



POSTPARTUM PSYCHOSIS

(Also known as Puerperal or Postnatal psychosis)



OVERVIEW

The term psychosis is the name for a group of mental illnesses where there is a loss of contact with reality. With time and careful management, most people do recover fully from these episodes – many never having another episode.

Women are most at risk of developing a significant mental illness during pregnancy or in the first year following birth. Of these, postnatal depression is the most common. Postpartum psychosis, although relatively rare, is the most dramatic and severe requiring emergency, specialist treatment in an in-patient psychiatric unit. Postpartum psychosis is considered to put the safety of the mother and her infant at risk. Whether the mother and her infant are cared for together or separately will largely be determined by the severity of the illness, the mother's symptoms, an individual needs assessment and/or the availability of mother baby unit beds. Not all places have mother baby units, so the options for in-patient treatment may differ depending on where the mother lives

Incidence and recurrence

Postpartum psychosis affects about 1:700-1,000 women in the immediate postpartum period and is more common after a first pregnancy. The rate of recurrence in a future pregnancy is relatively high (approx. 20%), especially if the interval between pregnancies is short, so careful family planning, monitoring and specialist follow up are essential.

Causes

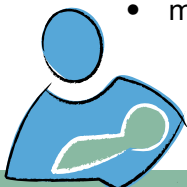
There is no real known cause, however, there are theories that the biological changes involved in pregnancy and childbirth may trigger it. Other factors which may contribute to its development include:

- a genetic predisposition
- previous mental illness
- environmental, social and psychological stress factors

Symptoms

Symptoms are generally marked, characterized by severely disturbed mood and behaviour.

- very high, elated mood, agitation, aggression or grandiose ideas about own abilities
- very low, depressed mood, withdrawal, tearfulness
- moods that swing rapidly from high to low



- thought disorder - a disturbance in thought processes which may be evident in the mother's speech
- delusions – false, firmly held beliefs. The mother is usually so convinced of her delusion that the most logical argument against it is useless and counter-productive (agreement is also counter-productive)
- conversations may be nonsensical; words may be expressed rapidly, jumping from one point to another
- hallucinations involving disturbances in perception, hearing, feeling, smelling, tasting or touching something that is not actually there
- behaviour may be odd or uncharacteristic. The mother may do things she would not normally do and respond inappropriately to the baby
- sleep disturbances, such as difficulty getting to sleep, waking frequently during the night or getting up very early unrelated to baby's needs
- failing to recognize or accept that help is warranted.

The possibility of suicide or infanticide is very real. The degree of risk to the mother and her infant require careful assessment and consideration. The relationship between the mother and her infant and/or other siblings requires close monitoring as the ability of the mother to make safe decisions is compromised.

If the mother and her infant are separated, the infant should ideally be cared for by an immediate supportive family member with frequent visits to the mother where possible to enhance the mother/infant bond. Occasionally, this may not be in the mother's or the baby's best interests, so this should be based on an individual needs assessment.

Prognosis

Despite postpartum psychosis being an acute and severe disorder, recovery is generally complete with a 20% recurrence rate in future pregnancies.

This may involve a combination of several options including:

Treatment

Hospitalization

Admission to an in-patient psychiatric hospital is almost always necessary. Ideally, this would be in a specialist mother baby unit depending on suitability and availability.

Medication

This is also usually necessary and may include antipsychotic medication, mood stabilizers and/or antidepressants. These need to be carefully prescribed and monitored. The aim of these drugs is to reduce the symptoms of mania (if these are the predominant symptoms), restore sleep, reduce anxiety and lift the mood (if depression is the predominant feature). Response to mood stabilizers and antipsychotic medication is usually rapid, but antidepressants usually take several weeks to take effect.

If the mother is breastfeeding, this will need to be carefully discussed and options considered. Breastfeeding whilst taking mood stabilizers and antipsychotics is not recommended or encouraged due to the possible side effects to the infant. There is also currently a lack of reliable research to support their safety. Modern antidepressants are considered relatively safe and breastfeeding is generally not contraindicated in their use.

* The use of drug therapy should always be discussed carefully with sound, current medical advice. Most hospitals also have Lactation Consultants on staff that may also be able to offer some guidance and assistance with current information on this matter.

ECT (Electro-convulsive therapy)

The acuteness of the symptoms will determine whether ECT is considered an appropriate treatment. When used, it often has very rapid effects. Although it may sound frightening, the treatment itself is administered under a general anaesthetic and muscle relaxant and is painless. It is usually administered as a course of 6-8 treatments depending on the mother's response. It may be followed by a headache, nausea and temporary memory loss but these side effects are generally transient with no long-term problems.

Medication plus ECT

This combination often works rapidly to control acute symptoms and minimize long term effects of the illness.

Additional therapies following stabilization

These may include - counselling, relaxation, individual psychotherapy, and support groups – it is usually very helpful to talk to others who have been through the same experience.

Emotional and practical supports

This is crucial for short and long term recovery as return to normal may be a long and slow process, so a great deal of practical and emotional help and support is usually required not only for the mother but the entire family. Partners of women who experience postpartum psychosis require extra support and information to enable them to provide special care to their partners through a long and often intense recovery period.

Education and careful follow up

This is essential for the development of an understanding of the illness as well as for the prevention and early intervention of subsequent illnesses. Careful monitoring of medication, relational issues and mother/infant attachment is crucial as is careful family planning and linking in with specialist services. Doctors and maternal and child health nurses are primary health care professionals who may be an invaluable source of support and follow up.

The Post and Antenatal Depression Association (PANDA) is a community resource offering referral, phone support and education for sufferers, families, health professionals and other workers involved in the care of women with childbirth related mental illness.

References:

- Buist, A (1996). *Psychiatric Disorders Associated with Childbirth – a guide to management. McGraw – Hill.*
- Brockington, I (1996). *Motherhood and Mental Illness. Oxford University Press.*
- Hamilton, J.A; Neel Harberger, P. (1992). *Postpartum Psychiatric illness – a picture puzzle. University of Pennsylvania Press.*
- NHMRC (2000). *An information paper. Postnatal depression – a systematic review of published scientific literature to 1999.*



PANDA

Contact Us: 810 Nicholson St, North Fitzroy, VIC, 3068
Support: 1300 726 306, Admin: 03 9481 3377, Fax: 03 9482 6210 Email: info@panda.org.au