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Research paper

The structure of negative emotional states in a postpartum inpatient sample

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ABSTRACT

Background: Depression and anxiety disorders exhibit comorbidity, and the same relationships have been observed in postpartum samples. The tripartite model posits that anxiety and depression overlap due to shared and unique symptom components. The present study tested whether a one-factor model, or a three-factor model consistent with the tripartite model, provided a better fit to anxiety and depression symptoms in a postpartum sample.
Methods: The sample consisted of 663 postpartum psychiatric inpatients who completed self-reported questionnaires assessing symptoms of anxiety and depression.
Results: Confirmatory factor analysis revealed that a three-factor model consistent with the tripartite model provided a good fit to anxiety/depression data. This model consisted of three factors: positive affect, negative affect, and autonomic arousal. Positive affect was related to depressive diagnoses and negatively related to anxiety diagnoses; autonomic arousal was related to anxiety diagnoses; and negative affect was uniquely related to mixed anxiety–depressive diagnoses.
Limitations: The sample consisted of postpartum psychiatric inpatients and the generalisability of results to other postpartum samples is not known.
Conclusions: Postpartum anxiety and depression appear to be characterised by three differentiable symptom clusters. Postpartum anxiety, depression, and mixed anxiety–depressive diagnoses are differentially associated with these symptom clusters. These findings suggest that the tripartite model may be useful in guiding assessment, differentiation, and treatment of postpartum emotional disorders.
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1. Introduction

Many psychiatric conditions may present in the postpartum period. Depression is particularly common: approximately 10–15% of women will meet diagnostic criteria in the first postpartum year (Cooper and Murray, 1998). Whilst fathers can also experience difficulties in the postpartum period, the present paper focuses on maternal distress. The term 'postpartum depression' refers to depressive disorders occurring following childbirth, and substantial research has focused on delineating the course, symptomatology, and aetiological factors of postpartum depression (e.g., Cooper and Murray, 1995; Hendrick et al., 2000; Whiffen and Gotlib, 1993). The term has also served as an umbrella term for a wide spectrum of emotional disorders following childbirth (Rowe et al., 2008).

Whilst postpartum depression may not represent a diagnostic entity distinct from depressive disorder occurring at other life stages, the concept has arguably been useful for identifying factors that require special consideration when assessing and treating postpartum emotional disorders (Brockington, 2004; Riecher-Rössler and Rohde, 2005). The concept of postpartum depression has also been useful in distinguishing depressive disorders from other psychiatric conditions that may occur following childbirth, such as the mild and transitory postpartum 'blues', and postpartum psychosis (Grigoriadis and Romans, 2006). It has also been useful for raising awareness of postpartum emotional disorders in the community (Buist et al., 2008). Moreover, given increasing awareness of adverse consequences associated with postpartum psychiatric illness, screening instruments (e.g., the Edinburgh Postnatal Depression Scale, EPDS; Cox et al. (1987)) have been developed to detect depression in postpartum populations.

As discussed, whilst the concept of postpartum depression has been useful for a number of reasons, the terminology and use of this 'diagnosis' has not been without limitations. As aforementioned, the term has not been uniformly used to refer to a single diagnostic entity and postpartum depression has sometimes been

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confounded with other emotional syndromes (Rowe et al., 2008). In particular, anxiety has typically been subsumed within postpartum depression (Matthey et al., 2003). Anxiety has been observed in postpartum women, but until recently it was primarily viewed as a feature of postpartum depressive disorders (e.g., Pitt, 1968; Ross et al., 2003). The confounding of postpartum anxiety and depression is evident in the EPDS, which was described as a unidimensional depression scale, but factor analyses identify a distinct 'anxiety' factor (see Cunningham et al., 2014, for review). Furthermore, several studies have demonstrated that women with anxiety disorders score above validated cut-off scores for probable depressive disorder (Matthey et al., 2003; Rowe et al., 2008). Hence, there is a risk that postpartum anxiety disorders may be overlooked or misdiagnosed. As postpartum anxiety disorders are not routinely screened for in the postpartum period, they are more likely to be overlooked or misidentified compared to postpartum depressive disorders. Consequently, postpartum anxiety needs to be distinguished from depression, so that treatments can be appropriately targeted (e.g., Austin and Priest, 2005).

However, a major obstacle to detection of postpartum anxiety disorders is that few self-report anxiety scales have been validated for postpartum use (Ross et al., 2003). One approach has been to develop postpartum-specific anxiety measures (e.g., the Perinatal Anxiety Screening Scale; Somerville et al. (2014, 2015). However, anxiety and depression overlap as syndromes (e.g., high-correlation of anxiety and depression scales) and clinical disorders (i.e., high-comorbidity of anxiety and depressive disorders; Clark and Watson (1991)). This is inconsistent with their classification in diagnostic systems such as DSM-5 and ICD-10 as categorically distinct entities, and poses a difficulty for their psychometric assessment and discrimination. Hence, an alternative framework that accurately represents the relationship between anxiety and depression is required.

One such model proposes that anxiety and depressive disorders reflect a broader underlying syndrome, or "general neurotic syndrome" (Andrews, 1996). That is, emotional disorder symptoms represent insignificant variations in the manifestation of a broader syndrome that are erroneously classified as separate disorders. Whilst there is evidence for shared variance and genetic influences underlying depressive disorders, and anxiety disorders (Zinbarg et al., 1994), evidence for discriminating features of anxiety and depression contradicts the unitary position. For example, content analyses of scales suggested that the anxiety scales with the best discriminant validity tend to measure physiological symptoms of anxiety rather than anxious mood, and the depression scales with the best discriminant validity tended to assess loss of interest and pleasure rather than other aspects of depressed mood (Clark and Watson, 1991). Factor analytic studies have also provided evidence for more than one construct underlying affective experience.

An alternative model of anxiety and depression is the tripartite model (Clark and Watson, 1991). Anxiety and depression overlap due to a shared underlying general distress factor called negative affect (NA). However, anxiety and depressive disorders also have unique symptom components: depressive disorders are specifically associated with positive affect (PA), whereas anxiety disorders are specifically associated with autonomic arousal (AA). High PA reflects pleasant engagement with the environment, enthusiasm, and interest; whereas absence of (or low) PA is characterised as a tendency towards experiencing fatigue and lethargy (Clark and Watson, 1991). Depressive disorders are characterised by reduced PA. Previous evidence supports NA and PA as related but distinguishable constructs: thus, affective states may reflect low PA, high NA, or their combination (Watson et al., 1995a; Watson and Tellegen, 1985). AA is characterised by physiological symptoms reflecting overarousal of the sympathetic nervous system, and is specifically characteristic of anxiety disorders.

The tripartite model has received support across various clinical and non-clinical samples(e.g., Chorpita et al., 1998; Joiner, 1996; Watson et al., 1995a). Whilst these studies have differed in the hierarchical arrangement of these factors (e.g., Brown et al., 1998), they have broadly supported a tripartite structure of anxiety and depressive symptoms, and have provided evidence that the structure is stable across clinical and non-clinical populations.

The tripartite factors have demonstrated differential relations to anxiety and depressive disorder diagnoses. Brown et al. (1998) examined relations of anxiety and depressive disorder factors and tripartite factors in psychiatric outpatients. In the best-fitting model, NA emerged as a higher-order factor influencing all of the disorders; PA emerged as a higher-order factor influencing depression and social phobia; and AA emerged as a lower-order factor: rather than being related to all of the anxiety disorders, it was positively related to panic disorder/agoraphobia and inversely related to Generalised Anxiety Disorder.

The finding that NA accounted for substantial shared variance across anxiety and depressive diagnoses has been used to explain the comorbidity and has also led to the assertion that generic treatments can be designed to be applicable across emotional disorders (by targeting NA) (Barlow, 2004). Nevertheless, the finding that the tripartite factors could not be collapsed into one factor (Brown et al., 1998) suggests that PA and AA are also relevant to treatment, and psychometric discrimination of anxiety and depression may be improved by assessing these components (Clark and Watson, 1991). There is evidence that these symptom domains are differentially modified by particular treatments, including psychotherapeutic methods and pharmacological agents. For example, Kring et al. (2007) examined changes in NA, PA, and AA in patients treated naturalistically with cognitive-behaviour therapy. Consistent with the tripartite model, NA was associated with depression and anxiety symptoms; AA was more strongly related to anxiety; and PA was more strongly related to depression. Reductions in depression and anxiety symptoms corresponded with reductions in NA; and AA also decreased, particularly in patients with panic disorder. PA increased in treatment for patients with substantial decline in depression symptoms, but only over an extended treatment period. Nutt et al. (2007) reviewed preliminary evidence suggesting that antidepressants that enhance noradrenergic and dopaminergic activity may be more effective over serotonergic agents for symptoms of low PA. Consistent with their findings, Tomarken et al. (2004) observed greater impact of a dopaminergic antidepressant on low PA compared to anxiety symptoms. On the other hand, Dichter et al. (2005) did not observe differential effects of serotonergic and noradrenergic antidepressants on PA and NA – rather, both drugs led to changes in these symptom dimensions. If the tripartite model applies to a postpartum sample, these symptom dimensions may represent specific targets in treatment, and may lead to the development of treatment protocols that focus on targeting the symptoms that are most prominent.

Whilst the association of tripartite factors to anxiety and depressive disorders have been examined, the symptom profiles of comorbid anxiety/depressive presentations have scarcely been considered. Zinbarg et al. (1994) observed that subthreshold cases of anxiety and depression (i.e., not meeting full criteria for anxiety or depressive disorder) were characterised primarily by non-specific/NA symptoms and were differentiable from anxiety and depressive disorders by the lack of prominence of PA and AA. In previous studies, subthreshold and mixed diagnoses (including adjustment disorders) have often been assigned in the postpartum period (Austin et al., 2010; Matthey et al., 2003; Phillips et al., 2009).

Given increasing recognition for the need to assess and differentiate anxiety and depression, as well as increasing evidence that

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