



ANXIETY AND DEPRESSION IN PREGNANCY: CHARACTERIZATION OF PREGNANT WOMEN WHO RECEIVED PRENATAL CARE IN PUBLIC HEALTH UNITS

ANSIEDADE E DEPRESSÃO NA GRAVIDEZ: CARACTERIZAÇÃO DE GESTANTES QUE REALIZARAM PRÉ-NATAL EM UNIDADES PÚBLICAS DE SAÚDE

LA ANSIEDAD Y LA DEPRESIÓN EN EL EMBARAZO: LA CARACTERIZACIÓN DE LAS MUJERES EMBARAZADAS QUE RECIBIERON ATENCIÓN PRENATAL EN LAS UNIDADES DE SALUD PÚBLICA

Mônica Maria de Jesus Silva¹, Eliana Peres Rocha Carvalho Leite², Denismar Alves Nogueira³, Maria José Clapis⁴

ABSTRACT

Objectives: evaluating the presence of anxiety and depression in pregnancy and characterizing the profile of pregnant women. **Method:** a quantitative, epidemiological, descriptive, cross-sectional and correlational study conducted in public health units in a city in the southern Minas Gerais, Brazil with 209 pregnant women. Data collection occurred from January to May 2013 and there were used the Anxiety and Depression Hospital Scale and the characterization form. The study was approved by the Research Ethics Committee, protocol 113.129. **Results:** anxiety was more frequent than depression and pregnant women had few risk factors for the occurrence of these disorders in pregnancy, such as: low/middle education, low family income, history of complications in previous pregnancies and unplanned pregnancies. **Conclusion:** preventive initiatives to the occurrence of anxiety and depression in pregnancy, such as monitoring of mental health and its screening during the prenatal are required. **Descriptors:** Nursing; Anxiety; Depression; Pregnancy.

RESUMO

Objetivos: avaliar a presença de ansiedade e depressão na gravidez e caracterizar o perfil das gestantes. **Método:** estudo quantitativo, epidemiológico, descritivo, de corte transversal e correlacional realizado em unidades públicas de saúde em um município do Sul de Minas Gerais, Brasil, com 209 gestantes. A coleta de dados ocorreu de janeiro a maio de 2013 e utilizou-se a Escala Hospitalar de Ansiedade e Depressão e um formulário de caracterização. O estudo foi aprovado pelo Comitê de Ética em Pesquisa, protocolo 113.129. **Resultados:** a ansiedade foi mais frequente que a depressão e as gestantes possuíam alguns fatores de risco para a ocorrência desses transtornos na gravidez como baixa/média escolaridade, baixa renda familiar mensal, histórico de complicações em gestações anteriores e gravidez não planejada. **Conclusão:** iniciativas preventivas à ocorrência da ansiedade e da depressão na gravidez, como o monitoramento da saúde mental e a sua triagem durante todo o pré-natal são necessárias. **Descritores:** Enfermagem; Ansiedade; Depressão; Gravidez.

RESUMEN

Objetivos: evaluar la presencia de ansiedad y depresión en el embarazo y caracterizar el perfil de las mujeres embarazadas. **Método:** estudio cuantitativo, epidemiológico, descriptivo, transversal y correlacional, realizado en las unidades de salud pública en una ciudad en el sur de Minas Gerais, Brasil, con 209 mujeres embarazadas. La recolección de datos ocurrió entre enero y mayo de 2013 y utilizó la Escala Hospitalaria de Ansiedad y depresión y la forma de caracterización. El estudio fue aprobado por el Comité de Ética en la Investigación, el protocolo y 113.129. **Resultados:** la ansiedad era más frecuente que la depresión y las mujeres embarazadas tenían algunos factores de riesgo para la aparición de estos trastornos en el embarazo como bajo/medio nivel de educación, bajo ingreso familiar mensual, antecedentes de complicaciones en embarazos previos y los embarazos no planificados. **Conclusión:** las iniciativas de prevención de la aparición de la ansiedad y la depresión en el embarazo, como la vigilancia de la salud mental y su proyección durante el prenatal son obligatorias. **Descriptores:** Enfermería; Ansiedad; Depresión; Embarazo.

¹Nurse, Master Teacher of Nursing, Graduate Nursing Program, Integrated Colleges Asmec/Ouro Fino-MG. Borda da Mata (MG), Brazil. Email: monica.mjsilva@yahoo.com.br; ²Nurse Obstetric, Professor of Sciences, School of Nursing, Federal University of Alfenas/Unifal-MG. Alfenas (MG), Brazil. Email: eprcl@yahoo.com.br; ³Zootechnician, Professor of Statistics, Institute of Mathematical Sciences, Federal University of Alfenas/Unifal-MG. Alfenas (MG), Brazil. Email: denismar@unifal-mg.edu.br; ⁴Nurse, Professor, School of Nursing of Ribeirão Preto, University of São Paulo/ EERP-USP. Ribeirão Preto (SP), Brazil. Email: maclapis@eerp.usp.br

INTRODUCTION

In experiencing the physical, hormonal and psychic, and social inclusion changes, inherent in pregnancy, the woman becomes vulnerable to mental disorders occurring during the prenatal period,¹ among them anxiety and depression. During pregnancy, mental disorders present themselves as psychopathological conditions that compromise the development of pregnancy for both the mother and the fetus, in the short and long term, if coating of great importance for serious maternal and fetal consequences.²

Because of these consequences, anxiety is considered one of the main risk factors for the development of pregnancy, since its development during pregnancy may affect the fetus and is associated with adverse neonatal outcomes, such as: prematurity, low birth weight, lower Apgar scores, stunted fetal development, and lasting effects on the physical and psychological development of the child and obstetric complications such as vaginal bleeding and threats of abortion, besides being one of the main risk factors for postpartum depression.³

Since the deleterious effects of depression also would entail serious consequences for maternal and fetal health, such as: low birth weight, decreased Apgar score, prematurity⁴, reduced head circumference; poor development in the first year of life and suicidal ideation with attempts at self-extermination.^{3,4}

In light of these considerations, are made necessary studies to highlight and list the main causes and mental disorders occurrences such as anxiety and depression in pregnant women to provide subsidies to sensitize nurses as the importance of their role in the implementation of actions the mental health of pregnant women that allow effectively improve prenatal care, reducing the adverse effects on quality of life related to health of the pregnant woman, as well as other harmful results to maternal and newborn.

OBJECTIVES

- Evaluating the presence of anxiety and depression in pregnancy
- Identifying the profile of pregnant women that received prenatal care in Primary Care Health Units under the Unified Health System (SUS).

METHOD

It is an epidemiological, descriptive, cross-sectional, correlational study of a quantitative

approach carried out in five Units of Primary Health Care that provide prenatal care under the National Health System in a municipality of the South of Minas Gerais.

The population was of pregnant women to prenatal follow-up carried out in these health units. Based on an estimated population of 450 pregnant women who perform prenatal at the health city network last year, it was calculated the sample size in 209 pregnant women, considering a prevalence of 50%, margin of error of 5% and level 95% confidence.

There were adopted as inclusion criteria: voluntary acceptance on the participation of research and aged 18 years old; and as exclusion criteria: current diagnosis of anxiety disorders, depression and / or another mental disorder; current use of anxiolytic medication, depression and/or other psychotropic; not having participated in the earlier sample during pregnancy.

There was the selection of a random sample by drawing lots. Therefore, we used the numbers of medical records of pregnant women who would be attending the Health Unit in data collection day and that met the established eligibility criteria, and of these, has drawn up the middle.

Data collection was performed by the researcher in the period from January to May 2013, in a room reserved with privacy assured in Primary Care Units at Municipal Health in the days that were performed prenatal care assistance.

To obtain the data there were used two instruments: A characterization form of the sample and the Anxiety and Depression Hospital Scale (HADS).

The form, authored by researcher, contained 36 objective questions divided into four areas: socio-economic and demographic characteristics, current and former gestational anamnesis, lifestyle and pre-existing diseases, important events of life and interpersonal relationships.

The Hospital Anxiety and Depression Scale (HADS) was used to evaluate anxiety and depression in pregnant women. This scale is a self-report assessment tool, created by Zigmond and Snaith in 1983, consists of 14 multiple-choice items, divided into two subscales with seven items: an anxiety and another depression. The respondent is asked how he has felt in the last week, in a Likert 4-points scale, with zero range to three. The total score is the sum of the scores of individual items related to anxiety and

Jesus Silva MM de, Leite EPRC, Nogueira DA et al.

depression separately, ranging from zero to 21 points for each subscale.⁵

To interpret anxiety and depression self-informed, according to the Brazilian adaptation, there were adopted as cutoff points: Hospital Anxiety Subscale: 0-8 - without anxiety; equal to or greater than 9 - with anxiety; Hospital Depression subscale: 0-8 - without depression; equal to or greater than 9 - with depression.⁵

The first tool (form) was applied by the researcher, as the scale was filled out by the own participant after previous orientation, since it can be self-administered instrument (self-applied).

Data were entered into a Microsoft Excel 2007 program database aiming validation was held the procedure of "double entry" to avoid possible transcription errors. Categorical variables were described in absolute numbers and percentages and continuous variables, there were also presented the average, median, standard deviation, minimum, maximum, and quartiles.

The study was approved by the Research Ethics Committee of the Federal University of Alfenas, protocol 113.129, complying with the Guidelines and Norms Regulating Researches

Anxiety and depression in pregnancy: characterization...

with Humans of the National Health Council. Prior to collecting data, each patient was informed about the study and invited to participate and must sign for both the term of Informed Consent.

RESULTS

From the 209 women who participated in the study, 26,8% showed anxiety during pregnancy and 14.8% depression.

The socio-economic and demographic characteristics of pregnant women showed an average age of 29,51 years old (SD = 5,74 years), the age group at greatest proportion of 20-25 years old. Regarding education, the majority (37,3%) attended high school degree. There was a higher frequency of married or pregnant women who reported living with a partner (82,8%), Catholic (56,9%), living in own home (65,6%) and monthly family income of up to three minimum wages (63,7%). As to occupation, most of the women exercised labor activity (49,3%).

Table 1. Age and income of pregnant women who performed prenatal care in primary health care units. Alfenas-MG, 2013.

Descriptive Statistics	Variables Age (years)	Income (real)
Average	29,51	1463,65
Detour - default	5,74	1018,97
Minimum	18	339,00
Maximum	43	10000,00
1st Quartile (P25)	21	700,00
2nd Quartile (50 - Median)	25	1200,00
3rd Quartile (P75)	30	2000,00

Note: 1 Only for participants who reported income.

With regard to the current and previous obstetric history, prevailed pregnant women who had no difficulty getting pregnant (90,9%) and even underwent treatment for this purpose (95,2%); they were in the third trimester of pregnancy (39,7%); had no children (39,7%) and were multiparous (67%), including 35% experienced an abortion and/or premature labor in previous pregnancies and 47,1% had a history of complications in

previous pregnancies. Regarding the current pregnancy, showed no complications until the time of data collection (74,2%).

The difference observed between the numbers of participants who did not have children and the number of first pregnancy is due to the fact that some pregnant women reported loss of children coming from previous pregnancies due to abortions and/or after birth.

Table 2. Number of pregnancies and births among pregnant women who performed prenatal care in primary health care units. Alfenas-MG, 2013 (n = 209).

Descriptive Statistics	Variables	
	Number of pregnancies	Number of births
Average	2,22	1,55
Detour - default	1,23	0,90
Minimum	1	1
Maximum	9	6
1st Quartile (P25)	1	1
2nd Quartile (50 - Median)	2	1
3rd Quartile (P75)	3	1

There also prevailed pregnant women who did not plan the pregnancy (56,9%); however the desired (98,6%) and stated that this desire was also shared by the partner (99%). In addition, they counted on spousal support (99%) and family (99%) during pregnancy.

Concerning the lifestyle and pre-existing conditions, there was a predominance of women who did not have the habit of smoking (88,5%) did not consume alcohol (92,8%) and did not use drugs (97,6%). However, among women who reported use of tobacco, alcohol and other drugs, most referred consume up to 10 cigarettes per day (62,5%), drinking alcohol once a month or less (66,7%) and use predominantly cocaine (80%). Remember that some pregnant women who reported making use of more than one type of drug.

Most of the women said not yet have health problems (88%); and systemic arterial hypertension (40%) and diabetes mellitus (20%) predominated as the most frequent pathologies among those who had them (12%); not make use of daily medications (90,7%); however, among those who were taking the anti-hypertensive drugs were the most frequent (42,8%), which is in line with the main problem referred to health; and have no history of mental disorder (79,1%). Among pregnant women who have already had some psychological distress, depression was the most experienced mental disorder in the past (76,2%), most of which underwent treatment for the disorder lived (59,5%), which was predominantly type Pharmacological (72%).

Regarding the important events of life and interpersonal relationships, most of the women did not experience a landmark event in the last twelve months (33,5%), did not face marital conflicts (97%), did not suffer domestic violence in the past (90%) nor currently (99,5%). Among the participants who experienced domestic violence in the past, most reported having been the victim of physical violence (71,4%) and the only pregnant woman who confirmed being a victim of violence currently (0,5%) reported that this type of psychological or moral violence.

Most of the women claimed to have satisfactory interpersonal relationships (89,5%), and the family was identified predominantly as the group with whom the relationship is poor (91%). In addition, they also receive some kind of support/social support (60,8%), and family the most frequent provider of such support/support (88,9%), which is mainly financial and emotional/psychological (74,8%).

DISCUSSION

The study showed predominance of the age group between 20-25 years old. These results are consistent with data from the Brazilian Institute of Geography and Statistics present in the population census conducted in 2010, which determined that the total population, 97.348.809 are women. Of these, 42.396.035 were aged 18 to 44 years old. Of live births in 2010, the age of higher prevalence of mothers was understood in the age group 20-24 (729.955) and 25-29 (671.943).⁶

Despite the increase in the incidence of pregnancy at the extremes of reproductive life, before 20 and after 35 years of age, the findings allow us to infer in the majority incidence of pregnancy in the age range considered ideal for their development, which varies between 20 and 35.⁷

A similar study conducted to evaluate the frequency of anxiety and depression among pregnant women in Pakistan that also used the Hospital Anxiety and Depression Scale (HADS), corroborates the data from this study, observing that for a sample of 167 pregnant women, prevailed young women, including aged between 18 and 30 years old (70,1%), averaging 27,92 years old.⁸

At that matches the level of education, the findings allow us to infer the presence of a low profile/medium instructional level, which makes up most of the study participants, who have completed high level (37,3%) and incomplete primary level (20,6%).

This result contrasts with data evidenced by a study conducted in Pakistan, although not considered a developed country, showed most patients (70%) university graduates or graduate.⁸

Jesus Silva MM de, Leite EPRC, Nogueira DA et al.

Education, imbued in education, increases the possibility of choices in life and the acquisition of new knowledge that can motivate healthier attitudes and behaviors, possessing direct effect on the health of individuals. In this context, the low level of education can be an aggravating factor for the health of women, being considered by the Ministry of Health as an obstetric risk factor.⁹

In the context of a pregnancy, the level of schooling is intimately associated with adherence to prenatal care and there is a relationship between the level of mother's education and the number of prenatal consultations, as indicated by the Brazilian Ministry of Health.¹⁰

In the study, there was a higher frequency of married or pregnant women who reported living with a partner and Catholic. Other researchers have also shown a predominance of married mothers in their investigations, with percentages of 96% in a study conducted in Greece.¹¹

The presence of a partner can act to minimize the impacts related to changes resulting from pregnancy, whether hormonal, psychological, family or social inclusion, which can directly reflect on their mental health. In this context, the support of the husband or partner directly reflects the way the woman accepts and experiences of her pregnancy, as it faces intercurrent complications.

With regard to religious belief, it is worth mentioning that the mother, as well as any individual can pervade by conflicting situations that put them on the need to articulate means to cope and live with the aspects inherent in these situations. Particularly in pregnancy, conflicts sharpen up before the pregnant woman's condition to answer not only for their health but also for their child. Thus, religious belief, characterized as important and recognized health protection strategy, can act positively for the maintenance of psychological well-being.¹²

Concerning family income, there was a predominance of women who lived with up to three minimum wages; indexes corroborate those described by study conducted in Rio Grande do Sul, Brazil.²

Family income can negatively influence pregnancy as trigger situations of stress and insecurity.¹³ These psychological mechanisms in the context of a pregnancy, expected to be increased spending because of family growth, may be exacerbated by committing the pregnant woman's well-being.

Anxiety and depression in pregnancy: characterization...

In addition, lower family income has been associated with less frequent use of prenatal care, which may compromise pregnancy.¹⁴

In terms of occupation, the study showed that the majority of pregnant women exercising labor activity (49,3%). No different findings were described in a study conducted in Italy.³

About the occupation, it is important to reflect on its association with family income. During pregnancy, the occupation as an income source can provide a sense of tranquility to the mother, since the presence of a monthly salary decreases the worries and stress related to expenses arising from that period and the preparation for the birth of the child.

Most of the women said to live in own home (65,6%). This fact can be inferred that the ownership of a property provides tranquility to women in the context of a pregnancy. With the arrival of a child, the absence of a proper dwelling, associated with expenses spent on the rent of a property, can lead to stress and insecurity, mechanisms that negatively influence pregnancy.

As already evidenced in the literature¹¹, most study participants had no trouble getting pregnant.

Although the rate of women who had difficulty has been restricted (9,1%), it is worth mentioning that in our country, as in many societies, motherhood remains one of the main social roles of women. In this context, the difficulty to get pregnant exposes women, as well as their spouse, the pressures that make them vulnerable to changes in their physical and psychological well-being with repercussions on their social, emotional and sexual life.¹⁵

This set of factors associated with difficulty becoming pregnant, are in addition to issues related to realization of treatment for this purpose.

In this sample, most women did not need to perform treatments to get pregnant (95,2%). Although only 4,8% of pregnant women have resorted to treatments, it points out that the achievement of these can cause stress and wear not only the woman but also her partner affecting their quality of life, due to multiple factors entered into this context as positive outcome of uncertainty, the lack of treatment in some locations and the availability of resources for this purpose. Facts that are accentuated in cases where couples depend on public health services for the completion of treatment, in contexts

Jesus Silva MM de, Leite EPRC, Nogueira DA et al.

where this is not treated as a priority public health problem.¹⁵

With regard to gestational age, 39,7% of women were investigated in the third trimester of pregnancy, and percentage of pregnant women who were close in the second quarter (39,2%).

To discuss the gestational age, there is that of pregnant women care needs should be carefully observed in accordance with the priorities of each trimester, so that timely interventions take place, whether preventive or therapeutic.⁹

Among the respondents, 67% were multiparous the number of previous pregnancies ranging from one to nine, in addition to varying the number of previous births between one and six. Among the multigravidae, 35% experienced an abortion and/or premature labor in previous pregnancies.

Similar results are corroborated by another study that identified 54% of multigravidae, with 22% of them with abortions history previous pregnancies.¹¹

The abortion history and/or threat of premature birth can influence significantly the current pregnancy, causing damage to the welfare of pregnant women.

The experience of negative experiences in previous pregnancies can trigger during pregnancy feelings of insecurity, anxiety and fear of the last adverse outcome be repeated in the current pregnancy.⁴ In fact, it is inferred the importance of realization of prenatal care, in which detailed assessment of obstetric history by health professionals pregnant woman should be inserted.

Among the participants, there was predominance of women who have no children (39,7%). This finding is consistent with the trend observed in the country of successive and significant drops in fertility rates in recent decades, which was 2,38 children in 2000 and came to 1,90 in 2010.⁶ This decrease is due to greater participation of women in the labor market and changes in their social role, factors that have contributed to the planning of the number of children they want to have.¹⁶

The current obstetric anamnesis past has highlighted that among the multigravidae, most had complications in previous pregnancies (47,1%), a fact that was not observed during the pregnancy (27,8%).

These results allow us to infer that the knowledge of the history of the mother and her previous experiences by the health professional allows her to watch uniquely

Anxiety and depression in pregnancy: characterization...

woman with all its peculiarities, assuming importance in this context obstetric guidelines and the involvement that contribute to increase confidence of pregnant women, resulting in physical and mental well-being.⁹ Furthermore, there was showed the physiological profile of pregnant women and support the importance of prenatal care in the prevention and early detection of obstetric complications and development of educational activities that are essential to preserve the maternal-fetal health and reduce morbidity and mortality of mother-child binomial, emphasizing the predominant role of midwifery in this process.¹⁷

As documented by several researchers¹⁸, most of the interviewees reported having unplanned pregnancy.

The non-pregnancy planning is configured as a risk factor associated with adverse maternal and perinatal outcomes, including mortality and morbidity associated with unsafe induced abortions, especially in countries where abortion is illegal.¹⁹ The occurrence of an unplanned pregnancy results on many factors, including the lack of access and low utilization contraceptive methods.¹⁸ Thus, the greater access to family planning services is key to reducing the incidence of unplanned pregnancies, which should be accompanied by improved quality of service and availability of information on the effective use of contraceptive methods.¹⁹

The unplanned pregnancy can sometimes become synonymous with an unwanted pregnancy, as opposed to the wishes and the couple's expectations.

In this study, almost all of the women wanted the pregnancy and said that this desire was also shared by the partner.

Despite the unwanted pregnancy rate is extremely low in this study (1,4%), it is worth mentioning that this variable is a risk factor for gestational development with adverse health effects, both maternal and neonatal.¹⁹

Other researchers identified higher prevalence of unwanted pregnancies, referring 24% in Kenya.¹⁹

In this sample predominated mostly pregnant women who relied on spousal support and family during pregnancy, which corresponded to 99% for both variables.

This contrasts with the data in a South African research that noted the lack of support reported by women during pregnancy.²⁰

The placement of the child's father in relation to pregnancy and marital status are factors that influence acceptance of

Jesus Silva MM de, Leite EPRC, Nogueira DA et al.

pregnancy,²¹ since the support reflects the father's commitment to the newborn.¹⁸ In this context, the lack of spousal support is a risk factor closely linked to the onset of mood disorders in pregnancy and postpartum.²² Similarly, family support is also an essential factor for the welfare of the pregnant woman³, and her absence associated with a higher probability of pregnant women presenting common mental disorders such as anxiety and depression.²³

Concerning the lifestyle and pre-existing conditions, most of the women did not have the habit of smoking. Although the percentage of pregnant smokers was low (11,5%), it is noteworthy that among these, 62,5% reported consuming up to 10 cigarettes a day. Other Brazilian researchers found values of 19,5% in Pelotas, Rio Grande do Sul.²³

The habit of smoking during pregnancy is associated with adverse obstetric outcomes as the incidence of abnormalities in the fetus, restriction of intrauterine growth retardation, low birth weight, placenta previa, antepartum bleeding, miscarriage, pregnancy ectopic pregnancy and the newborn rising death.²⁴

Most pregnant women did not consume alcohol (92,8%); however, between 7,2% who reported alcohol use during pregnancy. Another study presented several percentage as alcohol consumption among pregnant women ranging from 3,7% to 60,5%.^{18,23}

Drinking alcohol during pregnancy can have negative effects on fetal brain development and teratogenic effects in any pregnancy, caused by ethanol.²⁵

Regarding drug use, 97,6% of women surveyed reported not to use. However, among cocaine users, it was the most used drug.

Drug use during prenatal affects hundreds of thousands of pregnancies a year, and a risk factor for the fetus capable of triggering delays in its development, and a variety of children's neurobehavioral problems, learning difficulties, social unrest and problems health throughout the child's life.²⁶

Among pregnant women, 88% reported not having health problems. In this context, it is inferred the importance of prenatal care in addressing the specificities of each pregnant women, essential to prevent maternal and fetal morbidity and mortality could be due to maternal health problems of complications.

Regarding the use of daily medications, most interviewees did not. However, among those who were taking the anti-hypertensive drugs were the most frequent, which is in line with the main problem of health said. Result

Anxiety and depression in pregnancy: characterization...

not corroborated by other Brazilian research, which was evidenced consumption of at least one drug for 99% of pregnant women with a predominance of the use of painkillers and anti-inflammatory.²⁷

Exposure to drugs during pregnancy can cause complications to the fetus, the first three months for the most critical changes that may cause functional and behavioral defects or even the immediate death of the fetus²⁸, so its use should be done with caution. However, even with risks, which currently has is a self-medication frame, sometimes indiscriminately, due to easy access.

The history of mental disorders among pregnant women was of 20,1% and depression mental disorder that experienced in the past (76,2%).

As documented in the literature, the history of mental disorder is a high risk of recurrence during pregnancy, which points to the need for intervention and prevention even before that period.^{3,4}

In this study, the participants who experienced mental disorders in the past, 59,5% underwent treatment, and the majority opted for the pharmacological treatment (72%).

Although the pregnant women who did not undergo index treatment for mental disorder experienced in the past has not been prevalent (40,5%), it is, however, relevant, which highlights a serious problem in public mental health care. Such a situation was found in another Brazilian study in which pregnant women with no prior history of depression performed psychiatric treatment.⁴

Not performing treatment cannot be attributed solely to lack of assistance in health. Cultural issues may also be imbued with this phenomenon, since culture can affect the perception of people about the need for mental health treatment, representing barriers to seeking help or access to health care.

The landmark event frequency in the lives of women interviewed in the last twelve months was of 33,5%, predominantly loved one's death. Other Brazilian researchers showed data that contrast with these findings.²³

The key events are characterized as life changes that require adjustments and therefore are configured as potential producers of stress, which in the course of a pregnancy, also characterized as an event that demands changes can get worse and cause damage to maternal and fetal health.

Jesus Silva MM de, Leite EPRC, Nogueira DA et al.

It is important to mention that in developing countries many factors may contribute to the exacerbation of stressful producing events during pregnancy because of inequities that pervade society.⁴

With regard to marital conflicts, pregnant women prevailed than those currently faced (97%).

A fragile marital relationship, marked by conflicts, impacts negatively on pregnancy as deteriorates the pregnant woman's well-being.

The fights with partners are seen as reasons for many women feel distressed and lamenting during pregnancy, especially in situations characterized by low economic and social power, when pregnancy increases the dependence of women in relation to the partner. In addition, a conflict marital relationship can worsen under the additional stress of pregnancy, being a major vulnerability factor for domestic violence.²⁹

In this study predominated pregnant women who have not suffered domestic violence in the past and even today, 90% and 99,5%, respectively. Other researchers presented top date to the present study, which identified in Cape Town in Africa, more than half of the women (63,8%) had experienced in the past or currently experiencing some form of violence, whether physical, sexual or psychological.²⁰

The experience of the reality permeated by violence Suffered During pregnancy is associated with serious maternal and fetal consequences for health, with Increased risk of low birth weight, maternal and fetal death, premature birth, miscarriage and subsequent behavioral problems in children and development of mental disorders the conspires against it the pregnant woman's well-being to be a source of grief and suffering for her.³⁰

Most of the women claimed to have satisfactory interpersonal relationships, and the family was identified predominantly as the group with whom the relationship is unsatisfactory. In another study, 33,3% of the women reported having conflicts with closed people.⁴

Constructive social relationships with family and friends are conducive to well-being.³¹ Thus, maintaining satisfactory interpersonal relationships may favor the development of the pregnancy as permeates the pregnant woman's well-being and makes her feel supported by a circle of people with whom she relates, which makes up part of her support network/social support.

Anxiety and depression in pregnancy: characterization...

Of the total sample, 60.8% of pregnant women received some kind of support/social support.

When addressing the presence of support during pregnancy it is relevant to consider the importance of acceptance and experience of pregnancy for the woman, who is desired or not, highlighting the midwifery team also acts as a provider of this support.

In this context, it appears in the literature as the lack of support is connected with the form of psychological coping with pregnancy.³²

CONCLUSION

The present study demonstrated the occurrence of anxiety and depression in pregnancy, and that the former was more common among pregnant women, which indicates that pregnancy is not always a period without injuries for most women. And yet, it characterized pregnant women with anxiety and depression in the prenatal period.

In short, it was observed that pregnant women had few risk factors for the occurrence of these disorders in pregnancy already evidenced in the literature as low/medium education, low family income, history of complications in previous pregnancies and unplanned pregnancies.

Thus inferred the need to implement interventions to preventing, detecting and treating mental disorders that can permeate the pregnancy as anxiety and depression, as conducting screening and monitoring of mental health during the prenatal period. Therefore, it requires the training of professionals involved in prenatal care, highlighted here the midwifery and inserted into the primary health care which shall incorporate the mental health of women in care of the everyday practices and the support of health managers through policies and programs involving the mental health of women, especially during pregnancy.

ACKNOWLEDGEMENTS

To the Federal University of Alfenas (Unifal-MG) for financial support.

REFERENCES

1. Apter G, Devouche E, Gratier M. Perinatal mental health. J Nerv Ment Dis [Internet]. 2011 [cited 2013 Aug 30];199(8):575-7. Available from: <http://www.ncbi.nlm.nih.gov/pubmed/21814083>

2. Almeida MS, Nunes MA, Camey S, Pinheiro AP, Schmidt MI. Transtornos mentais em uma amostra de gestantes da rede de atenção

Jesus Silva MM de, Leite EPRC, Nogueira DA et al.

básica de saúde no Sul do Brasil. Cad Saúde Pública. [Internet]. 2012 [cited 2013 Oct 22];28(2):385-93. Available from: <http://www.scielo.br/pdf/csp/v28n2/17.pdf>

3. Giardinelli L, et al. Depression and anxiety in perinatal period: prevalence and risk factors in an Italian sample. Arch Womens Ment Health [Internet]. 2012 [cited 2013 Oct 20];15(1):21-30. Available from: <http://link.springer.com/article/10.1007%2Fs00737-011-0249-8>

4. Pereira PK, et al. Complicações obstétricas, eventos estressantes, violência e depressão durante a gravidez em adolescentes atendidas em unidade básica de saúde. Rev Psiquiatr Clín (São Paulo, Online) [Internet]. 2010 [cited 2013 Aug 10];37(5):216-22. Available from: <http://www.scielo.br/pdf/rpc/v37n5/a06v37n5.pdf>

5. Zigmond AS, Snaith RP. The hospital anxiety and depression scale. Acta Psychiatr Scand [Internet]. 1983 [cited 2013 June 20];67(6):361-70. Available from: <http://www.ncbi.nlm.nih.gov/pubmed/6880820?f1000m,isrctn>

6. Instituto Brasileiro de Geografia e Estatística [Internet]. Censo Demográfico 2010. Fecundidade, Nupcialidade e Migração: resultados da amostra. Rio de Janeiro: Instituto Brasileiro de Geografia e Estatística; 2010. [cited 2013 Oct 14]. Available from: http://ftp.ibge.gov.br/Censos/Censo_Demografico_2010/Nupcialidade_Fecundidade_Migracao/tab1_1.pdf

7. Teles LMR, et al. Parto com acompanhante e sem acompanhante: a opinião das puérperas. Cogitare enferm [Internet]. 2010 [cited 2013 Nov 16];15(4):688-95. Available from: <http://www.ojs.c3sl.ufpr.br/ojs2/index.php/cogitare/article/download/20366/13527>

8. Ali NS, et al. Frequency and Associated Factors for Anxiety and Depression in Pregnant Women: A Hospital-Based Cross-Sectional Study. The scientific World Journal [Internet]. 2012 [cited 2013 Sept 12];(1):9. Available from: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3354685/>

9. Brasil. Ministério da Saúde. Secretaria de Políticas de Saúde. Assistência pré-natal: manual técnico. Brasília: Ministério da Saúde; 2000.

10. Brasil. Ministério da Saúde. Secretaria de Vigilância em Saúde. Departamento de Análise de Situação de Saúde. Saúde Brasil 2004: uma análise da situação de saúde. Brasília: Ministério da Saúde; 2004.

Anxiety and depression in pregnancy: characterization...

11. Gourounti K, Anagnostopoulos F, Lykeridou K. Coping strategies as psychological risk factor for antenatal anxiety, worries, and depression among Greek women. Arch Womens Ment Health [Internet]. 2013 [cited 2013 Aug 11];16(5):353-61. Available from: <http://link.springer.com/article/10.1007%2Fs00737-013-0338-y>

12. Soeiro RE. Religião e transtornos mentais em pacientes internados em um hospital geral universitário. Cad Saúde Pública [Internet]. 2008 [cited 2013 Sept 12];24(4):793-9. Available from: <http://www.scielo.br/pdf/csp/v24n4/09.pdf>

13. Ludermitz AB, Melo Filho DA. Condições de vida e estrutura ocupacional associadas a transtornos mentais comuns. Rev Saúde Públ [Internet]. 2002 [cited 2013 Oct 10];36(2):213-21. Available from: <http://www.scielo.br/pdf/rsp/v36n2/9214.pdf>

14. Pinto LF et al. Perfil social das gestantes em unidade de saúde da família do município de Teresópolis. Ciênc saúde coletiva [Internet]. 2005 [cited 2013 Sept 24];10(1):205-13. Available from: <http://www.scielo.br/pdf/csc/v10n1/a21v10n1.pdf>

15. Baldur-Felskov B, et al. Psychiatric disorders in women with fertility problems: results from a large Danish register-based cohort study. Hum Reprod [Internet]. 2013 [cited 2013 Nov 30]; 28(3):683-90. Available from: <http://humrep.oxfordjournals.org/content/28/3/683.short>

16. Organização Mundial da Saúde [Internet]. Mulheres e saúde: evidências de hoje, agenda de amanhã. Geneva: Organização Mundial da Saúde; 2011 [cited 2013 Sept 11]. Available from: http://www.who.int/eportuguese/publications/Mulheres_Saude.pdf

17. Spindola T, Penna LHG, Progiatti JM. Perfil epidemiológico de mulheres atendidas na consulta do pré-natal de um hospital universitário. Rev Esc Enferm USP [Internet]. 2006 [cited 2013 Nov 11];40(3):381-8. Available from: <http://www.scielo.br/pdf/reeusp/v40n3/v40n3a09.pdf>

18. Prietsch SOM, et al. Gravidez não planejada no extremo Sul do Brasil: prevalência e fatores associados. Cad Saúde Pública. [Internet]. 2011 [cited Oct 22];27(10):1906-16. Available from: <http://www.scielo.br/pdf/csp/v27n10/04.pdf>

Jesus Silva MM de, Leite EPRC, Nogueira DA et al.

19. Ikamari L, Izugbara C, Ochako R. Prevalence and determinants of unintended pregnancy among women in Nairobi, Kenya. *BMC Pregnancy Childbirth* [Internet]. 2013 [cited 2013 Nov 16]; 13(1):69. Available from: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3607892/>
20. Vythilingum B, et al. Screening and pathways to maternal mental health care in a South African antenatal setting. *Arch Womens Ment Health* [Internet]. 2013 [cited 2013 Nov 30];16(5):371-9. Available from: <http://link.springer.com/article/10.1007/s00737-013-0343-1>
21. Santos NA, et al. Perfil das gestantes com pré-eclâmpsia e fatores emocionais associados. In: 61º Congresso Brasileiro de Enfermagem, 2009, Fortaleza. Transformação social e sustentabilidade ambiental [Internet]. 2009 [cited 2013 Oct 20]. Available from: http://www.abeneventos.com.br/anais_61cb/en/files/01565.pdf
22. Rubertson C, et al. Depressive symptoms in early pregnancy, two months and one year postpartum-prevalence and psychosocial risk factors in a national Swedish sample. *Arch Womens Ment Health* [Internet]. 2005 [cited 2013 Sept 13];8(2):97-104. Available from: <http://link.springer.com/article/10.1007%2Fs00737-005-0078-8>
23. Silva RA, et al. Transtornos mentais comuns e autoestima na gestação: prevalência e fatores associados. *Cad Saúde Pública* [Internet]. 2010 [cited 2013 Aug 14];26(9):1832-8. Available from: <http://www.scielo.br/pdf/csp/v26n9/16.pdf>
24. Poletta FA, et al. Consumo y exposición al humo de tabaco en mujeres embarazadas de Ecuador. *Rev Panam Salud Publica* [Internet]. 2010 [cited 2013 Sept 11];27(1):56-65. Available from: <http://www.scielosp.org/pdf/rpsp/v27n1/09.pdf>
25. Yamaguchi ET, et al. Drogas de abuso e gravidez. *Rev Psiq Clin* [Internet]. 2008 [cited 2013 Aug 20];35(1):44-7. Available from: <http://www.scielo.br/pdf/rpc/v35s1/a10v35s1.pdf>
26. Bandstra ES, et al. Prenatal drug exposure: infant and toddler outcomes. *J Addict Dis* [Internet]. 2010 [cited 2013 Sept 10];29(2):245-58. Available from: <http://www.tandfonline.com/doi/pdf/10.1080/10550881003684871>
27. Oliveira ES, Chaves AFL, Vasconcelos HCA, Rocha RS, Costa FS. The prevalence of drug consumption during pregnancy. *J Nurs UFPE on line*. [Internet] 2013 Oct [cited 2013 Nov 29];7(spe):6083-92. Available from: <http://www.revista.ufpe.br/revistaenfermagem/index.php/revista/article/view/4554/pdf>
28. Daw JR, et al. Prescription drug use in pregnancy: a retrospective, population based 1. study in British Columbia, Canada (2001-2006). *Clin Ther* [Internet]. 2012 [cited 2013 Oct 2];34(1):239-49. Available from: <http://www.sciencedirect.com/science/article/pii/S0149291811007806>
29. Hanlon C, et al. Between life and death: exploring the sociocultural context of antenatal mental distress in rural Ethiopia. *Arch Womens Ment Health* [Internet]. 2010 [cited 2013 June 20];13(1):385-93. Available from: http://download.springer.com/static/pdf/594/art%253A10.1007%252Fs00737-010-0149-3.pdf?auth66=1417290186_7212c384c5de1c15f485139abbbe7b1e&text=.pdf
30. Hellmuth JC, et al. Risk factors for intimate partner violence during pregnancy and postpartum. *Arch Womens Ment Health* [Internet]. 2013 [cited 2013 Nov 30];16(1):19-27. Available from: <http://link.springer.com/article/10.1007/s00737-012-0309-8>
31. Baptista MN, Baptista ASD, Dias RR. Estrutura e suporte familiar como fatores de risco na depressão de adolescentes. *Psicol ciênc prof* [Internet]. 2001 [cited 2013 Oct 13];21(2):52-61. Available from: http://www.scielo.br/scielo.php?pid=S1414-98932001000200007&script=sci_arttext&tlng=es
32. Fisher J, et al. Prevalence and determinants of common perinatal mental disorders in women in low- and lower-middle-income countries: a systematic review. *Bull World Health Organ* [Internet]. 2012 [cited 2013 Sept 25];90(2):139-49. Available from: <http://www.scielosp.org/pdf/bwho/v90n2/v90n2a14.pdf>

Jesus Silva MM de, Leite EPRC, Nogueira DA et al.

Anxiety and depression in pregnancy: characterization...

Submission: 2014/12/02

Accepted: 2015/07/27

Publishing: 2015/08/15

Corresponding Address

Mônica Maria de Jesus Silva
Vila Tio Mazico, 34
Bairro Centro
CEP 37564-000 – Borda da Mata (MG), Brazil