Rom J Leg Med [25] 104-108 [2017]
DOI: 10.4323/rjlm.2017.108

Recurrent post partum depression and infanticide. A case report

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Abstract: Suicide and infanticide are the most severe complications of postpartum disorders such as depression and psychosis. Infanticide is more commonly correlated with a younger age of the mother, economic stress, unemployment and a history of psychiatric disorders. Infanticide may take several forms such as the altruistic infanticide, associated with the subsequent mother's suicide, may be in relation with acute psychotic symptoms of the mother, or it can occur in cases of fatal maltreatment of an unwanted child. We present the case of a 40 years old women diagnosed with post partum depression (PPD) who committed infanticide after the birth of her seventh child. The patient had a history of psychiatric disorder in relation with previous pregnancies for some of which she sought medical attention but did not follow a constant treatment. The management of the case was a challenging one with an initial cross-sectional diagnosis established upon admission (e.g post-natal depression) and a final one, established comprehensively by the therapeutic team, which included the current episode within the general psychopathological framework alongside with the personality traits and social context.
Key Words: post-partum depression, psychotic symptoms, infanticide.

The term infanticide, defined as the murder of a child committed by the mother within the first year after birth, is a criminal act that has important psychopathological repercussions and sociofamilial consequences [1]. Romanian legislation incriminates the followings related to the murder of a child: *1. Art. 200 penal code-the murder of the newborn comitted by the mother within 24 hours after birth (which is punished with prison form 1 to 5 years if the mother is suffering from a psychiatric disorder)* and *2. Art.188-Murder of a human being (punished with prison from 10 to 20 years and prohibition of several rights) completed by article 199 which states that if the criminal act is committed upon a family member the punishment foreseen by article 188 is increased by a quarter* [2].

In the psychiatric nomenclature post partum depression is enclosed within the chapter of Major Depressive Disorder, with a specifier of peripartum onset in the Diagnostic and Statistical Manual for Mental Disorders -5th ed. (DSM V) [3] and under Behavioral syndromes associated with physiological disturbances and physical factors in the International Classification of Diseases-10th ed.(ICD- 10) [4]. DSM V specifies for PPD the onset at anytime during pregnancy to the first 4 weeks following delivery.

The prevalence of post partum depression is between 10-15% [5] with the highest peak occurring in the first 3 months after childbirth, the same time frame being associated with most maternal infanticides (about 58%) [6].

Several studies tried to explain the relationship between the clinical symptoms of post partum depression and the act of infanticide. Thus, a study that analyzed the differences between women with and

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without psychotic symptoms at the time of committing filicide (the act of a parent killing his or her own child) showed that psychotic mothers were more likely to have a past or an ongoing psychiatric treatment, to be older, unemployed, divorced or separated and to have previous pregnancies when compared to non-psychotic mothers. Also, psychotic patients had suicidal or homicidal thoughts about their children before committing the act [7]. Another study that described ten cases of infanticide concluded that all women were displaying symptoms of severe depression at the time of murder, symptoms that included psychotic elements and suicidal thoughts. Also, another characteristic of the cases presented was an altered relation between the depressed patients and their own mothers who were perceived as demanding, rejecting and unsupportive [8].

A recent meta-analysis of post partum depression reported that the strongest predictors of such a disorder were: past history of psychiatric disturbances during pregnancy, poor marital relationship, low social support, and stressful life events [9].

CASE REPORT

We present the case of 40 years old women who had been admitted as an emergency to the Second Psychiatric Clinic of the Emergency County hospital Cluj-Napoca hospital, being brought in by the ambulance, police and gendarmerie after she threw her 2 months old daughter off the balcony.

The major complaints at the admittance in the emergency psychiatric room were: restlessness, avoidance of visual contact, and the confession that "she never wanted this baby, she wanted to have an abortion but she couldn't due to certain reasons". She also complained of the fact that her general mood and behavior aggravated soon after the baby was born, she felt overwhelmed and not able to take care of her, she had no feelings towards this child although she loved her other children and she refused breast feeding by auto medicating with ab lactating medication.

The patient agreed to hospitalization, signed the informed consent for voluntary admission in the psychiatric hospital and all examinations were performed with the acceptance of the patient, her family members, respecting the rules of good clinical practices and the Declaration of Helsinki.

The psychiatric exam performed upon her admission revealed negative hyperthymia, micromanic delusions of helplessness and ruin, incurability, inutility and guilt, delusions of interpretation and affective inversion towards her newborn.

The physical examination of the patients was in normal range.

Based on the initial assessments, the psychiatrist on duty established the diagnosis of Post partum severe depressive episode with psychotic features. Confinement week 8. Homicide.

Familial and social conditions revealed that the patient was a high school graduate, she never had job; she married a foreign Middle East citizen with whom she had 7 children including the last child who was born in august 2015. Until June 2015 she lived in her husband's country with 4 of their children. Before the birth of her last daughter she moved to Romania along with other two of her younger daughters and she lived with her mother due to financial reasons and marriage difficulties.

Medical and psychiatric history revealed 3 previous depressive episodes in 2004, 2008 and 2011, all of which were documented in the patient's psychiatric file received from the psychiatrist who treated the patient in her husband's country. Thus, in 2004 when the patient expected her fourth child she had experienced unusual feelings and symptoms of sadness, rejection of the baby and the family, lack of interest for the household and personal hygiene and tearfulness. Those symptoms lasted for two weeks and disappeared without any psychiatric intervention. In 2008, after the birth of her fifth child, the patient presented the same type of symptomatology but this time it was more severe and uncontrollable (she isolated herself, was disturbed by any noise or laughter, she wanted to get rid of the baby, she even threat to kill her twice by throwing her in the water tank), so she sought psychiatric assistance. She was diagnosed with Post-partum depression and put on an antipsychotic (Amisulpride) and other medication the patient could not remember, treatment that was followed for four months when the patient felt better and interrupted it. Recognizing the imminent threat towards the safety of the baby and the tensed situation, the husband was advised and took the baby to a relative who cared of her for 3 weeks, the patient being able to visit her upon demand anytime. In 2011 the patient gave birth to her sixth child and ten days later she developed symptoms of sadness, continuous worries about the baby (whether she slept, eaten, felt well), tearfulness, forgetfulness, distractibility, lack of interest, boredom, hopelessness, fatigability, irritability, guilt feelings related to the baby, sensations of heavily breathing and imminent death. The patient also presented suicidal thoughts (she was thinking about taking medication in order to die) and the wish to get rid of the newborn (to throw her at the garbage). She lost appetite and became underweight and she slept poorly having constant bad dreams about the baby. Psychotic symptoms such as auditory hallucinations (hearing sounds like someone was at the door) were also present during this episode. She applied for the medical services of her psychiatrist and was initiated back on an antipsychotic (Amisulpride), a tricyclic antidepressant (Amitriptiline), a sedative benzodiazepine (Diazepam) and other medication that the patient could not recall; she took the treatment for two weeks and interrupted it

afterwards without seeing a doctor.

Shortly after the discontinuation of medication, symptoms reappeared and the patient went to see another psychiatrist complaining of hopelessness, hypersensitivity, irritability, shortness of breath, isolation. She also stated that she hates her children, especially the newborn. She was again diagnosed with Post partum depression and started on a sedative benzodiazepine (Bromazepam 3 mg/daily). During this episode, the mother was separated from her newborn for 6 months until she felt better.

In august 2015, approximately 2 days after the 7th childbirth, in her home city, the patient presented negative hyperthymia, crying spells, delusions of inutility, hopelessness, ruin, affective inversion towards the newborn, fearfulness within the delusional context, avoidance of maternal roles, insomnia, reasons for which the patient was initially briefly assisted by her gynecologist and soon sought a psychiatrist who initiated an antidepressant (Amitryptiline) and sedative (Bromazepam) medication; she was adherent to the treatment but the symptoms worsened in the following three weeks and the patient became extremely irritable and irascible with imperative auditory hallucinations so she went back to the doctor where an antipsychotic (Olanzapine 5mg/daily) was added to her therapy for the next 7 days. After this change, hallucinations became less frequent but delusions, insomnia and the negative inversion were still present. The patient continued the antidepressant treatment alone with an increased intensity of the symptomatolgy that culminated with the infanticide act committed on the day of her admission to our hospital (after an intense telephonic quarrel with her husband and some explicit threats regarding the homicidal intentions and methods addressed to her mother).

During the hospitalization the patient underwent initial treatment with antidepressant medication (a tryciclic antidepressant initially-Amytriptiline-followed by a dual antidepressant-Venlafaxine), typical and atypical antipsychotics (Levomepromazine and Olanzapine), anxiolytics and sedatives (Lorazepam and Diazepam) with progressive remittance of the imperative auditory hallucinations, delusions and negative hyperthymia and significant improvement of the insomnia but with amnesia of the traumatic event, a perplex attitude and affective detachment from the infanticide act.

Several psychological assessments were performed during hospitalization; the first one consisted of tests assessing intellectual functions, depression and personality traits. Thus, The Raven Standard Progressive Matrices revealed a mean low intellectual potential (IQ=97), Hamilton Depression Rating Scale (HDRS) and Beck Depression Inventory (BDI) showed scores consistent with severe depression (30 and 33 points respectively). The Szondi test (a projective personality test) revealed the following results: a severe disturbance in the affective control area, instable affective balance, accumulation of anger and hatred with no positive mechanism of control; a repressed, typically compulsive ego; a depersonalized Ego, desire for revenge, jealousy, murder, suicidal act; the contact with reality revealed fear of losing affective support, the need to be loved and protected and intolerance to frustration. Personality assessment performed with the Structured Clinical Interview for DSM Axis II Disorders (SCID-II) showed preoccupations for order, perfectionism, lack of tolerance to frustrations and episodes of verbal and physical aggression towards her children.

The second report of psychological evaluation was completed by the psychologist from the Institute of Legal Medicine more than ten days after the infanticide. The applied tests were The Raven Standard Progressive Matrices (IQ=97), the EVIQ general cognitive aptitudes assessment test, Milton Clinical Multiaxial Inventory III, State-Trait Anxiety Inventory, Beck Depression Inventory, Positive and Negative Syndrome scalePANSS (which were all under clinical average), the Cognitive Aptitudes Tests Battery (52%-above clinical average) and the Mental Health Questionnaire (score 60-the equivalent of the Global Assessment of Functioning Scale-GAFS).

Based on the clinical and psychological assessments, at the discharge of the patient, the psychiatrist established the diagnosis of Severe mental and behavioral disturbances related to the puerperium. Recurrent depressive disorder. Current severe episode with psychotic symptoms. Mixed anankastic and impulsive personality disorder. Infanticide. Atypical parental situation. Relationship difficulties with the husband or the partner.

During her hospitalization the patient was evaluated by the commission of legal medical expertise which issued a final report with 3 conclusions: 1. The established diagnosis; 2. Absence of discernment at the time of infanticide and 3. Recommendation for mandatory hospitalization in accordance with art. 110 Penal Code.

After this final report, we drafted an act addressed to the General direction of social assistance and child protection with request of a point of view in respect with the current family situation of the patient. Their answer concluded that the patient is able and responsible for the raising and support of her two minor children.

The court of law rejected the recommendations of the commission of legal medical expertise regarding mandatory hospitalization and 11 months later, it also rejected the intimation of the prosecution regarding the safety measures foreseen by the article 109 Penal Code (compulsory medical treatment).

Thirty days after her admission to the hospital the patient was discharged and she returned back to her family. In the following year she presented regularly

to pick up her medical prescription and had two more depressive episodes that required hospitalization (symptoms of remorse and deep sadness intensified during suggestive moments-dates of the childbirth and infanticide) among other disturbing signs such as apathy, hopelessness, irritability towards her children and difficulties in fulfilling daily tasks.

DISCUSSION

The case presented raises several issues. From a medical point of view, the patient had previous depressive symptoms, intrusive suicidal and infanticide thoughts related to past pregnancies and deliveries. The current exacerbation of the depressive symptoms and the presence of psychotic elements such as the imperative auditory hallucinations led to the moment of infanticide [10]. Besides the main diagnosis, the patient has personality traits consistent with a mixed personality disorder, an association known to increase the risk for a criminal act [11]. Alongside with the psychiatric history, other social, economical and familial aspects (unemployment, financial difficulties and marital conflicts) represented significant risk factors for the infanticide in our case, as in most cases involving maternal infanticide [12]. In such cases a very carefully monitoring is needed in the eventuality of a new pregnancy. This monitoring must begin at the same time with a confirmed pregnancy until the risk of mother/infant complications may be ruled out and it should involve a multidisciplinary team consisting of a gynecologist, psychiatrist, psychologist and a social nurse.

Legal and social aspects are also important in such cases. Romanian medical literature data is scarce [13] on this pathology but data from international papers shows that women committing infanticide are usually obliged to medical treatment in western European countries or sentenced to more severe punishment in United States [10]. Our patient is now living with three of her children (two daughters and a son) and even if she is not obliged by the court of law, she presents monthly for her medical prescription. To our knowledge there are no social services interventions to assess the current family situation and inter familial relationships.

The major difficulties rely mainly in the late diagnosis assessment of the patients after the murder, when most of the signs and motives are less obvious [14].

The argumentation of the broader diagnosis established by the psychiatrist from the hospital took into consideration the recurrent type of onset of each episode with or without connection to pregnancies, childbearing; the variety of symptoms display, ranging from mild, self limited depression to severe depression with/without psychotic symptoms. Therefore the episode that was followed by infanticide could have been be related to the special context of the perinatal period but within a recurrent disease; the first episode was self-limited but the followings were severe enough to cause subjective distress, suicidal/homicidal risk, were enduring and reappeared shortly after medication cessation. Critical points of the case were: postnatal depression had been diagnosed and antidepressant but also antipsychotic medication was recommended after the last two previous deliveries and the protection of the newborn after homicidal threats by temporary separation had been employed. The last depressive episode, although in line with the previous two, benefited only temporary from antipsychotic medication and no social support of the mother and children.

CONCLUSION

Infanticide is a rare but very severe complication of postpartum disorders, a complication that may occur any time during pregnancy and four weeks after delivery. The broad framework of DSM-V insists on the carefully diagnosis of the mood disorder, its severity, permitting to specify whether there is a peri/postpartum onset, the severity of the episode, the presence or absence of psychotic features. This options permit a dimensional coherent diagnostic liberty, such as in the case of our patient, who developed two further major depressive episodes after three peripartum depressions, arguing the recurrent mood disorder. Women displaying such risks should be carefully evaluated and monitored in order to avoid such tragic consequences even after childbirth, with specific assessments regarding suicidal/ homicidal risk factors.

Conflict of interest. The authors declare that they have no conflict of interest concerning this article.

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