Treating Bipolar Disorder in Pregnancy

Based on: WebMD

Do you have bipolar disorder and want to become pregnant or are pregnant already? Perhaps you have bipolar disorder and do not want a pregnancy. Be sure to talk with your obstetrician and psychiatrist about the risks and benefits of bipolar medications and forms of birth control. For some women, a contraceptive injection that is only needed every few months is best. If you have bipolar disorder and become pregnant unexpectedly, take note: Stopping your medications suddenly may cause harm to you and your unborn child.

Complications of Bipolar Disorder in Pregnancy

Few studies have been done on bipolar disorder and pregnancy, so not enough is known about the risks of untreated bipolar disorder or the risks and benefits of medications during pregnancy. And the factors that lead to relapse during pregnancy are not clear. Bipolar disorder, however, can worsen during pregnancy. Pregnant women or new mothers with bipolar disorder have seven times the risk of hospital admissions than pregnant women who do not have bipolar disorder.

A 2007 study on bipolar disorder and pregnancy called into question a common belief that pregnancy may have a protective effect for women with bipolar disorder. The study followed 89 women through pregnancy and one year after delivery. When stopping bipolar medications for the six months before conception to 12 weeks after, the women had:

- Twice the risk of relapse
- A 50% risk of recurrence within just two weeks, if they stopped suddenly.
- Bipolar symptoms throughout 40% of the pregnancy -- or more than four times that of women who continued their bipolar medications.

Bipolar Medications During Pregnancy

Some women continue taking bipolar medications and have healthy babies. But a few bipolar medications have an increased risk of birth defects in the first trimester, such as:

- Neural tube defects
- Heart defects
- Developmental delay or neurobehavioral problems

However, you must weigh these risks against the risks of untreated bipolar disorder. It can lead to behaviors like these, which can also harm a baby:

- Poor prenatal care
- Poor nutrition
- A rise in alcohol or tobacco use
- Stress and trouble with attachment

Your doctor may suggest stopping gradually or changing medication. Or you may continue with medication and do regular tests to check on the health of your baby. But whatever you do, don't stop taking medications without first talking with your doctor.

Was your pregnancy unplanned? If so, know that stopping medications suddenly may do more harm than good.

Mood stabilizers. Taking multiple mood-stabilizing drugs has more risks than taking just one. Because of the rare risk for a particular kind of heart defect, lithium is sometimes not recommended during the first three months of pregnancy unless its benefits clearly outweigh the risks. Lithium may be a safer choice than some anticonvulsants. And when lithium is continued after childbirth, it can reduce the rate of relapse from 50% to 10%. It is important to recognize that all mood stabilizers are category C or D. Lithium, valproic acid, and carbamazepine are category D. Lamotrigine, oxcarbazepine, and the neuroleptic/antipsychotic medications are all category C. All this being said, lithium and haloperidol (despite risks) are considered the most effective and safest choices for pregnant patients with bipolar who need medication management. Additionally, it is important to remember that none of these medications are considered safe in breast feeding, with the exception of vaproic acid which is “probably safe.”

Treating Schizophrenia During Pregnancy

Clinical Psychiatry News

Pregnancy is a period of increased risk and vulnerability for women with schizophrenia and their future child.

An article in the May issue of "Clinical Psychiatry News" reported that when contrasted with women who don't have a mental illness, women who have schizophrenia have more unwanted sex and pregnancies, much poorer prenatal care, are at a increased likelihood of being a victim of violence during pregnancy, and a reduced likelihood of having a partner or husband. These are significant disadvantages that compound the risks for mother and child in addition to the direct impact of schizophrenia.

Following is a short excerpt from an interview with Dr. Laura Miller about inpatient work with women who have schizophrenia and are pregnant. Dr. Miller is a leader in women's mental health and manages a perinatal Mental Health Project at the University of Illinois at Chicago.

> CPN: What are the key risks of pregnancy and the postpartum period in women with schizophrenia?
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> Dr. Miller: During pregnancy, key risks include delayed recognition of pregnancy, less prenatal care, failure to recognize labor, and a greater incidence of obstetric complications. A particularly high-risk symptom is psychotic denial of pregnancy, a condition in which the woman denies that she is pregnant despite clear indications, and thereby refuses prenatal care, misinterprets signs of labor, risks precipitous and unassisted delivery, and fails to bond with the baby.
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> The postpartum period is a time of increased risk for exacerbation of schizophrenia. Symptoms of schizophrenia can also adversely affect parenting capability, which leads to high rates of custody loss. At times, delusions and/or hallucinations about the baby directly interfere with bonding and parenting.
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> Negative symptoms of schizophrenia, such as apathy or difficulty expressing emotions, may contribute to under stimulation or neglect of a baby. The additional risks of obstetric complications and parenting difficulties for offspring who may be genetically vulnerable further heightens the long-term risk of psychiatric problems in the children of women with schizophrenia.

In the story Dr. Miller notes that key things for doctors to do is to do a thorough assessment of the mental and physical health of the woman. After doing the assessment the optimal treatment solution includes medication and psychoeducation to educate the woman (and ideally her partner) about understand the normal bodily changes accompanying pregnancy. The goal is to minimize the delusional misinterpretation of these changes and help the mother recognize signs related to pregnancy complications and labor.

Specific efforts can also be made to reduce the risk factors that impact her child (see Preventing Schizophrenia). For example, there is a high prevalence of smoking during pregnancy in women with schizophrenia - and smoking is well-known to harm the fetus in many different ways, lowering IQ and increasing risk of many physical and mental disorders. An intervention to help the mother stop smoking can reduce these risks to mother and child's health. The doctor (and family members and/or husband of the woman who is pregnant) might also help with making extra sure the woman gets the proper nutrition (fruits and vegetables, and key vitamins like Folic Acid, Omega fatty acids, Vitamin D, Choline, etc). Clinicians can also make an effort to identify the woman's parenting strengths and weaknesses, as well as the specific effects of symptoms on parenting attitudes and behaviors. Research has shown that the parenting skills that a parent has can have a significant impact on the long-term health (physical and mental) of the child.

Medication is the mainstay of management for schizophrenia; thus, the primary agents used during pregnancy in women with the disorder are antipsychotics. Data on traditional, first generation medications are more extensive than for the newer, second-generation antipsychotics. However, as no single antipsychotic drug has emerged as clearly favorable during gestation, the agent that is efficacious for the individual woman must be given strong consideration. The medication to which the woman has had a sustained response will generally dictate the choice during pregnancy. Otherwise a single high potency agent such as haloperidol has the most robust research supporting safety. *Based on: Adv Schizophr Clin Psychiatry* 2007;3(2):48–55.