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Case Report

Postpartum Psychosis with Comorbid Anxiety and the Impact of Life Events: A Case Report

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ABSTRACT

This case study presents a 31-year-old female patient exhibiting symptoms consistent with postpartum psychosis, complicated by anxiety features. Following the caesarean delivery of her first child, the patient, a housewife with a postgraduate degree, had an extreme flare-up of her symptoms. Among the most notable symptoms were hyperactivity, suspicion, verbal and physical violence, repeated behaviours, and social anxiety that was exclusive to family relationships. According to the patient's medical history, she had mental health issues after a 2018 divorce that partially resolved throughout her pregnancy. The current episode, which started five days after giving birth, had a sub-acute beginning and progressed over time. A mental status evaluation revealed poor social judgment, persecutory delusions, fidgeting, and limited emotion. This instance emphasizes the intricate relationship between life events, hormonal changes, and mental health, underscoring the necessity of thorough evaluation and customized therapies in postpartum mental health care.

Keywords: *Postpartum Psychosis, Anxiety, Postpartum Mental Health, Life Stressors*

Postpartum psychosis (PPP) is a rare but severe mental health disorder that affects a small proportion of women after childbirth, with an incidence rate of about 1 to 2 per 1,000 deliveries (VanderKruik et al., 2017). This condition typically presents with a rapid onset of psychotic symptoms within the first two weeks postpartum, including delusions, hallucinations, disorganized thinking, erratic behaviour, and extreme mood swings. Without timely treatment, postpartum psychosis can lead to serious consequences for both the mother and the baby, including risks of self-harm or neglect of the newborn (Jones et al., 2014).

The origins of postpartum psychosis are complex and involve an interplay of biological, psychological, and social factors. Hormonal fluctuations, especially the sharp decline in estrogen and progesterone levels following childbirth, are believed to trigger psychotic episodes, particularly in women with a predisposition to mental health disorders (Bergink et al., 2016). In addition to hormonal changes, genetic factors are also important. Recent studies have found a genetic link between bipolar disorder and postpartum psychosis,

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suggesting that women with a history of mood disorders, particularly bipolar disorder, are at a higher risk for developing this condition (Meltzer-Brody et al., 2018).

Psychosocial factors also significantly contribute to the development and intensification of postpartum psychosis. Life stressors, such as relationship breakdowns, lack of support, or traumatic events, have been found to trigger or worsen the disorder. Research by Perry et al. (2021) underscores the importance of these psychosocial stressors, particularly those related to relationship changes or a history of mental health struggles, which can precipitate or exacerbate the symptoms of postpartum psychosis. Thus, childbirth not only serves as a biological trigger due to hormonal changes but also as a psychosocial trigger through life transitions such as divorce or remarriage.

Effective management of postpartum psychosis requires a comprehensive approach that addresses both the acute symptoms and the longer-term recovery process. Early intervention often includes pharmacological treatment, such as antipsychotics or mood stabilizers, to stabilize the patient's condition and control symptoms (Doucet et al., 2011). However, medication alone is often insufficient for long-term recovery. Psychological interventions, including cognitive behavioural therapy (CBT), and psychosocial support are essential for helping women process the emotional aftermath, regain functionality, and rebuild their relationship with their child (Plakun, 2015).

This case report examines the experience of a 31-year-old woman with a history of mental health challenges who developed postpartum psychosis after the birth of her first child. Her symptoms began during pregnancy and worsened postpartum, compounded by significant life stressors such as divorce and remarriage. This case aims to contribute to the understanding of postpartum psychosis by exploring the complex interactions between hormonal changes, existing vulnerabilities, and psychosocial stressors. It also highlights the importance of timely, personalized care and integrated treatment strategies in effectively managing postpartum psychosis (Howard et al., 2014).

The goals of this case report are as follows:

1. To better understand the risk factors for postpartum psychosis by providing a clear look at how the condition presents, how it is diagnosed, and how it is treated in a patient with a history of mental health issues.
2. To explore how personal life experiences and history can affect the development and progression of postpartum psychosis.
3. To discuss the challenges in making the right diagnosis and highlight the importance of a treatment plan that includes therapy, behavioral support, and medication.

Through this case, we want to raise awareness among healthcare professionals about how complicated postpartum psychosis can be, stressing the need for early detection and treatment, especially in women at higher risk. We also hope to encourage more research into how life events and personal history play a role in triggering postpartum psychosis, addressing gaps in the existing studies (Rai et al., 2015; Spinelli, 2019).

RESEARCH EVIDENCE

Sit et al. (2006) reviewed postpartum psychosis in detail and showed the complex neurobiological processes that underlie this serious mental illness. Their study showed that a neurochemical milieu susceptible to psychiatric disorders is created by the significant hormonal changes that occur after childbirth. Progesterone and estrogen levels dropping too

quickly might seriously alter the brain circuits that control mood, which may lead to psychosis. Hormonal variations and neurochemical systems, especially those involving dopamine and serotonin, were found to interact in a complicated way. Certain women are more susceptible to these hormonal changes, according to research, particularly those who have a history of mental episodes or mood disorders. A complex biological predisposition to postpartum psychiatric disorders may be the cause of this sensitivity.

Bergink et al. (2011) carried out an investigation on the genetic foundations of postpartum psychosis by thoroughly examining 100 maternal admissions. Significant familial dynamics and genetic markers that raise the likelihood of postpartum mental illnesses were found. The study found a significantly greater prevalence of mood disorders among first-degree relatives of women who suffered from postpartum psychosis. This discovery points to a possible mode of genetic transmission that transcends straightforward hormone or environmental explanations. There is a multifaceted risk profile for postpartum mental health issues due to the researchers' identification of particular genetic susceptibility which interact actively with environmental circumstances.

The effect of psychosocial stressors in prenatal mental health was critically examined by Meltzer-Brody et al. (2013). Using a combination of methodologies, the researchers investigated the effects of chronic stressors and life transitions on women's mental health during pregnancy. Psychiatric symptoms during pregnancy and the postpartum period are significantly more likely to occur when major life events, such as divorce, relationship upheavals, work interruptions, and financial instability, occur, according to the study. The research emphasized the idea of resilience, which identifies defence mechanisms that can lessen the impact of negative experiences, in addition to identifying risk factors.

CASE PRESENTATION

Patient Information and Demographics

The patient's spouse, her primary caregiver, was present during the assessment. She expressed her main concern with the words, "mujhe depression hai" (I have depression). The family reported the following symptoms:

Presenting Complaints

- Physical and verbal aggression, such as throwing objects and using profanity
- Hyperactivity, characterized by pacing and an inability to remain seated
- Excessive, incoherent speech, often rapidly discussing unrelated topics
- Suspiciousness, frequently checking her phone for imagined messages
- Repetitive behaviours, like continuously folding and unfolding clothes
- Social anxiety, particularly around relatives, though she is comfortable with strangers
- Difficulty caring for her newborn, including challenges with breastfeeding

History of Present Illness

Prior to 2018, the patient presented with no psychiatric symptoms. The precipitating event occurred when her first marriage ended in divorce after her spouse relocated to the USA immediately post-marriage and maintained no contact for five years. Following the marital dissolution in 2018, the patient relocated to her hometown where she maintained intermittent employment as an educator. During this period, she began exhibiting initial symptoms including social anxiety in crowded environments, psychomotor agitation (fidgeting), vocal stereotypy, and a single instance of visual misidentification where she perceived a stranger's face as that of a deceased relative.

In 2021, the patient entered her second marriage and initiated psychiatric care, including pharmacological intervention. She maintained stability on medication until early pregnancy. During the second and third trimesters, medication was discontinued with no apparent deterioration in her mental state.

Following caesarean delivery of her first child, the patient experienced an acute exacerbation of symptoms despite resumption of psychiatric medication. The postpartum presentation included verbal and physical aggression, psychomotor hyperactivity, paranoid ideation, social withdrawal specifically from family members, sleep disturbance, and behavioural dysregulation characterized by repetitive task performance. Additionally, she demonstrated significant difficulty with breastfeeding, which precipitated severe anxiety symptoms.

Past Psychiatric History

The patient's psychiatric issues began after her first marriage ended in divorce in 2018. Early symptoms included fidgeting, verbal stimming, and anxiety in crowded settings, alongside a visual hallucination of a stranger's face resembling a deceased relative. Following her second marriage in 2021, she began medication alongside therapy, remaining stable until her pregnancy, during which she discontinued her medication in the second and third trimesters without adverse effects.

Medical History

During her pregnancy, the patient was diagnosed with thyroid dysfunction, with no other notable medical conditions reported.

Personal and Social History

The patient has a strong educational background and an inconsistent work history as a teacher, marked by sporadic attendance. Her first marriage ended after her husband moved to the USA and did not return for five years. She is currently in an arranged second marriage.

Pre-morbid Personality

Prior to her illness, she was considered self-assured, outgoing, disciplined, and maintained positive interpersonal relationships and coping skills.

Mental Status Examination

- General Appearance and Behavior: The patient appeared moderately groomed, leaning forward in her chair. She made eye contact and was cooperative, though fidgeting was noted in her psychomotor activity.
- Speech and Language: Her speech was normal in spontaneity and fluency but showed reduced prosody. It was goal-directed yet verbose, with delayed response times.
- Mood and Affect: She described her mood as "theek hoon" (I'm okay). Her affect was depressed, anxious, restricted, and blunt, displaying a limited range but retained reactivity.
- Thought and Perception: Her thought content included persecutory delusions and misinterpretations, with both systematized and non-bizarre elements. Depressive and anxious thoughts were present, while perceptual disturbances were limited to illusions.

- Cognition: The patient was alert and oriented to time, place, and person. Tests revealed some impairment in attention and concentration, with a digit span of 5 forward and 3 backward. Recent memory showed mild impairment, but remote memory was intact.
- Judgment and Insight: Social judgment was poor, while test and personal judgment remained normal. Insight was assessed at Grade 2.

Diagnostic Assessments

Based on the clinical presentation and mental status examination, a provisional diagnosis of Postpartum Psychosis (F53.1) was made following ICD-10 criteria. Differential diagnoses included Postpartum onset Schizophrenia (F20.4) and Bipolar I Disorder with psychotic features, postpartum onset (F31.2). Further psychological assessments included:

- **Rorschach Test**: Results indicated thought disorder and impaired reality testing.
- **Positive and Negative Syndrome Scale (PANSS):** Total score of 98, suggested severe symptoms.
- **Millon Clinical Multiaxial Inventory-IV:** Elevated scores on the Schizotypal and Borderline personality scales.
- **Hamilton Anxiety Rating Scale (HAM-A):** Score of 32, indicating severe anxiety with particularly high scores on psychic anxiety and tension subscales.
- **Beck Anxiety Inventory (BAI):** Score of 38, indicating severe anxiety with prominent somatic symptoms.

TREATMENT PLAN

The treatment strategy focused on three key areas: pharmacotherapy, psychological interventions, and psychosocial support. The goal was to stabilize the patient's immediate psychiatric symptoms, facilitate her recovery, and prevent future episodes of postpartum psychosis.

1. Pharmacotherapy

The primary pharmacological treatment for postpartum psychosis often involves the use of antipsychotic medications to control the acute psychotic symptoms, alongside mood stabilizers or antidepressants when appropriate. In this case, the patient was started on a low dose of an atypical antipsychotic (such as Olanzapine) to address the delusions, paranoia, and aggression that were prominent in her presentation. A mood stabilizer, such as lithium or valproate, was also considered, given the patient's history of emotional instability and anxiety, although it was important to monitor for potential side effects, including impact on thyroid function, given her thyroid dysfunction during pregnancy.

Additionally, benzodiazepines were prescribed to manage the patient’s acute anxiety symptoms and improve her sleep, which had been severely disturbed due to her psychotic and anxiety symptoms. The use of medication was closely monitored in the inpatient setting to assess efficacy and tolerance, with regular blood tests to monitor for adverse effects and ensure the safety of both the mother and infant during breastfeeding.

2. Psychological Interventions

In addition to pharmacotherapy, psychological interventions were introduced early in the patient's treatment plan to help her gain insight into her condition, manage anxiety, and develop better coping strategies. These interventions included:

Supportive Therapy:
Supportive therapy sessions were scheduled twice weekly to provide a safe and empathetic space for the patient to express her feelings and concerns. The goal was to reduce feelings of isolation and improve emotional regulation. The supportive therapist helped the patient process her emotional distress, particularly related to her difficulty adjusting to motherhood and her strained familial relationships. Additionally, these sessions focused on building the patient's coping skills to manage stressors such as sleep deprivation, anxiety about her abilities as a mother, and ongoing relationship tensions.

Cognitive Behavioral Therapy (CBT):
CBT was implemented to assist the patient in recognizing and challenging the distorted thoughts associated with her paranoia and delusions. The therapist worked with the patient to identify thought patterns that contributed to her anxiety and psychotic symptoms, and to replace these with more realistic and adaptive ways of thinking. Special emphasis was placed on increasing the patient's insight into her condition and helping her regain a sense of control over her thoughts and emotions.

Mindfulness-Based Stress Reduction (MBSR):
MBSR techniques were incorporated to address the patient's heightened anxiety, particularly during moments of emotional distress and sensory overload. The patient was taught relaxation exercises, such as deep breathing and mindfulness meditation, to help her manage symptoms of panic and reduce agitation. These practices aimed to enhance her emotional regulation, increase her sense of self-awareness, and promote a sense of calm and stability.

Psychosocial Support and Family Involvement
A critical component of the treatment plan was the involvement of the patient's family in her care. The patient's spouse and mother-in-law were engaged in family therapy sessions to improve communication, address family dynamics, and educate them about postpartum psychosis. Given the patient's difficulty with familial relationships and the social withdrawal she exhibited, the family was encouraged to provide a supportive and non-judgmental environment that would promote her recovery. Psychoeducation for the family members focused on understanding the symptoms of postpartum psychosis, the importance of patience and empathy, and the need for consistent emotional and practical support.

Mothercraft Training and Baby Care Skills:
Given the patient's difficulty in establishing a bond with her infant, particularly her challenges with breastfeeding, mothercraft training was introduced. A lactation consultant and a pediatric nurse worked with the patient on improving breastfeeding techniques and resolving any physical issues that might have been contributing to her anxiety. These sessions were designed to foster positive interactions with her baby, reduce feelings of incompetence, and build the mother-infant bond.

Inpatient Care and Safety:
Because the patient presented with severe psychotic symptoms, including physical aggression, inpatient care was deemed necessary to ensure her safety and that of her baby. The inpatient unit provided a controlled environment where she could be closely monitored for changes in her mental state, ensuring rapid intervention if her symptoms worsened. During her hospital stay, she was provided with 24-hour psychiatric care, including frequent evaluations by the psychiatry team to monitor her progress and adjust medications as necessary.

Postpartum Follow-Up and Long-Term Support:
Upon discharge, the patient was scheduled for close outpatient follow-up, with appointments every week for the first month, followed by bi-weekly visits thereafter. Ongoing psychiatric care, including medication management, was crucial to prevent relapse and ensure her continued stability. The patient's family was encouraged to continue their involvement in her care, and further psychoeducation was provided to help them manage potential future episodes.

Outcome and Evaluation
The patient showed significant improvement during her inpatient stay. After two weeks of intensive care, her symptoms had notably decreased, with a reduction in psychotic features such as delusions and hallucinations. At the time of discharge, her PANSS score had decreased from 98 (severe symptoms) to 65 (moderate symptoms), indicating an encouraging response to treatment. At the one-month follow-up, she reported substantial improvements in her mood, a reduction in anxiety, and the resolution of psychotic symptoms. She was more engaged with her infant, successfully breastfeeding, and reported better sleep patterns.

Treatment Approach and Outcomes
The comprehensive treatment strategy employed in this case, which included pharmacotherapy, psychological interventions, and psychosocial support, aligns with current best practices for postpartum psychosis management (Gilden et al., 2020). The administration of antipsychotic medication, coupled with supportive therapy and family involvement, likely facilitated the rapid improvement noted during inpatient treatment.

The favourable outcomes at the one-month follow-up, including the resolution of psychotic symptoms and enhanced mother-infant bonding, illustrate the effectiveness of timely and comprehensive intervention. This supports Plakun's (2015) assertion regarding the value of a holistic treatment approach in fostering long-term recovery and preventing recurrences.

CONCLUSION

This case report serves as a crucial reminder of the profound challenges faced by new mothers dealing with severe mental health issues post-childbirth. The patient's recovery journey illustrates critical insights with broad implications for perinatal mental health care. Firstly, the case underscores the necessity for vigilance during the postpartum period. The rapid onset and potentially serious consequences of postpartum psychosis call for heightened awareness among healthcare providers, family members, and the community, advocating for a shift in postpartum care that emphasizes maternal mental health alongside physical recovery and infant well-being. Secondly, the multifaceted nature of the patient's symptoms—encompassing psychosis, mood disturbances, and anxiety—challenges the compartmentalized approach often seen in mental health diagnosis and treatment. It compels clinicians to adopt a more holistic viewpoint, recognizing the full range of psychological experiences during the postpartum period. This case highlights the need for nuanced assessment tools and diagnostic criteria that reflect the complex realities of perinatal mental health disorders. The positive outcomes achieved through an integrated treatment approach provide hope, demonstrating that with prompt intervention, appropriate pharmacological treatment, and robust psychosocial support, recovery from postpartum psychosis is attainable in a relatively short timeframe. This success story can help combat the stigma surrounding perinatal mental illness and bolster confidence in comprehensive care models. Additionally, this case emphasizes the vital role of social support and family engagement in

the recovery process. The involvement of the patient's husband and family in her treatment journey illustrates the potential benefits of family-centered interventions for improving outcomes in perinatal mental health care. It advocates for a shift towards inclusive, systemic approaches that recognize the family unit as both a source of stress and a powerful healing resource.

This case report transcends a mere clinical narrative; it serves as a call to action. It urges us to elevate our standards of perinatal mental health care, bridge gaps in understanding postpartum psychosis, and foster supportive communities for new mothers. As we move forward, may this case inspire continued research, enhanced clinical practices, and greater public awareness, striving for a future where no mother faces the challenges of postpartum psychosis in isolation, and every case receives prompt, compassionate, and effective care.

REFERENCES

Beck, A. T., Epstein, N., Brown, G., & Steer, R. A. (1988). An inventory for measuring clinical anxiety: Psychometric properties. *Journal of Consulting and Clinical Psychology, 56*(6), 893-897. https://doi.org/10.1037/0022-006X.56.6.893

Bergink, V., Nolen, W. A., Mirelman, A., Kelt, E., Kamperman, A. M., & Kushner, S. A. (2011). Characteristics of postpartum psychosis: A descriptive study of 100 maternal admissions. *Journal of Clinical Psychiatry,* 72(10), 1358-1364.

Doucet, S., Jones, I., Letourneau, N., Dennis, C. L., & Blackmore, E. R. (2011). Interventions for the prevention and treatment of postpartum psychosis: A systematic review. *Archives of Women's Mental Health, 14*(2), 89-98. https://doi.org/10.1007/s00737-010-0199-6

Hamilton, M. (1959). The Hamilton rating scale for anxiety: Development, reliability and validity. *Journal of Nervous and Mental Disease, 130*(6), 536-547. https://doi.org/10.1097/00005053-195912000-00002

Howard, L. M., Molyneaux, E., Dennis, C. L., Rochat, T., Stein, A., & Milgrom, J. (2014). Non-psychotic mental disorders in the perinatal period. *The Lancet, 384*(9956), 1775-1788. https://doi.org/10.1016/S0140-6736(14)61276-9

Jones, I., Chandra, P. S., Dazzan, P., & Howard, L. M. (2014). Bipolar disorder, affective psychosis, and schizophrenia in pregnancy and the post-partum period. *The Lancet, 384*(9956), 1789-1799. https://doi.org/10.1016/S0140-6736(14)61278-2

Meltzer-Brody, S., Larsen, J. T., Petersen, L., Guintivano, J., Florio, A. D., Miller, W. C., Sullivan, P. F., & Munk-Olsen, T. (2018). Adverse life events increase risk for postpartum psychiatric episodes: A population-based epidemiologic study. *Depression and Anxiety, 35*(2), 160-167. https://doi.org/10.1002/da.22697

Meltzer-Brody, S., Mayes, L. C., Shuman, M. S., Pearson, B., Yeaton-Massey, A., & Ward, A. (2013). Adversity and resilience in women with a history of psychiatric hospitalizations during the perinatal period. *Archives of Women's Mental Health*, 16(4), 297-306. https://doi.org/10.1007/s00737-013-0356-y

Miller, T. W., & Millon, C. (2004). *Millon Clinical Multiaxial Inventory-IV (MCMI-IV)*. Pearson Education.

Overall, J. E., & Gorham, D. R. (1988). The Positive and Negative Syndrome Scale (PANSS) for schizophrenia. *Schizophrenia Bulletin, 14*(2), 539-544. https://doi.org/10.1093/schbul/14.2.539

Perry, A., Gordon-Smith, K., Di Florio, A., Forty, L., Craddock, N., Jones, L., & Jones, I. (2017). Adverse childhood life events and postpartum psychosis in bipolar disorder. *Journal of Affective Disorders, 205*, 69-72. https://doi.org/10.1016/j.jad.2016.06.061

Plakun, E. M. (2015). Psychotherapy and psychosocial treatment: Recent advances and future directions. *Psychiatric Clinics, 38*(3), 405-418. https://doi.org/10.1016/j.psc.2015.05.012

Rai, S., Pathak, A., & Sharma, I. (2015). Postpartum psychiatric disorders: Early diagnosis and management. *Indian Journal of Psychiatry, 57*(Suppl 2), S216-S221. https://doi.org/10.4103/0019-5545.161481

Rorschach, H. (1942). *Psychodiagnostics: A diagnostic test based on perception*. The Rorschach Institute.

Sit, D., Rothschild, A. J., & Wisner, K. L. (2006). A review of postpartum psychosis. *Journal of Women's Health*, 15(4), 352-368. https://doi.org/10.1089/jwh.2006.15.352

Spinelli, M. G. (2019). Postpartum psychosis: A clinical guide for management. In L. M. Howard & E. Khalifeh (Eds.), *Perinatal mental health: A clinical guide* (pp. 187-204). CRC Press.

VanderKruik, R., Barreix, M., Chou, D., Allen, T., Say, L., & Cohen, L. S. (2017). The global prevalence of postpartum psychosis: A systematic review. *BMC Psychiatry, 17*(1), 272. https://doi.org/10.1186/s12888-017-1427-7

World Health Organization. (1992). *The ICD-10 classification of mental and behavioural disorders: Clinical descriptions and diagnostic guidelines*. World Health Organization.

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Conflict of Interest

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