

*Psychiatry* for Non-Psychiatrists

# Perinatal Psychiatry

**Bailey Brooks, MD**

Psychiatrist

Broadlawns Medical Center

# *Psychiatry* for Non-Psychiatrists

## DISCLOSURE

**I do not have any financial relationships with ineligible companies to disclose.**

# *Psychiatry* for Non-Psychiatrists

## Learning Objectives

- Understand the importance of family planning in psychiatric patients of reproductive age
- Understand the basics of psychiatric illness in pregnancy and the postpartum period
- Be able to recognize postpartum psychosis and it being a psychiatric emergency
- Become familiar with resources tailored for providers treating pregnant and lactating individuals

# Psychiatry for Non-Psychiatrists

## DISCLAIMER 1

*Note: I recognize that not all people who are able to become pregnant identify as women, and I attempted to use gender inclusive language in this PowerPoint and presentation.*

# *Psychiatry* for Non-Psychiatrists

## DISCLAIMER 2

- This is a **huge** topic for a 1 hour lecture/discussion

# *Psychiatry* for Non-Psychiatrists

## Patient Case Study

Brief H&P: A 25 year old G1P0 year old female with a history of bipolar disorder comes to you at 12 weeks gestation.

What do you want to know?

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## Patient Case Study

Planned versus unplanned?

Stability and severity of bipolar illness?

Family history?

Current medications?

Therapy?

Support?

Sleep?

Substance use?

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## Patient Case Study

H&P continued...

This was an unplanned pregnancy. She had confirmation of pregnancy via ultrasound at 8 weeks, which was when she became aware of this pregnancy. Although unplanned, she is very excited about this pregnancy while also being nervous and having a lot of questions for you.

She tells you that she has a history of bipolar 1 disorder, with one prior manic episode at age 23 and three depressive episodes, one at 19, one at 22, and one following her manic episode. None of these mood episodes have included psychotic symptoms. She has been relatively stable with lithium monotherapy for the last year. Her mother also has bipolar 1 disorder and had significant postpartum depression, requiring hospitalization after her first child. She meets with her therapist regularly. She has been unable to see her medication management provider since she found out she was pregnant, and she stopped her medication one month ago.

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## Patient Case Study

What do you do next?

... We will come back to this 😊

# Psychiatry for Non-Psychiatrists

## Family Planning in Psychiatric Patients of Reproductive Age

- Over 80% of persons who can become pregnant will have at least one pregnancy
- **~45% of pregnancies are unintended/unplanned**
- Over half of patients who seek psychiatric care are assigned female at birth and have the ability to become pregnant

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## Family Planning in Psychiatric Patients of Reproductive Age

- Persons with depression, anxiety, schizophrenia, opioid use disorders and other substance use disorders are all at increased risk for unintended pregnancies
- Unintended pregnancies are associated with new episodes of psychiatric disorders
- Persons diagnosed with mental illness and co-morbid substance use disorders are less likely to receive prescription contraceptives than those without this comorbidity

# *Psychiatry* for Non-Psychiatrists

## Family Planning in Psychiatric Patients of Reproductive Age

### **THE MAIN POINTS:**

We take care of these patients, and these patients are at risk

AND

We need to know how to care for them

# *Psychiatry* for Non-Psychiatrists

Family Planning in Psychiatric Patients of Reproductive Age

**The Conversation Starts\*  
Preconception!**

# Psychiatry for Non-Psychiatrists

## Family Planning in Psychiatric Patients of Reproductive Age

Both medication and substances can have a variety of effects on reproduction related goals

- ◆ Reduction in Contraceptive Effectiveness
- ◆ Reduction in Medication Effectiveness When Taking Contraceptives
- ◆ Increase in Medication Levels (Risk for Toxicity) When Taking Contraceptives
- ◆ Mood Sensitivity with Hormonal Changes \*
- ◆ Reduction in Fertility
- ◆ Teratogenicity
- ◆ Reduced Medication Effectiveness in Pregnancy
- ◆ Adverse Obstetrical Outcomes
- ◆ Neonatal Complications
- ◆ Neurodevelopmental Effects in Offspring

# *Psychiatry* for Non-Psychiatrists

## Family Planning in Psychiatric Patients of Reproductive Age

### **KEY POINT:**

*AVOID Valproic Acid in reproductive age assigned females at birth due to profound potential adverse fetal outcomes. If it **MUST** be used, a **HIGHLY** effective contraceptive method should be in place.*

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## Family Planning in Psychiatric Patients of Reproductive Age

### **TAKE AWAYS:**

*Know your patients reproductive goals and help support these goals, which may mean referrals to someone for contraception needs or for their psychiatric care*

*Discuss potential risks of medications and substances if the patient were to get pregnant\**

*If a patient is considering becoming pregnant, discuss taking folate (400 mcg) and a prenatal vitamin.*

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## Basics of Psychiatric Illness in Pregnancy/Postpartum Period

### FACTS:

- Assigned females at birth (AFAB) have unique risk periods for development or exacerbation of mental illness across their lifetime. In particular, risk increases during their premenstrual phase of their cycle, **pregnancy and postpartum**, and during peri-menopause.
- “Perinatal mental health and substance use disorders are common, undertreated and the leading cause of maternal mortality in the United States.”
- Postpartum mental illness is the most common complication of childbirth
- Suicide and overdose deaths are more common in the second half of the postpartum year

# Psychiatry for Non-Psychiatrists

## Basics of Psychiatric Illness in Pregnancy/Postpartum Period

### NOTES:

- DSM 5 Major Depressive Disorder, Bipolar I and II Disorder "with peripartum onset" Brief Psychotic Disorder "with postpartum onset" qualifier of means pregnancy and up to 4 weeks postpartum\*
- Perinatal definition: pregnancy and up to one year postpartum
- The reality is that 1 out of 4 women with perinatal depression will have symptoms 3 years postpartum

\*There is no official qualifier in the DSM for anxiety disorders and obsessive compulsive disorders

# Psychiatry for Non-Psychiatrists

## Basics of Psychiatric Illness in Pregnancy/Postpartum Period

### **SOME ESSENTIALS:**

- Baby blues and intrusive thoughts VS psychopathology
- Perinatal mental health disorder affects 1 in 5 mothers
  - Depression, bipolar mood episodes, anxiety disorders, OCD, PTSD, Postpartum Psychosis
  - Depression and anxiety\* are most common
  - Importance of screening for Bipolar disorder
    - Average age of onset corresponds with childbearing years – childbirth = potent precipitant of hypomania/mania
    - First episode of nonpsychotic postpartum depression can be a marker of bipolar disorder
    - Nearly ¼ of individuals with a positive perinatal depression screen will be found to have bipolar disorder if further evaluated
    - Risk of psychiatric hospitalization in the postpartum period is significantly greater than at any other point in their lives
- Depression during pregnancy is the best predictor of postpartum depression
- Risk of relapse is high for major depressive disorder and especially for bipolar disorder with medication discontinuation

# Psychiatry for Non-Psychiatrists

## Basics of Psychiatric Illness in Pregnancy/Postpartum Period

### **Untreated or undertreated mental health potential effects:**

- Poor engagement in medical care
- Exacerbation of medical conditions
- Smoking during pregnancy/postpartum period
- Substance use disorders
- Adverse obstetrical outcomes --- severe maternal morbidity and mortality
- Maternal suicide
- Adverse fetal, neonatal and infant outcomes -- stillbirth, preterm birth, FGR, LBW, SGA, impaired bonding, adverse infant neurodevelopment, and increased mental health concerns for the offspring long term

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Basics of Psychiatric Illness in Pregnancy/Postpartum Period

“Nothing is more important than maternal euthymia” –  
Dr. Lee Cohen, MD (Massachusetts General Hospital)

# Psychiatry for Non-Psychiatrists

## Basics of Psychiatric Illness in Pregnancy/Postpartum Period

- Recommendations for Universal Screening (PHQ9 or EPDS)
- Rule out medical causes (TSH, CBC, Vitamin B12, Vitamin D, Folate)
- Awareness of predictive factors for PPD:
  - **History of depression\***
  - **Depression and/or anxiety during pregnancy**
  - **Stressful life events**
  - **Marital dissatisfaction**
  - **Stress related to child-care**
  - **Inadequate support**
  - **Difficult infant temperament**
  - **Low self-esteem**
  - **Family history of PPD (heritability 44-54%)**
  - **Unwanted or unplanned pregnancy**
  - **Lower SES**
  - **Single**
  - **Postpartum blues**

# Psychiatry for Non-Psychiatrists

## Basics of Psychiatric Illness in Pregnancy/Postpartum Period

- Your job is to present information to patients and ultimately come to shared decision making within a complex decision.
  - “Risk vs risk” – untreated mental illness versus potential risks of medications in regards to the pregnancy and fetus/infant/child \*
- “What we say and how we say it matters” – Dr. Robin Kopelman, MD
- Stopping medication is NOT the standard of care.

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## Basics of Psychiatric Illness in Pregnancy/Postpartum Period

- ACOG recommends against withholding or discontinuing medications for mental health conditions due to pregnancy or lactation status alone.
- ACOG recommends against discontinuing mood stabilizers, except for valproate, during pregnancy due to the risk of recurrence or exacerbation of mood symptoms.
- ACOG recommends that pregnant patients taking lithium in the first trimester receive a detailed ultrasound examination in the second trimester.

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## Basics of Psychiatric Illness in Pregnancy/Postpartum Period

### **PEARLS OF MEDICATION USE:**

- Use what has previously been effective
- Use the lowest EFFECTIVE dose
- Avoid polypharmacy
- Minimize switching
- Understand physiologic changes of pregnancy
- Consider untreated/undertreated mental health disorders as an exposure
- There are few psychiatric medications that have absolute contraindications in lactation
- Maximize non-pharmacologic interventions

# *Psychiatry* for Non-Psychiatrists

## Basics of Psychiatric Illness in Pregnancy/Postpartum Period

### **PEARLS OF MEDICATION USE:**

- Provide patient centered care
- \*There is no perfect decision\*
- Goal = REMISSION of mental health symptoms and/or PREVENTION of relapse

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## Basics of Psychiatric Illness in Pregnancy/Postpartum Period

### SSRIs:

- Some of the most studied class of medications in pregnancy
- Evidence does not support an increased risk of birth defects
  - Note on paroxetine
- Evidence does not support any negative long term effect on neurobehavioral outcomes in children
- Counsel on risk for:
  - Transient Neonatal Symptoms: self-limited, not mitigated by tapering dose in third trimester
  - Persistent Pulmonary Hypertension: inconsistent evidence, absolute risk is small
  - Potential risk for low birth weight and pre-term labor\*
- If no previous medication trials:
  - Reasonable to start with sertraline > escitalopram > fluoxetine\*
    - \*long half-life increases risk for NAS and accumulation in breastmilk although is not contraindicated if has been effective previously

# *Psychiatry* for Non-Psychiatrists

## Basics of Psychiatric Illness in Pregnancy/Postpartum Period

### **SNRIs:**

- Less data compared to SSRIs
- Effects on prolactin with venlafaxine?
- Risks of SAB in 1<sup>st</sup> trimester?
- Risks of gestational hypertension and pre-eclampsia

# Psychiatry for Non-Psychiatrists

## Basics of Psychiatric Illness in Pregnancy/Postpartum Period

### **SSRI/SNRIs:**

- Initiate at HALF the lowest recommended dose to prevent early side effects such as agitation or insomnia
- Treatment of anxiety and related disorders (OCD) often require titrating up to higher doses than depression

### **Treatment Duration Recommendations for Depression/Anxiety with SSRI/SNRIS:**

- If discontinued prior to or during pregnancy, consider reinitiating after delivery
- Continue for 6-12 months after symptom remission before considering discontinuation
- Longer remission period recommended in those with anxiety disorders (12 months)

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## Basics of Psychiatric Illness in Pregnancy/Postpartum Period

### **Benzodiazepines:**

- Risk of cleft lip/palate?
- Risk of SAB?
- Risk of neonatal toxicity and withdrawal?
- Avoid longer acting benzodiazepines and those with active metabolites
- Lorazepam preferred in pregnancy

# Psychiatry for Non-Psychiatrists

## Basics of Psychiatric Illness in Pregnancy/Postpartum Period

### **Lithium:**

- Ebstein's Anomaly: 0.05-0.1% risk (versus baseline risk of 0.0005%)
  - Initially thought to be 400 times more common in infants exposed to lithium
  - Dose dependent (>900 mg/daily)
- Requires close monitoring during pregnancy
- Fetal cardiac ultrasound/echocardiogram between 16-18\* weeks gestation
- Close monitoring at delivery to prevent toxicity\*
- Controversial with lactation

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## Basics of Psychiatric Illness in Pregnancy/Postpartum Period

### **Lamotrigine:**

- Very well studied (epilepsy)
- No evidence of increased malformations, neonatal complications, or adverse neurodevelopmental outcomes
- Levels may be significantly decreased in pregnancy
  - Estrogen induces glucuronidation
  - May be helpful to monitor levels in pregnancy
- Close monitoring after delivery due to fast downward shifts in estrogen
  - Requires dose decrease to prevent toxicity
- Note on efficacy with mania/hypomania

# Psychiatry for Non-Psychiatrists

## Basics of Psychiatric Illness in Pregnancy/Postpartum Period

### ~~Valproic Acid, Carbamazepine, Oxcarbazepine:~~

- Congenital malformations
- Long-term neurodevelopmental effects

**Do not use**

# Psychiatry for Non-Psychiatrists

## Basics of Psychiatric Illness in Pregnancy/Postpartum Period

### **Antipsychotics:**

- More data on FGA compared to SGA
- SGA data is generally reassuring
- Quetiapine has the lowest placental passage and thus is often a preferred first-line antipsychotic
- A slightly increased risk in overall and cardiac malformations noted for risperidone
  
- If a history of isolated postpartum psychosis, antipsychotic should be re-initiated in third trimester or the absolute latest would be at time of delivery

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## Basics of Psychiatric Illness in Pregnancy/Postpartum Period

### **Neurosteroids:**

- Brexanolone (Zulresso) and Zuranolone (Zurzuvae)
- Analogues of allopregnanolone and allosteric modulators of GABA receptors

# Psychiatry for Non-Psychiatrists

## Basics of Psychiatric Illness in Pregnancy/Postpartum Period

“The absolute risks of adverse obstetric, perinatal, or infant developmental outcomes for almost all psychiatric medications appear to be low and should be balanced against the high risk of illness recurrence. In general, for most pregnant individuals and for most medications, this balance favors continuation of psychopharmacotherapy.” - ACOG

# Psychiatry for Non-Psychiatrists

## Basics of Psychiatric Illness in Pregnancy/Postpartum Period

### LACTATION PEARLS:

- Breastfeeding has a BIDIRECTIONAL relationship with depression
- If breastfeeding is the preferred form of infant feeding, those with mental health conditions should not be discouraged from doing so\*
- If stable on a medication during pregnancy, do not change it postpartum due to lactation (increased exposure to fetus during pregnancy compared to child during breastfeeding)
- A relative infant dose <10% is considered negligible and compatible with breastfeeding
- Other things to consider: drug half life, oral bioavailability, molecular weight and medical stability of the infant
- Sertraline and paroxetine have the lowest passage into breastmilk of SSRIs
- Lithium is not an absolute contraindication but requires high level of monitoring and coordination of care with the pediatrician\*
- Recommendation of monitoring in infants who are exposed to carbamazepine\*, valproic acid\*, lamotrigine, and antipsychotics through lactation

# Psychiatry for Non-Psychiatrists

## Postpartum Psychosis is a PSYCHIATRIC EMERGENCY

- Prevalence: 1-2 out of 1000 perinatal individuals
- Associated with suicide and infanticide → requires PSYCHIATRIC HOSPITALIZATION
- Risk factors: history of bipolar disorder, history of postpartum psychosis, primipara individuals, medication discontinuation, family history of PPP, perinatal or infant loss, lack of sleep
- Typical onset within days and up to 2 weeks postpartum\*
- Often a delirium like presentation along with insomnia, mood reactivity, irritability, disorganized behavior, obsessions
- Differentiating from OCD
  - PPP - ego-syntonic thought (often an altruistic component)s, lack of insight, high risk of harm to baby
  - OCD – **ego-DYSTONIC** thoughts with good INSIGHT and high distress, avoidant of baby, low risk of harm to baby
- Lithium has the strongest evidence for prevention and is effective monotherapy or adjunct therapy
- Antipsychotics and/or benzodiazepines can also be first line treatment in the acute setting
- Sleep perseveration is critical (strongly consider foregoing breastfeeding overnight)
- If treated quickly and appropriately, full remission is usually achieved by 2 months postpartum
- Postpartum prophylaxis is indicated in those with a history of postpartum psychosis

# *Psychiatry* for Non-Psychiatrists

## So... What Happened With Our Patient?

- Thorough review of psychiatric symptoms was assessed
- Lithium level was obtained, which was in fact at 0
- She was encouraged to start folate 400 mcg and/or a prenatal vitamin
- Sleep was emphasized
- Need for support was discussed
- The “risk versus risk” conversation took place
- Coordinating care between specialties was initiated starting with a referral to a reproductive psychiatrist

# Psychiatry for Non-Psychiatrists

## Case Wrap Up

After establishing care with her reproductive psychiatrist and a thorough risk versus risk conversation, she restarted her lithium. A fetal cardiac ultrasound was performed at 16 weeks gestation, which was normal. Her OB/GYN and psychiatrist continued to coordinate her care throughout her pregnancy. She remained stable throughout her pregnancy and the postpartum period with careful monitoring of her lithium levels, dose adjustments, adequate support from her partner and prioritizing at least a 5 hour stretch of sleep each night. Her baby was born healthy without additional care needs. She chose not to breastfeed to honor her sleep needs, and although at times she feels guilty for this, she is mostly confident in this decision. She is grateful for your support.

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Resources for Providers Treating Pregnant and Lactating Individuals

## **\*MGH Center for Women's Mental Health**

<https://womensmentalhealth.org/>

*Highlights most current and up to date research in this field*

- Subscribe to Our Newsletter\*
- Virtual Rounds at the Center for Women's Mental Health (Wed 1-2 PM CT)
- Essential Reads
- Educational Programs (extra cost)

# Psychiatry for Non-Psychiatrists

Resources for Providers Treating Pregnant and Lactating Individuals

## **\*ACOG Clinical Practice Guidelines**

<https://www.acog.org/clinical/clinical-guidance/clinical-practice-guideline>

*Intended audience for OB/GYN providers, but these practice guidelines are very thorough and a great review.*

- Number 4 “Screening and Diagnosis of Mental Health Conditions During Pregnancy and Postpartum” June 2023
- Number 5 “Treatment and Management of Mental Health Conditions During Pregnancy and Postpartum” June 2023

# *Psychiatry* for Non-Psychiatrists

Resources for Providers Treating Pregnant and Lactating Individuals

## **APA Perinatal Mental Health Toolkit**

<https://www.psychiatry.org/psychiatrists/practice/professional-interests/women-s-mental-health/maternal-mental-health-toolkit>

*Educational material created and released in 2023*

# Psychiatry for Non-Psychiatrists

## Resources for Providers Treating Pregnant and Lactating Individuals

### **Massachusetts Child Psychiatry Access Program (MCPAP) for Moms**

<https://www.mcpapformoms.org/Toolkits/Toolkit.aspx>

*The state of Iowa does not currently have a Perinatal Access Program, but hopefully this is something that will change in the future. MCPAP for Moms is an amazing resource for providers in Massachusetts, but also can serve as educational material and an example for other providers outside of Massachusetts.*

- Obstetric Provider, Pediatric Provider and Substance Use Provider Toolkit
- Presentations and Webinars – Grand Rounds for Obstetrics, Family Practice, Psychiatry, and Pediatrics
- (Additional Resources) Scientific Literature on Perinatal Mental Health Resources

# Psychiatry for Non-Psychiatrists

Resources for Providers Treating Pregnant and Lactating Individuals

## **\*Postpartum Support International**

<https://www.postpartum.net>

*Incredible resource for patients and also providers*

- **Perinatal Psychiatric Consult Line (1-877-499-4773)**
  - free and available by appointment
- Trainings and Webinars
- PMH-Certification

# Psychiatry for Non-Psychiatrists

## Resources for Providers Treating Pregnant and Lactating Individuals

- **LactMed** <https://www.ncbi.nlm.nih.gov/books/NBK501922/> Website that provides a database on information including pharmacokinetics and safety profile of medications and substances related to breastfeeding
- **ReproTox** <https://reprotox.org/> Website that is **free for residents** that provides a summary of information for medications, substances, and other exposures including effects on pregnancy, lactation, neurodevelopment, and reproduction
- **InfantRisk** Phone based app developed by Texas Tech University Health Sciences Center. \$9.99 for one year subscription.

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## Resources for Perinatal Patients

- **988 Suicide & Crisis Lifeline** (Call 988 or Text HOME to 741741)
- **National Maternal Mental Health Hotline** (1-833-TLC-MAMA | 1-833-852-6262)
- **Postpartum Support International** <https://www.postpartum.net/>
  - *HelpLine* [1-800-944-4773](https://www.postpartum.net/help-line) (4PPD).
- **MotherToBaby** <https://mothertobaby.org/fact-sheets/>
- **National Pregnancy Registry for Psychiatric Medications**  
<https://womensmentalhealth.org/research/pregnancyregistry/>
- **National Domestic Violence Hotline** 1-800-799-SAFE (7233)
- **National Human Trafficking Hotline** 1-888-373-7888

# Psychiatry for Non-Psychiatrists

## References

- 1) American College of Obstetricians and Gynecologists Clinical Practice Guidelines <https://www.acog.org/clinical/clinical-guidance/clinical-practice-guideline>
- 2) American Psychiatric Association Perinatal Mental Health Toolkit <https://www.psychiatry.org/psychiatrists/practice/professional-interests/women-s-mental-health/maternal-mental-health-toolkit>
- 3) Guttmacher Institute <https://www.guttmacher.org/fact-sheet/unintended-pregnancy-united-states>
- 4) Hall KS, Steinberg JR, Cwiak CA, Allen RH, Marcus SM. Contraception and mental health: a commentary on the evidence and principles for practice. Am J Obstet Gynecol. 2015 Jun;212(6):740-6. doi: 10.1016/j.ajog.2014.12.010.
- 5) MGH Center for Women's Mental Health <https://womensmentalhealth.org/>
- 6) McCloskey LR, Wisner KL, Cattan MK, Betcher HK, Stika CS, Kiley JW. Contraception for Women With Psychiatric Disorders. Am J Psychiatry. 2021 Mar 1;178(3):247-255. doi: 10.1176/appi.ajp.2020.20020154.
- 7) National Alliance on Mental Illness <https://www.nami.org/mhstats>
- 8) National Curriculum of Reproductive Psychiatry <https://ncrptraining.org/>
- 9) Pew Research Center <https://www.pewresearch.org/social-trends/2018/01/18/theyre-waiting-longer-but-u-s-women-today-more-likely-to-have-children-than-a-decade-ago/#fn-24248-1>
- 10) Postpartum Support International <https://www.postpartum.net>
- 11) Terplan M, Hand DJ, Hutchinson M, Salisbury-Afshar E, Heil SH. Contraceptive use and method choice among women with opioid and other substance use disorders: A systematic review. Prev Med. 2015 Nov;80:23-31. doi: 10.1016/j.yjpm.2015.04.008.
- 12) The Policy Center for Maternal Mental Health <https://policycentermmh.org>

A teal background featuring various office supplies: a black tray with gold paper clips and binder rings in the top left, a white mug of black coffee in the middle left, a green succulent plant in the bottom left, and a black pencil case with green pencils in the top right.

# Psychiatry

for Non-Psychiatrists

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