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Original article

The mode of delivery and some selected obstetric factors as predictors of post-partum depression

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Abstract

Background: The most prevalent mental or emotional problem associated with childbirth is post-partum depression (PPD). This study was designed to determine the psychological responses of Iranian women to difficult childbirth.

Methods: In this prospective cohort design, incidence rate and associated obstetric predictors of PPD over twelve week's post-partum were investigated among 1801 non depressed pregnant women attending primary health centers (PHCs) of Mazandaran province from January to June 2009 using the Iranian version of the Edinburgh Postnatal Depression Scale (EPDS > 12). Using logistic regression analyses, odds ratios (ORs) for the significant obstetric risk factors that were significantly associated with PPD from chi-square tests were calculated. The associations were controlled for possible socio-demographic confounding factors.

Results: The incidence proportions of depression occurring over a 12 weeks period of post-partum were 12.30%. The regression model showed that the risk of PPD was increased by experienced recurrent urinary infection [OR=2.25, (95% CI: 1.15-4.38), unwanted pregnancy [OR=1.97, (95% CI: 1.15-3.35)] and gestational diabetes [OR=3.41, (95% CI=1.46-5.88)] during pregnancy.

Conclusions: Although the mode of delivery was not predictive of PPD, other difficulties during pregnancy were associated with higher levels of depressive symptoms over 12 week's post-partum that needs on-time interventions.

Keywords: Depression, Obstetrics; Post-partum, Risk factors

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Introduction

Post-partum depression (PPD) is the most common psychiatric disorder following childbirth and a key concept for women-infant mental health (1, 2); a moderate to severe depression symptoms that lasts longer than post-partum blues and with adverse effect on whole family (3). The women at risk are seldom identified during pregnancy or at the delivery time (4). This condition particularly occurs in many developing countries where psychological issues are almost ignored (5). It is estimated that up to 80% of cases do not report it and thus, are not diagnosed by respective specialists (6). A literature review have shown a range of 74.0% to 82.1% of PPD in some countries (3).

Coupled with the existing diagnostic vagueness, there is also considerable lack of information about the risk factors linked with the incidence of this psychiatric disorder (7). The epidemiological studies reported

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psychosocial and socio-demographic risk factors such as experienced depression during pregnancy (8), poor marital relationship (9) and younger maternal age (10). The association between obstetric factors and PPD has been investigated in a number of studies and several studies reported an association (11, 12), but others did not (13, 14). Still, the existing evidence is incompatible and effect size is small (15, 16). The purpose of this project was to investigate whether complications during pregnancy or delivery could predict PPD over 12-week post-partum among Iranian women. To our knowledge some of these complications studied for the first time. Determination of PPD risk factors could assist health care providers comprehend why a woman becomes depressed, in addition to assisting in planning and implementing a preventive program and adequate treatment.

Materials and Methods

This follow-up cohort study was conducted among rural and urban pregnant women attending Primary Health Care center (PHCs) of Mazandaran province to investigate whether perinatal complications put women at greater risk for depression at 2, 8 and 12 week's post-partum. All, literate, singleton, 16-45 years old pregnant women with gestational age 32-42 weeks pregnancy, who attended PHCs for prenatal care were invited to take part in this study. Women on pharmacological treatment for psychiatric problems and whose Edinburgh Postnatal Depression Scale (EPDS)(17) scores were more than the cut-off point (>12) during 32-42 weeks of pregnancy were excluded from the study. During the study time frame from January to June of 2009, 9187 women (4,684 in urban and 4,503 in rural) who were in their 3rd trimester of pregnancy were registered at the 308 clinics. Among them, 2,626 women were eligible and approached in the study and of those, 2,359 (89.8%) volunteered. Finally, 2,279 (96.6%) completed the EPDS and other questionnaires. Of those, 1,801 women were free of depression and followed to 12 weeks postpartum.

Data were collected using a reliable questionnaire (Cronbach's alpha=86) contains socio-demographic and obstetrics factors. These variables were selected based on literature review. Participants provided information on complications during pregnancy, delivery and after birth to estimate risk of PPD. For accuracy, obtained data rechecked by women's documents in PHCs. Concerning obstetric and gynecological variables, questions were placed in chronological order. Women were first asked about their history of medical problems with focus on obstetric and gynecologic history in multiparous women from earlier pregnancy, and also pregnancy related factors. They were then asked about their labor and delivery experiences and factors pertaining to prenatal and postnatal problems after delivery. Information was also gathered on the neonatal characteristics.

Obstetric and gynecological data of interest included history of medical problems, infertility, history of abortion, any complications during previous and this pregnancy, gestational age at the first antenatal care visit, gestational age at the time of delivery, number of antenatal care visits, unwanted pregnancies, participation in health education programs, weight gain, mode of delivery, place of delivery, intrapartum excessive bleeding, puerperal complications, birth weight, gender of the baby and neonatal morbidity.

Gestational age was determined by a fetal ultrasound examination conducted during pregnancy. Birth was classified as preterm if it occurred before 37 weeks of gestation. Type of delivery was divided into three categories: (1) vaginal delivery; (2) elective caesarean section; (3) emergency caesarean section. Location of the delivery was either at a private hospital or in governmental hospital. Unwanted pregnancy was defined if the women had not desire this pregnancy at the time of confinement or planned it.

Covariates

Based on the literature, the following non-obstetrical factors were considered as possible confounders in the association between perinatal complications and PPD: women age, age at marriage, women and husbands' education, women and husband' employment status, family structure, housing's holds, total household income, gravidity and location of the health center. Income was categorized into three groups based on monthly income according to the Iranian Ministry of Finance report based on family income for five people during the data collection period.

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During pregnancy and after birth the women were asked to fill the Iranian version of the EPDS. It includes 10 Likert items that takes 10 minutes or less to answer. Each sample selects one of four possible responses ("no", "not at all", "yes", and "quite often") according to their feelings within the past seven days. The score of all questions was computed (18). A score of greater than 12 was a valid cut-off value for the provisional diagnosis of PPD in the Iranian sample (19).

Verification of some items in socio-demographic and obstetric and gynecological questionnaires was also done. Most of the questions (e.g. parity, age, number of visits, weight gain, gender of the baby, mode of delivery) after being completed by subjects were checked again with their documents in the health centers. All women and babies in the study were weighed with the same scales which were made from the same company in all health centers. To reduce errors and to obtain better accuracy, all scales were checked prior to being used.

Analysis

All analyses were performed using the IBM-SPSS software version 20. Chi-square tests were used to describe the association between sample socio-demographic characteristics and perinatal risk factors (categorical variables) with PPD. Using logistic regression analyses, we calculated odds ratios (ORs) for the risk factors that were significantly associated with PPD, as indicated by the chi-square tests. The associations were controlled for possible confounding factors. All tests with p-values of less than 0.05 were taken statistically significant.

Ethical approval was obtained from the Medical Ethics Committee, University Putra Malaysia (UPM) and Ethic Committee of Mazandaran University of Medical Sciences in Iran.

Results

Attrition over the 12 weeks data collection was 14.15% and this reflected a total of 255 mothers who completed phase 1 of the study (i.e. during 32-42 weeks of pregnancy) but did not respond to post-partum 2nd, 8th and 12th week's data collection request. No significant difference was found in terms of the average age, women' and their husbands'

Table 1. Socio-demographic characteristics by post-partum depression status.

Variables	No-PPD	PPD	p-value
Age (Years)			0.002
< 25	544 (80.2)	134 (19.8)	
25-35	673 (85.5)	114 (14.5)	
36 or older	75 (92.6)	6 (7.4)	
Age at marriage (Years)			0.090
< 25	1114 (82.9)	229 (7.1)	
≥ 25	178 (87.7)	25 (33.4)	
Education (Years)			0.020
Lower secondary (≤ 9)	465 (81.4)	106 (18.6)	
Upper secondary (10-12)	644 (83.5)	127 (16.5)	
Completed High School (>12)	183 (89.7)	21 (10.3)	
Husband education (Years)			0.240
Lower secondary (≤ 9)	527 (82.3)	113 (17.7)	
Upper secondary (10-12)	562 (83.5)	111 (16.5)	
Completed high school (>12)	203 (87.1)	30 (12.9)	
Total household income in tomans (monthly)			0.002
Low (< 350,000)	806 (81.3)	185 (18.7)	
Medium (350,000-450,000)	305 (85.9)	50 (14.1)	
High (> 450,000)	181 (90.5)	19 (9.5)	
Gravida			0.009
1	673 (81.2)	156 (18.8)	
2	413 (85)	73 (15.0)	
+ 3	206 (89.2)	25 (10.8)	
Age of Last Child (months)			
< 24	61 (77.2)	18 (22.8)	0.020
24-36	58 (87.9)	8 (12.1)	
37-72	192 (90.6)	20 (9.4)	
> 72	229 (86.7)	35 (13.3)	
Gender of Children			0.860
Female	242 (87.4)	35 (12.6)	
Male	238 (86.2)	38 (13.8)	
Both	61 (88.4)	8 (11.6)	
Family Structure			0.040
Extended	341 (80.4)	83 (19.6)	
Nuclear	951 (84.8)	171 (15.2)	
Housing			0.330
Renting	492 (82.4)	105 (17.6)	
Own house	800 (84.3)	149 (15.7)	
Employed			0.001
Housewife	1208 (82.9)	249 (17.1)	
Employ	84 (93.4)	5 (5.6)	
Husband Employed			0.340
Business	140 (82.8)	29 (17.2)	
Farmer	82 (78.1)	23 (21.9)	
Government servants	874 (83.7)	170 (16.3)	
Other	196 (86.0)	32 (14.0)	
Location of health centre			0.730
Rural	636 (83.2)	128 (16.8)	
Urban	656 (83.9)	126 (16.1)	

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Table 2. Frequencies of history of obstetrics gynecological complications by post-partum depression

Variables	No-PPD	PPD	P-value
Abortions	214 (84.3)	39 (18.7)	0.840
Illegal	38 (80.9)	9 (19.1)	0.440
Legal	174 (85.3)	30 (14.7)	
Infertility	106 (86.9)	16 (13.1)	0.300
Medical diseases	145 (81.0)	34 (19.0)	0.320
Anemia	113 (77.4)	33 (22.6)	0.030
Diabetes	3 (75.0)	1 (25.0)	0.380
Obstetric complications in previous pregnancy	192 (82.8)	40 (17.2)	0.280
Preterm birth	19 (82.6)	4 (17.4)	0.210
Elective cesarean section	67 (91.8)	6 (8.2)	0.050
Emergency cesarean section	112 (83.6)	22 (16.4)	0.990

education among women who were followed and those who dropped out.

The mean age and age at marriage of women was 25.9±5.2 years and 20.4±4 years respectively. About half of women and their husbands' had less than a high school education (50.5% and 41.3 %, respectively), and their mean household income was 319,985±1.5 Tomans (3500 Tomans = 1 US Dollar) per month. The majority of women were housewife (92.7%), had husbands who were employed in business (67.5%), owned their own home (62%), and lived in nuclear families (71.7%). About two third of women (61%) did not have any children. Half of women (50.6%) were recruited from rural PHCs, the remainder were recruited from urban PHCs.

The obstetric data that were gathered for the study included obstetric and gynecological history, pregnancy-related, delivery- related and perinatal characteristics. In this study 16.5% of women reported a history of abortion. The minority of women experienced infertility, 7.9% and medical conditions (12.2%) which the most predominant of those was anemia with 77.4% of cases. In multiparous women, 39.8 % of their previous pregnancy were complicated; emergency cesarean section constituted almost half (42.6%) of the complicated cases.

Most women (45%) entered the study with gestational age of more than 13 weeks. The majority of women (60.1%) had a prenatal visit less than 9 times; the mean number of visits being 9.3±3.6. Less than half of the women (42.3%) had weight gain of 12.5-18 Kg during this pregnancy. The most common complication (10.7%) in pregnancy was recurrent urinary infection, morning sickness and back pain was the second and third most common (6.7%, and 4.3% respectively). Pregnancy complications were the reason for 81 women to be admitted to the hospital. Out of 111 (6.2%) women who took sick leave, 40% were because of pregnancy difficulties. Most women (80.6%) had planned pregnancies and 85.6% of them participated in health education programs.

The babies of most women (83.1%) were born between 37-42 weeks of gestation with a mean of 38.6±1.69 weeks. Approximately, one third of women (34.5%) entered labor naturally and about half of the babies (53.9%) were born vaginally. Nearly all births (85%) took place in government hospitals. At time of delivery 10.8% of women experienced excessive

Table 3. Frequencies of pregnancy related variables by post-partum depression

Variables	No-PPD	PPD	P-value
Gestational age at first antenatal visit (weeks)			0.370
< 6	209 (81.6)	47 (18.4)	
6 - 12	499 (85.2)	87 (14.8)	
≥ 13	584 (83)	120 (17.0)	
Number of prenatal visits			0.910
< 9	768 (83.8)	149 (16.2)	
9-12	318 (83.7)	62 (16.3)	
≥ 12	205 (82.7)	43 (17.3)	
Weight gain(kg)			0.200
< 9	214 (87.0)	32 (13.0)	
9-12	481 (83.8)	93 (16.2)	
12 - 18	531 (83.1)	108 (16.9)	
≥ 18	65 (77.4)	19 (22.6)	
Obstetric Complication:			
Gestational diabetes	46 (70.8)	19 (29.2)	0.004
Gestational hypertension	50 (83.3)	10 (16.7)	0.960
Preeclampsia/ Eclampsia	9 (81.8)	2 (18.2)	0.290
Recurrent urinary Infection	123 (73.2)	45 (32.8)	0.001
Morning sickness	88 (81.5)	20 (18.5)	0.540
Back pain	54 (78.3)	15 (21.7)	0.220
Premature contractions	12 (75.0)	4 (25.0)	0.150
Vaginal bleeding	21 (91.3)	2 (8.7)	0.150
Miscellaneous	44 (88.0)	6 (12.0)	0.390
Admission to the hospital Because of pregnancy Complications	57 (87.7)	8 (12.3)	0.360
Sick leave in pregnancy	78 (78.8)	21 (21.2)	0.180
Unwanted pregnancy	1048 (84.8)	188 (15.2)	0.010
No participation in health Education program	1108 (84.2)	208 (15.8)	0.080

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Table 4. Frequencies of delivery related variables by post-partum depression

Variables	No-PPD	PPD	P-value
Gestational age at time of delivery (weeks)			0.750
Premature (<37)	225 (83.0)	46 (17.0)	
Term (≥37)	1066 (83.8)	206 (16.2)	
Mode of Delivery			0.690
Emergency cesarean section	372 (84.4)	69 (15.6)	
Elective cesarean section	252 (84.8)	45 (15.2)	
Vaginal	668 (83.0)	139 (17.0)	
Place of Delivery			0.080
Private hospital	193 (81.1)	48 (18.9)	
Government hospital	1099 (84.4)	203 (15.6)	
Intra-partum excessive bleeding	149 (82.8)	31 (17.2)	0.740
Puerperal complications	346 (81.0)	81 (19.0)	0.090
Breast feeding complications	208 (84.2)	39 (15.8)	0.770
Infection	37 (71.2)	15 (28.8)	0.010
bleeding	70 (78.7)	19 (21.3)	0.190
laceration	39 (86.7)	6 (14.3)	0.570

bleeding.

During puerperium, approximately one third (25.5%) of women experienced puerperal complications. The most dominant condition (54.17%) was breast feeding problems. At three months post-partum, 85.4% of babies were still breast fed exclusively by women. The majority of infant birth weight (96.1%) was more than 2,500 gm with a mean of 3,388± 429.3 gm. About half of the infant gender (50.8%) was male. A small numbers of infants (11%) experienced neonatal morbidity after birth, premature birth consisted the majority of those cases (46.25%).

Over the 12-week period of post-partum, there were a total of 254 new cases of PPD. The cumulative incidence rate of depression occurring at 2, 8 and 12 weeks post-partum was 6.9% (120), 4.6% (69) and 4.8% (65) respectively.

The frequency and percentages for PPD status are presented for each level of the categorical variables in the following manner: socio-demographic, obstetrics and gynecological history.

The incidence of PPD was more common in women whose age were younger than 25, gave up their education at lower secondary level, their family income were less than 350,000 tomans per month, experienced pregnancy for the first time (P=0.009), being a housewife and living in the extended family (Table 1).

The proportion of women with PPD increased in anemic women (22.6%) compared with non-anemic women (15.8%) (P=0.03) (P=0.001) (Table 2).

The proportion of PPD in women increased among those who reported having gestational diabetes (29.2%), recurrent urinary infection during pregnancy (32.8%) and unplanned pregnancy (21.2%) compared with women who did not experience gestational diabetes (15.9%) or recurrent urinary infection (15.2%) and had a plan for their pregnancy (15.2%) (Table 3).

Women in group of vaginal delivery (17%), and who gave birth a baby at a private hospital (18.9%) had a higher incidence of PPD compared with women who gave birth to a baby by other methods and who delivered their baby in governmental hospital, although the difference was not at a significant level. Also, higher EPDS scores were associated with experiencing infection during puerperal period (28.8%) compared with women who did not report infection (16%) (Table 4).

There was not any significant association between higher EPDS scores and neonatal complications (Table 5).

The logistic regression model showed that there was increased risk of PPD with experienced recurrent

Table 5. Frequencies of neonatal characteristic by post-partum depression

Variables	No-PPD	PPD	P-value
Birth Weight (gm*)			0.580
LBW** (<2500)	56 (86.2)	9 (13.8)	
Not-LBW (≥2500)	1236 (83.6)	243 (14.6)	
Sex of the Baby			0.640
Male	664 (83.2)	134 (16.8)	
Female	28 (84.1)	119 (15.9)	
Neonatal morbidity	151 (80.3)	37 (19.7)	0.190
Prematurity	89 (82.4)	19 (17.6)	0.720
Infection	3 (75.0)	1 (25)	0.640
Jaundice	64 (84.2)	12(15.8)	0.880
Hospital stay of neonate	126 (80.8)	30 (19.2)	0.310
Breast feeding status at three months			0.180
Exclusive breast feeding	1162 (83.6)	228 (16.4)	
Bottle feeding	21 (72.4)	8 (27.6)	
Mix Feeding(breast feeding and bottle feeding	97 (86.6)	15 (13.4)	

* gm=Gram
** LBW= Low birth weight

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Table 6. Obstetrics gynecological factors as predictors of depressive symptoms over 12 weeks post-partum using logistic regression model (n = 1546).

Risk Factors	B	SE	Odds ratio	95% Confidence interval	P-Value
Mothers' age (years)	-.054	.032	.947	.890-1.008	.089
Education (years)	-.03	.043	.96	.88-1.04	.37
Mothers 'employ	.97	1.080	2.64	.31-21.93	.36
Household income	.00	.000	1.00	1.00-1.00	.27
Family structure	.31	.294	1.36	.76-2.42	.29
Gravida	-.01	.285	.98	.56-1.72	.96
Age of last child	-.00	.004	.99	.99-1.00	.68
Unwanted pregnancy	.67	.272	1.97	1.15-3.35	.013
Recurrent urinary infection	.81	.341	2.25	1.15-4.38	.017
Gestational diabetes	1.22	.441	3.41	1.47-8.09	.005
Anemia	.20	.374	1.22	.58-2.54	.59
Post-partum infection	.99	.555	2.69	.90-7.97	.07
Constant	0.37				

urinary infection [OR = 2.25, (95% CI: 1.15-4.38)], unwanted pregnancy [OR = 1.97, (95% CI: 1.15-3.35)] and gestational diabetes [OR = 3.41, (95% CI: 1.46-5.88)].

Table 6 shows B coefficient estimates and the corresponding adjusted odds ratios indicating the independent effect of each significant variable controlling for the effect of other variables in the model.

Discussion

This study evaluated a wide range of perinatal complications as risk factors for PPD in a large sample size of a developing nation.

Although the incidence rate is a significant finding from both academic and clinical perspectives, few studies have actually investigated it (20). The incidence of depression in our sample was found to be comparable to other incidence studies using the same scale of measurement and the cut-off score in the longitudinal study (9, 21, 22).

The incidence of PPD in this study (6.9%, 4.5%, and 4.8% respectively) at 2, 8, and 12 weeks after birth are consistent with the incident rates reported in UK (5.31% and 2.61% at 8 and 32 weeks after birth, respectively) (23) and exceeded 3.5% and 2.3% incidences reported at the same time points in English women (22). However, the incidence rate reported in current study is less than that of 9.3% and 4.4% report at 12 weeks and one year after birth, respectively in Spain (9). The important issues which made a comparison of PPD incidence difficult are using different instruments, the variation in the timing of evaluation and accuracy of all cases that take place after birth (20).

In the current study, the three strongest obstetric predictors of PPD were unwanted pregnancy, gestational diabetes and recurrent urinary infection.

The results of this study are consistent with the majority of the studies that revealed PPD is more prevalent among women with unwanted pregnancy than those women who have a planned it (13, 24, 25). Unwanted pregnancy can cause adverse physical, psychological and social consequences in the short- and long-term for women (25,26). As for the relationship between unwanted pregnancy and PPD, it should also be mentioned that it is not just about the mothers' feeling toward the fetus, but it also reflects the feelings of others affected in this circumstance (16). Beck (2001) stated that even if the surprise pregnancy becomes a welcome one, a woman still has to contend with the consequence of this unplanned event which will subsequently affect the rest of their lives (27).

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Few studies have looked specifically at the association between recurrent urinary infection in pregnancy and PPD, whereas the finding of the current study revealed the link between these difficulties with the increased risk of PPD. A published study, which identified positive association between symptoms of urgency and incontinence after birth and PPD, postulated that both might occur with the same causal factors (28). Similarly, Groer and Morgan (2007) reported more frequent symptoms of infection occurring in depressive women after birth. The authors are suggested that PPD may be associated with a dysregulated hypothalamic-pituitary-adrenocortical (HPA) axis and possible depressed cellular immunity (29).

In agreement with the findings of the current research, one study has acknowledged a statistically significant increase in depressive symptoms among women with gestational diabetes (30). This retrospective cohort study during the 6 months prior to one year following delivery found that women with gestational diabetes had experienced nearly double the odds of depression (15.2% vs. 8.5%) during the post-partum compared with those without diabetes(30). Approximately 20% to 25% of diabetic patients are influenced by depression, which is about twice as many in the general medical population (31). Moreover, nearly 2% to 9% of pregnant mothers have difficulties due to diabetes (32). The primary etiology in relation to the association between diabetes and depression is not evident; however, depression may occur due to stress, such as the effects of hyperglycemia and insulin on the thyroid and stress axis, the metabolic impact of diabetes on the brain and psychological burden of handling a chronic disease during pregnancy, as well as post-partum period (33).

Another important obstetrics risk factor of PPD that has been suggested is the type of delivery. In association with some of the studies this study did not find any association between type of delivery and PPD (13, 34, 35). The results are similar to those in developing countries such as Lebanon, Iran and Brazil (36, 37). In a meta-analysis and review of 24 studies, the evidence for a link between cesarean section (C/S) and PPD during one year after delivery was rather weak and the relationship had not been established (38).

There are differences in opinion concerning women's attitude and insights toward C/S and its role on PPD. Studies in diverse settings such as Lebanon in Asia and Nigeria in sub-Saharan of Africa, have demonstrated that some women consider C/S as a problem and they prefer normal delivery (39, 40). A study in Lebanon illustrated that women who delivered their baby by C/S were protected from PPD only in the urban areas, while it is a weak protective factor for those in the rural areas, in which natural birth is highly desired as part of the traditional culture (39). In Nigerian cultures, it is even perceived as a failure of womanhood to have a cesarean delivery (40). In contrast, in Latin America, the women considered C/S as a desirable and safe mode of delivery (41). Some of the other reasons may be fear of vaginal delivery, fear of baby's death during prolonged labor, feeling of no-assisted by hospital staff that make mothers' experiencing stress, insecurity, as well as having prolonged labor and extreme pain for a long time causing increased cortical level which is linked to stress (29, 37).

The contradictory findings concerning the relationship between mode of delivery and PPD may be indicated more deep. Therefore, qualitative studies are needed to conduct to establish the role of the mode of delivery on PPD. Due to the high rate of delivery by C/S in Iran, determining whether it is a risk factor for PPD is a worthwhile endeavor in aiding clinicians to identify a growing number of at risk mothers for PPD.

Conclusion

This is one of the first study that longitudinally examined the incidence and obstetric gynecological risk factors of depression over 12 weeks after birth carried out in the community recruited from PHCs in the developing world using a reliable instrument. Results demonstrated a woman's mental health could be challenged by pregnancy, delivery and post-partum difficulties during post-partum period. The limitation of the study were exclusion of illiterate women from the study, other factors that may contribute to PPD were not evaluated and not all pregnant women and not all PHCs participated in this study.

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Conflict of interest

The competing interests not declared.

References

1. Wisner KL, Parry BL, Piontek CM. Postpartum depression. New England Journal of Medicine. 2002;347(3):194-199.
2. Alici-Evcimen Y, Sudak DM. Postpartum depression. Primary Care Update for OB/GYNS. 2003; 10(5): 205-264.
3. Norhayati MN, Hazlina NH, Asrenee AR, Emilin WM. Magnitude and risk factors for postpartum symptoms: A literature review. J Affect Disord. 2015;1(175):34-52.
4. Nielsen Forman D1, Videbech P, Hedegaard M, Dalby Salvig J, Secher NJ. Postpartum depression: identification of women at risk. BJOG. 2000;107(10):1210-1217.
5. Halbreich U, Karkun S. Cross-cultural and social diversity of prevalence of postpartum depression and depressive symptoms. J Affect Disord. 2006;91(2-3):97-111.
6. Kelly RH, Russo J, Katon W. Somatic complaints among pregnant women cared for in obstetrics: normal pregnancy or depressive and anxiety symptom amplification revisited? Gen Hosp Psychiatry. 2001 May-Jun;23(3):107-113.
7. Halbreich U. The association between pregnancy processes, preterm delivery, low birth weight, and postpartum depressions--the need for interdisciplinary integration. Am J Obstet Gynecol. 2005;193(4):1312-1322.
8. Hamdan A, Tamim H. Psychosocial risk and protective factors for postpartum depression in the United Arab Emirates. Arch Womens Ment Health. 2011;14(2):125-133.
9. Escribà-Agüir V, Artazcoz L. Gender differences in postpartum depression: a longitudinal cohort study. J Epidemiol Community Health. 2011 Apr;65(4):320-326.
10. Sword W, Landy CK, Thabane L, Watt S, Krueger P, Farine D, Foster G. Is mode of delivery associated with postpartum depression at 6 weeks: a prospective cohort study. BJOG. 2011;118(8):966-977.
11. Lee SH, Liu LC, Kuo PC, Lee MS. Postpartum depression and correlated factors in women who received in vitro fertilization treatment. J Midwifery Womens Health. 2011;56(4):347-352.
12. Räisänen S, Lehto SM, Nielsen HS, Gissler M, Kramer MR, Heinonen S. Fear of childbirth predicts postpartum depression: a population-based analysis of 511 422 singleton births in Finland. BMJ Open. 2013;3(11):e004047.
13. Gaillard A, Le Strat Y, Mandelbrot L, Keïta H, Dubertret C. Predictors of postpartum depression: Prospective study of 264 women followed during pregnancy and postpartum. Psychiatry research. 2014;215(2):341-346.
14. Abbasi S, Chuang CH, Dagher R, Zhu J, Kjerulff K. Unintended pregnancy and postpartum depression among first-time mothers. J Womens Health (Larchmt). 2013;22(5):412-416.
15. Cantilino A, Zambaldi CF, Albuquerque T, Paes JA, Montenegro ACP, Sougey EB. Postpartum depression in Recife–Brazil: prevalence and association with bio-socio-demographic factors. J Bras Psiquiatr. 2010;59(1):1-9.
16. Robertson E, Grace S, Wallington T, Stewart DE. Antenatal risk factors for postpartum depression: a synthesis of recent literature. Gen Hosp Psychiatry. 2004;26(4):289-295.
17. Cox JL, Holden JM, Sagovsky R. Detection of postnatal depression. Development of the 10-item Edinburgh Postnatal Depression Scale. Br J Psychiatry. 1987;150:782-786.
18. Rychnovsky JD, Brady MA. Choosing a postpartum depression screening instrument for your pediatric practice. J Pediatr Health Care. 2008 Jan-Feb;22(1):64-67.
19. Najafi K, Avakh F, Nazifi F, Sabrkonandeh S. Prevalence of Postpartum Depression in Alzahra Hospital in Rasht in 2004. Guilan University of Medical Sciences Journal 2006;15 (59):97-105[Persian].
20. Chaudron LH, Klein MH, Remington P, Palta M, Allen C, Essex MJ. Predictors, prodromes and incidence of postpartum depression. J Psychosom Obstet Gynaecol. 2001;22(2):103-112.
21. Evins GG, Theofrastous JP, Galvin SL. Postpartum depression: a comparison of screening and routine

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clinical evaluation. Am J Obstet Gynecol. 2000 May;182(5):1080-1082.
22. Heron J, O'Connor TG, Evans J, Golding J, Glover V. The course of anxiety and depression through pregnancy and the postpartum in a community sample. J Affect Disord. 2004 May;80(1):65-73.
23. Evans J, Heron J, Francomb H, Oke S, Golding J. Cohort study of depressed mood during pregnancy and after childbirth. BMJ. 2001;323(7307):257-260.
24. Goker A, Yanikkerem E, Demet MM, Dikayak S, Yildirim Y, Koyuncu FM. Postpartum depression: is mode of delivery a risk factor? ISRN Obstet Gynecol. 2012;2012:616759.
25. Karaçam Z, Önel K, Gerçek E. Effects of unplanned pregnancy on maternal health in Turkey. Midwifery 2011;27(2):288-293.
26. Goto A, Yasumura S, Reich MR, Fukao A. Factors associated with unintended pregnancy in Yamagata, Japan. Soc Sci Med. 2002 Apr;54(7):1065-79.
27. Beck CT. Predictors of postpartum depression: an update. Nurs Res. 2001;50(5):275-85.
28. Hullfish KL, Fenner DE, Sorser SA, Visger J, Clayton A, Steers WD. Postpartum depression, urge urinary incontinence, and overactive bladder syndrome: is there an association? Int Urogynecol J Pelvic Floor Dysfunct. 2007 Oct;18(10):1121-1126.
29. Groer MW, Morgan K. Immune, health and endocrine characteristics of depressed postpartum mothers. Psychoneuroendocrinology 2007;32 (2):133-139.
30. Kozhimannil KB, Pereira MA, Harlow BL. Association between diabetes and perinatal depression among low-income mothers. JAMA. 2009;301(8):842-847.
31. Anderson RJ, Freedland KE, Clouse RE, Lustman PJ. The prevalence of comorbid depression in adults with diabetes: a meta-analysis. Diabetes Care. 2001 Jun;24(6):1069-1078.
32. Cunningham FG. Williams obstetrics: McGraw-Hill New York; 2005.
33. Dennis CLE. Preventing postpartum depression part II: A critical review of nonbiological interventions. Can J Psychiatry. 2004 Aug;49(8):526-538.
34. Kim YK, Hur JW, Kim KH, Oh KS, Shin YC. Prediction of postpartum depression by sociodemographic, obstetric and psychological factors: A prospective study. Psychiatry Clin Neurosci. 2008 Jun;62(3):331-40.
35. Fatoye FO, Oladimeji BY, Adeyemi AB. Difficult delivery and some selected factors as predictors of early postpartum psychological symptoms among Nigerian women. J Psychosom Res. 2006;60(3):299-301.
36. Chaaya M, Osman H, Naassan G, Mahfoud Z. Validation of the Arabic version of the Cohen perceived stress scale (PSS-10) among pregnant and postpartum women. BMC Psychiatry. 2010;10(1):1-7.
37. Cantilino A, Carvalho JA, Maia A, Albuquerque C, Cantilino G, Botelho Sougey E. Translation, validation and cultural aspects of postpartum depression screening scale in Brazilian Portuguese. Transcult Psychiatry. 2007;44(4):672-84.
38. Carter FA, Frampton C, Mulder RT. Cesarean section and postpartum depression: a review of the evidence examining the link. Psychosom Med. 2006;68(2):321-330.
39. Chaaya M, Campbell OMR, El Kak F, Shaar D, Harb H, Kaddour A. Postpartum depression: prevalence and determinants in Lebanon. Arch Womens Ment Health. 2002 Oct;5(2):65-72.
40. Ukpong DI, Owolabi AT. Postpartum emotional distress: a controlled study of Nigerian women after caesarean childbirth. J Obstet Gynaecol. 2006;26(2):127-129.
41. Hopkins K. Are Brazilian women really choosing to deliver by cesarean? Soc Sci Med. 2000;51(5):725-240.

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