



ANTENATAL DEPRESSION; FREQUENCY AND FACTORS ASSOCIATED IN PATIENTS PRESENTING IN TERTIARY CARE HOSPITAL

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ABSTRACT... Objectives: To determine frequency of Antenatal Depression by ICD_10 diagnostic criteria in patients presenting to a tertiary care hospital and contributing factors for antenatal depression. **Study Design:** Cross-sectional study. **Setting:** Department of Psychiatry and outdoor of Gynae & Obs Sir Ganga Ram Hospital / Fatima Jinnah Medical College Lahore. **Period:** November 2012 to May 2013. **Materials and Method:** Three hundred and fifty (350) patients were included in this study. SPSS version 12 was used for data analysis. Frequencies and percentages were calculated to present qualitative variables and mean \pm standard deviation was calculated to present quantitative data. **Results:** A total of 350 patients were included in this study. Out of 350 patients, depression was found in 104 patients. Out of these 104 patients, 52 patients (50.0%) had mild depression, 37 patients (35.6%) had moderate depression while 115 patients (14.4%) had severe depression. **Conclusion:** Antenatal depression was noted in 29.7% of patients. Most common contributing factor was low socioeconomic status (64.4%) a second factor was no partner social support (22.1%) and previous history of psychiatric of psychological consultation (13.5%) of antenatal depression.

Key words: Antenatal depression, Psychological consultation.

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INTRODUCTION

In Asia 30.7% women suffering from depression before and 63.3% after child birth.^{1,2} Most common cause of this antenatal depression is hormonal imbalance. Some other factors include pregnancy sickness, tiredness, economic status and relationship with partner and family. This psychosocial stress and depression in pregnancy may lead to low birth weight and abortion.^{3,4} In Pakistan a strong correlation is observed between maternal depression and retardation factors.^{5,6} but many developed countries have made a Strong plan for early detection and management of perinatal depression.⁷ Some studies also reported that psychosocial support in low income societies make a lot of difference for better fetal outcomes in depressed women. Antenatal depression considered as a risk factor after birth depression in mother that ends with morbidities.⁸ In a study conducted on adult patients of depression reported that chances of depression were 4.7% greater in 16 year olds who exposed to antenatal depression as compared to

unexposed subjects.⁹ In a study conducted on pregnant women above 18 year. 39% women found to be depressed and out of them 60.3% were from low economic families (income less than 2000 rupees/month).¹⁰ Another cause of antenatal depression is poor partner support. In a study pregnant female of age 15 years to 18 years and gestational age 20 weeks to 28 weeks were included. Study reported that depressed female who have poor partner Support were 20.4%¹¹ and 23% were those who have previous psychiatric consultation.¹¹

MATERIALS AND METHODS

This cross sectional study was conducted in OPD of gynecology and obstetrics of Sir Ganga Ram Hospital, Lahore from November 2015 to May 2016. Total 350 patients fulfilling inclusion criteria were taken. The researcher got informed consent and interview. Data was collected on predesigned performa, then applied ICD_10 symptom checklist (annexure IV to measure the frequency and severity of depression). Women who became

positive for depression were also assessed for contributing factors i.e. socioeconomic status, partner support and previous history of psychiatric or psychological consultation. Patients with previous history depression (previous history of antidepressant medication), Pregnancy induced hypertension (B.P > 140/90 mmHg), Gestational diabetes (BSL fasting 126mg/dl, random 200mg/dl) and history previous antipsychotic drug abuse were excluded from the study. All the data entered and analyzed using SPSS version 12.0. The quantitative variables were presented by calculating mean and standard deviation, frequency and percentages were calculated for qualitative data.

RESULTS

A total of 350 patients were included in this study during the study period of six months from November 2012 to May 2013. Mean age of the patients was 27.3 ± 7.5 years (Table-I).

Mean Age	27.3±7.5	
Depression	Frequency	Percentage (%)
Yes	104	29.7 %
No	246	70.3%
Severity of Depression (n=104)		
Mild	52	50.0%
Moderate	37	35.6%
Severe	15	14.4%

Table-I. Mean age and Percentages of Depression

Out of 350 patients, depression was found in 104 patients. Out of these 104 patients, 52 patients (50.0%) had mild depression, 37 patients (35.6%) had moderate depression while 15 patients (14.4%) had severe depression (Table-I).

Contributing factors were as follows: Low socioeconomic status 67 (64.4%), no partner social support 23 (22.1%) and previous history of psychiatric or psychological consultation 14 (13.5%) (Table-II).

Contributing factors	Frequency	Percentage
Low socioeconomic status	67	64.4 (%)
No partner social support	23	22.1 (%)
Previous history of psychiatric or psychological consultation	14	13.5 (%)

Table-II. Distribution of cases by Contributing factors (n=104)

DISCUSSION

Universally it is accepted that pregnancy is a suitable time to screen out depressed women especially in those whose socioeconomic status is not supporting for better antenatal and maternal health.¹²

Preterm birth and low birth weight can be controlled by early and accurate diagnosis of antenatal depression. In developing countries women from low socioeconomic status were having a greater risk of becoming depressed during pregnancy and poor birth outcomes if once they have antenatal depression. Frequency of depression is greater in pregnant women who were living below poverty line because of unsafe environment and dietary insufficiency.^{13,14}

There are so many direct and indirect usual pathways by which depression put adverse effects on birth outcomes; one of them is release of stress hormone cortisol and catecholamine by dysregulation of hypothalamic pituitary adrenocortical axis. These biochemical changes end with placental hypofusion and oxygen deficiency in fetus nutrition which may lead to preterm birth.^{15,16} Poor and difficult health facilities are also a cause of depressive symptoms, and these maternal depressive symptoms sometimes play a role to admonish the search of health care facilities.¹⁷ It's also challenging for medical professionals to differentiate the effect of depression and antidepressants on birth outcomes, most of studies investigate one thing not both. Second problem is type and dose of antidepressants that changes in different times. Another cause is treatment of depression from an irrelevant health professional.¹⁸

In Pakistan a confused state of mind due to social norms and religious myths play an important role in anxiety and woman maternal health. In our study a large number of women were literate but low education has been found to be a strong risk factor for depression¹⁹ in Pakistani population. In our study depression was noted in 104 (29.7%) patients. Our results are comparable with study of Dhillon and Macarthus who reported 30.7% depression during pregnancy. Our findings are

similar to the rates 25-29% found in other studies of pregnant women.^{20,21,82,104}

Out of 104 depression was as follows: mild depression 52 (50%) moderate depression was found in 37 (35.6%) patients and severe depression was present in 15 (14.4%) patients.

CONCLUSION

Antenatal depression was noted in 29.7% of patients. Most common contributing factor was low socioeconomic status (64.4%) a second factor was no partner social support (22.1%) and previous history of psychiatric or psychological consultation (13.5%) of antenatal depression.

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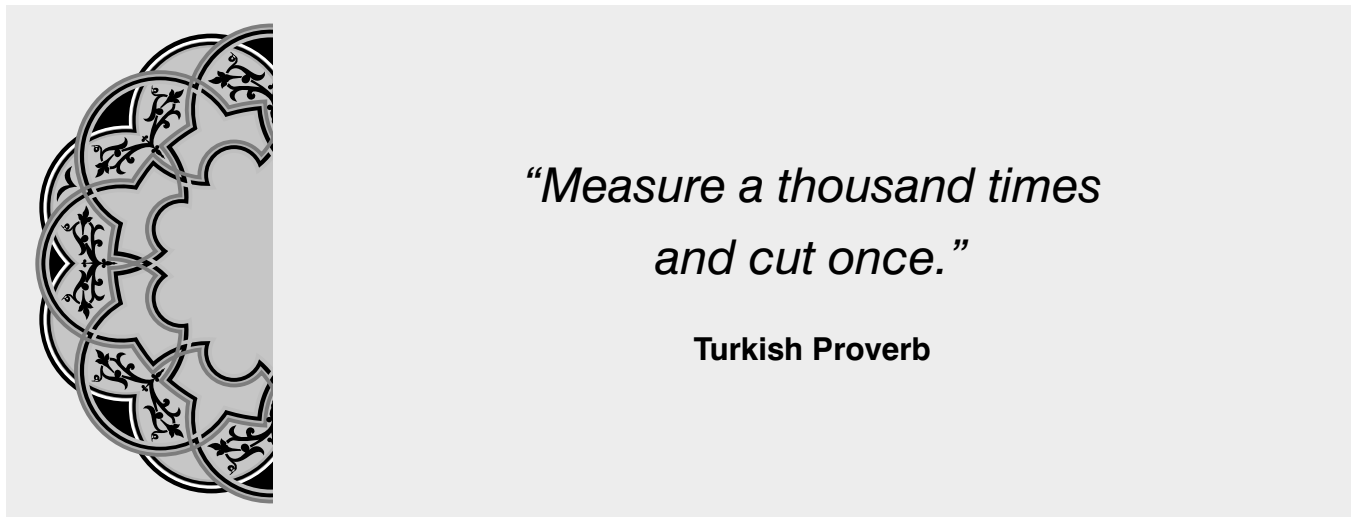
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2	Dr. Ammara Butt	Data collection, Manuscript writing	
3	Dr. Aamir Hameed	Data analysis, Data collection	
4	Dr. Aamir Furqan	Statistical analysis, Proof reading Help in manuscript writing	
5	Farman Ali	Statistical analysis	