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ORIGINAL ARTICLE

SCREENING OF DEPRESSIVE SYMPTOMS IN PREGNANT WOMEN OF HIGH-RISK PRENATAL

RASTREIO DA SINTOMATOLOGIA DEPRESSIVA EM MULHERES GRÁVIDAS DO PRÉ-NATAL DE ALTO RISCO

RASTREO DE LA SINTOMATOLOGIA DEPRESIVA EN MUJERES EMBARAZADAS EN EL PRENATAL DE ALTO RIESGO

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ABSTRACT

Objective: to describe the profile of women assisted in the high-risk prenatal. **Method:** descriptive, exploratory cross-sectorial study, qualitative-quantitative approach, carried out in December 2012 in the Health Institute Elpidio de Almeida (ISEA) in Campina Grande/PB/Brasil. There were 16 pregnant women interviewed using semi-structured script, identification form and EPDS, a self-applicable instrument. For data analysis a descriptive statistics and content analysis technique were used. The project was approved by the Ethics Committee in Research, CAAE 0532.0.133.000-11. **Results:** two categories were identified << What is not noticed, because it is naturalized: “it is a thing coming from pregnant woman” >> and << Women’s Identification with the EPDS: “everything that is written there is my everyday life” >>. **Conclusion:** it was detected presence of depressive symptoms in pregnant women and considered the use of the scale as important in prenatal routine. **Descriptors:** Depression; Pregnancy; Brief Psychiatric Degree Scales.

RESUMO

Objetivo: descrever o perfil da mulher assistida no pré-natal de alto risco. **Método:** estudo descritivo, exploratório, transversal, com abordagem quati-qualitativa, realizado em dezembro de 2012 no Instituto de Saúde Elpidio de Almeida (ISEA) em Campina Grande/PB/Brasil. Foram entrevistadas 16 mulheres grávidas utilizando roteiro semiestruturado, ficha de identificação e EPDS, um instrumento autoaplicável. Para análise dos dados, utilizou-se estatística descritiva e Técnica de Análise de conteúdo. O projeto teve aprovação pelo Comitê de Ética em Pesquisa, CAAE nº 0532.0.133.000-11. **Resultados:** foram identificadas duas categorias << O que não é percebido, porque é naturalizado: “é coisa de grávida mesmo” >> e << Identificação da mulher com a EPDS: “tudo que tá escrito aí é do meu dia a dia”. >> **Conclusão:** foi detectada a presença de sintomatologia depressiva nas mulheres grávidas e consideraram o uso da escala importante na rotina do pré-natal. **Descritores:** Depressão; Gravidez; Escalas de Graduação Psiquiátrica Breve.

RESUMEN

Objetivo: describir el perfil de la mujer asistida en el prenatal de alto riesgo. **Método:** estudio descriptivo, exploratorio, transversal, con enfoque cuantitativo y cualitativa, realizado en diciembre de 2012 en el Instituto de Salud Elpidio de Almeida (ISEA) en Campina Grande/PB/Brasil. Fueron entrevistadas 16 mujeres embarazadas utilizando guía semi-estructurada, ficha de identificación y EPDS, un instrumento auto aplicable. Para análisis de los datos se utilizó estadística descriptiva y Técnica de Análisis de contenido. El proyecto fue aprobado por el Comité de Ética en Investigación, CAAE nº 0532.0.133.000-11. **Resultados:** fueron identificadas dos categorías << Lo que no es percibido, porque es naturalizado: “es cosa de embarazada mismo” >> e << Identificación de la mujer con la EPDS: “todo lo que está escrito ahí es de mi día-a-día”. >> **Conclusión:** fue detectada la presencia de sintomatología depresiva en las mujeres embarazadas y consideraron el uso de la escala importante en la rutina del prenatal. **Descriptors:** Depresión; Embarazo; Escalas de Graduación Psiquiátrica Breve.

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INTRODUCTION

The pregnant-puerperal period is characterized by several physical and mental changes and also by social and family role changes of women. In this period they are more susceptible to develop some mood disorders, needing special attention to depression.¹

About one in five pregnant women shows depression, and most of these women are not diagnosed and treated properly.² This problem can get even bigger repercussions when involving a high-risk pregnancy. The unfavorable development of pregnancy can affect the health of mother and child, characterizing the high-risk pregnancy.³

In a document - High-risk Pregnancy - the Ministry of Health highlights that when providing assistance in high-risk pregnancy, the health team should consider the psychosocial and emotional aspects of the pregnant woman, among others, because the difficulties of adaptation are bigger than the term used to designate this "high-risk" group.³

The depression during gestational period is still a little explored topic in research, especially in developing countries. It must be understood as a public health problem in the country as being a key risk factor for postpartum depression.²

Given the above, this study aims to describe the profile of women assisted in the high-risk prenatal, detecting the presence of depressive symptoms and understanding their experience when responding to Post-Partum Depression Scale of Edinburgh (EPDS).

METHOD

Study with quantitative and qualitative approach and exploratory-descriptive and cross-sectorial typology, performed in December 2012 on the Health Institute Elpidio de Almeida (ISEA), located in the city of Campina Grande, Paraíba State.

The population was composed of women registered in the high-risk prenatal of ISEA. The sample consisted of 16 women, selected according to the inclusion criteria: be assisted in high-risk prenatal service of the maternity studied and accept to answer the EPDS. Exclusion criteria were: being a minor, being at the time of the interview under the licit or illicit drug use and being the bearer of some mental disorder or being on treatment. For sample number definition the criteria of information saturation was adopted.⁴

The information was collected through semi-structured interview, women's

identification forms and EPDS. The interview had as a central question: "How was your experience when answering to EPDS?"

The EPDS is a self-applicable instrument, evaluating the emotional aspects of the woman in the last seven days, consisting of 10 questions with points from 0, 1, 2 and 3 points, according to the increasing gradation of symptomatology. For the sum of the questions, the value 12 was used as a cutting point.¹ The scale issues address symptoms, dysphoric or depressed mood, sleep disorder, loss of pleasure, ideas of death and suicide, decreasing performance and blame.⁵

The data were processed by descriptive statistics and content analysis technique, of thematic type.⁶ All interviews were recorded and subsequently transcribed, the spelling has been retained in full, suppressing the vices of language. The participants were identified with the letter "M", followed by Arabic numeral, showing the order in which women were interviewed and assured confidentiality to their names.

The research project has been approved by the Ethics Committee in Research (CEP) at the State University of Paraíba by CAAE 0532.0.133.000-11. The participants have signed and received a copy of the informed consent term (TCLE), according to the guidelines of Resolution 196/1996, of the National Council of Health and were assured about the anonymity of the publication of results and the confidentiality of the information.

RESULTS

In the sample of 16 women, the age of respondents ranged from 19 to 43 years old; the most prevalent age group was 19 to 26 years old, representing the greater reproductive activity phase of women. A similar result was found by studying the profile of 549 women assisted in high-risk clinic of Pará, with age ranging of highest incidence from 21 to 30 years old.⁷

Different from other participants, only one had no partner, as she became a widow during the current pregnancy, an important fact to the possibility of greater distress for the woman experiencing such a loss during this period. Seven women did not exercise any remunerated economic activity and they considered as housewives. Of the women interviewed, seven reported having completed high school and nine had household income up to one minimum wage.

These characteristics show that despite the family income of the interviewed were up to two minimum wages, women have had more

years of study, enabling greater opportunity of jobs, what is reported by the literature as a protective factor for depression.⁸

Half the women were in their first pregnancy and ten participants of the sample were primiparous. This finding may be related to greater information and use of contraceptive methods by women today, reflecting pregnancy and parity decreasing.⁷

Five of the participants had a miscarriage chart, and three women had one miscarriage and two were in seventh pregnancy, with two miscarriages chart. The precedence of abortion represents risk component for depression in pregnancy.⁹

Six participants stated not planning the current pregnancy. This kind of situation occur in women, regardless of age or level of education to which they belong. The unplanned pregnancy may constitute a risk factor for depression during the gestational period.¹⁰

Concerning the depression chart, seven of the respondents claimed to have personal chart and others claimed family chart, which together represent a total of eleven women with a chart of this disorder. The presence of previous psychiatric disorder is a risk factor for depression in pregnancy.⁵

By assessing the speeches of the participants, two categories were identified that reflect what is being approached the maternal mental health in the context of high risk prenatal care.

♦ **What is not noticed, because it is naturalized: “it is a thing coming from pregnant woman”**

For the society, motherhood is commonly associated with the happiness of women. Thus, people do not easily accept that a mother feels sadness. However, it is necessary to understand that intrapsychical changes during pregnancy can generate states of imbalance, increasing common behaviors of depression.¹¹

From this, it can be understood that the feelings and the anguish of women go unnoticed, in most cases, by health professionals and even by those who most live and share this moment with her.

It is identified that the prenatal care provided to women during the consultations are directed to the clinical scope and compliance of protocols by health professionals. In addition to this, there is still great demand for service in short time, making precarious the approach of this woman's mental health or even non-existent.

[...]for the prenatal period, they have to know what's going on in our minds [...] they think we're fine to hear what they're saying, but we don't care at all. (M9)

The manifestation of crying was an event often reported by some women in the study, which is seen by the professionals and family members, as something “inherent” to the pregnancy, period the woman is more “sensitive”. In this context, women end up realizing this justification and do see this phenomenon as something important.

[...]every once in a while you just want to cry a little bit, is normal in pregnant women, it's only because the pregnant woman is more sensitive. (M11)

Although common sense, and often even the professionals consider such situations as “normal”, in addition to the physiological changes, pre-existing psychic and current factors are present in the emotional charge of the pregnant woman. In a high-risk pregnancy, emotional adjustment difficulties are even greater, for this woman being at “high risk”.³

It is necessary that the professional get knowledge and skills to identify the depressive symptomatology in prenatal care, through the integral care to women's health, with their self-esteem, emotional support network and prospects for the future evaluation.¹² Therefore, it is important the formation of an empathic relationship, of affection and confidence with the pregnant woman for linking construction.¹³

♦ **Women's Identification with the EPDS: “everything that is written there is my everyday life”**

The EPDS is an instrument already validated in Brazil, which addresses issues relating to women's emotional conditions. However, it is important to evaluate if represents a viable tool in health services, as well as what is the relevance that women take the EPDS. Therefore, the participants were asked about the scale they considered most important and why.

This approach is interesting by providing knowledge about negative emotional condition experienced by the woman even if the total sum of the score is lower than the cut-off point. Once the scale, being a screening and depending on the pregnancy moment, may not show levels of depressive symptomatology.

To be addressed about the item they considered more important, some respondents reported an identification with questions of the scale, for dealing with situations that are

being experienced in the current period of pregnancy, involving conflicts of their daily lives:

[...]because everything that is written there is of my day-to-day life. (M8)

For many women, pregnancy is considered a special moment in their lives, while others experience negative feelings on this stage, being necessary to understand that there are interrelationships between changes during pregnancy, self-image and self-esteem.¹⁴

The presence of negative feelings on the current pregnancy seems to be experienced by some participants in the study. The recurring reference to feelings of sadness and want to cry, for example, were present in the speeches in which sometimes, they reported the absence of concrete reason to feel that way.

Question 10 discussing suicidal ideation was considered as the most relevant question by five of the respondents. Two of these women reported suicide attempts at some point in their life, not referring relations with the context of pregnancy:

A suicide attempt are potentially lethal acts that do not result in death, but requiring major attention. It can reach up to a quarter of the population of pregnant women and it is linked to the diagnosis of depression.¹⁵ Before the impact and possible evolution of a depressive condition, a screening instrument operates in aid of professional health care and allows for early intervention.

When a woman experiences a mutual relationship with the health team she can express feelings of doubt and expectations present at the time of pregnancy. It is therefore necessary to understand, respect and care this moment.¹⁶ Thus, it must be understood that the EPDS is not the only way to approach the depressive symptomatology, but the professional should create a space of dialogue through open and frank conversation with the woman, in order to identify important issues for better conduct of their assistance.

The application of EPDS in this study had scores from 2 to 23 points, with cutting point of 12. The prevalence of depression was 37.5%. A study on a maternity of São Paulo identified 12% prevalence of smaller depressive symptoms (10 to 12 points) and 62.7% of bigger symptoms (more than 13 points) according to the EPDS.⁵

The results presented by the study reinforce the need for adequate prenatal care to pregnant women, whether in primary care or specialized institution, since the occurrence of depression in pregnancy is an

event not desirable, and the health professional should act for improving the psychosocial conditions of women.

CONCLUSION

The experience of being pregnant is experienced by women in a variety of ways, because social, demographic, psychological and hormonal, obstetrical causes interact in the construction of motherhood.

The present study identified depressive symptoms in women of high-risk prenatal, manifested by: cry need, feelings of sadness, failure and fatigue by accumulation of tasks.

The use of EPDS in prenatal care was seen by participants as something important because favors the professional creating a moment of dialogue with the expectant mother, and make them participants in their health. Therefore, it is noted the need for more studies on the psychic disorders during pregnancy and the incorporation of mental health in the context of the prenatal by professionals who provide assistance to these women.

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