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Preliminary report

The maternity blues and Hong Kong Chinese women: an exploratory study

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Abstract

Background: The maternity blues have been studied world-wide and are generally regarded as a cross-cultural phenomenon. However, low prevalence rates of the blues have been reported recently in studies of Japanese women. The purposes of this study are, firstly, to establish whether the low prevalence noted in Japanese women is also found in another group of Asian women, that is, Hong Kong Chinese women, and secondly, to describe the manifestations of the blues in this group of women. *Method:* A prospective survey involving a convenience sample of 88 women, recruited on the first day after normal or operative vaginal delivery. Participants completed a blues self-rating scale (Stein's Daily Scoring System) every day for the first 7 days after delivery. Data were analysed mainly in terms of descriptive statistics. *Results:* 39 (44.3%) women experienced an episode of the blues during the first week after delivery. The manifestations of the blues showed a typical peaking on the 5th postnatal day. *Limitations:* This is a short-term exploratory study. Further investigation is required into the factors influencing or precipitating the blues, particularly from the cultural perspectives of childbearing Hong Kong Chinese women. *Conclusion:* Hong Kong Chinese women experience the maternity blues in similar ways to those reported by studies of women in other countries and cultures, with the exception of those describing the blues in Japanese women.

Keywords: Maternity blues; Cross-culture; Hong Kong Chinese women; Postnatal disorders

1. Introduction

The maternity blues have been studied in a variety of countries and cultural groups, including Europe, United States, United Kingdom, Africa and Asia (Stein, 1980; Harris, 1981; Ehlert et al., 1990; O'Hara et al., 1990; Yoshida et al., 1993; Murata et al., 1998). Although no standard definition of the maternity blues has been used across studies, its prevalence has been fairly consistently reported as between ~40% and 60% (Harris, 1981; Condon and Watson, 1987; Levy, 1987; Ehlert et al., 1990; O'Hara et al., 1990). An exception to this has been found by Yoshida et al. (1993) and Murata et al. (1998) who found prevalence rates of the maternity

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blues in Japanese women of 25% and 15%, respectively. The reason for this low rate has not been satisfactorily explained, although Kumar (1994) suggested that it might be a reflection of the reputed stoicism of the Japanese character and their reluctance to show emotion. This raises a question whether the maternity blues are indeed a cross-cultural phenomenon, or are less prevalent and/or manifest differently in Asian women. In an attempt to answer this question this present study has investigated the prevalence and manifestation of the maternity blues in a specific Asian cultural group, that is, Hong Kong Chinese women.

Hong Kong is a city caught between traditional Asian culture and western ideas. Nevertheless, many facets of traditional Chinese culture remain which share features of a wider, Asian culture that has some similarities with Japanese practices. For example, under the influence of Confucianism, which focuses on interpersonal relationships and social obligations, Chinese people are required to practice self-restraint and exhibit prudence, benevolence and righteousness (Shih, 1996). Furthermore, many Hong Kong Chinese women continue to follow traditional cultural practices relating to childbirth which are similar to those of Japanese women, for example, the ritual of 'doing-the-month' which requires the woman to stay secluded, rest and follow various traditional practices for at least the first month after delivery (Pillsbury, 1978). During this time the woman is usually well supported by her family and may stay with her own mother for the one whole month. This is similar to the traditional Japanese practice described in the Murata et al. (1998) study. The blues have not been studied before in Hong Kong Chinese women and this study attempts to answer the question whether the low prevalence noted in Japanese women is also found in this other group of Asian women.

2. Method

2.1. Study design

This prospective study was conducted in a university-affiliated general hospital in Hong Kong. A convenience sample of 100 Hong Kong Chinese women were recruited into the study the first day following delivery, in order to facilitate tracking the maternity blues from the beginning of the postnatal period. Women delivered by caesarean section were excluded from the study because the pilot study revealed they were rarely sufficiently recovered from such recent surgery to feel able to participate. Inclusion criteria were thus: Chinese women, resident in Hong Kong, who had normal or operative vaginal deliveries, and whose babies were alive and not requiring special or intensive care.

Stein's Daily Scoring System (SDSS) (Stein, 1980) was used to record the manifestation and intensity of the maternity blues. The SDSS is a validated self-rating scale consisting of 13 common blues symptoms. Women scoring 8 or above on one or more days after delivery were considered to have had the blues.

In order to use the SDSS for a Chinese population, the scale was translated into Chinese. The translation was done by one of the researchers and back-translated by another bilingual midwife. Face validity was confirmed by a panel of local experts including a psychiatrist, an obstetrician and two experienced midwives. Ambiguous meanings in the Chinese translation were corrected.

Participating women were asked to complete the blues scale every evening for the first 7 days following delivery, posting back the completed forms if transferred home during that time. Demographic details, medical and obstetric histories of the participants were compiled from the medical records.

3. Results

3.1. Response rate and sample characteristics

Eighty-eight completed sets of SDSS were returned giving a response rate of 88%. No significant differences were found between the response and non-response group in terms of social and obstetric demographic characteristics. Table 1 summarises the sample characteristics.

3.2. Incidence and timing of the blues

The maternity blues were assessed as having occurred when 8 points or more were scored on the

Table 1
Sample characteristics

	Category	Frequency	Percentage
Age	18–24	15	17.0%
	25–29	33	37.5%
	30–34	29	33.0%
	35–39	11	12.5%
Education level	Primary	4	4.5%
	Secondary	75	85.2%
	Tertiary	9	10.2%
Marital status	Single	2	2.3%
	Married	86	97.7%
Occupation	Housewife	30	34.1%
	Working	58	65.9%
Parity	Parity 0	48	54.5%
	Parity 1	34	38.6%
	Parity 2	6	6.5%
Number of years in Hong Kong	<2	1	1.1%
	2–5	8	9.1%
	5–10	4	4.5%
	>10	16	18.2%
	Since birth	59	67.0%

SDSS on one or more days (Stein, 1980). According to this criteria, 39 women (44.3%) experienced maternity blues in the first 7 days after delivery.

Following analysis of the daily mean score of all subjects over 7 days, some differences were noted between the blues and the non-blues group. The blues group (Fig. 1a) showed a distinct peaking score on day 5, whilst the non-blues group (Fig. 1b) showed a slight peaking on day 2, afterwards progressively diminishing. Fig. 1c summarises the different groups mean score over the 7 days, demonstrating a difference in trend.

3.3. Demographic variables and blues

The blues group and non-blues group did not differ significantly on any of the following demographic variables: parity, education level, marital status, occupation, mode of delivery, feeding method, baby's condition, length of stay in hospital and number of years in Hong Kong. The only significant variable was age ($\chi^2 = 7.99$, 3 df, $P < 0.05$), women aged between 35 and 39 showing a lower incidence of blues.

3.4. Duration of the blues

Women experienced the blues for differing periods of time in the first week postpartum. Twenty-four (62%) experienced blues for just 1 or 2 days, 10 (25%) had blues symptoms for 3–4 days, while five (13%) had a prolonged period of blues symptoms for 5–6 days.

3.5. Manifestations

The time course for individual symptoms is shown in Fig. 2. Some symptoms, particularly crying, headache, dreaming, restlessness, concentration and anorexia, show a peak on day 5, mimicking the blues peaking trend. Depression and concentration peaked on both days 2 and 5. Others, such as irritability, anxiety, confusion, tension, insomnia, tiredness show a gradual daily diminution, possibly reflecting a recovery process after labour.

4. Discussion

The maternity blues have been observed in many different countries and cultures, the prevalence remaining fairly consistent. This study of Hong Kong Chinese women has shown that the prevalence of blues was 44.3% which is similar to reported prevalences from Britain (43%), United States (41.8%) and Europe (41%) (Kennerley and Gath, 1989; Ehlert et al., 1990; O'Hara et al., 1990). An important exception to this has been found in Japan, where lower prevalences of 25% and 15.5% have been demonstrated (Yoshida et al., 1993; Murata et al., 1998). There may be two possible reasons for these findings. Firstly, the lower prevalence of the blues in Japanese women may be explained by the different methodological approaches. The Hong Kong study, in common with many others, was prospective, participants being asked to record the symptoms daily throughout the first postpartum week. Yoshida et al. (1993) and Murata et al. (1998), however, took a retrospective approach, asking participants to recall on days 5 and 7 their experiences during the previous days. The second explanation offered concerns the rapid changes in Hong Kong's socio-economic environment over the past few decades, which has to

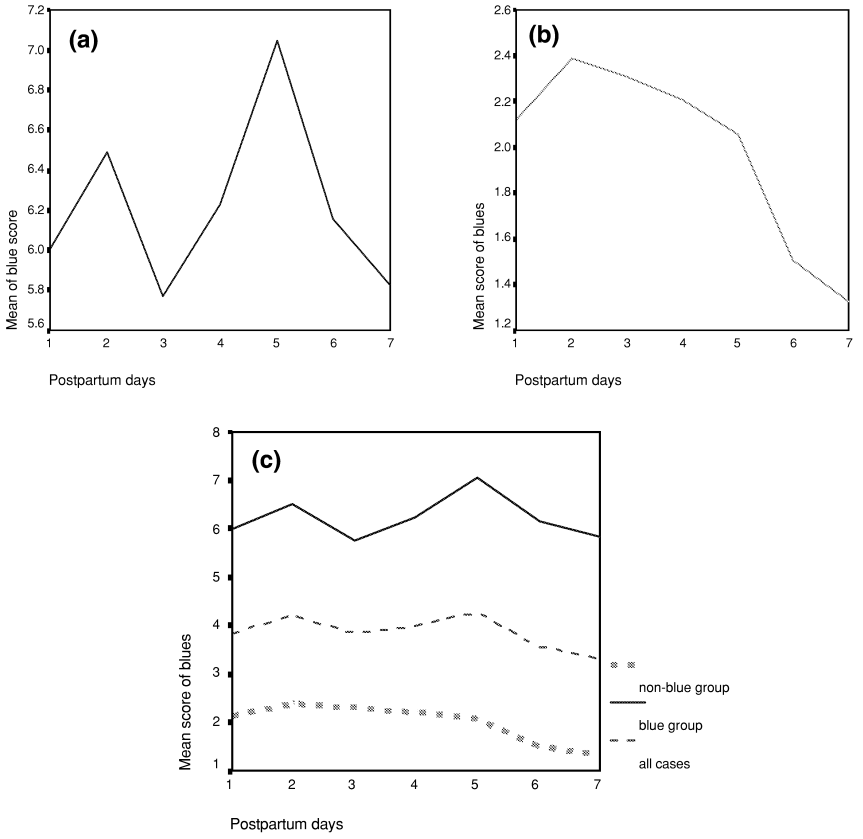

Fig. 1. Timing of blues.

some extent discolored and diluted the impact of cultural influences. Not all Hong Kong women 'do the month' and many have to cope with pregnancy and labour with limited help, similarly to women from Western countries. Murata et al.'s (1998) study was carried out in one of the most traditional districts in northern Japan, where the influence of the extended family is still predominant and newly delivered women receive much family support. This support may help to reduce the appearance and severity of the blues.

Concerning the timing of blues, the current findings showed a peaking of symptoms on day 5. This is consistent with many other studies (Stein, 1980; Kendell et al., 1984; Iles et al., 1989; Beck et al., 1992; Rohde et al., 1997).

The blues may be differentiated from a more general dysphoria by its tendency for symptoms to peak at around the 4th day following delivery. One point to note was that there seemed to be an additional, although less prominent, peak on day 2. This may be explained in the light of the three studies conducted to compare postpartum women with postoperative patients (Kendell et al., 1984; Levy, 1987; Iles et al., 1989), who found that postoperative patients had higher dysphoria scores on days 1 or 2 which declined steadily thereafter. They suggested that this might be a general response to the physical stressors of surgery. Referring to our findings, it seems reasonable to suggest that the physical stressors of parturition generate a dysphoric, but non-blues response similar to that experienced by patients 1 or 2 days following surgery. This suggestion is supported by the time course noted for individual symptoms. For example, in the blues group, crying, depression, headache, dreaming, restlessness and anorexia peaked on day 5, whilst other symptoms such as irritability, anxiety, tension, tired-

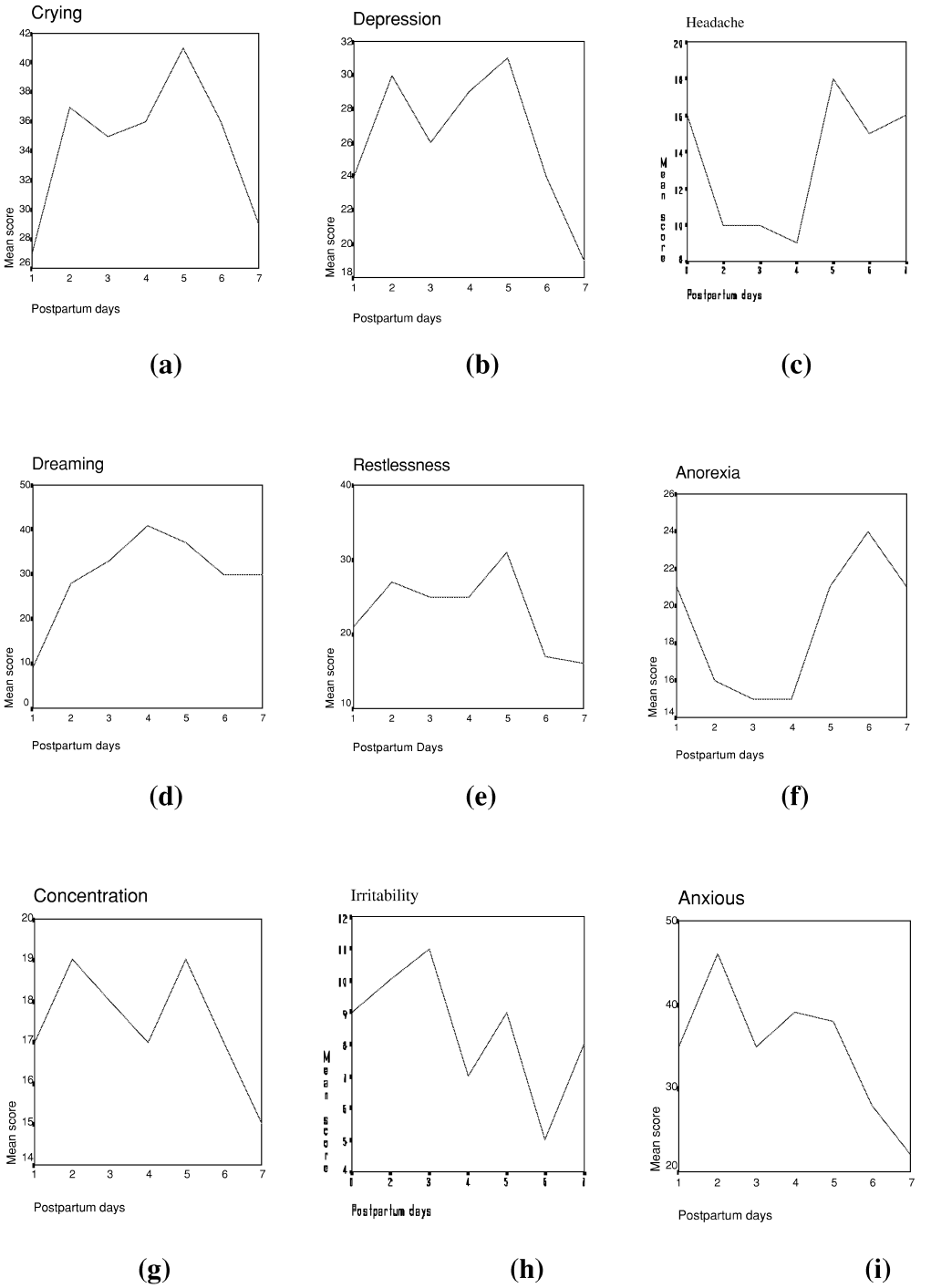

Fig. 2. The pattern of symptoms in the first postpartum week. (a) Crying; (b) depression; (c) headache; (d) dreaming; (e) restlessness; (f) anorexia; (g) concentration; (h) irritability; (i) anxiousness; (j) tension; (k) insomnia; (l) tiredness; (m) confusion; (n) forgetfulness.

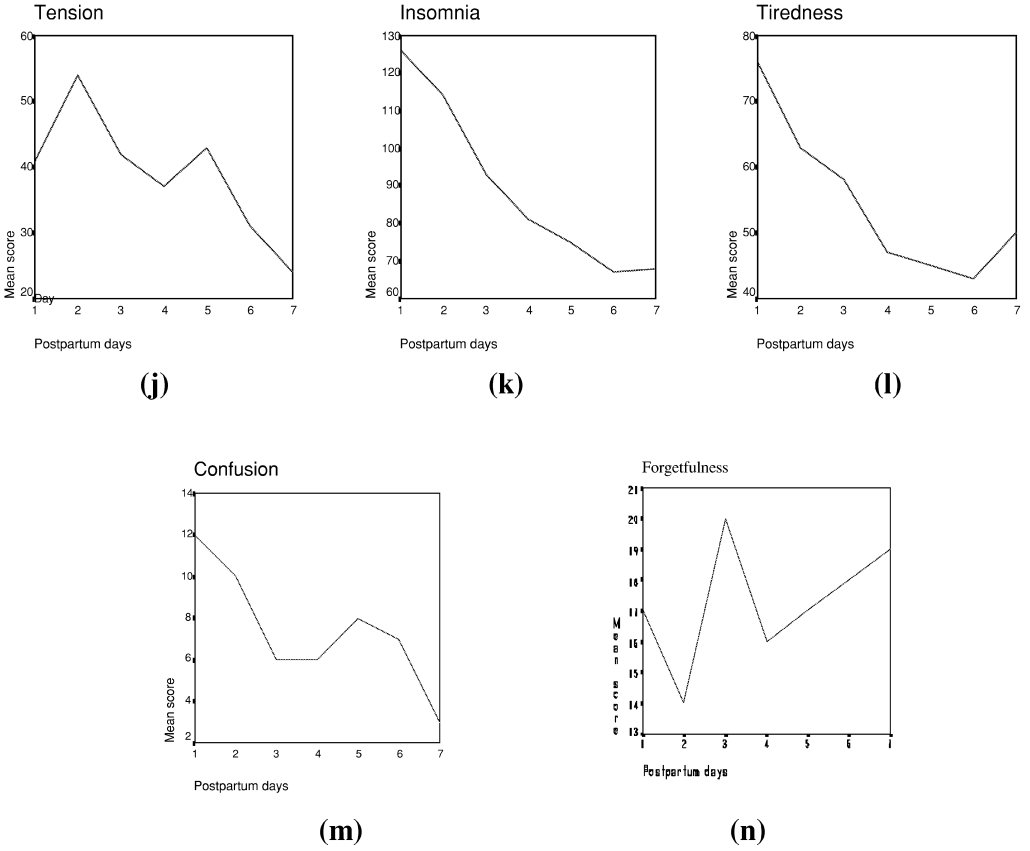

Fig. 2. (*continued*)

ness and insomnia showed a peak on days 1 or 2, gradually diminishing after this. The day 2 peaking symptoms were similar to those peaking in surgical patients (Levy, 1987). This suggests that both the postpartum and post-operative women may have experienced a similar response to physical stress and trauma, some of the symptoms mimicking those of the blues.

The only relationship found between the blues and psychosocial and obstetric factors was that of age, women between 35 and 39 years of age showed a significantly lower incidence of blues. Again these findings were generally in agreement with those of earlier published studies (Kendell et al., 1981; Kennerley and Gath, 1989; O'Hara et al., 1991; Lanczik et al., 1992).

To conclude, this is an exploratory study with only a small convenience sample. Nevertheless, it presents some unique aspects that offer a better understanding of the maternity blues, which have never been studied in Hong Kong. This study has confirmed that the maternity blues are experienced by Asian women, specifically, Hong Kong Chinese women, in a similar way to women in most other countries and cultures.

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