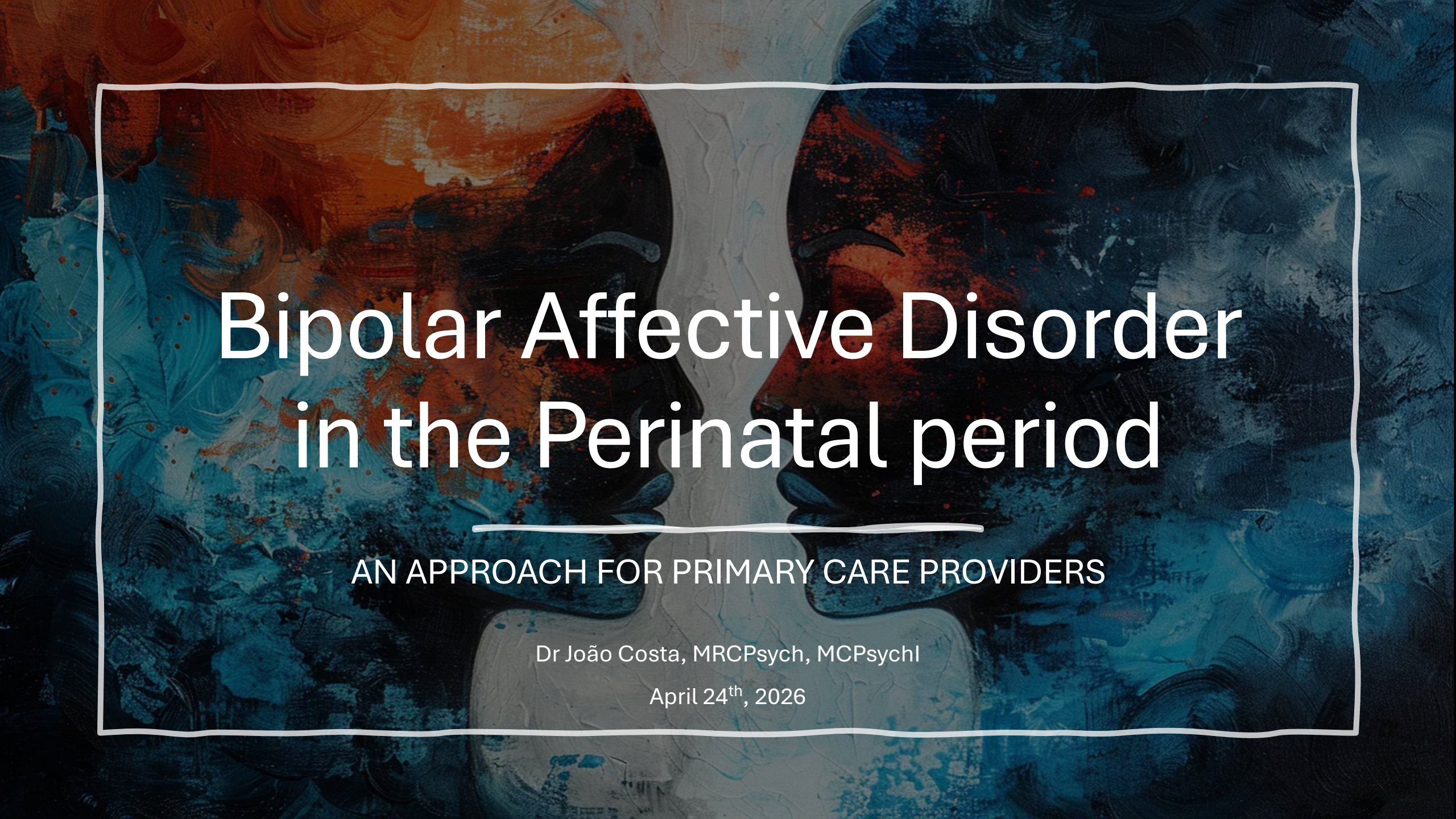

Bipolar Affective Disorder in the Perinatal period

AN APPROACH FOR PRIMARY CARE PROVIDERS

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Learning objectives

- Recognise clinical presentations of bipolar disorder in the perinatal period
- Differentiate BPAD from unipolar depression and other common perinatal presentations
- Identify red flags and psychiatric emergencies requiring urgent escalation
- Understand key principles of primary care management and psychoeducation
- Know when and how to refer for specialist assessment

I. Basics of BPAD

Epidemiology

Lifetime prevalence 0.3-1.5% (usually quoted at approx 1%)

Age of onset is usually late teens/early twenties

Age of onset is earlier than unipolar depression

After one episode of mania patients have a 90% chance of having a future episode

Rate of attempted suicide is 15-20% (completed suicide is 10%)

Definition (ICD 11)

Bipolar disorders are characterised by a **disturbance in mood**

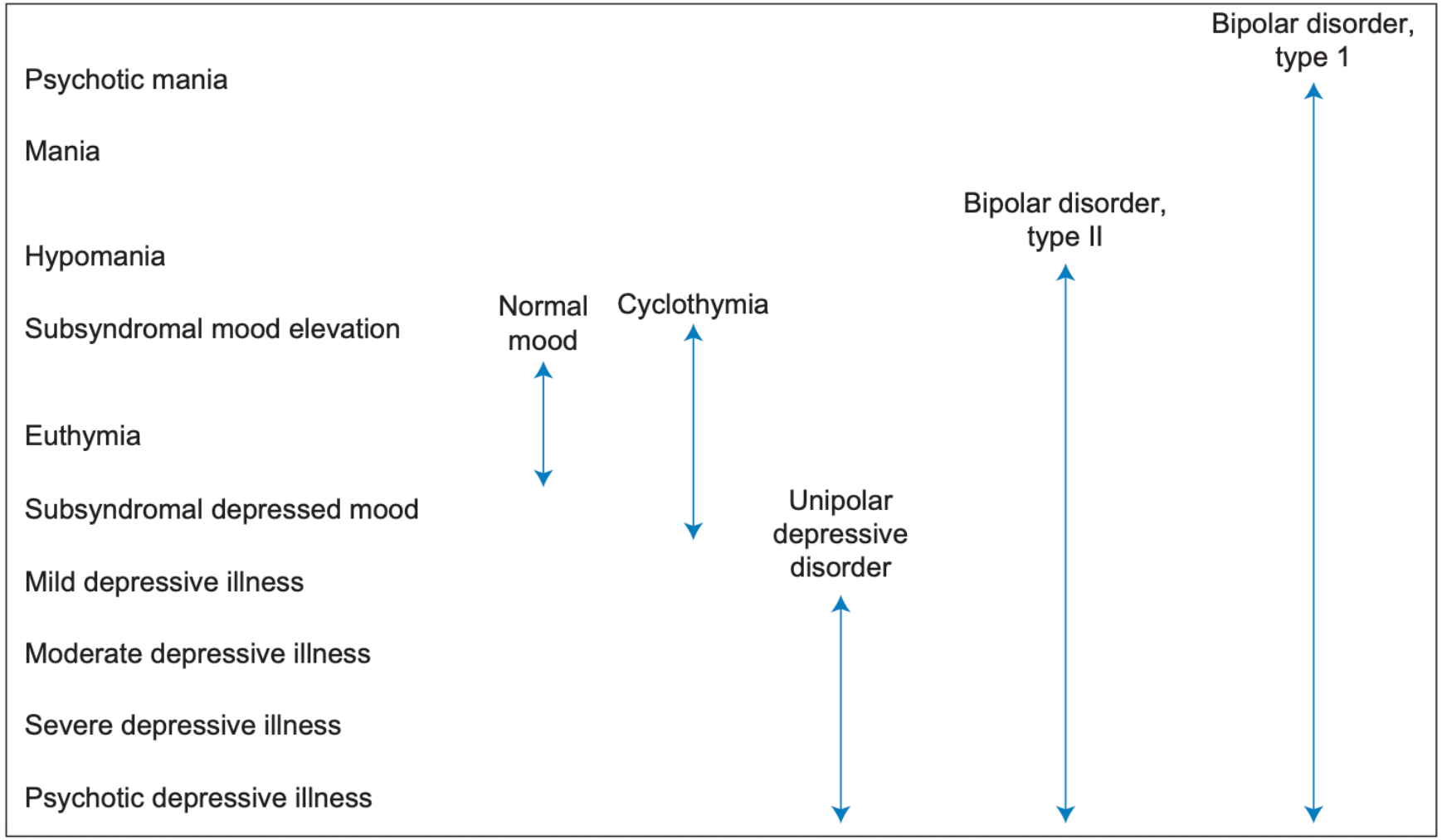
Elevated mood plus increased **activity and behaviour**

Mania, lasting **at least seven days** or **hypomania**, lasting a **shorter period**

Bipolar disorder also includes **lowering of mood and energy**, that is, **depression**

WHO, 2019

Spectrum of mood disorders



Geddes et al., 2021 (Mood disorders section)

Mania

A: Core features (both required)

Elevated, expansive or irritable mood

Increased activity or subjective energy

Present for at least several days, and typically ≥1 week

Or any duration if severe (e.g. requires admission)

B: Additional symptoms (several)

Increased talkativeness / pressured speech

Flight of ideas / racing thoughts

Inflated self-esteem or grandiosity

Decreased need for sleep

Distractibility

Impulsive or reckless behaviour

Increased goal-directed activity / sociability / sexual energy

C: Severity

Marked impairment in functioning

May require hospitalisation

Psychotic symptoms may be present

Hypomania

A: Core features (both required)

Elevated or irritable mood

Increased activity or energy

Present for several consecutive days (shorter than mania)

B: Additional symptoms (several)

Increased talkativeness

Distractibility / reduced concentration

Decreased need for sleep

Increased activity or restlessness

Increased sociability or overfamiliarity

Increased sexual energy

Mild impulsive / reckless behaviour

C: Severity

No marked impairment in functioning

No psychotic symptoms

If psychosis present → diagnosis = mania

MSE

Appearance & Behaviour:	Speech:	Mood:	Affect:
Dramatic/inappropriate/provocative clothing or attire Increased psychomotor activity Overfamiliar and intrusive Disinhibited Distractible May be irritable/aggressive	Increased in rate & volume Pressure of speech if severe-very difficult to interrupt and to identify connections between sentences Use of Clang Associations or Punning	Subjectively “great”, fantastic” Objective: elated/euphoric	Lability of affect (rapidly changing) Irritable If the above are present, then this is mood congruent

MSE

Thought:	Perception:	Cognition:	Insight:
• Increased in rate and quantity • Flight of Ideas if severe (evident in speech as Pressure of Speech) • Content is often grandiose and may be delusional • May also be Persecutory Delusions	• May be hallucinations (usually 2nd person auditory, content in keeping with grandiosity and inflated self esteem	• Inattentive • Distractible • Check orientation	• Usually limited or absent

Differential Diagnosis

- Schizophrenia/ Schizoaffective
- Organic Brain lesions
- Other Psychotic Disorders
- Personality disorder
- Cyclothymia
- Substance Misuse

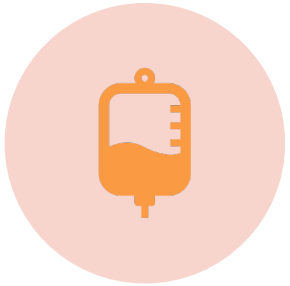
Bipolar Disorder in Women

DiFloria and Jones, 2011

More rapid cycling	Less substance abuse
More seasonal pattern	Less completed suicide
More (longer) depressive episodes	Later onset
More mixed and dysphoric mania	Hormonal changes e.g. puberty, menstruation, menopause, childbirth
More comorbidity with Anxiety disorders	
More BPII	

Bipolar Disorder in Women (2)

Medical comorbidity: thyroid disease, migraine, obesity *(Di Florio and Jones, 2011)* and **PCOS** *(Chen et al., 2020)*



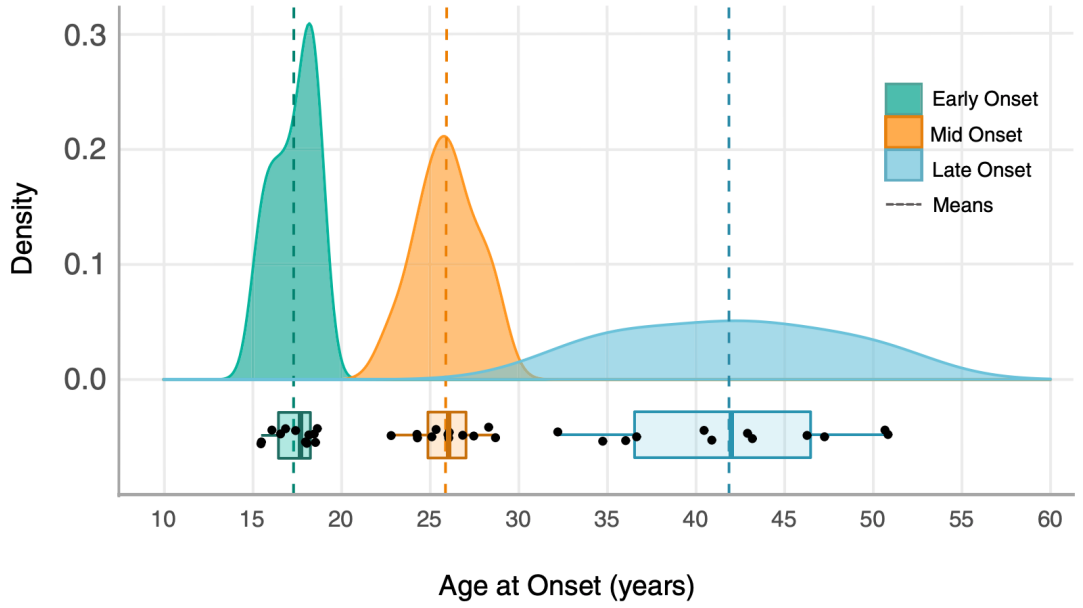
Obstetric associations: gestational diabetes, antepartum haemorrhage, placenta praevia, induction of labour, elective caesarean section *(Boden et al., 2012; Rusner et al., 2016)*

Long term mortality linked to **suicide** and **cardiovascular disease**

Risk reflects **both illness related factors and treatment related factors**, rather than medication exposure alone

Trimodal Age-At-Onset

- Maternal age at first childbirth in the EU (EU first birth mean age (2023): Eurostat, **29.8 years**



II. BPAD in the Perinatal period

Why this matters

Bipolar disorder often **missed in perinatal settings**

Postpartum = **highest relapse risk period**

Misdiagnosis → inappropriate treatment → worse outcomes

NHS Practitioner Health

Remembering Daksha and Freya Emson

25 Years On

Key risk factors for perinatal bipolar disorder

Non-modifiable

- BPAD-I
- Previous postpartum episode
- Family history

Modifiable

- Medication discontinuation
- Sleep deprivation
- Lack of support

Postpartum Psychosis

- Onset usually within 2 weeks
- Psychiatric emergency
- High risk of Suicide / Infanticide
- Requires urgent psychiatric assessment

Postpartum monitoring

- Normal Puerperal Changes
  - Sleep deprivation due to infant feeding
  - Mild emotional lability ("baby blues" resolving in 2 weeks)
  - Typical new-mother fatigue

- BD Prodrome / Relapse Warnings
  - Decreased NEED for sleep (feeling energized despite no sleep)
  - Rapid speech and cognitive disorganization
  - Paranoia or sudden onset of severe depression/apathy
  - Intrusive thoughts of harm

Prevention comes first

1. Knowledge of medical history

2. Assessing the context

3. Adapting treatment and care pathways

1. Knowledge of medical history

Lifetime evolution of the disorder

- Preceding pregnancies +++
- Preceding episodes
  - Number
  - Type and severity
    - Puerperal psychosis: highest risk
    - Hospitalisations?

Sensitivity to sleep deprivation

- Prevention +++

Treatments efficacy

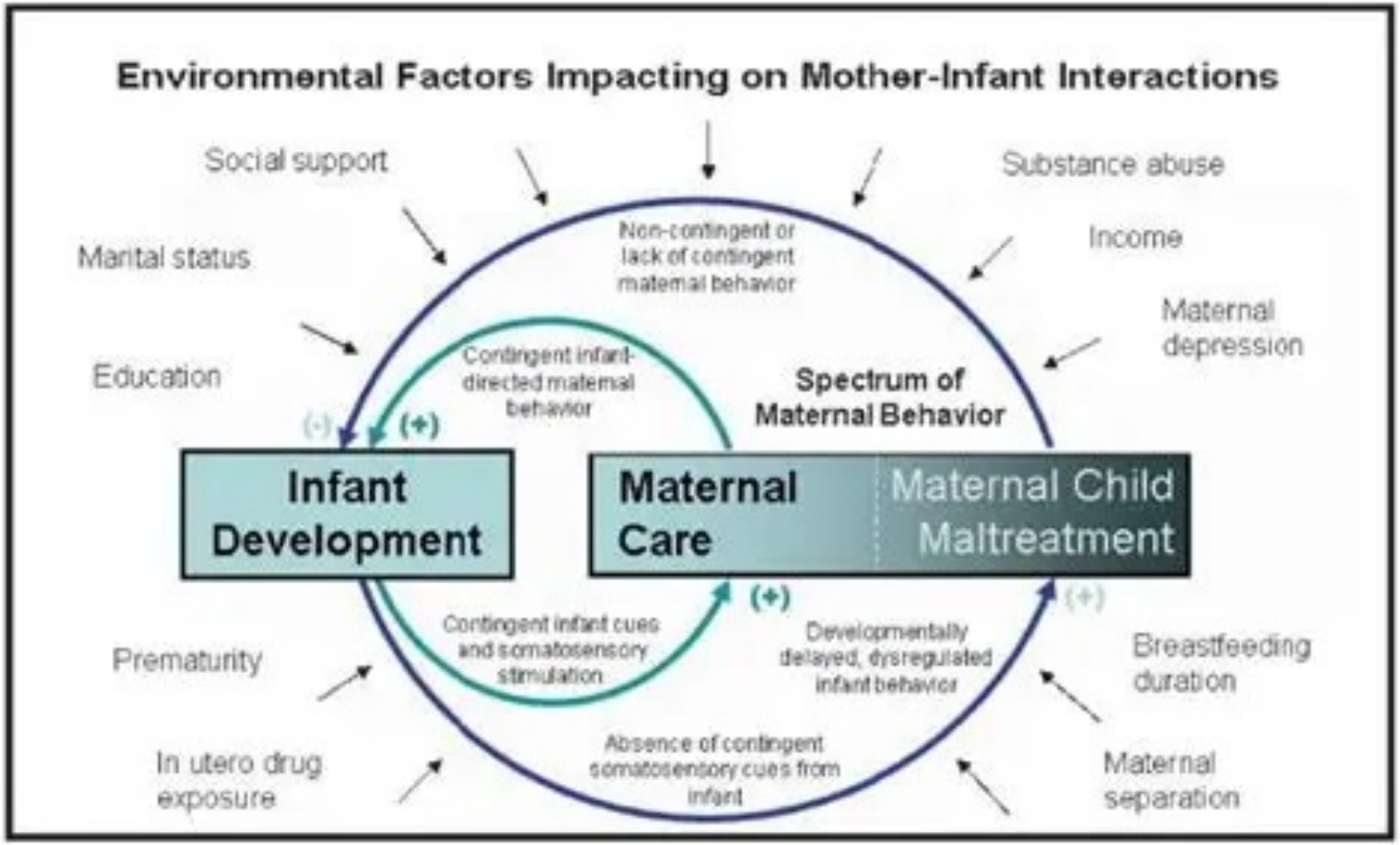
- Psychotropic drugs
- Psychotherapies
- ECT…

Family history, especially perinatal thymic episodes

Cochrane 2015, Clark et al., 2018, Sharma et al., 2020, Lasika et al., 2022, Akaishi et al., 2023

2. Assessing the context

- SES
- Professional status and involvement at work
- Maternity leave
- Paternity leave
- Social support (family, friends, others)
- Paternal mental health and past personal and familial history
- Prevention of domestic violence +++



Swain et al., 2007

3. Benefit-risk discussion

Most important and difficult part of the consultation	• Ethical and medico-legal issues • Parents must make their own decision
Benefits for the mother to be treated	• Reducing the risk of relapse • Avoid antenatal exposition to maternal relapse • Preparing to welcome the baby in good conditions

Risks for the baby of antenatal expositions requires	• Thorough knowledge of recommendations and up-to-date literature
	  • Psychotropic drugs
	  • Effects of antenatal exposure to maternal psychiatric pathologies
	• Knowledge of obstetrics and neonatal paediatrics resources in the area

Medication

Mood stabilisers reduce relapse

Lithium often most effective

Antidepressants alone may worsen bipolar disorder

Avoid valproate in women of childbearing age

Specialist input required

Adherence

Relapse risk spikes dramatically if maintenance lithium is abruptly discontinued (up to 73% recurrence).

Stopping medication → high relapse risk

Relapse can be severe postpartum

Treatment protects both mother and baby

Non-judgemental discussion is key

Sleep matters

"Protected Sleep" is not a luxury; it is a **strict medical intervention**

Sleep loss is a major trigger

Night waking can destabilise mood

Practical focus:

protect sleep where possible

involve partner/support

- 2 folds higher risk of puerperal psychosis if previous manic episodes triggered by sleep loss
- 3,5 times higher risk of suicide if suffering from insomnia or poor sleep quality

Palagini et al., 2023

Breastfeeding

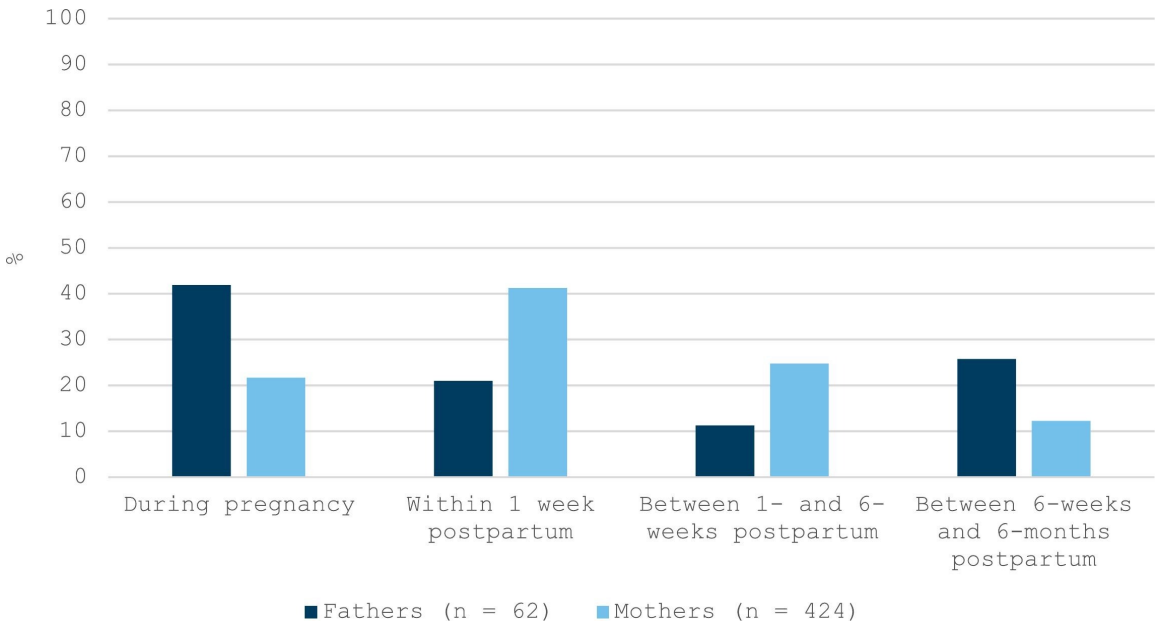
- Breastfeeding considerations
  - Benefits vs relapse risk
  - Sleep deprivation → major trigger
  - Medication exposure considerations
- Options:
  - Breastfeeding (with monitoring)
  - Formula feeding
  - Donor milk / human milk bank

➢ Maternal mental stability is the priority

Mother Infant Dyad

- BD and PPP → impaired bonding
- Developmental impact on infant
- Interventions: MBUs, Parent-infant therapy

➢ Treat dyad, not only the mother



Brooks 2025 et al.

Fathers

- Perinatal mood disorders in fathers with BPAD
- Fathers do not undergo the same biological changes
- Different timing, often during pregnancy
- Family system approach
- Support network = protective factor

What you can do (primary care)

1. Recognise warning signs
2. Ask about past episodes
3. Involve family/support
4. Encourage adherence
5. Reduce isolation
6. Escalate early

Relapse is the enemy, not treatment!

References

- Geddes, Price & McKnight (2021), *Psychiatry*, 4th ed., Oxford University Press, Mood disorders section, Specific disorders chapter.
- DiFloria and Jones, 2011
- *Chen et al., 2020*
- *(Boden et al., 2012; Rusner et al., 2016)*
- *ICD 11, WHO, 2019*
- Brooks 2025 et al. Perinatal mood episodes in fathers with bipolar disorder, Journal of Affective Disorders, Volume 390, 119856
- *Etc……*