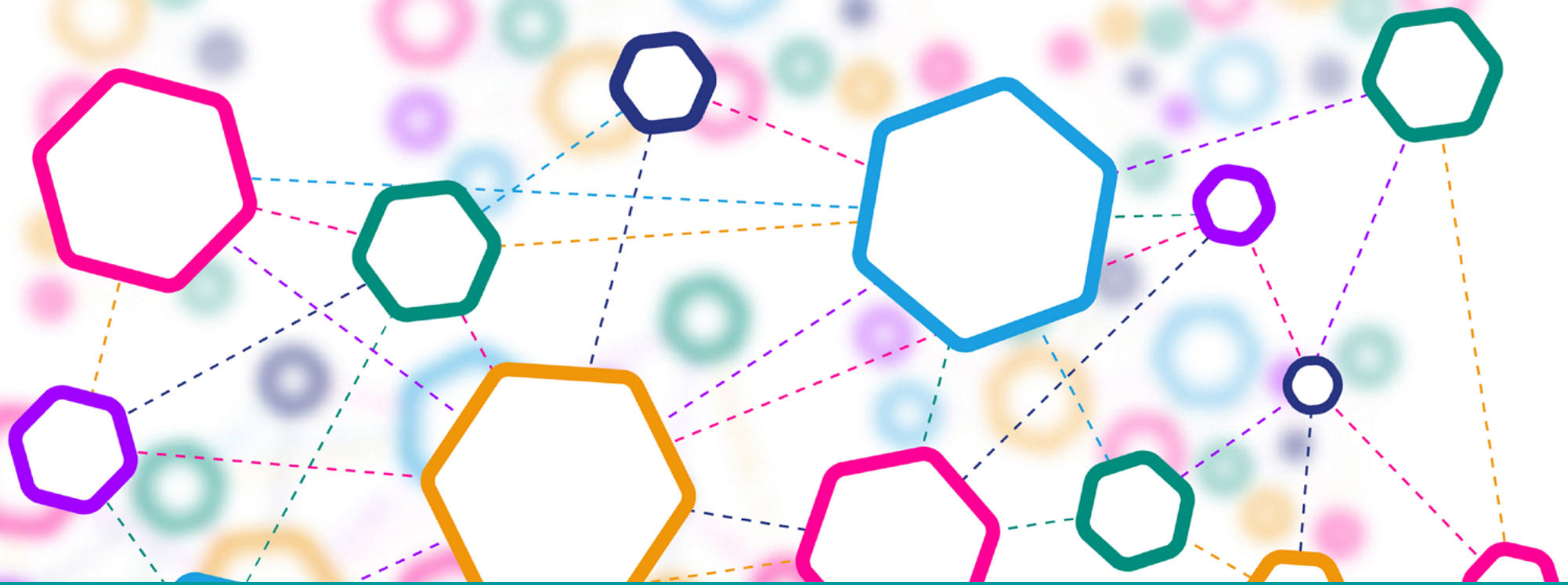


Addendum Evidence Tables

Bipolar Disorder, Postpartum Psychosis, and Psychotic Disorders during the Perinatal Period



March 2025



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For ease and clarity of writing, we use the terms woman/women within these documents. Within this we acknowledge that not all birthing people identify as women.

Postpartum (puerperal or postnatal) psychosis is a condition with a long history. For as long as people have written about childbirth there have been accounts of severe mood or psychotic episodes occurring following childbirth [1]. Despite the current diagnostic classification systems not recognising the condition, the term postpartum or puerperal psychosis has remained in widespread clinical use and there is an argument that the confusion around the classification of severe postpartum episodes has hindered research [2] and consequently advances in clinical practice. Qualitative research has revealed that a label of a postpartum psychosis is favoured by women themselves and this is the preferred term used by the key third sector organisation in the United Kingdom for women who have experienced a psychotic episode or symptoms during the perinatal period [3, 4].

Clinical Presentation, Prevalence and Impact

Severe mental health problems may occur in the postpartum period as the continuation of a pre-existing psychotic presentation that began in or prior to pregnancy, or suddenly shortly after childbirth. These later episodes, traditionally labelled as 'postpartum' or 'puerperal' psychosis most commonly take the form of mania, severe psychotic depression, or a mixed episode with features of both high and low mood [5]. Episodes of postpartum psychosis occur in around 1 in 500 to 1 in 1000 births [2, 6].

Women with previous bipolar episodes are at much higher risk—around 1 in 5 births [2, 6, 7], and women who experience postpartum psychosis are at high risk of subsequent episodes of bipolar disorder not related to childbirth [8]. The core features of psychosis such as delusions and hallucinations are common, and women may also be markedly confused or perplexed [1, 2, and 5].

The majority of episodes of postpartum psychosis have their onset within 2 weeks of birth, with over 50% of symptoms beginning between days 1–3 postpartum [9]. Sudden onset and rapid deterioration are typical and the clinical picture often changes quickly, with wide fluctuations in the intensity of symptoms and severe swings of mood [1, 2, and 5]. Postpartum psychosis can result in significant distress, may disrupt the developing bond between mother and child, and can have long-term implications for the well-being of the woman, the baby, her family and wider society. In rare but tragic cases, the condition can lead to suicide, a leading cause of maternal death, and even more rarely infanticide [2].

Psychological Interventions for women diagnosed with bipolar disorder, postpartum psychosis and psychotic disorders during the perinatal period

In the clinical care of women with postpartum psychosis the types of psychological interventions which might be delivered typically include interventions that target the psychotic and trauma related symptoms (e.g. Cognitive Behavioural Therapy and Eye Movement Desensitization and Reprocessing Therapy), interventions that target difficulties in the parent-infant relationship (e.g. Video-Interaction Guidance; Watch, Wait and Wonder; and Circles of Security), and interventions that target difficulties in the couple relationship (e.g. Behavioural or Systemic Couples Therapy). To inform the generation of the current document, a protocol for a Systematic Review in line with best practice guidance was developed and published on the PROSPERO registry: 'A systematic review of psychosocial interventions for women with a diagnosis of bipolar disorder, puerperal psychosis, and psychotic disorder during the perinatal period' (CRD42022295798).

The results of the literature search found that no studies met the inclusion criteria. It was not therefore possible to make specific recommendations about any particular model or treatment approach. When addressing the mental health needs of women who have experienced postpartum psychosis, the reader is referred to the Matrics Cymru evidence tables for bipolar disorder, psychosis/schizophrenia and Post Traumatic Stress Disorder.

Due to the lack of research evaluating the effectiveness of psychosocial interventions for this group of people, several empirical studies (the majority using qualitative methodologies) and systematic reviews investigating women's and family members' experiences of, and recovery from, postpartum psychosis, as well as their preferences for psychological intervention were drawn on to inform the following guidance [3, 10, 11 and 12]. The current guidance is also informed by the professional expertise and lived experience of an Expert Reference Group that generated the following best practice recommendations.

General Principles for the provision of psychological interventions for women with a diagnosis of bipolar disorder, postpartum psychosis, and psychotic disorders during the perinatal period

- All women diagnosed with bipolar disorder, postpartum psychosis and psychotic disorders during the perinatal period should be offered a specialist psychological assessment and formulation with a practitioner psychologist or other highly specialist psychological professional who is able to devise and implement complex formulations and interventions” .
- The psychological assessment and formulation should draw on a range of psychological theories and models relevant to psychotic and bipolar presentations inside and outside of the perinatal period, and the evidence base from Developmental Psychology on infant development and parent-infant relationships.

- The psychological assessment and formulation should consider the mother's mental health needs, the couple relationship, the parent-infant relationship, and the perinatal and family context (e.g., whether pregnant or postpartum, the impact of changes in life roles such as employment, education, caring for a new infant and participation in social activities).
- In the absence of specific evidence for psychological interventions during the perinatal period for women with bipolar disorder and postpartum psychosis practitioners are referred to the Matrics Cymru Evidence tables for Bipolar Disorder, Psychosis/Schizophrenia and Post-Traumatic Stress Disorder (PTSD). For interventions that target the parent-infant relationship please refer to the **Evidence tables from the Scottish Matrix**.
- There are multiple factors to consider when delivering psychological intervention across the perinatal period. For instance, practitioners may need to consider adaptations around stage of pregnancy when planning in vivo or imaginal exposure exercises, caring for an infant, changing roles, stigma associated with mental health difficulties, fears of disclosing intrusive thoughts in relation to harming the baby, sleep deprivation and its impact on cognition.
- A phase-based integrative intervention is recommended for women with difficulties in multiple domains (e.g. adjustment, grief and loss following postpartum psychosis, difficulties in the couple relationship or parent-infant relationship, and trauma-processing).
- Psychological intervention in the parent-infant relationship, if required, should be prioritised. When asked about their psychological needs, women who have experienced postpartum psychosis have emphasised an initial focus on safety and containment, followed by reconnection with their social network, and then the processing of experiences connected to the onset and course of the psychosis (e.g. trauma memories, complexities of adjustment to the maternal role or the addition of new children to the family, fear of relapse, and support planning future pregnancies) [10, 11].
- The psychological formulation underpinning the intervention(s) for postpartum psychosis should consider the impact of stigma and common fears that women have following postpartum psychosis (e.g. fears about having their baby taken away and/or beliefs about not being a good enough parent).
- Psychological interventions need to target perinatal specific cognitions, behaviours, and beliefs about pregnancy, childbirth, and parenting. This can often include addressing issues around the woman's own experience of being parented when she was growing up.

Recommendations for practice-based evidence collection and further research

- There is a need for practice-based evidence that could include single case series and randomised single case series designs. This is especially important given the rarity of the condition(s) as well as the practicalities and challenges of delivering larger scale RCTs with this population.
- Evaluations of psychological interventions for women with a diagnosis of bipolar disorder, puerperal psychosis, and psychotic disorders during the perinatal period need to recruit large and diverse enough samples to report statistically meaningful subgroup analyses of women meeting criteria for specific conditions.
- Where future research studies examining the effectiveness of psychological interventions for women with bipolar disorder and psychosis are conducted, it is recommended that results are reported by each condition in addition to the main analyses that combine participants into one 'severe mental illness' group. In the existing literature, women with a range of conditions are typically grouped into an overall 'severe mental illness group' which masks the ability to examine the effectiveness of the psychological intervention for specific conditions.

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Acknowledgements

- Dr Laura Coote (Cardiff and Vale UHB)
- Dr Matthew Lewis, Co-Chair (Swansea Bay, UHB)
- Dr Sarah Douglass (Aneurin Bevan UHB and Cardiff and Vale UHB)
- Dr Cerith Waters, Chair, (Cardiff University and Cardiff and Vale UHB)
- Dr Dwynwen Myers (Betsi Cadwalder)
- Judith Cutter (Cardiff and Vale UHB)
- Prof. Ian Jones (Cardiff University)
- Dr Jessica Heron (Action for Postpartum Psychosis)
- Dr Sally Wilson (Action for Postpartum Psychosis)
- Dr Molly Tong (Cardiff and Vale UHB)
- Dr Rebecca Forde (Aneurin Bevan UHB)