



Research paper

Perinatal depression among a global sample of Spanish-speaking women: A sequential-process latent growth-curve analysis



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ABSTRACT

Background: Despite high rates of perinatal depression among women from diverse backgrounds, the understanding of the trajectory of depressive symptoms is limited. The aim of this study was to investigate the trajectories of depressive symptoms from pregnancy to postpartum among an international sample of pregnant women.

Methods: Hispanic/Latina (79.2%), Spanish-speaking (81%) pregnant women ($N = 1796$; Mean age = 28.32, $SD = 5.51$) representing 78 unique countries/territories participated in this study. A sequential-process latent growth-curve model was estimated to examine general trajectories of depression as well as risk and protective factors that may impact depression levels throughout both the prenatal and postpartum periods.

Results: Overall, depression levels decreased significantly across the entire perinatal period, but this decrease slowed over time within both the prenatal and postpartum periods. Spanish-speaking women, those who were partnered, and those with no history of depression reported lower levels of depression during early pregnancy, but this buffer effect reduced over time. Depression levels at delivery best predicted postpartum depression trajectories (i.e., women with higher levels of depression at delivery were at greater risk for depression postpartum).

Limitations: Given the emphasis on language and not country or culture of origin this study was limited in its ability to examine the impact of specific cultural norms and expectations on perinatal depression.

Conclusions: Given these findings, it is imperative that providers pay attention to, and assess for, depressive symptoms and identified buffers for depression, especially when working with women from diverse communities.

1. Introduction

Pregnancy and childbirth are often thought of as special and happy times for the expecting mother. However prior research suggests that depression during and after pregnancy is a common experience for many women with approximately 12.4% of women in the general population reporting prenatal depression (Le Strat et al., 2011). Among pregnant Latinas¹ in the United States of America (U.S.A.), as many as 32.4% suffer from depressive symptoms (Lara et al., 2009). Unfortunately, giving birth does not alleviate women from depression, as roughly 13% of women experience postpartum depression (PPD; Goecke et al., 2012; O'Hara and Swain, 1996). The rate of PPD is even higher for women in Spanish-speaking countries (36.8%; Lara et al., 2009) and Latina immigrants to the U.S.A. (54%; Lucero et al., 2012).

Despite efforts to screen, prevent, and treat maternal mood disorders, perinatal (i.e., pregnancy and postpartum) depression often goes undetected and untreated (Bales et al., 2015; Cox et al., 2016). Prior research has identified low social support, poor partner relations, prior history of depression, and stressful life events as risk factors for perinatal depression (DeCastro et al., 2011; Ibarra-Yruegas et al., 2016; Lara-Cinisomo et al., 2016). Although effective prevention and treatment interventions for PPD have been established (Dennis, 2005; Dennis and Dowswell, 2013), a number of cultural, economic, and systemic barriers interfere with women's ability to access these services (Bijl et al., 2003; Patel and Wisner, 2013). For example, ethnic-minority women with low socioeconomic resources are less likely to seek mental health care during the perinatal months, perhaps due to transportation, cost, and childcare barriers (Alvidrez and Azocar, 1999; Song et al.,

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¹ Individuals of Latina/o ethnic identity refer to those who have cultural origins in Latin American countries. Latina/o and Hispanic are used interchangeably to reflect how it was listed in the cited literature and individual preferences.

2004). Cultural attitudes and beliefs related to a woman's role as a mother may also reduce the likelihood of accessing care. Latinas, for example, may hold a strong family ethnic identification that discourages them from seeking professional care, instead relying on partners or family members for support (Barrera and Nichols, 2015). Additionally, religion and other practices based on cultural expectations (e.g., *marianismo* among women from Latin cultures; Lara-Cinisomo et al., 2018) may influence and/or be seen as more acceptable than sharing intimate feelings about the transition to motherhood (Callister et al., 2011; Dennis and Chung-Lee, 2006).

Tracking depressive symptoms throughout the entire perinatal period is imperative because adverse developmental outcomes occur in children exposed to depression and stress in utero (Peer et al., 2013). Moreover, children exposed to chronic maternal depression following birth are at greater risk for developing depression, exhibit lower levels of social competence, and show less activation in the frontal lobes (Ashman et al., 2008). Finally, maternal depression can interfere with the quality of attachment relationships between the mother and the child and can negatively impact physical and mental health outcomes (Monk et al., 2008; Perry et al., 2011). To increase detection, engagement in treatment, and outcomes for perinatal women and their offspring, it is helpful to gain an understanding of the course of depressive symptoms that pregnant and postpartum women experience. Evaluating trajectories for depression in the perinatal period can be challenging, because prenatal and postpartum depression have different symptom profiles, as well as significant overlap between criteria for clinical depression and normal postpartum experiences (e.g., rapid weight changes, sleep disturbances, fatigue), which necessitates the use of different measures. For example, during the prenatal period, standard measures of depression can be used, but during the postpartum period, specialized measures (i.e. Edinburgh Postnatal Depression Scale [EPDS]; Cox et al., 1987) have been found to be more appropriate.

Prior research examining the natural course of perinatal depression reveals that depressive symptoms tend to decrease over the course of pregnancy and into the postpartum period (Ahmed et al., 2018; Banti et al., 2011; Bowen et al., 2012). A study by Bowen et al. (2012) assessed depressive symptoms of Canadian women at three time points: early and late pregnancy, as well as one month postpartum. Analyses revealed that depression symptom scores decreased from pregnancy to postpartum, with greater declines for women who were engaged in either psychotherapy or taking psychotropic medications. Christensen et al. (2011) found that mean depressive symptom scores declined among immigrant Latinas from pregnancy to one year postpartum among women with a history of major depression or who were classified as at-risk based on their current levels of depressive symptoms. Similar patterns were found in a sample of Mexican immigrant women who reported a decline in depression from pregnancy to roughly two months postpartum (Kieffer et al., 2013).

Women from ethnically diverse backgrounds are at greater risk for PPD compared to Caucasian or ethnic majority women, given the higher prevalence of external factors that may contribute to depression such as socioeconomic and immigration status, educational attainment, and marital status (Howell et al., 2005; Lara et al., 2009; Lara-Cinisomo et al., 2016). However, studies focusing on non-immigrant perinatal women residing in their country of origin are limited. An increased understanding from non-immigrant perinatal women would provide an outline for the trajectory of depression without additional confounding variables, such as acculturation stress, which is a factor to consider when examining these constructs among U.S.A. residents of Latina/o origin, for example. In addition, knowing the potential path or outcome of depression from pregnancy to the postpartum can be informative for the development and implementation of maternal mental health services, especially among communities where low service utilization is the norm and not the exception (i.e., low and middle income countries account for 80% of the world's population but possess less than 20% of available mental health resources; Patel and Prince, 2010).

There were two primary aims of the current study: first, to track the course of depression during pregnancy and into the first year postpartum among a sample of predominantly Spanish-speaking women residing in Latin American countries; and, second, to determine whether the course of depression symptoms during pregnancy, as well as a woman's level of depression at the time of childbirth, predicted her trajectory of postpartum depression symptoms. The use of distinct measures for prenatal (Center for Epidemiologic Studies-Depression [CESD]; Radloff, 1977) and postpartum (EPDS) depression, as well as the novelty of the research questions (i.e. how prenatal and postpartum trajectories relate to one another) required the specification of a *sequential-process growth-curve model* (SP-GCM), which allowed for the identification of trajectories of depression before and after giving birth along with associated risk factors (third aim).

2. Method

2.1. Participants

Of the 2966 women who consented to participate in a larger online prevention of postpartum depression trial (Barrera et al., 2015), 1862 women completed both the baseline assessment and at least one follow-up assessment. Women who experienced a termination in pregnancy other than childbirth (i.e. miscarriage), as well as women who indicated a final pregnancy length of below 25 weeks or above 45 weeks were excluded from this report. The final sample included 1796 ($M_{\text{age}} = 28.32$, $SD = 5.51$) women, representing 78 unique countries and territories who, on average, were 18 ($SD = 9.66$) weeks pregnant (see Table 1). The women were predominantly Spanish speaking (81%) and identified their ethnic background as Latina/Hispanic (79.2%). About two thirds of the participants were married or cohabitating (62.23%), 84.32% had attended or obtained a university degree, and 58% indicated that this was their first child. Within the sample, 572 (32.59%) women endorsed a subjective history of depression at the baseline assessment. The English- and Spanish-speaking participants differed significantly from each other on all demographic factors. For example, the Spanish-speaking participants were more likely to be Latina/Hispanic, of Mestizo descent, unmarried, and have less education. The women participated in an average of 2.35 ($SD = 2.96$) follow-ups with a maximum of 16 follow-ups. Participants came back for an average of 1.29 follow-ups ($SD = 1.66$) during the prenatal period and 1.06 follow-ups ($SD = 1.90$) during the postpartum period.

2.2. Measures

Assessment of demographic characteristics included participants' language, age, sex, ethnicity, race, marital status, education, employment, country of origin, and pregnancy history (number of weeks pregnant and number of prior pregnancies).

The Center for Epidemiologic Studies-Depression (CES-D; Radloff, 1977) Scale was used to measure current depressive symptoms at the baseline assessment and monthly during pregnancy. The CES-D is a 20-item, self-report measure that assesses for the presence of depressive symptoms within the past week (Radloff, 1977). Total scores range from 0–60 with higher scores indicating more severe depressive symptoms. A cutoff score of 16 or above indicates significant depressive symptoms (Radloff, 1977). The CES-D has been found to have good internal consistency and validity (Roberts and Vernon, 1983). The Spanish-version of the CES-D has been validated among Spanish-speakers, with sensitivity and specificity ranging from 72% to 92% and 70% to 74%, respectively (Reuland et al., 2009). The CES-D was used to track the prenatal trajectory.

The Edinburgh Postnatal Depression Scale (EPDS; Cox et al., 1987) was used monthly to measure depressive symptoms once participants indicated that they had given birth. The EPDS is a 10-item self-report measure that is designed to screen for depressive symptoms in women

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