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POSTPARTUM DEPRESSION FOLLOWING MATERNAL INTENSIVE CARE ADMISSION: A SYSTEMATIC REVIEW OF PREVALENCE AND OUTCOMES

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Abstract

Maternal admission to the intensive care unit (ICU) during pregnancy or the puerperium is a severe obstetric event with major physical and psychological sequelae, yet evidence on its psychological impact remains limited and difficult to compare. This study aimed to determine the prevalence of postpartum depression (PPD) after maternal ICU admission, identify its risk factors, and describe secondary psychological outcomes (post-traumatic stress disorder and anxiety) and mother–infant bonding. This systematic review followed the PRISMA 2020 guidelines, searching PubMed, Europe PMC, and OpenAlex for observational studies of women admitted to the ICU during pregnancy or up to 42 days postpartum. Three observational studies with a total of 569 participants from Turkey, Israel, and Colombia met the inclusion criteria. Positive PPD screening (EPDS ≥13) was found in 21.4% of mothers admitted to the maternal ICU only and 80.4% of mothers whose infants were also admitted to the neonatal ICU (versus 0.0% of controls; $p < 0.001$). PPD reached 51.6% at discharge and persisted at 12.5% at long-term follow-up (mean 2.3 years), with 10.9% meeting criteria for probable post-traumatic stress disorder. In hypertensive disorders of pregnancy, the prevalence of depression in the ICU reached 33.57%; depressive symptoms independently predicted ICU admission (adjusted OR = 4.83), yet only 7.3% of patients received a formal psychiatric evaluation. Maternal ICU admission is associated with a high and persistent burden of PPD, anxiety, post-traumatic stress disorder, and impaired mother–infant bonding, underscoring the need for systematic psychological screening and integrated mental health support.

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INTRODUCTION

Critical illness during pregnancy, childbirth, or the puerperium requiring admission to the intensive care unit (ICU) is a severe manifestation of maternal morbidity. Although advances in obstetric critical care have reduced maternal mortality, survivors often face substantial long-term physical and psychological sequelae. Postpartum depression (PPD) is a major psychiatric complication of childbirth characterized by persistent depressed mood, anhedonia, neurovegetative disturbances, and feelings of inadequacy. It impairs maternal recovery, disrupts infant development, and damages mother–infant bonding

(Cantellow et al., 2025; Dimcea et al., 2024; McAuliffe, 2017; Saharoy et al., 2023).

Although many studies have examined postpartum depression in general, research focusing specifically on women admitted to the maternal ICU remains limited. Differences in depression screening instruments, diagnostic criteria, and assessment time points make it difficult to compare findings across studies. Admission of the infant to the neonatal intensive care unit (NICU) may also influence maternal psychological outcomes. Beyond depression, these women may experience other psychological challenges, including post-traumatic stress disorder (PTSD), anxiety, reduced quality of life, and difficulties in forming a mother–infant bond. A comprehensive review is therefore needed to better understand the psychological impact of ICU admission on mothers (Manasyan et al., 2025; Mari et al., 2026).

Current research is limited by the small number of observational studies and by differences in the reasons women require ICU care, such as obstetric hemorrhage, hypertensive disorders of pregnancy (HDP), and sepsis. Follow-up periods also vary across studies, making it difficult to understand long-term psychological effects. In addition, most studies rely on self-administered screening questionnaires rather than formal clinical interviews to assess mental health conditions.

Based on these gaps, the research question of this review is: how prevalent is postpartum depression among mothers admitted to the ICU, which factors are associated with it, and what other psychological outcomes accompany it? This study aimed to determine the reported prevalence of postpartum depression after maternal ICU admission and identify associated sociodemographic and clinical risk factors; to describe secondary psychological outcomes, including PTSD, anxiety, and psychological distress; to examine the impact on quality of life and mother–infant bonding; and to evaluate the timing and utilization of psychological follow-up services.

RESEARCH METHODS

Study Design and Framework

This study is a systematic review of observational primary studies following the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) 2020 guidelines. A narrative synthesis approach was used to synthesize findings from heterogeneous studies. The review was structured according to the PECO framework. The Population was women admitted to the maternal ICU during pregnancy, childbirth, or up to 42 days postpartum. The Exposure was maternal ICU admission due to severe obstetric complications. The Comparator was women with obstetric complications without ICU admission, where available. The primary outcome was postpartum depression, while secondary outcomes included PTSD, anxiety, psychological distress, health-related quality of life, and mother–infant bonding.

Search Strategy and Eligibility Criteria

A comprehensive literature search was conducted in three major electronic databases, namely PubMed, Europe PMC, and OpenAlex. Search terms integrated Medical Subject Headings (MeSH) and free-text terms covering intensive care

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units, maternal/obstetric populations, and postpartum depression. Eligible studies were observational primary studies, namely prospective/retrospective cohort, case-control, and cross-sectional studies. Exclusion criteria were studies without maternal ICU admission, ineligible non-obstetric populations, literature reviews, editorials, letters, protocols, case reports, and non-primary abstracts.

Study Selection

A total of 280 records were identified through searches of PubMed (n = 81), Europe PMC (n = 48), and OpenAlex (n = 151). After removal of 80 duplicate records, 200 records underwent title and abstract screening. Of these, 190 records were excluded and 10 full-text reports were assessed for eligibility. After full-text assessment, seven reports were excluded, mainly due to the absence of maternal ICU admission (n = 6) and one study due to an ineligible population (n = 1). Ultimately, three studies met the eligibility criteria and were included in this systematic review (Figure 1).

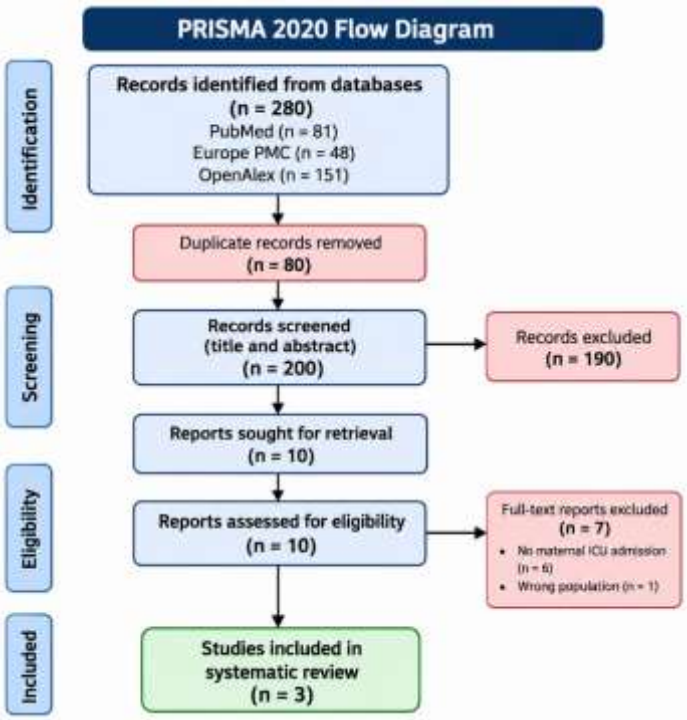

Figure 1. PRISMA flow diagram of study selection

RESULTS AND DISCUSSION

Three observational studies met all inclusion criteria and were included in this review, with a total of 569 participants from Turkey, Israel, and Colombia.

Yucel Yetiskin et al. (2026)

Yucel Yetiskin et al. (2026) conducted a cross-sectional observational study at Gaziantep City Hospital, Turkey. The sample consisted of 207 mothers (selected from 280 invited and 263 consenting, with 56 excluded due to unstable medical conditions, incomplete questionnaires, or language barriers). Participants were divided into four groups according to critical care exposure: maternal ICU admission only (MICU, n = 28), neonatal ICU admission only (NICU, n = 69),

combined maternal and neonatal ICU admission (MICU + NICU, n = 46), and non-ICU obstetric controls (n = 64). Demographic characteristics were generally comparable between groups, including maternal age (mean range 27.98–29.50 years; p = 0.63), gestational age at birth (median 38.00–38.50 weeks; p = 0.286), cesarean section rates (52.2%–64.3%; p = 0.51), and high perceived partner support (>91% in all groups; p = 0.844). All ICU admissions occurred in the immediate postpartum period within 48 hours of delivery. Admission severity was categorized as low (length of stay <48 hours, intravenous fluid/$MgSO_4$ support), moderate (length of stay 2–5 days, vasopressors or blood transfusion ≥3 units), or high (length of stay >5 days, mechanical ventilation, ECMO, hysterectomy, or multi-organ support).

PPD was evaluated as probable PPD based on positive screening with the validated Turkish version of the Edinburgh Postnatal Depression Scale (EPDS) at a cut-off of ≥13 in the first postpartum week before discharge. The overall prevalence of positive PPD screening was 24.64% (51/207). Prevalence by group varied significantly (p < 0.001): 0.0% (0/64) in controls, 11.6% (8/69) in the NICU group, 21.4% (6/28) in the MICU group, and 80.4% (37/46) in the combined MICU + NICU group.

In multivariable linear regression models for continuous EPDS scores (adjusted for birth weight, breastfeeding status, and maternal education), all ICU exposure categories were independently associated with increased depressive symptoms compared with controls: MICU (adjusted β = 1.91; 95% CI: 1.31–2.51; p < 0.001), NICU (adjusted β = 1.52; 95% CI: 1.17–1.86; p < 0.001), and combined MICU + NICU (adjusted β = 3.31; 95% CI: 2.62–4.01; p < 0.001). Qualitative risk factors included dual ICU exposure, not breastfeeding, delayed physical contact, and lower maternal education. Regarding other psychological outcomes, severe anxiety (Beck Anxiety Inventory [BAI] ≥16) was found in 0.0% of controls, 81.2% of the NICU group, 92.9% of the MICU group, and 100.0% of the combined group (p < 0.001; adjusted β = 17.24 versus controls). High general depression (Beck Depression Inventory [BDI-II] ≥14) was experienced by 0.0% of controls, 5.8% of the NICU group, 71.4% of the MICU group, and 89.1% of the combined group (p < 0.001). Severe attachment impairment (Maternal Attachment Inventory [MAI] ≤52) was found in 80.4% of mothers in the combined group, compared with 7.1% in MICU, 0.0% in NICU, and 0.0% in controls (p < 0.001).

Zerem et al. (2026)

Zerem et al. (2026) was a cross-sectional observational study with retrospective and prospective components at the Shaare-Zedek and Tel-Aviv Sourasky Medical Centers, Israel. Of 216 eligible obstetric ICU admissions (including 7 maternal deaths; 3.2%), the final interviewed sample consisted of 128 mothers, namely 64 ICU survivors and 64 non-ICU obstetric controls. The two groups were demographically comparable: mean maternal age was 32.4 ± 7.1 years in the ICU group and 30.8 ± 6.6 years in controls (p = 0.192), cesarean section rates were 57.8% and 51.6% (p = 0.473), and prior psychiatric history was nearly zero (0.0% in ICU and 1.6% in controls). However, mothers in the ICU group had higher pre-pregnancy medical comorbidity (32.8% vs. 12.5%; p = 0.005) and a significantly longer total hospital stay (10.9 ± 7.6 vs. 5.1 ± 3.0 days; p < 0.001).

All ICU cases were urgent admissions with a mean ICU length of stay of 2.7 ±

2.6 days. Admissions occurred antepartum (26.6%), intrapartum (1.6%), or postpartum (71.9%), mainly due to surgical/obstetric hemorrhage (45.3% requiring blood products) and severe hypertensive disorders; 31.3% required mechanical ventilation. Probable PPD was assessed using the EPDS (cut-off ≥13, positive screening). When evaluated retrospectively at hospital discharge, the prevalence of probable PPD was 51.6% (33/64) in ICU survivors versus 17.2% (11/64) in controls ($p < 0.001$; mean EPDS 12.2 vs. 6.7). At long-term follow-up (mean 27.8 months after admission), the prevalence of probable PPD decreased to 12.5% (8/64) in ICU survivors but remained significantly higher than in controls, at 0.0% (0/64) ($p = 0.003$).

Univariate analysis showed that maternal ICU admission was a strong risk factor for persistent depressive symptoms. Assessment of other psychological domains showed that probable childbirth-related PTSD (City Birth Trauma Scale, DSM-5 criteria) was found in the long term in 10.9% (7/64) of ICU survivors versus 1.6% (1/64) of controls ($p = 0.030$), with significantly higher total PTSD symptom scores in the ICU cohort (16.8 vs. 8.0; $p = 0.003$). Quality of life (SF-36) showed a characteristic biphasic trajectory: at hospital discharge, ICU survivors had severe deficits in all eight SF-36 domains ($p < 0.02$ for all domains), but at long-term follow-up physical functioning and general health had fully recovered with no significant differences between groups. Utilization of mental health services after discharge was notable, with 17.2% of ICU survivors receiving formal therapy or psychiatric intervention.

The mean follow-up duration was 27.8 ± 15.1 months (range 4.4–60.1 months). At the time of interview, all (100%) ICU survivors were living at home without requiring nursing care. Infant perinatal mortality was significantly higher in the ICU group (12.5% vs. 3.1%; $p = 0.048$), and infants of the ICU group had a significantly lower mean birth weight (2,658 ± 927 g vs. 2,989 ± 837 g; $p = 0.004$). Infant attachment scales were not administered in this study. The main finding of this study highlights a dichotomy between physical and psychological recovery: although physical quality of life fully recovered in the long term, psychological trauma (PPD and childbirth-related PTSD) persisted in more than 10% of ICU survivors. The main limitations of this study include recall bias from the retrospective baseline questionnaires, exclusion of non-Hebrew-speaking participants (14.4%), reliance on self-administered screening instruments, inability to separate the severity of severe maternal morbidity from ICU admission, and unmeasured social and economic buffering factors.

Murillo García et al. (2026)

Murillo García et al. (2026) conducted a prospective cohort study at Hospital Universitario San Jorge de Pereira, Colombia, involving 234 third-trimester pregnant women hospitalized for hypertensive disorders of pregnancy. Participants were divided into an ICU admission cohort (n = 143; 61.1%) and a non-ICU ward cohort (n = 91; 38.9%). Baseline characteristics showed a median maternal age of 25 years (IQR 21–31; $p = 0.762$), high rates of pre-pregnancy overweight/obesity (63.2%), pre-existing depression (15.4%), and a history of substance use (36.3%). Nulliparity was significantly more common in the ICU group (44.06% vs. 30.77%; $p = 0.042$), as was urban residence (59.44% vs. 46.15%; $p = 0.047$).

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ICU admission occurred in 61.1% of the cohort, mainly due to the need for continuous invasive hemodynamic monitoring (99.3%) and placental dysfunction (34.4%) in the context of severe preeclampsia (43.2%), chronic hypertension (15.0%), or gestational hypertension (7.7%). The median ICU length of stay was 2 days (IQR 2–4). Probable depression was screened using the EPDS (cut-off ≥10 or a positive response to item 10 on self-harm, according to Colombian guidelines) during the index hospitalization (60.1% assessed in the ICU, 18.9% on the day of admission, 11.2% after ICU discharge, and 9.8% before ICU admission). The prevalence of positive depression screening was 29.49% (69/234) overall: 33.57% (48/143) in the ICU group versus 23.08% (21/91) in the non-ICU group (p = 0.086).

In a multivariable Firth-penalized logistic regression model, positive-screen depressive symptoms (EPDS ≥10 or positive item 10) were independently associated with a nearly fivefold increase in the odds of ICU admission (adjusted OR = 4.83; 95% CI: 1.56–14.94; p = 0.006). Other independent predictors of ICU transfer included severe preeclampsia (OR = 28.36; p = 0.001), anemia/Hb < 11 g/dL (OR = 4.40; p = 0.023), and mean arterial pressure ≥102.5 mmHg (OR = 2.51; p = 0.042). In addition, multivariable Cox regression showed that depressive symptoms significantly prolonged hospital length of stay (adjusted HR = 0.69; 95% CI: 0.48–1.00; p = 0.048). Positive-screen anxiety (GAD-7 ≥10) was found in 23.1% of the total cohort but showed an unexpected inverse multivariable association with ICU transfer (adjusted OR = 0.29; 95% CI: 0.09–0.88; p = 0.029), presumably reflecting protective health-seeking behavior. The study also revealed a critical mental health referral gap: although 29.5% of participants had a positive EPDS and 41.0% had GAD-7 ≥7, only 7.3% received a formal psychiatric evaluation.

Prevalence of Postpartum Depression

All three studies consistently showed a high prevalence of PPD after maternal ICU admission, although its magnitude varied with design and assessment timing. In Yucel Yetiskin et al. (2026), overall positive PPD screening was 24.64% (51/207), with subgroup prevalence of 0.0% in controls (0/64), 21.4% in MICU only (6/28), 11.6% in NICU only (8/69), and 80.4% in combined MICU + NICU (37/46) (p < 0.001). In Zerem et al. (2026), probable PPD at hospital discharge was 51.6% in ICU survivors versus 17.2% in controls (p < 0.001) and remained significantly elevated at long-term follow-up (mean 2.3 years), at 12.5% in ICU survivors versus 0.0% in controls (p = 0.003). In Murillo García et al. (2026), antenatal/postpartum depression (EPDS ≥10 or positive item 10) occurred in 29.49% of the total HDP cohort (69/234), namely 33.57% in the ICU group versus 23.08% in the non-ICU group (p = 0.086); multivariable analysis established that depressive symptoms independently predicted ICU admission (adjusted OR = 4.83; 95% CI: 1.56–14.94; p = 0.006).

Secondary Psychological Outcomes

Regarding anxiety and psychological distress, Yucel Yetiskin et al. reported high anxiety (BAI ≥16) in 0.0% of controls, 92.9% of the MICU group, 81.2% of the NICU group, and 100.0% of the combined group (p < 0.001), while Murillo García et al. found probable anxiety (GAD-7 ≥10) in 20.98% of ICU participants versus 26.37% of non-ICU participants. Regarding post-traumatic stress disorder, Zerem

et al. evaluated PTSD using the City BiTS and found probable childbirth-related PTSD in 10.9% of ICU survivors versus 1.6% of controls ($p = 0.030$), with significantly higher total PTSD symptom scores (16.8 ± 15.3 vs. 8.0 ± 9.0; $p = 0.003$).

Regarding quality of life, Zerem et al. showed that the physical and mental health domains of the SF-36 were severely impaired when ICU survivors were discharged from hospital ($p < 0.02$ in all eight domains) but fully recovered at long-term follow-up. Regarding mother–infant bonding and dyadic outcomes, Yucel Yetiskin et al. reported severe maternal attachment deficits (MAI ≤52) in 80.4% of the combined MICU + NICU group and 7.1% of the MICU-only group, together with a complete absence of breastfeeding initiation (0.0%) in the combined group. Zerem et al. reported higher perinatal mortality (12.5% vs. 3.1%; $p = 0.048$) and lower neonatal birth weight (2,658 ± 927 g vs. 2,989 ± 837 g; $p = 0.004$) in ICU cases.

Interpretation of Findings

This systematic review shows that maternal ICU admission is associated with an increased risk of postpartum depression and other psychological complications. These findings confirm that mothers admitted to the ICU experience much higher rates of positive PPD screening (ranging from 21.4% to 51.6% in the acute phase and persisting at 12.5% at long-term follow-up), severe anxiety, childbirth-related PTSD (10.9%), and impaired mother–infant bonding.

The psychological distress observed after maternal ICU admission stems from life-threatening physical illness, invasive emergency interventions (such as mechanical ventilation and massive transfusion), pain, sleep deprivation, and traumatic separation from the newborn. The synergistic effect observed with combined maternal and neonatal ICU admission (80.4% PPD and 100% high anxiety) highlights the compounded psychological trauma of maternal recovery occurring alongside critical illness in the infant. Maternal ICU admission thus acts as a powerful stressor that triggers acute depressive, anxiety, and trauma symptoms, while dual exposure (simultaneous maternal and infant critical care) produces an additive or synergistic psychological burden.

These findings emphasize the importance of making mental health screening a routine part of obstetric critical care. The gap between the high proportion of women screening positive for psychological symptoms and the low rate of psychiatric referral (7.3% in Murillo García et al., 2026) indicates that many women may not receive the support they need. Integrating psychological care into routine obstetric ICU practice, together with trauma-informed nursing and planned mental health follow-up after discharge, can help ensure that women's psychological needs are recognized and addressed more effectively.

Strengths and Limitations

The strengths of this review are its adherence to the PRISMA 2020 guidelines, its coverage of an under-researched critical care population, and its synthesis of multidomain psychological outcomes from several international cohorts. On the other hand, its limitations are the small number of eligible primary studies (n = 3), reliance on self-administered screening instruments rather than clinical diagnostic interviews, and potential unmeasured confounders. In addition,

most available studies focus mainly on maternal psychological outcomes in the context of infant NICU admission, while studies specifically examining the psychological consequences of maternal ICU admission are very limited. This limited evidence restricts the ability to draw firm conclusions about the prevalence and risk factors of postpartum depression specifically among women admitted to the maternal ICU.

CONCLUSION

Maternal admission to the intensive care unit is strongly associated with a high prevalence of postpartum depression, anxiety, and post-traumatic stress disorder, both in the acute phase and in the long term, together with meaningful impairment of maternal quality of life and mother–infant bonding. The heaviest psychological burden is experienced by mothers whose infants are also admitted to the neonatal ICU, while most mothers with positive symptoms have not received a psychiatric evaluation. Routine psychological surveillance, mental health interventions integrated within critical care units, and longitudinal support after discharge are therefore essential to improve maternal mental health outcomes.

Statement on the Use of Artificial Intelligence

AI was used in the preparation of this manuscript. The authors used artificial intelligence tools solely to assist with language improvement, grammar checking, and editing for clarity and readability. The authors remain fully responsible for the accuracy, originality, integrity, and academic content of the manuscript. All AI-assisted content was reviewed and verified by the authors before submission.

Conflicts of Interest

The authors declare no conflict of interest.

Author Contributions

Conceptualization, C.A.; literature search and selection, C.A. and C.A.K.; data extraction, C.A.K.; data validation, C.A.; formal analysis, C.A. and C.A.K.; writing—original draft preparation, C.A.; writing—review and editing, C.A.K. All authors have read and approved the final version of the manuscript.

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