Unusual Distress 5 Months After Delivery

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PRESENTATION

A 36-year-old, married woman presented to the emergency department 5 months after the birth of her first child. While trying to move the baby from cosleeping to a crib due to a planned return to work, she had experienced 2 nights of almost complete sleeplessness, associated with racing thoughts and feelings of detachment from her baby.

The emergency department (ED) physician diagnosed her symptoms as a panic attack and prescribed alprazolam. With her husband’s support, the patient stayed with a friend for 2 days to get some sleep. She felt better after this, but not fully recovered. After returning home, she practiced good sleep hygiene, and her husband took over all of the night feedings, but she was still unable to sleep more than 5 hours per night. The patient and her obstetrician decided her symptoms represented some unspecified anxiety disorder; the obstetrician prescribed escitalopram 10 mg. After 2 days on this medication, she felt much better. However, within a week, her racing thoughts and general sense of not being herself returned, prompting a self-referral to a clinic specializing in problems related to pregnancy.

At her initial psychiatric assessment, the patient expressed concern about her mental condition, but not about physical symptoms. She specifically denied trembling, chest pain, fearfulness, sweating, intrusive thoughts, or compulsions. She also denied recent elation, distractibility, irritability, depressed mood, feelings of guilt, decreased energy, disrupted concentration, psychomotor retardation, suicidal or homicidal ideation, and auditory/visual hallucinations. She still felt somewhat detached from her baby. She reported that her husband could see she was different from her normal self, but her friends and co-workers could not.

The patient described being in a generally good mood throughout her pregnancy. She had not experienced postpartum blues — in fact, she recalled feeling quite elated at the time of delivery. Until 2 weeks before going to the ED, she had been “in high spirits” and productive.
Between 10% and 20% of women experience significant mood and anxiety symptoms postpartum. DSM-IV-TR recognizes only one category of postpartum disorder: “major depressive disorder with postpartum onset.” Women who become depressed postpartum usually describe dysphoria, fatigue, guilt, irritability, insomnia or hypersomnia, often accompanied by doubt about their ability to mother. While thoughts of escape or suicide may occur, thoughts of harming the baby are rarer; more often, women are concerned about inadvertently causing harm or not being able to provide adequate care.

The incidence and prevalence of mood and anxiety disorders is approximately equivalent in non-pregnant, pregnant, and postpartum women — about 6% to 16%. In about one-third of women who are depressed postpartum, the illness begins during pregnancy. Another one-third become ill within the first 4 weeks; the remainder develop symptoms between 2 and 6 months after delivery. These different patterns of onset may reflect different pathophysiologic and psychosocial processes.

Postpartum blues, a period of 2 to 10 days of unusual tearfulness, occurs in 30% to 80% of women, within the first 2 weeks of delivery. While women who experience blues do not typically develop depression, women who develop depression do typically experience blues. Mild hypomania in the first postpartum week, the “pinks,” may evolve into depression later on. This patient clearly did not fulfill criteria for depression, although the evolution of her symptoms over time was typical for a mood disorder of some kind.

The epidemiology of anxiety disorders during pregnancy and postpartum is less well established. Obsessive-compulsive disorder (OCD) may develop after delivery in 13% of women. For the obstetrician or psychiatrist, the main challenge is to separate signs of disorder requiring treatment from the typical problems associated with the birth of a child such as disrupted sleep, uncertainty, challenging new roles, marital strain, and so on.

The Antenatal Health Questionnaire helps identify women who are ill during pregnancy or at risk for a postpartum depression. The Edinburgh Post Natal Depression Scale is particularly helpful in distinguishing signs of depression and anxiety from those related to simply being postpartum. This scale has been used around the world for more than 20 years and shows excellent psychometric qualities.

This patient did not display the symptoms needed for a specific anxiety diagnosis; she was not focused on the bodily signs of panic, had only one acute episode of severe anxiety, did not describe obsessions or compulsions, and was not experiencing dread. Although stressed and concerned about her ability to function, she was more concerned and puzzled than helpless or completely overwhelmed.

Only 0.1% of women exhibit psychosis postpartum. This condition typically appears as overt deterioration in function, confusion, grossly disorganized thought and behavior, lack of insight, and delusions or hallucinations that may compromise the safety of the child. Psychosis begins within 10 days after birth — often within 72 hours. Both agitation and anergy may occur, sometimes oscillating. Postpartum psychosis is a medical emergency usually requiring hospitalization. This condition entails significant risk for infanticide. Postpartum psychosis and mania with psychotic features are distinct but overlapping syndromes; some women go on to a lifelong bipolar course, others do not.

Phenomenologically, this patient’s sleeplessness, racing thoughts without dread or helplessness, variable mood, and her sense of being not her normal self, coupled with sudden improvement then deterioration after starting escitalopram, suggested she was suffering from hypomania.

When asked, she noted that her mother has a history of substance abuse and depression and her brother has substance abuse and bipolar disorder. Although she herself had never received psychiatric treatment, she recalled experiencing anxiety, dissociation, and racing thoughts while breaking up with a longstanding boyfriend years before. In the remote past, she had also experienced some weeks of depressed mood, anhedonia, tearfulness, decreased focus and poor memory, including days when she had been “unable to get out of bed.”

**CLINICAL COURSE**

The patient agreed that hypomania, rather than panic, better described how she was feeling. Nevertheless, she was not sure she was bipolar, based on her brother’s more severe symptoms. Initially, she stopped escitalopram in the hope that her symptoms would prove to be
merely drug induced. Within about 3 days, she reported continued sleeplessness. She then started oxcarbazepine, with no benefit at initial doses. When 2 mg/day of risperidone was added, her sleep improved, and she felt more like her normal self. However, over the course of a month, she gained 4 lb. A brief return to oxcarbazepine alone, at therapeutic level of 13 mcg/mL (reference range, 10-35 mcg/mL), was not effective, and she was placed on 5 mg/day of aripiprazole. Her mental state normalized, although she still has total decreased sleep, but without severe fatigue.

The patient reported that her husband was opposed to her taking medication on an ongoing basis. He was invited to her fourth appointment, where he could express his concerns and learn the grounds for her treatment. While still uneasy, he now leaves treatment decisions up to her. At that visit, the long-term implications of her condition, including discussion about ways of dealing with symptoms in a future pregnancy, were also discussed.

DISCUSSION

Current descriptive diagnosis does not capture the range of mood and anxiety disorders that may be related, in part, to the hormonal and interpersonal changes of pregnancy, delivery, and early parenting. As with other psychiatric disorders, perinatal disorders cannot be confirmed or ruled out by objective tests. These disorders occur in women whose hormonal status does not differ from that of pregnant or postpartum women who are asymptomatic.14

Validating a provisional DSM diagnosis requires going beyond cataloging symptoms and the course of illness and matching these to criteria. To validate a diagnosis, the evaluator must decide if this is the right patient, with the right back-story, from the right family, and, when available, with the right treatment response. Although this patient’s symptoms were equivocal, her age, gender, postpartum status, developmental history, and family history all made the diagnosis sufficiently clear to allow early initiation of treatment.

Her treatment response confirmed that her current state was hypomania, suggesting that the most appropriate overall diagnosis of her condition is bipolar II disorder (recurrent depression with hypomanic episodes).15 The medical and personal context of a psychiatric disorder that develops during pregnancy or postpartum plays a critical role in treatment and outcome. Evaluating and mobilizing appropriate social and material support is critical. Fathers are as invested as mothers in the well-being of their infants. In two-parent families, a father may see his role as protecting his child from his wife’s medication. At the same time, fathers and other helping adults share the burdens imposed by a mother’s illness and impairment. Directly involving a woman’s network in decisions about her care reduces the stress related to her own and others’ ambivalence about accepting a psychiatric diagnosis and adhering to treatment. When a woman’s relationships are more generally conflicted than in this case, individual therapy that focuses on interpersonal concerns or couples/family counseling may play a crucial role.16 In this case, since the patient was no longer nursing, the choice of medication was unrelated to her postpartum status, but the strategic psychosocial intervention of directly involving her husband contributed to the successful outcome of treatment.

REFERENCES