AFRICAN-AMERICAN MOTHERS AT RISK

FOR POSTPARTUM DEPRESSION

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AFRICAN-AMERICAN MOTHERS AT RISK
FOR POSTPARTUM DEPRESSION

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Abstract

AFRICAN-AMERICAN MOTHERS AT RISK FOR POSTPARTUM DEPRESSION

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Having the ability to bring life into the world is a very fulfilling experience for most women. Babies bring joy, happiness and the connection that a mother has with her new baby, so why do so many women suffer from postpartum depression, especially in the African-American community? Postpartum depression is an illness that can occur in women after giving birth to a child. Symptoms that may occur in Postpartum depression may include: sadness, the feeling of worthlessness, anxiety, stress, and hopelessness and could last up to a year after a baby is born, a still birth or miscarriage.

Statistics show that postpartum depression can be caused from several factors including income, environment, education, age and lifestyle. The results of a woman who experiences postpartum depression can be very traumatic and unhealthy, so the importance of preventive measures is vital. The qualities and benefits of preventive intervention for low-income single African-American women at risk for postpartum depression will be compared to women who do not take preventive approaches. Through extensive research and studies single African-American women who are products of a low-income family, little or no education, their health, their food intake, and the likes all can result in postpartum depression.

Research and findings will provide information as to how these factors can be prevented through intervention and the impact it could have on the African-American community at large.
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Chapter One: Introduction

To be involved with low-income African-American single mothers is to realize that many single mothers from low-income communities go through postpartum depression because of the many social and economical reasons. Social service workers see these issues going on in the everyday lives of African-American mothers in every city in America where the social environment and the economical decline of their communities have them worried about how to provide for their children as a low-income single mother in the big cities and rural areas of America. African-American women are dealing with postpartum depression at a high level.

Research findings are important to the helping professions because positive intervention programs that can help them improve their management of the barriers that stress them in their communities will help them in the long run. This research will look at many different intervention programs and how their methods/tools that each one of them uses help single African-American mothers reduce the possibility of them having postpartum depression issues after the birth of their child or children when they complete the program.

Statement of the Problem

What are the qualities and benefits of a successful preventive intervention for low-income single African-American mothers at risk for postpartum depression at the prenatal level and how do low-income single African-American mothers without preventive intervention at the prenatal level compare with those who do receive preventive intervention?

Definition of Terms

Depression: When emotions are predominantly negative, Persistent sad, anxious, or empty mood, feelings of hopelessness or pessimism (Stosny, 2011).
Postpartum: A serious mental health problem characterized by a prolonged period of emotional disturbance, occurring in increased responsibilities in the care of a newborn infant (American Psychological Association, 2007).

Single: Not legally married (DePaulo, 2011).

Mother: A woman who conceives, gives birth to, or raises a child, parenting (Maisel, 2011).

Low-income: Less than average money or its equivalent received in return for work, from a business, or as profit from investments (Grant, 2004).

Preventive: Interventions to ward off the initial onset of a mental disorder (Satcher, 2007).

Intervene: The act of intervening, interfering or interceding with the intent of modifying the outcome (2004).

**Delimitations of Research** The research was conducted through the Milwaukee Public Library and Karmann libraries (University of Wisconsin-Platteville) over a period of forty (40) days. Primary searches were conducted via Internet through EBSCO Host with ERIC, and Academic Search Elite. Key search topics included “Preventive intervention,” “single African-American mothers,” and “postpartum depression.”

**Method of Approach** A review of literature related to research, studies, and anecdotal evidence of the history of successful preventive intervention for low-income single African-American mothers at risk for postpartum depression, and the impact that preventive intervention has had on helping low-income single African-American mothers avoid postpartum depression, will be conducted. The findings will be summarized and recommendations made.
Chapter Two: Review of Related Literature

Maternal postpartum and health

Maternal postpartum depression is a prevalent and serious public health problem, in community samples. The prevalence of new mothers reporting clinically significant levels of depressive symptoms beyond the immediate postpartum period is approximately 8-18%. For mothers with high socio-demographic risk profiles (e.g., low income, low education, single marital status, and/or young maternal age), the prevalence is substantially higher, with percentages of 35% to 67% reported in some studies (Beeghly, 2003).

High levels of maternal depressive symptoms are of concern to health professionals because they are associated with poor maternal psychosocial adaptation, compromised parenting, and child socio-emotional dysfunction, including insecure attachment, higher rates of behavior problems, aggression, and later psychiatric problems. These associations are stronger when maternal depressive symptom levels are severe or chronic (Beeghly, 2003).

Depressive symptomatology in Black women

Several investigators have reported that women of color (particularly Black women) have higher levels of depressive symptomatology than White women. However, this claim is difficult to evaluate because Black race/ethnicity and low socio-economic status (SES) are often confounded in this literature. Mothers from low-SES backgrounds in the U.S., who disproportionately tend to be women of color, typically report higher levels of depressive symptoms than their SES counterparts. This has made it difficult to isolate the effects of depression from the effects of other risk factors and to disentangle the race-SES confounding often found in some prior studies of postpartum women. As a consequence, little is known about the prevalence and stability of high levels of depressive symptomatology in otherwise healthy
postpartum Black women that is not confounded by these co-morbid risk factors (Beeghly, 2003).

Among studies that have controlled for socio-demographic variables, findings regarding racial differences in level of maternal depressive symptomatology have been inconsistent. In a sample of financially impoverished, urban women, no racial differences in risk for depression were found, suggesting that poverty rather than race was the primary factor influencing depression. Similarly, in a nationally representative sample of adolescent mothers from the National Maternal and Infant Survey, differences in depressive symptom levels between Black and White teen mothers decreased significantly after statistical control of family income and marital status. However, in a larger sample from the same national survey comprised of both teen and adult mothers, Black race continued to be associated with higher maternal depressive symptom levels, even after control of several socio-demographic risk variables. Whether level of socio-demographic risk is related to higher levels of maternal depressive symptomatology within a single cohort of Black women ranging in socio-economic status has not been empirically established.

**Postpartum and childbearing**

Postpartum depression is a common complication of childbearing, affecting approximately 13% of women. Although it is thought to be similar to general major depression in its clinical presentation, etiology, and treatment; it is unique in its potential impact on not only the mother, but also her infant and family. In particular, research suggests that untreated maternal depression is associated with disruptions in the infant’s cognitive, social, and behavioral development. As such, strategies to enable prediction and/ or early detection of postpartum depression are needed to prevent or ameliorate these potentially negative consequences for the
family. Considering that most women visit health professionals regularly during pregnancy and the early postpartum period, obstetrical services may be the optimal setting to maximize such strategies for early detection. Unfortunately, postpartum depression often remains undetected through routine obstetrical care. While several screening tools have been developed for the detection of this disorder, the expectation that a questionnaire will be administered to every woman seen antenatal may be unrealistic. Furthermore, a recent systematic review of antenatal screening studies found no evidence to support routine antenatal screening for postpartum depression. In order to identify variables that could facilitate prediction of postpartum depression, researchers have prospectively investigated a number of potential risk factors. However, there is a lack of expert consensus as to which cluster of variables best predict the development of postpartum depression. Some researchers suggest a biological etiology while others indicate that personal or social factors may be more relevant. However, one set of risk factors that have consistently been identified as predictive are maternal psychiatric history, including symptoms of depression or anxiety during the index pregnancy. The importance of maternal psychiatric history as a risk factor remains despite cultural factors as similar findings have been found among diverse samples. A more limited body of evidence has also associated family psychiatric history with risk for postpartum depression. Although the gold standard in psychiatric research is the use of structured diagnostic interviews for the assessment of personal and familial psychiatric history, obstetrical practices typically do not have the time or staff resources necessary to conduct such an assessment. Rather, any available data on personal and familial psychiatric history are provided through unstructured maternal report. The purpose of this study was to determine whether maternal self-reported data on personal and family
psychiatric history would significantly predict depressive symptomatology at 1 and 8 weeks postpartum.

In addition, the authors of this study sought to examine which psychiatric history variables (including both maternal and family history) were the best predictors of maternal postpartum depressive symptomatology for inclusion in a clinical assessment aimed at early identification of postpartum depression (Ross, Dennis, 2006).

Maternal depressive symptomatology is an important public health issue with negative consequences for both mothers and infants. Method: This study examined prevalence and patterns of depressive symptoms among 181 urban, low-income, first-times, African-American adolescent mothers recruited from urban hospitals following delivery. Follow-up evaluations were conducted at 6 (N=148; 82%) and 24 (N=147; 81%) month home visits. Depressive symptoms were measured with Beck Depression Inventory (BDI). Results: Half of mothers (49%) had BDI scores >9 at baseline, with significant correlations between BDI scores across all visits (r=0.28–0.50). Depressive symptom trajectories analyzed using group-based trajectory modeling revealed three trajectories of depressive symptoms: Low (41%), Medium (45%), and High (14%). The high depressive symptom group reported lower self-esteem, more negative life events, and lower parenting satisfaction than the low and moderate depressive symptoms groups. Limitations: Depressive symptoms were self-reported and not verified with a clinical interview. Findings are limited to urban, low-income, African-American adolescent mothers and may not be generalized to other populations. Conclusions: The high prevalence and relative stability of depressive symptoms through two years of parenting suggest the need for early identification and treatment of maternal depressive symptoms. Brief screening for maternal depressive symptoms conducted during pediatric well-child visits is a feasible and effective method for identifying
mothers with depressive symptoms; however, screening measures can not differentiate between high and low levels of depressive symptoms. Brief intervention may be an effective treatment for mothers with mild symptoms of depression; mothers with moderate to severe symptoms may require more intensive intervention (Ramos-Marcuse, 2010).

**Postpartum depression**

Depression is the most common mental health problem identified during pregnancy and following delivery. In light of increasing racial disparities in birth outcomes and infant mortality, understanding the risk factors associated with maternal health issues, such as antenatal and postpartum depression, among disadvantaged African-American women becomes crucial in the fight to improve the health of black women and their infants. Currently, research on antenatal depression among African-American women is scarce.

Most research addresses postpartum depression; however, there is increasing evidence that antenatal depression impacts maternal health and birth outcome. Accordingly, we undertook this study to identify risk factors for antenatal depression among African-American women. In the general population, the prevalence rates for both antenatal and postpartum depression vary considerably, ranging between 10% and 52%. The prevalence of pregnancy-related depression in disadvantaged populations has been consistently higher, however, with rates of antenatal depression as high as 41.7% reported for low-income women. Risk factors for antenatal and postpartum depression include young age, poverty, lack of education, and history of depression, history of miscarriage or abortion, anxiety, low self esteem, lack of social support, stressful life events, and history of abuse. There is also evidence that women diagnosed with postpartum depression in their first pregnancy are 50% more likely to develop the disorder in subsequent pregnancies or to develop depression that is unrelated to pregnancy. African-American and
Hispanic women have the highest rates of antenatal and postpartum depression. Single marital status and low income have been reported as being predominant risk factors for postpartum depression among African-American women. Disadvantaged populations have been found to be more vulnerable to depression, as they have less control over their surroundings, are more likely to suffer stressful life events have less access to financial and emotional resources, and are more likely to have experienced discrimination. Stress is a significant contributing factor to the onset of postpartum depression in African-American women. Mothers are often depressed because of medical conditions following delivery, including hypertension, infection, and recovery from surgery. Loneliness and abandonment, as well as such external factors as financial difficulties, employment concerns, lack of social support, lack of support from a partner, and sibling care, may contribute additional stress, which culminates in fatigue associated with the accumulation of stressful circumstances. Both antenatal and postpartum depression has been associated with an increased likelihood of developmental problems in infants of afflicted mothers. There is evidence that these infants are more likely to show signs of depression and stress and exhibit changes in brain activity that mimic the mother’s prenatal depressive state. The CDC estimates that as many as 50% of postpartum depression cases go undiagnosed every year. Identifying pregnancy related depression early is critically important in preventing postpartum depression and in improving birth outcome. In this study, we seek to identify factors associated with the risk for major antenatal depression among a low-income population of African-American women.

**Central Hillsborough Healthy Start Project**

Materials and Methods the Central Hillsborough Healthy Start Project (CHHS) is one of the community-based programs in the State of Florida funded by the federal government through the Maternal and Child Health Bureau’s Healthy Start Initiative. Implemented by the
Lawton and Rhea Chiles Center for Healthy Mothers and Babies, the CHHS project functions as a community/university partnership to narrow racial disparities in maternal and infant health outcomes in urban Tampa neighborhoods (Florida), where the black infant mortality and morbidity rates are more than double those among whites (unpublished data from the Florida Department of Health). In these neighborhoods, most of the births are to mothers who are black, many of who are young, unmarried, undereducated, and Medicaid eligible. Prenatal and postnatal risk reduction services are provided by the project within the local prenatal healthcare system framework, the Hillsborough CHHS Program, and its overarching state system, the Florida Healthy Start Program. In collaboration with the Florida Department of Health and the Healthy Start Coalition of Hillsborough County, local and state efforts are integrated in a complementary manner. Unique to Florida, all pregnant women and newborn infants are offered risk screens to identify those who would benefit most from risk reduction services. Mothers who voluntarily accept the screen and express interest in services are referred to local Healthy Start Programs. In Hillsborough County, women living in select East Tampa ZIP codes (33602, 33603, 33605, and 33610) that need services are referred to the CHHS Program for those services. Data were collected through services provided by the CHHS program during the period 2002–2007.

Florida’s universal screening of pregnant women and infants was used to identify women at risk of poor outcomes. Florida’s universal screening of pregnant women and infants includes a series of questions that focus on medical, environmental, and psychosocial factors that identify a patient as at risk. The score is determined by summing the contributing items, each worth 1 point, except for race, which contributes 2 points. The following 15 variables comprise the components of the screening score: black race, maternal age <18 or >39, unmarried, less than high school education, low maternal weight (<110 pounds), problems keeping appointments,
moving 3 times in the past year, feeling unsafe, going to bed hungry, tobacco use in the past 2 months, use of drug or alcohol in the past 2 months, unwanted pregnancy, current maternal illness, seeking prenatal care in the second trimester, and history of poor outcomes or no previous pregnancy experience. Women who scored 4 were considered at risk for adverse birth outcomes, which has been demonstrated previously. Women were administered the Edinburgh Postnatal Depression Scale (EPDS) during prenatal visits. Measurements were conducted at different times during pregnancy, and the aggregate sum of EPDS scores from participating mothers was used to determine the prevalence of depressive symptomatology consistent with risk for antenatal depression. We believe that this is a better approach to capturing prevalence than administering the EPDS at a single point in time. The EPDS is a screening tool used to identify women at risk for antenatal and postpartum depression. It is usually administered at the 6–8-week postpartum examination, with a recommended re-administration of the test after 2 weeks. The EPDS instrument has been validated for antenatal administration. The EPDS has been validated and used cross culturally throughout the world and has been administered numerous times to black women in the United States and England. The scale can only be used to indicate how the mother felt during the previous 7 days and is not intended to detect anxiety, phobias, or personality disorders. Questions evaluate symptoms of depression, such as the inability to laugh, the inability to look forward to things with enjoyment, self-blame, anxiety and excessive worry, fear and panic, difficulty sleeping because of sadness, crying, and self-harm. The maximum possible score is 30, with a cutoff point of 12=13 indicating that the mother is potentially suffering from major depression and a cutoff point of 9=10 indicating possible minor depression. According to Cox et al., the cutoff point of 12=13 results in a sensitivity of 86% and a specificity of 78%. A total of 724 women were administered the EPDS instrument prenatally. Of these
women, 75.4% (n=4546) were African-American. We restricted our analysis to African-American women because of a paucity of numbers for the other racial/ethnic groups in the sample. The study is cross-sectional in design, as we did not follow participants over time (Luke, 2009).

**Postpartum and abuse**

In spite of a national concern with postpartum events such as, child abuse failure to thrive teenage pregnancy sudden-infant death syndrome and parents with substance abuse and other psychiatric problems there is little research on how families organize themselves during the critical postpartum period. Little is known about what occurs to new mothers once they return home. Over the past 50 years, many changes surrounding childbirth have occurred in the United States. Early discharge from the hospital, isolated nuclear families decline in breastfeeding, and working mothers and grandmothers are all factors that result in a postpartum period that fails to provide necessary social support and assistance to the new mother and provides no social recognition for the change in her status. The difficulties extend to the point that there is no commonly recognized length of time designated as the postpartum period. The only recognition of the time is that many women return to work after two weeks, the typical transition period afforded by employers, or are presumed to be “back to normal” at six weeks when they are typically seen for their postpartum check-up from their health-care provider. Although there is no formal structuring during the postpartum period, there is a popular notion that this period is emotionally draining, and stressful. Postpartum depression is an atypical mood disorder characterized by the following symptoms: tearfulness, mood swings, despondency, feelings of inadequacy, inability to cope with the care of the baby, and increasing guilt about the birth and performance as a mother. Psychotic symptoms, such as severe delusions, are not present. Postpartum depression can be present for varying lengths of time and can occur any time during
the first year after giving birth. However, the condition usually arises from between two weeks and three months following birth. Symptoms have been known to be present for up to one year. Postpartum depression may have deleterious effects on the mother, baby, and family (Goodman, 2004). The United States Department of Health and Human Services has reports that postpartum depression incidences has risen dramatically in the United States over the past several years. The changing roles of women and the demise of the extended family have directly affected the manner in which mothering and childrearing take place. According to Stern and Kruckman, postpartum depression is a culture-bound syndrome, produced by Western industrialized societies like the United States (Ugarriza, 2006).

**Adaptation to childbirth**

The objective of this study was to examine a group of postpartum African-American mothers and obtain their assessment of their adaptation to childbirth. The two specific aims of the study were to: (a) measure the degree of acculturation of African-American postpartum women using the African-American Acculturation Scale-33; and (b) identify the cultural postpartum depression prevention elements found in African-American first-time mothers using specified prevention criteria (Stern & Kruckman, 1983).

The incidence of postpartum depression, estimated at 10-15% of new mothers, is affecting the lives of 1/5 of the nation’s childbearing women (NMHA, 2004). The cognitive and behavioral changes suffered by mothers with this illness have widespread effects on their babies and families as well. The notion of postpartum depression as a culture-bound syndrome in Western industrialized societies has received increasingly more recognition and acceptance as biological and psychological theories have failed to adequately explain its occurrence (Sword, 2005). Most women do not seek help for postpartum depression (Gordon, 2006). Minimizing the
symptoms, they typically ignore what is happening to them and find themselves quite uncomfortable for a long period of time. Missing many of the joys of motherhood, they drag through the days and are frequently frustrated with their own behavior. Some women do seek professional help but are often disappointed with their treatment options. Conflict over taking antidepressant medication and breastfeeding is an issue, as mothers are warned not to breastfeed while taking antidepressant medication (Ugarriza, 2006). In addition, the anti-depressant medication is often ineffective for this particular affective disorder characterized by much milder symptoms than a major depression (Ugarriza, 2006). Also, overburdened by the responsibilities of caring for the infant, attending support groups or other types of psychotherapy becomes a very real struggle. Postpartum depression can cause debilitating problems for women, such as intense feelings of inadequacy, social withdrawal, anorexia, weight gain, irritability, fatigue, loss of normal interests, inability to cope, and multiple somatic complaints (NMHA, 2004). Postpartum depression is a type of affective disorder peculiar to women in the postpartum period with, up to this time, an unproven etiology. According to Stern & Kruckman (1983), the absence of postpartum depression in countries such as Africa, Guatemala, and India where cultural rites and rituals are undertaken for postpartum women is astonishing proof of the ill effects the American culture has on its new mothers. Unknown is the comparison rates of postpartum depression by ethnicity, although evidence suggests there is no difference between African-American and Anglo American women in the United States (Rich-Edwards, 2006). The rate of depression for African-American women in the United States is approximated at twice that of Anglo-American women (Poleshuck & Giles, 2006). Does the African-American culture contain preventive practices that help diminish the occurrence of postpartum depression in that group? The fact that
one’s own culture can be the medium for the prevention of, as well as the production of, illness is worthy of investigation (Ugarriza, 2006).

The theoretical framework for this study has two elements. The first is the concept of acculturation, or the degree to which a person identifies with a culture. The second is the notion that cultures where postpartum depression is at its lowest incidence may contain cultural postpartum depression prevention practices. If so, it would be important to know what those practices are for individual cultures, as well as the degree to which persons participate in them. According to Landrine and Klonoff, acculturation refers to the extent to which ethnic-cultural minorities participate in the cultural traditions, values, beliefs, assumptions, and practices of a dominant society (acculturated), remain immersed in their own cultural traditions (traditional), or participate in the traditions of their own and the dominant society (bicultural) (Landrine and Klonoff, 1995). The authors state that some members of minority groups are highly traditional and some are highly acculturated. They further contend that there is an African-American culture and have identified empirical referents for many of African-American cultural values. Most of the values appear to have been in play in the African culture from where slaves were taken. These same values have survived the slavery experience and make up the core beliefs of the African-American culture. The researchers identified eight general areas of expression. The first three are as follows. Number one, religious beliefs and practices, is expressed in the deeply spiritual nature of all aspects of African life. Beliefs in the Holy Ghost or “getting the spirit” are reflections of this notion. The second, family structure and practices, is reflected in such practices as “child-taking” or “informal adoption.” Child keeping or informal adoption by kin is such a concept. This practice may have been common in African societies that regarded children as the offspring of the community as a whole. The third area of expression is socialization.
Childhood games such as “tonk” and “jumping double-dutch” are typical African-American games. Singing in the church choir is another such practice. The next two areas are preparation and consumption of food and a preference for African-American things. Food items include collard greens, ham hocks, and the like. These foods are far more likely to be eaten by traditional African-Americans rather than the more acculturated African-Americans. Traditional African-Americans have a preference for their own culture’s music, reading material, and social groups. Less traditional or more acculturated African-Americans have less of a preference. The sixth area, interracial attitudes, has to do with the attitudes African-Americans have regarding “Whites and White Institutions.” These attitudes are reflected in beliefs such as, “IQ tests were set-up purposefully to discriminate against Black people”; and “Deep in their hearts, most White people are racists.” Theoretically, these beliefs are more common among traditional African-Americans, but not among more acculturated African-Americans. The seventh area is that of superstitions. Highly traditional African-Americans may hold the following old, magical beliefs that were taught by their fore parents and whose origins may be quite ancient. Examples include: “You should never put a hat on a bed”; “If the dogs are howling, somebody died”; and “If a woman dreams about fish, she is pregnant.” Less traditional, more acculturated African-Americans tend not to hold these beliefs. The last area is that of health belief and practices. Fundamentally, these beliefs are that minor illness has natural causes and cures but that major illness has supernatural causes and cures. Wise old African-American women are seen as the primary healer for those illnesses that are treated with herbs, roots, and other ethno medical treatments. Cultures influence individuals’ beliefs about health, illness, treatment, and disease prevention. Because of its ties to a highly social event, such as childbirth, culture plays an important role in the structure of the childbirth experience. Customs, practices, rituals, and
parental roles are all steeped within cultural values. Most importantly, cultures may provide preventive practices that actually decrease the incidences of illnesses such as postpartum depression. This notion is captured in a 1983 cross-cultural analysis of postpartum depression implemented by Stern and Kruckman. Their work is the basis for the second element of the theoretical framework of this study. These researchers found that birth is almost universally perceived and treated as a traumatic life crisis and a time when women are considered to be at great risk. Interestingly enough, these authors found very little evidence of postpartum depression throughout non-industrialized countries. They posit that this omission suggests that postpartum depression, because of its high incidence in the United States and other industrialized countries and its low incidence or absence in other cultures, is a western culture-bound syndrome (Ugarriza, 2006).

Culture-bound syndrome is a descriptor that means a particular illness is present in a particular culture as a result of the interplay of implicit values, social structure, and shared beliefs. These interrelated systems produce unusual forms of psychopathology that are confined to local areas. The groups’ social and cultural factors produce special forms of emotional illness (Tseng, 2001). A classic example of a culture-bound syndrome found only in Western industrialized countries where food is abundant is Anorexia Nervosa, an illness virtually absent in cultures where maintenance of sustenance is not easily accomplished. Anorexia Nervosa has defied standard biological and psychological etiology. According to Stern and Kruckman (1983), in cultures where there is little or no postpartum depression basic preventive components are present. These are identified as: (a) structuring of a distinct postpartum time period; (b) protective measures and rituals reflecting the vulnerability of the new mother; (c) social seclusion; (d) mandated rest; (e) assistance in tasks from relatives and/or midwives, and social
recognition through rituals, gifts, etc. of the new social status of the mother. Now disappearing, a distinct postpartum time period was recognized in Spanish America and the Caribbean as the first forty days following birth. Protective measures and rituals reflecting the presumed vulnerability of the new mother were exemplified in Guatemala where midwives burn a candle for the protection of the mother and newborn. In the Philippines, a mandated eight-day period of seclusion was culturally encouraged wherein the mother was confined to home and given a special diet and elaborate medication. Mandated rest was exemplified in the Punjab culture where women were strictly secluded and assisted for five days following childbirth.

**Assistance from relatives and/or midwives**

Assistance in tasks from relatives and/or midwives is accomplished in most cultures where daughters, sisters, mothers, mothers-in-law or friends are considered the natural helpers of women (Mead & Newton, 1967). However, social recognition of the new social status of the mother through rituals or gifts is not as commonly practiced. One culture that does have this practice is the Ibibio who honor the new mother with a special feast where she is presented with a new dress by her husband and a tree is planted for the baby. These two theories, the 1995 Landrine and Klonoff assessment theory of African-American Acculturation and the 1983 Stern and Kruckman Postpartum Prevention theoretical framework, provided guidance for this study on postpartum adaptation in the United States. Acculturation was measured using the African-American Acculturation Scale (Landrine & Klonoff, 1995). Postpartum depression prevention criteria were assessed using a semi-structured questionnaire developed from the Stern and Kruckman postpartum depression prevention criteria (Ugarriza, 2006).
Chapter Three: Conclusions and Implications

In conclusion, a research study that identifies a women’s risk of postpartum depression early through early intervention not only benefits social work practice and the women served by social workers, but can also benefit the children and the families affected by the postpartum depression. Early preventive intervention will help the community that these women live in also. The issues that are a problem at this present moment is that there has not been much effort or research on why African-American mothers are having postpartum depression issues. Also easy to notice in the literature is that single marital status and low income have been reported as being predominant risk factors for postpartum depression. African-American mothers that have been put in the position with no help from the father of the child and not having an extended family have caused postpartum depression to rise in the urban community where African-American mothers live. The American culture has abandoned these mothers by not providing the preventive measures early in their postpartum timeframe. The fact also that one’s own culture can be the medium for the prevention of, as well as the production of the illness of postpartum depression is worthy of discussion also.
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Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

