

## Postpartum Depression in India: A Systematic Review and Prevalence

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### ABSTRACT

Postpartum depression (PPD) is a common complication of childbearing, and has increasingly been identified as a major public health problem. Untreated maternal depression has multiple potential negative effects on maternal-infant attachment and child development. Screening for depression in the perinatal period is feasible in multiple primary care or obstetric settings, and can help identify depressed mothers earlier. However, there are multiple barriers to appropriate treatment, including concerns about medication effects in breastfeeding infants. This article reviews the literature and recommendations for the treatment of postpartum depression, with a focus on the range of pharmacological, psychotherapeutic, and other non pharmacologic interventions.

**Keywords:** *Post-partum depression (PPD), Interpersonal Therapy, Cognitive behaviour therapy, Non-directive counselling*

Postpartum depression (PPD) is a type of depression that occurs after giving birth. It's more serious than the "baby blues" as it can interfere with a new mother's ability to function. It's important for new mothers and family members to be on the lookout for signs of postpartum depression. It's treatable and early intervention can be key to helping mothers feel better as quickly as possible.

Having a baby is a life-changing experience. Being a parent is exciting but can also be tiring and overwhelming. It's normal to have feelings of worry or doubt, especially if you are a first-time parent. However, if your feelings include extreme sadness or loneliness, severe mood swings and frequent crying spells, you may have postpartum depression.

Postpartum depression (PPD) is a type of depression that happens after someone gives birth. Postpartum depression doesn't just affect the birthing person. It can affect surrogates and adoptive parents, too. People experience hormonal, physical, emotional, financial and social changes after having a baby. These changes can cause symptoms of postpartum depression. If you have postpartum depression, know that you are not alone, it's not your fault and that help is out there. Your healthcare provider can manage your symptoms and help you feel better.

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### *Symptoms*

It's completely normal for new moms to feel tired, moody, or overwhelmed after giving birth. But when these symptoms interfere with a new mother's ability to function and care for their new child, it can be a sign of postpartum depression.

Symptoms of PPD vary from person to person. And they may fluctuate on a daily basis. In general, here are some symptoms that mothers with this condition experience:

- Crying and unexplained feelings of sadness
- Exhaustion yet inability to sleep
- Eating too little or too much
- Unexplained aches and pains
- Sudden changes in mood
- Feelings of disconnect with the new baby and guilt about not experiencing joy
- Difficulty making decisions
- Lack of interest in previously enjoyed activities
- Irritability, anxiety and anger that sometimes feel out of control
- Trouble concentrating, staying on task, and remembering things
- Feelings of hopelessness and helplessness
- Intrusive thoughts about self-harm or harming the baby

Symptoms typically appear within a few weeks of giving birth, but they may not surface until months later. They sometimes temporarily subside and then resurface.

The reported prevalence rate of postpartum depression (PPD) in India varies across different studies, ranging from 4% to 48.5%. Among mothers who gave birth either naturally or by cesarean section in a hospital setting, one study reported the lowest prevalence rate (4%).

### **REVIEW OF LITERATURE ON POSTPARTUM DEPRESSION**

**Dadhwal, Vatsla; Sagar, Rajesh; Bhattacharya, Debabani (2023)** investigated that Postpartum depression and anxiety (PPD/A) impact a woman's physical and psychological wellbeing. In the absence of corroboratory evidence from the community setting in India, the present study was undertaken to examine the prevalence, psychosocial correlates and risk factors for PPD/A in the rural community of India. This cross-sectional study included 680 women during the postpartum period from a rural community in northern India. Screening for PPD/A was done using Edinburg Postnatal Depression Scale and State and Trait Anxiety Inventory. Diagnostic assessment of screened-positive women was done using Mini-International Neuropsychiatric Interview (MINI). The psychosocial evaluation was done on parameters including women's social support, bonding with the child, functionality, parental stress, interpersonal violence and marital satisfaction. Results: The overall prevalence of PPD/A/both in community women was 5.6 per cent, with a specific prevalence of 2.2 per cent for PPD, 0.74 per cent for PPA and 2.8 per cent for both disorders. Comparative analysis indicated that women with PPD/A/both experienced significantly higher levels of parenting stress, poor lifestyle (prior two weeks), less support from their partner, parents-in-law and parents, less marital satisfaction, high intimate partner violence, poor bonding with infants and higher infant-focused anxiety. On multivariate logistic regression analysis, higher education, marital satisfaction, support from partners and in-laws were associated with reducing the risk of PPD/A/both. Interpretation & conclusions: Rural Indian women experience PPD/A/both which causes stress and impacts their functionality, bonding with the infant and relationship with their spouse and parents.

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Higher education, marital satisfaction and higher support from partners and in-laws reduce the risk of developing PPD/A/both.

**Deepali Kale (2019) Aim:** To assess the prevalence and risk factors associated with postpartum depression in India. **Material and methods:** Screening for postpartum depression was done with questionnaires distributed to our post-delivery women after informed consent. We used a 10-point questionnaire called “Edinburgh Postpartum Depression Scale” (EPDS), as it was easy to use and validate. We analyzed the data to identify risk factors and find the prevalence of postpartum depression in our patients over a 6-month period in a tertiary care hospital in central Mumbai which caters to low- and mid-income groups of patients. **Results:** We found the prevalence of post-delivery depression identified by EPDS questionnaires at day 3 and day 14 of delivery to be 4%. **Conclusion:** This shows the necessity to address mental health problems in our postpartum women. If 1 in 25 women has serious mental health issues post-delivery, it can affect the immediate postpartum recovery of mother and also have significant negative impact on maternal and fetal bonding. **Clinical significance:** The postpartum period which is immediately after delivery to 42 days later is an important and critical period for all mothers with physical, emotional, and psychological ramifications. Maternal mental health is an oft neglected area, and we need to provide more support after identification of such women.

**M. Sri Kiruba Nandini (2024) Background:** Postpartum depression (PPD) is defined as a depressive episode occurring during pregnancy or until 4-weeks post-childbirth. It is essential to diagnose postpartum depression since it can disrupt normal maternal and infant bonding and have a negative impact on both the short and long-term development of children. To determine the prevalence of postpartum depression and the associated risk factors in women delivering in a tertiary health care centre. **Methods:** A prospective observational study was conducted in a tertiary health care centre from January 2021 to June 2022 for a period of 18 months. Pregnant women were assessed using the Edinburgh postnatal depression scale (EPDS) at 2-3 days postpartum and at 6 weeks postpartum. The cut-off score for detecting major depression is a score greater than or equal to 13. **Results:** The study included 204 women, of which postpartum depression was present in 28 women. The prevalence of postpartum depression in this study group is 13.7%. Unplanned pregnancy, neonatal intensive care unit (NICU) admission of newborns, preterm delivery, lack of support from family, complications during pregnancy or birth, and delayed breastfeeding were significantly associated with postpartum depression. **Conclusions:** Psychological and emotional well-being should also be given priority in addition to the physical well-being of women. All women who are at high risk should be screened so that PPD can be detected earlier, and support should be extended in the form of counselling and treatment.

**S. Kalyani; Dr. C. N. Ram Gopal (2021)** Postpartum Depression is a major mental health concern affecting mothers and their infants. Various studies have been conducted across the Asian continent to estimate the prevalence and the risk factors associated with Postpartum Depression. The main objective of this current review is to determine the burden of postpartum depression in across the Asian continent to synthesize the important risk factors and to provide evidence-based data in order to prioritize maternal mental health and wellbeing. This review aims to assess the prevalence of Postpartum Depression in Asia and to ascertain risk factors for PPD in the period 2000-2020. **Methods** The literature search was done using electronic database like PubMed, Elsevier, PlusOne, Research Gate and Google Scholar. Search terms like postnatal depression, postpartum depression, risk factors, Asian

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Mothers were used to find relevant literature. Result Fifty-eight studies about postpartum depression were selected that were conducted across various Asian countries. The prevalence of postpartum depression varied widely due to the different cut off points and varying timelines used in different studies. 2 Studies in India (Gujarat and Karnataka) recorded the highest prevalence 48.50% and 46.90% respectively. 2 Studies conducted in Iran and Kuwait recorded the highest prevalence 40.40% and 45.90% respectively. 20 studies recorded a prevalence rate between 20%-40%. 6 studies estimated a prevalence less than 15%. The risk factors associated with PPD were classified under five different categories. They are 1. Socio-demographic variables, 2. Pregnancy and Birth Related Variables, 3. Infant Variables, 4. Family Relationships and Psychosocial factors. Conclusion The review highlights the burden of Postpartum depression and recommends frequent screening for maternal distress in the last trimester of pregnancy and in the post-partum period needs to be carried out by health care workers when mothers come for their postnatal review or at the immunization clinics.

### *Diagnosis*

- A physician or mental health professional can diagnose PPD. This diagnosis would be made after an interview and assessment.
- Many physicians routinely ask new mothers questions about whether they've had thoughts of hurting themselves or their babies and whether they're feeling down. This is part of the screening process for postpartum depression.
- Physicians may run some tests to rule out any health issues that may be contributing to symptoms. Thyroid conditions, for example, can cause depression.
- Once physical health issues have been ruled out, a diagnosis of postpartum depression might be made if the criteria are met.

### *Psychological and psychosocial treatments for postpartum depression*

Many mothers with postpartum depression are hesitant to take antidepressants due to concerns about infant exposure to medication through breast milk or concerns about potential side effects, and therefore often prefer psychological treatments. Although relatively few studies have systematically investigated non pharmacologic treatments for PPD, existing research supports the use of both psychological treatments (specifically interpersonal therapy, cognitive-behavioral therapy, and psychodynamic psychotherapy), as well as psychosocial interventions, such as nondirective counseling. A Cochrane meta-analysis of ten randomized controlled trials of psychosocial and psychological treatments for postpartum depression concluded that both psychosocial and psychological interventions are effective in decreasing depression and are viable treatment options for postpartum depression.

### *Interpersonal therapy (IPT)*

Interpersonal therapy (IPT) is a time-limited treatment for major depression based on addressing the connection between interpersonal problems and mood, which frames depression as a medical illness occurring in a social context. In IPT, the patient and clinician select one of four interpersonal problem areas (role transition, role dispute, grief, or interpersonal deficits) as a treatment focus. Over the course of the therapy (typically 12–20 weeks), strategies are pursued to assist patients in modifying problematic approaches to relationships and in building better social supports. IPT has been adapted to address problem areas relevant to postpartum depression such as the relationship between mother and infant,

mother and partner, and transition back to work. The fact that IPT is both time-limited and problem-focused fits well with the demands of the postpartum mother.

### ***Cognitive behavioral therapy (CBT)***

Cognitive behavioral therapy (CBT), a well-studied and effective treatment for major depression, is based on the premise that both perceptions and behaviors are intimately linked to mood. CBT focuses on helping depressed patients to modify distorted patterns of negative thinking and to make behavioral changes that enhance coping and reduce distress. There have been several trials assessing CBT alone or with other interventions for the treatment of PPD. In a randomized controlled psychotherapy-pharmacotherapy study, Appleby et al assigned 87 women with PPD to one of four conditions in a factorial design, varying based on treatment with either one or six sessions of CBT-based counseling, and treatment with fluoxetine or placebo. All four treatment groups had significant improvement in depressive symptoms. Women who received six CBT sessions versus one had greater decrease in depressive symptoms. Six sessions of CBT plus placebo pill was as effective as treatment with fluoxetine plus one session of CBT, but there was no added benefit in the group receiving 6 counseling sessions in combination with fluoxetine. It should be noted that the counseling sessions were delivered by briefly trained nonspecialists, and six sessions of CBT may not be a sufficient representation of a standard course of treatment. In another combination medication-CBT study, Misri et al randomized 35 women with PPD and comorbid anxiety either to paroxetine monotherapy or paroxetine and 12 weekly manualized CBT sessions with a psychologist. While both groups had significant decreases in depressive symptoms, there were no significant differences between the two groups in response rates, time to remission or dose of medication required, suggesting no measurable added benefit to the CBT treatment in combination with an SSRI over the 12-week study period, as consistent with Appleby's findings. In a randomized controlled trial looking at the effectiveness of CBT versus a control condition, Prendergast and Austin assigned 37 women with PPD either to six weekly one-hour home-based CBT sessions delivered by early childhood nurses (ECNs) or to "ideal standard care", which consisted of six weekly visits to ECNs in a clinic setting. Both groups with PPD had significant mood improvement, though there was a non-significant trend towards CBT being more effective at six-month follow-up. Among study limitations, ECNs administering CBT were not experienced therapists, though they received CBT training prior to the study and supervision throughout. Additionally, the control group more closely resembled a supportive psychotherapy rather than no-treatment. These studies support CBT interventions as helpful in the treatment of PPD, though they do not support an additional benefit to CBT in combination with pharmacotherapy and do not clarify a specific benefit of CBT for this population in comparison with other treatments. Two of these studies also suggest a role for the training of non mental-health professionals in this modality.

### ***Nondirective counseling***

As compared with IPT or CBT, psychosocial interventions are unstructured and nonmanualized, and include nondirective counseling and peer support. Nondirective counseling (also known as "person-centered") is based on the use of empathic and nonjudgmental listening and support. In the first notable study evaluating this intervention, Holden randomized 50 women with PPD to 8 weekly nondirective counseling sessions with a health visitor or routine primary care. A health visitor in the UK is a public health nurse who conducts home visits with pregnant and postpartum women. This study found that the rate of recovery from PPD for counseling (69%) was significantly greater than that of the control group (38%). In a similar study conducted in Sweden, Wickberg and Hwang

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randomized 31 women with PPD to receive six nondirective counseling sessions by child health clinic nurses or routine primary care. As in the Holden study, a significantly greater percentage of women in the treatment group (80%) had remission of depression than in the control group (25%). Study limitations include the removal of four study participants, two in each group, for more intensive mental health services due to illness severity.

### *Peer and partner support*

Epidemiologic data as well as some prospective studies have consistently identified inadequate social support as a risk factor for developing postpartum depression, thus raising the possibility of interventions aimed at increasing social supports as treatment options for perinatal depression. In a prospective cohort of pregnant Chinese women, Xie et al found that low support in both the prenatal and postnatal time period was associated with increased risk for postpartum depression, with the highest risk for postpartum women who had low objective or practical support. The broad applicability of this study is limited by the demographics of its cohort (limited to married Chinese primiparous women without significant obstetric complications, rates of Caesarean delivery over 70%) and the use of a rating scale most validated in the Chinese population. However, the finding suggests that tangible social support, such as assistance with caring for the newborn, may be particularly important and helpful in the treatment of postpartum depressed mothers.

## **CONCLUSION**

Postpartum depression is a major international public health problem that affects at least 1 in 8 mothers and their children in the year after childbirth worldwide. PPD may be more common and may be associated with more morbidity for both mothers and children in resource-poor countries. PPD has been associated with significant negative effects not only on depressed women themselves, but on the physical, cognitive and emotional development of their children. Early detection and intervention are important in mitigating these risks. There are validated and easily administered screening tools for PPD available in many languages, such as the Edinburgh Postnatal Depression Scale; most experts recommend screening women for PPD 4–6 weeks after delivery.

Psychological treatments for PPD are often the treatment of choice for women, as they are effective for the treatment of depressive symptoms and do not involve the risks of exposure to medications. Research supports both psychotherapy and other psychosocial interventions as effective in mitigating symptoms of PPD. Interpersonal psychotherapy, cognitive behavioral therapy, psychodynamic psychotherapy and other supportive interventions such as telephone-based peer support, counseling by a health visitor, and partner support have also shown benefit over wait-list or usual care controls.

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### **Conflict of Interest**

The author(s) declared no conflict of interest.

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