Singapore Med J 2012; 53(5) : e104

Understanding maternal mental illness: psychiatric autopsy of a maternal death

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ABSTRACT Maternal mental illness is a significant public health concern, with established adverse outcomes on both mother and infant, such as impaired mother-infant bonding and infant cognitive and emotional development. In severe cases, maternal mortality and infanticide can tragically occur. This is a report on the suicide of a mother who jumped to her death at three months postpartum. She suffered from puerperal psychosis with bipolar features, with onset at six weeks postpartum. The case highlights the burden of maternal mental illness in our community as well as the need for resources and services to care well for mothers. With a better understanding of its presentation and risk factors, early identification and intervention can reduce morbidity and mortality.

Keywords: maternal suicide, postpatum death, puerperal psychosis
Singapore Med J 2012; 53(5): e104–e105

INTRODUCTION

Postpartum depression is a recognised public health concern affecting some 8% of local women,[1] with adverse outcomes such as poor mother-infant bonding and child developmental issues. The most tragic outcome is maternal suicide. The impact is magnified due to the consequences to the motherless infant and the family that struggles to make sense of the tragedy.

With improved obstetric care standards, Singapore's maternal mortality rate has dropped drastically since the 1970s. At six per 100,000, it is currently even lower than rates in the USA and UK.[2] Although an earlier study has shown that maternal suicide remains an uncommon event locally,[3] it is possible that the true rate is higher due to under-reporting of cases, as with most suicide data. Indeed, in the UK, Australia and New Zealand, where maternal deaths are comprehensively studied in confidential enquiries involving case linkage with national birth registries and late maternal deaths are included, maternal suicide has been found to be a leading cause of maternal death.[4,5]

This case report recounts a completed maternal suicide, with the information derived from available case records and the account of the grieving husband. While searching for answers to his wife's condition, the deceased's husband had chanced upon a report of a similar case[3] and contacted this author.

CASE REPORT

The patient, a 30-year-old professional, had a missed abortion in the year 2000. She subsequently gave birth to a baby girl in 2002. Apart from having to cope with threatened preterm labour requiring admission at 30 weeks, the pregnancy was otherwise uneventful. She was well postnatally, appeared to enjoy motherhood and even won an award in her career. She had no known family or personal history of mental illness.

A year later, the patient conceived a much wanted and planned pregnancy. Unfortunately, foetal ultrasonography at 20 weeks revealed transposition of the great arteries. She was ambivalent about continuing the pregnancy, but with counselling and advice by the attending paediatric cardiac surgeon that the condition was treatable with reasonable results, she opted to keep the pregnancy. She remained stable throughout the rest of her pregnancy, delivering at 36 weeks. The baby required only a short stay in the neonatal intensive care unit, and she was discharged by the second day post delivery.

During the confinement month, the mother appeared to be coping despite the baby needing an operation in the second week of life. When news broke regarding the need for a second operation within the coming months, she became overwhelmed. At approximately six weeks postpartum, she became withdrawn, irritable, sensitive and suspicious, especially toward her in-laws. Believing that they would become closer to the baby than her, she asked them to move out, although they had previously lived together amicably. She argued with her husband over minor matters and insisted on managing the baby without help. She also slept poorly due to having to do night feeds. The patient defaulted her postnatal review and did not answer calls from the clinic, although she brought the baby for paediatric attendances regularly.

At three months postpartum, the patient's mood state began to shift. She started freelance editing work, spending about 16 hours working each day, with little sleep. Consequently, her irritability increased; on one occasion, after an argument with her husband over her in-laws, she left home in an agitated state. Her husband found her in a hotel after a desperate search, and brought her home. The situation worsened as she remained hostile toward her spouse, resulting in marital strain. During another argument two weeks later, the agitated patient

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threatened to jump off the building, but her husband managed to restrain her. She then accused him of being violent and called the police. The patient was referred to a hospital for help, but went unaccompanied by her husband. She told the attending psychiatrist that she was well but alleged that her husband was abusing her. The patient was assessed to have acute situational reaction and was allowed home on her own. Subsequently, she left with her children to stay with her twin sister. Two days later, the couple attended a lengthy investigation at the police station. A few hours after the session, at 14 weeks postpartum, the patient went missing and was found to have jumped from a block of flats. She had told her sister-in-law previously that she was afraid of being shamed in public.

Five years later, although the family has moved on, the scars that remain are deep. The children are now cared for by their paternal grandparents. The husband is seeking professional help for depression in order to cope, and has since gone overseas to work, as he found it too painful to remain in the country. He also had to grapple with the trauma of investigations into his wife's death, which were unpleasant, and he felt that there was little support and understanding from the investigating officers about the nature of maternal mental illness.

DISCUSSION

Without direct assessment, a definitive diagnosis is not possible. However, based on her husband's account and the current understanding of presentations of postpartum-onset mental disorders, it is likely that the patient suffered from a severe postpartum psychotic illness, which presented with features of depression (withdrawal, irritability) and paranoid ideation (suspiciousness toward the family). The illness morphology changed to hypomania, and was characterised by increased activity, irritability and a need for little sleep. By classification, the patient would qualify for the diagnostic category of puerperal psychosis, section F53.1: "Severe mental and behavioural disorders associated with the puerperium, not elsewhere classified",[6] of the ICD-10. Her illness had features that were suggestive of the classical bipolar subtype.[7]

This is a grave condition, as maternal suicide most commonly occurs in women suffering from puerperal psychoses, a pleomorphic group of conditions with classical features of affective shifts, confusional state, hallucinations and/or delusions.[6] Andrea Yates, a Texan woman who killed her five children, did so in a psychotic break when she was taken off haloperidol just two weeks prior.[7] Daksha Emson, a British psychiatrist who stabbed and set her three-month-old baby and herself on fire in a delusional state, was likewise in a bipolar psychotic state.[9] Established risk factors that highlight the need for proper care planning include past histories of non-pregnancy-related depression[10] and pregnancy-related mental illness[11] as well as a family history of mental illness (severe postpartum or bipolar disorder).[12]

In the absence of the above risk factors, as in this case, a high index of suspicion should be entertained in a mother who is under severe stress. This patient's stress stemmed from her baby's need for repeated operations, and she presented with symptoms of depression as well as abnormal changes in behaviour. It is possible that she had been ambivalent about her pregnancy, and some of these repressed feelings may have resurfaced under extreme stress. Indeed, feelings of jealousy and hostility toward the infant and/or a fear of losing one's self-identity are commonly experienced by mothers. By all accounts, she was a devoted mother who cared for the baby, but perhaps there was a part of her that had difficulties accepting her baby's condition, a state of mind that is not uncommon in parents facing such challenges.

Another challenge in dealing with these conditions is the rapid shift in mood states and subtle symptoms. Some recommendations to overcome this challenge include obtaining corroborative information and having a 48-hour period of observation. If resources are available, screening and early detection of at-risk women in various settings, including antenatal obstetric clinics and paediatric clinics, can be particularly effective. Efforts to destigmatise postpartum mental illness and to educate the community about the symptoms and impact of the illness are also important in helping afflicted women gain access to help.

This case highlights the burden of maternal mental illness in our society. With a better understanding of severe postpartum mental illness, we can aim to identify the disorder early and provide prompt intervention, which may help to ensure a better outcome for both mother and child.

REFERENCES

1. Chen H. Addressing maternal mental health needs in Singapore. Psychiatr Serv 2011; 62:102.
2. Maternal mortality (most recent) by country [online]. Available at: www.nationmaster.com/graph/hea_mat_mor-health-maternal-mortality. Accessed September 26, 2010.
3. Chen YH, Lau G. Maternal deaths from suicide in Singapore. Singapore Med J 2008; 49:694-7.
4. Oates M. Deaths from suicide and other psychiatric causes. In: Lewis G, ed. Why Mothers Die, Confidential Enquiry into Maternal and Child Health 2000-2002. London: RCOG, 2004.
5. King J, Slaytor EK, Sulliv4an EA. Maternal Deaths in Australia 1997-1999. Med J Aust 2004; 181:413-4.
6. World Health Organization International Classification of Diseases version 10, section F53.1 [online]. Available at: apps.who.int/classifications/icd10/browse/2010/en#/F50-F59. Accessed April 2, 2012.
7. Brockington IF, Cernik Kf, Schofield EM, et al. Puerperal Psychosis: phenomena and diagnosis. Arch Gen Psych 1981; 38:829-33.
8. Spinelli MG. Maternal infanticide associated with mental illness: prevention and the promise of saved lives. Am J Psych 2004; 161:1548-57.
9. Emson D. Obituary: Daksha Emson. Br J Psychiatry 2004; 28:152.
10. Cohen LS, Altshuler LL, Harlow BL, et al. Relapse of major depression during pregnancy in women who maintain or discontinue antidepressant treatment. JAMA 2006; 295:499-507.
11. Robertson E, Jones I, Haque S, Holder R, Craddock N. Risk of puerperal and non-puerperal recurrence of illness following bipolar affective puerperal(post-partum) psychosis. Br J Psychiatry 2005; 186:258-9.
12. Forty L, Jones L, Macgregor S, et al. Familiarity of postpartum depression in unipolar disorder: results of a family study. Am J Psychiatry 2006; 163:1549-53.