Original Article

Incidence of Depression: Prenatal to Postnatal

Farah Ishaq[1], Yousaf Jamal[2]

[1]Department of Psychology, University of Gujrat, Pakistan, [2]Professor, Department of Psychology, Hafiz Hayat Campus, University of Gujrat

***Address of Correspondence**: Farah Ishaq, Department of Psychology, University of Gujrat, Pakistan*
Email: farahumerch@gmail.com

Abstract

Objective: The main objective of the present study was to find out the difference between prenatal and postnatal scores on measures of Edinburgh Postnatal Depression Scale (EPDS) and Postnatal Depression Predictors Inventory -Revised (PDPI-R) among mothers of Sub-District Kharian, Pakistan.

Methodology: A prospective pre-post test design was used to carry out the research. Initially, a purposive sample of 210 pregnant women in third trimester of pregnancy was taken. 92 women completed both prenatal and postnatal phases of the research that were finally included in further analyses. Edinburgh Postnatal Depression Scale (Cox, 1987) translated in Urdu by Rahman, Iqbal, Lovel and Shah (2005) was used to screen women for prenatal and postnatal depression. Postnatal Depression Predictors Inventory-Revised (Beck, 2001) was translated into Urdu to investigate low self-esteem, marital satisfaction, social support, planned pregnancy, depression, anxiety, history of depression and stressful life events. Procedure of data collection comprised of two steps. In step 1 the scales were administered to prenatal sample and in step 2 the same procedure was revised for postnatal sample. Repeated measure t-test was employed to find the difference of scores among variables.

Results: Women were more depressed during prenatal period (M=10.35, SD= 4.88) as compared to postnatal period (M=8.9, SD=4.67), t (91) =3.07, p=0.003. The other findings showed that there was a difference in perceived stressful life events from prenatal (M=1.72, SD=1.45) to postnatal period (M=1.42, SD=1.42), t (91) =2.44, p=0.01.

Conclusion: The results showed that there was a significant drop in depressive symptoms after delivery of the child. Moreover, mothers during prenatal period perceived life events as more stressful as compared to during postnatal period.

Key words: Prenatal Depression, Postnatal Depression, Maternal Mental Health, PND in Pakistan.

Cite this article as:.Ishaq F, Jamal Y. Incidence of Depression: Prenatal to Postnatal. J.Soc. Obstet. Gynaecol. Pak. 2017; Vol 7(1):38-44.

Introduction

Prenatal mental health of mother has been considered inconspicuous, peripheral and marginal especially in developing countries. Pakistan has a high neonatal, infant and maternal mortality rate. Less than 60% pregnant women in Pakistan receive prenatal care from a skilled health professional at least once during pregnancy (Gulamani & Chagani, 2013; WHO, 2007).[1,2] Culturally women have specified roles in family that they must carry even during and after pregnancy. Undetected disorders related to childbearing have many times evoked serious consequences such as infanticide and suicide. Usually women are reluctant to speak about themselves and their feelings with a fear of being stigmatized. Feeling low or depressed during pregnancy or after the delivery of child is not considered a health problem rather a normal experience of motherhood period (Rahman & Creed, 2007).[3]

Research in the area of prenatal mental health has gained momentum in past few decades. The recent literature has focused that prenatal mental health issues can be a precursor for subsequent mental health problems in a woman's life. The global prevalence of prenatal depression is approximately 13 % to 18 % (National Institute of Health Care

Authorship Contribution: [1]Literature review, questionnaire design, data collection and drafted the manuscript, [2]Statistical analyses, Study Design and final approval of the study.

Funding Source: none **Received:** Dec 11, 2016 **Accepted:** Mar 17,2017

Conflict of Interest: none

Management United States, 2010).[4] The reported incidence of prenatal depression in Pakistan has been diverse falling between the range of 35% to 65% (Humayun, Haider, Imran, Iqbal, & Humayun, 2011).[5] In a hospital based study at Karachi by Hamirani, Sultana, Ibrahim, and Iqbal (2006) using EPDS the incidence of depressive symptoms was determined among a sample of 75 pregnant women during 26-36 weeks prenatal. The prevalence of prenatal depression was found as 34%.[6]

Similar studies depict a high incidence of postnatal depression as well. A study was conducted by Kalyani, Saeed, Rehman, & Mubbashar (2001) in Rawalpindi, Pakistan. EPDS was used at a cutoff point of 10.[7] The women screened as depressed were also interviewed clinically. It was found that 38% women were suffering from postnatal depressive symptoms. A literature review by Klainin & Arthur (2009) on postnatal depression in Asian countries summarized that incidence of postnatal depression is highest in Pakistan (63%) as compared to other countries.[8]

A longitudinal cohort study was conducted in Avon, by Evans (2001).[9] Mothers' mood during pregnancy and after childbirth using EPDS at a cut-off point of 12 or greater was demonstrated. The results concluded that depressive symptoms were more common during pregnancy (13.5%) than after the birth of child (9.1%). Similar findings were also obtained from various studies conducted in Pakistan. Rahman, Iqbal and Harrington (2003) assessed women during third trimester of pregnancy and again at 10-12 weeks after delivery (N=541) using Schedule for Clinical Assessment in Neuropsychiatry (SCAN) in southern Kahuta, Pakistan.[10] The results showed that the prevalence during prenatal and postnatal phase was 25% and 28% respectively. In another study by Rahman and Creed (2007), the persistent pattern of prenatal to postnatal depression was investigated. The results revealed that poor women that have more psychological symptoms during pregnancy are more likely to remain depressed after one year of child birth. It can be concluded that the difference in reported incidence of prenatal and postnatal depressive symptoms is due to the difference in screening instruments and cut-off points in various related studies.

Prenatal phase is highly significant for both the mother as well as child not only in terms of physical health but also psychological health. Connor, Heron, and Glover (2002) investigated that prenatal maternal stress is related to high rate of developmental and cognitive delay as well as high rate of emotional and behavioral problems among children.[11] Overall, about 10 % of women reported that the symptoms they experienced during the postnatal period actually precipitated during pregnancy (Sadiq, 2009). Thus, the symptoms of depression detected during pregnancy can predict early postnatal depression (Verkerk, Pop, & Vanson, 2003).[12]

Significance of the Study: Prenatal and postnatal depression not only disrupts the life of mother but also cause adverse effects on the development of the fetus. There is a worldwide surge to pay attention to maternal and neonatal mental health. As a result, an improved maternal and neonatal mental health has become an integral part of millennium development goals by World Health Organization. Unfortunately, maternal mental health such as prenatal and postnatal depression is still a greatly neglected area in Pakistan and most of the cases simply go unnoticed. The incidence of prenatal and postnatal depression in Pakistan is not precisely determined. However, there is consensus that prenatal and postnatal depression is highest in Pakistan as compared to other countries. This study also supports high incidence of depressive symptoms during prenatal and postnatal period.

Methodology

A prospective pre-post test design was used for the present study.

Sample: All pregnant women in 3rd trimester of pregnancy during June 2014 to September 2014, routinely coming to maternity unit of Tehsil Head Quarter Hospital (THQ) Kharian were the target population. A sample of 210 pregnant women was initially approached through purposive sampling. Among this sample, 92 women completed both prenatal and postnatal period of the study (Figure 1).

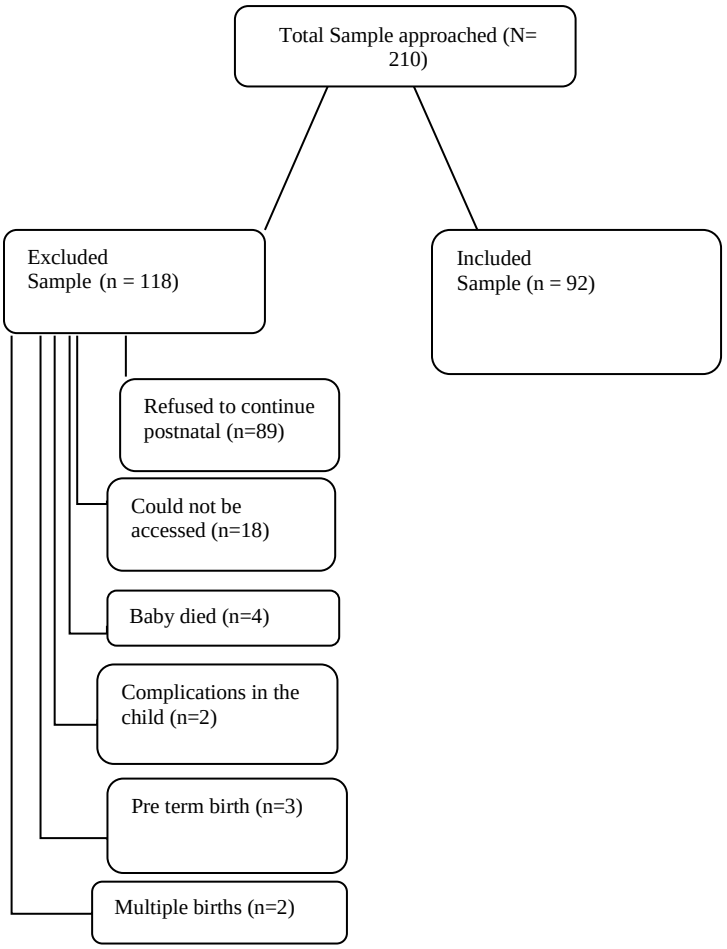


Figure 1. Flow chart regarding sample selection of participants

Instruments

Edinburgh Postnatal Depression Scale (EPDS).

The Edinburgh Postnatal Depression Scale (EPDS) was developed by Cox, Holden, and Sagovsky (1987). [13] The instrument was translated in Urdu by Rahman, Iqbal, Lovel, and Shah (2005). The instrument is 10 items, 4 point likert type scale that range from 0 to 3 depending on the severity of the response. It provides severity of symptoms during the past week. Higher scores indicate more severe depressive symptoms with a maximum total score of 30.

The instrument has moderate to high reliability i.e. from 0.70 - 0.88 (Murray, 2000; Rahman et al., 2005; Westall, 2011) and validity with a sensitivity of 86% and specificity of 78% (Beck & Gable, 2001; Records, 2007).[14,15,16] Urdu version of EPDS has been widely used in studies related to postnatal depression in Pakistan.[17,18,19,20,21] (Bjerke, 2008; Husain et al., 2012; Khooharo et al., 2010; Muneer, 2009; Rahman et al., 2005).

Postnatal Depression Predictors Inventory Revised (PDPI- R). The PDPI-R was developed by Beck (2001).[22] The guided questions of the Inventory are in Yes/ No format. PDPI-R prenatal version assesses 10 predictors of prenatal and postnatal depression. Item scores are summed up to obtain a total score. In addition each predictor can also be scored individually.

PDPI-R was translated in Urdu using MAPI guidelines for translation of instruments (Beaton, Bombardier, Gullemin, & Ferraz, 2000).[23] The permission was taken from the test developer to use this instrument for the study. The reliability co-efficient during prenatal was 0.86 for the translated version.

Procedure

Permission letter regarding data collection was provided to the concerned authority of Government Tehsil Headquarter Hospital Kharian. After the permission was granted a meeting was arranged with the head of obstetric department to ascertain the procedure for data collection. The women were accessed in maternity unit while they were coming up for their routine follow-ups. After written consent the questions were read out to the women sitting side by side so that they could also read the questionnaire while it was read out to them (both for the illiterate and the women that were able to read) for uniformity of procedure and to minimize missing items. Instructions as provided in the original questionnaires were followed. During the second phase the women were approached a second time within 4 to 6 weeks postnatal.

Statistical analyses. SPSS Version 20 was used for analyses of data. Results were summarized as frequency and percentages. Paired sample t-test was used for determining the difference of prenatal and postnatal scores of study variables

Results

Table I, shows the demographic profile of participants. They were all married mostly young, multigravida, housewives and belonged to extended, low income families. A few house wives enjoyed the personal stipends in the form of bank fixed profits or rental properties from which they were beneficiaries.

The employed women were the earning members of house. They were mostly school teachers' or religious scholars. Other self employed women were running small business (beauty parlors, hair dresser saloon, sales women, lady tailors and embroidery workers etc).

Table I: Demographic Profile of Sample (N=92)

Variables	*f*	%
Age (In years)		
18-30	86	(93.5%)
31-42	06	(6.5%)
Education		
Illiterate	31	(33.7%)
1-12th grade	31	(33.7%)
13th-16th grade	30	(32.6%)
Occupation of mother		
Employed	37	(40.2%)
Unemployed	55	(59.8%)
Gravidity		
Nulligravida	27	(29.3%)
Multigravida	65	(70.7%)
Family Structure		
Nuclear	40	(43.5%)
Joint	52	(56.5%)
Family Monthly Income in Rupees		
20,000 or below	43	(46.7%)
21,000-50,000	36	(39.1%)
51,000 or above	13	(14.1%)

The family structure was categorized as belonging to nuclear family or as belonging to joint /extended family. The joint families were those that lived with parents of husband. The families that were living in separate units within same house hold or away from their larger family unit were considered as nuclear families. There was much diversity in depiction of household income in a family. Many couples were not earning members of the family rather they were given financial assistance from relatives abroad such as father in-law or brother in-law or had income from other sources. The demographic characteristics remained identical from first to second assessment.

Table II, depicted that prenatal mothers scored significantly greater in depression scores (EPDS) than the postnatal mothers. The prenatal mothers' also scored significantly greater in stressful life events as compared to postnatal mothers.

Discussion

Mothers experienced more depressive symptoms during pregnancy as compared to after delivery. The life events were perceived as more stressful during pregnancy than after delivery.

EPDS is the most widely used instrument during prenatal as well as postnatal period. Moreover, it is

Table II: ***Difference between Prenatal and Postnatal Scores on Measures of EPDS and PDPI-R (N=92)***

Variables	Prenatal	Postnatal			95% CI		Cohen's
	M (*SD*)	*M* (*SD*)	*t*	*p*	*LL*	*UL*	*d*
EPDS	10.35(4.88)	8.92(4.67)	3.07**	0.00	0.51	2.36	0.30
PDPI	12.77(6.32)	12.61(6.68)	0.37	0.71	0.71	1.04	0.03
Low Self Esteem	0.07(0.29)	0.14(0.50)	1.54	0.12	0.17	0.02	0.19
Planned Pregnancy	0.38(0.72)	0.36(0.74)	1.00	0.32	0.02	0.06	0.03
Lack of Social support	7.74(3.79)	7.96(3.95)	0.64	0.52	0.89	0.45	0.06
Marital Dissatisfaction	0.66(1.12)	0.62(1.06)	0.59	0.56	0.10	0.19	0.04
Stressful life events	1.72(1.45)	1.42(1.42)	2.44*	0.02	0.05	0.53	0.21
Depression during Pregnancy	0.50(0.50)	0.50(0.50)	0.00	1.00	0.09	0.09	0.00
Anxiety during Pregnancy	0.75(0.44)	0.68(0.47)	1.35	0.18	0.03	0.16	0.15
History of Depression	0.55(0.49)	0.51(0.50)	0.94	0.35	0.05	0.14	0.08

*Note. **p < .01. *p < .05*

confined to assess the women's feelings during the past week only when it is administered. Thus EPDS is more vulnerable to transitory changes of a specified time during which the questionnaire is being administered. Two sub scales of PDPI-R, marital status and family monthly income were excluded from t-test analysis. All women in current sample were married and no difference in family income from first assessment to second assessment was reported.

Roughly estimating the figures, almost one third women were screened as depressed during prenatal (24.3% - 32.6%) and postnatal period (27.2%). It shows that depressive symptoms remained higher during both assessments. The findings are consistent with the literature review of Klainin and Arthur (2009) on postnatal depression in Asian cultures that postnatal depression is highest (63.3%) in Pakistan as compared to other countries in the region.[9]

The women during pregnancy were significantly more depressed as compared to after delivery. The high incidence of depression during prenatal period can be explained in psychosocial and cultural context. The physical condition during pregnancy, and related health issues such as backache, vomiting, diarrhea, loss of appetite that a woman usually pass through with an additive burden of fear of complications during labor induce depression. Women can also feel anxiety to undergo a safe period of motherhood. Moreover, lack of psychosocial support during pregnancy makes the women more vulnerable to perceive life events more stressful. The event of having a baby and getting out of pregnancy period after the delivery of child is itself a relief for the mother that the journey has finally ended as the baby is out of her womb.

The drop-out rate of the study was high (56%). It means that many mothers that participated during prenatal period declined to participate during postnatal period. This pattern can be explained by the traditional patrilineal culture of Pakistan. During prenatal phase women were easily approached as they were routinely coming to maternity unit. After delivery the visit to hospital by new mothers is usually restricted to some severe pathological issue. It is commonly considered that interventions related to childbearing are significant till the baby is born. Lack of family compliance also influenced mother's consent to participate during the postnatal period while they were accessed in their homes. Mohammad, Gamble, & Creed (2011), discussed that in interview settings mother-in-law or other family members would not leave the new mother alone rather it happens that they hover nearby suspiciously. [24]

The results revealed that mothers were more depressed during prenatal period as compared to postnatal period. Moreover, they experienced more events as stressful during prenatal period as compared to postnatal period. This pattern of depression has also been observed in some other studies as well. In this regard, a study by Limlomwongse and Liabsuetrakul (2005) in Thailand showed that the prevalence of prenatal depression was 20 % whereas postnatal depression was 16.6 %. Leigh and Milgrom (2008) investigated incidence of depression as16.9 % prenatal and 11.2% during postnatal period.[25,26,32] Roomruangwong and Epperson (2011) depicted the prevalence rate of 20% during prenatal period remained consistent at 21.8% during postnatal period.[29] Rahman and Creed (2007) examined the course of postnatal depression in sub district of Rawalpindi, Pakistan. Women (N=701) were screened during prenatal period.[3] The prenatally depressed women were re-assessed at three time points. It was found that 56% women were persistently depressed at all time points. The incidence of depression decreased over time from 94% at 3 months, 76% at 6 months to 62% at 12 months. Moreover, the strongest predictors of persistent depression were depression and anxiety symptoms during pregnancy along with a history of psychiatric illness. One recent study by Sadat et al., (2014) found that the rate of postnatal depression decreased from first assessment (two months postnatal) to second assessment (four months postnatal).[30] Most of the studies on incidence and prevalence of prenatal and postnatal depression have depicted that the rate of prenatal depression is high that dropped during postnatal period. [28]

Vliegen, Casalin, and Luyten (2014) discussed that research on postnatal depression support that the symptoms of depression decrease from prenatal to postnatal and later over time as a long term pattern.[31] The critical review of studies from 1985 to

2012 showed that in community based studies 30% diagnosed women with postnatal depression were persistently depressed for up to three year after birth of the child. The reviewers have concluded that the chronic or persistent depression is a pattern that develops during motherhood period. It decreases over time due to improvement in symptoms but never recovers completely. In a continuum it represents a pre-existing depression or any other mood disorder.

Limitation

Women were not assessed for physical conditions such as anemia or thyroid deficiency. The findings should be interpreted within the cultural context. Relatively small sample size and attrition effect also hinder the generalizability of these findings. Edinburgh Postnatal Depression Scale is only a screening tool of depressive symptoms based on self reports of mothers. It does not manifest clinical depression.

Implications

Detection of prenatal depression is extremely important to reduce postnatal depression. The implications and research related to maternal mental health is still at a ground level. High incidence of postnatal depression in Pakistan can be dealt if the interventions are started during pregnancy.

ACKNOWLEDGEMENT

We would pay indebted gratitude to all the women who participated in this research and invested their precious time in this study and Dr. Tahira Naveed, Head of gynecological and obstetric care department, Kharian. We are also thankful to all nursing staff of Government Tehsil Headquarter Hospital Kharian city for their co operation. We would like to acknowledge the efforts of all Lady Health Workers who have given me endless support and volunteered their time and energy during data collection process.

Abbreviations

EPDS: Edinburgh Postnatal Depression Scale
PDPI-R: Postnatal Depression Predictors Inventory Revised
PND: Postnatal Depression

References

1. Cox JL, Holden JM, & Sagovsky R. Detection of Postnatal Depression: Development of 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry.1987;* 150: 782-786.
2. Rahman A, Iqbal Z, Lovel H, & Shah M. A. Screening for Postnatal Depression in the Developing World: A Comparison of the WHO Self Reporting Questionnaire (SRQ 20) and the Edinburgh Postnatal Depression Screening Sale. *Journal of PPS*.2005; *2*(2), 69-72.
3. Beck CT. Revision of the postpartum depression predictors Inventory Revised. *Journal of Gynecological and Neonatal Nursing.2001;31,* 394-402.
4. Gulamani S.S, & Ghagani J. Postpartum depression in Pakistan. *Nursing for Women's Health.2013;2*(17), 147-152 .doi:10.1111/1751-486X.12024
5. World Health Organization. *Promoting mental health concepts, emerging evidence and practice.2007;* Geneva: http://psycnet.apa.org/journals/amp/62/2/95/
6. Rahman A, & Creed F. Outcome of prenatal depression and risk factors associated with persistence in the first postnatal year: Prospective study from Rawalpindi Pakistan. *Journal of Affective Disorders*.2007;*100*(1-3), 115-121.
7. National Institute for Health Care Management (NIHCM). (2010, June).*Strategies and Considerations for health plans*. Washington, DC: Santoro.
8. Humayun A, Haider, I I Imran, N Iqbal, Humayun N. Antenatal Depression and its predictors in Lahore, Pakistan. *Eastern Mediterranean Health Journal*.2013;19(4),327-332. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/23882957
9. Hamirani M M, Sultana A, Ibrahim Z, Sultana S & Iqbal H. Frequency of prenatal depression in second and Third trimester of Pregnancy in Karachi: a hospital based study. *Journal of Liaquat University Med Health Sci*.2006; *5*(3):106-09. http://www.pakmedinet.com/printit.php?id=10182&choice=a
10. Kalyani G. H. S, Saeed K, Rehman CIU, & Mubbashar M. H. Incidence of depressive illness in Pakistani women during postnatal period. *Journal-College of Physicians and Surgeons of Pakistan*.2001;*11*, 246-248.
11. Klainin, P, Arthur, D. Postpartum depression in Asian Cultures; a literature review. International Journal of Nursing Studies.2009; 46(10), 1335-73.doi: 10.1016/j.ijnurstu.2009.02.012. Epub 2009 Mar 26
12. Evans J, Heron, J Francomb. H, Oke, S, & Golding I. Cohort Study of Depressed Mood During Pregnancy and after Childbirth. *BMJ.2001;* 23:257- 260.
13. Rahman A, Iqbal Z, & Harrington, R. Life events, social support and depression in childbirth: perspectives from a rural community in the developing world. Psychological Medicine.2003;33:1161-1167.
14. Connor, T. G, Heron, J., Golding, J, Beveridge, M, & Glover, V. Maternal Antenatal Anxiety and Children's Behavioral/emotional Problems at 4 years. *British Journal of Psychiatry*.2002; 180: 502-508.
15. Sadiq, U. *Psychosocial determinants of depression in prenatal and postnatal period.2009 (*Doctoral Dissertation*).*University of Karachi, Karachi. Retrieved from http://www.uok.edu.pk/research_institutes/icp/images/urooj.pdf
16. Verkerk G. J. M, Pop V. J. M & Van Son, M. J. M. Prediction of Depression in the postpartum period: A longitudinal follow up study in high risk and low risk women. *Journal of Affective Disorder.2003;77*,159-166.
17. Khooharo Y, Majeed T, Das C, Majeed N, Choudhry A. M. Associated Risk Factors for Postpartum Depression Presenting at a Teaching Hospital. ANNALS.2010; 16(2): 87-89. www.sciencedirect.com/science/article/pii/S1751485115307443
18. Westall C, Liamputtong, P. *Motherhood and Postnatal Depression: Narratives of Women and Partners*. London: Springer Dordrecht Heidelberg.2011
19. Murray L. The validation of the Edinburgh postnatal depression scale in a community sample. *British Journal of Psychiatry*.2000; *157;*288-290.

20. Records K, Rice M, & Beck C.T. Psychometric Assessment of the Postpartum Depression Predictors Inventory- Revised. *Journal of Nursing Measurement.2007; 15*(3) 17-25.

21. Bjerke, S. E.Y, Vangen, S., Nordhagen, R, Ytterdahl, T, Magnus, P, & Pedersen, B. S. Postpartum depression among Pakistani women in Norway: Prevalence and risk factors. *The Journal of Maternal Fetal and Neonatal Medicine.2008; 21*(12), 889-894.
22. Husain, N., Beve, I., Husain, M., Chaudhry, B., Atif, N., & Rahman, A. Prevalence and social correlates of postnatal depression in low income country. *Achieves of Women's Mental Health*.2006 doi: 10.1007/s00737-006-0129-9
23. Beck, C. T., & Gable, R. K. Comparative analysis of the performance of the postpartum depression screening scale with other depression instruments. *Nursing Research.2001; 50,* 242-250.
24. Cox E, & Holden, J. *Perinatal mental health: A guide to Edinburgh Postnatal Depression Scale.2005;*1: 9-13. London: Gaskell.
25. Beaton, D. E., Bombardier, C., Guillemin, F., & Ferraz, M. B. Guidelines for the process of cross-cultural adaptation of self-report measures, *Spine.2000; 25*(24): 3186-91.
26. Muneer, A, Minhas, F. A, Nizami, A T., Mujeeb, F, & Usmani, A. T. Frequency and Associated Factors for Postnatal Depression. *Journal of the College of Physicians and Surgeons Pakistan.2009; 19*(4), 236-239. Retrieved from http://jcpsp.pk/archive/2009/Apr2009/09.pdf
27. Leigh, B. & Milgrom, J. Risk factors for antenatal depression, postnatal depression and parenting stress.*BMC Psychiatry.2008; 8*(24). doi:10.1186/1471-244x-8-24
28. Mohammad, K. I., Gamble, J., & Creed, D. K. Prevalence and factors associated with the development of antenatal and postnatal depression among Jordanian women. Midwifery.2011;27(6):238 245. doi:http://www.midwiferyjournal.com/article/S0266-6138(10)00169-5/fulltext
29. Roomruangwong, C., & Epperson, N. Perinatal depression in Asian Women: prevalence, associated factors, and cultural aspects. *Asian Biomedicine.2011; 5*(2):179-193.
30. Sadat, Z, Atrian, M. K, Alavi, N. M., Abbaszadeh, F, Karimian, Z., & Taherian, A. Effect of mode of delivery on postpartum depression in Iranian Women. *The Journal of Obstetrics and Gynecology Research*.2014; *4*(1), 172-177.doi: 10.1111/jog.12150
31. Vliegen N, Casalin S, & Luyten P. The Course of Postpartum Depression. *Harvard Review of Psychiatry.2014; 22*(1). doi: 10.1097/HRP.0000000000000013
32. Limlomwongse, N., & Liabsuetrakul, T. Cohort Study of Depressive Moods in Thai women. *Arch Women Mental Health*.2005; *5,*53-58.