Management of Chronic Psychiatric Conditions in Pregnancy and Postpartum

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Project ECHO®

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Disclosures:

None

Objectives

1. Identify mental health symptoms/conditions that are unique to the perinatal period as well as conditions which are more commonly encountered during this period.
2. Recognize the perinatal period as a high-risk period for new-onset as well as recurring mental health episodes.
3. Appreciate general principles to consider when seeing a pregnant or lactating patient who needs psychiatric treatment.
4. Identify key components of a risk-benefit discussion with patients regarding psychopharmacologic treatment and be aware of resources for shared decision making.

Baby Blues	Perinatal Depression	Postpartum Psychosis
30–80%	10–25%	1-2/1,000 births
Appears within first few days postpartum; self-resolves within 2 weeks	Lasts longer than 2 weeks	Occurs within the first month postpartum; can occur rapidly following delivery (48-72h); strong link to **bipolar disorder** (perinatal period carries highest lifetime risk for first onset manic/mixed episode)
Difficulty sleeping, tearfulness, anxiety, emotional lability; symptoms are generally mild and do not cause functional impairment *No suicidal thoughts	Depressed mood, anhedonia, sleep problems, excessive guilt *Functional impairment *May experience **suicidal thoughts**	Mood swings, agitation, delusional thoughts (often related to the baby), paranoia, hallucinations, *May experience **suicidal and/or homicidal thoughts**
Generally does not require intervention; validation, education, and support	Requires intervention (therapy, psychiatric medications)	**Medical emergency**; almost always requires hospitalization

Other commonly encountered conditions

PTSD

- Estimated 5.6-9% of PP women
- Common themes: **perceived lack of communication**, fear of unsafe care, lack of choice, lack of continuity in providers, care being based solely on delivery outcome

Anxiety Disorders (GAD, Panic)

- 1 in 5 pregnant women, high comorbidity with perinatal depression

OCD

- Est. 3-9% of PP women
- Obsessions or intrusive thoughts (directly or indirectly harming the baby, contamination)
- Compulsions (e.g., cleaning, checking, counting)
- Fear of being left alone with infant or hypervigilance (protecting infant)

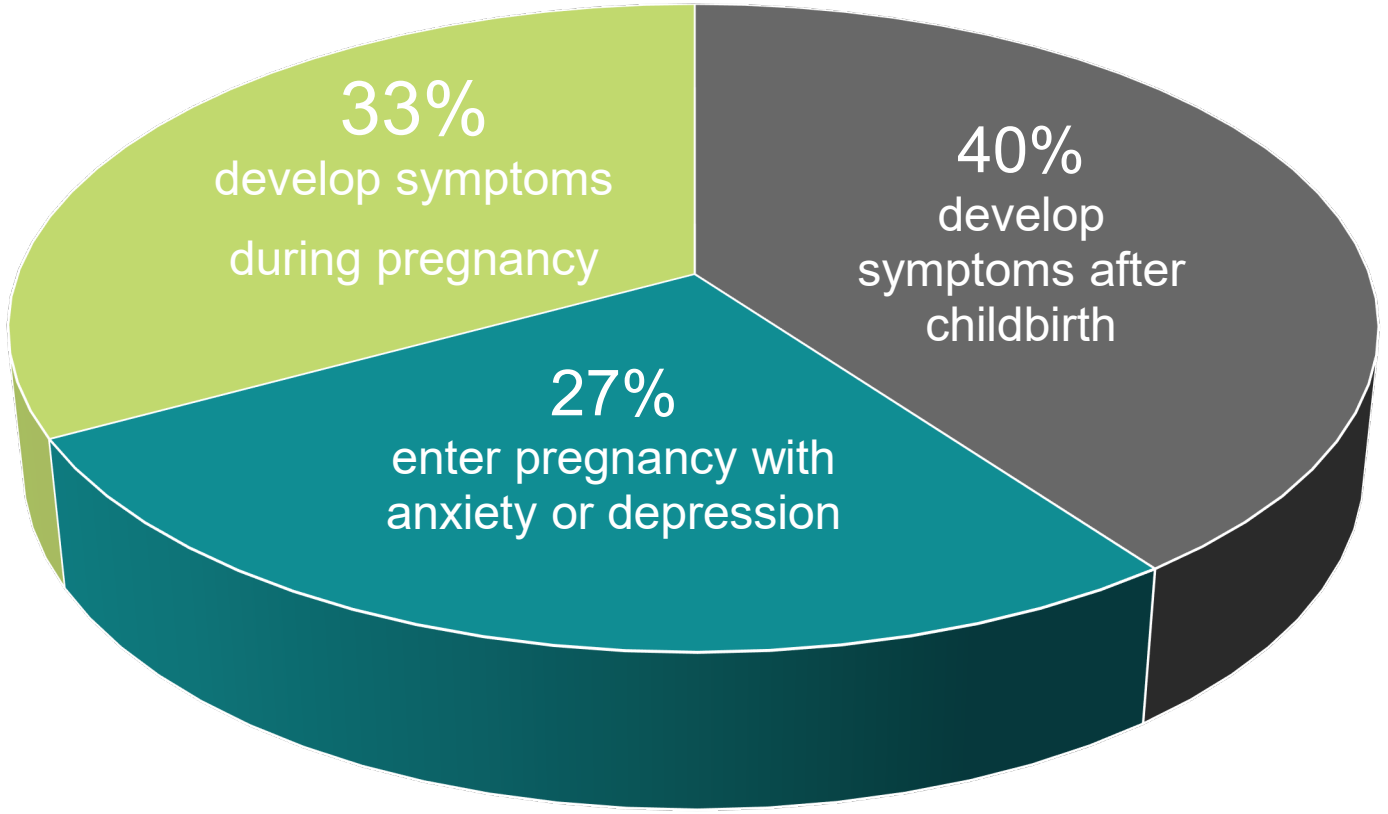
“Some moms may have **scary thoughts** about themselves or their baby. Does this sound like anything you've experienced?"

Because obsessions can include harm-related thoughts, it is important to differentiate between postpartum psychosis (which is associated with high risk of dangerous behavior) and postpartum OCD (which carries low risk of dangerous behavior).

	Postpartum Psychosis	Postpartum OCD
Prevalence	Rare (0.1-0.2%)	More common (3-5% of new mothers)
Types of Thoughts	- Ego-syntonic (perceived as consistent with the person’s own world view), fixed (strongly believed) delusions that are not based in reality - Can have hallucinations	- Ego-dystonic (against the person’s own world view), distressing, unwanted thoughts about accidental or intentional harm befalling the baby - No delusions and no hallucinations
Risk of Acting	High risk of acting upon delusional beliefs	Very low risk of being acted upon
Treatment	Psychiatric emergency; generally requires hospitalization and medication	Generally treated on outpatient basis with Cognitive Behavioral Therapy (CBT) +/- SSRI

From PPCL Handout "Understanding Postpartum Obsessive Compulsive Disorder (OCD)", adapted from MCPAP for Moms.
May be accessed here: https://ldh.la.gov/bureau-of-family-health/PPCL-Providers

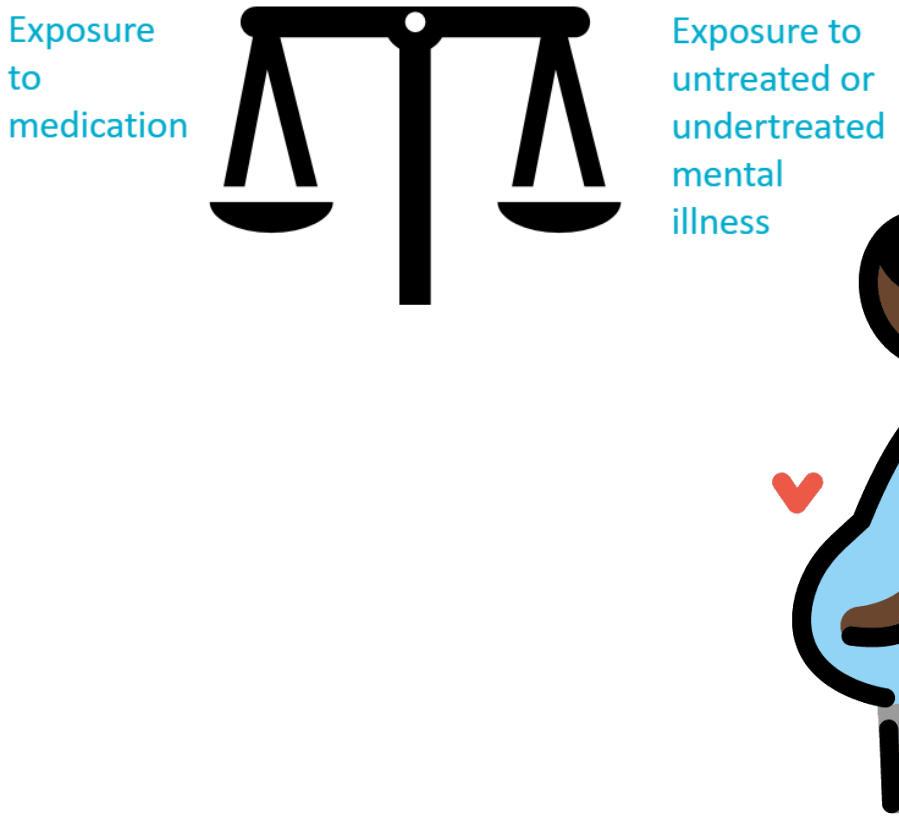
Perinatal Depression: Windows of Opportunity for Screening/Intervention



Wisner et al (2013)

Medications and the perinatal period

- Discussion of reproductive plans and contraceptive options is an essential component of caring for any patients who have the capacity to become pregnant
  - **Are you actively trying to get pregnant?**
  - **Are you actively trying to avoid pregnancy?**
  - **Are you open to pregnancy?**
- **<u>There is no such thing as non-exposure</u>.**
  - Balancing risks of medication treatment with the risks of untreated mental illness on birthing parent as well as fetus/infant.
- Focus on a treatment plan that **MINIMIZES risk** while acknowledging that it is not possible to REMOVE additional risk entirely.

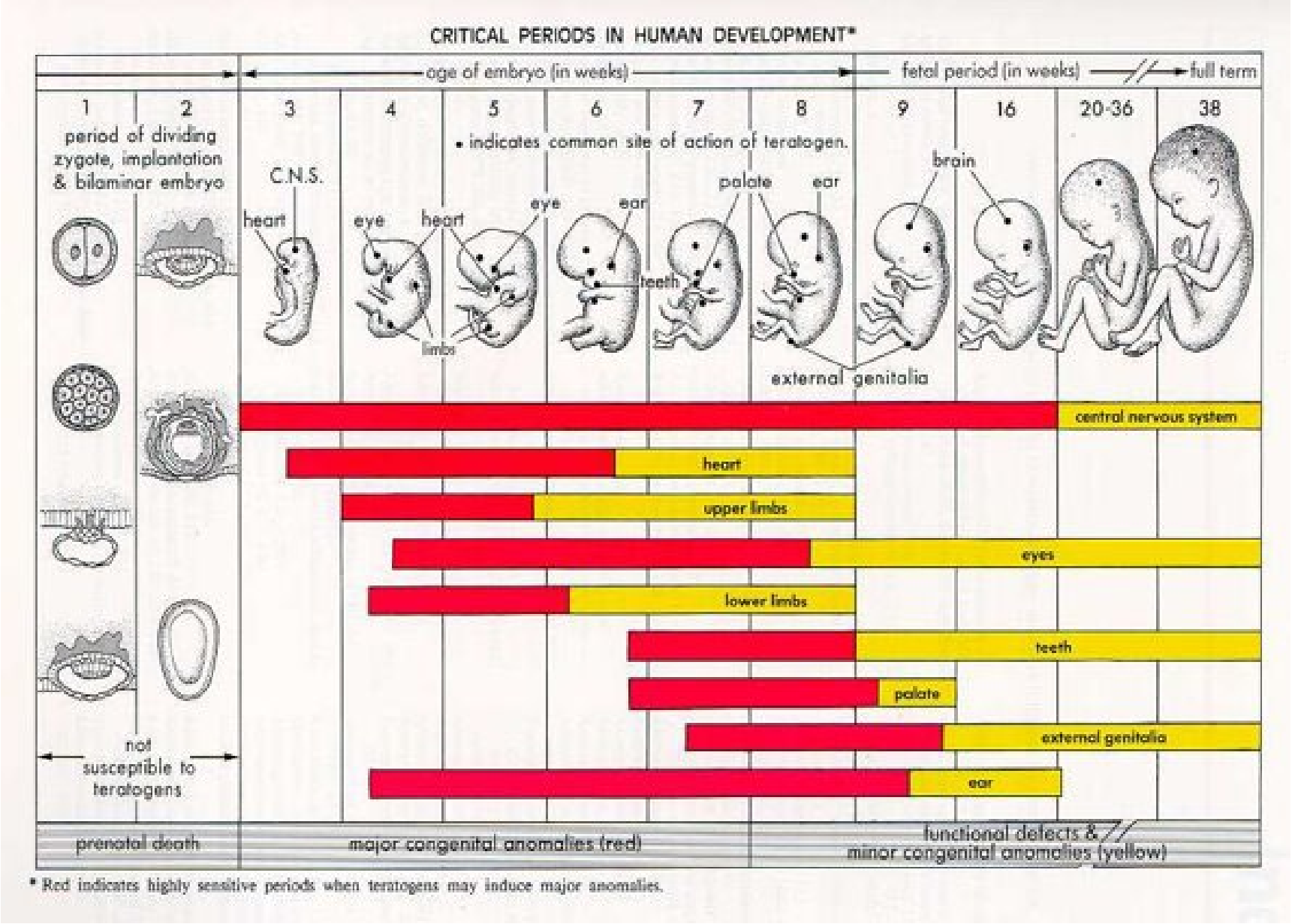


Some guiding principles…

- Avoid abrupt discontinuation of medications during pregnancy and breastfeeding
- Aim to minimize number of exposures (monotherapy > polypharmacy), but need to weigh against symptom stabilization if a particular regimen has kept a patient well
- DO NOT stop an effective medication…
  - In favor of a perceived "safer" medication (with some exceptions, such as **VALPROATE/DEPAKOTE!**)
  - Without carefully weighing risks/benefits with patient
  - Without having a plan in place (e.g., psychotherapy)
- Use lowest EFFECTIVE dose and treat to REMISSION
- Maximize non-pharmacologic interventions (e.g., therapy, social supports, sleep hygiene)
- Patient choice and coordination of care
- Preconception counseling is great when we can do it!

Clinical Considerations

- Patient preference
- Current/past severity of illness episodes
- Previous response to treatments
- Degree of illness recurrence
- Duration of current stability
- Access to interpersonal supports
- Access to non-pharmacologic treatment



* Red indicates highly sensitive periods when teratogens may induce major anomalies.

Pregnancy and Lactation Labeling Rule (PLLR)

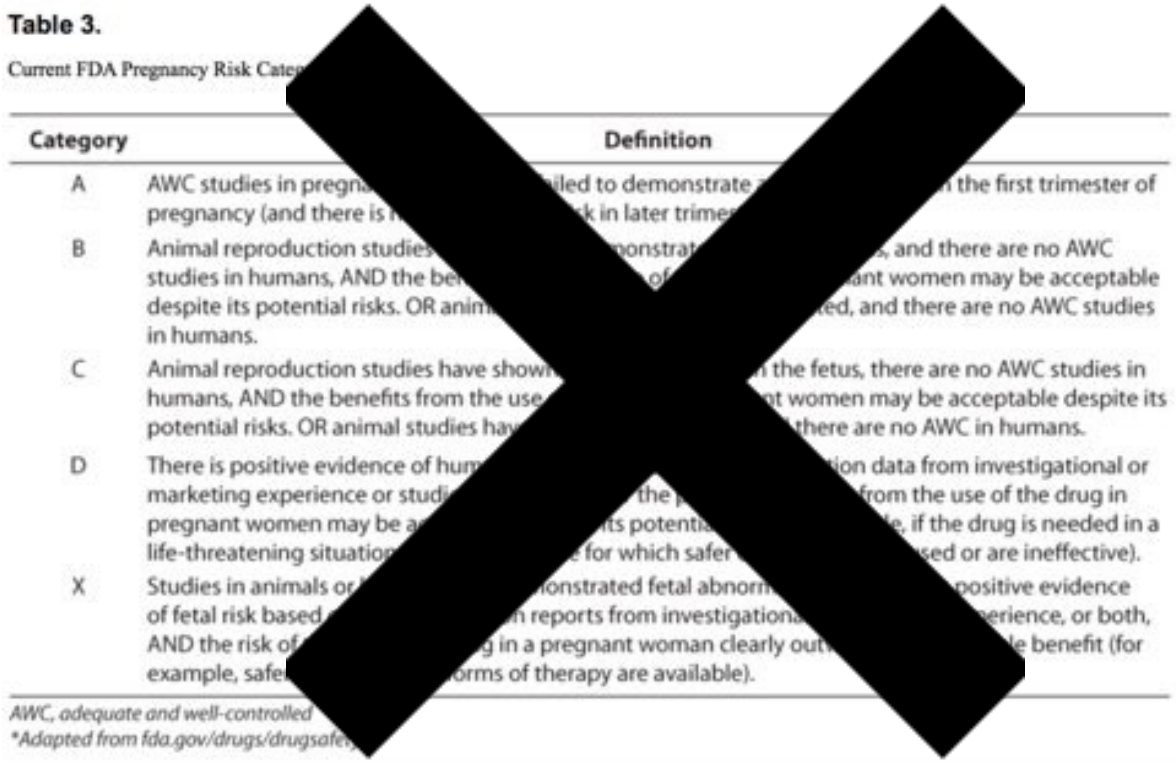


Table 3.

Current FDA Pregnancy Risk Cate

Category	Definition
A	AWC studies in pregna iled to demonstrate n the first trimester of pregnancy (and there is k in later trime
B	Animal reproduction studie monstrat , and there are no AWC studies in humans, AND the be of ant women may be acceptable despite its potential risks. OR anim ed, and there are no AWC studies in humans.
C	Animal reproduction studies have show n the fetus, there are no AWC studies in humans, AND the benefits from the use t women may be acceptable despite its potential risks. OR animal studies ha there are no AWC in humans.
D	There is positive evidence of hum ion data from investigational or marketing experience or studi the from the use of the drug in pregnant women may be a ts potenti e, if the drug is needed in a life-threatening situatio for which safer sed or are ineffective).
X	Studies in animals or monstrated fetal abnorm positive evidence of fetal risk based n reports from investigationa erience, or both, AND the risk of g in a pregnant woman clearly out e benefit (for example, safe orms of therapy are available).

AWC, adequate and well-controlled

**Adapted from fda.gov/drugs/drugsafe*

Research Limitations

- We rely on observational studies of pregnant women who choose to take medications versus pregnant women who do not, or on retrospective studies
  - Inherent bias
  - Is it the medication or the illness?
- Shared genetics between mother and child

Pregnancy Pharmacokinetics/Considerations

- Psychotropic medications cross the placenta and are present in amniotic fluid
- Renal drug clearance and liver metabolism increase during pregnancy
- Clinical relevance?
  - May need higher doses, particularly later in pregnancy
  - **Close clinical monitoring**

Lactation Pharmacokinetics/Considerations

- All psychotropic medications pass into breastmilk, but concentrations vary greatly
- Can consider various factors:
  - Relative infant dose (RID) **AAP considers <10% compatible with breastfeeding**
  - Milk/plasma ratio (M/P)
  - Clinical data on infant outcomes
- Drug half-life
- Age and medical stability of infant
- How psychiatric dx and social supports may impact ability to breastfeed
- Potential impacts of medication on milk production (e.g., aripiprazole, stimulants)
- Generally do not monitor serum level in infants unless clinical concern for toxicity (e.g., Lithium)
  - Ability to coordinate with pediatrician
- Avoid recommending “pump and dump”

Medication	Relative Infant Dose (RID) *from InfantRisk Center
Sertraline (Zoloft)	0.4-2.2%
Fluoxetine (Prozac)	1.2-12%
Escitalopram (Lexapro)	5.2-7.9%
Venlafaxine (Effexor)	6.85-10.89%
Bupropion (Wellbutrin)	0.11-1.99%
Lithium	0.87-7.29%
Lamotrigine (Lamictal)	6.62-18.27%
Olanzapine (Zyprexa)	0.28-2.24%
Quetiapine (Seroquel)	0.02-0.1%
Aripiprazole (Abilify)	0.7-6.44%
Amphetamine-dextroamphetamine (Adderall IR)	2.46-7.25%
Lorazepam (Ativan)	2.6-2.9%

“Risk-Risk” Discussion

SSRIs

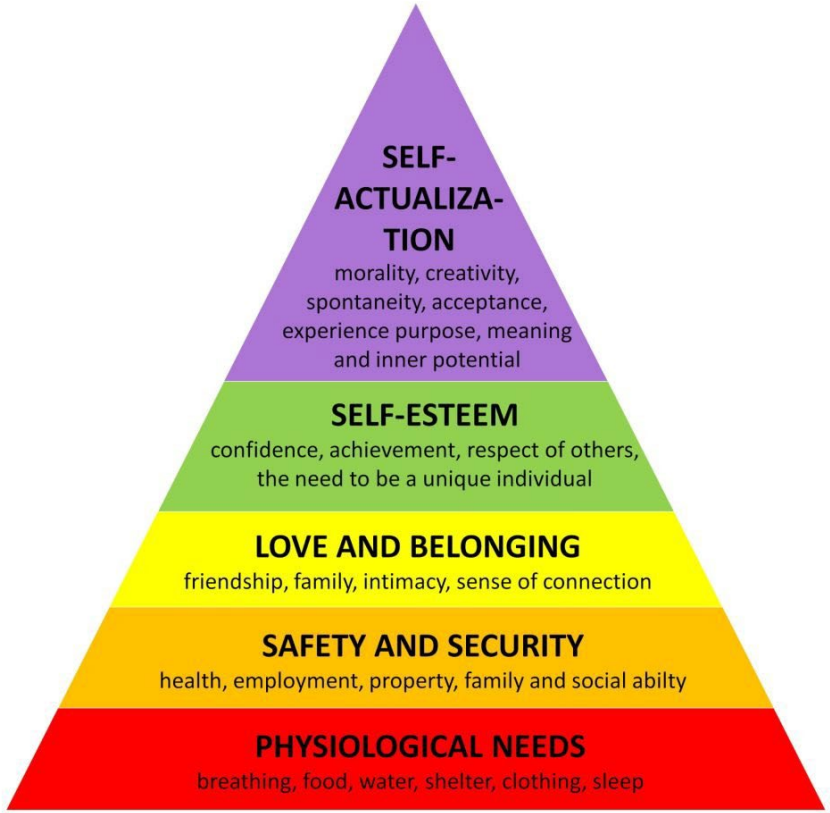
- Poor neonatal adaptation
  - 25-30%, transient & generally mild
- Persistent pulmonary hypertension of the newborn (PPHN)???
  - Inconsistent findings
- No evidence of other congenital malformations
  - Paroxetine as possible exception, with inconsistent findings
- Long term developmental outcomes generally reassuring

Untreated mood/anxiety disorders

- Pregnancy and neonatal complications
  - Low birth weight, preterm birth, breastfeeding difficulties
- Increased risk of substance use
- Challenges re: bonding and infant-parent relationship
- Safety concerns (suicide, infanticide, corporal punishment)

Non-pharmacological Interventions

- Psychotherapy
  - Individual (Cognitive Behavioral Therapy, Interpersonal Psychotherapy)
  - Dyadic (Child Parent Psychotherapy)
  - Group (Circle of Security)
- Maternal, Infant, & Early Childhood Home Visiting
  - Nurse-Family Partnership (NFP)
  - Parents as Teachers (PAT)
- Encourage self-care, exercise, and healthy diet
- Partner/family engagement and support
- Encourage engagement in social and community supports
  - Postpartum Support International: peer mentor program and online support groups
- Encourage sleep hygiene (CBT-I) and asking for help from others during nighttime feedings
- Psychoeducation on Parenting and Child Development (Zero to Three, AAP, CDC Milestone Tracker, Vroom)
- Basic needs (housing, food, supplies)



HRSA
Maternal & Child Health

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SUICIDE
& CRISIS
LIFELINE

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Resources

- MGH Center for Women's Mental Health:
- Postpartum Support International (PSI):
- Perinatal/Postpartum Psychosis:
  - PSI free online support groups and peer support program for PPP survivors and their families/partners:
  - MGH Postpartum Psychosis Project:
- Mother to Baby:
  - Medication fact sheets for patients/families
- Infantrisk.com:
  - Medication pregnancy and lactation data summaries, available as smartphone app
- LactMed:
- Louisiana Provider to Provider Consultation Line (PPCL):
  - Pediatric and perinatal mental health focused telephone consultation, resource and referral support
  - Screening tools, clinical handouts/guides for providers, resources for patients/families