Psychiatric Consultation to Primary Care

A behavioral health integration partnership program of Vista Hill, funded by San Diego County Department of Behavioral Health Services

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Depression in & after Pregnancy

There are some mood conditions that occur during pregnancy and the postpartum period that deserve a discussion from a psychiatric perspective because of their frequency and potential health impacts. These conditions can be a challenge to treat because of the dual risk of impacts and/or side-effects upon the mother and child but screening and intervention with or without medication is important to relieve suffering and improved outcomes.

Postpartum Blues: Symptoms of mood lability, irritable mood, interpersonal hypersensitivity and tearfulness are common in the postpartum period and are commonly known as the postpartum "blues". The incidence is up to 75% and the symptoms typically arise and resolve within 7-14 days after the delivery. Family and other psychosocial supports are needed and helpful interventions.

Postpartum depression (*PPD*): The prevalence of postpartum depression is 10-15%. The postpartum year is the greatest risk period for first-onset depression for women, with approximately 50% of women experiencing their first episode of depression during this period of time. A full 25% of women with a prior history of Major Depressive Disorder will experience postpartum depression and 50% of women who have had *PPD* will have a recurrence after their initial episode of depression. The Edinburgh Postnatal Depression Scale and Postpartum Depression Screening Scale are useful screening tools. Copies of these screens can be found on the www.pc2education.org website.

In addition to depressive symptoms, women with *PPD* will typically present with anxiety symptoms that involve distressing and intrusive thoughts about their infant's safety and feelings of guilt and inadequacy about mothering. Infants of depressed mothers have been found to be less responsive and more irritable than infants of non-depressed mothers. Infants of depressed mothers are also more likely to develop an insecure attachment because of (unintentional) maternal rejection of the baby. Treatment can make a difference.

If one suspects *PPD*, it is important to rule out medical conditions, like thyroid dysfunction and iron-deficiency anemia, as these are more common during pregnancy and in the postpartum period, but psychosocial intervention should not be delayed pending these evaluations. Interventions are important because the potential negative impacts on both mom and the fetus of substantial maternal anxiety and depression can be significant with pre-term delivery and other negative outcomes being higher for stressed moms and neonates.

Treatment: Medication can be an important treatment for postpartum depression, if it is moderate to severe and when non-medication approaches, like nurse home visiting, therapy and support groups have not been effective. SSRIs are the first line agents. Sertraline (Zoloft) is, in particular a good drug because of its relatively short half-life and availability of low dosing (as low as 12.5 mg per day). Other SSRIs can be considered as well.

At this time there are no FDA approved medications for *PPD*, mostly because it is difficult to conduct research in the post partum period. Of the SSRIs, sertraline and paroxetine are the least detectable in breast milk. Several case reports note an association between fluoxetine and citalopram use in lactating women and infant irritability, poor sleep, poor feeding, crying, and restlessness. This might be related to these medications' relatively longer half-life. Other case reports have not noted any adverse effects in infants of mothers taking fluoxetine and citalopram.

As previously mentioned, if one is considering treating *PPD* with a medication, sertraline is a good first line agent because of its relatively short half-life and ability to dose in smaller strengths--but if a woman is already on an antidepressant like fluoxetine with a good response, it is probably best to continue with the medication and monitor closely for side effects in the mother and infant.

The important take home point for treating depression related to pregnancy is to first consider non-medication treatments as viable options. If it is determined medication is needed, it is important to have a careful discussion about the risks and benefits and to try to use the smallest possible dose for the shortest length of time. Time spent reviewing risks and benefits of medication treatment serves both mom and baby.

Medication Treatment of Depression during Pregnancy: The depressed presents a challenge as serious depression is problematic for both mom and neonate while medication exposure of the neonate is also a concern. There is also a possible connection between SSRI use in the third trimester of pregnancy and development of persistent pulmonary hypertension in infants, so it is important to weigh risks vs benefits of medication trials with the mother and her family. Paroxetine is one drug to avoid as it is pregnancy category D with evidence that it increases the risk of birth defects, including cardiac effects.

While there are some reports of the risk of limb malformations with the tricyclic antidepressants like amitriptyline and nortriptyline, these have not been confirmed in more recent studies and these agents can be helpful as well. There have also been reports of newborns experiencing temporary discontinuation symptoms at birth, including jitteriness and irritability when a woman is treated with antidepressants during pregnancy.

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