Puerperal depression

A study of predictive factors

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ATTITUDES to pregnancy and childbirth vary from country to country, and in our culture in the past much ill-health has been accepted as the parturient woman's lot. Doctors and public have glibly described symptoms of depression as being normal at this time. Psychiatrists also, seem to confirm the public's suspicion that they deal only in madness, and they do not seem to have been particularly concerned with unpleasant symptoms that were not dramatic and did not necessitate the patient's admission to hospital.

Recently, Nillson and others[1] in Sweden carried out an investigation in which they asked puerperal mothers about various symptoms connected with puerperal illness. They found that 25 per cent had six symptoms or more. There was a significant correlation between the frequency of symptoms and postpartum gynaecological aberrations. The previous history of spontaneous abortion was significant, and depressive symptoms in pregnancy associated with a puerperal depression indicated a poor prognosis. This paper was in keeping with our own investigation as we felt that a mother only had to have one unpleasant symptom to feel unwell in herself, and, moreover, this could affect the whole family.

The symptoms on which we based our diagnosis were crying, discontent, disturbed sleep, loss of appetite, loss of interest, obsessional ruminations, restlessness, sadness, self-accusation, tension, and tiredness.

Method

The general practitioners and the psychiatrist who carried out the investigation had all taken part in educational discussion groups, similar to those described by Balint.[2] The general practitioners had therefore more than the usual interest in psychiatry, and had studied relevant aspects of the subject for some years. They also knew most of their patients well, and in giving them antenatal care were able to spend a considerable amount of time with them.

Although, for the investigation, unselected consecutive patients were taken, priority had to be given to clinical care. There were 112 patients in the series and the enquiry was extensive because so little was known about the frequency of psychiatric symptoms in the puerperium, or their aetiology.

The interview was conducted in each doctor's own manner and the order in which

the information was obtained varied from doctor to doctor and from patient to patient. Conformity was obtained by regular discussions throughout the survey.

In addition to the standard antenatal information, attention was paid to specific emotional factors, elicited throughout the pregnancy and supplemented by a long interview at, or about, the fourth month, that is, at the second antenatal consultation.

Among the factors recorded were:

The patient's attitude to the pregnancy, birth and increased family responsibilities.

The relationship with the husband and his attitude to the birth.

Previous sexual problems; however, no satisfactory way of statistically assessing the importance of these was found.

The relationship of the patient to her parents now, and as a child; and her relationship to her husband's parents.

A history of neurotic traits, shyness, stuttering, blushing, excessive minor sickness, phobias, tantrums, sleep-walking, excessive food-fads, overobedience, nail-biting, enuresis.

External stress: The absence of the husband at the time of the birth, finance, housing, a large family, relatives in the house, and physical illness were among the factors considered. The definition of husband away from home was that he should not be available for support both emotionally and physically.

Birth abnormalities: Any complication of the birth, which might affect the mother's experience adversely.

Antenatal examinations were made as necessary and findings finally tabulated according to trimesters. Postnatal psychiatric assessments were made at 10 to 14 days, six weeks and three months. A social worker was responsible for the three-month assessment and she also visited all patients delivered in hospital within two days of the birth. In addition to estimating any symptoms that the patient might have, she also assessed the mother's attitude to the baby.

Results of investigation

The 13 symptoms which were considered important in relation to puerperal depression have already been listed.

Twenty-six patients (23 per cent) of our series of 112 mothers had three or more symptoms during the three-month postnatal period, while a further 33 (29 per cent) had one or two symptoms. Several of the factors assessed during the pregnancy appeared to be related to those patients having three or more symptoms (the 23 per cent), but there was no statistical correlation between these factors and the patients with one or two symptoms only (the 29 per cent). When patients with any symptoms at all were considered, tiredness was found to be the most frequent symptom, being present in 33 of our series, tension was next and was present in 24, and crying third, being present in twenty-one. The symptoms in order of frequency were:

Tiredness	33	Disturbed sleep	11
Tension	24	Discontent	10
Crying	21	Loss of appetite	7
Lack of response	15	Self-accusation	6
Misery	15	Loss of interest	6
Sadness	12	Obsessional ruminations	5
Restlessness	12		

Recovery rates

Fourteen patients became depressed in the first two weeks and by the time of the second examination six weeks after the birth, seven more had become depressed while ten had recovered. By the end of the three months, five more had become depressed and a further ten had recovered. Treatment given to these patients was not classified and did not form part of the investigation.

Factors of statistical significance by the X^2 test were found to be:

Low tolerance to suffering at previous birth

Low tolerance to suffering associated with dysmenorrhoea

Husband away at time of birth

An ambivalent attitude towards, or an inability to accept, the pregnancy, in the middle trimester.

Low tolerance to suffering associated with previous birth or dysmenorrhoea could be interpreted as an absence of pleasurable anticipation of the event, thus making a depressive reaction more likely. If it can be assumed that the reaction of depression can be precipitated by the loss of a love-object and loneliness, the absence of the husband at the time of the birth would be an understandably significant experience.

It should be noted that attitudes in the first and third trimesters were not significant. Neither were the mothers' attitudes to the birth, except where conditioned by adverse experience, nor the idea of an increased family with the added responsibility. Possibly, most women had got over their immediate reactions of the first three months, and the movement of the foetus in utero may well have produced a more realistic attitude. Also they would not have reached the euphoric stage towards the latter part of pregnancy.

We should like to stress that all these four factors could be assessed easily and objectively by the family doctor in the course of antenatal care; and were they to be confirmed by investigation of a larger population, observation of them could be incorporated into the standard antenatal examination without much extra time or effort.

Factors of doubtful significance

The following factors appeared to be important but the numbers involved were too small for statistical treatment:

Troubled by "old wives' tales"
Abnormal birth
Five or more neurotic traits

A sensitivity to "old wives' tales" could denote a basic insecurity and reliance on a superstitious way of thinking and type of belief.

Abnormalities of birth have been mentioned from time to time as being important precipitating factors especially before the days of antibiotics when they were of physical importance. If they are indeed important nowadays it will be because of the general and psychological stress that they cause.

With regard to neuroticism, it was interesting that several patients who might have been considered unstable in this way did not suffer from puerperal depressive symptoms.

During the investigation, although information about sexual problems was not obtained in a manner suitable for statistical evaluation, there was a strong clinical impression that mothers with symptoms of puerperal depression had had such problems prior to their pregnancy. Similarly, on a clinical basis, it was a common finding that a patient referred to outpatients with puerperal depression had had a poor childhood relationship with mother, although abnormality of this relationship was not found to have any statistical significance in this investigation.

Factors not significant

The following factors were not found to be significant:

Age
Marital status
Previous marriage
Number of full-term pregnancies
Miscarriages
Patient's attitude to birth
Patient's attitude to increased family responsibility
Husband's attitude to baby
Patient's relationship to husband
Relationship of mother to patient
Relationship of father to patient
Physical separation from father in childhood
Relationship of patient to mother-in-law
History of previous psychiatric illness
Personality (clinical assessment)
Intelligence (clinical assessment)

Unexpectedly, a history of previous psychiatric illness was not significant. In the past a connection between previous psychiatric illness and puerperal depression had been noted but only among inpatients who presumably were more seriously ill, and

included schizophrenic patients[3]. Personality type was not significant, but our assessment was superficial. A negative relationship with the husband was found in 22 per cent of women, though this was not associated with depression.

Finally, one wonders what effect the doctors have on pregnant women by making special patients of them; and it should be noted that these mothers did not complain of their depression in the ordinary way. It is well known that patients with depression frequently do not complain of it, and in this context the meaning of the word 'patient' probably needs reassessment.

Many of the mothers enjoyed their part in the investigation and we do not know if the extra care and the opportunity for more personal contact with the doctor helped them or not.

Summary

The purpose of this investigation was to determine the extent to which general practitioners trained in psychiatry could predict puerperal depression from features presenting in their patients during the antenatal period; and to set out such features as may be easily assessed by any general practitioner in the course of standard antenatal care.

112 patients were investigated in detail by three general practitioners and followed up during the puerperium when three further examinations were made. The last, three months after the birth, was carried out by a social worker in psychiatry. Depression was assessed according to symptoms, rather than by syndromes, and of 13 symptoms, three or more were present in 26 patients during the puerperium. The following factors were found to be significant according to the X^2 test—

Husband away from home at the time of the birth
Low tolerance to suffering as indicated by attitude to dysmenorrhoea
Low tolerance to suffering at previous birth
An ambivalent attitude towards, or an inability to accept the pregnancy, during the second trimester.

Other factors such as five or more neurotic traits, abnormalities of the birth process, and sensitivity to "old wives' tales" were considered to be of doubtful significance because the group investigated was too small.

In view of the limited number of patients and recorders, the investigation should be regarded as a pilot study. It is hoped to pursue it with a larger number of recorders at an early date.

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