



Postpartum depression: Addressing misinformation and harmful attitudes

South Africa (SA) has a high prevalence of postpartum depression (PPD),^[1,2] with studies reporting 30 - 35% of women diagnosed with major depressive disorder in the postpartum period.^[1] A study in Khayelitsha, Cape Town, found a 34.7% prevalence, substantially higher than some international figures.^[3] In addition, SA has a large population of women living with HIV who are at even greater risk of PPD.^[4] PPD is accompanied by substantial morbidity and is the second most common cause of maternal death, contributing to 20% of all such deaths.^[5] Suicide, as the most severe effect of poor mental health, is a leading contributor to maternal mortality worldwide.^[6] PPD has been described as 'A thief that steals motherhood', with potential consequences including diminished mother-to-child bonding, impaired child growth and development, impaired child cognitive development and underdevelopment.^[7, 8] Mothers with PPD are at increased risk of poor health and socioeconomic outcomes, with adverse long-term implications.^[7]

Psychosocial factors are important drivers of PPD.^[1,3,4] These include a history of maternal depression, the infant being unwanted, father's negative attitude, mother's younger age, single marital status, financial insecurity, social isolation, lack of social support, lack of partner support, unplanned pregnancy, and experiencing emotional and physical intimate partner violence.^[4,6,9] In addition, more than 30 years of research in PPD also supports biological drivers of the condition.^[9,10] The strongest biological risk factors for postpartum depression are hypothalamic pituitary adrenal dysregulation and inflammatory processes.^[11] Preliminary investigations have also identified several hormones, common neurosteroids and biochemicals as promising biomarkers for predicting PPD.^[12,13]

Moderate to severe PPD is potentially a high-risk mental health condition. Feelings of hopelessness in severe cases can threaten life and lead to suicide.^[7] In addition, issues such as fear of harming the baby and weak attachment to the baby, and in extreme cases even infanticide, have been reported.^[7] Biological and social factors create intertwined causal pathways, and both biological and psychosocial treatments are indicated.^[14] The NICE guidelines (Antenatal and postnatal mental health: Clinical management and service guidance), updated in 2020,^[15] and a recent appraisal of systematic reviews on interventions for postpartum depression,^[16] suggest that psychotropic medication must be considered as part of the treatment regimen. Local clinical experience suggests that a multidisciplinary team approach results in better and safer outcomes for patients; this may include obstetrics and gynaecology, neonatology, psychiatry, psychology and social work. Psychosocial interventions are important, but the risks of not treating moderate to severe PPD with psychotropic medications may include harm to the mother through poor self-care, lack of obstetric follow-up care or self-harm, and harm to the neonate ranging from neglect (with long-term developmental implications) to infanticide. In very severe cases, urgent admission to a psychiatric inpatient treatment facility, including the prescription of both antidepressants and antipsychotics, is warranted.

Recently, a clinical psychologist and professor at a leading SA university was interviewed on a popular radio station. The context was recent Food and Drug Administration approval of a new drug

to treat PPD. The interview contained misinformation and attitudes that we believe may be harmful to pregnant and postpartum women and their families. She asserted that PPD is not a biological condition, stating, incorrectly, that 'all the research indicates that postpartum depression is not a biological condition, it doesn't have to do with ... hormones for instance'. She characterised PPD as a social problem only, and said that she is wary of the use of drugs for PPD. According to her, women with PPD are merely not supported, lonely, or angry. She asserted that PPD is diagnosed only 3 months after birth when hormones have already been restored, directly contradicting the *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition (DSM-V) criteria.^[15,17] These assertions are incorrect, not based on science or prominent evidence-based treatment guidelines. The interviewee also said:

'Depression is one word we can use, but I will use lonely, angry, sad, anxious, traumatised after birth often, after childbirth, so it is more complicated you know and we can medicate, we can kind of *klap* it away, you know, like say okay let's just give all of these women pills, but there's something that we have to address here, that's bigger than an individual's problem, of one woman.'

These comments are not only clinically harmful. They also erode trust in the healthcare team. Mental illness postpartum carries both external and internalised stigma, making taking medication, even when it is urgently needed, a difficult issue to navigate for both the woman suffering from the condition and the clinician treating it.^[18] Comments made in the interview such as 'I am very wary of drugs for postpartum depression' and 'I don't think the answer is medication' could convince women to decline or stop taking these treatments. In our practice, the multidisciplinary team understands that there are both biological and social drivers for PPD and therefore that both psychosocial and medical interventions for moderate to severe PPD are indicated. The inaccurate suggestion that doctors '*klap*' women on pills and ignore psychosocial drivers of PPD undermines our professionalism and does very little to grow important relationships between medicine and psychology. We have excellent relationships with our psychology colleagues, who share and shape our medical and psychosocial approach.

Having a biological driver of a condition does not discount the social and psychological drivers of that condition, as even a passing understanding of epidemiology shows, even when considering medical conditions such as hypertension or cancer. Healthcare personnel are trained to hold multiple drivers in mind simultaneously. We use this understanding to develop the best management plans within the context of the resources available.

Throughout COVID-19, influential people undermined the best efforts of public health practitioners to share science and keep people safe. Without a good understanding of the nature and evolution of scientific knowledge over time, lay people are at risk of discounting science entirely and putting their health at risk. In order for us to restore lay people's trust in science, clinicians must interact responsibly with media. We should agree to do interviews only if the subject matter is in our area of expertise, and do our best to share evidence-based information only. Controversial opinions not based on science may be submitted to peer-reviewed journals

where there is specialist oversight. In addition, the media should act responsibly with healthcare professionals. While the pressure to find an interviewee at short notice to comment on news is real, that pressure should not come at the cost of compromising the delivery of expert knowledge to the public.

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- Hung KJ, Tomlinson M, le Roux IM, Dewing S, Chopra M, Tsai AC. Community-based prenatal screening for postpartum depression in a South African township. *Int J Gynecol Obstet* 2014;126(1):74-77. <https://doi.org/10.1016/j.ijgo.2014.01.011>
- Atuhaire C, Brennaman L, Cumber SN, Rukundo GZ, Nambozi G. The magnitude of postpartum depression among mothers in Africa: A literature review. *Pan Afr Med J* 2020;37:89. <https://doi.org/10.11604/pamj.2020.37.89.23572>
- Tomlinson M, Swartz L, Cooper PJ, Molteno C. Social factors and postpartum depression in Khayelitsha, Cape Town. *S Afr J Psychol* 2004;34(3):409-420. <https://doi.org/10.1177/008124630403400305>
- Peltzer K, Rodriguez VJ, Lee TK, Jones D. Prevalence of prenatal and postpartum depression and associated factors among HIV-infected women in public primary care in rural South Africa: A longitudinal study. *AIDS Care* 2018;30(11):1372-1379. <https://doi.org/10.1080/09540121.2018.1455960>

- Jacques N, de Mola CL, Joseph G, Mesenburg MA, da Silveira MF. Prenatal and postnatal maternal depression and infant hospitalization and mortality in the first year of life: A systematic review and meta-analysis. *J Affect Disord* 2019;243:201-208. <https://doi.org/10.1016/j.jad.2018.09.055>
- Storm F, Agampodi S, Eddleston M, Sorensen JB, Konradsen F, Rheinlander T. Indirect causes of maternal death. *Lancet Glob Health* 2014;2(10):e566. [https://doi.org/10.1016/s2214-109x\(14\)70297-9](https://doi.org/10.1016/s2214-109x(14)70297-9)
- Slomian J, Honvo G, Emonts P, Reginster J-Y, Bruyere O. Consequences of maternal postpartum depression: A systematic review of maternal and infant outcomes. *Womens Health (Lond)* 2019;15:1745506519844044. <https://doi.org/10.1177/1745506519844044>
- Govender D, Naidoo S, Taylor M. Antenatal and postpartum depression: Prevalence and associated risk factors among adolescents in KwaZulu-Natal, South Africa. *Depress Res Treat* 2020;2020:5364521. <https://doi.org/10.1155/2020/5364521>
- Ghaedrahmati M, Kazemi A, Kheirabadi G, Ebrahimi A, Bahrani M. Postpartum depression risk factors: A narrative review. *J Educ Health Promot* 2017;6:60. https://doi.org/10.4103/jehp.jehp_9_16
- Rathi A, Khapre S, Chavada J, et al. Postpartum depression and its biological biomarkers. *Cureus* 2022;14(11):e31124. <https://doi.org/10.7759/cureus.31124>
- Yim IS, Stapleton LRT, Guardino CM, Hahn-Holbrook J, Schetter CD. Biological and psychosocial predictors of postpartum depression: Systematic review and call for integration. *Annu Rev Clin Psychol* 2015;11(1):99-137. <https://doi.org/10.1146/annurev-clinpsy-101414-020426>
- Yu Y, Liang H-F, Chen J, et al. Postpartum depression: Current status and possible identification using biomarkers. *Front Psychiatry* 2021;12:620371. <https://doi.org/10.3389/fpsy.2021.620371>
- Quintivano J, Putnam KT, Sullivan PE, Meltzer-Brody S. The international Postpartum depression: Action towards Causes and Treatment (PACT) consortium. *Int Rev Psychiatry* 2019;31(3):229-236. <https://doi.org/10.1080/09540261.2018.1551191>
- Stewart DE, Simone V. Postpartum depression. *N Engl J Med* 2016;375(22):2177-2186. <https://doi.org/10.1056/nejmcp1607649>
- National Institute for Health and Care Excellence (NICE). Antenatal and postnatal mental health: Clinical management and service guidelines. Last updated 11 February 2020. <https://www.nice.org.uk/guidance/cg192> (accessed 23 August 2023).
- Chow R, Huang E, Li A, et al. Appraisal of systematic reviews on interventions for postpartum depression: Systematic review. *BMC Pregnancy Childbirth* 2021;21(1):18. <https://doi.org/10.1186/s12884-020-03496-5>
- American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR). Washington, DC: APA, 2022. <https://doi.org/10.1176/appi.books.9780890425787> (accessed 23 August 2023).
- Dennis C, Chung-Lee L. Postpartum depression help-seeking barriers and maternal treatment preferences: A qualitative systematic review. *Birth* 2006;33(4):323-331. <https://doi.org/10.1111/j.1523-536x.2006.00130.x>

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