

PERINATAL PSYCHOLOGY AND MATERNAL MENTAL HEALTH: A STUDY WITH PREGNANT WOMEN IN THE FAMILY HEALTH STRATEGY

Rosane Cípola¹

Noemi Bandeira²

Highlights: (1) Biopsychosocial factors impact the mental health of pregnant women. (2) Risk factors for mental health during pregnancy have been identified. (3) Support groups for pregnant women and psychological support contributed to maternal well-being.

PRE-PROOF

(as accepted)

This is a preliminary, unedited version of a manuscript that was accepted for publication in Revista Contexto & Saúde. As a service to our readers, we are making this initial version of the manuscript available, as accepted. The article will still be reviewed, formatted and approved by the authors before being published in its final form.

<http://dx.doi.org/10.21527/2176-7114.2026.51.17046>

How to cite:

Cípola R, Bandeira N. Perinatal psychology and maternal mental health: a study with pregnant women in the family health strategy. Rev. Contexto & Saúde. 2026; 26(51):e17046

¹ Federal University of Rondonópolis. Rondonópolis/MT, Brazil. <https://orcid.org/0009-0003-0903-2164>

² Federal University of Rondonópolis. Rondonópolis/MT, Brazil. <https://orcid.org/0000-0003-4391-5414>

PERINATAL PSYCHOLOGY AND MATERNAL MENTAL HEALTH: A STUDY WITH PREGNANT WOMEN IN THE FAMILY HEALTH STRATEGY

ABSTRACT

Objective: To analyze, from the perspective of perinatal psychology, the mental health status of pregnant women followed up in prenatal care in a Family Health Strategy service and explore the relationship between biopsychosocial factors and mental health during pregnancy. **Method:** This qualitative study was carried out between February and October 2024. The participants were 27 pregnant women between 18 and 42 years old in the second and third trimesters of pregnancy. For data collection, a semistructured interview was conducted, and the Edinburgh Postpartum Depression Scale (EPDS) was used as an auxiliary instrument. **Results:** Content analysis resulted in the following 5 categories: Social representations about motherhood; Subjective history and mental health conditions; Perceptions attributed to the birth experience; Maternity, work, and subsistence; Support network. The EPDS, with a cutoff point of 10, screened depressive symptoms in 51.85% of the sample. The risk factors and mental health protective factors identified in the study sample were shown to be determinants of maternal mental health status. **Conclusion:** The results reinforce the need to expand public policies for maternal mental health care in Primary Health Care (PHC), promoting benefits for the mother, the mother–infant bond, and child development, with a positive impact in the long term.

Keywords: Perinatal psychology. Pregnancy. Mental health. Family Health Strategy. Prenatal care.

INTRODUCTION

Perinatal psychology, or obstetric psychology, comprises the mental health of pregnant women, parturients and postpartum women, covering topics such as infertility, family planning, adoption, assisted reproduction, abortion, perinatal grief and parenting¹⁻².

Pregnancy is considered a transition period with the potential for intrinsic crisis³, requiring psychological, interpersonal, and social reorganization, resulting in biopsychosocial transformations⁴. Sociocultural factors can intensify the risk of maternal mental illness⁵, such as the idealization of motherhood and the social imaginary, which links

PERINATAL PSYCHOLOGY AND MATERNAL MENTAL HEALTH: A STUDY WITH PREGNANT WOMEN IN THE FAMILY HEALTH STRATEGY

this role only to positive aspects, generating feelings of guilt and inadequacy in the face of difficulties³.

Perinatal depression is a public health problem that affects approximately 25% of pregnant Brazilian women⁶. Unlike postpartum depression, it refers to depressive episodes that begin during pregnancy or up to 12 months after delivery⁷.

Among the risk factors are a history of mental illness, lack of social support, unplanned pregnancy, marital conflicts, substance use, and socioeconomic vulnerability^{3-4,8-9-10}.

Protective factors include a satisfactory marital relationship, social support, physical activity, and multidisciplinary follow-up during prenatal care¹⁰⁻¹¹.

Perinatal mental disorders can affect the mother-baby bond, child development, and the woman's quality of life^{12,13}. Brazilian studies have related these disorders to premature birth, low birth weight, breastfeeding problems, low responsiveness to the baby's demands, increased cortisol levels in the baby, and problems in child development^{4,7,12-14-15}.

Gestational anxiety is equally relevant, affecting 37.38% of the pregnant women evaluated in a Brazilian study¹⁰. Its onset is associated with violence, a psychiatric history, and substance abuse¹⁰. Without adequate treatment, depressive and anxious symptoms can persist up to 2 years after delivery¹³.

Despite advances in postpartum depression care, few studies have investigated mental health during pregnancy. Professional experience in a Family Health Strategy service (FHS) corroborates this gap, given that less than 20% of pregnant women with depressive symptoms receive treatment⁶.

Therefore, the attentive eyes of health professionals who accompany women during prenatal care are essential for identifying the psychological demands that can influence the health of both the mother and the baby as a whole. Assessing and providing the necessary services to prevent complications during pregnancy is important in the short, medium and long term, in addition to benefiting the mental health of the pregnant woman and preparing her emotionally to deal with the puerperium, which is another challenging moment for mental health¹⁰. Prenatal care has the potential for the early detection and management of

PERINATAL PSYCHOLOGY AND MATERNAL MENTAL HEALTH: A STUDY WITH PREGNANT WOMEN IN THE FAMILY HEALTH STRATEGY

emotional demands. Law No. 14,721/2023¹⁶ supports the expansion of psychological care for pregnant women, parturients and puerperal women, reinforcing the importance of mental health during the perinatal period.

In this context, the following question arises: How are biopsychosocial factors related to mental health status during the gestational period? Thus, this study aimed to analyze, from the perspective of perinatal psychology, the mental health status of pregnant women followed up in prenatal care in a family health strategy service to explore the relationship between biopsychosocial factors and mental health during pregnancy.

MATERIALS AND METHODS

This is a qualitative study, carried out in an FHS in the city of Rondonópolis - MT. The sample consisted of 27 pregnant women between 18 and 42 years old. Women registered and treated in the FHS in the field of activity of the resident psychologist, aged ≥ 18 years, in the second or third trimester of pregnancy, were included. Pregnant women under 18 years of age and those who were not located after 2 contact attempts were excluded. Data collection took place from February to October 2024.

The study was conducted in a region characterized by socioeconomic vulnerability and structural challenges regarding social determinants of health, including limitations in access to essential services and the presence of contexts of violence.

Eligible pregnant women were contacted and informed about the objectives of the study, and upon signing the informed consent form (ICF), data collection occurred. Two instruments were used: 1) a semistructured interview prepared by the researcher, covering sociodemographic data, lifestyle, pregnancy history, history of violence and stressful factors, clinical history, mental health conditions, self-perception and social support network; and 2) the *Edinburgh Postnatal Depression Scale* (EPDS), which has been validated for use in Brazil¹⁷, including during pregnancy, with a cutoff point of ≥ 10 ¹⁸. Given the importance of content analysis for qualitative research, the EPDS was used as a complement for tracking depressive symptoms and not as a diagnosis. The interviews took place in a private space,

PERINATAL PSYCHOLOGY AND MATERNAL MENTAL HEALTH: A STUDY WITH PREGNANT WOMEN IN THE FAMILY HEALTH STRATEGY

were recorded, fully transcribed and identified by the letter “E” followed by a cardinal number, and were stored in the cloud with privacy protection and anonymity guaranteed.

Bardin's method of content analysis was followed, recognizing the emerging themes significant to the analytical object¹⁹, with the support of the *software* IRaMuTeQ. The process included three stages: In the preanalysis, the material was submitted to floating reading, initial impressions were identified, the recording units were established, and the rules of exhaustiveness and homogeneity were followed. In the exploration of the material, the corpus was processed in the IRaMuTeQ through Descending Hierarchical Classification (DHC), which grouped the text segments into lexical classes. Initially, preliminary categories were identified, after which they were condensed into intermediate categories and, finally, into five final categories. In the treatment and interpretation, the categories were analyzed in a critical and reflective way in light of the perinatal psychology framework, specifically focusing on the aspects of maternal mental health and the emotional and psychological implications of motherhood. The conceptual titles were defined only at the end. The analysis resulted in the following 5 final categories: (1) social representations about motherhood; (2) subjective history and mental health conditions; (3) perceptions attributed to the experience of childbirth; (4) maternity, work and subsistence; and (5) support network.

The project was approved by the Research Ethics Committee of the Federal University of Rondonópolis (opinion No. 6.652.850, CAAE: 76200423.0.0000.0126).

RESULTS AND DISCUSSIONS

Three participants (11.11%) were adolescents (<20 years old), all of whom reported alcohol and/or tobacco consumption, which are considered risk factors for mental disorders during pregnancy¹⁰. In terms of the sociodemographic profile, the predominant factors included being between 20 and 34 years old, having brown skin, having completed high school, being unemployed, having an income of up to two minimum wages, using social benefits and having a marital relationship (Table 1).

**PERINATAL PSYCHOLOGY AND MATERNAL MENTAL HEALTH: A STUDY WITH
PREGNANT WOMEN IN THE FAMILY HEALTH STRATEGY**

Table 1 - Sociodemographic Data		
	N = 27	(%)
Age group		
< 20 years	3	11,11%
20 - 34 years old	18	66,67%
35 years or older	6	22,22%
Ethnicity		
<i>Parda</i> (Brazilian racial/skin-color category)	20	74,07%
Black	6	22,22%
Yellow	1	3,70%
Education		
Fundamental – Incomplete	3	11,11%
Fundamental – Complete	3	11,11%
Medium – Incomplete	9	33,33%
Medium – Complete	10	37,04%
Superior – Incomplete	1	3,70%
Superior – Complete	1	3,70%
Maid		
Yes	5	18,52%
No	22	81,48%
Gross family income		
No income	3	11,11%
≤ 2 Minimum wages *	21	77,78%
≤ 4 Minimum wages *	3	11,11%
Social Benefit		
Yes	17	62,96%
No	10	37,04%
Relationship		
Yes	20	74,07%
No	7	25,93%

* Minimum wage in force in 2024 in Brazil (R\$ 1,412.00).

Source: Prepared by the authors (2025)

The application of the EPDS tracked depressive symptoms in 51.85% (14) of the participants, adopting a cutoff point ≥ 10 , as recommended¹⁸. The qualitative analysis revealed five thematic categories: Social representations about motherhood; Subjective history and mental health conditions; Perceptions attributed to the experience of childbirth;

PERINATAL PSYCHOLOGY AND MATERNAL MENTAL HEALTH: A STUDY WITH PREGNANT WOMEN IN THE FAMILY HEALTH STRATEGY

Maternity, work and subsistence; and Support network. From the perspective of perinatal psychology, how the components of each thematic category are articulated with the mental health condition of the pregnant women studied was analyzed.

Social representations about motherhood

In the social sphere, the expectations of the Western social imaginary about motherhood are made explicit by adjectives such as personal fulfillment, selflessness and guilt². However, the exercise of motherhood can be marked by ambivalence and frustration when the actual experience differs from the idealized experience. The silencing of maternal suffering reinforces the romanticized ideal of motherhood, with repercussions for mental health.

When the pregnant women interviewed were asked what it meant to be a mother, most attributed qualities such as strength, gift and inexplicable love to the maternal function:

I believe that, for me, being a mother is something extraordinary. For me, being a mother is a gift! [...] Because, the role of a mother, if you think about what a mother does for a child, then she is a rock! There are mothers who, even if the world is falling on her, keep her foot, to be able to show her child that she is there, even if she is falling, right? However, she is there, showing her strength, her resistance, so as not to show weakness to her child. (E17).

The description of E17, a pregnant woman experiencing motherhood for the first time, highlights the romanticized view of the mother as an unshakable figure, disregarding manifestations of fragility or dissatisfaction²⁰. Idealized beliefs can generate frustration and self-recrimination in the face of real difficulties, which can favor psychological illness.

The following excerpt portrays the experience of E8, who had experienced obstetric violence during the last delivery and, even after years, had repercussions on the current pregnancy:

Oh, I feel a little guilty, because it appears to be that, because I'm not caring much about pregnancy. [She cries]. Yes, I think I should be caring more about pregnancy. (E8).

**PERINATAL PSYCHOLOGY AND MATERNAL MENTAL HEALTH: A STUDY WITH
PREGNANT WOMEN IN THE FAMILY HEALTH STRATEGY**

The statement that she feels guilty evidence an internal conflict related to noncompliance with social expectations about motherhood.

Once again, the following statement expresses the feeling of guilt in the face of the discovery of an unwanted pregnancy in the context of marital crisis:

Oh, desperate! I was desperate, desperate. I was sad. Then, I blamed myself for being sad. I was too, it is... oh, so many things were coming into my head. (E13).

These findings corroborate Badinter's critique²¹ about the myth of maternal instinct and the social imposition of female guilt.

On the other hand, the perspective of motherhood as an improvement for mental health problems was evidenced by the report of E7, a primiparous woman with a previous history of anxiety disorder:

The baby was a very good thing that happened to me, because it was something I wanted too, and although I did not come at a good time, it seems that, it seemed that it was truly supposed to come, at this moment! In this crisis that I was in, it seemed that the pregnancy came to improve my life more, so... (E7).

The report expresses the emotional ambivalence of the gestational experience, which is simultaneously marked by crisis and resignified as positive. This perception is related to sociocultural influences, which link motherhood to female personal fulfillment²¹. This report also reflects what Maldonado²² defines as the expectation of pregnancy to meet psychological needs.

However, the ideal of motherhood as a cure for psychological issues, although it can serve as a source of resilience, can also lead to high expectations about the maternal role, making it difficult to self-perceive emotional difficulties and invalidating one's own suffering, thus promoting perinatal depressive outcomes¹⁰.

Multidisciplinary teams that address women from prenatal care to the postpartum period play a fundamental role. Their approach can reinforce romanticized representations or, on the contrary, stimulate more realistic expectations.

However, even today, it is common for health professionals to neglect the suffering and anguish of women during the pregnancy cycle²⁰. Therefore, in prenatal care, it is

PERINATAL PSYCHOLOGY AND MATERNAL MENTAL HEALTH: A STUDY WITH PREGNANT WOMEN IN THE FAMILY HEALTH STRATEGY

essential that the health team promotes the welcoming care, listening, and validation of emotional experiences.

Subjective history and mental health conditions

Understanding that biopsychosocial factors play a central role in maternal well-being is important for perinatal psychology. In this category, the life narratives and previous emotional experiences of pregnant women were analyzed, relating them to mental health conditions during pregnancy, on the basis of risk factors and protective factors described in the literature^{10-11,13}. Table 2 illustrates the mental health history of the sample:

Table 2 - Mental health history		
Variables	N = 27	(%)
Diagnosis of psychiatric disorders	7	25,93%
Psychopharmacological medication - previous use	8	29,63%
Psychopharmacological medication - current use	2	7,41%
Prior psychological follow-up	5	18,52%
Psychiatric hospitalization	5	18,52%
Self-injury	6	22,22%
Previous suicidal ideation	13	48,15%
Current suicidal ideation	1	3,70%
Suicide attempt	6	22,22%

There is a possibility that more than one variable is present in the same interviewee.

Source: prepared by the authors (2025).

Two pregnant women reported a history of suicide attempts during the previous perinatal period (E4, E19):

Actually, I did not think it would be better to be dead; I did! I hanged myself, when my baby was approximately 5 months old. (E19).

With respect to the group that reported previous suicidal ideation (48.15%), some reported ideation during the current pregnancy (E4, E16, E19, and E22). E4 stated:

**PERINATAL PSYCHOLOGY AND MATERNAL MENTAL HEALTH: A STUDY WITH
PREGNANT WOMEN IN THE FAMILY HEALTH STRATEGY**

I have thought a lot! However, I cannot either, right? (E4).

Furthermore, she scored 17 on the EPDS, indicating significant depressive symptoms. This context suggests the presence of untreated depressive disorder⁶, which is related to nonadherence to prenatal care, substance abuse, anxiety, insomnia, and impairments in the mother-baby bond. Screening and intervention in mental health during pregnancy have preventive potential in the short, medium, and long term.

With respect to participant E19, she reported a new suicide attempt when she discovered her current pregnancy:

[...] I even tried suicide when I determined I was pregnant. I took several boxes of medicine, which I did not want to accept because of the other pregnancy that had happened, which I suffered a lot alone in the hospital. [...] I had postpartum depression, because she was born prematurely and I had postpartum depression; she spent 7 days in the ICU at the time of COVID-19. (E19).

The report corroborates the literature, according to which mood disorders significantly increase the risk of suicide in the pregnancy-puerperal cycle¹⁰. Studies also show relevant emotional changes in the face of complications in pregnancy or childbirth²³.

The psychic vulnerability of E19 may result from exposure to risk factors beginning in adolescence:

I got married at the age of 15, because my father drank a lot and beat my mother, I witnessed violence. [...] I got married earlier because of that. (E19).

In addition to these factors (mental health diagnosis, abortion, multiparity, socioeconomic vulnerability, adolescent pregnancy, brown color, previous high-risk pregnancy, history of premature birth, alcohol and tobacco use, pregnancy difficult to accept, suicide attempt), she interrupted pharmacological treatment on her own in the sixth month of pregnancy, increasing the clinical risk. Two other interviewees (E2 and E12) also reported spontaneous interruption of treatment.

Domestic violence and conflicting marital relationships were related to psychological distress. Eight pregnant women (29.63%) reported having experienced some type of violence during their lives. The statement of E12 exemplifies this relationship:

PERINATAL PSYCHOLOGY AND MATERNAL MENTAL HEALTH: A STUDY WITH PREGNANT WOMEN IN THE FAMILY HEALTH STRATEGY

About emotions during pregnancy, it is only bad sometimes when, like I said, when there's an argument with my husband, then all that comes back, it just makes you want to cry, but apart from that... (E12).

The expression 'all that comes back' indicates the emotional impact of previous experiences (domestic violence, marital conflicts, family conflicts, teenage pregnancy, fragile support network). She obtained 15 points on the EPDS, indicating depressive symptoms.

Among the pregnant women who reported a previous diagnosis, two (E5, and E11) reported depressive disorder in previous pregnancies and received psychological and pharmacological treatment:

It made me despair [...] because in the previous pregnancy, I had depression before. Not after the birth, but before the birth, I had depression. I used medication for mental health, sleeping pills, and anxiety; I participated in the group, [...] I went to the psychologist. (E11).

These previous experiences of suffering acted as aggravating factors for emotional crises during the current pregnancy; however, coping resources favored recovery.

Perceptions attributed to the birth experience

Childbirth, although it is physiological and unique, is strongly influenced by sociocultural factors and shaped by personal experiences and social narratives. Most of the interviewees expressed negative perceptions, with the exception of E13, E15 and E16, which did not refer to pain or fear:

When I hear the word childbirth, I think of life, right? [...] Because I did not have bad experiences in my labors, so when I think about childbirth, it is the beginning of everything, I think about the beginning. (E13).

The positive perception of E13 contributes to strengthening maternal self-esteem, acting as a protective factor for mental health.

Even primiparous women (14.81% of the sample) reported negative worries and perceptions attributed to fear and anxiety:

**PERINATAL PSYCHOLOGY AND MATERNAL MENTAL HEALTH: A STUDY WITH
PREGNANT WOMEN IN THE FAMILY HEALTH STRATEGY**

I think it hurts a lot, because people only say that, that it hurts, hurts, suffers too much! [...] What I hear the most are stories about pain related to childbirth. (E14).

Fear by itself is not a risk factor and is expected in the face of an experience that is still restricted to the imaginary²⁴.

Ah, a lot of pain, a lot of pain, yes, a lot of suffering, God forbid! Yes, I have heard something related to pain at the time of childbirth. (E7).

In addition to the negative perception, E7 reported a history of anxiety disorder and a conflicting bond with the parent.

A multipregnant woman (E8) reported a traumatic experience with a previous birth, with repercussions for the current pregnancy:

It is a very complicated thing. My first [daughter], the birth was so cool that it was so peaceful. However, my second birth was a nightmare! [...] I'm even afraid to go to the hospital; my second birth was horrible! (E8).

The experiences included traumatic childbirth and obstetric violence, which are risk factors for maternal mental health²⁵⁻²⁶ and imply difficulties in bonding with the baby during the current pregnancy:

I have not even bought or started buying the baby's trousseau yet [...] because of what I went through too, in the last birth 7 years ago. (E8).

In addition, E8 obtained a score of 23 on the EPDS, indicating depressive symptoms during pregnancy.

Even today, obstetric violence affects many women and can generate repercussions such as perinatal depression and PTSD²⁶. Despite legal advances and debates on humanized childbirth, many women do not even recognize situations of obstetric violence because of a lack of information and access.

Reports that pointed to the advantages of vaginal delivery referred to faster recovery, especially in contexts with a limited support network or precarious socioeconomic resources.

Prenatal care, in addition to preventing complications, should empower and prepare women to experience childbirth in a dignified way, to be aware of their rights, to stimulate maternal protagonism and to recognize situations of obstetric violence. How the team

PERINATAL PSYCHOLOGY AND MATERNAL MENTAL HEALTH: A STUDY WITH PREGNANT WOMEN IN THE FAMILY HEALTH STRATEGY

transmits information in prenatal care can both intensify anxiety and promote conscious choices, avoiding unnecessary interventions²⁴.

Motherhood, work and subsistence

Among the 27 participants, 18.52% (5) were employed and 81.48% (22) were unemployed. Some of the unemployed maintained informal activities as a means of subsistence. A total of 62.96% (17) received social benefits (Bolsa Família). In terms of gross family income, 11.11% (3) had no income, 77.78% (21) had up to 2 minimum wages, and 11.11% (3) had up to 4 minimum wages.

When asked if the participants had to interrupt any dream or project due to pregnancy, 51.85% (14) mentioned an impact on work, including a reduction in pace, dismissal or nonhiring.

The history of women's economic emancipation is marked by selflessness and overload, often resulting in a triple shift²⁷, with the accumulation of professional, domestic and maternal functions. This overlapping of roles contributes to stress and physical and mental illness²⁷.

E4 expressed dissatisfaction with the pregnancy, which was perceived as an obstacle to work and sustenance:

I lost a lot of my services; it reduced a lot. Of 5 daily services in the week I had, I have only 2 [...] because after I said I was pregnant, they dismissed me. (E4).

It is necessary to consider the social markers of race, class and gender, as she is a black woman and single mother with low education and social vulnerability.

Socioeconomic difficulties are risk factors for maternal mental health, as they impose psychosocial vulnerabilities and stress^{4,28}. The context of E4 expresses multiple risk factors: unplanned pregnancy, difficulty in acceptance, multiparity, single motherhood, a fragile support network, a history of violence, nonadherence to prenatal care, and previous suicide attempts.

The exclusion of pregnant women from the labor market is often related to the fear of labor costs provided for by law²⁹.

PERINATAL PSYCHOLOGY AND MATERNAL MENTAL HEALTH: A STUDY WITH PREGNANT WOMEN IN THE FAMILY HEALTH STRATEGY

In some statements, the real impact of such prejudice was perceptible, placing pregnancy as an impediment to labor insertion:

I did not even get a job; I took the admission medical exam; I think it was found [...] and I determined that I was pregnant. I was upset [...] to realize that it seems that they did not hire me because of the pregnancy. (E25).

Given this reality, women in informal work resort to strategies such as hiding their pregnancy but without labor rights:

I only work 1 day a week, Friday, [...] I'm going to work in a bigger outfit, so as not to show that I'm pregnant, so I do not lose the last job I have. (E4).

This context expresses vulnerability and risk to mental health. In addition, the perception that pregnancy can cause damage can hinder the mother-baby bond. These perceptions express the need to readapt routine and psychic reorganization in the face of unwanted changes. The repercussions on self-esteem resulting from the regression of financial autonomy can affect self-perception as a woman, mother and worker:

I have been feeling worthless in the matter of not being able to work [...] the world goes on and I'm stopped, so this [...] even affects my self-esteem. (E17).

The findings show that the relationship between motherhood and work can reinforce pregnancy as a period of transition and crisis²², marked by financial and social deprivation, which generate ambivalent feelings such as anger and anguish. In summary, the perception of pregnancy as a regression of financial emancipation is a risk factor for maternal mental health.

Support network

Social factors are part of the biopsychosocial set and influence mental health, including during pregnancy. Depending on how the components of the family and social cycle position themselves in the face of the news of pregnancy, they can act as protective factors for maternal mental health. Studies have shown that the greater the level of perceived social support is, the lower the occurrence of perinatal depression⁹, while a lack of support is among the main risk factors for PPD¹¹.

**PERINATAL PSYCHOLOGY AND MATERNAL MENTAL HEALTH: A STUDY WITH
PREGNANT WOMEN IN THE FAMILY HEALTH STRATEGY**

The context of the dysfunctional support network, marked by criticism and judgments, has repercussions as a risk factor:

I was judged a lot since my second pregnancy [...] I hid it until the month before, because I could still hide my belly [...] from both my mother and his mother. (E22).

The following report expresses family judgment as a trigger for psychological suffering and risk:

However, the person I most hoped would give me a hand discouraged me with the pregnancy. It is like she was giving a little push [...] to interrupt the pregnancy [...] My mother made negative comments about the pregnancy, a lot! (E26).

For E26, instead of support, the mother's comments intensified the emotional distress.

I did not want to do prenatal care [...] And my mother told me that I had to start prenatal care [...] because my belly was not going to disappear. (E22).

In the case of E22, family support favored adherence to prenatal care and mother–baby bonding, even in a pregnancy that was difficult to accept.

On the other hand, E4, with depressive symptoms and multiple risk factors (category "Maternity, work and subsistence"), including the absence of family support, did not adhere to prenatal care or demonstrate a bond with the baby:

I went to the health center, I did the pregnancy test again, it was positive, I just opened the card, then I did not go anymore [...] I'm not going through prenatal care thus far [...] maybe it goes into the acceptance part. (E4).

In these cases, active search and home visits become essential. In addition to providing prenatal care, the FHS has the role of clarifying doubts, welcoming, and promoting autonomy and social support. Cases in which the woman does not have a family support network require the welcoming and attentive care of the team.

Yes, I had negative feelings when I determined I was pregnant, but more so, sometimes, it is because of my relationship with the baby's father. We fight a lot, then I was a little insecure. [...] when he fights, just like these times even though we fight, he says: I hope you and your child die in childbirth! (E12).

**PERINATAL PSYCHOLOGY AND MATERNAL MENTAL HEALTH: A STUDY WITH
PREGNANT WOMEN IN THE FAMILY HEALTH STRATEGY**

Conflicting marital relationships are a risk factor for maternal depression¹³. E12, with an EPDS score of 15, illustrates the influence of social relationships on gestational well-being.

The positive effects of the companion in labor and the postpartum period are known, providing security, tranquility and support³⁰. However, in fragile networks, some pregnant women reported uncertainty:

About the birth companion, I'm seeing it with the neighbor [...] but it is in the Lord's hand. (E18).

I have been feeling worried [...] the time to go to the hospital with whom I'm going to stay. This uncertainty... (E12).

On the other hand, virtual social networks appeared as information and support resources:

I'm getting a lot of support from social networks [...] I try a lot to study about what it is to be a mother, about what the arrival of a baby is, I try to know a lot about it, how to take care of a baby, [...] how to give a bath. (E17).

The FHS and the psychological care offered by the resident psychologist were also valued:

However, life with this baby will be easy; any little thing, I see that I will not be able to do it; I go to the health center, go to the psychologist, and so forth. (E5).

This statement reflects the importance of the FHS as a form of social support in the promotion of maternal and child well-being. Furthermore, participation in a prenatal group within the Family Health Strategy service, led by the resident psychologist, appeared to be a positive factor.

It was very good that the first day I participated in the group [...] I loved it a lot, I went home happy, with a lot of things in my head, I trusted: Oh, it will work out! [...] this helps a lot! (E17).

The literature highlights the importance of prenatal strategies that expand knowledge, strengthen rights, and stimulate affection, such as groups of pregnant women in the FHS³¹.

PERINATAL PSYCHOLOGY AND MATERNAL MENTAL HEALTH: A STUDY WITH PREGNANT WOMEN IN THE FAMILY HEALTH STRATEGY

Study limitations:

The small sample, obtained by nonprobabilistic sampling, limits the possibility of comparison with other contexts, as it is a single reality studied. In addition, self-reported data are subject to memory and perception biases, and the cross-sectional design prevents the establishment of causal relationships.

FINAL CONSIDERATIONS

The results of the study revealed that pregnancy is influenced by multiple biopsychosocial factors, significantly impacting women's subjectivity, relationships and social roles.

The qualitative analysis revealed that idealized social representations about motherhood, subjective history and mental health conditions, perceptions of childbirth, challenges related to the reconciliation between motherhood and work, and the quality of the support network are determining factors for maternal mental health status.

Various risk factors, such as socioeconomic vulnerability, a history of violence, previous mental disorders, and a lack of social support, were identified. In addition, the EPDS tracked depressive symptoms in most of the pregnant women interviewed. Protective factors such as physical activity, adequate social support, a satisfactory marital relationship, the absence of previous mental disorders, a satisfactory delivery history, and activities in the FHS, such as groups of pregnant women and psychological support, were essential for maternal well-being.

These findings highlight the importance of strengthening public policies for maternal mental health in Primary Health Care, with the multiprofessional team playing an active role in the early identification of psychological distress during pregnancy.

As an intervention proposal, the inclusion of mental health status in the pregnant woman's booklet and the use of the EPDS as a screening tool are recommended. For professionals to use this instrument appropriately, prior training is essential. Combined with clinical interviews, the EPDS can contribute to the early screening of depressive symptoms and to more comprehensive care. Investing in preventive strategies, in addition to being the

**PERINATAL PSYCHOLOGY AND MATERNAL MENTAL HEALTH: A STUDY WITH
PREGNANT WOMEN IN THE FAMILY HEALTH STRATEGY**

scope of PHC, benefits not only mothers but also mother-baby bonds and child development, with positive long-term effects.

REFERENCES

1. Schiavo RA. Scientific production in obstetric/perinatal psychology. *Braz J Health Rev.* 2020; 3(6):16204-12. DOI: <https://doi.org/10.34119/bjhrv3n6-046> . Available at: <https://ojs.brazilianjournals.com.br/ojs/index.php/BJHR/article/view/19754>. Accessed on: 10 out. 2024.
2. Iaconelli V. Anti-maternalist manifesto: psychoanalysis and reproduction policies. Rio de Janeiro: Zahar; 2023.
3. Dagostin SR, Simon C, Mello E, Franzosi TS, Trissoldi LP, Marmitt LP, et al. Waiting for arrival: emotional changes manifested in pregnancy. *Pedagogical Notebook.* 2024; 21(6):1-20. DOI: 10.54033/cadpedv21n6-191. Available at: <https://ojs.studiespublicacoes.com.br/ojs/index.php/cadped/article/view/5072>. Accessed on: 5 Jan. 2025.
4. Silva BP, Matijasevich A, Malta MB, Neves PAR, Mazzaia MC, Gabrielloni MC, et al. Common mental disorder in pregnancy and postnatal depressive symptoms in the MINA-Brazil study: occurrence and associated factors. *Rev Saúde Pública.* 2022;56:83. DOI: <https://doi.org/10.11606/s1518-8787.2022056004028>. Available at: https://repositorio.usp.br/directbitstream/ab805f51-f32f-4a85-9f1b-7f6de4d4ca5e/HNT_22_2022_por.pdf. Accessed on: 3 Jan. 2025.
5. Sadock BJ, Sadock VA, Ruiz P. *Compendium of psychiatry.* 11. ed. Porto Alegre: Artmed; 2017.
6. Brazil. Ministry of Health. *Manual of high-risk pregnancy.* Brasília, DF: Ministry of Health; 2022. 692 p.
7. Matijasevich A, Faisal-Cury A, Giacomini I, Rodrigues JS, Castro MC, Cardoso MA. Maternal depression and child mental health at five years of age: a MINA-Brazil cohort study. *Rev Saúde Pública.* 2023; 57(Supl. 2):5 s:1-12. DOI: <https://doi.org/10.11606/s1518-8787.2023057005560>. Available at: <https://revistas.usp.br/rsp/article/view/219368/202981>. Accessed on: 12 Nov. 2024.
8. FEBRASGO. Brazilian Federation of Gynecology and Obstetrics Associations (FEBRASGO). Postpartum depression. *FEMINA.* 2020; 48(8):454-63. Available at: <https://www.febrasgo.org.br/media/k2/attachments/EdioZWebZAtualizada.pdf>. Accessed on: 20 nov. 2024.

**PERINATAL PSYCHOLOGY AND MATERNAL MENTAL HEALTH: A STUDY WITH
PREGNANT WOMEN IN THE FAMILY HEALTH STRATEGY**

9. Renner AM, Azambuja CV, Martins ES, Ramos GF, Arteche AX. Postpartum depression: evidence of the predictive power of social support and marital relationship. *Psico-USF*. 2023; 28(2):253-65. DOI: <https://doi.org/10.1590/1413-82712023280204>. Available at: <https://ouci.dntb.gov.ua/en/works/9j1JdwNl/>. Accessed on: 03 jan. 2025.
10. Grillo MFR, Collins SMB, Zandonai VR, Zeni G, Alves LPC, Scherer JN. Analysis of factors associated with mental health in pregnant and puerperal women in Brazil: a literature review. *J Bras Psychiatr*. 2024; 73(2):e20230098:1-12. DOI: <https://doi.org/10.1590/0047-2085-2023-0098>. Available at: <https://www.scielo.br/j/jbpsiq/a/zrMGGVLtD6PVSBzTDtBqx5t/?format=pdf&lang=pt>. Accessed on: 04 Jan. 2025.
11. Campos CA, Silva HMM, Viviani MMF, Pereira MMA, Santos RC, Vasconcelos SE, et al. Risk factors, protection, diagnosis and treatment of postpartum depression in the context of primary care. *Rev Eletrônica Acervo Saúde*. 2021; 13(1):e5410. doi: <https://doi.org/10.25248/reas.e5410.2021>. Available at: <https://acervomais.com.br/index.php/saude/article/view/5410/3789>. Accessed on: 06 Jan. 2025.
12. Schiavo R de A, Perosa GB. Child development, maternal depression and associated factors: a longitudinal study. *Paidéia*. 2020; 30:e3012. DOI: <https://doi.org/10.1590/1982-4327e3012>. Available at: <https://www.scielo.br/j/paideia/a/msdNDYZfsMdgNwKzPY869bk/?lang=en&format=pdf>. Accessed on: 07 jan. 2025.
13. Faisal-Cury A, Tabb K, Matijasevich A. Partner relationship quality predicts later postpartum depression independently of the chronicity of depressive symptoms. *Braz J Psychiatry*. 2021; 43(1):12-21. DOI: <https://doi.org/10.1590/1516-4446-2019-0764>. Available at: <https://www.scielo.br/j/rbp/a/9LQzvXGL4S8hd4hfXnjNvZn/?lang=en&format=pdf>. Accessed on: 20 dez. 2024.
14. Schiavo RA, Rodrigues OMPR, Santos JS, Antonucci JM, Mormanno C, Pereira VA. Maternal-infant factors associated with the development of preterm and term infants. *Rev Psicol e Saúde*. 2020; 12(4):141-57. DOI: <http://dx.doi.org/10.20435/pssa.vi.1031>. Available at: <https://pepsic.bvsalud.org/pdf/rpsaude/v12n4/v12n4a12.pdf>. Accessed on: 24 Dec. 2024.
15. Zarske SSS, Pereira VA, Rodrigues OMPR, Arruda EJ. Mother-baby interaction: the relationship between the bonding process and parenting practices. *Interaction in Psychology*. 2021; 25(2). DOI: 10.5380/riep.v25i2.76257. Available at: https://www.researchgate.net/publication/354283027_Interacao_Mae-Bebe_a_relacao_entre_o_processo_de_vinculacao_e_as_praticas_parentais. Accessed on: 28 Dec. 2024.

**PERINATAL PSYCHOLOGY AND MATERNAL MENTAL HEALTH: A STUDY WITH
PREGNANT WOMEN IN THE FAMILY HEALTH STRATEGY**

16. Brazil. Law No. 14,721, of November 8, 2023. Official Gazette of the Union. 9 Nov. 2023. Available at: <https://legis.senado.leg.br/norma/37805657>. Accessed on: 12 Jan. 2025.
17. Santos IS, Matijasevich A, Tavares BF, Botelho IP, Lapolli C, et al. Validation of the Edinburgh Postnatal Depression Scale (EPDS) in a sample of mothers from the 2004 Pelotas Birth Cohort Study. *Cad Saude Publica*. 2007; 23(11):2577-88. Available at: <https://www.scielo.br/j/csp/a/vgVPPx877wxJhyHqrmqCLzb/?lang=en&format=pdf>. Accessed on: 20 out. 2024.
18. Bergink V, Kooistra L, Den Berg MPL, Wijnen H, Bunevicius R, Van Baar A, et al. Validation of the Edinburgh Depression Scale during pregnancy. *J Psychosom Res*. 2011; 70(4):385-9. DOI: <https://doi.org/10.1016/j.jpsychores.2010.07.008>. Available at: <https://pubmed.ncbi.nlm.nih.gov/21414460/>. Acesso em: 21 nov. 2024.
19. Minayo MCS, organizer. Social research: theory, method and creativity. 26th ed. Petrópolis: Vozes; 2010. Available at: <https://bibliocetas.fct.unesp.br/Arquivos%20P%C3%ABlicos/Pesquisa%20Qualitativa%20Pesquisa%20Social%20-%20Teoria%2C%20M%C3%A9todo%20e%20Criatividade%20-%20minayo.pdf>. Accessed on: 20 Sep. 2024.
20. Arruda ACC, Coelho GG. The importance of perinatal psychology as a field of investigation and professional performance. *Changes – Health Psychology*. 2022; 30(1):71-8. Available at: <https://revistas.metodista.br/index.php/mudancas/article/view/651/627>. Accessed on: 04 Nov. 2024.
21. Badinter E. A conquered love: the myth of maternal love. Translation: Waltensir Dutra. Rio de Janeiro: Nova Fronteira; 1985.
22. Maldonado MT. Psychology of pregnancy: childbirth and puerperium. 14. ed. São Paulo: Saraiva; 1997.
23. Segamarchi PR, Mateus VLE, Osório AAC. Mental health of postpartum women during the Covid-19 pandemic in Brazil. *Psychology: Theory and Practice*. 2023; 25(2). DOI: <https://doi.org/10.5935/1980-6906/ePTPCP14807.pt>. Available at: <https://editorarevistas.mackenzie.br/index.php/ptp/article/view/14807/11788>. Accessed on: 11 ja. 2025.
24. Damaceno NS, Marciano RP, Orsini MRCA. The maternal imaginary about cesarean and vaginal births. *Psicol: Ciência e Profissão*. 2021; 41:e224530:1-15. doi: <https://doi.org/10.1590/1982-3703003224530>. Available at: <https://www.scielo.br/j/pcp/a/B8ZZyDd34rGxp9B4RPrkvc/?lang=pt&format=pdf>. Accessed on: 28 nov. 2024.

**PERINATAL PSYCHOLOGY AND MATERNAL MENTAL HEALTH: A STUDY WITH
PREGNANT WOMEN IN THE FAMILY HEALTH STRATEGY**

25. Lopes AAL, Piovan S. The importance of perinatal psychology in the prevention of postpartum depression and its implications in the child's life. *Arq Mudi*. 2023; 27(3):91-102. DOI: <https://doi.org/10.4025/arqmudi.v27i3.70430>. Available at: <https://periodicos.uem.br/ojs/index.php/ArqMudi/article/view/70430>. Accessed on: 12 out. 2024.
26. Leite TH, Marques ES, Corrêa RG, Leal MC, Olegário BCD, Costa RM, et al. Epidemiology of obstetric violence: a narrative review of the Brazilian context. *Ciência & Saúde Coletiva*. 2024; 29(9):e12222023. DOI: 10.1590/1413-81232024299.12222023. Available at: <https://www.scielo.br/j/csc/a/LbMdhqnGHfRRhNfJWJgpPjd/?lang=pt&format=pdf>. Accessed on: 06 Feb. 2025.
27. Mota-Santos C, Azevêdo AP, Lima-Souza E. The woman in triple shift: discussion about the division of tasks in relation to the partner. *Management & Connections*. 2021; 10(2):103-121. DOI: 10.47456/regec.23175087.2021.10.2.34558. Available at: <https://periodicos.ufes.br/ppgadm/article/view/34558>. Accessed on: 23 Dec. 2024.
28. Cunha AN, Eroles NMS, Resende LM. Becoming a mother: high level of stress in pregnancy and motherhood after birth. *Interaction in Psychology*. 2020; 24(3). DOI: <https://doi.org/10.5380/riep.v24i3.62768>. Available at: <https://revistas.ufpr.br/psicologia/article/view/62768>. Accessed on: 14 Jan. 2025.
29. Silva LB, Gondim SMG, Sousa YSO, Simões ACA. Maternity and work of primiparous women: from pregnancy to return to work. *Rev Bras Orient Prof*. 2023; 24(1):57-69. DOI: 10.26707/1984-7270/2023v24n0106. Available at: <https://abraopc.org.br/site2022/wp-content/uploads/2023/08/a06v24n1-1.pdf>. Accessed on: 02 Jan. 2025.
30. Mazzetto FMC, Mattos TB, Siqueira FPC, Ferreira MLS. Presence of the companion from the perspective of the woman during labor, delivery and postpartum. *Rev Enferm UFPE online*. 2022; 16(1). DOI: <https://doi.org/10.5205/1981-8963.2022.252582>. Available at: <https://periodicos.ufpe.br/revistas/revistaenfermagem/article/view/252582>. Accessed on: 02 nov. 2024.
31. Morais K, Pinto A, Clemente M. Production of affection in prenatal care: an integrative review. *Psicol, Saúde & Doenças (Psychol, Health & Diseases)*. 2023; 24(2):451-61. DOI: <https://doi.org/10.15309/23psd240203>. Available at: https://www.sp-ps.pt/downloads/download_jornal/1002. Accessed on: 18 Jan. 2025.

Submitted: February 27, 2025

Accepted: May 24, 2026

Published: October 8, 2026

**PERINATAL PSYCHOLOGY AND MATERNAL MENTAL HEALTH: A STUDY WITH
PREGNANT WOMEN IN THE FAMILY HEALTH STRATEGY**

Author contributions	
Rosane Cípola:	Conceptualization, data curation, formal analysis, investigation, methodology, project administration, tool provision, data validation and experiments, data presentation design, original manuscript writing, writing - review, and editing.
Noemi Bandeira:	Conceptualization, methodology, obtaining funding, provision of tools, supervision, writing - review and editing.
All authors approved the final version of the text.	
Conflict of interest:	There is no conflict of interest.
Funding:	Has no funding
Corresponding author:	Rosane Cípola Federal University of Rondonópolis Av. dos Estudantes (MT-270), 5055, Bairro Sagrada Família, Universidade Federal de Rondonópolis. Rondonópolis/MT, Brazil. Postal Code 78736-900 rosane.cipola@hotmail.com
Editor:	Olga Valentim. Ph.D

This is an open access article distributed under the terms of the Creative Commons license.

