

Puerperal psychosis causes risk factors and treatment psychology essay



**ASSIGN
BUSTER**

Having a baby can be an exciting time in a woman's life however; it is a time of significant bio-psychosocial change which can bring about various difficulties including different psychiatric disorders.

The three main mental illnesses that can occur in the postnatal period are mania, depression and schizophrenia which are currently recognised as puerperal psychosis despite previous thoughts that puerperal psychosis was a special mental illness (RCPSYCH, 2008).

There are no obvious causes for puerperal psychosis however, a woman is most likely to be affected if she has already experienced such an illness previously or if there is a family history of serious mental illness (RCPSYCH, 2008). Puerperal psychosis can have significant impact not only on the mother and baby but on their immediate family and wider family, friends and society as a whole sometimes with fatal consequences.

The Diagnostic and Statistical Manual of Mental Disorders' (DSM IV-TR) diagnostic criteria for a major depressive event uses 'within postpartum onset' to refer to depression that starts within 4 weeks postnatal and happens within 3 months after birth. It should entail at least five of these symptoms being present; sadness, repeated thoughts of death, exhaustion, lack of sleep or hypersomnia, increased or decreased appetite changes leading to weight loss or gain, reduced libido, tearfulness, feelings of guilt and worthlessness, anxiety, agitation and irritability (APA, 2000).

Postnatal mood and anxiety disorder presents in three ways: baby blues, postnatal depression and puerperal psychosis. In baby blues there is a slight period of mild depression which many mothers encounter after having birth

<https://assignbuster.com/puerperal-psychosis-causes-risk-factors-and-treatment-psychology-essay/>

and this phase of depression resolves after a few days. But, about 15% of women tend to advance to postnatal depression. A small number of new mothers may develop a rarer and rather acute type of the postnatal depressive disorder with manic features (Puerperal psychosis) and requires immediate treatment (RCPSYCH, 2006) . Puerperal psychosis affects 1 in 500 women and starts days or weeks after childbirth.

This paper will focus on Puerperal psychosis, and explore its causes, risks and management with reference to literature and case history of Mrs X.

Case History

Mrs. X is a 31 year old married woman who used to work as an administrator. About 4 years ago, she became pregnant and described the pregnancy as an anxious pregnancy. She had a planned Lower Segment Caesarean Section (LSCS), and at 38 weeks gestation, she suffered a placenta praevia complication and had to have a blood transfusion. Baby A was born healthy with no abnormalities.

Two weeks after birth she began feeling anxious and could not sleep. She visited her GP complaining of feeling anxious which she was prescribed anxiolytics (temazepam, diazepam and zopiclone). These medicines gave her relief from her anxiety but after the medicines wear off she then experienced persistent anxiety, low mood, reduced appetite, poor concentration, poor sleep and felt lethargic.

She began to experience delusions about a physical illness that will cause her to die during the night and make her abandon her child. This feeling led

to sleep disruption and worry about her baby's health will be adversely affected due to her anxiety.

After 4 weeks post partum, she was seen again by her GP and also assessed by other mental health practitioners who advised admission into a mother and baby unit for treatment for a possible puerperal psychosis. On examination she was found to be acutely anxious, responding to hallucination (auditory and olfactory) and agitated. Mrs X was preoccupied about an 'evil spirit', which said "I am here, you are not alone" and she felt her body has been taken over by the evil spirit. She had ideas of death and smelt death (cotards syndrome). She also had feelings of persecution about being a bad mother and thought her baby was better without her but denied thoughts of harming her baby. Her appearance was unkempt, wearing her night dress but her behaviour and mannerism were appropriate. Her speech was coherent with normal rate and tone; there was no evidence of disordered thought. She described her mood as confused, afraid and anxious and said "I think am going crazy". Her mood appeared perplexed and dysthymic. She denied any thought of active suicide but reiterated the thought of death. It was concluded that she suffered puerperal psychosis which was evident of delusion of negation with a depressive feature.

Mrs X was subsequently admitted to a mother and baby unit for treatment. She was prescribed citalopram, lorazepam and risperidone. After about a month she was discharged and maintained on the medicine and fully recovered and lived symptoms free.

Three years later, Mrs X became pregnant with a second child. This time her pregnancy went smoothly without any feelings of anxiety. She gave birth to Baby B, with no complications or abnormality. A few days after her discharge from the delivery suite, she began to have hot flushes, panic attacks resulting in her anxiety levels increasingly becoming high. She began experiencing thought insertion about worthlessness and guilt. Family history revealed that Mrs X's sister suffers from clinical depression also her aunt suffered a complication of placenta praevia. During her second episode of puerperal psychosis, she was readmitted into hospital and has since been discharged and maintained on olanzapine and citalopram. Presently she is coping and mental health has improved substantially with immense input from the doctors and other mental health professionals.

Epidemiology and Aetiology

Puerperal psychosis is a rare disorder and its prevalence in the United Kingdom is 1 per 500 births (RCPSYCH, 2006) and 1-2 per 1000 births in the world population (Harlow et al., 2007). Puerperal psychosis pathophysiology is poorly appreciated or identified, but factors such as childbirth, difficulty in childbirth, genetical linkage, and hormonal changes have all been attributed as causable features. Mothers who have experienced a period of puerperal psychosis are at increased risk of developing another bout of postnatal psychosis. A follow-up study by Pfuhlmann et al., (2000) followed mothers' years after birth of their first child and treated for puerperal psychosis highlighted an increased recurrence of the illness after later deliveries. Another study by Garfield et al., (2004) also followed mothers over a ten year period after first presentation with the disorder also indicated

recurrence of puerperal psychosis in subsequent births ranging between 25% and 50%.

In spite of different views, evidence has shown that there is a strong correlation between bipolar affective disorder and puerperal psychosis and occurrence even higher in women with a diagnosis with bipolar affective disorder (Jones and Craddock, 2001). Research by Jones and Craddock (2001) has supported this evidence. Their findings also showed women with manic depression who had a family history of postnatal psychosis predisposed them to manic episodes following birth.

Genetic link

Twin and family studies has proposed a genetic link to puerperal psychosis. A genome-wide association study that permits trait linkage to a particular gene in the entire genome was conducted by Jones et al (2007) which found regions on chromosomes 16 and 8 possess genes that dispose women to developing puerperal psychosis. Using a genome-wide linkage analysis with single-nucleotide polymorphisms (SNPs) from women who had a disorder of mood (postnatal depression, manic depression or puerperal psychosis) and women who had once been pregnant Mahon et al (2009) found a major correlation for postnatal symptoms. They provided evidence of polymorphisms at HMNC1 and METTL13 genes and there are further findings are emerging from studies in genetic link to mood disorders.

Sleep disturbance

The effect on sleep on childbirth varies in first time mothers and those of multiple births. In a report by Lee, Zaffke and McEnany (2000) noted a rise in

overall sleep period including naps in the time preceding pregnancy and first trimester of pregnancy, in the second trimester period and the postnatal period, it was observed there was a decline in deep sleep by the mothers. Using sleep logs to study sleep patterns in mothers both first time mothers and also mothers of multiple births, Shinkoda, Matsumoto and Park (1999) evaluated their overall sleep and wakefulness cycle with women in the late pregnancy it highlighted a decreased sleep in the second week following childbirth. Also indicated by Nishihara and Horiuchi (1999) in their research, they found majority of mothers in week one, three and six after childbirth awake for most of the night leading to a disruption in their sleep pattern after taking into account care given to the infant during the night. Women having a history of mood and anxiety disorder, who during pregnancy exhibit agitation, elation and sleeplessness are at higher risk of developing puerperal psychosis within three weeks after childbirth (McNeil, 1986). It is therefore likely that sleep interruption during the pregnancy may play a role in mothers showing signs and symptoms of puerperal psychosis. Loss of sleep may also induce other medical and psychological factors that will trigger mood, anxiety and manic features in a mother in postpartum (Wehr, Sack and Rosenthal, 1987).

Hormonal contribution

The main role of hormones is to have a regulation of physiological bodily events and behaviour. Research has found irregularities in hormonal status and its impact on mental health problems (Sharma and Mazmanian, 2003). Clinical trials outcome has suggested symptoms in women often fluctuate during their menstrual cycle and at low oestrogen level, symptoms become

worse (Sherwin, 2005). In Pregnancy there is a rise in oestrogen and progesterone and immediately after birth these hormones return to their normal level as before conception (RCPSYCH, 2007). It has been observed postnatal deterioration is frequent and has led to proposal of a contributory factor to puerperal psychosis (Brockington, 1998). There has also been an association of abnormal functioning of thyroid and puerperal psychosis. Postnatal thyroiditis has been linked with presentation of postpartum psychosis nature manifesting in mood and psychotic features. Patients' symptoms resolved after treatment and becoming euthyroid (Bokhari et al., 1988).

Social factors

Nager, Johansson and Sundquist (2005) indicated women who are younger and single from poor socioeconomic background are susceptible to developing puerperal psychosis and being admitted to hospital for treatment. Using a hospital anxiety and depression scale, Lee et al (2007) in their research also observed being younger, history of substance abuse, unwanted pregnancy, lack of support from the partner, family, stressful life challenges, financial difficulties, loss of employment, previous significant negative event were predictors of maternal anxiety or mood difficulties in the postnatal phase. Some researchers have argued that there is no reliable connection between obstetric cause for postnatal disorder but this was refuted by Robertson et al (2004) who showed that certain complications in pregnancy like premature labour, caeseran birth, pre-eclampsia, excessive bleeding as risk factors for puerperal psychosis.

Risks

Puerperal psychosis, the most severe form of the postpartum mood disorders and it is deemed a psychiatric emergency. Its presentation is spectacular starting just after delivery and most mothers' exhibit symptoms within 2 weeks of childbirth. In most cases there is a dormant period of 2 days after birth, when symptoms begin to appear (Brockington and Kumar, 1988).

During onset the commonly reported symptoms are irritability, insomnia, severe mood swings and fatigue. There has been cases of rapid variability in mood prior to the inception of florid psychotic features which includes delusions (the most common delusions is about the child having special powers with reference to Satan or God as well as the baby being imperfect), paranoia, thought insertion and broadcasting, hallucinations mainly auditory and olfactory, while others have been reported of being perplexed and confused during first presentation of the disorder (Henshaw and Foreman, 2003). This period is a time when the mother is at increased vulnerability to self harm, suicide, infanticide and reports of mother and child attachment difficulties which also has an effect on the child development as well as mothers do not report their feelings to their General Practitioner, friends and family (Whitton, Warner and Appleby, 1996).

Infanticide

Puerperal psychosis has been found to be connected with child morbidity and mortality. About 4% of mothers with mood and anxiety disorders commit neonaticide and infanticide (Spinelli, 2004). Infanticide is the murder of a baby during the first year of birth and neonaticide is the murder of a baby within 24 hours after birth (Craig, 2004). There are some controversies

regarding cot deaths and infanticide which has suggested a small number of cases of cot death has a link to mothers having acute postnatal psychosis (Chandra et al., 2006). Killing a child by his or her mother is perceived as a hideous outrageous crime in society which according to the law is either murder or manslaughter (Kumar et al., 1995). The mothers who commit such a crime can be classified as a victim due to insanity of mind which is related to psychotic features post-childbirth (Wisner et al., 2002).

Chandra et al (2006) stated that thoughts of killing a child are common with women experiencing acute puerperal psychosis. These women often suffer from memory loss then drift into a floridly psychotic state showing symptoms of visual, olfactory and auditory hallucination and may be forced to commit acts of infanticide (Wisner et al., 2002). Reported case study involving 108 women who were admitted following a postnatal episode, 53% reported thoughts of suicidal ideations, 36% infanticide delusions and 34% of the women reported both suicide and infanticide thoughts (Chandra et al., 2006). They also found the women who exhibited delusional persecutory thoughts showed more care for the infants needs whereas mothers who had delusions of the child being a devil or imperfect showed violent tendencies or abusive behaviour towards their baby.

A finding by d'Orban (1979) of mothers who had committed infanticide and admitted to mental health unit of a prison suggested a connection between infanticide and stressors in the mother's life in general for example being in a violent relationship, separation from partner or an earlier parental separation and thoughts of suicide. Mothers who carry out neonaticide were

likely to be young with limited education, from a low socio-economic
<https://assignbuster.com/puerperal-psychosis-causes-risk-factors-and-treatment-psychology-essay/>

background, first time mothers who live with parents or relatives also women perpetrators of infanticide were more frequently married or living with partner, older, history of mental health history and alcohol, drug misuse (Friedman, Horwitz and Resnick, 2005).

Maternal and child bonding

Childbirth confronts the mother with sleep and social deprivation, care and feeding of the child but most importantly the initiation and maintenance of the attachment between the mother and the child. Mood and anxiety disorders have been suggested to have an effect on maternal bond with her child. Psychosis can disrupt the care giving to an infant by his or her mother and (Chandra et al., 2006). Mothers experiencing command hallucination and delusional beliefs regarding the infant were noted to forecast harm to the baby and sometimes to older children. Maternal psychopathology and lack of social support, its effects on attachment between the mother and child has been identified as a vulnerable period in the infant's development.

Attachment theory formulated by Bowlby and Ainsworth describes mother and baby attachment that develops during the first year of birth. It highlights behaviours of the child which represents care given by mother or caregiver. From these observations, attachment was categorised into secure attachment and insecure attachment which is divided into ambivalent and avoidant. A care given to an infant that is sensitive will lead to a secure attachment that will encourage the best possible development of the child and that of insecure attachment has lead to a low care which can be insensitive (Wan and Green, 2009).

Maternal psychotic disorder in the postpartum period has indicated isolation, lack of concern, detachment, hostility and dislike towards the infant. Some mothers exhibited beliefs of the eligibility of the baby as not being theirs (Kumar, 1997). Frequent maternal response to the infant has been found to be insensitive and unpredictable due to fixation on their symptoms, minimal insight into their mental health and the impact their actions are affecting the emotional and wellbeing of the child (Murray, Cooper and Hipwell, 2003).

Suicide and Self harm

Maternal suicidal rate in after birth ranges from 0.5 to 5.9 per 100,000.

Mortality in women suffering from puerperal psychosis in the first year postpartum in the United Kingdom has been reported to be 2 per 1000 births (Oates, 2003).

Oates (2003) in another report have stated that suicide in mothers in the postnatal period may be low but in women who develop psychotic disorder after birth are at increased risk of committing suicide in the first year of birth.

A study conducted by Schiff and Grossman (2006) also highlighted most of the mothers in their study used aggressive means of suicide which was premeditated and it correlated with Appleby, Mortensen and Faragher's (1998) findings where violent means were used by the women in the postnatal period than in the entire population. These women experienced severe psychotic behaviour in the postnatal period. They also emphasized a major link between suicide, self harm and thoughts of infanticide and death of the child being the main predictor of suicidal behaviour in a mother.

Increase in suicide were higher in unmarried mothers than those who were married and living with their spouses. Evidence has shown that a previous attempt at suicide increases the likelihood of death significantly following years after the first attempt at suicide (Harris and Barraclough, 1998).

Management

Due to the acute presentation of puerperal psychosis and the link with bipolar disorder, it should be treated as an affective psychosis and requires treatment in hospital preferably a mother and baby unit. The prognosis of women suffering from postpartum psychosis has been predicted to be encouraging Prompt treatment is highly essential in order to ensure the safety of the mother and child (Harlow et al., 2007). There has been several suggestions regarding the treatment of puerperal psychosis namely neuroleptics, mood stabilizers, antidepressants, hormonal therapy, electroconvulsive therapy and psychological interventions. Vulnerable women especially those with a history of bipolar affective disorder and other psychotic disorders are at a greater risk of developing puerperal psychosis and the initiation of drug intervention during the last trimester of pregnancy or immediately after delivery might be beneficial (Wisner et al., 2002).

Drug treatment

Maternal drug treatment before conception if pregnancy is not planned and also in the first trimester of pregnancy can be harmful to the developing baby depending on the active ingredients the drug possesses. Foetal exposure to certain drugs in the first trimester can lead to neural tube and several organ malformations. Other minor anomalies have also been

observed after drug commencement during the second and early third trimester (Yonkers et al., 2004).

Mood stabilizers (e. g. lithium, sodium valproate and carbamazepine) have been used in the acute treatment of puerperal psychosis and manic depression. Lithium is the most obvious choice of treatment of psychotic disorder and has been observed to prevent or lower relapse as opposed to the other mood stabilizers. Some mothers treated with sodium valproate tend to show diminished symptoms of mania (Wisner et al., 2004).

Yonkers et al (2004) have proposed in their research the effect of mood stabilizers on exposed babies leading to floppy baby syndrome, hypothyroidism, diabetes insipidus and the infants were observed to have a high birth weight in lithium exposed babies, low birth weight, hepatic toxicity in carbamazepine, irritability and difficulty feeding of the babies exposed to sodium valproate. Detection of lithium, carbamazepine, sodium valproate and lamotrigine were also found to be present in the serum of neonates and it was present in the breast milk and passed on to the infant. They however proposed that close monitoring of these mood stabilizers in women should be routine. Screening of the neonate in the first trimester of pregnancy for congenital abnormalities is also advised for the consideration by the women regarding abortion.

Antipsychotics (neuroleptics) like haloperidol, chlorpromazine, clozapine, quetiapine, olanzapine, aripiprazole etc have been associated with the treatment of psychosis. Antipsychotics bind to dopamine (D-2) receptors and serotonin (5-HT-2) receptors. Typical antipsychotics exposure on the foetus

and baby include respiratory distress and also floppy baby syndrome and also severe extrapyramidal side effects; tardive dyskinesia, neuroleptic malignant syndrome, dystonia among many in the mothers (Healy, 1997). Particularly due to psychotic disorder during pregnancy and the postpartum period, atypical neuroleptics have been suggested to be effective in the continued management. Research relating to atypical antipsychotics are limiting but they also result in side effects like weight gain, gestational diabetes, hyperglycaemia and preeclampsia have been indicated in women and the secretion through breast milk to the infant (Kirchheiner, Berghofer and Bolk-Weischedel, 2000). Olanzapine have been identified to possess mood stabilising effects in women with bipolar affective disorder and the preferred choice of treatment for acute mania due to improvement and satisfactory outcomes in mothers (Yonkers et al., 2004).

Benzodiazepines (e. g. lorazepam, diazepam and clonazepam) are predominately used to combat sleep disorders. Its effect on anxiety and agitation and for mood stabilization has been indicated (Healy, 1997). Due to the high incidence of addiction in patients, withdrawal symptoms as well as motor and other developmental delays in the infant have also been highlighted (Yonkers et al., 2004). Sleep disruption during pregnancy and the postnatal period is a high indicator for the causes and risk in puerperal psychosis. Research has revealed the need to treat lack of sleep in the prepartum and early postpartum period in order to prevent the trigger of puerperal psychosis, so the preferred choice by clinicians in the prescribing of zopiclone (non-benzodiazepine) which is safe for the neonate and is not secreted in breast milk (Dalfen, 2009).

ECT (Electro-convulsive therapy)

The severity of symptoms of the psychotic disorder in pregnancy or in postpartum and insensitive response to drug therapy will establish if ECT is the suitable course of treatment. Its combination with oral medication helps in the control and management of the disorder (Yonkers and Little, 2001).

Yonkers et al (2004) also indicated the side effect ECT causes with a course treatment of 6-8 sessions; temporary memory loss, low birth weight and congenital malformations of the infant.

Psychological and Social interventions

There have been several suggestions of psychotherapy and combination of drug treatment, joint admission of the mother and infant in a mother and baby unit is beneficial and effective as it safeguards the mother-child bonding rather than the mother alone in a general acute ward setting (Brockington, 2004). This mother and baby units provides a safe haven for early recovery and aid in relapse prevention and research has identified separation of the child from its mother during admission has a detrimental effect where the child might experience a sporadic care. However Hipwel et al (2000) have argued that the attachment between the baby and mother who suffer psychotic disorder that occurs in a mother and baby unit might not be in the baby's best interest during the admission.

Oates(2003) recommended that intensive community treatment and care may offer as a substitute to admission into hospital for mothers who are not suicidal and do not pose a danger to the infant and also women who have a dependable

social support. Psychological interventions (cognitive behavioural therapy, anxiety management, play therapy, motherhood groups) and occupational therapy have been established to be valuable in the mother's coping mechanism and preserve family life and engage mothers with the same disorder. (Brockington, 2004).

Conclusion

Childbirth has been identified to be the main precipitating factor to some women developing puerperal psychosis which makes the mother vulnerable to herself and the child. Cognitive impairment with hypomanic symptoms and associated hormonal disruption are attributed to a diagnosis of puerperal psychosis.

In the case of Mrs. X's psychosis, she had a family history of affective disorder and presented with anxiety, sleeplessness and agitation during her first pregnancy. It will be advisable to assess women during their pregnancy about these feelings so to prevent a full blown psychotic disorder in the postnatal period. Mrs X exhibited delusions of negation and the thought of death which may lead to her to abandoning her child, hallucination (auditory and olfactory) of an evil spirit as well as suicidal ideation although not active. Subsequent admission and prophylactic treatment has shown to be helpful in treating her psychosis and a recovery leading to her optimal level of functioning. Support from her husband and family had proven vital to her coping post discharge. Family education about the disorder and total support to the woman is essential in maintaining the emotional wellbeing of the mother.

After the birth of her second child Mrs X suffered another episode of puerperal psychosis and as the statistics have shown about its recurrence as highly increased in the multiparous woman.

The disorder is often predicted and in most cases avoided. Risk assessment highlighting contingency plans regarding relapse prevention and information sharing between the mother and baby unit, maternity, paediatric units and General Practitioners are important in early intervention treatment and prevention of another episode of puerperal psychosis in the multiparous woman. Collaboration with social services, child protection teams is also essential to safeguard the wellbeing, and prevent harm to the child if there is an indication of abuse to the child.