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THERAPEUTIC ITINERARIES OF PREGNANT AND PUERPEROUS WOMEN WITH ANXIOUS AND DEPRESSIVE SYMPTOMS, UP TO ONE YEAR AFTER BIRTH, IN THE MUNICIPALITY OF CHAPECÓ – SC

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Abstract: The present work aims to identify the characteristics of women with anxious and/or depressive symptoms during pregnancy and postpartum, within one year after birth, and their therapeutic itineraries, in the municipality of Chapecó - SC, considering assistance at the Care Center Psychosocial (CAPS II) and at the Family Health Center (CSF) Jardim América in the municipality of Chapecó/SC. The research has a qualitative nature and was carried out using a descriptive and exploratory approach, based on interviews and the application of questionnaires with pregnant or postpartum women diagnosed with anxious and/or depressive symptoms, within one period of childbirth. Data collection was carried out between March and June 2022. The data was analyzed using the content analysis technique. The project was submitted to Chapecó City Hall and the UFFS Research Ethics Committee. Among the eight women interviewed, six (75%) had, at some point, been diagnosed with depression and/or anxiety prior to pregnancy. As a therapeutic trajectory, six of the eight women interviewed reported improvements in symptoms after using medication. Two (25%) of the participants reported receiving comfort through religious practices. One (12.5%) respondent received psychological support during treatment. All (100%) participants underwent prenatal care in Primary Health Care (ABS). Finally, the present study provided a better understanding of the profile of women with depression and/or anxious symptoms during and after pregnancy. It is possible to understand the need for care and support for affected women, as treatment requires time and patience. Furthermore, family commitment is essential during the therapeutic process, as this contributes to the reduction of depressive and anxious symptoms during the peripartum period.
Keywords: women's health; mental health; puerperium; therapeutic projects.

INTRODUCTION

Mood disorders can occur in both sexes and regardless of age group, with anxious and depressive symptoms being the most prevalent in women in the reproductive period (WISNER, 2013). On the other hand, the existing idealization of the gestational and postpartum period tends to minimize maternal needs, in favor of the belief in innate happiness and fulfillment that accompany it. Therefore, socially, the existence of anxious or depressive symptoms during this period often ends up leading to judgments and blaming women for breaking the expectations that accompany motherhood (PICCINI et al., 2014). Therefore, quality and humanized prenatal and puerperal care is fundamental for maternal and neonatal health. In this sense, for this care to be properly executed, it is necessary to look at the health/disease process that encompasses the entire body, mind and environment in which the woman is inserted (BRASIL, 2005).

The term "perinatal mental illness" refers to psychiatric disorders that occur during pregnancy and up to 1 year after birth. These disorders are triggered by hormonal, physical, emotional and psychological changes that occur during pregnancy, which include low energy, extreme sadness, irritability and suicidal tendencies (O`HARA et al, 2014). It is estimated that around 50% or more of women who are in the first few weeks after giving birth feel symptoms related to anguish and sadness (BALARAM; MARWAHA, 2021). It is also known that mood disorders lead to changes in social behavior and that, when associated with the puerperal period, they generate negative effects on both the mother and the newborn, which can result in a greater incidence of violence during pregnancy. adolescence or adulthood (MUGHAL; AZHAR; SIDDIQUI, 2020).

Furthermore, anxious and depressive symptoms during the postpartum period increase the risk of early weaning, with breastfeeding considered a protective factor for the manifestation of postpartum depression (BRASIL, 2021). For the mother who experiences this context, it is possible that there is, more frequently, difficulty interacting with her children, less understanding from her partner, and less affection, support and support, fundamental characteristics given the moment she is experiencing. Furthermore, facing prejudice regarding the disease is present and challenging, as the mother is already in a moment of fragility and vulnerability (MELO et al., 2015). Therefore, the present study sought to accompany women who attend mental health services to understand how they coped during this postpartum period and what therapeutic itineraries they sought to treat themselves and feel better. Therefore, understanding how women who face mood swings seek to take care of their own health can help professionals and society to reduce prejudice and implement measures that can help them during pregnancy and the postpartum period.

METHOD

TYPE OF STUDY

The present study has a qualitative design, aimed at understanding human beings and their relationships, based on the meanings they attribute to their experiences (MINAYO, 2014). The research corpus consisted of identifying therapeutic itineraries (GERHARDT et al., 2016) of women who accessed CAPS II and CSF Jardim América, in the municipality of Chapecó, Santa Catarina, Brazil, in addition to collecting secondary data from medical records. The identification of the therapeutic itinerary will follow the explanatory model proposed by Kleiman (1980), which defines care systems in three sectors or subsystems: the professional healing sector *(professional sector)*, which consists of professionals in scientific medicine or traditional medicine, such as Chinese medicine; the popular cures sector *(folk sector)*, which includes non-professional healing specialists, such as those linked to religious and secular groups; and the informal sector (popular sector), which includes the family, the community and all types of activities and social network support.

FIELD OF STUDY

Psychosocial Care Centers (CAPS) are support networks designed to assist individuals in mental distress, exercising their domains under the profile of territoriality (MIELKE et al., 2009). These places operate at a secondary level, referring to primary care services, in order to offer monitoring and support to patients in more severe and persistent suffering. This way, it is possible to infer that CAPS are the reference institutions for the treatment of people who need more intensive and community assistance (LEAL; ANTONI, 2013). In the municipality of Chapecó, CAPS II is designed to care for individuals over 18 years of age, with any serious and persistent mental disorder, except for disorders related to the use of psychoactive substances. For the latter, the municipality has CAPS AD III, which specializes in caring for users of alcohol and/or other drugs. The Family Health Center (CSF) Jardim América was also included in the collection, since basic care operates with the assumptions of bonding and longitudinal care, being the gateway to prenatal, postpartum and postpartum care. throughout the child's early childhood.

DATA COLLECTION

Data were collected through 8 interviews with open questions (Appendix I), from March 2022 to June 2022. The sample size is related to the study design that was carried out, which does not have the objective of generalizing information, but rather of subjectively learning how each therapeutic itinerary was constituted, with data saturation being a frequent criterion in social science research in health.

In the interview guide, the researchers sought to explore aspects related to previous treatments for mental health problems, prenatal, postpartum and postpartum. To carry out the collection, in both services, contacts were obtained from patients who were undergoing treatment related to depression and/or anxiety, through a psychiatrist working at the CAPS II in question. Secondly, a list of pregnant and postpartum women registered at CSF Jardim América was requested. Using this list, the researchers obtained the patients' medical records, and then a search was carried out to verify which women fit the research criteria, namely: depression and/or anxiety.

This way, these patients were contacted, using a cell phone, so that the interview related to the research could be scheduled. Before the interview began, the Free and Informed Consent Form (ICF) was presented and read by the researchers (Appendix III) and, after signing the term, the interview began. The interviews were carried out in person, at home or at CSF Jardim América.

The researchers also used data from the participants' medical records (script - Appendix), aiming to complement the collection of information about the services where the women were treated, medications in use and prenatal, childbirth and postpartum data. The Chapecó municipal network's medical record is integrated and allows viewing of women's therapeutic itineraries through the municipal care network. To access the medical record data, the researchers signed the Term of Commitment for the Use of Archived Data (TCUDA) (Appendix IV) and undertake to use the data for research purposes, with coding of the participants' names, hiding the name, to reduce the risk of identification.

In total, interviews were carried out with 3 participants from CAPS II, and 5 participants from CSF Jardim América. All documents generated by data collection and analysis were stored in the main researcher's room at UFFS, remaining there for a period of 5 years, and then destroyed.

CRITERIA AND INCLUSION AND EXCLUSION

As inclusion criteria, pregnant or postpartum women were considered, over 18 years of age, who had treatment for depression and/or anxious symptoms up to one year after giving birth, described in the medical record, and who are linked to CAPS II or CSF Jardim America. As an exclusion criterion, the impossibility of collecting data was weighed by the occurrence of other mental health diagnoses, carried out by the service's doctors.

DATA ANALYSIS

To carry out data analysis, the content analysis method proposed by Bardin was used, considering that this systematization makes it possible to systematically and reliably perceive the results and responses obtained within a recognized and conceptualized scientific analysis system for qualitative analysis. of interviews. This method consists of three phases: pre-analysis, exploration of the material and treatment of results, inference and interpretation (BARDIN, 2011).

In this sense, in the pre-analysis, the collected material was read, according to the previously established inclusion and exclusion

factors. Then, according to the second phase of the method proposed by Bardin, the content already obtained was explored, in order to determine whether the previous phases were properly carried out, and then proceed with the data analysis. Finally, in the treatment phase, charts and tables were created to facilitate the visualization and interpretation of the information collected in the interviews.

ETHICAL ASPECTS

The research observed the standards on research ethics contained in Resolution 466 of 2012, of the National Health Council (BRASIL, 2012). The research project was submitted for evaluation by the education center linked to the Municipal Health Department of Chapecó, which evaluated the project and issued the acknowledgment and agreement (appendix IV), including allowing access to the participants' medical records. Afterwards, it was sent to the Ethics and Research Committee of ``Universidade Federal da Fronteira Sul`` (CEP UFFS) for ethical evaluation, with CAAE 51880721.7.0000.5564, the opinion number 5.038.320, and the date of approval on October 14, 2021.

RESULTS

The participants in the study in question were 8 women. Of these, 2 (25%) were pregnant women and 6 (75%) were mothers of children up to one year old. The majority of these women (75%) had, at some point in their lives, been diagnosed with depressive and/or anxious symptoms prior to pregnancy.

The main data that characterize these women will be presented in tables 1 and 2.

Of the eight participants involved in the study, all lived in the city of Chapecó, until the time of the interview. As for the hometown of the interviewees, three (37.5%) come from the city of Chapecó, one (12.5%) from the state of Paraná, and four (50%) from the state of Rio Grande do Sul. When asked about their partners all stated that they were in a stable relationship with the father of the child during their respective pregnancy. Of these, six (75%) were married and lived with their husbands and children. The two women who were pregnant (25%) lived alone, however, they plan to live with their partners until the end of the pregnancy. Regarding the participants' education, two (25%) had incomplete high school, four (50%) had completed high school, and two (25%) had a higher education degree. With regard to profession, three (37.5%) had an active employment relationship, four (50%) were housewives and one (12.5%) was retired due to disability.

Regarding health history, five (62.5%) of the participants do not have associated chronic diseases, while three (37.5%) have/had them during pregnancy, the conditions being: controlled hypothyroidism, gestational diabetes and epilepsy. In terms of medication, two (25%) of the interviewees were not using any medication at the time of the interview. Of the medications used by the remaining six participants, three were not associated with the psycho-emotional condition, being the *levothyroxine, tramadol hydrochloride* and *levetiracetam*. The drugs related to the psycho-emotional context used by the participants were: *sertraline hydrochloride* and *levomepromazine*. It was observed that the drug *sertraline hydrochloride* was the main medication choice for patients, being used by four (50%) of them.

In response to pharmacological treatment, six of the women interviewed reported improvements in symptoms after using medication. Of these participants, three (37.5%) used the drug *sertraline hydrochloride* during pregnancy. Regarding the same medication, one (12.5%) participant reported no improvement, believing that the current dose was low. Prior to pregnancy, two (25%)

	Origin	Age	Marital status	Education	Profession	Religion	Number of Children	Childbirth
P1	CAPS II	20	Single	Incomplete	From Home	Catholic	1	Pregnant
P2	CSF Jardim América	31	Married	Incomplete	Retired	Evangelical	2	1 Birth 1 Cesarean section
P3	CSF Jardim América	40	Married	Incomplete	Saleswoman	Evangelical	2	2 Cesarean sections
P4	CSF Jardim América	26	Married	Incomplete	BRF Production Coordinator	Evangelical	3	2 Births 1 Cesarean section
P5	CSF Jardim América	24	Single	Complete Higher Education	Teacher	Catholic	1	Pregnant
P6	CAPS II	20	Single	Incomplete	From Home	Catholic	1	1 Cesarean section
P7	CAPS II	23	Married	Incomplete	From Home	Evangelical	2	1 Cesarean section
P8	CSF Jardim América	24	Single	Incomplete Higher Education	From Home	The person does not have religion	1	Childbirth

Table 1 – Socioeconomic profile of pregnant and postpartum women with anxious and/or depressive symptoms up to one year after giving birth

Source: prepared by the authors (2022)

Patients	Age at Menarche (in years)	Contraceptive Method	Presence of Pregnancy Planning	Presence of Family History of Psychiatric Symptoms
P1	11	The person didn't use it	No	No
P2	11	Oral contraceptive	Yes	Three first-degree relatives with depressive and anxious symptoms
P3	15	Oral contraceptive	No	No
P4	11	The person didn't use it	Yes	Depressive first-degree family member
P5	11	Condom	No	Depressive first-degree family member
P6	13	Oral contraceptive	Yes	No
P7	12	Oral contraceptive	No	No
P8	11	Condom	No	No

Table 2 – Clinical history of pregnant and postpartum women with anxious and/or depressive symptoms up to one year after giving birth

Source: prepared by the authors (2022)

respondents stated that they used the drug fluoxetine, showing a good response to treatment for anxiety/depression.

All participants underwent prenatal care in Primary Health Care (ABS). Furthermore, three (37.5%) women are monitored at CAPS II, while five (62.5%) of the interviewees are users and frequent CSF Jardim América. When questioned about the quality of care and follow-up offered, all women assured that they had received good/great/excellent support and care. In addition to the assistance offered by these services, two (25%) participants reported receiving comfort from religious institutions, with the idea that proximity to the spiritual sphere was extremely important for their treatment. One (12.5%) interviewee is being monitored by a psychologist, through the SUS. The other five (62.5%) participants stated that they did not use other alternative therapies.

Regarding the practice of physical activities, all research participants reported not performing physical exercises during pregnancy. Before pregnancy, two (25%) used to go to the gym. After the birth of the baby, one (12.5%) respondent stated that she was exercising frequently. Regarding sleep quality, seven (87.5%) of the participants reported having irregular sleep during pregnancy. Regarding personal hygiene, all women interviewed stated that they had good general health in this regard, during and after pregnancy.

In a symptomatic context, the participants talked about the moment in which the main signs of anxiety and/or depression were observed, as well as about the possible triggering event for such manifestations. Therefore, six (75%) of the interviewees were able to identify moments that they believe were important for the occurrence of anxious and/or depressive symptoms. The other two (25%) participants elaborated on unresolved issues arising from childhood as being responsible for the manifestation of the psycho-emotional condition, currently.

From an emotional aspect, the interviewees were asked about the support network present when coping with anxiety/depression. In response, six of the participants (75%) stated that their respective mothers acted as the main support, together with their respective husbands/partners. One participant (12.5%) cited only the presence of her boyfriend, and one (12.5%) interviewed reported not having received support from anyone.

Regarding suicidal thoughts, or those related to death, six of the participants stated that they had them during pregnancy and/or at the present time, and two of the participants denied the presence of such ideas.

With regard to therapeutic itineraries, figure 01 was created, which seeks to illustrate how pregnant women are included in the municipal health care network.

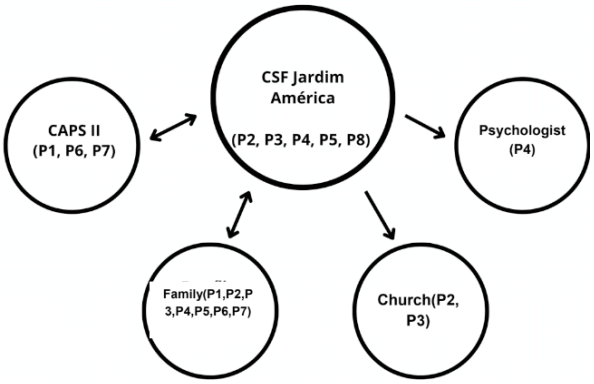

Figure 1 - Therapeutic Itinerary of Pregnant Women Included in the Municipal Health Care Network Source: prepared by the authors (2022).

Through the participants' statements, it was possible to understand some feelings involved in pregnancy and the postpartum period of women who had depressive or anxious symptoms. Below, some themes are presented that allow us to understand the triggers for the development and/or worsening of depressive

and anxious symptoms during pregnancy and the postpartum period.

When asked how they felt about discovering the pregnancy and birth of the baby, six women (75%), five of whom had recently given birth and one was pregnant, reported feelings of happiness for the new life they had created. However, they reported that, after this initial moment, triggers arising from past traumas awakened feelings of fear and anguish, highly related to their health and that of their child. Among these traumas, we can mention gestational complications, such as placenta previa, previous traumatic cesarean section, *Sar-cov*-2 infection, previous miscarriages, as well as insecurity due to living far from the family and lack of family support.

When asked about their feelings, women reported:

> P1 - "When I found out it was a boy, I canceled the baby shower. The little desire I had to do something went away.".
>
> P2 - "I was afraid of holding my son and watching him die".
>
> P3 - " *I was embarrassed to be a mother again after 21 years. I was scared and didn't even know if I was ready to be a mother again ".*
>
> P4 " *I was afraid to be close to my son and see that he was unhealthy.".*
>
> P5 " *When I found out I was pregnant, I was shocked, but I was happy. But now I feel alone and scared of not being a good mother*".
>
> P6 - "During the pregnancy, I had moments of joy and sadness. But, in all of them, the fear of not being prepared to be a mother predominated."
>
> P7 - "When the youngest was born, I felt like I was rejecting him because I loved the oldest more, in a way."
>
> P8 - "I think the hardest part during the pregnancy, and also after he was born, was the loneliness. I feel and know that I am alone. I only have him, and he only has me."

When asked about the impacts of these feelings on their maternal relationships, postpartum woman 4 reported that she had suffered miscarriages prior to her last pregnancy, and that she felt the need to get pregnant again to prove to her family her ability to carry a baby. However, the fear of losing another child, or that he would not develop well, aroused feelings described as "dread" and "distress", which made her move away from her child after his birth for fear of suffering another loss.

On the other hand, two women, participants 1 and 7 (25%), one of whom was pregnant and one who had recently given birth, both with unplanned pregnancies, stated that they rejected the child due to a lack of emotional ties. Participant 1, who was pregnant, reported that she "didn't imagine herself being a mother" and that she had a lot of difficulty accepting the pregnancy. Furthermore, she stated that her clinical condition worsened when she discovered that the baby's sex was not what she expected.

Patient 7 presented rejection by the child before and after birth. According to the patient, what made it impossible for her to form affection for the child was the fear of stopping loving her eldest son (aged four) with the arrival of the youngest, leaving the following report:

> [...] I breastfed, bathed and took care of the youngest, but I didn't feel a mother's love for him. For me, it was as if I would stop loving my other child if I loved this one [...] (P7)

When asked whether they considered themselves cured, the participants responded:

> P1 - "No. But I'm hopeful that I'll get better."
>
> P2 - "Yes. Today I consider myself completely cured. I think people who go through this must help themselves, and also trust in God."
>
> P3 - "I don't consider myself completely

cured yet, but I've improved a lot. I see it all as an experience. God gave me a second chance."

P4 - "Not completely. It's harder to deal with anxiety during pregnancy than when you're not pregnant. Having the baby helped me."

P5 - "I'm still very scared of losing the baby. But I think it will get better with time."

P6 - "I don't see any improvement as I'm still in the process."

P7 - "Not yet, but I have faith that things will get better."

P8 - "Not completely cured, but better than I was during pregnancy."

DISCUSSION

Initially, it is important to highlight that the sample selected in this study consists of pregnant and postpartum women treated exclusively by the public health system. In the present study, 62.5% of the participants were treated exclusively in the ABS and 37.5% with simultaneous monitoring of the ABS and Specialized Care (AAE), in the institution of the Psychosocial Care Centers (CAPS), until the date of the interviews.

With regard to psychiatric illnesses during pregnancy, Family Health Strategy (ESF) professionals must be responsible for identifying psycho-affective aspects of pregnancy, analyzing signs and symptoms that suggest difficulties in accepting pregnancy, expectations and behaviors in relation to the baby, the maternity and paternity (SANTA CATARINA, 2021). Furthermore, pregnant women who have a previous history of psychiatric illnesses, such as severe depression and generalized anxiety, must be referred to the AAE at the beginning of pregnancy (BRASIL, 2010).

Since, in the present study, only one of the women treated exclusively in primary care had access to follow-up with the psychologist from the Expanded Family Health and Primary Care Center (NASF-AB), there is a flaw in the follow-up of care within from ABS. It is possible that this finding indicates difficulties on the part of primary care professionals in identifying patients who require specialized care during the postpartum period.

In this sense, it is worth remembering that monitoring carried out in the prenatal period aims to take care of women's health and prepare them for childbirth and the postpartum period, this being a space for women to feel confident and safe to talk and clarify your doubts (SILVA et al., 2018). In the present study, when questioned about the quality of care received at the ABS and about the prenatal care carried out during the last/current pregnancy, the women interviewed reported being satisfied with the care received, within what they recognized as the duty of the SUS to this type of service.

However, it is notable that this study identified a low percentage of women (37.5%) who properly received psychological support during the prenatal period. This fact corroborates the assumption of difficulties in identifying, by the ESF, pregnant and postpartum women with depressive and anxious symptoms. In this sense, it is possible to bring, as an example of what would be an appropriate conduct to protect these women, Psychological Prenatal Care (PNP), a complementary practice to gynecological prenatal care, during which interventions of a psychoprophylactic nature are carried out with the aim of provide humanized care during pregnancy (BENINCASA et al., 2019).

In this context, it is necessary to consider that Arrais, Araujo and Schiavo (2019), in their study on the preventive role of psychological prenatal care in maternal anxious and depressive symptoms, considered the PNP as a protective factor for preventing

depressive symptoms in the postnatal period. childbirth or the chronicity of symptoms present during pregnancy. Furthermore, Benincasa et al. (2019) declared that the PNP is capable of providing a space for listening and differentiated attention, free from censorship and judgment, allowing pregnant women to experience their moment in a conscious and active way.

Regarding the sample profile, the age range of the women participating in this study varied between 20 and 40 years old. However, 75% were aged 20-29, in line with what was observed in another study carried out within the SUS (DELL'OSBEL; GREGOLETTO; CREMONESE, 2019). Furthermore, multiparity was also a risky conclusion for Premji et al. (2020), corroborating the finding of 50% of multiparous women in this study. The proposed study presents the profile of women, with depressive and/or anxiety disorders, predominantly white (100%), with complete secondary education (50%) and working as housewives (50%).

Regarding the marital status of the participants, the same proportion of single (50%) and married (50%) respondents was found. Furthermore, only one (12.5%) of the women in the study reported using psychoactive substances. In the aspect related to housing, all participants lived in regions relatively close to the urban center of the city of Chapecó – SC. According to the study carried out by Santos et al. (2022), the variable being single, or dating, showed an important association with the development of postpartum depression (PPD), when compared to married women.

Indications such as health problems during pregnancy or previous pregnancies, home insecurity, and lack of pregnancy planning were found in this study as aggravating factors for the depressive and/or anxiety symptoms presented by the participants, which is in line with what was presented by BANTE et al. (2021). Furthermore, Lebel et al. (2020), in their study on the elevated symptoms of depression and anxiety in pregnant women during the COVID-19 pandemic, concluded that the presence of threats to the baby's life, concerns about not receiving the necessary prenatal care, tension in the relationship and Social isolation worsens maternal psychological instability.

In this sense, it is worth understanding that, according to the study carried out by Silveira et al. (2018), the predominant profile in women, with depressive and/or anxious symptoms, is lack of prenatal care, active consumption of alcoholic beverages and tobacco, in addition to living far from urban centers. Furthermore, the prevalence of brown color/race, income below the minimum wage and the role of being a homemaker are factors that are potentially present in this group of women (TEIXEIRA et al., 2021).

Regarding the characteristic symptoms of depression and anxiety, it is worth mentioning the presence of changes in appetite, reduced strength and energy, predominance of feelings related to guilt and disability, as well as rejection by the baby and suicidal thoughts (CAMPOS, CARNEIRO-FÉRES; 2021). Of these characteristics, it was possible to notice that all, to some degree, are associated with the reports made by the interviewees. Furthermore, sleep disorders are also relevant in the majority of participants (87.5%).

In line with these data, the present study aims to identify the characteristics of women with depressive and anxious symptoms and their therapeutic itineraries. Taken together, the definition of therapeutic itineraries can be seen as a human action in a chain of successive events that form a unit. Thus, it is a set of plans, strategies and projects aimed at a preconceived object, in this case, psychological support for postpartum and pregnant women

in psychological distress (ALVES, 2016).

The treatment and medication monitoring in this study addresses the drug *sertraline hydrochloride* as the main choice for women with depressive and/or anxiety disorders during pregnancy and breastfeeding. Of the interviewees, four (50%) were using the aforementioned medication, with three (37.5%) saying they adapted and felt positive effects with the drug. Near to *fluoxetine hydrochloride, paroxetine hydrochloride, venlafaxine hydrochloride, fluvoxamine maleate and citalopram hydrobromide, sertraline hydrochloride* It is one of the most commonly prescribed medications (NOMURA, SILVA; 2007).

The use of alternative therapies has been shown to be significantly beneficial in the prevention and treatment of anxiety and/or depressive disorders. In this sense, the study carried out by Araújo et al. (2016) concluded that relaxation, according to Benson's technique, is an effective and safe measure to reduce symptoms related to depression. The aforementioned intervention is based on six steps: sit comfortably, close your eyes, relax your muscles, breathe calmly, remain silent after the process, and maintain a patient position in relation to the technique performed.

Furthermore, the practice of physical exercise, although not practiced by the women interviewed in the present study, has important effects on the quality of maternal and fetal life, especially. Among the expected results, the protective factor that exercises have against a possible future depressive condition stands out. Furthermore, physical activities contribute to reducing fatigue, controlling metabolic and cardiovascular complications, and preventing weight gain above that estimated for each woman, for example (CAMPOS et al, 2021).

It is also important to address the role of doulas in the pregnancy, labor and postpartum process. A doula is a professional responsible for providing psycho-emotional support to pregnant women, through words of support, encouragement and non-pharmacological techniques to maintain pain (BARBOSA et al., 2018). According to Silva et al. (2016), national and international studies show the positive influence that doulas have in strengthening the mother-child bond, breastfeeding, and preventing PPD.

In the sociocultural context, the act of gestation is seen as something closely linked to happiness, plans and acceptance. However, the reality of many women is different, both in physical and psycho-emotional aspects. At this moment, the pregnant woman may become frustrated, which may make her question her ability to love and take good care of her child. Along with this, feelings of guilt, fear, irritability and worry contribute to the formation of an anxious/depressive condition (SANTOS et al., 2022).

According to Asselmann, E. et al. (2020), another important factor to be considered in the manifestation of psychological symptoms during pregnancy is the maternal personality. Examining the role of personality revealed that women who were more emotionally stable experienced fewer depressive, anxiety, and stress symptoms during the peripartum period. Furthermore, the study revealed that pregnant women with active family participation, as a gestational support network, experienced fewer depressive, anxious and stressful symptoms during the peripartum period.

CONCLUSION

This article enabled a better understanding of the reality and factors contributing to the triggering of depressive and anxiety disorders in pregnant and postpartum women. Using the socioeconomic characteristics of the participants in this study, it was possible to find the profile of pregnant and postpartum women with depressive and anxious symptoms that is frequently described in the literature. Regarding the aggravating factors of this condition, triggers related to maternal and fetal health problems, during pregnancy or previous pregnancies, as well as home insecurity, were found to have the main influence on maternal psychological instability.

In this sense, the positive influence of the support network was observed regarding the treatment of the women interviewed, especially the mother of the majority of participants, as reported by them. In relation to the therapeutic itinerary of the participants, it is understood that, at a pharmacological level, the majority of interviewees used the drug *sertraline hydrochloride* during pregnancy, obtaining positive results.

The current study revealed flaws in the identification and referral of pregnant women in need of specialized psychosocial care, which requires further investigation. Furthermore, because it is a delicate and emotionally painful topic, some women chose not to participate in the study, which contributed to a smaller number of participants (08) than expected (10).

Therefore, there is a greater need for studies and attention for women who face anxiety and/or depressive disorders, especially during/after pregnancy, when there is an excessive responsibility for caring for a baby. As health professionals, it is essential to look closely at the entire context in which women are inserted, so that more effective and accurate therapeutic options are made.

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