

Postpartum Psychosis

What is postpartum psychosis?

Postpartum psychosis (PP), also known as puerperal psychosis and postnatal psychosis, is a severe illness that involves hallucinations, delusions, mania, severe confusion, or unusual behaviour occurring, often with acute onset, in the postnatal period.

Hallucinations involve hearing, seeing, feeling, or smelling things while awake that appear to be real but instead have been created by the mind.

A **delusion** is a false idea or belief that is held in the face of evidence to the contrary.

Mania involves periods of over-active and excited behaviour that can have significant impact on day-to-day life.

What is the risk of developing postpartum psychosis?

Postpartum psychosis affects 1-2 in 1000 women* after giving birth (0.1-0.2%) and untreated it can risk the safety of the mother and infant, including risk of suicide. Certain factors increase the risk of developing PP:

- Family history of postpartum psychosis in their mother or sister increases the risk to almost 3 in 100 (3%)
- A personal history of bipolar disorder (BD) or schizoaffective disorder (SD) increases the risk significantly to 1 in 5 (20%)
- If there are **both** of the above, the risk increases to 1 in 2 (50%)
- Risk also increases significantly to 1 in 2 if the individual has previously experienced postpartum psychosis (50%)
- However, **more than half of those who develop PP have no history of mental illness**^{1, 2, 3}.

Health visitors can find out more about the risks from the Action on Postpartum Psychosis (APP) leaflet "[*Planning pregnancy: a guide for women at high risk of Postpartum Psychosis*](#)".

What is the cause of postpartum psychosis?

People who develop postpartum psychosis may have a genetic susceptibility to the illness that is triggered by childbirth. Biological, probably hormonal, factors are likely to be involved. No consistent association with obstetric or psychosocial factors has been found to date. PP is more common after the birth of a first child, and in women with pre-eclampsia. Lack of sleep may be a trigger for some individuals^{2, 3}.

Managing a known past-medical history of bipolar disorder, schizoaffective disorder, or postpartum psychosis during pregnancy and the postnatal period

When there is a known past-medical history of bipolar disorder, schizoaffective disorder, or postpartum psychosis, it is recommended that a referral is made as early as possible during pregnancy to the local specialist perinatal mental health service (SPMHS), even if they are completely well and taking no medication. This is so that an individualised, multidisciplinary plan for pregnancy and the postnatal period can be created^{2, 4}.

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For additional resources see www.ihv.org.uk

The information in this resource was created on 26/04/2023.

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Health visitors can be involved in the development of these plans and explore them with families during appointments. If a history of these conditions is identified, but there is not yet a plan in place, it is important that the health visitor works with the family to raise awareness of the support that is available to ensure the best outcomes, with a referral to the SPMHS at this point.

Can postpartum psychosis be prevented?

In order to prevent severe mental illness, some individuals may need to take medication during pregnancy, and some will start immediately after the birth. For others, early intervention, through recognition and management of early symptoms, such as sleep disturbance, is key to accessing the appropriate treatment.

Health visitors can support families to make plans to help manage some of the risks. Plans to ensure that they have adequate help and support at home after the birth, help with night feeds, ensuring good sleep, and maintaining a calm environment are all important. See [APP website](#) for more information.

How does postpartum psychosis present?

Half of all cases develop within the first week after the birth. Sudden onset and rapid deterioration are typical. The clinical picture changes rapidly, with wide fluctuations in the intensity of symptoms. It can be very helpful to explore with partners and family members about their normal and recent behaviour. See [Early Symptoms of postpartum psychosis](#).

Symptoms include one or more of the following:

- Delusions
- Hallucinations
- Mania
- And / or severe confusion

They may present as:

- Excited, elated, or 'high'
- Depressed, anxious, confused or catatonic
- Excessively irritable, agitated, or changeable in mood.

They may also:

- Have trouble sleeping, insomnia or not feel the need to sleep
- Be more talkative or sociable than usual
- Have a very busy mind or racing thoughts
- Feel very energetic or agitated and restless
- Behave in a way that is out of character or out of control
- Feel paranoid or suspicious
- Feel that everyday events, or stories on the TV or radio, have special personal meaning
- Feel that the baby is connected to God or the Devil in some way, or hold other unusual beliefs about the baby.

In rare but tragic cases, it can lead to suicide and, extremely infrequently, infanticide. Maternal suicide is one of the leading causes of direct maternal deaths occurring during or within 42 days of the end of pregnancy and it remains the leading cause of direct deaths occurring between 6 weeks and within a year after the end of pregnancy⁵.

How is postpartum psychosis treated?

Postpartum psychosis is a psychiatric emergency and needs immediate psychiatric assessment and treatment. It is recommended that care is provided by specialist perinatal psychiatry teams and often involves admission to a mother and baby unit (MBU) rather than a general adult psychiatric ward. This is so that mothers and birthing people are not separated from their baby and can access specialist facilities and tailored care⁴.

The mainstay of treatment is antipsychotics and mood stabiliser medication, and the short-term prognosis is very good. Sometimes electroconvulsive therapy (ECT) is needed.

Health visitors can support individuals while they are still under the care of community psychiatric services, and afterwards, to develop a positive therapeutic relationship for the future and help to strengthen the parent-infant relationship. Health visitors can also provide crucial support to partners and other children within the family.

Many antipsychotic drugs are safe for use when breastfeeding, chest feeding or feeding expressed milk. Health visitors can discuss feeding preferences and ensure that the GP or psychiatrist has reviewed medication in accordance with their feeding plans^{4, 6}.

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Recovery

Recovery from severe symptoms may take a few weeks to a few months, but full recovery can take at least a year and can sometimes take longer. Having such a devastating illness can leave parents shocked, bewildered, and traumatised. Anxiety and severe depression can develop after the acute psychosis, often requiring further psychological input and peer support. However, with time, they should be encouraged to expect a full recovery⁷. You can find out more in APP's [Recovery after Postpartum Psychosis](#).

What is the risk of recurrence?

On recovery, individuals need to be counselled that 1 in 2 (50%) may experience a recurrence of postpartum psychosis following future births. Plans can be made with specialist teams to prevent episodes becoming severe. Individuals should be aware that avoiding further pregnancies may not guarantee no recurrence of illness. Some individuals may develop ongoing bipolar disorder, and 3 in 4 (75%) may have at least one further non-pregnancy-related episode of mental illness in their lifetime - menopause may be a time of particularly high risk⁸.

What if postpartum psychosis is suspected?

- Suspected postpartum psychosis is a medical emergency and requires psychiatric assessment within 4 hours.
- If the individual is known to be at risk, they should have a personal management plan which the health visitor can follow.
- If they are not known to be at risk, the health visitor can refer to their local Emergency Perinatal Mental Health Pathway. Depending on local provision, this may require making direct contact with the Crisis Team, calling 999, contacting the specialist perinatal mental health service, or advising the family to take them to A&E. You may also need to liaise with the GP.
- The health visitor can liaise with partners and family members to ensure that the individual is not left alone with the baby while awaiting assessment.
- Partners and family members can be signposted to APP for information and support.

What if there are safeguarding issues?

It is crucial to ask the individual directly if they are experiencing any thoughts of harming themselves or their baby, or ending their own life, or the life of their baby. Asking does not increase the risk of this happening. If there is any indication of suicidal or infanticidal thoughts, plans or fleeting ideas or impulses, the individual should not be left alone by their family or carers. This is because there is a grave risk to both them and their baby⁹.

Symptoms of postpartum psychosis and severe mental illness can impact parenting capacity, so it is important that the needs of the baby and any older children remain central to risk assessment. Health visitors can provide early signposting, support, and liaison with safeguarding services by following local child protection protocols. Parents should be reassured that, with the right support, most people make a full recovery and can then get back on with their lives and being a parent.

Preconception care

The preconception period presents an opportunity to prepare for a successful pregnancy and positive health outcomes for both parents and their child. If pregnancy is being considered by anyone with a history of bipolar disorder, schizoaffective disorder, or postpartum psychosis, the health visitor can support pregnancy planning and preconception health by signposting them to their psychiatrist to optimise their medication.

In addition, the health visitor can work with families to help them explore how they might optimise their physical and mental health and wellbeing, for example, signposting to [Planning a pregnancy when you have a severe mental health illness resources](#).

For those that do not wish to become pregnant again, it is important that reliable, long-acting contraception is offered. More information is available in the APP leaflet [Planning pregnancy: a guide for women at high risk of Postpartum Psychosis](#).

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Good Practice Points

- If a history of bipolar disorder, schizoaffective disorder, or postpartum psychosis is identified during pregnancy, a referral - at the earliest possible opportunity - to the local SPMHS is recommended (even if they are currently well).
- Health visitors can work in partnership with the individual and SPMHS to create a personalised wellbeing plan that considers their medication requirements and ways to ensure that they have adequate help and support at home after the birth. Help with night feeds, ensuring good sleep, and maintaining a calm environment are all important.
- If postpartum psychosis is suspected, **a psychiatric assessment is required within 4 hours**. If they are not known to the SPMHS, the health visitor can arrange this in accordance with their local Emergency Perinatal Mental Health Pathway.
- It is crucial to ask the individual directly if they are experiencing any thoughts of harming themselves or their baby, or ending their own life, or the life of their baby. If there is any indication of suicidal or infanticidal thoughts, plans or fleeting ideas or impulses, they should not be left alone by their family or carers.
- It is important to bring hope. Reassure parents that, with the right support, symptoms will reduce and most people recover.
- Health visitors can: support individuals throughout their recovery and beyond; help to develop a positive therapeutic relationship for the future; help to strengthen the parent–infant relationship; and provide crucial support to partners and older children in the family.

*The iHV has adopted a **gender-additive** approach to the language we use in policies, resources, projects, and events. A gender additive approach means using gender neutral language alongside the language of womanhood, to ensure that everyone is represented and included. Please note that this publication uses gendered terms when referencing research which is gender specific.

Additional Resources:

[Action on Postpartum Psychosis \(APP\)](#) is the national charity supporting and advocating for women and families affected by PP. APP offers health professional training, patient information and peer support services throughout the UK for women, partners, and grandparents affected by PP.

- [Planning pregnancy: a guide for women at high risk of Postpartum Psychosis](#)
- [Recovery after Postpartum Psychosis](#)
- [Planning a pregnancy when you have a severe mental illness](#)

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