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RECURRENCE OF PUERPERAL PSYCHOSIS IN BOTH PRE AND POST-PARTUM PERIODS: A CASE REPORT

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ABSTRACT

A case of recurrent pre and postpartum psychosis is described. Pre-partum psychosis was more severe in intensity when compared with postpartum psychosis and, if untreated, it may have continued as postpartum psychosis. Presence of bipolar affective illness in the family, ongoing stressor and unplanned pregnancy may be the risk factors for developing pregnancy- related psychosis. This case report also adds weight to the proposition that puerperal psychosis might occur in late pregnancy also.

Key words: recurrence, prepartum psychosis and postpartum psychosis

Brockington et al. (1990) proposed the following criteria to accept that puerperal psychosis can start before delivery: 1) Patients should fully recover from episodes of illness, and patients with chronic psychosis should be excluded. 2) The clinical picture should correspond to that traditionally reported for puerperal psychosis. 3) At least one episode should have started within two weeks following delivery. 4) A similar episode should start in late pregnancy 5) There should be no non pregnancy related episodes of psychosis. Later on Glaze et al. (1991) described two cases which fulfil these criteria. These cases exhibited episodes of psychosis during pregnancy and during postpartum but recurrence of psychosis was not noticed in pre and postpartum period. To our knowledge this is the first case report in which recurrence of psychosis occurred in both the periods.

Mrs S, 27-year-old, housewife from lower socio-economic joint family, experienced first psychotic episode in 1994 when she was in 30 weeks of gestation. This episode was characterized by laughing and crying without reason, running away from home, impulsive, abusive, irritable, neglecting personal care and disturbed biological functions. Her psychiatric symptoms worsened after delivery and she exhibited infanticide tendency by making attempt to throw the child in the fire. She showed spontaneous recovery and whole episode lasted for 5 months. In 1996, she experienced second psychotic episode 10 days after delivery which was similar in nature but was of mild intensity when compared to first episode. This episode remained for 3 weeks and remitted spontaneously. She developed third episode in 1998 following spontaneous abortion at 6 months of gestation and exhibited psychotic symptoms similar in nature but low severity as mentioned in first

episode. She recovered within 3 months without any treatment. In 2000, she had fourth psychotic episode 7 days after delivery of still birth child. The episode was mild in nature characterized by irritable and withdrawn behavior, decreased personal care, at times suspicious and occasional smiling to self, of 3 months duration. Her recovery was spontaneous. In 2001, she developed fifth psychotic episode which began around sixth month of pregnancy. This last pregnancy was unplanned and the couple was neither interested in continuing pregnancy nor for abortion. She was hospitalized due to severe psychiatric symptoms such as impulsive, abusive and wandering behavior, neglecting personal care and disturbances in biological functions.

She was treated with olanzapine 15 mg per day and was referred to a gynecologist for prenatal check-up. The last episode lasted for one month. There was no history of drug abuse or persistent mood symptoms or perceptual disorder. She never had any medical or neurological complication during the pregnancy and after childbirth.

There was a past history suggestive of dissociative disorder (possession state) following strained relation with her mother in law and patient continued to have conflict till the last episode. Her family history revealed that her maternal aunt was suffering from bipolar disorder. She had well adjustable pre-morbid personality. On examination she was restless, had increased psychomotor activity and exhibited inappropriate affect and paranoid delusion with grossly intact cognitive functions.

DISCUSSION

Although pregnancy has in the past been believed to protect against psychiatric illness, growing body of literature shows that this is not the case. Psychiatric symptoms in pregnant women are more common in those with a history of previous psychiatric illness and probably in those with serious medical complication affecting the course of pregnancy (Gelder et al., 1989). Our case fulfils the criteria proposed by Brockington et al. (1990) and gives weightage to the proposition that puerperal psychosis might occur in late pregnancy also. There are recent reports which have demonstrated that puerperal psychosis is preceded by prodromal signs (Thessier et al., 1998). In the previous case reports (Brockington et al., 1990; Glaze et al., 1991) pre-partum psychosis occurred in the second or subsequent pregnancy, a marked contrast with postpartum psychosis, which is more common after the first pregnancy. But in our case, pre- and postpartum psychosis was an interesting observation, which was not noticed in any literature and exclude possibility of episodic psychosis recurring by chance. Pre-partum psychosis was more severe in intensity and may have continued as postpartum psychosis if not treated properly. This report also showed that occurrence of psychosis during first pregnancy may be a risk factor for developing psychosis in subsequent pre- and post-natal period. Earlier study on women with previous postpartum psychosis revealed significantly greater risk (1 in 3) of psychotic episode following subsequent pregnancy (Cox , 1992). A history of postpartum psychosis confers a relapse risk of 20% to 33% (Kendell et al., 1987; Sichel, 1992). Having both bipolar disorder and prior postpartum psychotic episode increases the risk of a subsequent postpartum psychosis to 50% (Kendell et al., 1987). Primiparity and family history of bipolar disorder also appear to heighten the risk for postpartum psychosis (O' Hara, 1987). Women who have had an episode of postpartum psychosis are at risk of subsequent bipolar disorder, suggesting that postpartum psychosis may be a sub category of bipolar disorder (Burt & Hendrik, 1999). One Indian study showed a majority of postpartum cases had unspecified functional psychosis rather than bipolar disorder and developed psychosis after the birth of first child (Agrawal et al., 1997) Perplexity and lability of mood, which are characteristic of postpartum psychosis, were not observed in our case. In this case report family history of bipolar disorder, ongoing chronic stressor and unplanned

pregnancy might be the risk for developing both pre- and post-partum type of psychosis. Early prompt intervention by counseling or psychopharmacological treatment, absolutely necessary for psychosis during pregnancy, may prevent recurrence of postpartum psychosis.

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