Systems and Psychosocial Advances Research Center
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Improving Mental and Behavioral Health Services for Better Lives and Stronger Communities

Understanding barriers & facilitators to bipolar disorder treatment and ability to access pharmacotherapy during pregnancy: A formative study

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Background

Bipolar disorder among perinatal women (pregnant or within a year of birth) has harmful effects on birth and child outcomes,[1] as well as maternal behaviors including substance use[2] and infanticide.[3,4] Bipolar disorder occurs in 23% perinatal women who screen positive for depression,[5] and is often undetected, unaddressed or exacerbated through inappropriate treatment.[6,7] Bipolar disorder is the strongest and best-established risk factor for postpartum psychosis,[8] which carries a 4% risk of infanticide and a 5% risk of suicide. Treatment of bipolar disorder is particularly complex and challenging during the perinatal period.

Study Goals

The goals of this preliminary descriptive study were to:

- Identify barriers women with bipolar disorder face in accessing pharmacotherapy during pregnancy
- Identify strategies to overcome barriers

Methods

Participants were recruited from a purposeful sample of women from 12 weeks gestation to 24 months postpartum who:

- Scored ≥ 10 on the Edinburgh Postnatal Depression Scale
- Met DSM-IV criteria for bipolar disorder I, II or not otherwise specified using the Mini International Neuropsychiatric Interview version 5.0.

Participants were recruited from five obstetric practices affiliated with a tertiary care referral center in Central Massachusetts. In-depth, in-person interviews were conducted with 25 perinatal women with bipolar disorder to identify their perspectives on barriers and facilitators to bipolar disorder treatment during pregnancy.

Results

Table 1. Description of study participants

Variable	Mean	Std Dev
Age	30.96	5.84
Postpartum weeks (N=12)	36.65	27.90
Weeks pregnant (N=13)	21.71	6.75
Number of pregnancies (median, IQR)	3	1.5-5
Number of births (Median, IQR)	2	1-3
	N	**%**
Race		
Black or African-American	2	8.0
White	16	64.0
Other/Unknown	7	28.0
Hispanic/Latina	9	36.0
Education		
Less than high school	4	16.0
High school diploma or GED equivalent	5	20.0
Some college or technical/trade school	6	24.0
Associate degree or higher	10	40.0
Health insurance		
Medicaid or Medicare	12	48.0
Private health insurance	11	44.0
Combination	2	8.0

Percentages may not add up due to missing values. N=number, Std Dev=Standard Deviation, IQR=Interquartile Range

Barriers to treatment

- **Refusal of psychiatric providers to provide pharmacotherapy to perinatal women**
  "My psychiatrist told me he doesn't give medications to pregnant women and I have to stop the medication. He just told me that once I got pregnant I needed to stop immediately, not realizing that I've been with my medication for over three years."

- **Lack of knowledge among general psychiatric providers about management of pregnant women resulting in an inability to provide appropriate care**
  "She doesn't know what she's doing.... she told me that I was fine [and did not need medication treatment]. I need to see a doctor that is experienced with dealing with mental health issues with a pregnant person."

- **Limited availability of psychiatric providers who will treat pregnant women**
  "It's people being available, like counselors being available. Cause some places take even 4 or 5 months just to get in."

Facilitators to treatment

- **Having a psychiatric provider who specializes in/has knowledge about perinatal mental health**
  "It's just if I could find the right person that would be safe seeing a pregnant woman... I could get the right treatment."

- **Having a psychiatric provider who understands that women need to be well to care for their babies**
  "I don't like being what I'm on, but I think the outcome of being happy and not depressed and being able to take care of my 3 year old overpowers the downfall."

- **Education about the risks and benefits of medication use during pregnancy**
  "I need to know what medications are safe in pregnancy... just to be able to function every day."

Discussion

Study findings suggest:

- Pregnant women with bipolar disorder have limited access to evidence-based treatment.

- Interventions need to be developed to:
  - Build the capacity of general psychiatric providers to treat pregnant and postpartum women with affective disorders more broadly, i.e., not just perinatal depression.
  - Train psychiatric providers in the management of both bipolar disorder and perinatal pharmacotherapy.

- Enhancing psychiatric providers' knowledge and skills regarding treatment during pregnancy may improve patient care for pregnant women with bipolar disorder.

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