Review Article

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Postnatal Bipolar Affective Disorder: A Case Study

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Abstract

Bipolar disorder is a disorder of mood, in which a person has episodes of both elevated and depressed mood. These episodes of major change of mood are associated with distress and disturbance of function. Women who give birth, approximately 50 to 80% experience the "postnatal blues" following delivery. The incidence of mild to moderate depression is 10 to 16%. Severe, or psychotic, depression occurs rarely, in about 1 or 2 out of 1000 postpartum women. So special attention should be given to pregnant mothers who have past history of any psychiatric disorders. Possibly the psychiatrist face difficulty to make definite diagnosis of bipolar affective disorder (BPAD) against postnatal blues because the symptoms of postnatal blues usually begins 3 to 4 days after delivery, worsen by days 5 to 7, and tend to resolve by day 12. The aetiology of postnatal BPAD may very likely be a combination of genetic, hormonal, biochemical, psychodynamic and environmental influences. The treatment of postnatal BPAD varies with the severity of illness and may be treated with mood stabilizers, antidepressants and anxiolytics, along with supportive psychotherapy, cognitive therapy, group therapy, and family therapy. Multidisciplinary team, family members and friends may play vital role in the management of patient with postnatal BPAD.

Keywords: Postnatal; Bipolar Affective Disorder; Case Study; Multidisciplinary Team; Treatment.

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Introduction

26 years old primimother with gestational age 37 weeks 4days in early labor got admitted in to Obstetrics and Gynaecology department at 10 am on 14/12/2015 with complaints of pain in abdomen. Patient was denied for the vaginal delivery due to personal reasons. So she underwent LSCS at 1:50 pm and baby girl was delivered at 2:10 pm. Apgar score was 7 at first minute and 9 at fifth minute with 2.8 kg birth weight. Placenta was delivered completely and general health condition of mother was normal.

On second day of postnatal period, the woman suddenly developed certain affective and somatic symptoms like anxiety, irritable mood, feeling overwhelmed, unable to accept baby girl, hopelessness, childish behaviour, frequent mood swings and disturbed sleep pattern and appetite. So she was referred to psychiatric department for further proceedings.

The psychiatrist continuously assessed her for further 7 days and later diagnosed her a case of 'bipolar affective disorder, current episode mild depression' based on the above mentioned clinical features, past psychiatric history and findings of mental status examination. Psychiatrist put her on following pharmacological management,

Tab Perinorm 10 mg HS

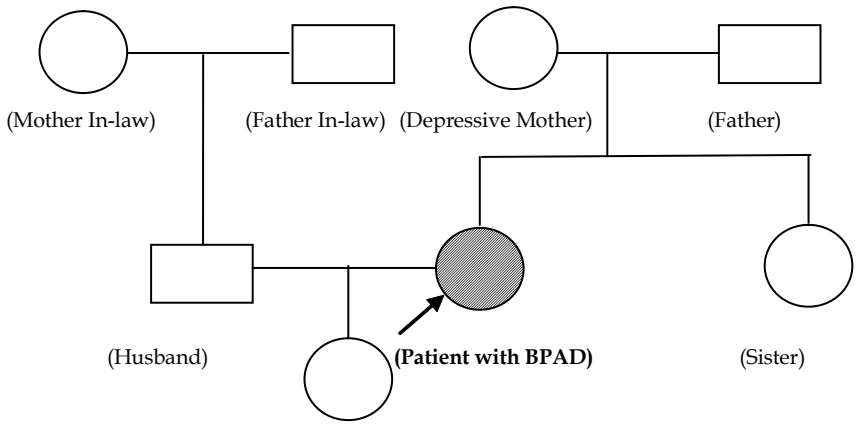
Tab Anxit 0.25mg HS,

Tab Betnesol 1 Stat,

Tab Rantac 150 mg HS,

Tab Imipramine 50 mg bd.

Family History



Mental Status Examination

The woman looked restless and was uncooperative. She had difficulty to establish eye-to-eye contact and rapport. Initiation of speech was minimal with delayed reaction time and slow rate of speech. She was anxious with labile predominant mood. She was aware of her abnormal behaviour and willing to take treatment.

Definition

Bipolar Affective Disorder is characterized by episodes of mania and depression in the same patient at different times. Typically, the patient experiences extreme highs (mania or hypomania) alternating with the extreme lows (depression); interspersed between the highs and lows are periods of normal mood [1].

Classification

As per ICD 10 classification BPAD is classified into 7 subtypes namely,

F31.0 Bipolar affective disorder, current episode hypomania

F31.1 Bipolar affective disorder, current episode mania without psychotic symptoms

F31.2 Bipolar affective disorder, current episode mania with psychotic symptoms

F31.3 Bipolar affective disorder, current episode mild or moderate depression

F31.4 Bipolar affective disorder, current episode severe

F31.5Bipolar affective disorder, current episode severe depression with psychotic symptoms

F31.6 Bipolar affective disorder, current episode mixed [2].

Patient is diagnosed as a case of BPAD, current episode mild to moderate depression (F 31.3).

Epidemiology

Lifelong prevalence rate of BPAD is 0.3-1.5%. It has significant morbidity and mortality rates. Approximately 25-50% of individuals with bipolar disorder attempt suicide, and 11% actually commit suicide. It occurs equally in both sexes. Rapid-cycling bipolar disorder (4 or more episodes a year) is more common in women than in men. Most cases commence when individuals are aged 15-28 years[1] [2].

Patient was 26 years old and had past history of BPAD.

Etiology

According to book precise cause is unknown. Bipolar disorder has a number of contributing factors, including genetic, biochemical, psychodynamic, and environmental elements.

Genetics Factors

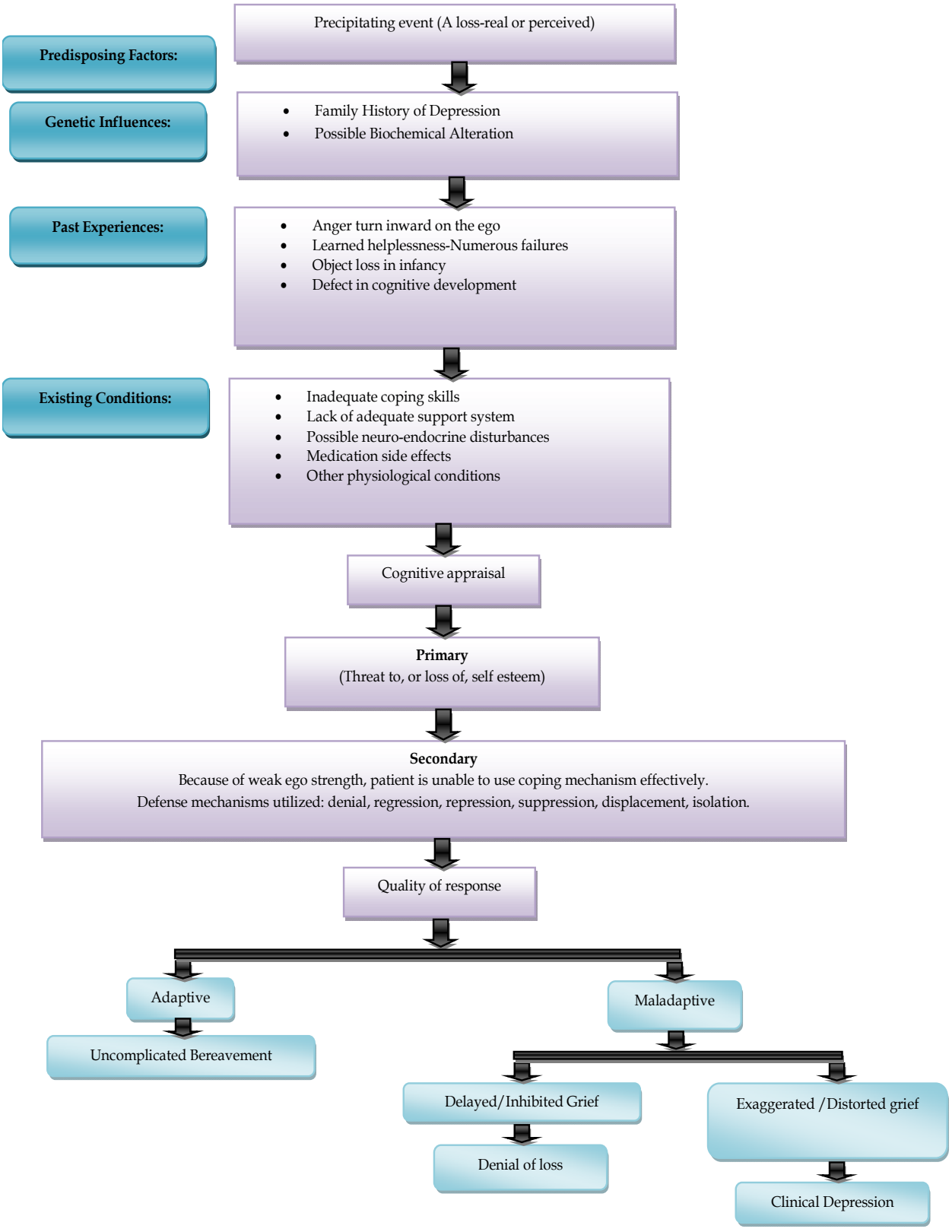
Twin, family, and adoption studies all indicate strongly that bipolar disorder has a genetic component. Bipolar disorder, especially BPI, has a major genetic component. First-degree relatives of people with BPI are approximately 7 times more likely to develop BPI than the general population.

Biochemical Factors

Catecholamine hypothesis -an increase in epinephrine and norepinephrine causes mania and a decrease in epinephrine and norepinephrine causes depression. Drugs like cocaine, which also act on this neurotransmitter system, exacerbate mania. Hormonal imbalances and disruptions of the hypothalamic-pituitary-adrenal axis [2].

Psychodynamic Factors

Depression is the manifestation of the losses, i.e., the loss of self-esteem and the sense of worthlessness. Therefore, that mania serves as a defense against the feelings of depression.



Psychodynamics of Bipolar Disorder (Depression) using Transaction Model of Stress/ Adaptation

Environmental Factors

Pregnancy is a particular stress for women with a manic-depressive illness history and increases the possibility of postpartum psychosis.

For the patient, there seems to be a mixture of causative factors namely biochemical, psychodynamic and environmental. During pregnancy there are hormonal imbalances and the disruption of the hypothalamic-pituitary-adrenal axis. Further, pregnancy is particular stress for women with a history of manic depressive illness and the increase the possibility of postpartum psychosis and poor self-esteem and faulty family dynamics may also predispose BPAD.

The Transactional Model

Bipolar disorder most likely results from an interaction between genetic, biological and psychosocial determinants. The transactional model takes into consideration these various etiological influences as well as those associated with past experiences, existing conditions and the individual perception of the event [1,3].

Signs and Symptoms

According to the book, signs and symptoms are as follows;

Manic Episode

- Expansive, grandiose, or hyperirritable mood.
- Increased psychomotor activity, such as agitation, pacing and hand wringing.
- Rapid speech with fight of ideas.
- Decreased need for sleep and food.
- Impulsivity, impaired judgment.

Depressive Episode

- Low self-esteem.
- Overwhelming inertia.
- Feeling of hopelessness, apathy.
- Difficulty concentrating or thinking clearly.
- Psychomotor retardation.
- Anhedonia, Suicidal ideation [4].

Patient in the current episode presented with anxiety, irritable mood, feeling overwhelmed, unable to accept baby girl, hopelessness, childish behaviour, frequent mood swings and disturbed sleep pattern and appetite.

Diagnostic Criteria

According to the book, diagnosis is made on the basis of history, presenting, signs and symptoms, mental status examination, ICD 10 criteria and American Psychiatric Association diagnostic criteria for manic episode [2].

In this case also, patient's history was taken. Patient was also examined and observed for mental status and signs and symptoms.

Treatment of Bipolar Depression

Comprehensive Clinical Assessment - Bipolar Depressive Episode

Clinical assessment requires patient cooperation and may not be possible if the patient is severely slowed physically and mentally.

It is essential to obtain collaborative information especially in cases where cognitive impairment is suspected:

- Suicide risk assessment.
- Exclude organic causes (neurological disorder, systemic disease, substance misuse, drug induced).
- Sophisticated appraisal of possible psychotic symptoms - especially pathological/delusional guilt and hallucinations.
- Check compliance with mood stabilizers.
- Conduct routine hematological and biochemical investigations (urea and electrolytes, full blood count, thyroid function tests, therapeutic drug monitoring).
- Additional investigations if indicated (e.g., brain scan, cognitive/ dementia screen)[5,6].

Continuing Failure to Respond

- Confirm correct diagnosis
- Re-evaluate psychological/social factors responsible for maintaining depression
- Consider adjunctive psychological therapies

Medications for Long-Term Treatment of Bipolar Disorder

Long-term treatment is often called the 'maintenance' phase of treatment or 'relapse prevention'. The goal of long-term treatment for bipolar disorder is to maintain

a stable mood and to prevent a relapse of mania or a depressive episode.

- Lithium: (Aim for serum concentration of 0.6 - 0.8 mEq/L)OR
- Valproate: (Usual dose range 1000 - 2500 mg; serum concentration 350 - 700 ìmol/L)OR
- Carbamazepine: (Usual dose range 600 - 1200 mg; serum concentration 17 - 50 ìmol/L)OR
- Lamotrigine: (Usual dose range 50 - 300 mg; serum concentration not useful)[6].

Pharmacological Intervention - Depressive Episode

New Depressive Episode	Breakthrough Depressive Episode On Single Mood Stabilizer	Failure To Respond
Initiate and optimizemoodstabilizer(Lithium, lamotrigine) **OR** mood stabilizer and antidepressant concurrently(MAOI, TCAs, SSRI)	Add antidepressant: [(SSRIs) and venlafaxine form the first-line choice of treatment.] MAOIs and TCAs should be considered as second-line treatment choices. **OR** Add second mood stabilizer (after blood levels) eg: Lamotrigine, combining of lithium and carbamazepine	Switch/substitute antidepressants **OR** Switch/substitute mood stabilizers **OR** Electroconvulsive therapy

Psychosocial Treatments

Learning to live with a continuous illness that is episodic is a major issue for people with bipolar disorder and their families.

- As an adjunct to somatic treatment.
- Repeated episodes of mania and depression tend to lead to increased rates of divorce, family breakdown, unemployment, a break in social networks and education, and financial difficulties

Cognitive Behaviour Therapy

Therapy aims at correcting the depressive negative conditions e.g. hopelessness, worthlessness and replacing them by new cognitive ideas and behavioural responses. It is used in mild to moderate depression and can be used along with somatic treatment.

Interpersonal Therapy

Therapy attempts to recognize and explore interpersonal stressors, role disputes and transitions, social isolation or social skill deficits, which acts as precipitants for depression.

Psychoanalytic Psychotherapy

Therapy aims at changing the personality itself rather than just ameliorating the symptoms. Its usefulness is uncertain.

Behaviour Therapy

This includes the various short term modalities like social skill training, problem solving techniques, assertiveness training, self control therapy, activity scheduling and decision making techniques. It is useful in mild cases of depression.

Group Therapy

Group psychotherapy can be useful in mild cases of depression. It is very useful method of psycho education in both recurrent depressive disorder and bipolar disorder.

Family and Marital Therapy

The main purpose is to ensure continuity of treatment and to reduce the intra-familial and interpersonal difficulties and to reduce or modify stressors which may help in a faster and complete recovery[6,7].

Conclusion

People who manage their bipolar disorder well provide assurance and hope that living with it and achieving a good lifestyle is now possible. The wider community is now more aware and understanding of bipolar disorder, and here are highly effective treatments now available. While there remains no cure, there is no reason to think that treatments will not improve even further in the future. Future research will aim to reduce the side effects of existing treatments and to develop better ones. With treatment, a person with bipolar disorder can lead a good quality of life.

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