

THE RELATIONSHIP BETWEEN HEALTH LOCUS OF CONTROL AND RISK FACTOR FOR POSTPARTUM DEPRESSION AMONG PRIMIPARA MOTHERS

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ABSTRACT

Background: Depression in postpartum period is a concern due to low social support, poor marital relationship and financial strain, **aim:** to assess relationship between health locus of control and risk factors for postpartum depression among primi-para mothers. **subjects and method:** a descriptive correlational research design was utilized. **setting:** the study was carried out in governmental hospital in port said city namely (port said general hospital, port foad general hospital, and specialized obstetric hospital. **subjects:** convenient was sample of 95 mothers. **tools:** the data was collected using three tools: interview schedule questionnaire, edinburgh postnatal depression scales multidimensional health locus of control scales. **results:** the majority of the women tested (60.1%) were at high risk for postpartum depression. there was statistically significant relation between depression scale and age, level of education, type of family, number of room, income, husband's age, education and occupation. **conclusion:** most respondent's had postnatal depression. factors that were increased these problems including psychological disturbance during pregnancy, low social support, and gender of new born and low income. while receiving postnatal instruction and help giving at home from women's husbands or from their relative's decrease risk for postpartum depression. there was a positive correlation between health locus of control and risk factors for postpartum depression. **recommendations:** it was recommended that awareness program for nurses and women who are at risk of developing postpartum depression for helping them to cope with difficulties encountered.

Key Words: Locus of control, postpartum depression, primipara mothers.

INTRODUCTION

The birth of a child is a significant life event that can be filled with expectation, joy, and excitement. Transitioning to new expectations, tasks and obligations, and changes in relationships, especially for first-time mothers, can be stressful. Furthermore, new mothers often experience physiological changes and battle with issues such as weight gain, body image, and libido and other physical difficulties as fatigue. These issues may worsen stress and leads to psychological problem as postpartum depression (Keri S, Menberu M & Niguse W 2017).

Postpartum depression (PPD) is a mood illness that affects about 10-16% of adult moms every year, with depressive symptoms lasting more than six months. It is common within a few months to a year after giving birth, Low mood, sleep disturbances, changes in appetite, poor attention, and irritability are symptoms that are comparable to those of depression at other times in life (Anokye R, Acheampong E, Ainoason A and Gyiman A 2018).

There are various factors causing postpartum depression and the subsequent consequences of PPD varies according to women ages, education level, races, ethnicities. Globally, preterm or low birth weight infants, unemployment, socio economic deprivation, poor social or emotional support , obstetric complication, sleep disturbances, low self esteem, negative attitude towards pregnancy, antenatal depression or anxiety, previous history of depression, poor marital relationship and childcare stress (Roumieh M ,et al 2019).

Health locus of control stands for health locus of control. This idea tries to persuade people that their health is influenced by their own actions (internal health locus of control (IHLC) and external health locus of control (EHLC). According to Pourhoseinzadeh et al. (2017), each person has unique thoughts and beliefs, which are important factors in making health-related decisions. It's a must-have. (Moshki M and Cheravi Kh 2016).

The Multidimensional Health Locus of Control Scales (MHLC) should be used to screen for potential depression risks throughout a woman's prenatal care, and the Edinburgh Postnatal Depression Scale should be used to screen for depression risk (EPDS). The health locus of control, popularized by Wellston, Kaplan, and Maida in

1970, is one of the most extensively used indicators of an individual's health belief. that their health is controlled by internal or external factors (Ozcakir et al 2014).

The Significant of the study:

Because of its great frequency, postpartum depression is considered a severe public health issue. Globally, the prevalence is much higher, at 100-150 per 1000 births. Because postpartum depression affects 68 percent of new mothers, (Mohamed N, Ragab A, El Bahy M & Zeina M 2015). As Salem et al (2017) reported that, prevalence of P P varying from 40- 51. The researchers showed that some factors were predictors of postpartum depression as age participants, unplanned pregnancy, death of the infants, current marital problem (Kerie S, Menberu M & Niguse W 2017)

AIM OF STUDY

to assess the relationship between health locus of control and risk factors for postpartum depression among primary-para mothers.

Research Objectives:

1. Identify high risk mothers for post-partum depression
2. Find out the correlation between PPD and Locus of Control

SUBJECTS AND METHOD

Design: A descriptive correlational study design was utilized.

Setting: Outpatient clinics of three governmental hospitals were selected namely Port Said General, Port Fouad General and Specialized Obstetric.

Subjects: Convenient sample of primipara mothers during the post-partum period without history of psychological problem.

Sample size: Ninety-five primipara postpartum mothers was determined by using the following

equation (*Dobson, 2002*): **Sample size (n) = $(z\alpha / \Delta)^2 p (100 - p)$.**

As P: means prevalence of mothers in the postpartum period in Egypt = 7.5% (*EDSH, 2014*).

Z α /2: a percentile of standard normal distribution determined by confidence level = 1.96

Δ : The width of confidence interval = 5%

$$n = (1.96/5)^2 7.5 \times (100-7.5)$$

Tools of data collections**Three tools were used as following:**

I- Interview questionnaire sheet was designed by the researcher after reviewing the related current and previous literature. It was used to assess mothers (questions numbers from 1 to 12) it included personal data such as, age, residence, educational levels, and occupation, Obstetric history such as (antenatal follow up, No of gravida , abortion,...etc). pregnancy problems and Gynecological history include indication for having a gynecological operation (chief complain), and the type of operation.

II- Edinburgh Postnatal Depression Scale (EPDS): This tool designed to identify women at risk for postpartum depression. The scale was developed by (Cox, Holden, & Zagorsky, 1987). The Arabic version of the EPDS was validated by Goulash et al. (1997). It is a reliable and validated screening tool consists of 10 questions.

Scoring System:

Mothers with a score of 10 or higher are more likely to have a depressive illness of varying severity. Question 1, 2, and 4 receive a score of 0, 1, 2, or 3, with the top box receiving a score of 0 and the bottom box receiving a score of 3.

Question 3, 5-10, is graded with a 3 in the top box and a 0 in the bottom box.

- Maximum point total: 30
- A score of 10 or higher indicates the possibility of depression.

Tool III: Multidimensional Health Locus of Control (MHLC) Scales:

Wallston, Wallston, and Devellis created and tested the scales (1978). It comprises of three independent items designed to determine whether an individual's health-related beliefs are primarily internal, a product of chance, or under the direction of major outside forces. The scale consisted of 17 self-report items that were used to examine an individual's perceptions of what factors influence health.

- Internal Belief (My personal choices have an impact on my health.)
- Chance Belief (My health is impacted by chance))
- Powerful Others Belief (My health is reliant on other people's skill). Each item on the scale is a statement of belief about the medical condition with which the user agrees or disagrees. Each remark is accompanied by a rating ranging from strongly disagree (1) to strongly agree (2). (6).

A pilot study was conducted to evaluate the tools' clarity, feasibility, and application. It was carried out on 10% of respondents from October to December 2018 before starting the data collection phase. The total sample size was not reduced by excluding mothers who participated in the pilot research. In addition, the pilot study provided the investigator with experience dealing with the subjects involved, as well as familiarity with the environment, as well as the time required to complete the data collecting questionnaire in the data gathering tools, changes were made as needed.

Field work:

The data collection process began on December 15, 2018, and ended in December 2019. After obtaining permission from the director of these hospitals, the researcher attended post-natal outpatient clinics in the previously stated hospitals from 9 a.m. to 2 p.m. for three days a week until the sample size reached the predetermined number (95).

The research was attended the previous maintained study setting started by introducing herself to each participate explaining the aim of the study through interviewing questioner study; each interview was consuming 15 minutes conducting in separate place to maintain confidentiality to gain mothers confidence and trust to participation in the study.

Administrative design:

An official approval was obtained from the director of the previous mentioned hospitals as an approval for data collection to conduct the study through written letter clarifying the purpose and aim of the study.

Ethical consideration:

All ethical consideration was met as the study's purpose was presented to each mother, and she gave her agreement orally. Participants were assured of confidentiality and privacy, as well as the fact that their information would only be utilized for research purposes. Then the researcher then met with each mother personally after filling out the necessary data. The replies were evaluated and pooled for data analysis.

Statistical Design: Upon completion of the data collection, collected data was coded, arranged, tabulated and analyzed according to the type of each data by using SPSS program. Number and percent are used represent qualitative data. Quantitative data were described by using mean and standard deviation. (χ^2) was used to compare qualitative variables. When p-

value ≤ 0.05 a significant level value was measured and a highly significant level value was indicated when $p\text{-value} \leq 0.001$, but $p\text{-value} > 0.05$ shows non-significant results.

RESULTS

Results revealed that approximately half of mothers (46.3%) were in the age group between 21-25 years, while only (10.5%) were more than 30 years old with Mean \pm SD 24.27 ± 4.92 . Concerning educational level, the less than half of studied mothers (39.2%) are secondary educated. In relation to mother's current employment status, majority of them (79%) were unemployed, slightly more than half of the women (51.6%) reported hardly income enough. As regarding the place of residence, the nearly more half of them (54.7%) lived in rural. Concerning marital status, the vast majority of the women (95.8%) were married, more than half of the studied subject (55.8%) lived in nuclear family. Regarding home condition, all of them had electrical, water and sanitation and good ventilation. As regarding husband's age, the minimum age was 22 years while the maximum age was 40 with Mean \pm SD = 29.65 ± 4.80 . Regarding husband's level of education, nearly half of husband's (46.3%) had secondary education and the majority of them (90 %) were worked

Table (1): shows about (78.9%) of mother's prim gravida, while only 4.2% of them were conceived three times. Regarding the number of abortions, approximately two-thirds of the studied mothers (68.4%) had no abortion and 8.4% of them had abortions two times. It shows that the majority of them (81.1%) were planned for pregnancy and about half of the studied mothers (50.5%) had complications with current pregnancy with the highest percentage to hypertension (18.9%), bleeding (10.5%), diabetes (12.5%) and iron deficiency anemia (8.4%). Regarding antenatal care follow up , it was observed that slightly more than half of them (51.6%) visited the doctor more than four times during pregnancy. More than half of studies women (54.7%) hadn't received health education about puerperium, while only 16.3% of them had received from physicians and nurses.

Table (2): It revealed that about half of the newborns were males (53.7%). Two-thirds of the studies women (70.5%) express newborn sex wanted. The majority of studied women (76.8%) reported their newborn weight increased satisfactorily, while (23.2%) reported newborn weight didn't increase. Concerning newborn health status, around one-third of newborns (35.6%) complained of health problems mainly Jaundice

(14%). Approximately two-thirds of newborn babies for the studied women (64.2%) were fed by breastfeeding.

Table (3) & Figure (1): Represent the percentage of women who at risk for Post-Partum Depression according to (EPDS). It indicated that the majority of them (61.1%) are at high risk for postpartum depression.

Table (4): Shows Primi-para mothers health locus of control score. It shows that the Mean \pm SD of health locus of control is 51.89 ± 10.71

Table (5): correlation between depression and health locus of control of studied primipara postnatal women. It shows a negative correlation between them.

Table (6): show relation between depression Scale (EPDS) with socio-demographic characteristics. It is noted that there is statistically significant relation between depression scale and age, level of education, type of family, number of rooms, income, husband's age, husband's education and occupation of the husband whereas $p < 0.05$

Table (7): Relation between depression and reproductive history. It is notes a statically significant relation between depression Scale (EPDS) with all reproductive history (Gravidity, Abortion, Planning and complication of pregnancy, Number of antenatal visits, and Receiving health education).

Table (8): shows the Correlation matrix between depression scale (EPDS) and health locus of control. It's noted that the depression scale was signific ally correlated with overall locus of control as well as internal and chance subscale of health locus of control. The table shows also that there is significant correlation between overall locus of control with all subscales of the Multidimensional health locus of control.

Table (1): Distribution of the studied Primi Para postnatal women according to reproductive history (n = 95)

Reproductive history	No.	%
Gravidity		
Once	75	78.9
2	16	16.8
3 or more	4	4.2
Abortion		
Once	22	23.2
2	8	8.4
No abortion	65	68.4
Data about Last pregnancy		
Planned pregnancy		
Yes	77	81.1
No	18	18.9
Occurrence complication of pregnancy		
No	47	49.5
Bleeding	10	10.5
Hypertension	18	18.9
Diabetes	12	12.6
Iron deficiency anemia	8	8.4
Other	8	8.4
Antenatal care visit		
No visit	14	14.7
Less than 4	32	33.7
4and more	49	51.6
Received health education about puerperium		
No	52	54.7
Yes	43	45.3
<i>If yes who gave education (n=43)*</i>		
Family	18	41.8
Relative	4	9.3
Friends	4	9.3
Physician and nurses (health team)	7	16.3
Media (T.V, Radio, Internet, newspaper)	10	23.3

Table (2): Distribution of the studied Primi Para postnatal women according to data about the newborn (n = 95)

Data about the newborn	No.	%
Newborn Sex		
Male	51	53.7
Female	44	46.3
Newborn Sex wanted		
Yes	67	70.5
No	28	29.5
Newborn weight		
know	36	37.9
Do not know	59	62.1
Min. – Max.	2.0 – 4.0	
Mean ± SD.	3.19 ± 0.40	
Newborn weight increased satisfactory		
Yes	73	76.8
No	22	23.2
Newborn health status		
Wellbeing	61	64.2
Complain from health problem	34	35.8
Type of health problem (n=34) *		
Jaundice	14	14.7
Growth problems	2	2.1
Stillbirth	2	2.1
Down syndrome	2	2.1
RDS	10	10.5
Congenital anomalies	4	2.2
Current newborn feeding		
Breast feeding	61	64.2
Bottle feeding	20	21.1
Both	14	14.7

*: More Than One Answer

Table (3): Distribution of the studied primi Para postnatal women according to level score of depression (n = 95)

Depression level	No.	%
Low risk <13	37	38.9
High risk >13	58	61.1
Total Score	(0 – 30)	
Min. – Max.	1.0 – 29.0	
Mean ± SD.	15.84 ± 8.91	
% Score		
Min. – Max.	3.33 – 96.67	
Mean ± SD.	52.81 ± 29.72	

Table (4): Descriptive analysis of the studied Primi Para postnatal women according to score of health locus of control (n = 95)

Health locus of control	Total Score(17 – 85)	% Score
Min. – Max.	36.0 – 72.0	27.94 – 80.88
Mean ± SD.	51.89 ± 10.71	51.32 ± 15.75

Table (5): Correlation between depression scale (EPDS) and health locus of control of studied primipara postnatal women (n = 95)

	R	P
Depression scale versus health locus of control	-0.886*	<0.001*

Table (6): Relation between depression Scale (EPDS) with personal data

Personal data characteristics	Depression Scale (EPDS)				Test of sig.	P
	Low risk<13 (n = 37)		High risk>13 (n = 58)			
	No.	%	No.	%		
Age (years)						
15 – 20	7	18.9	14	24.1	$\chi^2=$ 25.826*	<0.001 *
21 – 25	28	75.7	16	27.6		
26 – 30	0	0.0	20	34.5		
≥ 30	2	5.4	8	13.8		
Maternal education					$\chi^2=$ 9.543*	MC p= 0.041*
Does not read &write	2	5.4	14	24.1		
Read and write	4	10.8	10	17.2		
Intermediate	15	40.5	22	37.9		
University	14	37.8	10	17.2		
Postgraduate	2	5.4	2	3.4		
Occupation					$\chi^2=$ 3.215	MC p= 0.185
House wife	27	73.0	48	82.8		
Employee	10	27.0	8	13.8		
A worker	0	0.0	2	3.4		
Current place of residence					$\chi^2=$ 2.509	0.113
Urban	13	35.1	30	51.7		
Rural	24	64.9	28	48.3		
Marital status					$\chi^2=$ 2.664	FE p= 0.154
Married	37	100.0	54	93.1		
Divorced	0	0.0	4	6.9		
Type of family					$\chi^2=$ 12.537*	<0.001 *
Nuclear	29	78.4	24	41.4		
Extended	8	21.6	34	58.6		
Crowding index					$\chi^2=$ 3.320	0.068
<1	9	24.3	6	10.3		
≥1	28	75.7	52	89.7		
No. family members					t=1.427	0.159
Min. – Max.	3.0 – 3.0		2.0 – 3.0			
Mean ± SD.	3.0 ± 0.0		2.97 ± 0.18			
No. of rooms					t=5.269*	<0.001 *
Min. – Max.	1.0 – 4.0		1.0 – 5.0			
Mean ± SD.	3.14 ± 0.67		2.24 ± 0.98			
Income					$\chi^2=$ 24.140*	<0.001 *
Enough and more	14	37.8	2	3.4		
Hardly enough	19	51.4	30	51.7		
Not enough	4	10.8	26	44.8		
Home condition *					$\chi^2=$ 1.303	FE p= 0.519
Electricity is available	37	100.0	58	100.0		
There is water in it	37	100.0	56	96.6		
Information of the Husband						
Husband's Age (years)					$\chi^2=$ 11.062*	0.004*
<30	29	78.4	26	44.8		
30-<35	6	16.2	18	31.0		
≥35	2	5.4	14	24.1		
Husband's level of education					$\chi^2=$ 18.303*	MC p <0.001 *
Does not read &write	0	0.0	4	6.9		
Read and write	2	5.4	14	24.1		
Intermediate	14	37.8	30	51.7		
University & above	21	56.8	10	17.2		
Husband's occupation					$\chi^2=$ 12.419*	0.002*
Employee	18	48.6	12	20.7		
A worker	19	51.4	36	62.1		
Not working	0	0.0	10	17.2		

 χ^2 : Chi square test MC: Monte Carlo

FE: Fisher Exact

t: Student t-test

*: Statistically significant at $p \leq 0.05$

*: More Than One Answer

Table (7): Relation between depression Scale (EPDS) with obstetric history

Reproductive history	Depression Scale (EPDS)				χ^2	P
	Low risk<13 (n = 37)		High risk>13 (n = 58)			
	No.	%	No.	%		
Gravidity						
Once	37	100.0	38	65.5	18.148*	MC p <0.001*
2	0	0.0	16	27.6		
3 or more	0	0.0	4	6.9		
Abortion						
Once	2	5.4	20	34.5	20.481*	MC p <0.001*
2	0	0.0	8	13.8		
No abortion	35	94.6	30	51.7		
Data about Last pregnancy						
Planned pregnancy						
Yes	37	100.0	40	69.0	14.167*	<0.001*
No	0	0.0	18	31.0		
Occurrence complication of pregnancy						
No	31	83.8	16	27.6	32.662*	MC p <0.001*
Bleeding	2	5.4	8	13.8		
Hypertension	0	0.0	18	31.0		
Diabetes	2	5.4	10	17.2		
Iron deficiency anemia	2	5.4	6	10.3		
Antenatal care visit						
No visit	2	5.4	12	20.7	17.509*	<0.001*
Less than 4	6	16.2	26	44.8		
4and more	29	78.4	20	34.5		
Received health education about puerperium						
No	4	10.8	48	82.8	47.197*	<0.001*
Yes	33	89.2	10	17.2		
If yes who gave education (n=43) *	(n=33)		(n=12)			
Family	2	6.1	0	0.0	14.119*	MC p= 0.034*
R elative	2	6.1	0	0.0		
friends	6	18.2	2	20.0		
Physician and nurses (health team)	10	30.3	0	0.0		
Media (T.V, Radio, Internet, newspaper)	2	6.1	2	20.0		
0	4	12.1	0	0.0		
If yes who gave education (n=43) *	3	9.1	2	20.0		
Family	2	6.1	0	0.0		
R elative	2	6.1	2	20.0		
friends	0	0.0	2	20.0		

 χ^2 : Chi square test MC: Monte Carlo*: Statistically significant at $p \leq 0.05$

*: More Than One Answer

Table (8): Correlation matrix between depression scale (EPDS) and health locus of control (n = 95)

		Depression scale	Health locus of control			
			Overall health locus of control	Internal	Chance	Others
Depression scale	r		-0.886*	-0.854*	-0.872*	-0.138
	p		<0.001*	<0.001*	<0.001*	0.182
Overall health locus of control	r			0.935*	0.954*	0.306*
	p			<0.001*	<0.001*	0.003*
Internal	r				0.856*	0.143
	p				<0.001*	0.166
Chance	r					0.090
	p					0.384
Others	r					
	p					

r: Pearson coefficient

*: Statistically significant at $p \leq 0.05$

DISCUSSION

Postpartum period is recognized as the most vulnerable emotional period for mothers, an important stage for women and their families (Inglis et al 2014). This period is a critical step not only effect on mother's mental and physical health, but also on complete structure of the family (Miller ML, Kroska EB, & Grekin R 2017).

PPD, according to the US National Library of Medicine, is a mild to severe depression that develops within the first year of life, usually within the first three months. It affects an estimated 12% to 19% of pregnant women, making it one of the most frequent postpartum morbidities. With about 4 million births in the United States each year, this translates to anywhere from 520,000 to 760,000 moms affected by PPD annually.

LOC is defined as a person's perception of their ability to influence the outcome of life events (Rotter, 1966). According to the idea, persons with an internal LOC (also known as "internals") feel they have influence over their life's results, whereas persons with an external

LOC (also known as "externals") feel their life's events are determined by chance or fate (Rotter, 1966). As a result, the current study was conducted to determine the association between health locus of control and postpartum depression risk factors among primary-para moms.

Our finding denotes approximately two-third of studied mothers were at high risk for postpartum depression. This is may be due to more than half of them (52%) had not received enough preparation and health education during antenatal period and (35%) of them reported health problems for their babies.

On the same line with another study conducted in Australia by Jackman C (2017) which reported that 30% of mothers were at risk for postpartum depression. Conversely, a study conducted in Ethiopia the total prevalence of postpartum depression was 15.6 percent, according to Wubetu a D, Engidaw N A, and Gizachew K D (2018), who also reported moms with limited social support and a present hospitalized infant.

More than thirty of the women in this study, ranging in age from 26 to 30, had postpartum depression, which is consistent with the findings of (Giulia M & Joseph KS 2014), who found that women of advanced maternal age have significantly greater rates of depression than younger women. At the children's and women's hospital and health center of British Columbia, who continued to investigate the link between maternal age and depression. Postpartum depression affected forty percent of women with a secondary education. These findings are consistent with those of (Matsumura K & Hamazaki K 2019), who discovered that a lower education level was linked to a higher prevalence of postpartum depression. The findings of the Japan Environment and Children study.

The present study showed that there is a significant relation between postpartum depression and obstetric history. This was consistent with an Abdollahi et al, 2014 conducted on Predictors and incidence of post- partum depression which reports that women with gestational diabetes had almost three times higher risk of postpartum depression when compared with women who did not. But it can be clarified that the pregnancy diseases continue to be a psychological load on mothers, with major effects on postpartum depression incidence.

Additionally, among postpartum women in general, depression may be associated with lack of commitment to healthy lifestyle habits,

The present study shows that the Mean \pm SD of health locus of control is 51.89 ± 10.71 with maximum score 80.88%. this is in congruent with a study conducted in Iran by Moshki M, 2015 on Relationships among depression during pregnancy, social support and health locus of control among Iranian pregnant women, which showed that Internal, powerful others and chance beliefs had the highest mean scores. There is a negative link between health locus of control (internal, chance, and others) and depression scale agreement in the current study.

Our results showed that there is a significant correlation between maternal Locus of control and postpartum depression. On the same line, a study conducted in Australia by Jackman c (2107) which reported some statistically significant correlations between PPD and Locus of Control.

This was in disagreement with a study conducted in Iran by Moshki M, 2015 on Relationships among depression during pregnancy, social support and health locus of control among Iranian pregnant women, which found that there is no significant correlation between depressive mood and all dimensions of HLC.

CONCLUSION

Most respondent's had postnatal depression. Factors that were increased these problems including psychological disturbance during pregnancy, low social support, and gender of new born and low income. While receiving postnatal instruction and help giving at home from women's husbands or from their relative's decrease risk for postpartum depression. There was a positive correlation between health locus of control and risk factors for postpartum depression.

RECOMMENDATIONS

- Nurses caring for postnatal women must give more importance to instruct mothers regarding postnatal period with all the anticipated problems, and help them to cope with the difficulties encountered.
- Involvement of husband in program for women about instructions involved postnatal period as they are partners in this critical period to decrease stress on their wives.

- Further research is proposed to assess the effect of nursing intervention to prevent postpartum depression or help mothers who have signs and symptoms of postpartum depression to cope with this problem.

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عوامل التحكم في الصحة وخطورة التعرض لحدوث اكتئاب ما بعد الولادة للأمهات البكاري

الخلاصة

خلفية: يعد لاكتئاب ما بعد الولادة هو مصدر للقلق بسبب انخفاض الدعم الاجتماعي وسوء العلاقة الزوجية والضغوط المادية هدفت الدراسة الى : تقييم العلاقة بين موقع التحكم في الصحة وعوامل الخطر لاكتئاب ما بعد الولادة. منهجية البحث: تم استخدام تصميم بحث وصفي ارتباطي. أجريت الدراسة في مستشفيات حكومية بمدينة بورسعيد وهي (مستشفى بورسعيد العام، مستشفى بورفؤاد العام، ومستشفى التوليد التخصصي) الأدوات: تم جمع البيانات باستخدام ثلاث أدوات: استبيان عن طريق المقابلة الشخصية ومقياس إنتيرة لقياس اكتئاب ما بعد الولادة ومقياس التحكم في الصحة ومتعدد الأبعاد. النتائج: كانت غالبية النساء اللاتي تم اختيارهن (٦٠,١%) معرضات بدرجة عالية لاكتئاب ما بعد الولادة. كانت هناك علاقة ذات دلالة إحصائية بين مقياس الاكتئاب والعمر ومستوى التعليم، ونوع الأسرة، وعدد الغرفة، والدخل، وعمر الزوج. الخلاصة: خلصت الدراسة إلى أن نسبة كبيرة (٦٠%) من النساء اللاتي شملتهن الدراسة معرضات لخطر الإصابة باكتئاب ما بعد الولادة. ووجد أيضا أن من العوامل التي تسهم فيها الإجهاض المتكرر وحدوث مضاعفات اثناء الحمل والولادة وإنجاب طفل مريض. كما أكدت الدراسة على أن هناك علاقة سلبية بين الاكتئاب ومركز التحكم في الصحة. التوصيات: أوصت الدراسة بتصميم برنامج توعوي للممرضات والنساء المعرضات لخطر الإصابة باكتئاب ما بعد الولادة لمساعدتهن على التعامل مع الصعوبات المصادفة

الكلمات المرشدة : فترة النفاس، اكتئاب ما بعد الولادة، موضع السيطرة