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Common mental disorders, depression, and anxiety in high-risk pregnant women from a university hospital in southern Brazil

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Abstract: Common mental disorders may be present during high-risk gestation. The aim of this study was to investigate which common mental disorders are more prevalent in high-risk pregnant women treated in a hospital in southern Brazil. For this, researchers conducted a descriptive quantitative study. A total of 37 pregnant women responded to a sociodemographic data sheet, the Self-Reporting Questionnaire (SRQ-20), in addition to the Beck Depression Inventory (BDI), and the Beck Anxiety Inventory (BAI). Single and divorced women were 2.42 times more likely to have moderate/severe anxiety and 28 times more likely to have moderate/severe depression. Pregnant women who used alcohol were more likely to develop depression when compared to those who did not use it. Health-promoting interventions were needed to offer emotional support, in addition to adequate treatments for high-risk pregnant women.

Keywords: High-risk pregnancy; depression; anxiety.

Transtornos mentais comuns, depressão e ansiedade em gestantes de alto risco de um hospital universitário no sul do Brasil

Resumo: Os transtornos mentais comuns podem estar presentes durante a gestação de alto risco. O objetivo deste estudo foi investigar quais os transtornos mentais comuns são mais prevalentes nas gestantes de alto risco atendidas em um hospital no Sul do Brasil. Para isso, foi realizado um estudo quantitativo descritivo. Participaram 37 gestantes, que responderam a uma ficha de dados sociodemográficos, ao *Self-Reporting Questionnaire* (SRQ-20), além do Inventário Beck de Depressão (BDI) e do Inventário Beck de Ansiedade (BAI). Verificou-se que mulheres solteiras e divorciadas tiveram probabilidade 2,42 vezes maior de apresentar níveis de ansiedade moderado/grave e 28 vezes maior de apresentarem níveis de depressão moderado/grave. As gestantes que faziam uso de álcool apresentaram maior probabilidade de desenvolver depressão quando comparadas às que não faziam uso. Tornam-se necessárias intervenções promotoras de saúde que ofereçam apoio emocional, além dos tratamentos adequados para as gestantes de alto risco.

Palavras-chave: Gravidez de alto risco; depressão; ansiedade.

Introduction

Pregnancy is a complex event in a woman's life that involves significant changes in the maternal organism, both physical and psychological. The study used a time

scheme divided into three parts, that is, in trimesters of 13 weeks each (Brito, Lopes & Barros, 2019) to describe pregnancy. Some pregnancies are considered high risk because they involve factors or comorbidities, although they do not represent a specific pathology (Brazil, 2012).

In Brazil, there are about 470 thousand pregnancy cases considered high-risk each year, representing 15% of total pregnancies. This factor is often associated with the chance of unfavorable outcomes for the woman, the fetus, and the newborn. Therefore, the need to conduct studies on the attention to care for high-risk pregnant women and their particularities is justified (Brum, et al., 2019; Paz et al., 2022).

Pregnancy period is when a woman is receptive to changes and, as experienced, can be favorable to the future relationship with the baby. Thus, maternal attitudes and choices can reflect on the development and birth of a healthy baby. However, high-risk pregnant women may be more vulnerable to developing some type of emotional disorder, both during pregnancy and in the postpartum period (Allison, Stafford & Anumba, 2012; Azevedo, Hirdes & Vivian, 2020).

High-risk pregnancy refers to situations that may interfere with the typical evolution of pregnancy, both in aspects related to maternal and fetal health, and the profile causing possible emotional implications that may be amplified if the pregnant woman is admitted to a hospital (Azevedo, Hirdes & Vivian, 2020; Brazil, 2012). Thus, in addition to ensuring prenatal care and humanizing care, among other actions, special attention must be paid to a small portion of pregnant women who are carriers of diseases that may worsen during pregnancy or will present complications during this time (Antoniazzi, Siqueira & Farias, 2019).

During prenatal clinical follow-up, doctors usually emphasize physical problems. Psychological and emotional conflicts are not always given due attention, often due to the stigma associated with mental health. There is also the idealization of motherhood itself, with the belief that some feelings are inherent in the gestational period and that they do not need to be externalized to the health professional (Arrais, Araujo & Schiavo, 2018; Azevedo, Hirdes, and Vivian, 2020; Brazil, 2012). In this context, women may develop common mental disorders.

Mental Disorders (MD) is a set of symptoms, such as insomnia, fatigue, irritability, forgetfulness, difficulty concentrating, and somatic complaints, which do not meet the criteria for characterizing specific mental disorders. They are not a diagnostic category. Despite this, they can generate psychological suffering of a disabling nature

(Goldberg & Huxley, 1992). Therefore, non-psychotic symptoms are considered MD, being frequently found in several populations, are related to stress, anxiety, and depression (Alves, 2015; Moura 2022).

Studies investigated these disorders in different contexts and show that there is a higher prevalence among women, especially with regard to depressive and anxiety symptoms (Costa, Souza, Pedroso & Strufaldi, 2018; Viana & Andrade, 2012). Specifically in pregnancy, risk factors for developing a common mental disorder include a history of previous depression, unplanned pregnancy, having no partner, and unfavorable socioeconomic status (Lopes, Lucchese, Souza, Silva, and Mendonça, 2019). It is estimated that 37% of pregnant women have a prevalence of common mental disorders (Jha & cols, 2018).

A recent review of empirical studies on common mental disorders (CMD) highlighted that among cross-sectional studies, the prevalence of CMD ranged from 41.4% to 57.1%. In the same review, longitudinal studies showed CMD incidences between 3.5% and 33.6% in Brazil and 8.6% and 57.1% in European countries. Some factors that increase the likelihood of CMD are previous history of depression, unplanned pregnancy, lack of a partner, and unfavorable socioeconomic status (Lopes et al. 2019; Lowdermilk & Perry, 2008)

Pregnancy and puerperium are vulnerable periods for the emergence of mental health problems, with similar prevalence of MD both in pregnancy and postpartum (Bussel, Spitz, Demyttenaere, 2006; Costa, Souza, Pedroso & Strufaldi, 2018). Screening in the gestational period is scarce, although many studies seek to investigate psychological changes during pregnancy and obstetric outcomes (Fasal-Cury, Menezes, Araya & Zugaib, 2009). The high prevalence of common mental disorders in pregnancy, especially anxiety (Paz & Cols., 2022) and depression symptoms denote the need for their management and screening during the pregnancy-puerperal cycle (Lopes et al, 2019).

This study investigated which common mental disorders are more prevalent in high-risk pregnant women treated at a University hospital in southern Brazil. Specifically, the study analyzed the symptoms of anxiety and depression of these women during the hospitalization period.

Method

The current study presented a descriptive quantitative design.

Population and sample

The study included 37 women who were part of the Interdisciplinary Program for the Promotion of Maternal and Child Health and Early Childhood Care (Vivian & Cols., 2018). In this project, pregnant women and their children, after birth, were treated at the Gynecology and Obstetrics outpatient clinic, at the pregnant woman's home and joint accommodation of the University Hospital of Canoas-RS and the Physiotherapy Clinic-School, at the ULBRA Multiprofessional Center. All were invited to participate in the broader study from March to December 2018 and March to July 2019, in which they were asked to answer semi-structured interviews and fill out various mental health screening instruments.

The high-risk pregnant women who were hospitalized at the University Hospital of Canoas – RS also participated in weekly group interventions, lasting approximately one hour each. Thirty-three meetings were held from April 2018 to June 2019. The approach took place in an interdisciplinary team composed of professors and academics of Psychology, Medicine, Physiotherapy, and Dentistry and master's students of the Graduate Program in Health Promotion. Topics related to early childhood; pregnancy and mother-baby relationship; childbirth and puerperium; feeding and breastfeeding; and support networks were studied. These interventions, as well as qualitative interviews, were recorded and transcribed for further analysis.

Collection and organization of data

The research used secondary data from the study by Vivian et al. (2018) and selected all pregnant women over 18 years of age who filled out the sociodemographic data sheet. This instrument was used to characterize the sample, informing the sex, age, education, financial dependence, and marital status; in addition to the pregnant women who responded to the Self-Reporting Questionnaire (SRQ-20), the Beck Depression Inventory (BDI), and the Beck Anxiety Inventory (BAI).

The SRQ-20 includes 24 items, of which the first 20 are for screening for non-psychotic disorders and the last four for detection of psychotic disorders. It is a self-applied instrument containing dichotomous scale (yes/no) for each question. The neurotic symptoms assessed by this 20-item version (SRQ-20) approach common mental disorders (CMDs), which are characterized by non-psychotic symptoms such as insomnia, fatigue, irritability, forgetfulness, difficulty concentrating, and somatic complaints.

The Beck Depression Inventory (BDI) was used to assess depression. This scale is probably the most widely used self-assessment measure of depression in research and clinical practice (Cunha, 2001). It is a symptomatic self-report scale with 21 items, including symptoms and attitudes, whose intensity ranges from 0 to 3. The sum of the scores of the individual items provides a total score, which, in turn, constitutes a dimensional score of the intensity of depression, which can be classified into the following levels: minimal (up to 11 points), mild (from 12 to 19 points), moderate (from 20 to 35 points) or severe (above 36 points).

In turn, to assess anxiety, the Beck Anxiety Inventory (BAI) was applied, which consists of a self-report with 21 items and is used to measure the intensity of anxiety symptoms (Fernandes, Venâncio, Pasche, Silva, Aratani & Tanaka, et al., 2020). The items cover common anxiety symptoms, where the individual answers how they felt in the last week, including the day of application of the questionnaire. Each question has four possible responses: ‘no;” ‘mildly: it didn’t bother much;’ ‘moderately: it was very unpleasant, but I could bear it;’ and ‘severely: I could hardly bear it.’ Items evaluated include numbness and tingling, feeling hot, trembling in the legs, inability to relax, fear of the worst happening, lightheadedness or dizziness, palpitation or racing of the heart, imbalance, terror, nervousness, feeling suffocated, trembling in the hands, trembling, fear of loss of control, difficulty breathing, fear of death, feeling scared, indigestion or discomfort in the abdomen, feeling faint, drowned face, and sweating (not due to heat). The participant answers the 21 items, choosing the symptoms that most fit or do not fit regarding his feelings. The sum of the points (0 to 3) classifies the absence or level of anxious symptoms (above 10 points – mild anxiety; between 20 and 30 points – moderate anxiety; between 31 and 63 points – severe anxiety) (Gomes & Piccinini, 2010).

Data analysis

For statistical analysis, quantitative variables were described by mean and standard deviation or median and interquartile range. Categorical variables were described by absolute and relative frequencies. The study applied the t-student test to compare means, used the Mann-Whitney test to measure asymmetry, Pearson's chi-square or Fisher's exact test to compare proportions, and applied the Multivariate Poisson Regression model to control for confounding factors. The criterion used for the entry of the variable in the multivariate model was that the variable presented a p-value<0.20 in the bivariate analysis. The analysis calculated the prevalence ratio (PR) in combination with the 95% confidence interval (95% CI). The significance level adopted was 5% ($p<0.05$), and the analyses were performed using the SPSS software version 21.0.

The Research Ethics Committee of the Lutheran University of Brazil approved this study under Opinion n. 2,448,176. It followed ethical principles in accordance with resolution 466/2012 that governs the conduct of research involving human beings, determines that all research must respect the privacy, well-being and dignity of the participants. After understanding the objectives and agreeing to participate in the research, they signed the Informed Consent (IC). The pregnant women responded to the application of the instruments in a private room or in the bed in which they were.

Results

The demographic profile (Table 1) of the selected sample of 37 women who participated in the Interdisciplinary Program for the Promotion of Maternal and Child Health and Early Childhood Care showed a mean age of pregnant women of 32.5 (±6.9) years. Of these, 23 (63.9%) declared themselves white. Regarding the level of Education, 10 (27%) had completed High School, and 8 (21.6%) had incomplete Elementary School. Concerning work activity, 19 (51.4%) said they worked, and 17 (45.9%) said they had no paid employment.

Gestational age was 28.6 weeks (±8.9) (mean±SD), and of these pregnant women, 12 (32.4%) reported previous abortions, 9 with one abortion (24.3%), and 3 with two abortions (8.1%). Of these, 14 (46.7%) reported receiving treatment for depression, and 9 (30.0%) reported using alcohol.

Table 1
Distribution of the predominant sociodemographic characteristics in pregnant women treated in the Interdisciplinary Program of Maternal and Child Health and Early Childhood Care admitted to the University Hospital of Canoas – RS.

Variables	n = 37
Age (years) – mean ± SD	32.5 ± 6.9
Ethnicity (n=36 – n (%)	
White	23 (63.9)
Black	7 (19.4)
Brown	6 (16.7)
Marital status (n=36) – n (%)	
Single/Divorced	11 (30.6)
Married/common-law	25 (69.4)
Live with partner (n=29) – n (%)	
Yes	27 (93.1)
No	2 (6.9)
Level of Education – n (%)	
Illiterate	1 (2.7)
Incomplete Elementary School	8 (21.6)
Complete Elementary Education	9 (24.3)
Incomplete High School	6 (16.2)
Full High School	10 (27.0)
Higher Education	3 (8.1)
Works – n (%)	
Yes	19 (51.4)
No	18 (48.6)
Income (w. m.) – n (%)	
None	17 (45.9)
1	6 (16.2)
2 or more	14 (37.8)
Gestational age (weeks) – mean ± SD	28.6 ± 8.9
Number of previous pregnancies– median (P25-P75)	2 (1 – 4)

Previous abortions – n (%)	
Yes*	12 (32.4)
No	25 (67.6)
Planned pregnancy – n (%)	
Yes	15 (40.5)
No	22 (59.5)
Need for therapeutic follow-up in the family (n=30) – n (%)	
Yes	8 (26.7)
No	22 (73.3)
Treatment for anxiety/depression (n=30) – n (%)	
Yes	14 (46.7)
No	16 (53.3)
Uses drugs (n=30) – n (%)	5 (16.7)
Consumes alcohol (n=30) – n (%)	9 (30.0)
Smoker (n=30) – n (%)	4 (13.3)

Source: the authors (2022).

* 9 with one abortion (24.3%) and 3 with two abortions (8.1%)

Regarding the association of the mother's health conditions and common mental disorders, the study observed that 21 (56.8%) had symptoms evaluated by the SRQ (Table 2). When the BAI was analyzed, 11 (29.7%) were classified as minimal and mild risk, but 10 (27%) had moderate degree of anxiety. About the BDI, 17 (45.9%) had minimal symptoms of depression, while 9 (24.3) were moderate.

Table 2

Data relating to the instruments applied SQR, BAI, and BDI in pregnant women admitted to the Interdisciplinary Program for the Promotion of Maternal and Child Health and Early Childhood Care, admitted to the University Hospital of Canoas – RS.

Variables	**n=37**
SQR – mean ± SD	8.1 ± 3.5
SQR Rating – n (%)	
No symptoms (≤ 7)	16 (43.2)
With symptoms (>7)	21 (56.8)
BAI – median (P25 – P75)	15 (7.5 – 24.5)
BAI Rating – n (%)	
Minimum	11 (29.7)
Mild	11 (29.7)
Moderate	10 (27.0)
Severe	5 (13.5)
BDI – median (P25 – P75)	12 (6.5 – 17)
BDI Rating – n (%)	
Minimum	17 (45.9)
Mild	10 (27.0)
Moderate	9 (24.3)
Severe	1 (2.7)

Source: the authors (2022).

The following table shows the association between the investigated variables, the sociodemographic profile, and the SQR, BAI, and BDI instruments.

Table 3

Associations of socio-demographic data concerning the SQR, BAI, and BDI instruments in high-risk pregnant women treated in the Interdisciplinary Program for the Promotion of Maternal and Child Health and Early Childhood Care, admitted to the University Hospital of Canoas – RS

Instruments	Variables	No Symptoms Mild/ Moderate	With Symptoms Moderate/Severe	p
SQR		No symptoms (n=16)	With symptoms (n=21)	p
	Number of previous pregnancies – median (P25 – P75)	2 (1 – 3)	4 (2 – 5)	0.004
	Uses drugs (n=30) – n (%)	0 (0.0)	5 (29.4)	0.52
BAI		Minimum/ Mild (n=22)	Moderate/severe (n=15)	p
	Marital status (n=36) – n (%)			0.141
	Single/Divorced	4 (19.0)	7 (46.7)	
	Married/common-law	17 (81.0)	8 (53.3)	
	Live with partner (n=29) – n (%)			0,135
	Yes	18 (100)	9 (81.8)	
	No	0 (0.0)	2 (18.2)	
BDI		Minimum/ Mild (n=27)	Moderate/severe (n=10)	p
	Live with partner (n=29) – n (%)			0.052
	Yes	22 (100)	5 (715)	
	No	0 (0.0)	2 (286)	
	Consumes alcohol (n=30) – n (%)	5 (21.7)	4 (571)	0.153

Source: the authors (2022).

In the bivariate analysis, only the number of previous pregnancies was significantly associated with the existence of common mental disorders (p=0.004), and the number of pregnancies in women with symptoms is twice that of women without symptoms (Table 3). It is relevant to highlight that in the group of pregnant women with CMD symptoms, there was a trend of higher prevalence in the use of drugs (p=0.052). After adjustment by the multivariate model, the analysis found that only the number of pregnancies maintained a significant association with the presence of depressive symptoms, according to the SRQ (PR=1.19; 95% CI: 1.05 - 1.34; p=0.006). For each additional pregnancy, there was a 19% increase in the prevalence of depressive symptoms presence.

There was no statistically significant association between the study variables and the highest anxiety levels, as assessed by the BAI (Table 3). However, after adjustment by the multivariate model, the analysis showed that marital status presented a significant

association (p=0.050). And single or divorced women were 2.42 times more likely to have moderate or severe anxiety levels compared to married or common-law women (PR = 2.42; CI 95%: 1.00 - 5.84).

The research did not find statistically significant associations between the variables studied and higher levels of depression, according to Table 3. However, after adjusting for the multivariate model, it found that living status and alcohol consumption were significantly associated with higher levels of depression ($p<0.001$ and $p=0.031$, respectively). Women who do not live with a partner were approximately 28 times more likely to have moderate or severe levels of depression compared to those who live with a partner (PR = 28.1; CI 95%: 5.48 - 144). In addition, women who consumed alcohol were 4.6 times more likely to have high levels of depression compared to those who did not (PR = 4.62, CI 95%: 1.15 - 18.7).

Discussion

When analyzing the profile of the participants in this research, the study found that the pregnant women had a mean age of 32.5 years. The majority were white women with high school education (27%), and 45.9% of the participants did not receive a salary and were financially dependent on others. Regarding gestational age, the mean was 28.6 weeks, with a standard deviation of 8.9. Among the pregnant women of the study, 32.4% reported having had previous abortions, of which 24.3% had one abortion and 8.1% had two abortions. In a study by Silva, Sommer and Vivian (2021), some of the same socio-demographic variables presented in this investigation as income, education, pregnancy planning and lifestyle habits, intensified the vulnerability of high-risk pregnant women.

Thus, these findings also resemble the data obtained by Silva, Souza, and Vivian (2020), who investigated the social support received by 40 women hospitalized for gestational risk in a University hospital in the Metropolitan Region of Porto Alegre. In this study, most participants lived in Canoas/RS, had a partner, and had an average of 2 to 3 children. In addition, these women mentioned attending places of a religious nature. Regarding schooling, the sample showed variation in years of education, and most of the participants were unemployed and worked as a housewife.

A Brito et al. study (2019), which analyzed 293 medical records from April 2018 to April 2019, also identified the lack of salary income and dependence on other people. The authors observed, when tracing the epidemiological profile of high-risk pregnant

women, that the low socioeconomic status affected the woman's autonomy and generated conflicts during pregnancy due to the lack of financial stability, which hindered access to information and decision-making opportunities.

Another relevant information was the marital status of the participants, with a significant number of single or divorced women (30.6%) who did not plan pregnancy (50.9%). These data are significant since sharing life with a partner can provide support during the gestational and postpartum period, contributing to a better quality of life (Hertling-Schaal, Perrotin, Poncheville, Lansac & Body, 2001; Silva, Souza & Vivian, 2020).

Therefore, the analysis found the importance of social support for high-risk pregnant women. Studies affirm that social support awakens the expectations that the individual creates regarding the reactions and assistance that close people will offer, as well as the person chosen to share these moments (Brum & cols., 2019; Fernandes & cols., 2020; Hertling-Schaal & Cols, 2001; Silva, Souza & Vivian, 2020). In a qualitative study with reports of high-risk pregnancies, Antoniazzi, Siqueira, and Farias (2019) concluded that the childbirth experiences of these women were marked by anxiety and fear. In this context, the formation of a network of family support and health professionals can help pregnant women face these issues and mitigate suffering (Silva, Souza & Vivian, 2020).

Regarding the psychological aspects, this study observed that 56.8% of the participants presented symptoms of depression. As for the BDI (Beck Depression Inventory), 17 (45.9%) had minimal symptoms of depression, while 9 (24.3%) were classified as moderate. When analyzing the BAI (Beck's anxiety inventory), 11 (29.7%) were classified with minimal and mild risk, while 10 (27%) had a moderate level of anxiety.

In the study by Paz et al. (2022), conducted in the southeast, with 100 high-risk pregnant women hospitalized, 68% of pregnant women presented moderate to high anxiety, regardless of maternal age, marital status, or parity, but it identified the gestational trimester, history of abortion and length of hospital stay as risk factors for anxiety. These data demonstrated that high-risk pregnant women have symptoms of depression and anxiety. In addition, a study by Soares, Vivian, and Sommer (2022) that investigated maternal-fetal attachment, anxiety, and depression in high-risk pregnant women indicated (97.3%) of maximum attachment and (2.7%) of average attachment among the 37 participants. Most pregnant women had minimal anxiety levels (35.2%)

and depression (43.3%). Data identified severe depression in five pregnant women (13.5%) and severe anxiety in only one (2.7%).

A study of Brum et al. (2019) with similar results found a high prevalence of depression followed by anxiety. The evaluation of common mental disorders revealed that 69% (N=20) of the mothers had depression, of which 20.7% (N=6) had mild depression, 27.6% (N=8) moderate, and 20.7% (N=6) severe. Regarding anxiety, 58.6% had the diagnosis, being 27.6% (N=8) with mild anxiety, 27.6% (N=8) with moderate anxiety, and 3.4% (N=1) with severe anxiety.

One possibility for this high prevalence is the relationship between common mental disorders and socioeconomic variables. That is, socioeconomic factors can influence the development of these disorders during pregnancy. These results reinforce the importance of considering the socioeconomic status of pregnant women when assessing and addressing mental health during the pregnancy-puerperal period, in addition to clinical aspects. In this sense, studies with high-risk pregnant women attended by the Unified Health System corroborate these data (Silva, Sommer, Silveira & Vivian, 2021; Soares, Vivian & Sommer, 2021; Vivian, Souza & Marrone, 2020). The authors emphasize the need for interdisciplinary work in comprehensive care for pregnant women as a health promotion strategy.

This study's results are also in line with the findings of Antoniazzi, Siqueira, and Farias (2019), who highlighted the impact of hospitalization of high-risk pregnant women in their qualitative research with primiparous. According to the authors, hospitalization not only affected pregnant women but also caused stress in the family, home life, and professional career, requiring a reorganization that generated anguish in women. Another study conducted by Arrais, Araujo, and Schiavo (2018) pointed out that complications during pregnancy, such as hypertension, bleeding, and seizures, were the most common risk factors, leading to hospitalization and interruption of routine activities. These findings highlight the need for a comprehensive approach and adequate support for high-risk pregnant women, considering not only the clinical aspects but also the psychosocial repercussions of health conditions and hospitalization.

As highlighted by Antoniazzi, Siqueira, and Farias (2019), the interdisciplinary approach plays a crucial role in the comprehensive health care of pregnant women. Specifically, in the case of hospitalization in high-risk pregnancy, challenges may arise in the relationship between the patient and the health team, making it essential for health professionals to be able to maintain effective communication and an empathic

connection with the pregnant woman (Azevedo & Vivian, 2020; Azevedo, Hirdes & Vivian, 2020; Brum & cols, 2019; Hertling-Schaal & cols., 2001; Reis & cols., 2010; Santos & Vivian, 2018).

In this context, the psychologist plays a fundamental role as a team member, facilitating the integration of different knowledge and promoting dialogue and exchange between professionals (Wilheim, 2000). In addition, according to the same author, hospitalized pregnant women may face psychological difficulties, and offering a listening space in this context can help pregnant women to reflect and develop coping strategies in the face of their clinical condition. For several scholars (Azevedo, Hirdes & Vivian, 2020; Santos, Vivian & Botton, 2023; Silva, Sommer, Silveira & Vivian, 2021; Soares, Vivian & Sommer, 2022), the promotion of the mental health of pregnant women, including in the context of high risk, has been pointed out as fundamental to provide the emotional well-being of the mother, which also ends up having repercussions in an environment favorable to the development of the baby.

Conclusion

The high prevalence of common mental disorders during pregnancy, especially symptoms of anxiety and depression, alerts us to the need for the management and tracking of these disorders throughout the pregnancy-puerperal cycle. There must be adequate follow-up and psychological support interventions to ensure the mental well-being of pregnant women.

The participants in this study were part of the Program for the Promotion of Maternal and Child Health and Early Childhood Care, which aimed to carry out interventions and integrate the different areas of health in an interdisciplinary approach. The importance of a multi and interdisciplinary team is evident, as it provided the necessary support to meet the needs of these pregnant women. This care ranged from the initial reception before hospitalization to follow-up during the hospitalization period due to high-risk pregnancy.

The maternal experience can become even more challenging due to the emotional fragility that the mother faces with a high-risk pregnancy, added to the possible risks associated with her clinical condition. Ensuring dedicated care for high-risk pregnant women can help the mother feel more supported to get involved with the newborn after delivery. It includes everything from breastfeeding support to hygiene care, as well as the indispensable emotional support in this context.

The experience of the initial phase of pregnancy until the baby's birth can influence the psychic resources available for the woman to care for and protect her child. In this sense, it is crucial to offer physical and emotional support to high-risk pregnant women, in addition to creating a safe and welcoming environment for women to feel comfortable expressing their anxieties, fears, desires, anxieties, and expectations.

Emotional and social support play a key role in the well-being of high-risk pregnant women. The presence and involvement of the spouse or partner from the beginning of pregnancy play a significant role in the emotional support of the pregnant woman. The study observed that high-risk pregnant women in a stable union or who had a partner and did not use alcohol or drugs, had a lower susceptibility to common mental disorders (CMDs). In addition, these women had lower levels of anxiety and depression. It underscores the importance of social support for the pregnant woman during this period of ambivalent feelings inherent in pregnancy.

One of the potentialities of this study was the intervention in groups during the hospitalization period of high-risk pregnant women, which may have favored reflection on the necessary care in this delicate period. In addition, strategies to promote maternal and child health have been pointed out as important protective factors for the well-being of the mother-baby pair, favoring their mental health.

The present study was restricted to the analysis of secondary data of pregnant users of the Unified Health System serviced at a University hospital in Rio Grande do Sul. In this sense, there were limitations associated with the complexity of the analysis of the access, bond, and care categories due to the restriction of the data collection instrument used. For a deeper understanding, this analysis suggests the possibility of exploring qualitative aspects through reports of pregnant women and their families.

The limitations previously mentioned highlight the need for more comprehensive and diverse research that contemplates different regions and contexts. The inclusion of qualitative approaches could provide a more comprehensive overview of the experiences of high-risk pregnant women, allowing a more in-depth analysis of aspects related to access, bonding, and care during this critical period.

It is essential to consider these limitations when interpreting the results of this study, recognizing that they may be specific to the region and the sample studied. New research would be needed in different contexts, using more comprehensive data collection methods, analyzed from mixed perspectives, such as quantitative-qualitative studies, to obtain a broader and more generalizable understanding.

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