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Antenatal Depression And Anxiety In Bihar Women: A Systematic Phycological Study

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ABSTRACT:

There is good evidence to suggest that high prevalence of depression and anxiety in the postpartum period. However, very few studies have focused on antenatal depression and anxiety disorders and their associated risk factors. Further, there are only a handful of studies from India on common antenatal mental health disorders. With this background, we reviewed the existing evidence on antenatal depression and anxiety from the studies conducted in Indian pregnant women during the antenatal period and to explore the associated risk factors. All the major databases were searched systematically for English language studies on prevalence and risk factors for antenatal depression and anxiety in Indian pregnant females, published during the period January 2022 to May 2023. Quality assessment of studies was done with the modified version of Newcastle Ottawa Scale for cross-sectional studies. We found the overall prevalence of antenatal depression was ranged from 3.8% to 65% and antenatal anxiety from 13 to 55%. The most relevant risk factors associated with antenatal depression and anxiety during pregnancy were preference to have a male child, intimate partner violence, history of abortions, marital conflict, poor relationship with the husband/in-laws and lack of social support. To conclude, the systematic review suggests that depressive and anxiety disorders are quite common in Indian pregnant women in antepartum period with varying prevalence depending on various settings and scales used. Steps should be taken to promote obstetricians for regular mental health screening during the antenatal visits and prompt referral to mental health professionals when suspected.

Keywords: Antenatal Anxiety, Antenatal Depression, India, Risk Factors, Systematic Review

INTRODUCTION:

While pregnancy does bring happiness, it also ushers in several new physiological and psychosocial changes.[1] Oxford Languages define antenatal as 'before birth; during or relating to pregnancy'. The time and duration of pregnancy warrants certain physiological, hormonal and psychological changes that offset an increase in mental and emotional changes which can result in psychological distress in the expecting mother.[2] According to the World Health Organization (WHO), maternal mental health can be defined as 'a state of well-being in which a mother realizes her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her community'.[3] Antenatal psychological

distress is a major cause of concern not only for expecting women[4] but it can also have long term consequences on the behavioural and cognitive outcomes for children.[5] Meta-analysis of 29 studies on adverse outcomes of antenatal depression had revealed that higher risk of low birth weight (LBW) and preterm birth (PTB) in developing countries suggesting universal screening for depression and mental health issues during the antenatal period.[6]

DESCRIPTIONS:

As per the recent data, the prevalence of depressive and anxiety disorders was substantially higher in females than in males.[7] The National Mental Health Survey 2016 (NMHS) revealed that one in every tenth Indian suffers from depression and anxiety, and 20% of these depressed Indians are pregnant women.[8] Approximately, 15% of women are known to face depression at some point and predominantly during pregnancy and after childbirth, these symptoms can vary from mild to severe.[1] The prenatal depression rate and prevalence differ between countries on the basis of income (low, middle and high).[9] In developing countries like India, the prevalence of depression in pregnant females was ranged from 9.18% to 36.7%.[10] .It is a well-known fact that pregnant woman can have symptoms of anxiety or depression at any point of time during pregnancy, hence, screening women only once throughout pregnancy to diagnose or estimate prevalence is not sufficient;[1] which is usually done in most of the studies. This is one of the major limitations of all the published studies which usually take into account point prevalence rather than evaluating longitudinally throughout the pregnancy period.[7] The risk of suffering from prenatal depression increases markedly as the pregnancy progresses and clinically notable symptoms are relatively common in the mid and late trimester.[8] The prevalence of anxiety and depression during pregnancy is dynamic and depends on a multitude of factors; for example, studies had revealed greater anxiety and depressive symptoms in primiparous women during early and mid-pregnancy, while multiparous women report greater anxiety and depression during the 3rd trimester.[10] Further, few studies have also revealed that from anxiety and depressive symptoms decrease from 1st trimester to 3 months post-partum but later increased from 3rd month to 30th month post-partum, suggesting screening needs to be done at regular intervals after child birth too, if there are symptoms of anxiety and depression in the antenatal period. Risk factors for antenatal depression have been explored in great detail across several studies. These are mainly interpersonal risk factors, for example, insufficient social support and social conflicts,[5] unsatisfactory relations with in-laws, gender preference (feeling pressurized to deliver a male child),[6] etc. A recent systematic review of the literature (n = 23 studies) which focused on the burden of

common mental disorders (CMDs) among pregnant women revealed a prevalence of 1-37% of CMDs (depression – 1% to 30% and anxiety -1% to 26%) among pregnant women in low and middle income countries.[4] This review also reported lower socio-economic status, intimate partner violence, history of previous episodes of CMDs, history of mental illness in family and unmarried status to be some of the important risk factors for antenatal depression.[3] When we did a thorough review of the literature, we found that historically, the postpartum period has been of significant focus and has generated far greater research than the antenatal period. Some reasons for this ignorance could have been because of the general misattribution of emotional complaints to the hormonal changes that take place during pregnancy and the hesitancy to report symptoms due to the stigma associated with depression

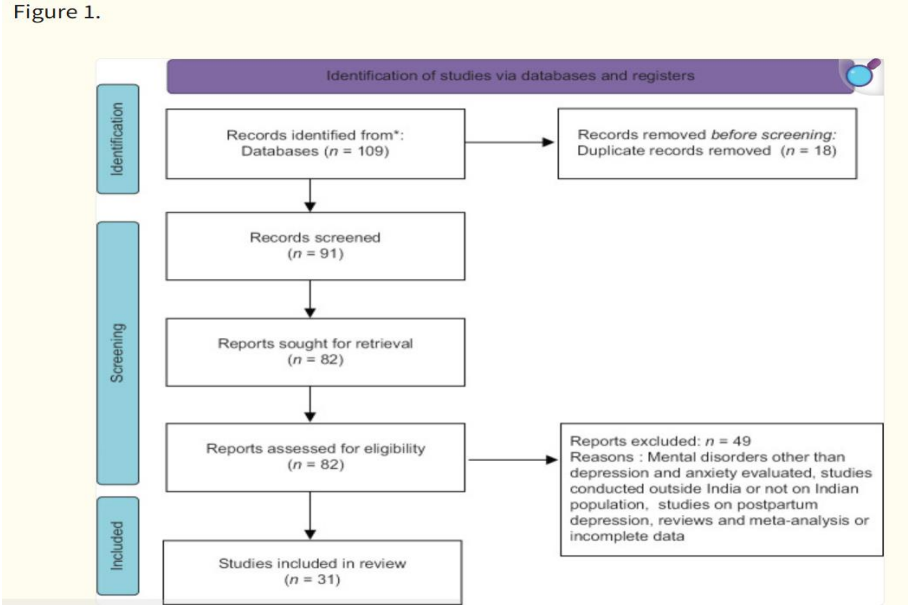
METHODOLOGY:

Literature search strategy: A thorough literature search was carried out in electronic databases (Google scholar, PsyInfo, Medline, PubMed and the Cochrane Library databases) during the 1 April 2022 and 31 May 2022 using combinations of the following keywords and MeSH terms 'antenatal depression'; 'antenatal anxiety'; 'prevalence of antenatal depression'; 'India'; 'antenatal mental health in India' and 'risk factors for depression/anxiety during pregnancy in India'. The articles published during the period from January 2022 to May 2022 were taken into consideration. The references of the articles were also cross-checked to identify any potentially eligible research articles. Inclusion and Exclusion criteria assessing depression in Indian pregnant females during the antenatal period irrespective of the gestational age using a validated tool/scale was included. All the articles published in English language and published between 1 January 2022 and 30 May 2022 was included. The research articles which assessed any mental disorder or recruited the women shortly after the delivery to assess the postpartum depression were excluded. The studies which have recruited Indian women residing in a country other than India were not considered. In addition to this, the research articles for which full text was not available were also excluded.

STUDY SELECTION:

Figure 1 outlines the literature search and selection of studies. 33 studies fulfilled the inclusion and exclusion criteria and were included in the systematic review. Studies excluded were those reporting prevalence of only post-partum depression, on policies, those not conducted in Indian population and those before the year 2000 and other reasons mentioned in PRISMA 2020[21] Flow diagram Figure 1.

Figure 1.



Prevalence of antenatal depression: All the included studies reported the presence of antenatal anxiety and antenatal depression. These rates varied in each trimester and across certain socio-economic variables. The prevalence of antenatal depression in the given studies from Table 1 ranged from 3.8%[6] to 65%.[5] Few studies found that prevalence of anxiety was significantly higher among women who were also depressed.[7] The prevalence of anxiety during the antenatal period had ranged from 13% to 55%.[24,25] The prevalence of suicidality in women in early pregnancy (<20 weeks) was 7.6%.[26] Table 1 depicts the summary of included studies.

RISK FACTORS:

Factors associated with the presence of antepartum depression had been explored in few studies. Most of the studies had revealed some similar factors such as poor relationships with one's spouse, poor relationship with in-laws and desire/pressure to have a male child, previous history of abortions, pregnancy associated with obstetric complications, alcohol abuse by husband, poor social support and domestic violence/intimate partner violence have been found to prominent risk factors for developing antenatal depression. Gender preference is also present more often among multipara women than among primiparous women. Women who report male gender preference or pressure tend to have both higher antenatal anxiety and depression levels. While some studies had also reported greater pregnancy-related anxiety and depressive symptoms in primigravida and in pregnant women aged more than 30 years others have reported greater depression in pregnant women less than 20 years of age or no such significant association with age[31,37] Various risk factors have been

tabulated in above Table 1 under inferences section.

DISCUSSION:

Emotional, behavioural and psychological distress in expecting mothers is quite common but has been an almost entirely ignored entity. Postpartum depression, blues and post-traumatic stress disorder are often more highlighted and widely studied. In this review, prevalence and risk factors for antenatal depression and anxiety were investigated. Table 1 shows all the studies that have been included and discussed in this review. A total of 31 studies included a total of 9937 culturally and demographically diverse pregnant women who were all above the age of 18 and without any history of psychotic disorder or co-morbid medical illness. They were either recruited for their respective studies while attending routine antenatal check-up or were randomly selected from the antenatal database of the hospital. 23 studies can be regarded as having quality of moderate level as per the quality assessment scale used. The results of this review confirm previous evidence with respect to prevalence and risk factors. There is prevalence of some degree of depression in each study, but this prevalence tends to strikingly increase during the third trimester. In most studies, the prevalence of depression and anxiety co-exists in pregnant women. The overall prevalence of antenatal depression ranged between 3.8% to 65% and the overall anxiety ranged between 13 to 55%. Previous studies have also reported similar prevalence rates. Most of the risk factors identified are common for both antenatal anxiety and depression. The co-morbid existence and prevalence of depression and anxiety is a frequent condition but the timing of which appears first is yet to be ascertained. Few studies have also reported that high levels of antenatal anxiety to be a predictor for postpartum depression. Among the various psychosocial factors, low social support had been found to be a significant predictor of anxiety. The relationship between depression and number of times the woman had been pregnant had been studied in few studies. While few studies claimed that depression during pregnancy is significantly associated with multigravidas,] another study suggested the reverse, i.e., more anxiety in primigravida's. The most highlighted risk factors found in this review of studies were pressure to have a male child, unemployment, financial difficulties, history of miscarriage, marital conflict or poor relation with the husband and lack of recreation. Another important risk factor for antenatal depression that has been validated by multiple studies is presence of previous history of abortions. Studies that have examined prevalence and potential risk factors have also used specific tools and scales that were translated to the regional language and culturally validated to be utilized on the Indian population. The scales that were the most popularly used were Edinburgh

Postnatal Depression Scale (EPDS), General Health Questionnaires, and Hamilton Rating Scales for rating severity of Depression and Anxiety. EPDS has been validated to assess antenatal depression in pregnant Indian women and had been adapted and used in different languages. Every study used some form of structured questionnaire or scale to measure socio-economic and demographic variables. These factors further became potential risk factors that had an association with antenatal psychological morbidities. However, out of 31 studies, none of the study had used all the required methodology to be having a good quality score of 10 as per the modified New Castle Ottawa Quality assessment scale and only 23 studies had moderate quality.

This review has re-highlighted the crucial role of detection and effective management of psychological disorders during pregnancy. All expecting women should be screened for depression during their routine antenatal check-ups and this should be one of the most important maternal and child health prioritiesMore research is needed regarding the actual estimation of antenatal mental health issues at primary level, associated risk factors and possible preventive strategies during pregnancy.

LIMITATIONS:

This review does not include a meta-analysis, which may have added additional information about the differential impact risk factors. This review has also excluded cross-cultural studies, studies that focused on other district of the Bihar which have similar socio-demography and studies that focused only on postpartum depression. Another limitation of this review is that a significant number of these studies had been conducted in South India and in the rural population; therefore, we could not estimate a actual estimate of prevalence of antenatal depression and anxiety across the country.

CONCLUSIONS:

Pregnancy is a great time for extra care and precautions. Women may experience their first depressive episode during pregnancy or can be at the risk of recurrence if they have a previous history of depression and anxiety in this review, we report high prevalence of antenatal depression (3.8 to 65%) in Indian pregnant women along with associated risk factors of antenatal depression. To get a holistic picture of the psychological distress that pregnant women undergo longitudinal studies pan India measuring prevalence and risk factors in each trimester are needed. The need of the hour is to include the aspect of correctly identifying the women at risk of suffering from antenatal anxiety and depression. This would further benefit both the patient and research. Identifying women at risk would allow us to follow them up while their pregnancy and postpartum. It will aid in recognizing the initial symptoms and impact of depression and anxiety.

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