards the premenstrual tension syndrome which represents, a prepregnancy state, we can consider it as an indicator for the tolerance and threshold of the future mother for biological and hormonal alteration. A mother having the premenstrual tension syndrome means that she is vulnerable to such variation i.e. she is the one whose threshold for hormonal or biological variations is relatively low. Pregnancy and delivery are associated with hormonal variations and reorganization. Maternity blues could be psychic equivalent to such low threshold of tolerance. It has been pointed out that changes in mood in the puerperium have frequently been attributed to hormonal changes occurring in the few days after delivery (Harris, 1980).

The other group that has been different significantly is related to the possible etiological factors and general background of the mother : A mother with maternity blues has shown that pregnancy has worsened her figure more than the other group as if they are more aware about their general appearance. This could be interpreted in terms of such a mother being a little bit egoistic and self- centered which goes with the dynamic aspect of depression as an indicator of self-centered attitude and easily frustrated tendency. It could be also interpreted to be related to some hidden possibility of unwanted pregnancy. It is found from table (20) that the item of unwanted pregnancy shows no significant difference . This should not be taken for granted as such because in our culture both religion and social attitude inhibit any awareness about such a possible rejection. While the mother says verbally that she is wanting this pregnancy and wanting such sex, this may be simply a mechanism hiding the unconscious rejection which is permitted to manifest itself in this indirect way declaring that the pregnancy worsened her figure. Also the significant difference resulting from pregnancy worsening her face is parallel to the significant result of the presence of depression in such a blues

result of the the possible view of the depressed to herself. However, we have also such a items as "mother health problem" which have been shown more in the blues sample to be considered either as indirect manifestation of such a hidden rejecting attitude or as an etiological factor participating in predisposing to the blues reaction.

Considering certain biological functions and indicators, we noticed that neither irregular menstruation nor any known complication of pregnancy whether in early pregnancy or late pregnancy or primigravida have been statistically valuable. We could have expected that they could have existed more in the blues sample simply because they are at least partly determined by the psychological make up of such a mother. Those who manifest such problems are hypothesized to be vulnerable to the maternity blues as one manifestation of this low threshold to biological variations. However, failure to detect such differences is not a final disapproval of this hypothesis, it may need another way of investigation using deeper probing or qualitative analysis of the given data as well as further elaboration of various types of irregularities and complications delineating those based on a circumscribed organic basis.

Neither the fact of the newly born being wanted or not nor the desired sex has come as have been desired for both groups. At this point we come again to the way of interrogation since we depended on the immediate verbal response on a questionnaire, while these deeply seated motivations may be handled in this socioeconomic culture by mechanisms such as reaction formation, that is to say we are not in the safe position to take the expression"I did not want this child or this sex for its face value". Further interrogation perhaps may reveal the reverse, thus we just cite this information at this stage of research to advice deeper probing.

As regards the data related to the newborn health problems, they showed no significant difference in results between both groups. This may indicate that the blues is not a simple reaction to the difficulties or responsibilities layed upon a fragile, dependent mother. However, such complications have been minimal to both groups.

As regards the newly born sleeping problems, they were found to be statistically significant in other literatures (Bulletin WHO, 1983, Morsbachet,1983) while in our research, they were found to be statistically insignificant.This can be explained by the fact that the mother in a developed culture is almost solely responsible for caring after her baby so she is usually aware about such problems while in our culture where many people in the big family could take care of the newly born, this sleeping problem is diluted or over looked due to the multi -sources for caring after the newly born. Also the sleeping problems could not be considered in our culture as problematic. It could be considered as simple habitual incidence rather than as a health problem. Moreover the irregularity of feeding our children at any time in the day and night hides this possible sleeping problem.

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NATURE ET ATTRIBUTS DES "TROUBLES DE MATERNITÉ" DANS UNE COMMUNAUTÉ EGYPTIENNE

ABSTRAIT

Cette étude a été conduite dans le but d'explorer les "Troubles de Maternité" dans une communauté Egyptienne et de déterminer la nature psychiatrique et les attributs de ce trouble.

94 femmes admises á l'hopital général d'Ismailia pour accouchement, durant janvier 1987, ont été questionnées á leur domicile le quatriéme et le quinziéme jour suivant l'accouchement. Les résultats ont montré que la plupart de ces femmes était illétrées. 36 d'entre elles (38,3%) ont souffert de "Troubles de Maternité" les autres 58 femmes (61,7%) ont servis comme contrôles. Nous avons trouvé des differences, statistiquement significatives, entre ces deux groupes en ce qui concerne les symptomes somatiques, la dépression, la phobie et l'angoise ($P<0,05$). Des différences, statistiquement significatives, entre les deux groupes ont ainsi été notées concernant le syndrome de tension prémenstruelle, les problémes de santé de la mère , ainsi que l' image personelle des femmes enceintes ($P<0,05$).

Nous n'avons pas trouvé de différences entre les deux groupes en ce qui concerne les variations biologiques, relation avec le nouveau-né, ainsi que les traits hystériques et obsessionels.

Les résultats sont discutés et comparés avec les résultats d'autres travaux similaires dans des communautés différentes.

الموجز

كثيراً ما تتعرض بعض الأمهات لاضطرابات وجدانية عابرة خلال الأسبوع الأول من الولادة يطلق عليها "كآبة بشكل متوتر" فى سبيل قبول اسم "كآبة الأمومة" . لم تبحث من قبل العلاقة بين "كآبة الأمومة " والولادة فى مجتمعنا . ولذلك فقد أجريت مقابلة بمنازل الأمهات اللاتى وضعن بمستشفى الأسماعيلية العام وبلغ عددهم ٩٤ . وقد أجريت المقابلة فى اليوم الرابع والخامس عشر من النفاس.

وقد وجد أن نسبة كآبة الأمومة فى ٩٤ حالة هى ٣٨,٣٪ وقد قورنت المجموعة التى ظهرت عليها "كآبة الأمومة" بالمجموعة الباقية التى لم تظهر عليها أعراض الكآبة . وقد وجد أن هناك أرتفاعاً لة دلالة أحصائية بين المجموعتين فى أعراض الأكتئاب ،القلق ، الخوف ، والأعراض الجسمانية. ولم يوجد هناك فارق بين المجموعتين فى مستوى الهستيريا والوسواس. وذلك بتطبيق استبار(الميدل سكس) . كما وجد ارتفاعاً له دلالة احصائية فى أعراض "التوتر النفسى الذى يسبق الدورة الشهرية" فى المجموعة التى ظهرت عليها"كآبة الأمومة" وقد وجد ايضاً فى هذه المجموعة فارق احصائى بينها وبين المجموعة الضابطة فى أن للحمل تأثير فى تشوية شكل الوجة وأيضاً أن للحمل تأثير على المشاكل الصحية التى تعانى منها الأم بعد الولادة . بينما لم يكن هناك فارق له دلالة أحصائية على تأثير رغبة الأم فى الجنين أو الجنس المطلوب أو تأثير لمشاكل المولود الصحية بين المجموعتين.