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Research Article

Assessment of Postpartum Depression Among Women: Prevalence, Risk Factors, and Implications

Iman Hussein Alwan[1,*], Salah Mahdi Al-jubouri[2] ,

[1] *Assistant Professor, Psychiatric Mental Health Nursing Department, Faculty of Nursing, University of Baghdad, Iraq*

[2] *M.Sc. University of Al_Ameed, College of Nursing, Karbala, Iraq*

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ABSTRACT

This study aims to assess the prevalence of postpartum depression (PPD) among women in Karbala City and examine its association with key demographic, socioeconomic, and obstetric factors. Additionally, the study explores the broader implications of PPD on maternal well-being and healthcare practices.

A descriptive cross-sectional study was conducted between December 2023 and June 2024 in healthcare centers affiliated with the Karbala Health Department – Central Sector. A total of 225 postpartum women, aged 15 to 45 years and within the first week to six months postpartum, were selected using purposive non-probability sampling. Data collection involved the Edinburgh Postnatal Depression Scale (EPDS) and a structured demographic and obstetric questionnaire.

The findings indicate that 38.2% of participants experienced PPD, highlighting a significant public health concern. The majority of women were from extended families (52.0%) and aged 16 to 25 years (51.6%). Most pregnancies were planned (80.9%), and a considerable proportion reported sufficient monthly income (68.4%). While age ($p = 0.669$) and mode of delivery ($p = 0.495$) showed no significant association with PPD, socioeconomic status exhibited a near-significant correlation ($p = 0.048$), suggesting its potential impact on maternal mental health. Furthermore, factors such as limited social support, stressful life events, and previous mental health conditions were observed to contribute to PPD risk.

PPD is a prevalent issue among postpartum women in Karbala City, with socioeconomic and psychosocial factors playing a crucial role in its development. These findings emphasize the need for targeted interventions to address these factors and the integration of mental health services into primary healthcare settings to mitigate PPD's impact on maternal health. Recommendations : Strengthen the role of mental health units in primary healthcare centers to educate women about postpartum depression. Implement routine screening programs for early detection of PPD during postnatal care visits. Conduct further studies to examine the impact of social, demographic, and obstetric factors on PPD risk.

1. INTRODUCTION

The postpartum period is associated with significant physical and emotional changes that can lead to anxiety and mood disturbances. Postpartum mood disorders are categorized into three degrees: "baby blues," postpartum depression (PPD), and postpartum psychosis [5]

PPD represents a major public health issue that affects not only the mother but also the family. It impacts marital relationships and child development, making it crucial to prevent, diagnose, and treat effectively. Untreated PPD can have severe long-term consequences. For the mother, it may lead to chronic recurrent depression, and for the child, prolonged depression in the mother can contribute to emotional, behavioral, cognitive, and interpersonal challenges in later life [1].

PPD is a psychological disorder that typically manifests within the first few weeks or months after childbirth. Symptoms include abrupt mood changes, sleep disturbances, extreme fatigue, feelings of inadequacy, difficulty concentrating, and recurring thoughts of death or suicide [2].

The severity of postpartum mood disorders varies. "Baby blues" affect approximately 50-85% of women postpartum, while 10-20% experience moderate depression, and 1-2 per 1,000 women experience psychotic depression. "Baby blues" symptoms, such as tearfulness and anxiety, typically last about two weeks. Moderate depression presents as daily mood

*Corresponding author email: imanh@conursing.uobaghdad.edu.iq
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fluctuations, fatigue, irritability, loss of appetite, sleep disruptions, and loss of libido, with concern about baby care. Postpartum psychosis, a rare condition, involves agitation, indecision, and heightened risk of suicide and infanticide [3]. PPD is complex and debilitating, with significant effects on both the mother and child. It can disrupt the mother's ability to care for and bond with her infant, and it may hinder the infant's emotional and cognitive development [4].

1. 1 Etiology of Postpartum Depression (PPD)

The etiology of PPD is multifactorial, with biological, psychological, and social factors contributing to its development. The precise causes remain under investigation, though several factors are recognized as playing a significant role:

- Hormonal Changes: A rapid decline in estrogen and progesterone levels following childbirth is believed to contribute to the onset of PPD [6][7].
- Genetic Factors: A family history of mood disorders or depression can increase susceptibility to PPD [8].
- Psychosocial Stressors: Factors such as high stress levels, lack of social support, financial strain, and other social challenges significantly contribute to the risk of developing PPD [9].
- Previous Mental Health History: Women with a history of depression, anxiety, or other mental health disorders are more likely to experience PPD [10].

1. 2 Assessment of Postpartum Depression

Early assessment for PPD risk factors should begin at the first prenatal visit. Healthcare providers, especially nurses, should gather pertinent information regarding the mother's educational background, living conditions, financial stressors, pregnancy planning, social support systems, and family attitudes toward the pregnancy. Identified risk factors should be noted in the prenatal record, and referrals to prenatal support groups may be beneficial.

Postpartum nurses must be vigilant in recognizing risk factors such as a personal or family history of mood disorders, prenatal mood or anxiety symptoms, and the presence of postpartum blues. Further risks may arise from unmet expectations, sleep disturbances, and lack of family support [11-13]

Diagnosing PPD is challenging due to symptom overlap with other forms of depression. Its onset, which can occur within the first year postpartum, complicates timely identification. Stigma, societal perceptions, and the primary focus on physical recovery contribute to delays in diagnosis. Many women view mood swings as normal, which further hampers early detection [14][15].

The diagnostic process relies on assessing symptoms based on the criteria outlined in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) [2]. Additionally, the Edinburgh Postnatal Depression Scale (EPDS) is commonly used as a screening tool to help identify and evaluate PPD [16][17].

1. 3 Importance of the Study

- Prevalence and Early Detection: Understanding the prevalence of PPD is essential for early detection and timely intervention. Early intervention can significantly improve outcomes for both mothers and infants.
- Impact on Maternal and Infant Health: PPD can severely affect the mother and infant, leading to developmental delays in the child and long-term psychological effects on the mother [18].
- Long-term Consequences: Untreated PPD can lead to chronic psychological issues for the mother, affecting her ability to function in everyday life and care for her family.
- Improving Healthcare Interventions: Research helps develop effective screening tools, treatment approaches, and preventive measures to support new mothers.
- Informing Policy and Programs: Studies on PPD can guide public health policies and programs, improving maternal mental health support and resources [9]

1. 4 Administrative Arrangement

After submitting a request to the Nursing College at Al-Emeed University for a task facilitation letter, a scientific research request was then submitted to the Training and Development Department at the Health Department of Karbala. Upon approval, a request was further submitted to the Karbala Health Department, Central Sector, to facilitate the task at healthcare centers. Prior to collecting samples, official approvals were obtained from healthcare centers affiliated with the Karbala Health Department - Central Sector.

1. 5 Study Design and Period of the Study

The research design used is a descriptive cross-sectional study. The study period is from December 2023 to June 2024.

1. 6 Setting of the Study

This study was conducted in healthcare centers affiliated with the Karbala Health Department - Central Sector, including the following centers:

- Al-Nasr Primary Care Center

- Al-Tahaddi Wal-Samood Center
- Al-Wafa Center
- Al-Ghadeer Center
- Al-Kawthar Center
- Al-Abbasia Al-Gharbiya
- Al-Abbasia Al-Sharqiya

1. 7 Sample Size

The sample size consisted of 225 women from the city of Karbala, determined using G Power calculation.

1. 8 Type of Sampling

Non-probability sampling was employed, specifically purposive sampling.

1. 9 Inclusion Criteria

Women aged 15 to 45, within the first week postpartum up to six months postpartum.

1. 10Exclusion Criteria

Women suffering from psychiatric disorders were excluded from the study.

1. 11Study Instrument

The primary measuring tool used was the Edinburgh Postnatal Depression Scale (EPDS). Additionally, a separate questionnaire was used to obtain demographic data from the participants.

1. 12Respondent Demographics Characteristics

The questions in this section contain eight items related to the following demographic factors:

- Mother's age
- Maternal depression before childbirth
- Family type
- Desire for pregnancy
- Type of delivery
- Husband's educational level
- Mother's educational level
- Monthly income

1. 13Data Collection Technique

Samples were obtained through interviews with women, and data were collected using a structured questionnaire.

1. 14Scale Translation

The Edinburgh Postnatal Depression Scale (EPDS) was translated into Arabic by a research team led by Ghubash and others (1997). This translation adhered to the translation-back translation methodology. Professional translators with expertise in mental health and understanding of both Arabic and English cultures were employed. After the initial translation, the version was reviewed by a team of experts in Arabic language and mental health. The translated version was then tested on a small sample of Arabic-speaking individuals to assess their understanding of the questions and identify any clarifications or revisions needed. Adjustments were made based on the feedback and results. The validity of the Arabic version of the EPDS was published in the article "The validity of the Arabic Edinburgh Postnatal Depression Scale" in the journal *Social Psychiatry and Psychiatric Epidemiology* [22]

1. 15The Validity of the Arabic Scale

The validity of the Arabic version of the Edinburgh Postnatal Depression Scale (EPDS) has been confirmed in multiple Arab countries. Studies in Jordan, Lebanon, and Morocco have demonstrated high internal consistency and reliability. For example, Oweis (2001) reported a Cronbach’s Alpha coefficient of 0.87 in Jordan, while Chaaya et al. (2002) showed sensitivity and specificity of 73% and 90%, respectively, in Lebanon. Alami et al. (2006) and Sammour (2002) further supported the scale's validity, confirming its effectiveness in these populations [19-21].

1. 16Reliability of the Questionnaire

The internal consistency of the questionnaire was assessed using Cronbach's Alpha, with a value of 0.78, indicating acceptable reliability. This suggests that the instrument demonstrates a sufficient level of internal consistency and reliable measurement. The reliability analysis was conducted using IBM SPSS version 24.

TABLE.I. DEMOGRAPHIC VARIABLES OF THE STUDY SAMPLE (N 225)

Demographic data	Rating and intervals	Frequency	Percent
family type	nuclear family	108	48.0
	extended family	117	52.0
Age/years	16 - 25	116	51.6
	26 - 35	86	38.2
	36 - 45	23	10.2
	Total	225	100.0
wife's education level	Uneducated	35	16.5
	red and write	43	20.3
	Elementary	35	16.5
	middle school	43	20.0
	Institute / College	45	22.8
	Postgrad	11	3.9
pregnancy	planned	182	80.9
	unplanned	43	19.1
nature of birth	Normal delivery	119	52.9
	cesarean section	106	47.1
Monthly income	insufficient	33	14.7
	Sufficient	154	68.4
	Sufficient	38	16.9

Table I showed the distribution of woman according to their demographic characteristics. The age range at the time of the study was (15-25 years), with the highest percentage of 51.6% in the age group as for the educational level of the student's stage, the study found the low percentage that 3.9% were in the Postgrad. While for Monthly income for students, the highest percentage was Sufficient 68.4%. As for the pregnancy, the highest percentage of 80.9% was planned.

TABLE. II. ASSESSMENT OF POST-PARTUM DEPRESSION AMONG WOMAN: (N 225)

Post-partum depression	Freq.	%	M ± SD
Without PPD	139	61.8	12.444± 3.03812
With PPD	86	38.2	
Total	225	100.0	

M: Mean for a score, SD: Standard Deviation for a score, Freq: frequency, %: percentage (Without PPD <= 13, With PPD = 14+)

Table II explains of Assessment of post-partum depression among woman 38.2% suffering from PPD and 61.8% not have PPD.

TABLE. III. THE RELATIONSHIP BETWEEN POSTPARTUM DEPRESSION AMONG WOMAN AND THEIR LEVEL OF ECONOMIC (SOCIO-DEMOGRAPHIC CHARACTERISTICS): (N 225)

Demographic Data	Groups	N	without PPD	With PPD	Chi-Square Tests	Sig.
Level of economic	insufficient	26	7	33	5.704	.048
	Sufficient	88	66	154		
	Sufficient	25	13	38		
	Total	139	86	225		

N: sample number, M: Mean, Chi-Square Tests, Sig: Significance at $p \leq 0.05$. table III shows that is a significant relationship between the Level of economics and postpartum depression Among woman when (p. value =.048) at $p< 0.05$ level of significance.

TABLE. IV. THE RELATIONSHIP BETWEEN POSTPARTUM DEPRESSION AMONG WOMAN AND THEIR AGE (SOCIO-DEMOGRAPHIC CHARACTERISTICS): (N 225)

Demographic Data	Groups	without PPD	With PPD	Chi-Square Tests	Sig.
Age	16 - 25	71	45		
	26 - 35	52	34		

	36 -45	16	7	.669	.716
	Total	139	86		

N:sample number, M: Mean, SD: Standard Deviation, Sig.: Significance at $p \leq 0.05$. table IV shows that is a non-significant relationship between the age of woman and postpartum depression when (p. value =.669) at $p< 0.05$ level of significance.

TABLE.V. THE RELATIONSHIP BETWEEN POSTPARTUM DEPRESSION AMONG WOMAN AND THEIR EDUCATIONAL LEVEL FOR FATHER (SOCIO-DEMOGRAPHIC CHARACTERISTICS): (N 225)

Demographic Data	Groups	N	without PPD	With PPD	Chi-Square Tests	Sig.
Educational Level for mothers	Uneducated	21	3	18	7696	.158
	red and write	23	7	16		
	Elementary	41	19	22		
	middle school	72	28	44		
	Institute / College	36	28	36		
	Postgrad	3	1	3		
	Total	255	86	139		

N: sample number, M: Mean, Chi-Square Tests, Sig: Significance at $p \leq 0.05$, table V shows that is a non-significant relationship between the Educational Level for mothers and postpartum depression among woman when (p. value =.158) at $p< 0.05$ level of significance.

TABLE. VI. THE RELATIONSHIP BETWEEN POSTPARTUM DEPRESSION AMONG WOMAN AND THEIR NATURE OF BIRTH (SOCIO-DEMOGRAPHIC CHARACTERISTICS): (N 225):

Demographic Data	Groups	N	with PPD	without PPD	Chi Square Tests	Sig.
Nature of birth	Normal delivery	119	43	76	**.466**	**.495**
	cesarean section	106	43	63		
	Total	255	86	139		

N: sample number, M: Mean, Chi-Square Tests, Sig: Significance at $p \leq 0.05$, table VI shows that is a non-significant relationship between the nature of birth and postpartum depression Among woman when (p. value =.495) at $p< 0.05$ level of significance.

2. DISCUSSION

This study offers an in-depth examination of the socio-demographic characteristics of women in Karbala, providing valuable insights into the factors that may influence the prevalence of Postpartum Depression (PPD). The findings show that the majority of participants were from extended families (52.0%) and were within the 16-25 age range (51.6%). A significant portion of the participants had planned pregnancies (80.9%), which may indicate emotional preparedness and stability in managing the challenges associated with childbirth. Furthermore, most participants reported having sufficient monthly income (68.4%), which is likely to have a positive impact on their access to healthcare services and psychological support.

3. SOCIO-DEMOGRAPHIC CHARACTERISTICS

- Family Type: The distribution of family types (nuclear vs. extended) reflects the social diversity within the sample, which may play a crucial role in shaping women's experiences and the level of social support they receive during the postpartum period. Family support is an essential determinant of maternal mental health.
- Age: A substantial proportion of participants (51.6%) were between 16 and 25 years old. This underscores the importance of focusing health programs and mental health services on this specific age group, which may be at higher risk for PPD due to the unique challenges they face.

- Education Level: Most of the women in the study had low to moderate educational attainment. This finding may influence their capacity to cope with the psychological and health challenges associated with the postpartum period, as lower levels of education can limit access to knowledge and coping strategies for managing mental health.
- Type of Birth: The nearly equal distribution of normal and cesarean births suggests that both delivery methods might have comparable impacts on the likelihood of developing PPD.
- Monthly Income: A majority of participants reported having moderate to sufficient monthly income, which is likely to influence their access to essential healthcare and mental health services.

4. PREVALENCE OF POSTPARTUM DEPRESSION (PPD)

The study found that 38.2% of women experienced PPD, while 61.8% did not, highlighting the considerable prevalence of PPD among new mothers. However, no statistically significant correlation was observed between age ($p = 0.669$) or the type of delivery ($p = 0.495$) and the likelihood of developing PPD, suggesting that other factors might play a more significant role in the development of PPD.

5. SIGNIFICANT SOCIO-DEMOGRAPHIC ASSOCIATIONS WITH PPD

- Economic Status: A near-significant association between economic status and PPD was observed ($p = 0.048$), indicating that women with insufficient economic resources may be more vulnerable to PPD. This aligns with previous studies that have demonstrated a link between economic stressors and maternal mental health [23][26]. Education Level: No significant relationship was found between maternal education level and PPD ($p = 0.158$), suggesting that other factors, such as access to healthcare, social support, and stress related to education, may contribute to PPD risk. Previous research has yielded mixed results regarding the impact of education on PPD, highlighting the need for further investigation [24][27]
- Type of Birth: The study found no significant relationship between the type of birth (normal or cesarean) and PPD, which contradicts some earlier studies suggesting a higher risk of PPD in women who undergo cesarean sections due to longer recovery times and reduced physical activity [25]. The methodological differences between studies may explain this discrepancy, indicating the need for further research to better understand the underlying factors [28][29].

6. CONCLUSION

This study underscores that PPD is a significant maternal mental health issue influenced by various socio-demographic factors. The results suggest that targeted psychological interventions should be developed, particularly for women facing economic stress or those belonging to specific age groups. Additionally, continued research is needed to further understand the complex factors contributing to PPD and to improve mental health care for new mothers.

7. RECOMMENDATIONS:

1. Enhancing the role of mental health units in primary health care centers to educate women about postpartum depression
2. Implement regular screenings for early detection of postpartum depression during postnatal care visits.
3. Conduct additional research on the social and demographic factors influencing the risk of postpartum depression.

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Conflicts of Interest:

The authors declare that no conflicts of interest exist in connection with this work.

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Appendix

عزيزتي الام:

في ادناه مجموعة من الفقرات الخاصة ببحث البكالوريوس الموسوم **(تقييم الاكتئاب ما بعد الولادة لدى النساء)** راجين تفضلكم

بقراءتها جميعا والاجابة عليها دون استثناء بوضع علامة صح امام كل فقرة من الفقرات التي ترين انها تناسبك أكثر من غيرها ولا حاجة لذكر الاسم علما ان المعلومات ستكون سرية ولا تستخدم الا لغرض البحث العلمي فقط .

اولا: المعلومات الشخصية

١-العمر: ( ) سنة

٢-هل تعرضت الام الى نوبة اكتئاب قبل الحمل: **نعم** ☐ **لا** ☐

☐ ☐

٣- نوع الاسرة: الأسرة النواة ا لاسرة الممتدة

٤- الحمل: برغبة بغير رغبة

٥- طبيعة الولادة: طبيعي عمليه قيصرية

٦- المستوى التعليمي للزوج: لا يقرأ ولا يكتب يقرأ ويكتب
ابتدائي ثانوي
كلية \معهد دراسات عليا

٧- المستوى التعليمي للأم: لا تقرأ ولا تكتب تقرأ وتكتب
ابتدائي ثانوي
كلية \معهد دراسات عليا

٨- الدخل الشهري: ضعيف متوسط جيد

ثانيا: هنالك ١٠ اسئلة يجب الاجابة عليها دون استثناء

١ -لقد كنت قادرة على الضحك ورؤية الجانب المشرق من الأشياء:

- ☐ بالمقدار نفسه الذي استعطته من قبلُ
- ☐ ليس تمامًا بالمقدار نفسه الآن
- ☐ قطعًا ليس بالمقدار نفسه الآن
- ☐ كلا، مطلقا

٢-لقد تطلعت إلى الأمور بتمتع:

- ☐ بالمقدار نفسه مثل أي وقت مضى
- ☐ أقل نوعًا ما مما اعتدته

☐ قطعًا أقل مما اعتدته

☐ نادرًا .أبدًا

٣-لقد لمت نفسي دون داعٍ عندما سارت الأمور على غير ما يرام:

☐ نعم في معظم الأحيان

☐ نعم في بعض الأحيان

☐ ليس في أحوال كثيرة

☐ كلا، أبدًا

٤-لقد كنت قلقة ومشغولة البال دون سبب وجيه:

☐ كلا، أبدًا

☐ نادرًا

☐ نعم في بعض الأحيان

☐ نعم في أحوال كثيرة

٥-لقد شعرت بالخوف والذعر دون سبب وجيه:

☐ نعم، أكثر الأحيان

☐ نعم، في بعض الأحيان

☐ كلا، ليس كثيرًا

☐ كلا، ابدا

٦-تراكمت الأعمال عليّ، فلم أستطع القيام بها كلها

☐ نعم، في معظم الأحيان لم أستطع القيام بها

☐ نعم، في بعض الأحيان لم أستطع القيام بها كالمعتاد

☐ كلا، لقد استطعت القيام بها في بعض الأحيان

☐ كلا، لقد استطعت القيام بها كالمعتاد

٧-لقد كنت غير سعيدة لدرجة أنه كانت لديّ صعوبة في النوم:

☐ نعم، في معظم الأحيان

☐ نعم، في بعض الأحيان

☐ ليس كثيرًا

☐ كلا، أبدًا

٨-لقد شعرت بأنني لست سعيدة أو بائسة:

☐ نعم، في معظم الأحيان

☐ نعم، أكثر الأحيان

☐ كلا، ليس أكثر الأحيان

☐ كلا، أبدًا

٩-لقد كنت غير سعيدة وشعرت بألم مرير لدرجة أنني كنت أبكي:

☐ نعم، في معظم الأحيان

☐ نعم، أكثر الأحيان

☐ فقط من وقت إلى آخر

☐ كلا، أبدًا

١٠-لقد خطرت لي فكرة إلحاق الأذى بنفسي:

☐ نعم، أكثر الأحيان

☐ نعم، في بعض الأحيان

☐ نادرًا

☐ كلا، مطلقًا