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Comprehensive Treatment of Women with Postpartum Psychosis across Health Care Systems from Swedish Psychiatrists' Perspectives

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Studies concerning the psychiatrist's experiences of treating women with postpartum psychosis (PPP) or how they react to these women are limited in the literature. In this study a qualitative design is used. Data collection includes semi-structured interviews with nine Swedish psychiatrists working in psychiatric hospitals. The audio-taped interviews are transcribed verbatim and analyzed using content analysis. The findings consist of the categories: Protection, Treatment, Care, and Reactions. The psychiatrists describe emotions such as compassion, empathy and distress. A conclusion is that the psychiatrists focus on protecting the women from suicide and/or infanticide. Given the degree of stress the psychiatrists can experience caring for high risk challenging patients, health care organizations need to provide support and/or opportunities for peer supervision. Key Words: Psychiatrists, Postpartum Psychosis, Puerperal Psychosis, and Content Analysis

The puerperium has been associated with an increased risk of developing psychiatric disorders with the most serious being psychosis (Brockington, 2004; Kendell, Chalmers, & Platz, 1987; Terp & Mortensen, 1998; WHO, 1992). The focus of this study is to explore psychiatrists' experiences treating women with postpartum psychosis (PPP).

Psychiatrists who treat women with PPP face a number of challenges as they determine the best treatment in a given situation. Since PPP is a rare condition, most psychiatrists do not regularly treat this high risk population, they must balance between respecting their own decisions and consultations they obtain from colleagues in trying to determine the best plan of care (Seeman, 2004). One must believe this is a situation that is challenging for the psychiatrists who care for and treat a woman with PPP. Therefore the research question, how do psychiatrists experience providing care and treatment for women with PPP, is explored in this study.

It has been estimated that one to two in 1,000 newly delivered mothers will need hospitalization for PPP (Kendell et al., 1987; Noorlander, Bergink, & van den Berg, 2008; Terp & Mortensen, 1998). Postpartum psychosis is a very serious illness with a 4% risk of infanticide and 5% risk for suicide (Comtois, Schiff, & Grossman, 2008; Knops, 1993). The onset of PPP occurs within four weeks after delivery (APA, 2000) and usually begins with one or two sleepless nights. The woman may experience tearfulness, confusion, suspiciousness, and obsessions. Often the woman denies the birth, has delusions about the baby and/or thoughts of killing her baby (Friedman, Sorrentino, Stankowski, Holden, & Resnick, 2008; Heron, McGuiness, Robertson Blackmore, Craddock, & Jones, 2008; Koenen & Thompson, 2008). These acute symptoms warrant hospitalization on a psychiatric unit and close observation. Early detection, treatment, and intervention are crucial. Treatment should consist of antipsychotics, anxiolytics, and/or Electro Convulsive Therapy (ECT) depending on the clinical presentation (Boritz Wintz, 1999; Forray & Ostroff, 2007; Menon, 2008; Sharma, 2008). Although Lithium treatment is usually considered incompatible with breastfeeding, recent research has provided evidence to the contrary (Moretti, Koren, Verjee, & Ito, 2003; Viguera, Newport, Ritchie, Stowe, Whitfield, Mogielnicki, et al., 2007). Postpartum psychosis has a favorable prognosis with most women recovering in two to six weeks. However, some women will develop a psychiatric illness for a long period of time (Robertson Blackmore, Craddock, Walters, & Jones, 2008).

When a woman refuses hospitalization, involuntary commitment is often necessary due to the severity of the illness. Involuntary commitment of psychiatric patients is accepted worldwide as a needed measure in order to treat very ill psychotic patients who resist treatment. The Law of Compulsory Psychiatric Care Act in Sweden (The act, 1991:1128/2008:415) provides for compulsory care but only if the patient is suffering from a severe mental disorder and if the person's mental status requires psychiatric treatment which can not be met in a least restrictive environment. Patients who require involuntary commitment must be a danger to themselves or others. A patient who is detained under this Act may be strapped for a short-period of time with a belt or similar device, and/or isolated from other patients. Treatment should be provided in co-operation with the patient and family as much as is possible (The act, 1991:1128/2008:415).

Psychiatrists are experts and acquire their expert position through knowledge, clinical practice, personal skills and technical information (Razzouk, Mari, Shirakawa, Wainer, & Sigulem, 2006). According to Norman (2005) an expert has superior knowledge, formal and informal that is used in determining the solution to a particular problem as well as the ability to organize knowledge. Physicians' experiences related to treating patients and making medical decisions have been studied from the perspective of the 'difficult patient' from which the physicians sought innovative and creative ways to cope with their encounters (Steinmetz & Tabenkin, 2001). Experiences dealing with suicidal patients have been described as professionally challenging when striving for relatedness, intervening competently, and being emotionally involved (Sorensen-Hoifodt & Talseth, 2006). Accordingly, women with PPP are a high risk group of patients as the onset of the disease appears rapid and infanticide as well as suicide frequently occurs. Prevalence of PPP is as mentioned above fortunately quite low. That in turn gives the psychiatrists rare opportunities to develop experience-based knowledge related to PPP.

It is therefore important to present knowledge related to treating women with PPP to the public. However, no studies focusing on the psychiatrist's experiences related to treating women with PPP are found. Therefore the aim of the study is to describe the psychiatrists' experiences treating women with this severe psychiatric disorder.

Methods

Since little is known about psychiatrists' experiences with treating women diagnosed with PPP, a qualitative design is selected for this study. This design, which is developed by all the authors, makes it possible to obtain knowledge about the meaning people give to actions, processes, and beliefs in natural milieus. The inquiry takes into consideration their experiences, purposes, points-of-views, relationships, and values and thereby requires a holistic approach. A qualitative method can address many facets in relation to possibilities of interpretation (Crabtree & Miller, 1992; Miller & Crabtree, 1994; Polit & Beck, 2006).

Sampling

A convenience sample combined with snowball sampling was used in this study (Polit & Beck, 2006). In a Swedish middle-sized psychiatric hospital, about three to six women with PPP are admitted and treated per year. To guarantee the psychiatrists had had a chance to treat a woman with PPP, the inclusion criterion for participation was five years experience as a psychiatrist. One of the authors (the psychiatrist) was used as a gatekeeper (Polit & Beck) and selected the first three participants based on the inclusion criteria. After the first three interviews were completed, names of other potential participants were given to the interviewer by these three psychiatrists. In addition, two further names were given to the last author. A total of 12 psychiatrists were contacted and nine agreed to participate. Three psychiatrists declined due to heavy work-load and lack of time.

Participants

The participants included five male and four female psychiatrists, all Caucasians. They were all educated in Sweden requiring seven years and three months of medical studies, followed by an additional five years in psychiatry. Three of the participants were also PhDs. In Sweden, approximately 15% of the psychiatrists also have a PhD (Gunnarsdotter, 2006). Two of the participants had conducted research in general psychiatry and one participant conducted research specific for PPP. The average age of the psychiatrists was 59 years (45-65 years), and the average time of working as a specialist was 21 years (5-30 years). The amount of women with PPP cared for was between two and 30. They were all trained psychiatrists, but two of them had additionally training in forensic psychiatry.

Data Collection

The interviews were conducted from October 2007 through February 2008 in different locations in middle and southern Sweden. The first author, who also accomplished the interviews, contacted the participants by telephone. A letter of introduction describing the aim of the study was sent to each participant. Before the interviews begun, the participants once again received information about the study and written informed consent was obtained. Eight interviews took place in the participants' office and one was interviewed at home. The interviews lasted from 35-70 minutes. The interviews were conducted in Swedish. The quotations later translated by the first author into English and subsequently reviewed by a native-born American. The data was collected through interactive and probing semi-structured interviews. The interviews began by asking the psychiatrists to reflect on a specific situation when they had treated a woman with PPP. Furthermore, questions were asked regarding the diagnosis, planning treatment, and considerations for the baby and other family members. Finally the participants were asked to discuss their own responses/reactions to the women whom they had treated.

Data Analysis

All four authors contributed in the data analysis with their specific perspective. The first author (IE) as well as the third (GF) were psychiatric nurses. Although this may be seen as a limitation, it was balanced by the second author who was a psychiatrist (AA) and well experienced in the field of psychiatry. This author (AA) validated the results of the analysis and found them to be trustworthy. Since three of the authors had experience in the field of psychiatry, pre-understandings may be difficult to eliminate. Therefore, these authors consistently tried to be aware of their pre-conceptions. The fourth author (KN) had limited experience in psychiatry and therefore provided objectivity in the analytic process.

The data was analyzed using content analysis and dealt with manifest content (that is, what the text says) and described the visible, obvious components in the text, as well as latent content (that is, what the text is talking about) and dealt with the relationship aspect and involved an interpretation of the underlying meaning of the content in the text (Graneheim & Lundman, 2004). Following verbatim transcription of the interviews, each interview was listened to and read a number of times to obtain an overall impression. The analysis continued with extracting units of meaning (consisting of one or several words, sentences, or paragraphs) from the texts and then making the text shorter through condensing the units of meaning. The condensed text was then abstracted and labeled with a code. A code was similar to the text or gave an understanding of the content of the meaning units on a more abstract level (Table 1).

Table 1. Examples of meaning units, condensed meaning units, and codes

Meaning unit	Condensed meaning unit	Code
Important with security, "the mother will feel so bad if she hurts the baby"	Mother will feel bad if hurting the baby	Importance of security
Firstly, always on compulsory care – but with dignity!	Compulsory care important	Compulsory care

The codes are compared for differences (i.e., what is unique) and similarities (i.e., what is equal) in the codes, and are made with that aim in mind. Codes with their additional meaning units are grouped together related to its content. The process of categorization (Graneheim & Lundman, 2004) is a stepwise process. Meaning units, codes and categories is scrutinized in relation to each other. During this process categories are reduced in number and expanded in content. Finally is formed four categories and each category is divided into two to four sub-categories (Table 2).

Table 2. Examples of codes, sub-categories, and categories

Codes	Sub-category	Category
Treatment ECT Antipsychotics	Adjusted treatment	Treatment
Separation of mother and child Importance of bonding The pressure from family	Protection vs. bonding	Protection

To strengthen the trustworthiness of this study, the different codes, categories and sub-categories are reviewed and discussed among the authors (IE, AA, GF, KN) until agreement was reached. These discussions in the research team strengthen the dependability. Furthermore, the procedures used to generate the results, which are illustrated in Tables 1 and 2, confirm the credibility as the analysis of data could be seen. We suggest that the results are transferable to similar contexts, but, as Graneheim and Lundman point out, it is always the reader who decides the transferability of the findings. To facilitate this possibility, the results are illustrated with quotations (Graneheim & Lundman).

Ethical Approval

According to Swedish law, (The act, 2003:460 on the ethical examination of human research), approval from an ethics committee was not required prior to conducting the interviews (The act, 2003:460). However, according to this law and the Declaration of Helsinki, participants must give their informed consent. We have therefore followed the Swedish Research Council's recommendations (The act, 2003:460), meaning that

particular importance has been placed on obtaining informed consent and confidentiality of the participants' statements has been maintained. The quotations in the results are used to illustrate the statements provided by the participants.

Results

The results of this study describe the psychiatrists' experiences treating women with postpartum psychosis. An overview of the results is presented in Table 3. The results are organized in line with the categories and subcategories found in the analysis.

Table 3. Overview of categories and sub-categories

Categories	Sub-categories
Protection	Restraining from harming of self and others
	Creating a shielding environment
	Protection vs. bonding
Treatments	Honesty in giving proper diagnosis
	Adjusted treatment
	Facilitating treatment
Care	Involuntary care
	Alternatives in the care
	Facilitating care and treatment
	Involving the family
Reactions	Being compassionate and empathetic
	Emotions of distress

Protection

Women with PPP are considered as patients with a high risk for suicide and infanticide, why protection of the mother and her baby according to the psychiatrists are the primary focus of care. Therefore they make a point of that the woman is carefully monitored and frequently placed on one-to-one observation. The woman may need to be secluded and isolated from other patients. The burden of responsibility rests with the treating psychiatrist.

Restraining from harming of self and others. When the baby is cared for on the same ward as the woman, maintaining safety is critical. To protect the mother, the baby, and/or others, the psychiatrist assesses her status daily. If the woman is very aggressive and/or violent towards other patients or staff, or refuses medication the psychiatrist prescribe restraining. They use restraints, such as belt, with some hesitation, despite knowing that it is necessary as described below.

> ... and we hope that there will be no need of using the belt but to use compulsory care in a dignified way, even if they do not have to be in the belt, which is there all the time, so nothing will go wrong. But if it is

> needed, do use it! For the ones I have experienced, they are so explosive, so unpredictable…

Creating a shielding environment. At times, the woman may need to be restricted to her own room in order to protect her from embarrassing behavior and from harming other patients. The psychiatrist prescribes one-to-one-care and this promotes a trusting relationship between the woman and nursing staff and continues until the woman improves. Accordingly, the psychiatrists in collaboration with nurses are aware of that the environment should be quiet in the surroundings of the woman and her baby.

> … but the care is very much about health care environment. To have it calm and quiet, sheltered … some privacy, and to have the opportunity to have her child there now and then, to be watched over.

Protection vs. bonding. Decisions regarding keeping the patient and her baby together as well as continuing breastfeeding are based on the psychiatrist's ongoing assessment of the woman's status as the responsibility rests with him/her. Although they can experience pressure from the family to keep the mother and newborn together, keeping the woman and baby safe are the psychiatrist's priority.

> So the child's safety, yes, this I weight pretty high, that is. And the mother may not come in contact with her child until she is in a certain mental condition and definitely not take care of her child perhaps without supervision, and so, until she is in fairly good condition. To take into account the child's safety, I highly consider, perhaps more than I take into account the mother's own risk.

If the mother has delusions the mother and her child should not be kept together. Even if the bonding for the dyad is important, the psychiatrists think that the question is if it is possible to have a bonding-process going on when psychotic. For the baby the bonding-process might be possible with the father or another relative that take care of the baby and bonding with the mother might start later on. However, the psychiatrists present varied opinions about the importance of early bonding; some of them say it is very important and others have an opposite opinion. They all agree that keeping them together must not pass the point that their safety is at stake.

> … well I don't think that it is out of the question that the mother starts an attachment process even if she is psychotic. But she must be watched and assessed so she doesn't get even worse or she might get too worn out and then maybe get scared of her own child. You can mess up the situation too in this way. But I think that it is good to see the Mother-Child as one unit at least at this early stage.

Treatments

The psychiatrists find it important to treat the woman as quickly as possible in order to prevent a prolonged psychosis. If the woman opposes treatment, the need for involuntary care is determined based on the severity of her illness and risk for herself and her child.

Honesty in giving proper diagnosis. This disorder, according to the psychiatrists, is usually not too difficult to diagnose but is necessary to do before initiating treatment especially as this disorder can be stigmatizing and have a significant risk of developing PPP in subsequent deliveries. Once the diagnosis is determined, the woman and her husband receive information from the psychiatrists about the diagnosis and treatment. The psychiatrists' honesty in giving proper diagnosis is illustrated in the quotation below.

> But otherwise, I am of the opinion that if you suspect a diagnosis, then you should always give the diagnosis that you think it is. It does not help a patient to pretend another diagnosis and it's the same with the diagnosis of postpartum.

Adjusted treatment. The psychiatrists who participate in this study are very experienced. Treatment decisions are based on years of experience combined with intuition and sensitivity to the woman's health care needs. Although no manual is followed, treatment is based on clinical experiences over a number of years.

> The fact is that I follow no manual, or so, or follow the thick textbook of psychiatry to find out how I should deal with this. But for me ... and it may sound very unscientific, but I go for the gut feeling I have, and get an overall picture of it.

There are a number of different treatments that can be used with PPP. The treatment is based on the day-to-day assessment of each woman. The psychiatrists express they often use ECT as the treatment of choice, especially if the woman is still breastfeeding and is also faster in treating the psychotic symptoms compared with antipsychotic medications.

> They are so cumbersome. They are worried, they are running around all the time, difficult to get complacent, they have mood swings, may have conniption, crying one minute and laugh and really happy the next, they are disruptive to fellow patients … And to cure this with a good result we often use ECT.

In addition, antipsychotics are used to protect the woman "from a very intense psychosis and from suicide". Antidepressants are also commonly prescribed by the psychiatrists since women with PPP show mixed symptoms of mood and anxiety

disorders. The usual procedure is to start with ECT and antipsychotics and then add an antidepressant.

> ...later we supplemented the antipsychotics with antidepressant medication, not entirely uncommon in these contexts...

At times, lithium might be indicated prior to the delivery for women with previous psychiatric illness. This treatment is usually considered incompatible with breastfeeding but might be used under certain conditions along with safety precautions. When considering treatment options, the psychiatrist say they weigh the risks and benefits in each individual situation.

> …for those you have in treatment before the pregnancy then it is a question of thinking before, to discuss in advance: "how will it be when you become pregnant, how will we act then?" The guiding principles have changed, now you can be put on lithium and other psycho drugs …now you may still have lithium, because we found that it would be worse to take it away, than to keep it.

Care

The psychiatrists base the care of a woman with PPP on careful assessment, diagnostic skills, clinical judgment and past experience. As described earlier the care can be provided on a voluntary or involuntary basis. The responsibility for the care decisions weigh heavily on the psychiatrist particularly when the care is involuntary.

Involuntary care. Even if the Law of Compulsory Psychiatric Care Act states that treatment decisions be made in collaboration with the patient, the woman might be so ill that she is not able to participate in this process. According to the psychiatrists, involuntary care requires the staff to treat the woman with respect, honesty, humility and to provide information. Involuntary or compulsory care makes some aspects of the care easier because it is possible to provide treatment without the woman's consent.

> … I use compulsory care for these women, and, I take into account the woman, the family and the care...They just should stay on compulsory care, which certainly is the best for everyone. In me this is a very deep opinion inside…yes, that is my absolute point of view.

Alternatives in the care. In early inpatient treatment, the use of one-to-one-care is common to prevent devastating complications. In Sweden there are usually no alternatives to inpatient care. However if the woman is psychotic but calm, and has a family that can provide one-to-one observation 24 hours a day, outpatient treatment may be considered. However, considering the fluctuating status that is so typical of PPP in its early presentation, this regimen is, according to the psychiatrists, usually not possible until a stable remission has been confirmed.

> Inpatient care? Any alternative? Not when I think about the women that I…because they were so sick that there was no alternative. They needed this treatment…well… she needs to be attended to all the time. I think that they would have been worse off in an environment with more stimuli. That she is clean, gets enough fluids etc. So, no, I don't think there are any alternatives.

Facilitating care and treatment. The psychiatrists try to establish a trusting relationship with the patient as they think it is an important component in the care and could facilitate other components of the woman's treatment. This can include close contact with the patient, such as holding hands, sitting on the bedside, or giving a tap on the shoulder.

> I usually have quite a lot of physical contact with patients too. It might be so that I sit on her bedside holding her hand when talking to her and... yes, it is the most common, but it may be something else, too. Maybe a tap on the shoulder or so. Or some kind of marker which hopefully is good for her...

Involving the family. The psychiatrists consider that it is important to involve the family from the beginning of the woman's illness and throughout her hospitalization as the family know the patient the best. When the woman is admitted to the hospital, the husband is informed about the seriousness of the illness as well as the plan of care. Given that it is very difficult for family members to see their loved one in a psychotic state, the psychiatrists sit down with the family and try to help them understand the nature of psychosis. The psychiatrists have to take into consideration the great deal of information available on the Internet which at times can lead into misinformation.

> You have to take care of the husband...by talking to him. By that he gets his own touch, so to speak...he gets time with myself so I can explain what this is, and that it will be fine … and that "you should not blame yourself, what she said just now, like you are not the father of the child, and a bunch of other stuff". But she's just sick. Mostly they are quite bewildered, for this will come very quickly, and they understand nothing. So it is quite important, to have them with you on the train.

It is not unusual for family members to feel responsible in some way for the illness and experience a great deal of guilt. Therefore, the family involves in timely family meetings concerning care and treatment. If the woman relapses following discharge, it will be easier for the family to readmit the woman if a therapeutic relationship has been established.

> I may try to tie up so the relatives may learn the early signs of the disease, and so I have as good a relationship with them as possible, and I generally think that it's not so very difficult, as they often like very much if I'm there. And if I have been there in the hard parts of life, then it is quite easy to care for them later on in the outpatients.

Reactions

The psychiatrists experience a number of emotions when caring for and treating women with PPP. The female psychiatrists express their emotions with greater emphasis than their male counterparts. There is always a desire to do the very best for the women, and when the result is not the best, distress and sorrow emerge. Deep sorrow and frustration are experienced when women attempt suicide and/or try to harm their child. In these situations, psychiatrists can have feelings of guilt, question their treatment decisions, and worry that the woman will have a life-long psychiatric illness. The respondents describe being touched by and having strong feelings for these patients. When this type of patient arrives at the hospital, they know that tough days lie ahead partly due to their work load.

Being compassionate and empathetic. The psychiatrists describe being more involved with these women compared with other patients. Feelings of compassion are common as they recognize the lost time between the woman and her baby which may affect maternal infant bonding. They experience a great deal of responsibility for the woman, her baby and the family. When the woman responds positively to treatment, the treating psychiatrist feels joy and contentment. Since providing care for women with PPP can be difficult, painful memories can remain for a very long time.

> I am very touched by the fact that this is a very newly delivered woman, with such a small child to care for. That is the very special about this situation.

The psychiatrists describe having great empathy for the woman and her family. The illness is a miserable time for the woman and her family, and the time lost can never be reclaimed. It is a sad time, but the psychiatrists try their very best to provide optimum care and to ease the time for the woman and her family.

> ...these women arise a wish to take care of, it arises a feeling of wanting to guard mother and her child. And a hope that it will go well... yes, that is what it arises.

Emotions of distress. The degree of distress the psychiatrists experience depends on the responsibility for the mother and child. Emotional distress is associated with delayed mother-infant bonding and fear of harm when the mother is left alone caring for her child. Breastfeeding may intensify the illness and the woman may express her deep desire to breastfeed her child. There is always great concern that a woman might harm herself or commit suicide. Experienced psychiatrists have learned through the years that

they are not always in a position to master life and death; this recognition takes some pressure off their shoulders.

> Yes, because there is so much at stake. It is not just a woman with psychosis but also her child and its earliest experiences which are so extremely important. It is the bonding between her and her child, and the whole family if we consider there is a father involved... but in the middle of this case we also have the newborn baby.

When the patient arrives the psychiatrists know that tough days lay ahead, but that is part of their work. They have strong feelings of responsibility for the woman and her baby and family and they know that if the patient and her psychiatrist can go through this, the patient is saved. This gives a feeling of happiness and contentment when the acute phase is over.

> There are strong feelings of responsibility for me as a psychiatrist, but also thoughts about a big trauma, for the woman, the family and for the husband. There are strong feelings of empathy and of tragedy. But there are also feelings of optimism and of hope...we know that if we don't treat this illness there will be big complications, but just because we do treat we save the mother and her child.

There are also weaker feelings, and the psychiatrists narrate that they have no other feelings for these patients than for other young people that maybe are facing a life-long psychiatric illness.

> I feel no different for these women here than for another young woman or person affected of psychosis, and where we suspect that it is chronic.

The psychiatrists state that with advancement in their profession, they have less or no anxiety towards their work in general. But it was different when they were young doctors, and at that time they deeply felt the insecurity and watched their steps constantly to do the right thing.

> And I think this is because I was a young doctor at the time. The main thing was to do the right and not the wrong thing and not to make a fool of myself; to hold my tongue. And even though I have always been interested in the social and psychosocial aspects regarding the patient, the…the main thing for me was to focus and concentrate.

Discussion

The analysis of the interviews included expected and unexpected descriptions of the psychiatrists' experiences when treating women with PPP. There was a range in the number of patients that the participants had cared for in their careers, ranging from two to 30. They were all experienced in treating patients with psychosis (not related to

postpartum) and were confident in treating them. Although not all of the psychiatrists had treated many women with PPP, they were all knowledgeable about the illness, its symptoms, and diverse patient presentations. The main differences in treating this population were considerations for the newborn and the family. Although the sample size (n=9) in this study could be seen as a limitation, the interview data described relevant lived experiences and provided a deeper understanding of the phenomenon in question. Interviews using open-ended questions provided the opportunity for the psychiatrists to reflect on their experiences and to speak freely. Based on their own recollections of their clinical experiences with specific patients, they were able to respond to the open-ended questions with rich descriptions. Furthermore, the interviewer's knowledge and experiences in the field facilitated the interviews. The openness and the mutual understanding of the research field contributed to the richness of the data.

In this study, all of the psychiatrists described a deep feeling of responsibility that influenced their choices, decisions, and actions. They experienced great responsibility for the baby as well as for the woman. The experience of treating this population over time greatly influenced their decision-making. As they moved from novice to expert (Benner, 2004) they integrated their knowledge with their experiences. It is probably this integrated clinical experience in combination with scientific knowledge that is reflected in their statements that they provide care and treat without a textbook (Schmidt & Rikers, 2007). Their ability to combine different bases of knowledge has more or less become intuitive.

The desire to make decisions that will lead to positive outcomes for the mother, the child and the entire family was expressed by all psychiatrists. The principle to "do good" and cause as little harm as possible influenced decisions regarding treatment. This is consistent with a study conducted by Danerek, Udén, and Dykes (2005) concerning obstetricians who sometimes found themselves confronting ethical dilemmas and desired to make the best decision for the woman and her infant. Treating the woman's illness as quickly and effectively as possible always takes priority. Although there was always concern for the baby; the family and the pediatrician assume responsibility for the overall care of the baby.

Developing a trusting relationship with the husband and other family members was an important component of the woman's care. This is consistent with the literature review on PPP conducted by Sit, Rothschild, and Wisner (2006). In this review, the authors underscored the importance of including the family in the treatment plan during the woman's hospital stay and in the discharge planning process.

The psychiatrists in this study stated that they were very involved with their patients diagnosed with PPP, but maintained the professional distance needed in order to remain objective. In a study by Sorlie, Forde, Lindseth, and Norberg (2001), it was reported that male pediatricians maintained more professional distance than their female counterparts. In the present study, the female psychiatrists described having stronger emotions towards their patients compared with their male colleagues. The participants discussed the need to provide care that is evidence-based combined with knowledge of ethical issues and legal implications. Even when psychiatrists considered all of the above factors in making treatment decisions, they often continued to have some doubts, particularly in stressful situations (Hoop, 2004).

The psychiatrists spoke about their approaches to providing care and treatment for their patients with PPP. They reacted with empathy, sorrow and frustration as well as guilt. These feelings could be interpreted as trying experiences; however, they did not give any expressions of need for supervision. This interpretation could be strengthened by an earlier study by Sorlie, Lindseth, Udén, and Norberg (2000) who described the difficulty male and female physicians have discussing their emotional responses to patient situations. Physicians in this study typically spoke about what was seen, not what was experienced. Apker and Eggly's (2004) study, which described how physicians' professional identity was socially constructed during morning reports, indicated that the physician's identity develops by producing and reproducing conceptions of scientific medicine. The biomedical model guides treatment and humanistic approaches are marginalized (Apker & Eggly).

In a former study conducted by Engqvist, Ferszt, Ahlin, and Nilsson (2009) psychiatric nurses, at times, had negative reactions towards women with PPP. The nurses stated that they felt anger towards their patients when they observed them rejecting their child and/or attempting to hurt them. Negative reactions like these were not noted in this study; rather the psychiatrists sympathized with their patients. A possible explanation for this difference may be related to the amount of time nurses care for these patients compared with physicians who have short daily contact with them. Another possible explanation may be related to a difference in professional attitude. Psychiatrists are educated not to show emotions related to patients.

When involuntary care was needed, the psychiatrists recognized that this was essential to keep the woman safe and to provide the best treatment. According to Seeman (2004) prompt treatment can lead to a more positive long term outcome even though hospitalization of a newly delivered woman and her child was never taken lightly. In contrast, the Swedish nurses who participated in the study conducted by Engqvist et al. (2009) described feelings of discomfort and uneasiness when the woman needed involuntary care, were restrained and received injections by force. These differences may be related to the educational process of nurses and psychiatrists. The psychiatrists' education is primarily biomedical and the nurses' is more humanistic. Since nurses provide care 24 hours a day, it is not surprising that they may have more difficulty dealing with these heart wrenching situations.

The psychiatrists in this study stated that they experienced sadness and grief when a woman's life ended in suicide. When this occurred they felt guilty for a long time. It was hard for them to accept the fact that the treatment was not successful. At the same time, these experienced psychiatrists had gained confidence in their clinical skills which eased their emotional distress. This finding was consistent with a study by Sorlie et al. (2001) who interviewed male physicians about being in ethically difficult situations. These physicians were able to assuage their guilt knowing that some patients cannot be rescued.

In a study conducted by Koivisto, Janhonen, and Vaisanen (2004) patients diagnosed with psychosis believed that the care should protect them from their vulnerability and facilitate positive coping. In this study, the psychiatrists stated that protection of the woman and her child was of primary importance and the care should create a shielding environment. In the context of protection, the psychiatrists implied that they were confronted with many difficult dilemmas, often without one definitive solution.

The ward environment where patients were treated on an involuntary basis was overshadowed by control (Johansson, Skärsäter, & Danielsson, 2006). The psychiatrists therefore had to balance between control and openness when caring for the woman. They needed to trust their own intuitive knowing regarding some decisions such as the right time to bring the mother and child together. They had to trust their own decisions and seek consultation with colleagues when needed. However, ultimately the treatment decisions rest on their shoulders which can be a very lonely experience. In a study conducted by Lützén, Evertzon, and Nordin (1997) gender, age, length of experience and type of clinical practice influenced how psychiatrists addressed moral dilemmas.

According to Steinmetz and Tabenkin (2001) psychiatric patients are difficult to treat. The most difficult patients are those who show resistance and lack of co-operation with the doctor's recommendations. During the acute phase of PPP, women can be very difficult to treat given the severity of their psychosis, unpredictability, and suicidality. But with empathy, listening, patience, support and tolerance, psychiatrists can build trusting relationships that can lead to positive outcomes. The more experienced the physicians are, (Steinmetz & Tabenkin) the easier it is to treat difficult patients. These findings were certainly confirmed in this study.

In conclusion, in this study it was found that the psychiatrists focused on protecting the women with postpartum psychosis from suicide and infanticide. Treatment was focused on maintaining patient safety along with prompt treatment. Because psychiatrists' reactions of distress as well as empathy concerning their treating women with PPP have not been previously described in the literature, it is essential that studies that produce this knowledge should be published (Kim, 2000). Such information may be able to reassure psychiatrists, particularly in their first encounter with a woman with PPP. Given the degree of complexity treating women with PPP, the psychiatrists can experience caring for high risk patients to be extremely challenging. Health care organizations would be well-advised to consider providing support and/or opportunities for peer supervision.

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