Puerperal Psychosis and Neonaticide:

Case report and literature review

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Although, pregnancy and motherhood is usually a time of happiness and emotional well-being for a woman, it can also be a time of increased vulnerability to psychiatric conditions. Perinatal mental disorders have a negative and potentially detrimental impact on the health and safety of the affected mother and her offspring. These risks attribute to peripartum mental illness the significance of a true psychiatric emergency. The purpose of this presentation is to discuss a case of prepartum psychotic disorder that sadly led into the act of neonaticide and recap literature on puerperal mental disorders and infanticide. This presentation highlights the importance of the multidisciplinary approach, and updates issues of medical treatment.

CASE REPORT:

A newborn (24 hours) was murdered by her 30-year-old mother with the spike of her serum delivery system within the context of the increasingly deteriorating symptomatology of an acute puerperal psychotic disorder with a prepartum onset (4-5th month of gestation). The patient was convinced that her child was saved as it would be no longer tortured, and that, anyway, the child had been already half dead (psychotic libericide). The mother was detected shortly after her violent act while intending to commit suicide, but her disorder was managed only after neonaticide. She was positive for family history, but had no personal previous history of mental disorders.

MATERIAL AND METHODS: 120 articles throughout literature concerning perinatal psychiatric disorders were reviewed and evaluated via all electronic databases up to December 2018.

RESULTS: Poor prenatal and self care, substance abuse, and fetal abuse are usual short-term implications of puerperal mental disorders. Infanticide occurs in 4% of the cases with increased risk especially within 24 hours of delivery. The risk for malformations increases twofold as well as for prematurity - spontaneous preterm birth, poor fetal growth and fetal demise. There are also longer-term effects due to poor bonding, such as the offspring's increased vulnerability for psychosis and problematic relations with the mother. 4.5% of the mothers commit suicide, 33% have to live separately from their children (versus 3% controls), and 46% experience at least one relapse, therefore requiring subsequent hospitalization.

POSTPARTUM DEPRESSION (PPD): Affects 10-20% of women who experience a form of affective disorder during the postpartum period. Occurrence: potentially anytime during the

first 12 months postpartum, but usually between the 6th and 12th week. Clinical symptoms – except for the usual symptoms of a depressive episode: (a.) groundless maternal anxiety about the child's health; (b.) ideas of worthlessness about the maternal role; (c.) suicidal and sometimes infanticidal ideation.

20% of postpartum deaths are attributed to suicide due to postpartum depression. Approximately 80% of cases remain undiagnosed and untreated.

PREPARTUM DEPRESSION: 8.5-11% of childbearing women. 10-12% of postpartum depression has a prepartum onset. Often undiagnosed due to its resemblance to common pregnancy symptoms (weight gain, fatigue and sleep disturbances).

POSTPARTUM PSYCHOSIS: Heterogeneous diagnosis; 70-80% mood episodes with psychotic features within the spectrum of bipolar or schizoaffective disorder; 12% schizophrenia. Incidence: 1 in 1000 women in the general population. 1 in 4 women with bipolar disorder. 1 in 2 women with a history of prior postpartum psychosis. 90% of hospitalizations occur within 4 weeks after delivery. Clinical signs – abrupt onset; clinically prevalent psychotic symptoms - frequently changing delusions which are sometimes centered around the infant; severe cognitive impairment; coexisting affective disorder spectrum symptoms - mood lability; negation of pregnancy; insomnia; akathisia; irritability.

PREPARTUM PSYCHOSIS: Occurrence: 2nd and 3rd trimesters of gestation. Women with antenatal onset tend to experience postpartum deterioration and 50% have prenatal relapses in subsequent pregnancies (finding with a clear therapeutic impact highlighting effective and vigorous treatment in the prepartum period).

TREATMENT: Maintaining the risk-benefit equilibrium is especially important, as medication and parent disease may both have adverse effects on the fetus.

Avoidance of polytherapy; utilization of the lowest effective dose of drugs (antidepressants; mood stabilizers; atypical antipsychotics). The use of bupropion, maprotiline, clomipramine, amoxapine, valproate, carbamazepine, and benzodiazepines is contraindicated. Level 2 ultrasound controls performed in 11 to 13 weeks and 30 weeks (twice). Mostly preferred delivery by Caesarean section. Controlled or no exposure to breast milk. Upon delivery the infant should be monitored for withdrawal syndrome.

CONCLUSION: Effective management by multidisciplinary teams and treatment of prenatal psychiatric disorders is of exceptional importance.

(1) Bhat A. Postpartum: Balancing the Risks and Benefits. 37th Annual Advanced Practice in Primary and Acute Care Conference: October 9-11, 2014. (2) NICE guidelines (CG192) Antenatal and postnatal mental health: clinical management and service guidance; 2014. (3) Karakasi MV, Markopoulou M, Tentes IK, Tsikouras PN, Vasilikos E, Pavlidis P. Prepartum Psychosis and Neonaticide: Rare Case Study and Forensic-Psychiatric Synthesis of Literature. J Forensic Sci. 2017 Jul;62(4):1097-1106.