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Tatsuhiko Naito  
*Touro College*

Justin Chin  
*Touro College*

Jun Lin  
*Touro College*

Pritesh J Shah

Christine M. Lomiguen  
*Touro College of Osteopathic Medicine (New York)*, christine.lomiguen@touro.edu

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Postpartum psychosis in a non-native language–speaking patient: A perspective on language barriers and cultural competency

Tatsuhiko Naito, Justin Chin, Jun Lin, Pritesh J Shah, Christine M Lomiguen

SUMMARY
Postpartum psychosis is a condition characterised by rapid onset of psychotic symptoms several weeks after childbirth. Outside of its timing and descriptions of psychotic features, minimal research exists due to its relative rarity (1 to 2 per 1000 births in the USA), with greater emphasis on postpartum sadness and depression. With the existing literature, cultural differences and language barriers previously have not been taken into consideration as there are no documented cases of postpartum psychosis in a non–English-speaking patient. Correctly differentiating postpartum psychosis from other postpartum psychiatric disorders requires adeptly evaluating for the presence of psychotic symptoms with in-depth history taking. Here, we present a case of postpartum psychosis in a Japanese-speaking only patient, with an associated clinical course and culturally appropriate approach to treatment. A review of postpartum psychosis and language/cultural considerations are also discussed, with attention on the Japanese concept of ‘Satogaeri bunben’.

INTRODUCTION
Postpartum psychosis (PP) is a condition characterised by rapid onset of psychotic symptoms several weeks after childbirth. It is a psychiatric emergency that requires immediate detection and intervention due to the gravity of its consequences, ranging from suicide to infanticide.1 Hence, better understanding of risk factors is paramount in facilitating timely response and early intervention. Risk factors associated with PP; however, are poorly understood due to its relative rarity (1–2 out of 1000 childbearing women).1,2 While multiple studies have elucidated several epidemiological risk factors, including, but not limited to, history of bipolar disorder and primiparity, very little research explores sociodemographics, such as ethnicity or cultural practices, let alone one particular population.1-3 With no reports regarding PP among Japanese women in the USA, the aim of this case report is to present potential risk factors and management challenges unique to the population.

CASE PRESENTATION
Ms. K is a 35-year-old Japanese woman with a medical history of hypothyroidism brought to the emergency department (ED) after she attempted to stab herself with a knife. Her husband was able to interfere before the act was completed. In the ED, she presented with a depressed mood and expressed suicidal thoughts. One week prior to the incident, she had an uncomplicated vaginal birth to a baby boy at the same hospital and had no prenatal health issues. Several days after her discharge, she experienced multiple episodes of diaphoresis and became disoriented to time and place, which led to her current presentation. Of note, Ms. K had been living in the USA for only 5 months and spoke very limited English; her husband contributed the majority of the history.

Initial physical examination showed an alert, adequately nourished, anxious woman. Vital signs were within normal limits, except for an elevated blood pressure of 159/91. Head and neck, cardiovascular, respiratory, gastrointestinal, neurological and dermatological examinations were benign. During mental status examination, her affect was incongruent to her mood in which she would be smiling and cheerful, despite stating that she was anxious and sad. Her mood was labile, ranging from calm cooperation to extreme agitation. She was oriented to person, place, and time. She was cooperative and communicated using the only English she knew. Her grandiosity and positive delusions were benign. She thought the baby would die and expressed hopelessness about her future. She had an extensive history of hypothyroidism, with no evidence of psychosis.

Ms. K was limited in her ability to express herself efficiently, and her communication was hindered by her language barriers. Her insight was impaired, and she denied suicidal or homicidal ideation, although her husband noted her verbal communications were at times erratic. Her judgment was intact, and she cooperated during the examination. Ms. K had no prior history of mental illness.

Ms. K was admitted to a psychiatric hospital and was treated with antipsychotic medication. Her psychotic symptoms resolved over several weeks, with a marked improvement in her insight and capability to communicate. Her husband and family provided significant support during this time. Her mental status examination returned to baseline with no residual symptoms of PP.

DISCUSSION
Postpartum psychosis is a rare condition that is often underdiagnosed and undertreated due to its relative rarity and clinical presentation that may mimic depression or anxiety. The diagnosis of PP is typically made after the exclusion of other psychiatric conditions, such as depression and anxiety. Language barriers and cultural differences can complicate the diagnosis and treatment of PP, as seen in this case. The case report highlights the importance of considering cultural and linguistic factors in the diagnosis and treatment of PP.

In conclusion, postpartum psychosis is a condition that requires timely recognition and appropriate intervention to prevent serious harm to the mother and baby. Language barriers and cultural differences can complicate the diagnosis and treatment of PP. Further research is needed to better understand the epidemiology and management of PP in non–English-speaking populations.

References
PP is relatively a rare disorder that most commonly presents within the first 2–4 weeks after delivery, but can emerge as early as 2–3 days after childbirth. Rapid mood fluctuation is considered the hallmark; however, the rapid onset of paranoia, grandiosity, bizarre delusions, confused thinking and grossly disorganised behaviour may also be present. Insomnia, anxiety or depressed mood have been reported as early warning symptoms prior to PP. PP is a unique disease in that its trigger is definable: childbirth. Exact pathophysiology of the disease; however, has yet to be determined, with several theories ranging from hormonal change to immune dysregulation and circadian rhythm disruption. In this particular case, the patient’s history of hypothyroidism and levothyroxine use during pregnancy gives credence to an autoimmune aetiology to her PP, with literature demonstrating a strong association between PP and autoimmune thyroiditis/thyroid dysfunction.

Understanding of risk factors would facilitate timely and appropriate response from health professionals via heightened awareness and proper preventive measures such as lithium prophylaxis. These risk factors related to PP; however, are still poorly understood and rarely studied.

PP is a clinical diagnosis. The DSM-5 does not recognise PP as a distinct condition; rather, it adds a “with a postpartum onset” specifier if a woman met criteria for a brief psychotic disorder during or within 4 weeks post partum. Due to its similar presentation, bipolar disorder is an important differential diagnosis that must be considered, especially with prior history. Other psychiatric conditions that must be included, but are not limited to, are generalised anxiety disorder, obsessive compulsive disorder and postpartum depression, as well as organic causes of psychosis such as infection, recreational drugs and electrolyte disturbances to name a few. Notwithstanding the classification in DSM-5, PP is a psychiatric emergency that requires urgent evaluation, psychiatric referral and inpatient hospitalisation due to the gravity of consequences, such as suicide, infanticide, impaired mother–infant bonding, infant abuse and neglect. While the overall prognosis is positive for women who have sought help, screening protocols or treatment guidelines have yet to be established. Atypical antipsychotics, mood stabilisers and antiepileptics are common drugs of choice along with electroconvulsive therapy; however, there is a paucity of evidence to support their efficacy due to the difficulty of randomised trials.

In examining Ms. K, she represented several potential risk factors of PP that are unique to her experience as a non–English-speaking Japanese immigrant, which warrants further discussion. With consideration of the sociodemographic factors of her situation—her husband working long hours, being separated from her family and friends, inability to speak English and unfamiliarity with her new environment—it was evident that the patient severely lacked proper support in the perinatal period. Lack of social support has been strongly
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CONCLUSION

Japanese-born women living in the USA face unique circumstances that render them more vulnerable to PP and make its management more challenging. While greater research is needed to substantiate some of these potential risk factors, it has several implications. Once established, the vulnerable population can be educated of the risk factors at the community level so they can consciously engage in non-medical protective measures, such as Satogaeri bunben or more active attempts to build supportive groups. It would also lead to better detection of early signs of PP by family members which would greatly decrease the likelihood of consequences via early professional intervention. Cultural competency and awareness are needed for physicians and healthcare professionals who work with immigrant/non-native communities. Finally, this case is a stark reminder that different cultures can be predisposed to certain psychiatric disorders in unique ways such that research and management plans must be catered accordingly.

REFERENCES


Unique to this case is the Japanese custom of Satogaeri bunben, which describes the practice of the new mother returning to her parental home for up to 8–12 weeks peripartum of the delivery date (figure 1). During this time, the baby’s maternal grandparents provide a crucial social support in helping with daily needs, physician appointments and childcare after birth. Although there has been no empirical research in analysing a direct association between Satogaeri bunben and PP, several studies have demonstrated that the practice is associated with a significantly lower Maternity Blue Scale for postpartum depression as well as a protective factor against postpartum depression (SI 3 4).

Figure 1 Infographic for ‘Satogaeri bunben’ in describing its definition, rationale and associated research.
Tatsuhiko Naito is a third-year medical student at Touro College of Medicine in New York. Originally from Japan, he completed his undergraduate degree at Johns Hopkins University as a double major in Biology and Psychology. Subsequently he received his master degree in Medical Science from Boston University School of Medicine. During his undergraduate medical education career, he has served as the chapter president of the psychiatry interest group and student representative for his school’s wellness committee. His psychiatry research interests range broadly from the utility of mindfulness to the application of culturally sensitive practices in medicine.