A 28-Year-Old New Mother with Insomnia and Anxiety

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A 28-year-old woman presented to the emergency department (ED) for assessment of insomnia and anxiety. She had given birth to her first child 6 weeks previously, and although her infant was healthy and doing well, the new mother reported that she could not get a good night’s sleep and had felt increasingly stressed during the past 4 weeks.

She was tearful and somewhat tremulous. During the past month, she reported decreased sleep and appetite, low energy, depressed or irritable mood most days, reduced ability to focus, and excessive guilt about being a “bad mother.” She felt overwhelmed in her responsibilities as a new mother and worried about her ability to eventually return to work. She indicated that she was breast-feeding.

Basic laboratory tests, including a complete blood count, urine toxicology, blood alcohol level, complete metabolic panel, and thyroid-stimulating hormone, were unremarkable. The ED nurse administered the Edinburgh Postnatal Depression Scale (EPDS) and the patient scored a 12, above the cut-off screening score for postpartum depression. Given the patient’s level of distress and concern for risk, the ED requested a psychiatric consultation.

During the psychiatric interview, the patient’s affect was restricted. She appeared anxious. She showed no signs of psychosis and her thought process was linear, logical, and coherent. Her psychiatric history was notable for one mild depressive episode in her early 20s, which resolved with short-term psychotherapy. She reported that her mother suffered from anxiety. The patient revealed that she and her husband separated during her third trimester, and that she felt alone and overwhelmed in caring for her baby. The psychiatrist inquired further into the nature of her insomnia, and the patient reported that she was unable to sleep even when her infant was sleeping.

When asked about triggers for her insomnia, the patient initially stated she just could not “relax.” The psychiatrist inquired more specifically about fears the patient might be experiencing regarding her infant’s safety, and she stated that she felt compelled to “check” the infant multiple times per night to see if she was still breathing. In addition, during the past 2 weeks she had begun to worry that she might have put the baby in the oven instead of dinner, or might have left the baby in the hot car accidentally because she was overly tired. She stated that she experienced increased anxiety and fear when these thoughts popped into her head, because she loved her baby and would not want to harm her. Each time she experienced these thoughts, she felt compelled to check the oven or the car. She reported checking up to 20 times per day, with a feeling of brief relief after doing so. The patient’s mother recently moved into the patient’s home because the patient was afraid

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to be alone with the infant due to fear of “the bad thoughts.”

The psychiatrist clarified whether the patient had any desire or intent to harm herself or her infant, and the patient adamantly denied any suicidal or homicidal urges or intent. Throughout the interview, the patient repeatedly stated that she worried about being a “bad mother” and was fearful that her infant “would be forever messed up by terrible parenting.” She had always been a bit of a “worrier” and perfectionist, but denied any history of mania, hallucinations, or other psychotic symptoms.

**DIAGNOSIS**

**Major Depressive Disorder with Postpartum Onset and Obsessive-Compulsive Disorder**

**TREATMENT**

The psychiatrist contacted the patient’s mother, who was watching the baby while the patient was in the ED. The mother confirmed that the patient had become progressively depressed since giving birth, with obsessional fears related to the baby’s safety. Rather than the patient being “bad” at mothering, she was well bonded with her daughter and attentive to the infant’s needs. The mother had moved in with the patient and was helping care for her new grandchild. This diagnosis of obsessive-compulsive disorder (OCD) was made based on the patient’s descriptions of obsessional thoughts, which were ego-dystonic. These obsessions were paired with compulsions to check the oven and brought the patient temporary relief after doing so. The guilt related to being a “bad mother” appeared congruent with her depressive episode, rather than a belief that reached delusional proportions. The psychiatrist elicited no information from the patient or the patient’s mother that led him to believe that the patient had, or intended to, harm her child; on the contrary, the patient self-presented, was distressed by her symptoms, and a collateral source confirmed a lack of concern for abuse. The psychiatrist, therefore, did not contact child protective services (CPS). The patient declined voluntary hospitalization and stated she would prefer to follow up as an outpatient. After a risk-benefit discussion regarding the use of medication for depression and anxiety while breast-feeding, the patient (with the encouragement of her mother) wished to begin taking a selective serotonin reuptake inhibitor. The patient’s mother confirmed that she was able to stay with the patient and her infant for the foreseeable future and would accompany the patient to her outpatient appointments. The psychiatrist scheduled the patient for an appointment later that week.

**DISCUSSION**

Postpartum depression (PPD) is a relatively common diagnosis, occurring in approximately 10% to 15% of new mothers.[1,2] Risk factors for developing PPD include lack of social support, previous depression, life events, and poor relationship with the significant other.[3] Diagnosing PPD should be relatively straightforward for most psychiatrists; however, the elucidation of emerging psychotic symptoms and the assessment and estimation of risk for suicide and/or infanticide may be more challenging. In terms of screening, the EPDS is a validated, freely available, and easy-to-use self-report tool.[4] The EPDS can be easily administered in a variety of settings, from the ED to outpatient obstetrical or pediatric clinics. Generally, scores of 11 or higher on the EPDS suggest the presence of a depressive episode, although lower cut-offs have been used in research.[5] Special attention should be paid to any indication of suicidal thinking, because suicide is the cause of up to 20% of deaths in postpartum women.[6] Depressed postpartum women who are suicidal should be carefully assessed for overvalued or delusional beliefs concerning the need to “take” the infant with them should they commit suicide.[7] Physicians should also carefully assess for the presence of anxiety disorders, as nearly two-thirds of mothers with PPD also experience anxiety symptoms.[5]

Postpartum depressive and anxiety states should be differentiated from postpartum psychosis (PPP), which commonly presents early in the postpartum period with rapid shifts in moods, confusion, mixed or hypomanic states, and hallucinations or delusions.[8] Most mothers who experience PPP have bipolar disorder.[2] PPP is an emergent condition requiring treatment, as untreated PPP may result in infanticide.[9,10] In this case, our patient did not show any signs of psychosis; rather, she reported symptoms most
consistent with OCD. OCD may emerge for the first time in the perinatal or postpartum period.\textsuperscript{11} Obsessions of violence and aggression are common in OCD, occurring in up to 50\% of patients.\textsuperscript{12,13} These thoughts, however, are ego-dystonic, not associated with intent or desire to cause harm, cause marked anxiety, and often are paired with compulsions to negate the thoughts or assure the patient that he/she has not lost control or acted on the unwanted impulse.\textsuperscript{14} In addition, women may experience violent obsessions within the context of a postpartum depressive episode, and these obsessions may be infanticidal in nature.\textsuperscript{15}

One study found that 41\% of mothers with PPD have had thoughts of harming their child.\textsuperscript{16} Yet, physicians often do not ask patients about thoughts of infanticide or harm toward their children and may neglect to consider the presence of these thoughts.\textsuperscript{17} Mothers may hesitate to self-report intrusive thoughts of harm due to feelings of guilt, shame, or fear that voicing these thoughts will signify that they are a bad parent or trigger a report to CPS.\textsuperscript{18} Even mothers who are not depressed may experience ego-dystonic aggressive thoughts or urges toward their infants, particularly if their infants cannot be soothed (eg, because of colic).\textsuperscript{19} The source of the obsessional thoughts is critical, as OCD alone has not been shown to increase the risk of infanticide and, if anything, may decrease the risk.\textsuperscript{14} Common factors in mothers who kill their children include limited social support, considerable life and financial stress, alcohol use, personal history of abuse, and symptoms of psychosis, depression, and suicidality.\textsuperscript{20}

Clinicians treating mothers with infanticidal thoughts should also consider and document whether the child is at risk of harm and whether CPS should be notified. States generally require reporting when a mandated reporter either “suspects or has reason to believe that a child has been abused or neglected” or “observed or has knowledge of conditions that could reasonably result in harm to the child.”\textsuperscript{21} Often, a mother who is deemed at low risk of harming her child can be treated and followed without notification of CPS.

In terms of treatment, the patient in our case was not involuntarily committed due to the absence of severe depression, suicidal ideation, psychotic features, or imminent threat to herself or her child, as well as the presence of protective factors including the support provided by her mother. The patient did agree to start an antidepressant for depressive symptoms and OCD and to participate in psychiatric treatment. The psychiatrist inquired about breast-feeding, an important consideration when choosing treatment. If a new mother who is breast-feeding is medication-naïve, paroxetine or sertraline may be considered as a first-line treatment, given the low penetration into breast milk.\textsuperscript{22} Otherwise, in general, the patient should be continued on the antidepressant that she has responded best to in the past. The patient was referred for psychiatric follow-up within 1 week, which was optimal to closely monitor her response and to watch for any signs of decompensation. The patient and mother were educated about signs of emerging psychosis and worsening depression, including suicidal thinking, hopelessness, hallucinations, and confusion, and the patient agreed to return to the ED if any of these symptoms emerged.

REFERENCES
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