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PSYCHOLOGİCAL İNTERVENTİON PROGRAMS FOR WOMEN WİTH POSTPARTUM DEPRESSİON AND THEİR EFFECTİVENESS İSSUES

Fidan Yusif Abdurrahmanova
master's student at Khazar University
ORCİD: 0009 0008 7873 4553
E-mail: Abdurrahmanovafidan4@gmail.com

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Today, a progressive increase in depressive disorders is observed among the general population. Psychologists and psychiatrists have professionally examined the psychoemotional state of women and their quality of life, both during pregnancy and after childbirth, and this issue is also of interest to obstetricians and gynecologists (2;5).

The question of whether an anesthesiologist can influence the development of postpartum depression through the use of various pain relief methods during childbirth remains unresolved. Furthermore, the issue of studying and identifying modern criteria for analyzing women's health before and during pregnancy, as well as during childbirth and the postpartum period, remains relevant today. These criteria should adequately reflect the state of their physical, psychological, and social functioning.

Childbirth should be a positive event associated with positive emotions (7). However, pregnancy itself is a significant stressful life event that accelerates the intensity of depression (6). According to the WHO (The World Health Organization), depressive pathology is one of the most common problems, which in the near future will occupy second place in the structure of morbidity, second only to coronary heart disease. Postpartum depression, as a major depressive episode, has devastating consequences for the health of the mother, newborn, infant, and even the entire family (3).

Postpartum depression affects more than 10–15% of women worldwide (5). According to various authors, the registered incidence of postpartum depression varies widely, ranging from 6.5% to 29.5%. Moreover, statistical data differ depending on the time of depression diagnosis. This is mainly due to the fact that different studies use different diagnostic scales, which also affects the final result and introduces some confusion into statistical reporting.

An initial pathological fear of childbirth is a clear independent predictor of the development of postpartum depression. Fear of childbirth is not an isolated problem; it is associated with personal characteristics and relationships with loved ones. The most common causes of fear of childbirth are fear of pain and a suspected low pain threshold (1;6). Women who have a strong fear of childbirth must be monitored by a psychologist and, if necessary, by a psychiatrist. On the other hand, such women should be recommended to have a routine consultation with an obstetric anesthesiologist, who will professionally explain to the patient all possible complications of surgery and prevent psychological discomfort by discussing the possibilities

of various pain relief methods during vaginal delivery, thereby reducing women's fear of childbirth (3). In addition, the obstetric anesthesiologist will inform the pregnant woman about the possibility of using various pain-relieving techniques in the postoperative period if a cesarean section is performed.

Depression is a condition characterized by depressed mood and loss of interest in usual activities, which affects a person's thoughts, behavior, feelings, and well-being (2,9). Depression in adults has a significant impact on quality of life, productivity, and social significance (2,8). Women are known to be approximately 1.7 times more likely to develop depressive states (6).

One of the most common psychoemotional disorders in the postpartum period is postpartum depressive disorder, a problem that has become the subject of active attention in recent decades, not only by experts in psychiatry and psychology, but also by clinical medicine. However, until recently, the etiology and dynamics of depressive pathology remain poorly understood (9).

The problem of mental disorders in women after childbirth, which occur more frequently than at other periods of life, was documented in ancient medicine. Hippocrates (c. 460 BC – c. 370 BC) associated the presence of pronounced mental eccentricities with a delayed postpartum purification (4). Galen (c.131 – c. 200-217) expressed the opinion that in women, "hot blood" rushes to the head after childbirth, thereby giving rise to the development of mental disorders (4). This idea was supported for a significantly long time, until the 18th century.

The first attempts at a scientifically substantiated theory of the development of psychosis in the postpartum period were initiated by J. Esquirol (1772 – 1840), who, to explain the specific conditions in women during this critical period, introduced the term puerperal mania.

Postpartum depression is a serious public health problem worldwide, as the significant negative consequences of the postpartum period threaten not only the health of the mother and child but also the well-being of the entire family (7).

Pregnancy and the postpartum period are major life events that can cause anxiety, depression, and adjustment disorders in susceptible individuals. Depression, the most common disorder of the perinatal period and the first year after childbirth, affects up to 14% of women throughout pregnancy and the first year postpartum, according to statistics from developed countries (1; 6). According to published data, the incidence of depressive pathology varies depending on the standard of living and wealth of the population. Thus, in countries with low and average living standards and resources, depressive states of the population are observed from 6.5 to 12.9% or more (5).

Paspartum depression is a form of major depressive disorder, which is clinically manifested by a variety of symptoms (5): mood swings, a significant decrease in interest in everything around you and any activity, insomnia or, conversely, pronounced drowsiness, unexplained weight loss or weight gain, psychomotor retardation or agitation, increased fatigue, weakness, a sense of worthlessness, excessive feelings of guilt, deterioration in the ability to concentrate, focus, and the inability to comprehend what is happening and make informed decisions. This is accompanied by a decrease in lactation, and a disruption of the mother-child relationship. The extreme manifestation of a depressive state is the appearance of recurrent suicidal thoughts and even suicide attempts (1; 4).

Despite the fact that the number of studies devoted to the study of the problem of depressive

pathology in the postpartum period has progressively increased in the last decade, the etiology and pathogenesis of the development of depression in the postpartum period are still unclear. Perinatal depression is a heterogeneous disorder that can arise as a result of a wide range of medical, social, and mental disorders (7).

Currently, existing studies have shown the influence of various psychosocial and physiological factors on the incidence of postpartum depression. Psychosocial factors include the presence of depression or anxiety during pregnancy, stressful life events or changes during pregnancy, insufficient social support, a history of mental disorders, and nicotine use (2). Physiological factors include decreased norepinephrine or serotonin activity in the brain (6), decreased omega-3 fatty acid levels (4), vitamin D, fluctuations in oxytocin and beta-interleukinl. In addition, abnormalities in the hypothalamic-pituitary-adrenal axis contribute to the development of postpartum depression. A significant number of scientific studies indicate that past adverse events, such as negative experiences in childhood, sexual abuse, and physical abuse, disrupt the central nervous system's response to stress. This sensitization increases the risk of developing depression or chronic pain syndrome after physical or psychological stress (9). As noted above, the etiology and pathogenesis of postpartum depression have not been definitively established.

Factors that influence the development of depressive states in the postpartum period have now been identified. These include neurotic and neurosis-like reactions, distinctive characteristics of a woman's behavior and personality, and a predisposition to depressed mood. Of particular importance is the existence of depressive disorders and neurosis-like states in women, both during pregnancy and in the postpartum period, that were not diagnosed in due time or did not receive the necessary treatment in a timely manner. At the same time, women's social and economic living conditions, as well as psychological determinants such as low income, internal conflicts, and marital disharmony, are of great importance (5). At the same time, instances of violence against women during pregnancy clearly have a negative impact on the development of depressive symptoms in women in the postpartum period.

Many factors have been found to increase the likelihood of developing postpartum depression, including cesarean section (5–7). Cesarean section can cause adverse outcomes such as infection, postpartum hemorrhage, ureteral and bladder injury, uterine rupture, chronic pain syndrome, and gastrointestinal dysfunction (1, s. 7). These adverse outcomes and surgical trauma can increase stress, which in turn can affect psychological function and increase the risk of developing postpartum depression in mothers. Compared with women who delivered vaginally, patients who had a cesarean section are more likely to suffer from depressive disorders in the postpartum period (2). Caesarean section is an abdominal surgery and, therefore, is associated with tissue incision, pain, blood loss, weakness, limited mobility, and a visible scar shortly afterward. Women undergoing emergency cesarean section for indications that pose a direct risk to the life of the fetus are particularly vulnerable.

Postoperative pain and difficulties with infant feeding are two major factors determining the negative quality of life of women in the early postoperative period following cesarean section (1). Women who experienced severe acute pain had a 2.5-fold higher risk of developing chronic pain syndrome and a three-fold increased risk of developing postpartum depression compared to those with moderate pain (4).

Delayed lactation, which occurs with planned cesarean section, negatively impacts the mother's mental state, causing stress and further disrupting lactation. Many researchers report that women feel worse after cesarean section than after vaginal delivery. Patients after cesarean section have more problems with sleep, suffer from loss of appetite, and complain of fatigue and decreased libido. They also more often report feelings of fear of death, anger at their doctors and partners, and guilt (7; 8).

According to other authors, delivery methods such as vaginal delivery, instrumental delivery, or emergency cesarean section were not associated with an increased risk of developing postpartum depression (3). Thus, Josefsson A. et al. demonstrated the absence of any relationship between the type of delivery and the incidence of postpartum depression (2). Similar results were published in the work of Hung C.H. in 2004 (3).

In contrast to the above, Chaaya M. et al. (2002) reported that the incidence of postpartum depression was higher in women who gave birth vaginally compared to those who underwent surgery (1). Some researchers, on the contrary, have found that cesarean section leads to a reduced risk of developing postpartum depression, which they attributed to a delayed reaction of the body to severe stress (2; 4).

Most authors are of the opinion that the development of postpartum depression is facilitated by pain experienced during childbirth, which can develop into persistent pain and lead to a delay in recovery and rehabilitation, as well as an increased risk of developing postpartum depression (1; 3). In the postoperative period, severe pain experienced can cause various psychological disorders, as well as somatic diseases in women. In addition, acute pain is also a risk factor for the development of chronic pain syndrome, which may be associated with depression (9).

As early as 1936, A.P.Nikolaev pointed out that throughout pregnancy, the physician is obliged to "instill" in the pregnant woman the idea of the possibility of a painless birth; the physician must improve her health and restructure the woman's psyche, unfortunately raised on the idea of the eternity and supposed inevitability of labor pains (3). However, it should be noted that the opinion that a woman should experience pain during childbirth still persists.

In a study by Freedman S.A. et al., published in 2020, 16.5% of women reported that childbirth was the most traumatic event in their lives, and this led to the development of post-traumatic stress disorder, the incidence of which was 7.8% (4).

Various scales are used to diagnose postpartum depression. The Edinburgh Postnatal Depression Scale (EPDS), recognized worldwide, is most widely used for clinical assessment and to determine the severity of clinical manifestations of depressive pathology in the postpartum period. The EPDS represents the most advanced screening technology used in clinical practice. The scale is designed as a self-report questionnaire designed to identify depressive disorders in postpartum women not only in the emotional sphere but also in the area of cognitive perception.

The EPDS was first used in 1987 in Edinburgh. The scale includes 10 items, each with four answer options depending on the severity of manifestation (4). The method has a sensitivity of 86% and a specificity of 85.4%. All scores are then summed across all ten items. A score of 8–9 or higher indicates a high probability of postpartum depression (approximately 86% of cases), while a score of more than 13 points (the maximum score is 30 points) indicates a 100%

probability of developing postpartum depression (4).

The clinical questionnaire by K.K. Yakhin and D.M. Mendelevich is designed to study neurotic conditions (5). This standardized method for examining the psychological state of patients is widely used for the qualitative analysis of neurotic manifestations, while the questionnaire allows for the identification of the main syndromes of neurotic conditions. In 1978, the questionnaire was developed by D.M. Mendelevich and K.K. Yakhin. When conducting research based on this questionnaire, it is possible to adequately assess maladaptive emotional disorders and identify pathological disturbances in neurotic conditions (4).

The questionnaire includes 68 questions about the patient's current emotional state. All questions are categorized into six main scales: anxiety, hysterical response, neurotic depression, asthenia, autonomic dysfunction, and obsessive-phobic disorders (obsessive-compulsive disorder).

A score greater than 1.28 points indicates a healthy level and the absence of negative emotional states in patients. Scores less than -1.28 points indicate a morbid nature of the disorders being studied, with pronounced negative emotional states of various types present: asthenic, anxious, depressive, phobic, and hysterical (4).

The SF-36 Health Status Survey is a non-specific quality of life assessment questionnaire. At the Institute of Clinical and Pharmacological Research (St. Petersburg), the questionnaire was translated into Russian, and the methodology was tested (4;5).

The SF-36 questionnaire was standardized for the entire US population and representative samples of the populations of France, Australia, and Italy. Studies of individual population groups, stratified by age and gender, in European countries and the US demonstrated results for the identified indicators for both the healthy population and patients with chronic diseases (4;5).

According to this method, quality of life is based on the patient's subjective perception and is defined as an integrated characteristic of a person's psychological, social, and physical functioning. The questionnaire consists of 36 items, ranked into eight subscales: general health, physical functioning, social functioning, physical pain, role activity, vitality, emotional state, and mental health. Scores for each subscale range from 0 to 100, with a score of 100 indicating complete health. All subscales form two indicators: physical and psychological well-being.

Childbirth is considered one of the most painful experiences a woman will face in her lifetime, which can have psychological and emotional consequences in both the short and long term (5).

Painful uterine contractions lead to hyperventilation in the mother and an increase in stress hormone levels, particularly catecholamines, which can lead to hypoxemia in both the mother and fetus (8;9). Providing pain relief during vaginal childbirth eliminates hypoxemia and improves the condition of both the mother and fetus.

Currently available pain relief methods used during vaginal delivery are conventionally divided into non-pharmacological and pharmacological. Non-pharmacological methods of analgesia include psychoprophylactic preparation of pregnant women for childbirth (hypnosis and suggestion), acupuncture, transcutaneous electrical nerve stimulation, and electroanalgesia. The effectiveness of these methods varies significantly, and in most cases, additional pain relief methods are necessary. Pharmacological methods of analgesia include the use of systemic analgesics, inhalation analgesia, and various types of regional blockades (5;8)

During vaginal delivery, the methods of pain relief used should not negatively affect the condition of either the mother or the fetus, or inhibit labor. At the same time, women in labor must be conscious and able to actively participate in the labor process (7;9). The optimal method of pain relief during labor should provide adequate analgesia without any motor blockade and without adverse effects on the mother and fetus. Among the variety of pain relief methods for vaginal delivery, epidural analgesia remains the gold standard (2;8).

First and foremost, women experiencing pronounced negative psychoemotional states before childbirth require comprehensive clinical and psychological care aimed at improving and alleviating not only their physical well-being but also their psychoemotional state at the onset of labor. Immediately after childbirth, psychological care should be aimed at improving emotional perception and mitigating the postpartum stress response. During this period, women also receive psychological support (4). Thus, we concluded that anesthesiologists alone, using advanced pain relief techniques, cannot significantly impact women's psychoemotional status in the postpartum period. Therefore, pregnant women, women in labor, and women who have given birth should be actively monitored not only by an obstetrician-gynecologist and anesthesiologist, but also by a psychologist, and, if necessary, by a psychiatrist. Collaboration between obstetricians and gynecologists, anesthesiologists, and clinical psychologists will help prevent obstetric, somatic, and psychiatric pathologies during pregnancy, childbirth, and the postpartum period. At the same time, if psychosomatic pathology develops, such a collaborative alliance will allow for the earliest possible identification of the problem and the provision of professional assistance.

It should be remembered that postpartum depression in a mother not only has consequences for her own health but also has a detrimental impact on the well-being of newborns, particularly their emotional and cognitive development, as well as their subsequent social interactions. Children of parents suffering from depressive disorders are at significant risk of developing various illnesses, including psychiatric ones, which can begin in the neonatal period and persist into adulthood (8).

Based on the results of the research on the topic of the article, we can note that for early prediction of the likelihood of developing postpartum depression, as well as for the prevention and diagnosis of depressive symptoms, joint monitoring of women in the perinatal period by an obstetrician-gynecologist, psychologist and obstetrician-anesthesiologist is necessary. If psychoemotional disorders are detected, the anesthesiologist should explain to the woman the absolute necessity of using epidural analgesia during childbirth, which will not only sufficiently relieve pain during childbirth, but also help prevent the possibility of developing postpartum melancholia. At the same time, if a cesarean section is necessary, the anesthesiologist will discuss not only anesthesia during the operation, but also postoperative pain relief options. It is necessary to explain the possibility of using epidural analgesia and its benefits so that women do not fear this additional invasive procedure.

Relevance of the problem. Postpartum depression is an important social and medical problem. Over the past decades, the study of the mental and emotional state and quality of life of women in the prenatal, perinatal and postpartum periods has been a subject of close attention, practical and scientific interest for specialists in obstetrics and gynecology, clinical psychology

and psychiatry, anesthesiology and intensive care. The problem of postpartum depression has begun to attract attention due to its direct impact not only on the health and safety of the mother, but also on the well-being, cognitive development and social interactions of the newborn baby.

Scientific novelty of the problem. Syndromic types of depressive disorders of the neurotic level that arise in the postpartum period are described for the first time. Their nosological classification is justified. Clinical features of postpartum depression are determined depending on the nosological form. Diagnostic criteria have been developed to differentiate the nosological classification of postpartum depressive disorders. The role of personality, social, psychogenic, somatogenic, and endogenous factors in the development of postpartum depression of the neurotic level has been determined.

Practical significance and application of the problem. The factor predicting postpartum depression was determined based on the study of the initial psychoemotional state and clinical condition. The information obtained from this study has allowed the development of practical recommendations on the clinical features and factors influencing the development of postpartum depression to optimize the diagnosis and early detection of these disorders. These recommendations can be used by psychiatrists, psychotherapists and obstetricians to improve the quality of care provided to women in the postpartum period.

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F.Y. Abdurrahmanova

Psychological intervention programs for women with postpartum depression and their effectiveness issues
Summary

Childbirth should be a positive event associated with positive emotions. However, pregnancy itself is a significant life stressor that can accelerate the intensity of depression. A primary pathological fear of childbirth is a clear independent predictor of the development of postpartum depression. Fear of childbirth is not an isolated problem; it is associated with personal characteristics and relationships with close family members. The most common reasons for fear of childbirth are fear of pain and a perceived low pain threshold. Postpartum depression is a serious public health issue worldwide, as the significant negative consequences of the postpartum period threaten not only the health of the mother and child but also the well-being of the entire family.

F.Y. Abdurrahmanova

Doğuşdan sonra depressiyası olan qadınlar üçün psixoloji müdaxilə proqramları və onların effektivliyi yolları
Xülasə

Doğuş müsbət emosiyalarla əlaqəli müsbət hadisə olmalıdır. Lakin hamiləliyin özü depressiyanın intensivliyini sürətləndirən əhəmiyyətli bir stressli həyat hadisəsidir. Doğuşdan ilkin patoloji qorxu doğuşdan sonrakı depressiyanın inkişafının açıq-aydın müstəqil proqnozlaşdırıcısıdır. Doğuşdan qorxmaq təcrid olunmuş bir problem deyil; o, şəxsi xüsusiyyətlər və yaxınlarınızla münasibətlərlə əlaqələndirilir. Doğuşdan qorxmağın ən çox yayılmış səbəbləri ağrı qorxusu və şübhəli aşağı ağrı həddidir. Doğuşdan sonrakı depressiya dünya miqyasında ciddi bir ictimai səhiyyə problemidir, çünki doğuşdan sonrakı dövrün əhəmiyyətli mənfi nəticələri təkcə ana və uşağın sağlamlığını deyil, həm də bütün ailənin rifahını təhdid edir.

Ф.Ю. Абдуррахманова

Психологические программы помощи женщинам с послеродовой депрессией и вопросы их эффективности
Резюме

Роды должны быть позитивным событием, связанным с позитивными эмоциями. Однако сама беременность является значительным стрессовым событием в жизни, которое ускоряет развитие депрессии. Первоначальный патологический страх перед родами

является явным независимым предиктором развития послеродовой депрессии. Страх перед родами — это не изолированная проблема; он связан с личностными характеристиками и отношениями с близкими. Наиболее распространенными причинами страха перед родами являются страх боли и предполагаемый низкий болевой порог. Послеродовая депрессия — серьезная проблема общественного здравоохранения во всем мире, поскольку значительные негативные последствия послеродового периода угрожают не только здоровью матери и ребенка, но и благополучию всей семьи.

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