Chapter 7

Indigenous Models for Attenuation of Postpartum Depression
Case Studies From Fiji And Hong Kong

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INTRODUCTION

Cross-cultural epidemiologic data demonstrate that postnatal illness is a global and prevalent health problem. The prevalence of maternity blues is reportedly up to 50% or more of all postnatal women in some societies (e.g., Jamaica, Tanzania, and the U.K.). The reported incidence of postpartum depression varies considerably (depending on cultural context, interval after birth investigated, and methods of assessment), but is close to 10% in studies of postpartum women in cultures as disparate as the U.K., the U.S.A., Japan, Nigeria, Uganda, and Chile. Postpartum psychosis is somewhat more rare, but also potentially far more clinically serious, and occurs in 0.1–0.2% of recently delivered women (Kumar, 1994). Postnatal illness not only poses significant risk to the patient in terms of occupational and social function, and risk of suicide and even infanticide (Davidson & Robertson, 1985; Appleby, Mortensen & Faragher, 1998), but increasing evidence also suggests that it may adversely impact the maternal–infant relationship, with negative consequences for child development in the cognitive and socio-emotional realms (Murray & Cooper, 1997; Cooper et al., 1999). Thus, individual, family, and community costs associated with postnatal illness are potentially high.
The etiology of postpartum illness is poorly understood but likely to be multifactorial with psychological, biological, and social contributions; increasing evidence indicates that social factors may pose risk for or provide significant protection against postnatal depression. Specifically, in studies in European and American samples, social supports correlated negatively with postpartum depression (Paykel, Emms, Fletcher & Rassaby, 1980; O’Hara, 1986; Gjerdingen & Chaloner, 1994; Beck, 1996; Barnet, Joffe, Duggan, Wilson & Repke, 1996). Poor social support has also been identified as a risk factor for postpartum depression among Vietnamese, Arabic, and South African women (Stuchbery, Matthey & Barnett, 1998; Ghubash & Abou-Saleh, 1997; Cooper et al., 1999).

Despite the ample evidence that social supports may be protective against postpartum depression, there has been little investigation of how interventions aimed at bolstering social supports in the postpartum could reduce the risk of maternal depression. The very limited data do suggest, however, that this approach could be effective in reducing postpartum emotional distress. For instance, one study found that simple prenatal instruction meant to enhance postnatal social supports, such as instruction that infant care is a shared responsibility, that women should seek help from women more experienced in child care, and that postpartum women should get plenty of rest and sleep, was associated with significantly less postpartum distress than when no such instruction was given (Gordon & Gordon, 1960). Similarly, another study found that home visits in the prenatal and postpartum period by trained peers reduced psychological distress compared with women without these supports (Marcenko & Spence, 1994). Notwithstanding the current dominance of a biologic paradigm in Western psychiatric practice and research, this is still a rather surprising lacune in the postpartum literature.

Remarkable diversity in postnatal supports to new mothers has been reported cross-culturally, and it has been suggested that formal, socially structured supports may play a role in reducing the prevalence of postpartum depression in some societies (Stewart & Jambunathan, 1996; Dankner, Goldberg, Fisch & Crum, 2000). Whereas most societies restrict work postnatally, few societies suspend usual work duties for prolonged periods of time; indeed, approximately 50% of societies expect a full return to usual work responsibilities within a period of two weeks (Jiminez & Newton, 1979). Stern and Kruckman (1983) suggest that certain cultural traditions may be invoked to support women in the postpartum including a formal structuring of a distinct postpartum period, measures to protect presumed vulnerabilities of a new mother, social seclusion, mandated rest, assistance from relatives and midwives, and explicit social recognition of the mother’s new status. Indeed, there are numerous examples from the cross-cultural literature documenting locally sanctioned mandated rest periods for postpartum women. These range from a mandated 48 hour third-party reimbursed hospital stay for American women, to a seven day period of seclusion and mandated rest for Kokwet (Kenya) postpartum women (Harkness, 1987), to