

FAMILY CONFLICT AS PREDICTOR OF POSTPARTUM DISTRESS

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Citation: Aroyewun, B.A., Karatu, B.A. & Nwizu, I.H. (2022). Family conflict as predictor of postpartum distress. *KIU Interdisciplinary Journal of Humanities and Social Sciences*, 3(3), 46-58

ABSTRACT

The study investigated family conflict as a predictor of postpartum distress. Two hundred and seven (207) women in their postpartum period participated in the study and were purposefully drawn from two government-owned tertiary healthcare providers in Lokoja. One hypothesis was tested: Family conflict will be significantly related to postpartum distress. The symptoms distress checklist (SCL90) and Family Environment Scale were used for data collection. Linear regression analysis was used to analyze the data. The results showed a significant relationship between family conflict and psychosomatization ($\beta = .20$, $t = 2.98$, $P < .005$). The result also shows a significant relationship between family conflict and obsessive compulsion ($\beta = .20$, $t = 2.90$, $P < .005$). Family conflict and hostility are also related ($\beta = .24$, $t = 3.68$, $P < .005$). There was a significant relationship between family conflict and phobic anxiety ($\beta = .33$, $t = 5.04$, $P < .001$). The implication and limitations were discussed, and suggestions were made for further study.

Keywords: Family conflict, postpartum distress, and hostility.

INTRODUCTION

The characteristics of each person and the environment in which they reside and interact must be favourable and free from conflicts. This socialization unit, which also serves as the guardian of one's culture, has a substantial impact on a wide range of behavioural elements of people. The family is typically the initial port of entry into the stressful world, and it is from there that most environmentally acquired behaviours are learned, maintained, and reinforced. A family is a distinct social structure whose members are bound together by various ties, including those that are legal, sentimental, geographical, and historical. According to Voss and Massatti (2008), a healthy family atmosphere is one where everyone is free to express their emotions, and there is little inter-family conflict. They also identified a healthy family environment as critical in

developing individual resiliency and a powerful protection for association with emotional and physical health among family members.

Zabriskie and Freeman (2004) identify healthy families as a family where members can attentively listen to one another, express thoughts and feelings, show supportiveness and loyalty, share leadership, negotiates, and rely on one another. Entry into family systems is through birth, adoption, fostering, or marriage, and members can leave only by death (Carr, 2006). It is possible to get a divorce and separation but severing all connections is never possible except among childless couples, even at these emotional ties remain forever. Family unites individuals through the bond of kinship, which is present in all societies. However, with the high spade of single parenthood, divorce and separations, and remarriages, a narrow and traditional definition of family is no longer helpful (Parke, 2004; Walsh, 2003). The family, therefore, could be a network of an individual's immediate psychosocial field. They may include household members and others who, while not family members, play a significant role in the individual life. It provides companionship, socialization, and nurturing, instructs and guides the individual into social and moral values; it is the basic unit of social organization; it protects its members from harm and allows the development of emotional bound between them. (Witt, 1987).

The family has been conceptualized as a system, a dynamic whole that is greater than the sum of its parts (Kerig, Ludlow, & Wenar, 2012). Within this significant sum, naturally occurring sub-systems join the family as one entity. However, those sub-systems must be allowed to function independently; the only voluntary sub-system is the marital sub-system based on the complementary role of husband and wife. Thus this sub-system needs romantic fulfillment, the task of raising children, and functions as a leader for other sub-systems. Other sub-system includes parent-child and siblings sub-systems. However, with the spate of separations such as divorce, incarcerations, single parenthood, and African extended family systems, grandparent systems are also considered sub-systems. The sub-systems function effectively because there are boundaries that separate them; these differentiate them from other forms of social organization or systems. The boundaries define the role of individuals and allow family members the opportunity to meet and achieve their emotional and physical needs. The boundaries also allow permeation and adaptation, which promote emotional contact and independence (Minuchin, Lee & Simon, 2006). The absence of boundaries leads to enmeshment with the result that family members do not differentiate between one another, thereby losing individual freedom. Any attempt by any member to individuate will be perceived as a threat to the harmony of the family systems, which may arouse resistance or anxiety.

Family conflict is clashes, arguments, verbal disagreement, criticism, and physical aggression among family members (Davis, 1997). Interpersonal tension or struggle among two or more persons whose opinions, values, needs, or expectations are opposing or incompatible (Kramer, Boelk & Auer, 2006). Davis (1997) also defined family conflict as recurrent, stressful differences and disagreements, or overt interpersonal disagreement and a strong resentment toward a relative. Strawbridge and Wallhagen (1991) saw the family conflict as an interpersonal tension or struggle experienced by families in conflict and may be exemplified in overt behaviors, such as arguments, disagreements, name-calling or yelling, or covert feelings of resentment or anger among family members. Family conflict could lead to the failure of a mother to carry out her primary task of nurturing and teaching moral and social values to her children. It can be facilitated by cognitive appraisals of the effects of the roles and expectations from member(s) of a sub-system within the family system. As earlier stated, boundaries in the family signify the roles and obligations of each sub-system within the family system. However, when the family environment does not permit the performance of those roles, it breeds confusion and conflict. This, in turn, affects the entire family system's physical and emotional health because of its boundaries' permeability (Carr, 2006). Family conflict is different from marital discord or conflict; these occur between husband and wife, who are members of the family system.

According to Lazarus and Folkman (1984), a cognitive appraisal is a process of deciding whether an experience is positive, stressful, or irrelevant to the well-being of each family member and may serve as a source of conflict. A stressful appraisal occurs when individuals perceive that the environment's demands exceed their resources, endangering their well-being. Thus, family conflict and facilitation derive from assessing the relative demands and resources associated with family roles and focus on perceptions rather than objective characteristics that may operate outside the individual's awareness because such perceptions generally mediate the effects of more objective characteristics on outcomes (Edwards & Rothbard, 2005). Exposures to high levels of unresolved interpersonal and family conflict mediate the process of pathology. Family conflicts that are so intense are avoided through the hard pill of divorce and other forms of separation due to intractable conflict between the husband and wife, who are the only voluntary members of the family system, but this has effects on the physical and psychological well-being of other sub-systems. Many families may survive stress and conflict with a high cost to their physical and psychological health. For example, many husbands' ulcers, wives' headaches, children or child's nervous tics, and the development of anxiety and depression in the family are traceable to domestic tension and warfare (How family conflict affect health, 2016; Cumming et al., 2015; Blood, 1960).

Maternal blues is a mild symptom occurring within the first ten days of childbirth (Australia National Infancy Network, 2011; Kenerly & Gath, 1986; Pitt, 1973). It is characterized by a range of symptoms such as anxiety, crying, disturbance of sleep (Wilkie & Shapiro, 1992), irritability, the liability of mood between euphoria and misery, heightened sensitivities, tearfulness without associated sadness, restless and poor concentration (Yalom, 1968; Stein, 1982). Those symptoms may persist for hours up to several days. However, the symptoms may remit for a few days or weeks without experts' interventions (O'Hara, Neunaber & Zekoski, 1984). In some women, postpartum blues continues and becomes severe that expert attention is needed. The pattern of symptoms in women with postpartum distress is similar to those with clinical stress unrelated to childbirth (Wisner, Parry & Piontek, 2002). The clinical presentation of postpartum distress is characterized by tearfulness, despondency, emotional liability, feelings of guilt, loss of appetite, and sleep disturbances; other symptoms are feeling of inadequacy, unable to cope with infant care, poor concentration and memory loss, fatigue and irritability (Robinson & Stewart, 2001).

Screening for postpartum mood disturbances can be arduous because the numbers of somatic symptoms typically associated with having a new baby are also symptoms of significant distress (Nonacs & Cohen, 1998). Differentiating between distress and the supposed "normal" sequelae of childbirth, such as changes in weight, sleep, libido, and energy challenges, complicate clinical diagnosis (Hostetter & Stowe, 2002). However, efforts have been made by the International Classification of Diseases tenth edition ICD-11 (World Health Organization, 2019) and The Diagnostic and Statistical Manual of Mental Disorders 5th edition (American Psychiatry Association, 2013) to streamline diagnostic criteria for a postpartum depressive episode.

This study's objective is to determine if family conflict would predict postpartum distress. Postpartum distress in this study refers to the psychological distress that follows childbirth from the moment the placental is expelled to the sixth week after delivery. This study differs from other studies because the study tends to use a diagnostic measure because we do not intend to label our participants; we, therefore, adopt the Symptom Checklist -90 (SCL90). The postpartum distress measured in this study is psychosomatization, Obsessive – Compulsion, Hostility, and Phobic anxiety as defined by the SCL-90. Other studies on postpartum distress focused on other areas, especially postpartum depression, defined as depressive episodes following childbirth (Oyemaechi, Aroyewun, and Ifeagwazi, 2017). While family conflict refers to disagreements, fights, and loss of temper that occurs within the family as measured by the family conflict subscale of the Family Environment Scale (Moss and Moss 1986). Thus, we hypothesize that family conflict will significantly predict postpartum distress.

METHODS

Participants

The participants of this study were drawn from women who were attending immunization clinics and those who have given birth and are still in the maternity ward at the two tertiary hospitals in Lokoja. Mothers who delivered their babies from the moment the study commenced and those that delivered within the last two weeks before conducting the study were sampled. Those who had cesarean section and other assisted delivery methods were excluded from the study. A purposive sampling method was employed, and only those who agreed to participate in the study were included. The participants were 16-40 years, with a mean age of 28—a total of two hundred and seven women were sampled after obtaining written consent.

Instrument

Symptom Distress Checklist – 90 (SCL90: Derogates, Lipman & Covi, 1977): Comprised 90 items, and it was designed to assess ten primary categories of symptoms associated with distress among psychiatric outpatients and with the experience of anguish arising from the problems of living among people in the general population. The SCL 90 is administered individually or in groups after establishing adequate rapport with the clients. The categories of factors measured by the instrument are: (a) Somatization; bodily pains discomforted dysfunction; (b) obsessive-compulsive; irresistible thoughts, impulses, and actions; (c) interpersonal sensitivity discomfort in social situations; (d) Depression; loss of vital energy, interest, and motivation, (e) Anxiety; restlessness, Nervousness, and tension, (f) Hostility; feelings of anger, bared, repression and unfriendliness; (g) Phobic anxiety; Irrational fear and avoidance of persons, places, and situations. (h) Paranoid ideation; suspiciousness, distrustfulness, and blaming others. (i) psychoticism, hallucinations, delusions, and externally manipulated thoughts; (j) Neuroticism, poor sleep, and appetite feeding of meekness. Each of the subscales is scored separately. Derogates et al. (1977) reported alpha coefficients that ranged from .77 for psychoticism to .90 for depression. One-week internal test-retest reliability coefficients ranged from .78 and hostility to .90 for phobic anxiety. Erinoso (1996) reported significant concurrent validity between the retirement stress inventory (Omoluabi 1996) and SCL-90 scales which ranged from .26 for the scale (hostility) to .47 for the scale of neuroticism on the big five personality inventory. The inventory was pilot tested, and Cronbach's alpha of .96 using 56 lactating women from Nsukka district hospital.

Family Conflict Scale: The family conflict was measured using the family conflict subscale of the Family Environment Scale (Moss & Moss, 1986). The FES is a self-report

instrument consisting of 90 items with two response options: yes or no. The scale is designated to measure the social and environmental characteristics of families. The scale has three parallel forms, and each is compared in 10 subscales. The conflict subscale consists of 9 items that measure the amount of openly experienced anger and clashes among family members. The subscale contains questions like "Family members sometimes get so angry they throw things" and "we fight a lot in our family." The level of family conflict is calculated by adding up all nine items on the subscale. Moss and Moss (2002) reported an internal consistency coefficient of .64 for the conflict subscale and a test re-test of two months internal coefficient of .74. The instrument has a discriminate validity comparing the conflict subscale with the clinical scale of the MMPI. The highest correlation across male and female sample correlate with clinical scale 4 (psychopathic deviate), the conflict subscale $r=30$, and the infrequent scale .26 these relations family conflicts suggest the scale measured deviance, Whether behavioral or in response styles tend to be associated with family conflict (Saucier, Wilson & Warka, 2007). For this study, the researcher conducted a pilot testing of the instrument to establish its reliability among the Nigerian sample. The researcher obtained internal consistency and a total item correlation of .63 using 56 lactating mothers in Nsukka District hospital.

Procedure

The researcher met the Head of the immunization or maternal and child health clinic and introduced himself and the research assistants, who were postgraduate students; he explained the purpose of his visit and sought permission from the hospital authority to carry out the study. The on-duty officer introduced the researcher to the moms, and the researchers were permitted to provide the day's health talk to build rapport with mothers who were visiting the hospital for immunizations or who had just given birth and were still there. They were also given an explanation of the exclusion principle and the study's goal. After the participants had filled out the items on the instruments, the instrument was administered to them and then collected. No participant was permitted to take the instrument home with them. The study's participants received a debriefing and were thanked for participating. The maximum amount of time allotted for completion was three hours.

Design/Statistics

The design of the study employed was the cross-sectional design. Multiple linear regression was used for data analysis. Statistical Package for the Social Sciences version 20.0 was employed for data analysis.

RESULTS AND DISCUSSIONS

Table 1: Regression model summary showing Family conflict as predictors of somatization, Obsessive-Compulsion, Hostility, and Phobic Anxiety.

Variable	R	R Square	Adjusted R Square
Somatization	.34 ^a	.11	.08
Obsessive-Compulsion	.33 ^a	.11	.08
Hostility	.39 ^a	.15	.12
Phobic Anxiety	.43 ^a	.19	.16

The result of the model summary shows the strength of the relationship between family conflict on Somatization, Obsessive-Compulsion, Hostility, and Phobic Anxiety. It indicates R, R² and AR² as (Somatization .34, .11 and .08), (Obsessive-compulsion .35, .11, and .08), (Hostility .39, .15, and .12) and (Phobic anxiety .43, .19 and .16). Having portrayed adjusted R square (AR²) as follows; (Somatization .08), (Obsessive-compulsion .08), (Hostility .12) and (Phobic anxiety .16). It indicates that family conflict is implicated for about 8%, 8%, 12%, and 16% of the variation in Somatization, Obsessive-Compulsion, Hostility, and Phobic Anxiety, respectively among postpartum mothers.

Table 2: Linear regression Beta coefficients showing significant predictor Family conflict on psychosomatization

Variables	Unstandardized Coefficients		Standardized Coefficients	T
	B	Std. Error	Beta	
Family conflict	.971	.325	.206	2.985**

Note: ** P < .005

The table above shows a significant relationship between family conflict and psychosomatization ($\beta = .20$, $t = 2.98$, $P < .005$).

Table 3: Lineal regression Beta coefficient showing significant predictor Family conflict on obsessive-compulsion

Variables	Unstandardized Coefficients		Standardized Coefficients	T
	B	Std. Error	Beta	
Family conflict	.973	.335	.201	2.907**

Note: ** P < .005

The table indicate significant relationship between family conflict ($\beta = .20$, $t = 2.90$, $P < .005$)

Table 4: Linear regression Beta coefficient showing significant predictor Family conflict on hostility

Note: ** P < .001

Variables	Unstandardized Coefficients		Standardized Coefficients	T
	B	Std. Error	Beta	
Family conflict	1.040	.282	.249	3.684**

The table above shows a significant relationship between family conflict and hostility ($\beta = .24$, $t = 3.68$, $P < .005$).

Table 5: Linear regression coefficient showing significant predictor Family conflict on Phobic anxiety.

Variables	Unstandardized Coefficients		Standardized Coefficients	T
	B	Std. Error	Beta	
Family conflict	1.155	.229	.333	5.044***

Note: *** P < .001

The table indicates a significant relationship between family conflict ($\beta = .33$, $t = 5.04$, $P < .001$) and phobic anxiety.

Discussion

The finding indicates that family conflict is associated with psychosomatization during the postnatal period, thereby being implicated in the experience of distress during the postpartum period, thus confirming the hypothesis that states that family conflict will significantly predict postpartum distress. This finding supported the study of Guo (2010) posits that low conflict in the family could improve family interaction and reduce distress among new mothers. However, Nolen-Hoeksema (2004) observed that most African countries somatize due to the absence of an appropriate lexicon to express or adequately express emotional feelings. Goodenough (1995) observed that childbirth could be traumatic to the level that it could cause a somatic complaint; further, the typical pains associated with childbirth could be hardly separated from somatic complaints like sore muscles and fearfulness.

Family conflict also predicated obsessive-compulsions behaviour during postpartum distress and is responsible for some level of distress expressed by the postpartum mothers. Adebayo, Adekanle, Mosanya, and Opakunle (2013) observe that postpartum Obsessive Compulsive acts are directed or related to the foetus or the newborn child. While Abramowitz, Schwartz, and Moore (2003); Buttolph, and Holland (2009), reported that women with postpartum obsessive compulsion disorder harboured thoughts of harming their baby with a knife or any shape object, and ruminations are highly

intrusive and disturbing and, in severe cases may lead to abandonment or neglect of the baby out of fear of hurting the baby. Several case reports show that pregnancy and the postpartum period are associated with the onset of obsessive-compulsive disorder more frequently than other life events (Uguz and Ayhan 2011). The aetiology of postpartum onset obsessive-compulsive disorder is unknown. However, the acute onset may be due to the dramatic, rapid fall in the female hormones estrogens and progesterone, resulting in a dysregulation of serotonin, which then interacts with any predisposition to mental disorder. Another hypothesis regarding aetiology may be the rapid increase in oxytocin to a high level near the end of pregnancy and postpartum, which may trigger an exacerbation or the onset of obsessive-compulsive disorder (Beck and Driscoll, 2006). Conflict breeds mistrust, and the new mother in a conflict situation may develop obsessive thoughts about herself and harm the child. This obsessive thought triggers the compulsive behavior of checking and repeated cleaning of the house, hands, and other objects due to feelings that the child could be infected. This study confirms Arnold (1999), who observed that obsessive-compulsive symptoms could develop in the postpartum period with associated compulsive checking that may not be resolved without expert intervention.

Family conflict is also significant in the manifestation of postpartum distress. It is implicated in distress associated with childbirth (Mastrogiacamo et al., 2013) studied postpartum hostility in women with gestational hyperprolactinemia and found that hyperprolactinemia is implicated in developing postpartum hostility. Many studies have confirmed pregnancy and delivery as a period of isolation and reduced income and friendships (Thorpe & Elliot 1998). Family conflict tends to reduce social, emotional, and physical support associated with pain or trauma in childbirth.

Family conflict significantly contributed to the distress experienced during postpartum and is significantly related to postpartum distress. Phobia is an irrational fear of an object or a situation leading to avoidance. It is an abnormally fearful response to a danger that is imagined or irrationally exaggerated. Tokophobia can lead to a woman avoiding pregnancy, terminating the pregnancy of a very much-wanted baby, or demanding a cesarean section in subsequent pregnancies. It has been classified that a mother with infant-focused anxiety may develop a phobia of the infant. Brockington, Macdonalds, and Wainscott (2011) describe the fear of cot death and say that a cause of severe chronic anxiety in the postpartum is fear of sudden infant death syndrome. They are mothers who will not let their infants sleep; for fear that they may stop breathing and other may wake them to see if they are alive. These mothers experience severe insomnia because they must lie awake listening to the baby's breathing; they may check the infant 20-30 times every night. (Fear of childbirth) occurs during pregnancy, making

some women seek an abortion or cesarean section; after childbirth, this fear progresses as the woman fears that the baby may die from clot death. This makes the woman lose sleep and increases visits to the hospital, with many complaints about the child's health. Most of those women show vital signs of anxiety or depressive disorders.

Psychological literature about women in postpartum restricted itself to inwardly focused negative experiences; depression was the most studied psychological phenomenon during the postpartum period. Other aspects of women's emotions and changes that may occur to the women's psychological and social world after delivery are under-researched (Kassinove & Sauchodosky, 1995; Thomas, 1995). This may be due to stereotypes about women's emotional responses to negative experiences (Graham, label, and Stein- Deluca 2002). Hence this study has contributed theoretically and empirically to the body of literature to understand women's emotions at postpartum.

To the researcher's knowledge, much has not been found on psychological distress that includes psychosomatic complaints, hostility, phobic anxiety, and obsessive compulsion findings from this study may serve as a springboard to other researchers who may be interested in the study of women in their postpartum period. The study also included demographic attributes related to interpersonal relations and dynamics in a family setup, that is, peace and conflict within the system, and whether this factor could allow adjustment in the postpartum period.

The study did not dwell on the clinically diagnosed patient or use those that report to the hospital due to distress associated with the child. However, samples are taken from a population with high social and emotional support, with a culture of externalization of the attribute but using instruments employed in clinical diagnosis. Findings still show that significant percentages of women have a particular kind of distress or others without reporting the same for proper professional assistance.

CONCLUSION

The study concludes that family conflict predicts postpartum distress among women in Kogi state, Nigeria. The result of this study implies that family members should pay attention to their conflicts by preventing or resolving them promptly to enable the woman in the puerperium to thrive rather than being held back in distress by the effect of family conflict. Thus, enhancing conflict resolution strategies, quality, and positive relationships with family since the present study identifies family conflicts as influencing postpartum distress. Although the finding of a single study could not be generalized to the entire population, This study would then guide further studies in understanding factors that could lead to adjustments in childbirth and postpartum. Finally, despite the

study's broad conclusions and significant contributions to knowledge, the data for the study was gathered from two healthcare facilities in the exact location. Thus, there are no bases for comparing our data and findings with other healthcare facilities within and outside the nation.

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