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Psychosocial Aspects of Postpartum Depression in the United States

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The United States is a diverse country with many different cultural groups and modes of health care delivery, and high variability in population density and financial resources of its citizens. The complexity of these features combined with traditional risk factors for psychopathology such as biological and psychological predisposition, relationship discord, poor social support, and stressful life events undermines the generalizability of research findings that bear on causal pathways in postpartum depression (PPD), psychosocial consequences of PPD for mothers, children, and families, and effectiveness of preventive and treatment interventions. In the context of public health this diversity contributes to problems in generalizing findings of research that bear on access and barriers to care, screening, effective referrals, and ability to follow patients over time. Increasingly, primary care providers are screening for depression during pregnancy and the postpartum period. Barriers include reluctance to screen on the part of some providers, patient concerns about stigma, family response, intrusions by social service professionals, and later insurability. These barriers are being overcome with a variety of innovative interventions including brief counseling by non-mental professionals. The management of PPD will continue to evolve recognizing that in the context of health care one size does not fit all.

S1-4

A Country Case Study of Perinatal Mental Health and Poverty: Vietnam

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Most research about compromised perinatal mental health in women has been conducted in industrialised countries. Ethnographic studies concluded that culturally prescribed peripartum customs, which provided dedicated care, an honoured status, relief from normal responsibilities and social seclusion for mother and newborn were protective of mental health and that postpartum depression was rare in developing countries.

There is increasing evidence that contrary to this conclusion, mental health makes a significant contribution to maternal mortality and morbidity in poor countries. Vietnam is one of the poorest countries in the Asia - Pacific region: 14% – 16% of maternal mortality is attributable to suicide and depression after childbirth is two to three times more common than in women living in high income countries. Risk factors include lack of reproductive choice and unwanted pregnancy, crowded living conditions, critical coercion, intimidation or violence in intimate relationships, gender disparities in access to education and employment, unsettled infant behaviour and cultural preference for male children. Well educated women with secure salaried employment are at least risk and prevalence is highest among the poorest women. Ritualised postpartum care is not available to all is only protective if it includes practical contribution to household tasks and non-critical emotional support.