hallucinations, expressed a belief that they were in communication with God and that witchcraft had been practised against them by relatives or neighbours. Depressive symptoms of a somatic nature became more apparent during the admission of 2–3 weeks and in subsequent admissions.

Emphasizing that (i) the beliefs expressed were endorsed by the relatives who saw the patients as ill because of their *behaviour*, (ii) the patients never relinquished their beliefs, (iii) affect was appropriate, (iv) the content of the delusions and hallucinations were intelligible (in Jaspers' sense of Verstehende psychology), the acute psychotic reaction was contrasted with mania, Leonhard's affect-laden paraphenia, the anxiety-elation cycloid psychosis, the Scandinavian psychogenic psychosis, paranoid and oneroid psychosis. The possibility that this reaction was a classical Kraepelinian syndrome with a cultural flavour was considered, but it was felt that there were considerable affinities with the 'hysterical' (culture-bound) psychoses such as the Caribbean bouffées délirantes and the acute paranoid reactions of West Africa, although the typical clouding of consciousness was absent. The semiological aspects and the association with the dominant culture were related to the subsequent depressive phenomenology.

PUERPERAL PSYCHOSIS

Post-abortion Psychosis and its Implications for the Aetiology of Puerperal Psychosis

By Dr Colin Brewer,
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The aetiology of puerperal psychosis remains controversial. Because of the obvious psychological and emotional implications of childbirth, there is a school of thought which regards it as largely psychogenic and therefore relies heavily on a psychotherapeutic approach.

The other school points, in contrast, to the major hormonal and biochemical changes which follow delivery, and suggests that these could well precipitate mental disturbance even without the intervention of psychological factors. Adherents of this view may tend to treat the psychosis rather as they might treat a severe endogenous depression, believing that if medical treatment is successful there will be little need for psychotherapy.

Neither school has yet produced any direct evidence for the importance of particular psychological or biochemical disturbances, and research from both standpoints is difficult since the condition is relatively uncommon. However, certain inferences may be drawn from the relative incidence of psychosis following childbirth and that following induced abortion.

Two recent studies have shown that the incidence of post-abortion psychosis is no more than 0·3 per 1,000-abortions, while the incidence of puerperal psychosis is of the order of 1·5 per 1,000 deliveries. It seems difficult to argue that an abortion is five times less psychologically stressful than childbirth, but it is a reasonable supposition that the biochemical changes after abortion are much less than those which follow delivery. Even when abortion is done after foetal movements have been felt—which must be about as stressful as an abortion can be—serious mental disturbance remains exceedingly uncommon.

This suggests that physiological factors are of greater importance in the genesis of puerperal psychosis—and possibly of lesser puerperal disorders as well—than psychological factors. It follows that 'medical model' treatment may be regarded as of prime importance in such cases. Comparisons may be made with the rare but theoretically interesting post-thyroidectomy psychoses. I do not imply that psychological factors and psychological treatments should be ignored.

A Clinical Study of Puerperal Psychosis

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The case notes of 85 patients admitted to the Mother and Baby Unit and 50 non-puerperal women of the same age group, admitted to Withington Hospital, Manchester, were studied. All case notes were abstracted and all information about their mental state, stripped of contextual clues, was noted. The abstracts were reviewed by two social workers and two psychiatrists, all of whom were ignorant as to the number of patients with puerperal psychosis.

Fifty of the patients began their illness within two weeks of delivery. The two psychiatrists were generally able to identify these patients to within a significant level of 0·01, while the social workers were unable to do so beyond a chance level. Of the 50 puerperal psychotic women 36 were identified by one or other of the psychiatrists ($P = 0·0001$).

An analysis using Wing's 'PSE Syndromes' showed that clouding, lability, agitation and loss of reserve were significantly associated with the puerperal state. These results do not support the prevalent view that puerperal illness is non-specific. They are compatible with the hypotheses that this illness is *either* a specific psychosis *or* a manifestation of manic-depressive illness.