The Role of Midwives in Facilitating Recovery in Postpartum Psychosis

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Postpartum psychosis, an emergency psychiatric condition affecting one to two women per 1000 after childbirth, can result in a significant increased risk for suicide and infanticide. Symptoms of postpartum psychosis, such as mood lability, delusional beliefs, hallucinations, and disorganized thinking, can be frightening for the women who are affected and for families and obstetric care providers of those women. Women experiencing postpartum psychosis are often thrust into a mental health system that does not capitalize on the close relational bond that forms between midwives and the women they care for over the course of prenatal care. The purpose of this article is to propose using the Recovery Advisory Group Model of mental illness as a theoretical framework for care of women with postpartum psychosis, to assist midwives in recognizing symptoms, define the role of the midwife in treatment, and learn the importance of becoming part of the psychiatric mental health care team in order to facilitate optimum recovery for women with postpartum psychosis. J Midwifery Womens Health 2010;55:430–437 © 2010 by the American College of Nurse-Midwives.

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INTRODUCTION

In spite of the expansion of midwifery practice into both gynecologic and primary care, women still experience fragmentation in the delivery of perinatal services.[1] One of the needs in obstetric health care that remains crucial is meeting the needs of women who experience postpartum psychosis. In the current health care system, when women suffer an episode of postpartum psychosis they are thrust into a mental health system that does not capitalize on the close relational bond that forms between midwives and the women they care for during prenatal and intrapartum care. Without a familiar and sympathetic face in the psychiatric emergency room, women with postpartum psychosis may feel abandoned and frightened, which may further exacerbate the psychotic symptoms and delay recovery.

The Recovery Advisory Group Model for mental illness, established by Ralph et al.,[2] addresses the needs of patients with serious mental illness in the general psychiatric population and may provide a theoretical framework that can assist midwives in providing care for women with postpartum psychosis. The model, a consumer-driven, self-empowering approach, has not been studied in women with postpartum psychosis. The purpose of this article is to assist midwives in recognizing the symptoms of postpartum psychosis and to help midwives define their role in treating women with postpartum psychosis to achieve optimum outcomes for both women and their families.

POSTPARTUM PSYCHOSIS

Postpartum psychosis is an emergency psychiatric condition affecting one to two women per 1000 after childbirth. Although the incidence of postpartum psychosis is low, the risk for suicide and infanticide are substantially higher for women who are affected by this disorder than for women with any other postpartum mental illness.[3–5] Symptoms of postpartum psychosis are characterized by mood lability, delusional beliefs, hallucinations, and disorganized thinking (Box 1). Midwives must quickly recognize postpartum psychosis and immediately refer women for treatment to decrease the risk of harm to both mother and infant. Without early treatment, the condition may worsen and increase the risks for dangerous behaviors, recurrence in subsequent pregnancies (up to 90%), treatment resistant psychosis, relapse (57%; 95% confidence interval, 44–69),[6] and severe family dysfunction.[3–6] Women who have experienced postpartum psychosis may suffer long-term decreased self-esteem and altered mother–infant bonding.[7] Early intervention is a key factor in promoting a shorter recovery period and better long-term function.[8]

Etiology of Postpartum Psychosis

According to the *Diagnostic and Statistical Manual of Mental Disorders,* fourth revision (DSM-IV-TR), which defines diagnostic criteria for mental disorders, postpartum psychosis is considered either a severe form of major depression or the recurrence of a primary psychotic disorder such as schizophrenia.[9] There is also a large body of evidence suggesting that postpartum psychosis is a manifestation of an underlying bipolar disorder.[10,11]

Although no definitive cause has been identified, a combination of biologic and environmental factors have been implicated in the onset of postpartum psychosis (Table 1).[4] Risks for postpartum psychosis include family or personal history of psychiatric illness (especially bipolar disorder), a dramatic shift in hormonal levels after childbirth (especially the decrease in estrogen levels),

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BOX 1. POSTPARTUM PSYCHOSIS

R.W. is a 26-year-old primigravida who experienced a normal pregnancy and vaginal birth at 4 AM. During her initial prenatal visit, R.W. reported that she had experienced occasional symptoms of anxiety but had never experienced depression or psychosis. Her family psychiatric history also was significant for anxiety. During the initial postpartum hospitalization, R.W. had difficulty falling asleep and staying asleep, paced the hospital corridors, followed the nurses around the postpartum unit, and showed little interest in caring for her infant. R.W. returned home on the third postpartum day. Her family noted that she seemed agitated but ascribed this behavior to adjusting to becoming a new mother. Shortly after returning home, R.W. told her family that she was not feeling well, but she could not articulate what was wrong. She did not seem to be aware of her infant. Her speech became rapid and pressured. R.W. told her family to call 911, but they continued to try to console her. Her agitation continued to escalate and she started to accuse her husband of trying to kill her. The family then called 911. When the ambulance arrived, R.W. became combative and was placed in four-point restraints. Upon arrival at the hospital, she was given haloperidol, lorazepam, and benztropine intramuscularly.

The midwife who R.W. saw for prenatal care was informed of the hospitalization and went to see her. R.W. told the midwife that her husband and the emergency medical personnel had tried to kill her. The midwife assured R.W. that she was safe, that no one was trying to kill her, and that she might be suffering from postpartum psychosis. The midwife further explained that dramatic shifts in pregnancy hormones after childbirth and sleep deprivation can sometimes trigger a chemical malfunction in the brain and cause psychotic thinking. She further explained that these imbalances were temporary manifestations of postpartum psychosis and could be alleviated with medication and psychotherapy. Upon consultation with the medical staff managing R.W.'s inpatient care, the midwife facilitated a visit from her husband, facilitated removal of restraints, and explained to the couple that R.W. would be transferred to a psychiatric inpatient facility where her condition would be further stabilized with other medications.

After a 3-day psychiatric hospitalization, R.W. was maintained on a regimen of olanzapine and lamotrigine and weekly psychotherapy sessions for 6 months. She maintained weekly telephone contact with her midwife for the first 3 months. With R.W.'s permission, the midwife communicated with her psychiatrist as needed. At 6 months postpartum, R.W.'s psychosocial functioning and mother–infant bonding was normal, and she expressed a desire to share her story with others.

maternal age (>35 years), obstetric complications (including emergency cesarean section), abrupt cessation of antimanic medications, marital discord, sleep deprivation, primiparity, unplanned pregnancy, or life stress.[4,5,12–14] Primiparas are two to four times more likely to experience postpartum psychosis than multiparas. In a molecular genetics positional gene approach study of 54 sibling pairs affected by postpartum psychosis, Jones and Craddock[10] suggest that genetic factors—including a genome-wide significant linkage signal on chromosome 16p13 and a genome-wide suggestive linkage on 8q24—may be implicated in the etiology of postpartum psychosis.[10] Although low socioeconomic status and ethnicity are also risk factors for the onset of postpartum psychosis, they play a less prominent role.[3] The mean age of the onset of postpartum psychosis is 26.3 years. Despite evidence of risk factors, almost 50% of women with postpartum psychosis have not experienced any previous psychiatric hospitalizations.[15] Unless burdened with chronic mental illness, many women display high functioning before the onset of this disorder.[3]

While the assessment of R.W., whose case is presented in Box 1, did not reveal a personal or family history of bipolar or psychotic disorder, her personal and family history was positive for anxious symptomatology. R.W.'s age, primiparous status, and experience of sleep deprivation during labor and the first postpartum days are consistent with risk factors for the onset of postpartum psychosis.

Clinical Features

Most cases of postpartum psychosis occur within 2 weeks of childbirth.[3,13] Clinical features can include an odd affect; withdrawn behavior; distraction by auditory, visual, or olfactory hallucinations; confusion; incompetence; catatonia; jealousy; suspiciousness; grandiosity; sleeplessness; or lability of mood characterized by elation, rambling speech, agitation, and/or excessive activity (Table 1).[3,14]

In a qualitative study of nine nurses in Sweden, Engqvist et al.[16] found that women with postpartum psychosis displayed symptoms such as delusions, disconnection, aggression, self-absorption, changed personality, insomnia, chaotic behavior, suicidal ideation, and ''strange eyes'' that appeared black and vacant. In a retrospective study of 127 women with bipolar postpartum psychosis, Heron et al.[17] found that many women recalled feeling symptoms by 3 days postpartum, including euphoria (excitement and high levels of energy), feeling very talkative, racing thoughts, confused thinking, and having trouble sleeping. In a study comparing 21 women with postpartum psychosis to 21 women without postpartum psychosis who were matched on age, parity, and year of admission from the same hospital, Sharma et al.[13] found that nighttime deliveries with accompanying sleep deprivation were significantly higher in women with postpartum psychosis compared to the controls.[13] Women with postpartum psychosis may also display obsession with childbirth themes, concern about the infant's altered identity, or a sense of persecution from the infant.

Prodromal symptoms were evident from R.W.'s odd behavior of following nurses around the postpartum floor

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