Psychiatric Aspects of Labour and the Puerperium

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SUMMARY

The psychiatric complications occurring during the three stages of labour are described, together with those factors which predispose to delivery-room complications or abnormalities. The predisposing factors include conflicts in relation to feminine identity, repressed traumatic experiences during the early stages of psychosexual development, adverse social, educational and economic situation, and excessive fear and anxiety, particularly in the absence of support from the husband. The triad of fear-tension-pain, the influence of socio-economic and cultural factors, and the methods utilized to reduce both anxiety and fear are discussed.

The interrelation between environmental, hormonal and psychological manifestations in the postpartum period is briefly described, with specific emphasis on depression.


It has been postulated that obstetric, medical and psychological disturbances of varying types and severity occur during the three stages of pregnancy. The aetiology is multifactorial, including hormonal, neurohumoral, electrolytic, ecological, cultural, sociological and psychological factors acting singly or in combination.

PREGNANCY AND LABOUR

Pregnancy is obviously intimately related to parturition, and, as has been demonstrated earlier, abnormalities during pregnancy may be closely related to problems during labour and the puerperium, both somatic and psychological. The problems encountered during the progress of labour are also multifactorial, and again the psychological and somatic, sociological and environmental factors are closely interwoven. The personality of the woman may be a determining factor — 'the total person-ality, whether basically masculine or feminine, active or passive, determines the pattern of emotional reactions during labour' (Kretchmer (1950), quoted by Kroger and Freed'), as can be illustrated by several reported studies.

Long labour and inco-ordinated labour were more common in women with conflicts regarding feminine identity and reproductive and motherhood roles, and uterine inertia occurred more than twice as often in psychiatric patients than in controls. Similarly, Uddenberg and Fagerstrom describe disturbances which occur during deliveries by daughters of reproductively maladjusted mothers and which probably indicate problems in sexual identification. In this study the deliveries in the sample patients were characterized by higher incidences of toxaemia, pre- and postmaturity and malpresentation than found in the controls; induction of labour and episiotomy were necessary more often, and very long or very short labour was also more common.

Identification with the fetus as a part of the mother's own body may also lead to an ambivalent attitude to labour, and as a result prolong it. Repressed traumatic experiences during the early stages of psychosexual development (especially during bowel and bladder training) may be reactivated due to regression, particularly in the second stage, and the resultant tension interfere with the relaxation of pelvic muscles, causing long, painful labour.

Kretchmer (quoted by Kroger and Freed') states that unpleasant emotional and physical sensations are multiplied by fear and anxiety, leading to disturbed labour. Some fear and some anxiety are universal, as described by Assael et al.:' 'despite the frequency in everyday life it remains a significant event, heavily charged with emotion and surrounded with superstitions and irrational feelings'. This may not be the concept shared by the average doctor working in a hospital with a large maternity ward. While to the woman, motivated by biological and maternal instinctual drives, giving birth is of personal significance, it is often a commonplace event to the hospital doctor. Having been trained in the medical model, in which patients are largely seen and referred to as 'cases', the doctor unconsciously retreats from any psychological contact, tending to view this aspect of human reproduction as part of a factory production line, pregnancy being merely one of many facets in the 'conveyor belt' approach to modern living.

This approach is conceivably an unconscious ego defence mechanism; it is obviously impossible to devote individual, personal and psychological care to each pregnant woman. Maximal attention is paid instead to the physical state during antenatal care, particularly as this, in the main, has been the direction of medical training as a whole. In contrast, the 'village' general practitioner is far more likely to be fully involved with his patient, as a total being of psyche and soma, by virtue of the circumstances which pertain in such communities. It is not surprising that attacks of panic occur in the anxiety-ridden or hysterical woman, particularly in the absence of support from her husband. Davids and de Vault' indicate in a pilot study that women who are more anxious than normal during pregnancy have delivery-room difficulties and that those with a greater degree of psychopathology have delivery-room complications. Into this group fall the 'alienated', egocentric, pessimistic, distrustful, anxious and resentful; they are in a state of social and personal

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Date received: 1 April 1980.
Pregnancy and childbirth are considered to be developmental stages, all the adaptational processes, including anxiety, playing a major role, with the ability to utilize them productively and to work through the problem consciously being the prerogative of success. It has repeatedly been shown that ability to handle anxiety consciously, with active attempts at mastery, through anxious dreams and direct communication of concerns and fears, leads to shorter labour. Denial of the existence of problems leads to longer and complicated labour.

The study of Gorsuch and Key indicated that a number of obstetric complications — as well as infant defects — occurred not only when the woman was unable to handle the anxiety state but when other factors, which in themselves produced a state of stress and increased the level of anxiety, were present. Stott reveals a close association between illness and/or stress during pregnancy with non-epidemic illness in infants during the first 3 years, including early ill-health, mental retardation and congenital malformations. The stressful situations discussed above included severe matrimonial problems, severe illness or death of husband or child, personal difficulties such as sharing a house with in-laws or other relatives, and accommodation problems.

The fear of labour — related to the fear of death and fear of pain, particularly in the primiparous woman — is universal and aggravated by the many myths which are passed on by sensational women. It has long been known that fear may increase very markedly and intensely during the critical phases of labour, even in the patient who has previously been unafraid, and sudden and violent emotions may occur which can influence the behaviour of the mother, alienate her from her child, and precipitate a severe postpartum reaction. For a period of time general anaesthesia was employed, but this deprived the mother of the deep gratification of experiencing the delivery and of hearing the first cry of the baby, and therefore disturbed the relationship between mother and baby. Thus general anaesthesia is generally used as a last resort.

Being associated with smooth muscle contraction, labour results in severe pain, but this varies in intensity from individual to individual and is frequently increased in adverse circumstances, whether psychological, somatic or environmental. Pain is a physiological process but its experience is subjective to and dependent upon the experiencing individual. Furthermore, human beings, although acutely aware of pain at the time, tend to repress the experience, especially when other primary drives are being satisfied.

Pain and fear are particularly closely interrelated. Read (quoted by Kroger and Freed) draws attention to the triad of fear-tension-pain, elaborating on the mechanism of pain and devising methods of decreasing it without resorting to pharmacological anaesthesia. According to Read, fear, which is dependent on sociocultural factors, decreases cortical control, distorts interpretation of stimuli and increases motor response, creating tension of the circular muscles of the lower uterine segment and cervix and therefore increasing the resistance of the uterine outlet. Increased muscular tension, coupled with the simultaneous decrease in blood supply, causes true pain which, in turn, magnifies fear and starts the vicious circle anew. Fear can be assuaged by information and tension removed by relaxation, considerably reducing the pain the woman experiences.

Several studies support the concept of Read’s triad. Chertok (quoted by Cogan et al.) described an association between the pain women experience in labour and marital problems, and Nettelbladt et al. associate intense pain with a low standard of education, negative attitudes to pregnancy and motherhood, high levels of anxiety during delivery, and a high incidence of mental disorders in pregnancy. The psychosomatic methods applied during childbirth are summarized by Chertok (quoted by Cogan et al.) as combining learned relaxation and patterned breathing with information and support during labour; their effectiveness is controversial, however, although they are generally advocated. In their study mentioned above, Nettelbladt et al. failed to prove that there is a relationship between pain and the presence or absence of antenatal training or the presence or absence of support from the husband during delivery.

Rodway and Marrone and David (quoted by Cogan et al.) were unable to obtain evidence that antenatal exercises decrease pain or the quantity of anaesthesia required, although they agree that preparation for labour decreases fear. On the other hand, Tanzer and Enkins (quoted by Cogan et al.) found mothers who have had antenatal training to be more positive about their birth experience and to describe less pain, a view shared by Cogan et al. Similar findings were reported by Carpenter (quoted by Cogan et al.), who concluded that the woman who has been well informed during pregnancy will be less likely to need pharmacological anaesthesia during labour.

Markedly increased fear for self and/or for the baby was also found to be a major psychological factor in women with the following perinatal complications: prolonged labour, uterine inertia, the necessity for low forceps delivery and infants with Apgar scores lower than 7.

In summary, numerous aspects of labour have been considered in psychosomatic perspective: pain duration, pre- and postmaturity, malpresentation, complications in infancy and the need for instrumental delivery, induction of labour and episiotomy.

**THE POSTPARTUM PERIOD**

Six to eight days after delivery the levels of all hormones, such as oestrogen, progesterone and thyroid, return to pre-pregnancy levels, the greatest fall taking place during the first 3 days. This is the time when a combination of factors, psychological and hormonal, cause emotional upheaval. The baby becomes a tangible reality, requiring the intrapsychic reorganization of being a mother and
again reactivating the unconscious conflicts pertaining to pregnancy. Physical exhaustion sets in, hormonal havoc is undeniable, and postpartum bliss becomes a legend rather than a reality.

About two-thirds of women delivered experience some kind of emotional upset ('third-day blues') characterized predominantly by a decrease in mental acuity (foggy feeling, minor memory impairment, loss of concentration), a decrease in social interest, and a feeling of inactive sluggishness, dysphoria, depression and anxiety. The reactions vary from the minor, short-lived neurotic to the psychotic, with one-third of women remaining free of any symptoms.

The incidence and severity of disorders of the puerperium depend upon complex environmental, hormonal and psychological interactions. The wish for the child is instinctive and progesterone-dependent, but enjoyment and the ability to care for it can be hampered by personality factors such as generalized ego weakness, difficulty in expressing aggression, rejection of femininity and sexuality, and fixation to old relationships. These cause severe anxiety during pregnancy, which appears to be related to depression in the puerperium. Seriously depressed women are generally found to be characterized by emotional lability and increased levels of anxiety throughout pregnancy, followed by elation and a relative freedom from somatic symptoms, pointing, as mentioned before, to denial of pregnancy and inadequate working through of the developmental crisis. The environmental situation, with the availability of the support systems of the husband, the family and finance, also plays a major role.

It is believed that the 'blues' depend more on a relative than an absolute drop in hormonal levels at parturition, with the progesterone drop again being implicated particularly in the genesis of depression, related possibly to lingering noradrenaline depletion. It is also argued that 'blues' may depend on a lack of balance between oestrogens and progesterones, or tend to occur in women with either greater hormonal variations or a greater adverse response to variations, as evidenced by the incidence of emotional lability during pregnancy in patients with frequent premenstrual tension.

It is postulated that the 'postpartum psychosis' syndrome is non-existent, and that psychiatric disorders of the puerperium belong to one of the major categories such as schizophrenia, unipolar or bipolar affective disorders or acute situational reactions and are temporarily precipitated by psychological or endocrinological stress.

CONCLUSION

It is apparent that psychiatric disturbances during the three stages of labour and the puerperium are closely related to hormonal, psychological, environmental and cultural factors, occurring either singly or in combination. Furthermore, complications of labour and even in the infant are frequently dependent upon emotional disturbance, personality disorders and the inability to handle the anxiety state, as well as fears related to the labour. This emphasizes once again the complex mutual interactions between environment, psyche and soma.

It is therefore postulated that the complications of labour and the puerperium can be decreased or minimized through the assurance of adequate support, the provision of information and understanding by the staff in the obstetric ward, and psychiatric intervention during pregnancy and labour and in the puerperium, particularly in the case of women who are at particular risk.

We wish to thank the Department of Health for permission to publish.

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