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Review Article

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From Blues to Breakdown: A Psychiatric Reappraisal of Postpartum Psychosis with Real-World Cases

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Abstract

Background: Postpartum psychiatric illnesses, from the ubiquitous but generally self-limited baby blues to the comparatively unusual but potentially fatal postpartum psychosis, remain under-recognized in maternal mental illness. Despite growing attention, underdiagnosis, stigma, and absence of standardized diagnostic classification remain a threat to early detection and treatment. ***Aim and Objective:*** The purpose of this research is to critically assess current literature on the etiology, risk factors, prevention, and treatment of postpartum psychiatric disorders, with two model clinical vignettes. The aim is to discuss the multifaceted etiology, pathways, and management of these disorders, and to ask: Why is postpartum psychosis yet to be officially recognized considering its disastrous outcomes? ***Methods:*** The narrative review with systematic elements consisted of 10 peer-reviewed papers of different geographical and methodological backgrounds. Two clinical cases from practice were included to provide context and enhance the scope of the evidence. Inclusion criteria were papers on postpartum blues, depression, or psychosis in women up to one year postpartum. Exclusion criteria were literature that was not in English and non-clinical outcome studies. ***Results:*** Five studies were initially synthesized, followed by Case 1, a 35-year-old woman with postpartum depression. The other five studies were examined before Case 2, a 32-year-old woman with recurrent postpartum psychosis. The common risk factors were primiparity, bipolar disorder, immune dysregulation, and psychosocial stress. Lithium and antipsychotics were always indicated for postpartum psychosis, and SSRIs and psychosocial interventions were helpful for depression. Case 1 presented early-onset depressive symptoms like refusal to eat, tearfulness, and somatic complaints on Day 3 postpartum. Case 2, with a history of a previous psychotic episode following the death of her first child, presented relapse symptoms of hallucinations and disorganized thinking following the second delivery, again on Day 3 postpartum. ***Conclusion:*** Postpartum psychiatric disorders are multifactorial, recurrent, and underdiagnosed. There is an urgent need for early screening, Diagnostic and Statistical Manual of Mental Disorders (DSM) reclassification of postpartum psychosis, and integrated maternal mental health services.

Keywords: ***Postpartum depression, baby blues, postpartum psychosis, bipolar disorder, maternal mental health, infanticide risk, lithium, immune dysregulation.***

Introduction

Childbirth, although widely recognized as a special and happy life event, is also one of the most physiologically and psychologically susceptible times in a woman's life. At this time of hormonal changes, changes in identity, sleep deprivation, and complex social interaction, many women are at risk for developing mental illness ranging from mild mood disturbance to frank psychosis. These psychiatric complications, grouped together as postpartum psychiatric disorders (PPDs), comprise three major disorders: baby blues, postpartum depression (PPD), and postpartum psychosis (PPP). The postpartum period is one of extreme biological, physical, social, and emotional change, which demands significant personal and interpersonal adjustment, particularly for first-time mothers [1].

The baby blues, seen in as many as 80% of postpartum women, usually resolve spontaneously within 10 days. Postpartum depression, however, is seen in approximately 10–20%, often requiring clinical treatment. Postpartum psychosis, although uncommon (1–2 per 1,000 deliveries), is the most dangerous, with lifetime risks of suicide, infanticide, and psychiatric complications. Alarming, although of clinical importance, PPP does not exist as a discrete diagnostic entity in the DSM-5, thereby rendering it invisible to clinical practice. Approximately 20% or more of women will have a mental disorder during pregnancy or 1 year postpartum [2].

Scientific knowledge regarding these disorders has progressed, and multifactorial etiology involves genetic predisposition, hormonal changes, immunological imbalance, and psychosocial stress. Risk amplifiers are prior history of bipolar disorder, family history of psychiatric disease, primiparity, obstetric complicating factor, and inadequate social support. However, gaps in standardization of definitions, diagnostic time intervals, and evidence-based treatment algorithms still remain. Complicating the matter even further, thyroid dysfunction is comorbid with diverse psychiatric illnesses, for example, maternal depression [3].

While many studies have reviewed the different aspects of postpartum mental illness, an integration of empirical findings with real-life experience is still lacking. This paper seeks to bridge this gap by systematically reviewing the literature and basing findings on two moving case studies. The first case illustrates early

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postpartum depression in a multiparous woman suffering from gender disappointment, and the second describes a severe recurrence of psychosis in a mother grieving a loss, with a history of psychiatric illnesses.

Collectively, these researches and accounts illuminate not only the diversity of postpartum psychiatric trajectories but also the need for improved understanding, typology, and treatment models. As the global maternal mental health crisis continues to deepen, this synthesis aims to facilitate a transition toward the early identification, tailored care, and system transformation.

Methodology

This article employs a narrative review with systematic elements, augmented by pragmatic clinical considerations exemplified by two case histories. The purpose is to integrate current knowledge on the prevalence, risk determinants, preventive measures, and therapeutic approaches to postpartum psychosis and related mood disorders, with sensitivity to culturally responsive and psychosocially directed settings.

Search Strategy

The databases utilized were PubMed, PsycINFO, Scopus, and Google Scholar, employing various combinations of the following keywords: "postpartum psychosis," "postnatal depression," "baby blues," "prevalence," "risk factors," "maternal mental health," and "treatment." Finally, 10 articles were selected for the narrative review with systematic elements based on the PRISMA 2020 guidelines (**Figure 1**).

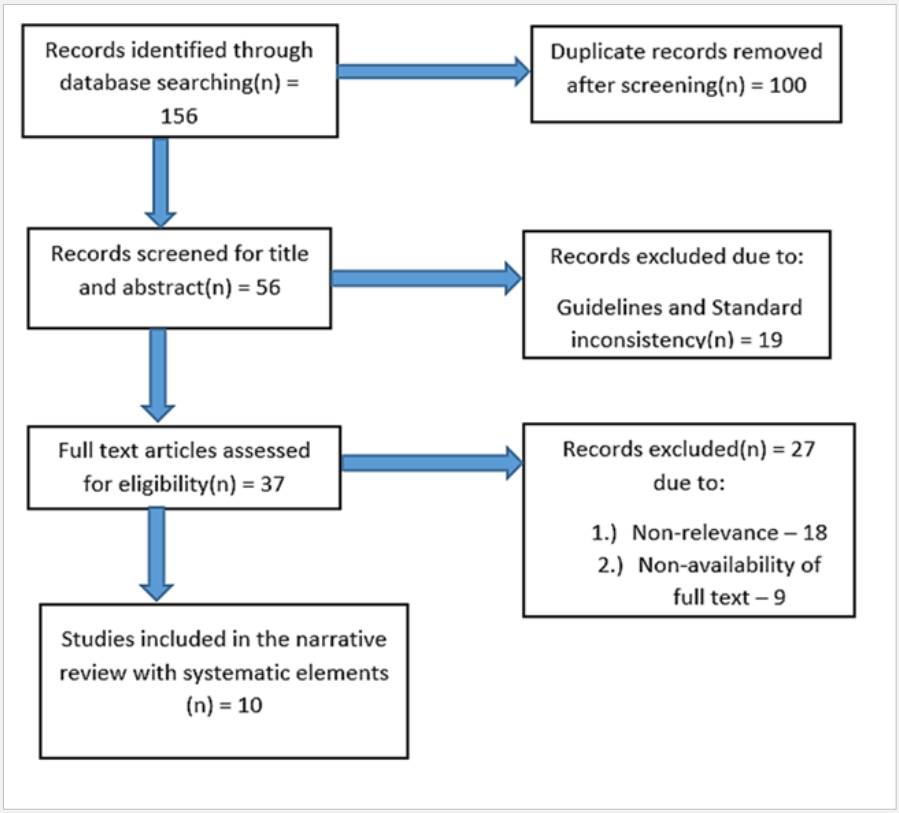

Figure 1: Flowchart for selection of studies in narrative review with systematic elements

Eligibility Criteria

Inclusion Criteria

Ten peer-reviewed articles were selected based on the following inclusion criteria:

- From 2015 to 2025
- Emphasizing psychiatric disorders in postpartum women, such as but not restricted to postpartum psychosis, depression, and blues
- Contained substantial information on prevalence data, etiological or risk factors, and treatment outcomes
- English language written

Exclusion Criteria

Exclusion criteria included:

- Non-human studies
- Conference abstracts
- Papers lacking full-text availability.

Data Extraction and Analysis

To complement the review findings, two anonymized clinical case reports were included from a tertiary care center in South India. The cases were chosen to have varied psychosocial backgrounds and the diverse timing of onset of psychotic symptoms after delivery. Informed written consent was obtained from the patients, and the cases were cleared by the institutional ethics committee.

Key data collected from the review studies were:

- Research features (author, year, location)
- Sample size and population
- Reported prevalence of postpartum psychiatric disorders
- Established risk factors (biological, psychological, social)
- Treatment modalities used (pharmacological, psychotherapeutic, community-based)

The case reports were analyzed thematically to highlight psychosocial triggers, clinical presentation, temporal patterns, and the care pathways followed. Combined with the review data, the

reports facilitated comparative and contextual observations to be derived from them.

Titles and abstracts of identified articles were independently screened by two reviewers (N.D. and G.V.) based on the inclusion and exclusion criteria. Full-text articles of potentially relevant studies were then retrieved and assessed for eligibility. Discrepancies were resolved through discussion and consensus.

The first author name (year), study deign, country of study, sample size, study characteristics and key findings were tabulated (**Table 1**).

Quality Assessment

The quality of included studies was assessed using appropriate tools relevant to their study design using the New Castle Ottawa Scale. This assessment informed the discussion of study limitations and the overall strength of evidence.

Findings

Case 1: A 35-year-old female with three daughters became severely depressed on day 3 post-delivery. Symptoms were crying, loss of appetite, somatic symptoms, and detachment. No history of psychiatric illness. Treated with SSRIs and counseling. Completely recovered in six weeks.

Case 2: A 32-year-old woman with a history of psychosis after her first child (died on day 3) relapsed with psychosis after delivery of her second child (female). Onset again on day 3. Hallucinations, delusions, disorientation. Treated with lithium and antipsychotics. Significant improvement in 10 days and remained in remission.

In Case 1, the patient began showing symptoms on Day 3 postpartum, which persisted for 5 days before pharmacological treatment with SSRIs and counseling was initiated. Symptoms gradually subsided, and she achieved full remission by the end of the sixth week. She was followed up at 3 months postpartum and remained stable with no recurrence.

In Case 2, psychotic symptoms began acutely on Day 3 and worsened over the next 48 hours. Pharmacological treatment with lithium and antipsychotics was started on Day 5 postpartum. Hallucinations and delusions began to resolve by Day 10, and she was clinically stable by the fourth week. At her 8-week follow-up, she remained in remission with continued maintenance therapy and is under monthly outpatient psychiatric review.

Results

Screening Flow

A total of 156 papers were initially identified through database searches. After removal of duplicates and title/abstract screening, 37 full-text articles were assessed for eligibility. Of these, 10 studies met the inclusion criteria. A summary of this selection process is illustrated in Figure 1 based on the PRISMA 2020 guidelines.

Narrative Review with Systematic Elements Key Findings:

- Postpartum psychosis (PPP) in 0.25–2 per 1,000 births
- Baby blues ~80%; postpartum depression (PPD) 10–20%
- Risk factors: bipolar disorder, primiparity, sleep deprivation, immune dysfunction, bereavement, trauma
- Treatment: lithium, SSRIs, antipsychotics, electroconvulsive therapy (ECT) in extreme cases
- DSM currently has no independent diagnosis for PPP (Table 2)

Figure 2 illustrates stepwise progression of postpartum psychiatric illness in Case 1 and Case 2, indicating the development of isolated risk factors—e.g., multiparity, history of psychosis, and gender disappointment—into individualized symptoms (e.g., crying, refusal to eat, and hallucinations), which in turn dictate the choosing of treatment modalities (e.g., counseling, SSRIs, or antipsychotics). This pathway-specific figure is indicative of the clinical variability and individualized nature of postpartum mental illness management.

Figure 3 is an alluvial chart illustrating the bifurcation of patient groups by psychiatric history (Yes or No), later onset of illness (Blues or Psychosis), and the treatment received (Counseling, Antipsychotics, Therapy). It supports the importance of psychiatric history as a predictor of symptom severity and pharmacotherapy, consistent with our results that recurrence of psychosis is much greater among those with a history of earlier mental illness.

Figure 4 is a Coxcomb-style plot of the relative contribution of studies included (2015–2023) in the investigation of postpartum psychosis. It illustrates that newer studies (e.g., Jairaj, Spinelli, Hazelgrove) have been concentrating more on treatment algorithms and immune markers, but the older studies (e.g., Hopkins, Brockington) established basic classifications—illustrating the increasing depth and direction of research focus. Weighted thematic analysis was conducted by assigning scores to common clinical themes (e.g., past history of bipolar disorder, immune disturbance, gendered stress) and plotting these on a Coxcomb diagram to illustrate their relative importance in psychiatric disorders of the postpartum.

Figure 5 is a word cloud summarizing the usual symptomatic presentation of postpartum psychiatric illness from case data and the literature. Dominant themes such as crying, insomnia, worry, and delusions reflect the spectrum from affective to psychotic, validating the review's emphasis on early emotional disturbance as a marker of more serious illness.

The risk factor and onset timeline overview for psychiatric disorders in postpartum patients was tabulated (Table 3)

Table 1: Summary of Included Studies - Characteristics and Key Findings

S. No	*Author (Year)*	*Study Design*	*Country*	*Study Characteristics (e.g. Mean Age, Comorbidities)*	*Sample Size*	*Key Findings*
1	Hazelgrove *et al.* [10] (2021)	Observational	UK	Elevated IL-6, hsCRP; immune dysregulation in PPP	N/A	Identified abnormal immune markers in postpartum psychosis
2	Jairaj *et al.*[17] (2023)	Algorithmic Review	India	Treatment-focused analysis of PPP cases	400+	Lithium + antipsychotics most effective; ECT for severe cases
3	Ghaedrahmati *et al.*[8] (2017)	Narrative Review	Iran	Depression risk factors: trauma, anemia, multiple births	N/A	Multidimensional risk model; baby gender disappointment relevant
4	Nguyen *et al.*[13] (2022)	Systematic Review	USA	Included obstetric complications, no psych hx	N/A	Sepsis, hemorrhage linked with PPP in previously healthy women

5	Spinelli *et al.*[19] (2021)	Commentary / Review	USA	Historical and diagnostic analysis	N/A	Advocated DSM inclusion of PPP due to infanticide risk
6	Bergink *et al.*[20] (2016)	Systematic Review	Netherlands	Genetic vulnerability + endocrine/immune link	N = 64	Lithium effective for acute/maintenance; 31% relapse after next pregnancy
7	Osborne *et al.*[11] (2018)	Clinical Guide	USA	Sleep and immune system focus	130 cases	3 PPP symptom clusters identified; highlighted early disorientation
8	Meltzer-Brody *et al.*[15] (2018)	Comprehensive Review	Multi-country	13–20% PPD prevalence; bipolar links to PPP	Large-scale	Emphasized sleep disruption and hormonal triggers
9	Hopkins *et al.*[4] (1984)	Critical Review	UK	Blues vs depression vs psychosis	N/A	Blues in 80%; psychosis rare but distinct in trajectory
10	Brockington *et al.*[6] (2004)	Editorial / Review	UK	Thyroid function and postpartum states	N/A	Advocated screening for autoimmune thyroid conditions

Table 2: Treatments, Preventive Strategies, and Analytical Summary of Merits and Gaps

S. No	*Author (Year)*	*Treatment/Prevention*	*Merits*	*Gaps/Limitations*
1	Hazelgrove *et al.*[10] (2021)	Immune marker tracking	Novel biomarkers for prediction	Small sample; lacks clinical trials
2	Jairaj *et al.*[17] (2023)	Lithium, antipsychotics, ECT	Practical treatment algorithm; India-specific	Observational; lacks global applicability
3	Ghaedrahmati *et al.*[8] (2017)	Psychosocial screening + anemia treatment	Broader framework of risk	Lacks interventional validation
4	Nguyen *et al.*[13] (2022)	Monitoring obstetric trauma	Highlights PPP in previously healthy mothers	Review only; lacks longitudinal follow-up
5	Spinelli *et al.*[19] (2021)	Diagnostic framework proposal	Advocates DSM change; draws legal attention	Lacks primary data
6	Bergink *et al.*[20] (2016)	Lithium + inpatient care	Strong relapse prevention data	Small intervention cohort
7	Osborne *et al.*[11] (2018)	Immune + sleep management	Classifies PPP subtypes; early warning system proposed	Primarily guide for OBs; lacks psychiatric outcomes data
8	Meltzer-Brody *et al.*[15] (2018)	Screening, SSRIs, bipolar detection	Integrates global prevalence with clinical action	Mixes disorders under wide "PPD" umbrella
9	Hopkins *et al.*[4] (1984)	Psychoeducation	Early theoretical classification	Pre-modern diagnostics
10	Brockington *et al.*[6] (2004)	Autoimmune screening	Links thyroid dysfunction to mood issues	Ambiguous results; no consensus

Table 3: Postpartum Psychiatric Disorders – Risk Factor & Onset Timeline Overview

Condition	**Onset Period**	**Prevalence**	**Key Risk Factors**	**Typical Duration**
Baby Blues	2–10 days postpartum	Up to 80%	Sleep deprivation, hormonal crash	Resolves within 10 days
Postpartum Depression	1–12 weeks	10–20%	History of depression, trauma, anemia, lack of support	Weeks to months
Postpartum Psychosis	3–10 days	0.25–2 per 1000	Bipolar disorder, primiparity, immune dysfunction, trauma	Weeks to months

Figure 2: Flow of Risk Factors to Symptoms and Treatment in Postpartum Psychosis

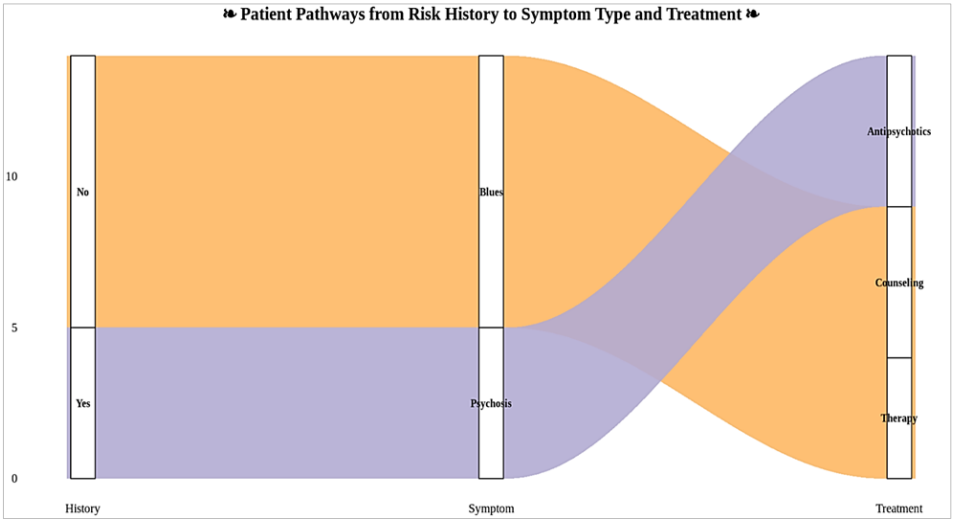

Figure 3: Alluvial plot for history, symptom and treatment

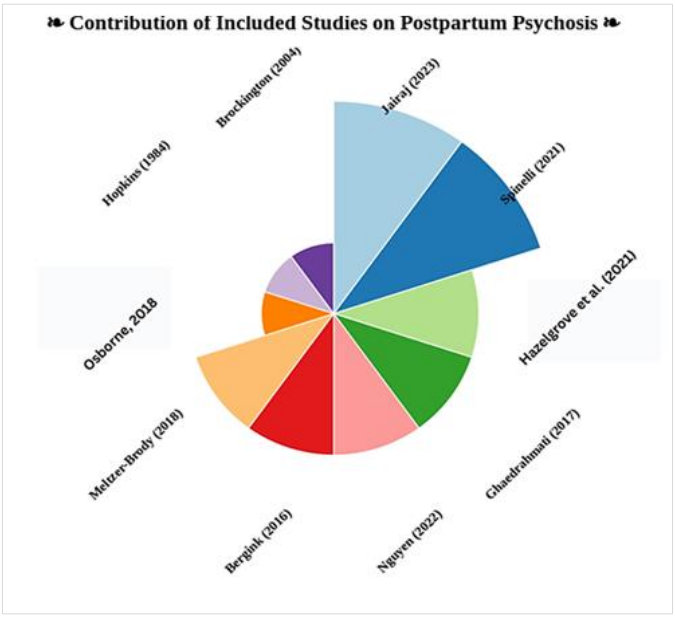

Figure 4: Coxcomb chart

Figure 5: Word cloud based on the intensity of symptoms

Discussion

Beginning with Hopkins *et al*. (1984), early studies on postpartum mental disorders grouped emotional responses into three broad categories: baby blues, depression, and psychosis [4]. This critique mentioned the high prevalence of baby blues, which may affect as many as 80% of new mothers, and highlighted differentiation-a concern that persists in contemporary practice. Early classification gives a basis for locating Case 1, who had depressive symptoms by Day 3 postpartum, within the broader context of these illnesses.

Baby blues usually occur within a few days of delivery, typically peaking on Day 5, and are characterized by mild mood fluctuations, irritability, anxiety, and tearfulness [5].

Brockington *et al*. (2004) further extended this domain with the hypothesis of an association between autoimmune thyroid dysfunction and postpartum mental illness [6]. Although this is not definitive, it is reinforced by Case 2, whose history of previous physiological distress and psychiatric relapse makes her susceptible to endocrine assessment. It implies the possible benefit of autoimmune testing in high-risk women. This study first indicated the possibility of further investigation into the possible etiological contribution of thyroid dysfunction to the causation of postpartum depression [7].

Ghaedrahmati *et al*. (2017) also put forward an integrated model of postpartum depression that encompasses biological, psychological, and social processes [8]. The significance of psychosocial context is best represented in Case 1, where the mother revealed emotional distress after giving birth to her third female child in a culturally sensitive setting. Gender disappointment, as documented within the Iranian populace, still holds good as an impelling factor. The risk factors revealed, including history of previous mental illness, marital conflict, and absence of proper social support, are present in both cases [9].

Hazelgrove *et al*. (2021) and Osborne (2018) identified immunological and circadian dysregulation as central mechanisms that underlie postpartum psychosis [10,11]. Both studies established that activation of the immune system and disturbed sleep may lead to the onset of severe psychiatric episodes. This is clear in Case 2, whose symptoms unfolded quickly and were accompanied by perceptual disturbances—characteristics characteristic of immune-mediated pathophysiology. The observation that Case 2 showed a quick psychotic relapse following bereavement evidences this concept; it is possible that sudden bereavement caused an immune-mediated process [12].

Nguyen *et al*. (2022) also highlighted the vulnerability of women without a psychiatric background to postpartum psychosis after obstetric trauma [13]. This is a point in favor of comprehensive postpartum monitoring rather than restricting evaluations to high-risk populations. While neither of the cases presented had major obstetric events, the psychological and emotional triggers were in line with Nguyen's findings on disorders with an acute onset.

Accordingly, an interdisciplinary approach involving psychiatrists, obstetricians, endocrinologists, and community health experts is required to effectively manage the complexities of postpartum mental illness. In addition, biological mechanisms like hormonal imbalance, genetic factors, and immune mechanisms play a key role in this process [14].

Meltzer-Brody *et al*. (2018) broadened the perspective and proposed that 13-20% of the cases of postpartum depression are associated with un-diagnosed bipolar spectrum disorders [15]. Case 2 demonstrates this hidden vulnerability; her psychotic attack went undetected during her initial postpartum period and resulted in a complete relapse after her subsequent delivery. This shift in perception underscores the value of systematic screening of bipolar characteristics in women with depressive symptoms in the postpartum period [16].

Jairaj *et al*. (2023) presented clinically applicable algorithms and suggested initial treatment with lithium and antipsychotics [17]. This specific protocol was applied in Case 2, leading to a state of remission within the eighth week. The effectiveness of the guidelines is best demonstrated by the success of the treatment [18].

Spinelli (2021) and Bergink *et al*. (2016) urged official inclusion in the diagnostic criteria of postpartum psychosis, citing high relapse rates and risk of suicide or infanticide [19,20]. As a result of the severe expression and typical course of Case 2, such recommendations are particularly relevant [21].

Osborne (2018) continued to note that most accounts of postpartum psychosis vary from those of common psychosis [11]. Rather than exhibiting common hallucinations, patients tend to present with disorientation and intrusive thinking, which is replicated by the strange delusional episodes presented in Case 2 [22].

Together, the studies collectively underscore that postpartum psychiatric illness is not a categorical illness but exists on a multi-dimensional continuum. The two case reports, depressive and psychotic, underscore the heterogeneity of the spectrum, risk factors, and prognosis. Early identification, culturally adapted treatment, and Diagnostic and Statistical Manual of Mental Disorders (DSM) reclassification of postpartum psychosis are the priorities of the future.

The two case studies set the context to the data-Case 1 illustrates a situational depressive response after gender disappointment, and Case 2 illustrates the recurrence of psychosis in a patient who is presenting with vulnerability with bipolar characteristics. The cases highlight the need for personalized care approaches, preparatory assessments, and evidence-based therapy measures.

Conclusion

This narrative review with systematic elements, enriched with actual clinical vignettes from practice, underscores the multidimensional nature of psychiatric illnesses following childbirth. From the relatively mild and transient baby blues to the life-threatening and severe postpartum psychosis, they all call for heightened clinical alertness and systemic adaptation. The review illustrates that psychosocial stressors, biological, immune system changes, and history of psychiatric illness all play a role in the development and course of postpartum mental illness.

Regions of growth would include formal designation of postpartum psychosis as a discrete diagnostic entity, enhanced access to perinatal mental health care, education of primary obstetric care providers, and more complete integration of psychiatric and obstetric care. Interdisciplinary collaboration, public health intervention, and large-scale research on hormonal, genetic, and immunological factors will support practice.

It's only by doing so that we can guarantee motherhood, for all women, as a time of safe passage and not silent endurance.

Strengths and Limitations

The main strength was that it integrated systematic data with practical case examples, addressed a broad spectrum of psychiatric outcomes (baby blues, depression, psychosis), and featured up-to-date data on immune, hormonal, and psychological aspects. There were some weaknesses, though. The case reports were confined to two patients and had limited generalizability. Some included studies were narrative summaries, rather than primary data. Sociocultural determinants were not systematically explored. There was no statistical meta-analysis.

Declarations

Ethical Approval

Informed consent was taken from patients in written and ethical approval from the ethics committee of our institution was granted.

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Conflicts of Interests

The authors report no conflict of interest.

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Article Category

Narrative review with systematic elements and case reports

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