

## Challenges in Diagnosing and Treating Postpartum Blues, Depression and Psychosis

Dr. Carol A. Lewis, Troy University/Global Campus  
Alison Daly Byers, Troy University/Global Campus  
Sarah Deann Malard, Troy University/Global Campus  
Dr. Gregory A. Dawson, Troy University/Global Campus

### Abstract

With recent media attention and a growing awareness in popular culture, the appropriate treatment for postpartum depression has taken center stage as a prevalent women's health issue. There is little agreement on the definition, existence and treatment of postpartum depression. Contributing to this factor is the lack of research that exists to support which method of counseling best treats postpartum depression. The intent of this paper is to suggest that with increased counseling and counselor involvement postpartum depression can be lessened, decreasing the length and severity of the symptoms without the use of anti-depressants

### Challenges in Diagnosing and Treating Postpartum Blues, Depression and Psychosis

Despite many research studies and a growing awareness throughout the late 20<sup>th</sup> century, postpartum depression (PPD) has remained an understudied phenomenon. When Texas housewife Andrea Yates murdered her five children in 2001, PPD returned to the forefront of media attention. Yates had a history of PPD and postpartum psychosis; she was eventually found not guilty by reason of insanity (Doherty, 2007). Moreover, when actress Brooke Shields (2005a) published her memoir detailing PPD, fellow actor Tom Cruise publicly condemned her use of antidepressants. Shields fired back by defending her choice and became a vocal advocate for women seeking help with PPD (2005b). These two incidents serve as important reminders that PPD is a prevalent counseling issue, which warrants further study.

Prichard (1835) reveals that mood changes in women after childbirth have been observed for hundreds of years, yet this condition has not been adequately addressed by the counseling profession. Albright (1993) states that at least 12% of women suffer from some serious form of PPD. At issue: At what point do the symptoms of depression become critical or dangerous to the life of the mother or the child?

PPD affects a significant number of new mothers and has a negative impact on families. PPD has been shown to impair mother-infant bonding (Moehler, Brunner, Wiebel, Reck, & Resh, 2006), family relationships and social functioning (Mauthner, 1998), and even infant development (Ramchandani, Stein, Evans, O'Connor, 2005; Whitaker, Orzol, & Kahn, 2006). PPD can become disruptive or dangerous to the life of the mother and/or the life of the child.

### Diagnosing Postpartum Depression

There is little agreement on the definition, existence and treatment of postpartum depression. Many factors contribute to the difficulty of diagnosing and treating the problem. The *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR*; American Psychiatric Association [APA], 2000) classifies PPD as major depression single episode or recurrent with postpartum onset. These symptoms are considered the same as those for disorders in non postpartum women. For instance, the *DSM* formally characterizes PPD as any major depressive, manic, or mixed episode which occurs postpartum. As such, a diagnosis of PPD is determined when one experiences at least five of the nine symptoms listed for major depression at least four

weeks following childbirth. These symptoms listed in the *DSM* (2000) include the following:

- persistent depressed mood
- lessened interest in performing tasks
- considerable weight loss or gain
- oversleeping or lack of sleep
- restlessness or lack of energy
- excessive feelings of remorse
- difficulty concentrating
- preoccupation with death (pp.349-356).

New mothers may suffer from the above symptoms; however, a diagnosis of PPD cannot be given until four weeks postpartum. The common feelings of exhaustion and anxiety while adjusting to an infant's arrival coupled with a significant decline in hormone production during the initial postpartum period is considered "baby blues" (Abrams & Curran, 2007; Hendrick, Altschuler, & Suri, 1998). Since these symptoms are typical of the postpartum experience, they are not yet considered pathological.

Beck (1983) describes a client's experience of depression when one or more of these ideations is present:

- A. Fatigability, crying spells, suicidal threats;
- B. The underlying motivational disturbances (if any), the wish to avoid activities or to escape from life;
- C. Underlying the motivation, a cluster of cognitions, such as the belief that striving toward a goal is futile, that there are no satisfactions ahead, and that he is defeated, deprived, and defective. (p. 265).

Adding to the debate surrounding symptoms, research conducted by Ugarriza (2002) discovered that mothers who self-reported symptoms of PPD often described milder or different symptoms altogether from those listed for major depressive disorder with postpartum onset in the *DSM* (APA, 2000). Curiously, the study also pointed out that health care providers cited biological factors as the cause of the mothers' symptoms, while mothers primarily attributed their symptoms to social factors or confidence, rather than hormonal or biological processes. Specific factors warranting a diagnosis of PPD include the following:

- lack of confidence in parenting skills
- complications with breastfeeding
- sleep deprivation (not sleep disorders)
- being overwhelmed by parenting responsibilities
- caesarean section delivery
- adjusting to numerous role changes
- little assistance from family or friends (pp. 227-233).

Ugarriza (2002) further observed that the depression was not persistent; instead, it came and went periodically. The two studies varied in that in Beck's study (1992) some of the participants experienced suicidal ideation, while none of Ugarriza's participants admitted to such thoughts. Similarly, a literature review (Lindahl, Pearson, & Cope, 2004) examining suicide during the postpartum period suggested that suicide was not a prevalent occurrence. While these symptoms are not exhaustive, they represent some of the problems that can occur when diagnosing PPD.

In contrast, two studies (Beck, 1992; Ugarriza, 2002) suggest different symptoms from those listed in the *DSM*. Symptoms which are not considered in the *DSM-IV-TR* but may contribute to the mothers' PPD include the following:

- hormonal imbalance
- conforming to new roles
- breastfeeding problems

- complicated pregnancy or delivery
- little assistance from family or friends (pp. 166-170).

Specifically, as related to PPD, these symptoms are usually recognized between two weeks and three months following birth. In addition, the symptoms of the condition tend to have a gradual onset (Ugarriza & Schmidt, 2006) and may last up to two years following birth.

Following childbirth, a large number of new mothers experience life altering mood swings. This period in a woman's life involves changes on numerous levels including hormonal, physical, emotional, social, and identity. This puerperal madness (Prichard 1835) is referred to as postpartum blues, postpartum depression or postpartum psychosis. According to the *DSM*, the prominent symptoms of postpartum condition may include depression, anxiety, extreme worry, panic attacks, short temper, irritability, moodiness, sleep problems, extreme fatigue, sadness, frequent crying, feelings of inadequacy, guilt, hopelessness and despair, not eating or eating too much, difficulty concentrating, making decisions, loss of sexual interest, persistent frightening thoughts of suicide, harm to the baby (APA, 2000).

While it is important to understand what postpartum depression is, it is just as important to understand what it is not. It lies between what is typically referred to as "baby blues" and the more severe postpartum psychosis as described in the *DSM* (APA, 2000 p. 423). The baby blues, which affects approximately 70% of new mothers, tend to be temporary and relatively harmless. Baker, Mancuso, Montenegro, & Lyons (2002) describe similar symptoms for baby blues that are also indicative of PPD: weepiness, feeling disoriented, sleeplessness, excessive worry, and unstable mood. The baby blues disappear after about fourteen days and are considered a transition into motherhood.

At the other extreme lies postpartum psychosis, a mood disorder that may be present in as many as one in 500 mothers following birth. Postpartum psychosis primarily affects women who have experienced mood disorders or postpartum mood disorders in the past. Like baby blues, it appears within the first four weeks postpartum (Luskin, Pundiak, Habib, 2007), but affected women are often consumed with thoughts of harming the infant or even a feeling that the child is "possessed" (APA, 2000 p. 422). Mothers, families, and health care providers must understand the differences among the three when considering treatment.

The pervasiveness and etiology of PPD has remained somewhat inconsistent through the years. O'Hara and Swain (1996) conducted a meta-analysis that reviewed the prevalence of PPD without psychotic features. Their review estimated that 13% of new mothers experience PPD. Likewise, Brett, Barfield, & Williams (2008) reviewed a related study that was conducted by the Center for Disease Control in which 11% to 20% of women self-reported PPD. In this study, tobacco use, physical abuse, financial stress, trauma, and partner-related stress were also identified as possible risk factors for PPD.

In addition, young mothers, mothers with less education, and mothers receiving Medicaid were more likely to report depressive symptoms. Finally, women were most likely to experience PPD if they were a minority, of low socioeconomic status, or if they had previously experienced depression (Rich-Edwards, Kleinman, Abrams, Harlow, McLaughlin, Joffe et al., 2006).

A wide range of diagnostic standards and a variety of assessment tools have been used by different researchers, resulting in many different conclusions (Albright 1993). In a review of eight different screening instruments for PPD, the conclusion reached showed that "given the lack of consensus about the utility and psychometric properties of screening measures in both clinical and research settings, additional research is needed to determine the best measure for large-scale screening efforts for PPD symptoms" (Boyd, Le & Somberg, 2005, p. 151).

### **Treating Postpartum Depression**

As PPD awareness grew, women were treated in a similar fashion as patients in a psychiatric ward with drugs, psychotherapy, or a combination of both (Dalton & Holton, 2001). Growing concern about the well being of new mothers prompted researchers to question the safety of this treatment. New research examined multiple

treatment methods in an effort to determine which ones were most efficacious. Common treatments for major depression such as psychotherapy, cognitive-behavior therapy, and non-directive counseling show effectiveness in treating PPD (Cooper & Murray, 1997). More recent research studying less conventional psychotherapeutic treatments such as hypnosis (Yexley, 2007), electroconvulsive therapy (Forray & Ostroff, 2007), art therapy (Perry, Thurston, & Perry, 2008), and exercise (Dritsa, Da Costa, Dupuis, Lowensteyn & Khalifé, 2008) have shown promise in relieving some symptoms of PPD.

With media attention and a growing awareness in popular culture, the appropriate treatment of PPD has taken center stage as a prevalent women's health issue. Both Milgrom, Negri, Gemmill, McNeil, & Martin (2003) and Ugarrizza & Schmidt (2006) contend that health care providers who recognize that depression exists simply prescribe an antidepressant, often without truly understanding the consequences which may arise from its use (Appleby, Warner, Whitton, & Faragher, 1997). Mothers who are reluctant to take an antidepressant may not be aware of other choices available to them. As a result, many depressed mothers do not receive treatment.

No general consensus exists among counseling professionals for treating PPD. Women have choices, such as taking antidepressants, individual or group therapy, art therapy, alternative therapies, or a combination of these, when considering treatment. However, women who breastfeed may display skepticism when prescribed antidepressants because of the undetermined effect on the infant (Pearlstein, Zlotnick, Battle, Stuart, O'Hara et al., 2006). Both cognitive-behavior therapy (CBT) and interpersonal psychotherapy (IPT) in individual or group settings have been popular choices among treatment providers (Springate & Chaudron, 2005).

Psychotropic medication use in the postpartum period is of great concern for mothers, especially those who breastfeed. At this time, there are no randomized, placebo-controlled studies for PPD to determine what, if any, long-term effects medication has on breastfeeding mothers and their infants. Apparently, all medications that pass through breast milk will be ingested by the infant, but how the infant is harmed by the medication is not always evident (Payne, 2007). Such uncertainty creates challenges in studying the effects of psychotropic medications in women that choose to breastfeed.

Even so, some researchers have studied various aspects of antidepressant use. Appleby et al., (1997) compared the use of an antidepressant and placebo with that of a cognitive-behavior therapy (CBT) group that met for either one or six sessions. They concluded that there was no clear advantage to using the antidepressant as a conjunctive treatment to the CBT therapy, and that six sessions of therapy were superior to one session.

For mothers who choose not to nurse, psychotropic medication still does not seem to be a popular choice. Pearlstein et al. (2006) studied choices of treatment among nursing and non-nursing mothers. They found that women without prior mental illness preferred psychotherapy over taking medication. In addition, they noted that women with a history of depression were more likely to prefer a medication instead of psychotherapy.

Professional intervention has been encouraged as a response to the stages of the condition where symptoms are noticeable to friends and family of the mother. The drawback is that it requires an action on the part of an already depressed mother or other family member to get the system involved. A pro-active approach would be beneficial in maintaining the barometer of normalcy. The family's community, village or town once formed a support system to remind a mother of the inevitability of these puerperal stages and to lend support. These support groups included mothers, siblings, aunts, cousins, neighbors and, grandmothers. The majority of responsibility now falls on the shoulders of counseling professionals to promote acceptance of these varying conditions as a postpartum norm requiring attention.

PPD is undeniably a distinct medical condition which warrants treatment. Despite this awareness, little research has been devoted to empirically determining the most effective methods of treatment. While many studies have examined possible treatments, much remains to be done to determine the most appropriate course of therapy.

### **Cognitive Behavior Therapy**

When treatment appears to be the most viable option, Appleby et al., (1997), Milgrom et al. (2005), Ugarriza & Schmidt, (2006) show that cognitive behavior therapy (CBT) is an effective treatment modality. For instance, CBT has been known to be as effective as taking a prescribed antidepressant thereby providing another, perhaps even safer, option for treatment. This is a substantial finding for the mother who is apprehensive about taking an antidepressant as Appleby et al., (1997) demonstrated CBT's efficacy in six sessions when compared to an antidepressant. Another study conducted by Milgrom et al. (2005) shows promise for CBT in both individual and group settings. Participants receiving CBT showed a vast decrease in symptoms when compared to women who only received counseling from a primary care manager. This study also demonstrated that individual therapy appears to be more beneficial than group therapy. Finally, Ugarriza & Schmidt (2006) tested the plausibility of CBT along with relaxation exercises and problem solving techniques delivered over the telephone. Their basis for delivering therapy via telephone was that women who are busy tending to a newborn have time constraints which make traditional therapy inconvenient. Interestingly, the same time constraints hindered telephone therapy. Not all participants were able to complete all phases of the treatment. However, women who minimally participated in this ten-week treatment reported considerable decreases in their levels of depression. Obviously, CBT can be a sensible treatment method for women with PPD. In many cases, mental health care providers are already well-versed in delivering CBT to clients and simply employ those same techniques for mothers with PPD (Springate & Chaudron, 2005).

### **Interpersonal Psychotherapy**

Interpersonal psychotherapy (IPT) is a brief, empirically-based psychotherapy that was initially used to treat major depression but has been adapted to treat many other mental illnesses. Practitioners of IPT focus on helping the client effectively deal with social and life events while lessening symptoms of depression. In addition, the goal is to promote autonomy independent of the therapeutic relationship (Weissman, Markowitz & Klerman, 2007).

The IPT counselor serves as an active and supportive element in the client's life. The counselor helps the client understand symptoms of the illness, and aid in problem-solving. The counselor does not determine the causes of the client's depression nor attempt to enforce drastic changes in the client's personality (Weissman, 1998).

Despite its versatility, IPT has not been extensively studied as a treatment option for PPD. Thus far, a true experimental design study that addresses IPT for PPD has yet to be published. However, completed studies have revealed that IPT for PPD is effective in both individual (O'Hara, Stuart, O'Hara, Gorman, & Wenzel, 2000; Clark, Tluczek, & Wenzel, 2003) and group settings (Klier, Muzik, Rosenblum, & Lenz, 2001; Reay, Fisher, Robertson, Adams, & Owen, 2005) and even as a preventative measure (Zlotnick, Johnson, Miller, Pearlstein, & Howard, 2001; Zlotnick, Miller, Pearlstein, Howard, & Sweeney, 2006).

Two studies have specifically studied individual IPT to treat PPD (O'Hara et al, 2000). The research design was well-planned with some limitations. First, the study was conducted with a large sample of women. A low attrition rate was maintained throughout the study. In addition, the researchers ensured that the counselors facilitating the therapy were well trained in delivering IPT. However, ten counselors facilitated the therapy, with each counselor treating a different number of clients. Also affecting the study was the fact that the women, on average, had been experiencing PPD for seven months which could have possibly biased the results. A final limitation was that participants were only qualified to participate in the study if they were married or living with a monogamous partner.

Similarly, Clark (2003) compared individual IPT with a mother-infant therapy group and a wait-list control group. Fifteen women completed treatment that was facilitated by four different counselors. In contrast to the participants in the O'Hara study, these women were likely to have had more severe depression because they were clinical patients at a psychiatric facility. As such, many still exhibited mild symptoms of depression post-

treatment. It must be noted, however, that this study contained important limitations. Foremost, many of the women assigned to the IPT group were exposed to antidepressant use which could have affected the results of the study. Second, women attending the IPT sessions frequently brought their infants to therapy and discussed parenting issues with the counselor. This was not entirely aligned with the focus of IPT, but it undoubtedly had therapeutic effects for the participants. All in all both results showed that women who participated in individual IPT reported a decline in their depressive symptoms and an improvement in their overall social functioning.

Two more studies have explored IPT in a group environment (Klier et al., 2001; Reay et al., 2005), but each study contained many limitations. Interestingly, neither study used a control group for comparison. This brings into question whether women who received no treatment would have experienced similar results. All participants in both studies were treated with IPT, but some of the participants in Reay et al., used antidepressants to supplement the IPT sessions. Therefore, it could have been possible that the antidepressant, rather than the IPT, was the therapeutic factor in treatment. Finally, both studies may have been limited by rater bias on the post-treatment assessments. Despite these limitations, IPT appeared to have therapeutic effects for women suffering from PPD.

Another variation to delivering IPT for PPD came in the development of a preventive intervention group. Zlotnick et al. (2001) developed an IPT-based intervention program aimed at preventing PPD. Both the pilot study and a larger scale study that followed (Zlotnick et al., 2006) yielded positive outcomes supporting IPT for PPD. Both studies greatly contrasted each of the other studies. To illustrate, only four sessions of the IPT-based intervention were administered to women prior to giving birth instead of the 12 suggested sessions. Additionally, the sessions functioned more as a psycho education group than as a therapy group where the women learned about parenthood, role transitions, and goal setting. A final variant to this study was in the shorter follow-up period observed in the study. This study only examined the development of PPD until the third month postpartum which could easily exclude women who develop depression late in the postpartum period.

### **Alternative Therapies**

Recent research has focused on alternative therapies such as hypnosis, electroconvulsive, art, and exercise. First, Yexley (2007) conducted a case study in which hypnosis successfully treated the participant's self-reported depressive symptoms. A larger study may assert the claim that this treatment is effective in treating PPD. However, research concerning hypnosis and other relaxation techniques is limited.

Second, Forray and Ostroff (2007) studied the effects of electroconvulsive therapy for five women with severe PPD who had previously failed pharmacological treatments. The participants showed great improvement of their symptoms after three to six sessions. However, the use of electroconvulsive therapy to treat PPD should only be administered to those who display severe symptoms and do not respond well to other methods of therapy.

In addition, art therapy has been shown to have therapeutic effects for women with mild to moderate PPD (Perry et al., 2008). While it may not be effective for all women, research suggests that it is best used as an adjunct to medication or psychotherapy. It was difficult to find results on the efficacy of art or music therapy for reducing postpartum distress as little research has been documented. Relaxation or guided imagery was addressed in a study (Goldfried, 1974) and found to alleviate postpartum emotional difficulties and facilitate adjustment to the new maternal role.

Finally, a home-based exercise program has been shown to reduce the symptoms of mental and physical fatigue in mothers with PPD (Dritsa et al., 2008). Results of this study suggest that exercise can have a long-term impact on women with PPD. Results of three-month follow-up assessment revealed that women in the treatment group still exhibited less mental and physical fatigue when compared to those assigned to the control group.

Another alternative approach would be to institute post-partum therapy from the beginning of pregnancy as part of birthing classes or to prescribe counseling or group therapy sessions as often as the new baby sees a pediatrician. Many women refrain from telling others of their feelings because of shame, guilt or embarrassment. New mothers are expected to be happy, yet their depression escalates. Intervention is critical in helping to eliminate feelings of embarrassment or guilt with which the new mom may struggle in the absence of a required support group.

Overall, in society's current medical environment, there are few successful postpartum follow-up options. There are groups and private practices that address the subject of PPD as a legitimate condition worthy of treatment. They offer services such as screening, testing and in-home assistance (nurses, doulas and nannies), along with the prescription of readily available anti-depressants. The challenges that persist are the logistics of getting the postpartum mother to the physical location or getting the information and support to the now isolated new mother. Consequently, without further scientific research and the implementation of additional treatment alternatives, the postpartum mother is left to deal with these symptoms or the symptoms are being ignored until the situation becomes unbearable for all members of her family.

While different treatment options exist, certain options may not be suitable for every client. Women with PPD would benefit from working with a mental health care provider to determine an appropriate course of treatment. Likewise, mental health care providers have an obligation to familiarize themselves with both empirically-based treatments and emerging treatments to establish a proper treatment plan for their postpartum clients. Recommendations for further study include an investigation into whether increasing counseling for and counselor involvement for PPD can decrease the length and severity of symptoms without the use of anti-depressants.

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