# The Relational and Cultural Dimensions of Postnatal Depression: A Comprehensive Literature Review

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Abstract: There are multiple theories about the causes of postpartum depression (PDD). Genetics, hormones, social environment, and other physical and psychological factors can change parents' condition. As a result, the global rate of postpartum depression in mothers went from single digits percent to over 50 percent. One of the main consequences of PDD is a high risk of suicide. However, there is only a vague idea of how postpartum depression manifests itself in different ways for both sexes. What causes these differences? What causes postpartum depression in partner and maternal, apart from biological factors? This review describes the development of Postnatal Depression in recent years, from being ignored to being gradually classified into maternal and paternal postpartum depression, and explains the relationship between them. The article also describes the factors that associated with PPD: marital satisfaction and cultural differences. For the last, the review describes the common problems in the current research on PPD: insufficient diversity of samples in Western studies and the limitations of the same treatment and intervention methods in different regions. The article's significance is to invoke other researchers to consider discrepancies in PDD caused by gender, and the differences in the effectiveness of interventions for PDD in different cultural contexts.



## 1 INTRODUCTION

In the early edition of the DSM, postpartum issues were first mentioned as postpartum psychosis and did not have a category. In the DSM-4, postpartum depression (PPD) was included in the mood disorder. Within the revision process, researchers once considered there was no need to extend the definition or other symptoms of postpartum depression, which could be seen as the diagnosis and importance of PPD developed lately (Segre and Davis, 2013). Currently, PDD is defined as a major depressive episode that occurs during pregnancy or within 4 weeks after delivery (Serati et al., 2016). As the academic research deepens, PDD is subdivided into maternal postpartum depression and paternal postpartum depression. Even during the whole trimester of the pregnancy, the partner could have the chance to have the symptoms of PDD (Rao et al., 2020). Therefore, the diagnostic criteria and assessments of PPD also evolve, from observation to detection of dopamine, endorphin, or serotonin, etc. The inducement factors of PPD also vary with deepened understanding from psychology, and sociology, which will be discussed in this literature review. This paper will focus on the interaction of maternal and paternal postpartum depression, marital relationships, and different influencing factors in cultural differences.

## 2 MATERNAL AND PATERNAL PDD: IMPLICATIONS AND INFLUENCES

### 2.1 Maternal and Paternal Postpartum Depression

PPD is not a single gender or single situation disorder, it affects the status of the whole family. Both sides of the partner could suffer from PPD, and even families who adopt new members could experience PPD (Adler et al., 2023). Many factors come together to influence these family members, including family mental illness history, social-economic status, education level, and marital status (Alshikh Ahmad et al., 2021; Ansari et al., 2021; Khadijeh et al., 2023 & Wang et al., 2021). To be more specific, studies consider that the PPD of one partner could predict the psychological state of the other partner, which is strongly correlated (Barooj-Kiakalaee et al., 2022 & Zheng et al., 2022). As a result, PPD also produces



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interactions and contagion effects among family members in the same environment.

Although there is positive strong correlation between couples' psychological states, symptoms are different between maternal PPD and paternal PPD. For maternal PPD, patients showed internal tendencies, such as crying, depression, loss of interest, and guilt (Johansson et al., 2020). For paternal PPD status, they display external tendencies like anger, stress, and risky behaviors. The differences on both sides commonly stem from different expectations given by social roles. In many developing countries, fathers could suffer from PPD because of income, quantity of family, and financial issues (Wedajo et al., 2023). In contrast, maternal PPD would be more easily affected by physical influences: family history of psychiatric and pregnancy complications, especially gestational diabetes (Agrawal et al., 2022). This difference in introversion and extroversion reflects societal expectations of different gender roles and highlights the important role of marriage context in PPD.

## 2.2 PPD and Marital Satisfaction

PPD impacts on the long-term from individual health to relationship stability of couples. Many studies clearly show a correlation between PPD and marital satisfaction. A good marital relationship can not only provide emotional support but also relieve the mental burden of postpartum partners and improve the family's sense of atmosphere.

Marital satisfaction is usually used to assess happiness and relationship stability between couples (Tavakol et al., 2017). Multiple researchers pointed out that the rise of PPD has a strong negative correlation with marital satisfaction (Odinka et al., 2018 & Khalajinia et al., 2020). Besides, higher marital satisfaction also predicts lower paternal postpartum depression, which indicates that partner relationships affect depression levels (Barooj-Kiakalaee et al., 2022). In other words, the degree of PPD fluctuates as the marital relationship dynamic.

The Stress-Buffering Model has proved that supporting could reduce the negative effects of stress, particularly when dealing with major life events (Wheaton, 1985). Thus, emotional support is also an important factor in PPD. Studies show that higher emotional and social support is correlated with a lower risk of PPD (Khadijeh et al., 2023; Khalajinia et al., 2020; Cho et al., 2022 & Leonard et al., 2020). Emotional support is not only shown as understanding and company for partners but also practical help and encouragement during postpartum. Thus, partners would receive psychological comfort during mood swings and practical help in the parenting process. In general, the positive family atmosphere and social support brought about by high marital satisfaction can effectively alleviate the symptoms of postpartum depression.

## 2.3 Cultural Factors

Due to differences in cross-cultural variables such as national development level, people's cultural level, economic status, and understanding of research scale, some PPD measurement methods cannot be fully used in extraction in different countries, resulting in different results (Halbreich and Karkun, 2006 & Wang et al., 2021). For instance, the relationship between daughter-in-law and mother-in-law has become an important predictor of PPD for some cultures. In China, it is normal for women to live with their husband's family during marriage. Different from the influence between husband and wife, a disharmonious relationship with the mother-in-law significantly increases the risk of PPD (Zheng et al., 2022). Because of the value differences between the old generation and the new generation with expectations, conflicts between mother-in-law and daughter-in-law became the effect factor for PPD. For cultural reasons, whether or not one gets along well with one's partner's parents is a factor that is rarely considered in many Western PDD studies.

Apart from the impact caused by the forced integration of two families, mothers in Asian households often hold a culturally specific role. They are expected to devote themselves to raising their children after giving birth. As societal role expectations evolve and life responsibilities increase, mothers' contributions to the family become more significant yet often invisible, frequently perceived as routine or taken for granted. Consequently, the lack of additional support or care from other family members during this period can result in feelings of isolation and helplessness, potentially contributing to PPD. Furthermore, cultural norms and expectations imposed by elders place additional stress on mothers, exacerbating their vulnerability to PPD. family members rarely offer additional support or care in response.

Under other cultural backgrounds, the risk factors of PPD are also different. Due to political instability and social conflict, the prevalence rate of PPD in some Arab countries remains high, and Palestine refugee women in Amman refugees are more likely to suffer from PPD than other women in Irbid in Jordan (Yoneda et al., 2021). The rise in PPD due to

particular political factors is associated with post-traumatic stress disorder (PTSD). It has been shown that postpartum is associated with PTSD. PP-PTSD is the strongest risk factor for PPD (Liu et al., 2021).

Overall, cultural, political, and social factors in different regions have led to complex regional differences in the risk of PPD. The existence of these cross-cultural factors means that prevention and intervention for PPD are needed on a global standard, and these differences need to be taken into account.

# 3 DISCUSSION

## 3.1 Discussion and Suggestion

PPD is a global disease that faces significant challenges in research since high-risk factors and prevalence could change across cultures. It creates a common challenge researchers face—the diversity of sample populations. With limited diversity, the research findings could be less valid. Differences in cultural backgrounds and geographic locations may be solved by self-report measures or questionnaires. Researchers could choose to translate the language into the local language and then translate the results back. It could solve most issues but also expose another problem: these scales were not initially designed for different background countries and language restrictions. Questions on the assessment tools may not be entirely suitable for local people. Besides, due to the diversity of cultural backgrounds, impact factors for PDD in one region may not be considered in another district; for instance, the relationship between mother-in-law and daughter-in-law resulting from cohabitation in a collectivist society is rarely considered in a relationship between couples living alone in an individualistic society. This evidence proved that assessment tools could not be sustained for various backgrounds.

Another limitation is the reliability of the self-reported data. Due to the influence of social desirability bias or misinterpretation, participants may hide or underestimate their symptoms. In more than half of the cases, potential patients refused to disclose their symptoms (Carlson, 2024). Disparities in understanding PDD are also evident. Cultural norms often lead patients to feel ashamed or dismissed, discouraging them from seeking help. These cultural influences exacerbates differences in awareness and prioritization of PDD across regions, contributing to an uneven recognition of the condition. Since the research sample size and regional development are the key predictors of PPD prevalence, addressing these limitations is essential (Wang et al., 2021). Improving cross-cultural validity in PDD research not only enhances the universality of findings but also guides the creation of more inclusive and culturally sensitive assessment tools.

## 3.2 Limitations of Treatment and Intervention Approaches

Traditional treatments include medications, such as antidepressants, intravenous injections, and psychotherapy. This standardized treatment method requires observation of the treatment effect based on individual preferences. Different countries and regions make this tendency more obvious. For example, in religious countries, patients may prefer to seek spiritual support from religious leaders or through religious rituals. Religious counseling and prayer may be more acceptable to these populations than standard medication or psychotherapy. In some other areas, traditional therapies (such as herbal remedies, acupuncture, etc.) are considered more natural and safer for the treatment of PPD and may be preferred. Although community and family support can partially replace formal therapy in areas where mental health services are scarce, they often lack professionalism, may not provide timely psychological intervention, and may even be misleading.

Many standardized psychotherapies, such as cognitive behavioral therapy (CBT), were originally developed within a specific Western cultural framework, which may limit their ability to identify culturally specific depressive symptoms. Applying these methods directly to patients from various cultural backgrounds risks reducing their effectiveness. These cultural mismatches highlight the need for treatment approaches beyond medication to be adapted with greater cultural sensitivity. Without sufficient flexibility, global standards for the diagnosis and treatment of PPD may fail to address diverse cultural needs, ultimately resulting in suboptimal treatment outcomes.

# 4 CONCLUSION

This review explores the evolving definition of postpartum depression (PPD) in recent editions of the DSM. Currently, PPD is categorized into two distinct forms: maternal postpartum depression and partner postpartum depression. Within a marital relationship, the mental health of partners strongly influences each other, exhibiting a significant positive correlation.

However, this correlation does not indicate that the two forms of PPD are identical. Maternal PPD is more likely to be influenced by internal factors, such as physical health, pregnancy-related complications, and a family history of psychiatric disorders. In contrast, paternal PPD is often shaped by external social role pressures.

In addition to marital dynamics, cultural factors significantly impact the manifestation of PPD. Cross-cultural differences introduce diverse variables, such as generational communication conflicts in cohabiting households and the instability caused by political and social unrest in certain regions. These cultural variations highlight the necessity for region-specific prevention and intervention strategies for PPD. Moreover, the assessment tools used for PPD diagnosis must account for cultural diversity, ensuring flexibility and effectiveness to achieve global standardization in testing.

Future research should focus on developing culturally sensitive assessment tools that consider the unique sociocultural factors influencing PPD in different regions. Longitudinal studies investigating the interplay between maternal and paternal PPD can provide deeper insights into their bidirectional influence. Additionally, research exploring the effectiveness of culturally tailored interventions and prevention programs will be essential in addressing the global diversity of PPD experiences.

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