RIASE
REVISTA IBERO-AMERICANA DE SAÚDE E ENVELHECIMENTO
REVISTA IBERO-AMERICANA DE SALUD Y ENVEJECIMIENTO

MENTAL HEALTH APPROACHES AND INTERVENTIONS IN POSTPARTUM CARE FOR WOMEN: AN INTEGRATIVE REVIEW

ABORDAGENS E INTERVENÇÕES EM SAÚDE MENTAL NO CUIDADO DA MULHER NO PUERPÉRIO: UMA REVISÃO INTEGRATIVA

ENFOQUES E INTERVENCIONES EN SALUD MENTAL EN EL CUIDADO DE LA MUJER EN EL PUERPERIO: UNA REVISIÓN INTEGRATIVA

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Received/Recebido: 2025-07-16 Accepted/Aceite: 2025-08-06 Published/Publicado: 2025-08-08

DOI: http://dx.doi.org/http://dx.doi.org/10.60468/r.riase.2025.11(0).766.51-61

VOL. 11 SUPPLEMENT 1 JULY 2025

Abstract

Introduction: During the puerperium, women face profound changes that have a significant impact on their mental health, which is often neglected. **Objective:** To identify approaches and interventions that promote the mental health of women in the puerperium, with an emphasis on obstetric nursing. **Method:** Integrative literature review centered on the PubMed and EBSCOhost, including articles published between 2020 and 2025. **Results:** Thirteen studies were included that demonstrated the effectiveness of early screening, online emotional support, culturally sensitive practices, and the promotion of maternal self-care. The integration of these strategies into primary health care was associated with better mental health outcomes. **Conclusion:** Midwifery plays a strategic role in promoting humanized perinatal care, contributing to improving maternal mental health and quality of life in the pregnancy-puerperal cycle.

Keywords: Delivery of Health Care; Mental Disorders; Women; Postpartum Period; Mental Health.

Resumo

Introdução: Durante o puerpério, as mulheres enfrentam mudanças profundas que impactam significativamente a saúde mental, frequentemente negligenciada. **Objetivo:** Identificar abordagens e intervenções que promovam a saúde mental de mulheres no puerpério, com ênfase na atuação da enfermagem obstétrica. **Método:** Revisão integrativa da literatura centrada na PubMed e EBSCOhost, incluindo artigos publicados entre 2020 e 2025. **Resultados:** Foram incluídos 13 estudos que evidenciaram a eficácia do rastreamento precoce, do suporte emocional *online*, de práticas culturalmente sensíveis e da promoção do autocuidado materno. A integração dessas estratégias nos cuidados de saúde primários mostrou-se associada a melhores desfechos na saúde mental. **Conclusão:** A enfermagem obstétrica desempenha um papel estratégico na promoção de cuidados perinatais humanizados, contribuindo para a melhoria da saúde mental materna e da qualidade de vida no ciclo gravídico-puerperal.

Palavras-chave: Cuidados de Saúde; Distúrbios Mentais; Mulheres; Período Pós-Parto; Saúde Mental.

Resumen

Introducción: Durante el puerperio, las mujeres se enfrentan a profundos cambios que tienen un impacto significativo en su salud mental, que a menudo se descuida. **Objetivo:** Identificar enfoques e intervenciones que promuevan la salud mental de las mujeres en el puerperio, con énfasis en la enfermería obstétrica. **Método:** Revisión bibliográfica integradora centrada en PubMed y EBSCOhost, incluyendo artículos publicados entre 2020 y 2025. **Resultados:** Se incluyeron trece estudios que mostraron la efectividad del cribado precoz, el apoyo emocional *online*, las prácticas culturalmente sensibles y la promoción del autocuidado materno. La integración de estas estrategias en la atención primaria se asoció con mejores resultados de salud mental. **Conclusión:** La obstetricia desempeña un papel estratégico en la promoción de una atención perinatal humanizada, contribuyendo a mejorar la salud mental materna y la calidad de vida en el ciclo embarazo-puerperio.

Descriptores: Atención a la Salud; Trastornos Mentales; Mujeres; Periodo Posparto; Salud Mental.

Introduction

The postpartum period represents a critical phase of intense physical, emotional, and social transformations in a woman's life[1,2]. Although recognized as essential for public health, maternal mental health in the immediate postpartum period remains undervalued within healthcare systems[3-5]. The traditional focus on the newborn's physical well-being contributes to the invisibility of the mother's emotional needs, favoring underdiagnosed cases of depression, anxiety, and other disorders[6,7]. Postpartum depression (PPD), for example, affects between 10% and 20% of women, with higher prevalence rates in contexts of social vulnerability[8,9].

Traumatic childbirth experiences, often marked by obstetric violence, increase the risk of conditions such as depression and post-traumatic stress disorder, impacting self-esteem, mother-infant bonding, and quality of life during the postpartum period. These consequences highlight the need for respectful and humanized obstetric care[10,11]. Moreover, the normalization of symptoms such as intense sadness and exhaustion, combined with fear of social judgment and the lack of safe spaces for emotional expression, hinders women's access to specialized care[12-14]. This vulnerability is further aggravated by the fragmentation of healthcare services, with limited integration among obstetrics, pediatrics, and mental health, contributing to the silencing of emotional suffering in the postpartum period[15,16].

In response to this scenario, innovative strategies have emerged, notably telepsychiatry programs that expand access to the diagnosis and treatment of postpartum depression in remote areas[17]. Similarly, the use of mobile technologies (mHealth) provides psychological support for vulnerable populations[18]. However, experts emphasize the need for public policies that ensure connectivity, digital literacy, and data protection in order to prevent the widening of social inequalities[19].

The strengthening of perinatal mental health clinics and online therapeutic groups has demonstrated effectiveness in reducing anxiety and depressive symptoms while fostering support networks among women[3,7]. In this context, the role of certified nurse-midwives is essential. Strategies such as active listening, home visits, health education, and the organization of support groups are crucial for providing welcoming and empowering care[15,20].

Models that integrate psychological support into routine obstetric care have improved the effectiveness of services, enhancing the mental health of women receiving care[21]. The leadership of nurse-midwives in early screening and initial support is particularly valuable in contexts with limited access to specialized professionals[20].

Social determinants such as poverty, low educational attainment, domestic violence, and the absence of support networks directly affect maternal mental health and treatment adherence[2,22]. Therefore, intersectoral public policies that link health, education, and social assistance while considering cultural and territorial specificities are necessary[23]. In this regard, cultural adaptation of interventions proves essential, especially for migrant women or those exposed to obstetric trauma, with positive impacts on emotional well-being and the strengthening of mother-infant bonding[19,24-27].

The biopsychosocial model, which encompasses biological, emotional, and social factors, guides a comprehensive understanding of the maternal experience[28]. From this perspective, the promotion of self-care emerges as a crucial yet often underestimated strategy in the face of the idealization of motherhood[12,13]. Issues such as poor sleep quality, common in the postpartum period, exacerbate depressive symptoms and underscore the need for welcoming spaces and educational interventions[29].

The training of healthcare professionals represents another challenge. Many report feeling unprepared to address the emotional needs of women during the postpartum period[16]. A lack of adequate communication skills and supportive environments hinders women's ability to share their emotional needs[14]. Investing in continuous professional development and integrating perinatal mental health into educational curricula is therefore urgent[8].

Recognizing mental health care during the postpartum period as a human right and an integral part of reproductive health requires the implementation of integrated strategies that combine psychological support, obstetric care, systematic screening, and the strengthening of support networks[30]. The use of validated instruments, such as the Edinburgh Postnatal Depression Scale (EPDS), and woman-centered approaches, such as the HAVEN model (Hear, Ask, Validate, Encourage, Normalize), are essential for building trust-based relationships and facilitating emotional expression[8,15].

Despite advances, few reviews systematically consolidate evidence on the role of obstetric and gynecologic nursing in contexts of vulnerability[8,20]. This gap justifies the present integrative review, which aims to compile interventions and care practices that promote culturally sensitive, ethically grounded, and humanized mental health care for women in the postpartum period[19,24]. This review seeks to gather evidence to support qualified maternal mental health actions and to inform public policies that are more responsive to the realities of women during the postpartum period[1,6].

Thus, the objective is to identify approaches and interventions that promote the mental health of women in the postpartum period, with an emphasis on the role of obstetric nursing.

Method

To address the research question, we conducted an integrative literature review, a methodology considered appropriate as it allows for the integration of findings from studies with different methodological designs, providing a comprehensive and evidence-based understanding of the topic.

The formulation of the research question was based on the PIO strategy, summarized in Table 1.

Based on these elements, the guiding question of this review was defined as: "What are the obstetric nursing approaches and interventions used in mental health care for women in the postpartum period?".

Table 1: PIO Question Formulation.

Element	Description
P (Population)	Women in the postpartum period
I (Intervention)	Approaches and interventions in obstetric nursing
O (Outcomes)	Promotion of mental health

The study collection was carried out between March and April 2025 using the electronic databases PubMed and EBSCOhost (MedicLatina, Psychology and Behavioral Sciences Collection, MEDLINE, and CINAHL). Controlled MeSH and DeCS descriptors were used: "women," "postpartum," "mental health," "health care," and "mental disorders," combined using the Boolean operators AND and OR, resulting in the following search equation: ("women" AND "postpartum") AND ("mental health" AND "health care" AND "mental disorders").

Inclusion criteria for this review encompassed articles published between 2020 and 2025, studies available in full text in Portuguese, English, or Spanish, and publications presenting care models, clinical practices, or mental health interventions specifically targeting women in the postpartum period. Exclusion criteria included duplicate articles, studies focusing exclusively on prevalence or risk factors without proposing intervention strategies, and works with incomplete methodology or focused solely on the gestational period.

The selection process for the studies was systematized following the PRISMA model guidelines (Figure 1), allowing for an organized presentation of the different stages of the review, including identification, screening, eligibility assessment, and inclusion of the articles that comprised the final sample.

In the initial phase of the integrative review, 103 articles were identified through searches in PubMed and EBSCOhost. After removing 27 duplicates, 76 articles remained for screening. Titles were reviewed, resulting in the exclusion of 33 studies that did not have a direct connection with the defined thematic criteria. The remaining 43 articles were then screened by abstract reading, leading to the exclusion of 15 that did not meet the inclusion criteria, mainly due to the absence of practical interventions or a focus outside the postpartum period.

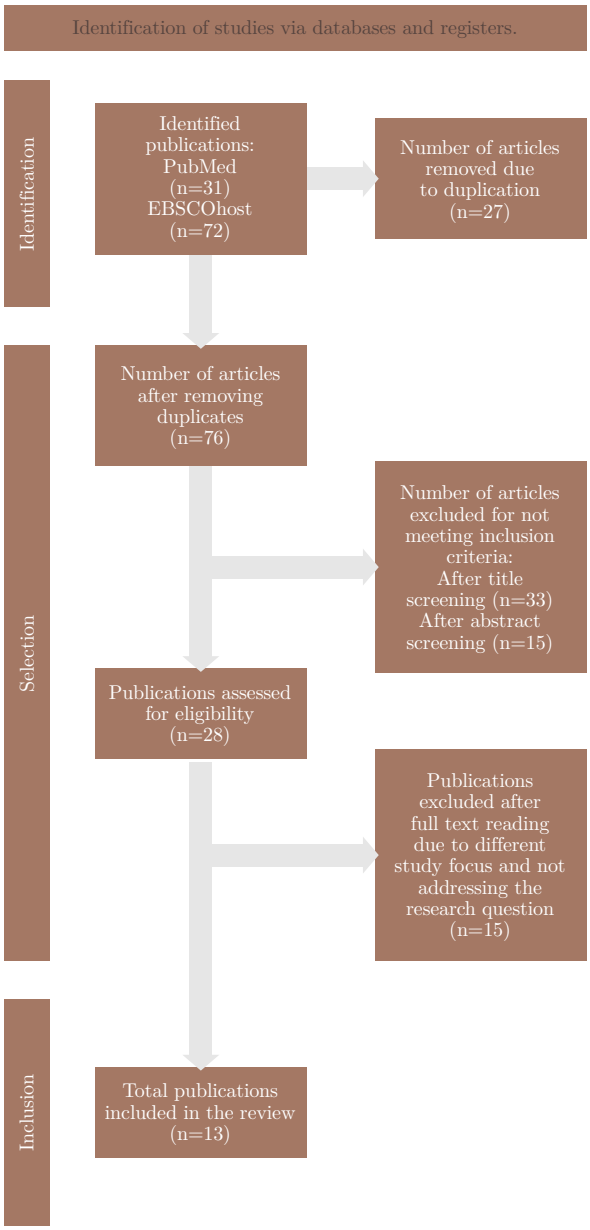

Figure 1: Study selection process – PRISMA flow diagram.

Subsequently, 28 articles were selected for full-text reading, after which 15 were excluded for not meeting methodological adequacy or for not describing concrete approaches to mental health in the postpartum period.

At the end of this process, 13 articles were included in the analysis of the present integrative review, as they met the inclusion criteria and provided evidence on approaches, clinical practices, and interventions aimed at promoting mental health among postpartum women.

The entire selection process was carried out by two of the authors. Any disagreements that might have arisen would have been resolved with the other authors; however, no such disagreements occurred.

Results

The findings extracted from the studies included in this integrative review are presented in Table 2, summarizing the care strategies and various types of interventions aimed at promoting and strengthening the mental health of women during the postpartum period. The level of evidence of the articles included in the review was assessed using the guidelines of the Joanna Briggs Institute (JBI).

Discussion

The promotion of perinatal mental health has increasingly taken on a central role in contemporary obstetric practice, especially in light of the multiple clinical, psychosocial, and sociocultural factors that influence the maternal experience throughout the pregnancy-postpartum cycle[2,8,12]. This integrative review gathered relevant evidence on structured clinical practices, coordination with primary healthcare, culturally sensitive interventions, remote emotional support, technological challenges, early screening, and the promotion of maternal self-care, all fundamental elements for building more humanized, equitable, and evidence-based perinatal care[3,17,20].

Specialized clinical interventions have shown consistent results in reducing emotional symptoms during the postpartum period[31]. They indicate rapid and sustained improvements through intensive programs focused on the mother and newborn. In outpatient settings, Caropreso *et al* demonstrate the effectiveness of multidisciplinary care in reducing depressive and anxious symptoms[7]. Caropreso *et al* and Morlans-Lanau *et al* highlight that the effectiveness of these actions depends on the continuity of care, clinical

Table 2: Results of the Selected Articles.

Authors/Year/Country/ Study title	Study type and level of evidence	Study objectives	Sample	Results and Conclusions
Ammar Saad, Olivia Magwood, Tim Aubry, Qasem Alkhateeb, Syeda Shanza Hashmi, Julie Hakim, Leanne Ford, Azaad Kassam, Peter Tugwell, Kevin Pottie. 2021, Canada. Mobile interventions targeting common mental disorders among pregnant and postpartum women: An equity-focused systematic review.	Systematic review of experimental studies. Level I evidence.	To evaluate the effectiveness and equity impact of mobile (mHealth) interventions for the prevention and management of depression, anxiety, and stress among pregnant and postpartum women.	18 studies (13 RCTs, 4 non-randomized, and 1 quasi-randomized), with a total of 7,181 pregnant or postpartum women.	Mobile interventions, particularly CBT, showed a significant reduction in perinatal depression. Effectiveness varied by ethnicity, age, and education level. The authors advocate for the use of mobile technologies to promote equity in access to perinatal mental health care.
Carmen Kiraly, Betty Boyle-Duke, Liat Shklarski. 2024, United States of America. The role of maternal and child healthcare providers in identifying and supporting perinatal mental health disorders.	Descriptive cross-sectional study. Level VI evidence.	To analyze differences in screening, referral, and support practices in perinatal mental health between obstetricians and other primary care professionals (pediatricians, nurses, physician assistants).	101 professionals (16 obstetricians, 85 pediatricians/nurses).	Obstetricians identified more symptoms and discussed emotional and social aspects; other professionals prioritized the EPDS, educational materials, and made more referrals to mental health services. The study highlights gaps in screening consistency and recommends increased ongoing professional training and the integration of standardized tools with open-ended interviews.
María del Carmen Míguez, María Belén Vázquez. 2023, Spain. Prevalence of postpartum major depression and depressive symptoms in Spanish women: A longitudinal study up to 1 year postpartum.	Observational longitudinal study. Level IV evidence.	To determine the prevalence and trajectory of major depression and depressive symptoms up to 1 year postpartum.	561 postpartum women assessed at three time points: 2 months, 6 months, and 1 year after childbirth.	The prevalence of probable depression (EPDS ≥ 10) was 30.3% at 2 months, 26.0% at 6 months, and 25.3% at 12 months. Major depression (SCID) was found in 10.3%, 10.9%, and 14.8% of participants, respectively. While probable depression decreased over time, major depression increased. The study highlights the high prevalence of symptoms even after one year and recommends systematic screening up to 12 months postpartum.
Luisa Caropreso, Sarah Saliba, Lindsay Hasegawa, Jack Lawrence, Caitlin J. Davey, Benicio N. Frey. 2022, Canada. Quality assurance assessment of a specialized perinatal mental health clinic.	Descriptive study with pre- and post-intervention statistical analysis. Level VI evidence.	To evaluate the effectiveness of a specialized perinatal mental health service by assessing changes in anxiety and depression symptoms in pregnant and postpartum women.	226 patients treated at the Women's Health Concerns Clinic (WHCC).	Significant reduction in EPDS and GAD-7 scores after the intervention, especially in severe cases. The specialized multidisciplinary model demonstrated strong clinical effectiveness and is recommended as a reference for public perinatal mental health policies.
Jane Fisher, Karin Stanzel, Hau Nguyen, Patsy Thean, Danielle French, Sally Popplestone, Thach Tran. 2024, Australia. Impact of a private sector residential early parenting program on clinically significant postnatal depressive symptoms experienced by women.	Quasi-experimental study. Level III evidence.	To evaluate the immediate and 6-week impact of a five-night private residential program on postpartum depressive symptoms and identify factors associated with improvement or persistence of symptoms.	1220 women with complete data participated (between 05/2021 and 09/2022).	The mean EPDS score decreased from 11.7 pre-admission to 7.1 at discharge and 5.7 at 6-week follow-up. More than 80% showed clinical improvement; lower response was observed in cases with borderline traits, low parental confidence, or multiple stressors. The program effectively reduced symptoms, strengthened maternal agency, and enhanced parenting competencies, indicating the need for additional support in cases of greater psychological complexity.
Christina L. Felten, Kayla S. Smith, Melissa B. Aylesworth. 2024, United States of America. An Integrated Approach to Address Perinatal Mental Health Within an Obstetrics Practice.	Implementation study. Level V evidence.	To report the development and implementation of the WAVES model for integrating screening and support for perinatal mental health within an obstetrics practice.	More than 600 women were referred; 323 received direct care through the WAVES program.	The model enabled systematic screening using EPDS, PHQ-9, and GAD-2, internal referrals, and psychological support. Women felt supported, and professionals reported feeling better prepared. The initiative demonstrated effectiveness and was well-received by patients, especially for its empathy and active listening.
Miriam Morlans-Lanau, Maria L. González-Vives, Alberto Rodríguez-Quiroga, Mayte M. Casbas, Jitka Klugarová, Miloslav Klugar. 2022, Spain. Establishing midwife-led continuity of care interventions in perinatal mental health in high-risk pregnancies.	Evidence-based review/ opinion. Level VI evidence.	To propose and discuss midwife-led continuity of care models for perinatal mental health, particularly in high-risk pregnancies.	120 women with high-risk pregnancies were treated at a public hospital.	Midwife-led models foster bonding, emotional safety, and early detection of mental health symptoms. They improve adherence to care and reduce anxiety and depression symptoms. The study emphasizes the importance of specific training and continuity in the professional-woman relationship.
Jane Fisher. 2023, United Kingdom. Perinatal mental health issues: early recognition and management in primary care.	Narrative review based on clinical guidelines. Level VI evidence.	To discuss early recognition and management of perinatal mental health problems in primary care.	Not applicable (review/ clinical opinion).	Highlights the importance of tools such as the EPDS, observation of subtle signs, and active listening. Recommends training for primary care professionals and integration with specialized mental health services. Early identification improves prognosis and strengthens the professional-woman relationship.
Courtney King, Marie Hayes, Lizmarie Maldonado, Elizabeth Monter, Rubin Aujla, Erin Phlegar, Claire Smith, Liz Parker, Kerry Blome, Amanda Sandford, Edie Douglas, Constance Guille. 2025, United States of America. A perinatal psychiatry access program to address rural and medically underserved populations using telemedicine.	Descriptive/program implementation study. Level VI evidence.	To evaluate the Moms IMPACTT program, providing access to perinatal psychiatry via telemedicine for rural regions.	903 contacts; 881 women served, the majority from underserved areas (89%).	The program expanded access to perinatal psychiatric care, with high acceptance and integration into primary care services. It promoted professional training and effective coordination, overcoming geographic and structural barriers.
Neesha Hussain-Shamsy, Amika Shah, Lori Wasserman, Greer Slyfield Cook, Kaeli Macdonald, Keisha Greene, Geetha Mukerji, Simone N. Vigod, Juveria Zaheer, Emily Seto. 2024, Canada. Virtual connection and real community: the qualitative experience of participating in a videoconferencing-based psychotherapy group for postpartum depression and anxiety.	Interpretive qualitative (descriptive) study with data triangulation. Level VI evidence.	To understand the experiences of women participating in virtual postpartum psychotherapy groups for depressive and anxious symptoms, assessing perceptions of community, emotional impact, and implications for care.	14 women and 3 facilitators participated in weekly 8-week sessions (5-6 women per group) via Zoom, based on adapted interpersonal psychotherapy.	Three major themes emerged: (1) Virtuality and the transition to motherhood were normalized; (2) The groups fostered real connections, with the facilitator's role being crucial; (3) Participants reported increased authenticity but also limitations, such as lack of informality and childcare challenges. Virtual therapy was well-rated for its accessibility and positive impact.
Hanna Andersson, Katri Nieminen, Anna Malmquist, Hanna Grundström. 2024, Sweden. Trauma-informed support after a complicated childbirth – An early intervention to reduce symptoms of post-traumatic stress, fear of childbirth and mental illness.	Quasi-experimental study. Level III evidence.	To evaluate an early trauma-informed intervention following complicated childbirths, aimed at reducing symptoms of PTSD, fear of childbirth, and psychological distress.	101 women (43 intervention, 58 control); the intervention was delivered within the first 72 hours postpartum after complicated deliveries.	The intervention significantly reduced post-traumatic stress symptoms (median IES-R: 7 vs. 15; $p = 0.002$) and lowered the proportion of women with PTSD-compatible symptoms (12% vs. 26%). Systematic implementation in postpartum services is recommended.
Soledad Coo, María Ignacia García, Natalia Awad, Heather Rowe, Jane Fisher. 2019, Chile. Cultural adaptation of an intervention to prevent postnatal depression and anxiety in Chilean new mothers.	Cultural adaptation study with pilot evaluation. Level V evidence.	To culturally adapt the "What Were We Thinking" (WWWT) program for Chilean women, focusing on the prevention of postpartum depression and anxiety.	10 Chilean mothers in 3 pilot groups within public health services.	The intervention was well received, especially due to its inclusion of infant mental health and partner involvement. Linguistic and cultural adaptations facilitated implementation. It showed promise for integration into Chilean primary care.
Jéssica Kelly Alves Machado da Silva, Amuzza Aylla Pereira dos Santos, Crislane de Oliveira Pontes, Jovânia Marques de Oliveira e Silva, Yanna Cristina Moraes Lira Nascimento, Clarice Isabel Rosa dos Santos. 2021, Brazil. Identification of early signs of change/mental health disorders in postpartum women to promote self-care.	Exploratory qualitative study. Level VI evidence.	To identify early signs of mental health changes and/or disorders in postpartum women, promoting self-care.	20 postpartum women receiving care at the Robson Cavalcante Health Unit, Maceió – AL.	Early signs identified included persistent sadness (40%), insomnia (75%), guilt, low self-esteem, and poor self-care (85%). The women acknowledged the importance of self-care but faced barriers. The study advocates fostering connections with the healthcare team and implementing educational initiatives as a strategy to prevent mental health disorders during the postpartum period.

support, and the presence of social support networks[7,20]. In this context, Fisher reinforces the importance of integrating mental health into routine obstetric care as part of comprehensive care for women[8].

Digital health initiatives have also shown a positive impact, especially in contexts marked by access barriers. The Moms IMPACTT program, analyzed by King *et al* and Saad *et al*, demonstrates that telemedicine can expand the reach of specialized care, particularly when integrated with primary healthcare services[17,32]. Whether in-person, outpatient, or remote, interventions that employ validated protocols and approaches centered on women's emotional needs make a decisive contribution to perinatal care throughout the entire pregnancy-postpartum cycle, as highlighted by Hussain-Shamsy *et al* and Morlans-Lanau *et al*[3,20].

The consolidation of perinatal mental health within primary healthcare has proven to be an effective strategy for the early identification of psychological distress and the strengthening of therapeutic bonds. The WAVES model (Wellbeing and Antenatal Visit Engagement Strategy), described by Felten *et al*, shows that systematic screening, combined with clinical support and, when necessary, pharmacotherapy, fosters the development of trust-based relationships and the timely detection of symptoms[21]. Morlans-Lanau *et al* complement the findings mentioned above by demonstrating that consultations led by obstetric nurses, using tools such as the Edinburgh Postnatal Depression Scale (EPDS) and the 7-item Generalized Anxiety Disorder Scale (GAD-7), promote effective assessments and high adherence to care protocols[20].

In line with this evidence, Fisher argues that the role of obstetric nurses, especially when guided by active listening and sensitive screening, serves as a central pillar in the humanization of perinatal care[8]. The integration of clear screening and referral protocols, as highlighted by Felten *et al*, facilitates timely access to specialized care, preventing the worsening of psychological distress[21]. This integrated approach, grounded in the coordination of early screening, empathetic reception, and continuity of care, is essential to ensuring effective interventions[20,21].

Considering cultural and psychosocial factors is also fundamental for the adherence to and effectiveness of interventions. Programs adapted to linguistic, religious, and family specificities, such as the "What Were We Thinking" program in Chile, described by Coo *et al*, foster stronger therapeutic bonds[19]. Andersson *et al* demonstrate that flexible psychosocial interventions, even without explicit cultural adaptations, are effective in validating women's subjective postpartum experiences[26]. For Hussain-Shamsy *et al*, safe-sharing environments and emotional validation are key to strengthening bonds in contexts of vulnerability[3]. Saherwala *et al* and Morlans-Lanau *et al* emphasize that culturally sensitive practices reduce stigma, personalize care, and promote treatment continuity[20,24].

These approaches should not be understood merely as inclusion strategies but as essential therapeutic components for effective perinatal care. When combined with qualified listening and personalized care, Hussain-Shamsy *et al* and Morlans-Lanau *et al* regard them as the foundation for innovative interventions, therapeutic groups, and digital platforms for emotional support, which will be explored in the following section[3,20].

Online groups and digital interventions have shown a positive impact on perinatal mental health. By combining psychosocial support with accessible technologies, they help reduce emotional symptoms and postpartum social isolation[3,32]. King *et al* highlight their role in strengthening maternal resilience, including in rural areas[17]. The construction of meaningful bonds in these spaces, combined with active listening and emotional validation, as proposed by Fisher in the HAVEN model, is crucial to the success of interventions. Caropreso *et al* also point out that the combination of clinical support and social networks enhances therapeutic effects in contexts of vulnerability[7,8].

However, the use of digital technologies also presents challenges. Saad *et al* and King *et al* warn of barriers such as digital exclusion, low technological literacy, and privacy concerns[17,32]. Fisher adds that sensitive listening, even in virtual environments, is essential to prevent these platforms from exacerbating existing inequalities[8]. The effectiveness of these

solutions depends not only on technological infrastructure, but also on the cultural adaptation of interventions, the training of healthcare teams, and the support of public policies that ensure access and data protection, as emphasized by Hussain-Shamsy *et al* and Saad *et al* Meanwhile, Fisher and King *et al* stress that the quality of the therapeutic relationship and the continuity of care are decisive factors for the success of interventions, regardless of the medium used[3,8,17,32].

The early detection of emotional distress during the pregnancy-postpartum cycle goes beyond the simple application of screening tools. Kiraly *et al* state that the effectiveness of scales such as the EPDS and GAD-7 is directly linked to the sensitivity and training of the professionals who administer them[15]. Obstetricians, nurses, and pediatricians tend to adopt different approaches, which can influence the identification of symptoms[5]. Morlans-Lanau *et al* emphasize that continuity of care and trust-based relationships are crucial for early detection, especially in contexts where follow-up is fragmented[20].

Fisher proposes integrating emotional screening systematically into primary care, always in conjunction with empathetic listening[8]. Kiraly *et al* and Morlans-Lanau *et al* advocate for the continuous training of multidisciplinary teams and the adoption of integrated protocols across obstetrics, nursing, pediatrics, and mental health, aiming to improve interprofessional coordination and the response to maternal distress[15,20]. Jones, however, warns that the mechanical use of screening scales can lead to feelings of judgment and distance women from care[12]. When conducted in a welcoming and sensitive environment, as demonstrated by Fisher and Hussain-Shamsy *et al*, screening encourages emotional expression and strengthens the therapeutic bond, especially in contexts marked by social vulnerabilities[3,5,23,31].

The underrepresentation of racialized populations, migrants, LGBTQ+ individuals, and women from rural areas highlights structural gaps in perinatal mental health policies and interventions. Saad *et al* and King *et al* warn that the absence of specific strategies for these groups perpetuates historical inequalities in access to care[17,32]. Even when available, interventions are not always culturally adapted, which compromises their adherence and effectiveness. King *et al* argue that continuous emotional support is essential to mitigate the effects of inequalities, especially when combined with intersectoral policies in health, social assistance, and education, as also advocated by Silva *et al*[2,17].

Gender-based violence, often invisible during the postpartum period, is a critical factor in the worsening of maternal psychological distress. Salahuddin *et al* identify that women exposed to domestic violence exhibit higher levels of depressive and anxious symptoms, which can also affect the bond between mother and newborn[23]. Hussain-Shamsy *et al* emphasize the importance of safe therapeutic spaces as a strategy for addressing these traumatic experiences[3].

In this context, Andersson *et al* propose a trauma-informed approach, which has proven effective in reducing symptoms of post-traumatic stress, fear of childbirth, and emotional distress. They highlight the importance of early interventions that prioritize continuous, safe, and respectful emotional support[26]. Studies aligned with the complementary articles by Silva *et al* and Kohan *et al* demonstrate how obstetric violence, as an institutional form of gender-based violence, profoundly undermines mental health in the postnatal period[10,11]. These practices negatively affect self-esteem, well-being, and the mother–newborn relationship, and are directly associated with the development of depressive disorders and stress-related conditions. The convergence of these studies reinforces the urgency of public policies and humanized care practices grounded in the promotion of women's rights and the recognition of the consequences of obstetric trauma[8].

Overcoming the fragmented logic of biomedical care requires the incorporation of social determinants into care practices. As emphasized by Fisher and Morlans-Lanau *et al*, this involves delivering sensitive responses that are committed to social justice and equity in access to care[8,20]. Within this context, maternal self-care, historically linked to the expectation of female self-sacrifice, must be recognized as a fundamental dimension of mental health during the perinatal period, especially in settings marked by violence and emotional overload[12,28].

Silva *et al* and Shivairová *et al* identify that factors such as insomnia, physical exhaustion, feelings of guilt, and low self-esteem hinder the maintenance of psychological well-being[2,22]. The qualitative research by Machado da Silva *et al* confirms that, even when recognizing the importance of self-care, many women face concrete barriers-ranging from lack of support to institutional invisibility-that hinder its practice[13].

Obstetric and gynecological nursing plays a crucial role in this context. As highlighted by Fisher and Morlans-Lanau *et al*, trained professionals can promote maternal empowerment through active listening, the facilitation of support groups, and culturally sensitive health education. These elements strengthen autonomy and enable women to take ownership of their care process[8,20].

Throughout this review, it becomes clear that maternal self-care should be understood as an essential component of preventive strategies in perinatal mental health. Its promotion, when integrated into early screenings and psychosocial interventions, strengthens the potential of woman-centered practices[3,12,28,31].

As highlighted by Fisher, Silva *et al*, and Hussain-Shamsy *et al*, the promotion of mental health in the postpartum period should not be limited to symptom treatment, but must involve the development of policies and practices that foster well-being, equity, and humanization. In this regard, integrating maternal empowerment, recognition of social determinants, and culturally competent approaches is now an urgent challenge for perinatal health services[2,3,8].

Figure 2 presents an infographic outlining the main approaches and interventions that obstetric nursing can develop to promote the mental health of women during the postpartum period.

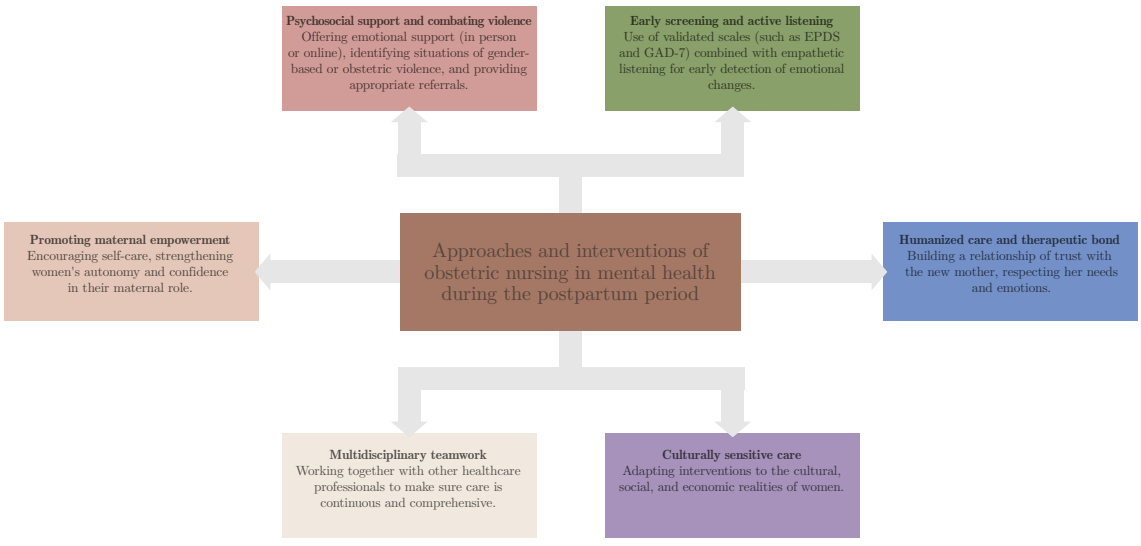

Figure 2: Infographic summary of the main findings.

Conclusion

The data analyzed in this review reinforce that mental health care during the postpartum period must not be fragmented or treated as secondary. Integrated approaches that are sensitive to the cultural, social, and emotional dimensions of women, led by qualified professionals, particularly in obstetric nursing, yield the best outcomes. Active listening and the humanization of care spaces emerge as essential pillars to ensure the right to mental health as an inseparable part of reproductive health.

The implementation of integrated obstetric care models in primary care, led by obstetric nurses, has proven effective not only in the early detection of psychological distress but also in promoting maternal empowerment and strengthening therapeutic bonds. The collected evidence highlights the importance of public policies that consolidate these practices as central strategies in contemporary perinatal health systems.

Therapeutic success is not based solely on the technique used, but above all on the ability of the care model to engage with the culture and reality of the patients. Respect for women's cultural diversity and spirituality not only encourages adherence and reduces stigma, but also enhances therapeutic effects. In this regard, it is urgent to promote continuous training in cultural competence and to strengthen intersectoral partnerships involving community and religious leaders.

The expansion of therapeutic groups and online emotional support demonstrates the effectiveness of digital interventions adaptable to different sociocultural contexts. However, it is important to emphasize that technology should be seen as a complement, not a substitute, for in-person therapeutic relationships. To avoid deepening pre-existing inequalities, technological innovation requires policies committed to digital inclusion, equitable access, and ongoing professional training.

Finally, more than a technical act, perinatal mental health screening should be conceived as an act of care: a practice that combines clinical knowledge with sensitive listening, capable of creating safe spaces for emotional expression. Recognizing and addressing the social, cultural, and emotional vulnerabilities of women in the postpartum period is essential for building care that is holistic, ethical, and truly transformative.

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LA; AJ; YG; CS: Study coordination, study design, data collection, storage and analysis, review and discussion of results.
LA; AJ; YG; CS: Data collection and analysis.
OZ; PB: Study coordination, review and discussion of results.
All authors have read and agreed with the published version of the manuscript.

Ethical Disclosures/Responsabilidades Éticas
Conflicts of Interest: The authors have no conflicts of interest to declare.
Financial Support: This work has not received any contribution, grant or scholarship.
Provenance and Peer Review: Not commissioned; externally peer reviewed.
Conflitos de Interesse: Os autores declararam não possuir conflitos de interesse.
Suporte Financeiro: O presente trabalho não foi suportado por nenhum subsídio ou bolsa.
Proveniência e Revisão por Pares: Não comissionado; revisão externa por pares.