

PARENTHOOD AND POSTNATAL DEPRESSION

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INTRODUCTION

For women the pregnancy and the motherhood are very intense and significant psychological experiences because they imply a deep reorganization of the sense of identity. In this regard, the psychoanalytic literature provides an important framework for studying and interpreting the psychological experiences of motherhood. In fact, pregnancy is an essential part of the process of separation and individuation from the woman's own mother. If the woman has had enough good experience with her mother, she can identify with an omnipotent and fertile mother (able to give life), reaching further growth of the self (Bowlby, 1951). So, this period must be understood as a time of growth and change, both personal and relational: a normal developmental crisis (Bibring, Dwyer, Huntington, Valenstein, 1961; Pines, 1972). Stern, Brusweiler-Stern and Freeland (2000) point out that to the physical birth of the child corresponds "the psychological birth of the mother"; the woman should prepare herself in a "motherly attitude" which enables her to hold the child in his own mind (Ammaniti, 1992; Stern, 1995; Brustia Rutto, 1996). If this process does not happen properly, the woman may have negative or inconsistent mental representations of herself as a mother. Often these unconscious representations are found in the onset of depressive disorders in the postpartum (Kendal-Tackett, 2005).

Psychological problems during pregnancy and childbirth are very heterogeneous both in features and appearance, both severity of symptoms. The postpartum is therefore a very tricky period, in which women (and men) can experience unpleasant feelings of anxiety, fear, confusion, compared to their maternal ability and their sense of identity (Josefson, Angeliö, Berg, Ekström, Gunnervik, Nordin, Sydsjö, 2002).

From the psychodiagnostic point of view, we can distinguish three clinical types of puerperal mood disorders, located on the basis of a continuum of severity, clinical manifestation, prevalence and course: Baby-blues or Maternity Blues, Postpartum depression (PPD), Post-partum psychosis (PPP). Maternity blues is identified with a mild transient emotional disorder which affects more than half (50% to 80%) of Western women in the days immediately following childbirth. It is characterized by crying, mood swings and hypersensitivity, which is becoming more evident around the fifth day after birth and tend to last a few hours or days (Horowitz, Damato, Duffy, Solon, 2005). The emergence of these emotional reactions, which may be part of a normal adaptation to the postpartum, can give birth to a rather common phenomenon (which affects between 11 and 85% of women) called Maternity blues. The most common symptoms of Maternity Blues are: anxiety, mild mood swings, decreased concentration, irritability, tearfulness, crying spells and insomnia (Goodyer, Herbert, Secher, Pearson, 1997). This symptomatology gradually disappeared within the first days in normally two weeks after childbirth, with the acquisition of enhanced security capabilities with the support of the environment and maternal affection.

In some cases, however, depressive symptoms are a sign of a more severe depressive reaction: the Post Partum Depression (PPD), a mood disorder which affects 12-15% of women giving birth (O'Hara, 1987; O'Hara, Schlechte, Lewis, 1991). On a scientific level, the Post-partum depression is conventionally recognized according to the diagnostic classification systems DSM-IV-TR (Diagnostic and Statistical Manual of Mental Disorders; American Psychiatric Association, 2005) and ICD-10 (International Classification for Diseases; World Health Organization, 1996). Postpartum or postnatal depression is defined as a non-psychotic depressive disorder that begins or extends, in the postpartum period, mild to moderate / severity, characterized by symptoms overlap with that of a picture of depression which manifests itself in other periods of life.

The onset of the PPD can be as early as 1 day or, in

many cases happens, several months following delivery.

The symptom to make diagnosis of PPD follows the same criteria as for non pregnancy related depression. Symptoms that characterize this disorder may include: feelings of inadequacy, incompetence and desperation, anger, hypersensitivity, anxiety, shame, hate and neglect toward themselves and the child, sleep and appetite disturbances, decreased sexual desire and suicidal thoughts (Nonacs, 2005; Raphael-Leff, 1991). Other symptoms reported by mothers toward their children are obsessive thoughts, unjustified concerns or fears not related to the real situation, such as harming their child, but also thoughts of infanticide.

In some types of personality, however, these symptoms can cause imbalances so dramatic and deep to set up the clinical picture of Puerperal Psychosis or Postnatal Psychosis (PPP). Symptoms of Postnatal Psychosis (PPP) are: changes in somatic function, anxiety, high delusion, hallucination, fast mood swings, severe sleep and appetite problems, psychomotor restlessness. Various studies (Harrington, 1995; Raphael-Leff, 1991; Soifer, 1971) have shown the existence of various forms of Puerperal Psychosis.

Usually the Postnatal Psychosis it's a manifestation of bipolar disorder and it typically presents into 2 weeks after delivery or can onset a few months after birth like the consequence of a delusional depression (1 on 1000 of women).

Regarding the etiology and interpretation of psychological disorders in the puerperium, we can observe that there remains a considerable heterogeneity in the conclusions of the studies; despite the fact that, also recently, a large number of scientific articles on Postpartum depression continues to be published, remains a considerable uncertainty on its etiology, determinants and consequences. In particular, about PPD, in the literature we can be found different etiological theories: physiological and psychological; the first refers to fetal implication (preterm birth, small head circumference, low APGAR scores; low birth weight), the second to familiar implication (partner depression, familiarity with depression, to be alone, infant development). Among the factors that may have influence the onset of PPD, it's possible to find hormonal changes, but the fact that most women have rapid hormonal changes after childbirth and that only some of them present a depressive syndrome has suggested that there may be a multifactorial etiology of PPD (physical, biomedical, psychological, relational) (Raphael-Leff, 1991).

Brown and Harris (1989) have identified four factors of vulnerability to PPD: loss of mother in childhood, lack of an intimate marital relationship, lack of paid work, have 3 or 4 children under the age of 14 years; Rafael-Leff (1991) says that a woman is at increased risk of developing postnatal depression if she feels to be hindered in achieving her expectations regarding motherhood. Moreover, the main prenatal predictors would be: a personal history of previous depressive episodes before pregnancy, prenatal anxiety and apprehension, lack of social support, material and emotional conflict with the partner, stress-related health status and care of the child, stressful life events. According to the psychodynamic etiological model, PPD occurs as a result of the failure of adaptation to motherhood and the woman's unconscious experience of loss of fusion-symbiotic relationship with the fetus after birth (Deutsch, 1945; Bibring, 1959; Pazzagli, Benvenuti, Rossi Monti, 1981; Maier, 1989; Brustia Rutto, 1996; Scopesi, Viterbori, 2003); these difficulties would be determined by the presence of unresolved childhood conflicts.

Many authors have pointed out that mothers' postpartum depression affects mother-child relationship because a mother that is not emotionally available to her baby tends to have difficulty interacting with him (Field, 1992, 1994; Sameroff, Seifer, Zax, 1982; Tronick, Weiberg, 1997; Zuckerman,

Bauchner, Parker, Cabrai, 1990).

Given the current situation of the research and the need to better understand the phenomenology of mood disorders associated with motherhood, we should understand what are the risk and protective factors for depressive disorders in the postpartum.

OBJECTIVE

The aims of our research are:

- to explore the maternal and paternal perceptions during the pregnancy (T1: 6^o month) and then in the immediate post-partum (T2: 2^o month).
- to detect the presence of maternal and paternal depression during pregnancy as risk factor for maternal post-partum depression, investigating the presence of depressive and anxious symptoms in a sample of women and men in Piedmont.

MEASURES

In addition to a questionnaire for the collection of socio-personal information, we used:

Edinburgh Postnatal Depression Scale (EPDS) (Cox, Holden, Sagovsky, 1987), a questionnaire with 10 self-report items with a focus on the emotional and cognitive characteristics of depression, while somatic symptoms are given less importance. The EPDS has been validated for use postnatal and during pregnancy. The EPDS is a screening instrument in which a score of ≥ 13 is widely used to indicate a probable depressive disorder in women;

State-Trait Anxiety Inventory (STAI Y) (Spielberger, 1983), that measures the level of anxiety. It consists of 40 items, the subject must respond in terms of intensity;

Center for Epidemiological Studies Depression Scale (CES-D) (Radloff, 1977), a self-report questionnaire for assessment of depression. It consists of 20 items that investigate the person's mood last week;

PROCEDURE

The procedure provides for the administration of a battery consisting of multiple choice questionnaires self-report of a duration of about 25-30 minutes. Subjects completed the battery of questionnaires during the pregnancy (T1) and then in the immediate post-partum (T2).

The criteria by which they were chosen from participants in the research were as follows: a fixed address, the ability to speak and understand the Italian language, the absence of a previous psychiatric disorders or no psychopathologies; in addition, was sought participation of the couple, then both the woman and man. The data were treated with the highest confidentiality and privacy.

PARTICIPANTS

The total sample collected for this work consists of 180 subjects of which: 90 males (M = 33.24, Min = 25 years, Max = 44 years, SD = 4) and 90 females (M = 31.28, Min = 24 years, Max = 41 years, SD = 4). All subjects are resident in Piedmont. Regarding the qualification of the women who participated in the research, the 2.2% has a qualification in lower secondary school, the 3.3% attended a professional course of study, the 53.3% has a high school diploma, 33.3% has a university degree, 6.7% has a PhD or a post-graduate, 1.1% another degree. The 64.4% of participants is married, 35.6% is living with her partner. Regarding the qualification of the men who attended the research, 6.6% has a qualification in lower secondary school, 10% attended a professional course of study, 62.2% has a high school diploma, 16.7% has a university degree, 4.4% has a PhD or a post-graduate.

DATA ANALYSIS

For the data analysis we used SPSS Version 18.

Here we present the main monovariate analysis concerning the group of male and female participants, the main findings from the bivariate and multivariate analysis and the results of reliability analysis of the scales used.

About their state of health, 95.7% of the women's group claims to have a good health and only 4.3% claim to have one or more health problems. Among the participants, 42.4% was in the thirty-second week

of gestation, 16.6% in the thirty-sixth, 17.4% in the thirty-fourth, 11.2% in the thirty-fifth, 10.4% in the thirty-eighth and, finally, 2.0% in the thirty-seventh. None of the subjects had used assisted fertilization. The 78% of women were at first pregnancy, 16.6% had one child, 5.4% had had two or more pregnancies earlier; in addition, the 38.5% said they had deliberately sought pregnancy, for the 23.5% the pregnancy was unexpected but sought, for the 21.1% was expected but not sought, for the 16.9% unexpected and not sought. When subjects were asked for their reactions to the news of the pregnancy (it was possible to provide more than one answer), 50% of women responded that they felt astonishment, 15.7% pride, 78% joy, 29.9% confusion, 23.6% fear, 3.2% anxiety, 1.1% rejection, 2.2% other feelings and one person said she did not feel anything in particular. 23.6% of pregnant women claims to have emotional problems during pregnancy. The women reported that their partners' reactions to pregnancy were: astonishment (52.7%), pride (32.1%), joy (89.7%), confusion (24.1%), fear (7.8%) and anxiety (2.2%). Half of participants noticed a change in the relationship with their partners during pregnancy. Men said they had deliberately sought pregnancy in 36.8% of cases, that the pregnancy was unexpected but sought in the 23.2% of cases; instead, for the 17.3% was expected but not sought, for the 22.7% unexpected and not sought. When subjects were asked for their reactions to the news of the pregnancy (it was possible to provide more than one answer), 47.7% of men responded astonishment, 34.6% pride, 87.2% joy, 21.7%, confusion, 13.3% fear, 1.1% other feelings and one person said he did not feel anything in particular. About half of male subjects (45.6%) asserted that their partners have had emotional problems during pregnancy.

For each scale which composes the questionnaire was evaluated reliability by the Cronbach's alpha, distinguishing the female and male sample (Tab. 1). Tab. 1: Cronbach's alpha female and male groups

Measures	Cronbach's alpha female group	Cronbach's alpha male group
Status Anxiety STAI Y1	.93	.91
Trait Anxiety STAI Y2	.92	.84
CES - D	.93	.90
EPDS	.83	.60
DAS	.74	.73

Women's and men's mean scores on subscales at T1 are shown in the table below (Tab. 2).

Tab. 2: Women's and men's mean scores at T1

Measures	Female group	Male group
	M (SD)	M (SD)
Status Anxiety (STAY Y1)	36.49 (9.13)	32.78 (8.45)
Trait Anxiety (STAY Y2)	36.99 (8.44)	32.43 (6.36)
CES - D	10.19 (8.52)	6.41 (7.03)
EPDS	6.03 (4.60)	6.41 (7.03)
DAS	7.01 (2.19)	6.87 (2.38)
MC-SDS	6.20 (1.32)	6.22 (1.36)

Women's and men's mean scores on subscales at T2 are shown in the table below (Tab. 3).

Tab. 3: Women's and men's mean scores at T2

Measures	Female group	Male group
	M (SD)	M (SD)
Status Anxiety (STAY Y1)	34.42 (7.37)	31.03 (6.88)
Trait Anxiety (STAY Y2)	35.49 (8.18)	31.19 (5.73)
CES - D	8.16 (7.44)	5.05 (5.92)
EPDS	5.36 (4.77)	3.44 (2.88)
DAS	6.99 (2.04)	6.81 (2.16)
MC-SDS	6.26 (1.41)	6.22 (1.48)

Taking into account the most important steps for us

in terms of the objectives of the research, namely the steps involved in Anxiety State (STAI Y1) and Trait (STAI Y2), Depression (CES-D and EPDS), was performing the ANOVA (see Tab. 4) which has highlighted significant differences between female and male groups.

Tab. 4: ANOVA Anxiety State and Trait, Depression

	df	F	Sig.
Status Anxiety (STAY Y1)	3	7.143	.00
Trait Anxiety (STAY Y2)	3	11.526	.00
CES - D	3	7.914	.00
EPDS	3	7.955	.00

With regard to the State Anxiety subscale, Bonferroni post hoc test shows that there is a significant difference between the mean of the mothers' group at T1 and the mean of the fathers' group at T1 ($p < .05$), and still a significant difference with the mean of the group of fathers at T2 ($p < .05$).

Mean score on the Trait Anxiety subscale in the group of mothers at T1 significantly differs from the mean of the group of fathers to T1 ($p < .05$) and fathers' mean score at T1 from fathers' mean score at T2 ($p < .05$); in addition, as regards the group of mothers at T2 there is a significant difference between the mean of the group of fathers at T1 ($p < .05$) and the group of fathers at T2 ($p < .05$).

As regards the mean score on the CES-D scale of the female group, Bonferroni post hoc test shows a significant difference with the male group at T1 ($p < .05$) and the male group at T2 ($p < .05$); moreover, the women's group at T2 has a significant difference in the average male group at T2 ($p < .05$).

Finally, the EPDS scale of the group of mothers at T1 shows a significant difference with the mean of the group of fathers at T1 ($p < .05$) and the group of fathers at T2 ($p < .05$), in addition, the group of mothers at T2 shows a significant difference with the group of fathers at T2 ($p < .05$).

From the regression we can detect the presence of two predictors, which can predict the presence of depressive symptoms in post partum (Tab.5).

The dependent variable, consisting of the scores for the post-partum depression (CES-D_M_T2), was regressed on the independent variables at T1 maternal depression (CES-D_M_T1) and paternal depression (CES-D_P_T1) at T1. The variance explained by the model is equal to 29.5% ($R^2 = .295$ correct) and F values, useful for the significance of the hypothesis, were significant ($F = 15,241$, $p < .00$).

Tab. 5: Multiple standard regression of maternal depression in the postpartum.

Predictors	β	t	p
CES-D_M_T1	0.591	5.451	.00
CES-D_P_T1	-0.291	-2.689	.09

As we can see, all the beta coefficients of regression were significant (see Table 5).

RESULTS

About the first aim of our research we can observe that women have higher scores than men at the scale of state trait anxiety, but also in scales that measure symptoms of depression in the pre and postpartum.

As regards the second aim of our study, by means of the regression analysis we could demonstrate the effects and impact that the maternal and paternal depression during pregnancy have on the development of depressive symptoms in the postpartum: women with depression during pregnancy tend to continue to have symptoms of depression after childbirth, and a woman, which during pregnancy is related to the partners who had a depressive symptomatology in postpartum has the possibility of improving the score at CES-D scale.

The data obtained are in line with the main national and international literature. In relation to data is clear the importance of taking charge soon, in a moment so delicate as puerperium. The preventive action should be oriented both to man and to woman because the waiting and the birth of a child is a developmental crisis that involves both members of the couple. In fact, it has been established by our investigation that the emotional difficulties of the future father during pregnancy have an impact on well-being mother's after childbirth.

This kind of attention to the needs of the parental couple could have positive effects on different levels

in Health Care like the primary prevention. In fact, since depression has a profound impact on parenting behavior, it's important preventing the transmission of an high psychopathological risk to the child, thus influencing its subsequent development.

Then becomes essential to monitor for signs in high risk women and men during the pregnancy, to educate women and family members before childbirth, to increase social support prior to delivery and starting therapy or psychological support during third trimester or immediately after delivery.

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