Clinical Approach to the Treatment of the Peripartum Patient

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Disclosures/Disclaimers/Acknowledgments

Julia N. Riddle, MD - none

Emily S Miller, MD, MPH - none

Lucy Hunter, MD - Cofounder of Phoebe, Inc., consultant and advisor to Gemma, Inc.

Lauren M Osborne, MD - none

Amanda Yeaton-Massey, MD, PMH-C - none

Marika Toscano, MD - none

How to use this material

- Review slides individually or as a self study group.
- For questions, go to normal view and read the notes.

Learning Objectives:

- Develop an approach to psychiatric assessment in the perinatal period.
- Discuss risks associated with untreated depression in pregnancy and postpartum.
- Practice risk-risk discussions in pregnancy with a focus on depression management.
- Appreciate unique factors in the management of perinatal depression in the context of risks of both medications and untreated psychiatric illness.

Outline:

- Introduction
- Screening: recommendations for type and timing
- Case example following perinatal depression to illustrate clinical management key points
- Counseling: risk-risk paradigm
- Treatment: key clinical considerations
- Cases

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We will focus some on perinatal depression - as this is a digestible way to emphasize some concepts about diagnostic criteria for perinatal mental health and differential diagnosis.

Perinatal Depression: Definitions

Criteria for the DSM-5 specifier “with peripartum onset”:

> “Current or most recent major depressive episode had onset during pregnancy or in the first 4 weeks postpartum”

Challenges:

- Some symptoms overlap with “normal” pregnancy include fatigue, changes in appetite, poor sleep.
- Conflates antenatal and postpartum depression - which may have divergent pathophysiologies
- Does not acknowledge later onset perinatal depression

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The diagnosis, from the DSM, is MDD with peripartum onset.
This refers to current or most recent major depressive episode had onset during pregnancy or in the first 4 weeks postpartum

There are similar issues with other mental health conditions - acknowledging that the onset can be during or after pregnancy is an important first step in case finding.

Important to remember that a positive screen screen is not a diagnosis. Some symptoms overlap - important to remember to assess whether anhedonia or depressed mood are present

While research is ongoing, there are some that hypothesize antenatal and postpartum depression have different underlying pathophysiologies.

Also important to know that many in the field are advocating for this to be extended beyond 4 weeks to 12 months, given the ongoing exposures and risks for MDD

Differential Diagnosis

Most commonly, depression and anxiety disorders, but also consider:

- Bipolar disorder
- Psychotic disorders
- Trauma and stressor-related disorders
- Obsessive compulsive disorder
- Eating disorders
- Substance use disorders

Refer to MDD lecture for more details

Caveat

- Lecture will focus on pharmacotherapy
- Psychotherapy should be 1st line treatment for all birthing people
  - Psychotherapy is synergistic with pharmacotherapy
  - Often not accessible or acceptable, so medications are only practical treatment option
  - Pharmacotherapy (+psychotherapy) should be recommended for moderate or severe depression

Psychotherapy: practical tips

How to answer common questions about therapy:

1) **What do psychotherapists ("therapists") do?**

   "Behavioral health counselors offer mental health counseling and can help with issues like depression, anxiety, stress, relationship issues, parenting, trauma, grief and loss, concerns during and after pregnancy, sexual issues, and chronic pain."

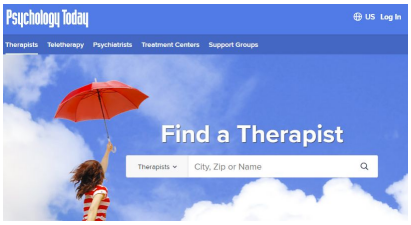
2) **Why do I need psychotherapy? Can't I just take a medication?**

   "Medications can't do all the work to fix the root causes of your [mood or anxiety disorder]. You also need to work to change your thought patterns, relationship styles, sleep and, stressful triggers. Problem-solving therapy with the help of a professional can help you break these overwhelming issues into bite-sized, manageable pieces."

3) **What can I expect when I go to therapy?**

   "At your first visit, you will be asked about your medical and mental health history, current things going on in your life, and your goals for therapy. At follow up visits, your therapist will check in about how things are going and help you progress towards your goals of feeling better."

Psychotherapy: practical tips

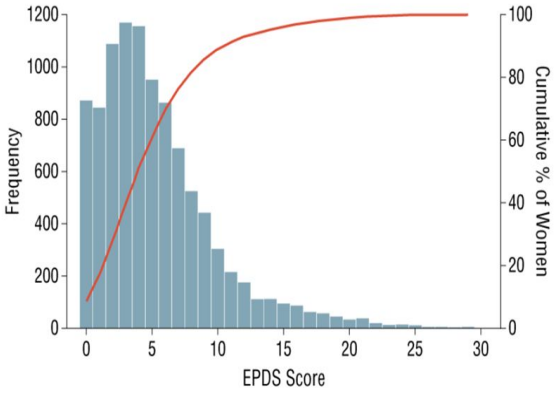


How to search for nearby mental health providers:

- **Psychology today** (https://therapists.psychologytoday.com/rms/)
  - Filter by women's health AND insurance AND location
- **American Psychological Association** (https://locator.apa.org)
- **Postpartum support international** (www.postpartum.net)
  - Online support groups
  - Support hotline (1-800-944-4773)
  - International therapist locator (https://postpartum.net/get-help/providerdirectory)

Three great resources are listed above

Epidemiology



- Perinatal mental illness is the most common complication of pregnancy
- Affects 1 in every 5-7 birthing people
  - 20% will have symptoms after the 1st year postpartum
  - 13% will continue to have symptoms after the 2nd year postpartum
- Can be either a new presentation or relapse/ exacerbation of existing mental illness

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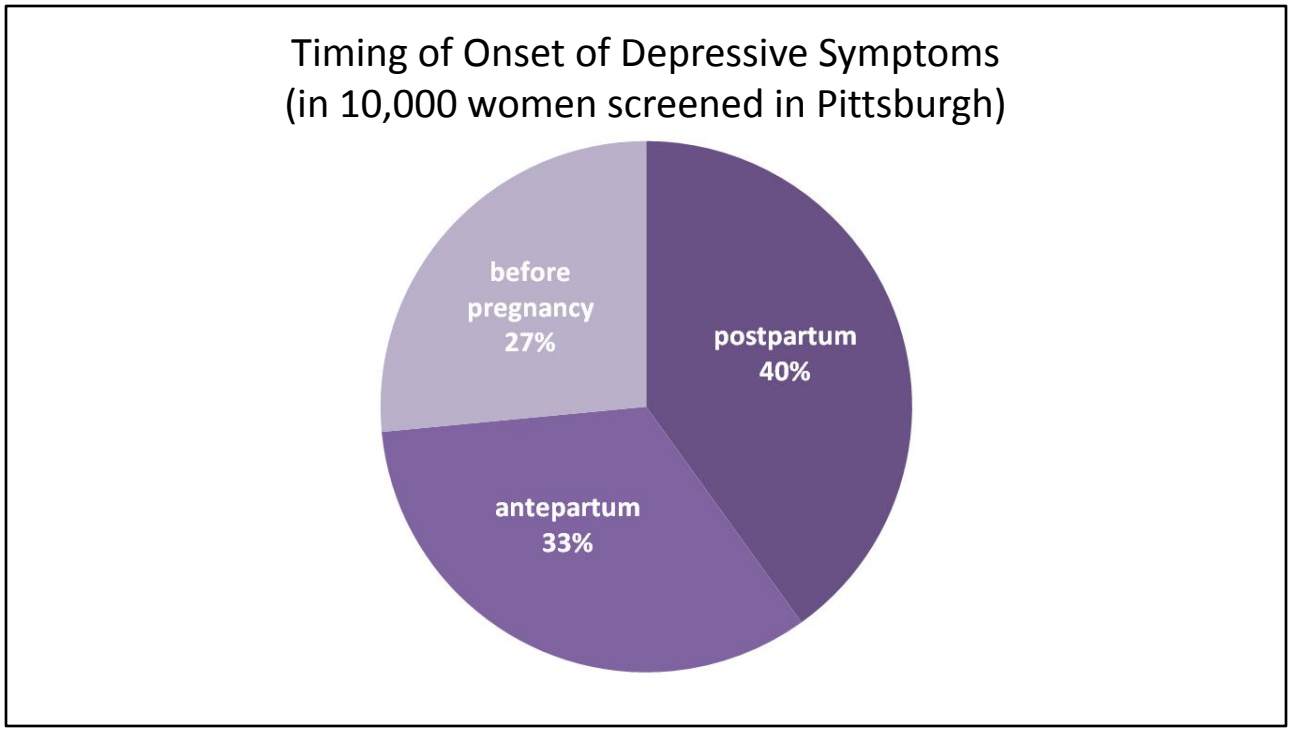
This histogram depicts the number of women with each EDPS score in a large prospective cohort of 10,000 postpartum women in Pittsburgh who were screened for perinatal depression using the EPDS

Of the 10,000 women screened:
7.0% screened positive for major depression. This is not an uncommon finding.

Wisner, K. L., Sit, D. K., McShea, M. C., Rizzo, D. M., Zoretich, R. A., Hughes, C. L., ... & Hanusa, B. H. (2013). Onset timing, thoughts of self-harm, and diagnoses in postpartum women with screen-positive depression findings. *JAMA psychiatry*, *70*(5), 490-498.



This is data from that same cohort of the 10K women in Pittsburgh screened for perinatal depression. For women who screened positive, when asked about timing of onset of symptoms, 40% of women reported that their symptoms began within the 3 months postpartum. Given the short time duration, this remains the time of highest day by day incidence of depressive symptoms.

But 33% of women developed depressive symptoms during pregnancy and 27% reported symptoms starting even before pregnancy began. This means that if we were to screen only postpartum, we may leave 60% of women with depression un-identified and un-treated during their pregnancy.

This finding led to the change in nomenclature to reflect perinatal depression - not just postpartum depression.

Due to this and other similar findings, ACOG “strongly encourages” screening both antenatally and postpartum. We would recommend screening each trimester during pregnancy and again postpartum as an ideal. A reasonable alternative would be to screen at least twice during pregnancy --- once at the first prenatal visit and once again in the 3rd trimester --- and again postpartum.

Wisner, K. L., Sit, D. K., McShea, M. C., Rizzo, D. M., Zoretich, R. A., Hughes, C. L., ... & Hanusa, B. H. (2013). Onset timing, thoughts of self-harm, and diagnoses in postpartum women with screen-positive depression findings. *JAMA psychiatry*, *70*(5), 490-498.

Screening

Multiple professional societies, including ACOG, AAP, SMFM and USPSTF have recommended screening for perinatal depression both during pregnancy and postpartum

Screening

Screening Tool	Number of Items	Time to Complete	Sensitivity/ specificity	Spanish Available	Cut-off (positive screen)
Edinburgh Postnatal Depression Scale (EPDS)	10	Less than 5 min	Sensitivity: 59–100% Specificity: 49–100%	Yes	≥ 13
Postpartum Depression Screening Scale (PDSS)	35	5–10 min	Sensitivity: 91–94% Specificity: 72–98%	Yes	> 60
Patient Health Questionnaire-9 (PHQ-9)	9	Less than 5 min	Sensitivity: 75% Specificity: 90%	Yes	≥ 10
Beck Depression Inventory (BDI)	21	5–10 min	Sensitivity: 47.6–82% Specificity: 85.9–89%	Yes	≥ 10
Beck Depression Inventory-II (BDI-II)	21	5–10 min	Sensitivity: 56–57% Specificity: 97–100%	Yes	> 20
Center for Epidemiologic Studies Depression Scale (CES-D)	20	5–10 min	Sensitivity: 60% Specificity: 92%	Yes	>16
Zung Self-Rating Depression Scale (Zung SDS)	20	5–10 min	Sensitivity: 45–89% Specificity: 77–88%	No	> 50

ACOG Committee Opinion 453

Conway, C. A. (2010). ACOG encourages screening for depression during and after pregnancy. *Health Law Perspectives. February*.

ACOG does not endorse a specific perinatal depression screening tool. The USPSTF recommends screening at least once during pregnancy and once postpartum. Because symptoms can arise at any time, this may be inadequate, and reproductive psychiatrists recommend screening once per trimester and at all postpartum visits.

Listed here are the 7 most commonly used scales. Each takes less than 10 minutes to complete, has good testing characteristics. Cut-off scores for positive screens are listed here.

The two most commonly used are the EPDS or the PHQ9. Both are freely available online, in multiple languages, are brief, and have reasonable test characteristics

Screening ≠ Diagnosis

- All positive screens must be followed up with a diagnostic interview for further assessment
- See module on “perinatal depression” for more information on recommended screening frequency in the perinatal period as well as how to respond to a positive screen

Case: 27 y/o G1P0 at 18w3d

- Past medical history: Asthma
- Social history: Married, safe relationship
- Allergies: None
- Pregnancy: Planned, unremarkable, consistent prenatal care
- EPDS: 17, no self-harm

Case: 27 y/o G1P0 at 18w3d

Psychiatric history:

- One episode (~6 weeks) in college that she reports she was depressed and was treated with escitalopram 15 mg for a year and responded well
- Sees a therapist twice a month since college to cope with stressors

Pause for a Mental Health History: Risk Stratify

Important questions to cover for background to risk stratify:

1) Have you ever felt like this?
2) Have you ever had treatment? → if successful, use first!
3) Have you ever had a period of time where you felt the OPPOSITE of depression, had enormous energy and did not need to sleep for many days at a time? → risk for bipolar disorder, screen before antidepressant
4) Have you ever been psychiatrically hospitalized? → high risk, close follow-up
5) Have you ever been suicidal or attempted suicide? → high risk, close follow-up
6) Are you having suicidal thoughts now? → ER eval/inpatient

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Before even beginning treatment discussion, the patient must be assessed for high acute risk of suicide/homicide/inability to care for self.

Case: 27 y/o G1P0 at 18w3d

Risk stratification:

- No suicidal thought or passive death wishes
- No history of suicide attempts
- No psychiatric hospitalization
- Assessed to be reliable in her report

Proceed to initiating treatment….

Important clarifying questions

It can benefit the practitioner to take a moment to assess for any history of bipolar illness. Brief questions like this can help assess for the risks associated with standard depression treatment (ie. SSRIs triggering mania). Patient with a history of bipolar disorder require different treatment considerations and are at risk of postpartum psychosis. For more clinical detail, please see the section on Bipolar Affective Disorder and Postpartum Psychosis.

Important clarifying questions

The important question!

Risk-risk paradigm

There is no such thing as non-exposure

Counseling birthing people on whether to start or continue medication during pregnancy includes assessing the risks and benefits of the medication as well as the risks related to the illness.

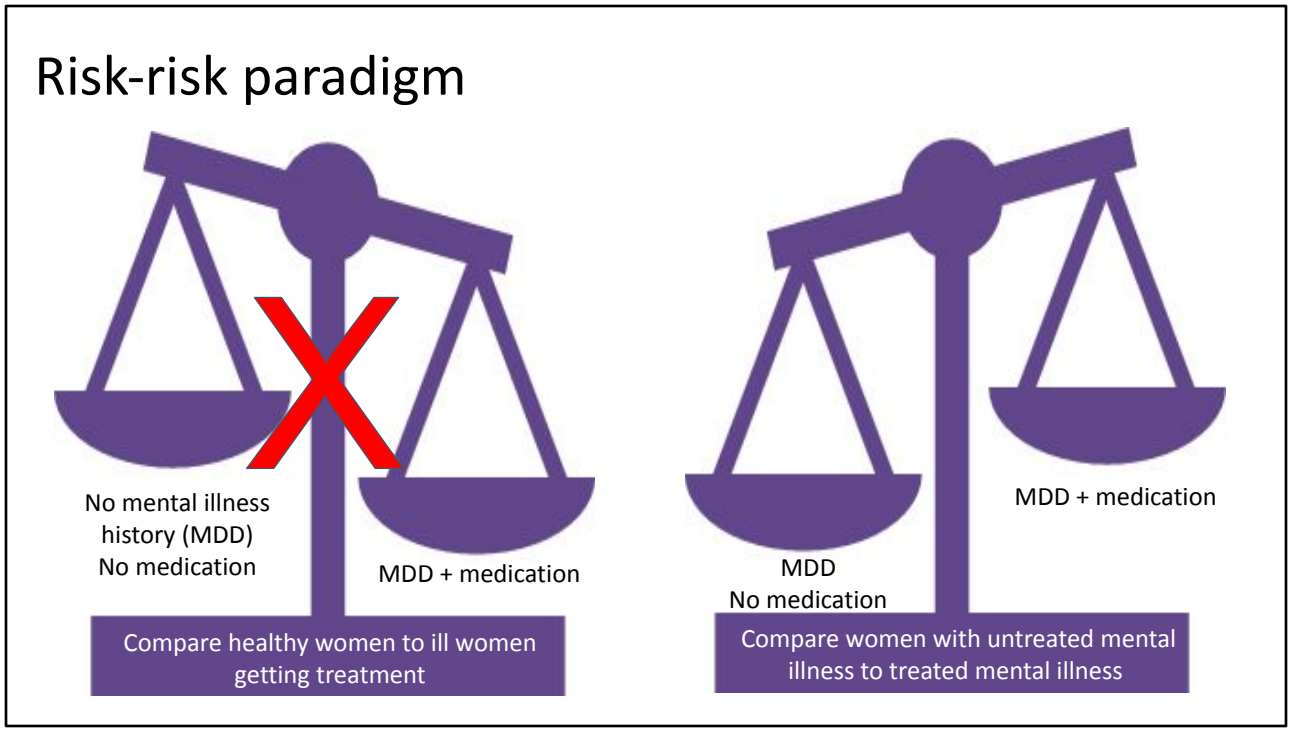
Consider:

Medication = An Exposure

Illness = An Exposure

Undertreated Illness = Exposure to both (illness and meds)

...and try to decrease maternal exposures associated with adverse outcomes



Most of the literature compares healthy women without MDD (and no exposure to medication) to women with MDD on medications. They often ascribe any observed associations to the medications themselves

But this isn't the clinical choice in front of us. This leads to risks of SSRIs being weighed more heavily than the benefits.

The proper design of studies is to compare untreated depression with treated depression - and when this is done, the findings often diverge from prior literature

Risk-risk paradigm

Risks of untreated perinatal depression:

Worse quality of life

More missed days of work

Suicide attempts/completion

Risk of substance use

Hypertensive disorders of pregnancy

Cesarean delivery

Preterm birth

Small for gestational age birth

Insecure attachment patterns

Developmental delays

Risks of medication (SSRI) use in pregnancy:

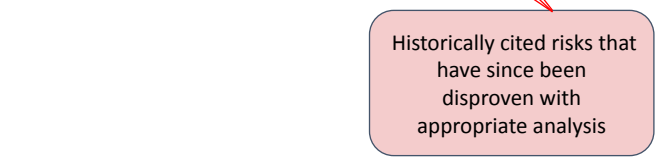
~~Congenital malformations~~

~~Preterm birth~~

~~Developmental delays~~

Neonatal adaptation syndrome

PPHN



Important to present counseling that balances the risks of untreated depression with the risks associated with medication.

Crossed out items have been previously considered but are now dis-proven with more appropriate analyses.

Presenting the paradigm in this manner allows providers and patients to realize the balance, for most birthing people, favors treatment with pharmacotherapy

For details on these specific risks, see MDD lecture

General principles:
Prescribing psychopharmacotherapy in pregnancy

- Collaborate with the patient
- Consider prior treatment trials
- Set realistic expectations
- Use side effect profile to your advantage
- Ensure an adequate trial of medication before switching
- Maximize one medication before adding another

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Collaborate with the patient:

- use their prior medication history or family medication history to choose a medication

Set realistic expectations: there will be small incremental improvement in target symptoms, but not a dramatic instant improvement with initiation of medication. A symptom log can often help patients track improvement in their target symptoms.

- Side effects will often occur prior to substantial benefit.
- In some patients, a solution will not occur with the first medication prescribed
- Inform that withdrawal symptoms may occur with abruption cessation of certain medications

Different psychoactive medications are associated with different side effect profiles:

- Educate patients/provide anticipatory guidance on potential side effect profiles for medications prescribed
- Explain that some early side effects are transient and bearable, others develop later or may be persistent and these will necessitate dose adjustment or medication change
- Sedating medications may be more appropriate for patients with anxiety or sleep difficulties
- An activating medication may be more appropriate for those with inertia symptoms
- Ask about weight gain or sexual side effect concerns and factor the answer

- into medication choice

Ensure an adequate trial of medication before switching:

- Make sure patient is taking at prescribed dose
- An adequate trial is: at least 6 weeks, on at least ⅔ max dose - max dose

"I am, but is it OK during pregnancy?"

"That's a great question. Recurrence of depression is not uncommon during pregnancy, so let's talk about our options.

It sounds like you did well with escitalopram in the past so I would be inclined to start with that.

The way that we think about treatment is as a risk-risk decision and discussion. We have to balance the risks of exposure to untreated mental illness against the risk of exposure to medicine."

Risk-Risk Conversations

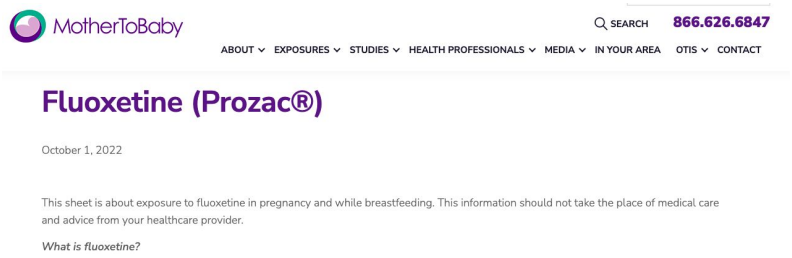
- This is a structured conversation to provide patients with the information to understand that untreated illness IS an exposure
- Brief discussion on risks as laid out on Slide 17
  - “There is no option that is ‘no risk’ but SSRIs, like escitalopram, have reassuring safety data in pregnancy and we currently consider them low-risk”
- May need a moment to further discuss neonatal adaptation syndrome
  - See slide 33

Risk-Risk Conversations: Provider resources

- Not sure of a medication's safety profile in pregnancy or lactation?
- Resources available:
  - Reprotox (requires subscription)
  - Lactmed (free)
  - Psychiatry access programs (postpartum support international or state-funded)
  - Slide 51 has additional resources

Risk-Risk Conversations: Patient resources

- Can provide patient with additional take-home information
- A useful resource are the [Fact Sheets from Mother To Baby]



Pharmacotherapy Initiation: Clinical Considerations

1. What is likely to work?
2. What are the medication side effects?
3. How much data do we have for each of our options?
4. What do the data tell us about each of our options?
5. What is the patient's preference?

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When psychopharmacologic treatment is indicated during pregnancy, there are some "general tenets" to consider when formulating a treatment plan. To start, it is helpful to consider some questions which are not unique to the perinatal patient. After considering the patient's comprehensive clinical presentation, consider what medications are likely to work for this patient and what are the common side effects for the various medications that might be clinically efficacious? It is critical to examine these two questions first as although a specific medication may be regarded as having the most reassuring risk profile in pregnancy or lactation, if that medication does not effectively treat the underlying illness, the patient is left with both an exposure to the prescribed medication as well as an exposure to the underlying illness. Furthermore, if a medication is potentially efficacious but is intolerable for the patient, she is unlikely to adhere to its use.

After these first two clinical considerations, the astute obstetrician will consider both the quality of the data regarding risk in pregnancy and lactation as well as the degree to which that data is reassuring or not. For example, a relatively new medication may have reassuring data, but this data may be limited to a handful of case reports. When comparing this new medication to an older medication that will likely have a more established safety profile, the quality of the information must be factored into the analysis.

Finally, it is important to inform the patient of the various treatment options along with the corresponding risks, benefits, alternatives and side effects and to make decisions in a collaborative fashion. If the patient is incapacitated by her mental illness, a substitute decision-make should be designated.

pregnancy status

Discussed in detail more in MDD

Pharmacotherapy Initiation: Clinical Considerations

- Starting medications at low doses is done to minimize side effects
  - I.e. SSRIs can have early side effects of increased anxiety and GI distress due to serotonin receptors in the brain/stomach. These side effects generally remit after a few days as receptors adapt and the patient can continue to increase dose in a stepwise manner.
- If the patient stopped a working medication when she found out she was pregnant, the pregnancy is already exposed to that. Consider restarting it!

Pharmacotherapy Initiation: Clinical Considerations

- Sertraline is not the only medication that is low risk in pregnancy. If a patient is on escitalopram, you should NOT switch to sertraline. That is two exposures and we don't know that sertraline will be as effective
- Almost all medications will need to be increased after initiation
  - Sertraline, for example, is often started at 25-50 mg, but most patients need 100+ mg for optimal treatment
- Physiologic changes: e.g. expansion of blood volume, increased GFR (e.g. lithium), changes to cytochrome CP450 system

Pharmacotherapy Initiation: Dosing

	Starting Dose (↓side effects)	Range often needed for MDD/PPD	Range often needed for GAD	Range often needed for OCD
Sertraline	25-50 mg	150-200 mg	100-200 mg	200-400 mg
Fluoxetine	10 mg	20-60 mg	20-80 mg	40-120 mg
Escitalopram	5-10 mg HS	15-30 mg	20-40 mg	20-60 mg
Citalopram	10 mg	20-40 mg	20-40 mg	20-80 mg
Fluvoxamine	50-100 mg HS	--------	--------	100-300 mg

Goal: Lowest EFFECTIVE dose (AKA increase!)

- "Lowest dose" or "target dose" does not necessarily mean it's effective
- If the patient is taking medication and is still psychiatrically ill, then the fetus is getting TWO exposures now
- Continue to increase medication until symptom remission
- Optimize non-pharmacological modalities (therapy, exercise, yoga, routine) to maximize outcome

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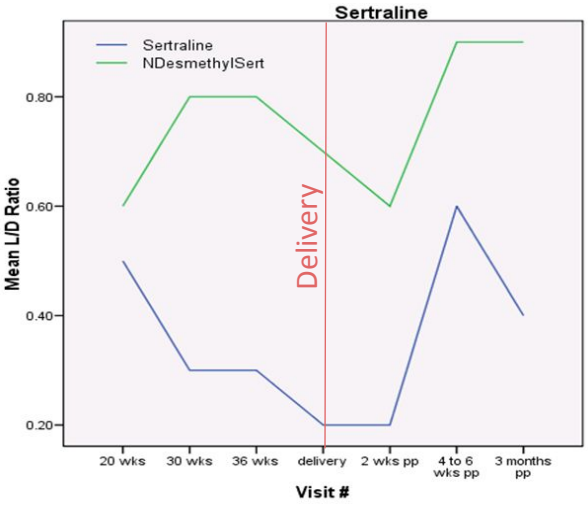
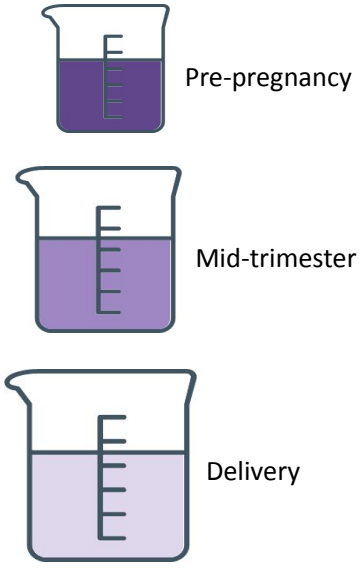
Most people need >100mg sertraline, need to titrate to remission

Wisner KL, Perel JM, Peindl KS, Hanusa BH, Piontek CM, Findling RL. Prevention of postpartum depression: a pilot randomized clinical trial. *Am J Psychiatry*. 2004;161(7):1290-1292. doi:10.1176/appi.ajp.161.7.1290

Dose adjustments in pregnancy





Graph of left demonstrates the mean level:dose ratio (Y axis) and the gestational age or weeks postpartum (X axis)

This graph is specific to sertraline, but similar graphs have been developed for many of the SSRIs. Note that the blue line is sertraline (active drug) and the green is N-desmethyl-sertraline which is the inactive metabolite

When prescribing SSRIs in pregnancy, it is useful to describe this. I use the analogy of kool-aid being diluted in larger volumes of water to explain that often we need to increase the dose as pregnancy progresses to get the same therapeutic response. It also emphasizes how a dose increase is not more exposure to the fetus - it optimizes the chance of only one exposure (medication) and not two exposures (suboptimally treated MDD + medication)

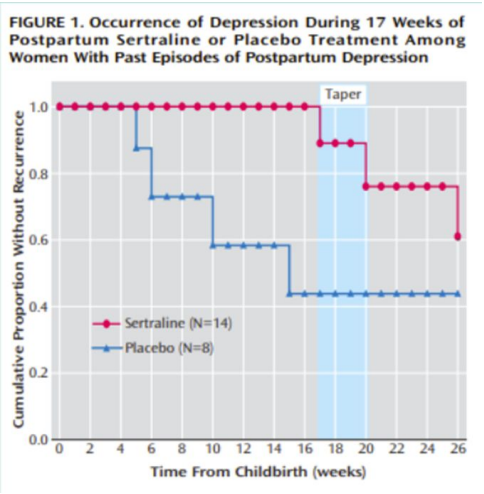
Sit, D. K., Perel, J. M., Helsel, J. C., & Wisner, K. L. (2008). Changes in antidepressant metabolism and dosing across pregnancy and early postpartum. *The Journal of clinical psychiatry*, *69*(4), 2488.
Hamad, G. G., Helsel, J. C., Perel, J. M., Kozak, G. M., McShea, M. C., Hughes, C., ... & Wisner, K. L. (2012). The effect of gastric bypass on the pharmacokinetics of serotonin reuptake inhibitors. *American Journal of Psychiatry*, *169*(3), 256-263.

Case: 27 y/o G1P0 at 30w3d

- She responds well to a discussion of treatment and begins escitalopram, which you increase to 15 mg
- At her 30 week follow-up, her EPDS is 15 again and she shares that some of her symptoms have re-emerged. She agrees to increase to 20 mg, but….
- She expresses a desire to taper her dose down and discontinue medication prior to birth in order to “not make my baby have to go through medication withdrawal”

Relapse

- The postpartum is a vulnerable time for all-comers but especially for those with history of mental illness
- Please see Depression module for outcomes related to untreated depression in the postpartum



Wisner, K. L., Perel, J. M., Peindl, K. S., Hanusa, B. H., Piontek, C. M., & Findling, R. L. (2004). Prevention of postpartum depression: a pilot randomized clinical trial. *American Journal of Psychiatry*, *161*(7), 1290-1292.

Neonatal Adaptation Syndrome

- 20-30% of SSRI-exposed newborns
- May have symptoms of jitteriness, increased muscle tone, rapid breathing – but these are transient, self limited, and not dangerous.
- Risk is not related to dose
- Risk remains even if SSRI is stopped in third trimester

https://www.reprotox.org/
https://mothertobaby.org/fact-sheets/

Case: 27 y/o G1P1, 2 week PP mood check

- She remains on escitalopram 20 mg
- Labor and delivery were unremarkable
- Baby did not experience any issues with neonatal adaptation symptoms.

She is, however, seeking reassurance that it's okay to breastfeed while taking escitalopram.

Postpartum and Breastfeeding

Postpartum:

- **Do not stop treatment in the postpartum period.** This is the HIGHEST risk time. Most patients need to remain on treatment for a year postpartum.

Breastfeeding:

- The vast majority of psychiatric medications are low risk in breastfeeding. Exceptions that require further input: Lithium, Clozapine (avoid), and benzos
- LactMed: https://www.ncbi.nlm.nih.gov/books/NBK501922/

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Burt VK, Suri R, Altshuler L, Stowe Z, Hendrick VC, Muntean E. The use of psychotropic medications during breast-feeding. *Am J Psychiatry*. 2001;158(7):1001-1009. doi:10.1176/appi.ajp.158.7.1001

Weissman AM, Levy BT, Hartz AJ, et al. Pooled analysis of antidepressant levels in lactating mothers, breast milk, and nursing infants. *Am J Psychiatry*. 2004;161(6):1066-1078. doi:10.1176/appi.ajp.161.6.1066

Breastfeeding: Further medication considerations

Benzodiazepines:

- Discuss risks of sedation with infant care
- Monitor infant for sedation (rare), but worth noting

Lithium:

- Discuss with your reproductive psychiatry colleagues as there are ways to successfully breastfeed

Clozapine:

- Discuss with your reproductive psychiatry colleagues. This is not a medication that you would be starting at any point.

For more information…

On risk-risk discussions outside of SSRIs:

https://ncrptraining.org/wp-content/uploads/2019/12/Risk-Risk_Medications-in-Pregnancy-Self-Study_Trainee.pdf

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https://ncrptraining.org/wp-content/uploads/2019/12/Risk-Risk_Medications-in-Pregnancy-Self-Study_Trainee.pdf

For more information…

The organizations below offer FREE comprehensive toolkits/algorithms for OBGYN providers to address maternal mental health conditions

- **ACOG** (https://www.acog.org/programs/perinatal-mental-health)
- **Council on Patient Safety in Women's Healthcare (alliance for innovations on maternal health)** (https://saferbirth.org/psbs/perinatal-mental-health-conditions/)
- **MCPAP for moms/Lifeline for Moms** (https://repository.escholarship.umassmed.edu/handle/20.500.14038/44263)
- **RCOG** (https://www.rcgp.org.uk/clinical-and-research/resources/toolkits/perinatal-mental-health-toolkit.aspx)
- And many others…

Other stuff… SLEEP!

We cannot say this enough: new parents, especially those with psychiatric vulnerabilities, need to prioritize sleep. In fact, we often prescribe sleep.

Prescribe sleep? YES

Sleep is medicine and, especially in first weeks postpartum, we strategize with the patient for 3-5 UNINTERRUPTED hours.

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Leistikow N, Baller EB, Bradshaw PJ, Riddle JN, Ross DA, Osborne LM. Prescribing Sleep: An Overlooked Treatment for Postpartum Depression [published online ahead of print, 2022 Mar 16]. *Biol Psychiatry*. 2022;S0006-3223(22)01097-6. doi:10.1016/j.biopsych.2022.03.006

Other stuff… SLEEP!

Brief discussions including:

- Current sleeping arrangements: Together in one room? Who is getting up with baby if they need something? How much is baby currently sleeping?
- Alternative sleep spaces: Do you have a spare place that you could sleep while your spouse/family member/alternative caregiver cares for the baby, e.g. guest room, basement, den?
- Are you able to take naps during the day?
- What are some ways that you think you can carve out 3-4 hours of uninterrupted sleep?

Breastfeeding: Breastfeeding goals and the role of pumping/formula/feeding will naturally come up. One option, if exclusively breastfeeding is to ask if there is a way that the alternative caregiver can bring the baby in to feed, then take them as soon as they are done for burping/changing/soothing.

Summary

- Perinatal mental illness is common
- Screening can be done at intake
- There are efficient strategies to initiate treatment
- It is a risk-risk discuss: Between exposure to untreated illness or exposure to treatment
- Patients DO get better
- Patients almost always need more than the starting dose of an SSRI/SNRI

NATIONAL CURRICULUM IN REPRODUCTIVE PSYCHIATRY FOR OBSTETRICS AND GYNECOLOGY

https://www.reprotox.org/

https://mothertobaby.org/fact-sheets/

Key references

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- 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.

Resources list

- **Psychology today** (https://therapists.psychologytoday.com/rms/)
- **American Psychological association** (https://locator.apa.org)
- **Postpartum support international** (www.postpartum.net)
  - Online support groups
  - Support hotline (1-800-944-4773)
  - International therapist locator (https://postpartum.net/get-help/providerdirectory)
- **MCPAP for Moms OB Toolkit** (https://www.mcpapformoms.org/Toolkits/Toolkit.aspx)
- **Lifeline for Moms OB toolkit** (https://www.umassmed.edu/lifeline4moms/products-resources/materials-for-providers/)
- **Reprotox** (https://www.reprotox.org/)
- **Mother to Baby** (https://mothertobaby.org/fact-sheets)
- **NCRP** (https://ncrptraining.org/wp-content/uploads/2019/12/Risk-Risk_Medications-in-Pregnancy-Self-Study_Trainee.pdf)
- **ACOG** (https://www.acog.org/programs/perinatal-mental-health)
- **Council on Patient Safety in Women's Healthcare** (https://saferbirth.org/psbs/perinatal-mental-health-conditions/)
- **RCOG** (https://www.rcgp.org.uk/clinical-and-research/resources/toolkits/perinatal-mental-health-toolkit.aspx)