ORIGINAL RESEARCH

Impact of Humanistic and Psychological Nursing on Postpartum Women: A Comparative Study

Peiyu Gu, MD; Ying Chen, MD; Minna Wu, MD

ABSTRACT

Context • Postpartum care primarily focuses on the mother's physical recuperation, encompassing the prevention and treatment of postpartum ailments. However, healthcare practitioners have relatively neglected the psychological needs of mothers. Postpartum depression (PPD) is a psychological health concern that necessitates attention and timely intervention

Objective • The study intended to explore the effects of postpartum humanistic care and psychological nursing on maternal quality of life (QoL) and the levels of anxiety and depression of postpartum women, ultimately to provide effective postpartum-care strategies for medical institutions, enhance maternal mental health, and augment overall satisfaction and QoL.

Design • The research team conducted a randomized controlled trial.

Setting • The study took place at the Affiliated Hospital of Jiangnan University in the Binhu District, Wuxi City, Jiangsu Province, China.

Participants • Participants were 80 postpartum women at the hospital from June 2023 to March 2024.

Interventions • Using a random number table method, the research team randomly divided participants into two groups, with 40 participants in each group: (1) the control group, who received routine nursing intervention after delivery, and (2) the intervention group, who received humanistic care and psychological nursing.

Outcome Measures • At baseline and postintervention, the research team measured participants' (1) QoL, using the 36-Item Short Form Health Survey (SF-36) scale, and (2) anxiety and depression levels, using the Self-Rating Anxiety Scale (SAS) and Self-Rating Depression Scale (SDS). Postintervention, the team measured participants' levels of satisfaction with nursing care .

Results • At baseline, no significant difference existed between the groups: (1) in the Q0L ($P > .05$) or (2) in the SAS or SDS scores ($P > .05$). Postintervention, compared to the control group, the intervention group's: (1) QoL was significantly higher ($P < .001$), (2) SAS ($P < .001$) and SDS ($P < .001$) scores were significantly lower, and (3) nursing satisfaction level was 97.5%, which was significantly higher than that of the control group at 75.0% ($P = .003$).

Conclusions • Adding humanistic care and psychological nursing in postpartum care can significantly improve the QoL of postpartum women, reduce PPD, and improve their nursing satisfaction. (*Altern Ther Health Med.* [E-pub ahead of print.])

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In the context of rapid social and economic development in China, the demand for medical services has witnessed a significant surge in recent years. Within the realm of obstetrics and gynecology, postpartum care has emerged as a pivotal aspect.[1] Traditionally, postpartum care primarily focuses on the mother's physical recuperation, encompassing the prevention and treatment of postpartum ailments. However, healthcare practitioners have relatively neglected the psychological needs of mothers.[2]

Lowe found that an increasing number of studies, have begun to concentrate on psychological-care interventions during the postpartum period due to an escalating awareness regarding the significance of mental health, aiming to promote the mental well-being and overall quality of life (QoL) of mothers.[3]

Throughout the postpartum phase, mothers encounter a multitude of physiological and psychological changes, including hormonal fluctuations, breast engorgement, and parental stress, which may contribute to postpartum depression (PPD), decrease maternal QoL, and impede parenting capabilities, and in severe cases, negatively affect the mother-infant relationship.[4]

Postpartum Depression

PPD is a condition characterized by symptoms such as low mood, self-blame, insomnia, and loss of appetite that occur in women after childbirth. PPD can have detrimental effects on women's physical and mental health as well as QoL. It can also impact their families and social interactions, leading to increased anxiety and feelings of loneliness.

Oztora et al indicated that approximately 10% to 20% of postpartum women experience symptoms of PPD, which can persist for months or even years.[5] Consequently, PPD is a psychological health concern that necessitates attention and timely intervention.

Routine Nursing

Previous clinical nursing care for postpartum women primarily focused on routine care, but Oksuz and Inal highlighted the shortcomings of this approach in addressing the needs of postpartum women.[6] Routine care tends to prioritize disease treatment and pathological observation, without dedicating sufficient time and effort to address women's emotional states and QoL.[7] It primarily emphasizes physiological and medical care for the mother and infant, often neglecting women's emotional needs and the support they require. It also lacks a comprehensive understanding of individualized needs, potentially leading to depressive emotions and a negative impact on QoL.[8]

Prevention and treatment of PPD shouldn't solely focus on physiological and medical care. In response to this challenge, humanistic care and psychological nursing interventions have emerged as vital solutions.

Humanistic and Psychological Nursing

Humanistic care revolves around a patient-centered approach that emphasizes holistic attention and care from healthcare professionals, catering to patient's diverse needs, and ultimately, enhancing patients' satisfaction and QoL.[9] Psychological nursing interventions encompass evidence-based psychological approaches, such as emotional support and cognitive restructuring, aimed at alleviating depressive symptoms and fostering mental well-being among mothers.[10]

By enhancing the professional competence and skills of nursing staff and strengthening their psychological support and care for postpartum women, clinicians can effectively prevent and alleviate symptoms of PPD, ultimately improving the QoL and happiness of postpartum women. Postpartum humanistic care and psychological support is a nursing model that prioritizes the physical and mental health of postpartum women, aiming to enhance their self-care abilities, improve their QoL, and prevent and reduce PPD.[11]

This model emphasizes the humanistic needs of postpartum women, including providing a warm delivery-room environment, organizing postpartum group activities for the women, offering nutritious and comfortable diets, respecting women's choices and opinions, and providing counseling and support for postpartum psychological issues.

Postpartum women who receive humanistic care and psychological support experience increased feelings of love and support, helping them alleviate tension, reduce anxiety and depression symptoms, and improve their quality of life.[12] Additionally, this nursing model assists postpartum women in adapting to their new lives, enhancing their confidence and self-care abilities, and preventing the occurrence of postpartum complications.[13] Husain et al found that postpartum humanistic care and psychological support could significantly improve postpartum women's QoL and reduce depression compared to routine care.[14]

Tani and Castagna and Gobel et al confirmed the positive effects of postpartum humanistic care and psychological nursing on maternal QoL and depressive mood.[15,16] By establishing healthy family relationships and improving maternal QoL, it contributes to increased maternal happiness and life satisfaction and promotes maternal physical and mental health.[17]

Current Study

The present study intended to explore the effects of postpartum humanistic care and psychological nursing on maternal QoL and the levels of anxiety and depression of postpartum women, ultimately to provide effective postpartum-care strategies for medical institutions, enhance maternal mental health, and augment overall satisfaction and QoL.

METHODS

Participants

The research team conducted a randomized controlled trial, which took place at the Affiliated Hospital of Jiangnan University in the Binhu District, Wuxi City, Jiangsu Province, China. Potential participants were postpartum women at the hospital from June 2023 to March 2024.

As their doctor conducting a randomized controlled study, I collect data through a structured process to ensure the integrity and reliability of my research findings.

Here is how I collect data for my study:

1. **Participant Enrollment**: I recruit participants who meet the study criteria and obtain their informed consent before their inclusion in the study.
2. **Randomization**: Participants are randomly assigned to either the intervention group or the control group to minimize bias and ensure that the groups are comparable.
3. **Data Collection Methods**:
   - **Baseline Data**: I gather baseline information on participants before any intervention is administered.
   - **Intervention**: I implement the specified interventions as per the study design.
   - **Follow-up**: I conduct follow-up assessments at predetermined time points to track changes and outcomes.
4. **Data Collection Tools**:
   - **Surveys/Questionnaires**: I use standardized surveys or questionnaires to collect subjective data from participants.
   - **Physical Examinations**: I perform physical assessments to gather objective data.

5. **Data Recording**: I maintain accurate records of all data collected, ensuring confidentiality and compliance with ethical guidelines.
6. **Data Analysis**: Once data collection is complete, I analyze the data using statistical methods to draw conclusions and evaluate the effectiveness of the interventions.

The study included potential participants if they: (1) were between 18 and 35 years old; (2) had had no complications during any previous pregnancies; (3) had no history of psychological or mental illness before delivery; (4) had had no serious complications during vaginal delivery; (5) had, with their family members, voluntarily agreed to participate.

The study excluded potential participants if they: (1) had serious mental illness or psychological disorders; (2) had other serious illnesses or complications, such as hypertension or diabetes; or (3) their newborns had a birth weight below 2.5 kg or above 4.5 kg.

Participants signed relevant informed consent forms, and the hospital's ethics committee approved the study's protocols (28391). This study was conducted complying with the Helsinki Declaration.

Trial registration: Chinese Clinical Trial Registry Identifier: ChiCTR2100054199.

Procedures

Groups. Using a random number table method, the research team randomly divided participants into two groups, with 40 participants in each group: (1) the control group, who received routine nursing intervention after delivery, and (2) the intervention group, who received humanistic care and psychological nursing.

Data collection. The research team collected demographic and clinical information such as age, marital status, educational level, parity, and delivery mode.

Data Collection Methods: **Baseline Data**: I gather baseline information on participants before any intervention is administered. **Intervention**: I implement the specified interventions as per the study design. **Follow-up**: I conduct follow-up assessments at predetermined time points to track changes and outcomes.

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Data Recording: I maintain accurate records of all data collected, ensuring confidentiality and compliance with ethical guidelines.

Data Analysis: Once data collection is complete, I analyze the data using statistical methods to draw conclusions and evaluate the effectiveness of the interventions.

Outcome measures. At baseline and postintervention, the research team measured participants': (1) QoL, using the 36-Item Short Form Health Survey (SF-36) scale, and (2) anxiety and depression levels, using the Self-Rating Anxiety Scale (SAS) and Self-Rating Depression Scale (SDS). Postintervention, the team measured participants' levels of satisfaction with nursing care.

Nursing Satisfaction Survey. The survey included: (1) basic information—participant's name (optional) and contact information (optional); (2) a hospital-service evaluation—the hospital's overall quality of service, the comfort level of the hospital environment, the food and dietary options provided, and the hospital's cleanliness; (3) a nursing-service evaluation—the nurses' communication skills and attitudes, the level of care and support they provided; the nurses' professional knowledge and skill levels; and the nurses' protection of privacy and respect for the patient; (4) postpartum-care evaluation for nurses—postpartum physical care, breast care and breastfeeding guidance, postpartum recovery activities and exercise guidance, and postpartum psychological counseling and support. The survey also included a section for suggestions and comments for improving hospital services and nursing quality.

The implementation and assessment of the survey included: (1) participant recruitment—the research team provided the survey to postpartum women and their families at an appropriate time, such as during discharge or follow-up visits; (2) survey completion—participants filled out the survey as instructed, rating each question or providing written responses; (3) data collection—the research team collected the completed surveys, ensuring that participants answered all questions and noting any additional comments or suggestions; (4) data compilation and analysis—the research team organized and summarized the collected survey data for quantitative analysis; the team could use statistical software or manual calculations to calculate total scores, averages, and percentages; (5) interpretation and evaluation of results—the research team evaluated participants' satisfaction with hospital services and nursing care based on the survey's results, which involved calculating the overall satisfaction rate as a percentage and analyzing scores for each question to identify areas for improvement; and (6) application and improvement of results— based on the evaluation's findings, the hospital and nursing team intended to make targeted improvements to services and nursing quality to meet the needs and expectations of postpartum women and their families.

Interventions

Control group. The routine nursing intervention included the following components: (1) basic medical care, with participants receiving regular monitoring of vital signs, such as body temperature, blood pressure, pulse, respiration, uterine contractions, and vaginal discharge; (2) observation of general condition, with nurses conducting regular rounds to observe postoperative bleeding, breast swelling and pain, urination, and lochia, to ensure early detection of any abnormalities; and (3) dietary care, with the participants being provided with nutrient-rich diets, including liquid and soft foods, to support their postpartum recovery.

After giving birth, women may experience physical changes, such as soreness or tenderness in the perineal area, which can make it uncomfortable to consume certain foods. Moreover, some women may have difficulty chewing or swallowing due to fatigue, pain, or other factors. In such cases, providing liquid and soft foods can be beneficial because they are easier to digest and require less effort to consume. Including liquid and soft foods in the postpartum diet ensures that women receive adequate nutrition while minimizing discomfort or digestive issues.

In addition, the routine nursing interventions included: (1) postpartum-lactation education, with nurses encouraging the women to make physical contact and provide emotional communication between them and their newborns, fostering bonding and promoting successful breastfeeding; (2) sleep care, with nurses ensuring that the women had sufficient rest time and a comfortable sleeping environment, promoting their physical and mental well-being; and (3) hygiene care, with the women receiving assistance with personal hygiene, including bathing and changing sanitary pads, to maintain cleanliness and prevent infections.

Intervention group. In addition to the routine nursing interventions provided to the control group, the group received humanistic care and psychological nursing. The interventions included: (1) establishing a good nurse-patient relationship, with nurses adopting a warm, friendly, and patient attitude toward the postpartum women, providing psychological comfort and support throughout their care; (2) postpartum psychological counseling, with nurses engaging in effective communication with the women, helping them recognize and alleviate discomforting emotions such as anxiety and depression; through counseling, the nurses aimed to assist the postpartum women in solving psychological problems and to enhance their self-awareness and self-regulation abilities; and (3) postpartum lactation guidance and support, with nurses offering guidance and support to the women in establishing correct breastfeeding techniques and breast care; they encouraged physical contact and emotional communication between the mothers and their newborns, fostering bonding and promoting successful breastfeeding.

In addition, the intervention included: (1) maternal and child-safety guidance, with the women receiving education on precautions for postpartum physical recovery; nurses provided instructions on the proper use of postpartum care products and offered guidance on preventing common issues, such as colds, ensuring the well-being of both the mother and the child; and (2) rich postpartum rehabilitation activities, with the women being provided with a variety of postpartum rehabilitation activities, including postpartum recovery exercises and yoga; these activities aimed to strengthen their physical fitness, promote physical recovery, and improve overall well-being.

The nurses tailored the interventions based on the individual needs of each postpartum woman. They engaged in thorough communication and actively sought feedback to better understand each woman's specific requirements and preferences, thus optimizing the interventions' effectiveness. Nurses also maintained regular records of the nursing care, documenting observed physiological and psychological changes as well as the feedback that the postpartum women provided. These records served as valuable data for subsequent evaluations and analysis.

Outcome Measures

QoL. The research team assessed participants QoL at baseline and postintervention, using the 36-Item Short Form Health Survey (SF-36) scale.[18] The SF-36 is a widely used questionnaire designed to assess a person's health-related QoL, with 36 questions covering various aspects, such as physiology, psychology, society, and health. The SF-36 provides a comprehensive assessment of an individual's well-being and functioning across various aspects of life. The SF-36 scores range from 0 to 100, with higher scores indicating a better health-related quality of life.

The SF-36 covers eight health domains: (1) physical functioning, (2) role limitations due to physical health problems, (3) bodily pain, (4) general health perceptions, (5) vitality, (6) social functioning, (7) role limitations due to emotional problems, and (8) mental health. The SF-36 further groups these domains into two summary scores: the Physical Component Summary (PCS) and the Mental Component Summary (MCS).

Anxiety and depression. The research team evaluated participants' levels of anxiety and depression at baseline and postintervention using the Self-Rating Anxiety Scale (SAS)[19] and Self-Rating Depression Scale (SDS),[20] respectively.

The SAS is a self-report questionnaire that consists of 20 items that assess various symptoms of anxiety, such as restlessness, nervousness, and feelings of tension. Participants rate the intensity of each symptom on a four-point scale ranging from none or a little of the time to most or all of the time. Raw scale scores for the SAS range from 20 to 80 with higher scores indicating higher levels of anxiety. Clinicians commonly use a cut-off score of 50 is to identify individuals with significant anxiety symptoms.

The SDS is a self-report questionnaire designed to assess the presence and severity of depressive symptoms. It consists of 20 items that measure various aspects of depression, including feelings of sadness, loss of interest, sleep disturbances, and changes in appetite. Participants rate the presence and intensity of each symptom on a four-point scale ranging from none or a little of the time to most or all of the time. Raw scale scores for the SAS range from 20 to 80, with higher scores indicating higher levels of depression. Clinicians commonly use a cut-off score of 50 to identify individuals with significant depressive symptoms.

Satisfaction with nursing care. Postintervention, the research team provided the postpartum women and their families with a self-made Nursing Satisfaction Survey to evaluate their satisfaction with the overall treatment and nursing care received from the hospital. The survey consisted

of 20 questions, and participants rated their satisfaction on a scale of 1 to 5. A total score lower than 70 indicated dissatisfaction, 70-89 indicated satisfaction, and 90 or above indicated a high level of satisfaction. The research team calculated the satisfaction rate as the percentage of participants who reported being very satisfied or satisfied out of the total number of participants.

Statistical Analysis

The research team analyzed the data using the Statistical Package for Social Sciences (SPSS) 27.0 (IBM SPSS, Armonk, NY, USA) and used GraphPad Prism 7.0 software (GraphPad Software, La Jolla, CA, USA) for image processing. The team (1) expressed continuous variables as means ± standard deviations (SDs) and compared the groups using *t* tests and (2) expressed categorical variables as numbers (Ns) and percentages (%s) and compared the groups using the chi-square (χ^2) tests. $P < .05$ indicated statistically significant differences.

RESULTS

Participants

The research team included and analyzed the data of 80 participants, 40 in each group (Table 1). The control group's mean age was 28.2 ± 3.1 y. In the group: (1) 36 participants were married (90.00%) and 4 unmarried (10.00%); (2) two had a junior-high-school education or below (5.00%), 20 had a high-school or technical-secondary-school education (50.00%), and 18 had a college education or above (45.00%); (3) the mean number of pregnancies was 1.5 ± 0.7; and (4) for the delivery mode, 25 participants had natural deliveries (62.50%) and 15 had cesarean sections (37.50%).

The intervention group's mean age was 27.8 ± 3.3 y. In the group: (1) 37 participants were married (92.50%) and 3 unmarried (7.50%); (2) one had a junior-high-school education or below (2.50%), 18 had a high-school or technical-secondary-school education (45.00%), and 21 had a college education or above (52.50%); (4) the mean number of pregnancies was 1.6 ± 0.8; and (4) for the delivery mode, 23 participants had natural deliveries (57.50%) and 17 had cesarean sections (42.50%).

No significant differences existed between the two groups in age, marital status, educational level, number of pregnancies, or delivery mode ($P > .05$).

QoL

The control group's mean SF-36 scores at baseline and postintervention were 70.4 ± 5.8 and 78.5 ± 7.2, respectively (Table 2 and Figure 1). The intervention group's mean SF-36 scores at baseline and postintervention were 70.9 ± 5.5 and 85.7 ± 10.1, respectively.

At baseline, no significant difference existed between the groups in the QoL ($P > .05$). The intervention ($P < .001$) and control ($P < .001$) groups' QoL both significantly improved between baseline and postintervention. Postintervention, the intervention group's SF-36 score was significantly higher than that of the control group ($P < .001$).

Table 1. Participants Demographic and Clinical Characteristics at Baseline (N=80)

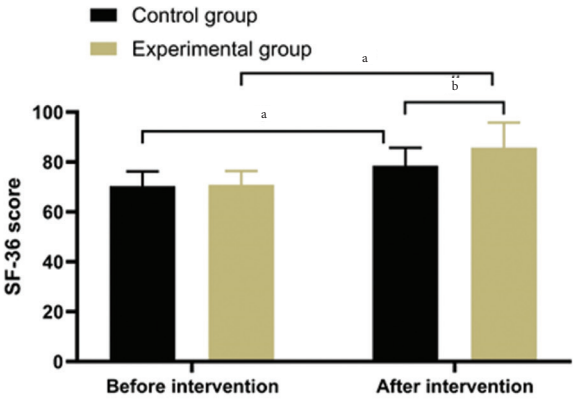
Characteristics	Control Group n=40 Mean ± SD n (%)	Intervention Group n=40 Mean ± SD n (%)	t/χ^2 value	*P* value
Average Age, y	28.2 ± 3.1	27.8 ± 3.3	0.558	.577
Marital Status			0.00	1.000
Married	36 (90.00)	37 (92.50)		
Unmarried	4 (10.00)	3 (7.50)		
Educational Level			0.200	.654
Junior-high-school and below	2 (5.00)	1 (2.50)		
High-school/technical-secondary school	20 (50.00)	18 (45.00)		
College and above	18 (45.00)	21 (52.50)		
Average Number of Pregnancies, n	1.5 ± 0.7	1.6 ± 0.8	0.595	.553
Mode of delivery			0.208	.648
Natural childbirth	25 (62.50)	23 (57.50)		
Cesarean section	15 (37.50)	17 (42.50)		

Table 2. Comparison of Quality of Life Between the Intervention and Control Groups (N=80)

Timepoint	Control Group n=40 Mean ± SD	Intervention Group n=40 Mean ± SD	*t* value	*P* value
Baseline	70.4 ± 5.8	70.9 ± 5.5	10.273	.823
Postintervention	78.5 ± 7.2	85.7 ± 10.1	11.637	<.001
t value	9.738	10.263		
P value	<.001	<.001		

Abbreviations: SF-36, 36-Item Short Form Health Survey.

Figure 1. Comparison of Quality of Life Between the Intervention and Control Groups Postintervention (N=80)



[a]$P < .05$, indicating that both groups' quality of life significantly improved between baseline and postintervention
[b]$P < .05$, indicating that the intervention group's quality of life was significantly higher than that of the control group postintervention

Abbreviations: SF-36, 36-Item Short Form Health Survey.

Anxiety and Depression

The control group's SAS scores at baseline and postintervention were 36.9 ± 7.8 and 30.8 ± 5.4, respectively, and its SDS scores were 38.7 ± 7.2 and 32.4 ± 6.6, respectively (Table 3 and Figure 2). The intervention group's SAS scores at baseline and postintervention were 32.4 ± 6.8 and 30.6 ± 5.5, respectively, and its SDS scores were 33.1 ± 5.9 and 32.3 ± 6.5, respectively.

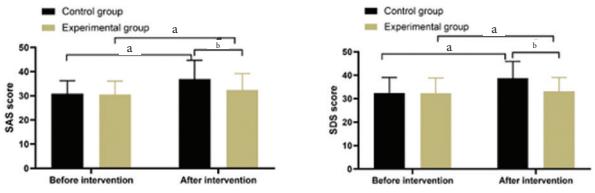
At baseline, no significant differences existed in the SAS and SDS scores between the groups ($P > .05$). The intervention group's SAS ($P < .001$) and SDS ($P < .001$) scores significantly decreased between baseline and postintervention, and the control group's SAS ($P < .001$) and SDS ($P < .001$) scores also significantly decreased during that period. Postintervention,

Table 3. Comparison of Anxiety and Depression Levels Between the Intervention and Control Groups (N=80)

	SAS Scores				SDS Scores			
Timepoint	Control Group n=40 Mean ± SD	Intervention Group n=40 Mean ± SD	*t* value	*P* value	Control Group n=40 Mean ± SD	Intervention Group n=40 Mean ± SD	*t* value	*P* value
Baseline	36.9 ± 7.8	32.4 ± 6.8	3.241	.821	38.7 ± 7.2	33.1 ± 5.9	5.890	.241
Postintervention	30.8 ± 5.4	30.6 ± 5.5	5.930	<.001	32.4 ± 6.6	32.3 ± 6.5	7.923	<.001
t value	8.290	10.922			14.022	11.293		
P value	<.001	<.001			<.001	<.001		

Abbreviations: SAS, Self-Rating Anxiety Scale; SDS, Self-Rating Depression Scale.

Figure 2. Comparison of Anxiety and Depression Levels Between the Intervention and Control Groups Postintervention (N=80)



[a]*P* < .05, indicating that both groups' SAS and SDS scores significantly decreased between baseline and postintervention
[b]*P* < .05, indicating that the intervention group's SAS and SDS scores were significantly lower than those of the control group postintervention

Abbreviations: SAS, Self-Rating Anxiety Scale; SDS, Self-Rating Depression Scale.

Table 4. Comparison of Nursing Satisfaction Between the Intervention and Control Groups (N=80)

Group	Very satisfied n (%)	Satisfied n (%)	Dissatisfied n (%)	Total Satisfaction Rate n (%)
Control group, n=40	9 (22.50)	21 (52.50)	10 (25.00)	30 (75.00)
Intervention group, n=40	16 (40.00)	23 (57.50)	1 (2.50)	39 (97.50)
χ^2 value				8.889
P value				.003[a]

[a]*P* < .01, indicating that the intervention group's total satisfaction rate was significantly higher than that of the control group

the intervention group's SAS and SDS scores were significantly lower than those of the control group ($P < .001$).

Nursing Satisfaction

In the control group, nine participants were very satisfied (22.50%), 21 were satisfied (52.50%), and 10 were unsatisfied (25.00%), for a nursing satisfaction rate of 75.00% for 30 participants (Table 4). In the intervention group, 16 participants were very satisfied (40.00%), 23 were satisfied (57.50%), and one were unsatisfied (2.50%), for a nursing satisfaction rate of 97.50% for 39 participants.

The intervention group's nursing satisfaction rate was significantly higher than that of the control group ($P = .003$).

DISCUSSION

The current study demonstrated that the intervention group had significantly better QoL after intervention, compared to the control group. The intervention group also exhibited significantly lower scores on the SAS and SDS compared to the control group ($P < .05$). Furthermore, the level of nursing satisfaction among the intervention group was significantly higher than that of the control group. These findings align with two previous studies,[15,16] confirming the positive effects of postpartum humanistic care and psychological nursing on maternal QoL and depressive mood.

Postpartum humanistic care and psychological nursing is a valuable approach that improves the QoL and reduces depressive symptoms in postpartum women. By providing personalized care, emotional support, and comprehensive interventions, this nursing model addresses the physical, psychological, and social needs of postpartum mothers. Implementing postpartum humanistic care and psychological nursing can enhance maternal well-being, promote the mother-infant relationship, and contribute to overall family health. Future research and continued efforts in nursing practice should further explore and promote the implementation of this nursing model to optimize postpartum care and support for women experiencing PPD.

Factors in Outcomes

Several factors contribute to these outcomes:

Personalized care. Postpartum humanistic care and psychological nursing address the unique needs of each mother by developing individualized care plans, better fulfilling their requirements.

Emotional support. The nursing approach focuses on providing emotional support to postpartum mothers, fostering a trusting relationship with caregivers and ensuring that mothers feel cared for, respected, and understood, which aids in alleviating PPD.

Scientific approach. Postpartum humanistic care and psychological nursing consider not only the psychological and emotional aspects but also the physiological and health-related aspects of postpartum mothers. Caregivers conduct comprehensive assessments and monitoring of mothers' physical conditions, developing corresponding care plans and interventions.

Long-term benefits. The effects of postpartum humanistic care and psychological nursing have sustainable long-term effects. As Muller study found, this care contributes to increased maternal happiness and life satisfaction and promotes maternal physical and mental health.[17]

Comprehensive approach. Postpartum humanistic care and psychological nursing is a comprehensive nursing model that addresses physiological, psychological, and social aspects of care, as well as factors related to maternal family and social environments. Through comprehensive interventions, maternal quality of life, happiness, and overall well-being can be improved more comprehensively.

Limitations

Nevertheless, the current study had several limitations: (1) the sample size was relatively small, potentially impacting the generalizability of the findings; further research with larger sample sizes is needed to validate the results; (2) the research team conducted the study in a specific setting,

which may limit the applicability of the findings to other cultural or geographical contexts; (3) the study relied on self-report measures for assessing QoL, anxiety, and depression, which can be subject to bias; future studies could include objective measures or interviews to gather more comprehensive data; (4) the study focused on short-term outcomes immediately after the intervention. Long-term follow-up studies are necessary to assess the sustained effects of postpartum humanistic care and psychological nursing on maternal well-being; and (5) the study didn't explore the specific mechanisms or processes by which postpartum humanistic care and psychological nursing influenced maternal outcomes; further research could investigate the underlying mechanisms to better understand the effectiveness of this nursing model.

CONCLUSIONS

Adding humanistic care and psychological nursing in postpartum care can significantly improve the QoL of postpartum women, reduce PPD, and improve their nursing satisfaction.

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