



Review article

Identifying the women at risk of antenatal anxiety and depression: A systematic review



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ABSTRACT

Background: Pregnancy is a time of increased vulnerability for the development of anxiety and depression. This systematic review aims to identify the main risk factors involved in the onset of antenatal anxiety and depression.

Methods: A systematic literature analysis was conducted, using PubMed, PsychINFO, and the Cochrane Library. Original papers were included if they were written in English and published between 1st January 2003 and 31st August 2015, while literature reviews and meta-analyses were consulted regardless of publication date. A final number of 97 papers were selected.

Results: The most relevant factors associated with antenatal depression or anxiety were: lack of partner or of social support; history of abuse or of domestic violence; personal history of mental illness; unplanned or unwanted pregnancy; adverse events in life and high perceived stress; present/past pregnancy complications; and pregnancy loss.

Limitations: The review does not include a meta-analysis, which may have added additional information about the differential impact of each risk factor. Moreover, it does not specifically examine factors that may influence different types of anxiety disorders, or the recurrence or persistence of depression or anxiety from pregnancy to the postpartum period.

Conclusions: The results show the complex aetiology of antenatal depression and anxiety. The administration of a screening tool to identify women at risk of anxiety and depression during pregnancy should be universal practice in order to promote the long-term wellbeing of mothers and babies, and the knowledge of specific risk factors may help creating such screening tool targeting women at higher risk.

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1. Introduction

Pregnancy and the postpartum can be times of joy and positive expectations but also of stress and difficulties. Pregnancy and delivery bring many physiological and psychosocial changes, and both mothers and fathers are required to face several new challenges during this period. Consequently, pregnancy and the postpartum are times of increased vulnerability for the onset or relapse of a mental illness (Smith et al., 2011). Depression and anxiety are the most common psychiatric disorders during pregnancy and the postpartum (Alipour et al., 2012) and the symptoms can range from mild to severe. However, we still do not know why some women are more “at risk” of developing depression or anxiety symptoms while others remain resilient even in the face of adversity.

The estimated prevalence of perinatal anxiety and depression varies between studies. The prevalence of antenatal depression is estimated to be between 7% and 20% in high-income countries (Andersson et al., 2003; Evans et al., 2001; Gavin et al., 2005; Lee et al., 2007; Marcus et al., 2003; Melville et al., 2010), while rates of 20% or more have been reported in low- and middle-income countries, although less research has been conducted in these areas (Faisal-Cury et al., 2009; Golbasi et al., 2010; Husain et al., 2012, 2011). Gavin et al. found that the prevalence of antenatal depression in the first trimester is 11.0%, then drops to 8.5% in the second and third trimesters (Gavin et al., 2005). In contrast, Bennett et al. found an opposite trend, with a prevalence of 7.4% during the first, 12.8% during the second, and 12% during the third trimester (Bennett et al., 2004). Postpartum depression prevalence is estimated to be between 7% and 30% across low-, middle- and high-income countries (Beck, 2001; Csatorjai et al., 2007; Parsons et al., 2012). Indeed, a recent review showed that, in 22 of 28 low- and middle-income countries, postnatal depression prevalence was higher than in high-income countries, with the highest values in Vietnam (33%), Zimbabwe (33%) and Guyana (50%), and lowest in Uganda (7.1%) and Nepal (4.9%) (Parsons et al., 2012). Prevalence of postnatal depression in high-income countries begins to rise after delivery and reaches the highest value in the third month postpartum (12.9%), and then declines to 10.6% at month 7 and to 6.5% after month 7 (Gavin et al., 2005). The prevalence of both classes of disorders tends to be higher when symptoms, rather than disorders, are investigated, or when depression or anxiety is assessed by a self-report rating scale rather than a structured interview, or when operational criteria are not used for the diagnosis (Bennett et al., 2004). In general, the postpartum period has historically been the focus of far greater research attention than the antenatal period, despite the fact that some studies have shown a decrease, rather than an increase, in depression and anxiety after childbirth (Heron et al., 2004). A recent review (Norhayati et al., 2015) has shown that antenatal depression and anxiety are significant risk factors for postnatal depression in both developed and developing countries, together with a previous history of psychiatric illness, poor marital relationship, stressful life events, a negative attitude towards the pregnancy, and lack of social support. The present systematic review will focus on the risk factors for antenatal depression and anxiety.

There are a number of reasons why mental health problems in the antenatal period have received much less attention than in the postpartum. For example, there is the misconception that women

are “hormonally protected” from psychological disturbance during pregnancy (Bennett et al., 2004). Moreover, women can themselves be reluctant to share symptoms of sadness and irritability owing to the stigma associated with depression and to the discrepancy between women's expectation of happiness during pregnancy (and the postpartum period) and their own experience (Marcus, 2009). Furthermore, there is a tendency to focus on (maternal and foetal) physical health during pregnancy, rather than mental health, and to misattribute emotional complaints to the physical and hormonal changes that occur during pregnancy (Bowen and Muhajarine, 2006a). Indeed, these women often present with atypical symptoms of depression and unspecified somatic complaints (Posternak and Zimmerman, 2001), such as fatigue, loss of energy, appetite and sleep changes, rather than depressed mood. Therefore, it can be difficult to distinguish between “normal” pregnancy symptoms, which are common during pregnancy, and atypical somatic complaints, which may be related to depression or anxiety (Lee et al., 2007; Marchesi et al., 2009). This obviously makes it more complicated to diagnose depression and anxiety without a standardized assessment (Andersson et al., 2006). For this reason, the most validated and widely used self-report screening tool for depression during the perinatal period, the Edinburgh Postnatal Depression Scale (EPDS), does not include questions about somatic complaints, fatigue and changes in appetite, as these complaints would not help to distinguish depressed from non-depressed women (Murray and Cox, 1990). Therefore, somatic complaints may lead to the overdiagnosis of depression during the perinatal period. However, it has also been argued that not considering somatic complaints may interfere with the measure of the severity of the illness (Yonkers et al., 2009). Indeed, most of the women with higher EPDS scores also present a greater number of somatic complaints (Apter et al., 2013; Zerkowitz et al., 2004). Therefore, there is a risk that clinicians and patients may attribute somatic symptoms to the normal course of the pregnancy and the postpartum period rather than to a depressive disorder (Klein and Essex, 1994).

Diagnosing antenatal depression can also be difficult if women are only screened once throughout pregnancy. In fact, multiple evaluations during pregnancy can show differences in the rates of depression and anxiety. To this end, some studies (Bunevicius et al., 2009; Lee et al., 2007; Marchesi et al., 2009; Yanikkerem et al., 2013) have shown that depressive episodes occur more frequently during the first and third trimester of pregnancy, compared with the second, possibly because the most vulnerable women are more likely to experience stress when they are coping with the new event of becoming mothers, and when they are about to deliver and start a new life (Marchesi et al., 2009). The fact that many women present anxiety or depressive symptoms at one or two time points implies that only one screening is not enough during pregnancy. These circumstances make antenatal depression among the most under-recognized and under-treated conditions (Marcus, 2009).

This lack of recognition has serious implications, as it is now widely recognized that maternal depression, anxiety and stress during pregnancy have powerful long-term effects on both mother and baby (Dunkel Schetter and Tanner, 2012; Glover, 2015). The underlying biological mechanisms have not been fully understood but it has been suggested that a decrease in blood flow to the foetus and/or an increased exposure of the foetus to cortisol may

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