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Review

Postpartum Depression in Saudi Arabia: A Narrative Review of Prevalence, Knowledge, Risk Factors, and Quality-of-Life Impact

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Abstract

Background and Objective: Postpartum depression (PPD) is a prevalent psychiatric condition with significant consequences for maternal, paternal, and infant well-being. In Saudi Arabia, some reported prevalence rates exceed global averages. This narrative review synthesizes the current literature on the prevalence, risk factors, awareness, and quality-of-life impact of PPD in Saudi Arabia. The aim is to identify methodological inconsistencies, highlight the risk factors, and guide future research and policy. Method: A comprehensive literature search was conducted using PubMed, Scopus, Web of Science, and Google Scholar. Studies published between 2010 and May 2025 were included if they addressed PPD in Saudi Arabia and the inclusion criteria were met. 38 articles were selected for full-text analysis and incorporation in the study. Results: PPD prevalence in Saudi Arabia ranges from 5.1% to 75.7%, with regional variation attributed to inconsistent methodologies, screening instruments, and diagnostic cutoffs. Risk factors encompass psychiatric history, marital conflict, limited social support, low income, cesarean delivery, unplanned pregnancy, anemia, and sleep disturbance. Nutritional and newborn-related predictors were inconsistently reported. Awareness among the public and healthcare professionals remains limited, and paternal postpartum depression is underrecognized. PPD exerts a pronounced negative impact on maternal quality of life, spanning physical, psychological, and social domains. Conclusions: PPD poses a substantial public health burden in Saudi Arabia. Routine screening with validated tools, integrated perinatal mental health services, and targeted public education campaigns may help address diagnostic delays and stigma. Future studies must adopt standardized diagnostic criteria and longitudinal designs to generate nationally representative prevalence estimates and evaluate preventive strategies.

Keywords: postpartum depression; Saudi Arabia; prevalence; risk factors; quality of life; knowledge; attitude; paternal postpartum depression

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1. Introduction

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition categorizes postpartum depression (PPD) as Major Depressive Disorder with Peripartum Onset, designating this specifier for cases where symptom onset occurs during pregnancy or within four weeks after delivery [1]. Although the manual constrains this window to 4 weeks, the designation "postpartum depression" is routinely applied in both clinical practice and

empirical inquiry to denote depressive syndromes manifesting any time during the first twelve months following delivery, consistent with the time frames used in epidemiologic syntheses [2,3]. Clinically, PPD is delineated by a durable set of emotional, cognitive, and somatic signs persisting for a minimum duration of fourteen days. Diagnostic criteria include a pervasively low mood, anhedonia in nearly all domains, notable alterations in appetite or body weight, disturbances in sleep, either psychomotor agitation or retardation, pervasive fatigue, disproportionate guilt or feelings of worthlessness, compromised ability to think or concentrate, and recurrent suicidal ideation. Of these, the presence of at least five, with either low mood or anhedonia as a mandatory feature, is requisite for diagnosis. Furthermore, the symptoms must inflict clinically significant distress or functional impairment and may not be ascribed to the direct physiological sequelae of a substance or another medical illness [1].

PPD screening typically employs the Edinburgh Postnatal Depression Scale (EPDS), a self-report instrument created to detect women susceptible to PPD. The scale comprises 10 items, each rated on a four-point Likert scale (0–3), yielding total scores that range between 0 and 30. The EPDS deliberately emphasizes cognitive and affective indicators of depression while omitting somatic complaints such as altered sleep patterns and appetite that frequently coincide with the postpartum period [4]. A score of 13 or above is generally accepted as indicative of clinically significant depression in research contexts, although cut-offs vary across studies, which contributes to between-study differences in reported prevalence [2,3].

PPD is often regarded as a significant public health issue because about 17% of new mothers worldwide experience this condition, though figures vary according to regional economic and cultural norms [3,4]. Wealthier nations generally report prevalence figures between 10 and 15 percent, yet in many low- and middle-income settings, especially across the Middle East, estimates frequently soar past 25 percent [5,6]. Evidence also shows that new fathers can experience PPD, with reported rates ranging from 4 to 25 percent, depending on the study design and local context [7,8]. Even so, signs of paternal postpartum depression (PPPD) are often overlooked and rarely discussed in clinics.

Despite high birth rates in Saudi Arabia, review articles on PPD are notably scarce and often lack national representativeness. Furthermore, local cultural expectations about family roles and attitudes toward mental illness shape both the expression of PPD and the way care is sought, highlighting the urgent need for context-specific data to guide clinical policy and research in the Kingdom.

2. Materials and Methods

This narrative review utilized PubMed, Scopus, Web of Science, and Google Scholar to bring together the existing literature on postpartum depression specifically in Saudi Arabia. The search was narrowed to articles published in English between 2010 and May 2025.

The search strategy combined the core terms “postpartum depression” with “Saudi Arabia” with at least one of the following keywords: “prevalence,” “risk factors,” “predisposing factors,” “associated factors,” “impact,” “quality of life,” “QoL,” “knowledge,” “attitude,” “screening,” or “prevention.” Boolean operators (AND, OR) structured the query so that results would be both relevant and manageable.

Initially, 57 articles whose titles appeared on-topic were identified. The team then read the abstracts to check whether each study met set inclusion criteria and focused on postpartum depression in the Saudi population. 19 papers were dropped at this stage: 10 of them pulled data from other countries, 6 addressed unrelated topics, 2 were duplicates, and 1 was excluded because the full text could not be obtained despite reaching out to the corresponding author.

Ultimately, the review incorporated and carefully examined 38 full-text articles, focusing on themes such as prevalence, risk factors, awareness, and the condition's impact on quality of life.

3. Evidence Synthesis

3.1. Prevalence

The prevalence of PPD across Saudi Arabia shows striking regional variability, with estimates ranging from 5.1% to 75.7%. This variation likely reflects differences in study methods, timing of assessment, sample characteristics, and the EPDS cutoff thresholds. In the Eastern Province, reported prevalence rates were 32% in Alhasa (EPDS $\geq$ 10) [9], 17.8% in Dammam assessed at 2–6 months postpartum (EPDS $\geq$ 13) [10], 16.7% in a small hospital-based sample from Al-Khobar and Dammam (EPDS $\geq$ 13) [11], and 31.7% in Madinah (EPDS $\geq$ 13) [12]. In Riyadh, estimates varied widely, with prevalence of 13.7% based on psychiatric confirmation in a large cohort (EPDS $\geq$ 13) [13], but higher rates of 38.5% and 50.3% reported in smaller hospital-based studies (EPDS $\geq$ 13), (EPDS $\geq$ 9) [14,15], likely reflecting methodological differences such as lower EPDS cutoffs and selection biases. In the Western Region, PPD prevalence was 20.9% in Jeddah (EPDS $\geq$ 13) [16], and another study documented a decline from 15.1% on day one postpartum to 5.1% at six weeks (EPDS $\geq$ 13) [17]. In the southern region, Najran showed a notably high prevalence of 66.7% (EPDS $\geq$ 14) [18], which may reflect the cross-sectional, self-report design without diagnostic confirmation used in the study. Notably, Jazan had the highest reported prevalence of 75.7%, with nearly one in five mothers expressing suicidal ideation, highlighting a critical burden (EPDS $\geq$ 10) [19]. In Qassim, a prevalence of 13.7% was observed, closer to global estimates (EPDS $\geq$ 14) [20].

3.2. Knowledge and Attitude

Grasping the full picture of PPD as a public health issue remains difficult, chiefly because mental health knowledge and the way society views it still vary greatly across Saudi Arabia. A number of recent investigations have tackled these gaps, revealing that different groups within the country hold very different levels of awareness and opinion.

In a nationwide survey that used an Arabic version of the Postpartum Depression Literacy Scale, overall awareness was rated as moderate, yet three key areas were still poorly understood. Of 2336 participants, scores were strongest for self-care tips and known risk factors, but belief in the value of professional help and willingness to spot PPD symptoms ranked at the bottom. Men, people with less formal schooling, and those living in central or northern regions earned notably lower literacy points. Those who had previously met women affected by PPD showed greater knowledge and tended to seek further information. Still, only 27.9 percent reported such direct experience [21].

Further evidence from a recent cross-sectional survey conducted among 226 women visiting obstetric clinics in Jeddah indicated that 53.5% demonstrated good overall knowledge of PPD. Higher awareness was linked to holding a postgraduate degree, working in the healthcare field, and not currently being pregnant. Nevertheless, almost half (46.5%) were either uninformed or misinformed about critical risk factors, including a family history of mood disorders and advancing maternal age. In terms of symptom recognition, most participants were able to identify sadness (89.4%), extreme fatigue (80.5%) and disrupted sleep (76.1%), with fewer acknowledging cognitive and behavioral signs like irritability (56.2%) or suicidal thoughts (64.2) [22].

Negative attitudes toward help-seeking continue to pose a barrier. In the same investigation only 47.3% of respondents held a broadly positive attitude toward PPD. Although a large majority rejected overtly stigmatizing remarks—such as the idea that an affected

woman is unfit to parent or should be isolated—a significant minority still endorsed negative stereotypes. Specifically, 16.8% admitted feeling ashamed of their symptoms or behavior, 28.8% questioned a mothers ability to care for her infant, and 36.3% believed PPD would render her incapable of sound decision-making Such internalized stigma, shaped by cultural norms, can deter many women from seeking the professional support that would alleviate suffering [22].

Among healthcare providers, marked gaps in their understanding of PPD was noted. In a survey of 324 perinatal nurses and midwives, only 63% answered basic questions accurately, with many missing key signs, risk factors, and the formal diagnostic criteria. Familiarity with established screening tools was especially poor; under one-third knew the EPDS or the Postpartum Depression Screening Scale. More than 70% undervalued the severity of suicidal thoughts and lacked knowledge about proven treatments, such as medication and cognitive behavioral therapy. Importantly, self-reported confidence in counseling mothers tracked closely with knowledge, yet only 13.3 percent of nurses and 22.4 percent of midwives rated their own confidence as high [23].

The combined evidence reveals deep-rooted educational and attitudinal barriers in both public and clinical spheres. Closing these gaps is crucial for lowering PPDs toll and improving mothers' mental health. Community awareness campaigns, mandatory mental health training for perinatal staff, and culturally relevant screening programs could together bridge the knowledge-to-care divide in Saudi Arabia.

3.3. Risk Factors

3.3.1. Psychiatric Factors

Psychiatric risk consistently underlies PPD for both mothers and fathers. A cross-sectional study from Al Kharj revealed that women with a past depression diagnosis faced almost four times higher odds of developing PPD [24]. Corresponding findings emerged in Dammam and Abha, where lifetime depressive episodes and a family mental illness history independently elevated EPDS scores [10,25]. A separate investigation in Riyadh likewise identified any prior mental disorder as a notable predictor of postpartum depressive signs [13].

PPPD has also been explored. A city-wide survey from Jeddah showed 27.3% of fathers screened positive for PPPD. Within that group, low self-esteem, disturbed sleep, and pervasive depressive feelings stood out as strong psychiatric markers [26]. Furthermore, fathers who perceived higher psychological stress during either the pregnancy or the early postnatal period were more prone to depressive symptoms [26].

Gathered investigations underscore that antecedent depression, familial psychiatric history, and elevated prenatal–postnatal distress are major contributors to PPD across Saudi Arabia.

3.3.2. Socio-Demographic Factors

Multiple studies across Saudi Arabia have identified socioeconomic disadvantage as a key contributor to PPD, with low household income consistently associated with increased depressive symptoms among postpartum women [24]. Lack of social or family support was also a frequent predictor, emphasizing the protective role of supportive interpersonal relationships during the postpartum period [19]. Unemployment or insecure employment status was significantly related to higher risk of PPD in several studies, reflecting the psychological burden of financial instability [27]. Younger maternal age, particularly below 26 years, was associated with elevated risk of PPD, suggesting that limited maternal experience or resources may heighten vulnerability [18]. Family conflicts or marital problems were also important contributors to PPD risk [28]. Although less common, one study found

that having more than three daughters increased the risk of antenatal depression, reflecting cultural influences on gender preference [29], and another identified exposure to intimate partner violence as a strong predictor of postpartum depressive symptoms [28]. Conversely, maternal education level, employment status, marital status, and infant gender were consistently reported as unrelated to PPD in many studies, suggesting these demographic factors may not be reliable predictors in this context [30,31]. Similarly, nationality and housing status were assessed but did not show consistent associations with postpartum depressive symptoms [32].

These findings underscore that socioeconomic disadvantage, young maternal age, unemployment, and lack of social support are consistent and significant risk factors for PPD among Saudi mothers, while variables such as maternal education, marital status, infant gender, and nationality appear unrelated to PPD risk in this context.

3.3.3. Obstetric Factors

The reviewed studies demonstrates that several obstetric factors significantly influence the risk of PPD. Cesarean delivery, particularly emergency cesarean section, was among the most consistently significant predictors of PPD. Multiple studies found higher depression rates in women who underwent cesarean compared to vaginal delivery, suggesting surgical birth may elevate psychological distress postpartum [24,33,34]. Birth difficulty, measured by mothers' subjective experience of labor, was also a strong predictor; women reporting very difficult labors had substantially higher rates of depressive symptoms than those describing easier births [35]. Unplanned or unwanted pregnancies emerged as another key obstetric factor, with several studies reporting that mothers experiencing unplanned pregnancies had significantly higher PPD scores than those with planned pregnancies [19,36]. Pregnancy complications, including conditions such as gestational diabetes, preeclampsia, or hemorrhage, were also associated with increased depressive symptoms, highlighting the impact of maternal medical events on postpartum mental health [37].

Parity showed mixed but important associations: while some studies reported that primiparous women were more likely to develop PPD, others indicated that higher parity increased risk, likely reflecting differences in social support and maternal role expectations [11,33]. Other factors, such as multiple pregnancies (e.g., twins) and higher birth order, were identified as significant in individual studies, with increased caregiving demands potentially exacerbating depressive [11,29]. Additionally, low birth weight was a significant predictor of PPD, possibly reflecting psychological stress linked to child health [9].

Conversely, many obstetric factors were consistently found not to be significantly associated with PPD. These included breastfeeding status, gestational age at birth, mode of delivery in several studies (despite significance in others), infant's sex in most cohorts, number of fetuses, and use of epidural analgesia during labor [24,34,37,38].

We find that cesarean delivery, unplanned pregnancy, and pregnancy or delivery complications consistently emerged as significant obstetric predictors of PPD, suggesting that maternal medical experiences and birth outcomes play crucial roles in postpartum mental health. Although, factors such as breastfeeding method, infant gender, gestational age, and mode of delivery in some cohorts were often not associated with PPD, indicating these routine obstetric variables alone are insufficient predictors. These findings highlight the need for clinicians to prioritize screening and support for mothers facing obstetric complications or unplanned pregnancies, rather than relying solely on general delivery characteristics to assess PPD risk.

3.3.4. Newborn Factors

The relationship between newborn characteristics and PPD has been inconsistently demonstrated in different studies. Several investigations found no significant associations between common newborn factors and maternal or paternal PPD, suggesting that routine neonatal variables alone are poor predictors of postpartum mental health outcomes. For example, infant gender was analyzed in Multiple studies but showed no significant relationship with maternal or paternal PPD risk [19,27,34,39]. Similarly, newborn birth weight and neonatal intensive care unit admission were generally not significant predictors of depressive symptoms among mothers [11,34].

Furthermore, while majority of studies found no significant association between newborn gender and PPD one study showed Mothers of female infants and those delivering low birth weight babies (<2.5 kg) had significantly higher rates of PPD, indicating that infant gender and birth weight may still increase maternal vulnerability under specific sociocultural or health contexts [9]. Having an infant younger than six months was significantly associated with elevated PPD risk, suggesting the earliest postpartum period may be a particularly sensitive time for maternal mental health [35].

Conversely, studies focusing on PPPD consistently reported no significant associations with newborn characteristics such as infant gender, baby age, birth order, or newborn health problems, underscoring that paternal depression may not depend on infant-related variables [27,39].

These findings highlight that while some newborn factors, particularly infant gender, low birth weight, and early infancy, can influence maternal PPD in certain contexts, most neonatal characteristics show limited predictive value for PPD.

3.3.5. Nutritional Factors

Local research studying the effects of diet on PPD has largely focused on the effects of dairy intake with much attention directed towards the effects of Laban intake. Laban, a beverage consisting of fermented milk, is wildly consumed among Middle Eastern and North African inhabitants. As with most dairy products, the drink is rich in probiotics and vitamin D, warranting the close inspection paid to it by local studies.

In one such study looking into the correlation between postpartum dairy consumption and PPD, consuming >1 serving of Laban per day was associated with a significant reduction in PPD risk. Likewise, total dairy intake of >1 serving per day was significantly associated with a reduction in PPD risk [40]. However, another study with a similar focus on postpartum dairy intake showed no significant association between any forms of dairy consumption and PPD risk, except for Laban, for which increased consumption was correlated with an increased risk of depression [41].

These conflicting results suggest that dairy products, particularly Laban, may have complex or context-dependent effects on PPD. However, the limited scope of nutritional research mainly centering on calcium and dairy has left substantial gaps in understanding other potential dietary influences. Broader nutritional assessments and longitudinal dietary studies should be considered to inform dietary interventions and preventative strategies.

3.3.6. Sleep Factors

Sleep disturbances are well-established contributors to psychiatric disorders, and local studies reaffirm this link in the context of PPD. For example, disturbed sleep at six weeks postpartum was significantly associated with PPD in a study of 354 women [34]. These findings are echoed in a 2023 Riyadh based study identifying sleep disturbance as a significant risk factor [15], and another study from Qassim reporting a positive correlation between poor sleep quality and PPD [42]. Notably, sleep disruption appears to affect both

mothers and fathers, as demonstrated by a Jeddah study linking paternal sleep difficulties to PPPD [26].

A more granular analysis in a 2023 study of 204 women found that the perceived sleep quality of mothers was significantly associated with the level of PPD in participants. Furthermore, sleep factors such as sleep latency were found to have an association with the severity of PPD, but the delay in sleep might be a manifestation of PPD. Other factors studied included sleep duration, habitual sleep efficiency, sleep disturbances, the use of sleep medications, and daytime dysfunction, which were all significantly associated with PPD [37].

The effects of sleep problems in PPD patients extend further still, affecting the overall quality of life of those affected. In a study looking into postpartum quality of life, sleep problems were found to be significantly associated with a reduction in quality-of-life scores. Specific domains' scores such as physical health, psychological health, and environment were also significantly affected by sleep problems [43]. This further highlights the impact that sleep quality can have on the holistic management of PPD and improvement of postpartum quality of life.

Altogether, local findings confirm that sleep plays a significant role in the development and severity of PPD. Disturbances in sleep are consistently linked to worsened outcomes with effects extending beyond mood symptoms and contributing to a decline in overall postpartum quality of life. This highlights the importance of routinely assessing sleep and addressing it as a core component in the diagnosis and management of PPD.

3.3.7. Maternal Medical Factors

Longstanding illnesses, including those affecting the endocrine, cardiovascular, and immune systems, routinely appear linked to more pronounced depressive symptoms in the postpartum period. A recent national cross-sectional survey conducted in Saudi Arabia found that 16.1% of recently delivered women reported such chronic conditions, specifically asthma, hypertension, diabetes, and thyroid dysfunction. Within this subgroup, depression rates surpassed those of mothers without pre-existing illnesses [34]. Likewise, another investigation showed that any documented chronic disease predicted significantly higher scores on the EPDS, highlighting how a mother's medical load may burden her mental health [44].

Anemia in pregnancy has repeatedly been linked to PPD. A cross-sectional study of 352 women in Saudi Arabia showed that nearly 40 percent of participants who reported depressive symptoms also had low hemoglobin, and just over 40 percent had laboratory-confirmed clinical anemia during gestation. When the data were adjusted for age, parity, and other variables, low hemoglobin remained significantly associated with greater PPD risk, suggesting that iron-deficiency anemia may disrupt mood regulation in the perinatal period [30].

Wider aspects of maternal health in the weeks after delivery—such as fatigue, sleep disturbance, and unresolved medical problems—also shape the course of PPD. In a recent national survey, women who rated their postpartum health as poor recorded markedly higher scores on the EPDS, and slow physical recovery emerged as an independent predictor of depressive symptoms [35]. Furthermore, having multiple coexisting conditions raised the odds of psychological distress still further, highlighting the tight linkage between somatic and mental well-being in the postnatal phase [35].

The evidence gathered points to maternal medical factors—chronic disease, anemia, and overall compromised physical status—as major drivers of PPD. Recognizing and treating these conditions should therefore be integral to any preventive mental health program in postpartum care.

3.4. Paternal Postpartum Depression

PPPD is a serious but often overlooked mental health issue that can strike new fathers in the weeks and months after a baby arrives. Unlike mothers, men usually are not routinely screened for depression after childbirth, so many affected dads slide by unnoticed even though research increasingly points to its widespread and damaging effects.

A cross-sectional study from Riyadh screened 290 fathers within six months of delivery with the Arabic EPDS, finding an apparent prevalence of 27.9% and a sensitivity- and specificity-adjusted rate of 16.6% [45]. At Prince Sultan Military Medical City, a slightly higher rate of 32.7% emerged among 226 fathers assigned a conservative cut-off score of nine on the same scale [39].

Although most Riyadh participants reported stable characteristics, where 94.3% were employed, 92.6% were married to one wife, and the average number of children was three, the prevalence of PPPD remained striking and may have been fueled by poor perceived health and low social support [45]. By contrast, the Military Medical City study found no statistically significant predictors after logistic regression, hinting that paternal-specific psychosocial stressors warrant deeper and broader measurement before firm conclusions can be drawn [39].

EPDS is still the most widely used tool for spotting PPPD, even though its creators designed the scale with new mothers in mind. Though researchers have confirmed its reliability in men, there is still some argument about where to draw the line; international work hints that a score of twelve or higher gives the best overall accuracy [45], while local studies use the more generous cut-off of nine to capture as many affected fathers as possible [39,45].

When PPPD goes untreated, the damage spreads beyond the father; bonding with the child suffers, home life becomes tenser, and children may show behavioral or developmental delays later on [39]. Early-onset depression in new dads also raises the odds of family quarrels and emotional distancing, reinforcing the idea that fathers need mental-health checks as routinely as mothers do after a birth [39].

Yet, despite what the evidence shows, guidelines, protocols, and health policies in many hospitals still overlook PPPD almost completely. In Saudi Arabia, where fathers are expected to play central, supportive roles, spotting the problem early and matching treatment to local customs could turn a growing public-health worry into a manageable one.

3.5. Impact on Quality of Life

As mental health can have effects extending beyond psychological symptoms, it is important to consider the broader impact of PPD on quality of life. A 2023 study assessing postpartum women in Madinah found that women experiencing PPD were found to have significantly lower quality-of-life scores, with disturbed sleep and higher maternal age contributing to further reductions, particularly in the physical, psychological, and environmental domains. Social support, especially from a significant other, was positively associated with higher scores across all domains, while support from family and friends was linked to improved social well-being [43].

Similarly, another study focusing on health-related quality of life in women with PPD found that both mental and physical health components were significantly lower in affected patients. Factors such as older maternal age, history of depression, and employment status were also associated with reduced quality of life, with employed mothers demonstrating a higher risk of both depression and health-related quality-of-life decline [32].

Altogether, these findings demonstrate that PPD affects more than emotional well-being; it impacts daily functioning, physical health, and social connectedness. Quality of

life should be considered not only in assessing the condition but also in guiding recovery and evaluating treatment outcomes.

4. Discussion

4.1. Methodological Drivers of Prevalence Variability

This paper reviews and synthesizes studies carried out in Saudi Arabia and highlights that PPD prevalence rates vary greatly, which appears to reflect a function of definitional inconsistencies, differences in screening instruments and thresholds, and variable postpartum time windows rather than true differences in population epidemiology. These issues are well documented in the perinatal mental health literature, including the lack of a single operational definition of the postpartum period in research and clinical practice, which complicates between-study comparability and meta-analytic inference [46]. Screening threshold variation further amplifies spread in prevalence estimates; individual-participant meta-analyses demonstrate that EPDS cut-points close to 11 to 13 optimize the balance between sensitivity and specificity against validated diagnostic interviews, whereas lower cut-points (as observed in the Jazan study) may inflate apparent prevalence through misclassification of transient distress [19,46].

4.2. Positioning Saudi Estimates Within a Global Context

The global overall prevalence is approximately 17% during the first year after childbirth, with substantial heterogeneity related to methods and context [2]. Estimates from Saudi Arabia, when aligned on the EPDS threshold and timing, are within the overlapping global range, while the highest local figures tend to reflect lower cut-offs. Earlier work also reported high pooled prevalence in several world regions, including the Middle East, although estimates varied according to timing, measurement, and study quality [3]. Within the Middle East, the high burden of disease on the region was attributed to several modifiable factors, including limited social support, marital discord, and unplanned pregnancy, which is relevant to the Saudi context and should inform prevention [5].

4.3. Screening Thresholds, Instrument Validity, and Standardization Needs

Measurement considerations specific to Arabic-speaking populations warrant emphasis. The Arabic EPDS has shown its EPDS validity is acceptable, but studies have used different EPDS cut-points, which in turn affect cross-study comparability and shift prevalent estimates [46,47]. Subsequent studies from Saudi Arabia ought to embrace a uniform and pre-registered case definition, a detailed, consistent timeframe within the postpartum period, and the use of validated, non-altered instruments. Moreover, whenever possible, it is recommended that positive screening tests be verified using standardized diagnostic interviews; this would, in turn, improve the interpretation of plausible prevalence estimates.

4.4. Risk Factor Profile in Saudi Cohorts

The risk factor profile observed across Saudi studies is broadly concordant with the risk factor profile outlined in umbrella reviews. Some clearly defined predictors are the presence of depression, antenatal depressive symptoms, difficult life circumstances, violence in relationships, unintended pregnancies, and a low level of social support [48–50]. In Saudi cohorts, the most important predictors consistently are the presence of depression, difficult life circumstances, conflicts in the marriage, unplanned pregnancies, and poor support from family or partner, which is consistent with the global evidence and emphasizes the need for preventative strategies in the perinatal care pathway [14,16,17,33]. Factors associated with delivery, like complications during the Cesarean and the surgery itself, have shown unclear associations, but associations like these should be interpreted cautiously

because of the differential timing of assessment and potential covariates related to the indication [16,33,44].

4.5. Quality of Life, Bonding, and Child Outcomes

Saudi and international data indicate that PPD is linked with lower scores across a range of health-related quality-of-life domains, including vitality, social functioning, role restriction, and mental health, with the impact growing more pronounced as the symptoms worsen [32,43,51,52]. In addition to the adverse effects on the mothers themselves, completely untreated PPD has the potential to impair the bonding process, foster unsatisfactory parenting behaviors, and result in poor socioemotional and cognitive development of the child, indicating the crucial need for early identification and prompt treatment of this condition as a public health issue [53]. Paternal depression deserves attention as well; pooled data reveal that roughly 10 percent of fathers suffer from perinatal depression, with the prevalence more pronounced during the 3 to 6-month postpartum period and a moderate relationship with maternal depression, highlighting the family-centered model of care and partner assessment for depression when applicable [54].

4.6. Practice and Policy Implications for Clinical Services

For practice in Saudi Arabia, there is a need to incorporate routine and scheduled obstetric and postpartum assessments and streamlined referrals. Authoritative guidance recommends screening at the initial prenatal visit, again later in pregnancy, and during postpartum visits, using validated tools and ensuring systems for diagnostic assessment, treatment, and follow-up. The first screening during the postpartum period can be done between 6 and 12 weeks, with the subsequent screening done between 3 and 6 months. These timings can coincide with the standard well-baby check-ups if obstetric follow-up is missed. Any positive screen should be clinically confirmed before treatment is started, with predefined urgent referral pathways for suicidality, psychosis, and intimate partner violence. These recommendations are directly applicable to the Saudi health system and can be operationalized in antenatal clinics, maternity wards, and primary care [55]. Moreover, primary prevention needs particular focus; counseling interventions such as cognitive behavioral therapy and interpersonal therapy have proven effective in reducing perinatal depression with sufficient evidence supporting this framework [56]. Adaptation within the Saudi context will require expansion of workforce capacity and integration of maternal mental health into routine antenatal and postnatal services. Nurses and midwives report limited experience with assessment and counseling for PPD. National planning analyses also indicate a substantial mental health workforce shortfall that may constrain scale-up [23,57–59].

4.7. Sociocultural Determinants and the Mental Health Environment in Saudi Arabia

As noted in Evidence Synthesis, PPD literacy and help-seeking behaviors differ across population groups, with gaps in recognition and confidence in available care [21,22]. Building on these findings, targeted initiatives should prioritize partner-inclusive education, targeted advocacy for populations identified in local data as having lower literacy, and simplified care navigation, with clear public-facing information specifying where and how to access services [21,22]. Additionally, expanding access to evidence-based pharmacologic and non-pharmacologic treatments, with clear guidance on lactation and safety monitoring, is relevant as therapeutic options evolve. Regulatory approval of novel agents, such as zuranolone, provides additional treatment options for severe or refractory cases when used within guideline-directed care and shared decision-making frameworks [60].

4.8. Priorities for Research and Service Development in Saudi Arabia

The evidence at hand directly points to three priorities concerning the Saudi Arabia strategy. The first is establishing consistency across studies and services concerning the definitions and methods used, with measures such as a standardized postpartum period, validated and unmodified scales, and confirmatory diagnostic measures. Additionally, prospective, diagnostically confirmed cohorts would help clarify temporal relationships; analyses should explicitly assess the independent and joint effects of pre-existing mental health disorders. The second is to implement longitudinal screening accompanied by guaranteed referrals and follow-up, and strengthened prevention through risk-stratified targeted counseling within antenatal and postnatal care. The third is addressing sociocultural barriers through literacy campaigns, partner and family engaged center care, and monitoring recovery quality-of-life outcomes beyond the symptom score to capture the full recovery process [21,22,55,56,61,62]. These steps will increase the comparability of studies, facilitate the clinical identification and treatment of PPD, and reduce the individual and societal burden of PPD in Saudi Arabia.

5. Conclusions

We note that studies on the prevalence of PDD in Saudi Arabia have reported very different estimates due to variations in case definitions, EPDS cut-off points, timing of assessment, and study settings, but when methods align, estimates converge with international ranges. Furthermore, there are consistent risk patterns of prior depression, antenatal symptoms, high stress, intimate partner violence, unintended pregnancy, and low social support that underscore the need for systematic case-finding integrated into routine obstetric and maternal healthcare, with clear referral pathways and evidence-based psychological interventions, and family-inclusive approaches that acknowledge paternal symptoms. Moreover, PPD appears to impair health-related quality of life and lead to adverse mother–infant outcomes; therefore, timely recognition and treatment are essential public-health priorities. Lastly, national progress will depend on method standardization, longitudinal and representative studies, and service development that reduces sociocultural barriers, strengthens workforce capability, and ensures continuity of care across maternity, pediatric, and primary-care settings.

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Abbreviations

The following abbreviations are used in this manuscript:

PPD	Postpartum depression
EPDS	Edinburgh Postnatal Depression Scale
PPPD	Paternal postpartum depression

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