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A Case Study on the Psychosocial and Emotional Challenges Associated with Adjustment Disorder in an Individual with Borderline Intellectual Functioning and Cluster B Personality Traits During the Postpartum Period

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Abstract: Postpartum psychiatric disorders can significantly affect maternal well-being, infant development, and family functioning. This case study presents a 33-year-old female admitted to a tertiary psychiatric hospital in India with a diagnosis of Adjustment Disorder with Mixed Emotional Disturbance, Borderline Intellectual Functioning, and Cluster B Personality Traits. The patient was admitted for the seventh time within a seven-month period due to recurrent episodes of aggression, agitation, emotional instability, and hostile behavior toward her infant son, husband, and mother-in-law. She had a previous history of Severe Mental and Behavioral Disorder Associated with the Puerperium (ICD-10: F53.1) diagnosed five months earlier.

Frequent psychiatric hospitalizations resulted in prolonged separation from her newborn, with the child being primarily cared for by the paternal grandparents. The recurrent nature of her psychiatric symptoms adversely affected mother–infant bonding and disrupted family relationships. Following discharge, the patient chose to reside with her parents due to persistent fear, emotional distress, and strained relationships with her in-laws, who remained reluctant to entrust her with the care of her child. These circumstances led to significant alterations in family dynamics and maternal role functioning.

This case highlights the complex interaction between postpartum mental health disorders, cognitive limitations, personality traits, and psychosocial stressors. It underscores the importance of early identification of high-risk mothers during the antenatal period, continuous postpartum follow-up, family-centered interventions, and specialized psychiatric care. Timely therapeutic interventions aimed at stabilizing mood, reducing anxiety, enhancing coping abilities, and strengthening mother–infant attachment are essential for promoting recovery and improving long-term maternal and child outcomes.

Keywords: *Adjustment Disorder, Postpartum Mental Health, Borderline Intellectual Functioning, Cluster B Personality Traits, Puerperal Psychiatric Disorder, Mother–Infant Bonding, Family Dynamics, Psychiatric Case Study.*

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I. INTRODUCTION

Adjustment Disorder with Mixed Emotional Disturbance, Borderline Intellectual Functioning, and Cluster B Personality Traits represent complex psychiatric conditions characterized by emotional dysregulation, impaired coping mechanisms, and cognitive limitations. The coexistence of these conditions presents significant challenges in assessment, treatment planning, and rehabilitation, often requiring individualized and multidisciplinary therapeutic interventions.

Postpartum psychiatric disorders are among the most serious mental health conditions affecting women during the perinatal period. Severe Mental and Behavioural Disorders Associated with the Puerperium, Not Elsewhere Classified (ICD-10: F53.1), commonly referred to as Postpartum Psychosis (PPP), is a rare but potentially life-threatening psychiatric emergency that typically occurs within the first six weeks following childbirth. The condition is characterized by rapid mood fluctuations, confusion, delusions, hallucinations, and disorganized behaviour. The incidence of postpartum psychosis ranges from approximately 1–2 cases per 1,000 deliveries worldwide.

Although a history of bipolar disorder is considered the strongest risk factor, nearly half of all women who develop postpartum psychosis have no previous psychiatric history. Clinical manifestations often include delusions involving the infant, impaired judgment, severe mood disturbances, and thoughts of self-harm or harm to the infant. Such symptoms may significantly compromise maternal functioning, infant safety, and family relationships.

In India, postpartum psychosis is frequently influenced by sociocultural factors, family dynamics, inadequate social support, and psychosocial stressors. The consequences of untreated postpartum psychosis may extend beyond the mother's mental health, adversely affecting mother–infant bonding, child development, and overall family functioning.

This case study explores the clinical course of a woman who developed severe psychiatric symptoms during the perinatal period, which worsened following childbirth. The case highlights the interaction between postpartum psychosis, cognitive limitations, personality traits, and adverse psychosocial circumstances. It further emphasizes the importance of early identification of high-risk mothers, prompt psychiatric intervention, comprehensive follow-up services, and family-centered care in promoting recovery and preventing long-term complications.

➢ *Objectives of the Case Report*

- To gain insight into the complex interaction between postpartum psychosis, borderline intellectual functioning, and Cluster B personality traits and their impact on patient outcomes.
- To identify and analyze the biological, psychological, and social risk factors contributing to the development and recurrence of postpartum psychiatric disorders.
- To highlight postpartum psychosis as a psychiatric emergency requiring immediate assessment, hospitalization, and specialized mother–infant care.
- To emphasize the importance of early detection, antenatal mental health screening, and timely intervention among high-risk women.
- To contribute to the existing literature by identifying potential precipitating, perpetuating, and predisposing factors associated with postpartum psychosis and its long-term consequences.

II. REVIEW OF LITERATURE

➢ *Kimberly C., Joanna G., and Victoria Su.*

In their case report titled *"Postpartum Psychosis in a Young VA Patient: Diagnosis, Implications, and Treatment Recommendations,"* the authors described a 31-year-old woman with no previous psychiatric history who developed disorganized behaviour two weeks after delivering her second child. The patient was diagnosed with postpartum psychosis and initially treated with olanzapine, which was later replaced with risperidone due to excessive sedation. Lithium therapy was subsequently initiated. Significant clinical improvement was observed before discharge. The study emphasized the importance of early diagnosis, prompt pharmacological intervention, patient education, and regular follow-up in preventing long-term psychiatric complications.

➢ *Seerat Arora and Rita Kumar*

In the case report *"Postpartum Psychosis with Comorbid Anxiety and the Impact of Life Events,"* the authors presented a 31-year-old woman who developed psychotic symptoms five days following a cesarean delivery. The patient exhibited persecutory delusions, impaired judgment, emotional instability, and anxiety-related symptoms. The report highlighted the complex interplay between hormonal changes, psychosocial stressors, and mental health. The authors emphasized the need for comprehensive assessment, individualized treatment planning, family involvement, and psychosocial support in facilitating recovery.

➢ *Sit D., Rothschild A.J., and Wisner K.L.*

In their review article *"A Review of Postpartum Psychosis,"* the authors suggested that postpartum psychosis may represent a manifestation of bipolar spectrum disorders triggered by significant hormonal changes following childbirth. The review discussed the effectiveness of pharmacological treatments, including mood stabilizers, atypical antipsychotics, and electroconvulsive therapy (ECT). The authors concluded that rapid recognition and timely treatment are essential for reducing the risks posed to both the mother and infant and improving overall outcomes.

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III. CASE PRESENTATION

➢ *Patient Information*

The patient is a 33-year-old married female, homemaker, and undergraduate who was admitted to the Psychiatry Department of a Government Hospital. She was brought to the emergency department by her father and husband under Section 89 of the Mental Healthcare Act (MHCA), 2017, which permits supported admission for individuals requiring high levels of care and supervision.

➢ *Presenting Complaints*

- *According to the Patient*

✓ Reports being physically and emotionally abused by her husband for the past 11 months.
✓ States that her in-laws frequently neglected her nutritional needs during pregnancy, claiming financial difficulties.
✓ Reports that her parents provided support for her dietary requirements during the antenatal period.
✓ Believes that her husband was dissatisfied with the birth of a male child and had preferred a female child.
✓ Reports persistent experiences of emotional distress, neglect, and domestic conflict.

- *According to the Informants (Father and Husband)*

✓ Altered behaviour and increased irritability for the past 3 months.
✓ Aggressive behaviour toward family members for the past 3 months.
✓ Attempting to hit the infant, neglecting childcare responsibilities, and displaying little interest in caring for the baby for the past 3 months.
✓ Aggression toward her husband and mother-in-law for the past 3 months.
✓ Presence of passive death wishes for the past 8 days.

IV. HISTORY OF PRESENT ILLNESS

➢ *Current Admission (Seventh Admission)*

The patient was admitted in April 2026, approximately 15 days after her previous discharge, with a diagnosis of Adjustment Disorder with Mixed Anxiety and Depressed Mood, Borderline Intellectual Functioning, and Cluster B Personality Traits. She presented with marked anxiety, fearfulness regarding the future, feelings of impending doom, and extrapyramidal symptoms (EPS), including tremors of the upper and lower extremities resulting in an unsteady gait. The current episode had a subacute onset and gradually worsened over time.

➢ *Past Psychiatric History*

The patient had a history of six previous psychiatric admissions:

- First Admission (November 2025): At eight months of gestation, she developed behavioural changes and emotional disturbances. She was initiated on antidepressant and antipsychotic medications and discharged after four days.
- Second Admission (December 2025): On the 12th day postpartum, she developed acute psychotic symptoms and was hospitalized for 20 days.
- Third Admission (February 2026): Readmitted 39 days after discharge because of recurrence of symptoms and discharged after nine days.
- Fourth Admission (March 2026): Admitted to a private hospital with psychotic symptoms, extrapyramidal side effects, and reduced interest in infant care. Discharged after two days.
- Fifth Admission (March 2026): Readmitted five days later with recurrent psychotic symptoms and mild EPS. Discharged after nine days.
- Sixth Admission (March 2026): Admitted again with adjustment difficulties and EPS and remained hospitalized for 20 days.

➢ *Past Medical And Surgical History*

There was no significant history of medical illness, neurological disorder, or previous surgical intervention.

➢ *Family History*

The patient resides with her husband, parents-in-law, and infant son. There is no family history of psychiatric illness. Her mother-in-law is a known case of diabetes mellitus and is receiving treatment. No other significant medical or psychiatric conditions were reported among family members.

➢ *Personal History*

According to the patient's mother, she was born through a full-term normal vaginal delivery. Mild delay in motor developmental milestones was reported, although detailed records were unavailable. She demonstrated average academic performance but experienced difficulties with attention and concentration during schooling. Menarche occurred at 14 years of age. Premorbidly, she was described as introverted, socially withdrawn, and emotionally sensitive. There was no history of substance use, alcohol consumption, or smoking. Sleep, bowel, and bladder habits were reportedly normal before the onset of psychiatric symptoms.

➢ *Marital History*

The patient had previously undergone a failed marriage characterized by physical and emotional abuse, ending in divorce after approximately one year. She reported experiencing similar domestic conflict in her current marriage, including emotional and physical abuse from both her husband and mother-in-law. Repeated criticism and stigmatizing remarks regarding her mental health reportedly contributed to increased emotional distress and aggression. During psychiatric evaluation, she expressed feelings of anger toward her husband and mother-in-law, which she believed were sometimes displaced onto her infant. Mental status examination revealed persecutory ideas, passive death wishes, and diminished interest in childcare activities.

➢ *Obstetric History*

During the third trimester of pregnancy (35–38 weeks gestation), the patient developed unexplained crying spells, irritability, and self-harming behaviour directed toward her

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abdomen, expressing a desire to terminate the pregnancy. She was admitted to a psychiatric facility and treated with antidepressant medications before discharge.

Approximately fifteen days later, she delivered a healthy male infant weighing 2.5 kg through normal vaginal delivery. The patient discontinued psychiatric medications six days before delivery.

Within 12 days postpartum, she experienced a severe exacerbation of psychiatric symptoms characterized by psychosis, emotional instability, neglect of infant care, refusal to breastfeed, preference for a female child, and an attempted act of harm toward the infant. Aggressive behaviour toward her husband and mother-in-law was also reported. She was diagnosed with Severe Mental and Behavioural Disorder Associated with the Puerperium, Not Elsewhere Classified (ICD-10: F53.1) and required hospitalization. During this period, the infant was cared for primarily by the paternal grandparents.

➢ *Physical Examination*

The patient was moderately built and nourished. Vital signs were stable:

- Pulse: 78 beats/minute, regular
- Blood Pressure: 134/82 mmHg
- Temperature: 97.6°F

Systemic examination revealed no significant abnormalities. Old healed abrasions were observed over both forearms along with stress-induced urticarial rashes. Abdominal examination revealed post-pregnancy striae. Neurological examination was largely unremarkable except for an unsteady gait and tremors attributable to extrapyramidal side effects of medication.

➢ *Mental Status Examination*

On admission, the patient appeared conscious and oriented to time, place, and person. She was appropriately dressed and groomed but initially resisted hospitalization and expressed a strong desire to return home. She appeared anxious, tearful, and emotionally distressed, requiring chemical restraint for behavioural control.

Eye contact was maintained intermittently, and rapport was established with difficulty. Psychomotor activity was increased, with observable tremors. Speech was coherent, relevant, spontaneous, and of normal rate and tone.

Thought content revealed persecutory ideas concerning her husband and mother-in-law, diminished interest in childcare, passive death wishes, and persistent beliefs that her husband was disappointed with the birth of a male child. No hallucinations or other perceptual abnormalities were elicited.

Mood was dysphoric, and affect was fearful and sad. Personal, social, and test judgment were impaired. Clinical assessment suggested below-average intellectual functioning. Memory assessment could not be completed because of limited cooperation. Insight was graded as Grade I.

➢ *Clinical Diagnosis*

Based on ICD-10 diagnostic criteria, the patient was diagnosed with:

- Adjustment Disorder with Mixed Anxiety and Depressed Mood (F43.23)
- Borderline Intellectual Functioning (R41.83)
- Cluster B Personality Traits (F60.3)
- History of Severe Mental and Behavioural Disorder Associated with the Puerperium, Not Elsewhere Classified (F53.1)

This case highlights the complex interaction between postpartum psychosis, personality vulnerabilities, cognitive limitations, psychosocial stressors, and inadequate social support, all of which contributed to recurrent psychiatric admissions and impaired mother–infant bonding.

V. CONCLUSION

This case highlights the complex interplay between postpartum psychiatric illness, borderline intellectual functioning, Cluster B personality traits, and psychosocial stressors in contributing to recurrent psychiatric admissions and impaired maternal functioning. The patient's repeated hospitalizations adversely affected mother–infant bonding, family relationships, and her ability to resume maternal responsibilities. Early identification of women at risk during the antenatal and postpartum periods, timely psychiatric intervention, continuous follow-up, and family-centered multidisciplinary care are essential for improving clinical outcomes and reducing the risk of recurrence. This case underscores the importance of individualized treatment plans that address both psychiatric symptoms and psychosocial needs to promote maternal recovery, strengthen mother–infant attachment, and improve long-term family well-being.

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