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New Onset Psychosis throughout Pregnancy and Postpartum: Risk Factors and Maintenance Therapy

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1. Introduction

New-onset psychosis during pregnancy and the postpartum period is a rare but severe psychiatric emergency with potentially life-threatening consequences for the mother and infant. Postpartum psychosis (PP) is most likely to present within the first two weeks after birth and is characterized by hallucinations, delusions, insomnia, mood fluctuation, irritability, and disorganized or risky behavior (1, 2). The condition is estimated to affect 1 to 2 women per 1,000 deliveries, with higher risk among those with underlying bipolar disorders or prior episodes of PP (3). Although prevalence is highest among this population, around 40% of PP cases occur in women with no prior psychiatric history, which complicates detection and timely intervention (4). Despite the fact that PP is not its own diagnosis in the DSM-5, it is classified as a specifier for mood or psychotic disorders with “peripartum onset,” defined as symptoms emerging during pregnancy or within four weeks postpartum (5). The American College of Obstetricians and Gynecologists (ACOG) recommends universal mental health screening at least once during the perinatal period, with additional screening for mood and anxiety disorders at the postpartum visit (6). Despite its severity, there are no formal guidelines for long-term maintenance treatment of PP (1). Clinical decisions are often guided by expert opinion and extrapolated from data on bipolar disorder, rather than psychosis-specific studies. This mini review aims to examine the clinical risk factors and treatment strategies for new-onset psychosis during pregnancy and the postpartum period.

2. Discussion

PP is relatively unique in that a clear etiological event can be defined, although the specific mechanism is unclear at this time. Many potential risk factors have been identified, ranging from biological to psychosocial to peripartum complications. One plausible biological trigger for psychosis includes hormonal withdrawal, as levels of estrogen and progesterone sharply decline after birth. However, immediate post-birth administration of estrogen in a small case series demonstrated no impact in women at risk for postpartum mood disorders (1). Immune system activation may also contribute to the development of acute PP, which is supported by evidence of the co-occurrence of PP with thyroiditis and autoimmune encephalitis. Sleep deprivation is the most consistently reported finding in women with psychosis. Labor can cause initial disruption of circadian rhythm, which is further compounded upon by newborn awakenings, which may contribute to emergence of psychiatric symptoms. Also, specific genetic variants of serotonin gene receptors are potentially implicated (1). Lastly, additional biological risk factors may include PP experience with previous births and family history. Furthermore, psychosocial vulnerabilities, such as lack of partner support, low socioeconomic status, exposure to adverse childhood events, and perinatal stress have also been outlined (1, 4). In addition, peripartum complications, such as preeclampsia, emergency cesarean section, postpartum hemorrhage, and ICU admission were more frequently observed in women who developed psychosis, suggesting that physical stress on the body may be involved in PP development (7). Lastly, studies are suggesting that PP episodes may indicate an underlying bipolar disorder. For instance, 14% of women with depressive episodes during the first postpartum month were later diagnosed with bipolar disorder within 15 years, compared to only 4% whose onset was unrelated to childbirth (1). This reinforces the need for more research to better characterize both the pathophysiological evolution and the treatment of PP.

Lithium remains the most evidence-based pharmacologic option for both the acute and maintenance treatment of PP. In the largest study to date (N = 64), lithium demonstrated robust efficacy in stabilizing acute symptoms and preventing relapse in the long term (1). When initiated within 24 hours postpartum in high-risk individuals, lithium maintenance therapy reduced relapse rates from 40–60% to under 20% (8). Given that women who experience PP are at a 31% risk of recurrence in subsequent pregnancies, early intervention and sustained mood stabilization are essential (1). Additionally, adjunctive antipsychotics are frequently used during the acute phase of PP, particularly in cases involving mania and agitation. Agents such as olanzapine and quetiapine are most commonly used, though clinicians must remain mindful of teratogenic risks and the potential for transmission through breast milk (8). Lastly, electroconvulsive therapy (ECT) is an especially valuable option for severe, treatment-resistant, or life-threatening presentations of PP, including those

complicated by suicidality or catatonia. Studies have reported remission rates as high as 80–90% in small case series, noting ECT's favorable safety profile in the postpartum period (8).

3. Conclusion

This review underscores the complexity of new onset peri- and post-partum psychosis and emphasizes the importance of risk factor recognition, routine screening, and long-term follow-up. Evidence consistently shows a multifactorial etiology of PP, which may include biological predisposition, psychosocial vulnerabilities, and peripartum complications. Lithium, antipsychotics and ECT have demonstrated efficacy in the treatment of PP, however, further research and standardized clinical guidelines are essential to optimize care.

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