Perinatal Depression

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Perinatal Depression

Common: 12-15% in pregnancy, 22% postpartum, in 5-10% of non-gestational parents, more common and lower rates of screening and treatment in BIPOC individuals

Screening:
PHQ-2 → PHQ-9/EPDS
Initial prenatal visit
At least once later in pregnancy
Postpartum visit
Well child visits through 12 mos postpartum

Differential Diagnosis:
*Major depressive disorder
*Persistent depressive disorder
*Adjustment disorder
*Depression secondary to medical condition (e.g. hypothyroidism, anemia)/substance use
*Depression secondary to another psychiatric disorder (e.g. bipolar disorder, PTSD)
*Consider postpartum psychosis (emergency)

For positive screens, assess safety (See page 27 for additional guidance)
Columbia Suicide Severity Rating Scale (CSSRS) or
Ask Suicide Screening Questions (ASQ)
3-item Patient Safety Screener (for acute settings)

Ask about thoughts about harming baby:
"It can be very overwhelming to be a new parent. Sometimes people have upsetting thoughts about hurting their babies, either by accident or on purpose. Have you had thoughts like this?"
Refer to emergency services as needed

For mild depression:
Education:
https://www.nimh.nih.gov/health/publications/perinatal-depression/index.shtml
Closer monitoring (PHQ-9/EPDS)
Exercise, behavioral activation
Social support
Address sleep issues
Rule out medical causes, bipolar disorder

Moderate/severe depression: Add medication and/or psychotherapy; shared decision-making with patient (and partner, as applicable), weighing risks of medications and untreated depression, and considering alternative/non-medication treatments

Risks of untreated depression:
*Functional impairment, hospitalization, suicide
*Poor prenatal care/self-care; smoking, substance use
*Higher rates of miscarriage, preeclampsia, preterm birth
*Problems with bonding/attachment
*Longer hospital stays, more NICU admissions for baby
*Increased rates of psychiatric disorders in children

Risks of antidepressants:
See table on next two pages

Alternative/additional treatments:
*Psychotherapy (CBT, IPT, therapy that has helped in past)
*Exercise, yoga, bright light
*For severe/treatment-resistant depression, consider ECT, TMS, brexanolone, day treatment/inpatient programs

Goal:
Treat to remission
Track PHQ-9/EPDS to measure progress/outcome

Perinatal Depression Medications

Drug Name	Starting Dose[a] (mg/day)	Up titration schedule	Use in Pregnancy	Use during Lactation
SSRIs[b]				
Citalopram (Celexa)	10	Increase to 20 mg/day after one week Then, increase by 10-20 mg every 4 weeks[c] (max dose 40 mg/day)[d]	SSRIs not associated with increase in malformations May need dosage increase later in pregnancy Possible increased risk of persistent pulmonary hypertension of the newborn (PPHN); 2.9/1000 vs. 1.8/ 1000 baseline; lowest risk with sertraline Transient neonatal adaptation syndrome (NAS) in 30% of exposed infants	RID[e] < 10%; reports of sedation, fussiness, weight loss in infants; monitor weight gain, behavioral effects
Escitalopram (Lexapro)	5	Increase to 10 mg/day after one week Then, increase to 20 mg/day after 4 weeks[c] (max dose 20 mg/day)		RID[e] < 10%; one report of necrotizing enterocolitis; monitor for sedation, irritability
Fluoxetine (Prozac)	10	Increase to 20 mg/day after one week Then, increase by 10-20 mg every 4 weeks[c] (max dose 80 mg/day)		RID[e] may be > 10%; monitor for behavioral effects, adequate weight gain
Paroxetine (Paxil)	10	Increase to 20 mg/day after one week Then, increase dose by 10-20 mg every 4 weeks[c] (max dose 50 mg/day)		RID[e] generally 5% or less; few adverse effects; monitor for agitation, irritability, poor feeding, poor weight gain
Sertraline (Zoloft)	25	Increase to 50 mg/day after one week Then, increase by 25-50 mg every 4 weeks[c] (max dose 200 mg/day)		Low concentrations in breast milk and infant; RID[e] generally 2% or less; few adverse effects in infants; considered preferred antidepressant in breastfeeding
SNRIs[b]				
Duloxetine (Cymbalta)	30	Increase dose to 60 mg/day after one week (max 120 mg/day; rarely need > 60 mg/d)	NAS (see above); possible inc risk of heart defects, miscarriage, postpartum hemorrhage	Few reports; RID[e] < 1%; no adverse effects; monitor for sedation, adequate growth
Venlafaxine (Effexor) XR	37.5	Increase to 75 mg/day after one week Then, increase by 37.5-75 mg every 4 weeks[c] (max dose 225 mg/day)	Increased risk for PPHN, NAS (see above under SSRIs); increased risk of gestational hypertension	RID[e] 3-13%; rare adverse effects reported in infants; monitor baby for excessive sedation, adequate weight gain
OTHER[b]				
Bupropion[f] (Wellbutrin) XL	150	Increase to 300 mg/day XL after one week Then, increase as needed to 450 mg daily after 4 weeks[c] (max dose 450 mg/day)	No overall inc in malformations ?inc in LVOT[g] heart defects	RID[e] generally <10% 2 reports of seizures in breastfed infants
Mirtazapine[h] (Remeron)	7.5	Increase to 15 mg qhs after one week Then, increase by 15 mg every 4 weeks[c] (max dose 45 mg/day)	No increase in malformations NAS (see above)	Few reports; RID[e] < 2%; no adverse effects noted; monitor for behavioral effects, adequate growth

Drug Name	Starting Dose[a] (mg/day)	Up titration schedule	Use in Pregnancy	Use during Lactation
Zuranolone[jkl] (Zurzuvae)	50	50 mg each evening x 14 days Lower dose if sedating (40 mg daily)	Indicated for postpartum depression, not for use during pregnancy Concerns about fetal harm; should use contraception while taking and for one week afterwards	Limited data; low concentrations in breast milk (RID[e] < 1%) No reports regarding effects on infants

[a]With comorbid anxiety disorder, use lower starting dose
[b]Antidepressants are associated with increased suicidal thinking and behavior in young adults; monitor closely for worsening or emerging suicidality
[c]as needed to treat continued depressive symptoms
[d]maximum dose 40 mg/day due to risk of QT prolongation
[e]RID = relative infant dose
[f]do not give if history of bulimia or seizures; seizure risk limits dose
[g]LVOT = left ventricular outflow tract
[h]increases appetite, sedating; may help with hyperemesis, insomnia
[j]Patients should not drive for 12 hours after each dose
[k]Avoid use with other CNS depressants (e.g., alcohol, benzodiazepines, opioids, tricyclic antidepressants)
[l]Available through select specialty pharmacies. Contact www.sagerx.com for information about how to obtain zuranolone for a patient

5/16/24

Perinatal Depression Resources

Review article:
Mesches GA, Wisner KL, Betcher HK. A common clinical conundrum: antidepressant treatment of depression in pregnant women. Seminars in Perinatology 2020; 44:151229.

PHQ-9 in multiple languages:
https://www.phqscreeners.com

EPDS in multiple languages:
Edinburgh Postnatal Depression Scale (EPDS) (perinatalservicesbc.ca)

Columbia Suicide Severity Rating Scale (CSSRS):
https://cssrs.columbia.edu/documents/c-ssrs-screener-triage-primary-care/

Ask Suicide Screening Questions (ASQ):
https://sprc.org/online-library/asq-ask-suicide-screening-questions-toolkit/

NIMH brochure for patients about perinatal depression (available in English and in Spanish):
https://www.nimh.nih.gov/health/publications/perinatal-depression/index.shtml

Mothers and Babies Program
Information, training, and resources for therapy for perinatal stress and depression based on cognitive behavioral therapy and attachment theory. Website also has information for patients/parents, including how to find a therapist.
http://www.mothersandbabiesprogram.org/

Article about interpersonal therapy (IPT) for postpartum depression:
This is an article for providers that describes interpersonal therapy (IPT) for postpartum depression, its rationale, structure, and content.
Stuart S. Interpersonal psychotherapy for postpartum depression. Clin Psychol Psychother 2012; 19:134-140.

Article about importance of and prescribing sleep for postpartum depression:
Leistikow N, Baller EB, Bradshaw PJ, et al. Prescribing sleep: an overlooked treatment for postpartum depression. Biological Psychiatry 2022, doi.org/10.1016/j.biopsych.2022.03.006