CME: Evaluation and Management of Postpartum depression in South Asian Women

Clinical Seminar

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Abstract

Postpartum depression is a worldwide phenomenon that affects about 10 to 20% of women within the first year of delivery. During the 12 months following delivery, about 85% of mothers experience a mood disturbance[2]. The importance of evaluating and managing postpartum depression is crucial as untreated postpartum depression can lead to a significant risk of morbidity for the child as well as the mother of the child[3]. Despite the remarkable prevalence of this diagnosis throughout cultures, the screening process for PPD is routinely missed, and the management is frequently incomplete for various reasons[3]. This phenomenon is exacerbated in minority populations such as South Asian women.

Learning Objectives

- Understand the prevalence of postpartum depression in the South Asian community.
- Describe the mental stigmas surrounding mental health diagnoses in new mothers in the South Asian community.
- Outline the necessity of diagnosing postpartum depression in the South Asian community and ways to manage this diagnosis effectively.

Introduction

Evaluating and managing postpartum depression in South Asian women is vital to maternal health care. Postpartum depression is characterized as having a major depressive episode within the first year of childbirth. The Diagnostics and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V), is the primary diagnostic tool used by healthcare providers to diagnose mental disorders, including postpartum depression (PPD). As the Diagnostic and Statistical Manual of Mental Disorders V outlines, the patient must fulfill specific criteria to be diagnosed with postpartum depression (PPD) within one year of delivery. This diagnosis encompasses various symptoms such as experiencing a depressed mood or loss of interest and pleasure in addition to four or more of the following symptoms for at least two weeks and is a change from previous functioning habits: hypersomnia or insomnia, fatigue, changes in appetite, changes in weight loss, psychomotor agitation or retardation, feelings of worthlessness or excessive guilt, decreased concentration, and suicidality. These symptoms cannot be attributed to

another medical condition or substance use, and they also need to be causing significant impairment or distress to the patient's life[1]. Postpartum depression has also been seen in mothers who have poor attachment and bonding with the newborn, feel a lack of adequacy, feel guilt for not being able to care for a child, and have excessive negative thoughts[2].

Despite the lack of importance that PPD is given at typical perinatal health office visits, PPD is prevalent with a risk of 10 to 15 percent[2]. Some recent meta-analyses suggest that 18.4% of mothers will experience an episode of major or minor depression during the perinatal period[4]. PPD can negatively impact a mother's care for herself before delivery and her parenting post-delivery[4]. Several symptoms of postpartum depression may not be as obvious or even overlooked in South Asian women. These symptoms include feeling sad or anxious, tearfulness, irritability, insomnia, hypersensitivity, and sometimes even elation[4].

Several consequences of untreated postpartum depression can lead to detrimental effects on both the mother and the baby, including the baby's cognitive and social development[6]. These include risky behaviors such as drinking alcohol and doing illicit drugs, including tobacco and other drugs of abuse[4]. Other consequences include effects on a milder scale, such as poor nutrition and a lack of self-hygiene. Due to the mother's depression affecting their physical condition, there is evidence that these patients also have higher rates of operative deliveries, increased nausea and vomiting throughout the pregnancy, more extended periods of maternal sick leave, increased occurrences of preterm delivery, and lower birth weights[4]. Another consequence of PPD on the baby includes an increased risk of being admitted to a neonatal intensive care unit after birth due to lower APGAR scores, a scoring system to rate a baby's health after delivery[4]. Overall, untreated depression in a new mother can also affect the baby's social development due to an increased risk of developing an insecure attachment style and a

delay in intellectual development[4]. The most significant and most damaging consequence of untreated postpartum depression in any population of women is suicide.

Cultural and social factors

Women from minority populations, such as South Asian women, are at a higher risk for developing postpartum depression due to cultural and social factors. Studies have shown a two-fold increase in PPD rates among South Asian women living in the States who were born abroad. According to the World Health Organization (WHO), approximately 13 percent of new mothers experience postpartum depression, with 22 percent being South Asian mothers. It is incredibly vital for healthcare providers to be aware of these factors when evaluating and treating postpartum depression in this population. Their quality of care is typically limited due to the lack of cultural competence in health care clinicians and due to language barriers[5]. In the United States, the guidelines used for evaluating and treating depression are not always the most practical or most effective when assessing and treating depression in the South Asian population. That is because Western concepts of depression do not always translate well to non-Western concepts of depression[4]. There is an enormous stigma surrounding mental health in South Asian culture, so many women hesitate to acknowledge their symptoms. In some South Asian cultures, only those who are severely mentally ill are typically the ones who are diagnosed and treated[4]. This phenomenon creates a stigma and, therefore, a barrier to care because women in these cultures are turned away from acknowledging their feelings. These women don't want to be seen as "severely ill" and therefore "looked down on" in their community. It could also be because they do not believe their symptoms are severe enough to discuss with a medical provider.

Every single mother should be screened for postpartum depression, whether or not they have risk factors that can predispose them. These include a personal or family history of

depression or other mood disorders, physical health conditions, other life stressors, unstable socioeconomic status, domestic abuse or violence, a history of "baby blues," and a poor support system[2]. Patients with these risk factors and those with nonviable deliveries must be screened. Those in the South Asian population have these risk factors along with a diverse array of other societal and cultural factors that influence their development and manifestation of PPD, including the impact of acculturation and migration. The medical provider must comprehend the woman's expectations during childbirth, pregnancy, and the perinatal period in the context of her cultural demands and expectations[4].

Low socioeconomic status is a significant risk factor for PPD, especially for South Asian women. Women in poverty are placed in a position where they have to endure unsafe neighborhoods, lack of suitable childcare, dependable and hazardous public transportation, and insecure employment or unemployment[4]. These factors increase the likelihood of developing PPD due to poverty, and these factors are exacerbated in a woman actively trying to assimilate into Western culture simultaneously. These factors are also heightened in women who do not have a stable and robust support system, which is shared with women who have moved to the States after getting married and are forced to leave their families behind in their home country. Another circumstance that South Asian women face is unreasonable expectations from their parents and in-laws. For all South Asian women with or without a newborn baby, there is an expectation to maintain the household. This expectation includes doing all the laundry, grocery shopping, meal preparation, cleaning around the house, and all the other chores required to maintain a household. These expectations are upheld even in new mothers and mothers with careers and full-time jobs. The burden on these women exponentially increases the risk of developing postpartum depression.

Another factor that affects South Asian immigrant women includes the fact that healthcare providers in America understand little to nothing about the experiences that these women have had, including their traditional norms from their country of origin[5]. Since most of these women have left their families behind, they now struggle with close family support, financial instability, social isolation, discriminatory experiences, and lack of confidence or understanding of mental health care practices in the United States[5]. This lack of understanding decreases the opportunity to connect with local health services[6]. In addition to having a newborn baby, these factors make the woman more vulnerable to developing postpartum depression[5]. Another significant factor frequently overlooked and not well-researched is the generational gap that divides the family from the new mother. South Asian parents are more likely to brush away the grievances of a new mother, using different prayers to fix the symptoms[7]. This can potentially jeopardize the new mothers' access to getting treatment[7].

The most apparent barrier to receiving postpartum depression care from clinicians is the language barrier. The research on healthcare quality due to language barriers with perinatal periods is scarce, possibly due to cost and various challenges[6]. Various studies have revealed that women with a different native language from their country of residence have increased anxiety with healthcare providers due to having to speak a second language they may not be proficient in, ultimately leading to hesitance in seeking healthcare[6]. A restricted understanding of medical terminologies has also been shown to correspond with feelings of isolation and reduced visits to clinicians[6]. With something as delicate and intimate as emotions, language proficiency is key in creating a good relationship with a health care provider and, ultimately, an appropriate treatment plan[6].

Since depression is not well understood in South Asian countries, it is hard for the South Asian diaspora to fully understand it even if they are experiencing it themselves. Women experiencing PPD may begin to withdraw from their social circles and isolate themselves. Many new mothers in the diaspora experiencing PPD have increased prevalences of self-isolation due to the lack of understanding from their partners, parents, family members, and in-laws[7]. One real-world example of PPD consuming a woman's life is the story of Nima Bhakta. An Indian-born and now California resident, she could not combat her depression following the birth of her first child. Accounts report that she became overly obsessed with her child, timing his urination and labeling every one of his items. Family witnesses revealed that she had even lied at doctor's visits stating she was "fine" and things were going "fine." She reluctantly started therapy and was prescribed medications but refused them, fearing it would harm her son while breastfeeding. She told family and friends she was ashamed of asking for treatment, especially because she had seen many new mothers cope alone. She felt she was failing herself, her friends and family, and society's expectations. Ultimately, this led to her suicide. South Asian culture is infamously silent when examining emotional and delicate topics. There is a heavy expectation that there should not be any struggle or depression during periods of time that should be celebrated. This phenomenon is harmful to all women experiencing depression.

Evaluation

The diagnosis of postpartum depression often gets missed. Since physical conditions - such as high blood pressure and gestational diabetes - are typically the focus of postpartum medical office visits, assessing new-onset mental conditions often gets overlooked[2]. There are various ways to diagnose postpartum depression, including scales such as Edinburgh Postnatal Depression Scale (EPDS), Postpartum Depression Screening Scale, and Beck Depression

Inventory. The Patient Health Questionnaire (PHQ-9) is considered the most reliable screening tool for depression. It has nine questions that assess the presence of symptoms as outlined in the DSM-V as well as the frequency of symptoms from the Likert scale from zero to three[7]. Assessment of postpartum depression should also include a safety screening for the mother and the baby[2]. Despite these widely used tools to screen for depression, South Asian women are less likely to report their symptoms to a provider due to the aforementioned barriers. With the growing South Asian diaspora, creating culturally appropriate and sensitive diagnostic and screening tools is critical to encourage more women to report their symptoms[7]. This paper emphasizes the lack of research and acknowledgment of diagnosing and treating PPD in South Asian women. In discussing this, it is crucial to recognize that the screening and diagnostic tools currently used in obstetric offices were created to diagnose mainly Caucasian women since most were constructed decades ago when the United States population was not as diverse.

One study was conducted to create a more culturally competent screening tool to diagnose and screen for PPD in South Asian women. Many factors were looked at while exploring this change. For example, there is an overlap in physical and somatic features associated with the perinatal period and depressive symptoms, such as sleep dysfunction, low libido, lack of energy, and appetite changes[7]. Since mild symptoms of PPD blend in with physiological adverse effects following childbirth, the diagnosis of PPD is often missed[7]. Additionally, the setting of the screening can determine the outcome. For example, a language barrier for the woman makes it necessary for another family member to be present to translate. In that case, the privacy of the interaction is removed and she may not feel comfortable expressing her genuine emotions. The patient's discomfort may also stem from the negative connotation of mental health being an ailment that warrants treatment and is a significant barrier to receiving the

appropriate care. In other words, the judgment by the community can prevent a new South Asian mother from seeking care.

Currently, the studies done in the United States on new mothers and postpartum depression focus on middle-class Caucasian women. This raises the question, "Is there a disparity in the research exploring postpartum depression from a cross-cultural viewpoint?[7]" Although childbirth is a global phenomenon, women across cultures experience it through different cultural frameworks[7]. In fact, there are some cultures where the concept of postpartum depression does not even exist[7].

Treatment and Management

Preventative measures should be the first steps taken throughout the perinatal period. However, the concept of preventive measures for mental health is not a concept that is widely discussed within the South Asian community[7]. The treatment for postpartum depression includes a combination of individual or group psychotherapy, medications, and a network of support from family and friends[7]. According to research, monotherapy antidepressant medication and cognitive behavioral therapy combined have the most beneficial outcomes in treating postpartum depression. Breastfeeding mothers should monitor their child's behavior before starting the medication[7]. They should also be started on the lowest dose of medication to begin with. There are some potential adverse effects of pharmacological treatment in breastfeeding mothers, with a concern about the risk of transmission from the mother to the baby via breast milk[7]. Studies have shown that the safest medications for breastfeeding mothers include venlafaxine, sertraline, fluvoxamine, nefazodone, and bupropion[7]. It is also imperative that the family, friends, and in-laws are informed about the treatment and can contribute with their support.

Conclusion

Healthcare professionals must be culturally competent, especially when assessing for PPD in minority women. In some instances, South Asian women may present and manifest symptoms of PPD differently than Caucasian women and from what is outlined in the DSM-V. Cultural and societal factors, such as social isolation, lack of support from a physically close social network, and societal expectations, may contribute to the development of PPD in South Asian Women. A meta-analysis study shows that many research studies do not reveal the demographics of their participants, potentially signifying that many healthcare providers use data and evidence from research studies that do not include the full breadth of diversity they treat[8]. Specific regulations should confirm that studies accurately report demographics to ensure that the data collected can provide external validity[8]. Uniquely understanding the risk factors that South Asian women face will make it easier for healthcare providers of any background to evaluate and treat PPD in South Asian women[9]. The most significant risk factor that mothers face includes the burden and pressures put on them by their community and familial social circles[10].

Clinicians should take the time to educate and provide more information regarding depression to increase the chance that these women will reach out for help and talk to their providers about any symptoms they may be having[4]. Unfortunately, the diagnosis of PPD transcends all cultures. As a medical community, we need to eradicate the stigma behind depression and advocate for the needs of new mothers. This, partnered with more accurate clinical studies, will promote widespread knowledge in typically marginalized communities and help facilitate more vulnerable and open conversations in the hope of reducing untreated postpartum depression in south asian communities.

- What are the diagnostic criteria outlined in the Diagnostics and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V) for postpartum depression?
- What is the stigma surrounding mental health disorders in the South Asian community, specifically with women?
- Why is evaluating postpartum depression difficult in the South Asian population?

Needs Assessment

A CME article for the topic of evaluating and managing postpartum depression in South Asian women is needed because it highlights gaps in evidence-based practice surrounding this diagnosis. The prevalence of postpartum depression in South Asian women inside and outside of Asia is high, yet many healthcare providers lack the knowledge and cultural competency to adequately diagnose and treat this mental health illness. Thus, this largely goes under-treated and under-diagnosed. Acknowledging these gaps will allow women's health and mental health care practitioners to develop effective evidence based interventions and implement a culturally attuned approach to treatment. Ultimately, by shedding light on these disparities, more women's health and health care practitioners will be able to effectively diagnose and treat postpartum depression in South Asian women.

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