



## Research paper

## Depressive and trauma symptoms in expectant, risk-exposed, mothers and fathers: Is mindfulness a buffer?

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## ABSTRACT

**Background:** Perinatal depression is reported in 15–20% of women (Marcus, 2009), 8–16% of men (Paulson and Bazemore, 2010) and low-SES, diverse populations are particularly at risk (Sareen, 2011). Trauma symptoms are commonly comorbid with depression, especially when individuals are exposed to risk factors such as community violence and poverty (Kastello et al., 2015; WenzGross et al., 2016). Parental mental illness places infants at risk for negative outcomes (Junge et al., 2016). Evidence supports that dispositional mindfulness is linked to mental health in many populations, however, a gap lies in the understanding of the relationship between mindfulness, trauma and depression in risk-exposed, pregnant populations, especially with fathers. We hypothesize that dispositional mindfulness is negatively associated with lower depression and trauma symptoms in pregnancy, in mothers and fathers.

**Methods:** Dispositional mindfulness, depressive and trauma symptoms were examined in women and men, exposed to adversity who were expecting a baby ( $N = 102$ ). Independent *t*-tests, and bivariate correlations examined the relationships between these variables. Hierarchical regression was utilized to understand how mindfulness and trauma symptoms may contribute to antenatal depression symptoms.

**Results:** Significant differences were observed with mindfulness and depressive symptoms, with no differences reported across gender. Mindfulness, depressive and trauma symptoms were associated in the expected directions. Total mindfulness, specifically being non-reactive to one's own thoughts and trauma symptoms predicted depressive symptoms.

**Limitations:** Limitations include small sample size, cross-sectional data and self-report measures.

**Conclusion:** Mindfulness and trauma symptoms were found to be significant predictors of depressive symptoms in parents-to-be. Those with lower mindfulness exhibited higher levels of depression. These findings may be helpful in disseminated mindfulness-based interventions aimed at treating antenatal depression in both expectant mothers and fathers who are exposed to adversity. Further research is necessary to understand the mechanisms of mindfulness in risk-exposed, expectant parents.

## 1. Introduction

Depression in pregnancy is a serious concern for expectant parents as well as the developing infant (Gentile, 2015; Glover et al., 2016). Antenatal depression is linked to poorer birth outcomes (Alhusen et al., 2012), postpartum mental health (Robertson et al., 2004), maternal morbidity (Marcus, 2009), and difficulty parenting during the postpartum period (Paulson et al., 2006; Perren et al., 2005). Depression and trauma symptoms are commonly comorbid (Seng et al., 2009) with rates of trauma exposure and associated symptoms of depression more prevalent in populations considered high risk due to exposure to

community violence and poverty (Kastello et al., 2015; Wenz-Gross et al., 2016). Despite potential efficacy, up to 50% of women decline pharmacological treatment for mental health concerns during the perinatal period due to fear of damage to the fetus in utero or by passing the drug to the infant during breastfeeding (Cohen et al., 2006). To prevent the deleterious effects of untreated mental illness, early detection and effective, acceptable, accessible, proactive treatment for antenatal depression, and trauma in pregnancy is crucial.

Mindfulness-based interventions (MBI) have shown promise as an effective method to reduce depressive symptoms (Segal et al., 2002), depressive relapse (Teasdale et al., 2000) and post-traumatic stress

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symptoms (Banks et al., 2015), however much of the depression research thus far has been conducted using low-risk samples of predominantly Caucasian, middle class participants. Before mindfulness interventions are disseminated to higher-risk communities, it is important to understand mindfulness levels in high-risk populations and relationships between mindfulness and psychiatric symptomatology in these groups. Additionally, if rates of trauma and depressive symptoms are comorbid in high-risk communities, as they are in low-risk communities, specific interventions that are trauma-informed may be indicated. Little is known about mindfulness during pregnancy, especially regarding fathers, and even less is known about fathers from higher-risk communities. This study aims to investigate the rates of depression and trauma symptoms in both mothers and fathers during pregnancy, and the relationship of these variables with dispositional mindfulness in a sample of expectant parents considered high risk due to their exposure to poverty and violence. Findings will inform the development of individualized interventions for vulnerable populations of expectant parents.

## 2. Trauma and depression in pregnancy

Perinatal depression, which is frequently comorbid with trauma, places mothers, infants and the mother-infant relationship at psychosocial and medical risk (Marcus, 2009). Studies show that 15–20% of women (Marcus, 2009) and 8–16% of men (Paulson and Bazemore, 2010) experience depression during pregnancy with even higher rates in low socio-economic-status (SES) populations (Lancaster et al., 2010). Symptoms of depression in pregnant women are a significant risk factor for poor maternal and child outcomes including preterm delivery, low birth weight, increased long-term risk for mental health problems in the mother and the infant (Field et al., 2004; Junge et al., 2016; Marcus, 2009) and increased risk for postpartum depression (Robertson et al., 2004).

Depression in fathers-to-be is understudied relative to mothers, however, emerging research has reported that men also experience emotional changes (Åsenhed et al., 2014) while their partner is pregnant and are at an increased risk for depression during the gestation of their baby and throughout the postpartum period (Kim and Swain, 2007; Matthey et al., 2001; Paulson and Bazemore, 2010; Ramchandani et al., 2008). Paulson and Bazemore (2010) estimate that 10% of men will experience depression during the postpartum period, whereas Field et al. (2006) found that 32% of fathers in a diverse, low to middle income sample were depressed during pregnancy. Furthermore, the transition to parenthood for men is associated with depressive relapse that not only affects the father, but also the mother and later, the child as well (Paulson et al., 2006; Ramchandani et al., 2008). Due to the pervasive, family-level effects of parental psychopathology, protective factors that reduce symptomatology and buffer their effects on parenting are critically needed.

Although there are currently no data examining trauma in expectant fathers, one known risk factor for the development of depression for expectant mothers is a woman's trauma history (Biaggi et al., 2016). As defined by the DSM-5 (APA, 2013), a traumatic event may include exposure as a victim or witness to interpersonal violence, natural and human-made disasters, medical illness, serious accidents and unexpected death (APA, 2013). Although most people will experience at least one traumatic event in their lifetime, (Kilpatrick et al., 2013), some individuals exhibit greater resilience and do not experience extreme trauma symptomatology in response to the event, and therefore do not meet clinical criteria for a PTSD diagnosis (Goel et al., 2013). Women who live in low-income, urban communities are more likely to be exposed to violence (Breslau et al., 1995), which may place them at increased risk for the development of psychiatric symptoms such as depression, anxiety and post-traumatic stress. Silverstein et al. (2010) found that, in a sample of urban mothers of young children, 29% met criteria for depression, 17% had symptoms indicating likely post-

traumatic stress disorder (PTSD), and 31% had both positive depression screens as well as a history of significant trauma. Other research has demonstrated that 84.5% of women with antenatal depression also had comorbid partial or full PTSD, suggesting that depression during the perinatal period is often comorbid with other disorders (Seng et al., 2009). Prior work has demonstrated that pregnant women experience nearly twice the risk of a PTSD diagnosis compared to non-pregnant women (Cook et al., 2004; Seng et al., 2009), and some posit that this is due to the fear of childbirth triggering a trauma reaction (Söderquist et al., 2004). The risks of trauma exposure extend beyond trauma symptoms in the mother to the health of the child; a pregnant woman's own history of child maltreatment is positively associated with the risk of premature birth and delivering a low birth weight baby (Seng et al., 2011). Furthermore, maternal trauma history is associated with lower child socio-emotional development at 12 months of age (Folger et al., 2017).

## 3. Mindfulness

The practice of mindfulness is commonly understood as a “*moment-to-moment awareness, cultivated by paying attention in a specific way, in the present moment, as nonreactively, nonjudgmentally, and open-heartedly as possible*” (Kabat-Zinn, 2011; Kabat-Zinn and Hanh, 2009). Mindfulness is conceptualized as a specific form of mediation as well as a trait or state mental attribute, that may be increased through mindfulness practice (Baer et al., 2006; Van Dam et al., 2017). Dispositional mindfulness often is defined as ability to observe and describe one's own thoughts, to act with awareness, as well as the ability to be non-reactive and nonjudgmental of one's own thoughts (Baer et al., 2006). Evidence suggests that all people have some level of dispositional trait mindfulness without any training, and training in mindfulness meditation increases this mental faculty (Brown and Ryan, 2003). Increased mindfulness is often linked to improved psychological wellness (Badker and Misri, 2017; Banks et al., 2015; Brown and Ryan, 2003). Research has reported participation in mindfulness-based interventions with lower depressive symptoms in the general population (Segal et al., 2002; Teasdale et al., 2000) and in pregnant women (Dimidjian et al., 2015; Duncan and Bardacke, 2010; Felder et al., 2016; Miklowitz et al., 2015), with higher levels of mindfulness associated with lower levels of depressive symptoms. Furthermore, higher trait mindfulness is linked to lower posttraumatic stress symptoms in violence exposed individuals (Bernstein et al., 2011; Garland and Roberts-Lewis, 2013; Smith et al., 2011; Thompson and Waltz, 2010), and greater ability to adjust psychologically after a potentially traumatic event (Thompson et al., 2011).

Mindfulness-Based Interventions have recently been adapted to include pregnant women. Dimidjian et al. (2015) adapted Mindfulness-Based Cognitive Therapy for postpartum depression (MBCT-PD) and reported an 18.4% rate of relapse within the 6 months post treatment in comparison to 50.2% relapse rate reported in the treatment as usual group. Additionally, a significant reduction in current depressive symptoms was found throughout the intervention. Similar results were reported after a brief, mindfulness-based childbirth preparation class, Mind in Labor (MIL) with a significant reduction in depression symptoms observed in comparison to a control group with effects lasting through six weeks postpartum (Duncan et al., 2017).

Despite the potential for mindfulness interventions to reduce psychiatric symptoms and improve wellbeing during pregnancy, especially in individuals who are most vulnerable to psychopathology, much of the extant research on mindfulness in pregnancy is focused on middle to high-income, educated women. Little is known about mindfulness in pregnant women's partners, and even less is known about expectant parents from culturally and socio-economically diverse backgrounds. To date, only two mindfulness studies have included low-income, diverse, pregnant populations. Goodman et al. (2013) reported positive attitudes towards the possibility of using Mindfulness Based Cognitive

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