Promoção da Saúde
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Assessment of pregnant women for identifying risk and protective factors for postpartum depressiont

Avaliação de gestantes para identificação de fatores de risco e proteção para depressão pós-parto

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ABSTRACT
Objective: To identify risk factors related to the development of Postpartum Depression (PPD) during pregnancy. Method: The methodology employed was action research, organized into three phases: I) exploratory, II) intervention, and III) intervention analysis. The instruments used included the Gestational Profile Questionnaire (GPQ) and the Beck Depression Inventory (BDI). Data were analyzed by comparing the scores of the GPQ and BDI instruments. Results: It was possible to identify that all participants during the gestational phase exhibited multiple risk factors for the development of postpartum depression. Conclusion: The study highlighted the importance and necessity of mental health evaluation for pregnant women by the entire health team responsible for prenatal care, as multiple risk factors for the development of PPD were identified in the study participants.

Keywords: Primary Health Care. Prenatal Care. Depression, Postpartum. Pregnant Women. Mental Health.

RESUMO
Objetivo: Identificar, durante a gestação, fatores de risco relacionados ao desenvolvimento da Depressão Pós-Parto (DPP). Método: Pesquisa-ação, que se organizou em três fases: I) exploratória, II) intervenção e III) análise da intervenção. Utilizou-se como instrumentais: Questionário do Perfil Gestacional (QPG) e Inventário Beck de Depressão (BDI). Os dados foram analisados mediante a comparação dos escores dos instrumentos QPG e BDI. Resultados: As participantes na fase gestacional apresentavam a presença de múltiplos fatores de risco para o desenvolvimento da depressão pós-parto. Conclusão: Evidenciaram-se a importância e a necessidade da avaliação em saúde mental das gestantes participantes, por parte da equipe de saúde responsável pela realização do pré-natal, uma vez que foi identificada a presença de múltiplos fatores de risco para o desenvolvimento de DPP nas participantes do estudo.

Palavras-chave: Atenção Primária à Saúde. Cuidado Pré-natal. Depressão Pós-parto. Gestantes. Saúde Mental.

INTRODUCTION

Postpartum depression (PPD) is described as a non-psychotic depressive episode that begins during the peripartum period[1]. Its symptoms are the same as those of other depressive disorders: depressed mood for most of the day, nearly every day (e.g., feeling sad, empty, or hopeless), a marked decrease in interest or pleasure in all or almost all activities for most of the day, significant weight loss or gain without dieting, or decrease or increase in appetite, insomnia or hypersomnia, psychomotor agitation or retardation, fatigue or loss of energy, feelings of worthlessness or excessive or inappropriate guilt, diminished ability to think or concentrate or indecisiveness, and recurrent thoughts of death or suicidal ideation.[1]

Due to this and the aforementioned adverse conditions, early identification of depressive symptoms is paramount as, if not identified, it becomes a serious obstacle to establishing a secure emotional bond between mother and child, which can lead to detrimental future repercussions in the child's developmental course.[2] It can be observed that motherhood is not as "naturalized" a process as it is popularly presented. On the contrary, it is intertwined with pain, suffering, and the internal struggle of adjusting to the new situation that presents itself in life. Puerperal psychological suffering is multifactorial, and evidently, the role played by mothers in Brazil is surrounded by overload and feelings of guilt and insufficiency.

Discrimination and inequality directed at women, especially in the capitalist context, are not a legacy of the pre-modern world but rather a formation of capitalism, grounded in existing sexual differences and reconstructed to fulfill new social functions.[3] Hence, the survival conditions of women, historically, have been marked by ethical-political suffering that also traverses them during the puerperal period.

Beyond contextual factors, there is a point that takes the form of a phantom, terrorizing women of childbearing age, known as the myth of the exemplary mother. Seen as the main responsible for the child's development, the mother faces strong social pressure, directing her to a certain self-abdication, anchored in the principle that the child must always come first, as a priority in her life.[4] Considering this, it can be stated that the vast majority of mothers will experience some degree of psychological suffering, and under these circumstances, postpartum depression may develop.

Research[5] demonstrated the association of risk and protective factors that can, respectively, potentiate or reduce the incidence of PPD. Risk factors are typically grouped into categories: psychosocial, sociodemographic/contextual, and physical risk factors, while protective factors are categorized similarly.

The main psychosocial risk factors include a history of previous depressive episodes, persistent stress during pregnancy, gestational anxiety, gestational depression, a history of previous PPD, idealization of motherhood, dissatisfaction with pregnancy, a family history of mental disorders, low social and familial support, marital conflict and dissatisfaction, lack of partner support, financial difficulties postpartum, lack of social support during the puerperium, exposure to violence, and family conflict.[6-8]

Sociodemographic/contextual risk factors include maternal age, low educational status, unemployment or underemployment, and being single.[9] Physical/obstetric risks include a history of premenstrual syndrome, hormonal and inflammatory cytokine dysregulation, early postpartum anemia, medical complications/intercurrent conditions during pregnancy, unplanned and/or unwanted pregnancy, a history of spontaneous abortion, not breastfeeding up to eight weeks postpartum, lack of gynecological prenatal care, and problems in the current delivery.[10]

Thus, if one or more risk factors are observed in a woman's life history, greater attention is required from both the professionals who accompany her and her family.

The body of information gathered from various studies reinforces the multifactorial perspective influencing the development of PPD. Established knowledge of risk and protective factors contributes to a better understanding of the issue, as well as to the creation of more precise prevention and diagnostic strategies.[10]

Among the aspects associated with the prevention of this condition, international research has referenced routine activities that can

be beneficial in controlling symptoms and improving psychosocial well-being. A previous study[11] points to the use of mobile devices in the prevention of postpartum depression. It is noteworthy that this topic is still underexplored in both national and international literature, so the findings of this study contributed by showing that apps targeted at postpartum women, aiming to reduce depressive symptoms associated with PPD, can be useful, especially when used early.[11]

Considering that mental disorders are common during the puerperium, beyond prevention, it is important to emphasize the aspect of health promotion during this period. It is essential that professionals understand the emotions experienced during the puerperal period to promote quality care, ensuring the health promotion of these women.[12]

Thus, factors such as the non-performance of physical examinations during consultations, exclusive attention to the newborn, failures in providing guidance on warning signs and common problems, and late performance of the first postpartum consultation can be crucial points that contribute to the development of health problems affecting both the physical and mental state of postpartum women, hindering health promotion actions.[13]

In this context, mental health care during pregnancy calls on health professionals to consider possible strategies to minimize psychosocial risks for pregnant women and provide psychological well-being throughout the gestational period. An important tool in this regard is the so-called Psychological Prenatal Care (PPC), which is a strategy capable of providing psychotherapeutic support to propose a healthy pregnancy, also adding value to gynecological prenatal care.[14]

PPC is relevant both for its psychoeducational aspect, where women learn to identify and manage their emotions more adaptively, and for the space for listening and support provided by group interactions among women.[15]

Therefore, this study aims to identify, during pregnancy, risk factors related to the development of Postpartum Depression.

METHODOLOGY

This is a quantitative research study. In quantitative research, results are presented in numerical terms, generally organized into tables and subjected to statistical tests.[16] In this particular study, data will be presented from the application of two instruments to the participants.

For the intentional design of the current investigative process, the guiding line was the proposal to evaluate the efficiency of a specific technique (PPC) in a specific group (pregnant women followed in the selected Basic Health Unit).

The study was conducted at the Basic Health Unit (UBS) Facility I, located in the municipality of Bela Cruz, Ceará, which has the highest number of pregnant women, totaling 28 women, who were monitored during the field research period in 2021.

Inclusion criteria were pregnant women, over 18 years of age, monitored by the aforementioned UBS during the information collection period, who agreed to participate in the study after reading and signing the Informed Consent Form, and who were in their third trimester of pregnancy. Exclusion criteria were women under 18 years of age, users not registered and/or not monitored by the UBS of Bela Cruz, those who refused to participate in the research, who were outside the predetermined gestation period, or who presented any type of excessive emotional distress or discomfort during the intervention. The pregnant women who participated in the study were already being monitored and participated in mental health promotion processes through the PPC.

During prenatal consultation days at the UBS, two group discussions were held, each on different days, covering all the pregnant women monitored at the unit, with an average duration of 25 minutes each, titled: “And my psychological prenatal care?”. During these sessions, after a brief explanation of the typical psychological processes of each period of the pregnancy cycle, the pregnant women asked questions, shared experiences with the researcher and with each other, promoting a dialogic experience. After this, the target audience was invited to participate in the study.

Subsequently, the pregnant women who agreed to participate and met the inclusion and exclusion criteria of the research signed the informed consent form and were directed to a reserved room where they completed the following instruments: Gestational Profile Questionnaire (QPG) and the Beck Depression Inventory (BDI). The sample consisted of a total of seven pregnant women who met the inclusion criteria and consented to participate in the study.

The application of the gestational profile questionnaire aimed to identify the presence of factors considered by the literature as risk factors for the development of postpartum depression in the responses of the seven participants during the third trimester of pregnancy.

The application of the BDI aimed to identify the presence and level of intensity of depressive symptoms in women before childbirth. In summary, this first stage sought to create a situational "snapshot," that is, a survey of the gestational profile of the participants, identifying the presence of risk factors for postpartum depression, as well as checking levels of depressive symptoms before participation in the PPC.

Preliminarily, a survey of the presence/absence of risk factors for the development of postpartum depression was conducted based on responses to the gestational profile questionnaire.

This research is part of a master's dissertation entitled "Group Psychological Prenatal Care in the Family Health Strategy: Contributions to the Prevention of Postpartum Depression," submitted to and approved by the Ethics Committee of the State University Vale do Acaraú, with favorable opinion under Certificate of Presentation for Ethical Consideration No. 42138920.5.0000.5053. The consent of the subjects was obtained through the application of the Informed Consent Form.

RESULTS

Regarding the nature of risk factors, these were grouped into categories: 1) sociodemographic, 2) psychosocial, and 3) physical-clinical-obstetric, according to the literature.[5]

For better understanding in presenting the results, each participant was identified using the term "Participant" (P) followed by a sequential number to indicate the quantity of pregnant/postpartum women (P1, P2, P3...). With that said, Chart 1 below presents the sociodemographic profile of the participants.

Chart 1. Sociodemographic risk factors for PPD, Bela Cruz-CE, 2021.

Participant	Marital status	Education	Occupation	Family Income	Age	Steady partner	Financial difficulties
P1	Married	Complete elementary school	Homemaker	Low	27	Yes	Yes
P2	Married	High school/technical school	Administrative assistant	Average	31	Yes	Yes
P3	Stable Union	Complete elementary school	Homemaker	Low	35	Yes	Yes
P4	Single	Incomplete elementary school	Homemaker	Low	21	No	Yes
P5	Single	Incomplete high school	Cleaning assistant	Low	19	No	Yes
P6	Single	Complete high school	Homemaker	Low	22	No	Yes
P7	Stable Union	Complete elementary school	Homemaker	Low	29	Yes	Yes

Chart 2 outlines the psychosocial risk factors categorized among the study group of women.

Chart 2. Psychosocial risk factors for PPD, Bela Cruz-Ce, 2021.

Participant	Previous depression	Other mental disorder	Family history of mental disorder	Planned pregnancy	Support network	Support from the baby's father	History of violence
P1	Yes	No	Yes	No	Yes	Yes	Yes
P2	Yes	Anxiety	Yes	No	Yes	Yes	No
P3	Yes	Anxiety	Yes	Yes	No	Yes	Yes
P4	No	Panic	Yes	No	No	No	Yes
P5	No	No	No	No	Yes	Yes	Yes
P7	No	Anxiety	Yes	No	No	No	Yes

Chart 3 presents the physical-clinical-obstetric risk factors for postpartum depression, based on the participants' responses.

Quadro 3. Physical-clinical-obstetric risk factors for PPD, Bela Cruz-Ce, 2021.

Participant	Physical illness during pregnancy	History of abortion	Parity status	Gestational age
P1	No	No	Multiparous	27th week
P2	No	Yes	Multiparous	29th week
P3	No	No	Primipara	29th week
P4	No	No	Primipara	29th week
P5	No	No	Primipara	30th week
P6	No	No	Primipara	31st week
P7	No	Yes	Multiparous	28th week

Chart 4 presents the results of the Beck Depression Inventory (BDI) for these same participants.

Chart 4. BDI results.

Participant	Degree of depression
Participant 1	Mild to moderate
Participant 2	No depression or mild
Participant 3	No depression or mild
Participant 4	Mild to moderate
Participant 5	Mild to moderate
Participant 6	Mild to moderate
Participant 7	Mild to moderate

The results presented in the charts will be discussed in the context of the literature in the discussion section, providing relevant reflections based on the findings of the research, in order to establish connections between the study's findings and previous research in the field.

DISCUSSION

Based on the data collected, four categories of discussion were identified.

SOCIODEMOGRAPHIC PROFILE

The sociodemographic data indicated that participants' ages ranged from 19 to 35 years. One participant had incomplete elementary education, three had completed elementary education, one had incomplete high school, and one had completed high school. Only one participant had completed technical high school education. Regarding marital status, 3 participants were single without a steady partner, 2 were in stable relationships, and 2 were legally married. Only 2 participants had formal employment (cleaning assistant and administrative assistant); the others did not have paid employment. One participant belonged to a middle-income family (household income of R$ 2,971.00), while the others were classified as low-income socioeconomic status (household income ranging from R$ 1,300.00 to R$ 2,238.20), according to the Brazilian Institute of Geography and Statistics (IBGE).[17] All participants reported experiencing some form of financial difficulty.

In summary, the sociodemographic profile revealed that the main risk factors identified in most participants were: "Financial Difficulties" (seven participants), "Being from a Low-Income Economic Class" (six participants), and "Low Educational Attainment" (five participants). Considering these factors and the predominance of participants from low economic backgrounds, several studies highlight such circumstances as strong predictors for developing postpartum depression.[18] A possible explanation for this reality is associated with fears of not being able to provide adequately for the baby's needs during such a crucial life stage, coupled with frustration over limited resources in terms of knowledge and skills to cope with the challenges arising from their social vulnerability.

Thus, based on the aforementioned factors and the additional risks identified (such as being single – three participants – and lacking a steady partner – three participants), it can be inferred that the participant group exhibited a sociodemographic gestational profile at risk for developing PPD.

PSYCHOSOCIAL RISK FACTORS

It is crucial to consider other aspects related to risk factors in different categories. The responses from the gestational profile questionnaire identified the presence of the following psychosocial risk factors for PPD[5,19]: unplanned pregnancy; personal history of depression or other mental disorders; family clinical history with mental disorder presence; impoverished social and family support network; lack of support from the baby's father; and history of being a victim of violence.

Among these factors, the most prevalent among the majority of participants were unplanned pregnancy (six participants); family clinical history with the presence of mental disorders (five participants); and history of being a victim of violence (five participants).

Regarding unplanned pregnancy, a cross-sectional study involving a sample of 110,231 pregnant women highlighted that dissatisfaction and lack of pregnancy planning are strongly associated with depressive symptoms in the postpartum period. Women who did not plan their pregnancies had a higher risk of PPD compared to those who did plan their pregnancies.

Additionally, the prevalence of a family history linked to mental health issues adds another layer to the constellation of factors contributing to the risk of developing PPD.

Regarding the history of being a victim of violence (physical, psychological, or sexual) and PPD, current literature reveals a strong correlation between the two. Some evidence[21,22], resulting from surveys applied to samples of postpartum women and pregnant women respectively, indicate that those who reported experiencing any type of violence before or during pregnancy showed a higher percentage of postpartum depressive symptoms.

Concerning an impoverished support network, pregnant women who lack the expected support during pregnancy to the postpartum period are three times more likely to develop depressive symptoms compared to those who perceive such support. This underscores the

significant role of social support in maintaining psychological stability.[23] These findings are consistent with results from another research.[24] Therefore, family support is crucial during the postpartum period, when the reality of motherhood becomes more tangible with the baby's presence in the world.

Regarding support from the baby's father, the lack of support, co-parental depreciation, and communication fragility, particularly within the father-mother-baby triad, are factors that can trigger PPD.[24]

Regarding the personal clinical history of any mental disorder, four participants reported such data. It is noted that, in addition to previous depression, anxiety disorder was indicated by the women. Anxiety disorder, characterized by symptoms such as racing thoughts, tachycardia, feelings of insecurity, incompetence, disrupted sleep patterns, among others, like depression, can begin during pregnancy and extend into the postpartum period, predisposing individuals to PPD.[5]

Moreover, there are several pieces of evidence in research[5,25] indicating that a history of previous depression episodes is one of the main risk factors for developing postpartum depression, as well as presenting signs and symptoms of current gestational depression. Regarding the latter point, it will be discussed further when presenting the results from the Beck Depression Scale. Based on the above, it is possible to affirm that the evaluated pregnant women present risk factors for PPD as described in the literature.

PHYSICAL-CLINICAL-OBSTETRIC RISK FACTORS

None of the participants had comorbidities that could classify them as high-risk pregnancies. Among the 7 participants, 3 were already mothers of at least one child. The gestational ages when they started the Psychological Group Prenatal (PGP) varied from the 27th to the 31st weeks (recorded from the date they completed the gestational profile), and two had a history of miscarriage.

Evidence associating multiparity or primiparity with PPD is not consistent in the literature.[5] Therefore, based on the focus on the clinical-obstetric profile data, it can be inferred that there were no significant risk factors among the majority of participants.

On the other hand, it is also valid to highlight protective factors for PPD identified within the participants' context. Protective factors are preventive measures or established situations that minimize the impact of risk factors or enhance positive influences that transform or improve personal responses.[26]

In a short-term longitudinal study[5] with an interventional research design involving 198 women, the authors identified 11 protective factors against PPD in the sample, including: "having family support" (n=63), "living with the partner" (n=57), "receiving support from the child's father" (n=55), "not experiencing financial difficulties" (n=52), and "having a satisfactory marital relationship" (n=41). The authors emphasize the importance of solid and supportive relationships with the baby's father and family support, as these factors can help women better cope with the burdens of motherhood through shared responsibility.

In the present study, protective factors such as family support, support from the child's father, and stable relationships with partners were found among the majority of participants. In summary, the presence of such factors can contribute to better coping with adverse events affecting women's mental health and may act as a shield against influences that enhance personal resilience.

BECK DEPRESSION INVENTORY

Having discussed the balance between risk and protective factors, the next section presents the results of the Beck Depression Inventory (BDI), which assesses an important risk factor: the presence of depressive symptoms. Given its relevance as a risk factor for PPD,[5,6] the results regarding depression levels during pregnancy obtained from the application of the Beck Depression Inventory are highlighted.

It is noteworthy that out of the seven participants, five exhibited symptoms characteristic of "mild to moderate" depressive states, while only two scored in the "no depression or mild depression" range according to the Beck scale.

Evidence demonstrates that prenatal depression is not only the most common mental disorder but also the primary risk factor for postnatal depression, often continuing from pregnancy.[5] These findings reinforce the importance of implementing actions that promote maternal mental health during pregnancy.

Research[5,27] indicates that significant psychological distress prior to pregnancy is often a key motivator for pregnant women to engage in psychological interventions when offered. Building on this premise and considering the presence of psychological distress during pregnancy in all participants of the current study, it can be inferred that this was one of the main factors encouraging participation in the research.

However, the PPC does not solely aim to reach women already experiencing mental distress. It is essential to reflect on nuances that may hinder both distressed and non-distressed pregnant women from participating in maternal mental health promotion actions, such as in the present study.

Other studies[26,28] describe potential barriers associated with the hegemonic understanding in social imagination that motherhood is instinctive and inherent, requiring no preparation or enhancement, as maternal nature is deemed sufficient to fulfill such a complex social role as motherhood. In other words, there may be a belief that there is no need to worry or prepare because motherhood is "given/ready" and does not need gradual construction or emotional and psychological development.

Beyond the process of constructing this "maternal identity," it is important to highlight that after childbirth, there is pressure to fulfill the ideal and exemplary role that theoretically embodies maternal function. Thus, the myth of the exemplary mother perpetuates psychological distress, starting from the idea that no preparation is necessary for motherhood, assuming it is a natural process inherent to the female figure.[4]

Moreover, particularly in rural areas, there is a prejudice regarding seeking mental health care, as evidenced in a recent study,[29] where the community generally refuses to seek psychological or psychiatric assistance "*...due to cultural reasons (prejudice) or by denying the presence of symptoms*" (p. 37). The cited author points out that mental health care in Primary Care is one of the main contemporary bottlenecks of Psychiatric Reform.[29]

These data reinforce the importance of disseminating PGP in the field of health, especially maternal mental health, as its process and development aim to break myths, taboos, stereotypes, and prejudices surrounding parenthood, fostering reflective and critical awareness.[5,30] Therefore, the dissemination and societal knowledge about PGP can lead to significant social change in the perception of the meaning of becoming parents.[28]

Therefore, given the framework of information gathered thus far, including that all women in this study exhibited some level of depressive symptoms, and that certain circumstances experienced during the pregnancy cycle (other risk factors) significantly contribute to the progression and worsening of depressive symptoms, eventually resulting in PPD, this investigation leads to the imperative inference that the combination of all these elements present in the life dynamics of the participating women places them at an exponential risk of developing PPD.

However, it is essential to highlight the difficulty in how well the verification of risk factors allows clinicians or researchers to distinguish between women who will become depressed and those who will not. This is due to the dynamic and subjective nature of these factors, which must be analyzed as a process and not as an entity in itself; after all, they must be relativized according to the subjectivity and life history of each woman.[5]

Due to the ethical commitment inherent in this type of research,[30] it is relevant to clarify that, as studies in the field indicate, the importance of identifying risk factors that can trigger a psychopathological condition in the postpartum period is paramount, and the earlier they are detected, the better the assistance offered can be directed. Considering that risk conditions were diagnosed for the participants, it is affirmed, however, that since this is an interventional psychotherapeutic action, no immediate referrals to other services were made. Instead, the emotional evolution of each participant was monitored to better decide the referrals that would need to be made, which in the end were

not necessary due to the reduction in depressive symptoms.

PRACTICAL IMPLICATIONS FROM THE STUDY

Based on the results discussed, it becomes evident that investigations into the mental health of postpartum women, particularly concerning factors surrounding postpartum depression, can yield significant benefits in structuring care pathways specifically tailored to this population. The presence of risk factors for PPD among study participants underscores the need to consider strategies, and potentially new public policies, to address the emotional demands experienced by women during this sensitive phase of their lives.

The study also highlights the necessity for ongoing professional development among healthcare providers, focusing not only on identifying signs and symptoms that may indicate a mental health diagnosis but also on fostering a supportive environment through active and empathetic listening. Continuous education can enhance the quality of care provided, ensuring comprehensive attention to maternal mental health needs.

Multidisciplinary and intersectoral collaboration is crucial, as indicated by the study findings, to address the various variables involved in mental health care effectively. This approach ensures holistic care that meets the diverse needs of users, particularly in navigating the complexities of maternal mental health during the postpartum period. Collaboration with other health and social assistance services can be beneficial in crafting tailored therapeutic projects for women in the postpartum phase.

CONCLUSION

In conclusion, these findings underscore the importance and necessity for prenatal care teams to conduct comprehensive assessments of mental health histories throughout pregnancy. The identification of multiple risk factors for PPD among all participants emphasizes the relevance of this research, which addresses an innovative and impactful topic in improving prenatal care conditions overall, offering emotional support, and continuous monitoring during pregnancy.

While this study yielded significant results, it did encounter limitations such as the small number of participants. These limitations highlight avenues for further research to explore and validate ongoing assessments of risk factors related to PPD and address methodological constraints, thereby supporting the expansion of this practice within healthcare settings.

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