SAÚDE E PESQUISA
e-ISSN 2176-9206

ORIGINAL ARTICLE

https://doi.org/10.17765/2176-9206.2025v18e13034

PSYCHOLOGICAL DISTRESS IN RISK AND HIGH-RISK PREGNANCY: A LITERATURE REVIEW

O SOFRIMENTO PSÍQUICO NA GRAVIDEZ DE RISCO E ALTO RISCO: UMA REVISÃO DA LITERATURA

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ABSTRACT: High-risk pregnancy is one in which the life or health of the mother and/or fetus and/or newborn are at a greater risk of being affected than those in the average population. This study aimed to analyze psychological distress in high-risk pregnancies. It is an exploratory study, employing a qualitative approach through a systematic literature review. Publications on the subject between 2012 and 2022 were sought on the following portals: BVS, PUBMED, Portal CAPES, and EBSCO. Following the PRISMA protocol, 52 articles were analyzed by thematic categories. The literature identifies stress, anxiety, depression, HIV, and suicide risk as indicators of psychological distress in high-risk pregnancies, exacerbated by factors such as a history of abuse and absence of partners.

KEYWORDS: Anxiety. Depression. High-risk gestation. High-risk pregnancy. Psychological distress. Stress.

RESUMO: Gestação de alto risco é aquela na qual a vida ou a saúde da mãe e/ou do feto e/ou do recém-nascido têm maiores chances de serem atingidas que as da média da população considerada. Esse é um estudo exploratório, de abordagem qualitativa, realizado por meio de revisão sistemática da literatura que teve como objetivo analisar o sofrimento psíquico em gestações de alto risco. Buscou-se as publicações sobre o assunto entre os anos de 2012 a 2022 nos portais: BVS, PUBMED, Portal CAPES e EBSCO. Foram adotados os procedimentos do protocolo PRISMA que possibilitaram a seleção de 52 artigos analisados por categorias temáticas. Os resultados apontam que estresse, ansiedade, depressão, HIV e risco para suicídio como indicadores de sofrimento psíquico na gestação de risco, intensificado por fatores como histórico de abuso e ausência de parceiros.

PALAVRAS-CHAVE: Ansiedade. Depressão. Estresse. Gestação de risco. Gravidez de alto risco. Sofrimento psíquico.

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Received: 14 aug. 2024
Accepted: 21 oct. 2024

INTRODUCTION

The Brazilian Ministry of Health has increasingly sought information and knowledge on high-risk pregnancy to clarify or reduce the suffering of the pregnant woman, fetus, or baby, as well as to reduce fetal mortality. To enhance the quality of care for high-risk pregnancies, specialized services have been established with a multiprofessional team. This way, exams, consultations, and follow-ups with various professionals have become more common, allowing a more humanized care approach (humanized approach to care) that addresses the psychological distress of high-risk pregnant women. Although scientists have made efforts to create scoring systems and tables to distinguish high-risk from low-risk pregnancies, no classification has been developed to predict (accurately determine) problems with precision. However, certain risk factors that are more common within the general population should be identified in pregnant women.[1]

According to the Ministry of Health's *Technical Manual for High-Risk Pregnancy*[1], classifications of higher or lower risk depend on an initial assessment, including medical consultation, anamnesis, general physical examination, and gynecological-obstetric examination. This document establishes some markers (criteria) for high-risk pregnancy, which are categorized by conditions (occurrences) existing before pregnancy, those arising during prenatal care, and those occurring at delivery. Risk factors present before pregnancy refer to individual characteristics and unfavorable sociodemographic conditions, specifically including: age under 15 or less than two years post-menarche, age over 35, height under 1.45m, gestational weight under 45kg or over 75kg (BMI <19 and BMI >30), structural abnormalities in reproductive organs, insecure marital situation, family conflicts, low educational level, adverse environmental conditions, and dependence on legal or illegal substances, including smoking and alcohol.

The manual also highlights risks associated with occupational exposure, physical strain, work hours, rotating schedules, exposure to harmful physical, chemical, and biological agents, and stress.[1] Among prior reproductive history factors, the manual underscores: habitual abortion, explained and unexplained perinatal death, history of restricted growth or malformed newborns, previous preterm birth, infertility, inter-pregnancy interval under two years or over five years, nulliparity, grand multiparity, hemorrhagic or hypertensive syndrome, gestational diabetes, prior uterine surgery (including two or more previous cesareans).

Preexisting clinical conditions such as hypertension, cardiopathies, pneumopathies, nephropathies, endocrinopathies (mainly diabetes and thyroid diseases), hemopathies, epilepsy, infectious diseases (considering local epidemiological context), autoimmune diseases, gynecopathies, and neoplasms (tumors) also classify pregnancies as high-risk.[1]

Additional risk markers include complications arising during pregnancy, such as accidental teratogenic exposure, obstetric diseases in the current pregnancy, uterine growth deviation, multiple gestations, amniotic fluid volume anomalies, preterm labor, prolonged pregnancy, inadequate weight gain, pre-eclampsia and eclampsia, gestational diabetes, pregnancy hemorrhage, premature amniorrhexis, cervical insufficiency, alloimmunization, and fetal death.[1]

Lastly, clinical complications during pregnancy are defined as infectious-contagious diseases experienced during the current pregnancy (UTI, respiratory tract infections, rubella, toxoplasmosis, and others) and clinical conditions diagnosed for the first time in this pregnancy (cardiopathies, endocrinopathies). Hypertension and hemorrhage are among the leading causes of maternal mortality in Brazil and worldwide, primarily due to inadequate prenatal and childbirth care. Approximately 830 women die every day from pregnancy-related complications associated with childbirth.

Adolescent pregnancy is also a critical issue affecting millions of girls aged 15-19 worldwide. This condition increases the prevalence of complications for the mother, fetus, and newborn and exacerbates existing socioeconomic problems[2]. Roughly 68% of pregnant adolescents attending school experience depressive symptoms due to heightened stressors. Moreover, studies suggest that up to 60% of pregnant adolescents have a history of physical or sexual abuse. The mother's emotional vulnerability, combined with adolescent pregnancy risks, makes the maternal experience more challenging.[3]

Women with high-risk pregnancies are also more likely to experience intense (heightened) fear and anxiety associated with fetal loss, particularly those with a history of spontaneous abortion. [4] The possibility of loss can impact emotions during pregnancy, affecting self-care and diminishing future expectations. Psychological distress (emotional suffering) in high-risk pregnancies may be related to pre-existing biological factors, exacerbating the risk of fragile health for both mother and baby.

Mental health during pregnancy has gained global attention, with studies documenting its prevalence and impact, particularly among high-risk pregnant women. In the United States, perinatal depression is well-documented, [4] in China, first-trimester depression is highlighted, [5] and in Brazil, emotional support and medical follow-up are emphasized. [6] Nevertheless, most studies still focus on physical aspects, with less attention to psychological impact, especially in women with a history of abuse. Sociocultural conditions affecting vulnerable women also remain underexplored, highlighting the need for an integrated, sensitive approach to the multifaceted dimensions of gestational distress. Thus, this study aimed to analyze the manifestations of psychological distress in high-risk pregnancies and identify health interventions to mitigate it.

METHODOLOGY

For this investigation, four databases were used to search for publications: Virtual Health Library (BVS), PUBMED, Portal CAPES, and EBSCO. The indexed descriptors used for the research were: “anxiety,” “stress,” “depression,” “psychological distress,” “high-risk pregnancy,” and “high-risk gestation,” with these terms combined with the descriptor “psychology” to centralize the research theme. The search was conducted by combining terms with the logical operators AND and OR. The following combinations were used: “anxiety” AND “stress” AND “high-risk pregnancy,” “psychological distress” AND “high-risk pregnancy” OR “high-risk gestation,” “depression” AND “high-risk pregnancy” OR “high-risk gestation” AND “psychology,” and finally, “stress” AND “high-risk pregnancy” OR “high-risk gestation” AND “psychology.”

Inclusion criteria for selecting publications included: A) access to abstracts and full texts in Portuguese, English, or Spanish; B) published between 2012 and 2022; C) publications related to psychological distress in high-risk pregnancies. Exclusion criteria included: a) articles not related to the topic and area of interest; b) articles not available in full or not in the specified languages; c) restricted-access articles.

Following the procedures outlined by the PRISMA protocol, the initial database search yielded 549 items on the research topic, including 394 articles, 127 journals, 17 general publications, 8 informational pieces, 1 conference procedure, and 1 case report. The organization and tabulation were conducted using the Rayyan software (https://new.rayyan.ai/reviews/675318/overview) and Pages for data management. After organizing the materials according to the inclusion criteria, 284 articles were excluded as they were irrelevant to the research, 1 was duplicated, and 58 were restricted access, leaving a total of 52 articles for analytical reading.

Figure 1 presents the procedures followed for identifying and selecting publications for the literature review study.

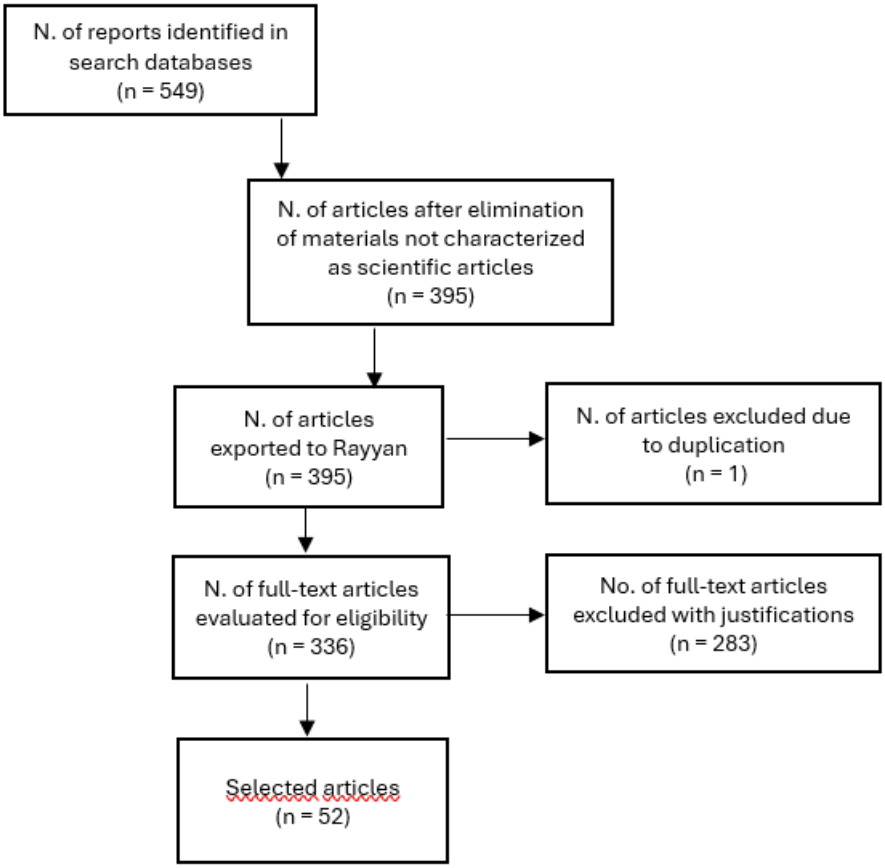

Figure 1. Created by authors (2023).

RESULTS AND DISCUSSION

It was observed that the highest number of publications occurred in 2016, with 12 articles, followed by 2018, with only 7. However, publications on the topic were also found between the years 2012 and 2022. Regarding language, 48 results were found in English, and only 4 in Portuguese. The country with the highest number of publications was the United States, with 10 articles, followed by Brazil and China, each with 6 articles.

The gestation period is characterized by the fetal development process involving various physical and psychological changes in women. This process is even more complex when pregnancy is considered high-risk, defined by the presence of potential risk to the life or health of the woman and/or fetus due to the pregnancy condition. About 22% of pregnancies are considered high-risk, and in this situation, women tend to experience intensified feelings of vulnerability, as well as the need to make personal routine changes, such as taking medication and even hospitalization in certain cases. [4]

Monochorionic twin (MC) pregnancies are considered high-risk due to the possibility of complications even in the womb and high mortality rates. In these cases, the pregnant woman's experience tends to become a stressful event, with common reactions upon receiving the news of the pregnancy involving shock, inability to plan for the long term, and blocked maternal fantasies, which are replaced by constant worries. There is evidence that prenatal attachment decreases in high-risk

pregnancies due to increased anxiety. In these cases, besides having to go through the process of psychic reorganization regarding pregnancy, the mother also has to cope with the constant risk of losing the babies during pregnancy, which makes her feel reassured only after birth. These stressors can significantly increase the likelihood of developing psychological disorders. Low anxiety levels in the pregnant woman and the attachment formed at the end of pregnancy are positive aspects in this phase. [7]

Pregnancy is often accompanied by stressors, becoming a time of heightened vulnerability for the pregnant woman, especially for those who have been victims of abuse. Such abuse has been associated with serious neurological impacts that alter behavior, which may make them more prone to develop certain psychopathologies such as depression, pre-eclampsia, and hypertension. [8]

In Brazil, safety strategies for high-risk pregnant patients consist of initial care at the Basic Health Unit (UBS) where risks are identified; if these are low, care continues at the same unit. This risk identification process must be individualized for each pregnant woman, considering each case's particularities. Communication and care, especially at the first moment, are emphasized, as an effective connection between the patient and health professionals is associated with higher levels of trust and identification, contributing to reduced anxiety levels in the pregnant woman. [6]

During the COVID-19 pandemic, increased feelings of fear and worry were identified, especially tied to uncertainties related to the virus. About a third of pregnant women recognized the importance of hospitalization as a protective factor for the mother's and baby's health and reported feeling safer within the hospital. In contrast, they also reported discomfort due to the absence of a partner on-site and difficulties in delegating household responsibilities and care for other children, when present, to others. In conclusion, there was no discrepancy in the behaviors of high-risk pregnant women during the pandemic, with the hypothesis being that the medical issues they experienced predated the pandemic. However, the support and sense of community shared with other women in the hospital room became a protective factor for the absence of family members [,9] a condition required at that time to control infection cases by COVID-19 in pregnant women.

Another study conducted in China during the COVID-19 pandemic identified the first trimester as having the highest prevalence rate of peripartum depression. This data was interpreted in conjunction with the different conditions experienced by pregnant women throughout pregnancy. In the first trimester, it is common for women to experience nausea and vomiting, contributing to greater discomfort during this period. In the second trimester, as described in the literature, the fetus enters rapid development, and symptoms tend to stabilize. In the third trimester, fatigue and difficulty sleeping often arise due to the baby's size and the consequent increase in the mother's belly size and weight. All these changes, although predominantly physical, affect the mental health of pregnant women according to their experience and symptom intensity.5 Studies also relate social support levels to how the pregnant woman experiences pregnancy, noting a relationship between lower support levels and increased stressors during gestation. [10]

Pre- and perinatal depression was also identified in the reviewed literature, characterized as a depressive disorder occurring during pregnancy or up to the first year postpartum. It requires the presence of five or more symptoms described in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). This disorder has been associated with increased gestational symptoms such as nausea, headaches, fatigue, insomnia, excessive guilt, and recurring thoughts of death.[11] It is considered a risk factor for postnatal depression if untreated during pregnancy and is correlated with events like miscarriage and preterm birth, phenomena closely linked to psychological distress during pregnancy.[12] Additionally, depression during pregnancy has negative effects on the family as a whole, with impacts

that tend to last long, from the baby's neurodevelopment to learning difficulties and aggressive behaviors in school-aged children.[9]

Studies indicate that depression is the most prevalent disorder among pregnant women, affecting approximately 10-20% of the population. It is important to note that in this population, adherence rates to treatment are low. Previous reviews on the topic suggest that experiences of abuse prior to pregnancy or during pregnancy are strong predictors of depression occurrence.[12] Pregnant women with poorer mental health levels may experience difficulty sleeping and breastfeeding, as well as impaired mother-baby bonding during the postpartum period. Women with high-risk or high-risk pregnancies often worry about their diagnoses and physical implications for themselves and the baby, relegating mental health to a secondary priority during pregnancy. Conversely, authors highlight the need to focus on mental health during this period and report that being depressed during the second trimester of pregnancy increases the risks of preterm birth. Previous studies also suggested that poor mental health could negatively interfere with uterine contractions and labor.[10]

A study conducted in São Paulo, Brazil, found that the prevailing period was in the first trimester of pregnancy. This data aligns with previous research, except for a study conducted in Indonesia, which found a higher prevalence of depression during the third trimester of pregnancy. The presence of a partner and the number of pregnancies may be considered protective factors in high-risk pregnancies. [11]

Studies focused on Latin pregnant women who migrated to the United States revealed that they are relatively more vulnerable to prenatal depression due to financial factors, stress, and discrimination. Cultural beliefs about the Latin maternal role were also linked to higher depression rates. Authors suggest that this role is associated with passivity and prioritizing others over oneself, leading to negative coping strategies like subordination, silence aimed at harmony in the relationship, and assuming a position of strength for the family.[13]

Factors such as alcohol and tobacco use by the partner have been associated with the onset of gestational depression.[14] Studies indicate that even if the pregnant woman does not use tobacco during pregnancy, many experience secondhand smoke due to their partner's usage or exposure in public settings. This exposure is often related to perinatal depression and suicidal ideation during pregnancy, especially during the second and third trimesters, affecting women aged 26-35 more intensely. [15]

In Asian contexts, the partner's employment status is also considered a relevant factor, as he often provides the primary family income.14 Conflicts with family members during this period tend to negatively impact the pregnant woman's mental health and increase the risks of prenatal and postnatal depression. [10]

Pregnant women diagnosed with gestational diabetes mellitus (GDM) also tend to have a higher incidence of depressive symptoms during pregnancy. GDM consists of increased blood glucose levels diagnosed in the second or third trimester of pregnancy. According to the literature, positive correlations exist between pregnant women who engage in leisure activities and maintain a healthy lifestyle compared to women who do not. It is thus observed that anxiety symptoms are less correlated only with blood glucose levels and more with the pregnant woman's competence to manage them. GDM diagnosis is typically defined between the second and third trimester of pregnancy. Recent studies have identified that experiencing depression before or at the beginning of pregnancy increases the chances of developing GDM, suggesting that this association may result from the less healthy lifestyle usually observed in depressed women.[16]

Obesity is a factor commonly related to depression and constitutes a specific high-risk group when both factors are associated. During pregnancy, there is a prevalence of 19% of obese women who experienced depressive episodes in the first trimester. These conditions are related to preeclampsia, cesarean delivery, and premature birth, as well as an increased risk of developing diseases such as

hypertension, gestational diabetes, and obesity in the baby. Among 13 studies, nine confirmed that the relationship between pregnancy and obesity leads to depressive symptoms. [24]

Pregnant women suffering from epilepsy also have a higher risk of experiencing depressive and anxious symptoms at the end of pregnancy and in the postpartum period. A Norwegian study compared the prevalence of these symptoms in groups of pregnant women with and without epilepsy and confirmed that higher rates were found in the first group. It was also indicated that women with numerous seizure episodes were the most affected group by depression and anxiety. A history of abuse was frequently associated with depression. However, according to the authors, depression tends to be less studied and recognized during pregnancies when the woman has epilepsy, hence they emphasize the importance of identifying the disorder before childbirth so that appropriate care can be provided to the pregnant woman.[18]

Other traumatic situations, such as recurrent pregnancy loss (RPL), are also related to depression and increased anxiety. RPL is characterized as the loss of at least two pregnancies. In a recent study relating both themes, it was observed that the rates of depression and anxiety were higher in women who had suffered the loss of a baby more than three times compared to women with fewer than two losses. A lower level of education was also related to higher risks of depression and anxiety in a study conducted with 782 pregnant women with RPL.[19]

As a strategy to reduce depressive levels, a study was conducted using relaxation techniques during the hospitalization of depressed women hospitalized with high-risk pregnancies, and a decrease in stress levels was perceived after the use of these techniques.[20]

Another aspect related to depression during pregnancy is the occurrence of intimate partner violence (IPV). A study conducted in Ethiopia identified that one in five pregnant women had experienced some form of IPV and found an association with depression. Previous studies reported that women who suffered IPV prior to pregnancy continued to suffer during pregnancy, which is associated with health problems for both the mother and the baby. Data collected in Ethiopia aligned with previous findings, showing that over 20% of pregnant women were victims of IPV, with 15% characterized as emotional violence, 10% physical, and 10% sexual. It was again found that pregnancy does not seem to be viewed as a protective factor against IPV. Stressful events, IPV, depression, and maternal mental health disorders are associated with food insecurity and poorer pregnancy outcomes. In a study conducted in South Africa, mothers who experienced emotional IPV or a history of childhood trauma were more likely to also experience food insecurity during pregnancy.[22]

A study conducted in China identified the association between experiences of IPV and the intensity of symptoms in cases of perinatal depression, as well as slow recovery compared to pregnant women without a history of IPV. According to previous studies, the data indicate that the traumatic situation contributed as a trigger for depression during pregnancy. According to this study, women tend to use negative coping strategies to deal with stress, such as distancing, self-blame, and substance use.[23]

Low-income women, in most cases, do not suffer from just one type of IPV but tend to suffer from all forms as a package and even face the risk of fatal violence from partners. These women are more likely to exhibit more intense symptoms of psychological suffering and develop depression during pregnancy. Women who experience psychological IPV also show lower levels of mental health than those who predominantly experienced physical violence. These women are more likely to smoke and consume alcohol during pregnancy.[6]

Regarding adolescent pregnancy, it is important to note that more often than not, pregnancy in this age group is unplanned, which leads to significantly higher risks of depression and anxiety. These risks are exacerbated by a lack of support and neglect. Adolescence, being a transitional period to

adulthood, is intrinsically marked by physical and psychological changes that make adolescents more vulnerable. When pregnancy is added to this context, symptoms of depression and anxiety tend to be even more intense. Additionally, health issues such as hypertension, low weight gain, and premature birth are also related to adolescent pregnancy.[24]

Despite the negative impacts that adolescent pregnancy can have, a study conducted by Pires confirmed that adolescents who view motherhood positively are less likely to develop significant psychological disorders during pregnancy. Studies also highlight the importance of social support during this period, especially from family and partners, as a protective factor against the worsening of depressive symptoms.[24] Another study conducted by Koleva and Stuart did not find a correlation between depressive symptoms in pregnant adolescents and socioeconomic factors, age, or employment. However, it identified a significant link between perceived social support and the intensity of depressive symptoms, validating previous findings.

Finally, a third study highlights the relationship between a history of abuse and alcohol use as predictors of more intense psychological suffering during adolescent pregnancy. According to this study, more than half of pregnant adolescents in this context have experiences or a history of abuse. [3]

The literature on pregnancy-related suicide points to risk factors such as a history of abuse, intimate partner violence, and associations with mental disorders during gestation. Studies indicate that suicidal ideation is more common in pregnant women than in the general population.[14] It is estimated that one-quarter of pregnant women attempt suicide, with 33% of these cases linked to depressive disorders. [25]

The risks of suicide during gestation peak before or after childbirth. While suicide attempts during pregnancy are less frequent compared to the general population, the proportion of suicidal ideation is higher. Pregnant women with a history of abuse are less responsive to treatments and often resort to more painful and lethal methods, likely due to familiarity with pain and diminished fear of death. This underscores the importance of adequate psychological assessment during pregnancy.[14]

Ectopic pregnancy (EP) is characterized by pregnancies in which the egg develops outside the uterus, having negative impacts on the health of both fetus and mother. Pregnant women who have experienced EP often go through trauma, changes in self-perception, and insecurity regarding future pregnancies. All these factors are related to an increased risk of suicide. Authors report that risk factors for suicide in pregnant women include disorders such as depression, anxiety, thoughts related to abortion, and absence of partners. A study conducted at the largest university hospital in Brazil, in São Paulo, confirmed hypotheses that the psychological distress resulting from an EP diagnosis increases the likelihood of depression. [25]

Research in South Africa, the eighth country with the highest suicide rates and significant HIV prevalence, established that pregnant women infected with HIV are more likely to experience suicidal ideation. Contributing factors include intimate partner violence (IPV), with approximately 33.2% of pregnant women infected with HIV and reporting suicidal thoughts having experienced such violence, alongside the stigma associated with HIV in the community. Feelings of isolation and being a burden to the family are also common factors that, when combined with the previous elements, increase the risk of suicide among pregnant women.[14]

In a second study conducted in the same country, the relationship between the stigma associated with the HIV-positive population, including pregnant women, and the feelings of shame and rejection they face was confirmed. However, this study noted that while social support is a predictor of improvements in the quality of life of pregnant women, its relationship with stigma was not positive. This suggests that social support alone is often insufficient when confronted with the negative stigma of

the disease. Data indicate that the prevalence of negative stigma is often associated with more vulnerable communities and higher levels of poverty.[26]

In another study conducted in Tanzania, 39% of HIV-positive women reported suicidal ideation during pregnancy, with associations consistent with previous data. It was observed that this rate tends to decrease in the postpartum period, and the marital status of pregnant women is related to suicidal ideation, with women in relationships showing less intense symptoms. Additionally, women experiencing more severe episodes are more likely to report suicidal thoughts.[27]

While there are associations between suicidal ideation and gestational depression, studies indicate that this relationship is not mandatory, and suicide is linked to various mental disorders. Social support is once again identified as a protective factor against the severity of symptoms. However, in cases of HIV, not all women feel comfortable sharing their condition with family, which leads to an increased feeling of isolation.[14] Another study in South Africa suggests that having an infected baby may be a protective factor, fostering a sense of belonging in women after childbirth.[28]

According to Di Florio,[29] in women with bipolar disorder, it is necessary to consider all previous episodes before pregnancy, not just the most severe ones. Studies indicate that, even if there are no difficulties during the first pregnancy, one-third of women experience some type of bipolar episode during a second pregnancy.

The analyzed publications highlight that the mother's perception of her own health issues during pregnancy or those of the baby is closely linked to the intensity of psychological distress experienced. When this occurs, women tend to exhibit heightened feelings of stress and anxiety, which may trigger perinatal depression throughout the pregnancy and potentially extend into the postpartum period if not properly treated.[4] In these cases, it is common for women to mourn the loss of experiencing a pregnancy that meets her expectations, which can intensify symptoms if she feels like her needs are unmet or lacks necessary support.[30].

CONCLUSION

High-risk pregnancy is defined as one in which the life or health of the mother and/or fetus and/or newborn has a higher likelihood of being affected compared to that of the general population. Psychological distress encompasses a range of symptoms and internal experiences that are often disturbing, confusing, and out of the ordinary. This study aimed to analyze the manifestation of psychological distress in high-risk pregnancies through a literature review.

The publications reviewed indicate that the mother's perception of her own health issues during pregnancy or of the baby's health is closely linked to the intensity of psychological distress experienced. Stress factors, such as anxiety and depression, when not adequately addressed, may become pathological. A history of abuse, alcohol use, abortion-related thoughts, and absence of partners are also considered predictors of elevated psychological distress. Feelings of fear and constant concerns regarding the diagnosis are common, as are experiences of grief due to not having the ideal pregnancy.

The period of high-risk pregnancy with the most significant psychological distress, according to the majority of results, is the first trimester, with intensified feelings after receiving a high-risk pregnancy diagnosis. However, there is no complete consensus among authors, as some studies identify the third trimester as the period with the highest distress in pregnant women. This variation may be explained by differences in study themes, with those identifying higher prevalence in the third trimester focusing on suicide and gestational diabetes.

Health promotion in high-risk pregnancies is essential to reduce complications and improve the quality of life of pregnant women, addressing not only disease prevention but also physical, emotional, and psychological well-being. High-risk pregnant women face mental health challenges, such as stress, anxiety, and depression, exacerbated by complications like gestational diabetes and hypertension. The implementation of health strategies, including regular follow-ups, education, and psychological support, can decrease maternal anxiety, increase treatment adherence, and reduce complications. Additionally, these actions yield social and economic benefits, such as lower hospital costs, and should prioritize comprehensive care by considering the pregnant woman's social and psychological context to ensure a healthy pregnancy.[6]

This study contributes to understanding psychological distress in high-risk pregnant women, highlighting the importance of early intervention by multidisciplinary teams and the implementation of care strategies with adequate psychological support. Evidence suggests that integrating psychological care from the beginning of prenatal care is essential, particularly for pregnant women with psychosocial risk factors. This requires greater training for healthcare professionals to identify signs of emotional distress, such as anxiety and depression. Integrating psychological support for pregnant adolescents and those in socially vulnerable situations is also crucial. The adoption of social and psychological support programs aligned with obstetric care can reduce gestational complications and improve maternal and neonatal health outcomes.

The study's limitations include the reduced number of studies available for review, based on the inclusion criteria, as well as the bias of self-reporting. Despite the considerable number of studies related to the topic, psychological distress in high-risk pregnancies remains a somewhat underexplored area and is often linked to psychological disorders.

As a recommendation from this study, we emphasize the importance of research on psychological distress in high-risk pregnant women, linking medical conditions to psychological disorders beyond depression, as fewer articles were found on this topic. Another recommendation includes investigating the subject in relation to teenage pregnancy, which, although a recurrent topic, still has limited studies available.

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