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EDITORIAL

Postpartum psychosis: an alternate explanation for symptom specificity

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Defining postpartum psychosis is simultaneously simple yet complex.[1] In short and at the most basic level, postpartum psychosis is the occurrence of a psychotic episode after childbirth. However, delimiting illnesses that constitute postpartum psychosis has been challenging, and it is here that the complexity arises. The fact that postpartum psychosis is not recognized as a distinct diagnosis in DSM-5 or ICD-11 may also contribute to the lack of clarity. Postpartum psychosis is characterized by a rapid onset of symptoms including delusions, hallucinations, bizarre behavior, confusion, and disorganization that may appear to be delirium. Phenomenologically, postpartum psychosis can be subdivided into depressive (41%), manic (34%), and atypical (25%) groups. The atypical profile is marked by disorientation and disturbance of consciousness.[2] Similar to postpartum psychosis, the diagnostic status of delirious mania, a neuropsychiatric syndrome with coexisting symptoms of mania and delirium, has been intensely debated. It is argued that the co-occurrence of mania and symptoms of delirium of varying intensity in some patients may contribute to the apparent uniqueness of postpartum psychosis.

Delirious mania

Cognitive disorganization is not uncommon in patients with mania. Referring to it as "an overlooked and hitherto unrecorded malady," Luther Bell published a monograph on delirious mania in 1849. Kraepelin described delirious mania as "a dreamy, profound clouding of consciousness, and extraordinary and confused hallucinations and delusions [...] the attack begins very suddenly; only sleeplessness or anxious moodiness may already be conspicuous one or more days [...] beforehand." A chart review of 16 cases admitted to McLean Hospital provided further details on the condition.[3] Patients hospitalized for co-occurring delirium and mania were more likely to be young females with a prior diagnosis of bipolar disorder. Delirious mania can also be a manifestation of physical illnesses or psychoactive substance use in the absence of bipolar disorder. Symptoms begin within hours or days and include changes in psychomotor activity, confusion, reduced ability to maintain focus, distractibility, racing thoughts, sleeplessness, abnormally and persistently elevated or irritable mood, pressured speech, grandiosity, delusions, hallucination, and occasionally catatonia. The presence of hypo/manic symptoms, personal history of mania or depression, and a family history of mood disorders have also been noted. Recommended treatments include benzodiazepines, antipsychotics, lithium, and electroconvulsive therapy. Delirious mania is a potentially life-threatening illness, but symptoms usually remit within a few days with appropriate treatment.

Postpartum psychosis and delirium

Karnosh and Hope in 1937 noted the most common denominator in postpartum psychosis was a delirium of varying intensity and "the more abrupt the onset the more profound is the clouding of the sensorium." A recent prospective study of women hospitalized for postpartum psychosis found 20% had disorientation and 10% suffered from disturbance of consciousness. Cognitive symptoms are also not uncommon in patients with stage III mania, which Carlson and Goodwin described as a loosening of associations, bizarre delusions, hallucinations, and disorientation to time and place, among other symptoms. Mayer-Gross, Slater, and Roth expounded on the relationship between mania and delirium: "Manic excitement in its most severe form leads to *confusion*, in which the typical symptoms of mania are obscured. Consciousness, which is clear in the less severe cases, becomes clouded, illusions, and hallucinations may be observed, and the condition may resemble delirium."

Distinct phenomenology of postpartum psychosis

The presence of psychotic features is the defining characteristic of postpartum psychosis. However, psychotic features are common in patients with postpartum manic or mixed episodes. A study from Italy found

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psychotic features were present in 67.8% of patients with mania and 87.5% of patients with mixed episodes postpartum.[4] Similarly, a U.S. study reported that 62% of women who required hospitalization for postpartum mania had Schneider's first-rank symptoms, compared with 28% in the matched control group. The temporal association with childbirth is also considered a distinctive feature of postpartum psychosis. Several epidemiological studies have shown an exponential increase in rates of psychiatric hospitalization within the first few weeks after delivery. A population-based study from Denmark found primiparous women were at increased risk of psychiatric hospitalization or outpatient contact during the first three months after delivery for a variety of diagnoses, including unipolar depression. In particular, the relative risk for hospitalization was exceptionally high for bipolar disorder. Thus, the close temporal association between delivery and onset of psychosis is not unique to postpartum psychosis and extends to other psychiatric disorders. For example, compared to non-postpartum obsessive-compulsive disorder, postpartum-onset cases are more likely to have rapid emergence of obsessions, with onset as early as the second postpartum day. Frequent occurrence of mixed states in the postpartum period may also have a pathoplastic effect on the symptom profile of mood and psychotic episodes after delivery. Delirium may contribute to both rapid onset and cognitive symptoms in postpartum psychosis. Since it can occur in the absence of pre-existing psychiatric illness, delirium after delivery may have a more favorable prognosis compared to postpartum psychotic episodes in the context of pre-existing mood or psychotic disorders.

To conclude, the characteristic features of postpartum psychosis, namely onset immediately after delivery, presence of cognitive symptoms, and circumscribed episodes, may not be unique to postpartum psychosis.[5] Symptoms of delirium alone or in combination with manic/mixed episodes are common after delivery and may affect the profile of postpartum psychosis, and both its short- and long-term outcomes. Many psychiatric and physical illnesses can present with psychosis postpartum; however, for most women, postpartum psychosis represents a manifestation of bipolar disorder. If the postpartum psychosis is placed within the context of the underlying disorder, this will increase the likelihood that optimal treatment is provided, thus improving the outcome, and perhaps preventing reoccurrences. To clarify the effect of childbirth on the phenomenology, course, and outcome of bipolar disorder, prospective studies of women with bipolar I disorder versus those with first onset of the disorder postpartum are needed.

Disclosure

The authors report no conflicts of interest.

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