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Title

Association of postpartum depressive symptoms and urinary incontinence. A cohort study.

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Clinician need to be aware that, although postpartum UI is often mild, it is followed by more new cases of depression or antidepressant consumption.
Association of depression and urinary incontinence. A cohort study

Fritel X, Tsegan YE, Pierre F, Saurel-Cubizolles MJ.

Abstract

Objective: Our objective was to clarify whether de novo urinary incontinence (UI) in the postpartum period is associated with depressive symptoms or antidepressant drug consumption.

Study Design: 2002 pregnant women were recruited between 2003 and 2006 for the EDEN mother–child cohort. This analysis included 1413 women who reported no UI before pregnancy. Severity of UI was assessed by the Sandvik index. At 4 and 12 months postpartum, depressive symptoms were assessed by the Edinburgh Postpartum Depression Scale (EPDS ≥ 10 defines depressive symptoms) and consumption of antidepressant drugs was reported.

Results: At 4 months postpartum, 198 women (14%) reported de novo UI; 74% (n=146) reported mild UI, 26% (n=52) moderate, and none severe; prevalence of depressive symptoms was higher in women with than without UI (22.1% vs. 15.9%, p=0.045), and consumption of antidepressant drugs was more frequent (4.7% vs. 1.4%, p=0.005). At 12 months postpartum, the mean (±SD) EPDS score differed between women with than without UI (7.30 ±3.46 vs. 6.57 ±3.72, p=0.016) but was half that at 4 months postpartum. The incidence of new cases of depressive symptoms or antidepressant consumption at 12 months was greater with than without UI (23.8% vs. 15.3%, p=0.012).

Conclusions: Although UI is mild in most cases at 4 months postpartum, it is followed by more new cases of depressive symptoms or antidepressant consumption at 12 months.

Key words: postnatal depression, antidepressant consumption, postpartum care, urinary incontinence, cohort study
Introduction

Urinary incontinence (UI) is a common symptom after childbirth (1). Most often postnatal UI is moderate and regresses after a few months (2). However, it can also persist and lead to deteriorated quality of life and requests for care later in life (3,4). Fear of postnatal UI can motivate women or obstetricians to request elective caesarean section even without a medical indication (5).

The postnatal period is also a period susceptible to depressive symptoms, sometimes severe, that could impair the relationship between the mother and her baby or even lead to suicide (6). In the general population, women with UI may be more depressed than others (7). Postnatal UI appearing de novo in women who were continent before pregnancy may induce or increase a depressive syndrome. The few studies of the postnatal period show that postnatal UI is associated with depressive symptoms (8,9). However, these investigations did not determine a causal link between the two situations.

A priori, risk factors of postnatal UI and those of postpartum depression differ. The main risk factors for postnatal UI are obesity, maternal age, and vaginal childbirth. Muscle and neurological vaginal birth trauma could explain the postnatal UI (10). The main risk factors for postnatal depression are personal or family history of depression, stressful life events, low partner support, or social isolation (11,12).

We aimed to test whether de novo postpartum UI is related to altered mood or taking psychotropic drugs and whether this association is maintained or increases over time.
Materials and methods

The data were derived from the EDEN cohort (Etude sur les Déterminants pré et postnataux précoces du développement psychomoteur et de la santé de l’ENfant, https://eden.vjf.inserm.fr/index.php?lang=en), whose aim was to study the pre- and postnatal determinants of child development and health. Study participation was proposed to all women visiting the prenatal clinic before their 24th week of pregnancy in the university hospitals of Nancy and Poitiers, our aim was to recruit women as early in pregnancy as possible. Exclusion criteria were multiple pregnancies, known diabetes before pregnancy, French illiteracy or planning to move out of the region within the next three years. Among the 3758 women invited to participate, 2002 (53%) accepted to be enrolled in the study. Recruitment started in February 2003 and lasted 27 months in each centre (1034 women from Nancy and 968 from Poitiers). On average, women were included at 15 weeks of pregnancy (range: 8-26). Their mean age was 29 years (range: 18-44) and 30% of the women were pregnant for the first time. Compared to the 2003 Enquête Nationale Périsetale (National Perinatal Survey: a sample of births recruited throughout the country), women included in EDEN and still followed-up at delivery, had a higher level of education.

To be included in this secondary analysis, the women had to complete a questionnaire about UI mailed 4 months after childbirth and declare that they did not have UI before the pregnancy. UI 4 months after birth was defined by a positive response to the question "during the past month have you had involuntary leaking of urine?" The severity of incontinence was assessed by the Sandvik severity index (15). This index is the product of the frequency and volume of leaks, ranging from 0 to 8. Four classes are defined for UI severity: 0, no incontinence; 1–2, mild incontinence; 3–4, moderate incontinence; 6–8, severe incontinence.

Depressive symptoms was assessed by questionnaires mailed 4 and 12 months postpartum by 2 indicators. The first, the Edinburgh Postpartum Depression Scale (EPDS), is a 10-item questionnaire, responses to each item ranging from 0 to 3 (16). The overall score ranges from 0 to 30; a score of 10 or higher defining probable depression. The second relates to the consumption of antidepressant drugs in the month preceding the mailed questionnaire.
Anthropometric and socio-demographic characteristics were maternal age at delivery grouped into 4 classes: < 25 years, 25–29, 30–34, ≥ 35 years; educational level in 4 classes: below high school diploma, high school diploma or equivalent, first university degree, above first university degree; occupational group in 5 classes: 1) managers or professionals; 2) middle management; 3) office or clerical workers and civil servants; 4) other employees in shops or services, farmers, and workers; 5) no paid occupation; marital status: married, part of an unmarried couple, or single; and body mass index (BMI). Tobacco use in pregnancy and at 4 months postpartum was described in dichotomic variables as smokers or non-smokers. For obstetric history, we retained the number of deliveries and their mode (caesarean delivery only, at least one vaginal delivery); history of birth of a baby weighing ≥ 4 kg; and for the last delivery, mode of delivery (caesarean, vaginal spontaneous, vaginal instrumental) and active second phase more than 30 min. Breastfeeding was considered in 4 modalities: no breastfeeding, ≤ 10 weeks, 11 to 17 weeks and still breastfeeding at 4 months at completion of the questionnaire.

UI was described by its incidence. Risk factors were studied by bivariate analysis of the relation of obstetric and socio-demographic data and UI (no, mild, moderate) by chi-square test. The relation between de novo UI and postpartum depressive symptoms was studied by comparing the proportion of depressed women and women consuming antidepressant drugs at 4 and 12 months. We also studied new cases of depressive symptoms at 12 months after excluding cases reporting depressive symptoms at 4 months. The mean change in EPDS score between months 4 and 12 postpartum was compared for women with and without de novo UI at 4 months; we also analysed new cases of consumption of antidepressant drugs. Then to evaluate the relation between UI and several risk factors simultaneously, multivariate analysis was performed by polytomic logistic regression; only variables with p<0.20 on bivariate analysis were introduced in the multivariate model, except for centre and mode of delivery which were forced in the multivariate model. A last analysis restricted to women respondent to follow-up questionnaires (4 and 12 months) was undergone to evaluate the relationship between UI and depressive symptoms or antidepressant consumption, we used chi-square test for nominal variables and t test for continuous variables;
adjusted OR for age, occupational group, marital status, parity, and centre were estimated using a logistic regression.

Data were analysed with SAS 9.3 (SAS Inst., Cary, NC). P<0.05 was considered statistically significant.

The EDEN study received approval from the ethics committee (CCPPRB, Comité Consultatif de Protection des Personnes en matière de Recherche Biomédicale) of Kremlin-Bicêtre Hospital on December 12th, 2002. Informed written consent was obtained from mothers for herself at enrolment and for her newborn child after delivery. The data files were registered with the French Data Authority (CNIL, Commission Nationale Informatique et Libertés).
Results

Among the 2002 women recruited during pregnancy, 1413 (71%; mean age 29.5 years ±4.7, range 17–44 years) were included in this analysis; 353 women who had not responded to questions about UI and 236 who reported UI before pregnancy were excluded. Included women were older, with a higher educational level, were more often in couple, and had a lower parity than excluded women (Supplementary Table S1). In total, 14% (n=198) declared de novo UI at 4 months postpartum; 74% (n=146) were mild, 26% (n=52) moderate, and none severe UI. The incontinence was related to stress only (leakage during physical effort, coughing, or sneezing) for 37% (n=74), urge only (leakage related to an urgent need to urinate) for 9% (n=18), mixed (stress and urge) for 47% (n=93) and other 7% (n=13). Table 1 shows the frequency of the postpartum urinary incontinence and its severity by medical and socio-demographic characteristics. Moreover, the frequency of UI and its severity were not at all related to smoking during pregnancy neither at 4 months postpartum.

In the multivariate model of UI (no, mild, moderate), factors contributing to UI were the occupational group, with the lowest risk among the more qualified occupations and a higher risk of moderate incontinence among women without a paid job, as well as duration of the second active phase of the last delivery, with a higher risk among women with a second phase of labour ≥ 30 min (Table 2).

At 4 months postpartum, 17.8% (215/1210) of women reported depressive symptoms (EPDS ≥ 10) or used antidepressants. The prevalence of depressive symptoms or antidepressant consumption was higher for women with than without de novo postpartum UI (Table 3). With a more severe definition of depression, the difference was still significant: the proportion of women with EPDS ≥ 13 or using antidepressants was higher among women with UI than among women without UI (14.4% vs 8.7%, p=0.02).

Among the 1413 women included in the analysis, 177 did not respond at 12 months postpartum; 12-month respondents were older, with a higher educational level, and were more often in couple (Supplementary Table S2). At 1 year postpartum, the mean EPDS score remained higher for women with than without UI, but the difference was reduced by half between 4 and 12 months.
postpartum (1.41 vs 0.73; Table 3). At 1 year postpartum, they were no more significant difference for depression or antidepressant consumption between women with and without de novo postpartum UI when the analysis was adjusted for age, occupational group, marital status, parity, and centre (Table 3). New cases of depressive symptoms or antidepressant consumption at 12 months were more frequent in women with than without UI at 4 months postpartum (Table 3). At 4 months postpartum, depressive symptoms or antidepressant consumption was more often reported in case of urge UI (50%, 7/14) than in case of mixed UI (32%, 26/81) or stress UI (15%, 10/67; analysis restricted to women respondent to both questionnaires, chi-square test, p=0.007). At 12 months postpartum we didn’t find any difference related to UI type: depressive symptoms or antidepressant consumption was reported by 7% in case of urge UI (1/14), 36% in case of mixed UI (29/81), 24% in case of stress UI (16/67); and 20% (2/10) in case of other UI (p=0.095).
In our sample, UI at 4 months postpartum was often mild and was associated with an increased postpartum depression screening score and frequent consumption of antidepressant drugs. Follow-up at 1 year postpartum demonstrated that postnatal UI was associated with an increased number of new cases of depressive symptoms or increased consumption of antidepressants. At 1 year postpartum, the mean screening depression score differed between women with than without postnatal UI, but the difference was reduced by half as compared with 4 months postpartum.

The strengths of our study are its longitudinal follow-up and the large number of women included. We use a standardised measure of UI that incorporates assessment of symptom severity, and a measurement of depressive symptoms at 2 time points in the first 12 months postpartum using a well-validated measure. With successive questionnaires, the EDEN cohort allows an exploration of the temporal relationship between UI and postnatal depression. One limitation is that urinary symptoms and incontinence history were reported at four months postpartum and not before. This may explain why only 236 women reported incontinence prior to pregnancy. Another limitation is the secondary and exploratory nature of this analysis, which did not allow for calculating a number of subjects required. The questionnaire for UI was not repeated at 12 months; therefore, the effect of postnatal depression on incident UI was not explored. Likewise, we could not specify whether the decrease observed between 4 and 12 months postpartum for the relation between UI and the depression score is associated with decreasing UI prevalence. Another limitation is that depressed women may over report UI condition. To examine this potential bias we performed an analysis limited to women without depressive symptoms at the time of UI assessment (4 months postpartum), and we observed more new case of depressive symptoms or antidepressant consumption at 12 months in case of UI at 4 months.

Studies using the EPDS found a score ≥ 13 in 7% to 17% of mothers between 6 weeks and 6 months after childbirth (8,9,17). These results are similar to our findings (8.2–10.5%). Results for the mean EPDS score should be interpreted with caution because the mean score is not used in
clinical practice. The scale was developed to detect postnatal depression by using a cut-off between 9 and 13 depending on the sensitivity and specificity expected.

Postnatal UI prevalence is estimated between 6% and 21% and is often mild: in the cohort reported by Altman et al., the prevalence of stress UI was 21% at 5 months postpartum and occurred less than once a week for three quarters of women (18); for Vikrup et al., the UI prevalence was 6% at 3 months postpartum and occurred daily for less than one quarter of women (1). In most cases, women are not bothered by postnatal urinary symptoms (19).

In our longitudinal study, postnatal urinary incontinence reported at 4 months postpartum was followed by an increase in new depression or intake of psychotropic drugs 8 months later. Brown and Lumley interviewed 1336 women 6 to 7 months after giving birth: the risk of depression (EPDS ≥ 13) was multiplied by 2 with UI (8). Hullfish et al. interviewed 146 women 6 weeks after childbirth: the depression score (EPDS) was associated with the urge incontinence quality of life impact score (URGE-IQ) but not urge incontinence symptoms (URGE-UDI) (9). In their longitudinal study, van de Pol et al. found a relationship between overactive bladder syndrome and depressive symptoms during pregnancy but not at 1 year postpartum (20). Mood disorders likely increase the impact of incontinence on quality of life. Depression is known to decrease health-related quality of life (21). Depression may be a factor favouring the reporting or complaining of incontinence symptoms and happiness may favour ignoring or underreporting leakage. A cohort study of older women (mean 60 years old) showed that depression was associated with incident UI, but UI was not associated with incident depression (22).

Although postnatal UI in our sample was often mild, it was associated with increased incidence of maternal depression or antidepressant use at 12 months postpartum. Thus, measuring the severity of incontinence (leakage frequency and quantity) captures only a part of the problem experienced by women. Clinicians need to be aware of the risk of depression associated with postnatal incontinence.
Acknowledgements


Funding

References


15  

22  
Table 1. De novo urinary incontinence at 4 months postpartum and severity by women's characteristics. Chi² test.

<table>
<thead>
<tr>
<th>Women's characteristics</th>
<th>De novo urinary incontinence at 4 months postpartum</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
<td>Yes, mild</td>
</tr>
<tr>
<td>N</td>
<td>1413</td>
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<tr>
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<td>&lt; 25</td>
<td>203</td>
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<tr>
<td>25–29</td>
<td>530</td>
<td>87.9</td>
</tr>
<tr>
<td>30–34</td>
<td>471</td>
<td>84.7</td>
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<td>≥ 35</td>
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<td>84.2</td>
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<tr>
<td>&lt; High school diploma</td>
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<tr>
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<td>84.0</td>
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<td>&gt; University, first degree</td>
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<td>88.9</td>
</tr>
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</tr>
<tr>
<td>Intermediate occupations</td>
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<td>86.8</td>
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<td>85.4</td>
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<td>Unmarried couple</td>
<td>565</td>
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<tr>
<td>Single</td>
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<tr>
<td>≤ 18.5</td>
<td>121</td>
<td>91.7</td>
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<tr>
<td>18.5–25</td>
<td>917</td>
<td>86.4</td>
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<tr>
<td>25–30</td>
<td>244</td>
<td>82.4</td>
</tr>
<tr>
<td>≥ 30</td>
<td>105</td>
<td>83.8</td>
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<td>Parity</td>
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<td>686</td>
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</tr>
<tr>
<td>2</td>
<td>504</td>
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<tr>
<td>3 or more</td>
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<td>Highest birth weight, g</td>
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<td>≥ 4000</td>
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<td>Delivery by</td>
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<td>Caesarean only</td>
<td>183</td>
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<td>Vaginal, at least one</td>
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<td>Mode of last delivery</td>
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<td>Last active second phase of labour</td>
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<td>≤ 30 min</td>
<td>1175</td>
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<tr>
<td>&gt; 30 min</td>
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<td>1–10 weeks</td>
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<td>11–17 weeks</td>
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### De novo urinary incontinence at 4 months postpartum

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<th>Yes, mild</th>
<th>Yes, moderate</th>
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<td>9.7</td>
<td>2.8</td>
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<td>no</td>
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<td>10.3</td>
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<td>Smoking at 4 months postpartum</td>
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<td>87.2</td>
<td>9.6</td>
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<tr>
<td>no</td>
<td>1098</td>
<td>85.6</td>
<td>10.6</td>
<td>3.8</td>
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</table>
Table 2. Risk factors of de novo urinary incontinence (UI) at 4 months postpartum.
Polytomic logistic regression adjusted for centre.

<table>
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<tr>
<th>Women's characteristics</th>
<th>De novo urinary incontinence at 4 months postpartum</th>
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<tr>
<td></td>
<td>No UI</td>
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<td>Vaginal, instrumental</td>
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Table 3. De novo urinary incontinence 4 months postpartum and depressive symptoms at 4 and 12 months postpartum. Non-adjusted p values, and adjusted odds ratios for age, occupational group, marital status, parity, and centre. Analysis restricted to women who responded both questionnaires (4 and 12 months postpartum; N = 1226)

<table>
<thead>
<tr>
<th>Depression indicators</th>
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<tbody>
<tr>
<td></td>
<td>% (n/N), or mean (± sd)</td>
<td>Yes % (n/N), or mean (± sd)</td>
<td>Non adjusted p value</td>
<td>Adjusted OR (95% CI)</td>
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<td>4 months postpartum</td>
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<tr>
<td>Depressive symptoms (EPDS ≥ 10)</td>
<td>15.9 (168/1054)</td>
<td>22.1 (38/172)</td>
<td>0.045</td>
<td>1.47 (0.98-2.21)</td>
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<td>Mean EPDS</td>
<td>4.84 (4.72)</td>
<td>6.25 (4.84)</td>
<td>0.001</td>
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<td>Antidepressant consumption</td>
<td>1.4 (15/1040)</td>
<td>4.7 (8/170)</td>
<td>0.005</td>
<td>3.13 (1.23-7.92)</td>
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<td>Depressive symptoms (EPDS ≥ 10) or antidepressant consumption</td>
<td>16.5 (172/1040)</td>
<td>25.3 (43/170)</td>
<td>0.006</td>
<td>1.67 (1.13-2.47)</td>
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<td>12 months postpartum</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depressive symptoms (EPDS ≥ 10)</td>
<td>20.5 (216/1054)</td>
<td>24.4 (42/172)</td>
<td>0.242</td>
<td>1.18 (0.80-1.75)</td>
<td></td>
</tr>
<tr>
<td>Mean EPDS</td>
<td>6.57 (3.72)</td>
<td>7.30 (3.46)</td>
<td>0.016</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean EPDS change between 4 and 12 months postpartum</td>
<td>+1.72 (4.45)</td>
<td>+1.05 (4.45)</td>
<td>0.067</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antidepressant consumption</td>
<td>2.8 (29/1048)</td>
<td>4.2 (7/166)</td>
<td>0.306</td>
<td>1.43 (0.61-3.37)</td>
<td></td>
</tr>
<tr>
<td>Depressive symptoms (EPDS ≥ 10) or antidepressant consumption</td>
<td>22.0 (228/1036)</td>
<td>28.9 (48/166)</td>
<td>0.049</td>
<td>1.37 (0.94-1.99)</td>
<td></td>
</tr>
</tbody>
</table>

New cases of depressive symptoms or antidepressant consumption at 12 months postpartum ‡

<table>
<thead>
<tr>
<th>Depression indicators</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% (n/N)</td>
<td>% (n/N)</td>
<td>Non adjusted p value</td>
<td>Adjusted OR (95% CI)</td>
</tr>
<tr>
<td>Depressive symptoms (EPDS ≥ 10)</td>
<td>14.4 (128/886)</td>
<td>20.9 (28/134)</td>
<td>0.053</td>
<td>1.53 (0.96-2.43)</td>
</tr>
<tr>
<td>Antidepressant consumption</td>
<td>1.5 (13/865)</td>
<td>1.6 (2/126)</td>
<td>0.928</td>
<td>0.85 (0.24-2.92)</td>
</tr>
<tr>
<td>Depressive symptoms (EPDS ≥ 10) or antidepressant consumption</td>
<td>15.3 (132/865)</td>
<td>23.8 (30/126)</td>
<td>0.012</td>
<td>1.70 (1.08-2.70)</td>
</tr>
</tbody>
</table>

‡ New cases of depressive symptoms or antidepressant consumption among women not reporting depressive symptoms or taking antidepressant at 4 months postpartum
Table S1. Characteristics of excluded women from the analysis (Chi² test).

<table>
<thead>
<tr>
<th></th>
<th>Included women</th>
<th>Excluded women</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N=1413 %</td>
<td>N=589 %</td>
<td></td>
</tr>
<tr>
<td>Age, years</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>less than 25</td>
<td>14.4</td>
<td>20.1</td>
<td></td>
</tr>
<tr>
<td>25-29</td>
<td>37.5</td>
<td>28.5</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>30-34</td>
<td>33.3</td>
<td>32.8</td>
<td></td>
</tr>
<tr>
<td>35 or more</td>
<td>14.8</td>
<td>18.7</td>
<td></td>
</tr>
<tr>
<td>Educational level</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; High school diploma</td>
<td>25.5</td>
<td>38.5</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>High school diploma</td>
<td>18.5</td>
<td>16.6</td>
<td></td>
</tr>
<tr>
<td>University, 1st degree</td>
<td>22.9</td>
<td>18.2</td>
<td></td>
</tr>
<tr>
<td>&gt; University, 1st degree</td>
<td>33.1</td>
<td>26.7</td>
<td></td>
</tr>
<tr>
<td>Occupational group</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Managers, professionals</td>
<td>11.4</td>
<td>9.9</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Intermediate occupation</td>
<td>39.6</td>
<td>31.6</td>
<td></td>
</tr>
<tr>
<td>Office or clerical workers, civil servants</td>
<td>23.3</td>
<td>18.6</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Shop, service, manual workers</td>
<td>19.8</td>
<td>32.7</td>
<td></td>
</tr>
<tr>
<td>No paid occupation</td>
<td>5.9</td>
<td>7.1</td>
<td></td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married couple</td>
<td>54.7</td>
<td>46.1</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Unmarried couple</td>
<td>40.2</td>
<td>44.0</td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>5.1</td>
<td>9.9</td>
<td></td>
</tr>
<tr>
<td>Parity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>48.6</td>
<td>32.9</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>35.7</td>
<td>39.4</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>2</td>
<td>11.7</td>
<td>18.9</td>
<td></td>
</tr>
<tr>
<td>3 or more</td>
<td>4.0</td>
<td>8.7</td>
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</tr>
</tbody>
</table>
Table S2. Characteristics of women who did not fill the 12 months questionnaire among those included in the analysis (Chi² test).

<table>
<thead>
<tr>
<th></th>
<th>Women without a follow-up at 12 months postpartum</th>
<th>Women with a follow-up at 12 months postpartum</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N=177</td>
<td>N=1236</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Age, years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>less than 25</td>
<td>24.3</td>
<td>12.9</td>
</tr>
<tr>
<td>25-29</td>
<td>39.0</td>
<td>37.3</td>
</tr>
<tr>
<td>30-34</td>
<td>26.6</td>
<td>34.3</td>
</tr>
<tr>
<td>35 or more</td>
<td>10.2</td>
<td>15.4</td>
</tr>
<tr>
<td>p</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Educational level</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; High school diploma</td>
<td>41.1</td>
<td>23.3</td>
</tr>
<tr>
<td>High school diploma</td>
<td>17.7</td>
<td>18.6</td>
</tr>
<tr>
<td>University, 1st degree</td>
<td>20.6</td>
<td>23.3</td>
</tr>
<tr>
<td>&gt; University, 1st degree</td>
<td>20.6</td>
<td>34.9</td>
</tr>
<tr>
<td>Occupational group</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Managers, professionals</td>
<td>6.2</td>
<td>12.2</td>
</tr>
<tr>
<td>Intermediate occupations</td>
<td>31.2</td>
<td>40.8</td>
</tr>
<tr>
<td>Office or clerical workers, civil servants</td>
<td>25.0</td>
<td>23.0</td>
</tr>
<tr>
<td>Shop, service, manual workers</td>
<td>30.1</td>
<td>18.3</td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married couple</td>
<td>47.4</td>
<td>55.7</td>
</tr>
<tr>
<td>Unmarried couple</td>
<td>41.7</td>
<td>40.0</td>
</tr>
<tr>
<td>Single</td>
<td>10.9</td>
<td>4.3</td>
</tr>
<tr>
<td>Parity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>46.9</td>
<td>48.9</td>
</tr>
<tr>
<td>1</td>
<td>35.0</td>
<td>35.8</td>
</tr>
<tr>
<td>2</td>
<td>15.2</td>
<td>11.2</td>
</tr>
<tr>
<td>3 or more</td>
<td>2.8</td>
<td>4.1</td>
</tr>
<tr>
<td>p</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>