

Postpartum-Onset Psychiatric Symptoms with Prolonged Functional Impairment: A Retrospective Clinical Case Report

¹Shyamaladevi. M, ²Sivasankari. M, ³Sreelekshmi. S. J, ⁴S.Rajeswari

¹ Assistant professor, Department of Mental Health Nursing, Pauls College of Nursing, Tamil Nadu, India.

² Professor, Department of Child Health Nursing, Pauls college of nursing, Tamil Nadu, India.

³ Nursing Tutor, Department of Mental Health Nursing, Pauls College of Nursing, Tamil Nadu, India.

⁴ Nursing Tutor, Department of Medical Surgical Nursing, Pauls College of Nursing, Tamil Nadu, India.

DOI: [https://doi.org/10.63001/tbs.2026.v21.i04.S.I\(4\).pp652-660](https://doi.org/10.63001/tbs.2026.v21.i04.S.I(4).pp652-660)

KEYWORDS

*postpartum psychosis;
puerperal psychiatric illness;
maternal mental health;
case report;
psychiatric rehabilitation*

Article Info

Received: 26.09.2026

Accepted: 04.10.2026

Published: 24.10.2026

Abstract

Background: Postpartum psychosis is an uncommon but potentially life-threatening psychiatric emergency characterized by acute severe mood, behavioral, cognitive, and/or psychotic disturbances after childbirth. Accurate diagnosis requires attention to symptom onset, phenomenology, medical mimics, and the longitudinal course.

Case presentation: A married adult woman, described as approximately 25 years old in a handwritten nursing presentation, was evaluated in a psychiatric rehabilitation setting for irritability, anxiety, disturbed thinking, reduced self-care, affective changes, and difficulty with infant care. Her family associated behavioral change with the postpartum period. Notes describe disturbed sleep, changes in mood, impaired social and occupational functioning, and a period of hospital-based psychiatric treatment. The educational record labels the condition postpartum psychosis, but the documented clinical chronology is internally inconsistent and does not establish a discrete, abrupt psychotic episode. The mental-status examination describes delayed, low-volume speech, restricted affect, impaired judgment and insight, and disorganized thought; hallucinations and fixed delusions were not elicited in the examination recorded. Antipsychotic medication and psychosocial/nursing interventions are described, with nonspecific improvement reported; independently verified outcome measures and long-term follow-up are unavailable.

Conclusion: This historical case illustrates the diagnostic and functional complexities of postpartum-onset psychiatric illness, including the limitations of retrospective nursing documentation. It emphasizes comprehensive medical and psychiatric evaluation, urgent safety assessment when postpartum psychosis is suspected, family engagement, and carefully documented longitudinal follow-up.

Introduction

Postpartum psychosis (PPP) is a severe psychiatric syndrome, usually emerging abruptly within days or weeks after delivery, and requires urgent psychiatric assessment because of potential risk to the mother and infant. It encompasses disturbances in mood, thought, sleep, behaviour and perception. The following five published studies establish the epidemiological,

phenomenological and diagnostic context of the present case.

Nager et al. (2005) examined 502,767 Swedish first-time mothers in a population-based cohort and assessed factors associated with hospital admission for postpartum psychosis. Older maternal age and single motherhood were associated with higher admission risk, whereas educational level was not. Their findings show

that social and demographic factors may influence presentation to services but cannot establish an individual diagnosis [1].

Bergink et al. (2011) prospectively characterized 51 women admitted with first-onset postpartum psychosis and compared them with 6,969 population controls. This study demonstrated the value of systematically documenting symptom onset and clinical features during the immediate puerperal period rather than relying solely on a retrospective diagnostic label [2].

Munk-Olsen et al. (2012) used Danish register data to examine whether psychiatric episodes beginning after childbirth predicted subsequent bipolar disorder. Their work supported the clinical importance of evaluating bipolar-spectrum illness when assessing severe psychiatric symptoms associated with delivery [3].

Wesseloo et al. (2016) synthesized 37 articles covering 5,700 deliveries in 4,023 women with bipolar disorder and/or postpartum psychosis. The pooled risk of postpartum relapse was 35% (95% confidence interval, 29%–41%), underlining the importance of past episodes, risk assessment and prospective treatment planning [4].

Kamperman et al. (2017) prospectively assessed 130 inpatients with postpartum psychosis and identified manic, depressive and atypical symptom profiles (34%, 41% and 25%, respectively). Irritability, abnormal thought content and anxiety were frequent, emphasizing that postpartum psychosis can be clinically

heterogeneous and that depressed or atypical presentations may be overlooked [5].

The present report examines a single historical nursing case record labeled postpartum psychosis. Its aim is to describe the recorded course, signs, function and interventions and to distinguish observed findings from diagnostic claims that cannot be independently confirmed from the available notes.

Case Presentation

Patient information and clinical context

The source describes a married woman, approximately 25 years old (age transcription requires confirmation), with one daughter, who received care in a psychiatric setting in Tamil Nadu, India. Identifying names, telephone numbers, exact addresses, and institution-specific admission details have been removed from this manuscript. The record lists schooling completed up to approximately the eighth standard and prior domestic/household responsibilities. The woman lived within a family setting and relatives contributed information about her symptoms. Her obstetric record describes one full-term pregnancy and a liveborn infant; delivery is described as normal without recorded intrapartum complications. The precise obstetric and neonatal documentation is unavailable.

The handwritten narrative describes symptoms attributed by relatives to the period after delivery, with irritability, anger, reduced emotional responsiveness, altered thinking, impaired ability

to care for herself, and difficulty providing infant care. Anxiety was described for about three months, emotional changes and disorganized thinking for about eight months, and impaired self-care for approximately two months. In another section the presenting problem was described as having persisted for two years. These durations appear to have been recorded at different stages and cannot be reconciled to an exact timeline.

Previous psychiatric and medical history

A previous psychiatric admission/treatment is mentioned, and the source labels the earlier illness postpartum psychosis. The historical account indicates referral or transfer for psychiatric management, improvement during treatment, and a subsequent rehabilitation phase. Prior medication names and durations are partly illegible. The record notes no reported alcohol, tobacco, or other substance use and no clearly documented chronic medical disorder. A complete systematic medical history, previous mood episodes, and a reliable family psychiatric history are not available. Childhood school avoidance and interpersonal difficulties are mentioned, but their relation to the index illness is uncertain.

Course of illness and symptom profile

Relatives reported irritability and angry outbursts around the time of pregnancy and following delivery. The source describes disturbed sleep, episodes of crying, difficulties in social interaction and self-care, changes in speech,

disorganized thought, and difficulties with infant feeding or caregiving. One portion describes the patient holding or handling the infant in ways perceived as concerning by relatives; the details are insufficient to characterize intent or injury, and no such conclusion is inferred. The time between childbirth and the first symptoms is inconsistently recorded: sections mention late pregnancy, the immediate postpartum period, and several months after childbirth. Therefore, exact timing cannot be established.

Clinical examination

The handwritten physical examination lists consciousness and orientation as present in one section, while other sections characterize the patient as lethargic. Height is noted as approximately 158 cm and weight approximately 60 kg. One set of observations records a temperature of 98°F, pulse around 74 beats/min, respiration approximately 20/min, and blood pressure around 100/70 mmHg, but these measurements were not independently corroborated. Head, neck, cardiovascular, respiratory, gastrointestinal and cranial nerve descriptions are largely nonfocal. A neurologic section records impaired tandem walking, abnormal reflex descriptions and reduced muscular strength, without adequate corroborating details or an established neurologic diagnosis. These findings are not used to draw neurological conclusions.

Mental-status examination

Appearance and behavior were described as disheveled, with reduced self-care, limited eye contact, and decreased psychomotor activity. Speech was described as slow and delayed, with reduced rate or volume. Mood was reported as irritable, and affect was noted as restricted or inappropriate in parts of the record. Thought processes were characterized as poorly organized, with reduced continuity and associated confusion. The examination explicitly records no hallucinations and no established delusions at the time of that assessment. Orientation appears preserved in several bedside responses, although attention, abstraction, memory, judgment, and insight were variably impaired. A low level of insight and compromised personal or social

judgment were noted. These are qualitative impressions without a standardized psychosis or mania severity score.

Recorded assessments

An Edinburgh Postnatal Depression Scale (EPDS) form and an Indian Disability Evaluation and Assessment Scale (IDEAS) form are included in the source. The EPDS score is not reliably recoverable as a validated total, and neither scoring date nor relation to childbirth is sufficiently reliable to support quantitative interpretation. The IDEAS form appears to denote moderate disability in at least one field, but item-level scores and total calculations are inadequately documented. Neither instrument alone diagnoses postpartum psychosis. Consequently, no numeric scale result is reported as a verified outcome.

Timeline

Approximate period	Documented event	Evidence qualification
Pregnancy / around childbirth	Family reported irritability and behavioral change; one full-term delivery documented	Exact symptom onset and delivery date unverified
Postpartum period	Mood change, disorganized behavior, disrupted sleep and impaired infant/self-care described	Historical account; durations inconsistent
Psychiatric presentation / admission	Psychiatric evaluation and treatment described; postpartum psychosis label used	Original physician assessment and admission record unavailable
Treatment period	Antipsychotic medication and	Dose, duration, sequencing and

	psychosocial support documented	adherence incompletely legible
Rehabilitation / nursing observation	Structured nursing care, activity, counseling and family involvement recorded	No validated repeated outcome scales
Later follow-up	Improvement asserted in notebook narrative	Date, remission criteria and relapse status unavailable

Diagnostic Assessment

The teaching record assigns the diagnosis “postpartum psychosis,” but the evidence available for an independent diagnosis is incomplete. A postpartum association is documented, together with affective symptoms, confusion/disorganized thinking and serious functional impairment. However, the record lacks reliable evidence of a clearly defined onset within days or weeks of birth, a contemporaneous psychotic symptom inventory, a documented mood-episode diagnosis, and exclusion of medical etiologies. Hallucinations and delusions were denied or not elicited during the recorded mental-status assessment; this does not rule out earlier psychotic symptoms, but their existence cannot be presumed.

The differential diagnosis includes (1) a bipolar-spectrum mood episode with psychotic features beginning in the postpartum period; (2) major depressive episode with psychotic features; (3) a primary psychotic disorder with onset or exacerbation after childbirth; (4) severe postpartum depression or anxiety with behavioral disturbance; and (5) organic psychiatric

syndromes, including thyroid disease, metabolic disturbance, neurologic conditions, medication effects or delirium. The record does not provide thyroid function, complete blood count, chemistry, toxicology, infection assessment, neuroimaging, or other targeted results. No laboratory value is invented. On available evidence, the most defensible wording is “historically diagnosed postpartum psychosis with persistent postpartum-associated psychiatric and functional symptoms,” pending independent clinical verification [1–4].

Therapeutic Interventions

The source contains references to antipsychotic pharmacotherapy. A later medication list appears to name risperidone and olanzapine, with a further drug name difficult to decipher; the handwriting does not permit confident reconstruction of dosing and scheduling. Some portions of the record list earlier psychiatric medications in uncertain spelling. The manuscript therefore does not attribute recovery to a particular dose, medication sequence, or combination. Exact prescriptions

should be obtained from the medication administration record before journal submission.

A nursing intervention table describes work directed at disorganized thought, anxiety, communication difficulties, impaired personal care, social isolation, and injury prevention. Measures included providing a calm environment, brief and clear communication, supportive interpersonal contact, assessment of cognition and risk, support with daily activities and hygiene, occupational or play activities, exercise, counseling, family participation, and psychoeducation. Daily nursing logs describe such activities across five observation days. Entries predominantly document that an intervention was “done” or “provided”; they do not constitute rigorous evidence of symptom resolution.

The handwritten record also describes psychotherapeutic and rehabilitation interventions and mentions follow-up, but does not provide a sufficiently reproducible protocol, number of formal sessions, or independently assessable response. There is no documented administration of lithium or electroconvulsive therapy to this patient in the accessible source. Their discussion below concerns published management evidence, not treatments established in this case.

Follow-up and Outcomes

The narrative states that the patient improved following psychiatric care, including reductions in some behavioral disturbances and improved participation in care. Nevertheless, it does not

identify the date of improvement, discharge mental state, standardized functional change, relapse, medication adverse effects, long-term infant/maternal outcomes, or the duration of monitoring. It also does not independently establish complete remission. Accordingly, the outcome is reported conservatively as “narratively described partial or clinical improvement of uncertain magnitude and durability.”

Discussion

This case describes a young mother with family-reported postpartum behavioural change, irritability, anxiety, reduced emotional responsiveness, disorganized thinking and impaired self-care. A previous psychiatric hospitalization and a recorded diagnosis of postpartum psychosis were documented, but the chronology and phenomenology needed to establish a discrete postpartum psychotic episode remain incomplete. The following five additional publications are compared separately with the case.

Bergink et al. (2015) evaluated a structured stepwise treatment approach for psychosis and mania in the postpartum period. Their work supports the importance of acute specialist care and carefully monitored pharmacotherapy. In the present record, antipsychotic medicines and rehabilitation interventions were noted, but the doses, treatment sequence and standardized response measures cannot be securely reconstructed. Therefore, treatment effectiveness cannot be attributed to a particular drug [6].

Bergink et al. (2012) studied prophylaxis in women at high risk of postpartum mania or psychosis and highlighted that prevention planning differs according to whether illness is limited to the postpartum period or occurs as part of an established bipolar disorder. The present chart references an earlier postpartum psychiatric episode, but lacks reliable documentation of prophylactic planning, making an individualized relapse-risk estimate impossible [7].

Rommel et al. (2021) prospectively followed 106 women with first-onset postpartum psychosis for four years. Thirty-four (32.1%) had episodes outside the postpartum period, while 72 (67.9%) did not. This finding is relevant because the current record describes symptoms over an extended period without sufficient long-term follow-up to distinguish persistent illness, recurrence, or a later mood-spectrum disorder [8].

Gilden et al. (2020) systematically reviewed long-term outcomes after postpartum psychosis and found that subsequent psychiatric illness can occur beyond the initial postpartum episode. This reinforces the need to report the duration of follow-up and any non-postpartum episodes. The original nursing notes contain qualitative improvement statements but no documented prospective relapse surveillance [9].

Jairaj et al. (2023) presented an evidence-informed treatment algorithm recommending urgent inpatient management, antipsychotic treatment, consideration of lithium for acute response and relapse prevention, and

electroconvulsive therapy in selected severe cases. Psychosocial care and psychoeducation were also emphasized. The source notebook records supportive counselling, structured activities, family involvement and nursing care, but contains no reliable proof that lithium or electroconvulsive therapy was administered [10].

Case interpretation and differential diagnosis. The reported affective instability, confusion, sleep difficulties and impaired maternal functioning are consistent with serious postpartum-associated psychiatric illness, but they are not pathognomonic of postpartum psychosis. A postpartum bipolar-spectrum episode, severe depressive episode with psychotic features, primary psychotic disorder, delirium and medical or substance-related conditions must be differentiated by a treating psychiatrist. The mental-status examination recorded no hallucinations or fixed delusions at one assessment; this does not exclude their occurrence earlier. Because laboratory testing, medical exclusions and precise symptom onset are absent, the recorded diagnosis should be treated as historical rather than independently verified.

Strengths and limitations. Detailed nursing observations, family history, mental-status descriptions, functional assessment forms and a five-day intervention log offer a useful view of psychiatric rehabilitation. Major limitations are uncertain age/transcription, inconsistent psychiatric findings, unclear timing after childbirth, absent original diagnostic documentation, unreliably readable prescriptions,

incomplete EPDS/IDEAS scoring, no quantitative treatment endpoint, and no verified longitudinal follow-up. This is an individual case report, not evidence of treatment efficacy or population risk.

Conclusion

This historical clinical record describes substantial postpartum-associated psychiatric symptoms and functional impairment in a young mother previously labeled as having postpartum psychosis. While its history is clinically concerning, available documentation is inadequate to confirm the precise syndrome, episode onset, medication regimen, or remission. The case emphasizes structured perinatal psychiatric history-taking, exclusion of medical causes, safety assessment, multidisciplinary treatment and transparent longitudinal reporting.

Patient Perspective

The available clinical documentation did not contain a voluntary first-person account of the patient's experience. Therefore, no patient quotation or reconstructed patient perspective is presented. A direct patient perspective may be added only if it is obtained voluntarily from the patient and approved for publication.

Ethics and Consent for Publication

This manuscript was drafted from an existing handwritten clinical teaching record; no new intervention or patient contact was undertaken for manuscript preparation. Personal identifiers were

omitted from this draft. The source record does not document written informed consent for publication or an institutional ethics determination. Before submission, the authors must obtain and document patient consent (or the journal-permitted alternative, if applicable) and obtain an institutional determination regarding ethics review. Until then, publication consent and ethics approval cannot be reported as granted.

References

1. Nager A, Johansson LM, Sundquist K. Are sociodemographic factors and year of delivery associated with hospital admission for postpartum psychosis? A study of 500,000 first-time mothers. *Acta Psychiatr Scand.* 2005;112(1):47–53. doi:10.1111/j.1600-0447.2005.00525.x.
2. Bergink V, Lambregtse-van den Berg MP, Koorengevel KM, Kupka R, Kushner SA. First-onset psychosis occurring in the postpartum period: a prospective cohort study. *J Clin Psychiatry.* 2011;72(11):1531–1537. doi:10.4088/JCP.10m06648.
3. Munk-Olsen T, Laursen TM, Meltzer-Brody S, Mortensen PB, Jones I. Psychiatric disorders with postpartum onset: possible early manifestations of bipolar affective disorders. *Arch Gen Psychiatry.* 2012;69(4):428–434. doi:10.1001/archgenpsychiatry.2011.157.
4. Wesseloo R, Kamperman AM, Munk-Olsen T, Pop VJ, Kushner SA, Bergink V. Risk of postpartum relapse in bipolar disorder and postpartum psychosis: a systematic review and

- meta-analysis. *Am J Psychiatry*. 2023;37(10):960–970.
doi:10.1177/02698811231181573.
- 2016;173(2):117–127.
doi:10.1176/appi.ajp.2015.15010124.
5. Kamperman AM, Veldman-Hoek MJ, Wesseloo R, Robertson Blackmore E, Bergink V. Phenotypical characteristics of postpartum psychosis: a clinical cohort study. *Bipolar Disord*. 2017;19(6):450–457. doi:10.1111/bdi.12523.
6. Bergink V, Burgerhout KM, Koorengevel KM, et al. Treatment of psychosis and mania in the postpartum period. *Am J Psychiatry*. 2015;172(2):115–123.
doi:10.1176/appi.ajp.2014.13121652.
7. Bergink V, Bouvy PF, Vervoort JSP, Koorengevel KM, Steegers EAP, Kushner SA. Prevention of postpartum psychosis and mania in women at high risk. *Am J Psychiatry*. 2012;169(6):609–615.
doi:10.1176/appi.ajp.2012.11071047.
8. Rommel AS, Molenaar NM, Gilden J, et al. Long-term outcome of postpartum psychosis: a prospective clinical cohort study in 106 women. *Int J Bipolar Disord*. 2021;9:31.
doi:10.1186/s40345-021-00236-2.
9. Gilden J, Kamperman AM, Munk-Olsen T, Hoogendijk WJG, Kushner SA, Bergink V. Long-term outcomes of postpartum psychosis: a systematic review and meta-analysis. *J Clin Psychiatry*. 2020;81(2).
doi:10.4088/JCP.19r12906.
10. Jairaj C, Seneviratne G, Bergink V, Sommer IE, Dazzan P. Postpartum psychosis: a proposed treatment algorithm. *J Psychopharmacol*. 2023;37(10):960–970.
doi:10.1177/02698811231181573.
11. Gagnier JJ, Kienle G, Altman DG, Moher D, Sox H, Riley DS, CARE Group. The CARE guidelines: consensus-based clinical case reporting guideline development. *Glob Adv Health Med*. 2013;2(5):38–43.
doi:10.7453/gahmj.2013.008.