



Research Article

Feasibility of screening and prevalence of prenatal depression in an obstetric setting in Spain



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Screening for prenatal depression can be integrated in an obstetrics setting in a large urban hospital in Madrid, Spain

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ABSTRACT

Objectives: Prenatal depression is a significant public health problem and one of the main risk factors for postpartum depression. Limited research in perinatal depression has been conducted in Spain. The objectives of this study was to: (1) examine the feasibility of integrating a screening program for prenatal depression in an obstetrics setting in a large urban hospital in Spain; and (2) provide an initial estimate of the prevalence rate of the severity of depressive symptoms during pregnancy.

Study design: Screening for prenatal depression was conducted during the first trimester in an obstetrics setting in an urban hospital in Madrid, Spain 2014–2015. The Patient Health Questionnaire (PHQ-9) was used as the main screener.

Results: Of the 730 women asked to complete the screening protocol, 445 (60.9%) completed the PHQ-9 during the first trimester. Those who did not complete the screening were more likely to be immigrants and did not read Spanish. The prevalence of moderate to high severity of prenatal depressive symptoms prenatal depressive is 14.8% (PHQ-9 ≥ 10).

Conclusion: It is possible to integrate screening for prenatal depression in an urban obstetrics setting, but there are significant structural barriers to implementation. The prevalence of significant prenatal depressive symptoms is similar to previous research in Spain and adds to the limited research in this area.

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Introduction

Major depression is the leading cause of disease burden for women in both high-income and low- and middle-income countries [1]. Women of childbearing age are at higher risk for developing mood disorders. Perinatal depression (PD) encompasses the period between pregnancy and the postpartum period, and is considered the most common complication during this period [2]. Studies have been conducted in both clinical and non-clinical samples of pregnant women, demonstrating a wide range of prevalences, from 6.9% to 12.4%. [3,4]. In a recent review, the overall prevalence in developing countries is about 20% and in developed countries ranges between 10% and 15% [5]. PD is associated with well documented negative outcomes for women and their families [6,7]. Risk factors for postpartum depression include psychiatric history of depression or anxiety, low social support, and stressful life events [8–10]. Of these risk factors,

depression during pregnancy has been found to be one of the strongest risk factors for postpartum depression [6]. Recent initiatives in the USA from the American College of Obstetricians and Gynecology [11] and the U.S. Preventive Services Task Force [12] and the NICE guidelines in the United Kingdom [13] have recommended screening for perinatal depression in primary care settings using standardized validated screening tools, such as the Edinburgh Postnatal Depression Scale (EPDS) and the Patient Health Questionnaire (PHQ-9), as well as having in place appropriate follow-up and treatment services for women with PD. Therefore, obstetrics settings, in which most women receive prenatal care across multiple visits, is an ideal setting to implement screening for PD [14]. Unfortunately, few women are routinely screened in obstetrics clinics and provided follow-up interventions [15], and most of this research has been conducted in the United States, United Kingdom, and Australia.

The present study examines the feasibility of integrating a screening program for prenatal depression in an obstetrics setting in a large urban hospital in Madrid, Spain. We begin by describing the context of perinatal depression in Spain. Next, we describe our

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experiences in this development and implementation of screening through a partnership between researchers in the USA and Spain, and staff in an obstetrics setting within the hospital. In addition, this study aimed to provide an estimate of the prevalence of the severity of prenatal depressive symptoms.

Over the past decade, there has been increasing interest in perinatal depression in Spain, although research is still limited [16]. Spain has a National Health System (NHS), which provides universal coverage with free access to health care for all, regardless of nationality or legal status. Spain is divided into 17 Autonomous Communities, which have developed administrative competencies to manage effective health services [17]. Currently, “there is no nationally agreed quality assurance standards for perinatal mental health assistance in Spain. The availability of specialized care services in perinatal mental health in Spain is variable, and in most areas...absent” [16]. Therefore, there is a need for more work in this area in this country.

To date, there are a few studies that have examined the prevalence of perinatal depression in Spain. Two studies have reported that the rate of clinical depression, using diagnostic structured interviews, is 10.15% at 6 weeks postpartum [18] and 12.7% at 32 weeks postpartum [19]. More recently, García-Estève et al. [16] conducted a large scale study and recruited postpartum mothers at their 6-week postpartum visit in an obstetrics setting in Barcelona and compared native Spanish women (N=1214) and Latin American Immigrant (LAI) women (N=164) – a rapidly growing population in Spain. The authors found that rates of postpartum depression were higher among LAI than native Spanish women (17.3% vs. 11% for minor and major PPD, and 11.4% vs. 7.7% for major PPD, respectively). Additionally, two studies have reported varying rates of significant postpartum depressive symptoms: 32.7% shortly after birth [20], and 21.7% at 6 weeks postpartum [21]. To our knowledge, only one study has examined the prevalence of depressive symptoms during pregnancy in Spain. Escribà-Agüir et al. [22] reported a rate of 10.3% for women and 6.5% for men during the third trimester of pregnancy.

To expand on the limited research on PD in Spain, the purpose of this study is to examine the feasibility of integrating a screening program for prenatal depression in an obstetrics setting in a large urban hospital in Spain. The first goal was to describe the steps that we took to initiate this program and the lessons learned from this process. The second goal was to provide an estimate of the prevalence of the severity of symptoms of depression during pregnancy.

Materials and methods

Study overview and context

This study was a partnership between researchers at two academic universities and the staff at the obstetrics (OB) department at the San Carlos Clinic Hospital. This hospital site was chosen for several reasons. First, we wanted a site that provided multiple services and was accessible for perinatal women. San Carlos Clinic Hospital is one of four hospitals in Madrid, and its OB department includes both an outpatient clinic and a labor and delivery clinic; its providers (7 obstetricians, 20 midwives, 4 nurses) care for approximately 7000 women and a labor and delivery clinic that provides an average of 1850 births per year. Second, we wanted to reach women who were at potentially high risk for depression due to multiple risk factors. This hospital also has a Neonatal Intensive Care Unit, serving high risk women. In addition, the women seen at this hospital also tended to be from low- or middle-income status, some women with more resources tend to self-pay for private insurance and obtain care in private hospitals. Third, pragmatically, the first author had a personal

connection with one of the psychologist in the OB setting, which provided the entrée to the staff and director of the OB department. Before program implementation, the first author met with the director and several staff members in the OB department to assess the need for PD services in their patient population in 2013. The overwhelming consensus from these informant interviews and focus groups was that some of their patients are at risk for perinatal mood and anxiety disorders, but this was not formally assessed in the department. In their setting, one psychologist provides psychological treatment, but mostly for women with ovarian and breast cancer. For women with more severe psychiatric problems, all providers refer these patients to an outpatient mental health clinic. Other staff, especially the obstetricians and midwives, felt that they did not have the clinical expertise or time to screen for women. The staff perceived a gap in their services and expressed much enthusiasm for prospectively determining more formally the rates of PD within their system and to provide in-house prevention services (not described in this study). The latter would also serve to address the limited access to mental health resources and potentially decrease the stigma associated with having mental health issues.

Based on the needs assessment, researchers and staff determined that women could be screened for PD in the waiting room, which enabled women privacy while completing the forms. Nurses were identified as the front-line staff who would be available to provide follow-up information and referrals based on the screening and preventive intervention study. As the screening program continued, the nurses reported that they had only limited time to explain the screening and study procedures for them. As a result, the staff decided to decrease screening from every day to the two days in which the ultrasound was given during which the nurses had more time to discuss the results of the screening to the patients. The timing of the first ultrasound also allowed enough time in the prenatal period for women to participate in the 8-week group preventive intervention if they met high risk criteria and agreed to participate. In addition, patients were provided with an informational brochure that described the purpose of screening and prevention study. Eligibility criteria included being pregnant, receiving prenatal services at the hospital, and fluency in Spanish. Women were informed of the study purpose and provided written consent for the study. Due to time constraints, the nurses did not systematically keep track of who (i.e., demographics) refused to participate in the screening. This study was approved by the Institutional review board at the Hospital.

There are several instruments available to screen for prenatal and postpartum depression [23,24]. The Patient Health Questionnaire [25] was chosen as the main screening instrument for pragmatic reasons. First, this instrument measures the frequency of the 9 symptoms of the DSM-IV criteria for a major depressive episode, required for a diagnosis of major depression and other mood disorders [25,26]. Second, this instrument has been validated in many studies with high sensitivity and specificity and widely used in obstetrics and other primary care settings [27,28]. Third, the PHQ-9 has been recommended by the U.S. Preventive Services Task Force [12] and the NICE guidelines in the United Kingdom [13]. Fourth, the PHQ-9 also performed well in a range of cultures and with a range of translations, including Spanish [29]. Finally, although we also considered the more widely used EPDS as a potential screener, the researchers and OB staff felt that this measure fit in better with the other measures that were already asked within this setting.

Item response options on the PHQ-9 range from 0 “not at all” to 3 “nearly every day.” Cut-off scores reflect levels of severity: 0–4 = minimal; 5–9 = mild, 10–14 = moderate, 15–19 = moderately severe, and 20–27 = severe [25]. Women who met “high risk” criteria (PHQ-9: 10–14) were invited to participate in the

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