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# Nursing Management of Patient with Post Partum Psychosis

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***Abstract:****Postpartum psychosis is the most severe form of postpartum affective disorder which has been recognized, it leads to 2 in 1000 women being admitted to a psychiatric hospital following childbirth, mostly in the first few weeks of postpartum. Although relatively rare condition, there is a marked increase in the risk of suffering from a psychotic illness following childbirth, it is also remarkably constant across nations and cultures. Care of patients with postpartum psychosis, new born and family members requires collaboration with various members of the health care team. Nurses can play a vital role in assessing the risk and its management. The nursing care management is illustrated through a case study presented in the article.*

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## I. Introduction:

In India it is widely said that giving child-birth is like having to die and reincarnating. This is because of the tremendous psychological and physiological pressure the women have to undergo during the perinatal period. The pressure they undergo makes women experience enormous range of feelings, which if not properly handled can make these women more vulnerable to develop postpartum psychosis. The postpartum presentations to a psychiatric unit might be termed as postnatal blues, postpartum depression and postpartum psychosis(1). The family who expects a wider range of good and happy emotions might turn up to having negative emotions because of the mother falling ill due to the process of pregnancy and delivery of the child. This cause a huge stress to the family in whole and to the immediate care givers of the mother and the child. Postpartum psychosis is a severe mental illness(2)which develops actually in the early postnatal period (the first 6 weeks of postpartum). It is a psychiatric emergency, because if not treated on time the illnesscan put the mother's and her child's life into risk due to the psychosis that the mother develops due to the psychological and physiological pressure experienced(3). Identifying women at risk allows developing early detection plans and render prompt treatment to prevent development of complications and unnecessary hospitalizations.

**Definition:** As citied by Kaplan and Sadock, The Diagnostic Statistical Manual Edition IV has defined postpartum psychosis as developing psychosis within 4 weeks of postpartum period (4)
Postpartum psychosis (also referred to as puerperal psychosis or postnatal psychosis) is an acute mental disorder or a psychotic reaction occurring in a woman following childbirth or abortion. The episodes of psychosis usually begins 1-3 months of delivery.Although the onset of symptoms can occur at any time within the first 3 months after giving birth, women who have postpartum psychosis usually develop symptoms within the first 2-3 weeks after delivery

## II. Epidemiology:

**Onset:** The onset of puerperal psychosis occurs in the first 1-4 weeks after child birth. PPP is a presentation of bipolar disorder which coincides with hormonal shifts after delivery (5). Onset is usually related to hormonal, immunological and/or circadian rhythm changes which precipitates the episode of postpartum psychosis (6). Abrupt, especially within about 3- 10 days after delivery or 3 to several weeks after delivery.
**Incidence:**A study states that the incidence of postpartum psychosis varies from 0.25 to 0.6 every 1000 births. 20% to 50% women have postpartum psychosis without any precipitating cause and on the other hand the rest of the women present with episode of postpartum psychosis which could be out of perinatal period which is within the mood spectrum (6)

**Prevalence:** The prevalence of postpartum psychosis is much less common then baby bluesor postnatal depression accounting to 0.1% to 0.2%.Postpartum psychosis become a presentation of psychotic disorder such as schizophrenia (3.4%), bipolar disorder (20% to 30%) (3). More common in primi parous then multi parous women.

**Predisposing factors:** The precise cause is unknown. However, the following are risk factors to the development of postpartum psychosis:

- Genetic/ hereditary (example: chromosome 16)
- Hormonal changes (example: Estrogen, Progesterone)
- Family / personal history of depressive episodes
- Lack of social and emotional support
- Death of a loved one
- Low sense self-esteem due to a woman's postpartum appearance
- Feelings of inadequate as a mother
- Financial problems
- Major life changes, such as moving or starting a new job
- Poor marital relationship
- Single parent
- Childcare stress
- Prenatal anxiety
- Low socio economic status
- Prenatal depression
- Unplanned/ unwanted pregnancy
- Infant temperament problems
- Substance abuse
- Family history of mental illness
- Labour pain
- Infection

**Etiology**: Kaplan and Sadock say that the psychological bonding that the mother has on her unborn child is important for the child's development. They add saying that the mother draws an art about the child on an empty board, when those art are found to be wrong or when the pressure on her is huge she becomes angry on herself. On the other hand they say the intent to harm her own child is seen as a reflection of the mother showing anger towards self(4).

**Organic causes**: Organic causes of postpartum psychosis would be Ischemic or haemorrhagic stroke, Electrolyte imbalance such as hyponatremia or hyponatremia, hypoglycaemia or hyperglycaemia, Thyroid or parathyroid abnormalities (hypothyroidism, hyperthyroidism, hypocalcaemia, and hypercalcemia), Vitamin B12, and folate or thiamine deficiencies

**Signs and symptoms:**The patient might develop psychosis, cognitive impairment, and disorganized behaviour which is markedly different from the pre-morbid state, due to which there can be high risk for the safety and well-being of both the mother and the baby (5). The common presentations of postpartum psychosis are suicide during postnatal period (7), hallucinations (Example: Auditory- commanding the patient to kill the baby), delusions (Example: baby is an embodiment of evil), illogical thoughts, insomnia, irritability, confusion, memory impairment, disorientation, sadness, crying spells, fatigue/exhaustion, extreme fear and/or ecstasy, irrational guilt, mutism, stupor, catatonia, misrecognition(misrecognition can be common and may take form of not recognising her partner or mistaking the others, such as male staff for her partner), mood disturbances (can be both manic and depressive in nature. Often mothers may present as having difficulty on sleeping, which van be the first sign of a euphoric or manic state), depersonalization (during this phase, the mother may find it difficult to relate to the environment around her and may feel detached from reality).

**Complication:**Complications of postpartum psychosis would include suicide, infanticide, homicidal thoughts, lack of a normal mother and infant bond i.e., difficulty in caring for the baby and marital and family problems

**Prognosis:** The relapse rate of individualized postpartum psychosis was found to be 31% in a study done by Bergink (6). There is a 50% chance of mothers developing postpartum psychosis in the recurrent pregnancy also (3).

**Management:**Postpartum psychosis is a condition which is usually is under-diagnosed. On a regular post-natal visit to the obstetrician as a part of regular screening for complications, assessment of postnatal depression, postnatal blues and postnatal psychosis can be done to detect the onset of postpartum psychosis and help in managing it at a much early stage(1). Management of the patient with post-partum psychosis relies on the underlying morbidities, mood disorders, current symptom presentation, response to previous treatments sort, side effects and adverse effects caused by drug administered then, the preference of the mother to feed her baby.

Mothers with postpartum psychosis need physical and neurologic examination and basic medical workup like complete blood count, metabolic profile and urine toxicology screening (8). The physical treatment that can be given include anti-manic agents, atypical antipsychotics, and ECT (5). Lithium was found to be more effective for both acute and maintenance treatment, ECT is also reported to be successful(6,9). It becomes important to prevent the illness than to treat in cases which have known risk factors (10). Ensure that the physical and emotional needs of mother and baby are met. Rapid or immediate hospitalization, if she thought to pose a threat to the baby, herself or others.Psychological counselling i.e., psychotherapy, education for mother and family member, husband and family and or social support, support group therapy establishing contact with other mothers, rest, adequate nutrition, discharge should only occur with close follow up in place.

**Management of new born:** Breastfeeding is contraindicated in the acute presentations of puerperal psychosis to decrease the harm to the child through lactation (8). Mothers requiring lithium treatment can be encouraged to breast-feed(11)**.** Most antipsychotics are excreted in the breast milk, although there is little evidence of it causing problems. Where they are prescribed to breast-feeding women, the baby should be monitored for side effects. Clozapine is associated with agranulocytosis and should not be given to breast-feeding women**.**

**Case report on postpartum psychosis:**Mrs. A, 19 year old female got admitted for the first time in Acute Care Room. She was asymptomatic till 15 days after delivery. After which she developed high grade fever and chills and rigor. She was admitted in a local hospital and was treated there. As fever was not subsiding, she was referred to another hospital where she had allergic reaction to an IV drug, thereby worsening of fever. Then she started having feeling of throat congestion and feeling of difficulty in speech. Initially she said some people are doing Blackmagic against her. She presented with complaints of irritability, crying spells, agitation, not taking care of new born, biting the baby, expressing hearing a voice that commanding her to kill the baby, decreased sleep, loss of appetite, poor self-care expresses that her baby is an embodiment of evil since 3 days. She was on treatment physical restraints since she was agitated, she was started on Tab. Olanzapine 5 mg HSOD for 3 days followed by tab. Olanzapine10 mg, she was also advised to have 4 hours gap after medication before breast feeding and baby to be taken care by another person. Monitoring of breast feeding was done.Continuous monitoring was done for assessing any early signs of aggression and thus preventing violence. While under restraint he was monitored every hourly for any complications which may arise due to the restraining, as per the hospital restraint policy. Also, assistance was provided to meet his self-care needs and nutritional needs. Regular psychotherapy, milieu therapy, occupational therapy was given. After 2 weeks he was shifted to ward as there is decreased symptoms.

**Nursing management:**

**1. Nursing diagnosis:** High risk for violence directed towards others related to impairment of impulse control, inaccurate perception of the environment (delusion).

**Expected outcome: Patient** will not harm self or others while in hospital

**Interventions:** A low level of stimuli (lighting, people) was maintained. Removed dangerous objects. Maintained a calm environment. He was oriented often to reality. Administered tranquilizers as per doctor's order. Restraints were used as a least option. Restraint care was taught. Relaxation exercises were taught. Encouraged relatives to report if any anger, irritability is noticed.

**Evaluation:** Assaulting and abusive behaviour towards parents and staff was noticed during initial days of admission. After which she did not try to harm self or others.

**2. Nursing diagnosis:** Risk for injury related to psychomotor agitation, delusional ideas, side effects of drugs

**Expected outcome:** Patient remains free from injury as evidenced by absence of wound and abrasions.

**Nursing intervention:** Placed her in a calm and conducive environment.Taught the relatives about safety precautions .Monitored vital signs every 2 hours and observed the patient regularly for behavioural changes. Side rails were provided. Restraints were used judiciously.

**Evaluation:** patient was free from injury during discharge

**3. Nursing diagnosis:** Disturbed thought process related to psychosocial stressors,biochemical changes in the brain, inability to process the external stimuli

**Expected outcome:** She verbalizes reality based thinking in verbal and nonverbal behaviour as evidenced by absence of delusional ideas.

**Nursing interventions:** Used simple, concrete explanations, maintained appropriate facial expressions. Instructed her to approach if any frightening behaviour occurs, distracted her from delusion by engaging her in activities. Gave her teaching on thought stopping technique. Encouraged her to attend regular occupational therapy sessions

**Evaluation:** At the time of discharge he verbalized that he did not have any delusions

**4. Nursing diagnosis:** Ineffective family coping related to situational crisis, poor coping skills, inadequate support system.

**Expected outcome:** The family members demonstrate an increased ability to cope with anxiety and stress
**Nursing interventions:** Encouraged the family members to ventilate their feelings. Conveyed acceptance of their feelings. Involved the daily members as much as possible in the planning of client treatment. Maintained frequent contact with the client and family members. Taught the family members the fact about the illness, emphasized that it could strike any family. Assisted them developing a realistic plan to support her according to the family tolerance and capabilities.
**Evaluation:** Family members showing optimistic attitude towards the patient.

**5. Nursing diagnosis:** Self-care deficit (hygiene, grooming) related to cognitive impairment (such as delusions), agitation, negligence.
**Expected outcome:** Client consistently performs self-care activities consistent with her ability and health status.
**Nursing intervention:** Established the extent to which her self-care deficits interfere with her level of function, assisted the client as needed with personal hygiene, provided privacy for the client during self-care activities, Ensured that she is clean and well-groomed as much as possible, provided positive reinforcement for attempts at Self-care activities and any successfully completed task, Taught the family members the importance of promoting her self-care abilities.
**Evaluation:** self-care is attained she shows interest in personal hygiene

## III. Conclusion:

Post-partum psychosis is a very threatening mental illness that affects women. The pressure of bearing a child can lead women to handle physical, psychological and social stress, which can lead to development of the illness. Although few etiological factors are inevitable, the rest can be modified to help women cope better with post-partum period and prevent post-partum psychosis.

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