

# A disease you just caught: Low-income African American mothers' cultural beliefs about postpartum depression

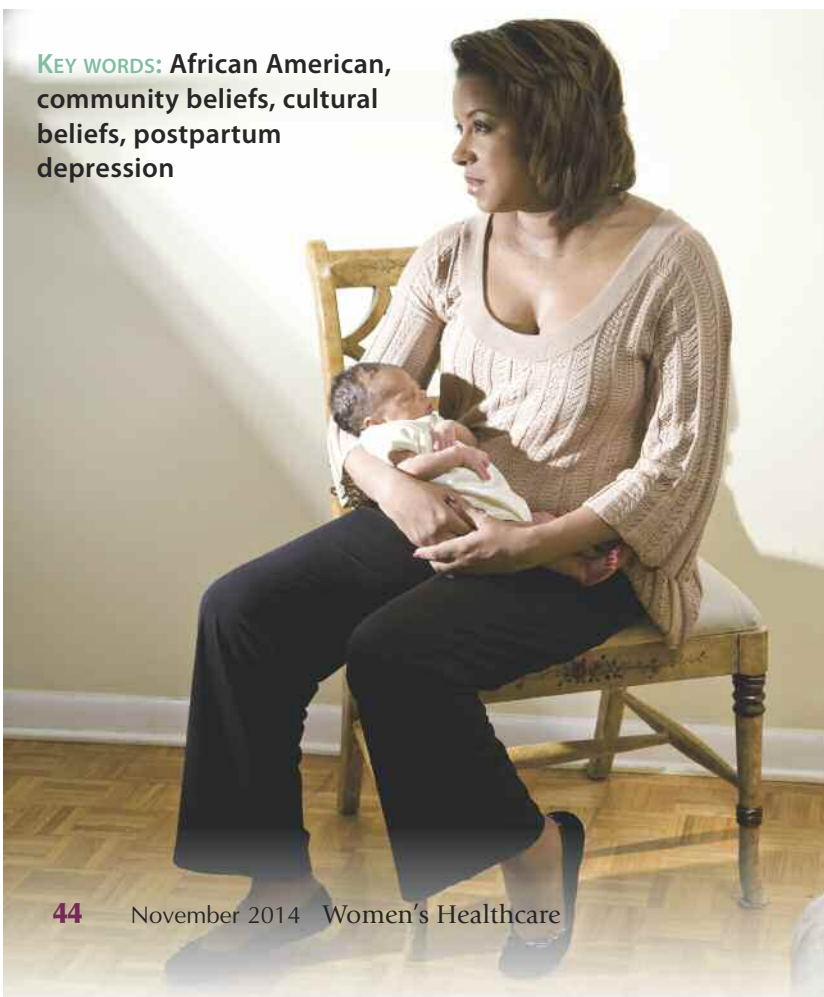
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Postpartum depression (PPD), the most common complication of childbirth, can have many adverse effects on a mother and an infant and interfere with family functioning. The aim of this study was to explore the experience and cultural beliefs regarding PPD in a small group of urban, low-income, African American women who had been previously screened for PPD. Results of the authors' thematic analysis of the qualitative data are presented here.

**P**ostpartum depression (PPD), which occurs in 15%-20% of women after giving birth, is the most common complication of childbirth.<sup>1</sup> PPD can have adverse effects on the mother, the newborn, and the family unit. Several factors increase PPD risk, including a past history of depression, perceived lack of social support, young maternal age, and low income.<sup>2,3</sup> *Table 1* lists these and other PPD risk factors.<sup>4</sup> Additional risk factors for PPD in African Americans (AAs) include life and environmental stressors, physical health problems, and perceived racism, stigma, and discrimination.<sup>5,6</sup> Rates of PPD are nearly twice as high in low-income, non-white women as they are in higher-income white women.<sup>7-9</sup>

Postpartum depression tends to go undetected and untreated in minority group members. These women are less likely to undergo PPD screening, and if they do experience PPD symptoms, they tend to minimize them or disregard them because of shame, perceived stigma, and/or cultural beliefs.<sup>2,10,11</sup> In one study, researchers found that when low-income AA women were diagnosed with PPD, they were half as likely as their white counterparts to utilize available mental health services.<sup>12</sup>

**KEY WORDS:** African American, community beliefs, cultural beliefs, postpartum depression



Multiple barriers to PPD treatment exist, including perception of the illness as a personal weakness; a general unwillingness to disclose negative feelings to friends, families, or healthcare providers (HCPs); and fear of being separated from one's children because of mental instability.<sup>10,11,13,14</sup> Time constraints, childcare concerns, and stigma have been identified as additional barriers to seeking treatment.<sup>15</sup> Other major barriers to treatment are lack of health insurance coverage, financial hardship, and limited access to healthcare services.<sup>15-18</sup> By contrast, several studies have shown that ongoing communication, transportation assistance, availability of on-site childcare, availability of services in an obstetric setting, and shared decision making with HCPs are factors that can increase PPD treatment rates.<sup>1,2,6</sup>

Cultural norms and beliefs about PPD may play a major role in terms of mothers' and HCPs' recognition of its symptoms.<sup>5</sup> For example, somatization of health problems may precede or mask psychological distress among AA women.<sup>5</sup> Culturally constructed and sanctioned expressions of language of depression are likely to be overlooked or misidentified by HCPs trained in mainstream definitions of depression.<sup>5,19</sup> Research exploring how cultural beliefs affect the experience and manifestation of PPD symptoms among low-income AA women is lacking. This study was conducted to help fill this gap.

## Method

**Research design and approach**—This qualitative study

**Table 1.** Risk factors for postpartum depression<sup>4</sup>

- Behavioral characteristics (e.g., outward manifestations of depression, anxiety)
- Ethnic minority status
- Family/marital conflict
- Life stressors (e.g., divorce, family problems, childcare challenges)
- Low educational attainment
- Low socioeconomic status
- Multiparity
- Perceived lack of social support
- Poverty
- Presence of physical/mental disability
- Receiving inadequate assistance from one's partner
- Residing in an urban area
- Single motherhood

used semi-structured interviews in focus group settings with patients at a family services program in Houston, Texas. Focus groups were used because of case workers' reports that clinic patients tend to be reluctant to engage with researchers in one-on-one interviews. Focus groups tend to offer opportunities for more interaction than a one-on-one interview format and may promote in-depth conversations about complex topics.<sup>20</sup>

**Participants**—Convenience sampling was used to recruit a homogeneous group of low-income AA women. Any AA woman who had given birth in the past 18 months and had been screened for PPD was eligible to participate in the study, was notified about the study, and was asked to take part in it. Sixteen women met inclusion criteria and signed a consent form. Among the 16 women, 12 (75%) were identified as having experi-

enced PPD. Demographics of the sample appear in *Table 2*.

**Data collection**—After the Institutional Review Board at the University of Houston approved the study, three focus groups were conducted over a 3-week period. The primary investigator moderated the groups with three research assistants in attendance. Participants were advised that researchers wanted to know their thoughts about culture and about postpartum depression. The term culture was taken from Leininger's work and was defined for participants as "shared values and beliefs of a particular group that guide thinking and decisions."<sup>21</sup> This group could include neighbors, friends, church acquaintances, or anyone with whom the women felt that they shared a culture. During the focus group sessions, each woman was asked the same questions:

- When I say *postpartum depres-*

**Table 2.** Demographic characteristics (N = 16)

Mean age: 23 years

Age range: 21-30 years

Average annual income: \$13,200

Proportion of participants with at least one episode of PPD: 75%

Highest education level completed

Less than high school: 13%

High school: 63%

Some college: 25%

- tion, what does it mean to you?
- What do other women, men, family, community—anyone that shares the same racial or ethnic group as you—say about postpartum depression?
  - What have people from your cultural group said about getting treatment from a therapist for postpartum depression?
  - What do you think might help or stop moms from getting help for depression after childbirth?

**Data analysis**—Audio-recordings of the focus groups were transcribed verbatim and compared with the transcripts to ensure accuracy. Transcripts were read by each researcher; key words and statements were highlighted and coded. A six-phase process of thematic analysis,<sup>22</sup> as described by Braun and Clarke,<sup>23</sup> was used to search for emergent themes regarding beliefs and experiences of PPD. Themes that emerged from the data were reviewed. Similar themes were grouped together and reported as results. Participants' responses were directly quoted, without grammatical corrections.

## Results

Five themes emerged from the

data: (1) lack of support, (2) differences between participants' own experiences and their perception of their community's beliefs about PPD, (3) participants' perception of their community's belief that strong mothers do not catch PPD, (4) a belief that

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mothers have everything to lose by seeking help for PPD, and (5) a need for culturally relevant education on PPD.

**Lack of support**—Depressive episodes were likened to feeling that *the whole world is on your shoulders pushing you down*. Most participants had family and friends residing in close proximity. Nevertheless, rather than providing support, the baby's father, other family members, and friends provided constant criticism. Elder females (mothers, grandmothers, and aunts) held

high expectations for them to parent in the same way that they had parented, and they expressed exasperation with the new mothers' moods. Many participants were single mothers who felt overwhelmed, exhausted, and constantly stressed while simultaneously trying to be self-sufficient.

One participant stated: *They'll say like you got too many mood swings. It's like you really moody. You need to see a doctor. It's not that you're moody; it's just like you need some help and it's like you don't have the help that you need and it's like— it's making you have these different type of mood swings. You up and you down; then you up then you down and it's like people don't understand— especially men....It's too much because ain't nobody tryin' to satisfy me. So, why should I be tryin' to please everybody else when y'all not gonna try to please me?*

**Differences between participants' own experiences and their perception of their community's beliefs about PPD**—Participants expressed feelings of overwhelming sadness, frustration, and stress, and reported periodic episodes of crying. They shared stories about long bouts of isolation and withdrawal, although most did not relate thoughts of harming themselves or others. A few did report fleeting thoughts of wanting to escape from or hurt their children.

When asked about what members of their community said about PPD, the participants believed that their family and friends considered PPD as involving *extreme* thoughts and crazy, dangerous behaviors (e.g., harming oneself or one's children). *Depression would be like*

you having thoughts of suicide, hurtin' someone, that type of thing. Another woman described her community's take on PPD as *mothers that hear voices that tell them to kill their kids*.

Even if participants described their own struggles with PPD as follows—*When he was crying, one of my kids, it would frustrate me and I thought crazy things. I wanted to kill my kid*—they would give more extreme examples when asked how they perceive that their community defines PPD. For example, one participant said, *She [referring to a neighbor] needed the help. Like she was to the point she left a newborn, she left her 2-year-old. She would like hop in the car and leave and the babies would be alone. We be sittin' here like "Are you serious?" She was like "I had to get away." You don't even let a neighbor know, your mama know. She was ill to the point she would shut down. She wouldn't feed them. She wouldn't clothe them. She was like seriously stressed and she was taking classes here and she would come in the meetings here and voice it. So, she was kind of beyond needing help.*

According to participants' perceptions of their community's views, postpartum reactions that did not involve extreme and dangerous thoughts and behaviors were *not* PPD. There seemed to be a discrepancy between what the mothers described as *their* experience of PPD and their impression of how their community identified PPD.

**Participants' perception of their community's belief that strong mothers do not catch PPD**—According to the study participants, their culture promotes the idea of the strong,

self-sufficient mother. Divergence from this image is discouraged. According to these women's perceptions of their community ethos, PPD can occur when a woman is not strong enough to handle the demands of mothering. One participant imitated a family member, saying, *That's your bull crap. There is no, there is no postpartum depression. Only white people go through it*. According to one participant, a neighbor said that to her, depression is something young mothers *do* to get out of need-

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ing to take care of their kids. A participant who had experienced PPD reported that a friend asked her: *What you goin' through depression for? Something wrong with you?*

Participants shared stories about asking for help or talking about their depression and anxiety, only to be met with others' judgments. One participant remarked: *Like if I had six kids and I decided to get depressed, they gonna be like well, you shouldn't open your legs up*. Women reported that in their community, acknowledging having depressive symptoms would result in being

seen as an unfit mother, as illustrated by this quote: *I mean, they make it seem like, it's like, oh, if you're depressed, oh my God, you're unfit. So for you to go through however you feel or whatever emotions you have they feel like you should be able to handle that....And it makes you feel like it's, like it's a disease that you just caught*. In other words, if someone were to admit feeling depressed, she believed that the community would see her as an unfit mother. It would be safer to deny these feelings than it would be to risk being labeled unfit.

**A belief that mothers have everything to lose by seeking help for PPD**—In the experience of most study participants, warnings that depressed mothers would be labeled *crazy* and lose their children abounded. One woman described it as follows: *I think a lot of it is people are scared. There are some people that either have warrants or whatever and they think that that's gonna come up or they knew that CPS [Child Protective Services] is gonna get involved or they think that some kind of law of some sort is gonna get involved to where either they're gonna get locked up or their children are gonna get taken away. They feel threatened. They feel scared. They feel that something's gonna be taken away from them. If it's not their children, it's their freedom. So, if maybe they think, well, maybe I'm a little crazy, but I'm not gonna go to the doctor because the doctor is gonna be asking me too many questions.*

These fears create insurmountable obstacles for initiating help-seeking behaviors. The participants believed that a woman would be jeopardizing her independence and personal

standing as a capable mother, not to mention her opportunity to keep her children, by admitting that something was wrong.

**A need for culturally relevant education on PPD**—When asked what would help them or other mothers seek help for PPD, the participants spoke of educating the community to serve as witnesses invested in their well-being. They wanted people in their community, within their own cultural group, to promote representations of what PPD looks like among their own people. Participants commented that in the AA community, depression does not *look* like depression. They added that crying, sad mood, and sleep difficulties were not the only symptoms of PPD and that a lack of these symptoms did not exclude a PPD diagnosis. They suggested that HCPs and mental health professionals *educate our family, our community*. They thought that education about PPD could increase awareness and decrease stigmas and false beliefs among the female elders and the men in their community.

One participant criticized current TV commercials for antidepressants, saying, *Based on what you see on TV and their commercials and the ones holdin' the dog by the window, that is so completely garbage*. When asked how a commercial that accurately portrays PPD would look, one participant gave this vivid example: *She movin' around. She drop-pin' the kids, you tired, you over-worked. She doin' the most, she cookin', she cleanin', she washin' dishes. Doin' everything at one time....Baby hollerin', hand doin' this here, I mean it's just no time to stop, no time to stop....Everything*

*has to be done. Nobody else is gonna do it.*

## Discussion

In this study, 16 postpartum, low-income, AA women conveyed how their community's beliefs about depression and expectations about motherhood placed intense pressure on them—and on women like them—to hide PPD symptoms. Perceived cultural beliefs led to the view that, following childbirth, women should be self-sufficient and endure the stresses of motherhood without exhibiting weakness or developing a mental illness.

Although most study partici-

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pants did reveal their symptoms to others, most of these disclosures were dismissed, denied, or even mocked. For AA mothers living in similar contexts, culture may serve as a barrier for those with PPD symptoms to seek professional help. Perceived messages about stigma and weakness were sometimes more powerful than the mother's own recognition of feeling depressed, overwhelmed, and in need of support. Perception of depression as a character weakness and PPD as an expression of extreme behaviors such as infanticide may lead women to dismiss mild or moderate PPD symptoms that are amenable to early treatment.

These symptoms, if left untreated, could progress to more extreme reactions and have much direr consequences.

An important point for HCPs: Many AAs with depression may not report feeling down or hopeless but, rather, will present as stoic, angry, or irritable.<sup>24</sup> In the current study, participants related their stories of depression, frustration, and feeling judged with very little affect. None of them cried, even when sharing painful memories. HCPs may dismiss depressive symptoms as routine stressors of life for low-income mothers, especially if the mothers appear angry and irritable rather than sad and depressed. HCPs screening for depression may not recognize that anger and frustration can be manifestations of depression. In fact, the manifestations and the communication of symptoms vary greatly from members of one culture to those of another culture, and may not be recognizable from the HCP's cultural vantage point.<sup>14</sup>

Asking for help in this sample of low-income AA women would have been in direct contrast to the perceived culturally embedded role of the mother as superwoman.<sup>14</sup> In this study, participants' calls for help often went unanswered, even when they told their own mothers, aunts, sisters, or partners about feeling overwhelmed, stressed, and angry for long periods of time. They reported that nobody seemed to be listening. Some participants expressed a fear of being labeled crazy. The possibility of losing custody of their children stopped many of them from seeking treatment for their depressive symptoms.

These women believed that increased community awareness and education would decrease the stigma about PPD, and that more women would be likely to report their symptoms and obtain treatment. Overall, the participants wanted to feel heard and understood and not stigmatized. Many had doubts and confusion, and were unwilling to self-identify with having PPD symptoms because of the negative cultural connotations associated with this disorder.

### Limitations of the study

Because this study was entirely qualitative in nature and was based in real-world community settings, it has certain limitations. The sample was obtained from a single site. Although this approach is common in qualitative studies, enrolling participants from different sites could have further supported these findings. Other mothers with similar demographics and life situations may have experiences similar to those reported in this study, but the results cannot be generalized to all urban, low-income, AA mothers. In addition, AA women from rural or suburban areas and those with greater economic resources may have responded differently.

The lead investigator who conducted the focus groups was white and from an academic setting, and was thus considered an *outsider*. To address this potential threat to recruitment and open discourse, the investigator was accompanied by students of various cultural backgrounds and by a case worker with whom the participants were familiar and who was present during recruitment. To deal with a poten-

tial threat of researcher bias, the lead investigator disclosed to the group that she was a mother who had only professional experience with PPD and wrote reflective memos after the groups met. Three other researchers participated in the coding process to minimize bias. Despite these limitations and small sample size, the study provides valuable insight from a group of women identifying with similar cultural norms and their perceptions of PPD experiences and their attitudes toward treatment.

If a depressed mother is at least aware of community resources' existence, she may be more likely to pursue them.

### Clinical implications

Because of the high incidence of PPD in minority and low-income groups, PPD screening should be implemented in all obstetric practice settings serving these populations. HCPs should assess pregnant patients for a history of depression, previous PPD, antepartum depression, and past history of mental illness; these conditions are the strongest predictors of PPD.<sup>25</sup> HCPs should discuss PPD, its symptoms, and possible treatments with patients during the prenatal period, prior to discharge after birth,

and at the 6-week-postpartum visit. HCPs should ascertain the presence of support from the patient's partner, family, and community. If a depressed mother is at least aware of community resources' existence, she may be more likely to pursue them. Many county-based community health centers offer mental health services for no fee or reduced fees.

In this study, women with PPD described themselves as feeling overstressed and overwhelmed. HCPs may find it necessary to discuss strategies and resources for lowering mothers' stress before even addressing the depression. Findings from this study also suggest a need for more culturally specific information about PPD and its symptoms. For urban, low-income, AA patients, increased education about the various expressions of PPD may help shift the mindset and destigmatize PPD. Educational outreach efforts could also be made in churches; spirituality has been cited as a focal point of recovery from depression among low-income minority women.<sup>26</sup>

Women with lives complicated by financial constraint, social isolation, non-supportive family, and limited access to mental and physical health services experience stresses that may contribute to or worsen PPD symptoms.<sup>27</sup> This reality underscores the need for proficient screening and awareness of social stressors when working with low-income mothers in the perinatal phase. Women in crisis and those with severe symptoms, suicidal ideation, or symptoms of postpartum psychosis require immediate mental health assessment that may warrant hospitalization.

## Conclusion

Postpartum depression carried tremendous stigma among this group of AA mothers. PPD was viewed as a sign of weakness and a disease prominent in other ethnic groups. This sample of low-income AA women believed that they had much to lose and little to gain by revealing depressive symptoms. Individual and community education may help address this misperception. ●

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