

Prenatal Depressive Symptoms and Postpartum Sexual Risk Among Young Urban Women of Color



S.D. Cunningham PhD^{1,*}, A. Smith MPH, MSW¹, T. Kershaw PhD¹, J.B. Lewis LMFT¹, A. Cassells MPH², J.N. Tobin PhD², J.R. Ickovics PhD¹

¹ Yale School of Public Health, New Haven, Connecticut

² Clinical Directors Network (CDN), New York, New York

ABSTRACT

Study Objective: To determine whether prenatal depressive symptoms are associated with postpartum sexual risk among young, urban women of color.

Design: Participants completed surveys during their second trimester of pregnancy and at 1 year postpartum. Depressive symptoms were measured using the Center for Epidemiologic Studies-Depression Scale, excluding somatic items because women were pregnant. Logistic and linear regression models adjusted for known predictors of sexual risk and baseline outcome variables were used to assess whether prenatal depressive symptoms make an independent contribution to sexual risk over time.

Setting: Fourteen community health centers and hospitals in New York City.

Participants: The participants included 757 predominantly black and Latina (91%, n = 692) pregnant teens and young women aged 14–21 years.

Interventions and Main Outcome Measures: The main outcome measures were number of sex partners, condom use, exposure to high-risk sex partners, diagnosis of a sexually transmitted disease, and repeat pregnancy.

Results: High levels of prenatal depressive symptoms were significantly associated with increased number of sex partners ($\beta = 0.17$; standard error, 0.08), decreased condom use ($\beta = -7.16$; standard error, 3.08), and greater likelihood of having had sex with a high-risk partner (odds ratio = 1.84; 95% confidence interval, 1.26–2.70), and repeat pregnancy (odds ratio = 1.72; 95% confidence interval, 1.09–2.72), among participants who were sexually active (all $P < .05$). Prenatal depressive symptoms were not associated with whether participants engaged in postpartum sexual activity or sexually transmitted disease incidence.

Conclusion: Screening and treatment for depression should be available routinely to women at risk for antenatal depression.

Key Words: Depressive symptoms, Sexual risk behavior, Pregnancy, Adolescent, Practice-based research network, Community health centers

Introduction

Young women who are pregnant or parenting are at increased risk for sexually transmitted diseases (STDs).^{1,2} Women 15–24 years of age have the highest rates of STDs,³ with pregnant teens approximately 5 times less likely to use condoms compared with nonpregnant teens, further increasing their risk of contracting an STD.² In addition to increased sexual risk behaviors, young women, especially of low socioeconomic status, have a higher likelihood of either being depressed or displaying depressive symptoms during pregnancy.^{4,5} Depression is at least twice as common among women compared with men, with peak onset during childbearing years.⁶ It is the most common psychiatric disorder associated with pregnancy with 10%–20% of women experiencing depression during the prenatal or the early postpartum periods.⁷

High levels of depressive symptoms are associated with risky sexual behavior, such as having multiple sex partners

and not using birth control during last intercourse among adolescents.^{8–10} Even depressive symptoms that do not meet the *Diagnostic and Statistical Manual* criteria for major depressive disorder have been significantly associated with increased sexual risk.¹⁰ Most of these studies have focused predominantly on white women and report findings based on cross-sectional data. Although some studies report higher rates of major depressive disorder in white persons compared with other races or ethnicities,^{11,12} most suggest that black and Latino individuals are more likely to report depressive symptoms than white individuals, particularly among youth.^{13–15} Evidence also suggests that the prevalence of antenatal depressive symptoms is greater among black women compared with white women.^{16–18} It is particularly important to develop a better understanding of the association between depressive symptoms and sexual risk behaviors among minority youth because they are also the population at highest risk for STDs.³

The objective of this longitudinal study was to determine whether prenatal depressive symptoms are associated with postpartum sexual risk behaviors and outcomes, including number of sex partners, condom use, exposure to high-risk sex partners, diagnosis of an STD, and repeat pregnancy among young, urban women of color. Depression is one of

Sharon Rising is President/CEO of the non-profit, Centering Healthcare Institute. There are no other known conflicts of interest to report.

* Address correspondence to: S.D. Cunningham, PhD, Yale School of Public Health, 135 College St, Room 226, New Haven, CT 06510; Phone (203) 737-4565

E-mail address: shayna.cunningham@yale.edu (S.D. Cunningham).

the most common complications of pregnancy; however, most of the focus has been on postpartum depression.¹⁹ If depressive symptoms are a precursor to sexual risk behavior, pregnancy might be an optimal time to intervene. Most women seek some form of prenatal care, and can be screened and subsequently treated for depression, potentially averting future risky sexual behavior, and improvement of self-management and clinical outcomes.

Materials and Methods

Data used for these analyses were obtained from a randomized control trial (trial registration number: NCT00628771) of Centering Pregnancy Plus, a group prenatal care model that aims to improve the reproductive and psychosocial health of young, pregnant women.²⁰ The curriculum consists of 10 structured sessions (120 minutes each) during which participants engage in self-care activities of weight and blood pressure assessment and participate in group discussions to address issues related to prenatal care, childbirth preparation, postpartum care, HIV prevention including sexual risk reduction, and mental health and psychosocial functioning (eg, depression, stress reduction). Fourteen community health centers and hospitals that are members of Clinical Directors Network, a primary care practice-based research network in New York City, were randomized to provide either the group prenatal care intervention or standard individual prenatal care. These analyses do not test for an intervention effect. Therefore, study condition was controlled in all analyses and all participants who completed an interview during their second trimester and at 1 year postpartum were included in the analysis.

Procedure

Between 2008 and 2011, young women (14–21 years old) who attended an early prenatal care visit at a study site were referred by a health care provider or directly approached by research staff for participation in the study. Eligibility criteria included less than 24 weeks' gestation, no medical indication of a high-risk pregnancy, younger than 21 years old at last birthday, ability to speak English or Spanish, and willingness to participate in the study procedures. Research staff explained the study to participants who were eligible, answered questions, and obtained informed consent. Participants completed surveys during the second trimester of pregnancy (14–24 weeks' gestation), third trimester (32–42 weeks' gestation), and at approximately 6 and 12 months (5–8 months and 11–14 months, respectively) postpartum using Audio-Handheld Assisted Personal Interview technology. This allowed participants to listen to questions with headphones while the questions were displayed on a computer screen. The analyses for this report use data collected at the second trimester and at the 1 year postpartum time points. Participants were paid \$20 for each interview. All procedures were approved by institutional review boards at Yale University, Clinical Directors Network, and each clinical site.

Dependent Variables

Number of Sexual Partners

During the second trimester of pregnancy and at 1 year postpartum, participants reported the number of different men with whom they had sex during the previous 6 months.

Condom Use

During the second trimester of pregnancy, participants reported the percentage of times they used condoms when having sex in the 6 months before becoming pregnant. One year postpartum, they reported the percentage of times they used condoms in the previous 6 months.

High-Risk Partner

Participants were classified as having had sex with a high-risk partner if they reported any sexual partners in the past 6 months had engaged in 1 or more of the following risk behaviors: had other sexual partners, is or was an intravenous drug user, has HIV or AIDS, ever had an STD, is a man who has ever had sex with a man, or has ever been in prison.^{21,22}

STD Diagnosis

Participants were classified as having a history of an STD if they reported having ever been diagnosed with any of the following STDs: chlamydia, gonorrhea, genital warts or human papilloma virus, herpes, syphilis, or trichomonas. One year postpartum, participants were tested for chlamydia and gonorrhea with urine-based ligase chain reaction. They were also asked if they were diagnosed with an STD (listed herein) since their previous interview. Participants were classified as having an incident STD if they tested positive for chlamydia or gonorrhea at the 12-month postpartum interview or they reported having been diagnosed with an STD after the 6-month postpartum interview. This approach ascertained STDs that might have been tested and treated between interviews.

Repeat Pregnancy

Participants reported whether they had become pregnant since their index pregnancy.

Main Predictor Variable

Depressive Symptoms

Participants completed the affect-only component of the Center for Epidemiologic Studies Depression Scale (CES-D).²³ This scale has been validated for use with diverse samples of adolescents^{9,24} and used successfully in studies of pregnant women.^{5,25,26} Participants rated over the past week how often they experienced affective components of depressed mood (eg, feelings of failure, guilt, hopelessness) on a 4-point Likert scale, ranging from none of the time (0) to all of the time (3; $\alpha = 0.87$). According to previous research with pregnant women, 5 psychophysiologic items of the CES-D related to appetite, disrupted sleep, and energy level were not included, because these indicators mirror symptoms associated with pregnancy.²⁵ Scores for each item were summed. Participants with a CES-D score greater than or equal to 16 were classified

Download English Version:

<https://daneshyari.com/en/article/3961315>

Download Persian Version:

<https://daneshyari.com/article/3961315>

[Daneshyari.com](https://daneshyari.com)