BIPOLAR DISORDER IN WOMEN OF REPRODUCTIVE AGE

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Bipolar I disorder:

- 1 or more **manic** or mixed episodes **lasting ≥1 week** (any duration if hospitalized)

- Manic episodes characterized by increased energy or activity, ≥3 (or 4 if irritable mood only) of the following:
  
  - Inflated self-esteem or grandiosity, decreased need for sleep, pressured speech, racing thought/flight of ideas, distractibility, increased activity, **excess pleasurable or risky activity** (usually related to sex and/or spending)

- Symptoms cause **functional impairment**, necessitate **hospitalization**, or there are **psychotic features**
Bipolar II disorder:

- Never had a full manic episode; at least 1 hypomanic episode and at least 1 major depressive episode; hypomanic episode lasting $\geq 4$ but $< 7$ days

- During the hypomanic episode, $\geq 3$ (or 4 if irritable mood only) of aforementioned features

- Unequivocal change in functioning, uncharacteristic of person, and observable by others

- Not severe enough to cause marked impairment, not due to substance or medical condition, and no psychosis (if present, then this is mania by definition)
LIFESTYLE CONSIDERATIONS

- **Changes in seasons**
  - Highest rates of admission for (hypo)mania during spring/summer (longer photoperiod)

- **Disruptions of sleep**
  - Predispose to relapse, particularly mania

- **Substance abuse**
  - Highest risk of comorbidity compared to all other Axis I disorders
  - Increased risk of mania in substances that directly affect dopamine
  - Marijuana-evidence for increased risk/severity of mania in pre-existing bipolar, increased risk of new-onset mania

- **Psychosocial stressors**
Mainstays of treatment: mood stabilizers (valproic acid, lithium, lamotrigine, carbamazepine) and antipsychotics (usually atypical)

- Weight gain, metabolic syndrome
- Galactorrhea (atypical antipsychotics, especially risperidone)
- Valproic acid

- Contraindicated in women of childbearing age, but unfortunately still occasionally prescribed
- Obesity, hormonal abnormalities, PCOS
Methods

- National Health Insurance Research Database of Taiwan

- 3721 patients with bipolar disorder and 14,884 controls, matched by gender and age

- enrolled between 2000 and 2010, followed up until the end of 2013

- Participants who developed any STI (HIV, syphilis, genital warts, gonorrhea, chlamydia, trichomoniasis) during follow-up period identified.

Cox regression analysis to examine risk of STI between patients with bipolar disorder and comparative controls.
RISK OF SEXUALLY TRANSMITTED INFECTIONS

- **Results**
  - Patients with bipolar disorder prone to develop STI (HR, 1.67; 95% CI, 1.27–2.18)
  - Especially HIV (HR, 3.59; 95% CI, 1.16–11.08) and syphilis (HR, 2.26; 95% CI, 1.06–4.85)
  - Incidence of STI higher among women than men (HR, 1.83; 95% CI, 1.41–2.39).

- **Conclusion**
  - “bipolar disorder is associated with an increased risk of developing STI, which has direct implications for the development of targeted prevention interventions or regular sexual health screening”
PSYCHOTROPICS IN PREGNANCY

Mood stabilizers

- **Lithium**
  - Congenital malformations (Ebstein’s anomaly; 1.1% vs 1.9%)
  - Risk of toxicity in mother (especially during delivery)

- **Valproic acid (Depakote)**
  - Neural tube defects, etc; ~10% risk malformation

- **Carbamazepine (Tegretol)**
  - Neural tube defects, etc; ~7% risk malformation

- **Lamotrigine (Lamictal)**
  - Generally safe, first choice
PSYCHOTROPICS IN PREGNANCY

Atypical antipsychotics
- Generally safe
- Clozaril - agranulocytosis

Benzodiazepines
- Safe in small doses

Antidepressants
- Safe from pregnancy standpoint
- Controversial due to risk of induction of mania in bipolar
THE POSTPARTUM PERIOD

Risks associated with relapse of bipolar disorder (WOMEN SHOULD NOT DISCONTINUE MEDICATIONS):

- Difficulty with self care, caring for baby
- Impaired bonding with baby
- Intentional or unintentional harm to baby (particularly with mania, psychosis)
- Neglect
- Poor decision making
- Attempts to harm the baby
THOUGHTS OF INFANT HARM

- Can be a feature of depression, anxiety, or psychosis
- Intrusive thoughts present in postpartum period in ~90% women, regardless of presence of psychiatric disorder
- Highest prevalence in first postpartum weeks
- May occur even in pregnancy
- Positive correlation with stress, infant crying
THOUGHTS OF INFANT HARM

Assessment

- Ego-dystonic thoughts
  - distressing to patient, no intent to act
  - NOT associated with increased risk of harm to infant
- Ego-syntonic thoughts
  - acceptable/logical to patient, intent to act
  - associated with personality disorders, psychosis
  - ARE associated with increased risk

Approach

- Ego-dystonic thoughts: normalization, shame reduction, reassurance baby will not be taken from mother, offer resources
- Ego-syntonic: EMERGENCY PSYCHIATRIC EVALUATION OF MOTHER (PES)
SYMPTOMS OF PSYCHOSIS

Hallucinations

- Auditory
  - Hearing things others can’t (usually a voice/voices)
  - Not psychosis: hearing baby cries when baby is not crying
- Visual
  - Seeing things others can’t (formed visually hallucinations rare with exception of organic disease (ie delirium) or personality disorder)
  - Not psychosis: Shadows, seeing movement out of corner of eye

Delusions

- Beliefs held in the face of significant evidence to the contrary
- Paranoia
  - Usually an elaborate and highly improbable/bizarre belief system
  - Not psychosis: overestimated/unrealistic fears (ie OCD worries)
- Worries that someone might try to take baby/harm baby more normal
- Worries that Catholic Church is spying on family in attempt to kidnap and enslave not normal
POSTPARTUM PSYCHOSIS: A PSYCHIATRIC EMERGENCY

- 1/500 mothers, usually presents in first 2-4 weeks after delivery
- Psychiatric emergency
- Most cases related to bipolar disorder, not schizophrenia
- Increased risk of infant harm (intentional and unintentional)
SPECIAL CONSIDERATIONS
POSTPARTUM

- Breastfeeding
  - Medications may complicate
    - Lithium
      - Sedation (difficulty waking to baby’s cries)
    - Sleep disruption
  - Sleep
    - Risk for relapse
    - Shifts with partner, family help, hired help
Comorbidity: bipolar disorder and history of trauma (across the lifespan)

Patients with history of PTSD can be triggered by events occurring during pregnancy/labor/delivery

Variation in PTSD trajectories across peripartum predicted by experience of pregnancy stress/trauma exposure, labor anxiety, lifetime PTSD symptoms

PTSD trajectory associated with postpartum adjustment; women whose PTSD symptoms rise during pregnancy most impacted by postpartum depression and bonding impairment

Encourage conversation between patient and physician/L&D staff about boundaries/triggers
Bipolar disorder differs from other mood disorders—can result in grossly impaired judgment that can result in long-term consequences (sexual, psychological, financial)

- Sensitivity to seasonal changes, sleep deprivation, substances, stressors
- Higher risk of sexually transmitted infections
- Medications have high rates of side effects
- Postpartum illness can include postpartum psychosis which is a psychiatric emergency due to risk of harm to infant
- Special considerations for breastfeeding and sleeping arrangements
- Significant comorbidity with trauma, risk of triggering/re-traumatization