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Psychosocial Factors affecting Risk of Postpartum Depression among Mothers and their Birth Satisfaction: A Systematic Review

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Abstract

Introduction: Negative birth experiences have been associated with an increased risk of Postpartum Depression (PPD). However, an exhaustive systematic analysis of existing literature examining this correlation is lacking. This systematic review investigates the association between birth satisfaction and the likelihood of PPD. Additionally, it seeks to identify modifiable psychosocial factors influencing this relationship by conducting a systematic analysis of existing literature.
Method: A systematic review of studies (2010–2024) was conducted using three databases per PRISMA guidelines. The study was conducted in three stages. The review focused on studies analyzing PPD, birth satisfaction, or both, with searches using a variety of relevant terms and limited to English-language publications.
Results: Twenty-one studies meeting the inclusion criteria were analyzed. A significant correlation was found between PPD and birth dissatisfaction. Furthermore, psychosocial factors such as social support, maternal self-esteem, and healthcare facilities were also identified as crucial factors influencing PPD and birth satisfaction.
Conclusion: Improving maternal care practices, ensuring respectful and compassionate support during childbirth, and addressing the psychosocial factors that influence birth satisfaction are essential for reducing the risk of PPD.

Keywords: Postpartum Depression, Birth Satisfaction, Healthcare Facilities; Social Support, Pregnant, Psychosocial Factors

Introduction

Women experience significant physiological and psychological changes throughout the perinatal period, which spans from pregnancy to the first year following childbirth [1]. Due to the various influences on this critical reproductive phase, women often have highly divergent experiences during pregnancy and the postpartum period. While some women maintain their health and psychosocial well-being, others face considerable challenges. For instance, up to 25% of women report dissatisfaction with their labor and delivery experiences [2]. Moreover, Postpartum Depression (PPD) affects approximately 20% of new mothers, potentially impairing both child development and the mother-infant bond [3].
The term birth satisfaction refers to a woman's overall feeling of well-being, contentment, and fulfilment after childbirth. It includes psychological, physiological, and emotional aspects related to the labor and delivery process. Expectations regarding childbirth differ among women, as do the levels of support they receive from family, friends, and healthcare providers [4,5]. Common expectations include being treated with respect, having comfort prioritized, being listened to, receiving desired pain relief, coping effectively during labor,

feeling in control, being well-prepared, avoiding major obstetric injuries, and achieving the preferred method of delivery. A positive birth experience can enhance a woman's self-esteem, foster a successful transition to motherhood, and contribute to personal development [6]. Conversely, a negative birth experience may lead to adverse health outcomes, including PPD, anxiety regarding future pregnancies, and a preference for cesarean delivery in subsequent pregnancies, or a reluctance to become pregnant again [7,8].

Martin et al. identified three core areas of childbirth satisfaction, which they incorporated into an effective measurement tool-Birth Satisfaction Scale (BSS) [9]:

i. Provision of services (e.g., home examination, birthing environment, support from medical professionals),

ii. Individual characteristics (e.g., coping skills, sense of control, preparedness for childbirth, bonding with the child), and

iii. The stressors encountered during labor (e.g., anxiety, obstetric injuries, quality of medical attention, obstetric interventions, pain, prolonged labor, and the health of the baby).

Patient satisfaction is widely regarded as one of the most important elements in the evaluation and improvement of healthcare services [10]. Assessing women's satisfaction with their childbirth experience can offer valuable insights into potential areas for service improvement. It can also help identify high-risk scenarios where dissatisfaction could contribute to negative health outcomes, including PPD [11]. Birth satisfaction is multifaceted, with women evaluating the events that occurred during labor in conjunction with these key factors [11]. Taheri et al. [12] identified maternal support, minimal interventions during labor, and thorough birth preparedness as critical factors contributing to positive childbirth experiences. Interestingly, pain management and relaxation techniques were not included in this group. Funai et al. [13] argue that the quality of the caregiver-patient relationship, particularly in terms of respect, communication, continuity of care, and shared decision-making, is one of the most significant factors influencing birth satisfaction. Similarly, Hildingsson et al. [14] found that personalized, high-quality care during labor is strongly correlated with higher levels of birth satisfaction. Consequently, satisfaction with childbirth is considered as a vital component of obstetric care. Around 2–4% of women experience Post-Traumatic Stress Disorder (PTSD) following childbirth, a condition closely linked to their level of satisfaction with the birth experience [15,16].

Promoting positive birth experiences can help prevent postpartum psychological trauma. Recognizing the importance of promoting positive childbirth experiences, the World Health Organization (WHO) has established global guidelines for postpartum care aimed at fostering positive experiences. The WHO [17] notes that implementing practices such as allowing mothers to choose a support person not employed by the hospital is directly linked to reduced rates of PPD.

PPD is a medical condition diagnosed based on specific criteria outlined in the International Classification of Diseases (ICD). Primary symptoms include mood disturbances, loss of interest in daily activities, fatigue, difficulties with concentration, excessive concern for the child, feelings of sadness, frequent crying, indecision, reduced libido, appetite changes, sleep disturbances, and, in severe cases, thoughts of death or suicide [18].

PTSD can also impair the mother-infant relationship [15]. Maternal PTSD is associated with lower self-esteem, reduced infant birth weight, breastfeeding challenges, and decreased sexual desire. Symptoms of maternal PTSD are also a predictor of PPD [16].

Depression is a clinical condition characterized by a combination of negative emotions (e.g., sadness, worthlessness), negative thoughts about oneself (e.g., guilt, self-blame), negative beliefs regarding personal control over life outcomes (e.g., helplessness, hopelessness), and physical symptoms (e.g., fatigue, appetite loss, sleep disturbances) (The American Congress of Obstetricians and Gynecologists (ACOG)) [19].

Numerous scholarly studies consistently demonstrate that negative childbirth experiences are a significant predictor of an increased likelihood of developing postpartum depression [20,21,22]. Psychosocial stressors, including insufficient social support and low maternal self-esteem, are also reliable predictors of PPD, as documented in studies by Beck [23], O'Hara [24], and Robertson et al. [25]. The global prevalence of PPD is estimated to be approximately 17%, with considerable variation across countries [26]. Factors such as birth dissatisfaction, stress, and lack of social support play a critical role in the onset of PPD. Additionally, other factors such as the number of previous pregnancies, mode of delivery, and an individual's mental health history may also contribute to the development of PPD [27]. The Edinburgh Postnatal Depression Scale (EPDS) is frequently used as a standardized screening tool for PPD.

It is a fact that the vast majority of women become pregnant at least once in their lives. Women's mental health during pregnancy has broad and enduring consequences for both women and their children. Psychological factors influence pregnancy and have long-term implications for fetal difficulties during pregnancy [28,29]. Therefore, it seems highly relevant to investigate psychological changes during pregnancy [30,31]. So, in light of existing research, the objective of this comprehensive and analytical study is to explore the connections between birth satisfaction and PPD. Additionally, this study aims to identify modifiable factors that could influence this relationship.

Method

This review was conducted in compliance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines [32]. Only peer-reviewed journal articles published between 2010 and 2024 were eligible for inclusion. Articles needed to meet the established inclusion criteria to be considered. Among them, only studies available in full text and published in English were included in the review. We searched three electronic databases—PubMed, CINAHL, and PsycINFO—

using Medical Subject Headings (MeSH), a controlled vocabulary thesaurus from the National Library of Medicine that standardizes biomedical literature indexing. Search terms included various combinations of "postpartum or pregnant," "maternal well-being," "birth satisfaction," "Postpartum depression," "Childbirth experience," and "Postnatal health". Boolean operators were employed to combine these terms, ensuring comprehensive retrieval of relevant studies. To be considered for inclusion, studies had to meet the following criteria:

- Provide original research in either qualitative or quantitative form, examining the relationship between PPD and a woman's childbirth experience, either through correlational analysis or as a part of broader research design.
- The Salutogenic approach given by Antonovsky, in 1996 [33] is particularly useful in maternity care. Considering this feedback of provided care and understanding experience from the mother's perspective is at the core of our research process to improvise on need-based intervention. So, we are only including studies that provided original data gathered either during pregnancy or both during pregnancy and postpartum, with a focus on maternal outcomes rather than solely infant outcomes.
- Employ qualitative or quantitative methodologies to evaluate PPD, birth satisfaction, or both.
- Published in peer-reviewed English-language journals.

The PRISMA approach was utilized to identify records through a comprehensive database search. After study inclusion, data were synthesized qualitatively (for qualitative studies) and quantitatively (for studies reporting numerical data). For the quantitative studies, standardized effect sizes (Cohen's d) and heterogeneity measures (I^2) were calculated, while qualitative data were analyzed thematically. The review followed a three-phase process of abstract screening, title screening, and full-text assessment to ensure methodological rigor. Studies focusing exclusively on the delivery method or other childbirth features, rather than the subjective experiences of women, were excluded. A total of 207 records were initially retrieved and supplemented by four additional records from other sources. After duplicate removal, 136 records remained. Specific limits reduced the count to 98. The titles and abstracts were screened, resulting in 63 records being reviewed, while 35 were excluded. Additionally, a manual examination of reference lists was conducted to identify any overlooked studies. Reference list searches added seven more records, bringing the total to 70. These studies were screened and evaluated based on the inclusion criteria. The screening process was carried out by two independent reviewers. Disagreements during the screening phases were resolved through discussion or consultation with a third reviewer. After 33 records were excluded due to insufficient data, 37 full-text articles were deemed eligible for further evaluation. Ultimately, 21 studies were included in the quantitative synthesis, while 16 articles excluded for various reasons. The process can be visualized in the following PRISMA flowchart (Figure 1).

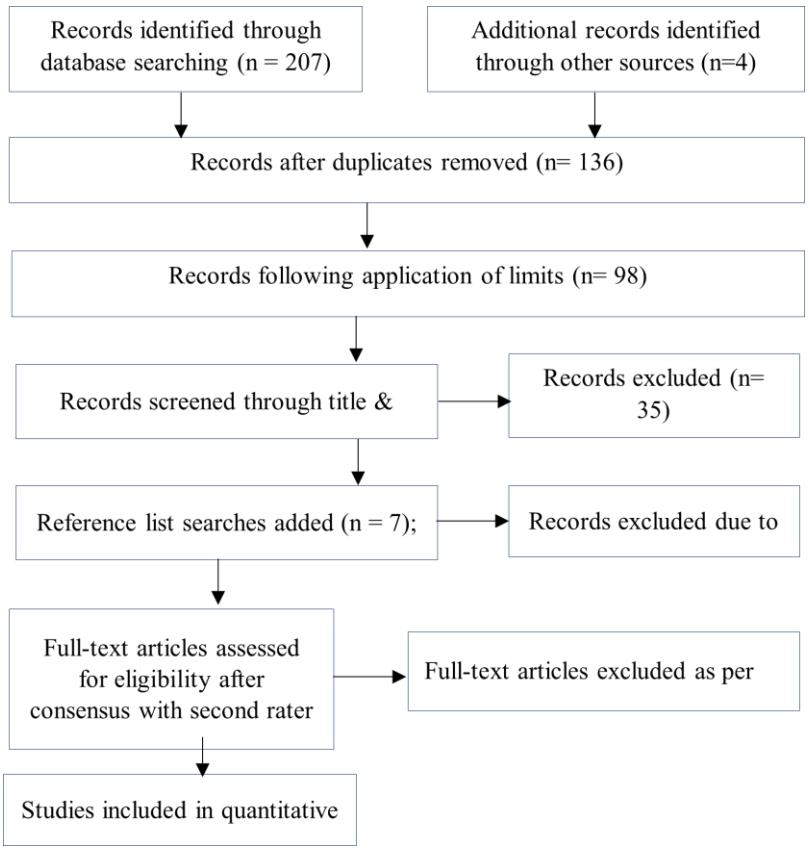

Figure 1. PRISMA flowchart for study identification and selection process.

Results

The years of publication varied from 2010 to 2024 containing 21 studies for final review. Several screening instruments and evaluation metrics were employed in various research, The Birth Satisfaction Scale (BSS), Birth Satisfaction Scale-Revised (BSS-R), and Birth Satisfaction Scale-Revised Indicator (BSS-RI) which are versions of the same scale were the most widely used instruments to measure birth satisfaction. Babies Born Better (B3) Survey, A 5-part questionnaire composed of demographic and obstetrics details Mackey's Childbirth Satisfaction Rating Scale (CSRS), and Childbirth Experience Questionnaire (CEQ) were also used.

For PPD, the most popular screening instrument was the Edinburgh Postnatal Depression Scale (EPDS) apart from some other scales.

Table 1 presents an overview of the features and findings of the research that were a part of the systematic review:

Table 1. Characteristics and Results of Studies included in the Systematic Review

Sr No.	Author	Objective	Sample	Measures	Findings
1.	Martin et al. (2011) [34]	To state the BSS's validity, reliability, and factor structure and develop a short version of the tool.	(n=228)	BSS-R	BSS-R is a valid, reliable, robust, and trustworthy tool. It is suitable for both domestic and international use.
2.	Urbanová et al.'s (2021) [35]	To examine the association between birth satisfaction and the risk of postpartum depression (PPD).	(n=584), women during 2 to 4 days postpartum	BSS EPDS Perceived Stress Scale (PSS)	Lower satisfaction with childbirth was associated with an increased risk of developing PPD.
3.	Tiwari, et.al, (2022) [36]	To translate the UK-BSS-R into Hindi, and psychometrically validate it on the Indian population.	(n = 312) postnatal Hindi speaking women in India	(Hindi)-BSS-R	It expands the cultural relevance of BSS within the Indian population by highlighting contextual aspects of the birth experience
4.	Luegmair et al. (2018) [37]	To evaluate women's satisfaction with care at the birthplace in Austria and to contribute data for cross-country comparisons within the international Babies Born Better project.	(n=539) women who had given birth in Austria within the last five years	Babies Born Better (B3) Survey	Positive experiences were mainly experienced as individuality in care. Negative experiences were related to issues of the existing infrastructure, breastfeeding counseling, etc.
5.	Martin et al. (2017) [38]	To streamline the instrument to create the BSS-RI.	NA	BSS-RI	Developing a brief and simple-to-administer, a shorter measure that assesses clinical service of delivery through the experience of women in the birth experience.
6.	Fleming et al. (2016) [39]	To confirm high birth satisfaction rates and the effectiveness of the BSS-R for women who gave birth at home or in a birth center.	(n=2229) childbearing women	BSS-RI	Satisfaction was higher for women with vaginal births compared with cesarean deliveries. BSS-RI is an important tool in promoting person-centered maternal healthcare.
7.	Jafari et al. (2017) [40]	Aims to address factors related to women's childbirth satisfaction in physiological and routine childbirth groups.	(n=340) childbearing women	A 5-part questionnaire composed of demographic and obstetrics details Mackey's Childbirth Satisfaction Rating Scale (CSRS), satisfaction with birth setting, Labor Agentry Scale (LAS), and Visual Analogue Scale (VAS)	To conclude a number of elements contribute to the happiness of childbirth, including better birth room environments, mothers' participation in labor, Birth satisfaction, and a sense of control.
8.	Maskálová et al. (2021) [41]	To understand the obstetric and socio-demographic aspects of satisfaction with childbirth	(n=161) primiparous women	Childbirth Experience Questionnaire (CEQ)	Highlight the significance of providing high-quality treatment (management of labor pain relief, improving and promoting professional support provided by midwives) and positive birthing experiences (promoting active participation of mothers during

					childbirth, supporting spontaneous vaginal delivery).
9.	Konieczka et al. (2024) [42]	To evaluate and determine the factors influencing women's satisfaction with their delivery experiences.	(n=275) childbearing women	Self-designed survey questionnaire	The highest levels of satisfaction was related to the best delivery facilities and favorable relations with medical professionals.
10.	Silverman et al. (2017) [43]	To examine the impact of history of depression on PPD and pre- and perinatal risk factors.	Nationwide cohort study	Diagnostic history	Women with history of depression are over 20 times more likely to experience post-traumatic stress disorder (PTSD). Gestational diabetes also raises the risk of PPD.
11.	Upadhyay et al. (2017) [44]	To estimate the prevalence of PPD in Indian mothers and associated risk factors.	(n=427) postnatal women in India	EPDS	Reported risk factors for PPD included economic difficulties, domestic violence, previous history of psychiatric illness, marital conflict, lack of spousal support, and birth of a girl child. It advocated for more funding for the treatment of maternal mental health issues
12.	Van et al. (2021) [45]	To identify both distinct and overlapping risk factors for anxiety and PPD.	(n= 1406) women at 3 weeks and 12 months postpartum	EPDS and State-Trait Anxiety Inventory (STAI-6)	Factors associated with a higher risk of depression are: a history of depression, low maternal self-efficacy, and poor health of the mother. Factors associated with a higher risk of anxiety are: higher educational level, history of depression, preterm birth, negative experience of delivery and first week postpartum, excessive infant crying, low maternal self-efficacy, low partner support and poor current maternal health.
13.	Li et al. (2017) [46]	To examine the vital association between depression and social support	(n=240) pregnant woman during the perinatal stage.	EPDS and Perceived Social Support Scale	Women's perceptions of social support and risk of PPD differed depending on the stage of the perinatal period and that social support was a major buffer against depression at every stage.
14.	Cardoso and Fonseca (2023) [47]	Examining the progression of anxiety and depressive symptoms in mothers with high risk for PPD from 3-4 months to 9-11 months postpartum and understanding difficulty in emotional regulation when faced with such conditions.	(n=156 women in the postpartum period)	Instruments accessing constructs of depressive, anxiety symptoms, emotion regulation difficulties	30% of mothers had depressive and anxious symptoms in comorbidity. Emotion regulation difficulties are significantly related to depressive and anxiety symptoms.
15.	Yim et al. (2015) [48]	A systematic review of research published from 2000 through 2013 on biological and psychosocial factors associated with PPD.	(n = 214 publications based on 199 investigations of 151,651 women in the first postpartum year	NA	The strongest biological risk predictors for PPD are hypothalamic-pituitary-adrenal dysregulation, inflammatory processes, and genetic vulnerabilities. Among psychosocial factors, the strongest risk predictors are severe life events, some forms of chronic strain, relationship quality, and low support from partner and mother.
16.	Abdollahi et al. (2018) [49]	Longitudinal study for assessing effects of PPD on Iranian women's health.	(n=1801 pregnant women without depression at 32–42 weeks of pregnancy)	EPDS, GHQ	Found that four years after birth, women who suffered PPD were more likely to suffer from depression and other physical and mental health concerns, so appropriate and early interventions are required.
17.	Batt et al. (2020) [50]	Evidence diagnostic distinction for PPD from depression	NA	NA	PPD occurring in the early postpartum period differed from

		concerning epidemiology, etiology, and treatment			depression in symptom severity, heritability, and epigenetic data suggesting PPD as distinct, whereas depression occurring in the later postpartum period was more similar to major depressive disorder occurring outside of the perinatal period.
18.	Martínez-Borba et al. (2020) [51]	Longitudinal Study examining biopsychosocial correlates of PPD	(n = 266, weeks 16-36 during pregnancy) (n = 101, weeks 2-4 during Postpartum)	MMF website was used to collect socio-demographic and biopsychosocial online	Biopsychosocial factors such as age, affective ambivalence, personality characteristics, social support, and depression are associated with concurrent depression during pregnancy, but the stability of depression over time declined.
19.	Yakupova & Suarez (2021) [52]	To examine the relationship between risk of PPD and birth experience, in Russia.	(n=190) ages 19 to 46, two months post-delivery.	Russian version of EPDS and BSS-RI	Emphasizing on experience of birth satisfaction to minimize risk of PPD and that individualized expert support throughout labor can help mothers in their experience.
20.	Ďuríčeková et al. (2024) [53]	To examine risk variables for PPD and symptoms of post-traumatic stress disorder (PTSD) in Slovak women.	(n=437) postpartum women	EPDS, City BiTS	Subjective views of birth, birth satisfaction, past trauma in anamnesis, and a lack of respect during childbirth are important risk factors for both PPD and PTSD.
21.	Dennis et al. (2024) [54]	Narrative review, providing a summary of PPD, examining the etiology and consequences, pharmacological and psychological treatments, and potential mechanisms of change and current barriers to care.	NA	NA	To collaborative care models, task-sharing with non-specialist clinicians, and virtual care are ways to improve accessibility and address the growing burden of PPD.

It is important to assess women's mental health during pregnancy and its impact on birth outcomes [55]. Its vulnerability interacts reciprocally with the environment, shaping the organism's responses to environmental challenges and being shaped by stressors and positive experiences over the life span. Very few studies have attempted to examine these integrated models with various psychosocial factors operating simultaneously. Thus, understanding psychosocial factors may help in the timely identification of women at risk and allow for the development of targeted prevention strategies. See PRISMA Flowchart (Figure 1) for a detailed study selection process. Collectively, these studies underscore the pivotal role that birth satisfaction plays in preventing postpartum depression. When taken as a whole, these studies demonstrate the vital importance that supportive relationships, high-quality healthcare, and effective pain management have in influencing women's overall contentment and their happiness with birth experiences. The findings strongly advocate for a compassionate, respectful approach to childbirth care, as this directly contributes to improved maternal mental health and a reduced risk of PPD. The studies on PPD emphasize the complex character of postpartum depression, emphasizing the importance of emotion control, psychosocial factors, social support, and focused interventions to help affected women avoid long-term health implications. By providing comprehensive care, healthcare professionals can support mothers through the postpartum period, reducing the likelihood of PPD and improving their childbirth experiences.

Discussion

The perinatal period represents a critical phase in a woman's life, marked by profound biological, psychological, and social changes. Several physiological factors contribute to PPD among mothers and influence birth satisfaction. These include hormonal changes, stress levels, and health concerns for infants, each of which can impact a mother's mental health and overall satisfaction with her childbirth experience. During this sensitive period, many women become more vulnerable to emotional distress and depressive symptoms, particularly nulliparous women who face additional challenges such as the transition to parenthood. The reorganization of mental self-representation, along with the usual psychological and relational adjustments associated with pregnancy, can create unique obstacles. Women encountering difficulties in navigating this transition are more likely to experience depressive symptoms, which can persist long after childbirth [56].

This review indicates that PPD is a serious mental health condition that affects women after childbirth, characterized by feelings of sadness, hopelessness, and emotional numbness. It can have a profound impact on a mother's ability to care for herself and her baby and is often influenced by factors such as low Socioeconomic Status (SES), inadequate social support, and early adverse

experiences [44]. Women who experience depression for the first time in the postpartum period are frequently those with histories of childhood maltreatment or poor-quality relationships during childhood. Factors such as low education levels, financial difficulties, poor housing conditions, and lack of support from spouses or significant others [45] have also been associated with PPD. Many mothers, especially those experiencing depression for the first time, do not receive timely psychiatric care, highlighting a significant gap in maternal mental health services. Research has shown that mothers with PPD often report negative childhood experiences [57]. Childbirth can trigger unresolved trauma from early life, which may influence emotional regulation and interpersonal behaviors later in life.

In these studies, age has emerged as a critical factor influencing birth satisfaction. Older women report higher levels of satisfaction with their childbirth experiences compared to younger mothers. This finding suggests that older women may have more realistic and attainable expectations of childbirth, while younger mothers may experience diminished self-efficacy and personal control due to limited life experience. Consequently, younger mothers tend to report lower satisfaction with their delivery experiences.

Similarly, multiparous women, those who have given birth to more than one child, consistently report higher levels of satisfaction with childbirth compared to primiparous women, who are giving birth for the first time [58]. Multiparous women may have a greater sense of control and familiarity with the birthing process, which contributes to their overall satisfaction.

Several psychological factors have been identified as cross-sectional predictors of prenatal depressive symptoms. These include age, neuroticism, affective ambivalence, and negative affect, all of which have been associated with increased risk for depressive symptoms during the perinatal period. In contrast, positive affect has been shown to serve as a protective factor against concurrent depressive symptoms, reinforcing the notion that psychological resilience plays a crucial role in mitigating prenatal depression.

Beyond these established risk factors, the present review also examined two additional variables with potentially protective effects against prenatal depression: extraversion and positive affect. Neuroticism, which refers to a tendency toward negative emotional states like anxiety and irritability, has been linked to an increased risk of PPD [59]. This trait may make women more vulnerable to stress during pregnancy and childbirth, thus increasing their likelihood of experiencing depressive symptoms in the postpartum period. On the other hand, positive affect, defined as the tendency to experience positive emotions like joy and contentment, has been shown to buffer against depressive symptoms by promoting greater emotional resilience confirming its protective role. Previous studies have often linked extraversion with lower levels of emotional distress due to its association with greater social engagement and positive social interactions. However, extraversion did not emerge as a significant factor in this review. This finding is somewhat unexpected, given previous studies that have linked extraversion to lower levels of emotional distress. One possible explanation for this discrepancy could be the particular characteristics of the sample population in this review. The participants in this study were predominantly well-educated adults, most of whom reported being in committed relationships. Given that this group might have had access to stronger social support networks, it is possible that extraversion, which is often tied to social engagement, did not play as critical a role as it might in more vulnerable populations with lower levels of structural social support.

Social support, typically defined as emotional, informational, and instrumental assistance, is often a key buffer against stress and depressive symptoms during pregnancy. However, the influence of social support may vary across populations, depending on the individual's ability to access and mobilize these resources.

In this context, it is important to distinguish between structural social support (e.g., having family, friends, or community resources) and functional social support (e.g., the quality of emotional and instrumental help received). While both structural and functional social support are critical, their influence on maternal mental health during the perinatal period may depend on the context. For example, in populations with limited access to external resources, structural support (such as having family members or friends to rely on) might be more important. In contrast, women with better access to healthcare and community resources may benefit more from functional support, such as emotional and informational support from partners or healthcare providers. Therefore, the type of social support that is most effective in reducing PPD symptoms may vary depending on individual circumstances. Acknowledging the complexity of the social support concept and the nuanced understanding suggests that social support's impact on prenatal depressive symptoms might enrich the discussion and be contingent on both the individual's social environment and the quality of support received.

The findings of this study indicate that intrapersonal processes, such as experienced emotions and self-regulation, are more significant predictors of prenatal depressive symptoms than interpersonal factors like social support. Positive affect, in particular, may offer protection against depression by fostering greater psychological resilience and improving emotional regulation during pregnancy.

While this review highlights significant trends linking birth satisfaction and PPD, it is important to acknowledge that many of the studies included in this review have limitations, such as sample bias and reliance on self-reported measures. Future research should aim to include more diverse populations, should explore whether similar patterns of association exist in other demographic groups, particularly among those who may face greater social or economic adversity. They should focus on longitudinal designs, and use objective measures of mental health to validate the findings. Additionally, more attention should

be given to understanding the cultural and contextual factors that may shape maternal mental health across different settings. This would provide a more critical perspective on the review findings and will provide valuable insights into the broader applicability of these findings. This will help tailor interventions to support maternal mental health across various social contexts.

Conclusion

This systematic review provides a comprehensive analysis of the literature surrounding birth satisfaction and PPD, demonstrating a significant correlation between the two. The findings highlight that positive birth experiences are associated with a lower incidence of PPD, while negative experiences significantly elevate the risk of depression. The factors that contribute to a positive birth experience include high-quality care, supportive relationships with healthcare professionals, and effective pain management. On the contrary, inadequate pain relief, poor communication, and lack of emotional support are commonly associated with negative birth experiences, which in turn increase the likelihood of postpartum depression.

This review underscores the importance of personalized and respectful maternity care in improving birth satisfaction and reducing the risk of postpartum mental health issues. By focusing on these aspects, healthcare providers can foster better maternal mental health outcomes and create a more supportive environment for mothers during the postpartum period. The findings suggest that addressing both the psychosocial and clinical needs of mothers during childbirth is crucial for preventing PPD.

In conclusion, improving maternal care practices, ensuring respectful and compassionate support during childbirth, and addressing the psychosocial factors that influence birth satisfaction are essential for reducing the risk of PPD. The insights derived from this review provide a valuable foundation for developing targeted interventions aimed at supporting mothers and enhancing their postpartum experiences, thereby promoting better mental health and well-being for both mothers and their infants.

Conflict of Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Ethical Approval

The Ethics Committee IMS BHU has approved Ms. P.hD Mineshi's project on “Moderating effect of Social support on the relationship between Psychological factors and Birth outcomes for mothers in postpartum period.” This research paper is a part of the same project.

Declaration of Generative AI and AI-Assisted Technologies

During the preparation of this work, the authors used PubMed, CINAHL, and PsycINFO in order to organize a systematic review as per PRISMA. After using these tools, the authors reviewed and edited the content as needed and take full responsibility for the content of the publication.

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