The Role of Midwives in Facilitating Recovery in Postpartum Psychosis

Bobbie Posmontier, CNM, PhD

Postpartum psychosis, an emergency psychiatric condition affecting one to two women per 1000 after childbirth, can result in a significant increased risk for suicide and infanticide. Symptoms of postpartum psychosis, such as mood lability, delusional beliefs, hallucinations, and disorganized thinking, can be frightening for the women who are affected and for families and obstetric care providers of those women. Women experiencing postpartum psychosis are often thrust into a mental health system that does not capitalize on the close relational bond that forms between midwives and the women they care for over the course of prenatal care. The purpose of this article is to propose using the Recovery Advisory Group Model of mental illness as a theoretical framework for care of women with postpartum psychosis, to assist midwives in recognizing symptoms, define the role of the midwife in treatment, and learn the importance of becoming part of the psychiatric mental health care team in order to facilitate optimum recovery for women with postpartum psychosis. J Midwifery Womens Health 2010;55:430–437 © 2010 by the American College of Nurse-Midwives.

keywords: midwives, postpartum psychosis, recovery

INTRODUCTION

In spite of the expansion of midwifery practice into both gynecologic and primary care, women still experience fragmentation in the delivery of perinatal services.[1] One of the needs in obstetric health care that remains crucial is meeting the needs of women who experience postpartum psychosis. In the current health care system, when women suffer an episode of postpartum psychosis they are thrust into a mental health system that does not capitalize on the close relational bond that forms between midwives and the women they care for during prenatal and intrapartum care. Without a familiar and sympathetic face in the psychiatric emergency room, women with postpartum psychosis may feel abandoned and frightened, which may further exacerbate the psychotic symptoms and delay recovery.

The Recovery Advisory Group Model for mental illness, established by Ralph et al.,[2] addresses the needs of patients with serious mental illness in the general psychiatric population and may provide a theoretical framework that can assist midwives in providing care for women with postpartum psychosis. The model, a consumer-driven, self-empowering approach, has not been studied in women with postpartum psychosis. The purpose of this article is to assist midwives in recognizing the symptoms of postpartum psychosis and to help midwives define their role in treating women with postpartum psychosis to achieve optimum outcomes for both women and their families.

POSTPARTUM PSYCHOSIS

Postpartum psychosis is an emergency psychiatric condition affecting one to two women per 1000 after childbirth. Although the incidence of postpartum psychosis is low, the risk for suicide and infanticide are substantially higher for women who are affected by this disorder than for women with any other postpartum mental illness.[3–5] Symptoms of postpartum psychosis are characterized by mood lability, delusional beliefs, hallucinations, and disorganized thinking (Box 1). Midwives must quickly recognize postpartum psychosis and immediately refer women for treatment to decrease the risk of harm to both mother and infant. Without early treatment, the condition may worsen and increase the risks for dangerous behaviors, recurrence in subsequent pregnancies (up to 90%), treatment resistant psychosis, relapse (57%; 95% confidence interval, 44–69),[6] and severe family dysfunction.[3–6] Women who have experienced postpartum psychosis may suffer long-term decreased self-esteem and altered mother–infant bonding.[7] Early intervention is a key factor in promoting a shorter recovery period and better long-term function.[8]

Etiology of Postpartum Psychosis

According to the *Diagnostic and Statistical Manual of Mental Disorders,* fourth revision (DSM-IV-TR), which defines diagnostic criteria for mental disorders, postpartum psychosis is considered either a severe form of major depression or the recurrence of a primary psychotic disorder such as schizophrenia.[9] There is also a large body of evidence suggesting that postpartum psychosis is a manifestation of an underlying bipolar disorder.[10,11]

Although no definitive cause has been identified, a combination of biologic and environmental factors have been implicated in the onset of postpartum psychosis (Table 1).[4] Risks for postpartum psychosis include family or personal history of psychiatric illness (especially bipolar disorder), a dramatic shift in hormonal levels after childbirth (especially the decrease in estrogen levels),

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1526-9523/$36.00 • doi:10.1016/j.jmwh.2010.02.011

BOX 1. POSTPARTUM PSYCHOSIS

R.W. is a 26-year-old primigravida who experienced a normal pregnancy and vaginal birth at 4 AM. During her initial prenatal visit, R.W. reported that she had experienced occasional symptoms of anxiety but had never experienced depression or psychosis. Her family psychiatric history also was significant for anxiety. During the initial postpartum hospitalization, R.W. had difficulty falling asleep and staying asleep, paced the hospital corridors, followed the nurses around the postpartum unit, and showed little interest in caring for her infant. R.W. returned home on the third postpartum day. Her family noted that she seemed agitated but ascribed this behavior to adjusting to becoming a new mother. Shortly after returning home, R.W. told her family that she was not feeling well, but she could not articulate what was wrong. She did not seem to be aware of her infant. Her speech became rapid and pressured. R.W. told her family to call 911, but they continued to try to console her. Her agitation continued to escalate and she started to accuse her husband of trying to kill her. The family then called 911. When the ambulance arrived, R.W. became combative and was placed in four-point restraints. Upon arrival at the hospital, she was given haloperidol, lorazepam, and benztropine intramuscularly.

The midwife who R.W. saw for prenatal care was informed of the hospitalization and went to see her. R.W. told the midwife that her husband and the emergency medical personnel had tried to kill her. The midwife assured R.W. that she was safe, that no one was trying to kill her, and that she might be suffering from postpartum psychosis. The midwife further explained that dramatic shifts in pregnancy hormones after childbirth and sleep deprivation can sometimes trigger a chemical malfunction in the brain and cause psychotic thinking. She further explained that these imbalances were temporary manifestations of postpartum psychosis and could be alleviated with medication and psychotherapy. Upon consultation with the medical staff managing R.W.'s inpatient care, the midwife facilitated a visit from her husband, facilitated removal of restraints, and explained to the couple that R.W. would be transferred to a psychiatric inpatient facility where her condition would be further stabilized with other medications.

After a 3-day psychiatric hospitalization, R.W. was maintained on a regimen of olanzapine and lamotrigine and weekly psychotherapy sessions for 6 months. She maintained weekly telephone contact with her midwife for the first 3 months. With R.W.'s permission, the midwife communicated with her psychiatrist as needed. At 6 months postpartum, R.W.'s psychosocial functioning and mother–infant bonding was normal, and she expressed a desire to share her story with others.

maternal age (>35 years), obstetric complications (including emergency cesarean section), abrupt cessation of antimanic medications, marital discord, sleep deprivation, primiparity, unplanned pregnancy, or life stress.[4,5,12–14] Primiparas are two to four times more likely to experience postpartum psychosis than multiparas. In a molecular genetics positional gene approach study of 54 sibling pairs affected by postpartum psychosis, Jones and Craddock[10] suggest that genetic factors—including a genome-wide significant linkage signal on chromosome 16p13 and a genome-wide suggestive linkage on 8q24—may be implicated in the etiology of postpartum psychosis.[10] Although low socioeconomic status and ethnicity are also risk factors for the onset of postpartum psychosis, they play a less prominent role.[3] The mean age of the onset of postpartum psychosis is 26.3 years. Despite evidence of risk factors, almost 50% of women with postpartum psychosis have not experienced any previous psychiatric hospitalizations.[15] Unless burdened with chronic mental illness, many women display high functioning before the onset of this disorder.[3]

While the assessment of R.W., whose case is presented in Box 1, did not reveal a personal or family history of bipolar or psychotic disorder, her personal and family history was positive for anxious symptomatology. R.W.'s age, primiparous status, and experience of sleep deprivation during labor and the first postpartum days are consistent with risk factors for the onset of postpartum psychosis.

Clinical Features

Most cases of postpartum psychosis occur within 2 weeks of childbirth.[3,13] Clinical features can include an odd affect; withdrawn behavior; distraction by auditory, visual, or olfactory hallucinations; confusion; incompetence; catatonia; jealousy; suspiciousness; grandiosity; sleeplessness; or lability of mood characterized by elation, rambling speech, agitation, and/or excessive activity (Table 1).[3,14]

In a qualitative study of nine nurses in Sweden, Engqvist et al.[16] found that women with postpartum psychosis displayed symptoms such as delusions, disconnection, aggression, self-absorption, changed personality, insomnia, chaotic behavior, suicidal ideation, and ''strange eyes'' that appeared black and vacant. In a retrospective study of 127 women with bipolar postpartum psychosis, Heron et al.[17] found that many women recalled feeling symptoms by 3 days postpartum, including euphoria (excitement and high levels of energy), feeling very talkative, racing thoughts, confused thinking, and having trouble sleeping. In a study comparing 21 women with postpartum psychosis to 21 women without postpartum psychosis who were matched on age, parity, and year of admission from the same hospital, Sharma et al.[13] found that nighttime deliveries with accompanying sleep deprivation were significantly higher in women with postpartum psychosis compared to the controls.[13] Women with postpartum psychosis may also display obsession with childbirth themes, concern about the infant's altered identity, or a sense of persecution from the infant.

Prodromal symptoms were evident from R.W.'s odd behavior of following nurses around the postpartum floor

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Table 1. Differential Diagnosis of Postpartum Psychosis: Risk Factors, Symptoms, and Presentation

Differential Diagnosis	Risk Factors	Symptoms and Presentation
Postpartum psychosis	• Personal or family history of bipolar disorder • Previous hospitalization for psychiatric disorder • History of unipolar depression with psychotic features • History of schizophrenia • Sleep deprivation • Delivery complications • Possible relationship to fall in estrogen levels • Age (>35 years) • Abrupt cessation of antimanic medications • Marital discord • Primiparity • Unplanned pregnancy • Life stress	• Sudden onset (48 hs–2 wks postpartum) • May have hypomanic symptoms and insomnia first 3 days postpartum • Odd affect and bizarre behavior • Withdrawn and disconnected • Suspicion • Cognitive disturbance and confusion • Lack of connection with reality • Aggression • Hallucinations (visual, auditory, tactile, or olfactory) • Disorganized thinking and behavior • Compulsion to act on delusional beliefs (persecution or jealousy) • Unable to assess consequences of actions • Mood lability—Elation to depression • Rambling speech and racing thoughts • Agitated/excessive activity to very quiet • Euphoria • Confusion • Obsession with birth themes, change in infant identity, and persecution from infant
Postpartum depression	• Personal or family history of major depressive disorder • History antepartum depression • Poor social support/marital conflict • Stressful life events • Unwanted pregnancy	• Depressed mood or loss of interest in usual pleasurable activities with four of the following: ○ Weight or appetite change ○ Sleep disturbance ○ Difficulty concentrating ○ Fatigue or loss of energy ○ Feelings of worthlessness or guilt ○ Recurrent thoughts of death or suicide ○ May have intrusive thoughts about harming infant or being a poor mother
Obsessive compulsive disorder	• Personal or family history of obsessive compulsive disorder • Stressful life events • Pregnancy and postpartum periods	• Intrusive thoughts (worry about contamination, harming children, violent or sexual images, preoccupation with religious themes, or need for symmetry) • Compulsive behaviors (cleaning, checking, counting, repeating, or hoarding) • Avoids anxiety-producing situations • Has rational judgment • Does not act on aggressive thoughts

Sources: Sit et al.,[3] Doucet et al.,[8] Engqvist et al.,[16] Heron et al.,[17] Nager et al.,[36] and Blackmore et al.[37]

day and night. Displays of suspiciousness and agitation were evidenced by frequent complaints about nursing care. Disconnection was evidenced by R.W. not wanting to personally care for her infant. R.W. may likely have experienced additional stress from sleep deprivation in labor evidenced by her 4 AM delivery. Excessive activity was evidenced by her constant pacing of the hospital corridors.

Once R.W. experienced the full effects of postpartum psychosis, she suffered persecutory delusions and stated that her husband and emergency personnel were trying to kill her. Although she did not express suicidal or homicidal ideation, she displayed aggression by becoming both physically and verbally combative.

Differential Diagnosis and Evaluation

Women displaying symptoms of postpartum psychosis need to be assessed for underlying organic medical conditions that may also produce psychotic-like symptoms, including the following: stroke; uremic encephalopathy; hepatic failure; diabetic ketoacidosis; sepsis; preeclampsia; Graves disease; parathyroid abnormalities; deficiencies in vitamin B_{12}, folate, and thiamine; adverse effects from medications, including steroids, opioids, sympathomimetics, antibiotics, and anticholinergics; substance abuse; meningitis; or HIV-related encephalitis.[3,5,18–21]

Postpartum psychosis also needs to be differentiated from postpartum depression (PPD) and obsessive

compulsive disorder (OCD; Table 1). Unlike PPD, postpartum psychosis includes cognitive disturbance, delusional beliefs, and disorganized behavior.[3] Women with postpartum psychosis are unable to act rationally and feel compelled to act on their delusional beliefs. In addition, they are unable to discern the consequences of their actions. It should be noted, however, that women with a history of unipolar psychotic depression are also at risk for developing postpartum psychosis shortly after childbirth.[3,22] In contrast to postpartum psychosis, women with OCD have intrusive thoughts but do not feel compelled to act on them. In addition, they maintain rational thinking but avoid situations that provoke anxiety.[3]

Laboratory studies used to rule out organic causes include a complete blood cell count, blood urea nitrogen (BUN), creatinine, glucose, levels of vitamin B_{12} and folate, thyroid function tests, calcium, electrolytes, liver function tests, HIV screening, urinalysis, urine culture in patients with fever, and a urine drug screen. Neurologic evaluation includes an assessment of vital signs, a computerized tomography scan, and magnetic resonance imaging to rule out organic brain dysfunction.[3]

TREATMENT OF POSTPARTUM PSYCHOSIS

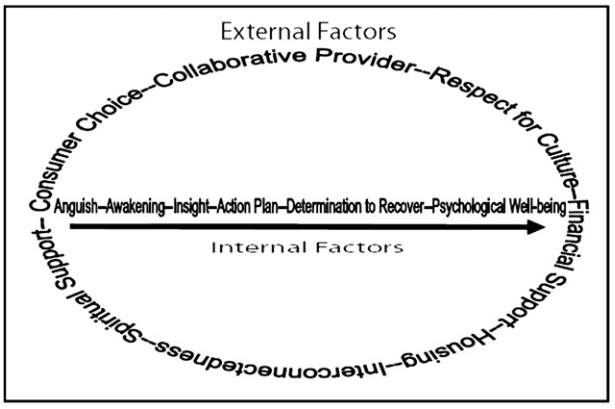
Holistic treatment of postpartum psychosis consists of a multidisciplinary team approach of educating women and their families about the course of their illness, treating women with pharmacologic agents, providing supportive psychotherapy, and providing continuous safety risk assessment for mother and infant.[3] While midwives can provide education, emotional support, and safety risk assessment, medication management is managed by mental health practitioners, such as advance practice psychiatric nurse practitioners and psychiatrists. Supportive psychotherapy is usually initiated during hospitalization after rational thinking has returned. Psychotherapy can help the individual cope with issues of loss, role change, problematic relationships, parenting, and any other stressors that can affect her outcome. A combination of medication and psychotherapy produces the most optimum therapeutic outcomes.[3] Midwives can be instrumental in educating women about the expected side effects of medications and the importance of treatment adherence.

There is no current standard treatment for postpartum psychosis; however, pharmacologic treatment is based on the underlying disorder (bipolar illness vs. unipolar psychotic depression vs. schizophrenia), concurrent medical illness, past response to medication, adverse effects, and the level of illness.[3] Monotherapy (use of one medication) in the lowest effective dosage is usually preferred over using combinations of medications and higher dosages to reduce the incidence of adverse effects and mitigate side effects on mothers and infants. Daily doses of psychotropics can also be given in divided dosing to avoid high peak levels during breastfeeding. The most common psychopharmacologic treatments for postpartum psychosis include mood stabilizers, such as lithium, antiseizure medication, benzodiazepines, and atypical antipsychotics.[3,23,24] Women who do not respond to psychotropic medication may require electroconvulsive therapy.[25]

Importance of Midwifery Support

Midwifery care for women for postpartum psychosis may be instrumental in reducing the fragmentation that exists between obstetric and mental health care systems. Some qualitative research has found that a patient's relationship with her health care practitioner is critical in preventing psychotic relapse and improving psychosocial functioning.[26] A qualitative study by Green et al.[26] (n = 177) found that among persons with schizophrenia, schizoaffective disorder, affective psychosis, and bipolar illness, the relational bond between individual and health care provider fostered collaborative care, facilitated medication adherence, and promoted patient decision-making. In a qualitative study of nine registered nurses with psychiatric training in Sweden who care for women with postpartum psychosis, Engqvist et al.[16] found that six out of nine expressed feeling sympathy, empathy, and compassion for women with postpartum psychosis and maintained that nurses need to establish a ''loving-giving relationship'' when encountering women with disturbing behaviors. According to Pembroke and Pembroke,[27] many midwives possess a spiritual strength that allows them to share their humanity; provide understanding, respect and support; be fully present with women; and give of themselves for the sake of helping others. It may be these midwifery qualities that could promote the relational bond that would facilitate recovery in women with postpartum psychosis.

According to a qualitative study of 10 women who had been diagnosed and treated for postpartum psychosis within the past 10 years, Robertson and Lyons[12] found that they felt guilty about not caring for their infants during their psychotic illness. Women also express feelings of loneliness, isolation, and anger with the health care system for not keeping them more informed during their illnesses. Robertson and Lyons[12] suggested that offering emotional and informational support could be critical in reducing the effects of the stress of postpartum psychosis on the family and marital relationship. In another qualitative study of 10 psychiatric nurses who cared for women with postpartum psychosis, Engqvist et al.[28] found five themes that illustrate effective nursing care including: 1) emotional and physical presence; 2) partnership with the patient; 3) helping the patient connect with reality; 4) instilling hope and affirming the patient's experience; and 5) explaining the illness to the patient and family. According to Peplau,[29]



Adapted from Ralph et al[30]

Figure 1. Internal and External Factors in Recovery

persons with psychiatric disorders also need respect, assistance in rebuilding interpersonal relationships, and education. Many midwives provide this type of support through active listening, providing an emotional and physical presence, actively including women in decision-making, and being responsive to the needs of women and their families. Therefore, they may be key in providing a calming presence for women and their families living through the experience of postpartum psychosis.[27]

THEORETICAL FRAMEWORK FOR POSTPARTUM PSYCHOSIS MIDWIFE INTERVENTION

The Recovery Advisory Group Model by Ralph et al.[30] is defined as a consumer-driven, dynamic, constantly evolving, nonlinear process that may provide a theoretical framework to assist midwives in providing care for women experiencing postpartum psychosis.[2,31] Although originally formulated to address recovery for persons with serious mental illness, such as schizophrenia and bipolar illness, this model may be applicable in assisting women to recover from postpartum psychosis. Rather than merely viewing mental illness as an outcome where resolution of all symptoms is measured by an external criterion, the model views mental illness as a process of recovery or the achievement of psychological well-being as measured by an internal sense of empowerment despite the possibility of residual symptoms and setbacks.

The process of recovery consists of internal factors where a person living with serious mental illness moves along a continuum of six stages of recovery, including anguish, awakening, insight, action plan, determination to recover, and psychological well-being; and external factors which include a trusted, supportive, and collaborative provider who believes in recovery; consumer choice; respect for cultural issues; financial support and

Table 2. Midwifery Management of Postpartum Psychosis

Management Area	Action
Preconception counseling for high-risk or acutely ill patients	• Referral to psychiatrist or advanced practice psychiatric nurse practitioner and obstetrician/perinatologist for collaborative evaluation and medication management • Discussion of waiting for conception until stabilized • Discuss risks that may precipitate postpartum psychosis
Recognition of signs and symptoms of postpartum psychosis or suicidality	• Referral and transfer to psychiatric emergency setting as indicated
Consultation with psychiatric mental health care providers	• Seek collaboration on patient's plan of care for psychoeducation and patient support • Discuss the value of your role
Provide supportive care to patient and family in emergency setting	• Consult and collaborate with psychiatric mental health team and visit with patients in acute setting as condition allows • Explain etiology and course of postpartum psychosis and expected plan of care after consultation with mental health team • Form emotional connection and instill hope • Facilitate patient connection to reality • Stress importance of sleep and medication adherence • Educate nurses as needed
Provide continuity of care	• Schedule follow-up postpartum appointments and telephone follow-up during treatment phase until patient regains normal psychosocial functioning. • Following the patient's lead to discuss and affirm the postpartum psychosis experience • Affirm the patient's role as a mother and assist with grief as needed • Encourage consultation with psychiatric mental health care provider as needed • Encourage avoidance of sleep deprivation • Reevaluate care as needed

Sources: Corrigan and Ralph[2] and Yonkers et al.[35]

housing; interconnectedness with supportive family and friends; and spiritual support (Figure 1).[31,32] The combination of internal factors and external factors in the process of recovery has the capacity to result in empowerment, which includes feeling control over the environment, finding meaning and purpose in life, and caring about what happens to self and others.

The following actions by the midwife caring for R.W. illustrate how the Recovery Advisory Group Model was used to facilitate the process of recovery. By connecting R.W. to reality, reassuring her that she was safe, and explaining the disease process, the author was empowering her to move from anguish to awakening to insight into her illness, thus addressing internal factors. Once insight is achieved, the midwife can support a woman in her action plan, determination to recover and psychological well-being. Until the midwife visited R.W. in the psychiatric emergency room, R.W. was isolated from her family and physically restrained. By compassionately connecting with R.W. in the same way that she connects as a midwife with women in labor, the midwife was able to reestablish a trusting relationship with R.W. Consulting with the psychiatric nurse facilitated a visit with her husband and removal of her restraints. In this way, the midwife addressed external factors. Although the family was initially frightened by R.W.'s behavior, the midwife engaged the family in psychoeducation by explaining the illness to decrease fear, social isolation, and support family interconnectedness. Providing psychoeducational services for families of women with postpartum psychosis is crucial to the recovery process. Because critical and/or emotionally overinvolved families predict psychotic relapse, the recovery model stresses that families need psychoeducation to understand the disease process and to learn coping and problem-solving skills.[32–34] Finally, by feeling an emotional connection with the midwife who believed in her recovery, R.W. expressed a need to help other women who experienced postpartum psychosis by telling her story and sharing what helped her to recover. This assisted empowerment.

CLINICAL IMPLICATIONS

By using the Recovery Advisory Group Model as a framework for caring for women with postpartum psychosis, midwives can facilitate empowerment, provide emotional presence, provide psychoeducation to decrease the fear of the illness, and decrease barriers to recovery. As illustrated in this case, midwives can be instrumental in assisting patients through a psychiatric crisis while under the care of mental health care professionals.

A recent joint statement by the American Psychiatric Association and the American College of Obstetricians and Gynecologists recognizes that obstetric providers, including midwives, are often the first to see women with risks for and symptoms of postpartum psychosis.[35] Midwifery management of high-risk women can consist of preconception evaluation and referral to a psychiatrist and obstetrician to obtain a plan that meets their obstetric and mental health needs (Table 2). The prompt recognition of signs and symptoms of postpartum psychosis is also critical to insure early treatment.

Midwives can visit acutely psychotic patients in the psychiatric emergency room after consultation with the psychiatric health care team. Seeing a familiar face in the midst of a stressful situation may help reduce anxiety, fear, and the sense of isolation among patients with postpartum psychosis. By using skills from midwifery practice, midwives can assist women to move along the continuum of recovery to psychological well-being and instill hope.

Because sleep deprivation is a high risk factor for the onset and relapse of postpartum psychosis, midwives can reinforce that anticipatory planning for a postpartum doula or family assistance at night is a vital part of discharge planning.[7] They can educate nurses working on maternity units to recognize prodromal symptoms of postpartum psychosis and to facilitate uninterrupted sleep for women at risk. Women and their families can be instructed about the importance of adherence to the medication and psychotherapy protocol, and to call their psychiatric practitioner if they experience any adverse effects from psychotropic medication. Facilitating follow-up appointments and assisting with grief as needed is also part of the role that midwives can play when caring for women experiencing postpartum psychosis.

Midwives can become part of the psychiatric health care team by initiating communication and following up with psychiatric health care professionals. Just as midwives collaborate with obstetricians and empower and nurture women through the process of labor, they can also collaborate with the psychiatric health care team and empower and nurture women through the process of postpartum psychosis and recovery.

CONCLUSION

Midwives can play a critical role in facilitating the recovery of women experiencing postpartum psychosis and reducing the fragmentation that exists between obstetric and mental health care. By using the Recovery Advisory Group Model; recognizing signs and symptoms of postpartum psychosis; providing emotional presence and anticipatory guidance; educating women and their families about postpartum psychosis; and educating nurses to recognize prodromal symptoms and facilitate sleep, midwives can empower women to achieve optimal recovery from postpartum psychosis.

The author acknowledges Barbara Granger, PhD, CPRP, LLC, for her help in editing this manuscript.

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