Previous prenatal loss as a predictor of perinatal depression and anxiety

Emma Robertson Blackmore, Denise Côté-Arsenault, Wan Tang, Vivette Glover, Jonathan Evans, Jean Golding and Thomas G. O’Connor

Background
Prenatal loss, the death of a fetus/child through miscarriage or stillbirth, is associated with significant depression and anxiety, particularly in a subsequent pregnancy.

Aims
This study examined the degree to which symptoms of depression and anxiety associated with a previous loss persisted following a subsequent successful pregnancy.

Method
Data were derived from the Avon Longitudinal Study of Parents and Children cohort, a longitudinal cohort study in the west of England that has followed mothers from pregnancy into the postnatal period. A total of 13 133 mothers reported on the number and conditions of previous perinatal losses and provided self-report measures of depression and anxiety at 18 and 32 weeks’ gestation and at 8 weeks and 8, 21 and 33 months postnatally. Controls for pregnancy outcome and obstetric and psychosocial factors were included.

Results
Generalised estimating equations indicated that the number of previous miscarriages/stillbirths significantly predicted symptoms of depression (β = 0.18, s.e. = 0.07, P < 0.01) and anxiety (β = 0.14, s.e. = 0.05, P < 0.01) in a subsequent pregnancy, independent of key psychosocial and obstetric factors. This association remained constant across the pre- and postnatal period, indicating that the impact of a previous prenatal loss did not diminish significantly following the birth of a healthy child.

Conclusions
Depression and anxiety associated with a previous prenatal loss shows a persisting pattern that continues after the birth of a subsequent (healthy) child. Interventions targeting women with previous prenatal loss may improve the health outcomes of women and their children.

Declaration of interest
None.

Method
Data
Data for this study were obtained as part of ALSPAC, an ongoing population-based study designed to investigate the effects of a wide range of influences on the health and development of children.

Study population
Pregnant women residing in the Avon area of south-west England who had an estimated date of delivery between 1 April 1991 and 31 December 1992, were invited to participate in the study. It was estimated that 85–90% of the eligible population participated. All data used for this study were collected via postal questionnaires. The study cohort consisted of 14 541 pregnancies and 13 998 children who were still alive at 12 months of age. The study protocol has been published previously, and further details can be found at: www.bris.ac.uk/alspac. Ethical approval for all measures was obtained from the ALSPAC Ethics and Law Committee and from local research ethics committees. The current study focuses on the 13 133 women for whom we had data on previous prenatal loss. The data for the current study are based on six assessments, two during pregnancy at 18 and 32 weeks’
gestation, and four in the postpartum period, at 8 weeks and 8, 21 and 33 months.

Measures

Prenatal loss
At the assessment at 18 weeks’ gestation, respondents were asked to report the number of previous miscarriages and the number of previous stillbirths that they had experienced. Although the terms ‘miscarriage’ and ‘stillbirth’ were not explicitly defined, in the UK a stillbirth certificate is issued where there was a prenatal death after 24 weeks’ gestation; accordingly, respondents who did experience a stillbirth would have had that document to designate formally a stillbirth. We also collected data on the number of previous elective terminations; these were counted separately.

Anxiety
Maternal anxiety at each occasion was measured using the anxiety items from the Crown–Crisp Experiential Index (CCEI), a validated self-rating inventory.21 It has been shown to correlate with the State (0.70) and Trait (0.76) subscales of the Spielberger State–Trait Anxiety Inventory.22 There is no established clinical cut-off, and so for categorical analyses we defined a mother as anxious if she scored in the top 15% of the sample.

Depression
Depression was assessed using the Edinburgh Postnatal Depression Scale (EPDS), a 10-item self-report questionnaire that has been extensively used and shown to be valid in and outside the postnatal period.23 A cut-off score of ⩾12 is recommended to identify cases of probable major depression.24

Covariates
A series of covariates were chosen because of their known links with depression and/or anxiety or because they were thought a priori to be a possible confound linking prenatal loss and depressive and anxiety symptoms. Specific covariates included maternal age at initial interview, currently living with husband or partner, number of living children, education level, ethnicity and use of tobacco and alcohol during the first 3 months of the pregnancy. Respondents were also asked ‘Have you ever had a severe depression?’ Those who answered ‘yes, in the past not now’ were classified as having a previous depressive episode. Birth weight was used as an indicator of healthy birth outcome; we dichotomised weight into ⩽2500 g or >2500 g representing low or normal birth weight. Gestational age at birth was dichotomised into <32 weeks or >32 weeks. A household crowding index was ascertained, which represents the number of residents per room. A high crowding index score is well established as an indicator of low socioeconomic status, a highly stressful situation, and is associated with high morbidity and mortality risks in a range of health outcomes.25

Statistical analysis
Generalised estimating equations (or GEE) is a method used for longitudinal data modelling. This method is semi-parametric and therefore does not require normal distribution assumptions to be met. Given that depression and anxiety can be treated as discrete or continuous data they do not meet normality assumptions for parametric data analysis. The GEE was performed to model the change of depression and anxiety over time. A backward elimination procedure was applied to control covariates and interactions. It should be noted that there were a significant number of missing values for depression and anxiety, especially for the last two visits. Specifically, sample sizes at the six visits were 12 121, 12 096, 11 710, 11 195, 10 259 and 9683. The impact of missing data was characterised by model estimates through two well-established missing data mechanisms: the missing completely at random assumption and the missing at random assumption.26 The missing completely at random assumption was tested by modelling the missingness as a function of observed responses and baseline covariates using logistic regression. It was found that depression at previous visit was a strong predictor, thus the missing completely at random assumption is inappropriate and weighted generalised estimating equations (WGEE) were used with weights estimated from the logistic model for missing data.26

Online Table DS1 provides descriptive data on the sample. The majority (n = 10 310, 79%) of women reported no miscarriages. Rates of previous stillbirths were low, with n = 106 (0.8%) reporting one and just three women reporting two prior stillbirths.

The first analysis examined whether stillbirths predicted subsequent depressive and anxiety symptoms more strongly than miscarriage. The non-parametric Wilcoxon rank sum test was applied to each visit to check whether there was any difference in depression and anxiety symptom scores between mothers who experienced a previous miscarriage and mothers who experienced a previous stillbirth. Results indicated that the difference between stillbirth and miscarriage was not significant (P = 0.27). Thus, stillbirth and miscarriage were combined in the analyses below.

Figure 1(a) and (b) present the mean (95% CI) scores of depressive and anxiety symptoms across the assessment period according to the number of previous losses (miscarriages and stillbirths). Table 1 presents results from the GEE model. Results indicate that, as expected, many of the psychosocial and sociodemographic covariates were associated with depressive and anxiety symptom scores. In addition, there was a significant prediction from the number of prenatal losses for both depressive and anxiety symptom scores. The magnitude of the effect was moderate: for each additional prenatal loss there was a corresponding increase in depressive and anxiety symptoms. Analyses to test the hypothesis that previous prenatal loss was a stronger predictor for pre- than postnatal assessments was carried out using an interaction between time of assessment and prenatal loss. For neither depressive nor anxiety symptoms was there an interaction between time of assessment and prenatal loss; that is, the association between prenatal loss and depressive and anxiety symptoms was not significantly different across the pre- and postnatal assessments (the interactions are not included in the final models in Table 1).

Table 2 shows the percentage and number of women who scored greater than 12 on the EPDS, which is indicative of a case of probable major depression, grouped by the number of losses.

Supplementary analyses
Analyses were re-run using categorical cut-off scores for depression and anxiety rather than a continuous scale. We found substantively comparable results using this alternate scaling. Given the overlap between depressive and anxious symptoms across the reproductive period, a final set of regression analyses (not reported; details available from the author) was carried out to investigate whether the effect of prenatal loss on anxious
Prenatal loss and depression and anxiety symptoms was distinguishable from that for depressive symptoms and vice versa. It was not. The association between prenatal loss and anxious symptoms was confounded by the association between prenatal loss and depressive symptoms and the high degree of covariation between anxious and depressive symptoms ($r = 0.70$ at each assessment).

**Discussion**

**Main findings**

We found no evidence that affective symptoms associated with previous prenatal loss resolve with the birth of a healthy child. Rather, previous prenatal loss showed a persisting prediction of depressive and anxiety symptoms well after what would conventionally be defined as the postnatal period. There were changes over time in the perinatal period in depression and anxiety, but these did not vary significantly for women with different histories of prenatal loss. The predictions of anxious and depressive symptoms were similar and inseparable, the result of comparable effect sizes and the high degree of overlap between the two dimensions. Previous studies had documented that women who had experienced miscarriage or stillbirth had significantly higher levels of anxiety and depression in a subsequent pregnancy.\(^5\)\(^6\)\(^9\)\(^6\)\(^27\) The current study extends this work by showing that the impact persists well past the subsequent pregnancy and despite the birth of a healthy child (indexed here by birth weight and gestational age of the subsequent child).

**Findings from other studies**

Our findings of prolonged and elevated depressive and anxious symptoms in women with a prior prenatal loss nearly 3 years after the birth of a subsequent child contrast with some previous studies. Hughes \(^14\) found that, compared with controls, women who were pregnant subsequent to a stillbirth had significantly higher levels of depression and state anxiety during pregnancy, but did not differ from controls at 6 and 26 weeks postpartum. Interestingly, the subset of women who conceived less than a year following the stillbirth had significantly higher depression and anxiety scores across all time points than women who conceived after a year. The possibility that time since previous prenatal loss moderates the persisting impact of distress could not be examined in this study because we did not have reliable information on the timing of the previous loss. It may be that a more recent loss is associated with higher levels of affective symptoms that continue in the postpartum period, perhaps as a function of bereavement.\(^6\)\(^14\)

Although Armstrong \(^18\) also reported that depressive and anxious symptoms during pregnancy decreased following the birth of a healthy child, they noted that mothers with higher levels

![Fig. 1](image-url) Mean (95% CI) of (a) depression and (b) anxiety symptom scores throughout the perinatal period according to number of previous prenatal losses (miscarriages + stillbirths). Numbers of participants are as follows: zero losses, $n = 10250$; one, $n = 2158$; two, $n = 515$; three, $n = 131$; and four or more, $n = 79$. 

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**Fig. 1** Mean (95% CI) of (a) depression and (b) anxiety symptom scores throughout the perinatal period according to number of previous prenatal losses (miscarriages + stillbirths). Numbers of participants are as follows: zero losses, $n = 10250$; one, $n = 2158$; two, $n = 515$; three, $n = 131$; and four or more, $n = 79$. 

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Symptoms were distinguishable from those for depressive symptoms and vice versa. It was not. The association between prenatal loss and anxious symptoms was confounded by the association between prenatal loss and depressive symptoms and the high degree of covariation between anxious and depressive symptoms ($> r = 0.70$ at each assessment).
of depression and anxiety in the postpartum period reported increased concerns about their investment in and health concerns about their infant. This raises the important issue of how and whether previous perinatal loss and associated mood symptoms may alter child outcomes. Limited available data suggest that mothers may have more concerns about and greater difficulty managing the needs of a child born after a prenatal loss;\textsuperscript{19,28} also, 12-month-old infants born following prenatal loss were reported to show higher rates of disorganised attachment patterns to their 12-month-old infants born following prenatal loss were reported should be seen as a general stressor, like any other life event.

Thus, even if there is no persistence of mood disturbance into the postnatal period, there may still be adverse effects of a previous prenatal loss on the parent–child relationship and child outcomes. This possibility requires further attention.

Brockington\textsuperscript{31} has argued that pregnancy and childbirth are major life events, a careful assessment of which may reveal information of value in understanding psychiatric morbidity.

**Clinical implications**

There are important clinical implications of this work. Currently, prenatal loss is not routinely considered a risk factor for antenatal or postpartum depression in the same way as, for instance, personal or family history of depression, exposure to stressful life events or lack of social support. Our findings suggest that routinely assessing loss history, which could be accomplished briefly and without some of the report bias that accompanies other assessments, would be valuable as a predictor of current...
and postpartum risk and as a possible marker for intervention. Approximately 15% of women experience clinically significant antenatal depression and anxiety, and so recognition of and effective treatment for perinatal mood disturbance are of the utmost importance. Both prenatal depression and anxiety are among the biggest predictors of postpartum depression, which in turn has deleterious effects on maternal—child attachment, child behaviour, and cognitive and neuroendocrine outcomes that persist into adolescence. Given the adverse outcomes of persistent maternal depression on both child and family outcomes, early recognition of symptoms can lead to preventive interventions to reduce the burden of illness, provide coping strategies to reduce anxiety and depression and promote healthy adjustment of the mother, family and child.

Strengths and limitations

Strengths of the study include the large community sample and detailed and repeated assessments of depressive and anxiety symptoms in the perinatal and postnatal period; the follow-up well past the postnatal period is a particular novelty in this area of study. There are, however, limitations. Participants were asked about the number of miscarriages and stillbirths experienced retrospectively, which could be subject to recall bias. However, the objective nature of the event provides some protection against this possibility, and the persistence of effect years after the enquiry about perinatal loss makes a simple recall bias account unlikely. Self-reports of perinatal loss may be underestimated insofar as mothers are often unaware of spontaneous early miscarriages. Accordingly, the current study is able to assess the psychological impact of perinatal loss, but is not positioned to examine biological hypotheses that there may be risk underlying both perinatal loss and the experience of depressive and anxiety symptoms. Finally, as noted, we were unable to assess the impact of time since loss as a potential predictor of postpartum mood.

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First received 26 May 2010, final revision 13 Oct 2010, accepted 9 Dec 2010

Funding

The UK Medical Research Council, the Wellcome Trust and the University of Bristol currently provide core support for ALSPAC. This particular project was funded in part by National Institutes of Health (NHI) grants R01 MH073842 and K23 MH08290.

Acknowledgements

We are extremely grateful to all the families who took part in this study, the midwives for their help in recruiting them and the whole ALSPAC team, which includes interviewers, computer and laboratory technicians, clerical workers, research scientists, volunteers, managers, receptionists and nurses.

References

1 Wong MK, Crawford TJ, Gask L, Grinyer A. A qualitative investigation into women’s experiences after a miscarriage: implications for the primary healthcare team. Br J Gen Pract 2003; 53: 697–702.


Table DS1  Sociodemographic and clinical characteristics of sample

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Total n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age at initial interview, years: mean (s.d.) range</td>
<td>27.78 (4.91) 15–45</td>
</tr>
<tr>
<td>Ethnicity, n (%)</td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>12 068 (97.39)</td>
</tr>
<tr>
<td>Black and minority ethnic</td>
<td>324 (2.61)</td>
</tr>
<tr>
<td>Education level, n (%)</td>
<td></td>
</tr>
<tr>
<td>None or Certificate of Secondary Education</td>
<td>2 522 (20.20)</td>
</tr>
<tr>
<td>Vocational</td>
<td>1 228 (9.84)</td>
</tr>
<tr>
<td>Ordinary Level/General Certificate of Secondary Education</td>
<td>4 323 (34.64)</td>
</tr>
<tr>
<td>Advanced Level</td>
<td>2 803 (22.45)</td>
</tr>
<tr>
<td>Degree</td>
<td>1 607 (12.87)</td>
</tr>
<tr>
<td>Number of previous pregnancies, mean (s.d.)</td>
<td>1.29 (1.39)</td>
</tr>
<tr>
<td>Number of living children, mean (s.d.)</td>
<td>0.85 (0.97)</td>
</tr>
<tr>
<td>Number of previous prenatal losses, n (%)</td>
<td></td>
</tr>
<tr>
<td>Miscarriage</td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>10 310 (78.50)</td>
</tr>
<tr>
<td>1</td>
<td>2 124 (16.17)</td>
</tr>
<tr>
<td>2</td>
<td>507 (3.86)</td>
</tr>
<tr>
<td>3</td>
<td>121 (0.92)</td>
</tr>
<tr>
<td>4+</td>
<td>71 (0.54)</td>
</tr>
<tr>
<td>Stillbirth</td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>12 994 (99.17)</td>
</tr>
<tr>
<td>1</td>
<td>106 (0.81)</td>
</tr>
<tr>
<td>2</td>
<td>3 (0.02)</td>
</tr>
<tr>
<td>Crowding index, mean (s.d.)</td>
<td>1.92 (0.94)</td>
</tr>
<tr>
<td>Living with current partner/husband, n (%)</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>9 696 (76.17)</td>
</tr>
<tr>
<td>No</td>
<td>3 033 (23.83)</td>
</tr>
<tr>
<td>Employment status, n (%)</td>
<td></td>
</tr>
<tr>
<td>Employed</td>
<td>7 357 (88.44)</td>
</tr>
<tr>
<td>Not employed</td>
<td>962 (11.56)</td>
</tr>
<tr>
<td>Birth weight (for the current pregnancy), n (%)</td>
<td></td>
</tr>
<tr>
<td>&lt;2500 g</td>
<td>400 (3.91)</td>
</tr>
<tr>
<td>&gt;2500 g</td>
<td>9 826 (96.09)</td>
</tr>
<tr>
<td>Tobacco use during first 3 months of pregnancy, n (%)</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>3 292 (25.19)</td>
</tr>
<tr>
<td>No</td>
<td>9 775 (74.81)</td>
</tr>
<tr>
<td>Alcohol use during first 3 months of pregnancy, n (%)</td>
<td></td>
</tr>
<tr>
<td>Never</td>
<td>5 910 (45.52)</td>
</tr>
<tr>
<td>&lt;1 glass per week</td>
<td>5 028 (38.73)</td>
</tr>
<tr>
<td>1 glass per day</td>
<td>1 798 (13.85)</td>
</tr>
<tr>
<td>1–2 glasses per day</td>
<td>208 (1.60)</td>
</tr>
<tr>
<td>&gt;3 glasses per day</td>
<td>39 (0.30)</td>
</tr>
</tbody>
</table>
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*BJP* published online March 3, 2011 Access the most recent version at DOI: 10.1192/bjp.bp.110.083105

**Supplementary Material**
Supplementary material can be found at:
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Published online 2011-03-03T02:58:28-08:00 in advance of the print journal.

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