Moms Who Kill

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Summary: Postpartum mood disorders are more common than we realize: Up to 80 percent of new mothers experience mild depression within a year of giving birth. If the "baby blues" persist, depression can escalate to dangerous levels, influencing some women to experience psychosis and-in rare and tragic cases-to kill their offspring.

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During the first six weeks after giving birth, Jennifer Moyer was grateful for her beautiful new son and supportive husband. Yet she wasn't herself. She felt somewhat irritable and was having difficulty sleeping. And just after her first postpartum physical checkup, things began to unravel-and fast. The feeling that some unnamed harm was coming to her son overwhelmed her; she became hyperprotective, not allowing anyone-even her husband-to hold the baby. One month later, after three sleepless nights, anxiety and fear consumed her to a point where her son had to be physically removed from her, and she was forcibly taken to the hospital. Moyer was in the throes of postpartum psychosis.

The focus of a lot of media attention recently, this illness gained a voice largely due to the story of Andrea Yates, the woman found guilty of drowning her five children in a bathtub in Texas last year. Yates, who has a long history of mental illness, confessed to jurors that Satan had ordered her to kill her children. Though diagnosed with postpartum psychosis, she was judged capable of discerning right from wrong and sentenced to life in prison.

Despite considerable research into the nature of postpartum mood disorders, there is still no clear medical consensus on what causes it and how it should be treated. "Having grown up expecting motherhood to be one of the best times of life, many women suffer alone, feeling miserable but unaware that postpartum mood disorders have a name," explains Karen Kleiman, M.S.W., founder and director of the Postpartum Stress Center in Philadelphia.

Discerning Symptoms

As many as 50 to 80 percent of all women experience some degree of emotional "letdown" following childbirth-the so-called "baby blues." Fortunately, its more extreme sister disorder, postpartum psychosis, is rare, affecting only about one in 1,000 new mothers.

The baby blues, though, are common for numerous reasons. The baby's crying and the mother's interrupted sleep and soreness from breast-feeding are enough to make any woman feel irritable, if not overwhelmed and tearful. These feelings typically begin three to four days after the baby is born, according to Kleiman, but normally dissipate on their own within a few weeks.

If the blues last for more than two weeks, however, the new mother may be suffering from a condition of intermediate severity, postpartum depression (PPD), a mood disorder on par with clinical depression. Twelve to 16 percent of women experience PPD, which results in feelings of despondency, inadequacy as a mother, impaired concentration or memory and/or loss of interest or pleasure in activities.

Some women, like Moyer, also become paralyzed with fear and concern for the baby's safety. If such symptoms appear, it is important to seek professional consultation to help differentiate PPD from other conditions such as obsessive-compulsive disorder. Symptoms of anxiety are frequently an aspect of clinical depression, but true obsessive-compulsive symptoms signify a different disorder that needs proper diagnosis and treatment.

Shoshana Bennett, Ph.D., a special-education teacher, began suffering from these types of anxious feelings almost immediately after giving birth. "I felt helpless and hopeless," Bennett says now. "I was so afraid someone was going to hurt my baby that every day after my husband went to work, I would place all movable furniture behind the front door."

Though debilitating, the emotional reactions to being a new mom that signify depression are not as severe as those associated with postpartum psychosis, of which the predominant symptom is a "break" with reality-a loss of the ability to discern what is real from what is not. For instance, a woman with PPD may experience violent thoughts about her baby but recognizes that those thoughts are wrong and potentially dangerous. In that case, she will not act on them.

A woman with full-fledged psychosis, however, has temporarily lost the judgment needed to make this assessment. Very often, a woman with psychosis experiences a frightening sense of merging-she can't differentiate between where she ends and where her baby begins. Psychotic merger is so terrifying that she may try to avoid losing her sense of self by either committing suicide or infanticide, also known as suicide by proxy.

This was the case with Andrea Yates, whose suicide attempts ended with the deliberate drowning of her children. Perhaps, in her mind, to prevent the "loss of self," she was compelled to kill her children or herself, or both.

Infanticide is a very rare phenomenon; only about 4 percent of women who become psychotic kill their babies. Perhaps even fewer tragedies would occur if proper education and treatment were more readily available.

Researchers who study infanticide distinguish several different groups of parents who murder their offspring. Some kill as a result of psychotic delusions-the dread of parent-child merger or the belief that the child is trying to harm or kill them. Others murder their children out of profound depression and hopelessness. Often they carry strong religious ideas that killing their child will enable them both to enter an afterlife more peaceful than their current life. Susan Smith, the South Carolina mother who attempted to drown herself and her children by driving her automobile into a lake, may be an example of someone in this group. Although Smith ended up killing her children but not herself.

Tragically, there are also parents who kill their children out of vengeance and rage against the other parent. They want to hurt the other parent by depriving them of their most cherished relationship. This type of infanticide is committed far more frequently by fathers.

Assessing the Source

As with most mental illnesses, what causes the onset of postpartum mood disorders is still a matter of research and debate. Much of the medical community believes these syndromes may be caused by chemical imbalances in the brain-specifically shifts in hormone levels. According to Postpartum Support International (PSI), a network of mental health professionals and others concerned with promoting postpartum mental health and social support, the most well-researched theory to date suggests that a sharp drop in estrogen and progesterone following delivery is the culprit.

Research currently under way at the National Institute of Mental Health is examining these hormone-mediated mood shifts and Victor Pop, Ph.D., of the University of Tilburg in the Netherlands, recently presented his own findings at the annual meeting of London's Royal College of Psychiatrists, suggesting that women who produce certain thyroid antibodies during pregnancy were nearly- three times more likely to experience depression after childbirth.

"I think there will be a role for hormones in treating postpartum illnesses in the future," says Valerie Raskin, M.D., clinical associate professor at the University of Chicago. "[Hormones] will probably be used as a treatment first, then later as a preventive measure. The reproductive process may be the kindling, and the drop in hormones after childbirth may be the ember that starts the fire."

Various nonhormonal factors may also contribute to postpartum disorders of mood. Some studies suggest a relationship between a traumatic obstetric experience and PPD. Women who had caesarean deliveries, for instance, were significantly more susceptible to mood disorders as noted in one study appearing in the *Australian and New Zealand Journal of Psychiatry*.

Thyroid disease may also be a physiological trigger, suggests research by Stephen Pariser, M.D., a psychiatrist and mood-disorders specialist at Ohio State University Medical Center. Women's thyroid levels drop significantly after giving birth, and low thyroid levels have long been associated with depression-like symptoms. Having a personal or family history of mood disorders also increases the odds of developing PPD, pointing to a possible genetic factor.

Women who develop PPD or postpartum psychosis following delivery have a significantly greater risk of developing these conditions after subsequent childbirth. These women should be counseled about future pregnancies. If they do conceive additional children, careful psychiatric monitoring is mandatory.

Certainly, social elements also play an integral role in postpartum well-being. One important factor is a lack of social support, which includes poor relationships with others and insufficient childcare during the pre- and postnatal period. Strong support systems can help nurture and maintain self-esteem at stressful times, Kleiman asserts. "In turn, high levels of self-esteem are linked with adaptive coping behaviors-feeling entitled to ask for help, for example."

As a society, we tend to romanticize motherhood, creating a disparity between a woman's expectations and the reality that she will experience. "Society reinforces the myth of the perfect baby in the arms of the perfect mother, with all her maternal instincts intact," says Kleiman. "When there is a significant discrepancy between what a woman anticipates and what she actually experiences, guilt, confusion and great unhappiness can result."

In addition to societal pressures, personal adversities such as loss of a loved one, marital conflict or lack of financial security, can put some women at greater risk, according to PSI. Lifestyle and role changes also create internal conflict and stress: A new mother may lose the independence, spontaneity, personal time, sleep and physical shape that she once had, along with her role as an attention-drawing pregnant woman or as a career woman. Finally, she may simply miss adult company in general. "Women with PPD will find adapting to these losses especially difficult," Kleiman notes, "because of their increased vulnerability."

Mending Mothers

Most experts agree that combining talk therapy with medication seems the most successful approach to treating PPD. "Medication is warranted," Raskin explains, "because the situation is urgent and the quickest treatment makes sense." Depending upon the patient, psychotherapy may be combined with both group support and medication, which is prescribed according to the patient's individual symptoms while monitoring the various drugs' side effects.

The most commonly prescribed are the newer antidepressants including Prozac, Zoloft, Paxil, Celexa, Wellbutrin, Serzone and Effexor, as well as anti--anxiety drugs such as Ativan, Lorazepam and Klonopin. When the underlying cause of PPD is bipolar affective disorder, mood stabilizers-Lithium or Depakote, for instance-are also appropriate.

For women experiencing postpartum psychosis, more aggressive treatment is required. These mothers may be a threat to both themselves and their babies. Psychiatric hospitalization, as well as anti-psychotic and other psychiatric medications, is standard treatment along with individual, group or cognitive behavioral psychotherapy.

And because at least half of women with PPD experience a recurrence of the illness after having another child, responsible parenting necessitates careful thought and medical planning before deciding to get pregnant again. Once PPD is present, "all resources must go toward treating the mother," advises Raskin. "Stress of any sort, including the stress of caring for children, will prevent the mother from healing."

Preventing PPD

Effective prevention would help render treatment less necessary, avert emotional damage to children and potentially save lives. Shoshana Bennett is one mother who might have benefited from preventive measures. Instead, her childbirth classes concentrated on breathing techniques and what to pack for the hospital. And during her first postpartum checkup, Bennett's obstetrician glossed over her weight gain of 40 pounds and uncontrollable weepiness.

When Bennett mentioned to her family that she was having a difficult time, her mother-in-law-a postpartum

nurse for 20 years-told Bennett's husband, "Shoshana is a mother now. She needs to stop complaining and just do it." Bennett's own mother was supportive but, despite her background in therapy, failed to recognize the signs of serious emotional illness. Bennett also began seeing a psychologist, who only probed for issues in her past. Eventually, about two years after the birth of each of her two children, Bennett's obsessive concerns finally faded on their own.

Several years later, Bennett happened to see a television program on postpartum depression. "I cried for an hour, looked at my husband and said, 'That's me!'" she says. Afterward, she earned her Ph.D. in clinical psychology and founded a self-help group for postpartum disorder sufferers. Then in 1992, she was named president of the Post-partum Health Alliance, a California state organization.

Today, the discussion of postpartum mood disorders is often inadequate in reference manuals. General physicians can find the terms postnatal depression, postpartum depression and puerperal psychosis in the *International Classification of Diseases* manual, says Cheryl Meyer, Ph.D., J.D., an associate psychology professor at Wright State University in Dayton, Ohio. "However, they may only use these diagnoses for patients whose symptoms do not meet criteria for other disorders, such as depression," she explains.

Jennifer Moyer, now a coordinator for PSI and a postpartum support consultant, understands firsthand why medical professionals need to pay more attention to postpartum mood disorders. For her, recovery came after two years of medication, therapy and family support, and she believes that talking to someone who has experienced a severe postpartum mood disorder firsthand is essential for recovery. She now combines her own experience with her background in health care marketing to advocate for education and prenatal and postnatal screening.

Until the health insurance industry and government agencies are willing to allocate sufficient resources to guarantee the presence of skilled psychiatrists and psychologists on pre- and postnatal-care teams, assessing and treating postpartum mood disorders will continue to fall through the cracks. Both Moyer and Bennett join other health care professionals in the hope that efforts to focus on women's emotional needs before and after pregnancy will gain momentum. This effort will help other women and their families avoid disabling yet treatable illnesses or, tragically, from having to endure another preventable murder of an innocent infant.

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