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European Psychiatry

journal homepage: <http://www.europsy-journal.com>

Original article

Correlates of postpartum depression in first time mothers without previous psychiatric contact

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ARTICLE INFO

Article history:

Received 1st April 2016

Received in revised form 8 July 2016

Accepted 10 July 2016

Available online

Keywords:

Depression
Path analysis
Peripartum
Postpartum
Primipara

ABSTRACT

Background: Postpartum depression (PPD) is a common disorder after childbirth. The strongest known predictors are a history of depression and/or a history of PPD. However, for a significant proportion of women, PPD constitutes their first depressive episode. This study aimed to gain further insight into the risk factors for PPD in first time mothers without previous psychiatric contact.

Methods: Women delivering in Uppsala University Hospital, Sweden, from May 2006 to June 2007, were asked to participate and filled out questionnaires five days and six weeks postpartum, containing *inter alia* the Edinburgh Postnatal Depression Scale (EPDS). Univariate logistic regression models, as well as a path analysis, were performed to unveil the complex interplay between the study variables.

Results: Of the 653 participating primiparas, 10.3% and 6.4% reported depressive symptoms (EPDS ≥ 12 points) five days and six weeks postpartum, respectively. In the path analysis, a positive association between anxiety proneness and depressive symptoms at five days and six weeks postpartum was identified. For depressive symptoms six weeks after delivery, additional risk factors were detected, namely depressive symptoms five days postpartum and subjective experience of problems with the baby. Caesarean section and assisted vaginal delivery were associated with fewer depressive symptoms at 6 six weeks postpartum.

Conclusions: Identification of anxiety proneness, delivery mode and problems with the baby as risk factors for self-reported depressive symptoms postpartum in this group of primiparas can be important in helping health care professionals identify women at increased risk of affective disorders in the perinatal period, and provide a base for early intervention.

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1. Introduction

The puerperium is a period characterized by a significant burden of affective disorders [1]. During the postpartum period, mood disturbances are prevalent in up to 85% of women, albeit only 10% to 15% of women experience clinically significant symptoms. Postpartum depressive disorders are typically categorized by severity as follows: postpartum blues, nonpsychotic major depression (postpartum depression [PPD]) and puerperal psychosis [2]. There is some controversy regarding the definition of PPD; according to the fifth edition of the Diagnostic and Statistical Manual for Mental Disorders (DSM-5), PDD is

defined as occurrence of a major depressive episode with onset during the first four months postpartum [3]. Nevertheless, differential clinical features of PPD, compared to major depressive episodes in other periods of life, have been described and majorly include parenthood-related clinical expressions, like anxiety for parenthood, feeling of inadequacy in the parental role and fear for the child's health [4]. Additionally, there is a lack of consensus regarding the duration of the postpartum period defining PPD, with many clinical studies extending it to include women with depression onset up to one year after delivery. PPD is distinguished from postpartum blues that comprises a rather mild and transient mood disturbance, occurring in 50–85% of women who have recently given birth, and usually resolving spontaneously by the tenth day postpartum [5]. However, some women with severe postpartum blues may be at risk of developing more persistent depressive symptoms later in the postpartum period [6].

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PPD often has devastating consequences for maternal wellbeing, and, if untreated, may develop into a persistent (chronic) depressive disorder [7], or in the worst cases suicide [8]. Furthermore, it might interfere with normal maternal-infant bonding and adversely affect marital relationship [9]. Detrimental effects on the cognitive and emotional development of children have been reported, with increased risk of emotional and behavioral problems, oppositional defiant and conduct disorder [10,11], as well as insecure attachment, poor social competence during school years, attention deficit hyperactivity disorder, and adolescent depression [12].

Consequently, identifying women at risk of developing PPD is of great importance. In this context, during the last decades, studies have been devoted to this task, and a number of physical and biological, psychological, obstetric and pediatric, socio-demographic and cultural factors have been suggested to interplay in the pathogenesis of PPD [13]. The attempt to categorize the risk factors into those with strong, moderate and small effect on the risk of PPD has been made in several meta-analytic and large-scale studies. The factors found to have the strongest impact on the development of PPD are previous depressive episodes (postpartum or non-postpartum), as well as antenatal depression and anxiety [14,15]. Moderate predictors of PPD include severe postpartum blues, life stress, neurotic personality traits, low levels of social support, low self-esteem, marital relationship problems, and problems with the baby, such as colic, jaundice and feeding problems [15–17]. Factors such as low socioeconomic status and low educational level seem to have smaller effect on the risk of PPD [18,19], while obstetric factors such as unplanned pregnancy, pregnancy complications and mode of delivery have also been debated as potential risk factors [20,21]. Other factors such as young maternal age, lack of breastfeeding, parity, baby gender, difficult child temperament and premenstrual syndrome have also been implemented in the pathogenesis of PPD, although the results remain equivocal [22–28]. In a study by O'Hara et al. [29], the authors suggest that risk factors for PPD can be categorized into three main risk factor patterns; history of psychiatric illness, life stress and poor social relationships.

Life stressors, such as stressful life events, medical conditions and lack of social support, can challenge the adaptive capacities of the individual. In the postpartum period, childbirth and puerperium-related stress may impact on the adjustment of the individual to the parenthood era. However, not all individuals exposed to the same stressors will be affected in the same way, and in this context not all women experiencing stress during or after pregnancy will develop PPD [30]. A number of inherent and environmental factors may moderate the impact of childbirth-related stress on the postpartum adjustment, and it is considered important to unravel the complex interplay of these moderators on the development of PPD.

Previous episodes of depression and/or PPD are the strongest known risk factors for postpartum depressive symptomatology and often help in clinical settings for the identification of high-risk women. Nonetheless, the absence of a single risk factor strongly associated with a disease does not necessarily indicate a low-risk, as other factors either alone or in combination may impact the risk. Indeed, for a significant proportion of women, a PPD episode constitutes their first depressive episode in life [31]. For this group of women, and especially those giving birth to their first child – never before having been at risk for developing PPD – evidence on where to focus screening efforts is lacking. This paucity of risk factors, along with the lack of experience within this group regarding the discrimination of emotions logically related to early parenthood from depressive symptoms, as well as their general unfamiliarity with psychological diseases, makes screening for PPD difficult.

The aim of the present study was to gain further insight into risk factors for self-reported PPD in a low-risk group in Sweden, namely first time mothers with no previous history of psychiatric contact, which, to our knowledge, has not previously been studied.

2. Methods

2.1. Study sample

In the context of the UPPSAT Project, a population-based cohort study on risk factors of PPD in the county of Uppsala, Sweden, all women giving birth at Uppsala University Hospital between May 2006 and June 2007 were contacted by their midwife shortly after delivery and given information on a longitudinal study on maternal, paternal and infant wellbeing. Two thousand four hundred and ninety-three women gave written consent to participate, and 2318 of these answered at least one of in total three questionnaires. Women were not eligible to participate in case of (a) difficulties with the Swedish language, (b) protected identity or for (c) intrauterine demise or immediate infant admission to the neonatal intensive care unit (441 women excluded).

The study protocol was approved by the Regional Research and Ethics Committee of Uppsala on August 9, 2006 (#2006/150). The UPPSAT study has been described in detail in previous reports [22,28,32–34].

2.2. Outcome measures and study variables

In the present study, the aim was to investigate correlates of PPD in a population of first time mothers with no previous psychiatric contact. Therefore, women who had ever had a contact with a psychologist, psychiatrist or women who had contacted the clinic specialized on fear of childbirth were excluded, as well as multiparous women.

The structured questionnaires contained the Swedish version of the Edinburgh Postnatal Depression Scale (EPDS) [35]. The EPDS is a widely used research and clinical screening tool for PPD. The EPDS has been validated in a Swedish setting, where the cut-off of 12 or more points provided a good sensitivity and specificity [36]. Hence, the EPDS-based postpartum depression status at five days and six weeks postpartum was used as the main outcome measure, and women with ≥ 12 points on the EPDS were considered cases of self-reported PPD [36].

The structured questionnaires also contained questions on socio-demographic characteristics (age, marital status, education and birth place) and previous medical history. A previous history of premenstrual syndrome was determined by questions based on the DMS-IV criteria, and has been described in detail in a previous study [22]. The variable “history of mood swings during oral contraceptive use” was determined by asking the women “Have you ever experienced mood swings while using oral contraceptives?” with yes/no alternative answers.

Information on the index pregnancy (mood during pregnancy, pregnancy intention, use of in vitro fertilization, alcohol consumption, delivery mode and delivery experience) was collected. Mood during pregnancy was determined by asking the women “How were you feeling during the current pregnancy?”, and answers included the following: as usual; somewhat worse; depressed; happier than I usually am, and these were dichotomized into normal (as usual, happier than I usually am) and depressed (somewhat worse, depressed). Although this is not a validated instrument, it is the question recommended for midwives to use in antenatal care, according to the Swedish Society of Obstetrics and Gynecology [37]. The pregnancy intention was determined by asking the women “Was this a planned pregnancy?” with yes/no

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