FEATURES OF DEPRESSIVE DISORDER IN WOMAN DURING PREGNANCY

https://doi.org/10.37096/SHDISJ-20-1.1-0004

Molotokas Antonina
https://orcid.org/0000-0002-0061-1528

Abstract

Purpose of the article is to show features of depressive disorder during pregnancy and how it can be different according to various personal indicators.

Pregnancy and depression often go hand in hand. This condition affects about every tenth pregnant woman. According to recent research, sudden surges and changes in the hormonal background that accompany the entire pregnancy can really affect brain biochemistry, which in turn can lead to real clinical depression. *The procedure* of research registered at the women's consultation and obstetric ward and pathology department of pregnancy in Maternity hospital No. 3 (Kyiv). It lasted for 5 months. *The group* of pregnant women consisted of 100 people aged 18 to 42 years. Among them were 35 women in 1 trimester of pregnancy, 40 women in 2 trimester of pregnancy, 25 women in 3 trimester of pregnancy. To identify the presence and severity of depression among pregnant women, we used the following methods: Hamilton Depression Scale, Behterev Depression Questionnaire (female version).

Anxiety and depression in women during pregnancy require early detection and correction due to their significant negative impact on pregnancy, childbirth, postpartum and further psychophysical development and social adaptation of children. Different indicators of age and trimester affect the level of expression of the depressive disorder.

If woman had problems with conception or she was treated for infertility, the probability of her depression in her pregnancy increases by 10 times. Depression may be more likely to eclipse pregnancy and women who have suffered mental illness, anxiety, or depression before conception. This disorder may also occur in problematic relationships, as well as in situations where relatives have had a depression or mental illness, a woman has already had a miscarriage or her current pregnancy is a high-risk group. Depression during pregnancy has significant implications for pregnancy outcomes and maternal and child health. There is a need to identify which family, physical and mental health factors are associated with depression during pregnancy.

Key words: pregnancy, anxiety, depression, depressive disorder, research, postpartum period.

Introduction

The phenomenon of pregnancy is one of the most important factors in the formation of a specific complex of anatomical, neuro-psychological, psychological and social-psychological formations and changes of women, which are most often described in the literature by the term "maternal sphere of personality", "motherhood" (Filipp 2002).). In this case, pregnancy in women and its phenomena are, firstly, a specific phase of gender and individual ontogeny, and secondly, a multilevel, multidimensional formation

that causes the above-mentioned specific changes in her gender status. (Filippova, 1996)

From the point of view of medical psychology, pregnancy as a specific variant of health ("third condition") (Pushkareva, 2005) is an element of the continuum "health-illness", inevitably reflected in the woman's consciousness (more precisely in the maternal sphere of woman's consciousness), and thus , reflecting in consciousness, should be combined with its internal picture - the internal (subjective) picture of pregnancy (IPP - the internal picture of pregnancy), as well as other clinical phenomena (health, illness, treatment, outcome of illness, etc.) are represented in the internal picture of disease and health (Nechaeva, 2005).

The developed classification of types of attitude to pregnancy is presented, based on the theory of relations of V.M. Myasishcheva.

Purpose of the article is to show features of depressive disorder during pregnancy and how it can be different according to various personal indicators.

Theoretical background

Depression and depressive disorders are more commonly considered in psychiatry, but lately, this disorder has been extensively studied in medical and clinical psychology, particularly in terms of the features of depressive disorders in pregnant women.

From early pregnancy to the postpartum period many important changes occur simultaneously at the biological, psychological and social levels. Adapting to these changes can put women at risk of psychological distress. The literature highlights a particularly difficult period of adaptation for first-time pregnant women (Figueiredo).

It is proved that for the development of the child the most dangerous are pathological reactions to stress and the appearance of affective pathology in the second and third trimesters of pregnancy. The effects of stress on pregnant women adversely affect the psychophysiological characteristics of infants at birth and are found to be similar to mothers addicted to smoking. Mechanisms of development of psychopathological symptomatology of non-psychotic level are conditioned by correlation of personality typology, degree of personal maturity, social and psychological factors, nature of social functioning (Pushkareva, 2017).

The most common emotional disorders encountered during gestation are anxiety and anxiety-depressive disorders. Anxiety noted by the most pregnant women is believed to be a major factor in allowing the line between women with normal physiological pregnancy and complicated pregnancy (Kolesnikov, 2012).

In this regard, obstetricians and gynecologists need effective data to help pregnant women with their current psychological status, which is largely determined by the state of the emotional sphere (Pushkareva, 2005).

The risk of developing psychosis of the gestational period in the general population is 0.1-0.25%. At the same time, postpartum psychoses account for 45% - 86% of all psychoses, for lactation (during the feeding period) - 10% -42% and psychoses of the pregnancy period - 3% - 15%. It is considered that the level of severe mental disorders during pregnancy is the same or even lower compared to the level of soreness outside of childbirth. Postpartum psychoses occur at a frequency of 1-2 per 1000 births (Targum, 1979)

Psychoses of pregnancy are a combined nosological group. In this case, pregnancy itself is not a cause of psychosis, but can only provoke the onset or exacerbation of already existing mental disorders. Psychotic disorders can be facilitated by various somatic pathologies that develop during this period. Psychological difficulties (family disharmony, loneliness, death of loved person) are essential (Nechaeva, 2005).

An important role in the pathogenesis of psycho-emotional disorders in women during pregnancy is played by the premorbid level of functioning of the individual, which prevails during the period of onset of pregnancy - the level of maturity of gender-role identity, which the woman has acquired by this time. It has been proven that during pregnancy there are changes in the emotional sphere of women in the direction of increasing lability. Woman becomes more sensitive and more susceptible to mood swings.

During pregnancy the subcortical structures of the brain increase the phenomenon of excitation, and in its cortex - signs of induced inhibition. Mature personality functioning correlates with better adaptation to the condition pregnancy, a more flexible adaptation to hormonal (internal) and social (external) changes during pregnancy. (Evans, Heron, 2001)

A number of foreign studies have shown that anxiety and depression in women during pregnancy require early detection and correction due to their significant negative impact on pregnancy, childbirth, postpartum and further psychophysical development and social adaptation.

Anxiety and depressive disorders in women during pregnancy can be predictors of anxiety and depressive disorders for mother mother during the first year of child's life, which adversely affects the woman's adaptation to motherhood and causes early childhood developmental abnormalities (Pushkareva, 2005).

When depressive disorders occur during pregnancy, one-third of women have depression after delivery. (McNeil, Blennow, 1988). Pre-natal depression is regarded as the most significant risk factor for the development of postpartum depression, which has a known pathological effect on the functional state of the mother, the formation of maternal-infant relationships. Depressive disorders also adversely affect the social functioning of pregnant women (Beck, 1996).

In psychiatry the interconnections and mutual influences of functional features of the central nervous system, complications of pregnancy and psychological features of the pregnant woman have been studied. Depressive disorders in women have hardly been studied in pregnancy. Dysharmonic marital relations in the family of a pregnant woman are considered by foreign authors as a significant etiological factor in the development of depressive disorders. Even with a fairly harmonious relationship of the couple, the family, which is expecting the birth of the baby, is going through the verge of serious changes, its functioning becomes unstable. As you move to a new stage in the life cycle of a family, its structure changes, new functions appear, and this affects the mental state of a pregnant woman. In turn, changes occurring in her body and psyche, largely determine the psychological situation in the family, the nature of the relationships of its members (Eydemiller, Dobryakov, Nikolskaya, 2003).

Methodology

The study of the features of depressive disorders in pregnant women was conducted on the basis of the Department of Pathology and Women's Consultation of the Maternity Hospital No. 3 (Kyiv). The procedure of research registered at the women's consultation and obstetric ward and pathology department of pregnancy in Maternity hospital No. 3 (Kyiv). It lasted for 5 months.

To identify the presence and severity of depression among pregnant women, we used the following methods: Hamilton Depression Scale, Behterev Depression Questionnaire (female version).

The group of pregnant women surveyed consisted of 100 people aged 18 to 42 years. Among them were 35 women in 1 trimester of pregnancy, 40 women in 2 trimester of pregnancy, 25 women in 3 trimester of pregnancy.

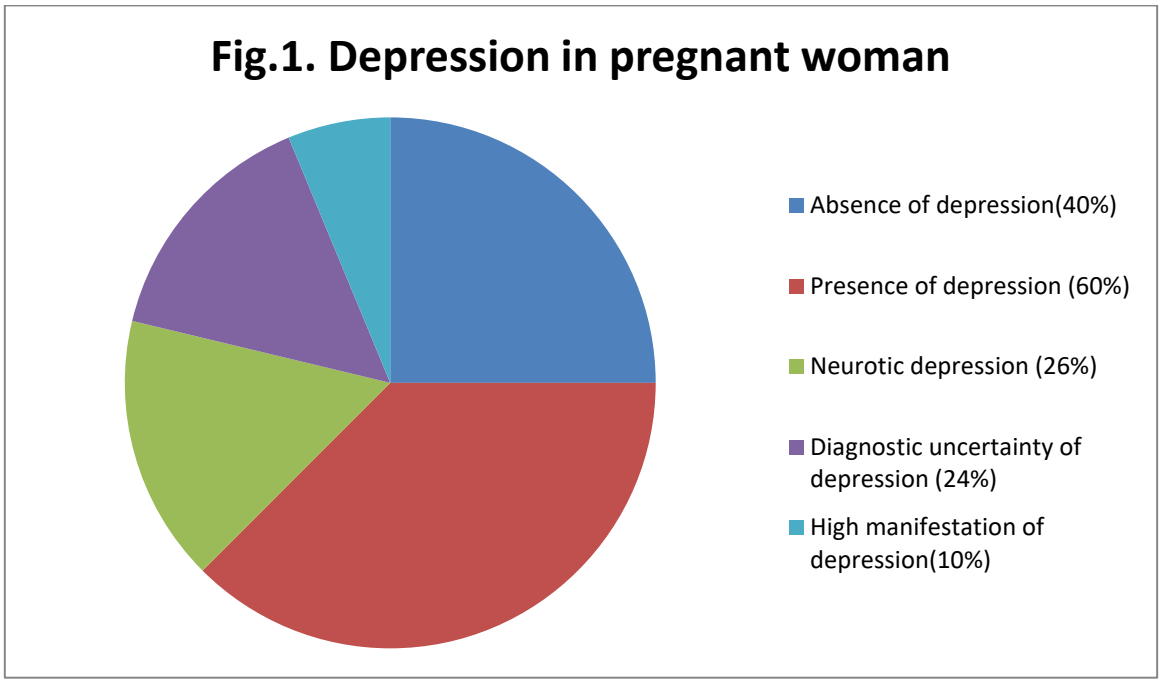
Analyzing the anamnestic data, it was possible to identify the main negative events in patients' lives in the last few months. These include:

- conflicts with husband - 60%;
- social and material problems - 37%;
- physiological changes - 26%;
- conflicts with parents or colleagues -23%;
- death of a relative - 6%;
- Other - 24%.

Results

According to the Behterev Depression Questionnaire received the following data of depressive states in pregnant women (Fig. 1). In 40% of the surveyed pregnant women did not find depressive manifestations, which is an optimal indicator of their well-being and mood, and in 60% of women, certain characteristics of depressive states were established, which made it possible to diagnose the presence of depression. At the same time, the neurotic spectrum of depression was found in 26% of respondents who have a combination of depressed moods with anxiety for themselves and the child, are excessively emotional, pay attention to any unclear symptoms and information and therefore have an increased neurotic background.

Another 24% of pregnant women are characterized by the diagnostic uncertainty of depression, episodic manifestations of certain symptoms that may indicate a pregnant woman's predisposition to depressive experiences, but because of the lability of such conditions, the clinical form of depression cannot be unequivocally diagnosed. Provided timely provision of psychological care, such depressive symptoms will not remain. Only 10% of pregnant women surveyed have significant manifestations of depression (both physiologically and well-being).



Analyzing the manifestations of depressive states in pregnant women of different ages, we found that they were absent in 9 young women under 20 years (36%), 13 women aged 30–39 years (37.1%) and in 18 pregnant women aged 20–29 years (Table № 1). It should be noted that two pregnant women of the oldest category (over 40 years of age) have a neurotic spectrum of depression (40%), two have diagnostically undefined characteristics (40%) and one pregnant woman has a clearly significant manifestation of depression (20%).

Table 1. Depression in pregnant woman of different ages

Age / Depression	Total (n=100)		Age under 20 years (n=25)		Age 20-29 years (n=35)		Age 30-39 years (n=35)		Over 40 years (n=5)	
	n	%	n	%	n	%	n	%	n	%
Absence of depression	40	40%	9	36%	18	51,4%	13	37,1%		
Presence of depression	**60**	**60%**	**16**	**64%**	**17**	**48,6%**	**22**	**62,9%**	**5**	**100%**
Neurotic depression	26	26%	8	32%	6	17,1%	10	28,6%	2	40%
Diagnostic uncertainty of depression	24	24%	6	24%	8	22,9%	8	22,9%	2	40%
High manifestation of depression	10	10%	2	8%	3	8,6%	4	11,4%	1	20%

The neurotic spectrum of depression was detected in 8 pregnant women under 20 (32%), in 6 women aged 20–29 years (17.1%), in 10 women aged 30–39 years (28.6%) and observed in 2 pregnant women over 40 years (40%). Thus, the absence of depression (36%) or its neurotic spectrum (32%) is most characteristic for young pregnant women under 20 years, and the most seen characteristic for women aged 20–29 is the absence of depression (51.4%) and its neurotic form. manifestation (32%). Pregnant women aged 30-39 years do not have depression (37.1%), but about a third of them have a neurotic spectrum and diagnostic uncertainty about depression

(28.6% and 22.9%). Pregnant women over 40 are most prone to depression - 40% of those surveyed have a neurotic spectrum of depression and diagnostic uncertainty, and 20% of them have obvious manifestations of depression.

At different trimesters of pregnancy, women also have different manifestations and symptoms of depression - its absence is most characteristic of women in the second trimester of pregnancy, when the first experiences about the health of the child decreased, and before the birth is enough time not to think about them prematurely (Table №2):

Table № 2. Depression in pregnant woman at different trimesters

Trimester of pregnancy / **Depression**	**I Trimester (n=35)**		**II Trimester (n=40)**		**III Trimester (n=25)**	
	n	**%**	**n**	**%**	**n**	**%**
Absence of depression	14	40%	20	50%	6	24%
Presence of depression	**21**	**60%**	**20**	**50%**	**19**	**76%**
Neurotic depression	9	25,7%	8	20%	9	36%
Diagnostic uncertainty of depression	10	28,6%	8	20%	6	24%
High manifestation of depression	2	5,7%	4	10%	4	16%

Absence of depression is characteristic of 40% of pregnant women in the 1st trimester, half of pregnant women in the second trimester (50%) and only 24% of women in the third trimester of pregnancy.

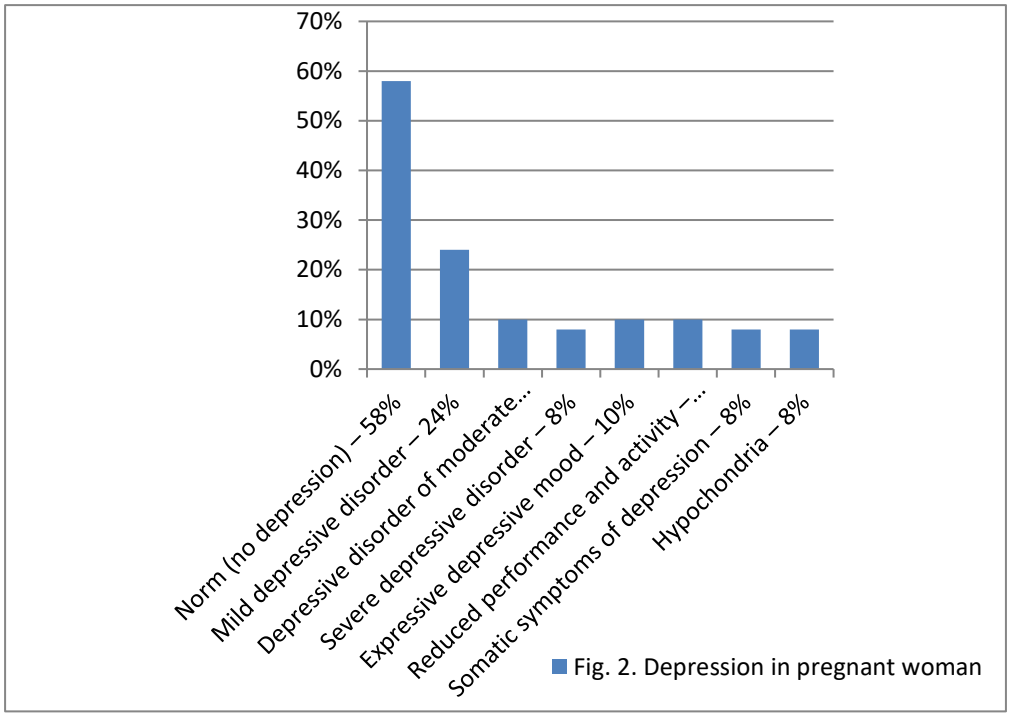
The neurotic spectrum of depression is found in third of pregnant women in the third trimester (36%), 25.7% of women in the first trimester and 20% in the second trimester. We consider this situation quite obvious, because during the third trimester women are growing anxious and anxious about the last weeks of pregnancy, they are worried about childbirth, afraid of it, thinking about what kind of mother she will become, worried that she will not be able to understand the needs of their newborn children, etc. .

Diagnostic uncertainty of depression is found in a similar number of women in the 1st, 2nd and 3rd trimesters of pregnancy (from 20% to 24%). And high manifestation of depression is most seen in pregnant women in the third trimester (16%). In this case, the manifestations of depression are almost absent in women who are in the first trimester of pregnancy.

Therefore, women in the first trimester of pregnancy are most characterized by the absence of depression (40%) and the diagnostic uncertainty of depression, episodic manifestations of individual symptoms (28.6%). Half of pregnant women in the second trimester are characterized by the absence of depression, and another 20% of women have a neurotic spectrum of depressive experiences. In the third trimester, women have a clear predominance of neurotic depression (36%), and it is in the third trimester that most women have a significant depression (16%) associated with fear of giving birth, feelings about their baby's future.

To clarify the conclusions about the characteristic manifestations of depressive states among pregnant women, we used Hamilton's depression scale, which analyzed not only the degree of depression (from the norm (absence) to severe), but

also some of the most expressive symptoms (Fig.№ 2, Table №2). In 58% of pregnant women there was no depression, which indicates the norm of their psycho-emotional well-being. In 24% of pregnant women have mild depressive disorder, episodic manifestations of minor symptoms of depression. Another 10% of pregnant women have moderate-grade depressive disorder, and 8% have severe-grade depressive disorder.



Expressive depressive mood, impaired ability to work and passivity are manifested in 10% of pregnant women, clear somatic symptoms of depression and hypochondria (excessive anxiety due to their own health) - in 8%.

The following results were obtained regarding the distribution of depression in pregnant women of different ages (Table № 3).

For young pregnant women under the age of 20, the most characteristic is the absence of depression (64%), another 24% of them have mild depressive disorder, such symptoms of depression as expressive depressive mood (helplessness, feeling of inferiority), and reduced working capacity and passivity occur in only 4% of young pregnant women.

Table 3. Depression in pregnant woman of different ages

Age / Depression	**Total (n=100)**		**Age under 20 years (n=25)**		**Age 20-29 years (n=35)**		**Age 30-39 years (n=35)**		**Age over 40 years (n=5)**	
	n	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
Norm (no depression)	58	58%	16	64%	23	65,7%	19	54,3%		

Mild depressive disorder	24	24%	6	24%	7	20%	9	25,7%	2	40%
Depressive disorder of moderate severity of depression	10	10%	2	8%	3	8,6%	3	8,6%	2	40%
Severe depressive disorder	8	8%	1	4%	2	5,7%	4	11,4%	1	20%
Symptoms of depression:										
Expressive depressive mood	10	10%	1	4%	4	11,4%	3	8,6%	2	40%
Reduced performance and activity	10	10%	1	4%	2	5,7%	4	11,4%	3	60%
Somatic symptoms of depression	8	8%			2	5,7%	2	5,7%	4	80%
Hypochondria	8	8%			2	5,7%	3	8,6%	3	60%

Pregnant women aged 20–29 years are also most characterized by the absence of depression (65.7%), and another 20% have mild depressive disorder. At the same time 11.4% of pregnant women of this age have a distinct depressive mood (depression, helplessness, feelings of inferiority).

More than half of pregnant women aged 30-39 years have no depressive symptoms. However, 25.7% of women of this age are characterized by mild depressive disorders, and 11.4% have severe depression. Expressive depression and hypochondria (excessive anxiety due to health) are characteristic of 3 women (8.6%), and 4 women (11.4%) have decreased ability to work and passivity.

Analyzing the responses of pregnant women over the age of 40, we note the prevalence of mild to moderate depression in most of them (40% each) and the finding of severe depression in 20% of women of this age. In this case, 80% have clear common somatic symptoms, 60% have reduced performance and lack of activity, hypochondria (excessive anxiety due to health), and 40% have a clear depressive mood.

At different trimesters of pregnancy, women exhibit a different tendency for depressive states (Table 4):

Table 4. Depression in pregnant woman at different trimesters

Trimester / Depression	I Trimester (n=35)		II Trimester (n=40)		III Trimester (n=25)	
	n	**%**	**n**	**%**	**n**	**%**
Norm (no depression)	20	57,1%	24	60%	14	56%
Mild depressive disorder	10	28,6%	8	20%	6	24%

Depressive disorder of moderate severity of depression	4	11,4%	4	10%	2	8%
Severe depressive disorder	**1**	**2,9%**	**4**	**10%**	**3**	**12%**
Symptoms of depression:						
Expressive depressive mood	4	11,4%	4	10%	2	8%
Reduced performance and activity	4	11,4%	3	7,5%	3	12%
Somatic symptoms of depression	1	2,9%	3	7,5%	4	16%
Hypochondria	3	8,6%	2	5%	3	12%

Most pregnant women do not have depressive symptoms (57.1% of women in the first trimester, 60% of women in the second trimester, 56% of women in the third trimester). However, mild depressive disorder manifests in 28.6% of women in the 1st trimester, in 20% of women in the second trimester, in 24% in the third trimester. Medium-severity depressive disorder is most characteristic of women in the 1st trimester (11.4%), while and third trimester (12%).

At the same time, expressive depressive mood is observed in 11.4% of women in the 1st trimester, reduced performance and passivity are manifested in 11.4% of women in the first trimester and 12% of women in the third trimester. And the clear general somatic symptoms of depression are prevalent in women in the third trimester (16%), also these women are most characterized by hypochondria (excessive anxiety about their health and baby's health).

Table 5.Relations between features of pregnant woman and presence of depression

Features	**Pearson correlation coefficient (to presence of depression)**
Age	,385*
Trimester	,419**

(** indicates significant correlation with a 99% confidence level and * indicates significant correlation with a 95% confidence level.)

Discussion

The issue of diagnosing emotional conditions in women during pregnancy is currently very acute in the field of obstetrics and psychodiagnosis. Over the last 10 years, the issues of anxiety and depressive disorders during pregnancy have been raised several times in national science, which means that there is no proper level of development of this issue. The main objective of our study was to show that the problem of depression in pregnant women is , even if it is silent and ignored. Our goal is to introduce a psycho-diagnostic background in maternity hospitals, to introduce the principle of emotional involvement of a doctor in obstetric practice, to develop current studying programs for this issue.

In foreign science, the level of development of the issue of emotional problems in pregnant women is higher. There are studies that indicate that women who have a high level of anxiety or depression during pregnancy have children with different neurological problems in the future: mental retardation, delayed language development, stuttering, enuresis, fears, emotional lability. (Zabolzaeva, Kozlova, Cherny`sheva, 1998)

Also important is the fact that in most cases postpartum depression has its manifest during pregnancy, but due to inadequate diagnosis, it goes unheeded. (O'Hara, Zekoski, Philipps, 1990)

Conclusion.

The development of depressive and anxiety disorders of the non-psychotic registry may be conditioned by the specific personality characteristics of women in combination with the disturbance of the interpersonal relationships system, unreacted past stressful influences and complex social factors that lead to poor quality of life. Special attention should be paid to the experts on the occurrence and exacerbation of anxiety - depressive disorders and neurotic reactions to stress at different stages of pregnancy.

Our study and a lot of literature about medical and psychological aspects of pregnancy have shown that anxiety and depression in women during pregnancy require early detection and correction due to their significant negative impact on pregnancy, childbirth, postpartum and further psychophysical development and social adaptation of children.

Anxiety and depression disorders in women during pregnancy can be predictors of anxiety and depression disorders in Mother during the first year of motherhood and postpartum period at all.

Today there are many methods of prevention and overcoming of depressive disorders, developed within various therapeutic schools. Because depression in all its typical features is deeply individual in nature, building a strategy for its elimination and prevention requires the selection of methods that are most relevant to the psychological characteristics of each client. Formation of qualities in a person that will provide her personal stability with the effect of depressogenic factors are psycho-psychological factors relapses.

References

Bárbara Figueiredo, Ana Conde (2011). Anxiety and depression symptoms in women and men from early pregnancy to 3-months postpartum. *Journal of affective disorders*, No. 132, 146-157.

Beck C.T. (1996). *A meta-analysis of predictors of postpartum depression.* PubMed, No. 45, 297-303.

Eydemiller E.G., Dobryakov I.V., Nikolskaya I.M. (2003). *Semeynyiy diagnoz i semeynaya psihoterapiya: ucheb. posobie.* SPb: Rech.

Evans J.(Ed.). (2001). *Cohort study of depressed mood during pregnancy and after childbirth* . BMJ, 323, 257. https://doi.org/10.1136/bmj.323.7307.257

Filippova, G.G. (Ed.). (1996). Razvitie materinskogo povedeniya v ontogeneze. Psihologiya segodnya. Ezhegodnik Rossiyskogo psihologicheskogo obschestva, 3, 133.

Filippova, G.G. (Ed.). (2002). Psihologiya materinstva: ucheb. posobie. Moskva: Yzd-vo Ynstytuta Psykhoterapyy.

Kolesnikov I. (2012). *Nevroticheskie depressivnyie rasstroystva i semeynoe funktsionirovanie u beremennyih zhenschin.* Retrieved from HTTP://MPRJ.RU/ARCHIV_GLOBAL/2012_5_16/NOMER/NOMER05.PHP

McNeil T.F., Blennow G. A. (1988). *Prospective study of postpartum*

psychoses in a highrisk group. Relationship of birth complication and neonatal abnormality. Acta Psychiatrica Scandinavica, 78, 613-617.

Nechaeva, M.A. (2005). *Psihologicheskie faktoryi ontogeneza materinskoy sferyi, vnutrenney kartinyi beremennosti i perinatalnogo razvitii.* Chelyabinsk:YUrGU.

O'Hara M.W., Zekoski E.M., Philipps L.H. (1990). *Controlled prospective study of post-partum mood disorders: comparison of childbearing and nonchildbearing women.* J Abnorm Psychology, 99, 3-15.

Pushkareva T.M. (2005). *Poslerodovaya depressiya: rasprostranennost, klinika, dinamika.* Kyiv: Psihichne zdorov'ya.

Pushkareva T.M. (2017*). Algorytm skryningovoyi diagnostyky depresyvnyx ta tryvozhno-depresyvnyx rozladiv u zhinok pid chas vagitnosti ta pislya pologiv.* Kyiv: Zdorov`e zhenschynu, 1, 62-66.

Targum S.D. (1979). *Dealing with psychosis during pregnancy.* JAPhA, Vol. 9, 18-21. https://doi.org/10.1016/S0160-3450(15)32299-6

Zabolzaeva I.V., Kozlova M.A., Cherny`sheva L.V. (1998). *Vliyanie psikhotravmiruyushhikh situaczij vo vremya beremennosti na dal`nejshee razvitie rebenka.* SPb: Akademiya mediko-soczial`nogo upravleniya.