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CROSS-CULTURAL EXPERIENCE OF MATERNAL POSTNATAL DEPRESSION

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ABSTRACT---*The prevalence of maternal postnatal depression (PND) varies from 0% to 60% globally. This wide variety brings up the issue of whether PND is a universal medical condition or whether it is an idea impacted by cultural and social translations, and the labelling of signs and symptoms. The objective of this review was to understand women's experience of PND in different countries. Studies reporting women's experiences of PND were searched through databases of CINAHL, PubMed, MEDLINE, Psy INFO and ASSIA databases using specific key words. Articles published between 2006 and 2016 were filtered for inclusion criteria. A total of 27 studies on maternal experience of PND conducted in ten different countries including America, Canada, South Africa, United Kingdom, Norway, Australia, New Zealand, Bangladesh, China, and Taiwan were reviewed. Findings indicated that while women recognized the emotional changes in themselves after their childbirth, they were unable to perceive these as burdensome symptoms, resulting in delayed diagnosis of PND. The issues of cultures and traditions were perceived by Asian women as one of the contributing factors to PND.HCPs were regarded by the women as having a lack of knowledge in supporting mental wellbeing among postnatal women. Therefore, it is crucial to educate both HCPs and communities to notice and react to women's depressed feelings. The management of maternal PND should acknowledge the social and cultural element as many women associated this with the development of PND.*

Keywords---*qualitative; mothers; perspectives; experiences; postnatal depression; maternal mental health.*

I. Introduction

Maternal postnatal depression (PND)is a burdensome disease which most much of the time starts 2 to 3 weeks after birth and that may keep going for a year and may have considerable consequences for new moms, babies, accomplices and families.[(1,2)]Without proper management, PND can cause adverse effects on mother, baby and partners, impacting familial relationships as well as the maternal ability to care for their baby. [(3–5)]

The wide variety of prevalence of PND (between 0% to 60%) in new mothers from various societies[(6)]raises doubt about whether PND mirrors an all-inclusive therapeutic determination as characterized by the Diagnostic and Statistical Manual of Mental Disorders (DSM)- V, or an idea that is impacted by cultural and social elucidation and labelling of signs and symptoms.[(7)] It was recommended that cultural and social elements should be incorporated in

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managing maternal PND,[8–11]therefore it is crucial to understand how women from different cultural backgrounds describe their experiences of PND and to what extent it affects their help seeking behaviours.

Whilst previous qualitative studies have explored the experience of women with depressive symptoms in various cultural backgrounds,[12–14]limited studies have specifically examined women's experiences and perceptions of PND across different cultures. In their review, Dennis and Chung-Lee [15] included 40 studies on maternal coping styles and ideal treatment in dealing with PND. Women in their review did not disclose their feelings due to several barriers. First, the women perceived that their family members and healthcare professionals (HCPs) were reluctant to respond to their emotional and practical needs. Second, the women had a lack of knowledge about PND, therefore were unable to recognize PND symptoms. Third, women were afraid of being labelled as mentally ill and of losing their right to care for their newborn.

Dennis et al. [16] reviewed 51 studies on traditional postpartum practices in over 20 countries. They had found that there were commonalities and difference in practices across cultures. Regardless of their cultural backgrounds, women in their review reported that they were supported by their family members during the early postnatal period with restrictions on their freedom to perform their normal household tasks. In many cultures, women described restrictions on their behaviour, for example some food was prohibited and some permitted and they were prescribed certain hygiene practices (such as washing genitalia with soap and water, avoiding sexual intercourse).[16]Despite the similarities, there were variations in terms of duration of postnatal practices, participants in the postnatal practices, and the influence of supernatural or religious beliefs.

Although issues of barriers to help-seeking and maternal treatment preferences, traditional postpartum practices and rituals were discussed in the previous review articles [15,16] there are no cross-cultural reviews available on the women's description of the symptoms of PND, and their interpretation of the perceived causes of those symptoms. The aims of this review were to systematically examine whether there are cross cultural differences in maternal PND experience and in their coping styles, and to examine positioning of sociocultural factors as explanations for PND.

II. Methods and methodology

A qualitative synthesis of women's experience of PND was conducted. Qualitative synthesis allows researchers to employ systematic methods of scientific inquiry in order to aggregate or summarize the previous qualitative data.[17] The outcome of this process was the generation of new themes. It is through this process that makes qualitative synthesis used in this review differs from literature reviews.

Papers included in this review based on the following criteria: using qualitative data collection and analysis; conducted among women with PND and published in English from year 2006 to 2016.Two previous reviews on PND relied on data reported in 2005 and July 2006.[15,16]Only qualitative papers are considered in this review as the aim is to capture the experience of PND as expressed by the women, not based on the women's interpretation of the specific set of depressive symptoms found from self-reported questionnaires to detect PND. The search strategy is

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shown in Figure 1. The Critical Appraisal Skills Program (CASP)[18] was used not only to assess the quality but also to review methods and methodology the included papers. To guide the writing of the result of this review, the Enhancing Transparency in Reporting the Synthesis of Qualitative Research (ENTREQ) statement was adopted.

Papers selected for this review were analyzed using thematic analysis. Based on this type of analysis, repeating concepts or ideas from the selected papers were recognized and analyzed transparently. [19, 20] The selected papers were exported toNvivo for the purpose of data management and analysis. The interpretation and conclusion of this review were derived from three systematic steps. First, findings of the selected papers were read line-by-line and relevant ideas will be coded along with the reading. Second, the 'descriptive themes' were developed based on the coding in the first step. The coding was compared across the papers. Third, 'descriptive themes' were analyzed and the new construct (analytical themes)were developed.

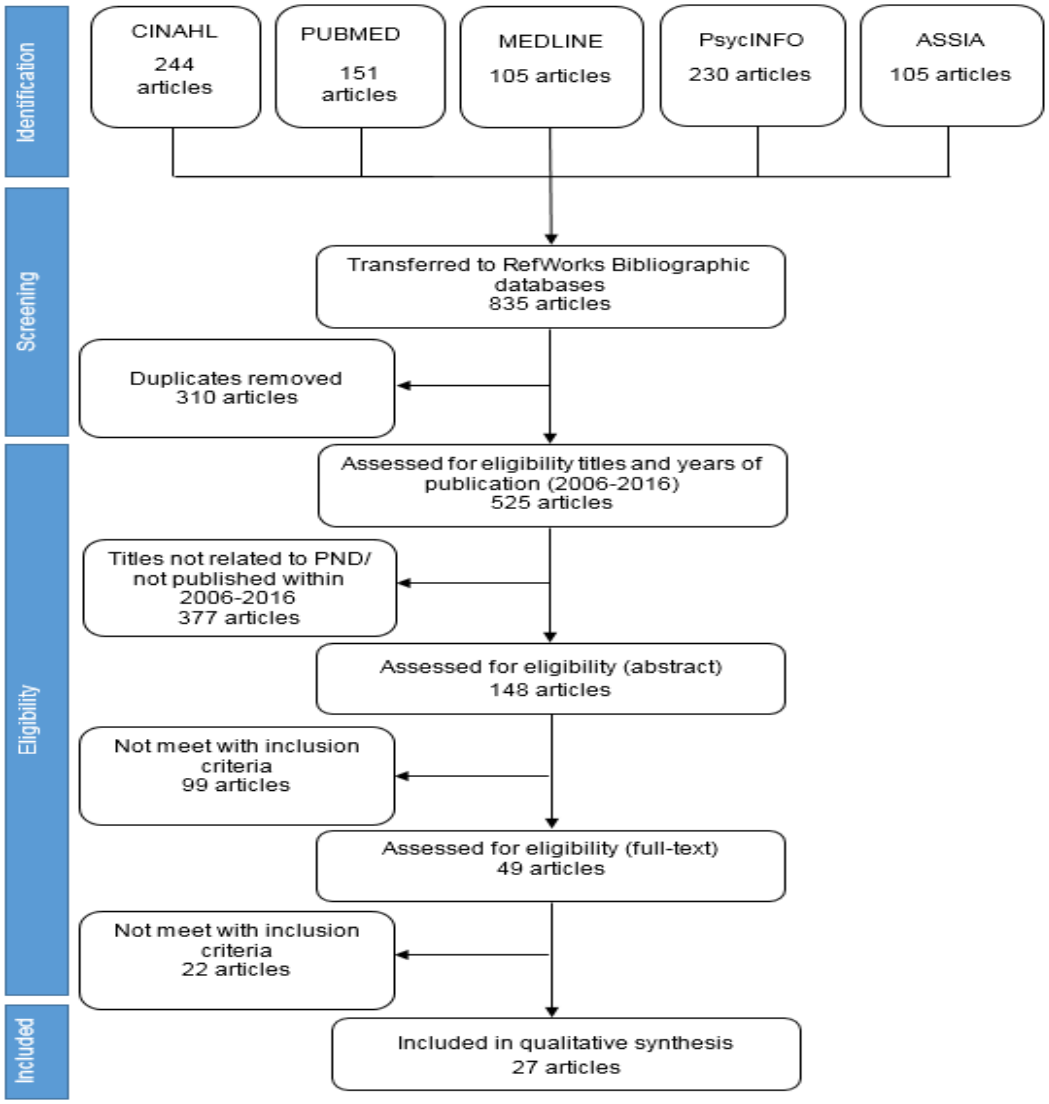

Figure 1: Search strategy

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III. Findings

A total of 27 selected studies came fromten different countries (America, Canada, South Africa, UK, Norway, Australia, New Zealand, and Bangladesh, China, and Taiwan). Almost all papers meeting most of the CASP criteria, indicating high quality of the papers. Results of this review were classified under three themes as indicated below.

Symptoms

The experience of PND was described by the women as a sudden change in their normal self, sadness, and oversensitive. They connected these experiences with emotional disturbance, tearfulness, so much pressure, feeling guilty, anxiety, and self-blaming. [21–29] Women, especially those in the two studies from South Africa uncovered that they had short-tempered, feeling irritated, disturbing thoughts and self-destructive ideation. In one study, this irritability was converted into forceful conduct, for example, hitting kids and notwithstanding cutting their husband.[24] Women in Canada, South Africa, Taiwan, and Bangladesh reported difficulty in sleeping, being absent minded, weight reduction, absence of hunger, stomach torments, chest torments, migraine, tipsiness, low or hypertension, jaundice, urinary issues, gastric issues, and experiencing difficulty strolling after childbirth.[22,24,26,27,30]

Women's attribution of the symptoms

The women' attribution of PND was essentially connected with their social circumstances which were accounted for by practically most of the studies. While women across cultures recognized biophysical factors as adding to PND, the essentialness of cultures and tradition were especially talked about in three Asian studies.[22,30,31] Women linked their experience of PND with an absence of help from their informal community, money related issues, multiple roles, and problematic relationships which led them to feelings of isolation, fear, disappointment, powerlessness, and sentiments of being disregarded.[21–24,26,29,30,32–39]

Financial constraints were discussed by many women from American, South African, Indian, Welsh, Chinese, Bangladeshi and immigrant women in the USA and Canada as one of the cause for their PND [22–24,26,31,32,34,36,40]Various studies had found that women with PND experienced trouble in adapting to their different duties as another mother and put remarkable weight on them.[21,25,29,31–35,38,40]The sense of inability to fulfil expected roles became significant when there was a mismatch between maternal desire and the truth of turning into a mother.[21,26,29,31,33–36,39,42,43]

Problematic relationships were highlighted across different studies.[22,24,26,30,32,33,37,42]While Australian women revealed that their partner was not understanding and unsympathetic towards the manner in which they were feeling and this lead to disappointment, Asian migrant ladies in Canada depicted conflicts with their relative who they frequently portrayed as uncalled for or unsupportive, coinciding with PND.[26,33]

Most of the women in this review linked their PND experience to unpleasant occasions during the postnatal period such as having breastfeeding problems, multiple roles, and insufficient rest and sleep.[21–26,30–33,35,36,38,39]While women in western countries regarded their motherhood as 'less or no reward', 'being unable to escape', 'not worth',

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and 'no-win' situation,[23,33,35,36] Asian women described it as 'collapsing', 'cursing' 'feeling drained' and 'had no physical strength'.[22,30,31]

Women's accounts indicated that their experience of PND were related to traumatic labour experiences, articulating the feeling that they 'couldn't really recover', 'stressful', and 'frightened during labour and delivery'.[21–23,32,33] Women who had high expectations of breastfeeding appeared to describe that their high desire to continue breastfeeding increased their distress and gave them the sense of disappointment whenever they had breastfeeding problems.[21,31,41]

In certain communities, traditional postnatal practices were reported as women from PND, yet it could likewise add to a negative effect in another culture. For instance, South African women perceived such practices as quiet, alleviating, helping with relief from discomfort, and advancing profound sleep.[23] Similarly, in Canada, a study of immigrant women suggested that the absence of the practices had decreased the women's supportive network which had exposed them to PND.[26,40] However, many Asian women reported that their traditional rituals during postnatal period had contributed to their PND experience.[30,31] For instance, the Chinese women portrayed the practice of remaining inside the house for a month during postnatal period as 'being in jail' and losing of authority over themselves.[30,31]

The issues of gender preference of the newborn and the presence of an 'external power' were highlighted by Bangladeshi, Chinese and Indian women. They reported that they were blamed by their husband and in laws for not having the option to bring forth a male child.[21,25,30] Some Asian women connected their PND experience with the presence of an external power and they described the power as 'evil eye', 'evil fortune', and 'satanic whisper'.[22,28–30]

Help seeking behaviours

It appeared that women included within this review have limited understanding of PND. It is due to this lack of knowledge that made them unable to identify the symptoms, therefore embracing self-improvement measures to alleviate the symptoms.[21,25–27,29,33,34,36–38,42,44,45] Those women who had a certain level of knowledge on depressive symptoms attempted to conceal their feelings because of not wanting being labelled asa weak or bad mother or being viewed 'differently' by their society, and to avoid the consequences of losing their when the referral to social services becomes necessary.([23,25–27-29,33–37,40,42–45] A lack of knowledge of PND among family and HCPs were also reported by the women. They were described by the women as not being supportive in getting professional help and had normalized their depressive symptoms. [21, 24–27,29,34-38,40,42-45] Nevertheless, some women chose to seek help when they were encouraged by their HCPs, spouse, relatives and friends to do so. [25,27,45] Women portrayed the supportive HCPs as 'good listener', 'goddesses', and 'understanding and unrushed'.[21,37,38,44].

Women used various strategies to improve their depressive conditions such as having social support, practicing self-help, and receiving professional support. [26,37,38] Practicing self-help and receiving social support were discussed

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more by Asian women, and they did not describe professional help at all.[22,29,30,38] Spiritual beliefs ere perceived by the immigrant women in Canada and South Asian women in England as beneficial in coping with the depressive symptoms, whereas women in Europe were bound to discuss perceiving their very own needs and individual alteration, for example, keeping occupied and escaping the house each day.[21,29,39–41] Women in other western countries (Australia, New Zealand, UK, and US) appreciated the professional help such as psychologically informed sessions, listening visits, home visits, and telephone-based services in promoting their mental well-being.[25,26,28, 33, 34, 36,37,41,44,45]

IV. Discussions

This review indicated that while social circumstances were equally discussed by all group of women as one of the main causes for PND, the issues of traditional postnatal practices were discussed more by Asian women. Similar to previous studies, this review recommends that non-performance of postnatal traditions and rituals has been inconsistently associated with PND and that performance of some postnatal traditions is related to PND.[46–49] The trend towards modernization, migration and globalization may reduce the capability of a woman to follow tradition postnatal practices or to feel stressed when they are asked to follow the practices that they no longer believe.[16]

Many women included in this review were reported as having a lack of understanding of depressive symptoms, resulting in delayed diagnosis of PND. While they recognized the emotional changes in themselves after their childbirth, they were frequently unable to perceive these as burdensome symptoms. Similarly, Dennis and Chung-Lee [15] suggested that the inadequate knowledge on PND had resulted in inability to recognize the symptoms of PND, therefore was considered as a major barrier for seeking professional help. Furthermore, women also regarded their HCPs as having a lack of understanding in supporting mental wellbeing among postnatal mothers. Therefore, it is crucial to educate HCPs and communities to acknowledge and react to maternal emotional changes after childbirth. [50]

This finding suggests that supportive social networks are for many women across cultures. [25,27,28,34,45] Within Asian communities, self-help was identified as the main coping strategies for PND. Similarly, Dennis and Chung-Lee [15] summarized that women preferred to have ‘talking therapies’ rather than receive medication. It was suggested that the therapy should acknowledge the social and cultural element [11] as many women associated this with the development of PND.

There were two limitations of this review. First, only studies published in the previous 10 years were included in this review. Second, there were wide variations in methods used across the included studies such as PND qualitative design, assessment time frame for PND and focus of topic guide, creating challenges for comparing findings across studies. Despite these limitations, this review addresses the literature on the women’s experience of PND across cultures and their help seeking styles, collectively.

V. Conclusion

This review suggested that women across cultures have limited understanding of postnatal mental wellbeing, therefore commonly were not able to acknowledge their emotional disturbance after childbirth as PND. While

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women across cultures shared some similarities of their PND experiences, there were some culturally specific experiences that were not common in other parts of the world. For instance, Asian women associated their PND experience with the issue of cultures and traditions during postnatal period. This possibly due to the impact of an interpretive lens that makes PND being interpreted differently from one woman to another. [51]This review recommends that the women's perceptions of their PND experience should be acknowledged within the clinical practice. For example, in offering the therapy for a woman with PND, HCPs could use the knowledge about the women's attribution of the symptoms to improve their adherence with the treatment plan. [52]

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Ethical Clearance: Not Applicable

Conflict of Interest: Nil

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