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Maternal Postpartum Psychosis: A Case of Infanticide

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Abstract | **Case Report**

Introduction: Postpartum psychosis (sometimes called perinatal psychosis or puerperal psychosis) constitutes a real public health issue given its prevalence and the serious symptoms it can present, sometimes endangering the mother-child prognosis. It affects one to two cases per 1,000 deliveries. Studies estimate that approximately 43% of patients with puerperal psychosis have thoughts of infanticide, 5% have committed suicide, and 4% have committed infanticide. ***Objectives:*** Through this work, we will attempt to review the scientific literature on the risk factors for postpartum psychosis and its impact on the mother-child relationship, to define this serious act of infanticide targeting one's own child by presenting a clinical vignette, and ultimately to highlight the importance of screening and early management of postpartum psychiatric disorders. ***Materials and Methods:*** We will base our work on the analysis of a clinical case of a 33-year-old woman who presented with postpartum psychosis with an act of infanticide followed by a suicide attempt, and a literature review using the keywords "postpartum psychosis, suicide, infanticide, mother/child relationship, postpartum psychiatric disorders" in various search engines: Google Scholar, PubMed, Embase, and PsychoInfo. ***Conclusion:*** Practitioners must carefully recognize and assess situations that present an emergency. The illustration of our clinical case shows to what extent the role of the psychiatrist is decisive in the prevention and therapeutic management of psychiatric disorders occurring post-partum and which can be complicated at any time by an act of infanticide or suicide.

Keywords: postpartum psychosis, infanticide, postpartum depression, hallucinations, delusions, criminal responsibility.

I. INTRODUCTION

Postpartum psychosis (sometimes called perinatal psychosis or puerperal psychosis) is a real public health issue given its prevalence and the serious symptoms it can present, sometimes endangering the mother-child prognosis. It affects one to two cases per 1000 births. Studies conducted in perinatal psychiatry have improved understanding of the disorders. Although the prognosis for the acute condition is generally favorable, the recurrence rate remains high with the risk of chronicity.

Postpartum psychosis can be interspersed with serious psychiatric complications, and the patient may present a danger to herself and/or to the newborn depending on the nature of the delusions and the degree of agitation. Studies estimate that around 43% of patients who present with postpartum psychosis have thoughts of infanticide, 5% have committed suicide and 4% have committed infanticide. Such thoughts of suicide or infanticide require careful monitoring given the high risk of acting upon them [1].

Infanticide is an extremely traumatic act of crime. It is characterized by its many forms, by the variety of its aspects and by the frequency of its hidden cases. The circumstances and methods of infanticide vary depending on the nature of the perpetrator and the sociocultural context. Infanticide often occurs in the context of acute and chronic structured psychiatric pathology (puerperal psychosis, manic-depressive psychosis, schizophrenia, epilepsy, drug addiction, etc.).

Sometimes, sociocultural constraints and confusion in postpartum adaptation play a role. Psychopathological justifications evoke a profound dysfunction in mother-child interactions, fears of division and regressive and infantile characteristics in the mother. From a medico-legal perspective, the question of the liability of an infanticide perpetrator is complex.

This kind of suicidal or infanticidal ideation requires careful monitoring given the high risk of acting on it. The practitioner must recognize and carefully assess situations that are urgent in nature. This clinical

case illustrates how crucial the psychiatrist's role is in the prevention and therapeutic management of postpartum psychiatric disorders, which can become complicated at any time by an act of infanticide.

This paper will attempt to examine the scientific literature on the risk factors for postpartum psychosis and its impact on the mother-child relationship, as well as to identify this serious act of infanticide targeting one's own child through the presentation of a clinical vignette, and finally to highlight the importance of screening and early intervention for postpartum psychiatric disorders.

II. METHODOLOGY

This study is based on the analysis of a clinical case of a 33-year-old woman who suffered from postpartum psychosis, including infanticide and a subsequent suicide attempt, conjoined with a literature review using the keywords" postpartum psychosis, suicide, infanticide, mother/child relationship, postpartum psychiatric disorders", in the various search engines, Google Scholar, PubMed, Embase and PsycINFO.

A young woman with no personal or family history of mental illness, who was married and had a stable marital life, was hospitalized following a suicide attempt and then committed infanticide ten days after giving birth. The murder took place during an initial psychotic episode that occurred suddenly one week after the birth and consisted mainly of a persecution mania, incoherent speech, auditory hallucinations, indifference and emotional coldness. This symptomatology lasted four months and completely regressed under antipsychotics. The diagnosis of postpartum psychosis was initially suggested, after ruling out severe melancholic depression and any organic disorder.

III. CLINICAL VIGNETTE

Ms. S.C is 33 years old, married, mother of four, housewife, originally from Mirleft and living in Sidi Yahya. She has a history of irregular psychiatric follow-up since 2017, a psychotic brother, and a mother who died by suicide. She was admitted to the emergency department of Ar-razi University Hospital Centre in Rabat-Salé (Morocco), taken in for a delusional speech, soliloquizing and a strangeness of behavior that endangered her four children. The patient attempted to strangle her 2-month-old baby and later attempted suicide.

Mrs. S.C. got married in 2006 and had 4 children between 2015 and 2024. Her first delivery went smoothly, but the illness seems to have started in 2017, 1 month after the birth of her second child. The patient became very suspicious, making delusional statements of persecution, and was put on olanzapine, with a good clinical improvement but without a return to the pre-morbid state. However, the patient reportedly stopped her treatment 1 year later on the pretext that she was no longer ill.

In 2019, after the birth of her third child, she reportedly experienced a similar episode and the symptoms reappeared, complaining of despair, irritability, isolation, insomnia with delusional ideation centred on her child, stating that she hated her children, particularly the newborn. She began taking benzodiazepines and antidepressants during this episode, which resulted in a slight improvement.

The current episode appears to have begun 2 months after the birth of her fourth child, when the patient gradually became insomniac, lost all appetite and started making delusional statements about a flea in her head, along with frequent soliloquizing. It is also alleged that she begun neglecting looking after herself and her four children, leaving her three eldest children in the street all day, and no longer providing for the needs of her infant, who could cry for hours without any reaction from his mother.

The patient displays profound sadness, apathy, despair and difficulty in carrying out daily tasks, with an inability to provide for her children. She even allegedly tried to strangle said child, claiming that she could no longer bear the screaming, before subsequently attempting suicide after a huge argument with her husband.

The diagnosis of postpartum psychosis arose primarily in view of the patient's personal and family psychiatric history, the onset of disorders just after childbirth, the conflictual relationships experienced, the circumstances of infanticide and the obvious delusional and hallucinatory elements.

The patient underwent a normal ECG and a pre-therapeutic biological assessment without any particularities; she was put on Olanzapine 20 mg and Fluoxetine 20 mg, achieving a progressive remission of the delirium and auditory hallucinations, an improvement in her mood and a restoration of her sleep and appetite, whilst retaining amnesia over the traumatic event. The improvement occurred under treatment by the end of the fourth month.

IV. DISCUSSION

The case presented raises several questions from a medical point of view. The patient had previously exhibited depressive symptoms related to previous pregnancies and deliveries, as well as suicidal thoughts and infanticidal tendencies. The current presence of psychotic elements such as delusions and auditory hallucinations led to the incident of infanticide.

The perinatal period (pregnancy and postpartum) is accompanied by upheavals that are somatic and hormonal, but also psychological, familial

and social. It is associated with an increased risk of incidence or decompensation of psychiatric pathologies [2]. Postpartum psychosis is a rare condition with an estimated incidence of 1-2/1,000 births. The clinical picture is polymorphic and fluctuating. It includes mood lability, confusion, delusional elements, hallucinations and behavioral disorders. Postpartum psychosis can entail dramatic consequences. It is a psychiatric emergency that requires immediate medical attention to exclude any organic cause. The risk of suicide and infanticide is high. Infanticide is a highly traumatic criminal act with marked psychopathological and socio-familial consequences. Due to the plurality of its forms and the diversity of its aspects, its prevalence is difficult to assess. It raises significant difficulties in terms of medico-legal responsibility and therapeutic intervention [3].

Suicide and infanticide represent the most severe complications of postpartum disorders including depression and psychosis [4]. Infanticide is more often correlated with young maternal age, economic stress, unemployment and a history of psychiatric disorders [5]. There are several forms of infanticide. Altruistic infanticide, associated with the subsequent suicide of the mother, can be related to acute psychotic symptoms in the mother, or it can occur in the event of lethal abuse of an unwanted child.

The case presented is involves a 33-year-old woman diagnosed with postpartum psychosis who committed infanticide after the birth of her fourth child. The patient had a history of psychiatric disorders related to previous pregnancies, for which she received counseling but did not adhere to a consistent treatment. The management of this case was particularly difficult, as an initial cross-sectional diagnosis (e.g., postnatal depression) was established upon admission. Whereas a final diagnosis was determined through a comprehensive manner that included the current episode within the broader psychopathological framework, considering both personality traits and the surrounding social context.

In terms of gynecological and obstetric risk factors, primiparity stands out. Hormonal changes, obstetric complications (low birth weight, perinatal death, postpartum hemorrhage, preeclampsia, emergency cesarean section) and lack of sleep could also contribute to the onset of postpartum psychosis [6]. As per the sociodemographic factors, maternal age over 35 and single motherhood could represent risk factors for this disorder. However, there appears to be no significant correlation concerning ethnic and/or socio-educational background. A history of psychiatric illness remains a significant risk factor, as a prior episode of postpartum psychosis would increase the likelihood of recurrence in a subsequent pregnancy by 30 to 50%, as observed in the case at hand [7,8].

Bipolar disorder is thought to carry a 30% risk of postpartum psychosis. Patients who have stopped their mood stabilizing treatment, particularly lithium, are thought to be at greater risk of having an episode of decompensation than those who have continued it (70% vs. 24%). A family history is also thought to be a significant risk factor, as presented in the clinical vignette. Thus, in women with bipolar disorder and a history of postpartum psychosis in a first-degree relative, the risk is estimated to be 74% [9,10].

Postpartum psychosis is an emergency that requires rapid assessment. The initial priority is to rule out somatic pathology. Key differential diagnoses include cerebral thrombophlebitis, retained placenta and infectious causes of mental confusion. Therefore, an in-depth clinical examination must be carried out urgently, incorporating both a gynecological and neurological examination. A biological assessment is necessary to eliminate a metabolic or nutritional cause, while magnetic resonance imaging is also necessary to rule out cerebral thrombophlebitis [11]. Emergency hospitalization in the adult psychiatry department, particularly to prevent the risk of suicide or infanticide, is necessary. There are currently no specific medication recommendations. Antipsychotic treatment, favoring atypical antipsychotics (risperidone, olanzapine, quetiapine, aripiprazole, amisulpride), is often the first-line treatment. Dosage is adjusted according to the clinic; our patient was put on olanzapine 20 mg.

Continuing to breastfeed is generally incompatible with the woman's clinical condition. It is not recommended if antipsychotics or mood stabilizers are prescribed, due to the potential risks to the newborn. A mood stabilizer treatment, preferably with lithium salts, or valproic acid, or carbamazepine, is used depending on the clinic and/or in the presence of a personal or family history of bipolar disorder. If depressive symptoms are present, antidepressant treatment may be prescribed with caution, given the link between bipolar disorder and postpartum psychosis and the risk of manic episodes or rapid cycling. Although monotherapy is preferable, dual therapy is often essential.

Electroconvulsive therapy can also be a preferred therapeutic option, enabling faster improvement in symptoms. It is recommended when the symptomatology is particularly severe and in the event of a vital danger to the mother and/or child, a major risk of suicide or infanticide, resistance to treatment, and/or intolerance to psychotropic drugs.

A psychotherapeutic approach – which involves the woman, the mother-child relationship, including the father and the family – is equally essential. The mother-baby bond must therefore be maintained or restored as soon as possible [12]. The condition generally resolves spontaneously within a few months. In 30% of cases, it

is a one-off episode; 60% will develop into a mood disorder and 10% into schizophrenia. The recurrence rate during a new pregnancy is approximately 30%. Mrs. S.C. has relapsed twice [13].

Screening for women at high risk of postpartum psychosis should be carried out at an early stage during pregnancy, particularly during the early prenatal check-up. In the case of women with bipolar disorder or a personal or family history of postpartum psychosis, close monitoring is vital. Prophylactic treatment in the immediate postpartum period may be considered, particularly in the case of a personal history of postpartum psychosis or bipolar disorder [14]. Several studies show that lithium salts can prevent recurrences in the postpartum period. However, the use of other therapies is less well documented. For example, carbamazepine could also be used as a second-line treatment [15]. In one study, olanzapine was reported to be beneficial. In contrast, divalproate was not shown to be beneficial in the prevention of postpartum psychosis. The use of oestrogens is controversial, while progesterone is reported to be of no benefit whatsoever [16].

Early detection of symptoms and appropriate treatment are therefore essential. Prompt and effective treatment is necessary not only for the health of the mother and child, but also to preserve the mother-child bond. Psychoeducation for both patients and their families is paramount. Perinatal healthcare professionals must remain vigilant in detecting the symptoms of postpartum psychosis. This clinical vignette demonstrated the complexity of the various psychological conflicts that can arise in the perinatal period, especially the re-experiencing of childhood trauma that led to depression during the pregnancy. The depressive episode that was not treated, coupled with the context of family estrangement, maternal suicide, and a deprived childhood, laid the groundwork for a postpartum psychosis, ultimately requiring hospitalization.

V. CONCLUSION

Infanticide is a rare but very serious complication of postpartum disorders. The broad framework of the DSM-V emphasizes the careful diagnosis of these disorders and their severity, making it possible to determine whether there is a peripartum or postpartum onset, to assess the severity of the episode, and to identify the presence of psychotic characteristics. It is a highly traumatic act with marked psychopathological and socio-familial retentions. Its prevalence is difficult to assess due to the plurality of its forms and the diversity of its aspects. It raises significant difficulties in terms of medico-legal responsibility and therapeutic management. Coordination between the psychiatry and maternity wards is essential to establish a preventive strategy. The practitioner must recognize and carefully assess situations that are urgent in nature. The illustration of our clinical case shows how decisive the role of the psychiatrist is in the prevention and therapeutic management of psychiatric disorders occurring in the postpartum period, which can lead at any time to infanticide or suicide.

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