

How would you approach developing a management plan for a pregnant woman who has a history of postpartum psychosis?

“Postpartum psychosis: ‘I’m afraid of how you’ll judge me, as a mother and as a person’” (Carver, 2017).

Intro

Postpartum psychosis is a mental illness that comes on days to weeks after birth and can cause the mother to have rapid changes in mood, as well as to have psychotic symptoms such as delusions (RCPSYCH, 2015). It is common for many women to experience ‘baby blues’ after birth, however postpartum psychosis, while less common (1 in 1000) (RCPSYCH, 2015), needs to be treated as a medical emergency (NHS, 2017). Talking about maternal mental health is very important because the leading cause of death within the first year of child birth is suicide (CEMD, 2001), with 60% of those committing suicide suffering from a “severe affective illness” (Di Florio, Smith and Jones, 2013). However, there is still a stigma attached to the illness as it tends to be cases involving infanticide that makes headlines, which may prevent mothers from seeking help (Carver, 2017). Therefore, it is vital we know how to give women the support they need. There are many risk factors for postpartum psychosis that we know of, including primiparity, pregnancy and delivery complications and caesareans. Another strong risk factor is a woman who has been affected by postpartum psychosis in a previous pregnancy (Di Florio, Smith and Jones, 2013) and these are the women that this essay will be focusing on. In fact, the recurrence rates of postpartum psychosis in subsequent pregnancies are 50% or more (Robertson et al., 2005) showing how important it is that we have an effective management plan in place for those at risk. This essay will be discussing how to approach developing a management plan for a pregnant woman with a history of postpartum psychosis, looking holistically at the patient through a biopsychosocial model.

Before discussing the management plan for a pregnant woman, it is important to recognise that there are ways to help women with a history of postpartum psychosis before they get pregnant. A psychiatrist (preferably a perinatal psychiatrist) should be involved in the care of women planning to get pregnant and her and her family should receive counselling before conception to discuss the risks of illness after delivery. She may also be on medications that need to be reviewed and decisions on whether the medication should be stopped or continued need to be made on an individual basis (Di Florio, Smith and Jones, 2013). Forming a relationship with the woman and her family before conception will help to maintain ongoing care throughout the pregnancy and after. Therefore, counselling and reviews before conception are useful but it is important to have a management plan in place during pregnancy which this essay will now discuss.

Psychological

First, this essay will discuss the psychological aspects to consider when developing a management plan. Before a plan is formed, it is essential that the patient is involved in developing a management plan and the final decisions are left to her. There should be a

clear, written plan throughout the pregnancy and postnatal period (Di Florio, Smith and Jones, 2013) and this plan should be communicated to her family and the mental health team that will be supporting her. One of the most important things throughout the pregnancy is psychoeducation. It has been shown that education around the condition “improves adherence” and strengthens the “decision making process about treatment and her feelings of self-efficacy and mastery over illness” (Sit, Rothschild and Wisner, 2006 p5). It is therefore a key part of the management plan. Some of the symptoms that the patient and her family should be informed of include mood swings, confusion, strange beliefs and hallucinations (Sit, Rothschild and Wisner, 2006). They should then be told that if anyone notices these symptoms, the patient’s physician should be contacted so that help can be given. Another important psychological aspect of the management plan is reviewing the woman regularly throughout the pregnancy and having a meeting later on with the patient, family and the team involved in her care so that plans can be made for her management during and after delivery, as well as what will happen if she does develop symptoms (RCPSYCH, 2015). Therefore, psychological interventions during the pregnancy should include psychoeducation and regular reviews later in the pregnancy to ensure everyone is aware of the management plan in place.

Psychological support is also essential after delivery. There should be regular visits to the mother for a few weeks after delivery to offer continuous support and pick up any early symptoms (RCPSYCH, 2015). All patients should be asked about the presence of symptoms and it is important that at the 6 week check, GPs ask about the mother’s mood to pick up on any problems at home (Sit, Rothschild and Wisner, 2006). If symptoms are picked up on then it is usually necessary for the mother and baby to be admitted to hospital because of how unpredictable the illness is and this is something that should be discussed with her before the onset of the illness (Jones and Smith, 2009). While checking her mood, emotional support and reassurance of her abilities is helpful for the mother to build her confidence (Sharma, Rai and Pathak, 2015). Interpersonal therapy may be helpful in this situation as it can help the mother adjust as well as improving depressive symptoms. Emotional support is also necessary for the partner and other household members as they are adapting to change and may be anxious about the wellbeing of their family (Sharma, Rai and Pathak, 2015). It can feel isolating and frustrating when their partner is suffering from symptoms so it is important that they receive help and have someone to talk to if they need it (RCPSYCH, 2015). When dealing with her family, group psychotherapy may also be useful so that everyone is involved in ensuring the family’s wellbeing. Therefore, psychological support after delivery is essential and should include regular reviews to ensure the mother’s wellbeing and pick up on early signs of psychosis as well as interpersonal or group therapy to help the family to cope.

Social

The next aspect to be considered when developing a management plan is social. We recognise there are certain risk factors for postpartum psychosis that are avoidable, including stress and sleep deprivation (Di Florio, Smith and Jones, 2013). Therefore, a management plan during pregnancy should aim to help women understand how they can reduce these risk factors. After delivery, preventing sleep deprivation is particularly important for reducing the risk of psychosis (Spinelli, 2009), so it may be possible to offer

respite services to allow women to catch up on sleep if needed (Sharma, Rai and Pathak, 2015). At this point it is also worth checking the support that the woman is receiving at home, including from her partner and family, to ensure that she is receiving enough help to prevent excessive sleep loss. It has been shown that a lack of social support may be one of the factors contributing to a risk of infanticide, and therefore assessing her support may allow you to identify women at high risk of this (Friedman, Resnick and Rosenthal, 2009). For women at high risk, it has also been suggested that avoiding breastfeeding may help, as this is a major cause of sleep loss (Sharma, Rai and Pathak, 2015). As well as minimising sleep disruption, it is important to review mother and baby to ensure they have all the practical help they need which can minimise anxiety and help bonding with the baby. As well as the mother, it is important that the social needs of the partner are met to improve their mood, as this will also help with family bonding. It is important that the partner stays healthy and gets enough rest which will make it easier to cope if the mother develops symptoms of psychosis (RCPSYCH, 2015). Therefore the social aspect is important to include in the management plan as it is essential that the mother minimises risk factors such as sleep deprivation in order to reduce her risk of psychosis.

Biological

Finally, it is necessary to consider the biological aspects of postpartum psychosis when developing a management plan. There are certain genetic risk factors for postpartum psychosis, including previous postpartum psychosis, family history of postpartum psychosis or a personal history of bipolar disorder (Di Florio, Smith and Jones, 2013). As the disease has a quick onset, there is a biological pathogenesis which involves changes in hormones, including a sudden drop in oestrogen at delivery that in turn reduces the levels of serotonin and dopamine. This increases the risk of affective symptoms and psychosis in women after delivery (Sharma, Rai and Pathak, 2015). Medications can be used in women at high risk, however the decision about whether or not to use them during pregnancy should be made on an individual basis. There also needs to be a full risk-benefit analysis with the patient being fully involved in decisions throughout the pregnancy (Jones and Smith, 2009). Lithium is the drug that has the most evidence for use as prophylaxis against postpartum psychosis, however it is not clear when the best time to start this is. Some recommend that it is started in the third trimester and others recommend starting immediately after delivery. Its efficacy is clear: a study on the use of lithium as prophylaxis against psychosis showed that 27% of women who took lithium suffered from psychosis within 3 months of birth, compared to 60% of those who had no treatment (Doucet et al., 2010). After pregnancy, lithium also has also been shown to be effective in reducing relapses for subsequent pregnancies in women who have suffered psychosis previously (Sharma, Rai and Pathak, 2015). Whichever decision is made, the patient needs to be fully informed of the risks (Spinelli, 2009). This includes a discussion about whether the medications are safe to take while breastfeeding or not and it has been found that olanzapine and quetiapine are the most acceptable to take while breastfeeding but the infant still needs monitoring (Sharma, Rai and Pathak, 2015). Therefore there is a biological basis for postpartum psychosis which can be addressed with medications, particularly lithium for prophylaxis, but decisions regarding medication needs to be made on an individual basis weighing up the risks and benefits.

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Conclusion

In conclusion, this essay discussed the development of a management plan for a pregnant woman with a history of postpartum psychosis through a biopsychosocial model. Biologically, lithium has the most evidence for use as prophylaxis against postpartum psychosis. Psychologically, education is important throughout pregnancy and after delivery therapy and regular reviews are helpful to minimise affective symptoms and pick up on early signs of psychosis. Socially it is important to ensure that the mother is minimising risk factors including sleep deprivation and ensuring a good social network. Overall, however, the management plan should be discussed with the mother and possibly her partner and family with the final decisions being made by the patient. Therefore, the management should be decided on an individual basis so the plan will be unique to each patient. It is very important that we talk about these subjects as there is still a stigma attached to this kind of condition. The quote at the start highlights why it is important that we educate the mothers on this condition as well as start discussions about how this illness affects families. We do not want women living in fear of what will happen if they seek help for the condition and hopefully by starting more discussions we can reduce some of the stigma surrounding postpartum psychosis.

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