•> CASE 39

A psychiatrist is called in to interview a 23-year-old woman 2 days after she delivered a healthy 7-lb boy by cesarean section. One day after the birth, she told the nurses that her baby was "the devil" and that to rid the world of evil she would have to kill him. The patient tells the psychiatrist the same story and claims that she hears the voice of God telling her that she must kill her baby.

On a mental status examination, the patient is alert and oriented to person, place, and time. Her hair is not combed and she has poor eye contact. She seems anxious and distracted. Her speech is within normal limits. She states that her mood is "upset" by the news that she must kill her child, and she notes she feels agitated, is not sleeping well, and wonders what she has done to be punished by God like this. Her affect is congruent with her mood and full-range. She denies suicidal ideation.

The patient's husband states that previously, she never had thoughts or ideas that were considered strange. He claims that the both of them were anxiously (and happily) awaiting the birth of the baby, who was planned for and wanted. The patient does not use drugs or alcohol and has no medical problems.

- **What is the most likely diagnosis?**
- **What are the next steps?**

ANSWERS TO CASE 39: Mood Disorder Not Otherwise Specified

Summary: A 23-year-old woman experiences auditory hallucinations in which God tells her to kill her baby, and the delusion that the baby is evil and must be killed in order to save the world coupled with a sudden-onset depression with extreme mood lability. These mood and psychotic symptoms appeared suddenly 24 hours after the delivery of the baby, and the patient did not have them before. Her husband reports that she was not depressed prior to the delivery either. The patient does not have a history of drug use/abuse or of medical problems.

^ **Most likely diagnosis:** Mood Disorder Not Otherwise Specified. This patient can be developing a major depression, single episode, postpartum onset, severe with mood-congruent psychotic features.

• **Next steps:** The mother should be allowed to see her child, but only under close observation at all times. Under no circumstances should she be discharged home with the infant. The patient may require hospitalization in a psychiatric inpatient unit if the psychoses and depression do not remit immediately. She should be treated with an antipsychotic agent and an antidepressant.

Analysis

Objectives

1. Understand the diagnostic criteria for postpartum depression and the range of postpartum psychiatric disorders.
2. Recognize the danger in this situation for both parent and infant and take appropriate steps to keep both safe.
3. Know the recommended pharmacologic treatment for this disorder.

Considerations

This patient presents with sudden-onset psychotic symptoms (hallucinations and delusions) and depression after the birth of her child. She has no previous history of a psychiatric disorder. The symptoms lasted for more than I day and less than 1 month; because of the brief duration the patient cannot be diagnosed as having a major depression with psychotic features at this time. However, the possibility that she is having an incipient major depression with psychotic features needs to be at the forefront of your considerations.

APPROACH TO POSTPARTUM DEPRESSION

Definition

Delusion: A fixed, false belief that is held to be true by a patient. It is a symptom of psychosis.

Postpartum blues: Transient mood changes occurring shortly after delivery characterized by mood labiality, depressed or irritable mood, interpersonal hypersensitivity and tearfulness that usually resolves within 7 to 14 days after delivery.

Clinical Approach

Diagnostic Criteria

Postpartum blues are observed commonly and can be considered normative in the first few days after delivery with an incidence of 49% to 75%. Obstetricians should alert pregnant women to the possibility of developing postpartum blues to make sure that patients know it is not uncommon but should be reported so the physician can monitor for the development of more severe psychiatric disorders. Otherwise, the new mother can fear that something is wrong with her for not feeling joy at the birth of a new child and can conceal feelings of depression or thoughts of psychosis.

The criteria for diagnosing nonpsychotic postpartum depression are no different from those used for diagnosing major depression at other periods in **a** patient's life. Because the mother is often having her sleep disrupted by the infant, it can be difficult get a clear history of sleep disturbance. However, these women often cannot sleep or nap even when their baby is sleeping and not needing attention. The postpartum year is the time of greatest risk for first-onset depression in women, with up to 65% of all women experiencing their first episode of major depression in that time interval.

Postpartum psychosis occurs in 1-2 women per 1,000 deliveries. These episodes are often associated with confusion and extreme mood lability along with the psychosis.

Treatment

Use of the tricyclic antidepressants (TCAs) and selective serotonin reuptake inhibitors (SSRIs) are commonly used to treat the depressive component of this disorder and in those with psychotic symptoms should be treated with a neuroleptic. Because two-thirds of mothers breast-feed their infants, considerations of the transfer of medication into the breast milk and then the infant must be kept in mind. Although there is no evidence to suggest that exposure to antidepressants is harmful, similarly, there is no evidence to say that it is safe

either. Because of their potential for anticholinergic effects and cardiotoxicity, TCAs are typically used as second-line drugs to SSRIs in this population. Doxepin has been reported to accumulate in breast milk at elevated levels. Of the SSRIs, sertraline and paroxetine are the least detectable in nursing infants.

A limited number of studies suggest that placing a patient with a history of postpartum depression on an antidepressant before delivery can help prevent recurrences.

Hormone therapy to prevent postpartum depression is currently being investigated but cannot be clinically recommended at this time.

Patients can also benefit from trained lay person support and group and individual psychotherapy.

Care must always be taken to assure that the mother does not present a danger to the infant especially in the case of postpartum psychosis.

Comprehension Questions

[39.11 A 28-year-old woman delivered her firs! child 2 months previously and is noted to have significant postpartum depression. She is reluctant to take antidepressant medications and asks about the use of hormonal therapy. Which of the following is the most accurate statement about hormonal therapy?

A. It is strictly investigational.
B. It can be used in small doses with success.
C. It must be used in large doses and is associated with side effects.
D. It must be used with deep venous thrombosis prophylaxis.

[39.2] Which of the following statements regarding postpartum mood disturbances is most accurate?

A. The second year after birth is a high-risk period for first-onset depression in women.
B. Postpartum mood disturbances are relatively rare, occurring in 1% of births.
C. The incidence of postpartum psychosis is more common than that of postpartum depression.
D. Criteria for postpartum-onset major depression are no different from at other times.
E. The mother's sleep patterns don't seem to play a role.

Answers

[39.1] A. Hormonal therapy is strictly in the investigational stages.

[39.2] D. The criteria for postpartum depression are the same for other individuals. The baby blues are quite common, occurring in up to 65% of delivering mothers.

CLINICAL PEARLS

Baby blues are a common phenomenon.

Treating a patient with antidepressants for several weeks to a month before delivery can prevent recurrence of postpartum depression in patients with a history of this disorder.

REFERENCES

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