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Access to Pharmacotherapy Amongst Women with Bipolar Disorder during Pregnancy: a Preliminary Study

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Abstract

Bipolar disorder among pregnant women has deleterious effects on birth and child outcomes and is currently under-detected, not addressed effectively, or exacerbated through inappropriate treatment. The goal of this study was to identify perspectives of pregnant and postpartum women with bipolar disorder on barriers and facilitators to psychiatric treatment during pregnancy. In-depth interviews were conducted with pregnant and postpartum women who scored ≥ 10 on the Edinburgh Postnatal Depression Scale and met DSM-IV criteria for bipolar disorder I, II or not otherwise specified using the Mini International Neuropsychiatric Interview version 5.0. Interviews were transcribed, and resulting data were analyzed using a grounded theory approach to identify barriers and facilitators to bipolar disorder treatment access in pregnancy. Participant identified barriers included perception that psychiatric providers lack training and experience in the treatment of psychiatric illness during pregnancy, are reluctant to treat bipolar disorder among pregnant women, and believe that pharmacotherapy is not needed for psychiatric illness during pregnancy. Facilitators included participants' perception that providers' acknowledge risks associated with untreated or undertreated psychiatric illness during pregnancy and provide psycho-education about the risks, benefits and alternatives to pharmacotherapy. Psychiatric providers are critically important to the treatment of bipolar disorder and need knowledge and skills necessary to provide care during the perinatal period. Advancing psychiatric providers' knowledge/skills may improve access to pharmacotherapy for pregnant women with bipolar disorder.

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Compliance with Ethical Standards

Conflict of Interest The first, third, fourth and seventh author have received salary and/or funding support from Massachusetts Department of Mental Health via the Massachusetts Child Psychiatry Access Program for Moms (MCPAP for Moms). The first author is also the statewide Medical Director of MCPAP for Moms. The first author has served on the Perinatal Depression Advisory Board for the Janssen Disease Interception Accelerator Program and the Physician and PPD Summit Advisory Board for Sage Therapeutics. The third author is the Lead Obstetric Liaison for MCPAP for Moms and has served on the Physician and PPD Summit Advisory Board for Sage Therapeutics, the fourth author has been the Program Director of MCPAP for Moms, and the eighth author has served as a Consultant for MCPAP for Moms. The second, fifth, sixth and seventh authors declare that they do not have not conflicts of interest.

Research Involving Human Participants All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Informed Consent Informed consent was obtained from all individual participants included in the study.

Keywords

Bipolar disorder; Perinatal; Pregnancy; Postpartum; Medications; Treatment

Introduction

Bipolar disorder among perinatal women has deleterious effects on birth and child outcomes, and is associated with self-injury, substance use, suicide, and infanticide [1]. Despite availability of effective evidence-based treatments, many women with bipolar disorder are not identified and do not receive adequate treatment during pregnancy [2]. Even when bipolar disorder is recognized, women may experience treatment access barriers including psychiatric providers who are not adequately trained or who are uncomfortable initiating, continuing or maintaining psychopharmacology treatment for pregnant women [3]. Treatment access and adequacy is a critical issue because discontinuation of pharmacotherapy increases risk for illness relapse [1].

There is a paucity of information on perceptions of women with bipolar disorder and their ability to access pharmacotherapy during pregnancy. The goals of this preliminary descriptive study were to identify: (1) barriers women with bipolar disorder face in accessing pharmacotherapy during pregnancy; and, (2) strategies to overcome barriers. In the discussion, we review how the findings inform intervention development aimed to improve pharmacotherapy access for women with bipolar disorder during pregnancy.

Methods

Participants were recruited from a purposeful sample of women from 12 weeks gestation to 24 months postpartum ($n = 25$) who scored ≥ 10 on the Edinburgh Postnatal Depression Scale [4] and met DSM-IV criteria [5] for bipolar disorder I, II or not otherwise specified using the Mini International Neuropsychiatric Interview version 5.0 [6]. Participants were recruited from four obstetric practices affiliated with a tertiary care referral center in Central Massachusetts. Informed consent was obtained and participants received a \$15 gift card to compensate them for participation. This study was approved by the University of Massachusetts Medical School Institutional Review Board.

In-depth interviews lasting 20 min were conducted in which participants responded to study probes regarding the barriers and facilitators pregnant women with bipolar disorder face in accessing pharmacotherapy. All interviews were audiotaped. Recordings were cleaned of any identifying data, transcribed, and checked for accuracy.

Transcripts were uploaded into Dedoose [7], a web-based software program that facilitates mixed methods data management for further coding, elaboration and specification of concepts and relationships. Interview content was organized theoretically, using a modified grounded theory approach with a phenomenological emphasis [8]. Using methods described by Miles & Huberman [9], categorizing began with an initial set of preliminary codes for themes suggested from the literature, research aims and previous work. Codes were added as they emerged from the data until saturation was achieved, and initial transcript sections were

re-categorized using the reformulated codes. Dedoose allows for the assembling of coded segments into selected configurations that facilitates identification of recurring patterns/clusters. Reliability was enhanced by the coding of data by more than one researcher.

Results

Participants represented a diverse and representative sample of women (Table 1). Fourteen participants met DSM-IV criteria for bipolar disorder type I, five for bipolar disorder type II and six for bipolar disorder, not otherwise specified. As described below, similar themes reflecting barriers and facilitators mental health treatment during pregnancy were identified by participants.

Barriers

Refusal of Psychiatric Providers to Provide Pharmacotherapy to Perinatal Women—Participants reported that general psychiatric providers are unwilling to provide pharmacotherapy, leaving them with limited treatment options.

"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 need to stop immediately and not realizing that I've been with my medication for over three years.... he just said there's a line you can call to see what medications are safe during pregnancy."

Participants noted that general psychiatric providers often discontinued psychotropic medications, without consideration of their impact on patients' mental health. Participants reported that such practices were common and made it difficult for them to stay psychiatrically healthy during pregnancy.

Lack of Training among General Psychiatric Providers—Participants expressed frustration that general psychiatric providers lacked sufficient knowledge about and training in management of pregnant women and thus are unable to provide appropriate and needed care.

"She doesn't know what she's doing.... after I explained to her everything that was going on with me... from top to bottom down the list... she told me that I was fine [and did not need medication treatment] ... they need to find a doctor to fill her position because she's not appropriate, 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—Participants reported long delays in getting treatment, noting that it takes four or five months to get an appointment with a psychiatric provider who accepts pregnant patients. One participant noted,

"[Timely and accessible mental health care] wasn't available. It took a while to get help."

Facilitators

Working with a Psychiatrist who Specializes in Perinatal Psychiatry—Getting referred to a provider who specializes in perinatal mental health was noted to facilitate appropriate treatment. Several participants perceived that their mental health would have benefitted if they had they been able to access such specialty care.

"It's just if I could find the right person that would be safe seeing a pregnant woman... I could get the right treatment."

Psychiatric Providers' Understanding that Women Need to be Well to Care for their Babies—Participants reported that when a psychiatric provider understood that they needed medications to function and feel well it empowered them and helped them to better care for their baby.

"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, the slight chance of risk of something being wrong with the baby."

Education Regarding the Risks and Benefits of Medication use during Pregnancy—Participants noted that knowledge about potential effects of both the illness and medication on the baby helped them feel that they were getting the best possible treatment and making the right choices about their care. Several participants noted that they appreciated hearing about studies and statistics as it built confidence in their treating provider. One participant noted "I need to know what medications are safe in pregnancy... just to be able to function every day."

Discussion

Psychiatric providers' reluctance to provide pharmacotherapy for pregnant women with bipolar disorder impedes women's ability to access evidence-based treatment and thus maintain or achieve psychiatric stability. Discontinuation of psychotropic medications by psychiatric providers, without consideration of their impact on patients' mental health, poses additional risk for women during a time of increased psychiatric vulnerability, which in turn may complicate birth, infant, and child outcomes [1]. Our findings build on prior studies in which obstetric providers reported that community mental health providers were reluctant to continue or initiate pharmacotherapy for pregnant women [3]. They also suggest that a better understanding of the benefits of and the need for treatment, regardless of pregnancy status, among psychiatric providers would enhance provision of evidence-based care for women.

Limitations include a small sample drawn from a single geographic region. Although our sampling focused on women with bipolar disorder, many of the barriers and facilitators may also apply to other psychiatric illnesses occurring during pregnancy. Including data on the perspectives of psychiatric providers would have enhanced our findings to understand provider perspectives on what makes bipolar disorder particularly challenging to manage during pregnancy. For example, is bipolar disorder more challenging to manage during pregnancy because providers perceive increased concerns about teratogenicity of mood stabilizers or antipsychotics as compared to antidepressants? Regardless, our study builds on

previous research on barriers to perinatal depression treatment [3, 10] by including women with bipolar disorder. Eliciting the perspectives of women with bipolar disorder is essential because bipolar disorder occurs in 23% of perinatal women who screen positive for depression [11] and the barriers experienced by women with bipolar disorder may be different than for those with unipolar depression. Bipolar disorder requires different treatment than unipolar depression and is particularly complex and challenging during the perinatal period. Providers may be even more uncomfortable treating bipolar disorder because the illness and pharmacotherapy is more complicated, thus creating a double vulnerability (i.e., pregnancy and bipolar disorder) for women [3].

The barriers identified by participants suggest important directions for interventions aimed to improve access to pharmacotherapy for bipolar disorder and possibly other psychiatric illness during pregnancy. While participants noted that access to a specialist in perinatal psychiatry facilitated care, many states, regions, and countries do not have such specialists—let alone a perinatal psychiatrist with expertise in bipolar disorders [12]. Thus, interventions need to focus on building the capacity of general psychiatrists to treat pregnant and postpartum women with affective disorders more broadly (i.e., not just perinatal depression). Advanced training in the management of both bipolar disorder and perinatal pharmacotherapy will be required to meet the needs of this population. Increased knowledge of the risk of psychiatric illness itself may mitigate abrupt discontinuation of psychotropic medications without adequate consideration of patients' mental health. Training for psychiatric providers should focus on how to weigh the risk of untreated illness and that of the medication.

Core competencies in perinatal mental health need to be developed and included in general psychiatrist residency training and maintenance of certification so the next generation of general psychiatrists can appropriately assess, counsel, and treat pregnant women in need of psychiatric treatment [12]. To build capacity for general psychiatric providers to provide bipolar disorder pharmacotherapy for pregnant and postpartum, improvement efforts could focus on developing an approach to care that includes expanded perinatal psychiatry training in residency and increased availability of consultation for general psychiatrists [13].

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References

1. Jones I, et al. Bipolar disorder, affective psychosis, and schizophrenia in pregnancy and the postpartum period. *Lancet*. 2014; 384(9956):1789–99. [PubMed: 25455249]
2. Vesga-Lopez O, et al. Psychiatric disorders in pregnant and postpartum women in the United States. *Archives of General Psychiatry*. 2008; 65(7):805–15. [PubMed: 18606953]
3. Byatt N, et al. Community Mental Health Provider Reluctance to Provide Pharmacotherapy May Be a Barrier to Addressing Perinatal Depression: A Preliminary Study. *The Psychiatric quarterly*. 2012
4. Cox JL, Holden JM, Sagovsky R. Detection of postnatal depression. Development of the 10-item Edinburgh Postnatal Depression Scale. *Br J Psychiatry*. 1987; 150:782–6. [PubMed: 3651732]

5. APA. Diagnostic and statistical manual of mental disorders. 4. 2000.
6. Sheehan DV, et al. The Mini-International Neuropsychiatric Interview (M.I.N.I.): the development and validation of a structured diagnostic psychiatric interview for DSM-IV and ICD-10. *Journal of Clinical Psychiatry*. 1998; 59(Suppl 20):22–33. quiz 34–57.
7. Dedoose. SocioCultural Research Consultants, LLC; Los Angeles, CA: 2012.
8. Morgan, D. Focus Groups as Qualitative Research. Thousand Oaks, CA: Sage Publications; 1988.
9. Miles, MH., AM. Qualitative Data Analysis. 2. Thousand Oaks, CA: Sage Publications; 1994.
10. Weinreb L, et al. What happens to mental health treatment during pregnancy? Women's experience with prescribing providers. *Psychiatr Q*. 2014; 85(3):349–55. [PubMed: 24682626]
11. Wisner KL, et al. Onset timing, thoughts of self-harm, and diagnoses in postpartum women with screen-positive depression findings. *JAMA Psychiatry*. 2013; 70(5):490–8. [PubMed: 23487258]
12. Kaiser, Henry J., F. Mental Health Care Health Professional Shortage Areas (HPSAs). 2016
13. Byatt N, et al. Improving perinatal depression care: the Massachusetts Child Psychiatry Access Project for Moms. *Gen Hosp Psychiatry*. 2016; 40:12–7. [PubMed: 27079616]

Biographies

Dr. Byatt is a psychiatrist, physician-scientist, and perinatal mental health expert who is focused on improving health care systems to promote maternal mental health. She is an Associate Professor of Psychiatry and Ob/Gyn at the University of Massachusetts Medical School. She is the inaugural Statewide Medical Director of MCPAP for Moms, a statewide program that addresses perinatal mental health and substance use disorders in Massachusetts by providing mental health consultation and care coordination for medical providers serving pregnant and postpartum women. She has been awarded several federal grants for her research that aims to ensure that pregnant and postpartum women with depression receive optimal mental health treatment. She frequently serves on national advisory boards and expert work groups focused on improving perinatal mental health. Her academic achievements have led to over 60 peer-reviewed publications and national presentations and numerous national awards.

Ms. Cox is a third-year medical student at the University of Massachusetts Medical School.

Dr. Moore Simas is an Associate Professor of Ob/Gyn, Pediatrics and Psychiatry at the University of Massachusetts Medical School where she is a practicing clinician, investigator, educator, and leader. She earned her medical degree from the UMass Medical School, her master of public health degree from the Harvard School of Public Health, and her master of education degree from UMass Boston. She is the Joy McCann Professor of Women in Medicine and the inaugural Ob/Gyn Research Division Director. Her research is focused on using adult education principles and public health initiatives to facilitate providers addressing and improving the health of maternal-offspring dyads and growing families. As such, Dr. Moore Simas is the lead obstetric liaison for MCPAP for Moms, and co-PI on a CDC-funded project investigating a stepped care approach to perinatal depression in OB/Gyn settings (the PRogram In Support of Moms, PRISM). Her academic achievements have led to over 60 peer-reviewed publications and national presentations and numerous national awards.

Dr. Biebel is an Associate Professor of Psychiatry and Deputy Director of the Systems and Psychosocial Advances Research Center (SPARC) in the Department of Psychiatry at the

University of Massachusetts Medical School. She has served as PI, Co-Investigator, and Evaluator on SAMHSA/CMHS, NIMH and foundation-funded projects focused on adults with serious mental illness, community integration, and family life. Her work has also focused on dissemination and implementation of mental health policy and programs. Dr. Biebel has worked for SAMHSA/CMHS as a Family-Centered Care Consultant, advising policy-makers and federal program officers on policy initiatives regarding families living with mental illness.

Ms. Sankaran is a Research Coordinator in the Systems and Psychosocial Advances Research Center at UMass Medical School. Her interest is in clinical and community-based research with regards to mental health, research ethics & regulatory affairs, nutrition & brain development and alternative non-medication based therapeutic interventions.

Dr. Swartz is Professor of Psychiatry at the University of Pittsburgh School of Medicine, and Western Psychiatric Institute and Clinic, Pittsburgh, PA. She is also the Medical Director of Depression and Manic Depression Prevention Program at Western Psychiatric Institute and Clinic. Dr. Swartz's research focuses on optimizing psychosocial treatments for mood disorders. She examines the impact of maternal depression treatment on offspring also receiving treatment and the role of psychotherapy in the management of bipolar II disorder. She is also interested in the process of moving efficacious psychosocial interventions to routine practice settings.

Dr. Weinreb is a Professor and Vice-Chair for Family Medicine and Community Health at UMass Medical School. Dr. Weinreb is recognized nationally as an expert on the health and support needs of homeless families and the integration of behavioral health and health care services for diverse populations. For more than 25 years, Dr. Weinreb has conducted both observational and intervention studies. She has extensive expertise in the development, implementation, and testing of health care-based interventions that integrate behavioral health and substance use services with health care for vulnerable populations, particularly women and children. Dr. Weinreb is an active clinician and has published extensively in journals including JAMA, American Journal of Public Health, and Pediatrics, and is frequently invited to speak at national meetings.

Table 1Description of study participants, ($N = 25$), demographics

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
Living with partner	19	76.0
Health insurance		
Medicaid or Medicare	12	48.0
Private health insurance	11	44.0
Combination	2	8.0
Household Income		
Less than \$15,000	4	16.0
\$15,000 – \$30,000	7	28.0
\$30,000 – \$60,000	4	16.0
More than \$60,000	7	28.0
Don't know	3	12.0
Relationship status		
Married	9	36.0
Divorced	4	16.0
Separated	1	4.0
Never Married	2	8.0
Not married but in a long-term relationship	8	32.0
Other	1	4.0
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

Percentages may not add up due to missing values

N = number, Std Dev = Standard Deviation, IQR = Interquartile Range