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TRACKING POSTPARTUM DEPRESSION IN YOUNG WOMEN RASTREANDO A DEPRESSÃO PÓS-PARTO EM MULHERES JOVENS RASTREANDO LA DEPRESIÓN POSPARTO EN MUJERES JÓVENES

Marciana Fernandes Moll¹, Aldo Matos², Tatiana de Aquino Rodrigues³, Tayná da Silva Martins⁴, Fabiana Cristina Pires⁵, Nathália Alves da Silva Pires⁶

ABSTRACT

Objective: to track postpartum depression among young women who are in the second week and in the sixth month postpartum. **Method:** it is a quantitative, descriptive, exploratory and cross-sectional study whose participants were women aged between 18 and 26 years, between the second week and the sixth month after delivery. The data was collected between August 2017 and January 2018, using the Edinburgh Postnatal Depression Scale and a sociodemographic survey. For the tabulation of data, the Microsoft Excel program was used, typing them by double entry and then transporting them to the BioEstat program, version 5.0. The chi-square test was applied for the descriptive statistical analysis and the results were presented in table form. **Results:** a probable postpartum depression was identified in 19.70% of the puerperae and this condition was associated with the following factors: baby age, multiparity and low level of schooling. **Conclusion:** it is evidenced that postpartum depression needs to be investigated in primary health care, which should value the sociodemographic and individual aspects to establish a comprehensive care plan from the prenatal period, with a view to preventing this frequent postpartum disorder. **Descriptors:** Nursing; Psychiatry; Primary Health Care; Assistance; Depression Postpartum; Disease Prevention.

RESUMO

Objetivo: rastrear a depressão pós-parto entre mulheres jovens que estão na segunda semana e no sexto mês após o parto. **Método:** trata-se de estudo quantitativo, descritivo, exploratório e transversal cujas participantes foram mulheres com idades entre 18 a 26 anos, entre a segunda semana e o sexto mês após o parto. Coletaram-se os dados entre os meses de agosto/2017 a janeiro/2018, por meio da Escala de Depressão Pós-natal de Edimburgo e de um inquérito sociodemográfico. Utilizou-se, para a tabulação dos dados, o programa *Microsoft Excel*, digitando-os por dupla entrada e, posteriormente, transportando-os para o programa *BioEstat*, versão 5.0. Aplicou-se o teste qui-quadrado para a análise estatística descritiva e apresentaram-se os resultados em forma de tabela. **Resultados:** identificou-se uma provável depressão pós-parto em 19,70% das puérperas e essa condição teve associação com os seguintes fatores: idade do bebê, multiparidade e baixo nível de escolaridade. **Conclusão:** evidencia-se que a depressão pós-parto precisa ser investigada na atenção primária em saúde, que deve valorizar os aspectos sociodemográficos e individuais para estabelecer um plano de cuidados integral desde o pré-natal, com vistas à prevenção desse frequente transtorno do puerpério. **Descritores:** Enfermagem; Psiquiatria; Atenção Primária em Saúde; Assistência; Depressão Pós-parto; Prevenção de Doenças.

RESUMEN

Objetivo: rastrear la depresión posparto entre mujeres jóvenes que se encuentran en la segunda semana y en el sexto mes después del parto. **Método:** se trata de estudio cuantitativo, descriptivo, exploratorio y transversal, cuyas participantes fueron mujeres con edades entre 18 a 26 años, entre la segunda semana y el sexto mes después del parto. Se recolectaron los datos entre los meses de agosto / 2017 a enero / 2018, por medio de la Escala de Depresión Post-natal de Edimburgo y de una encuesta sociodemográfica. Se utilizó, para la tabulación de los datos, el programa *Microsoft Excel*, digitados por doble entrada y posteriormente transportados al programa *BioEstat*, versión 5.0. Se aplicó la prueba chi-cuadrada para el análisis estadístico descriptivo, se presentaron los resultados en forma de tabla. **Resultados:** se identificó una probable depresión posparto en el 19,70% de las puérperas y esa condición tuvo asociación con los siguientes factores: edad del bebé, multiparidad y bajo nivel de escolaridad. **Conclusión:** se evidencia que la depresión posparto necesita ser investigada en la atención primaria en salud, que se deben valorar los aspectos sociodemográficos e individuales para establecer un plan de cuidados integral desde el prenatal, con miras a la prevención de ese frecuente trastorno, del puerperio. **Descriptores:** Enfermería; Psiquiatría; Atención Primaria de Salud; Asistencia; Depresión Posparto; Prevención de Enfermedades.

¹Doctor (Post-doctor), University of Uberaba / UNIUBE. Uberaba (MG), Brazil. Email: mrcna13@yahoo.com.br ORCID iD: <https://orcid.org/0000-0003-4794-4255>; ²Master. University of Uberaba / UNIUBE. Uberaba (MG), Brazil. Email: aldo.matos@uniube.br ORCID iD: <https://orcid.org/0000-0001-8924-5116>; ^{3,4,6}Nursing Students. University of Uberaba / UNIUBE. Uberaba (MG), Brazil. Email: enfermagemtatiakin@gmail.com ORCID iD: <https://orcid.org/0000-0001-5086-0314>; Email: maartinstayna@gmail.com ORCID iD: <https://orcid.org/0000-0003-3274-6555>; Email: nathaliapirex@gmail.com ORCID iD: <https://orcid.org/0000-0003-2769-9942>; ⁵Post-graduate students. University of Uberaba / UNIUBE. Uberaba (MG), Brazil. Email: enfermagem.pires@gmail.com ORCID iD: <https://orcid.org/0000-0002-8524-1449>

INTRODUCTION

It is known that postpartum depression (PPD) is a high prevalence mental disorder, since global analysis shows that this disorder affects 10% to 20% of women in the postnatal period and it is estimated that up to the year 2020, will be the second largest factor of morbidity among puerperas.¹⁻³

Generally, the PPD causes emotional, cognitive, behavioral and physical changes that usually begin between the fourth and eighth weeks after childbirth and intensify in the first six months.⁴⁻⁵

Signs and symptoms of PPD are identified by physical and psychic manifestations, physical symptoms being reduced by energy and activity levels, and may be associated with sleep problems, severe tiredness, loss or increase of appetite, and decreased sexual desire. Psychic symptoms are determined by lowering of mood, difficulty concentrating and experiencing pleasure in situations usually considered pleasant, decreased self-esteem and feelings of guilt. Through this clinical picture, in the individual, sensations of uselessness and incapacity are nurtured, and in some cases suicidal thoughts may arise⁶

The treatment of PPD is usually established according to the severity of the depressive picture presented. This treatment is based on the same one instituted for the depression that is not related to the postpartum, being able to be used the psychotherapy and / or the pharmacotherapy and, in case of attempts of suicide or infanticide, the electroconvulsoterapia.⁷

As a consequence of this disorder, the absence of mother-child interaction, which can be expressed by the following situations: hostility, rejection, neglect, aggressiveness, as well as less affection and greater anxiety of the woman when giving maternal care.⁶

In view of this reality, it is evident that the physical and emotional care provided to the baby is vulnerable, affecting possible affective and intellectual impairments of the child.⁶

Among the main risk factors are the low age of puerperal women, being single or divorced, and economic issues represented by the fact that the woman or her spouse is unemployed.⁸

The consequences for the women affected by PPD are represented by the difficulties of involvement and social interaction, presenting deficits in the regulation of their affective states.⁶

Precocious and late repercussions for children are also described. Early manifestations include poor performance in developmental tests and high levels of unsafe attachment to the mother at 12 months. Disorders of conduct, physical health impairment, unsafe connections and depressive episodes are characterized as late repercussions.⁶

It should be emphasized that the prognosis of this puerperal disorder is strongly linked to early diagnosis and rapid interventions. It is necessary for the woman to have an integrated care, both in pregnancy and in the puerperal period, in order to minimize the risk of developing PPD and to prevent the aforementioned consequences.¹

In the first weeks of the newborn's life, the search for the woman by the health service is emphasized, where the following interventions are commonly performed: encouragement of exclusive breastfeeding; vaccination in the baby and in the mother; test for neonatal screening; health risk assessment of mother and baby; guidelines on contraception; scheduling of puerperal and dental follow-up consultations for the mother, and evaluation of growth and development for the baby, and the indicative framework for PPD should be investigated.⁹

However, PPD is difficult to diagnose and, therefore, is often not detected by the nursing team or the obstetrician at first, since the initial symptoms may be confused with the period of postpartum emotional adjustment of postpartum postpartum sadness.¹⁰

It is considered important, from this context, to carry out scientific studies that track postpartum depression among young women (18 to 26 years old) so that, in the presence of this disorder, women are referred to specialized professionals and are qualified to establish the final diagnosis and initiate therapy. This intervention must occur predominantly in Primary Health Care (PHC), since the ideal period for this search is between two weeks and six months after childbirth, and it is in this period, women seek the services of the Family Health Strategy (FHS).¹¹

OBJECTIVE

- To track postpartum depression among young women who are in the second week and in the sixth month postpartum.

METHOD

This is a descriptive, exploratory, cross-sectional, quantitative approach study approved by the Human Research Ethics Committee of the University of Uberaba (CAAE: 68006017.6.0000.5145).

The research was carried out in health services of primary health care located in the sanitary district II of the urban area of a city in the interior of Minas Gerais. The choice of this sanitary district is due to its extensive coverage area, which covers a large number of family health teams (fifteen), composed of people and communities with mixed socioeconomic characteristics.

A total of 237 women were identified in this sanitary district, with different age groups, enrolled in the Monitoring System of the Prenatal and Birth Humanization Program (SisPreNatal). The study population, considering youth as a risk factor for PPD, was constituted by women aged 18 to 26 years.

The sample size was calculated considering a minimum prevalence of PPD of 15%, 95% confidence and 5% of error, being sampled for convenience.

The following inclusion criteria were established: age between 18 and 26 years; being in the postpartum period comprising the second week and the sixth month; reside in sanitary district 2 and be duly registered at SisPreNatal. The choice for this age group is due to the fact that scientific evidence indicates that, in Brazil, about 30% to 40% of the puerperas seen in primary health care tend to present high levels of depressive symptoms, which is directly related to associated to the following factors: low level of schooling; absence of a fixed partner; low socioeconomic conditions and submission to continuous stress.¹²

They were listed as exclusion criteria: having exceeded the sixth month after delivery; residing in rural areas of the health district 2 or residing in areas covered by sanitary districts 1 and 3 and not registered in SisPreNatal.

The data was collected from August 2017 to January 2018, in a private way, to protect the individuality of each participant, and for this purpose, the structure made available in each of said health units was used. The days and times of the collection were based on the schedules in which the most frequent puerperae (foot test, medical consultation of the woman or the child, breastfeeding groups, among others).

It was decided to investigate PPD for using the Edinburgh Postnatal Depression Scale (EPDS), which has ten items, and is currently in the public domain. This scale was developed in England in 1987 with the objective of tracking postpartum depression, favoring the use of the ease and speed of its application.¹³⁻⁴

The clinical and epidemiological values of this scale were confirmed by several validation studies performed in different countries, mainly among women in the postpartum period, with sensitivity and specificity in the 70-85% range, depending on the cutoff point. It should be noted that the scale (EPDS) was validated in several countries and its Portuguese version was made in 1996.¹³⁻⁴

EPDS is a self-registration instrument, composed of ten statements, whose options are scored (zero to three) according to the presence or intensity of the symptom. Psychological symptoms such as depressive mood (feeling of sadness, self-depreciation and guilt, ideas of death or suicide), loss of pleasure in activities previously considered pleasant, fatigue, decreased ability to think, (eg, insomnia or hypersomnia) and changes in behavior (crying). A sum of 30 points is scored, and a value of 12 or greater is considered a depressive symptomatology, as defined in the validation of the scale in a Brazilian sample. a sociodemographic survey that included the following approaches: age and schooling of the puerperal woman; family income; number of children; baby's age and marital status.

The data of the sociodemographic survey by the Microsoft Excel program was typed, tabulated and consolidated, by double entry, typing them independently to minimize failures in the database entry. The bank was transferred to the BioEstat program, version 5.0, through which the descriptive statistics were performed and the chi-square test was applied to evaluate the association between PPD and the age of the puerperal woman, her marital status, the family income, the number of children and the age of the baby.

RESULTS

The sample was constituted by 66 puerperae, with probable depression identified in 13 (19.70%) of them. The chi-square test was used to evaluate the association with the age of the puerperal woman, her marital status, her schooling, the family income, the number of children and the age of the baby, whose results are presented in table 1. The age of the

puerperae from 18 to 26 years was varied (median 23).

An association of the probable depression with the age of the baby was found, whose distribution is represented in table 1, being related to puerperal infants at the extremes of age - up to two months or five or six months.

There were offspring of one to ten children, with 50% of primiparous women. The association of probable depression with this variable was observed (Table 1), suggesting that the higher number of children is a risk factor for depression.

It is reported that the schooling of the puerperae ranged from incomplete elementary schooling to complete higher education, with the highest occurrence for incomplete secondary education (42.86%). An association was found between probable depression and the lowest level of education (Table 1).

Table 1 shows the percentage distribution of the marital status - with 54.55% of single puerperal women - and the family income. It is revealed that, for both variables, no association was found with the probable depression.

Table 1. Characteristics and factors associated with postpartum depression in postpartum women in the urban area. Uberaba (MG), Brazil, 2018.

Variable	Sample description (%)	Value of p
Number of children		<0.0001
1	50.0	
2	33.33	
3	10.61	
4 to 10	6.06	
Baby's age (months)		<0.0001
Up to 1	16.95	
2	15.25	
3	10.17	
4	18.64	
5	18.64	
6	20.35	
Family income (minimum wages)		0.6768
Up to 1	24.15	
1 to 2	40.03	
2 to 3	22.16	
3 to 4	6.02	
4 or more	7.64	
Marital status		0.5170
Single	54.55	
Married	18.18	
Living together	16.67	
Stable Union	10.6	
Maternal education		<0.0001
Incomplete elementary school	17.46	
Complete elementary school	15.87	
Incomplete highschool	17.46	
Complete highschool	42.86	
Incomplete higher education	1.59	
Complete higher education	4.76	

DISCUSSION

It is emphasized that PPD is a public health problem because, in different scientific studies, its frequency is significant, as evidenced in this investigation. A current study,¹⁶ carried out in Ethiopia, with the participation of 450 women, identified that 102 of them (22.4%) had depressive symptoms indicative of PPD, and that they predominated between the first six weeks after childbirth. Considering this reality, the period of the

puerperium and the location where the PPD is traced through the Edinburgh Scale should be valued, since when it is applied within 48 hours of the immediate puerperium in a hospital environment, the results are not so significant, since of 1487 women interviewed in the mentioned puerperal period and environment, in a medium-sized city in the south of the country, only 14% had symptoms compatible with PPD.¹⁷

It is revealed that, even in the face of this differential, in a study carried out in Brazil

with 23,894 puerperae, depression is one of the most frequent mental disorders in postpartum and is related to different sociodemographic and individual factors.¹⁸

The association between the probable depression was described, in this sense, through this investigation, with the following factors: baby's age, number of children and schooling.

It is added that in this study, there was association with the age of the baby at the extremes of age up to two months or with five and six months. It should be emphasized that before the maternity, the woman was adapted with the roles that were inherent to her (daughter, wife, worker, among others) and, after the birth of the baby, she must include, among these roles, maternity, which tends to provide intense changes in your life, requiring an adaptation so that the care with the baby can be carried out.¹⁹

It is considered that this condition may be associated with several other stressful phenomena (lack of support from the family, interruption of activities, and may lead to socioeconomic problems) and that the first six months correspond to a period of emotional adjustment and daily life that may cause frames depressive.²⁰

The association with the number of children in this investigation was represented by a offspring with four or more children. Similar results were also observed in studies that were carried out in Brazil between the years 2011 and 2012¹⁸ and, specifically, in a medium-sized city in the extreme south of that country during the year 2013,¹⁷ which point out that multiparturicity directly to the probable depression identified in both studies by the Edinburgh Scale. It is pointed out, in this sense that the large number of children tends to generate overload and stress in the woman.¹⁹

In this research, the low level of education was associated with the probable depression, which does not corroborate the findings of research carried out in Hatay, Turkey, which is with the developing economy, such as Brazil.²¹

However, it was identified in a recent Brazilian investigation by the EPDS,^{20,22} association between PPD and level of schooling.

It is noticed that, despite other authors finding association of PPD with family income,¹⁷ this was not observed in the sample of this study. It is added that the same authors found no influence of the father's support of the baby as a protection factor against PPD and,

in this respect, there was no association between the probable PPD and the marital status of the women who composed the sample.

CONCLUSION

Postpartum depression was identified in 19.70% of the 66 postpartum women who participated in the study and this condition was associated with the following factors: baby's age (two months or between five and six months), multiparity (having four or more children) and low level of schooling.

It is concluded that, although this study was developed in only one health district, it expresses relevance in the social and care contexts, since it has shown that postpartum depression needs to be investigated in primary health care, which should value socio-demographic and individual aspects to establish a plan of integral care, from the prenatal, with a view to the prevention of this frequent disorder of the puerperium. It is necessary, given this context, that members of the team working in primary health care, with emphasis on the nurse, who should assist women in all phases of the puerperal pregnancy cycle, to ensure the inclusion of screening and monitoring of the postpartum depression among the priority actions during the puerperium.

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Corresponding Address

Marciana Fernandes Moll
Av. Nenê Sabino, 1801
Bairro Universitário
CEP: 38055-500 — Uberaba (MG), Brazil