Postpartum psychosis

Synonym: puerperal psychosis

What is postpartum psychosis?

Postpartum psychosis is a severe mental illness which develops acutely in the early postnatal period. It is a psychiatric emergency. Identifying women at risk allows development of care plans to allow early detection and treatment. Management requires specialist care. Health professionals must take into account the needs of the family and new baby, as well as the risks of medication whilst breast-feeding.

Definition[1]

Postpartum psychosis is a severe mental illness which develops acutely in the early postnatal period, usually within the first month following delivery. Psychotic features are present. There is a close link with bipolar disorder.

How common is postpartum psychosis? (Epidemiology)

Postpartum psychosis occurs following 1-2 per 1,000 deliveries.[1] [2] Women have a higher risk of psychosis in the few weeks following childbirth than at any other time in their lives. Incidence is significantly increased in women with a history of hospitalisation for psychiatric illness, especially where the past history was related to pregnancy.[3] Women with a family history of postpartum psychosis have been found to have a six-fold increased risk themselves.[4] This is even higher if they have a first-degree relative with bipolar disorder.

Suicide and psychiatric conditions are known to be significant leading causes of late maternal death in the UK, and awareness of mental health problems in pregnancy and the postnatal period is vital.[5]

What causes postpartum psychosis? (Aetiology)

Women at high risk of postpartum psychosis include those with:[1]

- A past history of postpartum psychosis.
- A past history of bipolar disorder.
- A family history of postpartum psychosis or bipolar disorder.

It is thought that postpartum psychosis may be a manifestation of underlying bipolar disorder. Possible contributing factors include sleep deprivation, hormonal changes, stress and genetic influences.[6]

Postpartum psychosis symptoms (Presentation)[1] [6]

Presentation is typically within the first postnatal month. The transition between symptoms of mild anxiety to severe psychosis can be rapid and so the diagnosis can be easily missed. All significant changes to mental state in the postnatal period should be closely monitored, and should trigger referral to specialist services.

Symptoms may be depressive in nature (withdrawal, confusion, loss of competence, distraction, catatonia) or manic (elation, lability, agitation, rambling). There may be delusions (paranoia, jealousy, persecution, grandiosity). There may be hallucinations which may be auditory, visual, olfactory or tactile. There may be odd beliefs about the baby.

Differential diagnosis

Other psychiatric causes for symptoms include:

- Major depression with psychotic features.
- Schizophrenia.
- Bipolar disorder with postpartum onset (debatable whether this is indeed usually the case, or whether it is a condition in its own right).

Organic causes:

- Ischaemic or haemorrhagic stroke.
- Electrolyte imbalance such as hyponatraemia or hypernatraemia.
- Hypoglycaemia or hyperglycaemia.
- Thyroid or parathyroid abnormalities (hyperthyroidism, hypothyroidism, hypercalcaemia, hypocalcaemia).
- B12, folate or thiamine deficiencies.
- Side-effects of medication.
- Sepsis.

Investigation to confirm the diagnosis will be in secondary care, and guided by presentation, but will include blood tests and possibly CT/MRI scanning.

Postpartum psychosis treatment and management[1] [2]

Postpartum psychosis is a psychiatric emergency. It requires urgent assessment, referral, and usually admission, ideally to a specialist mother and baby unit.[7]

Management is primarily pharmacological, using the same guidance as for other causes of psychosis. Medication would normally involve an antipsychotic and/or mood stabilising drug. However, choice of medication must take breast-feeding into account. Mothers requiring lithium treatment should be encouraged not to breast-feed, due to potential toxicity in the infant. Most antipsychotics are excreted in the breast milk, although there is little evidence of it causing problems. Where they are prescribed to breast-feeding women, the baby should be monitored for side-effects. Clozapine is associated with agranulocytosis and should not be given to breast-feeding women. Electroconvulsive therapy (ECT) may also be considered in some cases.[8]

Education and supportive therapy for the woman and her family are important. There is no role for psychotherapy in the acute phase of the illness, but supportive psychotherapy may be of value during and after recovery. Child protection services may need to be alerted, and discharge should only occur with close follow-up in place.

Prevention[1] [2]

Both National Institute for Health and Care Excellence (NICE) and Scottish Intercollegiate Guidelines Network (SIGN) guidelines prioritise early detection of women at high risk of mental health illness during and after pregnancy. NICE guidelines advise that at first contact with health professionals in pregnancy and in the postnatal period, women should be asked about:

- Past or present mental illness.
- History of treatment by a specialist mental health team.
- History of severe perinatal mental illness in first-degree relatives.

Women with a history of severe mental illness should be referred to a secondary care mental health service. Women with a personal or family history of severe mental illness or perinatal illness should be monitored closely in the postnatal period. There should be a written care plan in place, involving the specialist mental health team, and decided in collaboration with the woman and her family. The woman and all involved professionals should have a copy. It should lay out key contact details, the monitoring plan, and goals/outcomes and how these will be assessed.

There is not yet evidence to support the use of prophylactic psychotropic medication to prevent postpartum psychosis in high risk women.[9]

Prognosis[10]

Prognosis for complete recovery is good, although there is significant risk of recurrence (1 in 2) after subsequent pregnancies. Women who have been diagnosed with postpartum psychosis should be monitored very closely and referred early if they become pregnant again.

Suicide is rare during the acute episode, but the rate is high later in the mother's life and in first degree relatives.[11]

Further reading

- Psychosis and schizophrenia in adults: prevention and management; NICE Clinical Guideline (Feb 2014 - last updated March 2014)
- Bipolar disorder - the assessment and management of bipolar disorder in adults children and young people in primary and secondary care; NICE Clinical Guideline (Sept 2014 - last updated December 2023)
- Mental Health Toolkit; Royal College of General Practitioners
- Osborne LM; Recognizing and Managing Postpartum Psychosis: A Clinical Guide for Obstetric Providers. Obstet Gynecol Clin North Am. 2018 Sep;45(3):455-468. doi: 10.1016/j.ogc.2018.04.005.
- Raza SK, Raza S; Postpartum Psychosis. StatPearls, June 2022.

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