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Antenatal depression and its relationship with problem-solving strategies, childhood abuse, social support, and attachment styles in a low-income Chilean sample

Marcia Olhaberry*[,1], Johana Zapata[2], Marta Escobar[1], Constanza Mena[1], Chamarrita Farkas[3], María Pía Santelices[4], Mariane Krause[5]

Pontificia Universidad Católica, Av. Vicuña Mackenna 4860, Santiago, Chile

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Abstract
A non-experimental, cross-sectional study was performed. A group of 96 pregnant Chilean women with low income and depression were contacted through Public Health Centers. The association between depressive symptoms (BDI $\geq$ 10) and other variables was analyzed. Low social support satisfaction (SSQ-6), high scores for negative orientation towards problems, childhood physical abuse, insecure attachment and recurrent depression were relevant variables for predicting depressive symptoms in the studied group.

Introduction

According to WHO reports, one out of every 20 people have had at least one depressive episode in the prior year (WFMH, 2012). In Chile, the prevalence of depressive disorders in the general population is 17.2%. The disorders are substantially more common among women, who show an incidence rate of 25.7% compared with 8.5% in men (Ministerio de Salud de Chile, 2009–2010).

Studies have shown that the psychological and social changes that occur during pregnancy may lead to depressive disorders (Morales et al., 2004), even though these changes are often confused with symptoms specifically related to

*Corresponding author at: Department of Psychology, Universidad Catolica de Chile, Av Vicuna Mackenna 4860, Macul, Santiago, Chile.
E-mail addresses: mpolhabe@uc.cl (M. Olhaberry), jszapata@uc.cl (J. Zapata), martaescobar@uc.cl (M. Escobar), cmena1@uc.cl (C. Mena), chfarkas@uc.cl (C. Farkas), msanteli@uc.cl (M.P. Santelices), mkrause@uc.cl (M. Krause).
[1]Tel.: +56 2 23544837.
[2]Tel.: +56 2 23545905.
[3]Tel.: +56 2 23547067.
[4]Tel.: +56 2 23547664.
[5]Tel.: +56 2 2354717.

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pregnancy (Klein & Essex, 1994). International studies have demonstrated that 6–38% of women suffer from depression during or after pregnancy (Field, 2011), with figures in developing countries, such as Chile, mirroring these numbers. Chilean studies have also demonstrated that women with depressive symptoms during pregnancy have a greater chance of maintaining those symptoms after childbirth (Alvarado et al., 2000).

Approximately one-third of pregnant women suffer depression during gestation. Studies have described adverse effects on the child during his or her development (Field, 2011). During gestation and at the point of childbirth, studies have shown a higher cardiac activity in the new-born (Emory & Dieter, 2006), a higher frequency of premature births, reduced growth, and a low birth weight (Diego et al., 2009). Other studies have also described negative consequences in cognitive and behavioral development (Milgrom, Gemmill, & Bilszt, 2008) as well as an increased risk for depression in different life stages (Pawlby, Hay, Sharp, Waters, & O'Keane, 2009). Regarding the quality of interactions between depressed mothers and their babies, studies have reported a higher frequency of crying, more negative affections, eye-contact avoidance among the children (Boyd, Zayas, & McKee, 2006), and a lower frequency of positive affections and synchronicity in the interaction (Svanberg, Mennet, & Spieker, 2010). A greater incidence of insecure attachment in the children of depressed mothers has also been described (Martins & Gaffan, 2000), especially among mothers who show depression of greater severity and frequency (McMahon, Barnett, Kowalenko, & Tennant, 2006). Although there is a substantial amount of literature regarding the adverse effects of prenatal depression on children, this is not always found in studies (Carro, Grant, Gotlib, & Compas, 1993; Dietz, Jennings, Kelley, & Marshal, 2009; Gere et al., 2013; Mezulis, Hyde, & Clark, 2004).

Blöschl (1998) developed a comprehensive depression model which considers the conjunction of biological, psychosocial and psychological factors. It assumes that whoever suffers from a depressive disorder has cognitive, affective and behavioral schemas that can be observed and measured. These schemas can be thought of as part of the deregulation of adaptive psychobiological mechanisms. In this context, the present study assesses psychosocial aspects which are considered risk factors for depression, such as lack of partner, low perceived social support, childhood sexual abuse and maltreatment. It also considers psychological factors such as maternal attachment style and problem-solving strategies, which show some cognitive and affective schemas.

A number of studies have described risk factors for depression during pregnancy. Considering socio-demographic variables, some studies have shown a positive association between depression during pregnancy, the absence of a partner, an inadequate socio-familiar support network, low income, and extreme maternal age (adolescent or older than 40 years) (Faisal-Cury & Rossi Menezes, 2007).

Factors associated with specific experiences in pregnancy that increase the risk of developing depression in this period, such as the lack of planning, an unwanted pregnancy, and excessive ambivalence towards motherhood (Bowen & Muhajarine, 2006), have also been described. Likewise, high levels of stress and an insufficient ability to cope with it, substance abuse, traumatic experiences early in life, family violence, partner conflict, low educational attainment, and prior depressive episodes are associated with this disorder (Escribe-Aguir, Gonzalez-Galarzo, Barona-Vilar, & Artazcoz, 2008; Gausia, Fisher, Ali, & Oosthuizen, 2009; Pajulo, Savonlahti, Sourander, Helenius, & Piha, 2001). This last factor is highly relevant, considering the fact that mothers who develop a depressive episode during pregnancy show a higher probability of displaying it postpartum if they do not receive sufficient support during pregnancy (Cooper & Murray, 1995).

Another individual factor that may influence the appearance of a depressive disorder is the type of maternal attachment. Evidence shows that pregnant mothers with depression tend to have distancing or intrusive behaviors most often, which both are characteristics of insecure attachment (Murray, Stanley, Hooper, King, & Fiori-Cowley, 1996). Furthermore, studies have found a positive association between insecure avoidance attachment and depression during pregnancy (Bifulco et al., 2004).

The negative effect of traumatic experiences in childhood, such as sexual and physical abuse, on mental health has also been widely documented. This situation has been described as leading to a greater propensity to suffer depressive symptoms in these victims (Briere, 1992; English, 1998; Nelson et al., 2002). Moreover, evidence has shown that women who report having lived physical or sexual abuse during childhood tend to report higher levels of depression than men with similar experiences (Weiss, Longhurst, & Mazure, 1999).

Regarding social support some authors highlight its contribution to the development of positive self-esteem and greater self-confidence, achieving greater personal control and satisfying the need for affection and belonging, as well as sufficient coping with stress. Social support is associated with lower levels of anxiety and depression (Acuña & Bruner, 1999; Aduna, 1998; Holtzworth-Munroe, Stuart, Sandin, Smutzler, & Mclaughlin, 1997; Orthner, Jones-Sanpei, & Williamson, 2004; Solomon, Mikulincer, & Avitzur, 1988). However, it is important to emphasize that the quality of perceived social support is associated with how effectively it reduces personal stress, independent of the number of people involved (Cohen & Wills, 1985).

Among pregnant women, it has been described that the perception of social support may determine their level of well-being (Spoozak, Gotman, Smith, Belanger, & Yonkers, 2009). Evidence has shown an association between depression and the perception of low social, emotional, and practical support in gestating women (Senturk, Abas, Berksun, & Stewart, 2011). The lack of partner support has also been shown to be associated with the perception of low social support and depression in pregnancy, independent of socioeconomic level (Bolton, Hughes, Turton, & Sedgwick, 1998; Patel, Rodrigues, & DeSouza, 2002). Some studies have suggested that social support may act as a protective factor, reducing the effects of stressful life conditions. However, in lower income populations this can also act as a source of stress (Séguin, Potvin, St-Denis, & Loiselle, 1995).

Likewise, the literature has consistently described deficits in the ability to solve problems among those who suffer depression. These people face high numbers of stressors and do not have the necessary cognitive abilities to manage these situations and generate adequate solutions (Marx, Williams, & Claridge, 1992).