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Coping strategies and postpartum depressive symptoms: A structural equation modelling approach

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ABSTRACT

Background: Variables such as the mother's personality, social support, coping strategies and stressful events have been described as risk factors for postpartum depression. Structural Equation Modelling (SEM) analysis was used to examine whether neuroticism, perceived social support, perceived life events, and coping strategies are associated with postpartum depressive symptoms at the 8th and 32nd weeks.
Methods: A total of 1626 pregnant women participated in a longitudinal study. Different evaluations were performed 8 and 32 weeks after delivery. Several measures were used: the Edinburgh Postnatal Depression Scale (EPDS), the Diagnostic Interview for Genetic Studies (DIGS), the Eysenck Personality Questionnaire (EPQ-RS), the St. Paul Ramsey life events scale and the Duke-UNC Functional Social Support Questionnaire. The brief COPE scale was used to measure coping strategies. SEM analysis was conducted for all women and in those women with a clinical diagnosis of postpartum depression.
Results: Passive coping strategies were associated with postpartum depressive symptoms at both visits (8th and 32nd weeks). Neuroticism was associated with more passive coping strategies and less active coping strategies. Neuroticism and life stress were positively correlated, and social support was negatively correlated with life stress and neuroticism.
Conclusions: Early identification of potential risk for symptomatology of depression postpartum should include assessment of neuroticism, life events, social support and coping strategies.
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1. Introduction

Between 10% and 15% of new mothers have severe emotional distress or postpartum depression (PPD) [11,14,54]. Mothers who have had PPD are 25 to 100% more likely to suffer a recurrent depressive episode in later pregnancies [76,40]. Maternal depression may have important implications for child development [3],

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contributing to emotional, behavioural and cognitive problems in later life [6,38,27] as well as childhood psychiatric disorders [60].

Several factors are thought to play a role in the risk of developing PPD: reproductive hormones [76], genetic alterations [63], obstetric complications [54], mothers' previous psychiatric history [54,40,7,39], family history of psychiatric illness [39], depressed mood during pregnancy [54,40,7,39] and prenatal anxiety [54,39], the mothers' neuroticism [45], cognitive attributional styles [4], stressful life events [54,53], perceived life stress [7], limited social support [60,44] and low self-esteem [44].

The birth of a baby is a major source of stress for mothers, who require a number of adjustments to the new situation. Coping strategies, perceived stress, social support, and the dispositional or personality traits of the mother are factors that have been largely reported to determine proper adaptation to the new role.

Coping with stressful conditions to ensure proper psychological adjustment does not operate in isolation. Rather, coping mediates the relationships between certain social conditions and adjustment (e.g., depression) or between contextual and individual variables and adaptive outcomes [69]. A recent review [59] concluded that perceived stress, social support and coping strategies are variables that influence the mechanisms of adaptation to stress in mothers after childbirth. Coping strategies are thought to mediate the relationship between neuroticism and depression in subjects experiencing stress [72]. A recent study suggests that low coping efficacy partially mediates the association between negative life events and incident depression [1].

Maladaptive or passive coping strategies, including denial, distancing, self-blame and substance abuse, are associated with symptoms of antenatal depression [20], and with higher odds of developing postnatal depressive symptoms [20,23], whereas positive reappraisal strategies tend to be protective [55]. Studies that evaluate problem centered coping (a form of active coping) among pregnant women, have shown contradictory results, linking this type of coping with both lower [9,50] and higher [65] levels of postpartum depression. Mothers with depressive symptoms during pregnancy and postpartum, tend to use emotional coping strategies, (a type of avoidant coping), more frequently than mothers without such symptoms [19].

Negatively perceived stress has been found to affect the well-being of mothers [59]. Perceived postnatal stress has been associated with symptoms of postpartum depression (PPD) [36,24,71,43] and higher anxiety levels [13]. Wells et al. reported that greater stress in pregnant women was associated with depressive symptoms if the mother did not report an active coping style [74]. A recent systematic review by Guardino and Schetter on coping during pregnancy indicates that although there is evidence that avoidant coping styles are associated with postpartum depression, the evidence on the buffering effect of active coping on mental health outcomes is inconclusive [28].

Social support, which is conceptualised as a resource for coping, is defined as the perception (or experience) that one is loved and cared for by others, esteemed and valued as part of a social network of mutual assistance and obligations [75]. Coping resources such as social support in turn affect coping processes that is, specific intrapsychic and behavioural actions that people use to manage stress [69]. Social support has been associated with major PPD [21,31,33]. Perceptions that family and friends would provide effective help during times of stress (i.e., perceived support) have been consistently linked to good mental health, including low rates of major depression [41].

High scores for neuroticism have been reported in women with PPD [45,58]. Scholars have recently shown that neuroticism is an independent predictor of PPD symptomatology and major depression at 8 to 32 weeks postpartum [45]. Previous studies suggest that the link between personality and distress can be mediated by the selection of ineffective coping strategies [12]. McWilliams et al. [48] showed that having fewer adaptive coping strategies (emotion-oriented coping) is associated with neuroticism and depression, whereas an inverse association was found for task-orientated strategies.

Despite the important contribution of these variables to PPD, a joint analysis of these coping resources involved in postpartum depression has not been performed. A Structural Equation Modelling (SEM) analysis would allow the integration of variables such as stressful life events, social support, neuroticism, anxiety, coping strategies and postpartum depressive symptoms in a conceptual model of vulnerability to PPD. Fig. 1 provides a visual model of the some variables involved in the mother-stress transaction in postpartum symptomatology. We tested the hypothesis that women with a higher level of neuroticism are more sensitive to the depressogenic effects of adversity and vital stress events. Neuroticism influences the pathogenic effects of exposure to stress among other causes, having a greater tendency to use passive coping or avoidance strategies and lower perceived social support, which maintains and increases depressive symptomatology.

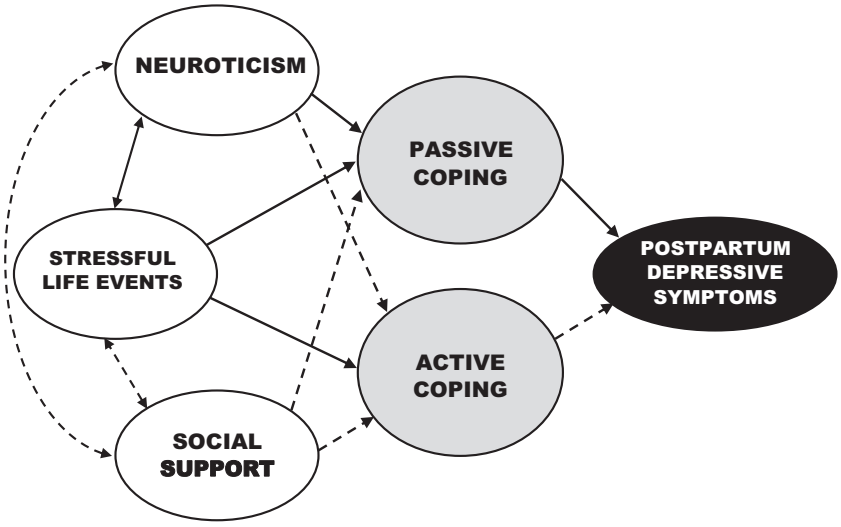

Fig. 1. Visual model of the relationship between variables involved in the mother-stress transaction in postpartum symptomatology. Solid lines represent positive relationships whereas dashed lines represent negative associations.

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