

Partner, Family and Community Support as Protective Factors Against Depressive Symptoms in Pregnancy: A Systematic Literature Review (Bibliometric Analysis)

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Abstract: Antenatal depression is a common maternal mental-health problem with consequences for women, infants, and families, and social support from partners, relatives, friends, communities, and health professionals is widely proposed as a protective resource. Because the evidence is dispersed across countries, measurement tools, and study designs, this systematic literature review (SLR) mapped and synthesised primary research on how social support relates to depressive symptoms during pregnancy, and described its publication trends, methods, geographical spread, collaboration patterns, and recurring themes. Following the PRISMA 2020 statement, records published from 2008 to 2026 were identified through PubMed and Google Scholar, supplemented by ResearchGate, Research Rabbit, DOI searching, and reference-list checking, and were managed in Zotero. Of 150 records identified, 77 full-text reports were assessed and 56 primary studies were included in a bibliometric and narrative synthesis. Publications increased over the review period and peaked in 2025. Fifty-five studies (98.2%) were quantitative, mostly cross-sectional, one (1.8%) was qualitative, and no mixed-methods study was eligible. The studies came from 24 countries, led by China (14), followed by Ethiopia, India, and Australia (four each). Across settings, lower perceived support, particularly from partners and family, accompanied higher depressive symptom scores, while stress, anxiety, intimate partner violence, unwanted pregnancy, financial hardship, health literacy, resilience, and maternal-fetal attachment shaped or modified this relationship. Social support therefore appears to be a clinically relevant and potentially modifiable target for nurses and midwives, but causal conclusions are limited by the dominance of cross-sectional, self-report designs. Longitudinal, qualitative, mixed-methods, and intervention studies are needed, especially in under-represented regions such as South Asia and among socially vulnerable pregnant women.

Keywords: Antenatal Depression, Social Support, Pregnancy, Maternal Mental Health, Nursing, Systematic Literature Review, Bibliometric Analysis.

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I. INTRODUCTION

Depression during pregnancy, usually described as antenatal or prenatal depression, is one of the most frequent mental-health complications of the perinatal period. Beyond low mood, it can weaken a woman's self-care, relationships, use of antenatal services, and readiness for motherhood, and when it is not recognised and managed early it has been linked with poorer maternal and infant outcomes (1,2,3). Reported

prevalence differs widely between settings: depressive symptoms affected 28.5% of women in the third trimester in China (3), 35.7% of women attending an antenatal clinic in Bangalore, India, screened positive (4), 39% of pregnant women in two peri-urban settlements of Cape Town reported depressed mood (5), and the point prevalence in rural Bangladesh reached 56% (6).

In this review, social support refers to the emotional, practical, informational, and companionship resources that a pregnant woman receives or perceives from her partner, family, friends, community, and health professionals. Adequate support may help women cope with pregnancy-related stress, whereas weak partner or family support may increase vulnerability to depressive symptoms (7,8). Greater family support was associated with lower odds of antenatal depressive symptoms in rural Bangladesh (6), partner-specific support with a lower likelihood of probable depression in Tanzania (9), and higher perceived support with fewer symptoms in Australia, China, and Vietnam (7,10,11).

The protective value of support is, however, not uniform. In Rwanda, partner and friend support were both linked with fewer symptoms in unadjusted analyses, but only partner support remained significant once other factors were controlled (12). Support also appears to act together with, and partly through, stress, anxiety, intimate partner violence, financial problems, unwanted pregnancy, health literacy, resilience, and relationship quality, either directly or by buffering the effect of stress (13,14). Zhang et al. reported that social support and maternal health literacy partly mediated the link between pregnancy stress and antepartum depression in Chinese women (14), and Lee tested whether support moderated the effect of stress in Korean women (15).

Despite this growing literature, the evidence is scattered across populations, healthcare settings, pregnancy stages, and cultures. Studies have measured partner, family, friend, perceived, and network support with different instruments, and have assessed depression with the Edinburgh Postnatal Depression Scale, the Patient Health Questionnaire, the Beck Depression Inventory, and locally validated scales (16). Most studies are quantitative and cross-sectional, so they cannot show whether low support precedes depression, and women's own accounts of their support needs and barriers remain under-explored (17). No synthesis has yet combined a bibliometric mapping of this field with a narrative summary of its findings.

This review therefore had three aims: (1) to describe the publication trends, methodologies, and research designs in the literature on social support and depressive symptoms in pregnancy; (2) to map its geographical, institutional, journal, and collaboration patterns; and (3) to identify recurring themes, key findings, gaps, and limitations that can guide nursing and midwifery practice and future research.

II. MATERIALS AND METHODS

➤ Design and Reporting Standard

This SLR was conducted and reported in accordance with the PRISMA 2020 (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) statement and its

flow diagram, which document the identification, screening, eligibility assessment, and inclusion of studies (18). The included studies were also analysed bibliometrically, covering publication year, journals and publishers, author influence, country and institutional distribution, co-authorship, and keyword co-occurrence.

➤ Information Sources and Search Strategy

PubMed and Google Scholar were the main sources. ResearchGate was used to locate additional records and full texts, and Research Rabbit served as a supplementary discovery tool for related studies and citation links. DOI look-ups, reference-list checking, and journal-website searches were used to locate and verify primary articles. The search was built around three concepts: social support, antenatal depression, and pregnant women. Terms included social support, perceived social support, partner support, family support, friend support, professional support, antenatal depression, prenatal depression, antepartum depression, perinatal depression, depressive symptoms, pregnancy, and pregnant women. OR linked synonyms within a concept and AND combined the concepts, for example:

("social support" OR "perceived social support" OR "partner support" OR "family support" OR "friend support") AND ("antenatal depression" OR "prenatal depression" OR "antepartum depression" OR "perinatal depression" OR "depressive symptoms") AND ("pregnant women" OR pregnancy OR antenatal)

Terms such as risk factors, associated factors, determinants, and predictors were added where needed to capture studies examining factors that shaped the support–depression relationship. Searches were adapted to each source and covered publications from 2008 to 2026. Because 2026 was still in progress when the dataset was prepared, counts for that year are partial.

➤ Eligibility Criteria

Eligible studies were primary quantitative, qualitative, or mixed-methods research involving pregnant women (or perinatal samples with separately reported antenatal data) that examined at least one form of social support in relation to depressive symptoms during pregnancy, published between 2008 and 2026, and available as an English full text with enough information to judge eligibility. Table 1 lists the inclusion and exclusion criteria.

Table 1 Inclusion and Exclusion Criteria

Inclusion criteria	Exclusion criteria
Published between 2008 and 2026	Published before 2008 or outside the review period
Pregnant women, or perinatal samples with clearly reported antenatal data	Animal studies, non-pregnant populations, or no relevant antenatal data

Primary quantitative, qualitative, or mixed-methods studies	Systematic or narrative reviews, correction notices, commentaries, editorials, and other non-primary publications
Examined social, perceived, partner, family, friend, or professional support	No relevant form of social support examined
Assessed antenatal, prenatal, antepartum, or perinatal depressive symptoms with pregnancy-related findings	No depression outcome, or no clear antenatal relevance; unrelated outcomes only (e.g., sleep, self-care, life satisfaction, prenatal education)
English full text with sufficient information to judge eligibility and extract findings	Conference abstracts, incomplete records, or insufficient information for eligibility assessment

➤ Study Selection and PRISMA Flow

The searches yielded 150 records (PubMed, 83; Google Scholar, 21; ResearchGate, 14; Research Rabbit, 32). Before screening, 35 records were removed: 15 duplicates identified in Zotero, 10 flagged as ineligible by automated search filters, and 10 not in English. Of the 115 records screened by title and

abstract, 10 incomplete articles were excluded. Full texts were sought for 105 reports, of which 28 could not be retrieved. Of the 77 reports assessed for eligibility, 21 were excluded (not in English, 5; did not address the review concept, 5; unsuitable study design, 11), leaving 56 primary studies (Fig 1). Screening and eligibility decisions were made by the author.

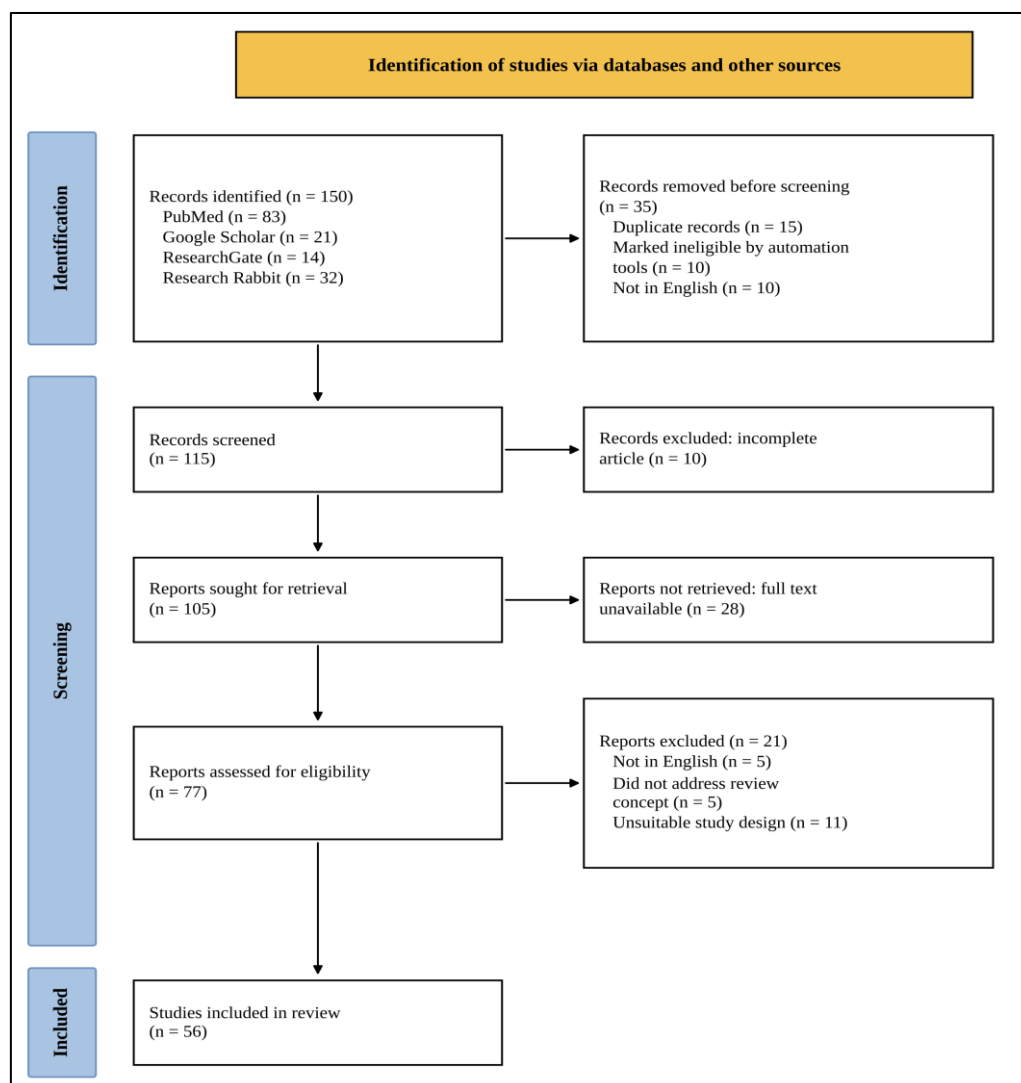


Fig 1 PRISMA 2020 Flow Diagram of Study Identification, Screening, Eligibility Assessment, and Inclusion.

➤ Data Extraction and Management

Bibliographic data for the 56 studies were exported from Zotero to Microsoft Excel, where publication year, journal, publisher, country of data collection, author affiliations, study design, and key findings on support and depression were recorded. Journal indicators (H-index, overall rank, and

impact score) were taken from publicly available journal-metric databases, and author indicators (citations, H-index, and i10-index) from Google Scholar profiles, at the time of analysis. Countries and institutions were plotted with Google My Maps, and co-authorship, keyword co-occurrence, and keyword density maps were generated with VOSviewer.

➤ Quality Appraisal

Because the review was designed to map and describe the evidence base, a formal risk-of-bias score was not assigned to each study. Methodological features relevant to interpretation, namely design, sampling setting, and the instruments used to measure support and depression, were extracted and are considered in the synthesis and limitations.

➤ Data Synthesis

The included studies differed in design, measures, cut-off scores, and populations, so a pooled effect size was not calculated. Findings were instead summarised narratively by source and type of support, direction of association, and psychosocial pathways. Bibliometric features were summarised with descriptive counts, charts, maps, and network visualisations.

➤ Ethics Statement

This review used only previously published, publicly accessible studies. No new data were collected from human or animal participants, no individual patient data were accessed,

and ethical clearance and informed consent were therefore not required.

III. RESULTS

➤ Study Selection

Fifty-six studies met the eligibility criteria (Fig 1). Fifty-five (98.2%) were quantitative and one (1.8%) was qualitative; no mixed-methods study was identified.

➤ Publication Trends

Output was low in the early years, with no more than two studies in any year from 2008 to 2017 and none in 2009 or 2010. Publications then rose to four per year from 2018 to 2022, six in both 2023 and 2024, and a peak of seven in 2025 (Fig 2). The five studies dated 2026 represent a partial year. This pattern suggests growing recognition that depression in pregnancy affects both mothers and infants, and increasing interest in support from partners, families, friends, and health professionals as a protective factor, including its links with pregnancy stress, health literacy, and self-esteem (14,15).

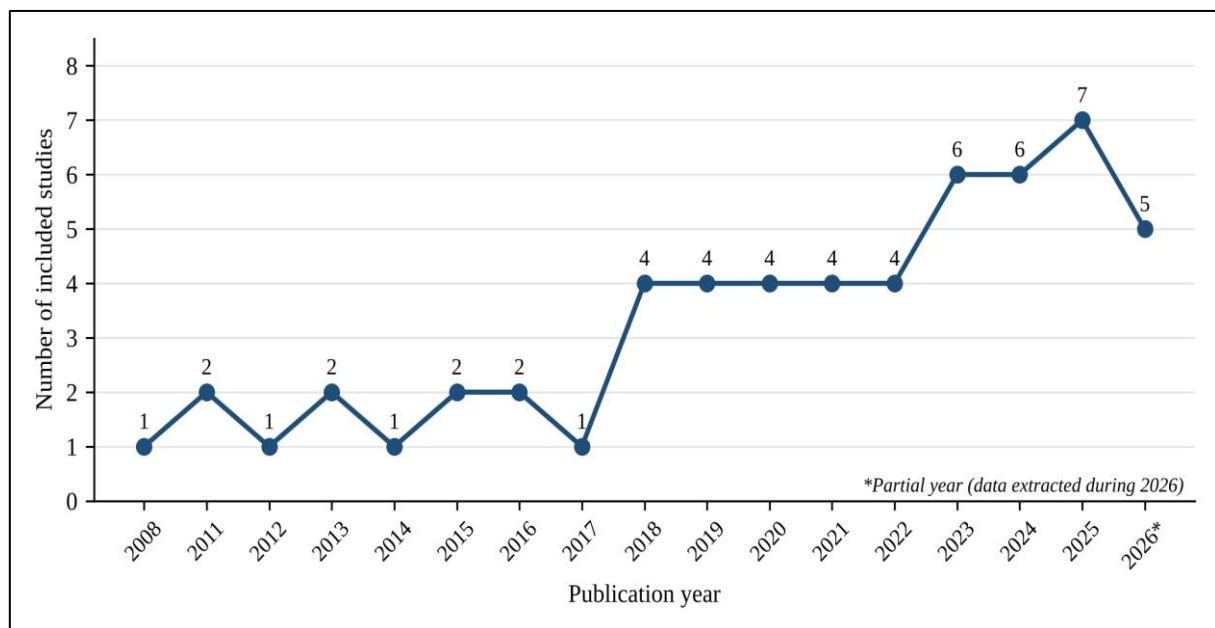


Fig 2 Annual Number of Included Studies, 2008–2026.

➤ Distribution Across Journals and Publishers

Because the topic spans maternal health, nursing, psychiatry, psychology, reproductive health, and public health, the studies appeared in a wide range of journals. BMC journals contributed most, with 16 studies across BMC Pregnancy and Childbirth (8), BMC Psychiatry (6), and BMC Psychology (2). Frontiers in Psychiatry and PLOS ONE

contributed four studies each and Reproductive Health three; Scientific Reports, Frontiers in Public Health, the International Journal of Environmental Research and Public Health, and Women's Health Nursing contributed two each, and the remaining journals one each (Fig 3). Table 2 lists prominent journals with their bibliometric indicators; most are Q1 titles in their subject areas.

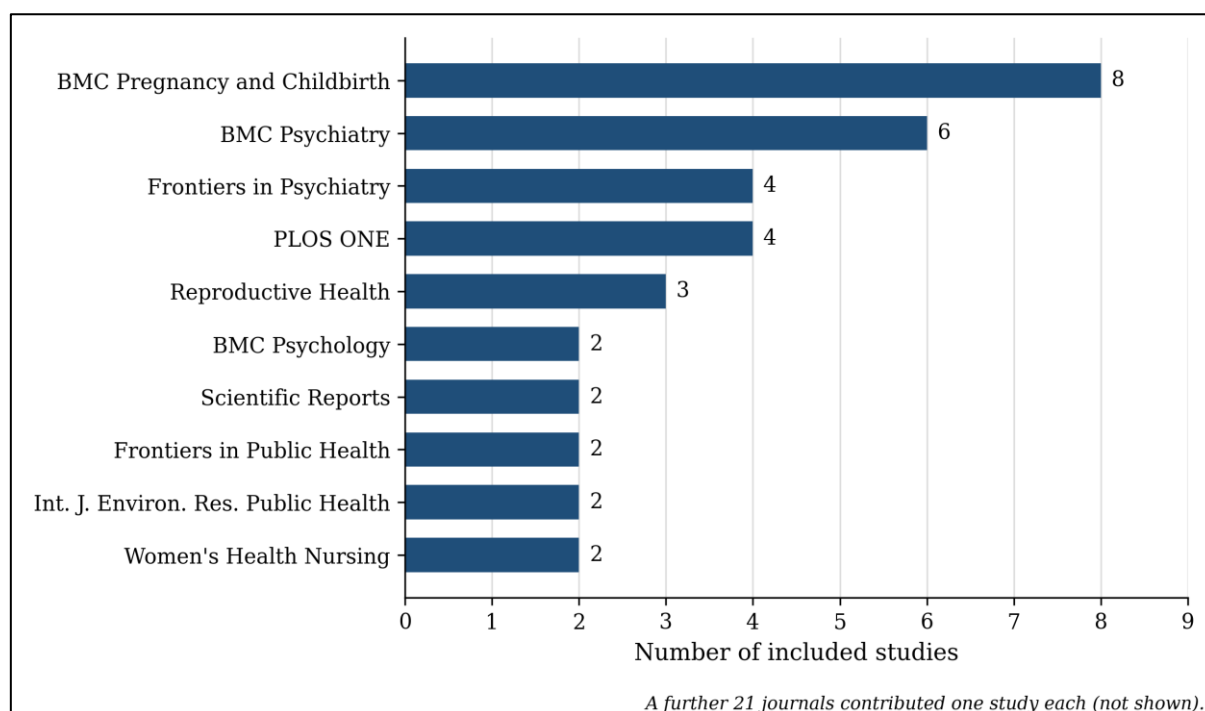


Fig 3 Distribution of Included Studies by Journal.

Table 2 Leading Journals Publishing the Included Studies, Ranked by Impact Score

Journal	n	Subject area (quartile)	H-index	Overall rank	Impact score	Publisher
Social Science & Medicine	1	Health (social science) (Q1); Medicine (misc.) (Q1)	270	1346	5.54	Elsevier Ltd.
Scientific Reports	2	Multidisciplinary (Q1)	382	5846	5.01	Nature Portfolio
International Journal of Environmental Research and Public Health	2	Public, Environmental and Occupational Health (Q2)	167	5680	4.53	MDPI
BMC Psychiatry	6	Psychiatry and Mental Health (Q1)	164	2668	4.30	BioMed Central Ltd.
Social Psychiatry and Psychiatric Epidemiology	1	Epidemiology (Q1); Psychiatry and Mental Health (Q1)	160	2206	3.78	Springer Nature
Journal of Reproductive and Infant Psychology	1	Obstetrics and Gynecology (Q1); Reproductive Medicine (Q1); Psychology (Q1)	54	5227	3.48	Routledge
Journal of Personalized Medicine	1	Medicine (misc.) (Q2)	41	7590	3.40	MDPI
Frontiers in Psychiatry	4	Psychiatry and Mental Health (Q1)	154	3742	3.30	Frontiers Media S.A.
BMC Pregnancy and Childbirth	8	Obstetrics and Gynecology (Q1)	131	4412	3.30	BioMed Central Ltd.
Reproductive Health	3	Obstetrics and Gynecology (Q1); Reproductive Medicine (Q1)	68	3638	3.26	BioMed Central Ltd.

➤ Most Influential Authors

Author influence was assessed by citation count, H-index, and i10-index (Table 3). Robert Stewart, Andrew N. Page, Louise M. Howard, and Mark Tomlinson recorded the highest citation counts among contributing authors. By number of contributions, Mark Tomlinson, Mary Jane

Rotheram-Borus, and Jeannette Milgrom were the most frequently represented, each co-authoring two included studies. Most other authors contributed a single article, providing evidence from diverse countries and healthcare settings and reflecting the multidisciplinary nature of the field.

Table 3 Most-Cited Contributing Authors (Top 10)

Author	Citations	H-index	i10-index
Robert Stewart	60,386	120	671
Andrew N. Page	59,357	64	208
Louise M. Howard	40,661	100	327
Mark Tomlinson	32,757	91	338
Alexander C. Tsai	29,501	85	292
Kingsley E. Agho	22,087	76	252
Michelle J. Hindin	17,879	63	142
Jens Søndergaard	16,691	59	277
Melanie Abas	10,519	51	108
Gemma Lewis	9,452	44	112

➤ *Geographic and Institutional Distribution*

The 56 studies were conducted in 24 countries (Fig 4). China contributed the most (14 studies), followed by Ethiopia, India, and Australia (four each) and Pakistan, South Korea, and South Africa (three each). The remaining studies came from Malawi, Malaysia, Peru, Iran, Rwanda, Turkey, Thailand, Vietnam, Tanzania, Qatar, Italy, Bangladesh, the United States, Canada, the United Kingdom, Japan, and Nigeria. Asia dominated the evidence, Africa was meaningfully represented through Ethiopia, South Africa, Malawi, Rwanda, Tanzania, and Nigeria, while North America and Europe contributed fewer studies and South America was

represented only by Peru, with two studies (19). Central America, Central Asia, and large parts of Africa were absent, and no included study was conducted in Sri Lanka.

Author affiliations showed a similar pattern (Fig 5): institutions were concentrated in China, South Korea, India, Pakistan, Iran, and the Middle East, with smaller clusters in Africa, Europe, North America, Peru, and Australia. Because family structures, cultural expectations, and access to maternity care differ between regions, this imbalance limits how far the findings can be generalised.



Fig 4 Geographical Distribution of Included Studies by Country of Data Collection.



Fig 5 Geographical Distribution of Universities and Institutions Represented by Authors.

➤ Study Designs

Quantitative designs dominated (55 studies, 98.2%; Fig 6). These mainly used questionnaires in cross-sectional surveys, with fewer cohort designs, and applied statistical analyses to relate support scores to depressive symptoms. The

single qualitative study explored the life situations and support experiences of Thai expectant mothers with depressive symptoms and their partners (17). No mixed-methods study met the inclusion criteria.

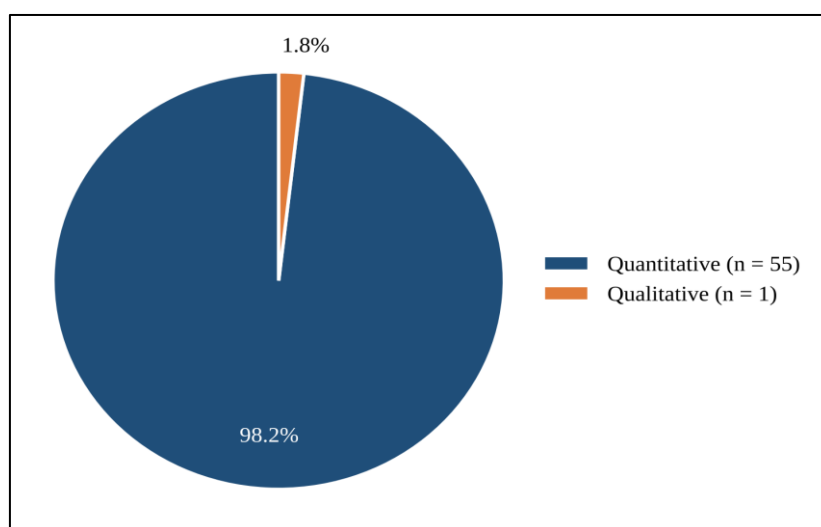


Fig 6 Distribution of Included Studies by Research Methodology.

➤ Co-Authorship Network

The VOSviewer co-authorship map contained one densely connected group of 22 researchers, all co-authors of a multicentre Italian study of depressive symptoms in pregnancy

(20) (Fig 7). Outside this group, authors rarely collaborated across studies, indicating that collaboration between research teams and countries remains limited.

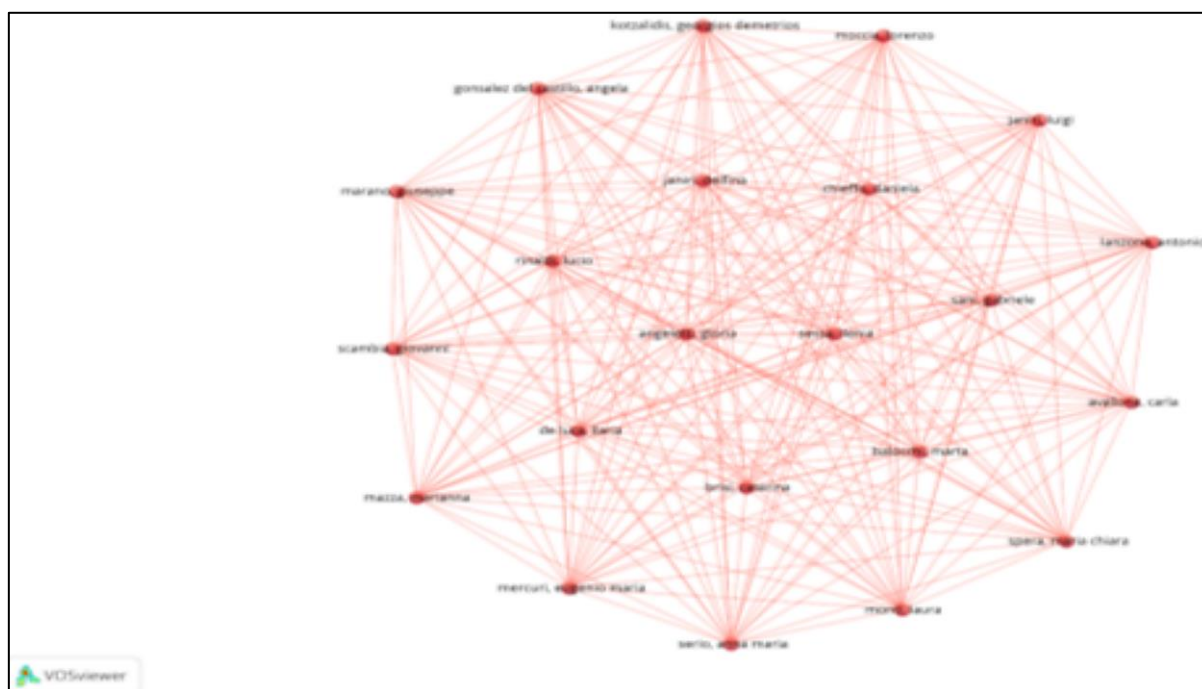


Fig 7 Co-Authorship Network Visualisation (VOSviewer).

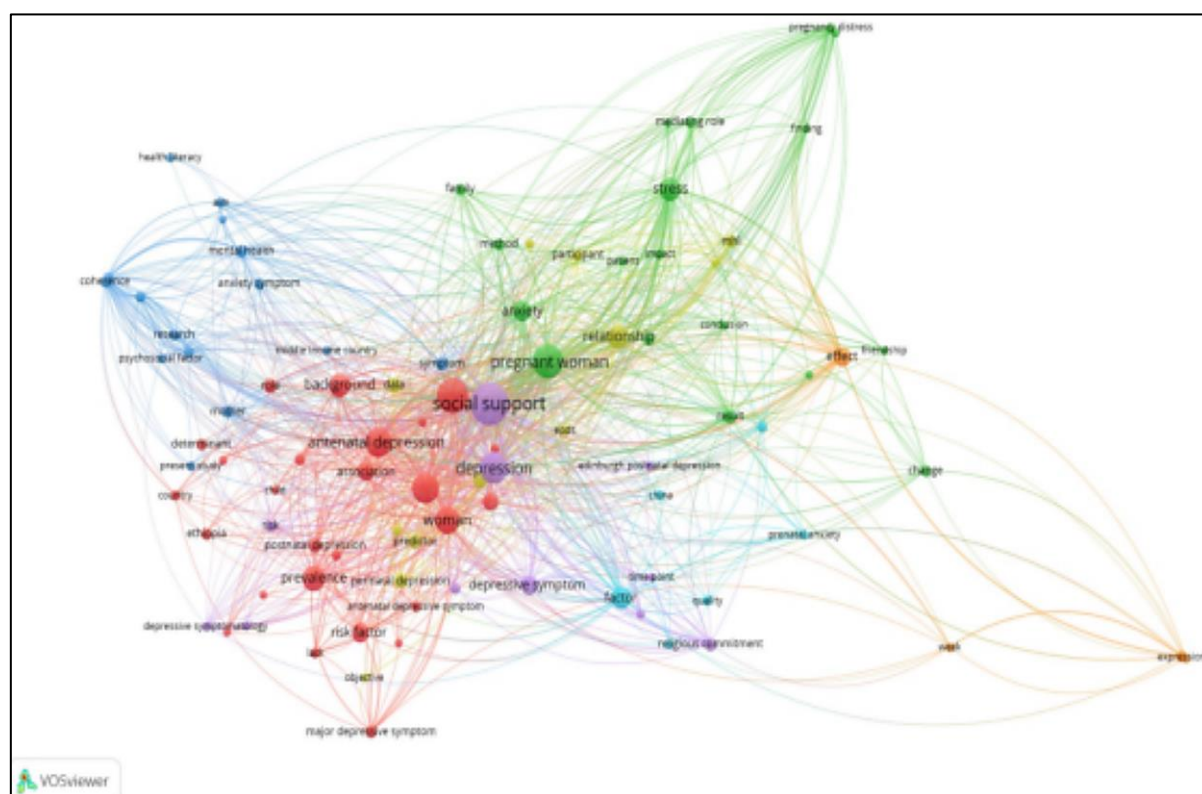


Fig 8 Keyword Co-Occurrence Network Visualisation (VOSviewer).

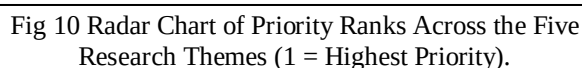
➤ Keyword Co-Occurrence and Thematic Clusters

In the keyword network (Fig 8), node size reflects how often a term occurred and links reflect how often terms appeared together in the same article. The most prominent keywords were social support, depression, pregnant woman, woman, and antenatal depression, closely connected with

stress, anxiety, risk factor, prevalence, and EPDS. Seven colour-coded clusters were identified (Table 4), indicating that current research focuses mainly on how support, stress, anxiety, and other psychosocial factors relate to depressive symptoms in pregnancy.



The five research themes were ranked from 1 (highest priority) to 5 (lowest) according to their relative prominence in the keyword and thematic analyses (Fig 10). Antenatal depression ranked first, followed by social support and psychosocial well-being during pregnancy (2), maternal mental health and psychosocial factors (3), assessment and predictors of perinatal depression (4), and postpartum depression and partner-related factors (5). These ranks describe relative emphasis only and do not represent prevalence, effect size, or statistical significance.



- *Direction of the Association*

Across countries and designs, women reporting stronger support generally reported fewer depressive symptoms, whereas limited or inadequate support accompanied a greater risk of antenatal depression (3,7,10,21,22). Partner support, family support, friendship, and practical and emotional help emerged as the most consistent protective resources.

Partner and family relationships were especially influential. Poor marital relationships, lack of partner involvement, intimate partner violence, family conflict, and inadequate practical help were repeatedly associated with higher symptom scores (2,6,9). Friend support was less consistent: its association with fewer symptoms in Rwanda disappeared after adjustment, whereas partner support remained significant (12). Family context also mattered, as the protective role of support differed between extended and nuclear family households in Turkey (8).

Pregnancy-related stress, anxiety, employment and financial difficulties, food insecurity, unwanted pregnancy, and previous mental-health problems further increased the risk of antenatal depression where support was limited (2,6,9,23,24,25).

• *Psychological Pathways*

Several studies modelled support as a pathway rather than a simple correlate. Support partly mediated the effect of stress on depressive symptoms in Pakistan and China (13,14), and in a Pakistani cohort it accounted for part of the association between low haemoglobin, a biological stressor, and antenatal depressive symptoms (26). Others found that support moderated the effect of perceived stress (27), or examined it alongside self-esteem, religious commitment, resilience, and maternal-fetal attachment (15,28,29). In high-risk hospitalised pregnant women in Korea, support correlated negatively with depression but was not an independent predictor once stress and attachment were considered (28), again showing that its effect can weaken after adjustment.

IV. DISCUSSIONS

This review indicates that social support is consistently associated with fewer depressive symptoms in pregnancy and that partner and family support are the most influential sources. The findings also suggest that antenatal depression arises from several interacting social, psychological, relational, and economic factors rather than a single cause (3,7,10), and that support may work both directly and by reducing the impact of stress (13,14,27). For nurses and midwives, this supports routine depression screening combined with an assessment of the support available to each woman, partner and family involvement where it is appropriate and safe, counselling and peer-support programmes, and timely referral to mental-health services (14,30).

The bibliometric results show a young but growing field. Output has risen steadily since 2018 and is published mainly in Q1 maternal-health and psychiatry journals, yet collaboration is fragmented and concentrated in a few countries. Three gaps emerge.

➤ *Empirical Gap:*

Most studies relied on self-reported, cross-sectional data. They show that weaker support and depressive symptoms occur together but provide limited evidence about causal direction or how the relationship changes across pregnancy (31). Intervention evidence testing whether partner involvement, family support, peer-support programmes, or professional counselling reduces antenatal depression is also scarce.

➤ *Population Gap:*

Evidence was concentrated in China and a few other countries, while Central America, Central Asia, most of South America, much of Africa, and South Asian countries such as Sri Lanka were absent or barely represented. Rural, migrant, and unmarried women, women experiencing intimate partner violence, women with limited access to maternity care, and women with high-risk pregnancies were rarely studied (28,32), which limits generalisability across cultures and health systems.

➤ *Methodological Gap:*

Fifty-five of the 56 studies were quantitative, one was qualitative, and none used mixed methods. Support and depression were measured with different instruments, definitions, and cut-off scores, making studies hard to compare and preventing meta-analysis. Little is known about women's own experiences and the cultural meaning of support during pregnancy.

➤ *Limitations of this Review*

First, eligibility was restricted to English full texts; 15 non-English records and 28 reports without accessible full texts were excluded, which may have introduced language and access bias and under-represented countries that publish mainly in national-language journals. Second, the search relied mainly on PubMed and Google Scholar with supplementary sources; CINAHL, PsycINFO, Scopus, and Web of Science were not searched, and grey literature, theses, and conference proceedings were not included, so relevant studies may have been missed and publication bias cannot be excluded. Third, screening and data extraction were performed by a single reviewer, and no formal risk-of-bias score was assigned, so the synthesis remains descriptive. Fourth, heterogeneity in designs, measures, and samples prevented a pooled effect estimate. Finally, citation counts, H-index values, and journal rankings change over time, and the 2026 publication count reflects only part of that year.

➤ *Future Research Directions*

Prospective cohort studies measuring support and depressive symptoms at several points from early pregnancy into the postpartum period are needed to clarify the direction of the relationship and identify periods of greatest vulnerability. Qualitative and mixed-methods studies should explore how women, partners, and families understand support, which forms they value, and what cultural, financial, and gender-related barriers prevent help-seeking. Randomised or well-controlled trials should evaluate partner-inclusive antenatal classes, peer-support groups, nurse- and midwife-led psychosocial support, group antenatal care, home visiting, and digital options such as mobile-health applications and telephone or video counselling, with antenatal depression as a primary outcome. Studies should report the source, type, and timing of support and use validated, culturally adapted scales with consistent screening cut-offs.

V. CONCLUSION

Adequate social support, particularly from partners and families, is consistently associated with fewer depressive symptoms during pregnancy, while limited support, poor relationships, intimate partner violence, stress, anxiety, and financial hardship are associated with more symptoms (3,7,10). Support is therefore a clinically relevant and potentially modifiable target for nurses, midwives, and other maternity professionals. The research base is growing but is dominated by cross-sectional, self-report studies from a limited number of countries.

Further studies are warranted to: (1) use longitudinal designs that capture changes in support and mood across

pregnancy; (2) apply qualitative and mixed-methods approaches to understand women's experiences and support needs; (3) evaluate support-strengthening interventions in randomised or well-controlled trials; and (4) include under-represented regions such as Sri Lanka and other South Asian countries, and socially vulnerable groups of pregnant women. Addressing these gaps would support culturally appropriate, nurse-led strategies that protect maternal mental health throughout pregnancy.

➤ Author Contributions

M. G. Minadi Chathunima: Conceptualization, Methodology, Literature search, Study selection, Data extraction, Formal analysis, Visualization, Writing – original draft, Writing – review & editing. The sole author has read and agreed to the submitted version of the manuscript.

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➤ Conflicts of Interest

The author declares no conflict of interest.

➤ AI Use Declaration

Generative AI (Claude, Anthropic) was used to assist with language editing, restructuring the manuscript to the journal format, and checking reference details against their DOIs. The literature search, study selection, data extraction, analyses, and interpretation were carried out by the author, who takes full responsibility for the accuracy and integrity of the manuscript.

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