The Comparison of Postpartum with Non-postpartum Depression: A Rose by Any Other Name

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A strong tradition exists in the psychiatric literature to consider postpartum depression a distinct diagnosis. However, the empirical evidence indicates that, in terms of etiology and relapse rates, postpartum depression is indistinguishable from non-postpartum depression. Symptomatically, postpartum depression seems to involve a milder disturbance, suggesting that it is best seen as an adjustment disorder. This paper summarizes the empirical evidence relevant to the distinct diagnosis question, and considers the benefits to be derived from challenging the traditional view of postpartum depression.

Keywords: postpartum depression, distinct diagnosis

Il existe une tradition dans la littérature psychiatrique selon laquelle la dépression postpartum est considérée comme spécifique sur le plan diagnostique. Cependant, les données empiriques suggèrent, tant sur le plan de l'étiologie que sur celui du taux de rechute, que la dépression postpartum ne peut être distinguée des autres formes de dépression. Sur le plan symptomatique, la dépression postpartum semble être accompagnée de moins de perturbation, ce qui suggère qu'elle serait plutôt à considérer comme un problème d'ajustement. Cet article présente un résumé des données empiriques qui touchent la question du diagnostique distinct de la dépression postpartum et met en lumière les bénéfices à tirer de la remise en question de sa conception traditionnelle.

Mots clés : dépression post-partum, diagnostique spécifique

In the past decade, well over 100 studies have been published on the subject of "postpartum depression." This statistic would excite little curiousity if it were not for the fact that this diagnosis is not recognized by the major diagnostic systems currently in use. The diagnosis "postpartum depression" does not appear either in the revised edition of the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM-III-R) (American Psychiatric Association 1987) or in the most recent version of the International Classification of Disorders (ICD 9) (World Health Organization 1978) published by the World Health Organization. In both North America and Europe, contemporary nosologists agree that postpartum disorders do not differ qualitatively from disturbances that are not precipitated by childbirth. Yet, both in research and in practice, a strong tradition exists to consider depression that occurs after childbirth to be a distinct diagnosis.

The consequences of this position for the study and treatment of postpartum depression have been profound. There has been little cross-fertilization between the general depression and the postpartum depression literatures. As a result, research on postpartum depression lags behind that on general depression, both methodologically and conceptually. This gap, and its implications, are especially apparent in the area of treatment. Cognitive therapy has been shown to be a highly effective treatment for depression (Rush et al 1977). Yet not one of the 100 odd papers published in the past decade suggested that cognitive therapy might be efficacious in the treatment of postpartum depression. In

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this paper, I will, first, consider the empirical evidence for the distinct diagnosis position. Next, I will outline the implications of the distinct diagnosis position for research and treatment, and consider the benefits to be derived from challenging the traditional view of postpartum depression.

What is Postpartum Depression?

Three types of postpartum depressive reactions are described in the literature. Recently a consensus has emerged that these should be delineated for research purposes (Hopkins et al 1984, Kendell 1985). Although they may eventually be seen as related phenomena, at this time, separating them conceptually will bring greater clarity to this research area.

The first type, which is often what people associate with the term "postpartum depression", is the maternity blues. This term refers to transient symptoms of tearfulness, irritability, depression, and labile mood, which develop within the first ten days postpartum. At least one of these symptoms is reported by two-thirds of all new mothers (Yalom et al 1968). The symptoms seem to be uniquely related to childbirth because they do not systematically follow related medical procedures, such as hysterectomy (Kendell et al 1984). However, the precise biological mechanism involved in the blues remains unknown. Because the syndrome is common and the symptoms are reminiscent of premenstrual tension, the blues are generally assumed to be related to the re-adjustment of hormonal systems after childbirth (Stein 1982).

The second type of postpartum depressive reaction is postpartum (or puerperal) psychosis, which is an acute psychotic reaction precipitated by childbirth. Postpartum psychoses are acute states, with a symptom picture dominated by hallucinations and agitation. Symptomatically, they are indistinguishable from non-postpartum affective psychoses (Herzog and Detre 1976). Women with postpartum psychoses also do not differ from matched controls in previous psychiatric history or in the rates of psychiatric disorder among their first degree relatives (Platz and Kendell 1988). Thus, the evidence suggests that most postpartum psychoses are indistinguishable from non-postpartum episodes. However, a minority of cases may be "genuine" postpartum psychoses, in that they occur after childbirth in women who are not otherwise vulnerable to affective psychoses (Platz and Kendell 1988).

The focus of the present paper is the third type, postpartum depression, which is a moderate to severe mood disturbance, comparable to a Major Depressive Episode in DSM-III, or to a Major or Minor Depression in the Research Diagnostic Criteria (RDC) system (Spitzer et al 1978). The criteria for Major Depression are similar in DSM-III and the RDC. These are: (i) depressed mood or loss of interest, and (ii) at least four symptoms from eight symptom groups, including appetite disturbance, sleep disturbance, agitation or retardation, loss of interest, fatigue, self-deprecation or guilt, indecisiveness or lack of concentration, and suicidal ideation. A diagnosis of Minor Depression requires a mood disturbance, and only two associated symptoms. DSM-III does not distinguish Major Depression that occurs with or without psychotic features except with a fifth digit code. This is unfortunate because psychotic and non-psychotic postpartum depression may be different constructs (Hopkins et al 1984). An approximation of this distinction is made in the literature: studies of hospitalized women are typically described as studies of "postpartum psychosis", while studies of community samples of women are described as studies of "postpartum depression". I will retain this distinction in the present paper. Thus, all of the studies cited in this paper were conducted with non-hospitalized samples of women.

Is Postpartum Depression a Distinct Diagnosis?

By using the adjective "postpartum" to describe this research area, investigators implicitly endorse a conceptual distinction between childbearing and non-childbearing depression. However, not all postpartum depression researchers agree that it is a distinct diagnosis. For instance, some assert that there exists a "continuity between 'post-natal' and 'other' depressions" (Watson et al 1984), while others insist that some disorders are "postpartum specific" (Steiner 1990). Researchers of postpartum depression tend to either adopt or reject the distinct diagnosis position in their work. For the most part, however, this choice is made without regard for the data, because very little empirical work has assessed similarities and differences in postpartum and non-postpartum depression. Only one study has actually compared a sample of postpartum depressed women who were not hospitalized with a matched sample of non-postpartum depressed women (O'Hara et al 1990, O'Hara et al 1991).

In a recent review of the empirical literature, I assessed the construct validity of the diagnosis "postpartum depression" (Whiffen 1991). If postpartum depression is a distinct diagnosis, then consideration of its phenomenology, prevalence, course, duration, and etiology should provide support for the view that it is qualitatively different from non-postpartum depression. In the review, I evaluated the evidence concerning several aspects of postpartum depression that are argued to distinguish it from non-postpartum depression. The results of this review are summarized here.

First, depression is believed to be more common in the postpartum than at other times. While it is certainly true that psychiatric admissions increase dramatically following childbirth (Kendell et al 1981), it is not clear that this increase can be attributed to increases in non-psychotic depression. Estimates of the prevalence of postpartum depression in community samples vary considerably. However, recent studies with large samples indicate that approximately 13% of childbearing women develop a diagnosable episode of depression in the postpartum (Whiffen 1991, Gotlib et al 1989). Interestingly, more than half of these episodes meet criteria for Minor but not Major Depression, which suggests

that postpartum depression tends to be relatively mild. To determine whether depression is more prevalent in the postpartum, the rates of Major and Minor Depression in postpartum samples were compared with those reported for non-hospitalized samples of women. This comparison demonstrated that depression, particularly Minor Depression, is more common in the postpartum than at other times. However, postpartum depression seems to remit at a faster rate than non-postpartum depression. Few cases of postpartum depression last as long as one year (Whiffen 1991), while epidemiological studies suggest that one-quarter of depressive episodes occurring in non-hospitalized samples last at least a year (Sargeant et al 1990). Episodes of postpartum depression may remit more quickly because they are milder.

Some researchers also assert that the symptoms of postpartum depression are "atypical". Pitt (1968) observed that postpartum depression is milder than the depression typically seen in psychiatric settings, and that postpartum depressed women present a different symptom picture, with less suicidal ideation and more anxiety and irritability. The empirical evidence suggests that postpartum depressed women do report different symptoms than do non-postpartum depressed outpatients, particularly more guilt and agitation. However, whether this is a meaningful difference is not clear; Postpartum depressed women may simply present a more mixed symptom picture, with more anxiety and fewer classic symptoms of depression, than do non-postpartum depressed outpatients.

These aspects of postpartum depression — its prevalence, remission rate, and symptomology — seem to be consistent with the hypothesis that postpartum depression is a distinct diagnosis. However, at the present time, the major difference between postpartum and non-postpartum depression seems to be that postpartum depression is milder. It is probably not useful to distinguish this diagnosis from other episodes of depression on the basis of severity alone.

On the other hand, several pieces of evidence suggest a continuity between episodes of postpartum and non-postpartum depression. For example, the women who are most at risk for developing postpartum depression are those who have a history of emotional problems, particularly of depression, prior to the pregnancy. Few studies have been conducted to determine whether postpartum depressed women are also more vulnerable to subsequent episodes of depression. However, one well-controlled study found that 80% of the women with postpartum depression had another episode of depression within the next 5 years (Philipps and O'Hara in press). Thus, the women who develop postpartum depression seem generally more vulnerable to affective disorders. This conclusion is inconsistent with the hypothesis that postpartum depression is a distinct diagnosis because the same women develop both postpartum and non-postpartum depressive episodes.

Surprisingly, many episodes of postpartum depression begin during pregnancy. Studies that have diagnosed depression both during pregnancy and the postpartum have found that as many as 40% of the postpartum depressed women were depressed during pregnancy as well (Gotlib et al in press). For these women, at least, the term "postpartum depression" is a misnomer because the episode cannot be related, etiologically, to any biological, obstetric, or psycho-social event that occurred during the postpartum period. If professionals find it useful to link depression with pregnancy, "childbearing depression" may be a more accurate term.

Finally, if postpartum depression is a distinct diagnosis, then it should be related etiologically to some variable, particularly one specific to childbirth, that is not present in the development of non-postpartum depression. This assertion is not borne out by the empirical literature. The variables most consistently associated with the development of postpartum depression are marital tension, low levels of social support, and negative life stress occurring during pregnancy and in the postpartum (Whiffen 1991). These same variables have been consistently associated with the development of non-postpartum depression as well (Barnett and Gotlib 1988). One study that compared the development of depression in 182 childbearing and matched, non-childbearing controls found the same predictors to be implicated in the development of depression in both samples of women (O'Hara et al 1991).

Postpartum depressed women also report many difficulties with infant care, including health problems and infant crying and temperamentality (Whiffen 1988). These findings have led some researchers to speculate that negative infant characteristics are implicated in the etiology of postpartum depression (Cutrona and Troutman 1986). However, these findings seem to parallel the reports of non-postpartum depressed women who find relationships with their children to be difficult and ungratifying (Weissman et al 1972).

The picture that emerges from the etiological studies is one where postpartum depression occurs when a woman experiences difficulties adapting to the new child. These difficulties may be exacerbated by a temperamentally difficult infant who challenges the mother's perception of herself as capable, by a social environment (ie. spouse, friends or family) that does not provide the woman with enough support to counteract negative messages about herself, or by a woman who is not resilient to stress.

To summarize, the central difference between postpartum and non-postpartum depression seems to be symptom severity, with postpartum depression involving a milder disturbance than is usual in depressed outpatients. This conclusion raises the possibility that the elevated rates of depression seen in the postpartum are artifactual. Postpartum depression researchers have focussed on a period in women's lives that is normally stressful and requires adaptation. Childbirth is a striking example, but other periods come to mind: For instance, when married couples separate or employed persons retire. One would expect that after these major life changes, rates of mild depression would also be elevated, and that the risk for depression would be greatest among people who have previously responded to life cir-

cumstances with depression. Researchers have not specifically identified the emotional upheaval accompanying these periods as "post-break up depression" or "post-retirement depression." Most likely they do not think it would be useful to distinguish depressions occurring at these times from those occurring otherwise. "Postpartum depression" seems to be a construct of similarly limited utility.

Implications for Research

If postpartum and non-postpartum depression are not distinct diagnoses, then what is true for one will generally be true for the other syndrome. Both literatures would benefit from an exchange of ideas. The postpartum depression literature, in particular, often seems to be re-inventing the wheel, as well-accepted global hypotheses about depression are tested in childbearing samples. General information about depression could be used to generate more refined hypotheses about the development of postpartum depression. Conversely, etiological models of depression could be tested in childbearing samples. The advantage of doing so is that a predictable proportion of women become depressed after childbirth. Women could be selected during pregnancy because they are at risk for postpartum depression, having, for instance, a psychiatric history. These women could then be followed prospectively to determine what variables contribute to the development of a depressive episode after a stressful life event.

Several studies used this strategy to test the attributional model of depression (Cutrona 1983, O'Hara et al 1982). However, more contemporary models have infrequently been tested in childbearing samples. One study examined the stress and coping model proposed by Lazarus and Folkman (1984) in a childbearing sample. Gotlib et al (in press) selected a sample of women who did not meet diagnostic criteria for depression during pregnancy. These women's stress levels and coping strategies, as assessed during pregnancy, were used to predict a diagnosis of postpartum depression. This design is a strong test of the hypothesis that stress and coping interact to produce depression, because none of the subjects were depressed at Time 1 and all underwent the same life stressor, childbirth, between Time 1 and Time 2. This study is an example of how depression models can be tested in childbearing samples.

Depression models may also be useful in understanding how postpartum depression develops. For instance, one model hypothesizes a characterological vulnerability to depression. Blatt et al (1982) argues that people who are prone to depression may be characterized as either dependent or self-critical. Both types of people need the approval of significant others to maintain self-esteem, and they differ primarily in the goals they pursue to secure this approval. While the dependent type explicitly strives to establish secure interpersonal relations, the self-critical type gains approval through work and academic success. There is evidence that interpersonal dependency, in particular, is a stable antecedent of depression (Barnett and Gotlib 1988). There is also empirical support for the view that dependency and self-criticism are especially associated with depression in intimate relationships that exacerbate the characterological vulnerability (Whiffen et al 1991).

Almost as an aside, Blatt et al (1982) noted that, in a sample of dependent women hospitalized with depression, the episode was often associated with childbirth. Women who are dependent may become vulnerable to depression when their marital relationship is disrupted by childbirth and infant care. Normally, the birth of a child has definite and negative consequences for the marriage: new parents are dissatisfied with their relationship and often feel estranged from one another (Belsky et al 1983). This normal experience may be difficult for the dependent woman to tolerate because her self-esteem is so contingent on the continued support and approval of significant others. When the support and nurturance which she is accustomed to receive from her partner are interrupted by the demands of parenthood, she may become depressed.

A different pathway to postpartum depression would be hypothesized by the "self" models. As represented by Kuiper and Olinger (1986), these models assert that individuals vulnerable to depression have tenuous self-esteem that is continuously evaluated and revised in light of feedback received from the environment. These individuals evaluate themselves in terms of "self-worth contingencies", that is, standards that they feel they must meet in order to feel worthy. For instance, a woman may feel that her self-worth depends on her ability to be the perfect wife and mother. Feedback that she is imperfect could trigger a negative self-evaluative cycle, leading to the conclusion that she has failed in this domain.

These examples illustrate the potential for the exchange of ideas between the general depression and postpartum depression literatures. Although the models were formulated to account for the development of depression generally, in both instances, specific hypotheses can be generated to explain the development of postpartum depression. Empirical studies based on well-articulated models of depression would represent a significant advance over the kind of research typically conducted on postpartum depression.

Implications for Treatment

The most common treatment for postpartum depression is time and time alone. In part, this may be due to the fact that postpartum depressed women tend not to seek help for their distress (Cox 1983). In addition, however, prevailing assumptions about the nature of postpartum depression work against its diagnosis and treatment.

Many practitioners, especially those in the health professions, believe that postpartum depression is a distinct diagnosis, and that its cause is some, as yet unidentified, biological variable. The most salient explanation, from this perspective, is that it is due to hormones, even though this hypothesis has not received empirical support (eg. O'Hara

et al 1991). What are the implications of postulating an hormonal mechanism? First, hormonal problems after childbirth are seen to be transient and self-regulating. As such, they do not require treatment: given time, the hormonal system will right itself. Second, in our culture, "hormonal" is almost a synonym for "irrational." When a practititoner attributes a woman's feelings to hormones, she or he is also likely to reject the woman's complaints as irrational and trivial. Thus, a woman's tearful assertion that she is a terrible mother or that her husband no longer loves her may be dismissed as hormonally-driven excess, rather than seen as symptomatic of her depression, and probably validated by her current experiences with her husband and child.

I do not know if this is an exaggerated view of the way postpartum depression is typically handled by the medical profession: there are no empirical data to address this question. However, the complete absence of references to the use of cognitive therapy in the treatment of postpartum depression suggests that it is not handled as a non-postpartum depression would be. My literature review also did not produce any controlled studies of the use of antidepressants with postpartum depressed women. Thus, the standard treatments for depression do not seem to be typically used with postpartum women. This indicates that postpartum depression is either not treated or is treated using methods that are not standard practice.

This situation may be changing. Some recent papers have suggested that postpartum depression can be treated with methods routinely used in the treatment of non-postpartum depression. For instance, two case studies — published by a behaviourist and a systemic therapist, respectively — reported successfully using assertiveness training and marital therapy in the treatment of postpartum depression (Philips 1986, Kraus and Redman 1986). In the future, I hope that controlled studies will be conducted to determine whether postpartum depression does respond to generic depression treatments.

Earlier in this paper, postpartum depression was characterized as an adjustment disorder that occurs when women have difficulty adapting to the stress created by a new child. This view of postpartum depression is supported by the etiological data, as well as the consistent finding that postpartum depressive symptoms tend to be mild. One investigator explicitly found depression to be more likely in the absence of social support (Cutrona and Troutman 1986, Cutrona 1983). This suggests that many cases may best be treated in peer support groups led by experienced therapists. These groups could provide the social support needed to counteract depressed women's negative self-evaluations. Similar groups have been found to be useful in facilitating adjustment to other life crises, such as divorce or the diagnosis of schizophrenia in a family member. Peer groups may help to normalize depressed women's feelings, and to validate their attempts to cope with the new child and to re-negotiate marital relations.

In conclusion, much is to be gained by challenging the traditional assumption that postpartum depression is a distinct diagnosis. Both research and practice would benefit from discarding the unsubstantiated view that postpartum depression is different from depression occurring at other times.

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