Beyond “Baby Blues”: Recognizing Postpartum Psychosis

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Abstract:

After childbirth, some women experience postpartum depression, and in most instances it subsides without treatment. In rare cases, however, women experience the sudden onset of psychotic symptoms following childbirth, a dangerous medical condition known as postpartum psychosis (PP). This article explores how to identify patients at risk for PP, what signs and symptoms to assess for, and how to support them and their families during treatment.

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Article:

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After childbirth, some women experience postpartum depression, and in most instances it subsides without treatment. In rare cases, however, women experience the sudden onset of psychotic symptoms following childbirth, a dangerous medical condition known as postpartum psychosis (PP). This article explores how to identify patients at risk for PP, what signs and symptoms to assess for, and how to support them and their families during treatment.

Beyond the blues

Postpartum depression is estimated to occur in 15% of new mothers, but PP is rare, occurring in only 1 to 2 of 1,000 new mothers. Over 50% of women with PP have delusions that their baby is being harmed or killed, and approximately 4% commit infanticide.[1]

A woman with postpartum depression may be listless and report feelings of worthlessness. In contrast, a woman with PP loses contact with reality and experiences psychotic symptoms, such as hallucinations and delusions (see *Recognizing PP*). For example, she may become convinced

that something is terribly wrong with her baby, or that someone is trying to harm her baby. These delusions may cause her to harm herself or the baby, or to entertain thoughts of doing so.

Women who experience PP may or may not have a history of mental disorders, but the risk is greater for those who have a personal or family history of mental illness. Women with a history of bipolar disorder, schizophrenia, schizoaffective disorder, and PP with previous pregnancies have a higher risk of developing PP.

Signs and symptoms of PP typically appear soon after childbirth, usually within 2 weeks of delivery, but some women don't experience symptoms until several months later.[2] Although the cause of PP is unknown, signs and symptoms appear to be triggered in high-risk women by the rapid hormonal changes that occur after childbirth.[3]

Screening for PP

During prenatal visits, ask questions to help determine if your patient may be at risk for PP, such as:

* Have you or anyone in your family had a mental illness or psychiatric treatment?

* Have you ever felt depressed or had mood problems after giving birth?

* Have you previously experienced PP after giving birth?[2]

If the answer is “yes” to any of these questions, a complete medical history and diagnostic workup should be completed.[3]

After the baby's delivery, a woman who's at risk for PP should be monitored more closely to ensure that she isn't having postpartum distress. Closely monitor postpartum women who lack family support, those who had a complicated pregnancy or delivery, those with high life stressors or emotional adjustment issues, and those with a high-needs baby because they're at higher risk for developing PP from the hormonal changes following delivery.[3]

Medical emergency

A woman experiencing PP must be hospitalized and shouldn't be alone with her baby. In most cases, the woman is admitted to a hospital psychiatric unit and treated with medications to alleviate symptoms. Because women with PP may continue to breastfeed after treatment, atypical antipsychotics such as olanzapine, quetiapine, and risperidone are preferred because of their safety in lactation. Benzodiazepines such as lorazepam and clonazepam may be used to induce sleep or control agitation. Mood stabilizers and antidepressants may also be prescribed based on the patient's underlying psychiatric conditions.[4]

Electroconvulsive therapy (ECT) has been effective in women who don't respond to or can't tolerate medication. The number of treatments depends on the severity of symptoms.[5]

Provide support

Many healthcare providers are sensitive to the importance of not separating mother and baby during the period of treatment and recovery. Some hospitals make arrangements for the baby to be admitted as well so mother and infant have an opportunity to bond. Their time together is always under supervision.

Once a woman is hospitalized with PP, ensure that she and her family are given information about ongoing treatment, educating them as needed about medications and ECT, and making them feel like part of the team. Teach families therapeutic communication techniques, including active listening and empathy, so they can provide support. Refer the mother and family to a PP support group if one is available. Mothers and families want reassurance that the cause of PP is biological and that recovery is possible and expected.[6] However, the rate of recurrence with subsequent pregnancies is high at 50%.[1]

Education is key

Educate all new parents and their families about the possibility of postpartum depression and PP. Because women are discharged so quickly from the hospital after childbirth, the family is likely to be the first to notice delusions, disconnection (not wanting to hold the baby), aggression, changed personality, or even being too calm or too quiet.[6]

Upon discharge, provide all new parents and their families information about what to do if they detect signs and symptoms of PP. Providing this information can protect the baby from harm and reduce the stigma and shame that can prevent women or their families from seeking treatment.

Rare but dangerous

Postpartum psychosis is a rare psychiatric disorder that few women experience. But for the women who do, immediate medical intervention is necessary. Left untreated, the disorder may have tragic consequences. With prompt intervention, however, the likelihood is great that these women will make a full recovery.

Recognizing PP [3]

Signs and symptoms of PP include:

* hallucinations (false perceptions—visual, auditory, or olfactory)

* delusions (fixed, false beliefs)

* disorganized thoughts

* bizarre behavior

* manic or depressed mood (or both)

* severe insomnia

* rapid mood changes

* anxiety

* irritability

* psychomotor agitation

* paranoia.

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