

Preventing Post Partum Depression: A Case Report

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Introduction

During the past ten years, we have read or heard about mothers who became violent and, in bizarre ways, killed one or more of their children. Many of these women were prescribed anti-depressants following the birth of a child and the onset of a post partum depression (PPD). In many cases, these mothers have been described as loving, caring, and well functioning women who were given prescriptions for antidepressant medications, especially one of the serotonin re-uptake inhibitor (SSRI) types such as Prozac[®] or Zoloft.[®] There is strong reason to believe that these SSRI anti-depressant drugs can radically alter the functioning of a person's brain chemistry and lead to changes in thinking, emotional reactions, and behavior resulting in homicidal and/or suicidal violence.^{1,2} This type of un-maternal murderous behavior has been both shocking and baffling to many people. Because a plausible explanation of this appalling incomprehensible behavior is rarely, if ever provided, public reaction of both lay people and professionals to these murders is to vilify the mother. Even though there is well-documented evidence that many of these mothers were on SSRI anti-depressants and/or other powerful psychotropic drugs at the time of their crime, this fact is rarely if ever explored by journalists or other professionals. Psychiatrists hastily rush to the defence of their profession and its dependence on SSRIs and/or other powerful psychotropic drugs as the "standard of care" for depression. They are quick to deny that anti-depressant drugs can affect some people in such adverse ways.

Preventing PPD

Since these are not isolated cases, it is critical that we address some important questions that relate to PPD and its treatment with toxic drugs that increase the risk of catastrophic outcome. In this context, are there underlying biochemical factors that predispose some women to experience clinically significant PPD? If so, what changes can be made in nutritional biochemical support in order to reduce the risk of PPD? Or, better yet, is it possible to use scientific nutritional interventions to prevent the clinical manifestation of PPD entirely? If we can reduce the risk of PPD or actually prevent the onset of this type of depression, then we can help new mothers avoid the exposure to these toxic SSRI drugs that are known to be associated with catastrophic violence.

Bernard Rimland, Ph.D. described drug treatment as a "toxi-molecular" approach because the use of psychotropic drugs is inherently toxic by the very nature of their constituent toxic chemicals. The term "ortho-molecular" was applied by Pauling to describe nutritional treatments of psychological and emotional problems because these types of treatment tend to be corrective and more natural than introducing toxic drugs into a person's system.³ Based on the clinical experience of this writer, there are data from hair tissue mineral analysis (TMA) that strongly suggest that excess copper and/or a low Zn/Cu ratio are major contributing factors to the risk of PPD.^{4,5,6,7} According to Pfeiffer, excess copper is related to the effect of the estrogen in the birth control pill and can lead to significant psychological problems. Excess copper can also be accumulated in the cells and tissues, particularly in liver and brain, as a result of the effect of estrogen in hormone treatment.⁸ Clinically, it is significant

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to note that the same TMA excess copper and/or low Zn/Cu ratio found in PPD also reflect the same mineral imbalances that are found in the pre-menstrual syndrome (PMS). Taylor and Dalton described the extreme mood swings and violent behavior of some women who were strongly affected by hormonal and neuro-endocrine changes with their menstrual cycle.⁹ In some women who have this particular mineral imbalance, they are unusually susceptible to the effect of stress and/or stimulant drugs. Stress or stimulant drugs can quickly exacerbate the effects of the hormone and mineral imbalances leading to the intense emotional volatility that is common to what is now called PMS.¹⁰ Eli Lilly & Co. recently began to capitalize on this similarity of symptoms between PPD and PMS by aggressively marketing its SSRI Prozac[®] under the new label of Serafem[®] for PMS. Also, a new psychiatric diagnosis has been created for PMS called premenstrual dysphoric disorder (PMDD). So Lilly's ad-vertisements now promote Serafem[®] for PMDD.

Case Report

In 1999, a 33 year-old woman contacted me because she was pregnant with a third child. She was terrified of facing a third PPD and possible psychiatric hospitalization because she had had a severe PPD reaction with each of her first two pregnancies which resulted in immediate psychiatric hospitalization with extensive drug treatment until her husband's insurance ran out. Since she had severe adverse reactions to the different psychotropic drug trials that were prescribed for her, there was little or no improvement in her depressed condition each time. She described her hospitalizations as horrible traumatic experiences that left her feeling that she was really mentally ill and, therefore, she should not have another baby. When her third pregnancy was confirmed, her fears were exacerbated by the alarm expressed by her obstetrician who told her she must go on anti-depressant drugs as soon

as the baby was born. Her doctor led her to believe that, based on her previous history of severe PPD, the probability of her having another severe PPD was a virtual certainty. In 1998, the mother of this woman had referred her to me for a nutritional assessment and supplement recommendations hoping that this approach would help the daughter to recover from her PPD experiences. A major part of this nutritional assessment was to obtain a hair tissue mineral analysis (TMA) profile on her. From this first TMA, I already knew that she had a distinctive mineral pattern that could account for her susceptibility to PPD. I also knew that she responded positively to the nutrition supplement program that I had recommended for her the previous year (1998). Her TMA pattern showed a high copper, low zinc ratio in a slow metabolic profile. The Zn/Cu ratio was 2.12 (ideal Zn/Cu = 8.0). The slow metabolic profile has a high tissue calcium level in relationship to phosphorus. Calcium also was high in ratio to potassium. This elevated Ca/K ratio is associated with diminished cellular energy production and susceptibility to depression^{11,12,13,14} because it can be related to dysfunction of the hypo-thalamic-pituitary-thyroidal axis.¹⁵ It is also not unusual to find a high sodium/ potassium ratio when the TMA copper level is high and/or the Zn/Cu ratio is very low. This was indeed the case here with a Na/K ratio of 7/1 (ideal Na/K = 2.4/1). The elevated Na/K ratio reflects a chronic high stress condition with a strong susceptibility to intense emotional reactions (anger and/or anxiety) associated with the fight or flight stress response.^{16,17} This high Na/K stress ratio also tends to bring out a powerful psychological reaction involving what I refer to as the "Judge," a pheno-menological psychological concept.^{18,19,20}

The Judge Phenomenon

The "Judge" can bring on feelings of doom, deep sadness, hopelessness, overwhelming guilt, worthlessness, and panic.

The feelings are so overwhelming and awful that the person experiencing a "Judge attack" desperately wants to run away, but there is nowhere that feels safe. Homicidal and/or suicidal feelings may accompany a "Judge attack." In this particular case, I recommended that we update her TMA in order to ascertain what changes if any had occurred during the preceding year. The major change was that her calcium level had dropped significantly from 110 to 26 moving her from a slow metabolic type to a fast metabolic type. However, she still had a high copper level and a low zinc/copper ratio (2.83) that is associated with a high risk for PPD. She also still had a high Na/K ratio of 7.67/1. These data provided a basis for recommending supplements that would help her with the low Zn/Cu ratio and the high Na/K ratio. The supplements that were most helpful to her were zinc, vitamins C and B₆, chromium, potassium and magnesium. It should be noted here that these are the same supplements that are very helpful with PMS. Supportive counseling was also provided to this young woman by a licensed professional counselor. The counseling included relaxation exercises and helping her to deal with her "Judge." The Judge is that part of our personality that judges and criticizes whatever we do. The Judge exercises psychological power and control by terrorizing our inner child causing us much pain, anguish, low self-esteem, anxiety and depression. One of the main functions of the Judge is to block us in growth and development towards realizing our true potential. We all have an inner Judge component in our personality. The development of the Judge is inherent to our human nature and the manner in which our mind and body are connected by means of the stress response. As stress intensifies, the Judge becomes more activated psychologically. With relaxation, the Judge diminishes in its psychological effect on a person. Since the Judge is universal and is present in every-

one's personality, it is a psychological factor that can adversely affect any one or any situation. Since the psychological activity of the Judge is closely related to the stress response, as a particular situation becomes more uncertain or stressful, then the activity of the Judge needs to be taken into account. This was indeed the case with this woman's pregnancy. The messages from the Judge, regardless of whether the source is internal or external, can be very convincing. This is because the Judge is a "collector of evidence" to support its biased position. In this woman's case, the "evidence" was her previous two episodes of the PPD. Obviously, this was quite convincing, especially when the obstetrician expressed her concern with such conviction that PPD was inevitable and that the only solution was to go on anti-depressant drugs immediately following delivery of the baby. Our psychological assessment was that the woman's Judge and the Judge in the personality of close family members as well as that of her obstetrician were trying to convince her that she was mentally "ill" and that another PPD was inevitable. Therefore, a major part of her treatment during the remainder of this pregnancy was to provide her with a good deal of emotional support and to help reduce the impact of the Judges within and around her. As part of the treatment approach, I worked with the woman's husband to help him to understand the Judge concept and encourage him to be protective of his pregnant wife and her psychological needs. The treatment combination of nutritional supplements and counseling for both the woman and her husband resulted in a very positive outcome. This woman carried her baby to full term and delivered a beautiful healthy girl. She experienced no PPD whatsoever and she had a marvelous birth experience with a healthy happy conclusion to this pregnancy. She had an opportunity to experience the joy of delivering a healthy baby, nursing her newborn daughter and feeling like a normal healthy

mother. She had been deprived of this experience with each of her first two pregnancies that resulted in her being taken away from her newborn babies and treated like a seriously mentally ill person. It is important to note that the frame of reference and the paradigm applied here clearly showed the presence of high tissue copper levels and low Zn/Cu ratios. The TMA profiles also showed the presence of high Na/K ratios and the intense stress that is associated with this elevated ratio. In addition, we had a psychological model incorporating the Judge and "inner child" concepts that facilitated a powerful counseling process that reduced this woman's stress reaction and the psychological effect of her Judge. When a TMA profile is obtained, it reflects important aspects of the underlying mineral relationships that relate to both physical and psychological functioning. The TMA profile served as a guide to selecting a set of vitamins and minerals that were well suited to this woman's biochemical needs and supported her nutritionally throughout the remainder of her pregnancy. The integration of this psychological model together with the TMA based nutritional approach had a powerful synergistic effect that not only reduced this woman's risk for a reoccurrence of her PPD, but in fact, entirely eliminated its clinical manifestation following the birth of her third child.

Conclusions and Implications

This particular case is instructive in a number of ways. First, it brought out clinical laboratory data (TMA) that clearly showed the presence of a high tissue copper level and/or a low Zn/Cu ratio in a woman with a previous history of severe PPD following each of her first two pregnancies. According to PPD research, with a history of PPD, this woman would have been considered a very high risk for another severe PPD reaction following this third pregnancy. The TMA data also showed a chronic high Na/K ratio that is associated

with intense stress and emotional volatility. This is also the same mineral pattern observed in severe PMS. Second, this case showed that it is possible to apply TMA concepts and data in a clinically useful manner in order to offset the adverse trends reflected in the initial mineral imbalances. Most psychiatrists assume that there is a "biochemical" imbalance in clinical depression or PPD that can only be treated with one or more antidepressant drugs. The use of TMA data and selected nutritional supplements that clearly prevented the manifestation of PPD in this high-risk case suggests that there is very good reason to question the theories and assumptions of mainstream psychiatry related to the treatment of clinical depression and PPD. Also, when there is significant risk to the fetus if a depressed pregnant woman is treated with a SSRI drug, it is vitally important for health care practitioners to become familiar with TMA and the nutritional supplements that can support a woman throughout the remainder of her pregnancy with a high probability of reducing the risk of PPD. It is strongly recommended that further research be carried out using TMA data to further assess cellular nutrient mineral imbalances that are associated with female hormonal and neuro-endocrine problems, especially PPD and PMS. In view of the fact that a SSRI antidepressant medication is being actively marketed for "treating" PMS, the same psychological risks that have been found with SSRIs and violent behavior in PPD are highly likely to be present with SSRIs being prescribed for PMS. TMA data can also guide research with nutritional supplements in a prophylactic approach to PPD. TMA data can shed light on why a typical prenatal vitamin/mineral supplement may have adverse effects on women with a TMA profile like that described here. The typical pre-natal vitamin formula has too much calcium for this particular TMA mineral pattern. The calcium in most pre-natal

supplements will tend to lower the potassium level and increase the Na/K ratio. This will tend to increase the risk for PPD and intensify the emotional reactions associated with it. This will also be a mineral pattern that puts the woman at very high risk for severe stress reactions that will become further exacerbated with SSRI drugs. If stress or a drug increases the Na/K ratio beyond a certain threshold, then the emotional reaction of the stress response can shift from anger and/or anxiety to rage or panic. With the shift to rage and/or panic, higher cognitive processes and rationality are cut off. Impulsive behavior is more likely to occur with no foresight of consequences. This case also illustrates the critical role of psychological factors operating within the pregnant woman, but also within the broader "system" of family members and health care practitioners in which she found herself trying to cope with her own beliefs and fears about her previous experience with PPD.

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