NATIONAL CURRICULUM IN REPRODUCTIVE PSYCHIATRY

SSRIs and Pregnancy
Risk-Risk Conversation
Facilitator's Guide

Contributors
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Pre-Reading (prior to session):

- Byatt, Nancy, Kristina M. Deligiannidis, and Marlene P. Freeman. "Antidepressant use in pregnancy: a critical review focused on risks and controversies." *Acta Psychiatrica Scandinavica* 127.2 (2013): 94-114.Warburton, W., C. Hertzman, and T. F.
- Yonkers, Kimberly A., et al. "The management of depression during pregnancy: a report from the American Psychiatric Association and the American College of Obstetricians and Gynecologists." *General hospital psychiatry* 31.5 (2009): 403-413.

Additional Reading (optional)

- Moses-Kolko, Eydie L., et al. "Neonatal signs after late in utero exposure to serotonin reuptake inhibitors: literature review and implications for clinical applications." *Jama* 293.19 (2005): 2372-2383.

Session Overview

- Introduction to Session and Case Discussion [20 minutes]
- Video [15 minutes]
- Small Group Activity [20 minutes]
- Large Group Discussion: Take-Home Points [5 minutes]

Objectives

- The learner will describe risks associated with untreated depression in pregnancy and postpartum
- The learner will formulate a perinatal case with a focus on depression management
- The learner will practice risk-risk discussions in pregnancy
- The learner will appreciate unique factors in the management of perinatal depression in the context of risks of both medications and untreated psychiatric illness

Case Scenario

Ms. D is a 25yo G1 female at 24 weeks gestation who presents for an initial evaluation with chief complaints of depression and anxiety. Ms. D has had difficulty finding a provider who is comfortable managing her psychiatric medications during her pregnancy and found your name on your institution's website.

Psychiatric History: Ms. D has been treated for depression since age 18. She reports that when depressed her symptoms include low mood, hypersomnia, anhedonia, avolition, and feeling "overwhelming frustration and hopelessness." She states that when she has been at her worst, she was "completely not functional, in bed 23.5 hours a day." Anxiety symptoms seem to occur in conjunction with depressive episodes and are characterized by constant worry, feeling easily overwhelmed, restless, "edgy," and tense.

Ms. D has periodically struggled with suicidal thoughts but has never had an attempt. She was hospitalized in 2015 for acute suicidality with plan to overdose on "pills and liquor." At other points, she has struggled with thoughts that it would be easier to die than to live with her depression.

Ms. D has had several medication trials in the past, including sertraline (ineffective at 200mg daily for 10 weeks), venlafaxine (ineffective at 225mg daily for 8 weeks), paroxetine (worked well but caused weight gain), and burpropion (exacerbated anxiety and was discontinued). Her current medication regimen includes:

- Escitalopram 20mg daily (for the last 2 years)
- Lorazepam 1mg as needed (which she takes approximately twice weekly)

During the interview today, Ms. D tells you that her family doctor has been managing her medications since her inpatient admission in 2015. At her last appointment, she told him about her pregnancy, and he referred her to a psychiatrist, Dr. T. When she met with Dr. T. he told her that she would likely not need medications during pregnancy as the "pregnancy hormones" would suffice, but that if she insisted that she needed medication, he could prescribe her only sertraline or bupropion. She was disappointed at this advice as neither of these medications have been helpful to her in the past. Additionally, she reports remission of her depression symptoms with escitalopram and is hesitant to change it and "start over."

Through her own online research, she concluded the advice of Dr. T "just simply is not true" and decided to seek another opinion. She would like to discuss her medication options during pregnancy, but states that she also plans to discontinue all medications 1 month prior to birth in order to "not make my baby have to go through medication withdrawal."

FACILITATOR PAUSES FOR DISCUSSION

Q: How would you characterize the severity of Ms. D's illness? Why?

Facilitator elicits the following:

- Severe; symptoms that cause dysfunction: in bed 23.5 hours a day, hopelessness, anhedonia
- Onset in young adulthood, multiple episodes
- Genetic loading (revealed later in the history)
- History of suicidal thoughts
- History of multiple inpatient admission
- Multiple failed medication trials
- Comorbid anxiety symptoms

Psychiatric History, continued

Patient reports mild depressive symptoms currently, which she attributes to financial stress.

Denies any current suicidal ideation.

No history of panic attacks, obsessions/compulsions, hallucinations, delusions or manic episodes.

Family Psychiatric History:

Mother: Depression

Father: Bipolar Disorder and Alcohol Use Disorder

Brother: Bipolar Disorder, anxiety, and substance abuse (specifics unknown)

Paternal Grandmother with history of completed suicide

Medical History:

Asthma, severe

Allergies: penicillin

No other pregnancies

Substance Use:

History of tobacco use; quit 2 years ago

Occasional alcohol use prior to pregnancy

No illicit drugs

Social History:

Patient lives with her mother and 2 siblings.

Patient was born and raised in a Cleveland suburb by both parents.

She was previously working in a "vape store" in New Mexico, "it was the first time I had a job that I loved," but has been unemployed since moving back to Cleveland 3 months ago (when she learned of the pregnancy).

Boyfriend is the father of the baby, is still in New Mexico, but planning to move to Cleveland in the near future.

History of verbal and physical abuse by her father throughout her childhood; reports that her mother worked long hours while her father was disabled and was in the home "watching porn" and drinking most of the time.

MSE:

General: Patient appears well dressed and groomed, no abnormal movements

Speech: Normal rate and volume

Mood: Mildly anxious

Affect: Appropriate, bright, reactive Thought

Process: Linear, goal-directed

Thought Content: No delusions, no hallucinations, no suicidality, no homicidality, no ruminations or obsessions

Behavior: Friendly, polite, interactive

Cognitive: alert and oriented x 3, language fluent

Insight/Judgement: good/good

FACILITATOR PAUSES FOR DISCUSSION

Q: What feedback would you give to Ms. D about the following?

- *Her risk of recurrence during pregnancy*
  Elicit the following:
  - Depression prevalence during the pregnancy/postpartum period is high in the general population (approximately 15%)
  - Pregnancy is not protective (Studies show that hormonal changes do not decrease depression in pregnancy although individual women may find that a specific pregnancy may make their symptoms worse or better, with no guarantee that the next pregnancy will be the same)
  - Ms. D's individual risk profile for recurrence is higher due to numerous previous depressive episodes

- *Her risk of recurrence during the postpartum period*
  Elicit the following:
  - Postpartum period is a time of highest vulnerability to relapse in psychiatric symptoms
  - Women are 23x more likely to have a first psychiatric admission in the first month postpartum than at any other time in their lives
  - Risk remains elevated for a year or more postpartum

- *If she has a recurrence, the risks associated with acute depressive episodes during pregnancy and the postpartum period*
  Elicit the following:
  - Untreated depression has risks in the pregnancy and postpartum periods
  - Risk of suicide with untreated depression
  - Ms. D's hypersomnia and risk of missing prenatal appointments
  - Nutritional status
  - Risk of relapse with cigarettes
  - For an advanced audience: risks of preterm delivery, low birth weight

Q: What would be your advice for Ms. D? What factors would you consider when selecting a medication for her to take during pregnancy?

Elicit the following:
- Untreated depression has risks in the pregnancy and postpartum periods
- Ms. D has had symptom stability with her current regimen of escitalopram and lorazepam
- Her baby has already been exposed to escitalopram, there are no contraindications to continuing it, and starting a new medication would be a new exposure to that medication and could include an exposure to untreated illness if it is ineffective
- Factors to consider with Ms. D: current symptom stability; previous treatment failures; regimen includes SSRI which is considered to be safe; destabilization has major implications/risks with her
- Factors to consider in general: previous treatment trials; previous pregnancies/postpartum periods; family history and treatment response in family
- Advice should be to continue current escitalopram but to explore whether lorazepam is conferring additional benefit and to see whether it can potentially be tapered to reduce the risk of respiratory depression in the baby

Q: Suppose you kept her on escitalopram. What would you tell her about the risks associated with taking escitalopram in the 3rd trimester? What would you advise her about her plan to discontinue the medication in the last month of pregnancy?

Elicit the following:

- Not recommended to discontinue medications in the last month
- Postpartum depression risk is highest in the first month postpartum; discontinuation of medications prior to that leaves Ms. D untreated in the most vulnerable perinatal period
- Potential postpartum decreases in sleep and increases in family stress and conflict which are common with any new infant also increase risk
- Untreated depression in the postpartum period interferes with bonding and engagement with the newborn (which can have effects on attachment)

Teach the following (or elicit from a more advanced audience):

- Theoretical risk of persistent pulmonary hypertension of the newborn but highly unlikely and absolute risk, if it exists is very small
- Risk of poor neonatal adaptation syndrome: 25-30% of infants exposed to SSRIs may have symptoms of jitteriness, increased muscle tone, rapid breathing – but these are transient, self-limited, and not dangerous.
- One study of discontinuing SSRIs in the third trimester showed that this practice does not decrease the infant's risk of this syndrome

Q: What non-medication recommendations would you have for Ms. D?

Elicit the following:

- Psychotherapy – Cognitive-Behavioral Therapy, Interpersonal Therapy
- Mindfulness for anxiety symptoms instead of lorazepam prn
- Enhance social supports – yoga, meditation
- Support groups for maintaining smoking cessation
- Trauma support groups

FACILITATOR SHOWS RISK-RISK DISCUSSION IN PREGNANCY VIDEO

FACILITATOR GIVES VERBAL INSTRUCTIONS FOR THE TABLE BELOW

1. Trainees divide into pairs
2. Based on Ms. D's case, fill in the middle column of the table
3. Once the tables have been completed, use them to practice how to talk to Ms. D about her individual risk profile
4. Open up for large group discussion.

Reproductive Domains	Risks Associated with Psychiatric Disorder	Risks Associated with SSRI Treatment
Congenital Malformations	Unlikely	Early studies: cardiac defects; PPHN (low absolute risk) More recent studies: no or very low association after corrections
Spontaneous Abortion	Unlikely	Equivocal studies; low odds ratios and same for women for stop SSRI prior to pregnancy
Length of Pregnancy	Preterm Delivery	Preterm delivery
Size Effects	Small for gestational age baby	Small for gestational age baby
Withdrawal (Short-Term Risks)	Impaired bonding with the baby in the post-partum period Increased risk of postpartum depression	Serotonergic withdrawal in newborn: - Gastrointestinal - Neuromuscular - Pulmonary - Psychiatric/behavioral Transient (24-48 hours); no treatment needed
Long-Terms Risks (Development)	Long-term risks associated with poor bonding to baby/attachment to parent Maternal depression → increased risk of child developing depression	Developmental studies show promise: - Prospective trials show catching up of any initial delays - Behavioral problems also occur in children of mothers with depression Autism studies are poorly constructed; no associations when sibling analyses and paternal factors are included
Other (e.g., Obstetrical Risks)	For Ms. D: -Hypersomnia might lead her to miss prenatal appointments -Increased risk of suicide -Risk of resumption of smoking -Dietary changes?	None known