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The relationship between perinatal psychiatric disorders and contraception use among postpartum women

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Abstract

Background: The relationship between perinatal psychiatric disorders and the use of effective contraceptive methods among postpartum women served by primary care clinics has not been established.
Study Design: This was a prospective cohort study with 831 pregnant women recruited from 10 primary care clinics of the public sector in São Paulo followed up to 18 months after delivery.
Results: Among 701 postpartum women, 644 women (91.8%) had resumed sexual activity. Two hundred fifty-three women (39.2%) were classified as using a less effective contraception method (LECM). The presence of perinatal psychiatric disorder (in pregnancy and/or postpartum) was not associated with LECM. Resumption of sexual life 3 months or beyond after delivery was associated with LECM (odds ratio=1.28, 95% confidence interval: 1.02–1.56).
Discussion: Although the use of an LECM after delivery is common, contraception choice is not associated with perinatal depressive/anxiety symptoms. However, women who delay the resumption of sexual activity after delivery should be counseled on the use of available contraceptive methods.

Keywords: Perinatal depression; Contraceptive counseling; Contraception; Primary care; Women's health; Common mental disorders

1. Introduction

Unintended pregnancies are common events both in developed and in developing countries. Although numerous contraceptive methods are widely available, nearly one half of all pregnancies in the United States are unintended, and nearly 40% of those end in abortion [1]. Unintended pregnancies during the postpartum period are a particularly serious problem since the short interval between pregnancies is associated with a higher risk for low birth weight and preterm birth [2,3].

Contraception choice has been related to social, cultural and psychological factors [4]. In addition, the choice of a particular contraceptive method may be influenced by depression. An American study showed that women screening positive for depression had significantly lower odds of choosing a more effective method of contraception [5]. Another study of lower-income women has also found a link between depressive symptoms and self-reported contraceptive nonuse [6]. However, a review of articles does not consider depression to be a factor associated with the use of less effective contraceptive methods (LECMs) [7].

The relationship between the use of more effective forms of contraception and depression in the perinatal period is even less clear. However, antenatal depression and postpartum events are also common, occurring in between 15% and 20% of women [8], with important consequences for both the mother and her infant [9]. In Brazil, several studies have shown a high prevalence of depressive symptoms during pregnancy [10,11] and in the postpartum period [12].

In the postpartum period, depressed women may present problems with sexual desire and have less sexual activity or may feel more anxious and worried about contraceptive methods if they are breastfeeding, both situations leading to the use of less reliable forms of contraception.

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To date, no prospective study has investigated the relationship between perinatal psychiatric disorders and the use of effective contraceptive methods among postpartum women served by primary care clinics. Our hypothesis is that women with perinatal psychiatric disorders are more likely to use LECM than those who do not have perinatal psychiatric disorders.

2. Methods

2.1. Study design and sample

This was a prospective cohort study, conducted between May 2005 and January 2006, with pregnant women recruited from 10 primary care clinics of the public sector in three administrative districts in the Western area of the city of São Paulo, Brazil. The study area was comprised of a heterogeneous population of approximately 250,000 inhabitants, where people with high, medium and low income live near each other. Public primary care clinics offer free antenatal care for all women living in their catchment areas. Antenatal care is offered regularly, usually once a month, generally starting as soon as the woman seeks the clinic for a pregnancy test. Women followed in these clinics are at low obstetric risk. After childbirth, women are also seen in the primary care clinics where they receive their PAP smear and receive contraceptive counseling. Pregnant women between 20 and 30 weeks of pregnancy, whose conception occurred naturally, with 16 years of age or older, with singleton pregnancies and who were receiving antenatal care in primary care clinics in the study area were considered eligible. Postpartum women were interviewed at home (mean time of interview after delivery: 11.1 months, SD: 2.3 months). Almost three fourths of the women were interviewed between 6 and 12 months, and 27.6% were evaluated up to 18 months. Further details of the study sample were described elsewhere [13].

2.2. Instruments

2.2.1. Perinatal psychiatric disorders

Presence of antenatal and postnatal psychiatric disorders was measured by the Self-Report Questionnaire (SRQ-20), which was developed for screening psychiatric disorders in patients treated in primary care settings [14]. The SRQ-20 was validated in primary care in Brazil, with 85% sensitivity and 80% specificity [15]. The SRQ-20 has good psychometric properties for diagnosing perinatal psychiatric disorders, performing even better than instruments specifically designed for this purpose [16,17]. The cutoff point of the SRQ-20 for the present study was set at 7/8 [15]. Four groups were defined according to the presence of a psychiatric disorder during pregnancy and/or postpartum: group 1, absence of both antenatal and postpartum psychiatric disorder; group 2, presence of antenatal psychiatric disorder only; group 3, presence of postpartum psychiatric disorder only; group 4, presence of both antenatal and postpartum psychiatric disorder.

2.2.2. Social support

A Brazilian version of the scale used in the Medical Outcomes Study was used. The original version showed good psychometric properties [18]. Items in the scale were translated and independently back-translated and adapted to Portuguese in five pretest steps and in the pilot study [19]. The Brazilian version was shown to have good test–retest reliability [20]. The 19-item scale measured five dimensions of social support: material, emotional, informational, affective and positive social interaction. For each item, the respondent indicated how often she perceived that kind of support: never, rarely, sometimes, very often or always. The scale allows the use of five dimension-specific scores or the total score. Social support dimensions showed internal consistency, with Cronbach's alpha coefficients ranging from 0.75 to 0.91 at test and from 0.86 to 0.93 at retest. The intraclass correlation coefficient was high in the five dimensions of the scale, with no substantial differences by gender, age or level of education.

2.2.3. Other exposure variables

Sociodemographic characteristics and obstetric information were obtained through a structured detailed questionnaire applied during the antenatal assessment. Such information included age, years of schooling, family income (in US dollars), marital status, skin color and frequency of contact with neighbors. Household goods included electricity, plumbing, computer, television, cable television, bathroom, telephone and refrigerator. A score of goods was created, where every existing item in the household was assigned a point. Previous and current obstetric data included planned pregnancy, number of previous abortions, number of pregnancies, gestational age, birth weight of infants and Apgar scores at 5 min. A dual "yes–no" classification of obstetric complications was developed. "Yes" was defined by the presence of gestational age less than 37 weeks or weight of newborns under 2500 g or 5-min Apgar less than 7. After childbirth, the questionnaire included questions about social support, breastfeeding, sexual life and contraception (which evaluated if and when postpartum women had resumed intercourse and if they were using any kind of contraceptive method). Breastfeeding was defined as feeding the baby with breast milk, regardless of supplementing with other food. Breastfeeding length was ascertained through a single question to the mother: "How long have you breastfed?" Contraceptive methods were classified into two groups: more reliable methods (injection or oral hormonal contraceptive, and intrauterine device) and less reliable methods (condom, withdrawn, periodic abstinence or no method at all).

2.3. Procedures

During the study period, trained research assistants visited the primary care clinics and approached all pregnant women.