Bipolar disorder in the perinatal period

A guide for health professionals

Bipolar disorder is characterised by intense and sustained mood shifts usually between episodes of depression and mania. Risk of relapse increases significantly in pregnancy (often following cessation of medication) and in the postnatal period (especially in the first few weeks after childbirth).

Prevalence

The prevalence of bipolar disorder in the general population is estimated to be **1 in 100**.

Causes

While the cause of bipolar disorder is unknown, it is frequently inherited and often linked to stressful life events.

Symptoms

Common behaviour associated with depression:

- Moodiness that is out of character
- Increased irritability and frustration
- Finding it hard to take minor personal criticisms
- Spending less time with friends and family
- Loss of interest in food, sex, exercise or other pleasurable activities
- Being awake throughout the night
- Increased alcohol and drug use
- Staying home from work or school
- Increased physical health complaints like fatigue or pain
- Slowing down of thoughts and actions.

Common behaviour associated with mania:

- Increased energy
- Irritability
- Overactivity
- Increased spending
- Being reckless or taking unnecessary risks
- Increased sex drive
- Racing thoughts
- Rapid speech
- Decreased sleep
- Grandiose ideas
- Hallucinations and/or delusions.

Providing antenatal and postnatal care

Care planning

In planning care for women with bipolar disorder, give priority to ensuring that health professionals involved take into account the complexity of the condition and the challenges of living with severe mental illness. Where available, involve specialist perinatal mental health services.

For women with bipolar disorder, a multidisciplinary team approach to care in the perinatal period is essential, with clear communication, a documented care plan and continuity of care across different clinical settings.

Preconception planning

Preconception planning should start at diagnosis of bipolar disorder among women of childbearing age. Many of these women will have poor health literacy and will need clear explanations of the importance of contraception if the woman is not planning a pregnancy, the effects of some medications on fertility, the risk of relapse in pregnancy or after the birth (particularly if medications are stopped) and the complexities of raising a child in the context of severe mental illness.

Preconception planning should include discussion of pharmacological treatments to be used after the birth, which will involve decision-making by the woman about whether she will breastfeed.

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Best Practice COPE Guideline

Antenatal care

Key considerations in providing antenatal care to women with bipolar disorder include:

- monitoring for early signs of relapse, particularly as medication is often ceased before or during pregnancy
- education about nutrition and ceasing smoking, illicit substance use and alcohol intake in pregnancy
- monitoring for excessive weight gain and gestational diabetes in women taking antipsychotics
- referral for multi-dimensional care planning early enough in the pregnancy (particularly if the pregnancy is unplanned) to build trusting relationships and develop a safety net for mother, baby and significant others.

Postnatal care

Women with bipolar disorder may find the early postnatal period particularly distressing for many reasons, particularly as their bond with the baby may be compromised. Ensuring partner, family or paid (e.g. nanny) support is important, particularly overnight so the woman can sleep. Sleep deprivation is a common trigger for relapse so prevention is worthwhile.

Careful monitoring is required in the first month after birth for women with bipolar disorder, with regular review in the following months.

Access to specialist intervention to support parenting skills, including the role of partners and significant others, and attend to the mother-infant attachment is a consideration for women and their families.

Such an approach can best be taken in specialist mother-baby units, however, availability of publicly funded mother-baby units that cater to both the woman and her infant is variable across Australian jurisdictions.

If relapse of bipolar disorder occurs, co-admission to a mother and baby unit is recommended. In some instances, it may be necessary for women to cease breastfeeding if they are too unwell, require night-time sedation, or sleep disruption (to feed the infant) would have an adverse effect on their mental state.

Psychosocial and psychological therapies

Psychoeducation and supportive therapy that includes family and significant others is most important for women with bipolar disorder. Cognitive behavioural therapy and other psychological interventions can be beneficial in managing secondary depression or anxiety.

Pharmacological treatments

Medications should only be prescribed after careful deliberation with the woman and her significant others when she is planning a pregnancy, is pregnant or breastfeeding. Involving a psychiatrist is advisable.

Antipsychotics – While the evidence on the safety of antipsychotic use in pregnancy is limited, evidence from the general population supports their use to treat psychosis. However, clozapine is known to cross the placenta and the evidence on its safety in breastfeeding women is limited.

If considering use of clozapine in pregnant women, seek specialist psychiatric consultation.

Anticonvulsants – There is a risk of birth defects if anticonvulsants (particularly sodium valproate) are taken during pregnancy. There is uncertainty about the passage of some anticonvulsants into breast milk.

Do not prescribe sodium valproate to pregnant women.

Lithium – Antenatal monitoring of lithium levels is advised as requirements increase during pregnancy. There is potential for high passage of lithium into breastmilk and risk of infant toxicity.

Where possible, avoid the use of lithium in women who are breastfeeding.

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Tips for providing support

Listen and reassure

- Encourage the woman to discuss any symptoms she may be experiencing.
- Assure the woman that bipolar disorder can be treated and managed.

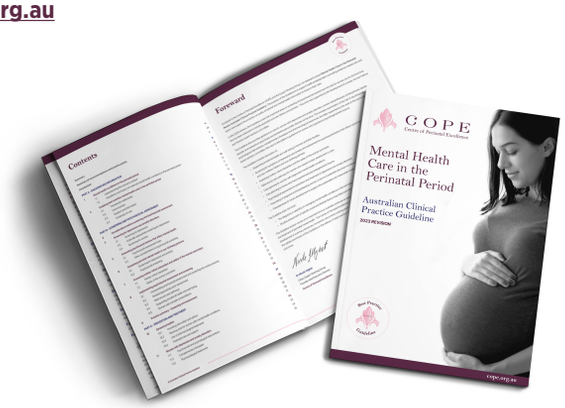
Provide information

- Refer all women to **Ready to COPE** – to receive ongoing information and support strategies throughout her pregnancy and/or the postnatal period.
- Provide the woman with quality information about bipolar disorder – see COPE consumer fact sheet.
- Provide details of helplines if she is feeling distressed and needs support.
- Offer information to the woman's partner/others.

Direct to care and support

- Encourage the woman to consult with her general practitioner (GP) or other qualified health professional.
- Encourage the woman to identify and draw on possible supports and services that may be available to her for practical and/or emotional support.
- Remind the woman that she can go to her doctor or local hospital if she is at risk of harming herself or others.

This resource was developed from the *Mental Health in the Perinatal Period: Australian Clinical Practice Guideline* (2023). The Guideline can be downloaded from the COPE website at cope.org.au



Information for women and their families:

Ready to COPE Guide:

Women and their partners can receive free weekly information about emotional and mental health throughout the perinatal period, via the Ready to COPE Guide. Visit readytocope.org.au for more information.

Information:

Provide women with consumer fact sheets on bipolar disorder in pregnancy and the postnatal period.

Telephone support:

To access peer support person or health professional support and advice, call the SANE helpline on 1800 187 263 (Monday to Friday 10.00am – 10.00pm AEST/AEDT)

Further mental health information:

To find out about other perinatal mental health treatment and support services, visit the eCOPE Directory

COPE
Centre of Perinatal Excellence

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