Postpartum depression and melancholic type of personality: a pilot study

Depressione postpartum e personalità melanconica: uno studio pilota

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Summary

Objectives

This is a pilot study on the relationship between a personality structure called "melancholic type" (typus melancholicus, TM) and postpartum depression. We tested the following hypotheses: 1) the main features of TM (orderliness, conscientiousness, hyper/heteronomia and intolerance of ambiguity) portray the personality structure of a group of mothers prone to a kind of postpartum depression whose clinical features are characterized by psychomotor retardation, depression and guilt feelings/ideas ("melancholia" sensu Tellenbach); 2) the features of the puerperal crisis taking place during the early phases of motherhood in these women bears deep analogies with the kind of existential pathogenic situation ("pre-melancholic situation" sensu Tellenbach) characterized by "includence", "remanence" and "despair" which (according to phenomenological literature) leads to "melancholic" depression.

Methods

We analyzed 31 cases of postpartum depression. To assess personality features we adopted the Criteria for Typus Melancholicus (CTM). To characterize the puerperal crisis we adopted the Pre-Melancholic Situation Criteria (PMSC). These instruments operationalize the main features of melancholic type of personality and the pre-melancholic situation. To assess clinical features, the AMDP system was used. Diagnosis was established according to DSM-IV-TR criteria for "major depression".

Results

14 of 31 women showed clinical features of "melancholia", as well as the personality traits of the TM kind of personality. These women also showed, in the period following delivery, a critical state characterized by conflicting roles leading to a phase of disorganized behaviour and confusion that paved the way to the melancholic decomposition. Thus, both our hypotheses were consistent and encouraged us to proceed with large scale quantitative studies.

Conclusions

TM personality structure may represent a valid model for the early diagnosis of a group of women at risk to develop episodes of postpartum depression, even in those cases in which an anamnesis of mood disorder or symptoms before and during pregnancy cannot be established. The TM structure can also enhance our capacity to understand the interplay between personality traits, the characteristics of the life-event "motherhood" and the presentation of depressive symptoms.

Key words

Melancholic type • Postpartum depression • Pre-morbid personality • Psychopathology • Temperament

Introduction

This report builds upon and extends on the conceptualizations contained in the monograph *Melancholie* [1], perhaps the most detailed (at least in the area or phenomenological psychopathology) attempt to theoretically describe the pre-morbid personality of persons vulnerable to major depression ("melancholia") as well as the pre-melancholic situation, i.e. the constellation of life-events preceding and precipitating melancholia. With "melancholia", we intend a subtype of major depression mainly characterized by felt loss of vitality, feelings of loss of feelings and delusions of guilt. With melancholic type of personality (*typus melancholicus*, TM), we refer to a personality structure whose main features are *orderliness, conscientiousness, hyper/heteronomia and intolerance of ambiguity* [2]. With "pre-melancholic situation", we address a constellation of life-events in which the TM feels trapped characterized by includence and remanence, having pathogenic implications.

Based on the analysis of 31 cases of postpartum depression taken from our own practice, we tested the following hypotheses: a) the main features of TM – *orderliness, conscientiousness, hyper/heteronomia* and *intolerance of ambiguity* – as defined by Tellenbach [1] and confirmed by several authors (2-15) characterize the personality structure of a group of mothers prone to a special subtype of postpartum depression, i.e. "melancholia" in the sense stipulated by Tellenbach [1], and confirmed by previous

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empirical studies (9-15); b) the puerperal crisis which takes place during the early phases of motherhood in TM mothers who will develop this kind of postpartum depression bears deep analogies with the "pre-melancholic situation" characterizing the prodromes of "melancholia".
If the present study would confirm these hypotheses, then the TM personality structure may implement the clinician's capacity to establish an early diagnosis of women at risk to develop an episode of postpartum depression, even in those cases in which an anamnesis of major depression is not present. The TM construct may also improve the clinician's capacity to understand the interplay between personality traits, characteristics of the life-event "motherhood" and presentation of depressive symptoms, thus enhance preventive and psychotherapeutic strategies.

Materials and methods

From a sample of 31 women with a diagnosis of postpartum depression recruited from our own clinical practice and from the Family Advisory Councils of Pescara during the birth preparation courses, we selected a subgroup of patients affected by "melancholia" (Table I). The group under consideration is composed of women with a mean age of 32-38, two in their third pregnancy, and the others in their first pregnancy; six of 14 had a positive anamnesis for major depression. To select our target group, we first established a diagnosis of major depression according to DSM-IV-TR criteria [16] and then assessed the clinical characteristics of depression in these patients using the AMDP system [17]. Women who were positive for AMDP items 42 (delusions of guilt), 60 (feelings of loss of feeling) and 62 (loss of vitality) were diagnosed as affected by "melancholia". All women were also assessed with the Criteria for Typus Melancholicus (CTM) [14], a semi-structured interview assessing the value-structure and social behaviour including four criteria – "*orderliness*", "*conscientiousness*", "*hyper/heteronomia*" and "*intolerance of ambiguity*" (Table II). All women were also assessed with an *ad hoc* semi-structured interview, the Pre-Melancholic Situation Criteria (PMSC), by which the main features of the pre-melancholic situation, as described by Tellenbach and including the concepts "*includence*", "*remanence*" and "*despair*", are operationalized (Table III).
Clinical assessment was also implemented by adopting an open framework of interview [18] that encouraged patients to explicate their personal experiences beyond the strict boundaries of standard assessment procedures. In the course of interviews, patients were encouraged to narrate, conceptualize and elaborate on the answers they gave on the themes explored by the semi-structured questionnaires. Their comments were typed verbatim and are succinctly reported in the following section ("clinical vignettes").

TABLE I.
Major "Melancholic" Depression (Association for Methodology and Documentation in Psychiatry, AMDP system, 1979, 1995). *Depressione maggiore melanconica (Association for Methodology and Documentation in Psychiatry, AMDP system, 1979, 1995).*

Feelings of loss of feeling
Patient complains about loss of affective resonance and affective void (item 60)
Delusions of guilt
Conviction of having failed in one's duty or having wronged others. The patient believes he has failed in his duty to God or some higher moral (item 42)
Felt loss of vitality
Depression of general bodily feelings subjectively experienced. Disturbance of underlying feeling of being alive. Reduction in liveliness and vigour. Also included are the general feelings of loss of vitality, physical and psychical integrity, physical illness (item 62)

TABLE II.
Criteria for Typus Melancholicus [14]. *Criteri per il Typus Melancholicus [14].*

Orderliness
Fixation in harmony in interpersonal relationships
Conscientiousness
Commitment to prevent guilt attributions and guilt feelings
Hyper/hetereonomia
Exaggerated norm adaptation and norm receptiveness
Intolerance of ambiguity
Inability to emotionally and cognitively host opposite feelings and perceive opposite features concerning the same object, person or situation

Clinical vignettes

By presenting these 14 clinical vignettes, we intend to restrict our focus to those features that may help to portray these patients, characterized by the melancholic type of personality and affected by "melancholia" which they developed after a prodromal phase of "pre-melancholic situation".

Case 1

A 25-year-old woman always feels tired and unable to have a rest: *"I can do everything but rest. In the morning, I clean everything in a hurry because I think that, if*

TABLE III.
Pre-melancholic situation [1]. *Situazione pre-melancolica [1].*

The constellation "includence" A self-contradiction in which TM is encapsulated within limits that he or she is finally no longer able to transcend in the direction of the regular accomplishment of its order	*"I fell asleep while I was breast-feeding. I woke up at 4 and I realized I'd slept all the time. I was very angry because I should have ironed, I had so many things to do" (Case 1)* *"I feel paralyzed by this whole burden and I can no longer do anything. I feel bad. I have no more strength to keep going" (Case 7)*
The constellation "remanence" The feared danger of remaining behind one's demands on oneself, the being in debt (by the feeling of being in debt)	*"In the morning, I clean everything in a hurry because I think that, if something should happen to me, everything is in order" (Case 1)* *"I am a very meticulous person. I need too much time. This seems awfully sad to me and makes me feel guilty because I can't do my job. What a shame!" (Case 9)* *"I don't think I am as good mother as my own mother was" (Case 6)*
Situation "despair" Feeling encapsulated within an unsolvable doubt, so that a decision is not possible. This situation may lead to psychomotor block	*"I am in a sad situation; on one hand, I feel a constant impulse to work carefully as much as I can but, on the other hand, inhibition creates obstacles for me. I can't stand it any longer" (Case 9)*

something should happen to me, everything is in order. When someone helps me, I feel guilty. I do everything by myself. I don't want to have someone to thank". *"I do everything because I have to do it. If I cannot organize my day, I become nervous. If I cannot fulfill the programme I scheduled in the morning, I feel anxious and I must try to make up for lost time"*. This regular life, she says, has been upset by motherhood: *"Yesterday, for example, I fell asleep while I was breast-feeding. I woke up at 4 and I realized I'd slept all the time. I was very angry because I should have ironed, I had so many things to do. I don't know how to keep up with everything, I think I'm no longer able to do anything. I cannot recognize myself. I'm not the woman I used to be"*.

Case 2

A 32-year-old woman. Following the birth of her first child she reports feeling in the grip of a strong anxiety without being able to understand what is happening to her. *"I think I'm living in a surreal dimension. I've always managed to achieve my goals efficiently, but now, when I am with my daughter, I'm not able to do anything. I'm not the woman I used to be, I'm no longer able to do anything, neither the things I used to do before, nor those things I should do now, with my daughter. I feel empty, I'm not able to feel anything, I only feel guilty for not being able to give my daughter the love she deserves"*.

Case 3

A 42-year-old woman has just given birth to her third child after many years since the birth of her first two children. She cannot stand still and keeps repeating that she should not have had this baby. *"I have always loved my two children, so I thought it would be the same with the third baby. I thought I would love her as I did with the other two, but it isn't so. I cannot take care of her, I think I neglect the others, my husband and the house. I hate to think that the first two have to suffer because I am no longer able to provide for everything and give them all they need. I cannot take them to school or the swimming pool: all things I used to do before. I feel inadequate. I wish this third child had never been born"*. *"I think that if I had neither a husband, nor children it would be better for me. When I think of this, I fear they could disappear. Sometimes, while I wash the dishes and my daughter is crying, I think about hitting her with a fork. I can't bear this thought! I only feel guilty. I feel nothing for this baby. I can't love her. I'm a bitch"*.

Case 4

A 40-year-old woman with a 3-month-old baby: *"Now, while I get ready to go to work I feel as if I had robbed a bank: euphoric about the job, but guilty. I think that I am a good person and I cannot rob a bank without having serious psychological reactions. I cannot manage this feeling of guilt. At first, when I returned to work I felt my former enthusiasm sprout anew. But now I feel so guilty about my daughter that I can't get on with my job or embrace my daughter when I come back home. I'm seriously thinking about quitting my job. Perhaps, if I concentrate on my role as a mother I will be able to fill this void and feel love for her"*. *"When I feel the burden*

of the things I have to do, I don't know where to start, I cannot recognize priorities. I feel stuck, I cannot get anything done".

Case 5

"I've always been a cheerful and efficient person". "I planned everything in my life. Once I got married and my husband got his last promotion, I thought it was the right time to have a baby. When I realized I was pregnant, I wasn't just happy. I was euphoric and I concentrated on all the necessary preparations for the baby's arrival. I did everything a woman is required to do. So it was till the birth of the baby. Everything was arranged, but, very soon, I realized that hearing her cry, changing her, feeding her never fit in with my plans and I started losing control. I wasn't born to be a good mother. Someone else should take care of my child. I'm not a good mother and I think I have never even wished I were a mum".

Case 6

Forty-year-old: *"In the morning, I clean everything in a hurry because I think that something might happen to me. So, if something happens to me, everything is in order. Since the birth of my child I do everything automatically, because it must be done. Anyway, this is the role of a mother and I should be happy to play this role. I'm not happy. I feel nothing. Breastfeeding, staying with the child, for me, it's like ironing or cooking. I just do it. I don't think I am as good mother as my own mother was. The problem is that I feel guilt about my condition. I should be happy, but I don't feel so. I don't feel anything". "I feel paralyzed".*

Case 7

"All this is too much even for me! How can I keep up with everything? I need to meet my plans and, with her, I cannot carry out anything. I don't know what to do. At first, I tried to keep up with both my normal activities and my new ones; now I feel paralyzed by this whole burden and I can no longer do anything. I feel bad. I have no more strength to keep going. I feel stuck. All this makes me upset. I feel numb. I'm no longer able to do anything".

Case 8

A 35-year-old woman, after her first delivery: *"This child has upset my existence. All my priorities seem to have no more value. I feel totally swallowed up by what is happening around me: breast-feeding, taking care of my child, playing with him, putting him to bed, starting to love him. My maternal duties are prevailing over all my previous order and I don't know who I am. I do everything because I think it must be done but I feel like a clone who follows the commands it was programmed for". "Since the birth of my child I do everything automatically because it must be done. Anyway, this is the role of mother and I should be happy to play this role. I'm not happy. I feel nothing".*

Case 9

"I usually attach great importance to what others think. I always try to do everything with the greatest care so that nobody can blame me for anything. I am in a sad situation; on one hand, I feel a constant impulse to work carefully as much as I can but, on the other hand, inhibition creates obstacles for me. I can't stand it any longer. I am a very meticulous person. I need too much time. This seems awfully sad to me and makes me feel guilty because I can't do my job. What a shame!".

Case 10

A 33-year-old woman asks for an interview because she feels very confused and worried: "*Should a new-mom go back to work? If so, when? How important is it to spend the first three years of a child's life at home with him? Once grown up, will I have the occasion to look back and regret not having planned things differently? I'd feel guilty for all my life if I decided to go back to work and, at the same time, I think that I could go crazy if I stayed at home with him. There's nothing I can do. My life is finished and I don't see any possibility".*

Case 11

One month after the birth of her first child: *"I can't even cry any more. Everything is a burden to me. I feel different and, above all, I feel guilty. I have always been scared to have debts, not only debts concerning money but also in relationships with others. I have always been a very active person and I never rested. Now, I can no longer do anything. I won't be able to pay all my moral debt towards my son, my husband, my family. All this it is definitely greater than my strength can bear".*

Case 12

Since her first delivery she feels deeply changed, catapulted into a surreal dimension: *"I'm not me anymore. My child makes me feel like an incompetent. I have strange thoughts. I think that the child is not mine and that, after all, I never wanted to be a mother. I have conflicting feelings towards him which cause me an unbearable anxiety. I really can't stand him. I can't stand to hear him crying and his continuous requests. I cannot go on this way. I'd prefer to stay away, I'd prefer to be in a different place".*

Case 13

36-year-old woman. She has reduced movements and speaks very slowly: *"I've always been a very precise*

woman who likes carrying out all her tasks. I like being in harmony with the people around me. I like being at peace with others; it's something that I need. I hate inaccuracy and I think that there are some rules that must be met. Everything, for me, has an order and must be done in a specific way. After my delivery all this order escaped me and I don't know what to do anymore. How can I do everything and in the right way? I can no longer do anything and I am not me, anymore".

Case 14

"I feel guilty about everything I do or don't do. It seems like everything is wrong from the beginning. If my baby cries I feel guilty because I think I have done something wrong. When he sleeps I feel guilty because I have forgotten he exists and when I breast-feed him I feel guilty because I can't wait to finish. It is not normal for a mother to have these thoughts towards her child; it is not natural".

Results

In our sample, 14 of 31 patients affected by major depression showed clinical features of "melancholia" (loss of vitality, feeling of loss of feeling and delusions of guilt). All patients affected by "melancholia" also showed TM traits of personality. In these women, the puerperal crisis also showed strong affinities with the "pre-melancholic situation". In the following, we will illustrate these results in detail, providing first-person experiences that we registered verbatim during interviews.

Personality traits

All patients affected by "melancholia" were characterized by TM traits of personality as assessed by CTM. Interviewees confirmed by spontaneous self-descriptions of their own value-structure and social behaviour.

1. *Orderliness*. Case 5 uncritically describes her orderliness by rigidly organizing the subsequent steps of her conjugal life with the following sentence: *"I planned everything in my life. Once I got married and my husband got his last promotion, I thought it was the right time to have a baby"*. Case 13 also egosyntonically depicts her need for an inflexible order in social relationships: *"I've always been a very precise woman who likes carrying out all her tasks. I like being in harmony with the people around me. I like being at peace with others; it's something that I need"*.
2. *Conscientiousness*. While orderliness in these persons represents a rigid precision in managing interpersonal relationships, conscientiousness shows that this commitment is aimed at keeping a clear conscience, avoiding feelings of guilt or inadequacy: *"When someone helps me, I feel guilty. I do everything by myself. I don't want to have someone to thank"* (Case 1), or *"I always try to do everything with the greatest care so that nobody can blame me for anything"* (Case 9).
3. *Hypernomia/heteronomia*. The inclination to conform to social expectations and to impersonally embody social roles and rules are also well represented in our interviewees. Case 5: *"When I realized I was pregnant, I concentrated on all the necessary preparations for the baby's arrival. I did everything a woman is required to do*". Like Case 5, Case 1 also uncritically and passively follows the rules and impersonally does all she thinks one is expected to do according to the one's social role.
4. *Intolerance of ambiguity*. Finally, in our women, the inability to emotionally and cognitively host opposite feelings and perceive opposite features concerning the same object, person or situation is also characteristic. For instance, Case 12 says she can't stand to have ambivalent feelings towards her child: *"I have conflicting feelings towards him which cause me unbearable anxiety"*.

Pre-melancholic situation

This group of mothers report that, before becoming clinically depressed, they went through a phase in which they were incapable of organizing and managing their activities: *"When I feel the burden of the things I have to do, I don't know where to start, I cannot recognize priorities. I feel stuck, I cannot get anything done"* (Case 4). We can distinguish two moments in the pre-melancholic phase. The former is characterized by the presence of the *constellations* called *includence* and *remanence*; the latter by the situation called *despair*, characterized by a deep change in the way to relate with oneself and with the world.

1. *Includence*. Is a self-contradiction in which the TM is encapsulated and she is finally no longer able to transcend in the direction of the regular accomplishment of her order. Case 8 thus describes the way motherhood conflicts with the order she had strived to establish and preserve in her previous life: *"This child has upset my existence. All my priorities seem to have no more value. I feel totally swallowed up by what is happening around me (…) I don't know who I am"*.
2. *Remanence*. Is characterized by the feared danger of remaining behind one's own standard and fulfill one's demands on oneself, and by the feeling of being in debt. When TMs crash into unexpected, casual and unforeseen situations, all the schemes are broken and a melancholic crisis can easily develop. Case 6 thus explicates her paradoxical need to extinguish in advance all possible debts: *"In the morning, I clean everything in a hurry because I think that something*

might happen to me. So, if something happens to me, everything is in order".

3. *Despair*. This is a peculiar kind of depersonalization characterized by a feeling of disunion and inconsistency. A movement backward and forward towards two or more conflicting goals, none of which can be accomplished, as with Case 13: *"After my delivery all this order escaped me and I don't know what to do anymore"*. The conflict between the role of mother and that of workingwoman is thus epitomized by Case 10: *"There's nothing I can do. My life is finished and I don't see any possibility"*.

What follows is a phase of stagnation, psychomotor block and existential paralysis, as described by Case 7:*"I feel stuck. All this makes me upset. I feel numb"*.

Clinical features of postpartum depression in TM women

The presentation of symptoms in our cohort is characterized by three main psychopathological dimensions:

1. *Loss of vitality*. This is a very common symptom that accompanies serious forms of major depression. Women complain for their reduction of drive, energy, liveliness, vigour and for bodily feelings of loss of physical integrity, and compare this subjectively experienced loss of vitality with their standard energy level, that is usually rather high: *"I feel paralyzed by this burden and I can no longer do anything. I feel bad. I have no more strength to keep going*" (Case 7). Loss of vitality is often accompanied by feelings of depersonalization, as in Case 1 and in Case 2: "*I'm not the woman I used to be*".
2. *Feelings of loss of feeling*. Much more characteristic than loss of vitality are complaints about one's loss of emotional resonance and emotional void – a symptom quite different from low mood or sadness. This phenomenon is clearly evident when our patients blame themselves for their inability to feel interest in the things surrounding them: *"Since the birth of my child I do everything automatically because it must be done. Anyway, this is the role of mother and I should be happy to play this role. I'm not happy. I feel nothing*" (Case 8). They particularly blame themselves for the loss of attunement with their children: *"I feel empty, I'm not able to feel anything, I only feel guilty for not being able to give my daughter the love she deserves"* (Case 2).
3. *Delusions of Guilt*. Guilt feelings and delusions of guilt are very common features in our sample of TM mothers: *"I feel guilty about everything I do or I don't do"* (Case 14). Guilt is connected to, and possibly arises from, the feeling of the loss of feelings: *"I can't even cry any more. Everything is a burden to me. I feel different and, above all, I feel guilty"* (Case 11). Sentiments of anguished indifference are central to this: *"Breastfeeding, staying with the child, for me, it's like ironing or cooking. I just do it. The problem is that I feel guilt about my condition. I should be happy, but I don't feel so. I don't feel anything"* (Case 6).

Since these women are inclined to compare the way they feel and think during the acute phase with the way they used to feel and think, the authenticity of the feelings related to the pre-melancholic condition is questioned. They particularly question the genuineness of their desire of motherhood, their love for the other children and, more generally, their capacity to be good mothers: *"I wasn't born to be a good mother. Someone else should take care of my child. I'm not a good mother and I think I have never even wished I were a mum"* (Case 5).

Discussion

The definition of postpartum depression is highly controversial [19]. Postpartum depression is not a homogeneous psychopathological entity, but rather a chapter heading for a number of distinct disorders. This unclear definition and classification has lead to severe problems in research [20]. Postpartum mood disturbances are commonly classified into three categories in order of increasing severity: blues, depression and psychosis [19 21 22]. Postpartum blues refers to a mild affective syndrome often seen in the first week after delivery. The blues is characterized by symptoms such as depressed mood, crying spells, irritability, anxiety, mood lability, confusion and sleep and appetite disturbance [23-25]. In the first 7 days following delivery, 62% of women experienced blues for 1 or 2 days, 25% for 3 to 4 days and 13% for 5 to 6 days [26]. Postpartum depression refers to a depressive episode that begins in or extends into the postpartum period [27 28]. The two internationally recognized classification systems for psychiatric illness, the DMS-IV [16] and the ICD-10 [29], have differing approaches to the classification of postpartum mental disorders. The DSM-IV refers to the current or most recent episode if the onset of the episode lies within the first 4 weeks postpartum. In the ICD-10, mental illness associated with the puerperium are coded according to the occurring psychiatric disorder and a second code (O 99.3) indicates association with the puerperium [20 30]. Several studies diagnose postpartum depression relying on standardized diagnostic criteria for depression [31-33]. Criteria for a diagnosis of postpartum depression usually include: dysphoric mood, sleep, appetite and psychomotor disturbance, fatigue, excessive guilt and suicidal thoughts [16 34 35]. These symptoms are not greatly different from the symptoms that occur with mood disorders, unrelated to childbearing [20 36]. Additional symptoms include feelings of guilt or inadequacy about the new mother's

ability to care for the infant and a preoccupation with the infant's well-being or safety severe enough to be considered obsessional [37-39]. Postpartum psychosis, also called puerperal psychosis, occurs in approximately 1 of 500-1000 births and usually starts within the first 48-72 hours after delivery [21 40-42]. Typically, symptoms include elation, lability of mood, rambling speech, disorganized behaviour and confusion, delusions and paranoid hallucinations which focus on the infant and increase the risk of infanticide [27 42-44].

It is much beyond the aim of this study to face the intricacies of nosographical definitions of postpartum pathology. We simply wish to establish the nexus between a clinical syndrome, a given type of personality and a specific type of pathogenic life-event constellation. To do so, we focused on a group of 14 women showing a clinical syndrome typically characterized by stagnation, loss of vitality, painful emotional freezing, delusions of indignity and guilt. These patients also showed, in their pre-morbid personality, a type of vulnerable rigid existential order akin to the TM kind of personality, i.e. orderliness, conscientiousness, hyper/heteronomia and intolerance of ambiguity. Additionally, these women experienced, during the first period after delivery, a paralyzing conflict between motherhood and the pre-existing order these mothers had strived to establish and preserve; this conflict situation closely resembles the pre-melancholic pathogenic situation described by Tellenbach in his monograph *Melancholia*.

Clinical presentation of postpartum depression in our group of patients

Our study focuses on a subtype of postpartum depression, which bears close resemblance to melancholia *sensu* Tellenbach. We found disorganized behaviour and confusion only at the very beginning of the episode and especially during the pre-melancholic phase. Elation and mood lability were not in the foreground. The theme of delusions was mainly guilt and indignity. In short, in our women affected by postpartum depression the main clinical features seem to be the triad loss of vitality (patients are incapable to set up priorities and experience a insurmountable existential paralysis), feeling of the loss of feelings (they are unable to feel any emotion and bond of affection) and delusional ideas of guilt and indignity (especially concerning one's inadequacy for a maternal role). This triad overlaps with the clinical features of melancholia as it has been studied within the phenomenological psychopathology tradition [1 3 15 45-49].

Personality features of women at-risks to develop postpartum "melancholia"

An important focus of research into postpartum pathology is the identification of risk factors for this common and often disabling disorder. Risk factors can be divided into three main categories: psychosocial, clinical and risk factors related to pre-morbid personality or temperamental features.

There is some consensus that the psychosocial risk factors play a fundamental role [50]. The most frequently cited are marital conflict [51], lack of a confidant [52], difficult psychosocial conditions [52 53], negative life events during the year preceding childbirth [54] and financial and professional difficulties [55]. Beck [56-59] devised a checklist of eight risk factors (PDPI) including prenatal depression, prenatal anxiety, history of previous depression, social support, marital satisfaction, life stress, child care stress, self-esteem, maternity blues, socioeconomic status, marital status and unplanned/unwanted pregnancy. Two meta-analyses consistently identified prenatal depression or anxiety, marital dissatisfaction, inadequate social support and life stress as major risk factors [28 56]. The main focus of interest of our study is on the personality style of women vulnerable to postpartum depression. Personality style has been identified as a risk factor (for review see Boyce) [60]. The Vulnerable Personality Style Questionnaire [61] includes nine personality dimensions associated with vulnerability to postpartum depression: neuroticism, interpersonal sensitivity, obsessionality and dysfunctional cognitive style are the traits that increase risk of developing postnatal depression. Robertson et al. [62] found that neuroticism and cognitive attributional style are candidate risk factors for postpartum depression. Others [63 64] describe a state of psychological vulnerability called "neuroticism" [65]. Neuroticism can be defined as a psychological disorder that is usually distressing, but allow one to think rationally and function socially. Neuroticism measured in women antenatally was found to be a weak-to-moderate predictor of postpartum depression [28 66]. Johnstone et al. [67] found that "nervous," "shy, self-conscious," or "worrier" women were significantly more likely to develop postpartum depression. Moreover, women with negative cognitive attributional styles (e.g., pessimism, anger, ruminations) were more likely to develop postpartum depression [28].

By comparing the data concerning the pre-morbid personality in our group of patients with current literature, we must keep in mind that we restricted our analyses to persons who developed a special kind of postpartum depression, whereas data on psychological vulnerability traits from literature mainly do not make distinctions between different subtypes of postpartum pathology. Some, but not all, of these personality dimensions show similarities with the TM personality. For instance, organization, interpersonal sensitivity and obsessionality may overlap with some traits exhibited by TMs, as it occurs with the tendency to rumination and worrying. Tellenbach's sample (119 cases of melancholia in TMs) includes 6 clinical vignettes with a diagnosis of postpartum depression. Five

of them exhibit features of postpartum depression [1 68]. We recently re-analyzed these cases and documented the reliability of personality as well as axis I diagnosis [68]. The present study builds on and develops Tellenbach's intuition on the relationship between postpartum, TM and melancholia (depression with psychotic features). To our knowledge, there are no other studies relating TM personality and postpartum depression.

The pre-morbid existential order of those women who develop postpartum "melancholia" can be referred to the kind of existence of the TM characterized by *orderliness, conscientiousness, hyper/heteronomia and intolerance of ambiguity* [1 3 15]. The existence of TM turns on the following features: TMs wish to limit their field of action and follow forever a reassuring life in which the new is neutralized, the established order is preserved, conflicts are avoided and debt is paid off even before contracting it.

Motherhood and pre-melancholic situation. Motherhood is like a *quid novi* in which a previous existential equilibrium is put at risk [69-71]. TM women are compelled to adapt their own way of being to the new situation and to the changes it involves. Motherhood is a threat to the rigid existential order of TM women, and it is a danger to their *orderliness*. TM women tend to distort the meaning of birth, which is not perceived, at the same time, as a moment of task/duty as well as an opportunity/possibility of self-development and existential self-realization. The reason for this distortion of the meaning of birth lies in the feature of TM called *intolerance of ambiguity*. The birth is conceived as an obligation characterized by necessity, tasks to fulfill – according to the rules given by *consciousness* and *hyper/heteronomia* – which are typical of TM personality. This is why we suggest that the TM women may be considered at risk of developing a postpartum depression.

The pre-melancholic situation seems to play a crucial role in the kindling of melancholia, as well as in the understanding of the relationship between TM personality and melancholia. The concept of "situation" means a person's way of living the relationship with his own world. It isn't the simple relationship between the life-events and the subject who has to manage them. Rather, it is an unavoidable bond in which the man is tied (*engagé*) [1] to his context by a peculiar interdependent relationship.

The pre-melancholic situation is characterized by a constant growth of pre-established tasks which upsets the typical order of TM personality and kindles typical role conflicts that may have pathogenetic implications [3 15 72-74]. In this condition, the TM is unable to set a priority order because she cannot distinguish what could be temporarily put aside or avoided [75 76]. As a consequence of this, disorganized behaviour and confusion may characterize the prodromal phase of postpartum depression. The pre-melancholic situation is thus characterized by the presence of the situation of *includence*, i.e. the TM encloses herself within the boundaries of her *ordo* – and *remanence* – i.e., she remains encapsulated within these boundaries thus "remaining in self-default" [1].

In the cases analyzed by Tellenbach, as well as in our cases, the situation "motherhood" shares many features with the pre-melancholic situation in general. Motherhood is a situation that generates anxiety and role conflicts since it introduces a new role and another burden of responsibility to be managed. The experience of being a mother is not a way of self-realization, but just an event full of new rigidly conceived and fully idealized tasks to be fulfilled. This role-conflict can disclose its pathogenic force.

Thus, for TM women, there is a tragic paradox hidden in motherhood. On one hand, motherhood represents the fulfillment of the existential project for *all* women: family, that is to say, the cornerstone that in the TM's conscientious and basically traditional outlook represents the essence of social order. On the other, there is a terrible trap hidden in the arduous construction of this *ordo*: the incapacity to make the family work according to one's values and rigid expectations. The experience of one's incapacity to fulfill one's idealized role of *mater familias*, the crisis of one's idea of family, as well as the lack of continuity with the inherited traditions, are the prelude to melancholia. Becoming a mother according to such a rigid and idealized standard and, at the same time, continuing to be a dependable wife, a reliable colleague, a daughter faithful to one's parents' values and prescriptions are extremely difficult to harmonize. The need to fulfill these roles with precision and accuracy triggers a role conflict. TM women can hardly give up one of these roles, thus become more and more embroiled in a situation of "*despair*", characterized by an unsolvable doubt in which a definitive decision about one's existential priorities cannot be achieved. The stagnation that derives from despair paves the way for melancholic inhibition, emotional freezing and guilt.

Conclusions

In this pilot study conducted on 31 cases of postpartum depression, we analyzed the role of the personality structure called *typus melancholicus* (TM) in the pathogenesis of this disorder occurring after delivery. We extrapolated from clinical protocols elements which allowed us to make a diagnosis of TM personality in pregnant women by applying criteria of *orderliness, conscientiousness, hyper/heteronomia* and *intolerance of ambiguity*. We also analyzed the clinical presentation of depressive symptoms in our cohort by administering an in-depth psychopathological interview. Results are consistent with those provided by both qualitative [1] and quantitative [15] studies. The prevailing symptoms are the feeling of loss of feel-

ings, delusions of guilt and indignity and psychomotor inhibition. We also identified, in the period immediately following delivery, a critical state bridging the TM kind of existence with postpartum depression, which is characterized by conflicting roles leading to a phase of disorganized behaviour and confusion, which paves the way to the melancholic decomposition whose core feature is a type of existential paralysis. Even in this case, the results are consistent with those reported by Tellenbach who described the pre-melancholic situation as characterized by includence, remanence and, finally, despair.

Our analysis suggests that the TM personality structure may represent a valid model for the early diagnosis of women at risk to develop an episode of postpartum depression, even in those cases in which a clear anamnesis of major depression, as well as other types of mood disorder or symptoms before and during pregnancy, cannot be established. The TM structure can also enhance our understanding of the interplay between personality traits, the characteristics of the situation "motherhood" and the presentation of depressive symptoms.

The major limitations of this study are due to the characteristics of the study design (pilot study): the small number of patients and the cross-sectional nature of the study which did not allow to establish a longitudinal diagnosis (e.g. bipolar disorder) after follow up. Also, the absence of a standardized scale for the assessment of TM which could be applied to a larger sample of patients is a major limitation of this study. Overcoming these limitations is part of our research agenda.

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