NATIONAL CURRICULUM IN REPRODUCTIVE PSYCHIATRY

Perinatal Depression
SSRIs and Pregnancy
Risk-Risk Conversation
Trainee Guide

Contributors
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Pre-Assessment Learning
- Payne JL. Psychiatric Medication Use in Pregnancy and Breastfeeding. Obstet Gynecol Clin North Am. 2021 Mar;48(1):131-149. doi: 10.1016/j.ogc.2020.11.006. PMID: 33573783.
- Wisner KL, Oberlander TF, Huybrechts KF. The Association Between Antidepressant Exposure and Birth Defects-Are We There Yet? JAMA Psychiatry. 2020 Aug 5. doi: 10.1001/jamapsychiatry.2020.1512. Epub ahead of print. PMID: 32777006.
- 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]

Learning Objectives
1. The learner will describe risks associated with untreated depression in pregnancy and postpartum
2. The learner will formulate a perinatal case with a focus on depression management
3. The learner will practice risk-risk discussions in pregnancy
4. 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 bupropion (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."

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

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: 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

1. What feedback would you give to Ms. D about the following?
    - Her risk of recurrence during pregnancy
    - Her risk of recurrence during the postpartum period
    - If she has a recurrence, the risks associated with acute depressive episodes during pregnancy and the postpartum period

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

3. 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?

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

VIEW RISK-RISK DISCUSSION IN PREGNANCY VIDEO

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		
Spontaneous Abortion		
Length of Pregnancy		
Size Effects		
Withdrawal (Short-Term Risks)		
Long-Terms Risks (Development)		
Other (e.g., Obstetrical Risks)		

References

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