

Postnatal depression in women in Primary Health Care

Depressão pós-natal em puérperas na Atenção Primária à Saúde

Josué Araújo de Souza¹ 
Gabriela Xavier Pantoja² 

Thais Cristina Flexa Souza Marcelino³ 
Antonio Jorge Silva Correa Júnior⁴ 
Luana Cristina de Souza Barbosa⁵ 

¹Corresponding contact. Universidade do Federal do Pará (Belém). Pará, Brazil. josue.arauujo@gmail.com

²Universidade do Federal do Pará (Belém). Pará, Brazil.

³Secretaria de Estado de Saúde Pública (Belém). Pará, Brazil.

⁴Universidade de São Paulo (São Paulo). São Paulo, Brazil.

⁵Secretaria Municipal de Saúde de Marituba (Marituba). Pará, Brazil.

ABSTRACT | OBJECTIVE: To evaluate the prevalence of postpartum depression among women attending primary health care consultations. **METHODS:** A descriptive cross-sectional study was conducted in 2024 with puerperal women enrolled in two Unidades Básicas de Saúde (Primary Health Care Units) in Marituba, Pará. Data collection included obstetric and socioeconomic questionnaires and the Edinburgh Postnatal Depression Scale (EPDS, Likert-type). Descriptive analyses were performed using Microsoft Excel. **RESULTS:** Thirty-four women participated. Most were aged 24–29 years (47%), had incomplete secondary education (38%), one child (47%), and no history of miscarriage (65%). During prenatal care, 58% attended 4–9 consultations, 64% cared for the baby alone, and 97% reported no previous use of antidepressant medication. EPDS scores ranged from 5 to 24, with 58% ($n = 20$) scoring ≥ 12 , indicating risk for postpartum depression. Although all participants reported the ability to laugh and see the funny side of things, high frequencies of negative symptoms were observed: guilt without reason (100%), feeling overwhelmed by daily tasks (100%), anxiety (80%), unexplained fear or panic (90%), and thoughts of self-harm (60%). Severe symptoms, such as frequent crying, were less frequent. **CONCLUSION:** Anxiety, emotional overload, and negative feelings were the most prevalent symptoms, with a significant proportion of women at potential risk of self-harm. Findings underscore the need for systematic postpartum depression screening and training of multidisciplinary teams for early detection and timely intervention.

KEYWORDS: Postpartum Depression. Postpartum Period. Primary Health Care.

RESUMO | OBJETIVO: Avaliar a ocorrência de depressão pós-natal em puérperas durante as consultas realizadas na atenção primária à saúde. **METODOLOGIA:** Estudo descritivo-transversal realizado em 2024 com puérperas cadastradas nas duas Unidades Básicas de Saúde no município de Marituba, no Pará. Aplicaram-se questionários obstétricos e socioeconômicos e a Escala de Depressão Pós-Parto de Edinburgh (EPDS), com análise descritiva das respostas, utilizando o software Microsoft Excel. **RESULTADOS:** Participaram 34 puérperas; a maioria das participantes tinha entre 24 e 29 anos (47%), possuía ensino médio incompleto (38%), tinha apenas um filho (47%) e não apresentou abortamentos (65%). No pré-natal, 58% realizaram entre 4 e 9 consultas e 64% cuidavam sozinhas do bebê; 97% nunca usaram medicação para depressão. Os escores da EPDS variaram de 5 a 24, sendo que 58% ($n = 20$) apresentaram escore ≥ 12 , indicando risco para depressão pós-parto. Apesar de 100% relatarem capacidade para rir e achar graça das coisas, os sintomas negativos foram expressivos, incluindo culpa sem motivo (100%), sensação de estar esmagada pelas tarefas diárias (100%), ansiedade (80%), medo ou pânico sem razão aparente (90%) e pensamentos sobre autolesão (60%). Sintomas mais graves, como choro frequente, foram menos comuns. **CONCLUSÃO:** Os resultados indicam predominância de sintomas relacionados à ansiedade, sobrecarga e sentimentos negativos, evidenciando também uma parcela significativa de mulheres com risco potencial de autolesão. Esses achados reforçam a importância da triagem sistemática da depressão pós-parto e da capacitação das equipes multiprofissionais para a identificação precoce e intervenção adequada.

PALAVRAS-CHAVE: Depressão Pós-Parto. Período Pós-Parto. Atenção Primária à Saúde.

Submitted Feb. 8th, 2025, Accepted Oct. 13th, 2025,

Published Dec. 4th, 2025

J. Contemp. Nurs., Salvador, 2025;14:e6121

<https://doi.org/10.17267/2317-3378rec.2025.e6121> | ISSN: 2317-3378

Assigned editor: Tássia Macêdo

How to cite this article: Souza JA, Pantoja GX, Marcelino TCFS,

Correa Júnior AJ, Barbosa LCS. Postnatal depression in women in

Primary Health Care. J Contemp Nurs. 2025;14:e6121. <https://doi.org/10.17267/2317-3378rec.2025.e6121>

org/10.17267/2317-3378rec.2025.e6121



1. Introduction

During the gestational period, there are major transformations, including changes in the woman's body, alterations in routine, and shifts in social relationships¹. Furthermore, other stages of pregnancy include childbirth and the postpartum period, which each woman experiences in different ways and which are considered determining factors in their lives. Along this journey, various challenges may arise, potentially causing distress and triggering some type of physical or emotional disorder, such as depression¹.

According to the World Health Organization (WHO), depression is a widely prevalent psychiatric syndrome, affecting between 3% and 5% of the world's population². Currently, it is a significant public health problem, being one of the main causes of disability, as it compromises the physical, personal and social functioning of individuals³. During the postpartum period, there are significant hormonal fluctuations, a loss of expectations of returning to the pre-pregnancy body, sexual rejection by the partner, changes in sleep patterns caused by breastfeeding, and the demands and routines of the baby, which make women more vulnerable to developing mental disorders during this period³.

According to a prospective cohort study with 699 pregnant women in Acre, the incidence of common mental disorders in the first and second evaluation during pregnancy was revealed in 36.2% and 24.5% of these women⁴. Another quantitative study, carried out in the Triângulo Mineiro region, identified that probable postpartum depression was associated with maternal age, income, marital status, education, number of children and age of the baby, being more frequent in the peripheral neighborhood ($p=0.0234$; $\alpha=0.05$)⁵.

Postpartum depression (PPD) is a highly prevalent mental disorder². PPD is characterized by the occurrence of one or more depressive episodes after the birth of a child, with symptoms usually beginning between the fourth and sixth weeks after delivery, reaching their peak around the sixth month². Global estimates indicate that between 10% and 20% of women in the postnatal period are affected by this

mood disorder, which tends to become the second greatest factor of morbidity among postpartum women⁶. In the Brazilian context, studies indicate that up to 40% of postpartum women may be affected by PPD, which highlights the urgent need for strategies aimed at early diagnosis and appropriate intervention for this condition⁷.

According to the book Rezende fundamental obstetrics⁷, one option for the first approach to postnatal depressive symptoms is the use of the Edinburgh Postnatal Depression Scale (EPDS), which is quick and easy to apply, even for non-specialized health professionals⁸⁻⁹. This scale has been translated into different languages and has undergone validation studies in several countries, including Brazil⁸. A study was carried out in Manaus in 2019 using this scale, concluding that 15.06% of postpartum women presented signs and symptoms suggestive of postpartum depression, with no association with socioeconomic or clinical-obstetric factors, highlighting the relevance of early screening during the hospitalization period, that is, 48h to 72h after childbirth⁹.

The EPDS is a tool to support multidisciplinary work, especially in nursing, and is useful for early identification of signs and symptoms of postpartum depression, indicating the likelihood rather than the diagnosis of the disease¹⁰. Thus, in the current context of primary health care, the importance of shared care among team members is emphasized, with nursing playing a central role in identifying and leveraging opportunities for awareness-raising and education of pregnant women. These actions, both prenatally and postnatally, are essential to promote a healthy pregnancy and an adequate postpartum period¹⁰. Therefore, the objective of this study was to evaluate the occurrence of postnatal depression in postpartum women during primary health care consultations.

2. Methodology

This is a descriptive, cross-sectional study with a quantitative approach. Cross-sectional studies are studies in which exposure to the factor or cause is present at the same time or time interval analyzed¹¹.

The research was conducted in two Unidade Básica de Saúde — UBS (Basic Health Units) in the municipality of Marituba, Pará. Data collection took place in the second half of 2024, between August and December.

For the study, two UBS were selected from among the 17 Primary Health Care (PHC) units in the municipality, three of which are conventional UBS and fourteen are Family Health Strategy — FHS units. These units were intentionally selected based on the higher population density of their respective coverage areas. Both have three multidisciplinary health teams integrated into the Programa de Agentes Comunitários de Saúde — PACS (Community Health Agent Program) and are composed of higher-educated professionals, including nutritionists, social workers, physicians, nurses, and a Family Health Strategy (FHS) team.

The sample was non-probabilistic and for convenience, composed of 34 postpartum women registered in the selected units, over 18 years of age and who consented to participate in the research after reading and signing the Informed Consent Form (ICF). Postpartum women who had physical or psychological conditions that prevented their participation were excluded from the sample.

Data collection took place during the researcher's visits to the health units, where the instruments were administered. The initial survey took place in the unit corridors, and the questionnaires were administered in a private room to ensure confidentiality. The instruments were divided into two parts, each lasting an average of five minutes: the first consisted of questions addressing the participants' obstetric and socioeconomic profile, and the second corresponded to items from the Edinburgh Postnatal Depression Scale (EPDS).

The interviews were conducted during the postpartum women's return to the units for postpartum nursing appointments, neonatal screening, and pediatric care. Although a structured psychiatric interview was not administered, participants were counseled on symptoms of depression and anxiety before the scale was administered.

The EPDS is a widely used self-report instrument for screening for depressive symptoms in the postnatal period. Composed of 10 items, the scale was developed to identify the likelihood of depression, without, however, measuring symptom severity (mild, moderate, or severe)⁸. Each EPDS item has four response options, scored from 0 to 3, resulting in a total score ranging from 0 to 30. In this study, a score ≥ 12 was considered the cutoff point, indicating a higher risk for clinical depressive symptoms.

The scale was administered in a single contact with each participant. Analysis was based on the total number of valid responses per participant, respecting the established screening criteria. The EPDS structure allows for the identification of different emotional manifestations in the postpartum period: items 1 and 2 refer specifically to depressed mood; items 3, 4, and 5 assess symptoms of anxiety; and items 6 to 10 cover both depressive and anxious symptoms. The EPDS is considered a practical, sensitive, and effective tool for use in primary care, especially in maternal mental health screening and surveillance settings¹².

Data analysis was performed using simple descriptive statistics, considering the scores obtained on the instrument's Likert-type scale. The quantitative approach involved calculating absolute and relative frequencies (percentages), as well as measures of central tendency, such as means, and distribution analysis. The data were tabulated and analyzed using Microsoft Excel software to describe the sociodemographic and obstetric profiles and Edinburgh Postnatal Depression Scale (EPDS) scores among the participants, allowing for a comprehensive overview of the observed reality in the study group.

The research project was submitted for evaluation by the Research Ethics Committee of the Universidade Federal do Pará (UFPA), under CAAE number 80473424.3.0000.0018 and Opinion No. 6.920.286, after authorization from the Secretaria Municipal de Saúde de Marituba (Municipal Health Secretariat of Marituba), in accordance with Resolution No. 466/2012 of the National Health Council (Conselho Nacional de Saúde — CNS), and with CNS Resolution No. 510/2016.

3. Results

As shown in table 1, of the 34 women in the postpartum period, the majority were between 24 and 29 years old (47%), had incomplete secondary education (38%), were single (58%), had domestic activities as their main occupation (76%) and declared a monthly income of less than one minimum wage (76%).

Table 1. Sociodemographic profile of postpartum women in UBS in the municipality of Marituba - PA, Brazil, 2024. (N=34)

Sociodemographic profile	n (%)
Age	
18 - 23	4 (12%)
24 - 29	16 (47%)
30 - 35	10 (29%)
36 - 40	4 (12%)
Education	
Incomplete Elementary	6 (18%)
Complete Elementary	6 (18%)
Incomplete High School	13 (38%)
Complete High School	4 (12%)
Incompleted College	1 (2%)
Completed College	4 (12%)
Marital Status	
Single	20 (58 %)
In domestic partnership	8 (24%)
Married	2 (6%)
Cohabit with their partner	4 (12%)
Professional Occupation	
Housewife	26 (76%)
Food Technique	2 (6%)
Saleswoman	2 (6%)
Student	4 (12%)
Family Income	
Minus 1 salary	26 (76%)
1 - 2 salaries	8 (24%)

Source: the authors (2024).

Analyzing the obstetric data in table 2, almost half of the postpartum women had only one living child (47%), most did not have an abortion (65%), and more than half did not plan the pregnancy (53%). Regarding prenatal care, the majority had between four and nine appointments (58%). Regarding support in caring for the baby, the majority cared for the baby alone (64%), and only 2% reported using medication for anxiety, while 97% had never used medication for depression.

Table 2. Obstetric characterization of postpartum women in UBS in the municipality of Marituba – PA, Brazil, 2024. (N=34)

Obstetric characterization	N (%)
Number of living children	
One	16 (47%)
Two	10 (29%)
Three	4 (12%)
Four	2 (6%)
Six	2 (3%)
Number of abortions	
None	22 (65%)
One	10 (29%)
Three	2 (6%)
Planned pregnancy	
Yes	16 (47%)
No	18 (53%)
Number of prenatal consultations	
None	2 (6%)
One to Three	8 (24%)
Four to Six	12 (34%)
Seven to Nine	8 (24%)
Ten to Twelve	4 (12%)
Who helps with daily baby care activities	
Nobody	22 (64%)
Husband/partner/baby's father	6 (18%)
Mother	2 (6%)
Brother	2 (6%)
Aunt	2 (6%)
Use of psychotropic medications	
Yes	1 (2%)
No	33 (98%)

Source: the authors (2024).

The total EPDS score among participants ranged from 5 to 24 points, with a mean of 3.4 (Standard Deviation [SD] = ± 3.06). Considering the cutoff point used to indicate the probable presence of clinical depressive symptoms (score > 12), of the 34 puerperal women evaluated, 14 (42%) obtained scores below 12, while 20 (58%) presented a score equal to or higher, compatible with the risk of postpartum depression.

Table 3. Total scores from the Edinburgh Postpartum Depression Scale of postpartum women in UBS in the municipality of Marituba - PA, Brazil, 2024. (N=34)

Edinburgh Postnatal Depression Scale (EPDS) Scores	n (%)
5	4 (11,8%)
6	3 (8,8%)
7	2 (5,8%)
8	1 (3,0%)
9	2 (5,9%)
10	2 (5,9%)
12	11 (32,3%)
19	6 (17,6%)
20	2 (5,9%)
24	1 (3,0%)

Source: the authors (2024). SD=standard deviation.

The table 4 presents the frequency of responses from the 20 women who scored 12 or higher on the EPDS, indicating signs suggestive of postpartum depression. Although 100% reported being able to laugh and find things funny (item 1), the majority presented negative symptoms, such as unnecessary guilt (100%, item 3), and a feeling of being overwhelmed by daily tasks (100%, item 6). High percentages also indicated anxiety (80% on item 4), feelings of panic (90% on item 5), and thoughts of self-harm (item 10).

Table 4. Relationship of scores in each EPDS question of postpartum women with a score ≥ 12 , in UBS in the municipality, Marituba - PA, Brazil, 2024. (N=20)

Edinburgh Postnatal Depression Scale Items	n (%)
1. I have been able to laugh and see the funny side of things.	20 (100%)
2. I have looked forward with enjoyment to things.	16 (80%)
3. I have blamed myself unnecessarily when things went wrong.	20 (100%)
4. I have been anxious or worried for no good reason.	16 (80%)
5. I have felt scared or panicky for no very good reason.	18 (90%)
6. Things have been getting on top of me.	20 (100%)
7. I have been so unhappy that I have had difficulty sleeping.	16 (80%)
8. I have felt sad or miserable.	10 (50%)
9. I have been so unhappy that I have been crying.	2 (10%)
10. The thought of harming myself has occurred to me.	12 (60%)

Source: the authors (2024).

4. Discussion

In this study, we found that postpartum women with low levels of education, single women, housewives, and low-income women are more likely to experience postpartum depression symptoms. A study of postpartum women living in the extreme south of Brazil¹³ points to education as a protective factor, with the greater the number of years of completed education, the greater the protection against depression. Furthermore, factors such as being single and/or being an adolescent predispose these women to developing depressive symptoms³.

In this study, most participants were single, a condition that can make it difficult to share household chores and reduce the family support network. This finding is corroborated by the fact that most postpartum women reported caring for the baby alone (64%). This scenario highlights a disarray in the socially constructed expectations of family, in which parental responsibilities are shared and mutual support is assumed¹⁴. Research¹⁴ indicates that financial organization before the baby's arrival is essential to reassure the family. Regarding occupation, it was observed that most mothers primarily perform domestic tasks, without formal employment, indicating a repetitive routine, no fixed income, and report relying on some type of benefit from social programs, characterizing minimal resources for survival. Uncertainty about the financial future can be a significant factor in triggering postpartum depression¹⁴.

A study conducted in Goiás, in line with the findings of this research, showed that socio-family conditions and maternal occupation significantly influence mental health during the postpartum period. The study also indicates that factors such as concerns about the newborn's health and needs, returning to work, fear of unemployment after maternity leave, insecurity, and insufficient financial resources contribute to increased distress and worry, favoring the emergence of mental disorders during this period¹⁵.

Regarding obstetric variables, it was observed that one-third of women had already had at least one abortion (35%), and more than half did not plan the pregnancy (53%). Regarding the number of abortions, a study revealed that women who have already experienced spontaneous or repeated abortions are at risk of developing postpartum depression, as the event was a potential stressor, developing traumas and anxieties that influence the future condition of the puerperal woman¹⁶. And regarding family planning, the scientific literature shows that unplanned pregnancy is one of the risk factors that can trigger postpartum depression¹⁷.

Regarding prenatal care, most postpartum women in this study had between four and nine appointments (58%). The literature indicates that qualified listening during prenatal care, combined with an effective support network and healthy social relationships, contributes to the prevention of various social problems and to the improvement of postnatal care¹. In this context, the importance of providing more information about postpartum depression and offering pregnant women adequate time to discuss this possibility is highlighted. Such an approach would favor early detection of the condition and allow for the timely initiation of necessary care for both physical and mental health¹⁰.

Regarding support for psychotropic medication use, only 2% of participants reported using medication for anxiety. Furthermore, according to Galvão et al.¹⁸, the metabolic changes observed during pregnancy are preponderant factors for the onset of postpartum depression and other mental disorders in the postpartum period¹⁸. In this sense, postnatal monitoring and postpartum consultations are essential, as they allow health professionals to identify early signs and symptoms related to changes in mood, behavior, and cognition. Based on this assessment, it is possible to implement timely interventions aimed at mother-infant interaction and the promotion of maternal mental health¹⁹.

Scientific literature shows that the use of the Edinburgh Scale contributes to the early diagnosis

of the disease in the postpartum period, minimizing problems between mother and baby¹². And in the present study, it was found that 20 postpartum women (58%) obtained scores equal to or greater than 12, revealing a high risk for postpartum depression. This finding reinforces the need for the primary care team to strengthen bonds with the pregnant woman, carry out qualified listening, early detection of depressive symptoms and encourage the participation of the pregnant woman and family in prenatal care¹⁰.

In this regard, another important finding in this study refers to a higher frequency of women with depressive symptoms but who do not seek help or receive guidance during prenatal care on early identification of signs and symptoms of PPD. This occurrence corroborates the findings of another study²⁰, which indicates that many women fail to seek medical or psychological care due to lack of information, shame, and/or prejudice. Therefore, it is emphasized that cultural and social barriers — such as stigma and embarrassment — need to be addressed during prenatal and well-child visits, with early identification of the risk of postpartum depression. This allows these women to be referred for specialized evaluation and appropriate treatment, contributing to the prevention of more severe conditions²⁰.

International scientific literature indicates that, during prenatal and postpartum consultations, it is essential to assess psychosocial and obstetric factors, as both are directly associated with the emergence of depressive symptoms²¹. Furthermore, the importance of investigating the quality of family relationships is highlighted, as the support received during this period can significantly influence maternal mental health and mother-infant interaction²². In the present study, it was observed that most postpartum women cared for the baby alone, highlighting a fragile support network. This finding, combined with the lack of adequate guidance during prenatal care, suggests a significant gap in professional practice, reinforcing the need for health professionals trained to address and investigate psychosocial and family aspects to prevent the worsening of depressive symptoms in the postpartum period²¹.

The analysis of the responses of women who scored ≥ 12 on the EPDS revealed that the most prevalent symptoms were anxiety, feelings of panic, and thoughts of self-harm, indicating the severity of the observed emotional situation. Studies indicate that the risk of postpartum depression is associated with family conflicts, often accompanied by feelings of guilt in the postpartum period⁹. This risk is heightened in situations of greater vulnerability, such as a history of sexual abuse or previous depression. In this context, the use of the Edinburgh Postpartum Depression Scale (EPDS) proves to be an effective tool in nursing practice, as it enables the early identification of these risk factors and the timely referral of women to psychological care during the postpartum period⁹.

In the present study, it was found that all postpartum women (100%) reported task overload, which highlights an important risk factor for gradual mental health deterioration. During the postpartum period, many women's primary expectation of family support is the active presence of their partner, and when this expectation is not met, they may experience symptoms of anxiety, excessive worry, and even panic attacks²³. Fatherly participation in sharing household chores and infant care is essential, as it is directly related to reducing maternal stress and promoting a more balanced family environment²³. Conversely, the lack of this shared responsibility exposes mothers to physical and emotional overload, favoring the development of depressive symptoms and increasing their vulnerability to postpartum depression²².

In this study, we found that postpartum women experienced episodes of sadness, frequent crying, fatigue due to daily events, and difficulty sleeping. These symptoms may be related to the demands of the postpartum period, such as the intense routine of caring for the baby, household chores, breastfeeding, and the bodily and physiological changes inherent to this phase²⁴. Furthermore, the lack of family support exacerbates these factors, favoring the emergence of feelings of sadness, insomnia, and frustration²³.

Within the EPDS, two postpartum women reported having had suicidal ideation. This finding suggests a high risk for PPD. Mothers with depressive symptoms may experience thoughts of self-harm, so a clinical evaluation by a primary care healthcare professional is necessary, with a detailed safety

assessment that includes a history of childhood abuse and current symptoms of sleep disturbances and anxiety²⁵. The safety assessment includes exploring suicidal or homicidal ideation or attempts, past or recent hospitalizations, recent medication changes, intolerable medication effects, alcohol and other substance use, family history of suicide, and assessment of protective factors²⁵.

The results obtained are relevant; however, one of their limitations is the cross-sectional design, which, while essential for estimating prevalence and identifying factors associated with postpartum depression in specific populations, does not allow for establishing causal relationships or monitoring the progression of symptoms over time. Furthermore, the use of the Edinburgh Postnatal Depression Scale, as a self-report instrument, is subject to response bias. This limitation was compounded by the context of data collection, which was scheduled but often with newborns present, which may have compromised the accuracy of responses and influenced data interpretation.

5. Conclusion

The results of this study indicate that 58% of the postpartum women evaluated were at significant risk for postpartum depression, based on a score of 12 or higher on the scale used. Furthermore, most of these women had low levels of education, were not employed, and many were single mothers, emotionally and socially overwhelmed. These conditions, coupled with uncertainty about the future, are factors that exacerbate fear and insecurity, reinforcing the need for specific policies and interventions to support the mental health of postpartum women.

The EPDS scale revealed a predominance of symptoms related to anxiety, overload, and negative feelings, also highlighting a significant portion of women at potential risk of self-harm. Thus, the scale constitutes a valid and effective instrument for use in nursing consultations. However, it highlights the need to train healthcare teams, especially those responsible for prenatal care, to identify pregnant women at high risk of developing PPD early. Timely referral to specialists for evaluation and appropriate intervention is essential for clinical management.

This highlights the importance of the EPDS as a tool combined with qualified listening and comprehensive mental health care during prenatal and postpartum care for the early identification of signs of depression. Systematic incorporation of the EPDS into prenatal consultations, accompanied by clarification of its relevance to pregnant women and professionals, can facilitate early diagnosis and the implementation of effective therapeutic interventions, resulting in better maternal health outcomes.

Future studies could investigate the effectiveness of educational programs aimed at training multidisciplinary teams and assess the impact of early screening on reducing the incidence and severity of postpartum depression. Longitudinal studies would also be useful for monitoring symptom progression and treatment adherence, contributing to the development of culturally sensitive protocols.

Authors' contributions

The authors stated that they made substantial contributions to the work in terms of research design or design; data acquisition, analysis or interpretation for the work; and writing or critical review of relevant intellectual content. All authors approved the final version to be published and agreed to take public responsibility for all aspects of the study.

Competing interests

No financial, legal or political conflict involving third parties (government, companies and private foundations, etc.) has been declared for any aspect of the submitted work (including but not limited to grants and funding, participation in advisory board, study design, manuscript preparation, statistical analysis, etc.).

Indexers

The Journal of Contemporary Nursing is indexed by [DOAJ](#) and [EBSCO](#).



References

1. Piccinini CA, Lopes RS, Gomes AG, Nardi T. Pregnancy and motherhood. *Psicol Estud*. 2008;13(1):63-72. <https://doi.org/10.1590/S1413-73722008000100008>
2. Barros MVV, Aguiar RS. Sociodemographic and psychosocial profile of women with Post-department depression: an integrating review. *Rev Aten Saúde [Internet]*. 2019;17(59). Available from: https://seer.uscs.edu.br/index.php/revista_ciencias_saude/pt_BR/article/view/5817/pdf
3. Gonçalves AMC, Teixeira MTB, Gama JRA, Lopes CS, Silva GA, Gamarra CJ, et al. Prevalence of depression and associated factors in women covered by Family Health Strategy. *J Bras Psiquiatr*. 2017;66(3):148-55. <https://doi.org/10.1590/0047-2085000000192>
4. Silva BP, Matijasevich A, Malta MB, Neves PAR, Mazzaia MC, Gabrielloni MC, et al. Common mental disorders in pregnancy and postnatal depressive symptoms in the MINA-Brazil study: occurrence and associated factors. *Rev Saude Publica*. 2022;56:83. <https://doi.org/10.11606/s1518-8787.2022056004028>
5. Matos A, Moll MF, Pires NA, Vasconcelos TF, Ventura CAA. Fatores associados à depressão pós-parto: um estudo na atenção primária em bairros central e periférico Factors associated with post-delivery depression: a study on primary care in central and peripheral neighborhoods. *Braz J Dev*. 2020;6(10):77690-703. <https://doi.org/10.34117/bjdv6n10-265>
6. Moll MF, Matos A, Rodrigues TA, Martins TS, Pires FC, Pires NAS. Tracking postpartum depression in young women. *Rev Enferm UFPE Online [Internet]*. 2019;13:e239181. Available from: <https://periodicos.ufpe.br/revistas/revistaenfermagem/article/view/239181/32252>
7. Montenegro CAB, Rezende Filho J. Rezende obstetrícia fundamental. 14th ed. Rio de Janeiro: Guanabara Koogan; 2017.
8. Santos IS, Matijasevich A, Tavares BF, Barros AJD, Botelho IP, Lapolli C, et al. Validation of the Edinburgh Postnatal Depression Scale (EPDS) in a sample of mothers from the 2004 Pelotas Birth Cohort Study. *Cad Saude Publica*. 2007;23(11):2577-88. <https://doi.org/10.1590/S0102-311X2007001100005>
9. Aloise SR, Ferreira AA, Lima RFS. Depressão pós-parto: identificação de sinais, sintomas e fatores associados em maternidade de referência em Manaus. *Enferm Foco [Internet]*. 2019;10(3):41-5. Available from: <https://enfermfoco.org/article/depressao-pos-parto-identificacao-de-sinais-sintomas-e-fatores-associados-em-maternidade-de-referencia-em-manaus/>

10. Marques BL, Tomasi YT, Saraiva SS, Boing AF, Geremia DS. Orientações às gestantes no pré-natal: a importância do cuidado compartilhado na atenção primária em saúde. Esc Anna Nery. 2021;25(1):e20200098. <https://doi.org/10.1590/2177-9465-EAN-2020-0098>
11. Creswell JW. Projeto de pesquisa: métodos qualitativo, quantitativo e misto. 5th ed. Porto Alegre: Penso; 2021.
12. Lima NC, Ravelli APX, Messias LSF, Skupien SV. Depressão pós-parto baseada na Escala de Edimburgo. Rev Conex UEPG [Internet]. 2016;12(2):268-77. Available from: <https://revistas.uepg.br/index.php/conexao/article/download/8557/5287/32195>
13. Hartmann JM, Mendoza-Sassi RA, Cesar JA. Depressão entre puérperas: prevalência e fatores associados. Cad Saude Publica. 2017;33(9):e00094016. <https://doi.org/10.1590/0102-311X00094016>
14. Brocchi BS, Bussab VSR, David V. Depressão pós-parto e habilidades pragmáticas: comparação entre gêneros de uma população brasileira de baixa renda. Audiol Commun Res. 2015;20(3):463-73. <https://doi.org/10.1590/2317-6431-ACR-2015-1538>
15. Camargo Júnior EB, Andrade ACS, Fernandes MNF, Gherardi-Donato ECS. Association between childhood trauma and postpartum depression among Brazilian puerperal women. Rev Latino-Am Enfermagem. 2024;32:e4170. <https://doi.org/10.1590/1518-8345.6761.4170>
16. Reardon DC, Craver C. Effects of Pregnancy Loss on Subsequent Postpartum Mental Health: A Prospective Longitudinal Cohort Study. Int J Environ Res Public Health. 2021;18(4):2179. <https://doi.org/10.3390/ijerph18042179>
17. Brito CNO, Alves SV, Ludermir AB, Araújo TVB. Depressão pós-parto entre mulheres com gravidez não pretendida. Rev Saúde Pública [Internet]. 2015;49:1-9. Available from: https://www.scielo.org/pdf/rsp/v49/pt_0034-8910-rsp-S0034-89102015049005257.pdf
18. Galvão DS, Rodrigues BL, Carril TV, Marques Jr NR, Siqueira TD. Perspectivas sobre a depressão pós-parto: uma revisão de literatura. Bol Inf Uni Soc- BIUS [Internet]. 2019;14(8). Available from: <https://periodicos.ufam.edu.br/index.php/BIUS/article/view/6880>
19. Luca BL. Os efeitos da depressão pós-parto na interação mãe-bebê [undergraduate thesis] [Internet]. Brasília (DF): Centro Universitário de Brasília, Faculdade de Ciências da Saúde; 2005. Available from: <https://repositorio.uniceub.br/jspui/bitstream/123456789/3089/2/20109602.pdf>
20. Arrais AR, Mourão MA, Fragalle B. O pré-natal psicológico como programa de prevenção à depressão pós-parto. Saude Soc. 2014;23(1):251-64. <https://doi.org/10.1590/S0104-12902014000100020>
21. Joinson C, Drake MJ, Fraser A, Tilling K, Heron J. Bidirectional relationships between depression, anxiety and urinary symptoms in women: A prospective cohort study. J. Affect. Disord. 2025;369:516-22. <https://doi.org/10.1016/j.jad.2024.10.035>
22. Al-abri K, Edge D, Armitage CJ. Prospective analysis of factors associated with perinatal depression. Midwifery. 2024;128:103871. <https://doi.org/10.1016/j.midw.2023.103871>
23. Frizzo GB, Martins LWF, Silva EXL, Piccinini CA, Diehl AMP. Teenage Motherhood: Support Systems in the Context of Postpartum Depression. Psicol. (Univ. Brasília). 2019;35:1-13. <https://dx.doi.org/10.1590/0102.3772e3533>
24. Lazzaletti DSB, Rücker KP, Nesi SB, Sordi KARC, Benetti JE, Pedrosa AF, et al. Depressão pós-parto e seus impactos: relato de uma mãe e uma psicóloga no município de Chapecó-SC [Internet]. In: Anais de Psicologia. Chapecó (SC): UCEFF; 2022. Available from: <https://uceff.edu.br/anais/index.php/psico/article/download/377/377>
25. Sit D, Luther J, Buysse D, Dills JL, Eng H, Okun M, et al. Suicidal ideation in depressed postpartum women: Associations with childhood trauma, sleep disturbance and anxiety. J Psychiatr Res. 2015;66-67:95-104. <https://doi.org/10.1016/j.jpsychires.2015.04.021>