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# Postpartum Practices and Depression Prevalences: Technocentric and Ethnokinship Cultural Perspectives

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*Reports of non-Western prevalence of postpartum depression (PPD) are highly variable. This variation may indicate that the label of PPD may be unacceptable in some groups or not used, that manifestations may vary by culture, or that cross-cultural diagnostic standards do not match Western clinical criteria. These factors complicate efforts to explore the relationship of postpartum traditional practices to PPD between Western and non-Western cultures. Although Stern and Kruckman viewed PPD as a culture-bound phenomenon of Western culture, an expanding international literature has demonstrated that PPD occurs in a variety of countries. To address these issues, the authors examined the literature to describe cultural postpartum traditions, to explore possible relationships among practices and PPD prevalence, to critique the culture-bound theory, and to discuss clinical practice implications.*

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**Keywords:** *postpartum practices; depression; culture; technocentric; ethnokinship*

Postpartum depression (PPD) affects 10% to 15% of White middle-class women (Beck & Gable, 2000; Glasser et al., 2000; O'Hara & Swain, 1996) and up to 30% of non-White indigent women in Western cultures (Ferguson, Jamieson, & Lindsay, 2002; Hobfoll, Ritter, Lavin, Hulsizer, & Cameron, 1995; Yonkers et al., 2001). Devastating consequences include cognitive, behavioral, and emotional difficulties in children; abnormal family functioning; spousal depression; increased risk for more severe and chronic depression; and lack of maternal role attainment (Abrams, Field, Scafidi, & Promdromidis, 1995; Beck, 1998; Bernazzani, Saucier,

David, & Borgeat, 1997; Boath, Pryce, & Cox, 1998; Brennan et al., 2000; Cohen et al., 2001; Jones & Venis, 2001; Miller, 2002; Sharp et al., 1995; Sugawara, Kitamura, Toda, & Shima, 1999).

The majority of studies concerning PPD have been conducted in Western cultures (Affonso, De, Horowitz, & Mayberry, 2000). In addition, reports of non-Western prevalence of postpartum depression (PPD) are variable, with rates ranging from 0% to 40%. This variation may indicate that the label of PPD is unacceptable in some groups or not used, that PPD manifestations may vary by culture, or that cross-cultural diagnostic standards do not match clinical criteria documented in the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text revision) (*DSM-IV-TR*; American Psychiatric Association, 2000; Chen, Tseng, Chou, & Wing, 2000; Park & Dimigen, 1995; Stewart & Jambunathan, 1996; Yoshida, Yamashita, Ueda, & Tashiro, 2001). These suggested factors complicate efforts to explore the relationship of postpartum traditional practices to PPD between Western and non-Western cultures.

Stern and Kruckman (1983) formulated a theory to explain the differences in prevalence of PPD between Western and non-Western cultures. Based on their review of studies of non-Western postpartum practices and their cultural anthropological explorations, they concluded that PPD was either rare or nonexistent outside of Western countries. They hypothesized that PPD is a culture-bound illness found only in Western cultures because of the absence of a social support structure. Thus, Stern and Kruckman theorized that the occurrence of PPD was influenced by the presence or absence of the following elements:

1. a postpartum social structure,
2. recognition of vulnerability of the new mother,
3. a mandated rest period,

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4. social seclusion,
5. recognition of the role transition and social status of the new mother, and
6. assistance with household tasks from female family, friends, and midwives.

Although Stern and Kruckman added the importance of social support to the existing body of knowledge and provided a framework for cultural comparisons, the methodology they used to reach their conclusion may have been flawed. Recent evidence in the literature has indicated that PPD crosses cultural boundaries and is not a culture-bound illness (Affonso et al., 2000). In addition, the terms Western and non-Western may no longer be adequate to describe global cultural variation in postpartum practices.

To explore these issues, the authors reviewed the literature concerning international postpartum practices and their relationship to PPD. The purposes of this literature review are to suggest alternate terms for Western and non-Western cultures that more accurately describe global variation in postpartum practices, to compare the cultural influences on the occurrence of PPD through the lens of Stern and Kruckman's theory, to examine the utility of the culture-bound theory, and to discuss clinical practice implications based on the findings of this review.

### DEFINITION OF POSTPARTUM DEPRESSION

According to *DSM-IV-TR* criteria (American Psychiatric Association, 2000), PPD is a subtype of major depression that includes depressed mood or anhedonia (decreased experience of pleasure in usual pleasurable experiences) plus four or more (or three or more if depressed mood and anhedonia are both present) of the following symptoms: weight or appetite disturbance, sleep disturbance, psychomotor disturbance (agitation or psychomotor retardation), fatigue or loss of energy, difficulty concentrating, feelings of worthlessness or guilt, and recurrent thoughts of death. The onset of symptoms must occur within 4 weeks of parturition. PPD is indistinguishable from major depression, except for its onset within 4 weeks postpartum, and its negative effect on the relationships between the mother, her infant, and her family (Miller, 1999). The diagnosis of PPD does not include postpartum blues (a mild, transient, emotionally labile condition that is experienced by up to 80% of women during the first 2 weeks postpartum) or postpartum psychosis (an emergency condition with onset typically within the first 2 weeks postpartum that is characterized by confusion, mania, hallucinations, bizarre behavior, and homicidal ideation).

### EMERGENT CULTURAL CLASSIFICATIONS

*Technocentric* is a term that refers to cultures in which use of technology to monitor the well-being of the new mother

and infant is the primary focus of the immediate postpartum period. This technology ritual consists of obtaining vital signs, monitoring bodily fluids, bathing, and perineal monitoring for both mother and infant. Maternal-infant separation may occur to strengthen the efficiency of the technology ritual. Once potential danger associated with the birth process is over, societal postpartum practices beyond 24-to-48 hour monitoring are not prescribed. New mothers are discharged from the hospital to a social system that does not have formalized traditions or norms. Use of technology prevents many adverse outcomes in both mother and infant; however, in technocentric cultures, technology is valued over social support networks. Technocentric cultures occur primarily in the United States, Canada, the United Kingdom, Western Europe, New Zealand, and Australia.

*Ethnokinship* refers to cultures in which the performance of social support rituals by family networks are the primary focus of the immediate and later postpartum periods. These social support networks share racial, national, tribal, religious, linguistic, or cultural practices. Advanced technology may be used to promote safe and optimum postpartum outcomes, but family social support retains primary importance. Ethnokinship cultures examined in this article are Korean, Chinese, Japanese, Hmong, Mexican, African, Arabic, and Amish.

The terms technocentric and ethnokinship are used in this article in the place of Western and non-Western cultures, respectively. Regardless of geographic location, ethnokinship culture may exist within a dominant Western culture, and a technocentric culture may exist within a non-Western culture. The Amish community is one example of an ethnokinship culture that exists within a dominant technocentric culture in the United States. Moreover, some cultures contain a mixture of technocentric and ethnokinship components. For example, in Japanese culture, advanced technology dominates during the birthing process (technocentric), but the importance of family support rituals emerges during the postpartum period (ethnokinship) (Fiedler, 1997).

Many ethnokinship cultures are in a constant state of evolution as a result of technological advances in communication and economic demands. Furthermore, many postpartum traditions have been lost in modern cultures. Even within ethnokinship cultures, emerging evidence indicates abandonment of these traditional practices in an effort to cope with rising economic demands (Honikman, 2001).

### TECHNOCENTRIC CULTURES

#### Postpartum Support Structures

In technocentric cultures, postpartum support structures primarily involve maternity and parental leave. Because the number of women in the workforce has increased dramatically since the 1960s, many governments have instituted job-protected and paid maternity leaves to decrease maternal and

child morbidity and mortality in the postpartum period (Kamerman, 2002). Among 128 industrialized and developing countries surveyed, the average paid job-protected maternity and/or parental leave was 16 weeks. This leave period allows parents to spend time with their children in the postpartum period free from anxiety or financial worries (Kamerman, 2002).

However, among 29 industrialized countries, three countries—the United States, Australia, and South Korea—offer only unpaid maternity leaves (Kamerman, 2002). In addition, although the Family and Medical Leave Act of 1993 was passed in the United States to provide 12 weeks of unpaid parental leave, the act only pertains to women who work in companies with 50 or more employees. Women who worked less than 1,250 hours in the past year, who were employed for less than 1 year, or who were among the 10% of highest paid employees were ineligible for this provision. Furthermore, many women who are covered under the act are unable to take advantage of it because of the debt they would accrue without an income for 12 weeks. Five states (California, Hawaii, New Jersey, New York, Rhode Island) have instituted a paid maternity leave through temporary medical disability programs; however, fathers are excluded from this benefit. Fathers, who could provide infant care and thereby help mothers to get needed rest during the early postpartum period, often have to return to work because of economic demands.

#### **Mandated Rest and Assistance with Household Tasks**

In the United States, new mothers typically return to seminormal routines by 2 weeks postpartum (American College of Obstetricians and Gynecologists, 1999; Arizona Wellness Center, 2003; Professionals for Women's Health, 2003). Postpartum care when discharged from the standard 2-day hospital stay typically consists of giving the mother brief discharge instructions pertaining to activity, bathing, diet, infant feeding, sexual activity, elimination, warning signs, and follow-up appointments (American College of Obstetricians and Gynecologists, 1999).

Because extended family care is often unavailable because of financial constraints or geographic distance, many new mothers do not receive instrumental, informational, emotional, or social support during their 4- to 6-week recuperation period at home (Rooks, 1997). Many new mothers are forced to resume total self-care within a few days of returning home from the hospital. Furthermore, new mothers generally are expected to return to work after their brief maternity leave and to assume all responsibilities for their children and household duties (Hayes, Roberts, & Davare, 2000).

In the United States, women typically are discharged from the hospital within 24 to 48 hours after an uncomplicated delivery. If medical insurance provides a benefit, some of these mothers receive a postpartum visit on the 3rd or 4th postpartum day from a visiting nurse. This limited

postpartum contact leaves little opportunity to assess new mothers for PPD, and many mothers do not even receive this level of home care. In contrast, routine postpartum care in the United Kingdom consists of seven postpartum visits by midwives in the first 2 weeks postpartum and a visit with the obstetrician at 6 to 8 weeks postpartum (MacArthur, Winter, & Bick, 2002). Because of the additional support received, new mothers with depressive symptoms in the United Kingdom are more likely to come to the attention of health care professionals.

#### **Vulnerability**

According to Stern and Kruckman (1983), all cultures, including technocentric cultures, recognize that the new mother is in a vulnerable period of her life. The postpartum period typically is viewed as an intense period of turmoil and role adjustment in which new mothers require close physical and psychological monitoring (Tulman & Fawcett, 2003). However, although technology often prevents adverse medical outcomes for mothers and their infants during this period of vulnerability, technological interventions can produce a separation period between mothers and their infants in the hospital, institutionalized interference with breastfeeding-on-demand, early discharge from the hospital, and an overall lack of maternal rest (Hayes et al., 2000). As a result of these practices, mothers are likely to have little opportunity to be educated about realistic expectations concerning their new role.

#### **Social Seclusion**

Formal social seclusion periods are not endorsed in technocentric cultures. Except for limitations on the number of visitors during hospitalization for the first 1 to 3 days postpartum, little evidence exists regarding protective barriers between the new mother and outside visitors.

#### **Recognition of Role Transition**

New mothers are not celebrated in technocentric cultures to the extent that they are in most ethnokinship cultures. Mothers often receive limited social recognition, and infants tend to be the primary focus of attention (Kruckman, 1992). The shift in attention from mothers to infants may contribute to feelings of maternal isolation and decreased self-esteem. Finally, most technocentric cultures do not provide a rite of passage for new mothers that emphasizes maternal role change and status. Lack of postpartum rituals might contribute to role conflict and decreased self-esteem among new mothers (Cox, 1988).

## **ETHNOKINSHIP CULTURES**

#### **Postpartum Support Structure**

In ethnokinship cultures, social structure in the postpartum period is clearly recognized. In many of these cultures, the

postpartum period is defined as 30 to 40 days. This period is provided to promote the new mother's recuperation from childbirth and adaptation to her new role. Korean mothers are given *SAM CHIL ILL*, or a 21-day to 5-week rest period (Park & Dimigen, 1995). In Korea, PPD is not defined, although increased somatic symptoms are noted in some Korean mothers in the early postpartum period, and elevated depressive symptom levels have been documented (Affonso et al., 2000).

In reviews of sociocultural aspects of PPD, Cox (1988, 1999) described the Chinese practice of "doing the month," or *Zuo Yue*, during the postpartum period. *Zuo Yue* is a formalized month-long postpartum recovery period when new mothers, assisted by extended family, have the opportunity to restore the balance of yin (properties of female, dark, cold) and yang (properties of male, bright, hot) within their bodies (Loh, 1986).

Many Japanese women receive *Satogaeri bunben*, a period of prenatal and postnatal support (Yamashita, Yoshida, Nakano, & Tashiro, 2000). The pregnant mother returns to her family-of-origin home around 32 to 35 weeks gestation. She is cared for by her family, especially by her mother, from the time she returns home until 2 months postpartum. At 2 months postpartum, she returns to her husband in her marital home.

New mothers among the Hmong, an Indochinese group that originally migrated from China to Vietnam and Laos, experience the social support from spouses and families (Cheon-Klessig, Camilleri, McElmurry, & Ohlson, 1988). The culture is chiefly patrilineal, with the oldest male member of the family making family decisions. In a study by Stewart and Jambunathan (1996), Hmong immigrants were not diagnosed with PPD, but they did have symptoms of crying, insomnia, dizzy spells, decreased energy, and confusion related to being an immigrant in the United States. A small percentage of Hmong women attributed their symptoms to cultural differences, language barriers, and worries about financial matters. The participants indicated that they had control of customs within their homes but had no control of events outside their homes in the United States.

*La Cuarenta*, a postpartum rest period, has been observed among Mexican women (Kruckman, 1992; Niska, Snyder, & Lia-Hoagberg, 1998). New mothers in Mexico typically experience a 40-day rest period that includes protective seclusion; proscription from household chores, shopping, and sexual intercourse; and assistance and education from female relatives.

Okafor (2000) described traditional Nigerian practices surrounding pregnancy and the postpartum period. Pregnancy for the young couple is guided by elders, usually the mother or mother-in-law. The new infant is seen as the future for the family bloodline. When a Nigerian woman delivers, the birth is celebrated as a victory, especially if she delivers a

male child. The new mother is given exquisite attention and the best food that the family can provide for about 1 month.

The Amish of Tennessee, a subculture in the United States, have a formalized postpartum support structure consisting of a designated period of rest and an organized system of social support from extended family and the community (Finn, 1995). Remarkably, despite this group's high prevalence of bipolar disorder, a known risk factor for PPD, (Cohen, Sichel, Robertson, Heckscher, & Rosenbaum, 1995; Pauls, Morton, & Egeland, 1992), some midwives who work with the Amish (June Power, Claire McCormack, Jane Martini, personal communication, November 12, 2003) have noted a low reported prevalence of severe postpartum depression in this community.

### Vulnerability

In most ethnokinship cultures, the postpartum period is recognized as a vulnerable time when new mothers require special treatments. During this period, new mothers are often given special foods to assist them in healing. In Korea, special foods, such as seaweed soup and soft and hot foods, are prepared for the new mother. The mother also is kept constantly warm so that *BARAM* (or chill) is prevented. *BARAM* is not expected to respond to medication (Park & Dimigen, 1995).

In China, during *Zuo Yue*, the new mother, who is considered in an extreme yin state (female, dark, cold) after childbirth, must avoid eating raw or cold food or chicken, being blown about by the wind or becoming chilled, washing, engaging in sexual intercourse, reading, and crying (Cox, 1988, 1999). This practice is believed to restore the balance between yin and yang.

New mothers in Jordan are surrounded by the extended family after the birth and are treated to special foods (Nahas & Amasheh, 1999). However, Jordanian women are also expected to assume the traditional role of wife and mother. Expectations include producing children without feeling depressed. Women who deviate from these norms are considered bad mothers (1999). Jordanian women gain social status as mothers, especially with the birth of a male child.

The Hmong recognize the vulnerability of the new mother. Most Hmong have knowledge of herbs, but an herbalist may be consulted in areas concerning childbirth (Cheon-Klessig et al., 1988). The new mother may be given a chicken soup boiled with a plant called *Ntiv* to rid her of "bad postpartum blood." In addition, because depression is attributed to a "broken liver" (analogous to a broken heart in technocentric cultures), to the soul leaving the body, or to bad spirits that inhabit the house, a Shaman, or *Txi Neng*, may be called on to perform a ceremony to bring the soul of the new mother back to her body (1988).

In Mexico, special foods are prepared for the new mother (Kruckman, 1992; Niska, Snyder, & Lia-Hoagberg, 1998). Bathing is restricted to protect the new mother from cold or

evil air (*mal aire*). The new mother wears a *faja* (an abdominal band), warm and loose fitting clothing, socks, and a head covering to avoid uterine or breastfeeding problems.

### Mandated Rest

In many ethnokinship cultures, new mothers have a mandated rest period. New mothers among the Chinese, Jordanian, and Hmong receive extra attention and rest (Cheon-Klessig et al., 1988; Cox, 1988; Nahas, & Amasheh, 1999).

### Social Seclusion

New mothers in ethnokinship cultures typically experience total social seclusion for 5 to 9 days. During this time, the only contacts are female relatives, friends, and midwives who prepare special foods, keep the new mother warm, care for other children, take over household chores, assist the new mother in bathing, and allow the new mother to sleep at night. This period is followed by modified social seclusion for 30 to 40 days following childbirth when new mothers are nurtured with physical, emotional, and informational support.

In rural Korea, a *SAM CHUL* (thick rope referred to as the fetal line) is hung over the doorway of homes to signify that the new mother is in social seclusion (Park & Dimigen, 1995). The only visitors permitted in the home are those who assist with the care of the new mother and baby. The new mother is gradually weaned from this support before she assumes her routine responsibilities. A formalized period of seclusion also is practiced in China during *Zuo Yue* (Cox, 1988, 1999). Postpartum practices in Arab countries include a similar 40-day seclusion period (Hundt et al., 2000).

In Mexico, a specialized sequence of visits from female relatives during the postpartum period is performed to "neutralize spiritual impurity" (Kruckman, 1992, p. 144) and to assist the new mother to resume her role in the community. The husband also helps the mother during *la cuarenta* by caring for the new infant. Once *la cuarenta* is over, the new mother resumes her routine household and childcare chores, and the husband goes back to work. Study results have indicated that *la cuarenta* facilitates maternal adaptation to parenthood and decreases the rate of PPD (Kruckman, 1992; Niska et al., 1998).

### Recognition of Role Transition

Ethnokinship cultures focus attention on both mother and baby (Kruckman, 1992). Ethnokinship cultures provide activities or ceremonies that welcome or reintegrate the new mother back into society and recognize her new role and status. Korean, Japanese, Hmong, Mexican, and Nigerian cultures all contain rituals that celebrate the status of the new mother (Kim-Godwin, 2003; Park & Dimigen, 1995; Niska, et al., 1998; Okafor, 2000; Stewart & Jambunathan, 1996; Yamashita et al., 2000).

### Assistance with Household Tasks

Abundant evidence of assistance with household tasks is found among ethnokinship cultures. In Korea, during *SAM CHIL ILL*, parents or in-laws care for the new mother (Park & Dimigen, 1995). In China, female relatives, usually including the mother-in-law, attend to the needs of the new mother, including relieving her of household chores during *Zuo Yue* (Cox, 1988, 1999). New mothers also receive assistance with household chores in the Japanese, Hmong, Mexican, Nigerian, and Amish cultures (Finn, 1995; Niska, et al., 1998; Okafor, 2000; Stewart & Jambunathan, 1996; Yamashita et al., 2000).

Jordanian culture emphasizes the importance of the social support from extended family members (Nahas & Amasheh, 1999). Family structure includes the nuclear family, parents and servants, those related by consanguinity, and the family of the in-laws. Women commonly marry at a young age, and marriage is considered a contract. Because Jordanian husbands can have up to four wives—provided that they treat each wife equally—a new mother may not have an exclusive relationship with her infant's father but may have close contact with other wives.

Research findings provide evidence that cultural social support structures may mitigate PPD. For example, in an ethnographic investigation, Nahas and Amasheh (1999) interviewed 22 Jordanian mothers who emigrated to Australia and were experiencing PPD. According to these women, PPD is unknown in Jordan. The new mothers stated that they developed PPD because in their new country, they were separated from the normal 40-day support period that their extended families in Jordan would have provided. As in other Western cultures, Jordanian husbands living in Australia were unable to fill the void in social support because they returned to work because of financial obligations. Without the support of their social network, these women may have been more vulnerable to the onset of PPD.

## UTILITY OF STERN AND KRUCKMAN'S CULTURE-BOUND THEORY OF PPD

Stern and Kruckman (1983) provided a useful framework to outline key features of the postpartum period. They proposed that specific cultural factors are protective forces that buffer new mothers from PPD. Stern and Kruckman maintained that postpartum rituals in ethnokinship cultures support the nourishment, protection, rest, and healing of vulnerable new mothers and babies. Thus, such rituals protect against the occurrence of PPD. Current research literature provides evidence that social support, a component of traditional postpartum practices, is associated with decreased PPD severity (Lasek, 2000; Logsdon, Birkimer, & Usui, 2000; Marks & Siddle, 2000; Misri, Kostaras, Fox, & Kostaras, 2000; Stowe & Nemeroff, 1995; Wolman, Chalmers, Hofmeyr, & Nikodem, 1993). Stern and Kruckman also rec-

ognized the limitations of biological theories and existing psychological theories as complete explanations for the etiology of PPD. Rather, they proposed an interdependence of biological, psychological, and cultural factors, and they emphasized that family structure and role expectations contribute to PPD's etiology.

However, Stern and Kruckman's (1983) conclusion that PPD is a culture-bound phenomenon found only in technocentric cultures is faulty as a result of their methodology. Although they found that ethnographic studies conducted in ethnokinship cultures produced scant evidence of PPD, they did not address the possibility that expressions of PPD may vary according to culture. For example, Korean, Japanese, and Hmong mothers may express PPD in the form of physical complaints, and they may not identify other distress symptoms as signs of depression. Physical distress may be more acceptable in these cultures than psychological or emotional symptoms associated with depression that are recognized in technocentric cultures. In addition, Jordanian mothers are discouraged from expressing depression in the postpartum period. Because Stern and Kruckman may have viewed PPD through their own technocentric lens, variant manifestations of PPD in ethnokinship cultures may have gone unrecognized and unexplored.

Moreover, outcomes from studies involving cross-cultural samples provide mounting evidence that PPD is not an exclusively Western disorder. In a recent study, Affonso et al. (2000) examined depressive symptomatology among 892 women from 9 countries. Results indicated that postpartum symptomatology crossed cultural boundaries, and, therefore, was not the culture-bound syndrome depicted by Stern and Kruckman (1983; Kruckman, 1992). Remarkably, Affonso et al., (2000) found that at 4 to 6 weeks and 10 to 12 weeks after delivery, postpartum depressive symptoms were lowest among European and Australian women and were highest among new mothers from non-Western countries (i.e., Taiwan, Guyana, Korea, and India) where traditional (ethnokinship) postpartum practices are commonly followed.

A growing body of research demonstrates that women from Asian countries experience PPD. For example, Chen et al., (2000) reported mild to severe PPD symptoms among 40% of mothers at 6 weeks postpartum in a prospective study of 60 Taiwanese women. Results of this study confirmed that PPD symptoms occurred within an ethnokinship culture and also demonstrated that social support (*Tso-Yueh Tzu*) contributed to significant decreases in depression symptoms for the group that received *Tso-Yueh-Tsu* social support.

Park and Dimigen (1995) did not find support for Stern and Kruckman's (1983) hypothesis regarding PPD. When comparing the prevalence of PPD between Korean and Scottish mothers, they found that Korean mothers had higher depression scores despite their high level of family social support.

Yamashita et al. (2000) conducted a study of 88 new Japanese mothers to ascertain their rate of PPD. Sixty-seven percent received the support of the *Satagaeri bunben*. The findings of the study revealed a PPD prevalence of 14% (a rate similar to that found in Western or technocentric cultures). The investigators concluded that the rate of PPD was independent of educational level and social support. Yoshida et al. (1997) found lower rates of PPD in Japanese women but attributed this finding to the observation that Japanese women are less likely to express their feelings than are Western women. Yoshida et al. (2001) conducted another study to examine the practice of *Satagaeri bunben* and the prevalence of PPD among Japanese women living in England and Japan. Rates were 12% among Japanese women in England and 17% in Japan.

As with Asian women, Arab women receive familial support after childbirth. Yet, despite the presence of postpartum support structures within Arabic cultures, reported PPD prevalence rates are similar to those found in technocentric cultures. Moreover, in a prospective study, Abou-Saleh (1997) found that psychosocial factors associated with PPD in the United Arab Emirates included marital problems, polygamy, life crises, previous psychiatric history, first child, and infants' illnesses.

The nature of the support provided to new mothers may influence whether or not social support mitigates PPD. Stern and Kruckman (1983) did not address the quality of the social support offered by family networks in ethnokinship cultures. Social support offered in ethnokinship cultures may not always be beneficial to the emotional well-being of new mothers, especially if mothers view it as intrusive. Despite a high level of social support, Aderibigbe, Gureje, & Omigbodun (1993) found a 14% rate of PPD at 6 to 8 weeks postpartum in a sample of 162 Nigerian women. In Nigerian culture, in-laws move in with the young couple to help them decide what is best for the baby. The researcher hypothesized that this intrusiveness could be a source of stress for new mothers. Danaci, Dinc, Deveci, Sen, & Icelli (2002) found a 14% prevalence of PPD among Turkish mothers. Three factors related to the onset of PPD included a negative relationship with in-laws, a large number of children, and poverty. Matthey, Panasetis, and Barnett (2002) found that 18% of Chinese immigrant mothers in Australia felt ambivalent about traditional practices in the postpartum period and that the reason that they followed the practice was to please their in-laws. In addition, they found that adherence to traditional practices was not protective against the onset of PPD.

Horowitz, Chang, Das, & Hayes (2001) conducted a qualitative study of new mothers in nine countries—Australia, Finland, Guyana, India, Italy, Korea, Sweden, Taiwan, and the United States. The investigators found that women in traditional (ethnokinship) cultures were ambivalent about traditional practices when the infant belonged more to the in-laws than to the new mother. In addition, women expressed dis-

stress that their opinions were not heard. Mothers in the technocentric cultures without a formal postpartum support structure expressed distress as the result of inadequate social support. Thus, women viewed various ethnokinship and technocentric cultural practices as being relatively helpful or valued; concurrently, they experienced aspects of some practices as distressing. The investigators concluded that cultural practices described in the study were, therefore, neither intrinsically supportive nor detrimental to the mental health of the new mothers, and they proposed that individual cultural contexts need consideration by clinicians who care for new mothers in all cultures.

Variation in methods used to identify and measure depression symptoms across studies also affect estimations of PPD prevalence. Researchers did not use formal diagnostic interviews or standardized depression measures in the studies of ethnokinship cultures reviewed by Stern and Kruckman (1983). In addition, Stern and Kruckman did not examine the ethnographic field observations of the researchers of ethnokinship cultures. Because the researchers from technocentric cultures were more likely to use standardized instruments to measure depression symptom levels, PPD may have appeared to be more prevalent and, therefore, more culture-bound.

Timing of data collection also is a relevant methodologic issue in postpartum research. The studies examined by Stern and Kruckman (1983) had inconsistent interview periods from 1 day postpartum to 6 months postpartum. Presence of depression symptoms during the immediate postpartum period do not reflect current diagnostic criteria for PPD. According to the *DSM-IV-TR* (American Psychiatric Association, 2000), clinicians can only diagnose PPD after 2 weeks following childbirth when postpartum or maternity blues would have resolved. To explore cross-cultural PPD prevalence rates, comparison of depression symptom levels is recommended across samples at the same time periods as illustrated in the method used by Affonso et al. (2000).

Finally, Stern and Kruckman (1983) did not address how technocentric cultures may offer advantages in postpartum adjustment that may not be available in ethnokinship cultures. Technology that prevents adverse maternal and neonatal outcomes may also serve to buffer the effects of PPD. For example, the use of antidepressants to balance serotonin levels in the brain may provide relief for some new mothers suffering from PPD.

In summary, Stern and Kruckman's (1983) conclusion that PPD is a culture-bound phenomenon limited to industrialized countries is not supported by the research literature. International prevalence rates of PPD provide evidence that women from countries around the world experience PPD. Furthermore, Stern and Kruckman's assumption that traditional postpartum practices are universally beneficial to mothers was based on limited research that did not support generalization to other populations.

## CLINICAL IMPLICATIONS

Several clinical implications from this analysis emerge that may inform nurses' efforts to provide culturally sensitive and effective care. By understanding that PPD is an international phenomenon that occurs across cultures, nurses will be more likely to assess all new mothers for culture-specific signs of PPD, regardless of their cultural affiliation. Creative strategies involving collaboration between nurses and new mothers could be used to identify components of ethnokinship cultural practices that mothers value and that may be safely incorporated into technocentric clinical care. By merging desired components of cultural practices with standard clinical practices, nurses may ease the stress of becoming a mother for many women who immigrate from their countries of origin and give birth in a foreign culture and for women who identify with traditions associated with their cultural heritage.

Increased sensitivity to the effects of technocentric postpartum care on all new mothers may lead to revision of common practices concerning separation of mother and infant, breastfeeding on demand in the hospital, and scanty postpartum follow-up. Focusing attention on both mother and infant rather than primarily on the infant may decrease feelings of maternal isolation and decreased self-esteem. Allocating time during prenatal and postpartum care to educate new mothers about realistic expectations of motherhood could decrease feelings of maternal incompetence. Protecting privacy of all new mothers could convey a feeling of respect and recognition of the new mother's status. To promote mothers' postpartum mental health, nurses also can become advocates for paid, job-protected maternity leave for all women in all cultures.

Evidence that PPD crosses cultural boundaries informs practice by increasing nurses' awareness that symptoms may be covert or manifested in different ways with various attributed meanings (Committee on Cultural Psychiatry, 2002). Expressions of PPD may appear as somatic symptoms in cultures that have no name for PPD. For example, there is no term for PPD in Korea (Park & Dimigen, 1995). Women from ethnokinship cultures may need referral to a culturally sensitive provider who understands somatic or other expressions of PPD to receive relevant and effective therapy.

Optimal nursing care includes culturally sensitive assessment of the quality of social support that a new mother receives. If a new mother in a technocentric health care system or setting expresses concern that she is not getting the quality or type of social support that she would receive within her own culture, the nurse may be able to collaborate with the mother to develop culturally sensitive problem-solving strategies to address specific concerns. Furthermore, by evaluating aspects of postpartum practices that mothers view as helpful or distressing, nurses can intervene. For example, postpartum difficulties might be mitigated by identifying

desired sources of postpartum support and harnessing the necessary resources in collaboration with a woman before and after delivery. Alternately, by identifying stressful aspects of a woman's support system, the nurse may strategize with the mother, for example, by asking the mother what her preferences are rather than assuming that she wishes to follow a specific ritual or custom.

Immigration of an individual from one culture to another is likely to be stressful and might result in decreased social support. As a result, immigrants may be particularly vulnerable to PPD (Glasser et al., 2000; Nahas, Hillege, & Amasheh, 1999). Therefore, incorporating an assessment of stress related to immigration may be helpful in planning care and education for new mothers who have been recently separated from their family support networks.

New mothers from ethnokinship cultures also may be more vulnerable to PPD as a result of cultural insensitivity to rituals surrounding childbirth and the postpartum period. However, nurses may lessen this risk by learning about various postpartum cultural practices. By incorporating questions about cultural practices into the initial assessment interview, nurses can elicit information needed to personalize their care. In addition, cultural competency skills could be incorporated into hospital orientation programs.

Knowledge about common cultural practices will assist nurses to provide effective care. For example, in many ethnokinship cultures, cold items (perineal ice-packs, cold foods) and a lack of privacy and seclusion are viewed as harmful to the new mother's recovery process. Providing the new mother with warm blankets, adjusting the room temperature, and providing privacy during hospitalization can go a long way toward preventing culturally induced distress. Knowing that bathing or showering is prohibited in the early postpartum period to prevent the new mother from becoming ill is necessary nursing knowledge to provide effective postpartum care. Acceptable alternatives to bathing, such as sponge bathing, can be explored with the new mother. According to some cultural traditions, early activity and ambulation may be considered harmful to the new mother's recovery process. Acceptable compromises may need to be explored to prevent venous stasis, such as a range of motion exercises that can be performed in bed. During hospitalization, visitation rules that preclude family network involvement may need to be adjusted to respect the mother's and the family's traditions, as long as the mother's safety is protected as well. Provision of special postpartum foods that the new mother and her family consider critical to her well-being also may be helpful.

## CONCLUSIONS

Although Stern and Kruckman (1983) concluded that PPD is a culture-bound phenomenon within technocentric

cultures, an expanding international literature has demonstrated that PPD occurs in a variety of countries, including those with ethnokinship cultures. Mounting evidence that women from countries around the world experience PPD refutes Stern and Kruckman's formulation and supports the conclusion that PPD is not simply an artifact of Western or technocentric culture. However, Stern and Kruckman's work retains value concerning the importance of social support as a potential buffer against PPD. In addition, Stern and Kruckman also provided a useful framework for cross-cultural comparisons.

Revising culture-laden views of PPD is critical to providing competent clinical care for childbearing women and their families. PPD 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. Finally, nurses can revise some technocentric postpartum practices to honor the wishes and status of all new mothers.

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