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Postpartum Depression in South Asian American Mothers: An Examination of Screening Tools and Associated Cultural Factors in Assessment

Heer Panchal

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Postpartum Depression in South Asian American Mothers: An Examination of Screening Tools
and Associated Cultural Factors in Assessment

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Psychology at National Louis University in partial fulfillment of the requirements for the degree
of Doctor of Psychology in Clinical Psychology.

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The Doctorate Program in Clinical
Psychology Florida School of Professional Psychology at National Louis University

CERTIFICATE OF APPROVAL

Clinical Research Project

This is to certify that the Clinical Research Project of

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has been approved by the
CRP Committee on August 11, 2021
as satisfactory for the CRP requirement
for the Doctor of Psychology degree
with a major in Clinical Psychology

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Abstract

Postpartum depression is a disorder impacting an overwhelming number of women after childbirth with symptoms of depression, anxiety, guilt, and hopelessness. Due to limited research and understanding of postpartum depression in the growing South Asian population in the United States, it is vital to gather data and research on this population to increase understanding of patterns and experiences that occur within the South Asian American population and to incorporate cultural factors into the screening process. The current research's objectives include discussing the facets of postpartum depression, current tools used to screen for postpartum depression, and helpful interventions to create a diagnostic screening tool that may be used in the diagnostic screening process to detect postpartum depression in South Asian American women.

**POSTPARTUM DEPRESSION IN SOUTH ASIAN AMERICAN MOTHERS: AN
EXAMINATION OF SCREENING TOOLS AND ASSOCIATED CULTURAL
FACTORS IN ASSESSMENT**

©August 2021

Heer Panchal, M.S., M.A.

DEDICATION

This research project is dedicated to my grandmother, Kumudbala Jerambhai Sidpara, for her unwavering support, her immense pride, and her overwhelming love. To all the women and families who have struggled with postpartum depression—I also dedicate this project and my future clinical endeavors to you.

ACKNOWLEDGMENTS

*त्वमेव माता च पिता त्वमेव ।
O Divine Source of Life,
I acknowledge that you alone are my mother and my father,*

There are no words to convey the depth of my gratitude to my wonderful parents, who provided me with endless guidance, encouragement, and love. Without their relentless support, I would not be where I am today.

*त्वमेव बन्धुश्च सखा त्वमेव ।
You are my friend and my loving companion,*

I am deeply grateful to my close friends and family, who have been my cheerleaders throughout my personal and professional accomplishments. Your supportive words have carried me through my most trying days and the longest of nights.

*त्वमेव विद्या द्रविणम् त्वमेव ।
You are my wisdom and my wealth,*

My academic pursuits would be fruitless without the efforts of the teachers and mentors who have lent me their knowledge, support, guidance, and inspiration—to them, I owe my professional achievements. Special regard to my chair, Dr. Patricia Dixon, and co-chair, Dr. Gary Howell, for your time, flexibility, and your advice not only throughout the dissertation process but throughout my doctoral journey.

*त्वमेव सर्वम् मम देव देव ॥
I acknowledge that you are everything there is,
And that you are everything to me.*

My greatest gratitude is to God and my guru, Mahant Swami Maharaj, who have helped me overcome all obstacles through their blessings.

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CHAPTER I: INTRODUCTION

Postpartum Depression Background and Statistics

According to the World Health Organization, depression is one of the most debilitating disorders present in women in their childbearing years, which are between 18 and 44 (World Health Organization, 2001). Women generally experience “baby blues” after childbirth due to hormonal imbalance and adjustment. However, postpartum depression can be distinguished from the baby blues because it often resolves within 1 to 10 days after the delivery of the baby. The onset of postpartum depression often occurs two weeks after delivery of the baby but can appear up to a year after childbirth. Statistically, the prevalence of postpartum depression ranges from 10-15% (Pearlstein et al., 2009), which places a large emphasis on proper diagnosis and clinical intervention in this population.

Distinguishing Baby Blues from Postpartum Depression

The most frequent puerperal mood disturbance is postpartum baby blues, with prevalence estimates ranging from 30-75% (O’Hara et al., 1984). Symptoms appear a few days after delivery, generally on day three or four, and can last for hours or even days. Mood swings, irritability, tearfulness, generalized anxiety, and sleep and appetite disturbances are among the common symptoms that can describe the baby blues (Noble, 2005). The symptoms of postpartum baby blues are time-limited and moderate, and they generally remit with reassurance from care providers. The baby blues are unrelated to psychiatric history, environmental stresses, cultural context, breastfeeding, or parity; yet, these factors may determine whether the blues lead to serious depression (Miller, 2002). In the first year after giving birth, up to 20% of women with blues will develop serious depression (O’Hara & Swain, 1996).

According to data from a large population-based survey, nonpsychotic postpartum depression is the most prevalent consequence of pregnancy, occurring in 10-15% of women after delivery (O'Hara & Swain, 1996). It normally starts during the first six weeks after giving birth, and most cases necessitate medical or psychological attention. Depressed mood, anhedonia, and low energy are common indications and symptoms of postpartum depression, which are similar to those seen in major depression at other times outside of the postpartum timeline. Suicidal ideation is also reported frequently by those who are suffering from postpartum depression.

Postpartum depression is not currently defined as a separate condition; it is diagnosed as part of affective or mood disorders in both DSM-V (American Psychiatric Association, 2013) and ICD10 (International Classification of Diseases, 10th Edition) (World Health Organization, 1992). The specifier “with peripartum onset” in the DSM-V is used to identify affective or brief psychotic episodes that occur during the postpartum period; an episode is designated as having a postpartum onset if it occurs within the first four weeks following birth (American Psychiatric Association, 2013). In ICD-10, the episode must be diagnosed inside a primary diagnostic category with the specifier to identify the relationship with the peripartum period (World Health Organization, 1992).

DSM-V Definition of Major Depressive Disorder

Due to postpartum depression having characteristics that align with major depressive disorder, the symptoms and criteria for this condition are essential to review. Major depressive disorder is defined by the presence of five of the symptoms as listed in the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2013), one of which must be either depressed mood or decreased interest or pleasure in activities. This symptom is generally combined with symptoms of physiological disturbance such as dysregulation of sleep,

appetite, and cognition that is pervasive for most of the day nearly every day for at least two weeks. An episode of depression is considered to have postpartum onset if it begins within four weeks after childbirth. However, onset within three months after delivery is the time frame commonly used by investigators based on epidemiologic studies (Wisner et al., 2002). The complete set of DSM-V criteria for major depressive disorder is listed below:

- A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.
1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, hopeless) or observation made by others (e.g., appears tearful). (Note: In children and adolescents, can be irritable mood.)
 2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation).
 3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. (Note: In children, consider failure to make expected weight gain.)
 4. Insomnia or hypersomnia nearly every day.
 5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
 6. Fatigue or loss of energy nearly every day.
 7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).

8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
 9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.
- B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- C. The episode is not attributable to the physiological effects of a substance or to another medical condition.

Note: Criteria A-C represent a major depressive episode.

Note: Responses to a significant loss (e.g., bereavement, financial ruin, losses from a natural disaster, a serious medical illness or disability) may include the feelings of intense sadness, rumination about the loss, insomnia, poor appetite, and weight loss noted in Criterion A, which may resemble a depressive episode. Although such symptoms may be understandable or considered appropriate to the loss, the presence of a major depressive episode in addition to the normal response to a significant loss should also be carefully considered. This decision inevitably requires the exercise of clinical judgment based on the individual's history and the cultural norms for the expression of distress in the context of loss.

- D. The occurrence of the major depressive episode is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified and unspecified schizophrenia spectrum and other psychotic disorders.

E. There has never been a manic episode or a hypomanic episode. Note: This exclusion does not apply if all of the manic-like or hypomanic-like episodes are substance-induced or are attributable to the physiological effects of another medical condition. Specifier: With peripartum onset. This specifier can be applied to the current or, if full criteria are not currently met for a major depressive episode, the most recent episode of major depression if onset of mood symptoms occurs during pregnancy or in the 4 weeks following delivery” (American Psychiatric Association, 2013, p.161).

Causes and Risk Factors Related to Postpartum Depression

The causes of postpartum depression can vary greatly but are highly associated with hormonal imbalance, specifically with estrogen and progesterone (Merritt et al., 2001). Hormonal etiologies, such as estrogen, progesterone, and prolactin, are all active contributors to the development and course of postpartum depression (Hendrick et al., 2000; Wisner et al., 2002). Individuals with postpartum depression are also significantly more likely to present with anxious features than non-clinical populations (Hay et al., 2008). Studies also show a lower response to pharmacological treatment in postpartum depression vs major depressive disorder (75% in non-postpartum depression vs 36% postpartum depression) (Horowitz & Goodman, 2005), which indicates that there are facets of postpartum depression that are more psychopharmacologically treatment-resistant than major depression.

Risk factors for postpartum depression include major depressive disorder during pregnancy, anxiety during pregnancy, previous nonpuerperal major depressive disorder, previous premenstrual dysphoria, stressful life events during pregnancy, poor social support, marital conflict, low income, immigrant status, poor partner support, and young maternal age (Robertson et al., 2004; O’Hara & Gorman, 2004). Lesser-known risk factors also include lifelong

depression in the spouse, age of the mother younger than 20 years, sick leave during pregnancy, worries about or lack of access to childcare, previous miscarriage, poor relationship with the current mother's own mother, a congenital malformed infant, personality traits, and bipolar disorder (Patel et al., 2012).

Impact of Postpartum Depression on the Mother-Infant Relationship

The literature suggests that postpartum depression has considerable and specific impacts on the mother-infant relationship and child development and success. Infants of mothers with postpartum depression have more prominent psychological, conduct, and relational issues than offspring of mothers who do not have postpartum or peripartum depression (Stewart et al., 2003). Mothers with postpartum depression rarely engage in verbal communication with babies, seldom express positive facial emotions and verbal expressions, and infrequently show physical feelings. Postpartum depression is also related to decreased execution of preventive measures (e.g., baby safety seats, power outlet covers, smoke detectors) and the reduced use of preventive services for babies, such as well-child visits and vaccination appointments (Klainin & Arthur, 2009).

Detecting Postpartum Depression

A prominent tool used to detect postpartum depression is the Edinburgh Postnatal Depression Scale (EPDS) created by Cox et al. (1987). It is a 10-item scale used to detect postpartum depression in women who lived in Edinburgh and Livingston in Britain. While the ethnic demographic was not discussed in the initial study, the population was likely entirely or mostly Caucasian. Another evidence-based screening tool used to detect depression in routine screening is the Patient Health Questionnaire (PHQ-9), which has been widely validated for use in primary care settings (Spitzer et al., 1999). This nine-item questionnaire is often used in

gynecological and obstetric practices, making it relevant, as postpartum women are largely seen in these settings. While these are the two most widely used instruments to detect postpartum depression, others are also discussed in depth throughout the project.

Today, health care providers must evaluate and treat an increasingly diverse population in the United States. Yonkers et al. (2001) found evidence that ethnic minorities, notably African Americans and Hispanics, have a higher risk of postpartum depression than European Americans. However, there is also a correlation between income status and postpartum depression (Abrams et al., 2009). Additionally, Hmong women in the United States are less likely to report symptoms of postpartum depression, implying that cultural beliefs and practices play an important role in supporting adjustment during the postpartum period (Stewart & Jambunathan, 1996). As the South Asian population grows in the United States, sparse research has been carried out on the pattern or experience of postpartum depression among this population or the cultural factors that influence their experience with this mood disorder. This study reported on the prevalence of postpartum depressive symptomatology and began to discover culturally bound associations.

Statement of Problem

Given the growing number of South Asian Americans in the United States, nearly 5.4 million according to recent census data (U.S. Census Bureau, 2017), it is vital to gather data and research on this population to increase understanding of patterns and experiences that occur within the South Asian American population and to incorporate cultural factors into the screening process. The current research gathered data to create a diagnostic screening tool that may be used in the diagnostic screening process to detect postpartum depression in South Asian American women.

This study focused on the South Asian American postpartum population, which has limited current research as far as cultural variations, risk factors, and normative data. It is important to delve into the specifics of symptoms and diagnosis in the postpartum South Asian American population due to the effects of postpartum depression on the mother and the child. Postpartum depression increases the chances of suicidal ideation, psychosis, and other severe mental health issues in mothers. Studies show that postpartum depression can increase symptoms in the baby, including excessive infant crying or colic, sleep problems, and temperamental difficulties (Pearlstein et al., 2009). Many women in the South Asian American diaspora have higher isolation rates when experiencing postpartum depression due to a lack of support and understanding from their parents, in-laws, and their significant other. The generational divide also plays a role in this dynamic, as most mothers and mothers-in-law dismiss the new mother's mood and grievances as a "modern thing" or attempt to engage her in various religious practices, such as pujas, to ward off the potential evil eye. Within these complex cultural factors, the lens of the issue is shifted from the root of the problem to external and potentially unrelated factors that compromise the mother's access to treatment (Goyal et al., 2006).

Purpose of Literature Review

This critical review of the literature evaluated past and current literature to support developing a screening tool specifically for detecting postpartum depression in South Asian women. Given the lack of empirical research on this specific area of research and in this specific population, this project highlighted the limitations of current research to provide more context for specific criteria that comprehensively assess postpartum depression in South Asian women. There is a gap in research in terms of identifying postpartum depression in South Asian American women and considering the impact of cultural factors in diagnosis and cultural/ethnic

variables. The data examined in this study helped develop a tool that makes it more accessible for healthcare providers to screen for postpartum depression in South Asian American mothers.

Research Questions

The following questions were used to frame the context of the literature review and to examine the cultural factors associated with postpartum depression, assess the diagnostic methods, and explore the current interventions implemented in postpartum care:

1. What are the current screening and diagnostic methods used to detect postpartum depression?
2. Which interventions and treatments are currently used to treat postpartum depression?
3. What cultural factors are unique to the expression of postpartum depression in the South Asian population?

Research Procedure

The research of this critical review of the literature included a comprehensive review of peer-reviewed articles and books. Various databases were used to identify scientific journals obtaining articles that address postpartum depression diagnosis, treatment, and impact in the South Asian population. Databases included EBSCO, ProQuest, PsycINFO, PubMed, Google Scholar, and Connected Papers. Search terms included *postpartum depression*, *South Asian women*, *Indian women*, *peripartum depression*, and *perinatal depression*. The various challenges faced by clinicians and individuals diagnosed with postpartum depression were also researched. Exploration of treatment was evaluated with consideration of diagnostic screening tools used in clinical practice.

CHAPTER II: CURRENT METHODS OF SCREENING AND DETECTING POSTPARTUM DEPRESSION

Defining “Screening” for Postpartum Depression

The terms *screening* and *diagnosis* address medically relevant issues: breast cancer screening, cervical screening, or cholesterol screening. According to Wald (2001), screening is “the systematic application of a test or inquiry to identify individuals at sufficient risk of a specific disorder to warrant further investigation or direct preventive action, amongst persons who have not sought medical attention on account of symptoms of that disorder” (p. 1). While the initial use of screeners may have been limited to medical diagnoses, recently, screening in medical, primary care, and integrated settings has included a psychosocial component to address emotional distress, risk of self-harm, and substance use disorders. Many individuals can be involved in the postpartum screening process, including but not limited to, front office receptionists, triage nurses, mid-level medical professionals, midwives, doulas, obstetrical and gynecological physicians, mental health professionals, and social work specialists. Due to the variance in the expertise of the individuals involved, Grimes and Schulz (2002) described the screening process as “a double-edged sword, sometimes wielded clumsily by the well-intended” (p. 259).

Contributing Factors to Screening Performance

Given the variety of somatic symptoms commonly associated with having a new baby and indications of major depression, such as sleep and appetite disturbances, lower libido, and poor energy, screening for postnatal mood disruption can be difficult (Nonacs & Cohen, 1998). While highly severe postpartum depression symptoms are identifiable, less severe forms of mental disorder are often ignored as normal or natural outcomes of childbirth.

Many of the signs and symptoms that make up the diagnostic criteria for depression are also frequent physiological or emotional responses to pregnancy and childbirth, and their incidence varies depending on when the screening is conducted. Prenatal screening is used to either identify current depression—which is not classified as postpartum depression—or identify women at risk for postpartum depression (Stewart et al., 2003).

The clinical setting is inextricably linked to timing, but it can also affect screening performance in other ways. For example, a mother's propensity to disclose depression symptoms may vary depending on the situation, such as her comfort level and familiarity with the provider or her anxieties about being judged as a parent. The setting may also impact whether mothers who have a positive screening test obtain appropriate diagnostic and treatment services. For instance, they may feel comfortable pursuing further services and interventions if provided in-house at their primary care provider's office versus having to seek out unfamiliar providers. Here, the provider and/or administrator of the screening tool also plays a significant role in the mother's openness to answer questions truthfully (Myers et al., 2013). Currently, there are an array of formal, validated screening tools used to detect postpartum depression.

Edinburgh Postnatal Depression Scale

A prominent tool used to detect postpartum depression is the EPDS created by Cox et al. (1987). It is a 10-item scale used to detect postpartum depression in women who lived in Edinburgh and Livingston in Britain. While the ethnic demographic was not discussed in the initial study, the population was likely entirely or mostly Caucasian. For women who do not speak English as a first language, there are several variations of the EPDS (although not all of them have been validated using a standardized psychological interview), including translations in Spanish, Chinese, Italian, and Hindi. Holden et al.'s (1994) research suggested that women

found the EPDS provided them the “permission to speak” and appreciated a chance to concentrate on their emotions in an open and safe setting.

Patient Health Questionnaire (PHQ-9)

The Patient Health Questionnaire (PHQ-9) has also been widely used to detect depression in individuals. It consists of nine questions assessing the presence of each of the symptoms of depression as described in the DSM-5, and the frequency of each symptom over the preceding two weeks is evaluated on a Likert scale from 0 to 3. The PHQ-9 is considered by some to be the “best accessible depression screening tool for primary care” (Nease & Malouin, 2003, p. 52) because of its relatively short length, reasonably high positive predictive value (55% in primary care settings), and ability to provide information on both diagnostic criteria and depression severity. The PHQ-9 has been successfully utilized as a screen in obstetrics and gynecology practices that include women of childbearing age and older women (Gjerdingen & Yawn, 2007).

Postpartum Depression Screening Scale

The PDSS was developed by Beck and Gable (2000) to improve the detection of mood symptoms related to postpartum depression. Beck and Gable picked up on the necessity for a measure other than the EPDS in detecting postpartum depression as they worked heavily off of research indicating depression was the last of 10 symptoms to be reported in postpartum depression (Dalton, 1996). In fact, the five most commonly reported symptoms were: anxiety, insomnia, agitation, irritability, and confusion. According to Dalton (1996), irritability was an often-overlooked symptom of postpartum depression that was an outlier when it came to diagnosis, hence the term *irrational irritability* in the context of postpartum depression. Beck’s further research also indicated the need for the addition of further symptoms to assess, such as difficulty concentration, loss of self, loneliness, and reality distortion (Henshaw & Elliott, 2005).

Beck and Gable also intended to create an instrument with items that pertained specifically to new mothers, such as “Even when my baby is asleep, I have difficulty falling asleep,” to help mothers relate their emotions with the behavioral changes in their environment. Ranges of elevation are used to interpret each of the seven symptom content subscales that make up the PDSS. When a woman’s score for a particular symptom subscale is in the elevated range, it signals to the clinician that the mother is having difficulties with that symptom and that intervention is likely required (Henshaw & Elliott, 2005).

The PDSS is a summative 35-item Likert-type self-report measure (Beck & Gable, 2000). Beck’s qualitative research program on postpartum depression served as the conceptual foundation for the PDSS and its seven symptom/distress categories. The PDSS consists of the following seven factors: sleeping/eating disturbances, anxiety/insecurity, emotional lability, mental confusion, loss of self, guilt/shame, and contemplating harming oneself. Unlike the EPDS and PHQ-9, which are open-access diagnostic screeners that can be accessed freely on the Internet, the PDSS needs to be sought out and purchased from a distributor of psychological testing materials.

Beck Depression Inventory (BDI-II)

The Beck Depression Inventory is a copyrighted, 21-item scale that assesses affect, cognitive symptoms, behaviors, somatic complaints, and interpersonal domains to measure the presence and intensity of depressive symptoms (Beck et al., 1979). It is one of the most widely used general self-report questionnaires with considerable psychometric data. Items are graded on a 4-point scale ranging from 0 to 3, with higher scores indicating lower mood over the previous seven days. The BDI-II and its performance with postpartum women were recently evaluated, and the results were satisfactory (Beck & Gable, 2001). Although these tools serve as a starting

point in identifying the presence or risk for postpartum depression, they do not necessarily translate to multiple cultures.

Limitations of Validated Screening Tools in Detection

While the screening tools above have all been shown to have clinical utility in detecting postpartum depression, it is important for care providers to identify and understand the benefits and disadvantages of each tool. The EPDS is a quick screening tool that is simple to use, free to providers, and used in various ethnic and socioeconomic groups and settings. It is also available in various languages, which is a strength in assessing minority populations across demographic profiles. Additionally, the PDSS may prove beneficial to care providers due to its assessment of multiple domains to target interventions to patients. The drawbacks of the PDSS include its length and expense per use and a more complicated and time-consuming retrieval method (Chaudron et al., 2010).

Demographic Disparities in Diagnosis and Access to Care

Currently, in the United States, the majority of postpartum depression research focuses on middle-class Caucasian women, highlighting a gap in the literature investigating postpartum depression from a culturally diverse perspective. Other minority women, including South Asian American women, are largely underrepresented in research. While the incidence of pregnancy and childbirth is universal to humankind, the event is experienced and conceptualized differently across cultures by women in the cultural framework (Okano et al., 1998). Effectively, in some cultures and countries, the clinical concept of postpartum depression simply does not exist. In fact, according to Stern and Kruckman (1983), an examination of the anthropological literature revealed very little evidence of postpartum depression as a phenomenon outside of Western diagnoses.

As for other demographic disparities, research has identified several barriers that new mothers may perceive as preventing them from seeking professional help for their emotional problems, namely “knowledge, attitudinal and practical/structural barriers” (O’Mahen & Flynn, 2008, p.1306). Moreover, minority women also report having limited knowledge of available services, treatment options, and psychosocial outcomes (Bilszta et al., 2010; Byatt et al., 2012). Feelings of guilt, shame, and stigma that are attitudinal barriers associated with perinatal /postpartum depression may prevent new mothers from seeking professional help. New mothers may feel guilty or ashamed to share with their social circle that they are experiencing emotional struggles regarding their child’s birth (Bilszta et al., 2010). They may also feel embarrassed when sharing their difficulties with health professionals (Callister et al., 2011). Structural barriers identified included financial obstacles and work restrictions, childcare stressors, and limited access to healthcare (Callister et al., 2011).

CHAPTER III: TREATMENT AND INTERVENTIONS FOR POSTPARTUM DEPRESSION

Treatment of postpartum depression can vary. However, the most beneficial treatment plans include integrated care consisting of medication management, individual and/or family psychotherapy, and group psychotherapy (Nonacs & Cohen, 1998).

Prevention of Postpartum Depression

It can be ascertained that the first step in treating a disorder is to create strategies for prevention. Any strategy that reduces the likelihood of a condition affecting an individual (primary prevention), interrupts or slows the progression of a disease/condition through early detection and treatment (secondary prevention), or slows the progression of a disease/condition and reduces the resulting disability through treatment of established disease (tertiary prevention) is considered a preventive intervention (Dennis, 2003). To guide the nature of preventive interventions, specific knowledge about potentially modifiable risk and protective factors that impact the development of postpartum depression can be used by care providers.

Medical Management of Postpartum Depression

Psycho-Pharmacological Therapies

According to research, postpartum depression is a variant of depression that responds similarly to typical antidepressant medication (Guille et al., 2013). Antidepressants should be begun at a low dose and gradually increased over time, and monotherapy is largely preferred over polypharmacy to avoid negative side effects. Mothers who are starting a medicine are urged to monitor their babies before and after starting the prescription to verify that there are no behavioral changes, especially in newborns who have any health issues (Fitelson et al., 2011). There are unique concerns with the administration of pharmacological treatment to the

postpartum population, including metabolic changes occurring within the mother's body and the risk of transmission of psycho-pharmacological agents to the infant through breastmilk. Research indicates sertraline, venlafaxine, nefazodone, fluvoxamine, and bupropion to be effective in the psycho-pharmacological management of postpartum depression. However, the greatest benefit was found with administering a sertraline regimen with the combination of cognitive behavioral therapy (CBT) sessions in non-breastfeeding women (Fitelson et al., 2011).

Non-Psychopharmacological Medical Approaches

The World Health Organization and American Academy of Pediatrics strongly recommend that new mothers breastfeed their infants for six months after childbirth, as this can prove beneficial both to the mother and child's physical, immunological and emotional health. However, breastfeeding is often not a viable option for all mothers, and the stigma associated with not breastfeeding their baby can often be seen as a trigger for emotional distress, which can exacerbate the symptoms of depression. (Fitelson et al., 2011). Hormonal therapies can prove beneficial to new mothers' emotional health, and estrogen treatment was shown to reduce the symptomology of postpartum depression in non-breastfeeding mothers (Hendrick et al., 1998).

Psychological and Psychosocial Interventions

Cognitive Behavioral Therapy

The assumption of CBT, a well-studied and successful treatment for major depression, is that mood is influenced by both perceptions and behaviors. According to cognitive theory, many psychiatric problems are caused by faulty beliefs and maladaptive information processing. CBT focuses on assisting depressed individuals in modifying distorted negative thought patterns and implementing behavioral changes that improve coping and minimize discomfort. Several trials evaluating CBT alone or in combination with other therapies for the treatment of postpartum

depression have been conducted and shown to be helpful in the reduction of depressive symptoms through the use of cognitive reframing, implementation of thought and mood logs, and management of unrealistic expectations (Hollon, 1998).

Interpersonal Therapy

Interpersonal therapy (IPT) is a time-limited treatment used to address symptoms of major depression based on tackling the connection between interpersonal problems and mood. In IPT, the patient and clinician choose one of four interpersonal problem areas to focus on for treatment (i.e., role transition, role conflict, bereavement, or interpersonal deficiencies). IPT generally has three phases, with the first being diagnosis and evaluation, in which the clinician gathers biopsychosocial history with an emphasis on current social functioning, close relationships, and patterns between the current interpersonal situation within one of the four interpersonal problem areas (i.e., grief, interpersonal role disputes, role transitions, or interpersonal deficits). The second phase includes creating a treatment plan that emphasizes learning and implementing strategies listed in the IPT manual to tackle maladaptive relational patterns in the individual's life. The third phase consists of support to recognize and strengthen therapeutic gains and develop ways to identify and counter depressive symptoms if they occur throughout the individual's lifetime (Dennis, 2003).

Throughout the therapy, which usually lasts 12-20 weeks, patients are given tools to help them change their dysfunctional relationship approaches and create stronger social supports. IPT has been developed to address postpartum-depression-related issues such as the mother-infant relationship, the mother-partner relationship, and the mother's return to the workspace. IPT fits nicely with the demands of the postpartum mother because it is both time-limited and problem-focused (Stuart & O'Hara, 1995).

The Reach Out, Stay Strong, Essentials for New Mothers (ROSE) program and the efficacy of an adaptation of the ROSE program, relaxation, encouragement, appreciation, communication, helpfulness (REACH) intended specifically for racially and ethnically diverse pregnant adolescents, have been researched in studies that analyze the utility of IPT in postpartum depression. Zlotnick et al. (2006) developed the ROSE program, a brief, manualized IPT-based group intervention to help pregnant women on public assistance enhance interpersonal connections, form social support networks, and manage the role transition to motherhood. During pregnancy, the intervention consists of 4 weekly 60-minute group sessions. Identifying and managing role transitions, setting goals, developing social supports, and identifying and resolving interpersonal conflict were among the themes covered in the sessions (Werner et al., 2015).

Peer and Partner Support Groups/ Group Therapy

Interpersonal therapy can also be modified for group settings and peer or partner support groups for women who experience postpartum depression and can include their spouses and families (Goodman & Santangelo, 2011). This group setting can allow mothers to process their emotions in a safe and open environment and form a social network that provides support and encouragement. The goal of group therapy aligns with that of individual therapy, which is to strengthen interpersonal interactions and reduce depressive symptomology. The therapist conducting group therapy must maintain constant effort to focus on each individual's presenting issue while still employing the group process as a therapeutic tool. The goal of the group setting is to make it easier to transmit interpersonal skills learned in group meetings to the participants' own interpersonal lives. Conducting a therapy group with patients who have the same diagnosis may also assist the patients in breaking patterns of social isolation and increasing their awareness

of the dangers of self-stigmatization (Nasiri et al., 2015). Peer and partner support groups also provide safe spaces for partners to discuss and process the changes in their relationship and day-to-day life with the birth of a child and complications of postpartum depression.

Supportive Care

Laboring mothers have become more separated from the network of supporters who were formerly a defining characteristic of childbirth as a significant number of modern births are performed in hospitals and other medical settings. Although partners and relatives are permitted to be present during delivery, a significant majority of women nonetheless go through labor without constant assistance. Furthermore, obstetrical care has seen labor as a high-risk event, leading to the complete isolation of mothers due to the strict restrictions related to COVID-19. Women have traditionally been encouraged to see their primary health care physician six weeks after giving birth. However, other experts believe that beginning postpartum treatment sooner may help prevent or detect problems such as postpartum depression earlier (Dennis, 2003). Along with the increased frequency of visits with providers, it may also be important for women in their postpartum period to feel comfortable with the setting of their visits—for instance, women may be more comfortable in their own homes for home visits or at their primary care provider's clinic versus follow-up visits at the hospital.

Postnatal psychological debriefing is a narrowly studied form of treatment typically consisting of a single semi-structured psychological interview during which the care provider explores an individual's childbirth and postnatal experience to reduce psychological distress. Debriefing in the postnatal setting usually takes the form of an organized conversation of labor and delivery events with an empathic listener immediately after birth. The intervention is divided into two parts: an educational component and a counseling component. The former consists of

explaining and clarifying the events surrounding the birth, while the latter entails encouraging participants to discuss their emotional reactions to the unexpected events, based on the premise that a lack of information contributes to psychological symptoms postnatally. The number of sessions and their duration were determined on a case-by-case basis by the care provider; the number of sessions ranged from 1 to 4, and the total duration of all sessions was between 25 and 50 minutes, with a median total time of 35 minutes. The implementation of this intervention resulted in significantly lower scores of depression in the experimental group versus the control group (Werner et al., 2015).

Relaxation Techniques and Strategies

Relaxation refers to a state of being free of physiological and psychological stress, whereas imagery refers to all thoughts that elicit a sensory component, which can be auditory, motor, tactile, gustatory, or olfactory. Due to the reciprocal nature of imagery enhancing relaxation and relaxation promoting image visualization, relaxation and imagery are frequently utilized together to aid in the reduction of anxiety, depression, and low self-esteem (Dennis, 2003). Relaxation and imagery reduce tension, discomfort, and anxiety and promote a more positive mindset and a stronger sense of well-being. With relaxation, a person can place a higher value on their individual self and make well-informed decisions about their own mental health and well-being and that of their child. This insight helps promote the development of positive self-esteem (Nasiri et al., 2015).

Mindfulness Techniques

The Buddhist idea of mindfulness entails the use of meditation to hone the skill of mindfulness, which has been described as “awareness of being aware” as well as “moment-by-moment awareness” (Sheydaei et al., 2017). According to research, mindfulness training is

useful in lowering postpartum depression in mothers. This is because mindfulness provides mothers with a type of awareness that provides them with valuable information about harmful occurrences such as burdens, sleep difficulties, and so on. According to Peters et al. (2011), such training exercises help curb maladaptive behaviors and emotions. Additionally, mindfulness training helps mothers focus on their experiences, allowing them to control their sentiments, particularly negative ones like guilt and worthlessness. Since hormonal events during pregnancy and childbirth can be a source of postpartum depression, mindfulness training can help mothers reduce the physical and emotional effects of depression by increasing their awareness of psychological issues (Sheydaei et al., 2017).

The mindfulness meditation practices and cognitive behavioral treatment strategies used in mindfulness-based cognitive therapy (MBCT) are combined uniquely. MBCT is based on the theory that people with a history of depression are more vulnerable to depressive relapse during times of stress or challenge, such as after childbirth, because associations between emotion and cognition that were active during previous depressive episodes are reactivated from the current event, therefore increasing the risk of relapse. Mindfulness meditation methods are taught to develop an awareness of such automatic linkages and give a “present-focused, decentered, accepting, and nonjudgmental” manner of interaction with one’s environment and condition (Dimidjian et al., 2016).

CHAPTER IV: CULTURAL FACTORS UNIQUE TO THE EXPRESSION OF POSTPARTUM DEPRESSION IN THE SOUTH ASIAN POPULATION

Examining the Context of Cultural Factors in Postpartum Depression

“Society: Don’t blame anyone, don’t blame my husband, my in-laws, or my family—they are not responsible for anything. I felt the way I felt because of myself. . . . I lost the Nima I knew. . . . Please let me go in peace.” These were the words penned on the last note written by young South Asian mother Nima Bhakta before she passed away through the completion of suicide in July 2020. The 31-year-old South Asian mother was silently struggling with postpartum depression after giving birth to her son. She voiced in the letter, *“It was something you guys wouldn’t understand because the Indian society does not fully understand postpartum depression”* (VICE, 2020). A quick search of scholarly databases echoed Nina’s words—not only does Indian society not fully understand postpartum depression but there is very little research available on postpartum depression in the South Asian population and even less available literature on the diaspora, specifically South Asian American women.

There is a fascinating theory in cognitive psychology known as the Sapir-Whorf hypothesis. Introduced in 1929 by Edward Sapir and later advanced by Benjamin Whorf, this theory proposes that the structure of a language determines an individual’s perception and categorization of experience. Simply put—language affects thought (Kay & Kempton, 1984). The Inuit tribe has over 50 words for snow, from “aqilokoq” for softly falling snow to “piegnartoq” for snow that is good for sledding. From the emphasis on snow for the Inuit language, we can see just how much of a role this must play in their everyday lives (Robson, 2013). South Asian languages do not often accommodate mental health terminology, referring to those with mental health issues as “sick” or “crazy.” The use of negative terminology when

speaking of mental health largely contributes to the stigma and discrimination present in the South Asian community regarding mental health issues. For this reason, those struggling with mental health may experience higher levels of isolation because they feel they may be further shunned by family, friends, or society if they speak about their mental health or attempt to access care.

Culturally Bound Risk Factors

Indian and Western women experience shared risk factors for postpartum depression such as poor marital relationships, antenatal depression, lack of spousal support, or domestic violence; cultural factors such as the gender of the child may explain the relatively high rates of postpartum depression in Indian women (Kapoor, 2021). While many of the risk factors leading to postpartum depression in the South Asian American population were similar to general risk factors, some other culturally bound risk factors included in literature were “financial difficulties, birth of a female child, marital conflict, lack of support from the family, past history of psychiatric illness, high parity, complications during pregnancy and low maternal education” (Upadhyay et al., 2017, p.711).

The stressors of having a female child in India are due to the financial liability of her dowry and because she cannot be considered the successor of her family lineage (Kapoor, 2021). The literature also suggests that while gender parity may be more divisive in rural versus urban populations in South Asian countries, it pervasively permeates throughout the diaspora due to its sociocultural implications (Kapoor, 2021).

Social and Cultural Contexts of Motherhood

Somatization of Psychological Symptoms

Between groups of Caucasian and South Asian Indian women presenting in medical clinics in India, Upadhyay et al. (1989) found no significant differences in the prevalence of depression or levels of somatic and psychological symptoms. However, notably, when asked the reason for seeking medical attention, the South Asian Indian women stated it was only for physical problems, whereas the Caucasian mothers said it was more likely because they were emotionally depressed. This could be related to South Asian women's unwillingness to disclose the emotional depressive symptoms due to cultural expectations of parenthood.

Although individuals in the West publicly express their depressive symptoms, new mothers in Asian culture tend to express their emotional problems through physical complaints (Kim & Buist, 2005). Chinese women expressed inner fatigue and feeling squeezed and burdened (Bashiri & Spielvogel, 1999). Korean women who experienced postpartum depression had symptoms of "polyarticular joints, joint pain, chills, headache, numbness, sleep disturbance, dizziness and anxiety" (Kim & Buist, 2005, p. 69). Somatization may be a special social way of expressing psychological problems in pan-Asian cultures. The ability to suppress negative emotions may be viewed as a measure of a higher level of education, maturity, and decent family history in this population (Kim & Buist, 2005).

Arranged Marriage

An arranged marriage is one in which a man and a woman are introduced by their parents based on caste, education, family background, and mutual family appropriateness (Prakasa & Rao, 1979). Arranged marriage is a significant cultural institution since it symbolizes the uniting of the bride and groom and both of their families. As a result, when families plan weddings, the

couple's interpersonal relationship often does not play a role in these partnerships before marriage, and meetings between the couple prior to marriage are accompanied by family members to uphold the family and couple's societal reputation (Goyal et al., 2012). While these arrangements are less prominent in the current South Asian American population, the practice of arranged marriages has not completely vanished. These partnerships lead to a spousal relationship based on familial compatibility rather than spousal compatibility, which can cause interpersonal difficulties in parenting. According to Patel et al. (2015), living in a nuclear family reduces the risk of postpartum depression by 11 times compared to staying in a joint family, despite the fact that around 90 percent of women reported having positive ties with their in-laws. Women subjected to domestic violence have an almost 10 times higher risk of developing postpartum depression than women who are not subjected to domestic violence.

Gender Roles and Their Impact on Postpartum Depression

In South Asian culture, the female role and the gender of the child are inextricably linked. Jambunathan (1992) investigated the role of sociocultural factors in the development of postpartum depression in 30 non-pregnant women in Madurai, India, and the study results indicated that being a woman was seen to be a "curse." In particular, one participated stated, "instead of being born a girl, it is better to be born as a free sparrow or a crow . . . or one should die" (Jambunathan, 1992). This idea of limited freedom is likely pervasive in the ability of women in South Asian cultures to freely express their emotions, especially negative emotions.

Preference for Male Children

In communities where there are gender inequities and low female status, there is a preference for male children (Winkvist & Akhtar, 2000). According to Patel et al. (2003), "The preference for male children is deeply rooted in Indian society . . . women who already have a

female child face greater stress because of their wish that their new infant be a boy” (p. 35).

Male offspring are preferred by South Asians not only because they are expected to support their parents in their old age, but also because, according to Hindu beliefs, supposedly only a son or male relative can continue the family line or perform the funeral rites that ensure the soul’s safe passage through Hindu purgatory (Choudry, 1997).

Pregnancy Traditions and Rituals

New mothers in South Asian cultures rely on practical and emotional assistance from family members such as the mother, mother-in-law, extended relatives, and their spouse, but postpartum behaviors in current Western societies are considered individualistic in comparison. Given that women are physiologically and psychologically vulnerable after childbirth, most Asian cultures support a “convalescence” time, prescribed diets, and culturally specific activities to aid recuperation and restore physical equilibrium. Postpartum depression is said to be protected by such cultural practices (Klainin & Arthur, 2009).

After birth, postpartum confinement is frequent for both the mother and the infant (Choudry, 1997). Following the birth of their child, South Asian women are often to be restricted to their houses for six to eight weeks postpartum. The mother and the newborn are said to be protected from evil spirits and disease during this time of relative isolation. Some women adhere to the tradition of staying with their own mothers in the weeks leading up to and following childbirth or having their own mother come stay with them. Other women in the house, generally extended relatives, take care of the newborn during postpartum confinement (Choudry, 1997). While social support has been shown to be an effective method of reducing postpartum symptoms, strained relationships with their spouse or other family members in the home may further isolate women from positive social support due to this tradition. Women in Rajasthan and

other rural areas of India are given intricate henna tattoos (artistic body and foot painting) and 40 days of home care after giving birth (Klainin & Arthur, 2009). New mothers are prohibited from doing any physically strenuous activity, such as household tasks, to preserve the beauty of the intricate henna patterns. Older children are cared for by friends and relatives, and all home tasks are completed, allowing the mother to rest and form significant bonds with her infant (Klainin & Arthur, 2009). This research suggests that the postpartum confinement period may prove beneficial for decreasing the symptomology of postpartum depression.

In these pregnancy and postpartum rituals and traditions, the women may not have chosen to participate in the rituals but were forced to do so by their family (e.g., mothers-in-law, husbands, mother) to avoid unwanted interpersonal confrontations. If the preexisting interpersonal relationships between the family members and the new mother are strained, creating a caring bond between infant and mother during the confinement period may become challenging. Due to these nuanced variables, certain components of postpartum rituals—particularly limitation of activities—might cause stress, tension, and frustration in the mother (Klainin & Arthur, 2009).

Motherly Roles in South Asian Cultures

Maternal depression is often undiagnosed in South Asian cultures, leaving women feeling alone and lonely (Hearn et al., 1998). Others have claimed that South Asian mothers with postpartum depression are less likely to seek medical help because they believe their symptoms are mild side effects of childbirth (Patel et al., 2003). India's cultural constructs have set expectations for "good" mothers, leading to stigma when deviating from the so-called "norm." Childbirth is labeled the happiest time in a woman's life; thus, feelings of anxiety or sorrow are considered taboo (Upadhyay et al., 2017). The mother figure is idolized in Indian culture:

“Mother India,” viewing the cow as a motherly entity due to the nourishment it provides and countless other references in media, religion, and pop culture.

CHAPTER V: CLINICAL IMPLICATIONS, FUTURE DIRECTIONS, AND PROPOSAL OF A NOVEL SCREENING TOOL

An extensive review of the literature indicated limited research available on South Asian American women's experiences of postpartum depression. According to findings from qualitative studies, having a female infant increases the risk of postpartum depression in the South Asian population. Other factors that may influence the risk of postpartum depression include social support, gender-based characteristics, and cultural customs. Additional areas for future research include exploring the experiences of South Asian women within the United States and women who identify as South Asian American. Thus, the clinical practice of detecting and treating postpartum depression in this population is in a much-needed early phase of development. Postpartum depression is widely recognized as a serious disease that has ramifications for women, children, and families. This study proved beneficial in creating a screening tool allowing practitioners to detect postpartum depression in the South Asian American population.

Clinical Implications and Limitations

The primary objective of this research project was to review the available research and provide a comprehensive analysis of postpartum depression in the South Asian population to facilitate more accurate diagnosis and identify unique risk factors through the understanding of culturally specific knowledge. The review of the literature revealed many limitations of available studies, including the use of a variety of screening/diagnostic tools (including self-report or a standardized clinical interview); varied consensus on cutoff points on the EPDS, and other diagnostic screener scores to determine the diagnostic threshold for postpartum depression; variance in postpartum timeframes when conducting research; and small sample sizes and

convenience sampling, which may lead to diminished generalizability of the research. As a result, there was insufficient evidence to prove that the measurements accurately captured the idea of depression in the South Asian population.

Furthermore, a large subset of the literature on postpartum depression and its characteristics in the South Asian population was drawn from countries outside the United States such as Malaysia, Bangladesh, India, Canada, and the United Kingdom. While these studies provide valuable knowledge on the culturally specific profile of the South Asian population and postpartum depression in various settings, there is still a gap in knowledge and literature for postpartum depression and other psychological phenomena in the South Asian diaspora in the United States. The gap in the literature not only lies in the geographical limitations of the study but also the interdisciplinary disparities in which postpartum depression is addressed. A large portion of the literature available on postpartum depression is included within medical, nursing, and public health journals. This gap in literature poses a unique opportunity for psychological journals to expand their knowledge base and provide clinicians and researchers with the platform to highlight postpartum depression.

The available screening tools discussed in this study indicated utility in detecting postpartum symptoms of depression in women. However, when placed in varied cultural contexts, these tools fail to address culturally bound risk factors and nuanced cultural variables. As such, through the review of these culturally bound factors in the South Asian population, a novel screening tool was proposed to address factors that may contribute to postpartum depression in the South Asian American population, such as the gender of the infant, marital satisfaction, familial interactions, psychosomatization, and internalization.

Proposed Screening Tool to Detect Postpartum Depression

The screening tool (found in Appendix A) seeks to incorporate validated screening tools used to detect postpartum depression while also integrating culturally bound contextual variables related to postpartum depression in the South Asian population, as discussed in the available literature. As such, the screening tool assesses the self-reporter to rate their emotions on a Likert scale (from Strongly Agree to Strongly Disagree) while also collecting information on the patient's demographic background, living situation, and interpersonal family dynamics. The tool is also meant to be used in the context of a clinical encounter where the provider would further discuss any relevant answers given by the respondent.

Analysis of Components of the Proposed Novel Screening Tool

Demographic Data Collection

The following items are at the beginning of the proposed screening tool to assess the patient's demographic information:

- What is your self-identified race/ethnicity?
- What is your age?
- What is your marital status?
- What is your education level? (Appendix A)

These items are important to assess so that the clinician can conceptualize the patient based on age, marital status, and level of education and use this information to guide the remainder of the screening process. To facilitate honest responses and thorough diagnostic interviewing, it is recommended that this tool be used as a self-report measure that is then used as an interviewing tool facilitated by further questioning based on the patient's responses. Ideally, the screening tool would be administered to the patient at the beginning of the appointment with the instructions to

fill out the form based on the instructions on the page(s). The respondent should be encouraged to ask questions about any of the items on the screening tool while they complete the measure. Once the measure is complete, the clinician or care provider should then review the answers given by the respondent and engage in a discussion based on the patient's responses. Due to the heavily based nature of this screening tool, it is recommended that it be used collaboratively with another validated screening tool (e.g., EPDS, PDSS) as a qualitative screening measure in the South Asian American populations.

Assessing Depressive Symptomology

This screening tool intends to assess not only the emotional symptomology of depressive disorders—as women in South Asian populations may internalize their emotions out of shame or fear of stigma, but also to assess psychosomatic symptoms and repression of emotions through the following items:

- I have body aches and/or headaches.
- I am generally happy and can laugh about things.
- I keep my emotions to myself.
- I sleep more or less than usual.
- I feel guilty about my actions.
- I am irritable.
- I am anxious, nervous, or worried.
- I have thoughts of harming myself or others.
- I am sad or hopeless (see Appendix A).

Marital and Familial Information

As a collectivist culture, the South Asian culture is often identified by strong family ties and the emphasis on keeping peace within the family over prioritizing one's own emotions. As such, it is important for clinicians to assess the role of marriage and familial interpersonal patterns present in the patient's life. Postpartum confinement expectations should also alert the clinician to probable postpartum difficulties due to isolation. These are assessed through the following items:

- I feel that I have strong support from my family emotionally.
- I feel that I have strong support from my family financially.
- If married or engaged, was the relationship arranged?
- If married or engaged, are you satisfied with the relationship with your partner?
- What best describes your current living situation?
- In your postpartum recovery, have you been expected to stay solely in the home for more than two weeks? (see Appendix A)

Assessing the Role of Gender Roles

Postpartum depression has been connected to a history of depression or psychiatric history, sexual abuse history, reproductive issues, pregnancy loss, and, more specifically for South Asian women, the child's gender. As such, it may be vital to assess South Asian patients about their preference for a boy or a girl. The following items were incorporated in the novel screening tool to assess for gender roles:

- I am happy about the gender of my child.
- My family is happy about the gender of my child (see Appendix A).

Future Directions

Research on postpartum depression in the South Asian population would benefit from delving deeper into the impact of cultural elements to address the aforementioned knowledge gaps and methodological flaws in the existing literature. Longitudinal investigations in clinical and community settings with larger and more representative populations are encouraged to broaden the study's perspective. In addition, further qualitative data are also needed to better understand women's postpartum experiences overall, including postpartum psychosis and postpartum obsessive-compulsive disorder along with postpartum depression.

Concerning the screening tool presented in this research project, this author recommends an empirical study to assess the validity of the screening tool within the South Asian American population. The author proposes a cross-sectional study carried out over 6 months up to a year with willing participants over the age of 18 that identify as South Asian American and have given birth within a year of the study execution. Exclusion criteria would include ethnicity other than South Asian American, history of severe mental illness, history of head injury or TBI, or other significant neurological damage. The survey to recruit participants would collect the participants' age, level of education, marital status, information about the birth and gestational period, questions about perceived familial support, level of education, and demographic information about race. To validate the screening tool, study participants will be asked to complete this survey through recruitment on various platforms, including social media, psychology association Listservs, intra-university email groups, and outreach to various pre- and postnatal care providers. The screening tool would then be administered to the eligible recruited participants in a clinical setting after informing participants on the study's objectives, risks, and benefits, and after obtaining informed consent forms from each participant. The Cronbach's

alpha and Spearman-Brown coefficients of the survey will be calculated to determine survey items' internal consistency and reliability. After data collection, frequencies and percentages will be computed for all independent variables and participants' reports on items assessing for postpartum depression.

Correlation analyses will then be computed to analyze whether multiple factors are correlated with participants' reported levels of postpartum depression. Multiple regression analyses will also be computed to potentially explore the predictive effects of participants' factors on their depression levels. The validation of such a proposed screening tool for the South Asian American population would allow clinicians and other care providers to have access to a screening tool that would best provide detection of postpartum depression in the South Asian American population.

Conclusion

It is vital that there be a continuation of research focused on symptoms of postpartum depression in South Asian American women. For clinicians working with the postpartum population, it is crucial to begin examining their patients outside of the Eurocentric lens of training and begin to incorporate a culturally competent and culturally informed perspective into their practice. Longitudinal studies focused on participants from early pregnancy and following them as they progress throughout their pregnancy, birthing process, postpartum recovery, and subsequent childbirths may provide important data to allow for a greater understanding of postpartum depression in this population as well as begin to create a framework for diagnosis, screening, and interventions. Once there has been headway made on the detection of postpartum depression, the development of treatment specifically tailored to the South Asian American population may also be important to explore.

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Appendix A:

Proposed Screening Tool for Postpartum Depression in the South Asian American

Population

What is your self-identified race/ethnicity?

Caucasian	African American	South Asian/Pacific Islander	Hispanic/Latinx	Native American/Indigenous
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What is your age?

Under 18	18-25	26-30	31-35	36-40	41 and above
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What is your marital status?

Single	Married	Divorced	Widowed	
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What is your education level?

Less than 12 years completed	High School Diploma/GED	AA Degree or similar	Bachelor's Degree	Master's Degree	Doctoral Degree
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Do you have a history of depression?

Yes	No			
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If married or engaged, was the relationship arranged?

Yes	No			
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What best describes your current living situation?

Live alone	Live with Spouse	Live with Spouse and Extended Family		
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In your postpartum recovery, have you been expected to stay solely in the home for more than two weeks?

Yes	No		
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Please rate the following statements:

If married or engaged, are you satisfied with the relationship with your partner?

5 Strongly Agree	4 Agree	3 Neither Or N/A	2 Disagree	1 Strongly Disagree
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I feel that I have strong support from my family emotionally.

5 Strongly Agree	4 Agree	3 Neither Or N/A	2 Disagree	1 Strongly Disagree
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I feel that I have strong support from my family financially.

5 Strongly Agree	4 Agree	3 Neither Or N/A	2 Disagree	1 Strongly Disagree
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I have body aches and/or headaches.

5 Strongly Agree	4 Agree	3 Neither Or N/A	2 Disagree	1 Strongly Disagree
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I am generally happy and can laugh about things.

5 Strongly Agree	4 Agree	3 Neither Or N/A	2 Disagree	1 Strongly Disagree
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I am happy about the gender of my child.

5 Strongly Agree	4 Agree	3 Neither Or N/A	2 Disagree	1 Strongly Disagree
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My family is happy about the gender of my child.

5 Strongly Agree	4 Agree	3 Neither Or N/A	2 Disagree	1 Strongly Disagree
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I keep my emotions to myself.

5 Strongly Agree	4 Agree	3 Neither Or N/A	2 Disagree	1 Strongly Disagree
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I sleep more or less than usual.

5 Strongly Agree	4 Agree	3 Neither Or N/A	2 Disagree	1 Strongly Disagree
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I feel guilty about my actions.

5 Strongly Agree	4 Agree	3 Neither Or N/A	2 Disagree	1 Strongly Disagree
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I am irritable.

5 Strongly Agree	4 Agree	3 Neither Or N/A	2 Disagree	1 Strongly Disagree
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I am anxious, nervous, or worried.

5 Strongly Agree	4 Agree	3 Neither Or N/A	2 Disagree	1 Strongly Disagree
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I have thoughts of harming myself or others.

5 Strongly Agree	4 Agree	3 Neither Or N/A	2 Disagree	1 Strongly Disagree
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I am sad or hopeless.

5 Strongly Agree	4 Agree	3 Neither Or N/A	2 Disagree	1 Strongly Disagree
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Appendix B:

PHQ-9

**PATIENT HEALTH QUESTIONNAIRE-9
(PHQ-9)**

Over the **last 2 weeks**, how often have you been bothered by any of the following problems? (Use “✓” to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

Appendix C:

EPDS

Edinburgh Postnatal Depression Scale (EPDS)

Name: _____ Address: _____

Your Date of Birth: _____ Baby's Date of Birth: _____

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

Here is an example, already completed.

I have felt happy:

- Yes, all the time
- Yes, most of the time This would mean: "I have felt happy most of the time" during the past week.
- No, not very often Please complete the other questions in the same way. No, not at all

In the past 7 days:

- | | |
|--|---|
| <p>1. I have been able to laugh and see the funny side of things</p> <p><input type="checkbox"/> As much as I always could</p> <p><input type="checkbox"/> Not quite so much now</p> <p><input type="checkbox"/> Definitely not so much now</p> <p><input type="checkbox"/> Not at all</p> <p>2. I have looked forward with enjoyment to things <input type="checkbox"/> As much as I ever did</p> <p><input type="checkbox"/> Rather less than I used to *7 I have been so unhappy that I have had difficulty sleeping</p> <p><input type="checkbox"/> Definitely less than I used to</p> <p><input type="checkbox"/> Hardly at all</p> <p>*3. I have blamed myself unnecessarily when things went wrong</p> <p><input type="checkbox"/> Yes, most of the time *8 I have felt sad or miserable</p> <p><input type="checkbox"/> Yes, some of the time</p> <p><input type="checkbox"/> Not very often</p> <p><input type="checkbox"/> No, never</p> <p>4. I have been anxious or worried for no good reason</p> <p><input type="checkbox"/> No, not at all</p> <p><input type="checkbox"/> Hardly ever</p> <p><input type="checkbox"/> Yes, sometimes</p> <p><input type="checkbox"/> Yes, very often</p> <p>*5 I have felt scared or panicky for no very good reason</p> <p><input type="checkbox"/> Yes, quite a lot</p> <p><input type="checkbox"/> Yes, sometimes</p> <p><input type="checkbox"/> No, not much</p> <p><input type="checkbox"/> No, not at all</p> | <p>*6. Things have been getting on top of me</p> <p><input type="checkbox"/> Yes, most of the time, I haven't been able to cope at all</p> <p><input type="checkbox"/> Yes, sometimes I haven't been coping as well as usual</p> <p><input type="checkbox"/> No. Most of the time, I have coped quite well</p> <p><input type="checkbox"/> No, I have been coping as well as ever</p> <p><input type="checkbox"/> Yes, most of the time</p> <p><input type="checkbox"/> Yes, sometimes <input type="checkbox"/> Not very often</p> <p><input type="checkbox"/> No, not at all</p> <p><input type="checkbox"/> Yes, most of the time</p> <p><input type="checkbox"/> Yes, quite often</p> <p><input type="checkbox"/> Not very often</p> <p><input type="checkbox"/> No, not at all</p> <p>*9 I have been so unhappy that I have been crying</p> <p><input type="checkbox"/> Yes, most of the time</p> <p><input type="checkbox"/> Yes, quite often</p> <p><input type="checkbox"/> Only occasionally</p> <p><input type="checkbox"/> No, never</p> <p>*10 The thought of harming myself has occurred to me</p> <p><input type="checkbox"/> Yes, quite often</p> <p><input type="checkbox"/> Sometimes</p> <p><input type="checkbox"/> Hardly ever</p> <p><input type="checkbox"/> Never</p> |
|--|---|

Administered/Reviewed by _____ Date _____

Source: Cox, J. L., Holden, J. M., & Sagovsky, R. (1987). Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry*, 150, 782-786.

²Source: Wisner, K. L. Parry, B. L., & Piontek, C. M. (2002). Postpartum Depression. *Northern England Journal of Medicine*, 347(3), 194-199.

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