

p-ISSN : 2708-2091 | e-ISSN : 2708-3586

DOI(Journal): 10.31703/gsr  
DOI(Volume): 10.31703/gsr/.2024(IX)  
DOI(Issue): 10.31703/gsr.2024(IX.III)



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**GSR**  
Global Sociological Review

# GSR



**GLOBAL SOCIOLOGICAL REVIEW**  
HEC-RECOGNIZED CATEGORY-Y

**VOL. IX, ISSUE III, SUMMER (SEPTEMBER-2024)**

  
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Double-blind Peer-review Research Journal  
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### Article title

Childhood Trauma, Perceived Social Support, and Post-Partum Depression among Newly Married Women after Miscarriage

### Global Sociological Review

p-ISSN: 2708-2091 e-ISSN: 2708-3586

DOI(journal): 10.31703/gsr

Volume: IX (2024)

DOI (volume): 10.31703/gsr.2024(IX)

Issue: III Summer (September-2024)

DOI(Issue): 10.31703/gsr.2024(IX-III)

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### Abstract

The study examined childhood trauma, perceived social support, and postpartum depression in married women with first-time miscarriages. After reviewing the literature, these hypotheses were formed. 1) Childhood trauma, perceived social support, and postpartum depression are significantly associated with newly married women with first miscarriage. 2) Early trauma and support networks are two major contributors to the new-onset maternal depression in newly married women experiencing a first perinatal loss. 3) There are significant family system differences in early trauma, support networks, and new-onset maternal depression for newly married women experiencing a first perinatal loss. The research has surveyed 250 newly married females in the b/t age group of 18–35 years after their first loss event. The sample includes public and private hospitals in Lahore and Faisalabad. Calculations were done according to the psychological measures: 1) Childhood Trauma Questionnaire 2) Perceived Social Support, and 3) Edinburgh Postnatal Depression Scale. Data analysis was done through SPSS.

**Keywords:** Childhood Trauma, Perceived Social Support, Post-Partum Depression, Married Women with First Time Miscarriage

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**Pages:** 1-16

DOI:10.31703/gsr.2024(IX-III).01

DOI link: [https://dx.doi.org/10.31703/gsr.2024\(IX-III\).01](https://dx.doi.org/10.31703/gsr.2024(IX-III).01)

Article link: <http://www.gsrjournal.com/article/A-b-c>

Full-text Link: <https://gsrjournal.com/fulltext/>

Pdf link: <https://www.gsrjournal.com/jadmin/Author/31rv1olA2.pdf>

Citing Article

01	Childhood Trauma, Perceived Social Support, and Post-Partum Depression among Newly Married Women after Miscarriage						
	Author	Anam Naz Aqsa Sattar Sitwat Fatima		DOI	10.31703/gsr.2024(IX-II).01		
Pages	1-16	Year	2024	Volume	IX	Issue	III
Referencing & Citing Styles	APA	Naz, A., Sattar, A., & Fatima, S. (2024). Childhood Trauma, Perceived Social Support, and Post-Partum Depression among Newly Married Women after Miscarriage. <i>Global Sociological Review</i> , IX(III), 1-16. <a href="https://doi.org/10.31703/gsr.2024(IX-III).01">https://doi.org/10.31703/gsr.2024(IX-III).01</a>					
	CHICAGO	Naz, Anam, Aqsa Sattar, and Sitwat Fatima. 2024. "Childhood Trauma, Perceived Social Support, and Post-Partum Depression among Newly Married Women after Miscarriage." <i>Global Sociological Review</i> IX (III):1-16. doi: 10.31703/gsr.2024(IX-III).01.					
	HARVARD	NAZ, A., SATTAR, A. & FATIMA, S. 2024. Childhood Trauma, Perceived Social Support, and Post-Partum Depression among Newly Married Women after Miscarriage. <i>Global Sociological Review</i> , IX, 1-16.					
	MHRA	Naz, Anam, Aqsa Sattar, and Sitwat Fatima. 2024. 'Childhood Trauma, Perceived Social Support, and Post-Partum Depression among Newly Married Women after Miscarriage', <i>Global Sociological Review</i> , IX: 1-16.					
	MLA	Naz, Anam, Aqsa Sattar, and Sitwat Fatima. "Childhood Trauma, Perceived Social Support, and Post-Partum Depression among Newly Married Women after Miscarriage." <i>Global Sociological Review</i> IX.III (2024): 1-16. Print.					
	OXFORD	Naz, Anam, Sattar, Aqsa, and Fatima, Sitwat (2024), 'Childhood Trauma, Perceived Social Support, and Post-Partum Depression among Newly Married Women after Miscarriage', <i>Global Sociological Review</i> , IX (III), 1-16.					
	TURABIAN	Naz, Anam, Aqsa Sattar, and Sitwat Fatima. "Childhood Trauma, Perceived Social Support, and Post-Partum Depression among Newly Married Women after Miscarriage." <i>Global Sociological Review</i> IX, no. III (2024): 1-16. <a href="https://dx.doi.org/10.31703/gsr.2024(IX-III).01">https://dx.doi.org/10.31703/gsr.2024(IX-III).01</a> .					



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## Title

**Childhood Trauma, Perceived Social Support, and Post-Partum Depression among Newly Married Women after Miscarriage**

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## Abstract

*The study examined childhood trauma, perceived social support, and postpartum depression in married women with first-time miscarriages. After reviewing the literature, these hypotheses were formed. 1) Childhood trauma, perceived social support, and postpartum depression are significantly associated with newly married women with first miscarriage. 2) Early trauma and support networks are two major contributors to the new-onset maternal depression in newly married women experiencing a first perinatal loss. 3) There are significant family system differences in early trauma, support networks, and new-onset maternal depression for newly married women experiencing a first perinatal loss. The research has surveyed 250 newly married females in the b/t age group of 18-35 years after their first loss event. The sample includes public and private hospitals in Lahore and Faisalabad. Calculations were done according to the psychological measures: 1) Childhood Trauma Questionnaire 2) Perceived Social Support, and 3) Edinburgh Postnatal Depression Scale. Data analysis was done through SPSS.*

### Keywords:

[Childhood Trauma](#),  
[Perceived Social Support](#),  
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[Married Women with](#)  
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## Introduction

Women often go through the emotionally taxing experience of miscarriage, which affects about 10-20 percent of pregnancies (Beck et al., 2017). Feelings of melancholy, pessimism, and impaired functioning are hallmarks of postpartum depression, which can strike newlywed women at a higher risk after a miscarriage. Childhood trauma may enhance this sensitivity because it leaves psychological scars that make people more prone to depression. An increasingly pressing

issue is postpartum depression, a severe mental illness that impacts new mothers (Wang et al., 2022).

One of the most significant risk factors for this condition is a miscarriage, which makes up between 10 and 20 percent of all pregnancies. This is especially true for women who have just tied a wedding (Beck et al., 2017). During the perinatal period which includes both the pregnancy and the postpartum periods women undergo tremendous personal and societal transformations as well as physical and mental





changes (Beck, 2001). Expectant mothers, especially those who have suffered a loss, may face a variety of emotional difficulties during pregnancy and childbirth, despite the positive portrayal of these events in popular culture. Millions of women around the world go through the traumatic experience of a miscarriage every year (Conway, 2018).

A significant depressive episode occurring within the first four weeks after giving birth is known as postpartum depression, and it affects 11% to 17% of mothers globally (Shorey et al., 2018; Woody et al., 2017). Estimates reveal that over half of women suffering from postpartum depression frequently go undetected, suggesting that the true frequency might be greater. Chronic depression (McCall-Hosenfeld et al., 2016) and difficulties with nursing and bonding between mothers and infants, as well as difficulties in bonding between mothers and partners, are some of the negative outcomes of postpartum depression (Becker et al., 2017).

One month following a miscarriage, other studies have shown that 34.1% of women experience moderate to high depression risk, and 33.1% of those women have thoughts of self-harm. Not only that, but male partners of women are known to be significantly more likely to have symptoms of PTSD, sadness, and anxiety, though to a lesser degree (Shorey et al., 2018). Postpartum depression, according to recent research, can last for years without treatment, so it's crucial to recognize the signs early on (Woody et al., 2017).

A lot of women want more help coping with the mental and physical changes that happen to their bodies after giving birth, as well as adjusting to their new roles as caregivers and mothers. According to women, postpartum depression symptoms are worsened when these needs are unmet (Dieser & Christenson, 2016). Taking care of a newborn, trouble sleeping, and juggling work and life obligations are all examples of everyday stresses that women may face for the first time during the postpartum period, which can add to their already high levels of perceived stress. Postpartum depression symptoms may be worsened or exacerbated by this high degree of perceived stress. Due to the fact that

postpartum depression symptoms are more likely to occur in women who report low levels of perceived social support and high levels of perceived stress, researchers have sought to gain a better understanding of these factors individually and to analyze the intricate relationships between them (May et al., 2019). Accordingly, the stress process model has been used to investigate postpartum depression symptoms, stress, and perceived social support; in this research, perceived social support mediated the relationship between stress and depressed symptoms (Razurel et al., 2016).

Furthermore, despite the greatest efforts of medical professionals to provide the highest possible level of assistance, postpartum women often only receive one visit from a clinician between four and six weeks after giving birth (unless there are considerable issues after birth requiring more intensive care). As a consequence of this, the probability of a diagnosis of postpartum depression being received by a woman after four or six weeks after giving birth decreases. Once this visit has been completed, it is not unusual for symptoms of depression to remain untreated or to be misdiagnosed (Becker et al., 2017). Research conducted in countries other than China has demonstrated that pregnant women who have had many miscarriages are more likely to have feelings of worry and depression if they do not get support from their social networks (Carvalho et al., 2016). It is these interpersonal resources more generally referred to as social support—that people often tap into to help cope with the stresses and strains they are subject to in everyday life. In that regard, partners, families, and friends were suggested by studies to be some of the forms of social support that could be key in reducing the chances of PPD. A study by Dennis and Ross (2006) discovered that the perceived social support from partners was inversely related to the symptoms of postpartum depression, while Leahy-Warren et al. (2011) discovered that peer support interventions improved mothers' mental health outcomes. These findings drive the fact that women should be complemented with a range of other support services, taking into regard their special needs during the perinatal period. Studies have shown that the intergenerational transmission of trauma and the

amount and quality of social support received by members are found to be different for nuclear or joint families (Khalifeh et al., 2014). These are some of the family relations elements that can impact the health of a mother: marital happiness, parental conflict, and the dynamics of co-parenting. Indeed, the need for social support is even more evident in cases when a woman has suffered from a miscarriage, as a woman's risk of acquiring postpartum depression greatly increases.

Probably one of the most important things a woman can do to help herself recover emotionally is to surround herself with strong supportive people (Razurel et al., 2016). The comfort derived from having loved ones who understand, empathize, and offer practical support during such a trying time of loss is immeasurable. Recognizing social support's role in decreasing the likelihood of postpartum depression places importance on developing relationships and promoting open dialogue within the family and social networks. The term "perceived social support" describes how individuals feel about their network of social relationships including spouses, family, and friends. In times of crisis, for example, after a miscarriage, social support provides emotional support, help with instrumental needs, and a sense of belonging, which becomes very valuable.

Social support would, therefore, facilitate coping and thus reduce feelings of loneliness and further enhance one's sense of control over the situation. All these factors can interplay to decrease the risk of postpartum depression. Recent studies have documented that 65% of pregnant ladies in Lahore suffer from prenatal depression which has emerged as an important public health problem in Pakistan. Researchers in Pakistan have recently reviewed 43 papers and reported that 37% of pregnant ladies and 30% of new mothers suffer from postpartum depression. Negative factors predisposing mothers to develop prenatal depression in Pakistan from a low socioeconomic background include social conflicts, economic constrictions, intimate partner violence, and unhealthy eating habits, among others (Kim, 2020).

The proposed study looks into the understanding of complex psychological factors that come into play in defining the mental health outcomes of a newly married woman having experienced a first miscarriage. While much literature is available on postpartum depression, little is known about its prevalence or effects following a miscarriage. It also acknowledges this fact by relating childhood trauma to long-term effects on mental health while considering the contribution it makes to postpartum depression after miscarriage. The research will, therefore, strive to establish whether women who have had a miscarriage report higher levels of postpartum depression and whether this in turn can be linked back to childhood experiences of trauma.

The study aims to identify how the level and quality of the received support can affect the intensity and probability of postpartum depression by analyzing the perceptions of social support among newly married women who have experienced loss. By doing this, this study could make very important contributions to the area of maternal mental health. A study of the relationship between postpartum depression, childhood trauma, miscarriage experience, perceived social support, and newlywed couples could help plan specific programs to aid this at-risk group. Early diagnosis of women at high risk for PPD is possible through the combination of two risk factors: childhood trauma and miscarriage. Counseling, support groups, or medicine can greatly improve the mental health results in mothers if this is treated early on. In other words, research into the role of social support in the protection of newly married women develops programs aimed at strengthening social networks, more so during miscarriage events.

### **Objectives of the Study**

1. To explore the association between childhood trauma, perceived social support, and postpartum depression amongst newly married females with first miscarriage.
2. To examine the impact of childhood trauma and social support on the development of

postpartum problem depression amongst newly married females with first miscarriage.

3. To discover the family system variances among childhood trauma, social support, and postpartum depression amongst newly married females with first miscarriage.

### Hypothesis of the Study

1. Is there any significant relationship between childhood trauma, perceived social support, and postpartum depression among newly married females with first miscarriage?
2. Significant influence of childhood trauma and social support on the development of postpartum depression among newly married females with first miscarriage.
3. There would be a significant family system variance among childhood trauma, social support, and postpartum depression among newly married females with first miscarriage.

### Literature Review

This is because postpartum depression represents a strong mental disorder affecting a large number of women after they give birth to their children. The adverse effects of PPD—prevailing feelings of sorrow, hopelessness, and inefficiency—are transmitted from mothers to their infants. The research has identified that about 10–15% of women will experience PPD during the first year following childbirth. This would include the identification of risk factors and the development of effective interventions for postpartum depression to promote maternal mental health and well-being (Vassilaki et al., 2022). Among the many possible causes of PPD, one growing issue is the number of newlywed women who experience miscarriage.

Miscarriage is estimated to affect 10–20 percent of all clinically diagnosed pregnancies, which is the spontaneous termination of the pregnancy before 20 weeks of gestation (Beck et al., 2017). Miscarriage can cause a wide range of emotions to be induced in a woman, from sadness to rage and loneliness. This emotional burden and issues related to early marriage may increase the risk of developing postpartum

depression [9]. Postpartum depression is a heterogeneous mental health problem with various contributing factors. Among other biological factors, changes in hormone levels after delivery may lead to PPD. Also, past history of mental illnesses like anxiety or depression plays a big role. Other social risk factors for PPD include a lack of social support and traumatic events of life events. PPD is highly influenced by biological factors at its onset. Changes in the level of hormones after giving birth play a big role. Hormone levels rise very high during pregnancy, especially estrogen, progesterone, and prolactin. The rapid fall in the level of these hormones soon after giving birth may quickly set in mood swings and emotional fragility. A possible cause that may cause the onset of PPD is an alteration in thyroid function. According to Qu et al. (2020), postpartum depression may be common in women with a history of thyroid problems. One of the major mental health disorders is postpartum depression, which affects a large number of mothers-to-be. Some of the unsuspected risk factors associated with postpartum depression are childhood traumas. This section will investigate the possible interplay among ACEs and other risk factors of postpartum depression in recently married women who have miscarried. The studies have documented that such ACE exposure is related to a variety of negative mental health outcomes, including depression, later in life. Aware of the important public health relevance of ACEs, the CDC has underlined such effects on physical health, social well-being, and mental health.

Negative long-term effects on brain development remain after exposure to ACEs.

Traumatic stress in childhood has permanent consequences on the developing brain, mainly in areas responsible for regulating emotions and responding to stress.

The hippocampus is one of the most critical areas affected since it controls the person's memory and emotional processing. ACEs and stress in childhood could affect a person's ability to deal with the stress and their emotions by leading to a reduced hippocampus volume. This might also apply to traumatic events in childhood, which could be

accompanied by overactivation in the amygdala, responsible for processing threats and fear, thus making a person more vulnerable to stress. While previous studies have shown that stress, social support deficiency, and a past history of depression are independent risk factors of PPD, few scholarly works have explained how the characteristic features of postpartum depression interact with traumatic experiences in childhood among married women who have just given birth. The definition of "perceived social support" is one's perception of those individuals who care for them, offer help, and show sympathy when life becomes difficult. When one perceives that they have a social network to fall back on, this perception is very instrumental in enhancing mental health and happiness (Becker et al., 2017).

Social support can be instrumental in coping with difficult times and ease some of the burden when faced with stress or adversity. After a stressful life event, such as a miscarriage, the person may begin to feel alone and overwhelmed by suffering and difficulties in coping. Depending on the specific case, supportive friends or family members can play the role of helping the person with strong social support to come to terms with difficulty more successfully and confidently, providing moral and practical support, and perhaps a new view. Social support can promote a perspective that is more positive toward the stressor and the development of good coping mechanisms; this was demonstrated to be the case in a number of studies.

Moreover, the existence of a social network of people encourages the individual to seek assistance when necessary and more likely to receive professional care. Various problems that newlywed couples may encounter during the early stages of the marriage process include shared housing, budgeting, and changing relationship dynamics (Dieser & Christenson, 2016).

The correlation between PPD and social support has been the subject of prior research (Munk-Olsen et al., 2011; Moore & Jackson, 2018). On the other hand, variables impacting social support and postpartum depression were not given any thought. A small number of studies have used moderation

analyses which show when or under what conditions a specific impact or relationship can be expected to define irrational beliefs as a vulnerability factor in terms of the cognitive diathesis-stress paradigm in the preceding research (Maghade et al., 2018). Seng et al. (2013) also observed that women with a history of childhood trauma were more prone to have symptoms of postpartum depression in their longitudinal study that tracked them from pregnancy to postpartum.

Field (2017) examined the mother's life and the factors that contribute to postpartum depression. For moms, the prevalence rate of PPD was around 20%. Mothers suffer behavioral and cognitive issues as a result of PPD symptoms. Factors that increased the likelihood of postpartum depression were immigrant status, low income and education levels, and difficulties during pregnancy and delivery. Social support, sleep disturbance, prenatal depression, and early childhood experiences are all psychological elements that can contribute to the genesis of postpartum depression symptoms (maltreatment, attachment, and sexual abuse). The lack of diagnosis and treatment puts low-income women at a higher risk of postpartum depression (PPD), according to research by (Hansotte et al., 2017). Social constraints, such as a lack of education and income, and cultural barriers constituted the therapeutic hurdles (family type, restrictions to gain antenatal and postnatal care and services). Postpartum depression symptoms were more common in women, according to (Underwood et al., 2017). Partners, children, and other family members also feel the negative effects of depression, in addition to the mother herself, during and after pregnancy. When a husband is sick or stressed out, his wife is more likely to experience signs of depression during her pregnancy and the postpartum period.

The connections between self-efficacy and PPD are shown by Fathi et al. (2017), based on the data, we can say that low income is strongly correlated with low self-efficacy. Furthermore, factors such as self-satisfaction, spouse age, occupational situation, and poor educational level significantly impact maternal self-efficacy. In order to boost mothers' confidence in their own abilities, this service is essential for the early



detection and treatment of postpartum depression. Moreover, according to research by Silverman et al. (2018), women with a history of depression showed symptoms of postpartum depressive disorders that were over 20 times higher than those without a history of depression. Women were more likely to experience PPD if they were younger, had a mild or moderate preterm delivery, had a cesarean section or other types of aided or cesarean delivery, or had gestational diabetes. Research by Mori et al. (2017) found that over 20% of moms suffered from postpartum depression. In the first six months after giving birth, depressive symptoms were significantly associated with those of physical health problems. Most of the symptoms were tiredness, dizziness, loss of appetite, thirst, backache, headache, eye infection, and body swelling.

A lack of social support, interpersonal relationships, self-neuroticism, and anxiety is a major contributor to postpartum depression, as Naveed & Naz (2015) elucidated. The responsibility of bearing a female child rests squarely on the shoulders of the mother in traditional Pakistani society. When husbands and in-laws learn that a woman is giving birth to a girl, their attitudes tend to shift. Postpartum depression symptoms manifest when a woman's life becomes even more unpleasant and disrupted as a result of her spouse and in-laws ceasing to assist her. Concerning the correlation between the frequency of PPD and the delivery method, Haque (2015) contended that the outcomes were unpredictable. Lebanese women who gave birth vaginally were more likely to have postpartum depression (PPD), whereas UAE women who gave birth via cesarean section reported more negative emotions following the procedure. According to research by Afzal and Khalid (2016).

### Research Methodology

The present study used a quantitative correlational research design. The population of the current study was newly married females N=250 who suffered from their first miscarriage having an age range of 18-35 years. The sample was drawn through a convenient and purposive (non-probability sample technique)

strategy from the public and private hospitals of Lahore and Faisalabad.

### Inclusion Criteria

- The sample was extracted from Lahore and Faisalabad city.
- Both educated and uneducated women were included.
- Only newly married women with first miscarriage were included.
- Females from any religion were chosen for this study.

### Exclusion Criteria

- Adolescent females were excluded.
- Those who belong to any other city than Lahore and Faisalabad were excluded.
- Females with second or third miscarriages were excluded from the study.

### Instruments

Self-report measures that provide valuable findings of the variables under study were used. According to the theoretical background, those instruments will be used in the present study that will have good psychometric properties. The idea of these instruments is as follows:

1. Demographic Questionnaire
2. Childhood Trauma Questionnaire (Bernstein, Ahluvalia, Pogge, & Handelsman, 1997)
3. Perceived Social Support Scale (Zimet et al., 1988)
4. Edinburgh Postnatal Depression Scale (EPDS; Cox et. al., 1987)

### Demographic Questionnaire

The demographics involved the age, marital status (married or unmarried), socio-economic status (low or high), education level (matric, intermediate, bachelor, master), and family system (nuclear or joint) of the participants of the research.

### **Childhood Trauma Questionnaire (CTQ)**

This self-report tool can help individuals with conversion disorder estimate the extent to which they endured traumatic events during their formative years. Two forms of childhood trauma the death of a parent and sexual abuse were assessed by this survey. This scale measures the impact of sexual abuse and parental loss based on the participants' subjective evaluations of these experiences. The subject was asked to rate the intensity on a scale from 1 to 10, with 1 representing the least intense and 10 the most intense (Bernstein et al., [1997](#)).

### **Perceived Social Support Scale (PSSS)**

Participants will evaluate their social support from three different groups using the Multidimensional Scale of Perceived Social Support (MSPSS): friends (Items 6, 7, 9, and 12), family (Items 3, 4, 8, and 11), and significant others (Items 1, 2, 5, and 10)<sup>50</sup>. Using a five-point Likert scale where 0 indicates strongly disagree and 4 indicates strongly agree, participants were asked to express their level of agreement with the statements. We considered total scores between 12 and 24 to indicate little social support, scores between 25 and 36 to indicate moderate support, and scores between 37 and 48 to indicate great support. The present study's reliability was .81 and valid (Zimet et al., [1988](#)).

### **Edinburgh Postnatal Depression Scale (EPDS)**

The most popular screening questionnaire for postpartum depression (PPD) is the Edinburgh Postnatal Depression Scale (EPDS), a 10-item instrument that asks mothers about their feelings during the previous seven days. A total score ranging from 0 to 30 was determined by scoring each participant's responses on a scale from 0 to 3 (or 3-0 in the event of a reverse score). High dependability of .85 was revealed by a split-half-item analysis with a strong correlation coefficient and a substantial link

between the overall scores and individual category scores (Cox et. al., [1987](#)).

### **Procedure**

The board of study meeting approved the synopsis, and then the psychology institute at Riphah International University Faisalabad gave their clearance for data gathering. All individuals who took part in the research were briefed on its goals. Those who were interested in taking part in the study and met the inclusion criteria were the only ones considered. They were given the option to stop participating in the study whenever they wanted without facing any consequences, and their responses would remain private. All of the evaluation measures were filled out by the participants independently after they were given the questionnaire.

### **Data Analysis**

Descriptive statistics, Pearson correlation, regression analysis, and t-test were performed to assess the proposed hypotheses of current research through SPSS version 26.

### **Results**

The objective of the research is to examine the impact of perceived social support and childhood trauma on postnatal depression. At first, the frequencies of the participants and then the psychometric properties of the study variables were computed. Pearson correlation was used to check out the relationship among study variables. Multiple regression analysis is also used to see the effect of perceived social support and childhood trauma on postnatal depression. Moreover, a t-test was used to find out the difference between postnatal depression among the nuclear and joint family systems of females with first miscarriage. The data analysis made on SPSS (26) revealed the following tables that show the results of the variables of the study.

**Table 1***Frequencies and Percentages of Participants (N = 250)*

Demographics variable	f	%
<b>Age</b>		
18-25	180	68
26-35	70	32
<b>City</b>		
Faisalabad	125	50
Lahore	125	50
<b>Education Status</b>		
Educated	128	51.2
Non-Educated	122	48.8
<b>Religion</b>		
Muslim	231	92.4
Non-Muslim/ Christian	19	7.6
<b>Family System</b>		
Nuclear	113	45.2
Joint	137	54.8

Table 1 represents the frequencies and percentages of females. Females from age 18-25 included ( $f=180$ , 68%) and females from the age range 26-35 included ( $f=70$ , 32%). Educated females ( $f=128$ , 51.2%) and non-educated females ( $f=122$ , 48.8%). Students belonging to Faisalabad ( $f=125$ , 50%), and Lahore ( $f=125$ , 50%). Among 250 sample (92.4% were Muslims and 7.6% were Non-Muslims mainly Christian). Moreover, (45.2% belonged to the nuclear family system) and (54.8% belonged to the joint family system).

**Table 2***Reliability Coefficient for the Research Measures (N=250)*

Research Measure	N	Cronbach's Alpha Coefficient
Childhood Trauma Questionnaire	25	0.79
Perceived Social Support Scale	12	0.82
Edinburgh Postnatal Depression	10	0.72

Note: N= Number of scales items

Table 2, as displayed, exhibits the reliability of the Childhood Trauma Questionnaire, Perceived Social Support Scale, and Edinburgh Postnatal Depression Scale. As per the results shown in the above table data was used for defining the reliability of measures. The reliability coefficient of the Childhood Trauma Questionnaire is 0.79 which is in the category of acceptable. The reliability coefficient of the Perceived Social Support Scale is 0.82 which is in the category of good. The reliability coefficient of Edinburgh Postnatal Depression is 0.72 which is in the category of acceptable.

**Table 3***Descriptive Statistics of the Study Variables*

	Mean	Standard deviation	Skewness	kurtosis
CTQ_total	58.89	12.508	.951	.492

	Mean	Standard deviation	Skewness	kurtosis
MSPSS	33.50	11.412	.790	.911
PND	14.97	2.618	.939	.731

Table 3, as displayed exhibited the statistical characteristics of Childhood trauma, Perceived social support, and Post-natal depression of females with first miscarriage. The mean, standard deviation, skewness, and kurtosis data are displayed in this table. In particular, the Childhood Trauma Questionnaire showed a mean value of an average of 58.8 with a 12.5 standard deviation. In addition, the average score on the Perceived Social Support Scale was 33.5, with a standard deviation of 11.4. Lastly, the Post-natal depression shows a mean of 14.9 with a 2.61 standard

deviation. The Skewness value of the childhood trauma questionnaire is .95, perceived social support is .79, and postnatal depression is .93. The Kurtosis value of the childhood trauma questionnaire is .492, perceived social support is .91 and post-natal depression is .731.

Hypothesis 1: There would be a significant relationship between childhood trauma, perceived social support, and postpartum depression among newly married women after miscarriage.

**Table 4**

*Summary of Inter scale Correlation of childhood trauma Perceived Social Support, and postpartum depression among newly married women after miscarriage*

Variables	1	2	3	4	5	6	7	8	9	10	11
CTQ_EA	-										
CTQ_PA	.990**	-									
CTQ_SA	.054	.018	-								
CTQ_PN	.989**	.993**	.012	-							
CTQ_EN	.980**	.983**	.049	.984**	-						
CTQ Total	.919**	.912**	.119	.913**	.910**	-					
MPSS	-.568**	-.561**	-.031	-.563**	-.564**	-.592**	-				
MSPSSO	-.371**	-.371**	.014	-.377**	-.388**	-.359**	.538**	-			
MSPSSfam	-.350**	-.339**	-.084	-.335**	-.339**	-.389**	.744**	-.049	-		
MSPSSFri	-.319**	-.327**	.073	-.332**	-.319**	-.315**	.409**	.461**	-.179**	-	
PND	.830**	.827**	.028	.822**	.825**	.867**	.683**	.454**	.436**	.355**	-

Note: CTQ= Childhood trauma questionnaire, PND= Postnatal Depression, MPSS= Perceived Social Support, EA=Emotional Abuse, PA=Physical Abuse, SA=Sexual Abuse, EN= Emotional Neglect, PN=Physical Neglect

Table 4 showed significant correlations ( $p < 0.01$ ) among childhood trauma, perceived social support, and postpartum depression among newly married females after miscarriage. A significant negative ( $p < 0.01$ ) correlation of perceived social support was found with subscales of childhood trauma and postpartum depression which means an increase in social support causes a significant decrease in the effect of trauma and postpartum depression. Whereas the relationship between childhood trauma and

postpartum depression was observed to be significantly positive ( $p < 0.01$ ). However, there was no association found between sexual abuse and other variables under study.

Hypothesis 2: There would be a Significant Effect of Childhood Trauma and Perceived Social Support on Postpartum Depression among Newly Married Females with Miscarriage.



**Table 5**

*Linear Regression Analysis Showing the Effect of Childhood Trauma and Perceived Social Support on Postpartum Depression Among Newly Married Females with Miscarriage (N = 250).*

Model	Unstandardized Coefficients		Standardized Coefficients	t	Sig.
	B	Std. Error	Beta		
(Constant)	8.212	.646		12.70	.000
CTQ Total	.149	.007	.712	19.92	.000
MSPSS	-.060	.008	-.262	-7.32	.000

a. *Dependent Variable: Postpartum Depression*

**Table 6**

*Summary of Analysis Showing the Effect of Childhood Trauma and Perceived Social Support on Postpartum Depression Among Newly Married Females with Miscarriage (N = 250).*

	R <sup>2</sup>	ΔR <sup>2</sup>	F	Sig.
Postpartum depression	.796	.794	480.589	.000

(R<sup>2</sup>=.796, F=480.589, p<.001)

Tables 5 and 6 showed the results of regression analysis to test if childhood trauma and perceived social support have an effect on postpartum depression of newly married females with miscarriage. The analysis found that Childhood trauma ( $\beta = .71$ ,  $p < .001$ ) and perceived social support ( $\beta = -.25$ ,  $p < .001$ ) affected postpartum depression of newly married females with miscarriage.

Hypothesis 3: There would be a Significant Family System Difference in Childhood Trauma, Perceived Social Support, and Postpartum Depression among Newly Married Females with First Miscarriage.

**Table 7**

*Means, standard deviations, and t-values for nuclear and joint family system on Childhood Trauma, Perceived Social Support, and Postpartum Depression among Newly Married Females with First Miscarriage (N = 250)*

Variables	Nuclear (n=113)		Joint (n=137)		t(248)	p	95% CI		Cohen's d
	M	SD	M	SD			LL	UL	
MPSS	33.8	10.3	33.1	12.2	-1.41	.157	-5.3	.87	0.06
CTQ	57.65	11.8	59.91	12.9	.473	.637	-2.1	3.54	0.1
PND	14.5	2.34	15.3	2.78	-2.29	.023	-1.4	-.107	0.3

Note: CTQ= Childhood trauma questionnaire, PND= Postnatal Depression, MPSS= Perceived Social Support, \*\*\*p<0.001

Table 7, represents the means, standard deviations, and t-values for nuclear and joint family systems on childhood trauma, perceived social support, and postpartum depression among newly married females with first miscarriage. The results showed that the

nuclear family system significantly scored higher on social support ( $M = 33.8$ ,  $p < .001$ ) than the joint system. A minor effect size was indicated by the value of

$\eta^2$ , in terms of MPSS which was 0.06. Childhood trauma showed a lower score on the nuclear family system ( $M = 57.6$ ,  $p < .001$ ) than the joint family system. An effect size was indicated by the value of  $\eta^2$ , in terms of CTQ which was 0.1. However, the findings also showed that postpartum depression ( $M = 15.3$ ,  $p < .001$ ) significantly scored higher score among the joint family system as compared to the nuclear family system ( $M = 14.5$ ,  $p < .001$ ). An effect size was indicated by the value of  $\eta^2$ , in terms of PND which was 0.3.

## Discussion

The present study aimed to investigate, within a sample of recently married women experiencing a first miscarriage, complex relationships among PPD, perceived social support, and traumatic experiences in childhood. The first hypothesis posited that the relationships between study variables would be found to be significant based on the Pearson correlation analysis. Furthermore, t-tests were conducted to determine if there existed any difference in PPD between first-time miscarriage sufferers with and without college degrees. Treatments were guided by an analysis of these differences and were sensitive to the distinct needs of each subgroup within the sample. Indeed, the hypothesis confirmed that there was a substantial relationship between childhood trauma, perceived social support, and PPD amongst newly married women who experienced a miscarriage. This means that higher levels of perceived social support correlate to lower levels of childhood trauma and PPD among newly married women who experienced a miscarriage.

Women who expressed that they felt socially supported through their pregnancy had lower percentages of prenatal and postpartum depression.

In contrast, the meta-analysis conducted by O'Hara and Swain during 1996, found that postpartum depression is less frequently found in facilities where there was a strong social support system.  $p < 0.01$  found that postpartum depression has a positive correlation to childhood trauma. The findings of the research study conducted previously

were that postpartum depression rates increased among women if they had more trauma in their childhood. It agrees with many of the conclusions of previous studies, including those that showed the long-term effects of traumatic experiences during childhood on postpartum depression among adult women. One such study indicated that postpartum depression was more common in women who underwent childhood traumas. Of great note is the fact that none of the other traits examined was found to significantly bear any relationship to sexual abuse. This may present a significant need for any of a variety of further interrogations of potential contributing factors such as unique characteristics of the sample population under discussion or weakness in the measuring instruments themselves. This hypothesis summarizes that newlywed women who lost their pregnancies are less likely to experience postpartum depression when they report high perceived social support, in that it may mitigate the harmful impacts of childhood trauma. These findings also contribute to the already existing body of research, placing enough emphasis on the role of socially supportive therapies in the prevention and treatment of postpartum depression. The second hypothesis was set out to determine if childhood trauma and perceived social support have a significant effect on postpartum depression (PPD) among newly married females who have ever experienced a miscarriage. This finding connotes the inscription of mental health outcomes due to adverse childhood experiences, mainly in a vulnerable period like post-loss.

Earlier literature proved the fact that childhood trauma placed a woman at higher risk in the postpartum period. Seng et al. (2013) opined, "Women with a childhood history of trauma were significantly more likely to report postpartum depression" than other women. Further, Shorey et al. (2018) reported a meta-analysis that had the same findings, hence presenting a further robust association between PPD and these kinds of traumatic experiences during childhood. In recently married women with a miscarriage, perceived social support certainly buffered against postpartum depression. The implication here is that, among the said sample, PPD

was lower for those with high levels of perceived social support.

It finds support in a vast literature that has shown the role of social support in reducing the risk of postpartum depression. For example, postpartum depression symptoms in the study by Dennis and Ross, [2006](#), related negatively to perceptions of social support from partners, family, and friends. The fact that it does not give the reasons childhood trauma leaves people vulnerable to PPD does not take away from the fact that perceived social support is one major buffer against the negative consequences of stress and trauma. The point here would be to focus on programs that would enable women who have had miscarriages or some form of childhood trauma to build stronger social support systems. Instead of just treating patients, modern medicine tries to improve the health and quality of their lives. Therefore, in its treatment, professional attention is focused on the achievement of non-medical goals, aimed at helping the patient to function on a regular basis in all areas of the psychological, social, and physical domains. Last but not least, the obtained result through regression analysis, confirms that postpartum depression is significantly determined by the perceived social support and childhood trauma of newlywed women who miscarried. These findings showcase the importance of comprehensive and multifaceted strategies in the betterment of the perinatal mental health of mothers.

These should encompass trauma-focused interventions, social support networks as well as individualized support for women that have undergone miscarriage.

Medical practitioners will be in a better position to identify vulnerable patients and appropriately devise apt interventions to promote maternal health and resilience if they understand the complex interplay of variables involved in the outcome (Mitchell et al., [2018](#)).

The third hypothesis was that women who had experienced a first miscarriage in the newlywed stage differed significantly in PPD, perceived social support, and childhood trauma according to the family system. More specifically, it compared nuclear-family and

joint-family women. A one-way ANOVA revealed that participants differ significantly between different family systems in relation to PPD,  $F = 4.003, p < 0.05$ . The study was initiated by comparing two types of family structures and indicated that with respect to perceived social support, the nuclear family system fared worse than the joint family system. The finding validated what other studies had indicated: people in joint family systems are more likely to have a large social support system made up of both immediate and extended family members.

For example, Sarkadi et al. (2008) found that mothers living in nuclear households reported less perceived social support in comparison to those living in extended family settings. In this network, emotional, practical, and instrumental support might make a difference so that the women can be helped to overcome the crisis of miscarriage and not drop into a postpartum depressive state (Inanici et al., [2017](#)). Also, the data received have shown that very high rates of traumatic experiences related to children were reported by nuclear families as compared to the joint families. This difference happened very clearly when one structure of the family was compared with the other one. Hence, this study indicated that multiple caregivers and close family bonding in the case of the extended family setup made the child much less likely to experience any unpleasant childhood events. Research evidence has shown that a supportive family background may provide protection against the negative influences of childhood trauma (Rutter, [2012](#)). Similarly, while the nuclear family could entail autonomy and privacy, it could also be less well-equipped, lacking pre-built support networks compared to those of joint family systems. In this respect, postpartum depression, loneliness, and distress are more likely in nuclear family women. In fact, some studies have shown that the provision of social support is associated with a decrease in the incidence of postpartum depression.

## Conclusion

The findings of this study on married women who have ever experienced miscarriage help in understanding the complex relationship linking PPD,

perceived social support, family structure, and trauma in childhood. First, the study indicates a strong relationship among postpartum depression, perceived social support, and traumatic experiences in childhood. The current study has reported an inverse relationship between the prevalence of depressive symptoms and higher levels of perceived social support and a positive association between a higher prevalence of childhood trauma and increased risk for PPD. This study therefore replicates earlier findings that social support indeed plays a role in buffering against stress and hardship, and that very early life experiences have long-lasting effects on the outcomes for adult mental health. The study found that contributions to postpartum depression came from both childhood trauma and participants' perceptions of social support. Any policy seeking to improve maternal mental health would need to consider the investigation of a history of trauma since childhood trauma remained a strong predictor for postpartum depression. On the other hand, when women described feelings of social support following a miscarriage, the likelihood of experiencing postpartum depression was reduced, which does show that women can indeed be empowered with the enrichment of support networks.

The study also discovered some relevance to postpartum depression, perceived social support, and

different family systems, as well as childhood traumatization.

In the comparison between the joint family system and the nuclear family system, subjects of the former reported less childhood trauma and more social support. The rates for postpartum depression, though the women in nuclear families scored low on measures of social support and childhood trauma. That is a surprising discovery, showing how complex family contexts influence maternal mental health outcomes: among nuclear families where there are no preexisting support systems for mothers, the occurrence of postpartum depression may be higher after a miscarriage.

### **Recommendations**

1. For future research, the data should be taken from various cities so the study findings can be generalized.
2. These variables can be explored among women with more than one miscarriage.
3. Future research should adopt a multifaceted approach to examining the complex interplay between individual and contextual factors influencing postpartum depression, considering factors such as cultural norms, familial relationships, and access to healthcare services.



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