Recognizing and Managing Postpartum Psychosis

A Clinical Guide for Obstetric Providers

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KEYWORDS

• Postpartum psychosis • Bipolar disorder • Perinatal psychiatric disorders
• Treatment

KEY POINTS

- Postpartum psychosis (PPP) is a rare psychiatric emergency that can endanger the lives of the mother and child.
- It most often arises within 10 days of childbirth and is characterized by bizarre thoughts and/or behavior, alterations of consciousness, and mood fluctuation.
- The single biggest risk factor is a personal history of bipolar disorder, and most women with PPP will go on to develop bipolar disorder.
- It carries high rates of suicide and infanticide, and suspected cases require psychiatric evaluation as soon as possible.
- Treatment requires hospitalization and aggressive pharmacologic management.

INTRODUCTION

Postpartum psychosis (PPP) is at once the most dangerous and the least understood of perinatal psychiatric disorders. It affects 1 to 2 per 1000 women and constitutes a true psychiatric emergency, one that requires immediate hospitalization and treatment.[1,2] The lack of knowledge about what it is, how to recognize it, and how to treat it, combined with stigma about perinatal psychiatric disorders in general and the lack of appropriate treatment venues, means that it is often missed, by both obstetricians and psychiatrists, with sometimes tragic consequences.

PPP has been noted since antiquity. Hippocrates described the first case known to the medical literature in 400 BC; his patient was delusional, confused, and had

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insomnia within 6 days of a twin birth.[3] A medieval gynecologist attributed the disorder to "too much moisture in the womb, causing the brain to fill with water."[4] By the late eighteenth century, German and French obstetricians and neurologists were beginning to write more frequently about the disease. In 1858, French psychiatrist Louis Victor Marcé[5] published his *Treatise on the Madness of Women who are Pregnant, Recently Delivered, or Nursing*.[5] Marcé's carefully observed treatise, although suggesting treatments that today seem woefully barbaric (applying leeches to the vulva, for example), is a model of observation; Marcé saw in his postpartum mothers the same symptoms that doctors struggle to control today. His observations led him to conjecture about the role of the immune response and the endocrine system, 2 systems that today are widely acknowledged to contribute to postpartum mental illness.

CLINICAL PRESENTATION

The name PPP is not, perhaps, the best moniker for an illness that is at least as much an affective, or mood, disorder as it is a psychotic disorder. Many clinicians mistakenly think that the term can be applied to any psychotic symptoms in the postpartum period or that its clinical features will be identical to those of schizophrenia or other primary psychotic disorders. In fact, the symptoms of PPP are distinctive and unique. The onset is typically sudden and occurs within the first 2 weeks post partum.[6–8] The literature has frequently described the distinctive clinical features (**Box 1**), which include a delirium-like waxing and waning of consciousness, disorganization and confusion, depersonalization, and bizarre delusions (often concerning the child or childbirth). Early warning symptoms include insomnia, anxiety, irritability, or mood fluctuation. Although the psychotic symptoms are often the most dramatic manifestation, women also present with mood symptoms: mania (can be irritable or elevated), depressive symptoms, or mixed symptoms. A recent clinical cohort study tracked the phenotypic characteristics of 130 consecutive cases of PPP and used latent class analysis to describe 3 separate symptom profiles:

1. Cases characterized by mania and/or agitation, with irritability much more common than elevated mood (34%)
2. Cases characterized by depression and/or anxiety (41%)
3. Cases showing an atypical or mixed profile (25%)[9]

Across all cases, 25% of patients were disorganized, 20% disoriented, 10% had disturbed consciousness, and 5% developed catatonia. Seventy-two percent had abnormal thought content, which most often consisted of persecutory delusions; a minority had frank hallucinations. See **Boxes 2–4** for representative clinical case presentations.

Box 1
Clinical features of postpartum psychosis

- Disorganization
- Confusion
- Depersonalization
- Insomnia
- Irritability
- Abnormal thought content (delusions and/or hallucinations)
- Abnormal mood (mania or agitation, depression, mixed)

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