Bipolar Disorder
Postpartum Psychosis
Integrative Case Conference
Trainee Guide

Contributors
Sarah Nagle-Yang, MD, University of Colorado School of Medicine
Ran Zhao, MD, MPH, Johns Hopkins University

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Taber Lightbourne, MD, Perelman School of Medicine, University of Pennsylvania
Sarah Nagle-Yang, MD, University of Colorado School of Medicine

Pre-Assessment Learning

- Bergink, V., Rasgon, N., & Wisner, K. L. (2016). Postpartum psychosis: madness, mania, and melancholia in motherhood. *American journal of psychiatry*, *173*(12), 1179-1188.
- Wesseloo R, Kamperman AM, Munk-Olsen T, Pop VJ, Kushner SA, Bergink V. Risk of Postpartum Relapse in Bipolar Disorder and Postpartum Psychosis: A Systematic Review and Meta-Analysis. Am J Psychiatry. 2016 Feb 1;173(2):117-27.

Optional Supplemental Reading

- Bergink, V., Armangue, T., Titulaer, M. J., Markx, S., Dalmau, J., & Kushner, S. A. (2015). Autoimmune encephalitis in postpartum psychosis. American Journal of Psychiatry, 172(9), 901-908.
- Bergink, V., Burgerhout, K. M., Koorengevel, K. M., Kamperman, A. M., Hoogendijk, W. J., Lambregtse-van den Berg, M. P., & Kushner, S. A. (2015). Treatment of psychosis and mania in the postpartum period. American Journal of Psychiatry, 172(2), 115-123.
- Kamperman, AM, Veldman-Hoek, MJ, Wesseloo, R, Robertson Blackmore, E, Bergink, V. Phenotypical characteristics of postpartum psychosis: A clinical cohort study. Bipolar Disord. 2017; 19: 450– 457.

Overview
The goal of this module is to utilize a clinical case presentation to broaden learners' knowledge of Postpartum Psychosis. After completion of this module, learners should have a preliminary understanding of the epidemiology, phenomenology, pathophysiology, diagnostic considerations, prevention, and treatment of post-partum psychosis. 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 some clinical experience with pregnant and/or postpartum patients. Prior to the session, residents should read the articles included in the pre-reading section of this module.

Session
- **Clinical Vignette: read aloud (5 minutes)**
- **Residents divide into small groups and discuss questions 1-5 (15 min)**
- **Each group presents their findings to the large group (15 minutes)**
- **Large group continues with "Case Continued" and discusses questions 6-8 as a large group (15 minutes)**
- **All residents participate in large group discussion led by facilitator (10 minutes)**

Learning Objectives
1.Understand the epidemiology of Postpartum Psychosis.
2. Identify and diagnose Postpartum Psychosis utilizing phenomenology.
3. Understand current theories of etiology.
4. Create a differential diagnosis list based on diagnostic considerations.
5. Provide evidence-supported treatment.
6. Develop prevention strategies to be used with patients and their support networks.

Case Presentation

Mrs. L is a 29-year-old G1P1 female @ 6 days postpartum with no known psychiatric history. She was brought to the Emergency Department by her husband who reported increasingly bizarre behaviors at home.

Mr. L described Mrs. L as a cheerful and friendly person at baseline, with several close friends in different social groups. He reported that her pregnancy had been highly desired and that both her pregnancy and delivery had progressed without complication. Their son was born via SVD at 39 weeks, weighing 7lbs and 3oz. Mr. L reports that Mrs. L seemed to do "fine" in the first couple of days after delivery- she was fatigued and sometimes anxious but seemed enamored with their son and was able to initiate breastfeeding with support from lactation consultants. However, a couple of days after discharge from the hospital (postpartum day 4) he noticed some odd behaviors, such as checking behind counters and under tables for no apparent reason. When he approached her about these incidents, she responded "I just want to make sure our baby is safe."

Over the next 2 days her behavior was increasingly bizarre, and her personal hygiene declined. Her husband found her pacing around the baby's room at night while he was soundly sleeping. When he encouraged her to "get some rest," she appeared confused and disoriented, stating that she wasn't tired and needed to be there for her son. Her husband noticed she had thrown away many of the soaps and lotions that had been given to them as gifts at their baby shower and when he asked her about it she reported they smelled "off," she knew they were contaminated and didn't want to expose their son to "those poisons." On the day of evaluation, the patient's husband was worried about her health, and thought she might need some relief from the stress of caring for their child. He decided to stay home from work to give her some relief. Around noon time, he heard the infant crying on the baby monitor, and went to check on him. When he walked into the room, he saw patient holding a pillow standing by the side of the crib. He immediately attempted to take the pillow from her. She initially resisted his efforts, repeatedly stating "I must save him, what are you doing", but subsequently released the pillow and allowed him to bring her to the Emergency Department.

On exam, she appeared her stated age, her hair was uncombed. She was wearing mismatched socks and a wrinkled shirt with visible food stains. She was calm, and cooperative with the exam, but was guarded, made poor eye contact with the evaluator, and often looked around the room apprehensively. She exhibited psychomotor agitation evidence by repeated rocking motion with her upper torso. Her speech was spontaneous, and was normal in articulation, prosody, and rhythm. Her volume varied from shouting at the evaluator to whispering under her breath. She described her mood as "afraid" and at times appeared irritable; her affect was labile. Her thought process was tangential, at some points she exhibited loose associations. She endorsed an occasional auditory hallucination of a baby crying. She exhibited delusional beliefs that she had "holy powers" and that she and her son were on a "divine mission." She reported she had been "receiving messages" giving her information about this mission and went on to elaborate that the "only way to make sure his soul ends up in the right hands is to send him to heaven myself." She had poor insight and judgement. No illicit substances were detected on initial urine toxicology screen, and blood alcohol level was <10.

Additional history was gathered from patient's husband and her mother (via telephone). Mrs. L's maternal aunt was diagnosed with "manic-depressive" disorder, but details are unclear as she passed away at a young age. Otherwise, the patient's family did not have a history of mental illnesses or substance abuse. There were no suicides in the family. She grew up in a supportive and loving middle class household with both parents and her brother. She excelled academically, and successfully obtained a law degree from their state university. She is currently on maternity leave from her job at a local real estate law firm. She has no psychiatric history; she saw a school counselor several times in high school after a classmate committed suicide, but she did not know this classmate well. She has never taken any psychotropic medications, and does not use tobacco products or drink alcohol. She tried marijuana in college several times, but has had no other illicit substance use since then. She has no medical problems, and her only surgery was a tonsillectomy at age 12. She has no known drug allergies.

Discussion Questions

1. Please describe the epidemiology of postpartum psychosis (PPP). Specifically, how common is PPP and when are women at highest risk? What psychiatric diagnoses are associated with PPP?

2. For this patient, what are the chances she will develop another episode of postpartum psychosis after subsequent births? What about psychiatric symptoms outside of the postpartum period?

3. Please describe the phenomenology of postpartum psychosis. Specifically, when do symptoms usually start? What are common symptoms of PPP? How are symptoms of PPP similar or distinct from affective psychosis in non-perinatal patients? What is the expected duration of symptoms if left untreated?

4. Please describe current theories of postpartum psychosis pathophysiology.

5. What are some differential diagnostic considerations? What diagnostic tests should be considered?

Case Presentation Continued

After a thorough assessment and evaluation for underlying causes, you determine that Mrs. L has PPP. You explain the diagnosis to Mr. L, who appears to take comfort in having a diagnosis and asks "So what do we do now? How will she get better?"

Discussion Question

6. Describe potential treatment for Mrs. L. What level of care will she need? What treatment strategies might you suggest?

Case Presentation Continued

Upon further discussion with Mr. and Mrs. L, Mrs. L is agreeable to inpatient admission. She expresses relief that she may not have to "feel like this forever." She does have questions about what to expect. Specifically, she asks the following questions: "Can I continue to breastfeed while I am in the hospital? How long will I need to be on these meds? Won't being apart from my baby make it hard for us to bond?"

Discussion Question

7. Discuss how you would address Mrs. L's concerns.

Case Presentation Continued

Six months after initial presentation, Mrs. L attends a follow-up appointment with her outpatient psychiatrist. She has been stable since her hospital discharge 5 months ago with good treatment adherence. She states she would like to discuss the idea of her having another baby in the future, perhaps in the next year. She asks you "will the same thing happen again if I have another child?"

Discussion Question

8. Discuss how you would address Mrs. L's question, including information about the risk of recurrence and therapeutic strategies to reduce her risk.