Clinical and Forensic Aspects of Postpartum Disorders

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The deaths in Texas of five children, aged 6 months to seven years, at the hands of their mother, Andrea Yates, has focused national attention on postpartum depression and psychosis. No one could have foreseen the tragic murder of the five Yates children. However, given Ms. Yates' psychiatric history, there is no doubt that this family was at high risk for some of the more common consequences of these potentially serious disorders. According to media reports, Ms. Yates experienced postpartum depression after the birth of her fourth child in 1999. Many of her family members have had problems with depression. Ms. Yates' first episode of postpartum depression was so severe that she made at least one suicide attempt. She was treated with both an antidepressant and an antipsychotic, indicating the probable presence of psychotic or delusional symptoms. Her husband reported that she recovered with treatment, and at some point, stopped taking the medication. Ms. Yates had another episode of depression six weeks after the birth of her fifth child. Three months later, her father died after a long decline due to Alzheimer's disease, another severe stressor for Ms. Yates. Although she was again treated with medication, her husband reported that, this time, his wife did not seem to respond as well as she had previously. Nevertheless, Ms. Yates remained at home, responsible for the care and home schooling of five young children.

The Preventive Treatment of Postpartum Disorders

The tragedy of the deaths of these children is compounded by the fact that Ms. Yates' recurrent illness may have been prevented by prophylactic treatment with antidepressant medication. Postpartum depression, a major depressive episode during the puerperium, affects between 10 percent and 22 percent of adult women before the infant's first birthday.[1] Approximately 560,000 new mothers experience postpartum depression every year. Severe cases of postpartum depression may be complicated by mood-congruent delusions. Postpartum psychosis occurs in only approximately one to two of one thousand deliveries. The majority of these psychoses appear to be primary mood disorders with psychotic features. Fifty percent or more of women who have had a previous episode of postpartum depression experience relapse after a subsequent pregnancy. The relapse rate for postpartum psychosis is 80 percent or higher.[1–4]

Although the symptoms of depression may remit spontaneously, many women are still depressed at one year after childbirth.[4] A growing body of evidence demonstrates that chronic and severe maternal psychiatric illness can result in suboptimal interactions that affect attachment, temperament, and behavioral and cognitive development in newborns and in older children.[5–8] Maternal depression is a major predictor of negative parenting behaviors, such as yelling and spanking. For each depressive symptom, the odds that the mother will show at least one form of negative interaction increase by 25 percent, and the odds that she would engage in low levels of positive behaviors increase by 40 percent.[9] Other consequences of parental mental illness, such as income loss, family disruption, and placement out of the home, may further impair child development.[10] Child abuse and neglect are more common among women who have postpartum psychiatric illness.[5]

Treatment with antidepressant medication has been demonstrated to be effective in reducing the risk of relapse of postpartum disorders[11] and can be

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initiated toward the end of the pregnancy or immediately after delivery.[2,12–15] One recent study[16] had more equivocal data regarding the efficacy of prophylaxis with the use of a tricyclic antidepressant. However, clinical experience is consistent with the more common finding that prophylactic treatment is often successful in preventing the recurrence of postpartum disorders. Of note is that in comparison to women with nonpostpartum depression, women with postpartum depression appear to take longer to respond to pharmacotherapy for depression and require more antidepressant agents to elicit a response.[17] Thus, this illness may be easier to prevent than to treat once it has recurred.

The use of antidepressants during pregnancy and while breast-feeding requires a careful risk-benefit analysis, weighing the risks of the use of medication against the risks of untreated illness.[18,19] The need for such analysis is heightened by the fact that no antidepressants have been approved by the U.S. Food and Drug Administration for use during pregnancy or breast-feeding. Psychotropic use during pregnancy and breast-feeding exposes the fetus or infant to the medication,[2,14] although the amount of exposure through breast-feeding is significantly less than *in utero* exposure.[20] In addition, data regarding the use of medication during pregnancy and breast-feeding are limited, and no absolute conclusions regarding safety can be drawn. One study[21] indicated that the use of fluoxetine during the third trimester was associated with some perinatal complications for the neonate. Nevertheless, an increasing body of data indicates that the use of antidepressants during late pregnancy and postpartum carries relatively little risk to mother and baby.[2,10,20,22–30] No studies have demonstrated a definitive association between the use of antidepressants and an increased incidence of congenital anomalies, perinatal complications, or long-term neurobehavioral adverse effects.

Certainly, at least with breast-feeding, if the risks of infant exposure seem too high, bottle-feeding can be considered. However, this raises emotional issues for many women. Breast-feeding is a vigorously promoted practice, and has been demonstrated to have multiple benefits for both mother and child.[10,30,31] Sixty percent or more of women with postpartum depression, approximately one quarter of a million each year, plan to breast-feed.[32] Social pressure to continue breast-feeding and guilt resulting from the cessation of breast-feeding can lead many women to believe that they must make a choice between breast-feeding and their own mental health. However, a mother who is too depressed or disorganized to breast-feed her infant or to adequately care for the infant or other children also poses risks to herself and her children.

The relatively low risk of the use of psychotropic medications during breast-feeding, or the pros and cons of bottle-feeding, must be weighed against the risk of untreated postpartum disorder and the benefits of improvement in maternal mood. Ultimately, the decision to use medication while pregnant or breast-feeding is extremely personal and depends on many factors, including a woman's values and perception of risk. However, many women are unwilling to seek help of any kind, because they are ashamed to admit that they may be feeling depressed at a time when they are "supposed" to be happy, or because they are having "unnatural" thoughts about harming their children. They often feel tremendous guilt, and believe that they are bad mothers and women. National organizations providing education, support, and referrals for treatment, such as Depression after Delivery (1-800-944-4773) and Postpartum Support International (1-805-967-7636), have done much to help women overcome the shame and stigma associated with postpartum depression. Physicians should also consider education regarding the nature of postpartum depression and available treatment as part of routine primary care for women planning families.

The prevention of the predictable recurrence of postpartum depression, even absent the risk of suicide, infanticide, or filicide, is of immeasurable benefit to mothers, their newborn children, and the older siblings. Decisions regarding the use of medication, as opposed to other interventions such as interpersonal or cognitive therapy, must be guided by the severity of the illness. However, in cases such as that of Ms. Yates, the risk of recurrence of severe depression, psychosis, and suicide clearly outweighs the relatively minimal risk of the use of medication during late pregnancy or immediately after delivery. When the possibility of recurrence of postpartum psychosis or depression with psychotic symptoms occurs, the consideration of prophylaxis becomes even more imperative. Postpartum psychosis can lead to the most severe disturbances seen in psychiatry. One of the most disastrous outcomes involves harm to the infant or other children.

The Forensic Aspects of Postpartum Disorders

According to Justice Department statistics, approximately 200 children a year are killed by their mothers. Fortunately, the murder of one's own children is a rare consequence of postpartum depression. However, it is more likely to occur in women who have psychotic symptoms.[5,33–35] Rates of infanticide associated with untreated puerperal psychosis have been estimated to be as high as four percent.[2,3,36] However, as the child grows older, the risk of being killed by a parent decreases. Children under one year old are at much greater risk of being killed by their parents than are older children.[36] Statistics regarding parental infanticide by age bear out that older children appear to be at less risk. Of the children killed by parents in 1999, 42 percent were younger than one year; only 6 percent were older than four years.

Despite the popular myth of the Medea syndrome, women rarely kill their children for revenge or as a form of manipulative behavior. Few mothers kill their children in a cold-hearted or calculating manner.[37] Depression is the commonest cause of the murder of older children by their mothers, with the possible exception of child abuse.[5] Most neonaticides are perpetrated because the child is unwanted due to illegitimacy, rape, or other reasons, not typically related to mental illness.[35] In contrast, filicide, the murder of a child typically older than one year, often indicates a much more profound disruption in emotional or mental status than the killing of a newborn. A newborn child or infant is more easily viewed as an object than is an older child with whom a relationship has developed over a period of years. Women who commit filicide are more likely to have psychotic illness. In one study,[35] psychosis was evident in two thirds of a group of women who committed filicide. A serious element of depression was found in 71 percent of the filicide group, and suicide attempts accompanied the filicides in one third of the cases.

Filicide is typically viewed by the mother as an altruistic act of mercy intended to relieve the victim of real or imagined suffering.[5,35] These beliefs often stem from mood-congruent psychosis or delusions. The mother often believes that she has hurt or damaged the child in some profound way. Andrea Yates, for example, has reportedly said that she believes that she is possessed and that she was such a bad mother that all her children had been hopelessly damaged. Alternatively, the mother kills to spare the child the misfortune of being motherless after her intended suicide. She feels that if she takes her own life she cannot leave the child behind to be neglected by others.

Whether Ms. Yates intended to survive her children is unknown. However, she was placed on a suicide watch while in custody. In addition, Ms. Yates killed her children in a Texas county in which 62 people have been executed since 1982. If treated as a state, this county would trail only Texas as a whole and Virginia in the number of executions since the U.S. Supreme Court lifted the ban on capital punishment in 1976.[38] The fact that Ms. Yates killed her children in a place where execution for a capital crime is statistically more likely is probably an artifactual coincidence. That is where they lived. However, one could speculate that Ms. Yates knew that her acts could ultimately result in "suicide by execution."

Ms. Yates' has been charged with one count of capital murder and additional charges may follow. She has reportedly confessed to the murders and has made no attempt to hide what she did. This is consistent with altruistic, depressive filicides. Mothers surviving such events typically make no attempt to conceal the crime; indeed, they typically confess and request punishment.[5] Her attorneys have indicated that they are likely to use an insanity defense. In some 30 countries around the world, including Britain, Canada, and Australia, the crime itself would be enough to provide grounds for a lesser charge. Those countries rule out murder charges for women who kill their children in the first year after giving birth. However, an insanity defense based on postpartum depression is not often successful in the United States.[39,40] This is, in no small part, because altruistic homicide, even in a psychotically disorganized individual, is voluntary, often premeditated, planned logically, and accomplished methodically, always in full consciousness, and perfectly remembered.[5]

Conclusions

Whether Ms. Yates was advised of her risk of relapse and offered preventive treatment or she chose not to take prophylactic medication is unclear. Also, because the parties in the case are now under a gag order, many of the details, including complications surrounding the use of medication are also unclear. However, the scope of this tragedy is very clear indeed. We can only imagine the

nightmare her children endured in their last moments and the hell that awaits Ms. Yates once she is restored to reality. It is unlikely that it will matter to her whether she is sentenced to death or life imprisonment. No sentence will compare to the suffering Ms. Yates is likely to endure when she realizes what has happened. The events in Texas arose from a relatively rare set of circumstances. Nevertheless, any woman at risk for a relapse or new onset of postpartum depression should consult a psychiatrist to discuss options for preventive treatment, should she become pregnant.

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