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# PSYCHOSES RELATED TO CHILDBIRTH

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# INTRODUCTION

Since the time of Hippocrates, physicians have been impressed by the occurrence of mental illness which appeared to be closely related to childbirth. This is the so-called puerperal or post partum psychosis. Investigators such as McIlroy (1) have reported that these psychoses may account for as high as 10% of female mental illness. This problem takes on even greater significance when the psychological, social, and economic aspects of an abnormal early mother-child relationship are considered.

Therefore it is the purpose of this thesis to review the literature on the psychoses related to childbirth in order that some conclusions may be drawn regarding what is known about the subject and what remains to be determined. A study will be made of the mental pathology and etiological factors involved including premorbid personality development and psychodynamics. Prophylactic measures will also be discussed. Two cases will be presented typifying many of the factors involved.

## HISTORY OF PSYCHOSES RELATED TO CHILDBIRTH

Hippocrates, according to McIlroy (1), was among those early medical authors who described mental illness of the puerperium. In Hippocrates time bleeding from the mothers nipple was thought to be a sign of impending mania. Mental illness was considered to be caused by suppressed breast milk mis-directed to the brain or similarly caused by suppressed local discharges.

Zilboorg (2) also mentions that Celsus, Galen, and Soranus, the leading obstretrician-gynecologist of ancient times, all described pathological mental changes related to childbirth.

In 1847 James Macdonald (3) presented a study of sixty-six cases of mental disorders occuring during pregnancy, parturition, and lactation from among patients at Bloomingdale Hospital. He refuted the theory of suppression of breast milk and of its metastases to the brain and other parts of the body as a cause of puerperal insanity, by noting that no milk had been found in the abdominal cavity or cranium on post mortum examination. However, he subscribed to the theory that milk diathesis during lactation or some effect from the reproductive organs was responsible for the reactions. Macdonald also stated his theory that disturbed uterine function might be responsible for the obscene ideas expressed by puerperal psychotics. He felt that this characteristic

obscenity along with the intensity of mental excitement and excessive incoherence could be observed to distinguish puerperal from other psychoses. He discussed treatment by blood letting to relieve cerebral congestion, emetics, warm baths, wine, emmenogoges and sedatives.

Smalldon (4) relates that Marce (5), who wrote a book in 1856 in which puerperal psychoses was discussed, was among the first to conclude that these psychoses are in no way specific but that any form of insanity might occur in the puerperal period. Geoffery Clark (6) demonstrated this change in trend of thought toward puerperal psychoses when he wrote in 1913 that, "A decade ago most of the text books on insanity and midwifery described the mental disorders associated with reproduction as though they were entirely different diseases from those occurring apart from childbirth. Today the pendulum has swung to the other extreme, and many of the more modern text books do not devote even a short chapter to the so-called puerperal insanity, but they give pregnancy, childbirth and lactation as exciting or associated causes in many of the various forms of insanity, which they describe in detail." No further specific references will be made to this

period of transition in attitude toward puerperal psychiatric disturbance other than to mention Boyd's (7) statement that the literature from 1900 to 1915 was concerned with demonstrating that puerperal psychosis was not a specific entity and reclassifying it according to regular psychiatric disorders.

During the last fifty years the trend has been to consider puerperal or post partum psychotic reactions not at all different from the ordinary types of psychiatric disturbances except that they occurred in close sequence to the act of child birth and that child birth was a precepitating psychological and, or, physiological stress factor, and nothing more. Among noted exceptions to this trend are the observations and conclusions of Linn (8) who presented the argument in 1941 that certain post partum psychoses are apparently a homogeneous clinical entity. Hemphill (9) has also stated recently that certain post partum depressions appear to be clinical entities similar to involutional melancholia and also that puerperal schizophrenia seems to differ from regular schizophrenia in its greater resistance to therapy.

The incidence of psychiatric disturbances associated with childbirth is somewhat variable according to studies reported to date. This is undoubtedly due to differences in communities and types of institutions where the study takes place as well as variability in criteria for choosing case material and the changing concepts inherent in the swiftly growing field of psychiatry.

Clark (6) reported that about 5% of female psychoses fell in the post partum group in his study of cases at London county asylum in 1913. In 1928 Zilboorg (2) tabulated the reports of a number of observers including Macdonald. He found that about 8.7% of female psychoses were related to pregnancy, puerperium, or lactation. 40% to 86% occurred in the puerperium as such, 3% to 23% in gestation and 6% to 45% in the lactation period. McIlroy (1) reported 10% of female psychoses to be puerperal from his studies in 1928. Smalldon (4) found about 8% of female admissions for mental illness were associated with childbirth and the puerperium in his study of 220 cases from 1922 to 1938. Brew and Seidenberg (10) reported a smaller incidence of 3.0% pregnancy and post partum psychoses in a study of female admissions to Syracuse Psychiatric Hospital from 1933 to 1946.

Karnash and Hope (11) plotted cases of post partum psychoses against total number of births at various Hospitals in Cleveland from 1927 to 1937. They found a high degree of variability from year to year. The chances of any expectant mother developing a post partum psychosis varied from 1:458 to 1:1370. Hemphill (9) in a comparable study of 81,000 deliveries in Bristol reported an incidence of psychiatric disturbances of 1.4:1000. This constitutes a somewhat lower incidence than that reported by Boyd (7) who, in 1942, surmised from the literature and his own observations, that the expected ratio of psychotic reactions to deliveries would be about 1:400. It appears that further studies on incidence will be of interest.

## CLASSIFICATION AND MANIFESTATIONS OF MENTAL PATHOLOGY

There is considerable variation found in the literature on the classification of types of psychoses related to childbirth.

In a study of 72 admissions to Bloomingdale Hospital from 1911 to 1923, Kilpatric and Tiebout (12) classified their cases as 32% deleria (about one half of which had demonstrable toxic factors), 50% manic depressive, 14% dementia praecox (all paranoid) and 4% psychoneurotic. It was noted that the duration of the toxic cases was longer than expected, indicating that other factors might be involved besides purely those of toxicity.

This study at Bloomingdale was followed by that of Smalldon (4) in which 220 cases were observed from 1922 to 1938. These cases were listed as 107 manic depressive, 64 dementia praecox, 1 paranoid, 8 toxic exhaustive, 28 psychoneuroses, 10 psychoses with psychopathic personality, and 2 psychopathic personality.

Smalldon calls attention to the fact that 3.6% were attributed to toxic and infectious cause and that most of these were diagnosed thus in the early part of the series. This may indicate a tendency to consider physical factors of less importance in the etiology of post portum psychoses as well as indicate better medical care.

In regard to manifestations, overt or disguised hostility toward the child was reported by Smalldon in over 70% of manic depressives. These patients may talk of hate for the child or insist that it belongs to someone else. They often fear it has been or will be harmed. A few attempted infanticide, sticking with pins, choking, deserting, and refusing to nurse the infant. Frank indifference was shown in nearly half the cases. Seventy-five per cent showed hostility to the husband ranging from indifference to attempted homocide. Some denied marriage and some feared for the safety of the husband. One half of the depressive cases showed ambivalence toward themselves, their husband, or child.

Smalldon did not find hostility toward the child more frequent in depressives than in manics or schizophrenics as did Zilboorg (13) in his earlier study. Also in contrast to Zilboorg's findings (which will be discussed further in the consideration of psychodynamics) Smalldon found that overt incest desires and homosexuality were noted in less than one tenth of the cases. He did find chronic masturbation to be rather frequent, however.

In contrast to Smalldon's findings, Davidson (14) found infanticide ideas much more common in depressives than manics. He described the ideation of the manic post partum psychotic patient as that of delusions of grandeur, usually showing rejection of the husband. These patients may show feelings that the husband is socially and biologically inferior by delusions of marrying some important person.

Schizophrenics are different, according to Davidson, in that they commonly show a bizarre rejection of the entire marital situation by producing delusions of virginity, that they are the Holy Virgin, etc. Infanticide attempts are also common in schizophrenia, he states.

In the classification of their 50 cases in 1926 Strecker and Ebaugh (15) found 18 manic depressives, 13 dementia praecos, 17 psychotic with somatic disease, one paresis and one neurosis.

One of the first studies in which more schzophrenic than manic depressive cases were noted was that of Brew & Seidenberg (10) in 1950. In their series of 103 cases 51.8% were schizophrenic (dementia praecox) and of these over half were of the catatonic type. Manic depressives accounted for 42% (half manic and half depressive), and 7% were toxic delirium cases.

In 1952 McNair (16) described 34 cases of post partum psychosis in which admission to a psychiatric hospital had taken place within one year following delivery. These were cases of the first mental illness with absent prenatal symptoms. All of these were classified schizo-affective. However, some had been treated as catatonic schizophrenia when first evaluated.

McNair reported a high frequency of auditory hallucinations and delusions of death and that the end of the world was at hand. These patients appeared to live in a pseudo-community of unfriendly people. Many feared the husband would leave or that their place would be taken by someone else. Fears that the child would be abnormal or die accompanied by expressions of guilt and selfblame were common. Other symptoms, aside from suicide attempts, were the reenforcement of religious interests and statements of hostility toward themselves. The patients occasionally made erotic advances to their doctor and some expressed delusions that the doctor had fathered the child.

From the above mentioned references, it appears that there has been for a time a tendency to classify more of puerperal psychoses as functional entities and less as the toxic-infectious or exhaustive variety. The functional cases have been classed with the commonly

accepted categories of psychiatric disturbances.

There have been some noted exceptions to this tendency. Linn (8) in 1940 presented an argument for the classification of certain cases of post partum psychosis, typically occurring within a two week period following delivery, into a homogeneous clinical group. He stated, however, that more knowledge of the etiology of the disease would be needed before this point could be determined finally.

Victoroff (17) in his study in 1952 presents his views somewhat differently. He considers post partum ("parapartum" as he chooses to term it) psychoses as a clinical entity with a definite onset and course and with a variable outcome. His patients were described as falling into certain symptom categories represented as those depressed, phobic schizophrenic, hypochondriacal, obsessive-compulsive, and various combinations. He believes the division between psychosis, delerium, neurosis, and psychopathy were so blurred that "reaction" should be substituted for "psychoses".

Victoroff noted in his study that the most frequent symptoms shown by a majority of patients were expressions of inadequacy in the care of the child, expressions of guilt and self condemnation, severe

depression, apathy, and withdrawal. Overt rejection of the child was shown in 38 of 55 cases, 33 of which showed strong aversion. Slow identification with the child along with suicidal impulses or attempts were noted in 34 of 55 cases. Only 20 showed strong homocidal feelings.

Victoroff concludes that <u>not all signs of over solicitude are signs of hostility in disguise</u> but that some represent feelings of insufficiency.

As previously mentioned, Hemphill (9) has come to hold the opinion that there are clinical entities, the puerperal depression, and a certain type of schizophrenia, which are specific post partum reactions.

It now appears that some investigators are returning to a tendency to consider certain post partum reactions as clinical entities. This problem will be touched upon again as etiological factors are discussed.

## ETIOLOGY

In 1913, Clark (6) stated that the cause of post partum psychoses was failure of the mind to adapt, except in the toxic type of condition. This was one of the first evidences of the psychodynamic approach to be noted in the literature.

Perhaps Zilboorg (2-13-18) is the investigator who has done more than any other to demonstrate the dynamics involved in post partum psychoses.

In his study of dynamics Zilboorg (18) stated that there are schizophrenias definitely related to childbirth, which are slow in developing. Thus their relationship is often overlooked. He stated that depressions combined with suicidal and homocidal trends develop more slowly. These reactions differ in no basic way from other psychoses. Patients developing post partum schizophrenia are often, if not usually, in their 30's and have marked schizoid premorbid personality traits. They are chronic masturbators and are sexually frigid. Usually they are potentially homosexual, although these tendencies do not become overt until the psychosis is fully developed.

This, Zilboorg explains, is due to the carrying over of anal libidinous attitudes or being arrested in what Freud terms the phalic stage of psychosexual development. He also believes that these patients have clung to the Oedipus situation subconsciously and that this is also interwoven with the desire to be male or to identify with the father. It can be demonstrated psychoanalytically that these patients have a severe "penis envy" combined with sadistic tendencies toward men. They identify in part perhaps to try to replace the father figure but retain a feeling of revengefulness toward men. Thus they tend to avoid men and marry late under social pressure and after a long courtship.

Zilboorg goes on to say most of the women are consistently frigid until just before the onset of the psychosis which occurs after the birth of the first, or more likely, a second or later child. At this time these women may become interested in sex and have orgasm for the first time. After this they typically become antagonistic toward their husbands and may even attack their husbands genitals demonstrating their penis envy as the psychosis progresses.

Zilboorg notes that these psychoses occur most often in a multipara who has given birth 3 to 10 years previously and who has shown a withdrawl from domestic interests and an attempt to assume a more masculine role in the meantime. Dynamically these patients do not reveal much of a sense of guilt but subconciously consider themselves already punished for their sinful Oedipus strivings by not having the male organ. These women are basically narcissistic in their personality structure since the female castration complex combined with regressive father identification represents the basic psychodynamics.

Zilboorg states that the act of childbirth is more important in the development of the psychosis as evidenced by the finding that 40-80% of reactions occur in the puerperium, the remainder being left to the pregnancy and lactation periods. This may be explained by the postulations that the child during pregnancy may represent the incarnation of the penis subconciously. Thus childbirth becomes a narcisstic injury and in the typical post partum schizophrenia, the feeling toward the child is one of regret, not hatred or revengefulness. This feeling is compensated for by indifference toward the child. The activation of early infantile fanticies

of "anal child" result in the aversion toward the child which accounts for the delusions of the child being dead.

When mental symptoms develop just prior to childbirth, Zilboorg attributes these to the fact that the actual Oedipus situation is the most prominent feature and an unconcious sense of guilt, the pressure of which becomes very great as time of childbirth approaches. He notes that this is opposite from normal reactions in which most neurotic symptoms occur early in pregnancy and disappear later. The sense of guilt was noted in two of the cases studied where depressive tendencies were noted and where severe conscious or unconscious attachment to the father was noted.

Zilboorg concludes that the value of differentiating post partum schizophrenia from other schizophrenia lies in the possible criteria for estimating a womans "psycho-biological capacity" and applying mental hygiene before severe psychosis develops. He feels frigidity is very important as an indication or expression of many potential post partum neurotic psychotics psychodynamic constellations and may provide a prophylactic point of reference.

In discussing depressive reactions related to childbirth, Zilboorg (13) has stated his impression that

hostility against the child is the main point of the depression and that the hostility is often so unconscious that it breaks through in the form of over concern for the child. The denial that she was married or the claim that she conceived immaculately represents a flight from reality. Unlike schizophrenia the characteristics of post partum depressions are that the drive to masculinity is not as strong and patients are inbetween homosexuality and acceptance of femininity. They are usually only partly or transitorily frigid, are ambivalent toward marital partners, childbirth and themselves. "They vacillate constantly between love and hate and between submissiveness and aggressiveness".

Frumkes (19) has noted the frequency of the delusion of the baby being dead. In general he agrees with the dynamic factors described by Zilboorg and states that unresolved incestuous drives stand as a barrier to parenthood. Patients with these drives have often been pressed into marriage and develop mental disorders at the time when it would seem they are achieving identification with their parent of the same sex. They develop the mental disorder as a method of solving their conflict. They thus come to deny their children or marriage.

Some writers approaching the subject from a psychoanalytic point of view, perhaps in varying degree, have not been able to substantiate Zilboorg and Frumkes' findings entierly. Thus Anderson (20) working with 50 cases in 1933 found no material difference in pre-psychotic sexual life between puerperal and non puerperal psychoses. He did not find frigidity to be constant or distinctive or of any prognostic or anticipatory value as had Zilboorg. He found masturbation to be only slightly more common in post partum psychoses and also found no constancy in attitude toward the husband or child.

Davidson (14) in a study of 30 cases presented in 1936 was inclined to agree with Anderson. He found frigidity to be present but not particularly prominent in post portum psychoses. He found the age group to be lower than that of Zilboorg's study also, ranging from 16 to 28 years.

Smalldon (4) in his study of personality and dynamics found that 73% of manic depressives were extroverts. 68% of schizophrenics had been introverts. Hebophrenics were most introverted, paranoids were less, and catatonics least introverted.

In contrast to Zilboorgs work, Smalldon found less evidence of incest wishes and homosexuality and no evidence of the castration complex. He did find the schizoid personality with shyness, aloofness, long courtship, and late marriage in the background of post partum schizophrenics. He felt he could not completely verify that this background, plus persistant frigidity, represented a sign of impending psychoses. He found a constant antagonism toward the husband but little evidence that the patients become hypersexed for a short time before resuming post partum frigidity. He also found homosexuality to be rare and little or no evidence of assumption of the masculine role between pregnancies as Zilboorg had reported. He concluded that every case was an individual non-generalizable problem.

Some investigators have recently reported findings which are again more in agreement with Zilboorg on certain points. Among these are Brew and Seidenberg (10), who in their survey of cases at Syracuse Psychopathic Hospital from 1933 to 1946 found the average age to be 28.5 years. About half the patients were multiparas. 60% had abnormal premorbid personality patterns of schizoid, cycloid or unstable type. They found evidence of latent homosexuality in most cases, as had Zilboorg.

Linn and Poletin (21) in a study of 22 cases in 1950, stated the personality background was found to be predominantly that of schizoid, depressive, hysterical, phobic, or hypochondrical nature. All but 2 cases expressed varying degrees of dissatisfaction with the fact that they were women. They felt the latent homosexuality as described by Zilboorg was evident. Almost one half the cases in their series had previous incapacitating psychiatric illness. Nearly all the patients showed overt satisfaction with pregnancy and the authors warn that this apparent favorable attitude should not prevent prophylactic psychiatric treatment during pregnancy when the above mentioned findings are apparent.

McNair (16) in his analysis of 34 cases in 1952 found that the patients were regarded well by their associates but that they had "vulnerable personalities". In general they were dependent, challenged by their baby, and not emancipated from their parents. They showed an excessive need for love and had a naive trust in people to the point of gullibility. Their families had been over protective and the patients had felt subordinate in their relationships to one parent. There was an ambivalent reaction toward the rejecting, over critical parent and no warm

relationship with either parent. The family sometimes appeared to try to achieve increased status vicariously by use of the patient. The patients are over concerned with what people will think, are socially and morally perfectionistic and prudish. They use clothes to bolster low self concept and keep house immaculately. They have many sexual guilt feelings. These people usually marry older husbands and appear to seek a substitute parent. They are easily made jealous over the husband's other interests.

Victoroff (17), in his study of 55 cases, stated the findings that in 31 cases an inadequate father and dominant, rejecting mother was noted. The most characteristic personality traits were referable to weak ego structure with strong dependency patterns, inferior feelings, chronic nervous tension, and passivity. Twenty-two cases were impetuous, narcissistic and credulous. Thirty were obsessive-compulsive, perfectionistic, rigid and had low tolerance for personal failure. Along the line of Zilboorg's findings, twenty-four were found to have unresolved libidinal relations toward their father and the classic Electra complex. Nineteen showed repudiation of feminine goals, identification with masculine ideals and wish for the phallus on deep insight therapy.

Many of the patients felt guilty for failure in the role of being a female and for their inability to surrender the father ideal and accept the husband as the love object. Some patients may feel they are instruments from which neuropathic background from which they came will be passed on. Victoroff concludes that no aggregation of factors common to all patients could be isolated.

In recent years some interesting speculations and findings have been made on the physical factor which may be involved in puerperal psychoses.

Davidson (14) has reported two cases of autopsy findings in post partum psychosis cases. Masculine hair distribution, hypoplasia and dysplasia of the genitalia were noted in these cases along with evidence of damage to the reticulo-endothelial system. The ovaries were noted to show luteinization and conspicuous reduction in graafian follicles. Davidson noted that the findings were inconsistant and non specific, but felt that altered biochemical states with disturbance of neuro-physiological processes might be a large factor in the psychiatric disturbance. The changes in the ovaries might indicate hormonal changes which would alter the affective constellation of the patient.

Thus multiple factors would be involved in the development of the psychoses including mental conflict arising from discord of integration of the basic personality, neuro-endocrine and metabolic changes, along with dysfunction of the reticulo-endothelial system. The precipitating factor would be that of childbirth. Davidson uses theelin, antuitrin-s, and thyroid in the treatment of post partum psychoses along with other standard treatment.

In 1950 Roland (22) reported the successful treatment of 18 cases of post partum depression by giving alpha-estradiol benzoate. He noted that most of the cases had a delay in the return of menses and considered them not unlike a temporary menopausal syndrome.

Blumberg & Billig (23) report a case of post partum schizophrenia in which exacerbation of symptoms occurred during post-ovulation phase of the menstrual cycle. A sudden decrease of symptoms on the first day of menstruation or on the expected first day when menstruation did not occur was also noted. The authors felt that the hormonal change and degeneration of the placenta following parturition and exacerbation of symptoms in the post ovulatory phase of the menstrual cycle indicate that disturbed

endocrine ballance probably related to progesterone is an important basic factor. Progesterone seemed to complete recovery, which insulin shock would only partially produce or maintain recovery temporarily.

Along with this same trend of thinking concerning endocrine factors in post partum psychoses, Hemphill (9) in his study of the subject in 1952 states that he feels the basic factors are an acute alteration in the physiology and endocrinology associated with childbirth operating upon a susceptable personality. Certain cases with acute onset during the first 2 weeks following delivery are examples of this. Since there is certain evidence that E.C.T. and insulin therapy may work by endocrine changes he postulates that slow response of these patients to shock therapy may indicate underlying endocrine imbalances. He urges further research into this problem.

In regard to other etiological factors it has already been noted that cases classified as toxic infectious or exhaustive in etiology are declining in number.

Clark (6) formed the opinion from his study of 75 cases that toxic effects of septic conditions played a minor role in post partum psychoses. Although deliria occurs in sepsis, these reactions clear soon

when physical health is restored.

Harris (24) reports that toxic exhaustive reactions are like those occuring elsewhere and are noted within a few hours to a week following delivery. These patients show clouding of consciousness, confusion, disorientation, memory loss, and hallucinations. These reactions may or may not follow difficult labor, hemorrhage or infection. The ease with which these reactions develop may depend upon basic emotional stability, Harris believes. Yaskin (25) generalizes that if the cause is removed these organic types of reactions should quickly recover. If not, constitutional factors must be assumed responsible. The reader is referred to the work of Mac Googan (26) for detailed description of toxic cases.

In regard to situational or exciting factors, Ordway and MacIntire (27) suggest economic stress, incompatable marriage, undesired pregnancy, and feelings of inadequacy about motherhood as factors of importance.

Most authors tend to de-emphasize the importance of situational factors. Brew and Seidenberg (10) noted a drop in incidence during war years and stated there was no correlation with stress conditions.

Hemphill (9) concluded from his study that immediate psychological stress, physical illness, and

multiple births were of no significance in the production of mental reactions. Victoroff (17) describes various situational factors found in his case studies but concludes that no cases could be attributed to extensive situational factors alone.

PROPHYLAXIS

The problems of anticipation and prophylaxis are far from simple. Ideally, psychoanalytic and psychotherapeutic as well as medical and obstetrical care would be involved. The taking of psychiatric histories on obstetrical patients who show any evidence of personality traits of the type described by Zilboorg (2-13-18) and others, as noted in the discussion of personality and psychodynamics, might be of value. These findings will not be reiterated here in detail, but certain observations and suggestions of various investigators seem pertinent.

Boyd (7) thought that certain prodromal warning signs could be detected during gestation in his study of post partum psychoses in 1940. Among the things to be looked for were a change in attitude toward pregnancy or toward the husband, statements of envy of men, emotional instability, attempted abortion, increasing anxiety, suspiciousness, or sustained change in personality with withdrawl. He generalized that all of sexual life is culminated in pregnancy, and those patients having a mental conflict over moral issues and who may feel that sex is disgusting and immoral, even in marriage, develop an uncontrollable

shame and guilt in relation to childbirth. This sexual immaturity is probably an index of general emotional immaturity, Boyd believes, and evidence of it should be considered a warning sign.

Boyd also stated that probably no pregnancy should occur for 2 or 3 years following a post partum psychosis. The patients fears, ideas, religious beliefs, and physical health, as well as social and economic factors, must be considered in advising future pregnancy. Contraception may be used if the patient can and will co-operate intelligently. Sterilization may be used if there is too much fear of failure and if contraception is considered necessary.

In regard to other prophylactic measures, Boyd urges the promotion of better standards of mental hygiene in the community with a view toward developing better emotional maturity of future parents. He also emphasizes the necessity of including factors of psychiatric fitness and social, marital, and moral problems in the evaluation and care of the obstetrical patient as well as the need to take time to help the patient with her anxieties and fears about reproduction.

Linn and Palatin (21) emphasize that the first step in prophylaxis is case finding. They state that the basic personality is abnormal with shyness,

seclusiveness, frigidity, and a tendency to be negative, as prominent features. These women are rarely satisfied with the role of a housewife. Fifty per cent have had previous incapacitating psychiatric illness. The authors feel that patients having these characteristics should receive psychiatric therapy prenatally. An apparently favorable attitude toward the pregnancy should not be considered reason to neglect therapy.

Linn and Palatin (21) also note that analgesia may aggravate the tendency to illness by reducing the reality of the childbirth to the mother. Breast feeding may likewise be aggravating in susceptible patients because failure to feed the infant successfully may result in a psychologically traumatic effect.

Helene Deutch (28) in her book on the psychology of women has expressed the opinion that to best maintain the mental health of the mother and optimum mother-child relationships a technique of delivery is necessary in which the psychic value of the mother's active participation is taken into account. It is also important, she believes, to unite the mother and child as soon as possible after delivery.

Women put great trust in their obstetrician and become somewhat dependent upon him, Harris (24) points out in his discussion of prophylaxis. The obstetrician should take care to be straightforeward and truthful yet careful not to create fears and doubts in the mind of the patient. He should note fear and anxiety, and arrest these by frank discussion of the various aspects of pregnancy. Harris recommends the reading of Read's (29) Childbirth Without Fear for further reference. He concludes by emphasizing the wide social and economic implications of favorable mother-child relationships in our society.

## PRESENTATION OF CASES

The following case record is taken from the files of the Nebraska Psychiatric Institute.

Case #1

Mrs. V. H. is a 19 year old, white, married, Protestant housewife, the mother of one daughter.

Present Illness@ Sixteen days prior to admission the patient gave birth to a baby daughter. She had reported feeling "different" after the delivery but her course had been uneventful on the obstetrical ward except for a low grade post partum infection. Upon returning home the patient had great difficulty adjusting to her family and caring for her baby. She could not nurse the baby and required help in it's other care. She showed excessive variations of activity and expressed much concern over the delivery and the anesthesia she had undergone. She expressed ideas that she had committed great sins and was going to be severely punished. She was stuporous upon admission.

Personal History: The patients father was apparently a quiet man with little interest in his family and little was heard about him or from him. Her mother was described as an ailing, demanding, agressive person with many difficulties the blame for which she readily projected onto others. She wondered whose fault it was that the patient was sick. The mother described the patient as a "bad girl" who had been contrary to everyone. She stated the patient had gotten her own way too much, had read too many pocket novels and run around with too many teen-agers. She also thought the patient had too much interest in sex and had gotten married too young. The patient had been incontinent while in her catatonic stupor and her mother seemed unable to understand this and was quite intolerant of it.

The patient was described as a nervous child, shy even in her own home. She engaged in thumb sucking until the age of 10, at which time she substituted gum chewing. Her social adjustment at school was reported to be very poor but she did have some friends in the later years.

The patient had 2 older brothers and an older sister. The patient was reported to have felt dominated by the sister and to have been quite close

to one of the older brothers. She had felt guilty over things she thought she should have done for this brother.

There was no history of premarital sexual relations and the marital adjustment was apparently satisfactory. The patient was married at 16 years of age.

Psychiatric examination: At the time of admission the patient was described as being in a catatonic stupor. She also appeared ill, had a low fever, a low grade post partum infection and was mildly dehydrated. (These physical abnormalities cleared rapidly with medical therapy.) Under amytal interview the patient expressed feelings of guilt about being a bad patient, not eating and not talking. She also expressed self blame for not having done things she should have at home and for feeling mean toward her family. She thought her brother's eyes had been shot out and he might die and that she was to blame. She also thought her parents were possibly dead, her husband dead or severly injured, and that she was going to be punished for her deeds.

The patient was alert to people around her but misidentified people, was not sure where she was and spoke of hearing voices. She believed she had "germs" or that something was wrong so that no one could possibly wish any thing to do with her.

When she began to come out of her catatonic stupor the patient looked around and walked very slowly. She was rigid and inhibited in her movements and her mood was very depressed. Physical, neurological, and laboratory examinations were negative except for a

mild subinvolution of the uterus and a small amount of lacteal discharge.

<u>Course and Treatment:</u> The patient slowly improved to her premorbid level of adjustment under symptomatic physical treatment and occupational, recreational and psychotherapy. She was dismissed 2 months and 10 days after admission.

<u>Diagnosis:</u> Post partum catatonic schizophrenia. On a 2½ year follow up the patient was found to be adequately adjusted socially and had just completed another pregnancy without signs of mental illness.

This case is clearly a catatonic schizophrenia occurring early in the puerperal period. However, it is easy to see how the presence of fever, post partum infection and dehydration could have lead to the consideration of toxic or exhaustive factors as the primary cause of illness by early investigators. In fact it is difficult for us to determine how important these physical findings are in regard to onset of the psychosis even now. We must be guided by our knowledge of the past history and personality make up of the patient and by the course of the illness and the symptoms of mental disease.

The difficulty in caring for the baby reminds one of the frequency of such inadequacy pointed out by Victoroff. The common expressions of guilt and self condemnation are noted here along with delusions of death among loved ones and the fear of injury or death overtaking the husband. The common findings of hostility toward the child expressed otherwise than perhaps by indifference are absent here, and there is no evidence of homosexuality, or homocidal or suicidal tendencies.

This patient does not show the traits of late marriage after a long courtship which were pointed out by Zilboorg. However, the shyness of the patient throughout childhood and the poor social adjustment in school indicate that the basic personality was probably of the typical schizoid variety. No information is available in regard to the psycho-sexual development and frigidity would probably have been uncovered in the history had it existed.

The description of the mother as aggressive, demanding, and quick to blame others suggests the description of parental attitudes found to be commonly present by McNair and Victoroff. The latter emphasized the frequency of an inadequate father and dominant, rejecting mother. Such a family background seems to

be definitely indicated by this case history. Prophylaxis in this case would have been difficult without a more detailed history of personality development. It can only be speculated that a careful inquiry into the childhood social adjustment, the family relationships, and attitudes toward sex would have given an indication of basic personality defect.

The concern the patient demonstrated about the anesthetic, the delivery, and the difficulty in breast feeding call to mind the remarks of Linn and Polatin. If the anesthesia had been a minimum and carefully administered in such a manner as to best maintain a sense of reality of the birth to the mother, it might have been of prophylactic value. As Helene Deutch pointed out there is psychic value in the active participation of the mother. In such a case, guarding against the added discouragement of failure at breast feeding would also be of prophylactic value.

Case #2

The following case record is taken from the files of Lutheran Hospital, Omaha, Nebraska.

Mrs. M. R. is a 27 year old, white, married housewife.

<u>Present Illness</u>: The patient was admitted to the hospital about 10 days after the birth of her first child with complaints of being depressed, frequent crying, lack of interest in life about her and lack of self confidence. She feared she was going to lose her mind and that she did not really love the baby. She had noted loss of appetite and loss of sleep with early morning awakening. She had self depreciatory suicidal thoughts.

<u>Past History</u>: The patient had married at 25 after a one year courtship.

The patient had felt babied by her father and dominated by her mother. She had done well in school. She had had a previous nervous breakdown following her engagement to a domineering man sometime prior to her marriage.

The patient had apparently made a good adjustment in marriage except that she feared getting pregnant too soon (even 4 months) after marriage because of what her mother and the townspeople might think.

The patient was reported to not have had sexual climaxes.

She was quite particular about her housework. She seemed to need much attention and love but showed neither hostility or affection very easily.

Diagnosis: Post partum depression.

The foregoing case is not a major psychotic reaction but this post partum depression clearly demonstrates some of the typical ideation and pre-morbid personality traits found in these and more severe disturbances.

The self depreciatory and suicidal thoughts along with the fear of not really loving her baby are again typical of the ideation of post partum reactions as described by Zilboorg, Smalldon, and Victoroff. This calls to mind Zilboorg's impression that hostility toward the child is the main point of the depression and that the hostility is often so unconscious that it breaks through as over concern for the child. This patient appears to be more nearly aware of her true feelings but they are so unacceptable to her that depression results. Again we find mention of a dominating mother and an indulgent, perhaps inadequate father.

The outstanding premorbid personality trait of this patient is her obvious inability to accept ordinary sexuality in herself and perhaps in others. This is demonstrated clearly in her unreasonable fear of criticism for becoming pregnant as late as four months after marriage and her reported frigidity. If this material along with the history of a previous nervous breakdown could have been obtained by the obstetrician and psychotherapeutic measures taken during gestation it is not unreasonable to assume that this patient's illness might have been prevented and that she could have become a much better adjusted, more adequate wife and mother.

# SUMMARY

A review of the literature on the psychoses related to childbirth has been presented in order that some conclusions might be drawn as to what is known and what remains to be determined about the subject.

A short discussion of the history of these psychoses has been presented along with reports by various authors on the incidence of the illness.

The mental pathology has been discussed including the classifications of the psychoses and the signs, symptoms and ideation of the manifest disease.

Under etiological factors premorbid personality and psychodynamics have been stressed, and a brief discussion of physiological and situational factors has been presented.

Some suggestions regarding prophylaxis have been presented. These are based upon the factors revealed in the discussion of etiology and also upon the reports by various authors in the literature.

Cases have been presented demonstrating some of the factors involved in the mental pathology, etiology and prophylaxis of psychoses related to childbirth.

## CONCLUSIONS

1. Incidence of psychoses related to childbirth ranges from 3.09% to 10% of all female psychoses.

2. The chances of a pregnant patient developing a post partum psychoses lies some place between 1 to 400 and 1 to 1370.

3. Post partum psychoses should probably not be considered a disease entity.

4. Reports on the frequency of the various classes of post partum psychoses are variable and no definite conclusions can be drawn at present. Recent studies indicate schizophrenic and schizo-affective cases may be in the majority.

5. The following signs, symptoms, and ideations appear most frequently as manifestations of these psychoses:

   (a) Overt or disguised indifference or hostility to the child.

   (b) Ambivalence or hostility toward the husband.

   (c) Delusions demonstrating rejedtion of the marital situation.

   (d) Masturbation conflicts.

   (e) Overt or latent incest desires and/or homosexuality.

   (f) Suicide, infanticide, homocide.

6. Childbirth is frequently an exciting or precipitating factor in the etiology of psychoses.

7. The following psychodynamic theories have been advanced to explain the etiology of psychoses related to childbirth:

   (a) Unresolved Oedipal conflicts and castration complexes result in rejection of normal sexuality in these patients.

   (b) Frigidity, chronic masturbation, and overt or latent homosexuality are commonly found as a result of "a".

   (c) The ultimate expression of sexuality in childbirth is too great a stress for these patients and they may lose contact with reality.

8. The place of endocrine and other physiological factors in etiology is as yet largely speculative.

9. Situational factors are only added emotional stresses and are not a significant cause of psychoses related to childbirth.

10. There has been a decline in the number of post partum psychoses classified as toxic-exhaustive or infectious in origin. This is undoubtedly due to:

    (a) Better medical care of obstetrical patients.

    (b) Greater emphasis placed upon psychic factors in recent times.

11. <u>The first step in prophylaxis is case finding</u> by taking sufficient psychiatric histories on obstetrical patients to determine the presence of the following personality traits or factors:

(a) A schizoid personality.

(b) Dissatisfaction with the feminine role in life.

(c) Reluctance to marry or late marriage under social pressure.

(d) Previous mental illness.

(e) Frigidity or masturbation conflicts.

(f) Incest (overt or latent) and homosexual conflicts.

(g) Emotional instability.

12. <u>An apparently favorable attitude toward pregnancy should not cause one to overlook the above mentioned points.</u>

13. Other prophylactic points are:

(a) Provide help regarding anxiety arising during pregnancy.

(b) Patients showing the above mentioned personality traits should have psychiatric evaluation and therapy if indicated.

(c) Allowing active participation of the patient as much as possible in the delivery in order to aid maintenance of a sense of reality.

(d) The patient should be guarded against attempting and failing at breast feeding.

(e) Subsequent pregnancy should be delayed or prevented for a variable length of time depending upon the condition, attitudes, and prognosis of the particular patient.

14. More information is needed in regard to:

1. Psychodynamic theories.

2. Endocrine and physiological factors.

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