

A Non-Prescriber's Guide to Psychiatric Medications in Pregnancy and Breastfeeding



Presenter:

Jessica Cosgrove, D.O.

- Reproductive Psychiatrist; Project Teach NY Faculty
- Associate Program Director of Psychiatry Residency Training, Northwell Mather Hospital
- Katz Institute for Women's Health
- Assistant Professor of Psychiatry, Donald and Barbara SOM

Contact: jcosgrove1@northwell.edu

Disclosures

I have nothing to disclose.

Objectives

- **Recognize the maternal, obstetrical, and child developmental consequences of untreated perinatal mental health disorders to support evidence-based decision-making regarding medication use during pregnancy and lactation.**
- **Describe the safety profiles and clinical considerations of common psychotropic medications used in the perinatal period, including serotonergic antidepressants, zuranolone and benzodiazepines.**
- **Support patient adherence and collaboration with prescribers by identifying patients who would benefit from psychopharmacologic evaluation, addressing patient concerns and facilitating linkage to psychiatric care and psychotherapy resources.**

Start with a poll..

Have you ever had a client ask you about their medication regimen during pregnancy or breastfeeding?

- Yes
- No

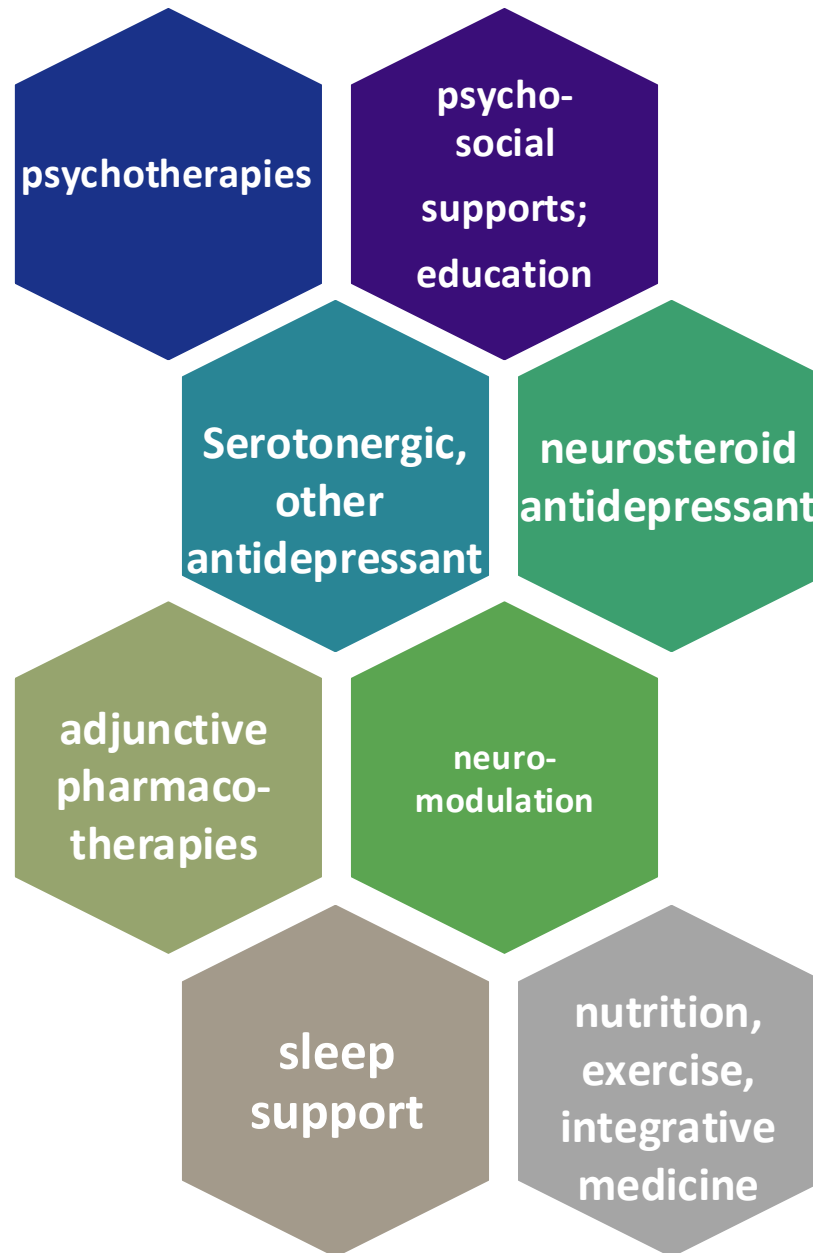
Perinatal Mood and Anxiety Disorders (PMADS)

- ⚡ Extremely common- occurs in 13%-20% of women per WHO.
 - Leading complication of childbirth
 - Mental health conditions were the leading cause of pregnancy-related deaths in NYS 2018-2021
- ⚡ PMADS! What does it mean?
 - Perinatal– During pregnancy through ~1 yr postpartum
 - Mood and Anxiety Disorders
 - Depressive Disorders
 - Anxiety Disorders
 - Bipolar Spectrum Disorder
 - Posttraumatic Stress Disorder
 - Postpartum Psychosis
- ⚡ PMHD may be more inclusive!
 - Perinatal Mental Health Disorders

PMADS

- ⚡ **Pregnancy previously thought to be protective against psychiatric illness!**
- ⚡ **We now know that this is not true!**
- ⚡ **Current estimates are likely underestimated given women are often fearful of seeking care!**
 - **Fear of repercussions**
 - **Fear of medication use**
 - **Thinking experience is “normal”**

Consider all therapeutic tools in our toolbox to treat Perinatal Depression



Treatment of Perinatal Mood and Anxiety Disorders

Mild to moderate severity

Psychotherapy

Moderate to severe severity

Antidepressants

Psychotherapy

Perinatal Depression Therapeutics

- **Psychotherapies**: monotherapy for mild-moderate unipolar perinatal depression
 - Interpersonal psychotherapy (IPT) (Reay R et al, 2012; Grote NK et al, 2010; Spinelli MG & Endicott J 2003; O'Hara MW et al, 2000; Klier CM et al, 2001; Stuart S & O'Hara MW 1995)
 - Cognitive behavioral therapy (CBT) (Milgrom J et al, 2016; Milgrom J et al, 2015; Ammerman RT et al, 2013; Le HN et al, 2011)
 - Mindfulness-based CBT (Dimidjian S et al, 2016; Dimidjian S et al, 2014; Goodman JH 2014)
 - Peer support and group psychotherapies (Dennis CL et al 2009; Dennis CL 2003; Chen CH et al 2000; Honey KL 2002; Milgrom et al 2005)

Perinatal Depression and Anxiety Therapeutics

- Serotonergic antidepressants (SSRI, SNRI, etc.): moderate/severe unipolar perinatal depression, FDA approved for major depression
 - *No* randomized, placebo-controlled trials (RCT) of antidepressants for antenatal depression
 - Meta-analysis of 11 postpartum RCTs showed that there may be a benefit of SSRIs over placebo in response (55% versus 43%; pooled risk ratio (RR) 1.27, 95% CI 0.97 to 1.66) and remission (42% versus 27%; RR 1.54, 95% CI 0.99 to 2.41) at 5 to 12 weeks' follow-up. (Brown JVE et al, Cochrane Database Syst Rev, 2021)
 - Antepartum vs postpartum use is associated with different risks
 - Treatment approach: titrate until efficacy/tolerability then treat acute episode at that dose -> once reach euthymia, continue treatment (continuation phase) for 6-12 mo. to prevent relapse.
 - Often best to combine with psychotherapies!

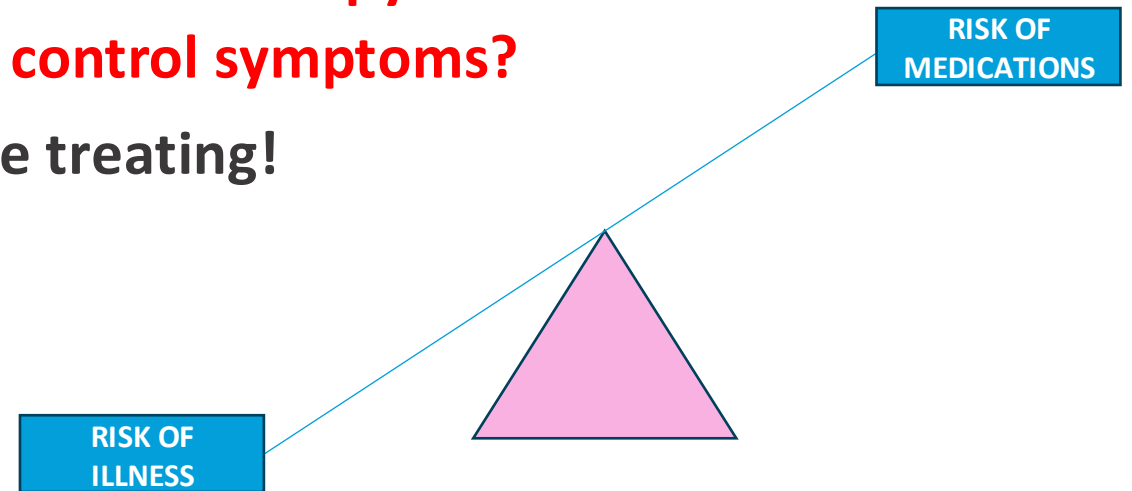
Poll #2

Have you ever had a stable client desire to switch their medication to Zoloft during pregnancy because they believed it was safer?

- Yes
- No

Medication Use

- First, consider how you would treat the patient's unipolar depression/anxiety if the patient were not pregnant.
- No decision is risk free
 - Consider:**
 - the risk of medication on fetus/newborn/mom**
 - risk of untreated illness on fetus/newborn/mom**
 - risk of switching to alternative pharmacotherapy**
 - Is the alternative safer? Will it control symptoms?**
- Especially important to know what we are treating!



Untreated Perinatal Mental Health Disorders are Associated with Adverse Maternal Outcomes

- Decreased maternal functioning (Field, T, 2010)
- Psychosis, suicidal ideation, homicidal ideation and suicide attempt are psychiatric emergencies that lead to psychiatric hospitalization, maternal death (Rodriguez-Cabezas et al, 2019)
- Bidirectional relationship between depression and gestational diabetes mellitus (Fischer et al, 2023)

Untreated Perinatal Mental Health Disorders are Associated with Adverse Obstetrical Outcomes

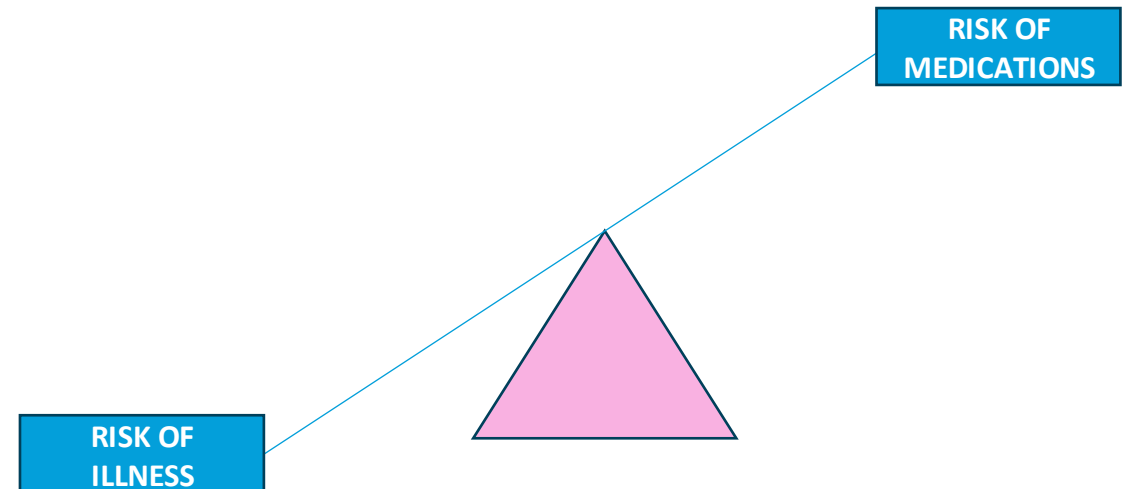
- **Preterm labor (Bansil P et al, 2010), preterm birth (Grigoriadis S et al, 2013), stillbirth/neonatal death and hypertensive disorders of pregnancy (Staub et al, 2012, Thombre et al, 2015, Delanerolle et al, 2022)**
- **Increased requirement for surgical delivery interventions (Wang SY & Chen CH, 2010) and cesarean delivery (Bansil P et al, 2010)**

Untreated Perinatal Mental Health Disorders are Associated with Adverse Infant and Child Development

- **Inadequate maternal-infant bonding prenatally and post-delivery** (Rossen et al, 2016; Betcher et al, 2020, Dagher et al, 2021)
- **Lactation failure or unplanned weaning** (Dennis CL & McQueen K, 2009; Stuebe AM et al, 2014)
- **Impaired child cognitive development** (Tuovinen S et al, 2018), **behavioral and emotional development** (Leis JA et al, 2014; Pearson RM et al, 2013)
- **Impaired child brain development/antenatal stress from mental illness is associated with accelerated development of offspring neural networks via fetal (developmental) programming** (Schinost D et al, 2016; Rotem-Kohavi, N et al, 2020; Wu et al., 2024)

Medication Use

- ⚡ There are no medications we can say are 100% safe during pregnancy!
 - Difficult to study!
 - Studies we DO have show SSRIs generally safe to use during pregnancy and lactation!
- ⚡ Do not use Drug Categories (A, B, C, D, X) to determine risk!
 - What took its place?



Poll #3

Have you heard of the PLLR system for prescription drug risks during pregnancy and breastfeeding?

 Yes

 No

Medication Use

- ☞ Drug Categories- **A,B,C,D,X– NO LONGER USED!**
 - Oversimplified and made drugs with no data appear safer and drugs with any data more dangerous!
 - Instead we can use the Pregnancy and Lactation Labeling Rule (PLLR) which provides narrative summaries to help inform risk/benefit analysis. Found online and in drug package inserts!

Poll #4

What have you heard about antidepressant use during pregnancy or lactation?

- **They are addicting**
- **They cause birth defects**
- **They cause autism**
- **All of the above**

Common Misconceptions

⚡ Addiction Potential:

- Antidepressants in general are not addicting, habit-forming, or cause dependence.

⚡ Teratogenicity:

- According to the CDC there is a 3% baseline risk for birth defects in babies born to women **NOT ON MEDICATION!**
- Most studies looking at babies born to women taking antidepressants generally show no increase in this risk, though studies that do find risk show that if there is a risk it is **VERY SMALL.**

⚡ Autism:

- According to the CDC the causes of autism are multifactorial and arising from the interplay of genetics and environmental exposures.
- Studies that are able to take into account family history do not find an increase in risk of autism with antidepressant exposure in utero.

Risk of Neonatal Complications with Antenatal Serotonergic Antidepressant Use

Postnatal adaptation syndrome (PNAS): delayed neonatal adaptation occurred in 11.2% of exposed vs 4.4% of unexposed infants. (Cornet et al, 2024)

- Infant irritability, abnormal crying, tremor, lethargy, hypoactivity, decreased feeding, tachypnea, respiratory distress, irritability, tachypnea, hypothermia, and hypoglycemia
- Severity and length are impacted by multiple factors including dose, timing, and duration of exposure and SSRI pharmacology.
- Symptoms typically self-limiting though can last through 1st month postnatal life.
- Not recommended to taper in 3rd trimester as risk of relapse of symptoms high and conflicting data on reduction of risk w/ taper.

General Considerations for Medication Management of PMADS

- Discussion of treatment of PMADs is patient specific and should always consider risk of untreated illness vs. risk of medication!
- Stick to what has worked in past!
 - Generally do not recommend switching medications as there is no guarantee new medication will control symptoms.
- Attempt to go into pregnancy with stability of symptoms!
 - Med changes ideally made prior to pregnancy with 6 months of stability prior to conception!
- Do not reflexively stop medications upon becoming pregnant!
 - Abrupt discontinuation of antidepressants in pregnant women with a history of depression is associated with high-risk of relapse without known benefit (L.S. Cohen et al., 2006).
 - Women with history of recurrent unipolar MDD or history of symptom recurrence associated with past reduction or discontinuation of pharmacotherapy should not discontinue their antidepressant during pregnancy.

Antidepressant Dosing for Perinatal Depression and Anxiety

(see drug labels at: <https://dailymed.nlm.nih.gov> for full prescribing info)

Medication	Indication	Starting dose	Usual dosage range
Fluoxetine	MDD, GAD, OCD	10 mg	10 – 80 mg daily
Sertraline	MDD, GAD, OCD	25 mg	50 – 200 mg daily
Escitalopram	MDD, GAD	5 mg	5-20 mg daily
Citalopram	MDD, GAD	10 mg	10-40 mg daily
Paroxetine	MDD, GAD, OCD	10 mg	10 – 50 mg daily
Venlafaxine	MDD, GAD	37.5 mg	75-225 mg daily
Bupropion XL	MDD w/o anxious distress Nicotine dependence	150 mg	150 – 450 mg daily
Mirtazapine	MDD with nausea	7.5 mg	15 -45 mg nightly

Use of Antidepressants During Lactation

World Health Organization and The American Academy of Pediatrics recommends that children are breastfed for their first 2 years of life.

The American Academy of Family Physicians and the American Dietetic Association recommend exclusive breastfeeding for the first 6 months of life and breastfeeding with complementary food from 6 months until at least 12 months of age and as long thereafter as desired.

Antidepressant use should not discourage women from breastfeeding; overwhelming benefits of breastfeeding usually outweigh risks of medication use in women with unipolar depression +/- anxiety

- PND is associated with ↓ breastfeeding duration and ↑ breastfeeding difficulties (Dennis CL 2009)
- Relative infant doses (RID) less than 10% of maternal dosage are generally acceptable per FDA
- Side effects to watch for: sedation, irritability, poor feeding, GI upset
- The National Library of Medicine at the NIH maintains the Drugs and Lactation Database (LactMed) found at: <https://www.ncbi.nlm.nih.gov/books/NBK501922/>
 - This useful database is maintained by a peer review panel who reviews scientific data to assure validity and currency. It includes information on levels of drugs in breastmilk and infant blood and the possible adverse effects in the nursing infant.

Infant exposure to maternal antidepressant use via breastmilk

The National Library of Medicine at the NIH maintains the Drugs and Lactation Database (LactMed) found at:

<https://www.ncbi.nlm.nih.gov/books/NBK501922/>

Medication name	RID (%)
Bupropion	0.2-5.1
Citalopram	3-10
Desvenlafaxine	5.5-8.1
Dextromethorphan/bupropion	Avoid during treatment and for 5 days after d/c; inadequate human data available (per manufacturer): dex (<1%);
Doxepin	AVOID: reports of hypotonia, sedation, vomiting, suppressed respiratory rate, weight loss
Duloxetine	<1
Escitalopram	5.2-7.9
Fluoxetine	0.6-20 (norfluoxetine detectable in infant serum)
Fluvoxamine	<2
Levomilnacipran	No data, monitor for agitation, irritability, poor feeding and poor weight gain
Mirtazapine	0.5-3
Nortriptyline	0.87-3.71 (watch for dry mouth, constipation, urinary retention)- favored TCA in lactation
Paroxetine	1.2-2.8
Sertraline	0.4-3
Venlafaxine	6-9
Vilazodone	No data, seek alternative
Vortioxetine	1.1-1.7
Zuranolone	<1

Postpartum Depression Therapeutics

First FDA-approved medication for moderate-severe postpartum depression (postpartum use only) was Brexanolone, a neuroactive steroid antidepressant, however as it was only available IV and due to success of Zuranolone, it is now discontinued.

Zuranolone is a synthetic analog of allopregnanolone and binds a specific type of GABA-A receptor in the brain

- First oral FDA-approved PPD treatment in 2023
- Once daily dosing (50mg PO qPM x 14 days only)
- Rapid-acting antidepressant effects at day 15, as early as day 3, maintained through day 45 (Deligiannidis K et al 2021, and 2023)
- Boxed warning for impaired ability to drive or engage in other hazardous activities due to CNS depressant effects
- May be used alone or as an adjunct to oral antidepressant therapy, but avoid other CNS depressants
- Schedule IV
- Take with fat-containing food around 8pm

Class comparison: antidepressant side effects

Sertraline (SSRI)

- ⚡ Nausea (26%)
- ⚡ Diarrhea/loose stools (18%)
- ⚡ Insomnia (16%)
- ⚡ Somnolence (13%)
- ⚡ Dry mouth (16%)
- ⚡ Tremor (11%)

Zuranolone (neurosteroid)

- ⚡ Somnolence (36%)
- ⚡ Dizziness (13%)
- ⚡ Diarrhea (6%)
- ⚡ Fatigue (5%)
- ⚡ Urinary track infection (5%)

all data from

<https://dailymed.nlm.nih.gov/dailymed/index.cfm>

Non-Prescribers Role

- Identify patients who would benefit from psychopharmacologic evaluation and refer early
- Can utilize screening tools
 - EPDS: 14 and over indicate concern for at least moderate MDD
 - PHQ9: 10 and over indicate concern for at least moderate MDD
 - GAD 7: 10 and over indicate concern for at least moderate GAD
- If in therapy, watch for signs that underlying disorder is preventing the patient from engaging meaningfully

Non-Prescribers Role

- Listen for signs the mental health concern is impairing their daily functioning
 - "I dread waking up in the morning"
 - "I know my OBGYN said I needed to get bloodwork but I'm just too overwhelmed even though I've been to that lab before"
 - "I stopped using the upstairs rooms because I'm too nervous I will drop the baby when I'm going down the stairs"
 - "Everything seems like a chore now, even things I used to enjoy like going for a run or singing with my toddler... it's all just kinda grey"
 - "It takes all my willpower to just get in the shower, even when my family is watching the baby"

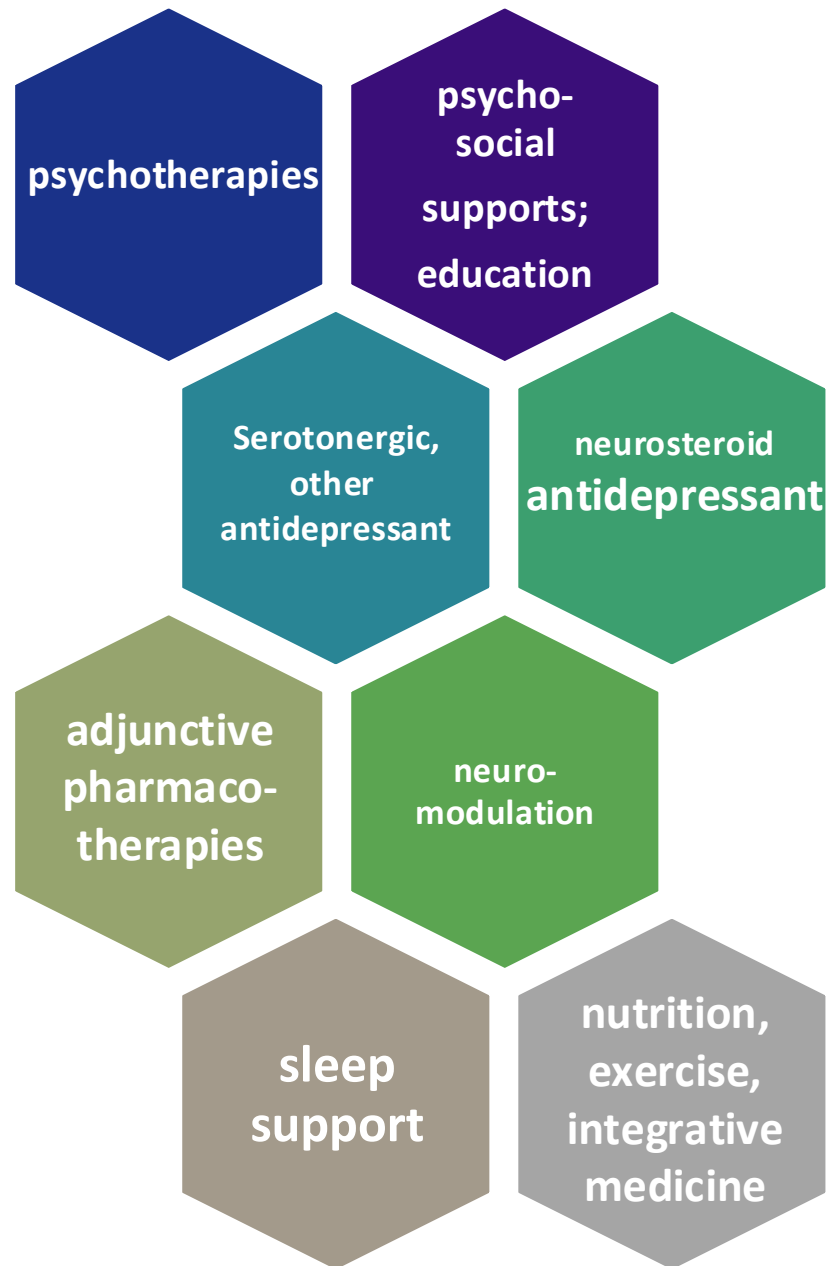
Non-Prescribers Role

- **Ask for patient's thoughts on medication**
 - Give space for patient to express their concerns
 - Challenge common misconceptions
 - “I can tough it out”
 - “I’m a bad mother if I need help”
 - “The doctor will force me to take medication”
 - Reduce stigma and provide hope
 - Reassure the patient, that you can get better
 - Remind patient depression and anxiety are medical problems and we don't hesitate to treat other medical problems like asthma or diabetes
 - If you have worked with others who have felt relief from medication, share that with the patient
 - Consider additional influences: family, partner, court system

Non-Prescribers Role

- **Encourage compliance, check in if patient is taking medication as prescribed**
 - **If not, ask why and consider strategies to help**
 - **If patient forgets- brainstorm:**
 - using an alarm
 - taking at the same time as they always do something else (brushing teeth)
 - have a pill organizer or a keychain pill case with extras
 - **If patient is unsure of how to take- Empower:**
 - Encourage the patient to bring this up with their prescriber and normalize that lots of people have these questions

Consider all therapeutic tools in our toolbox to treat PND





Moms supporting Moms.

Postpartum Resource Center of New York
Statewide Toll-free Helpline
855-631-0001
7 days/week | 9am to 5pm
postpartumny.org



Postpartum Resource Center of New York
Perinatal Mood and Anxiety Disorders: Finding the help you need

State-wide non-profit organization providing since 1998 free emotional support, educational information and healthcare and support group resources.

Moms on Call and Family Telephone Support

State-wide Perinatal Mood and Anxiety Disorders Resource Directory
www.postpartumny.org/resourcedirectory

Postpartum Resource Center of New York's Training Institute

NYS Lead Coordinator for PSI postpartum.net

Thank you!

Call us Monday – Friday • 9 am – 5 pm

1-855-772-2727

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www.ProjectTEACHny.org