**Postpartum Psychosis**

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**Current Practice Description**

Postpartum psychosis (PP) is a psychiatric emergency that is characterized by “bizarre thoughts, and/or behavior, alterations of consciousness, and mood fluctuations (Osborne, 2018). PP usually presents within ten days of childbirth and is associated with high rates of suicide and infanticide, which is why it requires immediate inpatient psychiatric treatment (Osborne, 2018). This is a relatively rare disorder with only 2 women per 1000 being affected, and the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) does not recognize postpartum psychosis as its own disease process (VanderKruik et al., 2017). Because the consequences of this development are severe, however, the onset of PP should be handled swiftly and aggressively. In season three, episode seven of *Call the Midwife*, one of the patients eventually contracts “puerperal psychosis,” endangering herself and her baby (Harris & Thomas, 2014). She receives prompt treatment and is able to return to her family eventually. While there is still a stigma that surrounds mental health problems today, especially those associated with childbearing, the episode proved that the stigma of seeking mental health treatment was even stronger in the 1940s (Harris & Thomas, 2014). Both the patient in the show and her family were put through extreme stress to seek treatment while also handling the stress of a new baby. I had not heard of this postpartum complication before, so I wanted to explore the subject to inform my future practice. Additionally, I thought it was an interesting way to combine maternity and mental health. In this paper, I will examine the historical practices surrounding PP, what current evidence says about its identification and treatment, and how practitioners are realistically handling PP today.

**Historical Practice Description**

 During episode seven in season three, Pamela delivers a healthy baby girl. She seems overjoyed and returns home to her husband following delivery. Over the next few postpartum visits, Pamela show signs of increasing agitation and an unwillingness to rest or relax. She cleans meticulously, doesn’t allow her husband to touch the baby because he is “carrying germs,” and eventually progresses to the point of accusing a midwife of trying to poison her and her baby (Harris & Thomas, 2014). The doctor concludes she needs a psychiatric evaluation, which is met with significant pushback by Pamela’s husband because he doesn’t want her to see a “head doctor and go to the loony bin” (Harris & Thomas, 2014). Eventually, Pamela nearly jumps off a bridge with her baby in winter because she believes the river will cleanse the baby of germs “like Moses” (Harris & Thomas, 2014). After being convinced that wasn’t the best option, Pamela goes to a psychiatric hospital, receives electric convulsive therapy (ECT), pharmacotherapy, and behavioral therapy. Her husband has a hard time accepting his new role as caregiver and is often ashamed of what others say about him and his wife. Eventually, Pamela bonds with her baby again and reintegrates back into her routine life with her family (Harris & Thomas, 2014).

**Literature Review**

Pamela’s story aligns with the current research on the development, manifestations, and treatment of PP. Symptoms include disorganization, confusion, insomnia, irritability, and abnormal thought content (Rundgren et al., 2018). Although the most common risk factor is a personal history of bipolar disorder, only a third of women who develop PP have a history of a psychiatric disorder and more than 90 percent are primiparous (Meltzer-Brody et al., 2017). Additionally, unlike postpartum depression, there appears to be no correlation to traumatic birth experience or socio-economic status in the development of PP (Meltzer-Brody et al., 2017). The first case of PP was described by Hippocrates in 400 BC, and medieval doctors observed PP as a result of excessive womb moisture (Osborne, 2018). In those days, PP was treated with ineffective interventions such as putting leaches on the vulva. Today, however, treatments are evidence-based. The treatment plan is lorazepam at first, haloperidol added on day 4 if needed, and lithium is symptoms persist. If pharmacologic interventions fail to reduce psychotic symptoms, ECT is recommended (Osborne, 2018). Surprisingly, ECT, which is also indicated for severe postpartum depression, has proven to be an effective treatment for PP, especially in cases in which the symptoms are severe (Rundgren et al., 2018). Pamela receives all of these treatments in the show, which made me wonder if practices concerning PP were advanced in the 1940s or if our current practices had not evolved since that time.

**Current Practice**

 Since the 1940s, practice has actually remained consistent. The research backing up these practices, however, has grown exponentially in the past ten years as the stigma surrounding postpartum mental illness is decreasing. It is theorized that birth is a biological trigger for PP but does not cause PP. In fact, 69 percent of women who had PP would come to meet the criteria for bipolar disorder after the puerperal episode of PP and after the late postpartum period (Osborne, 2018). Research suggests, however, that one of the most critical factors to reintegration into daily living is a supportive environment for both the mother and the family (Doucet et al., 2012). In the show, Pamela’s husband struggles to take on the role of caregiver for his newborn daughter, and research now shows that mothers recover more quickly when continually developing a bond with her child while seeking treatment, and partners cope better with social and informational support in caring for his or her family (Doucet et al., 2012). Sadly, in the United States, there are no psychiatric units that permit the baby to stay with the mother, so this may cause of delay in care because the lack of desire to be separated from the baby and the lack of support to leave the child (Osborne, 2018).

Another area of improvement for this postpartum complication could be improving access to care and expanding support systems to make seeking treatment a realistic option for couples. Additionally, most of the partners of women who developed PP felt they were “blindsided” by this disorder because their partners had no previous history with mental health issues (Doucet et al., 2012). This might be remedied by informing or preparing patients and their families for potential mental health complications and teaching them what to look for and when to seek treatment. Finally, in the show, prompt treatment and risk mitigation would have been possible without the multiple postpartum follow-up home visits (Harris & Thomas, 2014). In 2020, there are still many women who do not receive postpartum treatment until six weeks after delivery. In this way, we have regressed in quality of care. By adopting more programs that provide care to women more consistently after delivery, healthcare professionals can screen for postpartum mental health disorders as well as physical illnesses. I am confident patient outcomes would improve with these interventions. While there is a need for improvement and better awareness of postpartum psychosis, a lot of progress has been made since the times portrayed in *Call the Midwife*, and I feel that I am better equipped to assess for this postpartum complication in practice after observing and researching this phenomenon.

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