

Clinical Approach to the Treatment of the Peripartum Patient

Julia N Riddle, MD

Emily S Miller, MD, MPH

Lucy Hutner, MD

Lauren M Osborne, MD

Amanda Yeaton-Massey, MD, PMH-C

Marika Toscano, MD



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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



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

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



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

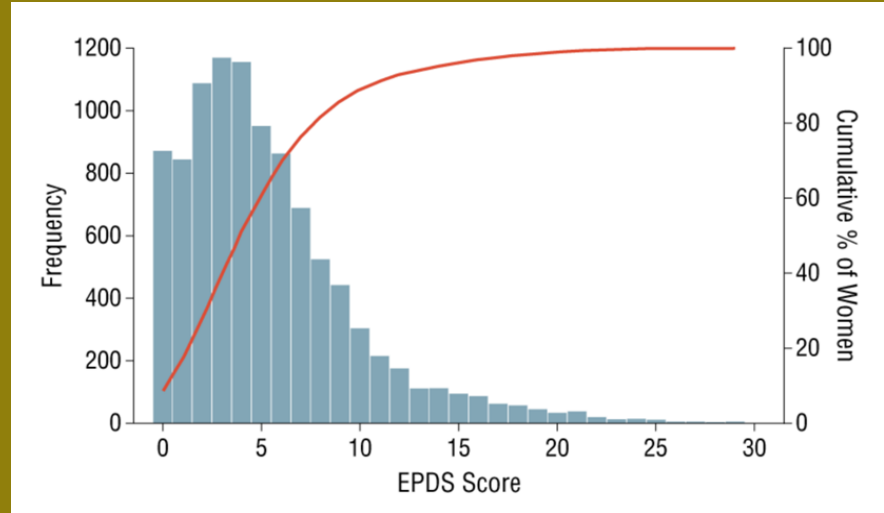
How to search for nearby mental health providers:

- **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>)



Epidemiology

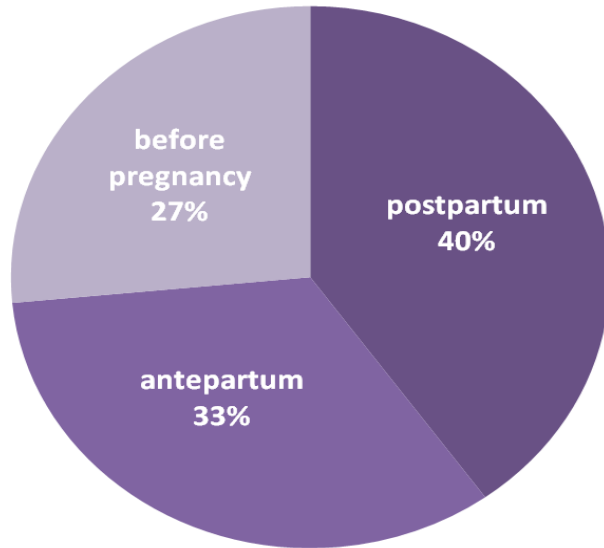
- Perinatal mental illness is the most common complication of pregnancy
- Affects 1 in every 5-7 birthing people
- 20% will have symptoms after the 1st year postpartum
- 13% will continue to have symptoms after the 2nd year postpartum
- Can be either a new presentation or relapse/ exacerbation of existing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



Wisner et al., 2013, *JAMA Psychiatry*.



Timing of Onset of Depressive Symptoms (in 10,000 women screened in Pittsburgh)



Wisner et al., 2013, *JAMA Psychiatry*.

Screening



The American College of
Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

ACOG COMMITTEE OPINION

Number 757

(Replaces Committee Opinion No. 630, May 2015)

Committee on Obstetric Practice

This Committee Opinion was developed by the American College of Obstetricians and Gynecologists' Committee on Obstetric Practice.

INTERIM UPDATE: This Committee Opinion is updated as highlighted to reflect a limited, focused change in the language and supporting evidence regarding prevalence, benefits of screening, and screening tools.

Screening for Perinatal Depression



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WOMEN'S HEALTH CARE PHYSICIANS



Obstetric Care Consensus | #8

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Interpregnancy Care



This document is endorsed by the American College of Nurse-Midwives and the National Association of Nurse Practitioners in Women's Health. This document was developed by the American College of Obstetricians and Gynecologists and the Society for Maternal-Fetal Medicine in collaboration with Judette Marie Louis, MD, MPH; Allison Bryant, MD, MPH; Diana Ramos, MD, MPH; Alison Stuebe, MD, MSc; and Sean C. Blackwell, MD

American Academy
of Pediatrics



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Guidance for the Clinician in
Rendering Pediatric Care

Clinical Report—Incorporating Recognition and Management of Perinatal and Postpartum Depression Into Pediatric Practice

Clinical Review & Education

Special Communication | USPSTF RECOMMENDATION STATEMENT

Screening for Depression in Adults US Preventive Services Task Force Recommendation Statement

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Screening

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

Cut-off (positive screen)
≥ 13
> 60
≥ 10
≥ 10
> 20
> 16
> 50

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 before?
- 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

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

“Have you ever experienced the opposite of depression - feeling elated, not needing sleep for multiple days, talking fast, doing more risky things?”



“No, that’s never happened to me. I always need my sleep.”



“The scale that we did with you indicates that you may be struggling with depression now. What do you think?”



“Yeah, I have definitely been struggling more with my mood for about four weeks.”



Important clarifying questions

“What have you been trying on your own?”



“I’ve been doing yoga and walking. I have also started seeing my therapist more often.”



“What are your thoughts about medication?”



“Is it OK during pregnancy?”



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

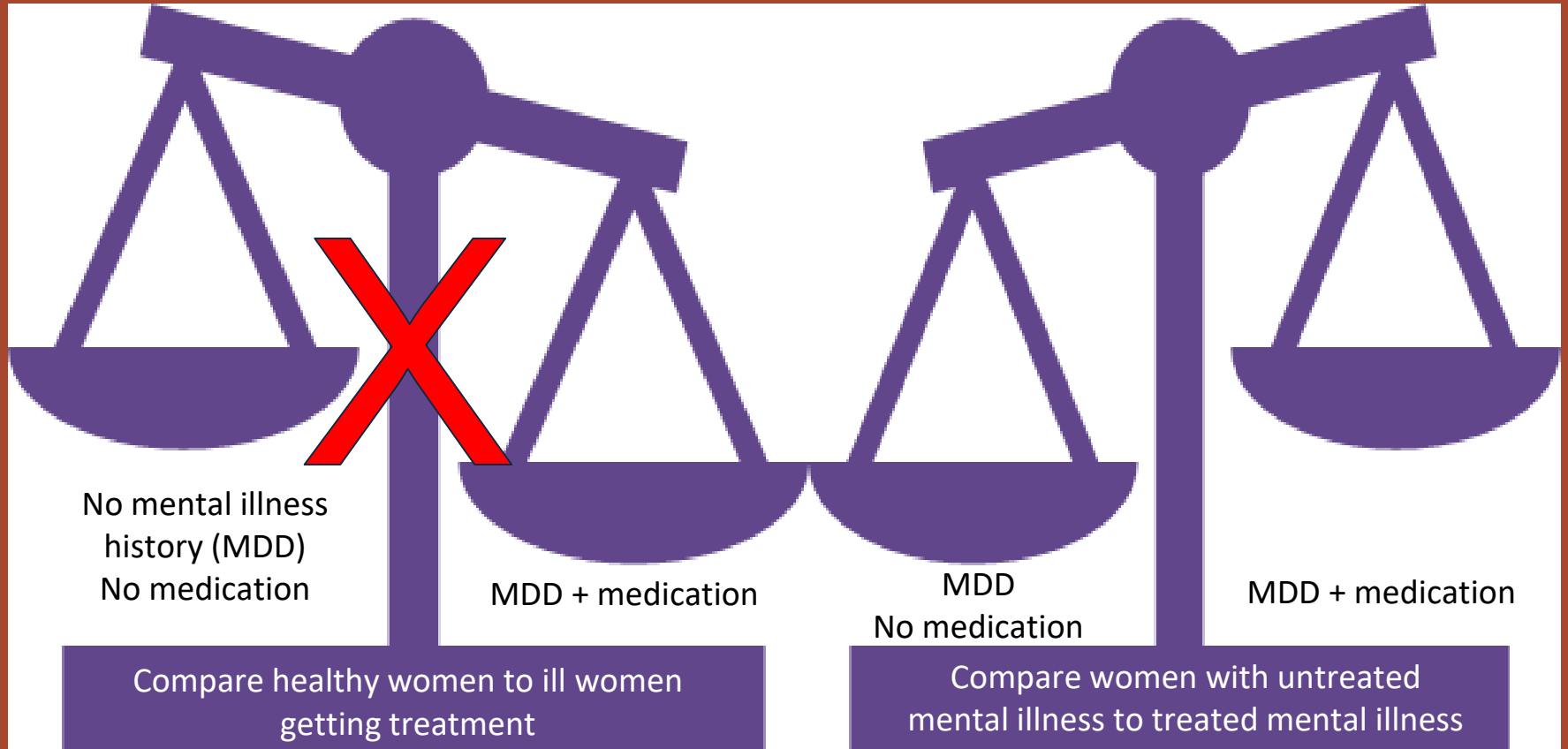
Illness = An Exposure

Undertreated Illness = Exposure to both (illness and meds)

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



Risk-risk paradigm



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

Risks of medication (SSRI) use in pregnancy:

- Congenital malformations
- Preterm birth
- Developmental delays
- Neonatal adaptation syndrome
- PPHN

Historically cited risks
that have since been
disproven with
appropriate analysis



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



“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.”



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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](#)



 MotherToBaby Q SEARCH **866.626.6847**

ABOUT ▾ EXPOSURES ▾ STUDIES ▾ HEALTH PROFESSIONALS ▾ MEDIA ▾ IN YOUR AREA OTIS ▾ CONTACT

Fluoxetine (Prozac®)

October 1, 2022

This sheet is about exposure to fluoxetine in pregnancy and while breastfeeding. This information should not take the place of medical care and advice from your healthcare provider.

What is fluoxetine?

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?



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

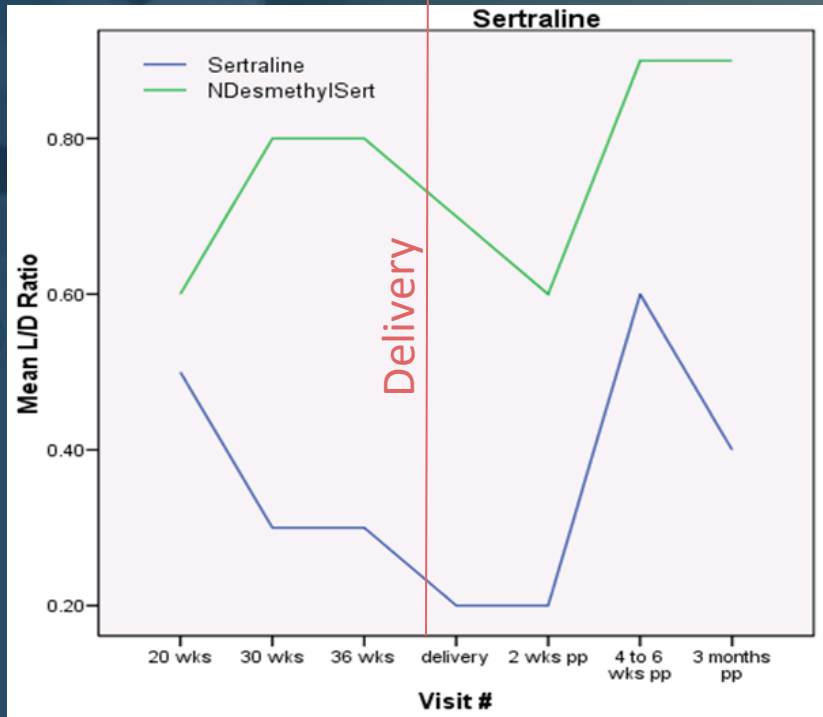
	Starting Dose (↓side effects)	Range often needed for MDD/PPD	Range often needed for GAD	Range often needed for OCD
Sertraline	25-50 mg	150-200 mg	100-200 mg	200-400 mg
Fluoxetine	10 mg	20-60 mg	20-80 mg	40-120 mg
Escitalopram	5-10 mg HS	15-30 mg	20-40 mg	20-60 mg
Citalopram	10 mg	20-40 mg	20-40 mg	20-80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



Dose adjustments in pregnancy



Pre-pregnancy



Mid-trimester



Delivery



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Case: 27 y/o G1P0 at 30w3d

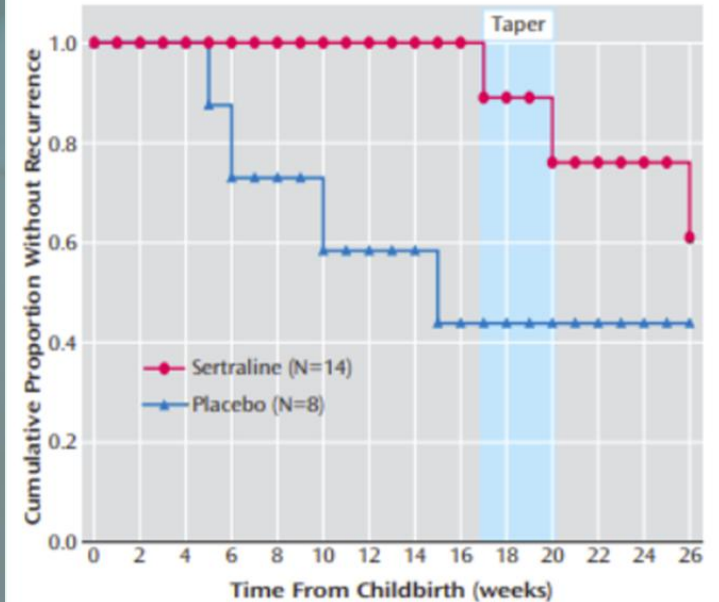
- She responds well to a discussion of treatment and begins escitalopram, which you increase to 15 mg
- At her 30 week follow-up, her EPDS is 15 again and she shares that some of her symptoms have re-emerged. She agrees to increase to 20 mg, but....
- She expresses a desire to taper her dose down and 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

FIGURE 1. Occurrence of Depression During 17 Weeks of Postpartum Sertraline or Placebo Treatment Among Women With Past Episodes of Postpartum Depression



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



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/>

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



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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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

Key references

- Wisner, Katherine L., et al. "Onset timing, thoughts of self-harm, and diagnoses in postpartum women with screen-positive depression findings." *JAMA psychiatry* 70.5 (2013): 490-498.
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- 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.
- 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>)

