Bipolar Disorder
Level 2 Case
Facilitator's Guide

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Pre-Assessment Learning

- Clark, C. T., Klein, A. M., Perel, J. M., Helsel, J., & Wisner, K. L. (2013). Lamotrigine dosing for pregnant patients with bipolar disorder. *American Journal of Psychiatry*, *170*(11), 1240-1247.
- NCRP general tenets of pharmacology in pregnancy

Optional Supplemental Reading

- Pinheiro, E., Wisner, K. L., & Clark, C. T. (2018). Quetiapine dose adjustments in pregnant and postpartum women with bipolar disorder. *Journal of clinical psychopharmacology*, *38*(1), 89.
- Deligiannidis, K. M., Byatt, N., & Freeman, M. P. (2014). Pharmacotherapy for mood disorders in pregnancy: a review of pharmacokinetic changes and clinical recommendations for therapeutic drug monitoring. Journal of clinical psychopharmacology, 34(2), 244.
- Bhella, V. S., & Garg, D. (2018). Use of liothyronine (L-T3) as an augmentation therapy for depression during pregnancy. *BMJ Case Reports CP*, *11*(1).
- Korevaar, T. I., Medici, M., Visser, T. J., & Peeters, R. P. (2017). Thyroid disease in pregnancy: new insights in diagnosis and clinical management. *Nature Reviews Endocrinology*, *13*(10), 610-622.

Overview
The goal of this module is to build upon core principles of treatment of individuals with Bipolar Disorder during the perinatal period. Relative to the introductory session in this module, this case has been designed to introduce additional complexity in the risk-risk equation of an overall treatment plan in addition to providing an overview of the use of lamotrigine during and after pregnancy.

This session is designed to last 60 minutes but can be modified for a longer or shorter session. The session is best utilized for psychiatry residents who have previously reviewed the introductory Bipolar Disorder module. Prior to the session, residents should read the articles included in the pre-reading section of this module.

Session

- **Clinical Vignette Part 1: read aloud (3 min)**
- **Discuss questions 1-3 (15 min)**
- **Clinical Vignette Part 2: read aloud (2 min)**
- **Discuss question 4 (5 min)**
- **Clinical Vignette Part 3: read aloud (3 min)**
- **Discuss questions 5-6 (10 min)**
- **Clinical Vignette Part 4: read aloud (2 min)**
- **Discuss questions 7-8 (10 min)**
- **Wrap up (10 minutes)**

Learning Objectives

1. Understand factors that influence the risk-risk discussion of pharmacologic treatment of perinatal individuals with bipolar disorder in complex treatment scenarios.
2. Consider pharmacodynamic and pharmacokinetic changes of pregnancy and their application to lamotrigine monitoring in the perinatal period.
3. Describe the current data informing the reproductive safety of second-generation antipsychotics during the perinatal period.
4. Review non-pharmacologic treatments of bipolar disorder and their application to the perinatal period.

Clinical Vignette Part 1

Ms. M is a 30-year-old G0 cis-gendered female who presents to you, a reproductive psychiatrist, for a pre-conception planning visit in the context of Bipolar Disorder Type 2. She and her husband would like to try to conceive in about 3 months. At present, she is utilizing an etonogestrel implant for contraception. She reports that her current medications have been working well for mood stability, and in fact she does not remember feeling this "level" for such a sustained period in her adult life. Her current psychiatrist, however, is uncomfortable continuing her current regimen during pregnancy. She has done some reading online about psychiatric medications in pregnancy and found your practice through an online search. She is excited to get established with someone "who understands the current data" and can treat her effectively during pregnancy.

Ms. M reports that she was initially diagnosed at age 14 with depression and has experienced recurrent depressive episodes since that time. Her depressive episodes have been characterized by a pervasive low mood, feelings of hopelessness, frequent tearfulness, increased appetite, decreased energy, decreased motivation, and low interest. She frequently experiences passive suicidal thoughts during depressive episodes: feeling that life is too hard to continue, or that those closest to her would be better off if she were gone. These episodes have typically lasted weeks to months; the last prolonged period of depression was about 5 years ago and in the context of trying to stop using tobacco.

In her 20s, Ms. M was diagnosed with Bipolar Disorder Type 2. Ms. M states that she realized herself that she experiences hypomanic episodes when she read about bipolar disorder in her college psychology class. She let her psychiatrist at the time know about her pattern of episodes, which lasted anywhere from 3 days to 2 weeks, where she would feel more self-confident, have more energy than is usual for her, would drink more alcohol, become more promiscuous and become very focused on exercise. She did very well in school during these periods as she could pull "all-nighters" without feeling tired. In retrospect, these episodes had been occurring since she was a teenager.

In more recent years, her primary concern has been difficulty managing her anger. She describes significant irritability and feels very easily overwhelmed. Describes herself as having "temper tantrums" where she yells, says "terrible things," feels physically agitated and at times has even thrown household items. Most often this has been directed towards her husband, or in her younger years, her parents. Ms. M has never physically harmed another person during one of these episodes, nor has she experienced a legal consequence related to her temper. She has, however, engaged in self-harming behaviors in the past in the context of intense agitation/anger. She hesitantly describes superficial cutting of her forearms and inner thighs to "just get me out of that state." Last self-harming episode was about a year ago. Describes irritability as a continued concern, however this has lessened considerably over the past year while on her current medication regimen.

Denies history of psychotic symptoms.

<u>Substance Use History:</u>

Ms. M reports that she uses nicotine (vape pen) several times per day and has had a very difficult time quitting. She has tried to utilize nicotine patches, however even when trialing a gradual, slow taper, she has experienced intense dysphoria fluctuating with mania. When asked to describe her manic symptoms in the context of tobacco cessation, she reports very high irritability, daily "temper tantrums," general feelings of restlessness and poor sleep.

On review of systems, she also endorses using medical cannabis products (edibles and tinctures) daily due to chronic pain from a previous motor vehicle accident. She drinks alcohol "occasionally," about 1 glass of wine 3 times per week.

Current Medications:
- Lamotrigine 200mg daily (started about 5 years ago, increased to current dose about 1 year ago)
- Oxcarbazepine 900mg daily (started 1 year ago)
- Aripiprazole 2.5mg daily (was taking up to 10 daily in the past but decreased due to irritability)
- Liothyronine 150mcg daily (for past 5 years, started for depression)

Psychiatric History:
Ms. M has been engaged in outpatient psychiatric medication treatment since early teenage years. She has intermittently engaged in psychotherapy, most consistently during college and graduate school. She has experienced passive SI and self-harming behaviors however has not had a suicide attempt. No inpatient treatment.

Previous medication trials include:
Several SSRIs (sertraline, fluoxetine, citalopram): all of these made her feel "all revved up, like I'm crawling out of my skin."
Bupropion: remembers this being helpful for depression in the past, not sure why it was stopped
Lurasidone: discontinued after 2 weeks at 20mg due to nausea.
Lithium: helpful previous treatment however after several months at 300mg daily dose, discontinued due to sedation
Quetiapine: trialed this at 25mg for insomnia; discontinued after the first dose as she woke up the next morning with a headache.

Family history: mother with alcoholism; maternal uncle "might" have bipolar disorder but hasn't been formally diagnosed.

Social History:
Childhood adversity: Ms. M reports that as a child, she always "had the necessities," and overall had a stable homelife. She reflects however that due to her mother's struggle with alcohol, her moods were unpredictable and at times she would be cruel and emotionally abusive. She experienced severe bullying in high school, an experience she correlates with the onset of her depressive episodes.
Traumatic events: About two years ago she was also in a serious motor vehicle accident. Another car suddenly pulled out in front of her in an intersection, and they collided. She reports chronic diffuse "all over" pain since this event.

Current social factors: Ms. M lives at home with her husband. They have been married for 3 years and overall have a supportive relationship however at times have struggled to communicate effectively. She has a "fine" relationship with her parents, who live about 2 hours away. She is an attorney. She has no guns in the home and no easy access to weapons. No legal issues.

Discussion Questions

1. Which aspects of Ms. M's history support the reported diagnosis of Bipolar Disorder Type 2? What differential diagnoses would you consider?
   Facilitator elicits the following:

Symptoms consistent with major depressive episode:
pervasively low mood
feelings of hopelessness
frequent tearfulness
increased appetite
decreased energy

decreased motivation
low interest
passive suicidal thoughts
Duration of weeks to months

Symptoms consistent with hypomanic episode:
Increased self-confidence (unclear if "inflated self-esteem")
Decreased need for sleep
Increase in goal-directed activities
Excessive involvement in activities that have high potential for painful consequences (promiscuity)
Above happen concurrently for a duration of up to 2 weeks and associated with a change in functioning.

Of note, one would need more information to better understand her periods of anger/"temper tantrums." While irritability is potentially a component of a major depressive, hypomanic or manic episode, it's not clear from above information if Ms. M experiences this symptom as a component of a discrete mood episode OR as a more pervasive, continuous feeling. The psychiatrist may want to further inquire about the time-course, relationship to traumatic experiences or reminders of trauma, and/or whether her irritability persists when other mood symptoms resolve.

Differential dx to consider:

- Bipolar I: From available information, it is not clear that Ms. M's manic symptoms were severe enough to cause marked impairment in functioning. She denied any experience of psychotic symptoms.
- Substance induced mood disorder: Would want to better delineate timeline of substance use/withdrawal in the context of Ms. M's mood symptoms.
- PTSD: While Ms. M clearly describes heightened arousal/reactivity, the psychiatrist would need to better assess Ms. M's experience of the described traumatic events and related symptoms within the domains of re-experiencing, avoidance, negative alterations in mood or cognition.
- Borderline Personality Disorder: While persons with BPD also experience affective instability, suicidality, and impulsivity, these present as an "enduring pattern" which is pervasive across a broad range of situations. Importantly, in the setting of BPD these traits are experience in the context of a markedly and persistently unstable sense of self and a pattern of unstable and intense interpersonal relationships.

2. What risk factors and protective factors present in Ms. M's history might inform her risk for illness relapse during a future pregnancy?
   Facilitator elicits the following:

Encourage learners to consider Ms. M's severity of illness, which likely could be described as moderate-to-severe based on the following factors:

Risk Factors:

- Substance use
- History of recurrent illness
- History of suicidal ideation
- History of self-harming behaviors

Protective factors:

- Currently endorsing stable mood
- Partnered
- Presenting for preconception planning
- No history of inpatient stay

3. Describe how Ms. M's overall presentation may inform a treatment plan? What components would this include? What specific advice would you offer regarding her medication regimen?
Facilitator elicits the following:

Every patient with bipolar disorder should have an individualized perinatal relapse prevention plan that is developed in collaboration with the patient, obstetrical and pediatric providers. It is important to be mindful of the patient's social and financial resources while developing this plan. The plan should include a description of pharmacotherapy, potential intervention strategies in case of relapse, as well as non-pharmacologic treatments and wellness strategies including:

Components to consider *in addition to maintenance medication* include:

- Individual psychotherapy: cognitive behavioral therapy, family-focused treatment, interpersonal and social rhythm therapy have evidence to support their utility in bipolar disorder. Depending on how you come to understand her traumatic experiences and related symptoms, one might consider trauma-focused cognitive behavioral therapy (TF-CBT) or Eye Movement Desensitization and Reprocessing (EMDR) as modalities of treatment.
- Substance use intervention and potential referral to substance use treatment: while Ms. M is requesting treatment for nicotine use, it is notable that she is also using cannabis daily and is drinking alcohol regularly. The psychiatrist should utilize motivational interviewing to better understand her use and readiness for change.
- Prenatal vitamin with folic acid beginning in the pre-conception period.
- Sleep hygiene plan to prioritize sleep in the postpartum period.
- Psychosocial support: may consider support groups prior to, during, and after pregnancy. Postpartum support international (https://www.postpartum.net/) maintains a helpful resource directory with group support for perinatal mood disorders as well as a provider directory.
- Instrumental support in newborn care (postpartum doula, night nanny, etc.)
- Close monitoring throughout the perinatal period
- Patient and partner/family psychoeducation regarding signs and symptoms of postpartum psychosis
- Safety plan to be actualized in the setting of suicidal thoughts and/or symptoms which significantly impair functioning.

<u>Regarding Ms. M's pharmacotherapy plan, consider the following:</u>

- Ms. M is currently on 4 medications to treat her mood disorder. Treatment planning should aim to minimize polypharmacy by purposefully selecting medications with the highest likelihood of efficacy with the lowest potential reproductive risk. While reproductive safety data is available on individual medications, it does not appropriately inform risks associated with combined treatment.
- Ms. M is on a sub-therapeutic dose of aripiprazole. While this medication has an overall reassuring reproductive safety profile, it is unlikely to be contributing in a meaningful way to her stability at the current dose and has been intolerable at higher doses. It would therefore be reasonable to discontinue this medication.
- Ms. M is taking 200mg of lamotrigine. This medication has an established evidence base for bipolar depression and maintenance treatment of bipolar disorder along with a reassuring reproductive safety profile. Given this information, it would be reasonable to continue this medication.
- Ms. M is taking 900mg of oxcarbazepine. This medication has not been well studied in pregnancy relative to other mood stabilizing medications. Data is too limited currently to conclude if oxcarbazepine increases the risk for birth defects, obstetrical complications, neonatal complications, or infant neurodevelopmental effects. This paucity of data represents its own risk regarding potential use during and after pregnancy. In this case, Ms. M reports an effective trial of lithium in her past and several incomplete trials of second-generation antipsychotics limited by side effects. The fact that she is presenting for preconception planning (as opposed to presenting already pregnant) provides an opportunity to explore whether a medication with a more established safety profile could be effective for her prior to any pregnancy exposures.
- Ms. M is taking a very high dose of liothyronine, three times the upper limit utilized in the landmark STAR-D trial which compared augmentation strategies in treatment-refractory depression. Liothyronine (L-T3) is not

well-established as a treatment for Bipolar Depression. While liothyronine is not well studied in pregnancy, there is reason for concern as this exogenous T3 administration is likely to suppress thyroid stimulating hormone production by the pituitary gland via negative feedback and result in an elevated T3:T4 ratio. As the placental transfer of maternal T4 is critical role for fetal neurodevelopment, liothyronine (particularly at this supratherapeutic dose) is a medication of concern in the context of pregnancy. It would be reasonable to initiate a taper of this medication.

As there are several potential changes to be made to maximize Ms. M's maintenance treatment, it is important to proactively discuss with Ms. M the following considerations:

- Changes to medications should be made sequentially so that each change can independently be assessed.
- Tapering of medications should be approached gradually with close monitoring.
- While you can work with Ms. M on how to balance the above considerations with her desire to start trying to conceive in 3 months, it is unlikely that 3 months will be adequate to both enact potential medication changes and gauge the results of such changes as maintenance treatment.

Clinical Vignette Part 2

At the first visit you discuss with Ms. M your overall clinical impression and proposed plan. You explore with her the timeline she presented, which included trying for conception in 3 months. You provide psychoeducation around the general tenets of disease management in pregnancy including minimizing polypharmacy, using lowest effective dose of medication, and selecting pharmacologic treatments based on likely efficacy, level of data (how *much* is known), and information concluded by the data (*what* is known). Ms. M expresses flexibility around her timeline for conception with a plan to prioritize finding a treatment regimen that she can continue throughout pregnancy. Medication treatment plan at the first visit is as follows:

1. Discontinue aripiprazole.
2. Re-trial nicotine replacement patch, starting with 21mg patch and reducing gradually every 6 weeks.
3. After brief period of monitoring off aripiprazole, begin taper of oxcarbazepine slowly (150mg every 2 weeks) with close monitoring.
4. Once oxcarbazepine taper is complete, will taper liothyronine. Will proceed in this "one step at a time" fashion so that the results of changes can be understood as specifically as possible.
5. As taper of oxcarbazepine, liothyronine, and nicotine cessation plan progresses, will continually evaluate need for increased lamotrigine or additional mood stabilizing medication.
6. Psychoeducation provided regarding cannabis use in the context of bipolar disorder and likely pregnancy. Motivational interviewing techniques are utilized. Ms. M reports she has a "close relationship with weed" and it feels overwhelming to consider cutting back or trying for abstinence given all the other changes that are discussed.

Ms. M returns for a series of follow-up visits on a every 2-week schedule:

- F/u #1: She has been off aripiprazole and utilizing a 21mg patch daily for two weeks and notices she is more emotionally reactive than previous, but otherwise OK. Laboratory results were remarkable for: TSH <0.015 mIU/L and T4 Free <0.10 ng/dL.
- F/u #2: Has started taper of oxcarbazepine. Is now on 750mg total daily dose. She is still on the 21mg nicotine patch. Reports in increase in anxiety, which is manageable at this point. Did have a visit with a therapist and thinks she might be a good fit.
- F/u #3: Stable with continuation of plan. No complaints.
- F/u #4: Is now on 450mg total daily dose of oxcarbazepine and 14mg nicotine patch. Ms. M reports an increase in irritability since last visit. States she wakes up every morning in a "terrible mood" and again started having "temper tantrums" daily. Feels physically restless and is sleeping only 3-4 hours per night. No active suicidal ideation. She is irritated that you are making her "give up" oxcarbazepine as a treatment option given how well it has worked for her in the past. While she was agreeable to the plan in the first

visit, she states that "newer data shows it can be safe." She is surprised and frustrated that you are recommending discontinuation of something that works.

Discussion Questions

4. What would be your approach to this change described by Ms. M? What would you recommend at this point in her treatment?
   Facilitator elicits the following:

This is an expected but critical time in the preconception plan outlined in Ms. M's first visit. While it was a reasonable plan to trial a purposeful and selective taper of specific medications, it is not surprising that doing so (while she is also tapering her daily nicotine dose) has in fact resulted in a destabilization of her mood. Thankfully, as she has engaged in frequent appointments and close monitoring, you are able to "catch" this change in mood early in its presentation and react accordingly.

During this follow-up visit, it will be important to provide Ms. M with reassurance that this experience gives both of you more information about her treatment needs and together you will create a plan to address her increased irritability and distress. Regardless of what recommendations you make, it will be important that Ms. M knows you have heard her frustration about the recommendation to taper oxcarbazepine and understand that it has been an effective tool for her in the past.

While it might indeed be reasonable option to resume oxcarbazepine at her previous effective dose at this point in the treatment plan, it remains notable her treatment history suggests that she may be able to benefit from other mood stabilizers which may have a more favorable reproductive safety risk profile. All 3 previous SGA trials have been limited by side effects rather than a lack of efficacy. Given this history, and again acknowledging that pre-conception planning allows for flexibility in exploring options with less established efficacy for a given patient, it would be most prudent to continue the taper of oxcarbazepine while introducing an alternative mood stabilizing medication.

Clinical Vignette Part 3

Ms. M proceeds with the plan for close monitoring and continual assessment of medication changes. After nearly a year, she is completely abstinent from nicotine and alcohol and has also considerably reduced cannabis use. She has been seeing a skilled therapist 1-2 times weekly who has helped her to process her previous traumatic experiences and to build emotional regulation and distress tolerance skills. About 10 months after your first visit, her ob/gyn physician removes her contraceptive implant. After another 3 months, you receive an urgent message from Ms. M via your electronic medical record patient portal system. She reports that she had a positive home pregnancy test the night before. Per her message, she is thrilled at this result however is "completely freaking out too." She asks, "which of my medicines should I keep taking now that I am really pregnant?" and "I am taking a prenatal vitamin but read on a blog post that I need to take high-dose folic acid too. Can you send that in for me?"

Ms. M's current medication are as follows:

- Lamotrigine 200mg daily
-Quetiapine 100mg AM and 300mg hs

Discussion Questions

5. What changes would you advise Ms. M to make now that pregnancy is confirmed?
   Facilitator elicits the following:

None! Assuming her mood is stable, she should keep on this treatment which was developed purposefully to minimize her overall risk during pregnancy. The benefit of preconception planning is that you have planned for this! You should share in her excitement, remind her to continue her prenatal vitamin, and encourage her to schedule her first prenatal appointment.

6. Ms. M is taking lamotrigine 200mg. What prescribing considerations might you keep in mind during pregnancy? How would you respond to her question about high dose folic acid?
   Facilitator elicits the following:

Lamotrigine metabolism occurs primarily via hepatic glucuronidation, which is greatly upregulated by rising estradiol levels in pregnancy. Thus, it is expected that Ms. M will experience a dramatic increase in clearance of this medication as pregnancy progresses, potentially up to 300% above her pre-pregnancy rate! It is important to monitor her mood closely during pregnancy and up titrate lamotrigine as needed.

While there is no established therapeutic window for lamotrigine when used for mood stabilization, and it is not standard practice in the management of bipolar disorder outside of pregnancy to obtain lamotrigine levels, this is a commonly recommended strategy during pregnancy. Ideally as Ms. M has been engaged in preconception planning, a baseline lamotrigine level was obtained prior to pregnancy. If not, this should be done as soon as possible. A common recommendation thereafter is to check the lamotrigine level monthly and to increase the dose in conjunction with clinical symptoms to keep the patient close to her established baseline level.

While high dose folic acid (4mg) is sometimes recommended with use of other anticonvulsant medications (i.e. valproic acid and carbamazepine) in women of reproductive age, lamotrigine does not affect the folate pathway and has not been associated clinically with neural tube defects. As the safety of high dose folic acid outside of indicated uses has not been well-established, the practice of prescribing this regimen specifically for decreasing risk with lamotrigine is not recommended.

Clinical Vignette Part 4

Ms. M presents for a f/u visit at 28 weeks gestation. She is now taking a slightly higher lamotrigine dose (300mg daily) and remains on quetiapine 100mg am and 300mg hs. She has established with an ob/gyn practice and been adherent to all prenatal care recommendations. At her 20-week ultrasound she was enamored by seeing an image of her baby and reassured by the feedback from the maternal fetal medicine physician performing the ultrasound reading. At that visit she found out she is having a boy and she has decided to name him after her father. She has started taking childbirth, newborn care and "breastfeeding basics" classes through the local hospital.

Given how smooth her experience has been, she is surprised to report at her visit today that her mood has been "off." Again, she is feeling an increase in her energy level, "but not in a good way," and reports low mood, negative ruminations, and feelings of hopelessness that she has not experienced for a very long time. She denies any thoughts of suicide or self-harm but reports "I don't like the direction my mood is going." She is worried about her options as she knows she is "maxed out" on lamotrigine as she has read that doses over 300mg are associated with an increased risk for oral cleft malformations.

Discussion Questions

7. How might you address Ms. M's current depressive symptoms?
   Facilitator elicits the following:

While it would be helpful to obtain a lamotrigine level at this point to compare to her previously measured "baseline," her clinical presentation supports that she may benefit from an increase lamotrigine and/or an increase in quetiapine to target bipolar depression. While initial reporting form the North American AED Registry did report an increased risk for oral clefts with exposure to lamotrigine in the 1st trimester, more recent population-based studies have not shown this association AND at 28 weeks, Ms. M's is beyond the period of risk for cleft palate anomalies.

8. As Ms. M is entering her 3rd trimester, how might you approach planning for the postpartum period? Given her current medication regimen, what guidance would you provide around her desire to breastfeed?
   Facilitator elicits the following:

If Ms. M's lamotrigine dose has been increased during pregnancy, her dose should be decreased by 25% in the immediate postpartum period with further decreases every 2-4 days until her pre-pregnancy dosing is reached. This strategy is meant to account for the rapid return to pre-pregnancy clearance of lamotrigine in the postpartum period and avoid toxicity for the Ms. M or her breastfed infant.

Lamotrigine is not a contraindication to breastfeeding, and only occasional adverse reaction has been reported among infants exposed to lamotrigine via breastmilk. Importantly, however, lamotrigine is transmitted in breastmilk at rates higher than many other psychiatric medications. The reported relative infant dose (RID) varies between 9 and 18 percent. When lamotrigine is utilized during lactation, it is important that infants are monitored for rash, apnea, and drowsiness. If symptoms emerge, infant's lamotrigine levels, platelet count and liver function tests may be required.

Quetiapine, on the other hand, has a very low RID at less than 0.1%. While baby's exposure is therefore likely to be minimal, Ms. M should be monitored for sedation on this medication in the postpartum period and in the context of her baby's 24- hour care needs. Available data suggests that Ms. M's clearance of quetiapine is also likely to increase during pregnancy, thus in the postpartum period she may experience a heavier side effect burden with this medication as her clearance returns to baseline. If she is unable to safely care for her infant during nighttime feeds due to sedating qualities of this medication, she may need to utilize other feeding supports at night and/or lower her quetiapine dose.

Lastly, Ms. M should be counselled on several general principles important to managing bipolar disorder during the postpartum. One such consideration is the importance of sleep to optimize mood stability and prevent onset of a major mood episode. She may want to consider seeking support for nighttime feedings so that she is able to get a consolidated time for sleeping (ideally 5+ hours continuous sleep). The risk of major mood episodes such as depression, mania, mixed episodes should be discussed, and warning signs reviewed. Individuals with bipolar disorder are also at risk for postpartum psychosis, which is a rare but severe psychiatric syndrome with rapid onset in the postpartum. Individuals with this syndrome experience psychotic, affective and cognitive symptoms. The risk of harm to self or infant is markedly elevated during these episodes. This syndrome is considered a psychiatric emergency so thorough counselling for the patient and family on signs and symptoms is important for maintaining safety.