NC MATTERS

Postpartum Psychosis: A Guide for Outpatient Providers

KEY FACTS[1-5]

- Postpartum psychosis is considered a treatable psychiatric emergency that often requires urgent evaluation and inpatient treatment.
- Postpartum psychosis is associated with an increased risk of both suicide and infanticide.
- Most episodes start rapidly and occur within three weeks of delivery; however, they can also occur later in postpartum.
- The estimated prevalence is 1-2 cases per 1,000 births, but the true incidence is not fully known.

Disclaimer: This toolkit addresses a complex psychiatric diagnosis.
Health care professionals in North Carolina can call NC MATTERS for case-specific questions.

RISK FACTORS[6-11]

- History of bipolar or schizoaffective disorder
- History of postpartum psychosis
- First-degree relative with history of postpartum psychosis
- Primiparity
- Family history of bipolar disorder
- Advanced maternal age
- Occurrence of mood disorder during pregnancy

CLINICAL PRESENTATION[12-14]

Postpartum psychosis has variable presentations and not everyone presents with psychotic symptoms, which can make it challenging to identify. Here are some symptoms (but this is not an exhaustive list):

Cognitive Symptoms	Mood Symptoms	Psychotic Symptoms	Catatonia
• Disorientation • Confusion • Memory Issues • Distractability • Depersonalization and derealization	Can include depressive symptoms and/or signs of mania such as: • Irritability • Agitation • Elevated Mood • Decreased need for sleep • Pressured speech	• Odd beliefs or delusions (often persecutory or referential) • Paranoia or marked suspiciousness, commonly toward their families (infants, partners) • Visual or command auditory hallucinations (e.g., voice telling the patient to do something) • Disorganized thinking or behaviors	• Marked decrease in movement, speech, or responsiveness • Estimated to occur in up to 20% of patients

IDENTIFYING POSTPARTUM PSYCHOSIS[12-16]

In postpartum psychosis, **symptoms can wax and wane** (similar to delirium). Patients may have periods of lucidity that can rapidly shift to periods of psychosis/mania. In other cases, patients may only present with cognitive symptoms. For these reasons, symptoms may be overlooked.

SCREENING AND ASSESSMENT

No dedicated screening measure currently exists for postpartum psychosis. Below are a recommended screening scale and some interview questions that can be helpful:

Mood Disorder Questionnaire[17]

Screens for mood elevation, which can be a feature of postpartum psychosis

- **13 items**
- **Not specific to the perinatal population**
- **Scoring**
  - > 7: requires further assessment

Interview Questions:

Are you experiencing difficulty falling asleep or needing less sleep than usual?

A high percentage of new parents experience intrusive thoughts of accidentally or purposefully harming their infant. Have you ever experienced that?

Are you experiencing any confusion, such as difficulty completing tasks of daily living or caring for children? Is it present sometimes or all of the time?

Assessments Should Include Collateral[18-20]

Collateral information from a partner, family member, friend, or another healthcare provider is essential to the evaluation, diagnosis, and risk assessment of postpartum psychosis, as emphasized in ACOG guidelines.

This is especially important because key features of the condition (e.g., lack of insight, fluctuating symptoms, first-time episode) can make patient self-report incomplete or unreliable. The questions listed on page 3 may be helpful while completing the assessment.

Key Areas of Concern to Address

Behavioral Changes	Sleep Patterns	Psychiatric and Family History	Substance Use	Safety concerns
• Have you noticed any behaviors that seem out of character for her, such as unusual actions, disorganized speech, or loss of inhibitions? • Are there things she has been doing or saying that she has not acknowledged or may not be aware of?	• How has she been sleeping in the past several days? • Have you seen a decreased need for sleep or inability to sleep even when she is exhausted?	• Does she have a personal history of bipolar disorder, mania, or a previous episode of postpartum psychosis? • Is there a family history of bipolar disorder or similar conditions among her first-degree relatives?	• Have you observed any recent use of alcohol or other substances that could affect her thinking or behavior? • Has there been any change in her use of prescribed or non-prescribed medications?	• Have you seen or heard anything that makes you concerned about her safety or the baby's safety? • Do you feel comfortable leaving her alone with the infant right now?

Consider Medical Causes of Postpartum Psychosis[21-22]

✓ Rule out medical etiologies listed below by considering CBC, CMP, blood glucose, vitamin B12, folate, thiamine, TSH, TPO antibodies, UA + culture, UDS.

- Neurologic: stroke, seizures
- Endocrinologic: diabetic ketoacidosis/hypoglycemia, postpartum thyroiditis, primary hypoparathyroidism
- Metabolic: hypo or hypernatremia, uremia, hepatic failure
- Nutritional deficiencies: vitamin B12, folate, or thiamine deficiency
- Inflammatory/autoimmune encephalitis
- Infectious: sepsis, meningitis/encephalitis, HIV encephalopathy

CT, MRI, LP, EEG may be considered if neurological symptoms are present

Acronym Guide:

- **CBC:** Complete Blood Count
- **CMP:** Comprehensive Metabolic Panel
- **TSH:** Thyroid-Stimulating Hormone
- **UDS:** Urine Drug Screen
- **TPO:** Thyroid Peroxidase
- **LP:** Lumbar Puncture
- **UA:** Urine Analysis

✓ Consider other psychiatric diagnoses on the differential:

- Perinatal OCD
- Postpartum depression
- Postpartum anxiety

✓ Ask about medications and substance use (corticosteroid use, narcotic use/withdrawal, anticholinergic toxicity, various antibiotics and antivirals)

Evaluate for Perinatal OCD as a Differential Diagnosis

The most critical distinction between perinatal OCD/intrusive thoughts and postpartum psychosis is the patient's level of insight. Individuals with perinatal OCD and intrusive thoughts recognize their intrusive thoughts as unwanted (sometimes called ego-dystonic) and these symptoms cause distress. Individuals with postpartum psychosis typically have limited insight into their symptoms.

Misdiagnosing perinatal OCD as psychosis can lead to unnecessary hospitalization and inappropriate antipsychotic treatment, while failing to identify postpartum psychosis in someone with harm-related thoughts constitutes a safety emergency. Careful, thorough assessment is therefore essential.

Perinatal OCD/Intrusive Thoughts	Psychosis
• Patient recognizes thoughts as unwanted and irrational • Patient is distressed by the thoughts and actively trying to prevent harm • Patient is avoiding the baby out of fear • Patient is self-presenting with distress	• Patient lacks awareness that something is wrong • Patient's thoughts are incoporated into a delusional framework • Patient engages in bizarre, disorganized, and/or out-of-character behavior • Patient is brought in by a concerned family member or support person

PREVENTION[8,23]

Prevention is especially critical for individuals with a history of bipolar disorder or previous postpartum psychosis.

Non-pharmacological	• Protected and consolidated sleep is essential (see treatment section on next page). • Educate the patient and her support network about the signs and symptoms of postpartum psychosis to enable earlier recognition and faster access to emergency care.
Pharmacological	• History of postpartum psychosis: Lithium monotherapy initiated immediately postpartum is highly effective in preventing postpartum relapse. • History of chronic bipolar disorder: Prophylaxis is important for maintaining mood stability throughout pregnancy and preventing postpartum relapse. The most evidence-based medication is lithium.

PROGNOSIS[8,17,24-27]

- With appropriate treatment, most individuals reach full remission.
- Postpartum psychosis is associated with a higher risk for eventual diagnosis of bipolar disorder and/or another episode of postpartum psychosis after subsequent pregnancies.
- Some individuals never have mood episodes of any polarity or psychosis outside of the perinatal period.

TREATMENT

Pharmacological and Interventional Treatment [7,17-18,22-23]

Below is some general information about interventions commonly used to treat postpartum psychosis. For details on dosing and specific applications please call the NC MATTERS line.

Lithium	Lithium has the most evidence for both the acute phase of treatment and maintenance. It has a unique role in preventing future episodes in women who have had this illness previously. Once patients achieve remission of symptoms: • Continue lithium at a therapeutic dose for at least 9-12 months • They may need to remain on lithium if they have a diagnosis of bipolar disorder
Benzodiazepines	• Lorazepam or clonazepam are used most commonly • Can be helpful in the short-term for promoting sleep and/or if catatonia is present
Antipsychotics	• Both typical and atypical antipsychotics can be helpful • Often used for the management of acute psychosis or mania symptoms • Can be used with benzodiazepines and lithium if needed
Electroconvulsive Therapy (ECT)	• For symptoms refractory to medications or catatonia • Can be highly effective for patients with severe catatonic features or depression with psychotic features

Non-Pharmacological Treatment

Below is some general information about complementary treatment options. Please call NC MATTERS for specific resource and referral information.

Psychotherapy[5,19,20]	• Initial psychotherapy involves psychoeducation for both patients and their families/support systems
	• Post-discharge psychotherapy:
	    ◦ Can support patients with processing the illness episode (especially if it is traumatic)
	    ◦ Can support continued recovery from symptoms as insight increases
	    ◦ Can aid in treatment of mood, guilt, shame, and worry

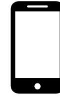
Protected and Consolidated Nighttime Sleep[21,22]	• Sleep is extremely important! • This often means cessation of overnight breast feeding and increased support for nighttime feeds by partner, family, or doulas

RESOURCES

For clinicians

Free Provider Consultation with NC MATTERS

NC MATTERS is a free consultation service for North Carolina healthcare professionals working with pregnant and postpartum women with mental health concerns. A perinatal psychiatry provider can answer your questions about patient care and help connect you to local resources.



Call
919-681-2909 x 2

Learn more at
ncmatters.org

Information on medication use during pregnancy and infant feeding

Mother to Baby
mothertobaby.org

- English and Spanish language fact sheets summarizing information about common exposures during pregnancy and breast/chest-feeding
- Chat with an exposure expert, enroll your patient in observational studies, or schedule a patient consult

Lactmed
ncbi.nlm.nih.gov/books/NBK501922

- Database which provides evidence-based information on drugs and other chemicals to which a breast/chest-feeding parent may be exposed

For patients

NC MATTERS

NC MATTERS - For Moms and Families

Find resources for moms and families—learn ways to care for your own well-being, get tips for supporting your partner, and explore tools to help you thrive in parenthood.

- https://www.med.unc.edu/ncmatters/for-moms-families-2

POSTPARTUM SUPPORT INTERNATIONAL

Postpartum Support International

PSI offers free virtual support groups for individuals with lived experience, as well as loved ones affected by postpartum psychosis.

- Call or Text 24/7: 1-800-944-4773
- Text en español: 971-203-7773
- postpartum.net

Massachusetts General Hospital Postpartum Psychosis Project

A research and clinical initiative that advances understanding, early identification, and treatment of postpartum psychosis to improve outcomes for birthing people and their families.

- https://www.mghp3.org

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