ISSN: 2318-8413 DOI: 10.18554/refacs.v8i3.4114

REFACS

Quality of life and indicative symptoms of puerperium depression

Qualidade de vida e sintomas indicativos de depressão no puerpério

Calidad de vida y síntomas indicativos de depresión en el puerperio

Received: 01/11/2019
Approved: 15/05/2020
Published: 01/07/2020

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This is a quantitative, cross-sectional study. It was carried out in 2017 with 103 mothers, and it aimed to analyze and measures the quality of life of puerperal women, and it identify the prevalence of indicative signs of postpartum depression and it associates quality of life scores with depressive symptoms. We applied socio-demographic conditions, health and obstetrics tools, the "Quality of Life Index" and the Beck Depression Inventory. The average total quality of life score was 24.77. The aspects with the smallest and largest scores were Socioeconomic and Family. The average of points on the Beck Inventory was 9.42, but 82.5% did not have indicative signs of depression. We noticed that the presence of indicative signs changed all quality of lives scores. The puerpereal women obtained high scores on quality of life, but indicative signs of depression influenced negatively the quality of life in all of its aspects.

Descriptors: Postpartum period; Quality of life; Adaptation, Psychological; Depression, Postpartum; Obstetric nursing.

Estudo quantitativo, de delineamento transversal, realizado em 2017 com 103 puérperas, que teve por objetivo analisar e mensurar a qualidade de vida de puérperas, identificar a prevalência de sinais indicativos de depressão pós-parto e associar escores de qualidade de vida com sintomas depressivos. Aplicou-se instrumentos sobre condições sociodemográficas, de saúde e obstétricas, "Índice de Qualidade de Vida" e o Inventário de Beck para Depressão. O escore de qualidade de vida total obteve média de 24,77. Os domínios com menor e maior escore foram Socioeconômico e, Família. A média de pontos obtida no Inventário de Beck foi de 9,42, porém 82,5% não possuíam sinais indicativos de depressão. Observou-se que presença de sinais indicativos alterou todos os escores de qualidade de vida e seus domínios. As puérperas obtiveram altos escores de qualidade de vida, contudo, sinais indicativos de depressão influenciaram negativamente a qualidade de vida em todos os seus domínios.

Descritores: Período pós-parto; Qualidade de vida; Adaptação psicológica; Depressão pós-parto; Enfermagem obstétrica.

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Descriptores: Periodoposparto; Calidad de vida; Adaptación psicológica; Depresión posparto; Enfermería obstétrica.

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INTRODUCTION

In 1998, the World Health Organization defined the concept of Quality of Life (QL) as the "*individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns.*"[1].

This concept includes: physical health, psychological and emotional status, level of independence, social relationships, spiritual and environmental dimensions, substantially affecting the health of individuals[1]. However, it is a subjective term, influenced by the environment and which reflects the current moment experienced by the individual[2].

Puerperium or postpartum corresponds to the period of physical, psychological and social changes caused by pregnancy and childbirth in women, which tend to return to the normality of non-pregnant situation[3]. It starts after the placental detachment, but its end is uncertain and individually variable, extending up to one year after birth[3,4].

During this period, women experience intense transformations[5], starting with the decrease in sleep hours or their deprivation, until the loss of autonomy, since their daily lives are controlled by the baby's schedules[6]. In view of the emotional lability typical of the period, a study pointed out that women are insecure, worried, afraid, irritated and guilty due to changing habits, the birth of their child, in addition to the loss of freedom imposed by motherhood[7].

Thus, puerperium is characterized by being a period of vulnerability in a woman's life, since physical and psychological changes can cause changes in health and emotional well-being, increasing the risk of developing psychiatric disorders[8].

Studies with different populations and samples show that the higher the rates of depression and/or anxiety in this period, the lower the QL scores, that is, the symptoms can negatively affect people's lives[9,10]; mainly in psychological domains and perception of general health status.

Among mental disorders, depression is the most prominent, due to the high and increasing prevalence (affects between 8 to 18% of puerperal women) and also due to work and social incapacity related to this disorder[11]. The diagnosis of depression in the puerperal period has special characteristics and, therefore, is coded with the postpartum depression specifier[12,13].

Postpartum depression has multifactorial causes, especially from biological, psychological and socioeconomic factors[14]. Depressed mood, loss of pleasure and interest in activities, change in weight or appetite, change in sleep, restlessness or psychomotor retardation, feeling of fatigue, feeling of worthlessness or guilt, difficulty concentrating or making decisions and even thoughts of death or suicidal ideation, are clinical symptoms related to postpartum depression[15]. These characteristics, in the case of postpartum depression, coincide with childbirth to characterize the diagnosis. However, it is also evident that women who showed symptoms of depression during pregnancy are more vulnerable to symptoms of postpartum depression[16].

Therefore, it is necessary to further explore women's experiences during this period, as well as values, feelings and needs[17] and general elements that interfere in adapting to motherhood, with the purpose that health professionals plan interventions that collaborate to improve puerperal women's QL[6].

However, it is observed that, although there are productions about QL, there are few studies that address the impact on women's health (physical and mental) and, more specifically, that evaluate her during puerperium and its impact on maternal and child well-being. Thus, this study aims to analyze and measure the quality of life of puerperal women, identify the prevalence of signs indicative of postpartum depression and associate quality of life scores with depressive symptoms.

METHOD

This is a quantitative, cross-sectional study, carried out in 2017 at a university hospital located in the city of Uberaba, in the state of Minas Gerais. The hospital is a reference for resolution of high-risk pregnancies, infectious diseases in the pregnant-puerperal cycle, pathological prenatal care in the cities of the Triângulo Sul region of Minas Gerais (27 cities), for normal pregnancies of residents of District I of Uberaba (about 150,000 inhabitants) and all cities in the Triângulo Sul region that do not have a hospital.

To determine the sample size, the PASS (Power Analysis and Sample Size) version 15 application was used, in which the following values and information were introduced: an initial determination coefficient $R^2 = 0.13$, with a significance level of $\alpha = 0.05$. The sample was non-probabilistic for convenience and data were collected from March to December of 2017.

The study included women who were experiencing puerperium (in the first week or up to 90 days after delivery), had their puerperium and/or newborn return scheduled at the institution; could read and write; were able to answer the questionnaire and consented to participate in the study, regardless of age (puerperal women under the age of 18 had the Free and Clarified Consent Form signed by parents and/or legal guardians and signed their consent). Postpartum women whose outcome was miscarriage, fetal death, stillbirth or neonatal death were excluded; as well as post-referenced mothers for puerperal return in BHU (Basic Health Unit) or FHS (Family Health Strategy) where they had prenatal consultations and women who had their birth assisted in other institutions.

The puerperal women were invited to answer the questionnaire that addressed sociodemographic data, health conditions, obstetric history, data on birth and Newborn (NB). This questionnaire was developed by the researchers themselves, based on information contained in institutional records and tested by means of a pilot study, proving to be adequate to answer the variables of interest in the study. The data were obtained through interviews with the mothers and/or extracted from the medical records of the mothers.

To measure the Quality of Life (QL) scores, the generic version of the Quality of Life Index - QLI, developed by researchers Carol Estwing Ferrans and Marjorie Powers, from the University of Chicago and Illinois - USA, in 1984, was used to measure quality of life. The instrument has two parts: the first is associated with satisfaction and the second reflects the importance attributed to its items[18,19]. The QLI is a validated instrument, translated into Brazilian Portuguese and available for free use, as well as its syntax. The instrument that measures QL in general divides its items in four domains, for which it generates the respective scores: Health and Functioning; Psychological and Spiritual; Family and Socioeconomic. The score varies in the range of 0-30, for all versions, and the higher the score, the better the QL[18,19].

It was observed that there is no qualified instrument to assess QL in puerperium. Ferrans & Powers' IQV[18,19] proved to be adequate to reach this study's objectives, since it allows the measurement of QL in healthy people and, considering that puerperium is not a state of morbidity[6], its use was justified.

To identify indicative signs of depression, the Beck Depression Inventory (BDI) was used, which was developed in 1961 by Beck and collaborators to assess and detect depressive symptoms. It was translated and validated into Brazilian Portuguese in 1982 and is capable of differentiating 'normal' individuals or those with symptoms of anxiety and/or depression, as well as being applicable in different age groups (including elderly and adolescents) and in different contexts[20].

The BDI consists of 21 questions that address symptoms and attitudes and has high reliability, internal consistency and validity. Through structured questions, it is possible to assess: mood, pessimism, feeling of failure, dissatisfaction, guilt, feelings of punishment, self-deprecation, self-accusation, desire for self-punishment, crying crises, irritability, social isolation, indecision, inhibition at work, disturbances sleep, fatigue, loss of appetite, weight loss, loss of libido and worry. All symptoms are assessed based on previous week to the present day.

Each question has four answer alternatives with scores ranging from zero to three points, with zero being absence of symptons and three, the presence of severe symptoms[20].

From the totalization of points, it is possible to classify as: zero to nine - absence of depressive symptoms; 10 to 18 points - mild depression; 19 to 29 points - moderate depression and, from 30 to 63 points - severe depression[20].

The collected data were stored in an Excel® spreadsheet, using double entry techniques and the bank was validated. Then, they were imported into the Statistical Package for Social Sciences (version 23), analyzed by simple descriptive statistics and, to determine the correlation between the indicative signs of depression and the QL scores, Pearson's correlation was used (for two quantitative variables). To assess the correlation between sociodemographic, clinical, obstetric and neonatal variables, Student's T-test (for qualitative variables and quantitative scores) and Pearson's correlation were used.

The following variables related to the puerperal women were analyzed: adolescents and elderly women (age>35 years); *pardas* and white; who either had a partner or not; either completed high school or not; Catholic or non-religious; with income below or above two minimum wages; either owned their homes or not; smokers; drinkers; who had pathologies prior to pregnancy; primiparous; who had premature, small or large newborns for gestational age; according to the type of delivery and gender of newborn; had complications during pregnancy or childbirth; were breastfeeding at the time of the interview, if it was exclusive breastfeeding and if there was nipple trauma; and whether they noticed an improvement or worsening of their health and the newborn's health after hospital discharge. Variables with a value of $p \leq 0.05$ were considered significant.

All participants signed the Free and Clarified Consent Form. The study was approved by the Research Ethics Committee (CEP) of the Universidade Federal do Triângulo Mineiro, filed under number 1,774,885 of October 14, 2016 and its entire development was guided by the Regulatory Guidelines and Norms for Research involving human beings contained in Resolution 466/12/CNS/MS.

RESULTS

A sample size (n) was obtained with a minimum of 99 and a maximum of up to 124 subjects, with the participation of 103 puerperal women. The average age was 25.81 years, ranging from 14 to 42 years, 9.7% were adolecents and 10.7% were over 35 years old; 41.8% declared themselves of *pardas*; 38.8% had completed high school; 48.5% were Catholic. Most were married (65%), did not execute any paid activities (55.3%); had an income of up to two minimum wages (59.2%), were their house's legal owners (57.3%) and hailed from the municipality (68%).

Regarding health conditions and habits, 8.7% reported drinking alcohol, 5.7% reported being smoking and only one puerperal woman reported using illicit drugs. 30.1% of women had pathologies prior to pregnancy, with arterial hypertension (25.8%) and hypothyroidism (22.6%) being the more frequents; however, 70.9% of the puerperal women reported that pregnancy had some pathology, being more frequent: hypothyroidism (18.4%), hypertensive syndromes (15.5%), gestational diabetes (8.7%), anemia and syphilis (both with a percentage of 3.9%) and depression (2%). Regarding the use of medications during pregnancy, 98.1% declared using them, with ferrous sulfate (89.3%) and folic acid (37.9%) being the most used; 2.9% reported using antidepressants during pregnancy.

As for obstetric data, the average number of pregnancies was 2.46±1.54, and the number of births was 2.23±1.41; the average number of prenatal appointments was 8.14±2.45 appointments and the average gestational age at birth was 38.54±1.53 weeks, ranging from 33 to 42 weeks.

In regards of type of delivery, 47.6% were cesarean sections and, of these, 40.8% were indicated for changes in fetal vitality; 22.4% for decompensating maternal pathology and

22.4% for iterativity. Vaginal delivery with episiotomy happened in 28.2% of cases, and vaginal delivery with no interventions corresponded to 24.3% of cases which, when put together, correspond to the majority of delivery routes (52.5%).

Birth weight had an average of 3,090±637 grams, which 81.9% of newborns had an appropriate weight for age, 13.3% had low weight and 4.8% had a weight superior to 4,000 grams. There was a slight predominance of male NBs (51.5%).

When asked about breastfeeding, 90.3% were breastfeeding, 70.9% were on exclusive breastfeeding; 64.1% considered breastfeeding to be excellent; 24.2% reported the occurrence of nipple trauma, with excoriation (15.5%) and cleft (8.7%) being more frequent.

The return of the puerperal woman in the institution varied from eight to 90 days, with an average return in 36.1±18.7 of days postpartum.

Among the interviewees, the average general score of the QL index, considering all the domains evaluated, was 24.77 points, with a variation of 16.11 points between the lowest and the highest value attributed. The evaluation by domains of quality of life indicate that the most affected aspects were socioeconomic, while family relationships had higher scores. The psychological/spiritual domain was the one with the greatest variation in scores in the responses (Table 1).

Table 1. Total Quality of Life Index (QLI) and by postpartum domains. Uberaba, MG, Brazil, 2017.

QLI	Mean	DP	Minimum	Maximun
Total	24.77	3.21	13.98	30
Health and functioning	24.51	4.00	12.79	30
Socio-economical	22.33	4.46	10.38	30
Psychological/spiritual	25.80	4.25	4.64	30
Family	27.55	2.40	20.40	30

The average score obtained in the BDI was 9.42±7.97, ranging from 0 to 49 points. From the score classification, 17.4% of interviewees had signs indicating depression at the time of the interview, 8.7% had mild signs; 6.8% moderate and 1.9% signs of severe depression.

The presence of signs indicative of depression altered all QL scores and all domains (Table 2). Although the association between QL and its domains and depression is considered weak, there are negative correlations between QL and depression, that is, the higher the score obtained on the BDI (signs of depression), the worse the general QL and all its domains. puerperal women (Table 2).

Table 2. Association of total Quality of Life Index (IQV) scores by domains and average score obtained from the Beck Inventory for Depression in puerperal women, Uberaba, MG, Brazil, 2017.

QLI	r	p
Total	-0,605	<0,001
Health and functioning	-0,517	<0,001
Socio-economical	-0,488	<0,001
Psychological/spiritual	-0,585	<0,001
Family	-0,230	0,019

Only three puerperal women (2.9%) were diagnosed with depression during pregnancy and took antidepressants, and of these, only one showed signs of depression measured by the BDI. When statistical tests were performed, no statistically significant associations were found between QLI and its domains and having a diagnosis of depression, as well as having previous depression and showing indicative signs at the time of the interview. However, due to the small number of cases, it was not possible to verify causal relationships between these variables, due to sample limitation.

When analyzing the possible influence of sociodemographic, clinical, obstetric and

neonatal variables on the averages obtained in the BDI, a statistically significant association was observed only for the variable living in one's own home (Table 3). No statistically significant associations were found with other sociodemographic, clinical, obstetric and neonatal variables and the BDI score (Tables 3 and 4).

Table 3. Sociodemographic, clinical, obstetric and neonatal variables and scores obtained in the Beck Depression Inventory of the 103 interviewed mothers, Uberaba, MG, Brazil, 2017.

Variable	n	Mean	p
Adolescents	10	7.10	0.335
Non adolescent	93	9.67	
Maternal age superior to 35 years old	10	7.80	0.502
Maternal age inferior to 35 years old	93	9.59	
White	33	8.36	0.348
Non white	70	9.91	
Civil union	67	9.51	0.877
No civil union	36	9.25	
Educational level superior to complete high school level	48	8.73	0.415
Educational level inferior to incomplete high school level	55	10.02	
Executes paid activity	47	8.62	0.353
Does not execute paid activity	56	10.09	
Religious	94	9.30	0.994
Non religious	9	10.67	0.994
Income superior to 2 minimum wages*	61	10.21	0.160
Income inferior to 2 minimum wages	37	7.86	
Owns the house they live in	60	10.63	*0.048*
Lives in rented or leased house (shared residence)	43	7.72	
Smokers	6	8.50	0.773
Non smokers	97	9.47	
Drinks alcohol	9	11.78	0.355
Does not drink alcohol	94	9.19	
Has previous illness	31	11.23	0.131
No previous illness	72	8.64	
Primigravida	33	10.09	0.558
Multigravida	70	9.10	
Vaginal childbirth	54	9.20	0.776
Cesarian section	49	9.65	
Premature NB*	11	7.82	0.698
Full term NB	69	8.72	
NB too small for gestational age (SGA)	13	11.46	0.325
NB with adequate weight	90	9.12	
NB too big for gestational age (BGA)	5	8.80	0.860
NB with adequate weight	98	9.45	
Maternal complications during pregnancy and/or labor	25	10.88	0.294
No complications	78	8.95	
Health issues with NB	8	11.63	0.417
Healthy NB	95	9.23	
Breastfeeding mothers	93	9.35	0.909
Interrupted breastfeeding	10	10.00	
Exclusive breastfeeding	73	9.04	0.481
Mixed or artificial breastfeeding	20	10.50	
Presence of nipple trauma	27	9.37	0.972
No nipple trauma	76	9.43	

* Only 98 mothers informed their income and the gestational age was written in only 80 medical files.

Table 4. Correlation of sociodemographic, obstetric and neonatal variables and the score obtained from the Beck Depression Inventory of the 103 interviewed mothers, Uberaba, MG, Brazil, 2017.

Variables	R	p
Number of pregnancyes	0.057	0.567
Number of residents in the house	0.056	0.576
Number of children	0.011	0.995
Gestational age	0.580	0.056
Number of prenatal appointments	0.089	0.498
Apgar score on the 1st minute of life	-0.111	0.271
Apgar score on the 5th minute of life	0.051	0.610
Newborn weight	0.000	0.999
Postpartum return days	0.039	0.697

DISCUSSION

The mothers had high QL scores. The most affected domains were socioeconomic, which obtained the lowest scores, and family domain, which obtained the highest scores. When compared to studies that used the same instrument to measure the QLI, it was observed that there was variation between the general scores and, in a study with adolescents, an average of 21.4819 was obtained, and among puerperal women, in general, a score was obtained. average of 25,826. However, in both studies, the socioeconomic domain obtained the lowest and the family domain obtained the highest score[6,19].

Quality of life scores were assessed in three different puerperal periods, between zero and 60 days. The worst QL scores were related to physical components - functional capacity, physical aspects and pain associated with the immediate puerperium. The mental component - vitality and social aspects, showed important differences between the immediate and remote puerperium, with improved scores in the remote puerperium (over 40 days). All scores showed an increasing trend throughout the puerperal period[17].

Similarly, a study carried out with 224 puerperal women in India, at three different times, between zero and 30 days after delivery, pointed out that QL scores improved for all interviewees over time[21], indicating the ability in postpartum to adapt to motherhood and its adversities. However, when assessing signs indicating depression, there were no statistically significant differences associated with the woman's puerperal period.

In research, indexes of signs indicative of depression in puerperium ranged from 4.7 to 53.3% of women[22-26]. There was a variation from 0.7 to 4.7% of the cases classified as severe signs of depression[22,23]. The average obtained in BDI in a similar study was 10.7823. And another study on the occurrence of postpartum depression indicated that 2.7% of mothers had already taken antidepressants before pregnancy[24]. These data point out that the study sample was within the verified averages, since 17.4% showed signs of depression, 1.9% being severe; the average obtained in the BDI was 9.42 and 2.9% used antidepressants during pregnancy.

In the present investigation, an association was found between mothers being their home's legal owners and higher averages obtained in BDI. This variable may be associated with the fact that women who own their homes may have concerns about payment of financing and this is a compromising factor in the puerperium, due to the occupational and financial difficulties imposed by motherhood. Another possible explanation would be the fact that being their own homes can be associated with living in leased homes, that is, shared with other people, which can strengthen support in this adaptation period. Having help from family members in the puerperium is seen as important and positive[27] and, generally, family members and the community are mobilized to help and welcome puerperal women in their demands[28].

However, in the search for factors associated with signs indicating depression, the following points are made: smoking; dissatisfaction with marital relationship; history of violence during pregnancy; cesarean delivery; use of antidepressants during pregnancy; lack of

support from partner during postpartum period and poor sleep quality[23,24], which showed statistically significant differences pointing to the influence of these factors on the occurrence of depressive signs.

The results showed that women with signs of depression had lower QL scores in all their domains, demonstrating the negative influence of the disease in the puerperal period. In similar studies, with low QL scores in general, changes in the following domains stood out: physical, mainly related to pain and general health; vitality, with lower averages in the emotional and mental health aspects and relationships (affinity/family/friends)[22,25,29,30]. However, a positive association was found between QL scores in the mental domain and greater capacity for maternal self-care[28].

It is possible that difficulties of different origins may influence, such as: adaptation to motherhood; reduced hours of sleep; constant crying of newborn; house chores; care for other children; advice and guesses from mothers-in-law, mothers and/or neighbors cause wear and tear for mothers. These negative aspects can have a direct or indirect impact on maternal and child health, since during puerperium there is an inseparability between mother and baby[31].

CONCLUSION

The puerperal women had high scores on quality of life. However, the socioeconomic domain was the most compromised, and the family domain was the one with the best scores, indicating importance and satisfaction in the face of birth and family configuration.

The BDI average was 9.42, and prevalence of signs indicative of depression found was 17.4%, being classified as: mild signs (8.7%); moderate (6.8%) and severe (1.9%). Only 2.9% of women used antidepressants during pregnancy.

All QLI domains (general; health and functioning; socioeconomic, psychological/spiritual and family) were negatively affected by the presence of signs indicative of depression among puerperal women, and a statistical association was found between higher BDI scores and owning a home.

The limitations of the study were related to the method used, as it is a study with a descriptive and cross-sectional design and with regard to external validity, since data cannot be generalized to other realities and causal relationships cannot be established. Still, this research contributes to the understanding of this relation and emphasizes the importance of an individualized and comprehensive view so that the assistance provided is effective, humanized and continuous after childbirth, to ensure better QL for mother and baby.

It is necessary to rethink attention in puerperium, given that it is a period of intense transformations, since the concept of QL is complex, multifactorial and influenced by several factors, and signs indicating depression were directly related to low QL scores in all its domains. Thus, early detection and intervention in the indicative signs of depression can increase the woman's QL during this period. In addition to this, it is worth mentioning the inseparability between mother and baby, as both maternal and neonatal conditions affected by the QL of both.

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CONTRIBUTIONS
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How to cite this article (Vancouver)
Silva SGF, Condeles PC, Parreira BDM, Moreno AL, Paschoini MC, Torreglosa Ruiz M. Quality of life and indicative symptoms of puerperium depression. REFACS [Internet]. 2020 [cited in *insert day, month and year of access*]; 8(3):416-426. Available from: *insert access link*. DOI: *insert DOI link*.

How to cite this article (ABNT)
SILVA, S. G. F.; CONDELES, P. C.; PARREIRA, B. D. M.; MORENO, A. L.; PASCHOINI, M. C.; TORREGLOSA RUIZ, M. Quality of life and indicative symptoms of puerperium depression. **REFACS**, Uberaba, MG, v. 8, n. 3, p. 416-426, 2020. Available from: *insert access link*. Access in: *insert day month and year of access*. DOI: *insert DOI link*.

How to cite this article (APA)
Silva, S.G.F., Condeles, P.C., Parreira, B.D.M., Moreno, A.L., Paschoini, M.C., & Torreglosa Ruiz M. (2020). Quality of life and indicative symptoms of puerperium depression. *REFACS*, 8(3), 416-426. Retrieved in: *insert day, month and year of access* from *insert access link*. DOI: *insert DOI link*.