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Original article

The perception of parental bonding in pregnant adolescents and its association with generalized anxiety disorder

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ABSTRACT

Background: The parental bonding is influenced by two dimensions: care and control or protection over the child of both parents. The lack of care during childhood may make the individual more susceptible to the onset of psychiatric disorders when adult. These psychiatric disorders when present during pregnancy may have a negative impact on the health of pregnant women and children. The aim of this study was to assess the association between generalized anxiety disorder (GAD) in pregnant adolescents and the perception of parental bonding.
Methods: This is a cross-sectional study with 871 pregnant women under the age of 19, receiving prenatal care in 47 Basic Health Units in the one city, Brazil. The generalized anxiety disorder was measured using the Mini International Neuropsychiatric Interview (MINI) and the perception of parental bonding in childhood using the Parental Bonding Instrument (PBI).
Results: The prevalence of GAD was 8.5%. Among all the parental bonding dimensions, only a perceived lack of maternal care under 16 years was associated with GAD.
Conclusions: The results showed that only the perception of maternal bonding was associated with later GAD. It suggests that an adequate maternal bond is an essential component of psychological health.

1. Introduction

Adolescents have an elevated risk for medical complications in pregnancy compared to adult women [1]. The rate of neonatal death for adolescent pregnancies, which includes stillbirth as well as infant death up to 28 days old, is roughly 3 times higher than adult pregnancies [2]. Moreover, teenage pregnancy also seems to heighten the risk of psychiatric disorders [3–5]. In this sense, the primary focus of extant literature is on depression, while anxiety disorders remain somewhat neglected.

Anxiety disorders during pregnancy are relatively common, with reported prevalence rates about 15%, and frequently associated with negative outcomes [6]. Specially, generalized anxiety disorder (GAD) is one of the most prevalent anxiety disorders, only after specific phobia. The disorder is characterized by excessive and persistent anxiety and worry about daily activities. The diagnostic criteria covers physical and psychological symptoms of anxiety, causing significant impairment in social functioning [7]. Furthermore, anxious pregnant women have a higher risk to develop postnatal depressive symptoms [8] and other psychiatric disorders after birth [9]. Antenatal anxiety disorders are also associated to a higher suicide risk (mainly attributed to generalized anxiety disorder) [10] and can bring adverse consequences for the baby [11].

While Faisal-Cury, Menezes [12] reported that worry and anxiety are among the most common psychiatric symptoms during pregnancy, there are virtually no studies on GAD in pregnant adolescents. A cohort study with pregnant adults showed that 9.5% of them have suffered from this disorder at some point during pregnancy, when the highest rate of GAD was 7% in the first trimester [13,14]. Another study reported an 8.5% prevalence rate in the third trimester of pregnancy [15]. Environmental factors such as being single and having lower education level [16] may be important for the development of GAD in women [17]. In addition,

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women with lower social support, history of child abuse and a past history of GAD in the family have greater risk of developing GAD in pregnancy [13]. The perception of parenting styles have also been considered as relevant environmental risk factors for the development of psychiatric disorders, such as anxiety disorders [18]. The transition to motherhood can refer to past relationships of parental bonds, especially in teenagers, whose social roles are still to be defined [19]. Although one study has found GAD patients to score both of their parents as uncaring and overprotective, this relationship has not been studied in pregnant adolescents [20].

Therefore, the main goal of this study was to determine if there is an association between the perception of parental bonding and generalized anxiety disorder in pregnant adolescents. Also, we aimed to verify the factors associated with GAD.

2. Materials and methods

2.1. Study type and sampling

This is a cross-sectional study with pregnant teenagers (up to 19 years old) who were using the public services for prenatal care under the Unified National Health System in the urban area of Pelotas, a city in southern Brazil. Data were collected in 47 primary healthcare units and in 3 public obstetric clinics, starting in October 2009 and ending in March 2011. The inclusion criteria were: to be pregnant, up to 19 years old and live in the urban area of Pelotas, RS (Brazil). The exclusion criteria were: present some physical or cognitive disability that did not allow the understanding of the questionnaire.

Table 1
Sample distribution according to socio-demographic characteristics, obstetric and behavioral variables and Generalized Anxiety Disorders in pregnant adolescents in the city of Pelotas.

Variables	*N* (%)	GAD (%)	p-value
Age (n=870)			0.807
≤16 years	240 (27.6)	19 (7.9)	
≥17 years	630 (72.4)	55 (8.8)	
Education (n=869)			0.102
Lessthan 5 years	142 (16.3)	11 (7.8)	
Between 5 and 8 years	374 (43.0)	41 (11.0)	
Between 8 and 11 years	277 (31.9)	20 (7.3)	
Between 11 and 14 years	76 (8.7)	02 (2.6)	
Socioeconomic status (n=851)			0.537
A+B	107 (12.6)	11 (10.3)	
C	530 (62.3)	45 (8.5)	
D+E	214 (25.1)	17 (8.0)	
Works (n=867)			0.261
No	755 (87.1)	61 (8.1)	
Yes	112 (12.9)	13 (11.8)	
Lives with partner (n=869)			0.804
No	324 (37.3)	29 (9.0)	
Yes	545 (62.7)	45 (8.3)	
Primiparity (n=859)			0.023
No	185 (21.5)	24 (13.1)	
Yes	674 (78.5)	50 (7.4)	
Previous abortion (n=642)			0.001
No	554 (86.3)	43 (7.8)	
Yes	88 (13.7)	17 (19.5)	
Unplanned pregnancy (n=869)			1.000
No	630 (72.5)	53 (8.5)	
Yes	239 (27.5)	20 (8.4)	
Social support (n=863)			0.041
No	22 (2.5)	05 (22.7)	
Yes	841 (97.5)	68 (8.1)	
Previous or current psychiatric treatment (n=865)			0.061
No	725 (83.8)	55 (7.6)	
Yes	140 (16.2)	18 (12.9)	
Psychiatric family history (n=861)			0.021
No	483 (56.1)	31 (7.6)	
Yes	378 (43.9)	42 (11.1)	
Tobacco use (n=868)			0.932
No	706 (81.3)	61 (8.7)	
Yes	162 (18.7)	13 (8.1)	
Maternal Care (n=802)			<0.001
No	260 (32.4)	30 (11.5)	
Yes	542 (67.6)	38 (7,0)	
Maternal Control (n=809)			0.787
Overprotection	210 (26.0)	17 (8.1)	
Protection	599 (74.0)	54 (9.0)	
Paternal Care (n=707)			0.015
No	251 (35.5)	30 (12.0)	
Yes	456 (64.5)	29 (6.4)	
Paternal Control (n=723)			0.520
Overprotection	197 (27.2)	14 (7.1)	
Protection	526 (72.8)	47 (9.0)	
Total	871 (100)	–	–