

Original Research Article

DEPRESSION AND ANXIETY IN MOTHERS WITH PRETERM BIRTH AND ITS ASSOCIATION WITH SOCIAL SUPPORT

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ABSTRACT

Background: The arrival of a highly premature infant significantly impacts family life. Research has consistently shown that 10% to 15% of women experience depressive symptoms after childbirth that are severe enough to qualify for a diagnosis of depression. The major contributors to the onset of postpartum depression are largely psychosocial in nature. Factors such as insufficient social support, history of depression, marital discord, and stressful life events have been shown to significantly increase the risk of developing postpartum depression.

Materials and Methods: A cross-sectional study was carried out among 100 postpartum women who had experienced preterm births. Depression severity was evaluated using the Edinburgh Postnatal Depression Scale, with scores above 13 indicating postpartum depression. Anxiety levels were assessed using the State-Trait Anxiety Inventory, with scores exceeding 40 suggesting the presence of anxiety. Social support was measured using the Multidimensional Scale of Perceived Social Support.

Results: There was an inverse relationship between postpartum depression and social support, with women having lower social support showing a significantly higher prevalence of postpartum depression compared to those with higher social support. The association was statistically significant. The average subscale scores for social support were notably lower in women who had high EPDS scores indicating postpartum depression. Similarly, an inverse relationship was observed between anxiety and social support. Several factors, including mother's age group, parity, number of living children, presence of congenital anomalies in the newborn, partner's substance abuse and family history of mental health disorders, showed significant association with postpartum depression and anxiety.

Conclusion: Postpartum depression and anxiety were common among mothers with preterm birth in the study area. Poor relationship with parents, history of marital violence and family history of mental health disorders were significantly associated with their occurrence. Strong support from friends, family and social networks played an important role in preventing postpartum depression and anxiety. Enhancing social support, particularly from spouses and family members, may help reduce the incidence of postpartum depression. The findings emphasize the need for targeted interventions to improve social support among postpartum women, along with effective screening methods for early detection.

Keywords: Edinburgh Postnatal Depression Scale; State-Trait Anxiety Inventory; Multidimensional Scale of Perceived Social Support; Postpartum depression; Preterm birth.

INTRODUCTION

Preterm birth is defined as the birth of a live baby before completion of 37 weeks of gestation. It remains one of the most important challenges in maternal and neonatal health because it affects not only the survival and physical development of the infant but also the emotional well-being of the mother. The birth of a preterm baby is usually unexpected and stressful, as mothers are suddenly exposed to fear regarding infant survival, prolonged hospitalization, neonatal intensive care unit admission, feeding difficulties and uncertainty about long-term outcomes. These circumstances may disturb the normal transition to motherhood and increase the risk of psychological problems during the postpartum period.^[1] Mothers of preterm babies often experience a different postpartum period compared with mothers of term babies. Instead of immediate bonding, routine breastfeeding and early discharge, they may face mother–infant separation, medical procedures, restricted handling of the baby and repeated communication with health-care providers. This environment can produce feelings of helplessness, guilt, sadness and fear. The mother may also blame herself for the early delivery or remain constantly worried about the baby's health. These emotional reactions can become more severe when they persist and interfere with sleep, appetite, self-care, infant care and family functioning.^[2] Depression and anxiety are among the most important mental health problems seen during pregnancy and the postpartum period. Postpartum depression may present with persistent sadness, crying spells, loss of interest, fatigue, irritability, disturbed sleep, poor concentration, guilt and reduced confidence in caring for the baby. Anxiety may present with excessive worry, restlessness, fearfulness, panic-like symptoms, repeated checking of the baby and inability to relax. In mothers of preterm babies, depressive and anxiety symptoms may coexist because the stress of prematurity, uncertainty about neonatal outcome and separation from the infant may act together. Early identification of both conditions is therefore essential for timely support and referral.^[3] Perinatal mental health is now recognized as an important component of maternal and child health services. Untreated depression and anxiety can affect the mother's quality of life, family relationships, breastfeeding, bonding and ability to participate confidently in newborn care. In the context of preterm birth, maternal mental health becomes even more important because the baby may require special feeding, follow-up visits, medications and developmental monitoring. A mother who is psychologically distressed may find it difficult to understand instructions, maintain follow-up and provide responsive care. Hence, assessment of maternal psychological status should be considered an important part of comprehensive postnatal care.^[4] Prematurity may increase maternal stress because it

changes the expected course of childbirth and early parenting. Mothers may feel emotionally unprepared to care for a fragile infant and may remain worried even after discharge from hospital. The neonatal intensive care environment, alarms, tubes, incubators and medical terminology may create fear and confusion. In addition, financial burden, travel to hospital, lack of privacy, sleep deprivation and disruption of household responsibilities may further increase mental strain. These factors make mothers of preterm babies a vulnerable group for depression and anxiety during the postpartum period.^[5] Social support is an important protective factor in the postpartum period. It includes emotional support, practical help, informational support and reassurance from husband, parents, in-laws, relatives, friends and health-care workers. Good social support can reduce loneliness, improve coping capacity, increase confidence in baby care and encourage timely help-seeking. In contrast, poor support, marital conflict, poor family relationships, violence, lack of partner involvement and criticism from family members may increase psychological distress. For mothers of preterm babies, support is especially important because they require assistance not only for their own recovery but also for infant care and hospital visits.^[6]

MATERIALS AND METHODS

This was a cross-sectional study conducted for a period of one year after approval by the Institutional Review Board. The study was carried out in the Department of Obstetrics and Gynaecology, Government Medical College, Kottayam. The study population included mothers of preterm babies in the Department of Obstetrics and Gynaecology, Government Medical College, Kottayam. A total sample size of 100 mothers was included in the study.

Inclusion and Exclusion Criteria

All mothers with preterm birth in the age group of 18–45 years after 2 weeks of postpartum period were included in the study. Mothers who were victims of rape and mothers who were medically too sick to participate in the study were excluded from the study.

Methodology : After informing the study procedure in detail, informed consent was obtained from the patients. Patients were interviewed in the counselling room while maintaining privacy. Severity of depression was assessed using the Edinburgh Postnatal Depression Scale. A score more than 13 was considered as depression, and the patients were divided into mild, moderate and severe depression using this scale. Anxiety was assessed using the State-Trait Anxiety Inventory, and a score more than 40 was considered to have anxiety. Social support was assessed using the Multidimensional Scale of Perceived Social Support. Socio-demographic details were collected by using a semi-structured questionnaire.

Data collection was done using a pretested semi-structured interview schedule along with a formal

informed consent form in Malayalam language. The Edinburgh Postnatal Depression Scale was used to assess depression. The EPDS is a 10-item questionnaire with a total score ranging from 0 to 30. Mothers were asked to fill it on their own without external influence in terms of the past seven days. A score more than 13 was considered as positive for postpartum depression.

The Multidimensional Scale of Perceived Social Support was used to assess social support. A study conducted with a group of Indian participants at University Malaya found that the scale demonstrated excellent internal consistency with Cronbach's alpha of 0.924, along with strong test-retest reliability of 0.71 and parallel form reliability of 0.92. The State-Trait Anxiety Inventory was used to assess anxiety. A study conducted to evaluate the validity and reliability of the STAI in Danish women aged 45 years and older with abnormal cervical cancer screening results found that the scale had excellent internal consistency, with a Cronbach's alpha of 0.93. The data obtained were entered into a Microsoft Excel spreadsheet and were analysed using IBM SPSS software.

RESULTS

[Table 1] showed the baseline characteristics of the study participants. Among 100 mothers, 47.0% were primigravida, 39.0% were primipara and 14.0% were multipara. Regarding education, majority of participants were graduates 52.0%, followed by school education 28.0%, preschool education 19.0% and illiterate 1.0%. According to economic status, 51.0% belonged to lower middle class, 32.0% to upper lower class and 17.0% to upper middle class. Most participants were in the age group of 26–35 years 45.0%, followed by 18–25 years 43.0% and 36–45 years 12.0%.

[Table 2] showed the association of socio-demographic characteristics with EPDS score and anxiety. Depression was more common among primigravida mothers 68.1%, followed by multipara

57.1% and primipara 43.6%, but this association was not statistically significant. Anxiety showed a significant association with parity, where moderate anxiety was highest among primigravida mothers 63.8%. Education was significantly associated with both depression and anxiety. All mothers with preschool education had EPDS score ≥ 13 and moderate anxiety. Economic status was also significantly associated with both depression and anxiety. Depression and moderate anxiety were highest among upper lower class mothers and lowest among upper middle class mothers.

[Table 3] showed the association of obstetric, medical and family history with EPDS score and anxiety. History of abortion, comorbid illness, ectopic pregnancy and previous caesarean section were not significantly associated with EPDS score or anxiety. However, infertility was significantly associated with both depression and anxiety, as 92.0% mothers with infertility had EPDS score ≥ 13 and 80.0% had moderate anxiety. Family history of alcoholism was also significantly associated, with 92.7% having EPDS score ≥ 13 and 85.4% having moderate anxiety. Similarly, family history of psychiatric illness showed significant association, with 92.3% having EPDS score ≥ 13 and 88.5% having moderate anxiety. [Table 4] showed the association of psychosocial, pregnancy and infant-related factors with EPDS score and anxiety. Poor relationship with parents and marital violence were significantly associated with both depression and anxiety. All mothers with poor relationship with parents and marital violence had EPDS score ≥ 13 . Unplanned pregnancy was significantly associated with depression and anxiety, with 71.2% having EPDS score ≥ 13 and 67.8% having moderate anxiety. Caesarean delivery was significantly associated with depression but not with anxiety. Infant complications were significantly associated with both depression and anxiety. Sleep deprivation showed a strong significant association, as 84.1% mothers with sleep deprivation had EPDS score ≥ 13 and 76.2% had moderate anxiety. Infant death was significantly associated with depression but not with anxiety.

Table 1: Distribution of participants according to baseline characteristics

Characteristic	Status	N	%
Parity	Primigravida	47	47.0
	Primipara	39	39.0
	Multipara	14	14.0
Education	Illiterate	1	1.0
	Preschool	19	19.0
	School	28	28.0
	Graduate	52	52.0
Economic status	Post graduate	0	0.0
	Upper lower	32	32.0
	Lower middle	51	51.0
	Upper middle	17	17.0
Age group	18–25 years	43	43.0
	26–35 years	45	45.0
	36–45 years	12	12.0

[Table 5] showed the association of MSPSS score and anxiety with EPDS score. Depression was highest

among mothers with low social support, where 97.9% had EPDS score ≥ 13 . Among mothers with moderate

support, 62.5% had EPDS score ≥ 13 , while only 11.4% mothers with high support had EPDS score ≥ 13 . This association was statistically significant. Anxiety was also significantly associated with EPDS score, as all mothers with moderate anxiety had EPDS score ≥ 13 , while only 12.2% mothers with mild anxiety had EPDS score ≥ 13 .

[Table 6] showed the association of MSPSS score with anxiety and logistic regression of significant variables associated with EPDS. Moderate anxiety was highest among mothers with low social support

95.8%, followed by moderate support 37.5% and high support 4.5%, showing a statistically significant association. On logistic regression, low social support was strongly associated with EPDS score with an AOR of 589.669, while moderate support also showed significant association with an AOR of 12.570. Sleep deprivation was also significantly associated with EPDS score with an AOR of 33.902. Economic status and complication of infants were not significant predictors in logistic regression.

Table 2: Association of socio-demographic characteristics with EPDS score and anxiety

Characteristic	Status	EPDS <13 N (%)	EPDS ≥ 13 N (%)	P value	Mild anxiety N (%)	Moderate anxiety N (%)	P value
Parity	Primigravida	15 (31.9)	32 (68.1)	0.074	17 (36.2)	30 (63.8)	0.036*
	Primipara	22 (56.4)	17 (43.6)		25 (64.1)	14 (35.9)	
	Multipara	6 (42.9)	8 (57.1)		7 (50.0)	7 (50.0)	
Education	Illiterate	1 (100.0)	0 (0.0)	<0.001*	1 (100.0)	0 (0.0)	<0.001*
	Preschool	0 (0.0)	19 (100.0)		0 (0.0)	19 (100.0)	
	School	9 (32.1)	19 (67.9)		9 (32.1)	19 (67.9)	
Economic status	Graduate	33 (63.5)	19 (36.5)		39 (75.0)	13 (25.0)	
	Upper lower	8 (25.0)	24 (75.0)	<0.002*	9 (28.13)	23 (71.88)	<0.001*
	Lower middle	22 (43.14)	29 (56.86)		24 (47.06)	27 (52.94)	
	Upper middle	13 (76.47)	4 (23.53)		16 (94.12)	1 (5.88)	

Pearson Chi-square test; *P value <0.05.

Table 3: Association of obstetric, medical and family history with EPDS score and anxiety

History	Status	EPDS <13 N (%)	EPDS ≥ 13 N (%)	P value	Mild anxiety N (%)	Moderate anxiety N (%)	P value
H/O abortion	No	30 (49.2)	31 (50.8)	0.149	33 (54.1)	28 (45.9)	0.224
	Yes	13 (33.3)	26 (66.7)		16 (41.0)	23 (59.0)	
H/O comorbid illness	No	20 (54.1)	17 (45.9)	0.098	21 (56.8)	16 (43.2)	0.301
	Yes	23 (36.5)	40 (63.5)		28 (44.4)	35 (55.6)	
H/O ectopic	No	39 (47.0)	44 (53.0)	0.107	43 (51.8)	40 (48.2)	0.289
	Yes	4 (23.5)	13 (76.5)		6 (35.3)	11 (64.7)	
Previous CS	No	35 (43.2)	46 (56.8)	1.00	37 (45.7)	44 (54.3)	0.207
	Yes	8 (42.1)	11 (57.9)		12 (63.2)	7 (36.8)	
Infertility	No	41 (54.7)	34 (45.3)	<0.001*	44 (58.7)	31 (41.3)	0.001*
	Yes	2 (8.0)	23 (92.0)		5 (20.0)	20 (80.0)	
Family alcoholism	No	40 (67.8)	19 (32.2)	<0.001*	43 (72.9)	16 (27.1)	<0.001*
	Yes	3 (7.3)	38 (92.7)		6 (14.6)	35 (85.4)	
Family psychiatric illness	No	41 (55.4)	33 (44.6)	<0.001*	46 (62.2)	28 (37.8)	<0.001*
	Yes	2 (7.7)	24 (92.3)		3 (11.5)	23 (88.5)	

Fisher's exact test; *P value <0.05.

Table 4: Association of psychosocial, pregnancy and infant-related factors with EPDS score and anxiety

Factor	Status	EPDS <13 N (%)	EPDS ≥ 13 N (%)	P value	Mild anxiety N (%)	Moderate anxiety N (%)	P value
Poor relationship with parents	No	43 (75.4)	14 (24.6)	<0.001*	47 (82.5)	10 (17.5)	<0.001*
	Yes	0 (0.0)	43 (100.0)		2 (4.7)	41 (95.3)	
Marital violence	No	43 (65.2)	23 (34.8)	<0.001*	49 (74.2)	17 (25.8)	<0.001*
	Yes	0 (0.0)	34 (100.0)		0 (0.0)	34 (100.0)	
Planned pregnancy	No	17 (28.8)	42 (71.2)	0.001*	19 (32.2)	40 (67.8)	<0.001*
	Yes	26 (63.4)	15 (36.6)		30 (73.2)	11 (26.8)	
Caesarean	No	37 (51.4)	35 (48.6)	0.007*	39 (54.2)	33 (45.8)	0.121
	Yes	6 (21.4)	22 (78.6)		10 (35.7)	18 (64.3)	
Complication of infants	No	35 (54.7)	29 (45.3)	0.002*	39 (60.9)	25 (39.1)	0.002*
	Yes	8 (22.2)	28 (77.8)		10 (27.8)	26 (72.2)	
Infant with anomaly	No	43 (45.3)	52 (54.7)	0.068	48 (50.5)	47 (49.5)	0.363
	Yes	0 (0.0)	5 (100.0)		1 (20.0)	4 (80.0)	
Sleep deprivation	No	33 (89.2)	4 (10.8)	<0.001*	34 (91.9)	3 (8.1)	<0.001*
	Yes	10 (15.9)	53 (84.1)		15 (23.8)	48 (76.2)	
Infant death	No	43 (46.2)	50 (53.8)	0.019*	48 (51.6)	45 (48.4)	0.112
	Yes	0 (0.0)	7 (100.0)		1 (14.3)	6 (85.7)	

Fisher's exact test; *P value <0.05.

Table 5: Association of MSPSS score and anxiety with EPDS score

Factor	Status	EPDS <13 N (%)	EPDS ≥13 N (%)	P value
MSPSS score	Low support	1 (2.1)	47 (97.9)	<0.001*
	Moderate support	3 (37.5)	5 (62.5)	
	High support	39 (88.6)	5 (11.4)	
Anxiety	Mild	43 (87.8)	6 (12.2)	<0.001*
	Moderate	0 (0.0)	51 (100.0)	

Table 6: Association of MSPSS score with anxiety and logistic regression of significant variables associated with EPDS

Factor	Status	Mild anxiety N (%)	Moderate anxiety N (%)	P value	AOR	95% CI of AOR	P value
MSPSS score	Low support	2 (4.2)	46 (95.8)	<0.001*	589.669	21.924–15860.036	<0.001*
	Moderate support	5 (62.5)	3 (37.5)		12.570	1.294–122.096	
	High support	42 (95.5)	2 (4.5)		Reference	—	
Economic status	Upper lower	—	—	—	Reference	—	—
	Lower middle	—	—	—	1.838	0.153–22.137	0.630
	Upper middle	—	—	—	4.647	0.238–90.635	0.311
Complication of infants	No	—	—	—	Reference	—	—
	Yes	—	—	—	1.712	0.270–10.843	0.590
Sleep deprivation	No	—	—	—	Reference	—	—
	Yes	—	—	—	33.902	3.120–368.403	0.003*

DISCUSSION

The present study included 100 mothers with preterm birth, of whom 47.0% were primigravida, 39.0% were primipara and 14.0% were multipara. Most participants were graduates 52.0%, followed by school education 28.0%, preschool education 19.0% and illiterate 1.0%. In relation to socioeconomic status, 51.0% belonged to lower middle class, 32.0% to upper lower class and 17.0% to upper middle class. Most mothers were in the age group of 26–35 years 45.0%, followed by 18–25 years 43.0%. These findings showed that postpartum psychological morbidity in the present study was seen mainly among young and socioeconomically vulnerable mothers. Shivalli et al. (2015) also conducted a study among rural postnatal women in South India and reported postnatal depression in 31.4% of women, with poverty and pregnancy complications or known medical illness as important predictors. In their study, poverty had an adjusted odds ratio of 11.95 and pregnancy complications or medical illness had an adjusted odds ratio of 17.4, showing that socioeconomic and obstetric vulnerability increased the risk of postnatal depression.^[7] In the present study, parity was not significantly associated with EPDS score, although depression was more common among primigravida mothers 68.1%, followed by multipara 57.1% and primipara 43.6%. However, parity was significantly associated with anxiety, where moderate anxiety was highest among primigravida mothers 63.8%. Education and economic status were significantly associated with both depression and anxiety. All mothers with preschool education had EPDS score ≥13 and moderate anxiety, while among graduates, 36.5% had EPDS score ≥13 and 25.0% had moderate anxiety. Similarly, EPDS score ≥13 was highest among upper lower class mothers 75.0% and lowest among upper middle class mothers 23.53%. Dadhwal et al. (2023) in a rural Indian community-based study of 680 postpartum women found that the overall prevalence

of postpartum depression, anxiety or both was 5.6%, and lower socioeconomic status increased the risk with odds ratio 2.7. They also reported that illiteracy in women and spouses, family history of substance use and primiparity were important risk factors, while higher education and better social support reduced the risk.^[8] In the present study, history of abortion, comorbid illness, ectopic pregnancy and previous caesarean section were not significantly associated with EPDS score or anxiety. However, infertility was significantly associated with both depression and anxiety, as 92.0% of mothers with infertility had EPDS score ≥13 and 80.0% had moderate anxiety. Family history of alcoholism was also significantly associated, with 92.7% having EPDS score ≥13 and 85.4% having moderate anxiety. Similarly, family history of psychiatric illness was significantly associated, with 92.3% having EPDS score ≥13 and 88.5% having moderate anxiety. Tebeka et al. (2021) in the IGEDEPP cohort of 3310 women reported early-onset postpartum depression in 8.3%, late postpartum depression in 12.9% and one-year cumulative incidence of postpartum depression in 18.1%. They also reported that 47.5% of women had a history of at least one psychiatric or addictive disorder, mainly depressive disorder 35%, supporting the role of psychiatric and addictive vulnerability in postpartum depression.^[9] The present study showed a strong association of psychosocial factors with depression and anxiety. All mothers with poor relationship with parents had EPDS score ≥13, and 95.3% had moderate anxiety. Similarly, all mothers with marital violence had EPDS score ≥13 and moderate anxiety. These findings indicated that poor family relationship and violence were major psychosocial contributors to postpartum psychological morbidity in mothers with preterm birth. Adamu et al. (2018) conducted a facility-based study among 618 Ethiopian postpartum women and reported postpartum depression symptoms in 23.3% of women. They found that domestic violence increased the odds of postpartum depression by 3.1

times, previous diagnosis of postpartum depression increased the odds by 4.41 times and dissatisfaction with marriage increased the odds by 2.9 times.^[10] Pregnancy and infant-related factors also showed significant association in the present study. Unplanned pregnancy was significantly associated with depression and anxiety, with 71.2% having EPDS score ≥ 13 and 67.8% having moderate anxiety. Caesarean delivery was significantly associated with depression, as 78.6% of mothers who underwent caesarean delivery had EPDS score ≥ 13 . Infant complications were significantly associated with both depression and anxiety, with 77.8% having EPDS score ≥ 13 and 72.2% having moderate anxiety. Sleep deprivation showed a strong association, as 84.1% of mothers with sleep deprivation had EPDS score ≥ 13 and 76.2% had moderate anxiety. Infant death was significantly associated with depression, with all mothers having EPDS score ≥ 13 . Reddy et al. (2020) studied 229 postnatal women in rural Srikakulam district and reported postnatal depression in 28.3% using EPDS score ≥ 13 . They found significant association of postnatal depression with socioeconomic status, mode of delivery, gender of newborn and complications in pregnancy, which was comparable with the present study findings regarding economic status, caesarean delivery and infant complications.^[11] The present study showed a significant association between perceived social support and depression. Among mothers with low social support, 97.9% had EPDS score ≥ 13 , while among mothers with moderate support, 62.5% had EPDS score ≥ 13 . In contrast, only 11.4% of mothers with high social support had EPDS score ≥ 13 . This showed a clear protective effect of higher social support against postpartum depression. Taştan et al. (2018) conducted a cross-sectional study among 110 mothers and reported that 47.3% of mothers had EPDS scores above the cutoff. They found mean EPDS score of 12.0 ± 4.7 and mean MSPSS score of 58.3 ± 13.0 , with a significant negative correlation between EPDS and MSPSS scores ($r = -0.42$, $p < 0.001$). This was similar to the present study, where low MSPSS score was strongly associated with higher EPDS score.^[12] The present study also showed a significant association between anxiety and depression. All mothers with moderate anxiety had EPDS score ≥ 13 , while only 12.2% of mothers with mild anxiety had EPDS score ≥ 13 . Social support was also significantly associated with anxiety, as moderate anxiety was present in 95.8% of mothers with low support, 37.5% with moderate support and only 4.5% with high support. Shetty et al. (2024) conducted a systematic review and meta-analysis on parents of neonates admitted to neonatal intensive care units and reported that mothers had high psychological morbidity, with pooled anxiety around 51%, depression 31% and stress 41%. This finding supported the present study, where mothers with preterm babies showed high anxiety and depression, especially when social support was poor.^[13] On logistic regression in the present study, low social

support remained the strongest predictor of EPDS score, with AOR 589.669, while moderate support was also significantly associated with EPDS score with AOR 12.570. Sleep deprivation also remained significantly associated with EPDS score with AOR 33.902. Economic status and infant complications were significant in bivariate analysis but did not remain significant predictors in logistic regression. Hergüner et al. (2013) compared mothers of very low birth weight, low birth weight and term infants and reported that mothers of very low birth weight infants had higher EPDS scores and lower perceived social support. They found high EPDS scores in 43% of mothers of very low birth weight infants, and EPDS score was negatively correlated with social support while positively correlated with duration of hospital stay. This supports the present study finding that low social support and stress related to preterm infant care were important determinants of postpartum depression.^[14]

CONCLUSION

Postpartum depression and anxiety were common among mothers with preterm birth. Low social support was significantly associated with higher levels of depression and anxiety. Psychosocial factors such as poor relationship with parents, marital violence and family history of psychiatric illness further increased psychological distress. Early screening and strengthening of family and social support may help in timely identification and prevention of postpartum depression and anxiety.

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