

Symptoms of psychosis and OCD in a patient with postpartum depression

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How would you handle this case?

Answer the challenge questions at [MDedge.com/psychiatry](https://www.mdedge.com/psychiatry) and see how your colleagues responded

Ms. A, age 37, has a history of postpartum depression. Four months after giving birth, she presents with possible auditory hallucinations and thoughts of harming her baby. How can you help her?

CASE Thoughts of harming baby

Ms. A, age 37, is G4P2, 4 months postpartum, and breastfeeding. She has major depressive disorder (MDD) with peripartum onset, posttraumatic stress disorder, and mild intellectual disability. For years she has been stable on fluoxetine 40 mg/d and prazosin 2 mg/d. Despite recent titration of her medications, at her most recent outpatient appointment Ms. A reports having a depressed mood with frequent crying, insomnia, a lack of desire to bond with her baby, and feelings of shame. She also says she has had auditory hallucinations and thoughts of harming her baby. Ms. A's outpatient physician makes an urgent request for her to be evaluated at the psychiatric emergency department (ED).

HISTORY Depression and possible auditory hallucinations

Ms. A developed MDD following the birth of her first child, for which her care team initiated fluoxetine at 20 mg/d and titrated it to 40 mg/d, which was effective. At that time, her outpatient physician documented potential psychotic features, including vague descriptions of derogatory auditory hallucinations. However, it was unclear if these auditory hallucinations were more representative of a distressing inner monologue without the quality of an external

voice. The team determined that Ms. A was not at acute risk for harm to herself or her baby and was appropriate for outpatient care. Because the nature of these possible auditory hallucinations was mild, nondistressing, and nonthreatening, the treatment team did not initiate an antipsychotic and Ms. A was not hospitalized. She has no history of hypomanic/manic episodes and has never met criteria for a psychotic disorder.

EVALUATION Distressing thoughts and discontinued medications

During the evaluation by psychiatric emergency services, Ms. A reports that 2 weeks after giving birth she experienced a worsening of her depressive symptoms. She says she began hearing voices telling her to harm herself and her baby and describes frequent distressing thoughts, such as stabbing her baby with a knife and running over her baby with a car.

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Table

Common symptoms of postpartum psychosis vs obsessive-compulsive disorder with postpartum onset

Category	Postpartum psychosis	OCD with postpartum onset
Overall functioning	Noticeable change in baseline functioning	Variable changes in baseline functioning
Mood	Rapid mood shifts. Fluctuates and varies; irritability more common than elevated mood. Anxious, depressed	Feelings of guilt and shame surrounding obsessions, compulsions, and reluctance to share. Anxious, depressed
Behaviors	Disorganized, erratic, restless	Compulsions: repetitive washing, checking, avoidance. Concealment/hiding behaviors. Seeking reassurance
Thought content	Bizarre and/or altruistic delusions often centered around infant. Delusions of persecution and ideas of reference are common. Delusions are often egosyntonic. Auditory hallucinations, often commanding	Obsessions more frequent than compulsions and are often egodystonic. Obsessions: concerns and worry about intentionally or unintentionally harming infant, worry about baby breathing or dying, worry about cleanliness
Orientation/awareness	Delirium-like waxing or waning confusion, attention, and awareness without medical cause. Depersonalization, disorientation, and loss of reality testing	Alert and oriented. Maintains ability to reality test
Risk of harm to infant	Elevated (4% risk of infanticide)	Rare

Source: References 1-6
OCD: obsessive-compulsive disorder

Clinical Point

Approximately 85% of birthing parents experience some form of postpartum mood disturbance

Ms. A says she repeatedly wakes up at night to check on her baby's breathing, overfeeds her baby due to a fear of inadequate nutrition, and notes intermittent feelings of confusion. Afraid of being alone with her infant, Ms. A asks her partner and mother to move in with her. Additionally, she says 2 weeks ago she discontinued all her medications at the suggestion of her partner, who recommended herbal supplements. Ms. A's initial routine laboratory results are unremarkable and her urine drug screen is negative for all substances.

What is the most robust risk factor in the development of postpartum psychosis?^{1,2}

- History of schizophrenia
- History of bipolar disorder (BD)
- Substance use disorder during pregnancy
- History of MDD with psychotic features

The authors' observations

Approximately 85% of birthing parents experience some form of postpartum mood disturbance; 10% to 15% develop more significant symptoms of anxiety or depression.³ The etiology of postpartum illness is multifactorial, and includes psychiatric personal/family history, insomnia, acute and chronic psychosocial stressors, and rapid hormone fluctuations.¹ As a result, the postpartum period represents a vulnerable time for birthing parents, particularly those with previously established psychiatric illness.

Ms. A's initial presentation was concerning for a possible diagnosis of postpartum psychosis vs obsessive-compulsive disorder (OCD) with postpartum onset; other differential diagnoses included MDD with peripartum onset and psychotic features

Clinical Point

Due to significant risks to the mother and child, postpartum psychosis is a psychiatric emergency that often requires hospitalization

(Table,¹⁻⁶ page 49). Ms. A's subjective clinical history was significant for critical pertinent findings of both OCD with postpartum onset (ie, egodystonic intrusive thoughts, checking behaviors, feelings of shame, and seeking reassurance) and postpartum psychosis (ie, command auditory hallucinations and waxing/waning confusion), which added to diagnostic complexity.

Although postpartum psychosis is rare (1 to 2 cases per 1,000 women),⁵ it is considered a psychiatric emergency because it has significant potential for infanticide, morbidity, and mortality. Most symptoms develop within the first 2 weeks of the postpartum period.² There are many risk factors for the development of postpartum psychosis; however, in first-time pregnancies, a previous diagnosis of BD I is the single most important risk factor.¹ Approximately 20% to 30% of women with BD experience postpartum psychosis.⁴

For many patients (approximately 56.7%, according to 1 meta-analysis⁷), postpartum psychosis denotes an episode of BD, representing a more severe form of illness with increased risk of recurrence. Most manic or mixed mood episodes reoccur within the first year removed from the perinatal period. In contrast, for some patients (approximately 43.5% according to the same meta-analysis), the episode denotes "isolated postpartum psychosis."⁷ Isolated postpartum psychosis is a psychotic episode that occurs only in the postpartum period with no recurrence of psychosis or recurrence of psychosis exclusive to postpartum periods. If treated, this type of postpartum psychosis has a more favorable prognosis than postpartum psychosis in a patient with BD.⁷ As such, a BD diagnosis should not be established at the onset of a patient's first postpartum psychosis presentation. Regardless of type, all presentations of postpartum psychosis are considered a psychiatry emergency.

The prevalence of OCD with postpartum onset varies. One study estimated it occurs in 2.43% of cases.⁴ However, the true prevalence is likely underreported due to feelings

of guilt or shame associated with intrusive thoughts, and fear of stigmatization and separation from the baby. Approximately 70.6% of women experiencing OCD with postpartum onset have a comorbid depressive disorder.⁴

Ms. A's presentation to the psychiatric ED carried with it diagnostic complexity and uncertainty. Her initial presentation was concerning for elements of both postpartum psychosis and OCD with postpartum onset. After her evaluation in the psychiatric ED, there remained a lack of clear and convincing evidence for a diagnosis of OCD with postpartum onset, which eliminated the possibility of discharging Ms. A with robust safety planning and reinitiation of a selective serotonin reuptake inhibitor.

Additionally, because auditory hallucinations are atypical in OCD, the treatment team remained concerned for a diagnosis of postpartum psychosis, which would warrant hospitalization. With assistance from the institution's reproductive psychiatrists, the treatment team discussed the importance of inpatient hospitalization for risk mitigation, close observation, and thorough evaluation for greater diagnostic clarity and certainty.

TREATMENT Involuntary hospitalization

The treatment team counsels Ms. A and her partner on her differential diagnoses, including the elevated acute risk of harm to herself and her baby if she has postpartum psychosis, as well as the need for continued observation and evaluation. When alone with a clinician, Ms. A says she understands and agrees to voluntary hospitalization. However, following a subsequent risk-benefit discussion with her partner, they both grew increasingly concerned about her separation from the baby and reinitiating her medications. Amid these concerns, the treatment team notices that Ms. A attempts to minimize her symptoms. Ms. A changes her mind and no longer consents to hospitalization. She is placed on a

psychiatric hold for involuntary hospitalization on the psychiatric inpatient unit.

On the inpatient unit, the inpatient clinicians and a reproductive psychiatrist continue to evaluate Ms. A. Though her diagnosis remains unclear, Ms. A agrees to start a trial of quetiapine 100 mg/d titrated to 150 mg/d to manage her potential postpartum psychosis, depressed mood, insomnia (off-label), anxiety (off-label), and OCD (off-label). Lithium is deferred because Ms. A is breastfeeding.

Ms. A is planning another pregnancy.

To prevent future episodes of postpartum psychosis, which psychotropic would you recommend?^{1,5,7}

- a) Haloperidol
- b) Valproic acid
- c) Lithium or a second-generation antipsychotic
- d) Sertraline

The authors' observations

Due to an elevated acute risk of suicide and infanticide, postpartum psychosis represents a psychiatric emergency and often requires hospitalization. The *Figure* (page 52) outlines steps in evaluating a patient with concerns for postpartum psychosis in a psychiatric emergency service setting. Due to the waxing and waning nature of symptoms, patients may appear psychiatrically stable at any time but remain at an overall elevated acute risk of harm to self and/or their baby.

If a patient is being considered for discharge based on yes answers to all questions in Step 2 of the *Figure*, the emergency psychiatric clinician must initiate appropriate psychotropic medications and complete robust safety planning with the patient and a trusted adult who will provide direct supervision. Safety planning may include (but is not limited to) strict return precautions, education on concerning symptoms and behaviors, psychotropic education and agreement of compliance, and detailed instructions on outpatient follow-up within

1 week. Ideally—and as was the case for Ms. A—a reproductive psychiatrist should be consulted in the emergency setting for shared decision-making on admission vs discharge, medication management, and outpatient follow-up considerations.

Because postpartum psychosis carries significant risks and hospitalization generally results in separating the patient from their baby, initiating psychotropics should not be delayed. Clinicians must consider the patient's psychiatric history, allergies, and breastfeeding status.

Based on current evidence, first-line treatment for postpartum psychosis includes a mood stabilizer, an antipsychotic, and possibly a benzodiazepine.⁶ Thus, an appropriate initial treatment regimen would be a benzodiazepine (particularly lorazepam due to its relatively shorter half-life) and an antipsychotic (eg, haloperidol, olanzapine, or quetiapine) for acute psychosis, plus lithium for mood stabilization.^{1,5}

If the postpartum psychosis represents an episode of BD, use of a long-term mood stabilizer may be required. In contrast, for isolated postpartum psychosis, clinicians may consider initiating psychotropics only in the immediate postpartum period, with an eventual slow taper. In future pregnancies, psychotropics may be reintroduced postpartum, which will avoid peripartum fetal exposure.⁸ If the patient is breastfeeding, lithium may be deferred in an acute care setting. For patients with evidence of catatonia, severe suicidality, refusal of oral intake with compromised nutrition, severe agitation, or treatment resistance, electroconvulsive therapy remains a safe and effective treatment option.⁶ Additionally, the safety of continued breastfeeding in acute psychosis must be considered, with the potential for recommending discontinuation, which would decrease sleep disruptions at night and increase the ability of others to feed the baby. Comprehensive care requires nonpharmacologic interventions, including psychoeducation for the patient

Clinical Point

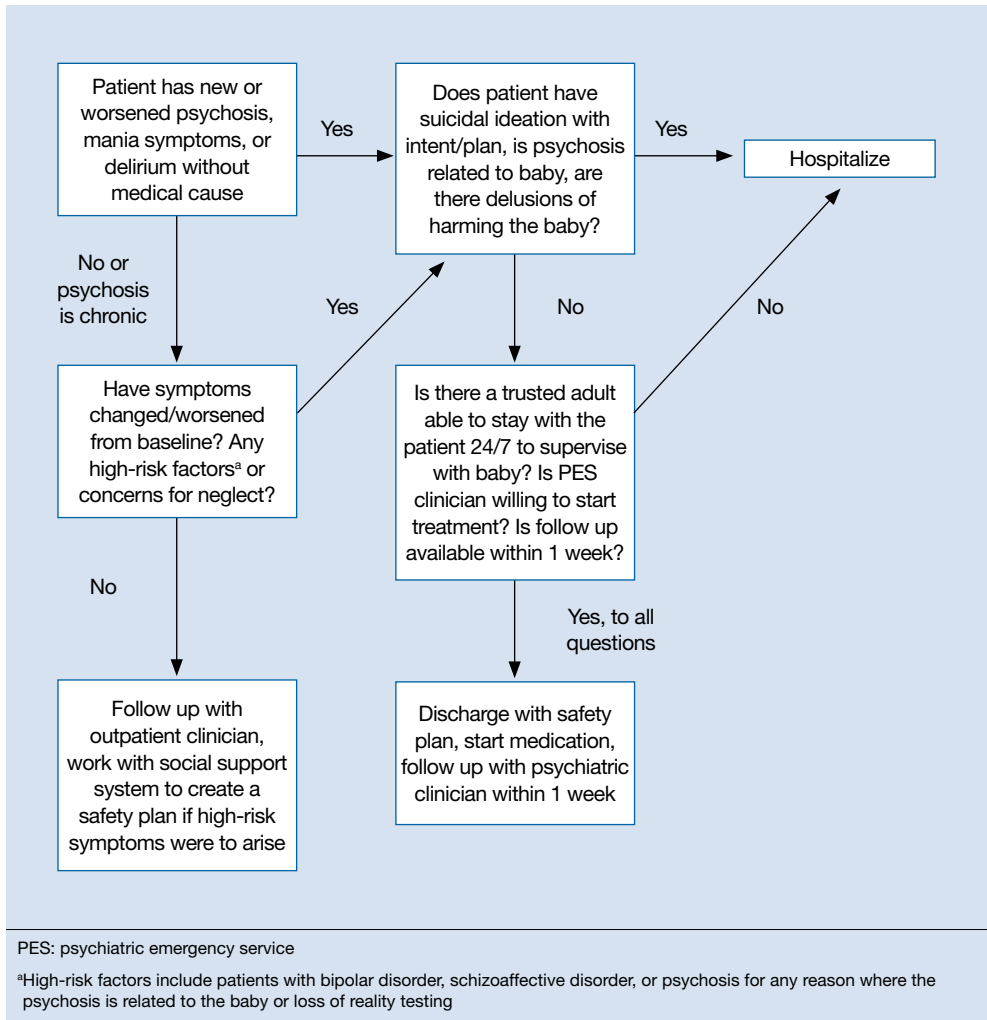
Postpartum OCD is likely underreported due to feelings of guilt or shame and fear of stigmatization and separation from the baby

Clinical Point

First-line treatment for postpartum psychosis includes a mood stabilizer, an antipsychotic, and possibly a benzodiazepine

Figure

Evaluation of postpartum psychosis in a psychiatric emergency service



and their family, individual psychotherapy, and expansion of psychosocial supports.

Patients who have experienced an episode of postpartum psychosis are predisposed to another episode in future pregnancies.¹ Current research recommends prophylaxis of recurrence with lithium monotherapy.^{1,2,5,6} Similar to other psychotropics in reproductive psychiatry, maintenance therapy on lithium requires a thorough “risk vs risk” discussion with the patient. The risk of lithium use while pregnant and/or breastfeeding must be weighed against the risks associated with postpartum psychosis (ie,

infanticide, suicide, poor peripartum care, or poor infant bonding).

OUTCOME Improved mood

After 7 days of inpatient treatment with quetiapine, Ms. A demonstrates improvement in the targeted depressive symptoms (including improved motivation/energy and insomnia, decreased feelings of guilt, and denial of ongoing suicidal ideation). Additionally, the thoughts of harming her baby are less frequent, and command auditory hallucinations resolve. Upon discharge, Ms. A and her

partner meet with inpatient clinicians for continued counseling, safety planning, and plans for outpatient follow-up with the institution's reproductive psychiatrist.

The authors' observations

Many aspects of Ms. A's initial presentation in the psychiatric ED were challenging. Given the presence of symptoms of both psychosis and OCD, a diagnosis was difficult to ascertain in the emergency setting. Since command auditory hallucinations are atypical in patients with postpartum OCD, the treatment team maintained high suspicion for postpartum psychosis, which represented an emergency requiring inpatient care.

Hospitalization separated Ms. A from her baby, for whom she was the primary caregiver. Additional considerations for inpatient admission and psychotropic initiation were necessary, because Ms. A was breastfeeding. Although Ms. A's partner was able to provide full-time childcare, the patient ultimately did not agree to hospitalization and required an emergency hold for involuntary admission, which was an additional barrier to care. Furthermore, her partner held unfavorable beliefs regarding psychotropic medications and Ms. A's need for hospital admission, which required ongoing patient and partner education in the emergency, inpatient, and outpatient settings. Moreover, if Ms. A's symptoms were ultimately attributable to postpartum OCD, the patient's involuntary hospitalization might have increased

Related Resources

- Sharma V. Does your patient have postpartum OCD? *Current Psychiatry*. 2019;18(5):9-10.
- Hatters Friedman S, Prakash C, Nagel-Yang S. Postpartum psychosis: protecting mother and infant. *Current Psychiatry*. 2019;18(4):12-21.

Drug Brand Names

Fluoxetine • Prozac	Prazosin • Minipress
Haloperidol • Haldol	Quetiapine • Seroquel
Lithium • Eskalith, Lithobid	Sertraline • Zoloft
Lorazepam • Ativan	Valproic acid • Depakene
Olanzapine • Zyprexa	

the risk of stigmatization of mental illness and treatment with psychotropics.

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Clinical Point

Patients who have experienced postpartum psychosis are predisposed to another episode in future pregnancies

Bottom Line

The peripartum period is a vulnerable time for patients, particularly those with previously diagnosed psychiatric illnesses. Postpartum psychosis is the most severe form of postpartum psychiatric illness and often represents an episode of bipolar disorder. Due to an elevated acute risk of suicide and infanticide, postpartum psychosis is a psychiatric emergency and warrants inpatient hospitalization for immediate intervention.