

COMMON MENTAL DISORDERS AND DEPRESSIVE SYMPTOMS IN PREGNANT WOMEN

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Highlights: (1) The prevalence of common mental disorders in the pregnant women analyzed was 63.5%. (2) 13.5% of the women had symptoms indicative of depressive disorder. (3) The occurrence of family conflicts was associated with common mental disorders.

PRE-PROOF

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ABSTRACT

Perinatal mental health has implications for both the mother and child, such as increased rates of depression and difficulties with self-care and bonding with the newborn, as well as for the rest of the family and even society. Objectives: To identify the prevalence of common mental disorders and depressive symptoms among pregnant women receiving primary care and investigate associated factors. Methods: A quantitative, analytical, cross-sectional study was conducted with 52 pregnant women between July and September 2023 in six primary care units in a municipality in the state of Pernambuco, Brazil. Sociodemographic, family, and obstetric characteristics were assessed. The presence of common mental disorders and depressive symptoms was investigated using validated instruments: the Self-Reporting Questionnaire and the Hamilton Depression Rating Scale, respectively. Data were analyzed using frequencies and association tests. Results: The prevalence of common mental disorders was 63.5%, and 13.5% of the women exhibited symptoms indicative of depressive disorder. Among the factors investigated, family conflicts and white skin color were significantly associated with the presence of common mental disorders. No significant associations were found between the occurrence of depressive symptoms and the other variables studied. Conclusion: The prevalence of conditions suggestive of common mental disorders was high among the pregnant women assessed and was associated with sociodemographic and family factors. These findings demonstrate the need for mental health monitoring and promotion strategies in prenatal care provided by primary care services.

Keywords: Pregnancy, Perinatal care, Anxiety, Depression, Primary care.

Introduction

Common mental disorders (CMDs) constitute a group of mental illnesses including depressive, anxiety, and somatic symptom disorders, which are often observed in primary health care settings. Such conditions are characterized by non-psychotic depressive and anxiety symptoms that can significantly affect the performance of daily activities. Key clinical manifestations include difficulty concentrating, forgetfulness, insomnia, fatigue, irritability, feelings of worthlessness, and somatic manifestations, such as frequent headaches, dyspepsia, and hand tremors, which are physical symptoms resulting from mental distress¹.

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Depressive disorders are characterized by feelings of sadness or emptiness and irritability, often accompanied by symptoms such as a lack of energy, loss of interest in daily activities, feelings of guilt and worthlessness, changes in sleep patterns and appetite, as well as suicidal ideation. For the diagnosis of depression, this mood pattern must persist for at least two weeks and cause significant functional impairment. Moreover, the symptoms must not be caused by medication or explained by bereavement².

Globally, CMDs constitute a serious public health issue, particularly in low- and middle-income countries, where rates are notably high³⁻⁴. According to the World Health Organization, more than a billion people worldwide currently live with mental disorders, the prevalence of which is higher among women, specifically regarding anxiety and depressive symptoms⁵⁻⁶. The evidence suggests that the female sex is a consistent risk factor for the development of CMDs, possibly due to the interaction of biological, psychological, and social factors⁶⁻⁷.

The gestational period is characterized by physical, emotional, and social changes. Studies involving pregnant women have shown high rates of CMDs and depressive symptoms⁸⁻¹⁰. Moreover, social pressure and expectations regarding motherhood, which may go unfulfilled, can aggravate the mental distress experienced by pregnant women¹¹. An integrative review investigating the risk factors for CMD and depressive symptoms during the perinatal period across different countries revealed rates ranging from 1.1% in Japan to 63% in Brazil, with the highest rates reported in Brazilian studies¹².

Another important aspect of pregnancy involves hormonal and physical changes, which can affect physical and psychological well-being, potentially leading to high prenatal stress. Such stress can have negative consequences for both the mother and fetus. Stress can serve as an epigenetic modifier, potentially leading to neurodevelopmental and metabolic alterations in the fetus. Maternal cortisol released in response to stress impacts the hypothalamic-pituitary axis and the stress response of the immune system, which increases the risk of chronic diseases in the fetus¹³. In the mother, elevated cortisol levels can trigger behavioral, cognitive, and emotional changes¹³⁻¹⁴.

The presence of CMDs during pregnancy has been identified as a significant predictor of postpartum depression¹⁵, and is associated with high-risk obstetric conditions, such as pre-eclampsia, premature birth, miscarriage, and low birth weight, while also contributing significantly to increased maternal-fetal morbidity and mortality¹⁶⁻¹⁸. A review

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study demonstrated that women who do not obtain support for mental distress during pregnancy and the postpartum period may accumulate traumatic experiences that can contribute to mental health issues in old age¹¹.

In the context of prenatal care, it is necessary to identify risk factors for CMDs and depressive symptoms during pregnancy, such as an unplanned pregnancy, adolescent pregnancy, pregnancy resulting from sexual violence, a history of mental disorders, lack of support from a partner, lack of family support, low socioeconomic and educational levels, as well as other stressful life events¹¹⁻¹².

Studies indicate that the mental health of pregnant women is often neglected. This situation is influenced by three main factors: the social notion of pregnancy as a time exclusively of fulfillment and well-being; the difficulty pregnant women may face in expressing emotional distress by associated it with hormonal changes related to pregnancy; and the greater emphasis healthcare providers place on mental disorders in the postpartum period, such as postpartum depression^{6,10-11}. However, greater emotional support is needed during pregnancy because it is in this stage that mental disorders can emerge¹¹.

Despite these factors, it is evident that public mental health policies in Brazil targeting women and children still adopt a disease-centered approach to the detriment of health promotion and illness prevention initiatives. Consequently, mental health is treated in pathological terms, consistently focusing on symptoms and disease detection. This demonstrates the prevalence of the biomedical model, which associates mental health with a set of conditions that require referral to specialized services for treatment, while disregarding the role of primary care in the promotion of mental health¹⁹.

However, a movement to strengthen legislative protections for the psychological well-being of pregnant women is evident in Brazil through the enactment of Law No. 14.721 in 2023, which amended two articles of the Statute of the Child and Adolescent. The first amendment expands psychological support for pregnant women, those in labor, and women in the postpartum period, providing for referrals following an initial assessment by the healthcare provider responsible for prenatal and postpartum care. The second relates to the development of health education regarding the pregnancy-postpartum cycle, with a focus on mental health. Such changes strengthen comprehensive protection for both mother and infant²⁰.

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Given this context, it is crucial for primary care professionals to understand and be attentive to factors that exert an influence on mental health during pregnancy in order to prevent future complications. Thus, the aim of the present study was to identify the prevalence of CMDs and depressive symptoms and investigate associated factors among pregnant women receiving care within the primary care system in the state of Pernambuco, Brazil. This study enables a more comprehensive approach by combining two distinct validated scales, thus ensuring greater accuracy in the assessment as well as the applicability of the findings in both clinical and academic settings.

Methods

An analytical, cross-sectional, epidemiological study with a quantitative approach was conducted at six primary care units in the urban area of a municipality in the state of Pernambuco, Brazil. The six units were selected based on convenience, considering two relevant aspects: 1) operational feasibility, ease of access, and the relevance of the activities carried out at these units to the research topic; and 2) geographic criteria aimed at covering different areas and population profiles within the municipality, which contributed to a greater diversity of contexts analyzed and the collection of more consistent, contextualized data.

The sample size was calculated using the formula for a finite population based on the following parameters: population size (N): 202 pregnant women receiving care at the primary care units serving as data collection settings between July and September 2023; 95% confidence level ($Z\alpha$): 1.96; sampling error (e): 10% or 0.10; and proportion of the phenomenon of interest (P): 63.0%⁹. The estimated sample size was 62 participants. Intentional sampling was employed because the final sample consisted of 52 pregnant women due to the number of births that occurred during the data collection period. There were no dropouts.

The inclusion criteria for the study were low-risk pregnant women 18 years of age or older receiving regular prenatal care at primary care units who had attended at least one monthly appointment during the second trimester. The exclusion criteria were women in the first trimester due to the greater risk of interruption of the pregnancy, twin pregnancies, which are considered high-risk, and individuals using antidepressant or antipsychotic medications at the time of recruitment, which indicated a pre-existing diagnosis.

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Data collection took place between July and September 2023. Pregnant women were identified through a survey conducted with nurses at the primary care units. All eligible individuals were listed on a spreadsheet to facilitate organization. Interviews were conducted in a private room at the unit by a duly trained student researcher while the women awaited their prenatal appointments; if a participant was called for the appointment, data collection was paused and resumed afterward. No difficulties regarding the completion of the questionnaires were encountered during the collection period. The average time required to complete the interview was 20 minutes.

The objective of the study was explained to all women invited. After agreeing to participate by signing the statement of informed consent, the women completed a questionnaire designed by the authors based on a literature review to gather sociodemographic, family, and obstetric data. The variables of interest were age, education level, skin color (self-reported), employment status, monthly family income, presence of debt, cohabitation with a partner, previous children, number and ages of children, number of household members, presence of family conflicts, gestational age, whether the pregnancy was planned, whether it was her first pregnancy, and history of miscarriage.

Next, the Brazilian version of the Self-Reporting Questionnaire 20 (SRQ-20) was administered to identify cases suggestive of CMDs. This instrument developed by the World Health Organization (WHO) was designed as a screening tool for measuring the level of suspicion regarding the presence of CMDs and does not offer a diagnosis of the type of disorder. Due to its screening nature, the SRQ-20 has adequate validity and reliability for use in populations, including the Brazilian population²¹.

The symptoms assessed by the SRQ-20 are characterized as non-psychotic: fatigue, irritability, insomnia, difficulty concentrating, forgetfulness, and somatic complaints. The instrument consists of 20 items with dichotomous responses (Yes/No), which the participant answers without the need for assistance from the interviewer. Each affirmative response scores one point, with a total of up to 20 points. The resulting classifications relate to the likelihood of depressive, anxiety, and somatic symptoms present in the past 30 days, ranging from 0 (no probability) to 20 (extreme probability). For the present study, a score of ≥ 8 points was established as the cutoff point, which is the threshold recommended for women in the most recent validation of the SRQ-20 in Brazil²¹, indicating the presence of mental distress.

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Lastly, the Hamilton Depression Rating Scale (HAM-D) was used to determine the presence of depressive symptoms. This instrument was developed at the University of London based on the original Hamilton Depression Scale and has favorable psychometric properties for use in the Brazilian population. The HAM-D is considered the “gold standard”, as it emphasizes the somatic symptoms of depression rather than focusing solely on cognitive and affective symptoms²². The version used in this study comprises 11 items, prioritizing somatic symptoms while excluding cognitive ones, which were not the focus of the study. The cutoff score was ≥ 15 points. Participants scoring between 15 and 24 points were classified as having characteristics of mild depression. A score between 25 and 30 points was classified as moderate depression. A score between 31 and 43 was considered indicative of severe depression, and ≥ 44 points was considered indicative of very severe depression.

The data were entered into an Excel spreadsheet by two researchers. IBM SPSS version 25 was used to perform the statistical calculations. Descriptive analysis was conducted using absolute and relative frequencies for categorical variables, and mean, standard deviation, and median for the age variable. Pearson’s chi-square test was used to assess associations between two categorical variables; Fisher’s exact test was used when the conditions for the chi-square test were not met. The significance level used in the decision of the statistical tests was 5% ($p < 0.05$).

The project received approval from the Human Research Ethics Committee of the Federal University of Pernambuco (Vitória Academic Center) under Opinion No. 6.106.091, in compliance with Resolution 466/12 of the National Health Council. The participation of the municipality was formalized through the signing of a Letter of Agreement by a representative designated by the municipal authority. All pregnant women interviewed signed the statement of informed consent after receiving clarifications about the study.

Results

Fifty-two pregnant women participated in the study. Age ranged from 18 to 41 years, with a mean of 27.33 years ($SD \pm 5.85$ years) and a median of 27 years. The majority self-identified as Black or Brown (78.8%, $n = 41$), had more than eight years of schooling (67.3%, $n = 35$), were unemployed (61.5%, $n = 32$), had a family income of one to two times the monthly minimum wage (61.5%, $n = 32$), and had debts (61.5%, $n = 32$) (Table 1).

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Table 1 – Sociodemographic characteristics of pregnant women treated at primary care units. Vitória de Santo Antão, Pernambuco, Brazil, 2023.

Variable	n (%)
TOTAL	52 (100.0)
Age group	
18 to 22	11 (21.2)
23 to 27	18 (34.5)
28 to 32	12 (23.1)
33 to 41	11 (21.2)
Skin color	
Black/Brown	41 (78.8)
White	11 (21.2)
Schooling (years)	
≤ 8	17 (32.7)
> 8	35 (67.3)
Employment status	
Unemployed	32 (61.5)
Employed	10 (19.2)
Free-lancer	8 (15.4)
Occasional worker	2 (3.9)
Family income	
< Monthly minimum wage	12 (23.1)
1 to 2 times monthly minimum wage	33 (63.5)
> 2 times monthly minimum wage	7 (13.4)
Has debt?	
Yes	32 (61.5)
No	20 (38.5)
Monthly minimum wage: R\$ 1,320	
Source: The authors	

Regarding family and obstetric characteristics, Table 2 shows that the majority of women were living with a partner (92.3%, n = 48), had previous children (55.8%, n = 29), and reported no family conflicts (82.7%, n = 43). Gestational age was between 20 and 25 weeks among 67.3% (n = 25). Only 28.8% (n = 15) had planned the pregnancy, 61.5% (n = 32) were multiparous, and 30.8% (n = 16) had a history of miscarriage.

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Table 2 – Family and obstetric characteristics of pregnant women treated at primary care units. Vitória de Santo Antão, Pernambuco, Brazil, 2023.

Variable	n (%)
TOTAL	52 (100.0)
Resides with partner?	
Yes	48 (92.3)
No	4 (7.7)
Previous children?	
Yes	29 (55.8)
No	23 (44.2)
Family conflicts?	
No	43 (82.7)
Yes	9 (17.3)
Gestational age	
20 to 25 weeks	35 (67.3)
25 weeks and 1 day to 30 weeks	2 (3.9)
30 weeks and 1 day to 35 weeks	8 (15.4)
35 weeks and 1 day to 40 weeks	7 (13.4)
Planned pregnancy?	
No	37 (71.2)
Yes	15 (28.8)
First pregnancy?	
No	32 (61.5)
Yes	20 (38.5)
History of miscarriage?	
No	36 (69.2)
Yes	16 (30.8)

Source: The authors

Table 3 presents the results regarding the likelihood of CMD and the occurrence of depressive symptoms during pregnancy. In this sample, 63.5% of the pregnant women had a probability of CMD and 13.5% exhibited symptoms indicative of depressive disorder.

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Table 3 – Distribution of participants according to the SRQ-20 and HAM-D questionnaires.
Vitória de Santo Antão, Pernambuco, Brazil, 2023.

Condition	With n (%) ⁽¹⁾	Without n (%) ⁽¹⁾
Common mental disorder	33 (63.5)	19 (36.5)
Depressive symptoms	7 (13.5)	45 (86.5)

(1) Percentages obtained from total of 52 pregnant women analyzed.

Source: The authors

In terms of symptoms of CMDs, significant differences were found between white and non-white participants (90.9% x 56.1%) as well as those with and without family conflicts (100.0% x 55.8%). No other significant differences were found in the group of variables presented in Table 4.

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Table 4 – Occurrence of symptoms of mental distress (SRQ-20) according to demographic, family, and obstetric characteristics. Vitória de Santo Antão, Pernambuco, Brazil, 2023.

Variable	Mental distress (SRQ-20)		TOTAL n (%)	p-value
	Present n (%)	Absent n (%)		
TOTAL	33 (63.5)	19 (36.5)	52 (100.0)	
Age group				$p^{(1)} = 0.165$
18 to 22	10 (90.9)	1 (9.1)	11 (100.0)	
23 to 27	10 (55.6)	8 (44.4)	18 (100.0)	
28 to 32	6 (50.0)	6 (50.0)	12 (100.0)	
33 to 41	7 (63.6)	4 (36.4)	11 (100.0)	
Skin color				$p^{(1)} = 0.040^*$
Black/Brown	23 (56.1)	18 (43.9)	41 (100.0)	
White	10 (90.9)	1 (9.1)	11 (100.0)	
Schooling (years)				$p^{(2)} = 0.175$
≤ 8	13 (76.5)	4 (23.5)	17 (100.0)	
> 8	20 (57.1)	15 (42.9)	35 (100.0)	
Employment status				$p^{(1)} = 0.088$
Unemployed	24 (75.0)	8 (25.0)	32 (100.0)	
Employed	5 (50.0)	5 (50.0)	10 (100.0)	
Freelancer/Occasional worker	4 (40.0)	6 (60.0)	10 (100.0)	
Family income				$p^{(1)} = 0.376$
< Monthly minimum wage	9 (75.0)	3 (25.0)	12 (100.0)	
1 to 2 times monthly min. wage	21 (63.6)	12 (36.4)	33 (100.0)	
> 2 times monthly min. wage	3 (42.9)	4 (57.1)	7 (100.0)	
Previous children?				$p^{(1)} = 0.416$
Yes	17 (58.6)	12 (41.4)	29 (100.0)	
No	16 (69.6)	7 (30.4)	23 (100.0)	
Family conflicts?				$p^{(2)} = 0.018^*$
No	24 (55.8)	19 (44.2)	43 (100.0)	
Yes	9 (100.0)	-	9 (100.0)	
Gestational age				$p^{(2)} = 0.282$
20 to 25 weeks	22 (62.9)	13 (37.1)	35 (100.0)	
> 25 to 35 weeks	8 (80.0)	2 (20.0)	10 (100.0)	
> 35 weeks	3 (42.9)	4 (57.1)	7 (100.0)	

(*) Significant association at 5% level (1) Fisher's exact test (2) Pearson's chi-square test.

Monthly minimum wage: R\$ 1,320

Source: The authors

With regards to the presence of depressive symptoms, no significant associations with sociodemographic, family, or obstetric variables were found, as shown in Table 5.

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Table 5 – Occurrence of symptoms of depression (HAM-D) according to demographic, family, and obstetric characteristics. Vitória de Santo Antão, Pernambuco, Brazil, 2023.

Variable	Symptoms of depression (HAM-D)		TOTAL n (%)	p-value
	With n (%)	Without n (%)		
TOTAL	7 (13.5)	45 (86.5)	52 (100.0)	
Age group				$p^{(1)} = 0.527$
18 to 22	2 (18.2)	9 (81.8)	11 (100.0)	
23 to 27	1 (5.6)	17 (94.4)	18 (100.0)	
28 to 32	3 (25.0)	9 (75.0)	12 (100.0)	
33 to 41	1 (9.1)	10 (90.9)	11 (100.0)	
Skin color				$p^{(1)} = 0.322$
Black/Brown	7 (17.1)	34 (82.9)	41 (100.0)	
White	-	11 (100.0)	11 (100.0)	
Schooling (years)				$p^{(1)} = 0.198$
≤ 8	4 (23.5)	13 (76.5)	17 (100.0)	
> 8	3 (8.6)	32 (91.4)	35 (100.0)	
Employment status				$p^{(1)} = 0.849$
Unemployed	4 (12.5)	28 (87.5)	32 (100.0)	
Employed	1 (10.0)	9 (90.0)	10 (100.0)	
Freelancer/Occasional worker	2 (20.0)	8 (80.0)	10 (100.0)	
Family income				$p^{(1)} = 0.112$
< Monthly minimum wage	4 (33.3)	8 (66.7)	12 (100.0)	
1 to 2 times monthly min. wage	3 (9.1)	30 (90.9)	33 (100.0)	
> 2 times monthly min. wage	-	7 (100.0)	7 (100.0)	
Previous children?				$p^{(1)} = 0.444$
Yes	5 (17.2)	24 (82.8)	29 (100.0)	
No	2 (8.7)	21 (91.3)	23 (100.0)	
Family conflicts?				$p^{(1)} = 0.590$
No	5 (11.6)	38 (88.4)	43 (100.0)	
Yes	2 (22.2)	7 (77.8)	9 (100.0)	
Gestational age				$p^{(1)} = 0.208$
20 to 25 weeks	4 (11.4)	31 (88.6)	35 (100.0)	
> 25 to 35 weeks	3 (30.0)	7 (70.0)	10 (100.0)	
> 35 weeks	-	7 (100.0)	7 (100.0)	

(1) Fisher's exact test.

Source: The authors

Discussion

The prevalence of common mental disorders (CMDs), including depressive disorders, among pregnant women varies widely, ranging from 1.1% to 78.2% throughout the world^{12,23}. This substantial variation is related to the heterogeneous socioeconomic

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development of different countries. Observational studies conducted in developing countries report rates of depressive disorder among pregnant women ranging from 15% to 78.2%, whereas studies conducted in developed countries report lower rates ranging from 1.1% to 10%^{12,23-24}, demonstrating that sociodemographic and economic stability serves as a protective factor for pregnant women.

In Brazil, a cohort study involving a sample of 712 pregnant women receiving primary care found that 41.7% had a probable mental disorder and that the prevalence of depressive disorders was 30.6%¹⁰. Another study, which followed up 300 pregnant women over a longer period within the primary care system in the metropolitan area of the city of São Paulo identified depressive disorders in 16.2% of the participants²⁵. This figure was close to that found in the present study regarding depressive symptoms, given that both studies involved pregnant women with a low socioeconomic status who were in their second or third trimester of pregnancy²⁵.

A longitudinal study involving the administration of the HAM-D scale to 122 pregnant women on three occasions (during the second and third trimesters and the postpartum period) found a higher rate of positive screening for depression during pregnancy (45.9% in the second trimester and 45.1% in the third) compared to the postpartum period (30.4%)²⁶. This finding may be attributed to the hormonal fluctuations and somatic changes characteristic of pregnancy, which can raise scores on instruments like the HAM-D due to symptom overlap. Psychosocial factors, such as greater anxiety regarding childbirth, financial insecurity, and changes in roles, may also increase depressive symptoms during pregnancy. Furthermore, the immediate relief associated with childbirth, clinical interventions performed between assessments, or differences in postpartum social support could reduce the occurrence of symptoms when assessed at later time points.

An integrative literature review investigating the occurrence of perinatal CMDs revealed that the city of Salvador in the state of Bahia stands out in Brazil, with a rate of 63%¹², which is very close to the figure found in the present study (63.5%). Furthermore, the prevalence of CMDs among pregnant women varies among the different regions of the country, with 36.2% in the state of São Paulo (southeastern region)¹², 36.2% in the state of Acre (northern region)¹⁵, 41.4% in the state of Rio Grande do Sul (southern region)²⁷, and 57.1% in the state of Goiás (central western region)¹².

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A cross-sectional study conducted in 2019 in the same municipality as that of the present investigation, involving 141 pregnant women and using the Self-Reporting Questionnaire (SRQ-20), found that 31.9% of the participants had indications of mental illness. Thus, a 31.6% increase in cases suggestive of mental illness was found in the municipality²⁶. This increase between 2019 and 2025 may be attributed to the COVID-19 pandemic, given that a significant rise in symptoms of anxiety and depression occurred in the post-pandemic period, directly impacting the mental health of the population, particularly in high-risk groups, such as older adults, children, and pregnant women²⁸.

In the present study, the presence of CMDs during pregnancy was significantly associated with white skin color and the occurrence of family conflicts. The association observed between skin color and CMD may have resulted from the homogeneity of the sample. Regarding family conflicts, it is noteworthy that all participants who reported such conflicts had CMDs. Some studies have shown that a pregnant woman's relationship with her partner and family can be considered a risk factor for both the emergence of CMDs and depressive disorders²⁹⁻³⁰. This finding may possibly be explained by the social support pregnant women may or may not receive from these relationships. Such support is fundamental to the prenatal and postnatal care that women receive and may help reduce the occurrence of stressful events during pregnancy and the postpartum period. Furthermore, family support is recognized as vitally important throughout all phases of a woman's life, particularly those in which she may be more vulnerable, as having a support network helps reduce emotional stress and excessive worry during pregnancy^{10,23,25,29}.

Regarding gestational age, a prospective study involving pregnant women found that the prevalence of CMDs was 22.4% during early pregnancy (12 to 20 weeks) compared to 10.7% in late pregnancy (28 weeks or more)³¹. This finding aligns with the results of the present study, in which the majority of pregnant women who exhibited symptoms of CMDs were between 25 and 35 weeks pregnant (80%), with this rate dropping to 42.9% as the pregnancy progressed beyond 35 weeks. This pattern may be attributed to the fact that women are often adapting to their new situation in the early stage of pregnancy and consequently face numerous stressors; as these stressors diminish with the advancement of pregnancy, the prevalence of CMDs decreases accordingly³¹.

Studies have shown that a low socioeconomic status and low levels of education are associated with the occurrence of mental disorders during the perinatal period^{9,12,15}.

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Although the manifestation of CMDs and depressive symptoms is slow and gradual, these conditions can severely interfere with a pregnant woman's activities of daily living if not properly identified and treated. This situation may lead to behavioral changes such as reduced self-care, alcohol and/or tobacco use, the neglect of nutrition, and a reduction in or the even abandonment prenatal care appointments.³²

In general, mental disorders make pregnant women susceptible to a greater risk of obstetric complications, such as pre-eclampsia and premature birth, in addition to increasing the incidence of behaviors that exert a negative impact on health³³. Moreover, one study found an association between mental disorders and the mother's perception of behavioral changes in the newborn, suggesting that the mother's mental health issues may influence the mother-infant relationship in the postpartum period²⁵.

Thus, the importance of the role played by primary care professionals becomes evident. These individuals serve as agents of knowledge regarding the prevention, screening, and early detection of CMDs in pregnant women, as prenatal care takes place in the primary care setting. However, the effectiveness of prenatal care can be influenced by numerous factors, such as professional training, the situation of the health unit, and knowledge regarding mental health. The lack of specific protocols for such cases may hinder the screening of mental distress, resulting in a failure to employ strategies such as paying greater attention to pregnant women during appointments and establishing a bond with the patient³².

However, these strategies may be flawed, given that pregnant women often overlook the signs and symptoms that they are experiencing, believing them to be solely related to the hormonal changes inherent to pregnancy³². Indeed, none of the pregnant women identified with CMDs was receiving psychological follow-up. Therefore, primary care professionals should practice active listening and familiarize themselves with mental disorder screening tools and necessary interventions in order to provide high-quality, comprehensive care to pregnant women³².

In this regard, it is essential to raise awareness and train primary care professionals to promote mental health during pregnancy within the Brazilian public health system, using an approach centered on the pregnant woman that also involves the family^{32,11}. Prenatal care offers a timely opportunity for preventing maternal and infant mental health issues, which has a direct impacts on the reduction in maternal and neonatal mortality²².

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The limitations of this study must be considered, such as the small sample size resulting from the limited number of pregnant women receiving prenatal care at the health units at the time of data collection. Although the scales employed contributed to the assessment of mental distress and depressive symptoms, it is important to acknowledge their limitations, as they may not fully reflect the specific characteristics of the pregnant women studied, thus restricting the generalizability of the results. Nevertheless, this study addresses a relevant topic on which the discussion is still in its early stages.

Moreover, this investigation provides epidemiological evidence for future studies in field of the maternal-child health, specifically regarding perinatal mental disorders, that can assist in promoting the mental health of pregnant women. It also identifies the need to incorporate new psycho-emotional interventions into prenatal care.

Future longitudinal studies should include additional variables to enhance the robustness of the findings, considering the use of complementary scales that could increase sensitivity in the detection of the variables analyzed. Qualitative studies identifying the meanings, motivations, beliefs, and values surrounding the topic are also recommended. Furthermore, the results of this study are expected to advance knowledge on the subject and assist in the establishment of proposals for improving prenatal care as well as public policies focused on the mental health of pregnant women in primary care.

Conclusion

The prevalence of common mental disorders among the pregnant women analyzed was 63.5%, while the rate of depressive symptoms was 13.5%. Moreover, white pregnant women and those reporting family conflicts were more likely to experience mental distress. This underscores the need to involve families in prenatal care with the aim of strengthening support networks, which could enhance prenatal and postpartum care within the Brazilian public health system.

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