Peiyue Care and Its Impact on Postpartum Depression: A Cross-Cultural Review

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**Abstract**

**Background:** Many original studies have evaluated that cultural practices, including rituals like "pieyue" care, are associated with postpartum experiences, sometimes contributing to postpartum depression, although not universally. However, the present review is a unique attempt to summarize the data in a critical framework show a corelation between peiyue care and its association with postpartum depression. The review paper aimed to explore the need for culturally tailored healthcare interventions and policies aimed at improving maternal and child health outcomes. The study underscores the critical role of cultural practices and rituals in assessing and managing postpartum depression, advocating for culturally informed approaches to maternal healthcare globally.

**Methods**: We searched PubMed, PsycNet, Google Scholar, related to the significant corelation between postpartum depression and peiyue care from January 2013 to 2023. Several keywords and criteria were applied to select studies before summarizing the data.

**Results**: These findings highlight the need for culturally tailored healthcare interventions and policies aimed at improving maternal and child health outcomes.

**Conclusion**: In India, the prevalence of postpartum depression (PPD) is influenced by a complex interplay of cultural rituals and practices. While these practices, such as postpartum confinement, diet, and family support, are often intended to aid recovery, they can have mixed effects. For some, they provide a supportive environment, reducing the risk of PPD. However, rigid adherence to these traditions, combined with societal expectations and stigma surrounding mental health, can exacerbate feelings of isolation and stress, potentially increasing vulnerability to PPD.

**Keywords:** Peiyue care, Postpartum depression, isolation, stress

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**Introduction**

While childbirth is a universal experience, cultural perspectives on maternal and child health vary widely. Health-seeking behaviours are often shaped by cultural beliefs and attitudes, which can, in some cases, negatively affect the health of mothers and their children. The importance of cultural knowledge and beliefs in maternal health remains a subject of ongoing debate1

Some researchers have emphasized the significant role cultural factors play in shaping the emotional well-being of mothers, suggesting that cultural beliefs and practices serve as important protective mechanisms during life transitions.2 Culture, defined as a set of socially shared views and behaviours, varies by region, with differing degrees of influence through practices and rituals—some of which can be beneficial, while others may be harmful or neutral regarding maternal health. In particular, certain harmful customs and traditional practices during pregnancy, childbirth, and the postpartum period have been linked to elevated health risks3

The postpartum period, following childbirth, is a critical phase of physical and emotional recovery for new mothers and parents. Globally, diverse cultures have established distinct postpartum traditions and rituals designed to support and heal new mothers during this time.4 In developed countries, nearly all women and their infants receive postnatal care, though the nature and frequency of this care vary significantly. The primary objective of postnatal care is to ensure the health and well-being of both mother and infant, while also fostering an environment that offers support for the interconnected social and health needs of the family and community.5 In this context, the traditional practice of *peiyue* (meaning "accompanying the month") requires family support during the first month after childbirth. This practice has been shown to reduce postnatal depression by alleviating work-related stress, nourishing the mother, and fostering a healthier relationship with her partner. However, the absence of adequate postnatal care, including *peiyue*, may increase the risk of postpartum depression (PPD). Research on PPD prevalence highlights that many countries, particularly those with limited healthcare services, are at greater risk of maternal mental health issues due to the lack of such supportive practices.11,12,13,14 PPD is a serious mental health condition that can negatively affect both mother and child, with major risk factors including a history of depression, stressful life events, poor marital relationships, and lack of social support.21,22 Symptoms typically emerge within 1 to 3 weeks after childbirth and may persist for months or even years if left untreated. Cultural factors play a crucial role in the development of postpartum depression, acting as both potential triggers and mitigators of depressive symptoms.17,18

This article aims to explore the cultural beliefs and traditional postpartum rituals, focusing on *peiyue* care practices, and their relationship with the prevalence of postpartum depression. Moreover, the influence of these cultural practices on postnatal health could inform interventions aimed at reducing maternal and neonatal mortality and morbidity on a global scale.23,24

**An exploration into the Postpartum Practices and Peiyue Care worldwide**

The postpartum period is a significant phase in a woman's life, particularly for first-time mothers, as it involves substantial social, physiological, psychological, and physical adjustments.28.29,30 Postpartum healthcare, typically administered within the first six weeks after childbirth, is crucial for the health and well-being of both mother and infant. However, in contrast to the extensive attention given to prenatal care and childbirth, maternal and infant health during the postpartum period has often been underemphasized.32,33According to estimates from the World Health Organization (2013), 99 percent of global maternal deaths— in total 286,000—occurred in developing countries.35 Furthermore, Ronsmans reported that approximately two-thirds of all maternal deaths in developing nations happen during the postpartum period.41 This situation, however, can be mitigated through comprehensive and effective postpartum care, such as *peiyue*, a cultural practice that plays a critical role in identifying early physical and psychosocial issues and minimizing postpartum complications.22,36,42

For example, Pillsbury (1978) explored the ritualistic postpartum traditions among the Chinese population, finding that postpartum depression (PPD) was relatively uncommon. This is attributed to the custom of *zuo yuezi* or "doing the month," where new mothers are exempt from household tasks, adhere to a prescribed diet, and follow specific behavioral guidelines such as staying indoors to avoid exposure to cold and wind. In addition, the practice of *peiyue* involves a senior female family member taking on most household and childcare responsibilities, providing a protective buffer against PPD and social isolation.36 Similarly, a hospital-based study in Taiwan involving 202 postpartum women found that adherence to the practice of "doing the month" was associated with lower severity of physical symptoms and reduced rates of PPD. However, in Malaysian women, stronger adherence to traditional postpartum practices was linked to higher depression scores.15

Jambunathan and Stewart (1996) conducted ethnographic studies on 52 Hmong women residing in the United States, focusing on their postpartum experiences. The Hmong, originally from the hills of Laos in Southeast Asia, observe a 30-day postpartum rest period involving a specific diet and familial support, particularly from spouses. These practices were found to offer protection against PPD, underscoring the role of cultural customs in promoting maternal mental health.6,7,9,10

Furthermore, Lee employed ethnographically informed epidemiological methods to examine sociocultural risk factors for PPD among 959 Chinese women in Hong Kong. The findings indicated that *peiyue* practices were linked to enhanced social support and a slightly reduced risk of PPD, contributing to better emotional well-being for mothers.25 These studies highlight the importance of culturally informed postpartum care in reducing the risk of PPD and improving maternal health outcomes.

**Postpartum rituals as an exacerbating or alleviating factor for postpartum depression: an insight into the studies done globally**

The postpartum period is marked by various traditional practices that continue to be observed across different cultures. In Japan, the ritual of *Satogaeri bunben* involves the expectant mother returning to her parental home between 32 and 35 weeks of pregnancy, where she remains for several months following childbirth. This practice provides the mother with supportive care and relieves her from household duties, which is believed to protect her from postpartum depression.19 However, a cross-sectional study of 186 Japanese women conducted by Yoshida et al. (2001) challenged the assumption that *Satogaeri bunben* shields women from depression.

Similarly, *pantang*, another postnatal care practice in Japan, encourages women to follow a strict diet after childbirth. Birth is viewed as a "cooling" process, necessitating a "warming" diet to restore balance. Additionally, the practice of "mother roasting," which involves warming the mother by dressing her in heated clothing or placing her in a warm room, was historically believed to reverse the chilling effect of childbirth found that women adhering strictly to the elements of *pantang* exhibited higher rates of depression, suggesting that these practices may exacerbate anxiety and discomfort, thereby increasing the likelihood of depression.42

In a study conducted among Chinese women, researchers explored the prevalence and risk factors for postpartum depression (PPD), with a specific focus on the impact of in-law relationships and traditional customs. The study revealed that approximately 80% of the women who developed PPD had received *peiyue* care, a traditional postpartum practice. While most women adhered to dietary and behavioural restrictions associated with "doing the month," *peiyue* care, along with strained relationships with in-laws, was linked to higher rates of depressive symptoms.34

Stewart and Jambunathan (1996) examined how traditional cultural practices influenced PPD in Hmong women living in the United States. The Hmong, originally from Laos, follow a 30-day rest period after childbirth, supported by family members. The researchers found that cultural dissonance and the inability to adjust to the practices in the United States contributed to a positive correlation between *peiyue* care and PPD among Hmong women.

Danaci and colleagues (2002) studied the cultural and epidemiological factors influencing PPD in Turkey, surveying women between 0 and 6 months postpartum at primary healthcare centers. They reported that 14% of women experienced PPD, with the prevalence of depression increasing from delivery to 12 weeks postpartum. The findings suggest that specific aspects of Turkish cultural practices may exacerbate postpartum depression.32

In India, Leung (2002) investigated the relationship between stress, social support, and postpartum depression. The study found that over 30% of participants lived with their in-laws, and 25% lived with their parents. Despite assessments conducted at three different stages postpartum, social support had little effect on mitigating stress and PPD.19-20 Instead, unmet expectations for support from spouses, parents, and in-laws significantly contributed to the onset of PPD. Women who received greater spousal and parental support reported lower rates of depression. While ritual practices reduced stress to some extent, particularly due to positive in-law support, they did not always provide full protection against PPD.26,27

Rodrigues et al. (2003) conducted a follow-up qualitative study with Indian women, focusing on the attitudes of mothers and their husbands towards childbirth, and how social adversity contributes to postpartum depression (PPD). The findings indicated that strained relationships with husbands, mothers-in-law, or both were key sources of distress. Several participants reported increased tension after the birth of a girl, with some husbands attributing their wives' emotional issues to the baby's gender.34 The study highlighted that poor marital relationships could be a significant risk factor for PPD, particularly when triggered by the birth of a girl. Conversely, even in unhappy marriages, the birth of a male child seemed to offer protection against depression. These findings underscore the profound impact of cultural norms and gender expectations on postpartum depression, particularly within the Indian context.

**Cultural Traditions as Neutral Effect on Postpartum Depression**

Several studies have challenged the association between cultural traditional support and the development of postpartum depression (PPD). For instance, Stewart et al. (1996) conducted a longitudinal study comparing two groups of Japanese mothers: those residing in England and those in Japan. The aim was to assess whether PPD rates differed between Japanese and Western women and to investigate if the traditional Japanese practice of **Satogaeri bunben**—where new mothers return to their maternal homes for support—was linked to lower PPD rates among Japanese women. The study revealed a PPD incidence of 12% among the English group, compared to 17% in the Japanese group. In terms of maternal support, 76% of English women received support from their mothers, while 67% of Japanese women received support through **Satogaeri bunben**. These findings suggested that the Satogaeri bunben tradition did not significantly affect PPD incidence.37,38

Another study, based on a sample from a community health center in Fukuoka City, Japan, explored the sociocultural context and role of Satogaeri bunben in modern Japanese society. Results indicated that over 70% of participants chose to follow the tradition. By comparing two groups—one adhering to Satogaeri bunben and the other not—the researchers were able to assess the impact of this cultural ritual on postpartum well-being. The findings indicated that the practice of **Satogaeri bunben** in the English group was inconclusive, while there was a notable correlation between the cultural beliefs and rituals and the occurrence of PPD among Japanese women.39,40

**Table 1**

Summary of Studies Addressing the practices and rituals followed during peiyue care

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Authors** | **Place** | **Postpartum Practices** | **Measurement of Independent Variable** | **Time of Assessment** | **Postpartum Care** |
| Heh et al. (2004) | Taipei Taiwan | Stay in postpartum nursing centres to take care of their newborn babies and perform the traditional Chinese ritual of Tso-Yueh-Tzu, the custom of a postpartum month-long rest. | PSSQa, EPDSb (cut off: 10) | 4th week postpartum(pp) | “doing the month” |
| Lee (2000) | Hong Kong | Follow traditional dietary practices to different degrees. These practices were characterized by an increased poultry consumption. Iron content of ginger vinegar soup was comparable to some iron-rich foods. | Psychosocial Assessment  BDIc EPDSb (Cut off: 9/10) | 2nd trimester(pp) | Peiyue and “doing the month” |
| Stewart and Jambunathan (1996) | USA | Women ideally have contact with a maternal care provider within the first 3 weeks postpartum. | GHQd, SCIDe, In depth Interviews | Within the 1st year pp | 30-day rest period postpartum and family support |
| Harkness (1987) | Kenya | Healthcare professionals visits the mother, scheduled within 48 hours after birth, 1-2 weeks, 4-6 weeks, and 4-6 months. | Reports of memories and dreams | At 2-3 weeks pp | One month of rest and support from mother and mother in law |
| Dankner et al. (2000) | Israel | ------------------- | EPDSb (cutoff: 9) | Immediately after delivery and 6-10 weeks pp | Parents attend mother and child clinics for routine visits 10 days after delivery, and again at one, two, four, six, nine, and 12 months after delivery. |
| Huang and Mathers (2001) | UK and Taiwan | Most women and babies are discharged from community midwifery care to their Health Visitor (community nurses responsible for health and development of babies and children) and General Practitioner (community doctor) around 10 days after they give birth, but can remain under CMW care until six weeks after birth. | EPDSb (cutoff: 12), socio- cultural questionnaire and indepth interviews | 0-3 months PP | “Doing the month” |
| Stuchbery et al. (1998) | Australia | In Australia, postnatal care is provided by multiple healthcare professions - midwives, obstetricians, general practitioners, paediatricians and nurses – across multiple settings, including public or private hospitals, in community-based primary care services, or at home | EPDSb (treated as continuous) and questionnaire on social support | 6 weeks PP | --------------- |
| Nahas and Amasheh (1999) | Australia | In some Indigenous Australian cultures, new mums/parents observe a traditional practice called yarning circles, during which they gather with other mums/parents to share their experiences and receive support during the postnatal period. | Participation observation and interviews | ------------ | Extended family support and diet for 40 days, and the importance of not being sad |
| Denaci et al. (2002) | Turkey | Women widely use traditional practices such as putting Koran (Holy book for Muslims) and packing needle under the mother's pillow to prevent mother from "al basması", pouring lead in a cup over the head of the newborn to repel evil spirits, and covering the baby's face with a piece of yellow ... | EPDSb (cutoff: 12/13) | Within 6 month PP | In laws involvement and interest in postpartum women declines over time |
| Leung (2002) | Hong Kong | “Doing the month”, also known as “sitting the month” or “Zuoyuezi”, is a traditional postpartum practice in Asian countries, particularly in China. | Demographic quesstionnare PSQg, PSSb, EPDSb (cutoff: 13) CSIi, PSSQa interviews | 3rd trimester 6-8 weeks PP, and 6 months PP | “Doing the month” |
| Patel et al. (2002) | Goa, India | Some traditional practices adopted by the new mothers to protect their baby from the evil eye included applying kajal to the baby's face, as well as the use of bangles, black threads, anklets and chains | GHQd, demographic quessyionnaire, obstetric history, maternal support quesstionnare. EPDSb (cutoff: 11/12) BDQj | 3rd trimester 6-8 weeks PP, and 6 months PP | -------------- |
| Rodrigues et al. (2003) | Goa, India | Some traditional practices adopted by the new mothers to protect their baby from the evil eye included applying kajal to the baby's face, as well as the use of bangles, black threads, anklets and chains | In depth interviews | 6-8 weeks PP | -------------------- |
| Amankwaa (2000) | USA | ------------------------- | Two identical in depth interviews, prestructured open-ended questions | Within 3 years PP | ------------------ |
| Yoshida et al. (2001) | UK and Japan | It is tradition for the baby to reside at their maternal grandparents' house during their first month, alongside their mother. The mother and baby typically stay in bed for the first 21 days following birth. Visitors are welcome to stop by and enjoy a special red bean and rice dish (osekihan) | SADSk, EPDSb (cutoff: 8/9 RDCl | 1 month PP, and 3 months PP, End of 3rd week PP | Satogaeri bunben |

aPSSQ: Postpartum Social Support Questionnaire (Hopkins et al. 1987)

b EPDS: Edinburgh Postnatal Depression Scale (Cox et al. 1987)

c BDI: Beck Depression Inventory (Beck, Ward and Mendalson, 1961)

d GHQ: General Health Questionnaire (Goldberg and Williams, 1988)

e SCID: Structured Clinical Interview for DSM-III-R (Spitzer, Williams, Gibbon, 1992)

f The Childbirth Questionnaire (Kruckman et al. 1984)

g PSQ: Postpartum Support Quesstionnare (Logddon and McBride, 1989)

h PSS: Perceived Stress Scale (Cohen, Kamarch and Mermelstein, 1983)

i CSI: Childcare Stress Inventory (Cutrona, 1983)

j BDQ: Brief Disability Questionnaire (Vonkorff, Ustun, Ormel, Kaplan and Simon, 1996)

k SADS: Schedule for Affective Disorders and Schizophrenia (Spitzer and Endicott, 1976)

l RDC: Research Diagnostic Criteria (Spitzer, Endicott and Robins, 1978)

m PPD: Postpartum Depression

### Table-2

### Other postpartum rituals/practices followed worldwide

|  |  |  |
| --- | --- | --- |
| Place | Practices | References |
| Thailand | Binding the abdomen to return it to its normal size | Davis, R. E. (2001). The postpartum experience for Southeast Asian women in the United States. *MCN: The American Journal of Maternal/Child Nursing*, *26*(4), 208-213. |
| Vietnam | Binding the abdomen to return it to its normal size | Kruckman, L. D. (1992). Rituals and support: An anthropological view of postpartum depression. *Postpartum psychiatric illness: A picture puzzle*, 137-148. |
| Cambodia | Binding the abdomen to return it to its normal size | Jambunathan, J. (1995). Hmong cultural practices and beliefs: the postpartum period. *Clinical Nursing Research*, *4*(3), 335-345. |
| Mexico | Binding the abdomen to return it to its normal size | Rice, P. L. (2000). Nyo dua hli–30 days confinement: traditions and changed childbearing beliefs and practices among Hmong women in Australia. *Midwifery*, *16*(1), 22-34. |
| Guatemala | Binding the abdomen to return it to its normal size | Callister, L. C., & Vega, R. (1998). Giving birth: Guatemalan women's voices. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, *27*(3), 289-295. |
| Hmong | Binding the abdomen to return it to its normal size | Callister, L. C., & Vega, R. (1998). Giving birth: Guatemalan women's voices. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, *27*(3), 289-295. |
| Pakistan | Baby’s abdomen is bound around the umbilical area to prevent abdominal colic, while the mother's abdomen is bound to hasten uterine involution and to flatten the stomach | Nahas, V. L., Hillege, S., & Amasheh, N. (1999). Postpartum depression: The lived experiences of Middle Eastern migrant women in Australia. *Journal of nurse-midwifery*, *44*(1), 65-74. |
| Goa (India) | An oil massage is believed to improve strength and maintain general health | Rodrigues, M., Patel, V., Jaswal, S., & De Souza, N. (2003). Listening to mothers: qualitative studies on motherhood and depression from Goa, India. *Social science & medicine*, *57*(10), 1797-1806. |
| Hawaiians | They use lomilomi massage to remove tensions, emotional anxieties and negative thoughts and feelings | Mayberry, L. J., Affonso, D. D., Shibuya, J., & Clemmens, D. (1999). Integrating cultural values, beliefs, and customs into pregnancy and postpartum care: lessons learned from a Hawaiian public health nursing project. *The Journal of perinatal & neonatal nursing*, *13*(1), 15-26. |
| Malaysia | The placenta, considered the baby's sibling, is placed in a ‘winding’ sheet and coconut shell and then buried | Laderman, C. (1987). Destructive heat and cooling prayer: Malay humoralism in pregnancy, childbirth and the postpartum period. *Social Science & Medicine*, *25*(4), 357-365. |
| Korea | The placenta is burned on the third day postpartum and the ashes are either buried or scattered on a road in a long black line to promote longevity | Sich, D. (1981). Traditional concepts and customs on pregnancy, birth and post partum period in rural Korea. *Social Science & Medicine. Part B: Medical Anthropology*, *15*(1), 65-69. |
| Mexico | A specialized sequence of visits from female relatives is performed to neutralize spiritual impurities | Kruckman, L. D. (1992). Rituals and support: An anthropological view of postpartum depression. *Postpartum psychiatric illness: A picture puzzle*, 137-148. |
| Nepal | Senior women of the household bless the new mother by applying a *tikka* to her forehead | Reissland, N., & Burghart, R. (1989). Active patients: the integration of modern and traditional obstetric practices in Nepal. *Social Science & Medicine*, *29*(1), 43-52. |

**Association between PPD its risk factors and Cultural norms across the globe**

Cultural and environmental norms can significantly influence the prevalence rates of postpartum depression (PPD). Socio-economic factors such as dietary practices, religious beliefs, poverty levels, stress, social support, gender roles, attitudes toward pregnancy and motherhood, and biological vulnerability are deeply embedded in cultural contexts that vary globally.8

In certain traditional cultures, instances of postpartum depression appear to be less prevalent. This may be attributed to a stronger emphasis on cultural norms that facilitate the transition to motherhood, thereby easing the physical and emotional challenges associated with becoming a new mother.8 For example, in various Eastern cultures, women are expected to rest in bed for the first three to six weeks postpartum, receiving care from their mothers who manage domestic responsibilities and child-rearing.21Such practices can enhance a mother's self-worth through the emotional support and closeness provided, potentially serving as a protective factor against the stresses of early motherhood.25 The initial postpartum phase typically includes enforced rest, social seclusion, recognition of the new social role through rituals and gifts, as well as assistance with household and childcare tasks.31 Consequently, feelings of sadness in the second and third months postpartum may emerge as a response to the conclusion of this supportive period and the challenges of adapting to motherhood.

Moreover, attitudes toward marriage, childbearing, and societal support for women in Eastern and West Asian cultures, including Japan, differ markedly from Western perspectives. During and after childbirth, women often receive greater social support from relatives rather than spouses. Additionally, cultural norms may discourage the expression of emotions; for example, prohibiting crying during the postpartum month may reflect a broader constrictive attitude toward emotional expression, which is often stigmatized as a sign of weakness. Kumar (1994) posited that the low reported prevalence of PPD in Japan may actually indicate a societal reluctance to acknowledge emotional distress.17 Other cultural factors that may affect the reporting of PPD prevalence include the inadequate provision of postnatal support services in many countries, which increases the risk of developing postpartum depression.21

Fellmeth (2023) identified several risk factors associated with postnatal mental health, drawing on data from previous studies. The sociodemographic variables included: age groups (<25 years, 25–29 years, 30–34 years, 35 years and older); registration status (births registered in either the parents' married names, joint (unmarried) names of parents living at the same address, joint (unmarried) names of parents living at different addresses, or the mother's sole name); age at completion of full-time education (16 years or younger, 17–18 years, 19 years or older); Index of Multiple Deprivation (IMD) quintiles (1 representing the least socio-economically advantaged to 5 representing the most socio-economically advantaged); ethnicity (White, Black, Asian, Mixed, or Other minority ethnicities); and country of birth (UK or outside UK).

The pregnancy and birth-related factors encompassed: pregnancy planning (planned or unplanned); parity (primiparous or multiparous); multiplicity (single or multiple birth); mode of birth (vaginal, instrumental, planned caesarean section, or unplanned caesarean section); gestational age at birth (preterm [<37 weeks] or term [≥37 weeks]); birthweight (low birthweight [<2500 g] or normal birthweight [≥2500 g]); neonatal admission (yes or no); birth experience (better than or as expected, worse than expected); and satisfaction with birth (measured on a scale from 0 [least satisfied] to 12 [most satisfied] using the 6-item Birth Satisfaction Scale Revised Indicator [BSS-RI] from the 2014 and 2020 surveys, or 6 of the 10 items on the BSS-R from the 2018 survey).

The biopsychosocial factors included: long-term physical health problems (yes or no); long-term mental health problems (yes or no); antenatal anxiety (yes or no); and antenatal depression (yes or no). Additionally, data on smoking during pregnancy (yes or no) and social support (measured using a Likert-type scale, with scores ranging from 0 [least support] to 6 [most support]) were gathered in the 2018 and 2020 surveys and incorporated into the regression models during sensitivity analyses.

Harrison and Quigley (2023) conducted a survey examining the prevalence of postpartum depression from 2013 to 2020. Their findings indicated that the prevalence of postpartum depression was 10.3% in 2014, rising to 16.0% in 2018 and further increasing to 23.9% in 2020. The differences in prevalence between the 2014 and 2018 surveys (+5.7%; 95% CI: 4.0–7.4; RR = 1.55; 95% CI: 1.36–1.77) and between the 2018 and 2020 surveys (+7.9%; 95% CI: 5.9–9.9; RR = 1.49; 95% CI: 1.34–1.66) were statistically significant (P < 0.001). Notably, the increases in prevalence observed between 2014 and 2018, as well as between 2018 and 2020, were consistent despite varying time intervals between the surveys.

Figure 1 illustrates the prevalence of postpartum depression as indicated in two smaller pilot surveys conducted between 2013 and 2020. These data series present prevalence rates for women recruited either three months (dotted line) or six months (continuous line) postpartum. Both pilot surveys included women recruited at either three or six months after delivery, resulting in two prevalence estimates for each year. The 95% confidence intervals for these estimates overlapped in both pilot surveys.

Fig.1

Prevalence of postnatal depression (EPDS ≥13) across the surveys

Stein (2023) conducted a multivariable analysis revealing several significant risk factors associated with postnatal depression. The analysis indicated that long-term mental health problems (adjusted relative risk [aRR] range = 1.48–2.02), antenatal anxiety (aRR range = 1.73–2.12), and antenatal depression (aRR range = 1.44–2.24) were all correlated with an increased risk of developing postnatal depression. Conversely, higher satisfaction with birth, as measured by the Birth Satisfaction Scale-Revised Indicator (BSS-RI), was associated with a decreased risk of postnatal depression (aRR range = 0.89–0.92) across all surveys, both pre-pandemic and during the pandemic. Specifically, for each one-point increase on the BSS-RI scale, the risk of postnatal depression decreased by 8% to 11%.

While these factors exhibited a consistent effect across the surveys, the influence of other risk factors varied. For instance, sole registration or joint registration (with different addresses) was linked to an increased risk of postnatal depression in both 2014 (aRR = 1.34; 95% CI: 1.00–1.79) and 2018 (aRR = 1.44; 95% CI: 1.11–1.88). Similarly, unplanned pregnancies were associated with an increased risk of postnatal depression in 2014 (aRR = 1.36; 95% CI: 1.10–1.69) and 2020 (aRR = 1.18; 95% CI: 1.03–1.35), while long-term physical health problems were linked to increased risk in 2018 (aRR = 1.34; 95% CI: 1.03–1.75) and 2020 (aRR = 1.24; 95% CI: 1.05–1.47).

Notably, the effect sizes for most risk factors tended to decrease across the successive surveys. Additionally, certain associations were unique to specific years: Black, Asian, Mixed, or Other minority ethnicities were associated with increased risk of postnatal depression only in 2014 (aRR = 1.51; 95% CI: 1.16–1.97); younger age groups (<25 years: aRR = 1.37; 95% CI: 1.06–1.78 and 25–29 years: aRR = 1.25; 95% CI: 1.01–1.56) were associated with increased risk in 2018 only; and fewer years of education (leaving education at 17–18 years: aRR = 1.15; 95% CI: 1.01–1.32) was linked to increased risk of postnatal depression in 2020 only.

Fig. 2

The prevalence of postnatal depression by survey year and selected pregnancy- and birth-related and biopsychosocial factors

**Conclusion**

This literature review emphasizes the significance of women's perceptions of tradition during the postpartum period. A detailed examination of disparate findings, particularly regarding women's interactions with their in-laws, suggests that certain rituals may adversely affect postpartum mood if women do not perceive them as beneficial. Future research should prioritize this subjective evaluation, as it plays a critical role in understanding postpartum experiences. It is essential to move beyond studies that merely assess prevalence, incidence, and descriptive characteristics across various cultures. Instead, there should be a more rigorous exploration of the diverse cultural customs and beliefs and their impact on postpartum depression. Researchers should address the differences between rural and urban populations by utilizing randomized sampling techniques. Additionally, studies must integrate both objective and subjective assessments, employ appropriate data analysis methods, and establish criteria for effective cross-cultural comparisons.

This review aims to enhance the understanding of health and mental health professionals regarding how various cultural norms influence the symptomatology of postpartum depression. To effectively address the needs of their clients and connect them with community resources, professionals must be aware of the cultural backgrounds of postpartum mothers. Facilitating access to culturally supportive resources is a vital objective of interventions linked to improved psychological well-being in postpartum mothers.

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