

# Postpartum Depression *and* Culture: *Desado Corazon*

## Abstract

The purpose of this article is to describe what the literature has shown about postpartum depression (PPD) in culturally diverse women. The majority of qualitative studies done with women identified as having PPD have been conducted with Western women, with the second largest group focusing on Chinese women. This article reviews the qualitative studies in the literature and discusses how the management of PPD in technocentric and ethnokinship cultures differs. Social support has been shown to be significantly related to fewer symptoms of PPD, and culturally prescribed practices may or may not be cultural mediators in decreasing the incidence of PPD. Nurses should be sensitive to the varied ways in which culturally diverse women perceive, explain, and report symptoms of PPD. Exemplary interventions for culturally diverse women suffering from PPD are examined in this article as well, although it is clear that additional research is needed to develop models for culturally competent interventions for PPD in culturally diverse women and to document the outcomes of such interventions.

**Key words:** Culture; Postpartum depression; Social support.



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and customs. Ancestral searches were also done and links to “related articles” in electronic databases were accessed. Inclusion criteria included articles published since 2006 in English focusing on PPD in culturally and ethnically diverse women. “Culture” used as a keyword could more widely include being socially disadvantaged, having immigrant or refugee status, being previously infertile, having experienced abuse, and other sociocultural contexts, but for the purpose of this article, cultural considerations were limited to culturally and ethnically diverse women. The theoretical framework was adapted from the work of Howell, Mora, Horwitz, and Leventhal (2005) (Figure 1).

Maternal and situational risk factors for PPD include pregnancy intendedness, parity and maternal age, couple and extended family relationships including the incidence of intimate partner violence; presence of social support

*Higher valuing of male children  
is a significant risk factor for  
PPD in some cultures.*

With the prevalence of postpartum depression (PPD) ranging from 7% to 50%, a significant number of culturally diverse women experience the symptoms of PPD, and the effects of PPD on women’s health and the health of their families are profound (Setse et al., 2009). PPD is becoming a major public health issue, and has been identified as a Healthy People 2010 priority goal. Unfortunately it often goes unrecognized by both women and healthcare providers.

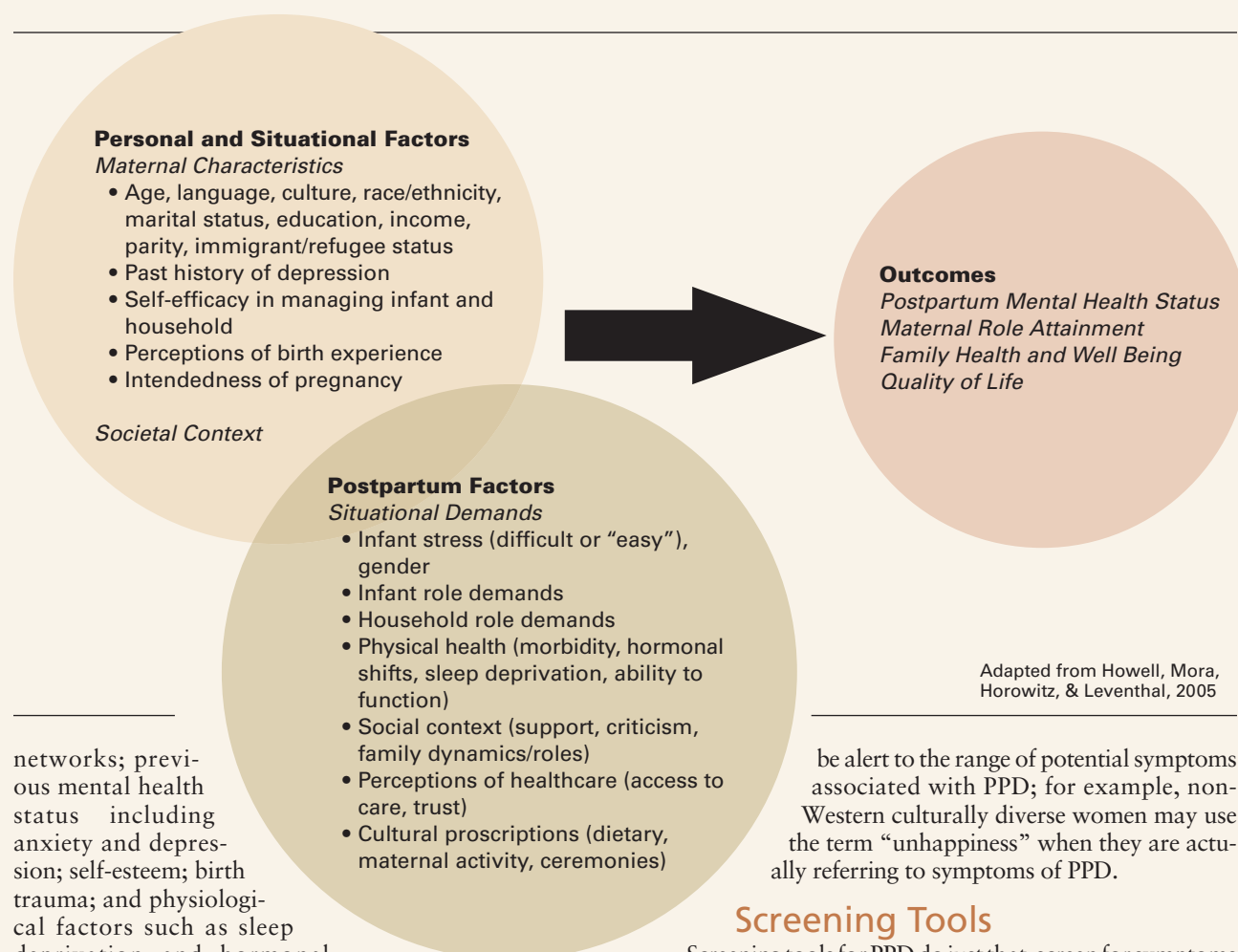
It is important to understand that PPD exists in varied cultures (Andajani-Sutjahjo, Manderson, & Astbury, 2007), and thus this article describes the literature that focuses on PPD in culturally diverse women. Methods used to access the literature are discussed, as well as the framework utilized for this review. Screening tools are defined. Qualitative studies of culturally diverse women with PPD and ethnokinship and technocentric care of childbearing women are explicated, with implications for clinical practice defined.

## Method

Electronic searches were done using MEDLINE, CINAHL, PsychINFO, DARE, and the WHO Reproductive Health Library using search terms such as PPD, postnatal depression, childbirth practices, rituals,



*Figure 1.* Model of Factors Related to Postpartum Depression



networks; previous mental health status including anxiety and depression; self-esteem; birth trauma; and physiological factors such as sleep deprivation and hormonal shifts (Beck, 2008a, 2008b, 2008c), what Beck calls “complicated interaction between biochemical, genetic, psychosocial, and situational life-stress factors” (2008a, p. 13). One unique risk factor for PPD in China, India, and Islamic societies is the higher valuing of male children (gender preference) (Goldbort, 2006).

## Prevalence of PPD

The prevalence of major PPD in culturally diverse groups of women varies widely. When evaluating this literature, however, comparisons should be made with caution because different tools were used and data were collected at varying times postpartum.

Screening for symptoms of PPD is associated with early detection, referral for mental health services, and treatment of PPD. When contemplating PPD screening, nurses should be sensitive to the cultural context of birth and understand the varying ways in which culturally diverse mothers “conceptualize, explain, and report symptoms of depression” (Dennis & Chung-Lee, 2006, p. 328), for some women may not recognize their symptoms as being related to PPD (Chaudron et al., 2005). Some women may not accept the term “postpartum depression,” and in some cultures women may not feel they are able to seek help, for they are expected to stoically fulfill their proscribed social roles with grace and dignity rather than asking for help. Nurses should

be alert to the range of potential symptoms associated with PPD; for example, non-Western culturally diverse women may use the term “unhappiness” when they are actually referring to symptoms of PPD.

## Screening Tools

Screening tools for PPD do just that: screen for symptoms of PPD. The tools are not diagnostic, but rather they provide quantitative evidence that PPD might be present. Patients who screen positive on these instruments should be seen by a mental health professional for a definitive diagnosis.

PPD screening tools include the Edinburgh Postpartum Depression Scale (EPDS), a 10-item self-report scale that has been translated into 23 languages and is available at no cost. The threshold score is 12 to 13, meaning that those scoring above 13 might have PPD. This instrument has a reported sensitivity of 78% and a specificity of 99% with a cutoff point of 80. In cultural groups in which women may be reluctant to disclose depressive symptoms, a lower cutoff (8–9) may be appropriate. It is essential that nurses become aware of “the social and cultural expectations and context of motherhood and reinforce the importance of clinical judgment when interpreting the EPDS score for all mothers regardless of language” (McQueen, Montgomery, Lappan-Gracon, Evans, & Hunter, 2008, p. 134). In a review of 37 studies utilizing this instrument, it was concluded that the EPDS may not be equally valid for English-speaking and non-English-speaking populations, but it is free, easy to administer, and acceptable to women (Gibson, McKenzie-Mcharg, Shakespeare, Price, & Gray, 2009).

Another useful tool is the 35-item Postpartum Depression Scale (PDSS), available in Spanish and English language (Beck, 2008a) with a specificity of 98% and a sen-



Table 1. Qualitative Studies

Citation	Design	Research Question	Sample Characteristics	Method/Tool	Findings
Buultjens and Liamputtong (2007)	Descriptive, qualitative	What are women's perceptions of PPD?	Australian women with PPD ( $n = 10$ )	Interviews	PPD a terrifying and isolating experience
Chen, Wang, Chung, Tseng, and Chou (2006)	Grounded theory	What is the process of experiencing PPD?	Taiwanese women with PPD ( $n = 23$ )	Interviews	Themes: Being reborn, shattered role identity, feeling trapped and breaking down, struggling for self-integrity, regaining vitality
Chien et al. (2006)	Descriptive, qualitative	How do women experience PPD?	Taiwanese women with PPD ( $n = 202$ )	Interviews	Women described stress and social isolation
Huang and Mathers (2008)	Qualitative, descriptive	What is the PP experience of migrant women?	South Asian migrant women living in Taiwan ( $n = 106$ )	Interviews	New families unsupportive, experienced stress/emotional distress
Letourneau et al. (2007)	Qualitative, descriptive	What are mothers with PPD perceived support needs?	Canadian women with PPD ( $n = 52$ )	Interviews	One-on-one postpartum support preferred
Sword, Busser, Ganann, McMillan and Swinton (2008)	Qualitative, descriptive	What are women with PPD care seeking experiences?	Canadian women with PPD ( $n = 18$ )  Swedish women with PPD ( $n = 22$ )	Interviews	Barriers/facilitators were on individual, social network, and health systems levels
Taniguchi and Baruffi (2007)	Descriptive, mixed method	What is the effect of giving birth in a foreign country on mental health?	Japanese-born women giving birth in the United States ( $n = 45$ )	Interviews	All primips had PPD stress and emotional distress was prevalent

sitivity of 94%. Another tool developed by Dr. Beck that may be used during pregnancy is the 32-item PPD Predictors Inventory-Revised, which can identify women at risk for PPD. It explains 67% of the variance of PPD symptoms with a sensitivity of 0.75 and a cutoff point of 10.5 (Beck).

One other screening instrument currently being used is The Postpartum Adjustment Questionnaire, a 15-item self-administered inventory that is a valid predictor of PPD symptoms, although it identifies only 40% of at-risk women (Davis, Cross, & Lind, 2008). Correlation with the PDSS is 0.28. Positive predictive values are low (36%–38%). Similar results were found using a single question from this tool rather than the entire 15 items, “*At times I have felt very depressed or loved during pregnancy.*” This may offer a cost-effective alternative to identify women at risk for PPD (Davis et al.).

In the literature on screening for PPD, some studies have shown beneficial effects of screening, but it is difficult to separate the effects of screening from interventions (Hewitt & Gilbody, 2009). Generally it is advised that increased screening for PPD by all healthcare providers is essential (Mancini, Carlson, & Albers, 2007), and that maternal screening can be done in various settings (such as during well-child visits in pediatric settings) because culturally diverse women may not return for their 6-week postpartum maternal checkup (Feinberg et al., 2006). Other innovative methods for PPD screening are telephone or Internet screening (Le, Perry, & Sheng, 2008; Mitchell, Mittelstaedt, & Schott-Baer, 2006), although these may not be appropriate for all culturally diverse women.

## Qualitative Studies of PPD in Culturally Diverse Women

Although evidence demonstrates that PPD occurs in most cultures, the majority of studies of PPD have been conducted with Western women as study participants, with the second largest group of studies focusing on Chinese women. Most studies are qualitative, with study participants identified through the use of PPD screening tools to assess for symptoms of PPD. Qualitative studies focusing on PPD in culturally diverse women, published since 2006, are listed in Table 1. Listening to the voices of culturally diverse childbearing women provides valuable data for healthcare providers (Humbert & Roberts, 2009).

## Cultural Beliefs, Rituals and Practices, and PPD

How women and their families seek to mediate PPD differs according to culture, and a broad cultural division can be made between technocentric and ethnokinship cultures. Technocentric refers to cultures in which the primary focus is on technological monitoring of new mothers and their infants; technocentric countries include the United States, Canada, the United Kingdom, Western Europe, New Zealand, and Australia. In these countries new mothers may or may not have assistance with household tasks, usually have a social network, and may not have a specific rite of passage to mark motherhood. Problems faced by new mothers in technocentric cultures have been noted to

## Table 2. Cultural Mentoring

- Postpartum social structure: a time of recuperation from giving birth
- Recognition of vulnerability of a new mother, with protective measures such as assistance with household tasks
- Specific hygiene practices such as avoiding bathing, ritual bathing, massage, abdominal binding
- Dietary proscriptions (such as avoiding cold foods and the preparation of specific foods)
- Mandated rest period
- Social seclusion for 4 to 6 weeks
- Emotional and informational support
- Taboos (such as avoiding exposure to cold water, drafts, joint strain)
- Recognition of the new mother with a celebration ("coming out")

be role conflict, maternal fatigue, and a diminished sense of self-worth (Posmontier & Horowitz, 2004). Although there is little evidence in the literature regarding the relationship between these cultural types and the prevalence of PPD, there are differences in how PPD is managed by women and their families.

Ethnokinship refers to cultures in which social support rituals by family networks are the primary focus of care for mothers and newborns during the postpartum period. For example, Korean mothers practice *sam chil sam ill*. A straw rope hung across the gate of the home announces the arrival of a new baby and is maintained for the 3 weeks during which the mother and newborn are secluded. Chinese mothers "do the month" (*zu yue*), which is the most significant cultural event associated with childbearing. Chinese women remain in seclusion with activity and dietary restrictions during this time. In Japan, during the third trimester pregnant women may go to their parental home and stay until 4 to 6 weeks of postpartum recovery, called *satogaeri bunben*. In Punjab, there are ritual ceremonies of shampooing and bathing the new mother by the midwife as well as serving ceremonial foods. *Jholabhari* is also practiced, in which a woman in her seventh or eighth month of gestation moves into her mother's home in preparation for the upcoming birth. Mexican women practice *la cuarenta*, a 30-day postpartum rest period also espoused by Hmong mothers. Amish women have a designated rest period and an organized system of social support, and Nigerian women are treated as though birth were a victory worthy of celebration. In Eastern Europe, women are secluded in birth houses for 5 days after giving birth, at this time the father and extended family members wait to greet the new mother and her baby for the first time, followed by social seclusion for the first month. Body massage and maternal abdominal binding is common in Latin America. In Uganda, the new mother is secluded until 3 months postpartum. In Somali, postpartum women wear

earrings made of garlic to deter the "evil eye" and after 40 days postpartum a celebration for the mother and newborn is held. In addition to household help and significant social support, in many cultures there are ceremonies that welcome the new mother and her newborn into society and recognize and reward the enhanced status of the mother (Dennis et al., 2007). Only some of these cultural beliefs and practices have been studied as they relate to PPD. This is a fertile area for future research.

## Are Culturally Prescribed Practices Associated With PPD?

Culturally prescribed practices may or may not be mediators in decreasing the incidence or severity of PPD, for research results are mixed. For example, "doing the month" among Chinese women living throughout the world is associated with lower severity of physical symptoms and lower odds of PPD (Chien, Tai, Ko, Huang, & Sheu, 2006). The cultural practice of *peiyue* (mandated family postpartum support) has been associated with better social support and a slightly lower risk of PPD. However, this custom (*peiyue*) that "mothers the mother" may be a mixed blessing, especially if tenuous relationships exist between a woman and the paternal grandmother, and if there are generational differences between traditional culture and modern lifestyles (Lau & Wong, 2008). *Satogaeri bunben*, the traditional ritual for childbearing women in Japan in which



*Cultural nurturing practices may be protective of mental health in postpartum women.*

they return to their original family town or home in the third trimester and remain until after they give birth and have a mandated rest period, does not appear to significantly decrease the incidence of PPD symptomatology (Kitamura et al., 2006).

Because we know that social support and social networks are significantly related to PPD (Surkan, Peterson, Hughes, & Gottlieb, 2006; Westdahl et al., 2007), it is important to consider literature on social networks as possible mediators to PPD. In an ethnographic study of low-income childbearing African American women, family support from mothers and sisters was viewed as essential in overcoming isolation and lack of resources (Savage, Anthony, Lee, Kappesser, & Rose, 2007). Leung, Arthur and Martinson (2005) found that women's perceptions of support versus stress in "doing the month" included being bound by environmental constraints, difficulties in following prescriptions, conflicts between parties involved, and making the transition to motherhood. Cultural nurturing practices viewed as protective of mental health in postpartum women are summarized in Table 2 (Kruckman, 1992; Posmontier & Horowitz, 2004).

Table 3. Practice Guidelines/Systematic Reviews

Citation	Design	Research Question	Sample	Findings
Dennis and Chung-Lee (2006)	Meta-synthesis	What are help-seeking barriers and treatment behaviors in women with PPD?	40 studies	Women's inability to disclose feelings reinforced by family/healthcare professionals, reluctance to respond to women's emotional/physical needs
Dennis et al., (2007)	Systematic review	What are traditional postpartum practices and rituals?	50 studies	Practices and rituals may have beneficial health effects and facilitate the transition to motherhood
Hewitt and Gilbody (2009)	Systematic review	Is it clinically cost-effective to screen for PPD?	5 studies	Individualized care Preventive strategies Use of EPDS Cutoff > 12 Use EPDS + clinical judgment
McQueen et al. (2008)	Evidence-based clinical guidelines updated	What factors relate to prevention, assessment, and interventions for PPD?	Canadian guidelines based on systematic reviews	No randomized controlled trials were found endorsing universal provision of postpartum support, but some evidence exists regarding efficacy.
Shaw, Levitt, Wong, Kaczorowski and McMaster University Postpartum Research Group (2006)	Systematic review	What postpartum support improves mothering, mental health, quality of life, and physical health?	9 studies	High-risk populations may benefit from postpartum support

## Clinical Nursing Implications for Culturally Competent Care

Practice guidelines in the literature as well as systematic reviews of interventions for PPD, which may be applicable to culturally diverse women, are described in Table 3.

In caring for women who may be experiencing PPD, it is important for nurses to engage in self-reflection, which requires realistic and ongoing self-appraisal including recognizing personal cultural biases. Nurses should also be sensitive to the cultural context of birth and gain an understanding of the varied ways in which mothers perceive, explain, report, and manage symptoms of PPD. Although it is not possible to have an extensive knowledge of all cultures, it is important to understand the predominant cultures in one's own healthcare facility. Implications for clinical practice are summarized in Table 4.

Many women with PPD do not access professional care and many do not seek help from their personal networks. In a survey of postpartum women, the need for help with PPD was identified as an unaddressed concern by the women themselves (Kanotra et al., 2007). In a recent study of attitudes, preferences, and perceived barriers to treatment for PPD in culturally diverse women, barriers to mental health care were identified as lack of time, stigma, and childcare issues. Study participants preferred to receive mental health services at obstetric clinics and identified the need to have understanding from a confidante, to receive support without having to ask for it, and to feel socially connected (Goodman, 2009).

Posmontier and Horowitz (2004) have pointed out the importance of taking into account culturally competent PPD care:

*"Postpartum depression may go unrecognized unless a culturally sensitive approach to assessment and care is used. To provide culturally competent and effective care in the postpartum period, collaboration between nurses from a technocentric framework and new mothers from ethnokinship cultures is needed to incorporate the best of both technocentric and ethnokinship postpartum practices into nursing interventions"* (p. 41).

### Exemplary Interventions

There are few exemplary interventions for culturally competent PPD care in the literature. Two of them are cited here. Baisch, Carey, Conway, and Mounts (2010) describe a health marketing campaign to improve screening and treatment of PPD implemented by the Wisconsin Association for Perinatal Care and the Perinatal Foundation, which resulted in the Perinatal Mood Disorders Initiative, which is outcomes focused and includes attention to cultural issues. Another intervention was studied in a randomized controlled trial that documented positive outcomes resulting from a cognitive behavior therapy intervention by primary health workers, with Pakistani women having symptoms of PPD. This demonstrates that psychosocial interventions can be effectively utilized in low-resource countries (Rahman, Malik, Sikander, Roberts, & Creed, 2008).

*Table 4.* Clinical Practice Guidelines

- Initiate screening strategies during pregnancy or early postpartum through the use of assessment tools, noting that cutoff criterion should be interpreted cautiously and may need to be adjusted for mothers who are immigrants, non-English speaking, use English as a second language, and/or are from diverse cultures. These should be interpreted in combination with clinical judgment
- Increase women's symptom awareness such as "not feeling like oneself" through educational programs. Women should not suffer in silence and isolation
- Provide individualized, culturally appropriate postpartum care based on identification of depressive symptoms and maternal preference, which incorporates cultural values as well as spiritual and religious traditions
- Recognize the potential influence of acculturation, discrimination, immigration, and refugee status on PPD
- Provide women with opportunities to discuss their birth experiences and challenges in making the transition to motherhood, which can act as an emotional "safety net"
- Provide supportive frequent interactions and ongoing assessment focusing on the mental health of new mothers
- Facilitate the provision of peer support in group settings
- Try such innovative and cost-effective strategies as telephone support and screening for PPD at well-child visits
- Encourage support from the personal networks of the woman, involving family and friends in the care of women with PPD
- Encourage appropriate rest, nutrition, and exercise in postpartum mothers
- Link women with resources such as Postpartum Support International, empowering them to develop skills and knowledge
- Provide cognitive/behavioral therapy when appropriate
- Involve culturally diverse women in generating and evaluating culturally appropriate interventions
- Evaluate healthcare models for childbearing women in other countries
- Advocate for changes in social policies related to increasing the availability of resources available to women with PPD in public and private care facilities

Sources: Beck (2008 a, 2008b, 2008c), Buultjens & Liamputtong, (2007), Cheng, Fowles, and Walker (2006), Dennis and Kingston (2008), Heh, Huang, Ho, Fu, and Wang (2008), Honikman (2006), Horowitz (2006), Letourneau et al. (2007), McQueen et al. (2008), Massey, Rising, and Ickovics, 2006; Morrissey (2007), Munoz et al. (2007), Rowan, Bick, and Bastos (2007), Segre, O'Hara, Arndt, and Stuart (2007), Shaw, Watt, and Krueger (2006), Sword et al. (2008), Teng, Blackmore, and Stewart (2007).

## Recommendations for Future Research

Further research is needed on all areas of postpartum maternal health (Sealy, Fraser, Simpson, Evans, & Hartford, 2009), including prevalence studies and reports of exemplary interventions to manage the symptoms of PPD. Ongoing questions include the following:

- a. How are symptoms of PPD manifest in culturally diverse women?
- b. Is it culturally appropriate to acknowledge PPD?
- c. Is it culturally appropriate to seek treatment for PPD?
- d. How does acculturation contribute to the identification and management of PPD?
- e. How can women adapt cultural PPD rituals to fit modern life?
- f. Which cultural rituals are most helpful in lowering the incidence of PPD?

Nurses have a holistic view on the care of women across the childbearing year, and are leaders in the field of culturally competent care (Beck, 2008a; Dennis et al., 2007; Douglas, Pierce, Rosenkoetter, Callister, Hattar-Pollara, Lauderdale, et al., 2009; Morrissey, 2007; Posmontier & Horowitz, 2004). We should now take the lead in research about PPD in varied cultures, and then develop appropriate interventions to help the most women possible. ❖

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ONLINE



**Support group**  
[www.communityresources.net/postpartumdepression.html](http://www.communityresources.net/postpartumdepression.html)  
**March of Dimes**  
[www.marchofdimes.com/pnhec/188\\_15755.asp](http://www.marchofdimes.com/pnhec/188_15755.asp)

**Center of Postpartum Adjustment**  
[www.postpartumsupport.com](http://www.postpartumsupport.com)

**Postpartum Support International—PSI**  
[www.postpartum.net](http://www.postpartum.net)

**Postpartum Stress Center**  
[www.postpartumstress.com](http://www.postpartumstress.com)

**Perinatal Mood Disorders Initiative**  
[www.perinatalweb.org](http://www.perinatalweb.org)

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