Neuroscience Education Institute

BEYOND THE BLUES: RISK, RECOGNITION, AND RELIEF FROM PERINATAL MOOD AND ANXIETY DISORDERS

Lisa Tremayne, RN, PMH-C, CBC
Founding Director, Center for Perinatal Mood and Anxiety Disorders, Eatontown, NJ

Presented at 2024 NEI Congress

Learning Objectives

1. Describe factors that may impact the risk and disease course of perinatal mood and anxiety disorders (PMAD)
2. Collaborate with patients, loved ones, and the interdisciplinary care team to improve the timely diagnosis of PMAD
3. Work with members of the interdisciplinary care team to implement evidence-based strategies for treating PMAD in order to improve patient and family outcomes

What Exactly Are PMADs?

This is the **"new"** word being used to correctly explain this multi-symptom, temporary, and treatable illness. It used to be called PPD for postpartum depression. The use of the term postpartum depression prevented many women from seeking help, simply because they did not feel "depressed."

Perinatal = this is defined as the period between pregnancy and one year postpartum

Mood = presents as rage, irritability, impatience, sadness

Anxiety = anxious, panic, racing thoughts, intrusive thoughts, OCD

Disorders = means that this is not a permanent mental health diagnosis, but it is causing an interruption of normal, daily functions

Did You Know?

- **Less than 8%** of pregnant women are diagnosed with gestational diabetes each year, and it is talked about, screened for, accepted, and treated
- Conservatively, **more than twice as many women, 21%,** will suffer from PMADs, often without being education, screened, or referred for help
- Why this discrepancy?
  - Women state shame, stigma, and lack of information and/or resources
  - Healthcare providers state lack of treatment options/pathways

THIS MAKES PMADS THE MOST COMMON COMPLICATION OF PREGNANCY AND CHILDBIRTH

Wisner KL et al. JAMA Psychiatry 2013;70(5):490-8.

Baby Blues vs PMADs
How Do You Know?

- The symptoms of BABY BLUES can resemble PMADs, which makes differentiation complex, except: they only emerge during the first 2–3 weeks postpartum; after that time frame, it is NOT the baby blues
- PMADs can start anytime during the perinatal period, affecting daily functioning, as well as disrupting mother/baby attachments, and can range from mild to severe; symptoms that—when identified—are temporary and treatable
- It is not the symptom itself that is diagnostic, rather it is the FREQUENCY, INTENSITY, AND DURATION of the symptoms

FREQUENCY + INTENSITY + DURATION = DISTRESS

What You Might Hear

- “I just don’t feel like myself”
- “I guess this is what motherhood feels like”
- “I think I made such a mistake”
- “Will I ever feel like myself again?”
- “I don’t think the baby likes me”
- “I don’t feel like hurting myself or the baby”

Recognized Risk Factors

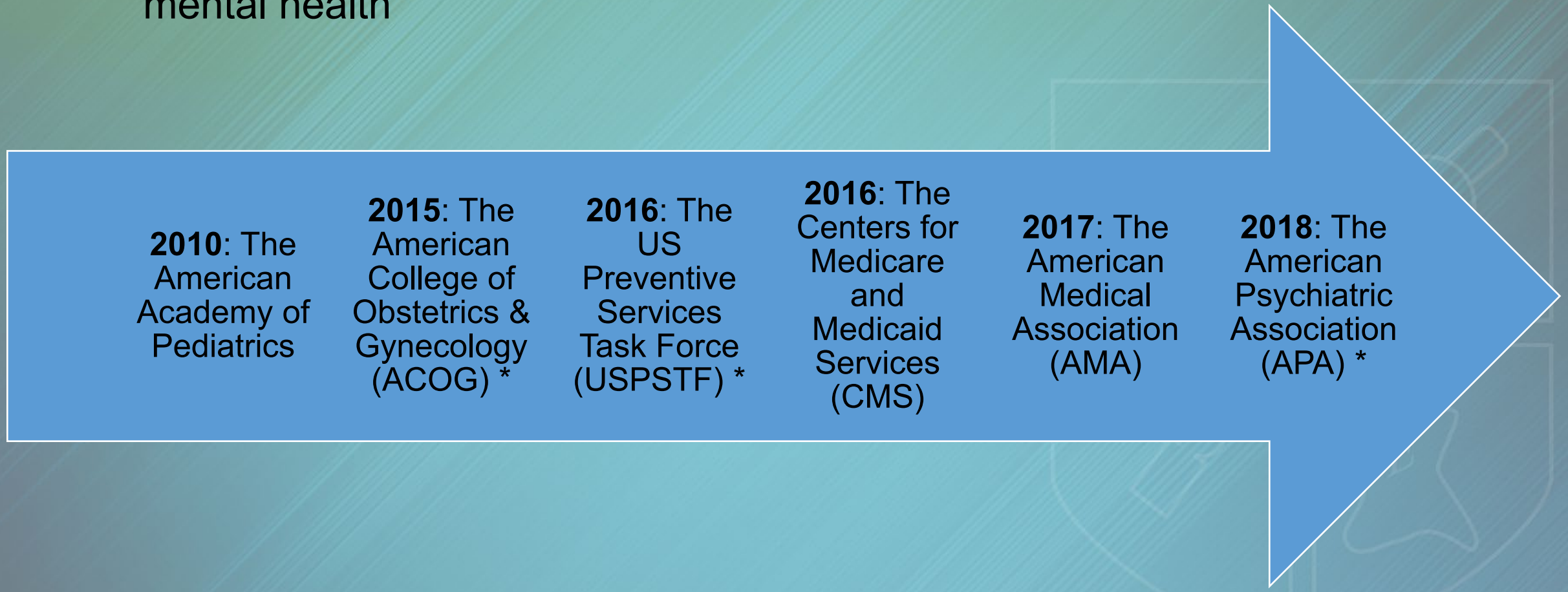
- History of anxiety/OCD, panic disorder, or depression
- History of bipolar disorder or psychosis
- Type A, perfectionist personality
- Family history of mental health disorders, bipolar disorder, or psychosis
- Prior history of loss (miscarriage, stillbirth, abortion, TFMR)
- Infertility treatment(s)
- History/currently experiencing trauma (IPV, sexual abuse, verbal/emotional abuse)

Recognized Risk Factors (continued)

- Experiencing stressful event in the last year (loss of parent/significant other, divorce, relationship problems, job loss, recent move)
- High risk pregnancy (expecting multiples, hyperemesis gravidarum, bed rest, pre-term labor)
- History of premenstrual dysphoric disorder (PMDD), hormone sensitivity
- Single mother
- Financial stress
- Away from home country/culture
- Limited to no help/support from partner/family members

Screenings

- Healthcare expert organizations prioritize SCREENING for maternal mental health



*Indicates screening recommended during pregnancy as well as postpartum

Screenings

- Now we have three of the top healthcare organizations in agreement that **screening** pregnant women for PMADs **is worthwhile**
- There is, however, no consensus on **WHAT** screening tool should be used, just that it should be validated
- There is also no agreement on **WHEN** to do the screening
- One of the organizations specifically promotes “ongoing assessment of risks,” but, again, **NO** risk assessment tool is identified
- Perhaps the loudest silence is that NO treatment options/pathways were specified

ACOG Screening Recommendations November 2018*

- ACOG recommends that the obstetrician/gynecologist and any other obstetric care providers **"screen patients at least once during the perinatal period…using a standardized, validated screening tool"**
- ACOG states there is evidence that screening alone can have clinical benefits, although **initiation of treatment or referral to mental health care providers offers maximum benefit**
- Therefore, clinical staff at OB/GYN practices should be prepared to initiate medical therapy, refer patients to appropriate behavioral health resources when indicated, or both
- Furthermore, **systems should be in place to ensure follow-up for diagnosis and treatment**

*ACOG overturned its 2015 guideline stating evidence for screening was not strong enough, as it did not lead to treatment

APA Screening Recommendations December 2018

- The APA recognizes that the risks for psychiatric illness in women are greater during the reproductive years of their lives, including during pregnancy and the postpartum period. To prevent long-lasting adverse effects on the mother, infant, and the family, APA strongly recommends:
  - All pregnant and postpartum women should be assessed for both the presence of and risks for a psychiatric disorder
  - All clinical providers should provide education to perinatal women on how to recognize the symptoms of depressive, anxiety, and psychotic disorders
  - Screening for depression with a validated screening tool twice during pregnancy…a systemic response to screening should be in place to ensure that psychiatric disorders are appropriately assessed, treated, and followed
  - Psychiatrists should educate their patients about the risks associated with untreated psychiatric illness during pregnancy, as well as the benefits—for both the woman and her baby—of using psychotropic medications while pregnant or breastfeeding

The USPSTF Guidelines February 2019

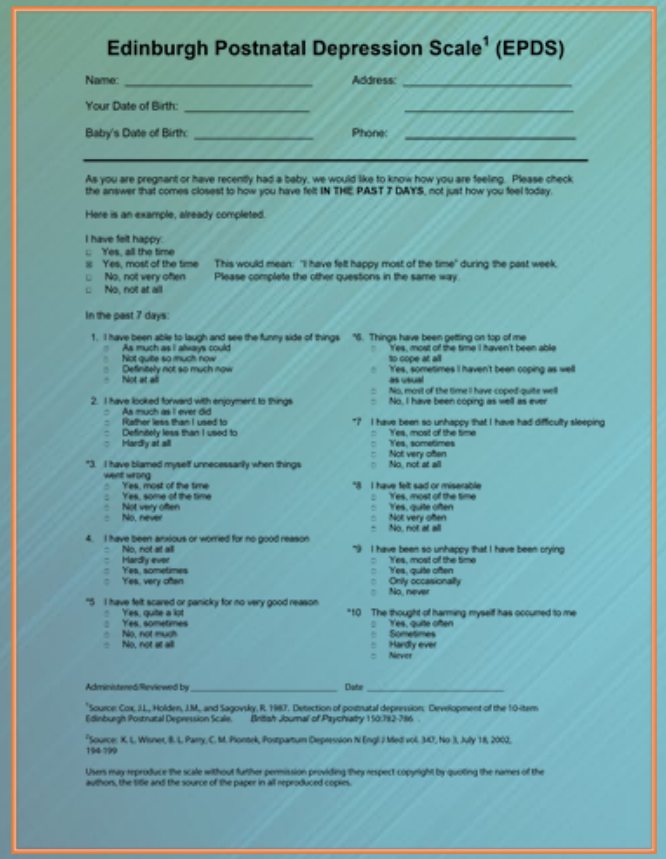
- The USPSTF found convincing evidence that counseling, such as cognitive behavioral therapy and interpersonal therapy, are effective in preventing perinatal depression
- The USPSTF recommends that clinicians provide or refer pregnant and postpartum persons who are at increased risk of perinatal depression to counseling interventions (B recommendation)
- There is no data on the ideal timing for offering or referral to counseling interventions; however, most were initiating during the second trimester of pregnancy
- Ongoing assessment of risks that develop in pregnancy and the immediate postpartum period would be reasonable, and referral could occur at any time

TO BE CLEAR—Screenings…

ACOG	APA	USPSTF
"…**screen at least once** during pregnancy using a validated screening tool…"	"…**screen twice** during pregnancy using a validated screening tool…"	"…**ongoing assessment** of risks during pregnancy and postpartum would be reasonable…"

Validated Screening Tools

Edinburgh Postnatal Depression Scale (EPDS)



Edinburgh Postnatal Depression Scale[1] (EPDS)

Name: _____ Address: _____

Your Date of Birth: _____

Baby's Date of Birth: _____ Phone: _____

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

Here is an example, already completed.

I have felt happy:
- ☐ Yes, all the time
- ☒ Yes, most of the time — This would mean: "I have felt happy most of the time" during the past week.
- ☐ No, not very often — Please complete the other questions in the same way.
- ☐ No, not at all

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   - ☐ As much as I always could
   - ☐ Not quite so much now
   - ☐ Definitely not so much now
   - ☐ Not at all
2. I have looked forward with enjoyment to things
   - ☐ As much as I ever did
   - ☐ Rather less than I used to
   - ☐ Definitely less than I used to
   - ☐ Hardly at all
3. I have blamed myself unnecessarily when things went wrong
   - ☐ Yes, most of the time
   - ☐ Yes, some of the time
   - ☐ Not very often
   - ☐ No, never
4. I have been anxious or worried for no good reason
   - ☐ No, not at all
   - ☐ Hardly ever
   - ☐ Yes, sometimes
   - ☐ Yes, very often
5. I have felt scared or panicky for no very good reason
   - ☐ Yes, quite a lot
   - ☐ Yes, sometimes
   - ☐ No, not much
   - ☐ No, not at all
6. Things have been getting on top of me
   - ☐ Yes, most of the time I haven't been able to cope at all
   - ☐ Yes, sometimes I haven't been coping as well as usual
   - ☐ No, most of the time I have coped quite well
   - ☐ No, I have been coping as well as ever
7. I have been so unhappy that I have had difficulty sleeping
   - ☐ Yes, most of the time
   - ☐ Yes, sometimes
   - ☐ Not very often
   - ☐ No, not at all
8. I have felt sad or miserable
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Not very often
   - ☐ No, not at all
9. I have been so unhappy that I have been crying
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Only occasionally
   - ☐ No, never
10. The thought of harming myself has occurred to me
    - ☐ Yes, quite often
    - ☐ Sometimes
    - ☐ Hardly ever
    - ☐ Never

Administered/Reviewed by _____ Date _____

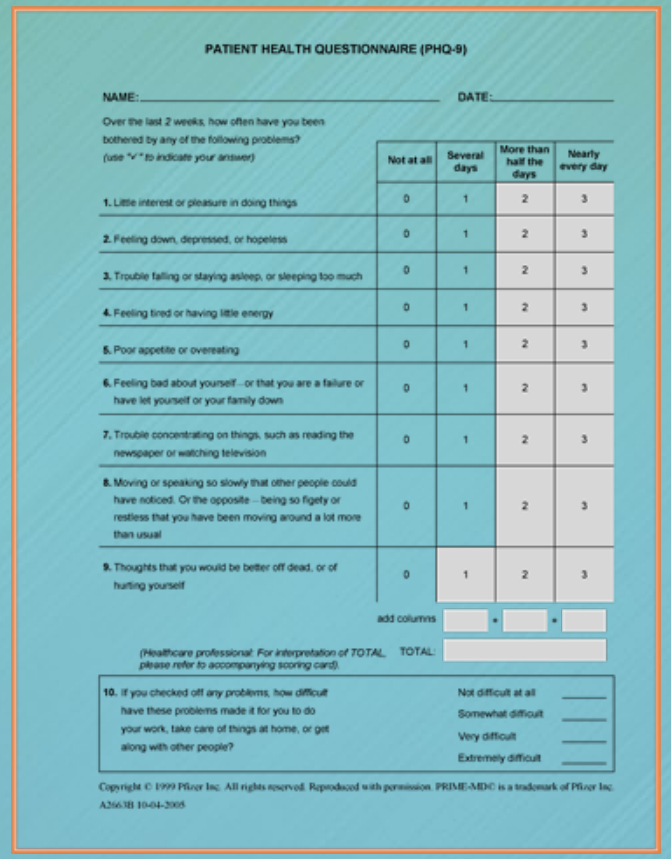
[1]Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression. Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786.

[2]Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression *N Engl J Med* vol. 347, No 3, July 18, 2002, 194-199

Users may reproduce the scale without further permission providing they respect copyright by quoting the names of the authors, the title and the source of the paper in all reproduced copies.

Cox et al., 1987

Patient Health Questionnaire (PHQ-9)



PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____ DATE: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(use "√" to indicate your answer)*

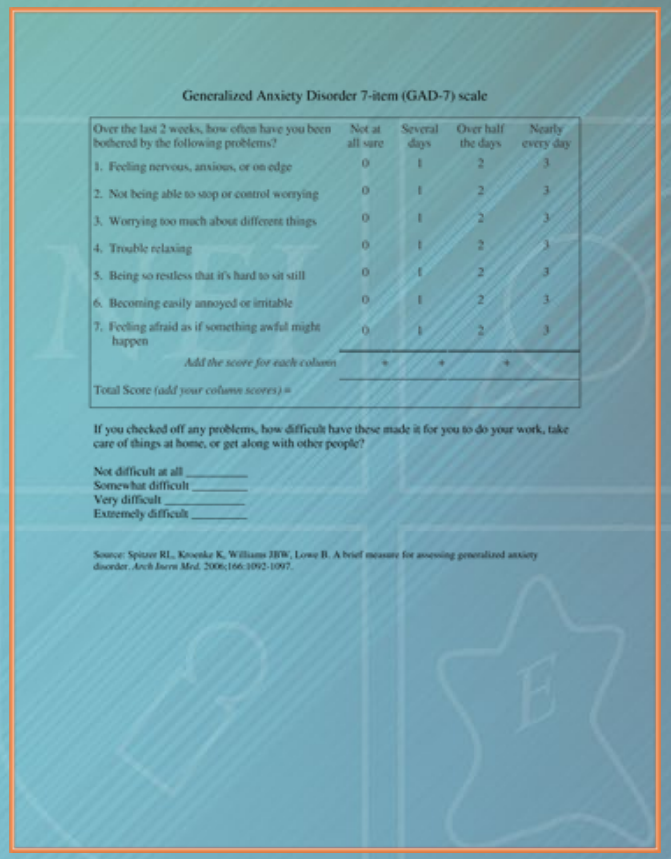
	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns		+	+	+
(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:				

10. If you checked off *any problems*, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all _____ Somewhat difficult _____ Very difficult _____ Extremely difficult _____

A2663B 10-04-2005

Kroenke et al., 2001

Generalized Anxiety Disorder – 7 item (GAD-7) scale



Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column		+	+	+
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____
Somewhat difficult _____
Very difficult _____
Extremely difficult _____

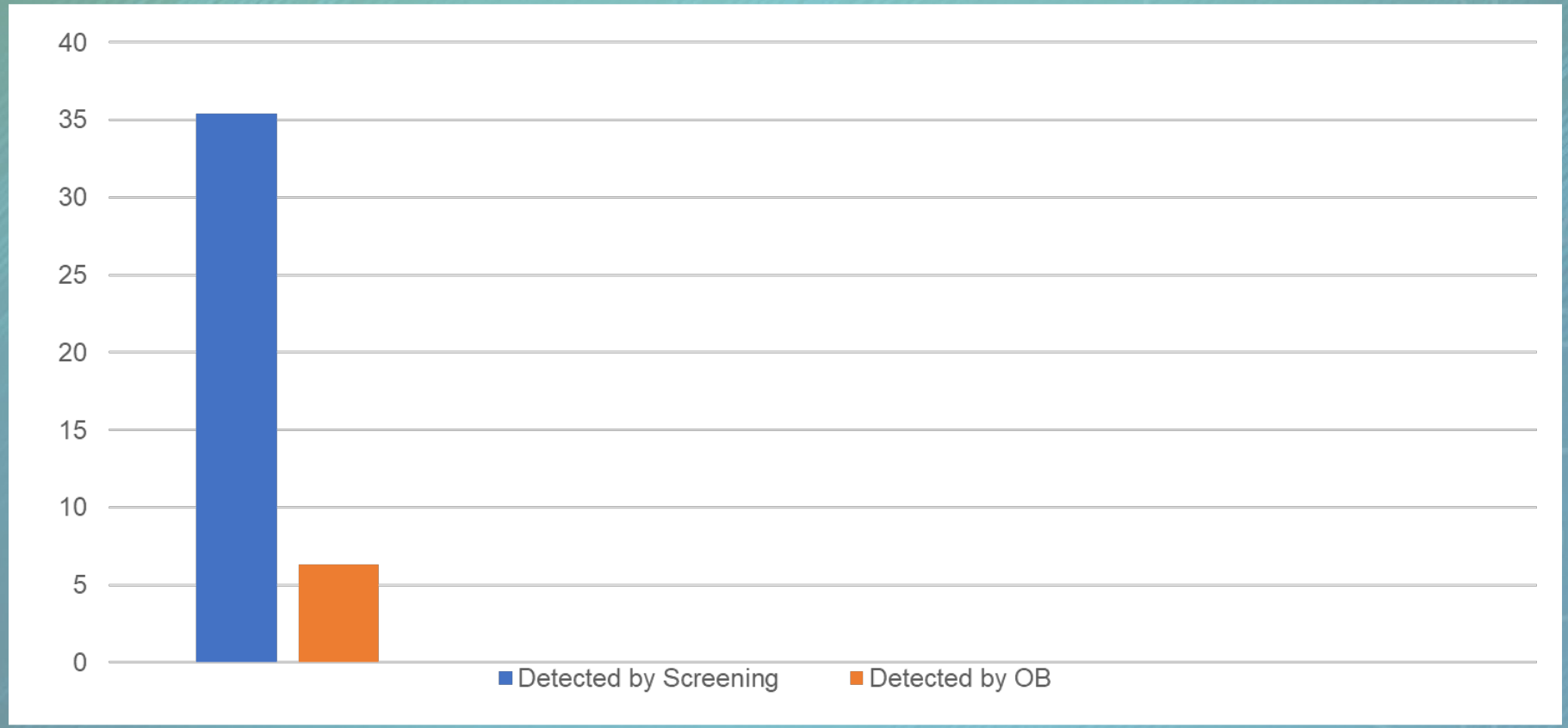
Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Intern Med.* 2006;166:1092-1097.

Kroenke et al., 2006

You Can’t Tell by Looking

How Do We Know Screening Helps Identify the Women Who Need Help?

In a 2000 study, 391 women were screened at OB practice using the EPDS



Evins GG et al. Am J Obstet Gynecol 2000;182(5):1080-2.

Now What?

NOW WE KNOW. We have identified, using risk assessment, patient history, family history, and validated screening tool(s), that we have a pregnant or new mom who **could be** at **increased risk** for developing or **IS NOW** experiencing one of the PMADs.

This, friends, is that we want—this is an **opportunity** to educate and empower this woman and her partner about this temporary and treatable illness, our chance to wrap her in resources, referrals, and follow through. This moment, right here, is the time I boldly say: We can **PREVENT** full blown PMADs and proactively help this mom not to have to crash and burn. Not to have to suffer through each day hoping she will feel better, telling herself, "This is what motherhood feels like," wondering what is so wrong with her because everywhere and **everyone has told her this is the happiest time of your life.**

"Do the best you can until you know better. Then when you know better, do better."

Maya Angelou

Evidence-Based Treatment Options

Support Groups

- Peer to peer
- Facilitator led

EVB Therapeutic Treatment Modalities

- Interpersonal Therapy (IPT)
- Cognitive behavioral therapy (CBT)
- Dialectical behavioral therapy (DBT)
  - Individual or group

Psychiatric Scope of Practice

- Psychiatric evaluation
  - Medication evaluation
  - Medication management

Evidence-Based Treatment Recommendations

All PPD

Self-care

Sleep protection

Exercise

Psychosocial support strategies

Investigate and manage social stressors, medical, and psychiatric comorbidities

Moderate PPD

Psychological treatments, including cognitive behavioral therapy and interpersonal therapy

Add selective serotonin reuptake inhibitor (SSRI) if insufficient response

Severe PPD

SSRI alone or with psychological intervention

Consider antidepressant switch and augmentation strategies if no response to SSRI alone

Brexanolone; zuranolone

Consider electroconvulsive therapy with severe suicidality or treatment resistance

*Prior to initiating SSRIs, screen for bipolar or mixed depression

Stewart DE, Vigod SN. Annu Rev Med 2019;70:183-96; Zheng W et al. Psychiatry Res 2019;279:83-9.

Support Groups

- **Peer-to-Peer Support**: an informal group of women with common life experiences meeting to support and lift up women in the same season; these are often led by women with lived experience with PMADs, providing support and empathy as well as being real life role models that you go to in order to get to feeling yourself (may or may not be formally trained)
- **Facilitator-Trained Support Group**: a group led by a trained facilitator to lead support groups—more structured, has guidelines, confidential, non-judgmental, and safe space for all who attend; facilitator directs the discussion, offers self-care strategies/options without giving advice, and has resources available as needed

Evidence-Based Psychotherapy Models

- **IPT**—Defined as a time-limited and focused approach to treat mood disorders; this is truly the **basis** for all therapeutic interventions, building the rapport with clients to heal wounds from other relationships; think of this time as building trust in the therapist as well as the therapist providing validation for the client's feelings
  - An example of this is addressing interpersonal deficits—a new mom cannot ask for the help, doesn't get her needs met, and therefore has unfulfilled relationships with partner and her family; IPT can help manage these expectations and reduce conflict in relationships
  - Therapists typically utilize IPT at the start of their therapeutic process

Evidence-Based Psychotherapy Models

- **CBT** —teaches clients to identify, evaluate, and change dysfunctional patterns of thinking, resulting in mood and behavioral changes
  - A great example of a common CBT component is helping a patient—in this case a new mom—learn how to ask for what she needs, accept help, and learn coping mechanisms for anticipatory anxiety
- **DBT**—is useful in treating mood disorders and suicidal ideation, as well as for changing behavioral patterns; it was originally designed to treat personality disorders
  - Think of DBT as therapy for people who feel emotions very intensely and this type of therapy helps you understand and accept your difficult feelings; for example, a patient that used to feel like suicide was the only solution now develops the skills that can help her feel the feelings without letting them take over

Psychiatric Evaluation

- This is a **very important part of the treatment process**, if needed, and is quite often **undervalued** by even the medical community
- Our job, as a member of this woman's treatment team, is to ALWAYS remember: there are 2 patients—the MOM and the BABY
- The risks of a depressed, anxious, or bipolar woman **not taking her medication** during pregnancy is **not often taken into consideration**
  - Poor prenatal care, increased risk of self-harm and behaviors which may negatively affect outcomes, including smoking and the use of alcohol and illicit drugs
- Risks often listed for women who stop taking prescribed medication, such as antidepressants, during pregnancy include:
  - Low birth weight, preterm delivery, and an increased risk of caesarean section
- **While we must advise our patients regarding the risks of exposure to medications, we cannot ignore the impact of untreated depression in the mother**

In Our Practice, We Refer to This as RISK VS. RISK

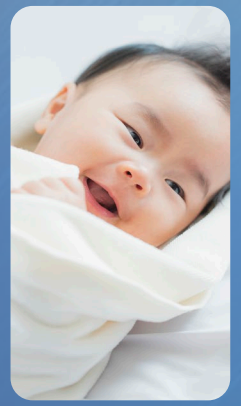
"While we must advise our patients regarding the risks of exposure to medications, we cannot ignore the impact of untreated depression in the mother. Untreated depression is associated with poor prenatal care, increased risk of self harm and behaviors which may negatively affect outcomes, including smoking and the use of alcohol and illicit drugs."

Nonacs R et al. SSRIs and pregnancy: putting the risks and benefits into perspective. MGH Center for Women's Mental Health. December 6, 2012. Accessed August 27, 2024. https://womensmentalhealth.org/posts/ssris-and-pregnancy-putting-the-risks-and-benefits-into-perspective/

Risks of Untreated PMADs

Risks to the mother:

- Worsening of medical conditions
- Poor nutrition
- Difficulty bonding with the baby
- Negative pregnancy outcomes



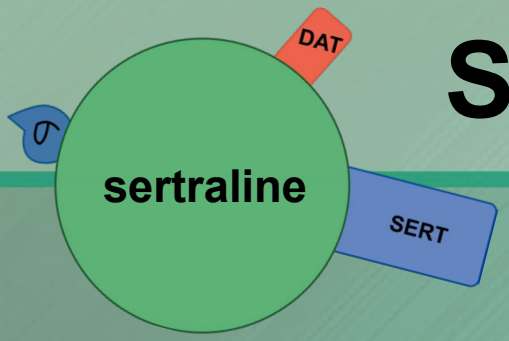
Risks to the baby:

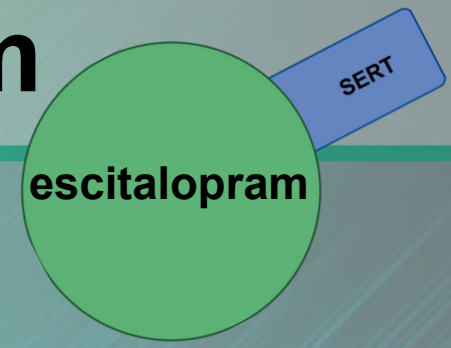
- Preterm birth
- Lower birth weight
- Insecure attachment

- All pregnancies have a risk of miscarriage or birth defects
- Most of the medications used in perinatal mood and anxiety disorders have **not** been shown to increase the risk of either of these adverse events occurring in humans
- Animal studies that suggest possible birth defects typically use doses of medications that are significantly higher than what is used in humans to treat perinatal mood and anxiety disorders

Kendig S et al. Obstet Gynecol 2017;129(3):422-30;
Dunkel Schetter C et al. Curr Opin Psychiatry 2012;25(2):141-8.

SSRIs: Sertraline & Escitalopram





Sertraline

Pregnancy

- Sertraline crosses the placenta, but this has **not been shown to increase birth defects**
- SSRIs were once thought to increase the risk of a lung condition known as persistent pulmonary hypertension in newborns, but the FDA has since retracted this warning as studies suggested there was **not an increased risk**

Lactation

- A **breastfeeding child receives about 0.5%** of the dose of sertraline that the mother is taking, which has not been shown to cause effects in the baby

Escitalopram

Pregnancy

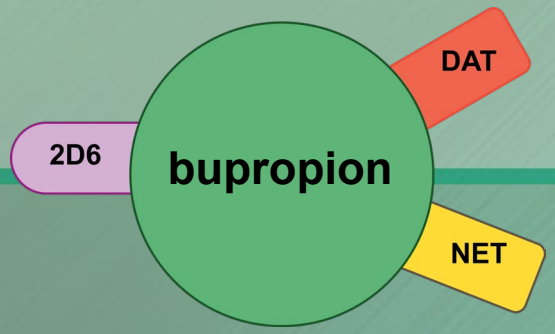
- Escitalopram has **not been found to increase the risk of birth defects**
- Using an SSRI late into pregnancy has been associated with neonatal jitteriness and irritability, but these symptoms usually last for less than 2 weeks after birth

Lactation

- **5–7% of escitalopram is transferred to the** baby during breastfeeding
- The transfer of this amount of medication is not likely to cause side effects in the baby

Myles N et al. Aust N Z J Psychiatry 2013;47(11):1002-12; FDA Drug Communication; Weissman AM et al. Am J Psychiatry 2004;161:1066-78; Moses-Kolko EL et al. J Am Med Assoc 2005;293:2372-83; Rampono J et al. Br J Clin Pharmacol 2006;62(3):316-22.

Bupropion & Aripiprazole



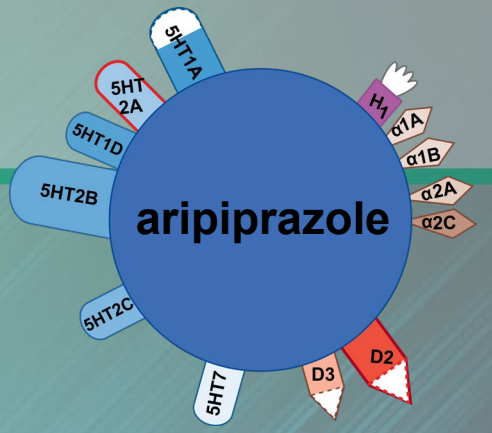
Bupropion

Pregnancy

- Bupropion has **not been shown to increase the risk of birth defects** compared to the general population

Lactation

- Bupropion excretion into **breast milk** results in a dose in the infant of **1.4–0.6%** of the dose in the mother
- In adults, high doses of bupropion may cause seizures
- The doses transferred to the baby are low, but bupropion should be avoided if there is a history of seizures



Aripiprazole

Pregnancy

- Aripiprazole has **not been shown to cause birth defects,** though there is limited data regarding its use in pregnancy
- During the **first trimester of pregnancy, the lowest dose possible should be** used to minimize risks

Lactation

- There is **limited data** on the use of aripiprazole **while breastfeeding**
- The possible side effects of aripiprazole in breastfeeding are theoretical and have not been seen in studies

The Bupropion Pregnancy Registry. Final report. 1 September 1997 through 31 March 2008. Issued August 2008. Kendle International, Inc., Wilmington, North Carolina; Anderson PO. Breastfeed Med 2021;16(1):5-7; Ennis ZN et al. Basic Clin Pharmacol Toxicol 2015;116:315-20; Klinger G et al. Pediatr Endocrinol Rev 2013;10:308-17.

Benzodiazepines

- Benzodiazepines such as clonazepam and alprazolam can be used for short-term management of anxiety or insomnia

Pregnancy

- Benzodiazepine use **during pregnancy has not been shown to increase the risk of birth** defects or neurologic issues such as autism spectrum disorder
- In rare cases, the use of benzodiazepines in the third trimester of pregnancies may cause neonatal symptoms such as shallower breathing
- These symptoms get better with time and are unlikely to occur with intermittent usage of lower doses of benzodiazepines, which is what is typically used for perinatal mood and anxiety disorders

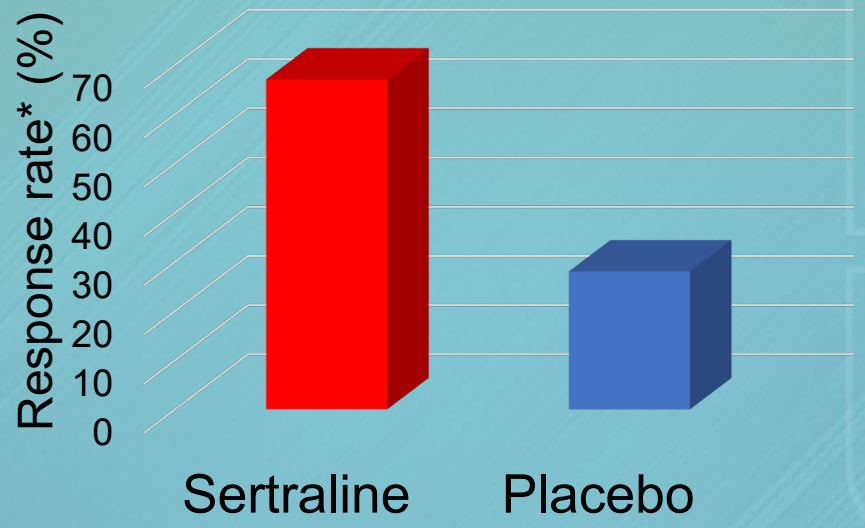
Lactation

- **Benzodiazepines can cross into the breast milk in small amounts**
- This may cause increased sleepiness in the infant, though in the majority of cases, no adverse effects are noted

Veiby G et al. J Neurol 2014;261(3):579-88; Bjørk MH et al. JAMA Neurol 2022;79(7):672-81; Birnbaum CS et al. Pediatrics 1999;104(1):e11.

Efficacy and Safety of Antidepressants for PMAD

- Several antidepressants (e.g., sertraline, nortriptyline, escitalopram) have shown efficacy for PMAD
- Agency for Healthcare Research and Quality (AHRQ) reports insufficient data for the efficacy of antidepressants for PMAD but no evidence of harm to mothers or infants



**Insufficient data collection in pregnant and lactating women

Response rate defined as score of ≤10 on HAM-D, minimum 50% decrease HAM-D score from baseline, and at least "much improved" on CGI

McDonagh M et al. Agency for Healthcare Research and Quality 2014; www.effectivehealthcare.ahrq.gov/reports/final.cfm; Hantsoo L et al. Psychopharmacology (Berl) 2014;231(5):939-48; Wisner KL et al. J Clin Psychopharmacol 2006;26(4):353-60; Misri S et al. J Clin Psychopharmacol 2012;32(5):729-32.

Considerations for Breastfeeding: Antidepressants

- Patients should be informed that there is some exposure of the infant to medication through breastfeeding (as there was some exposure across the placenta in pregnancy)
- All antidepressants require a discussion of risk of medication versus risk of not treating
- Certain risks have been found but difficult to ascertain due to medication versus due to risk of depression

Relative Infant Doses of Commonly Used Antidepressants

Antidepressant	Relative Infant Dose, %[a]
Bupropion	2
Citalopram	3 – 10
Desvenlafaxine	5.5 – 8.1
Duloxetine	< 1
Escitalopram	3 – 6
Fluoxetine	< 12
Fluvoxamine	< 2
Mirtazapine	0.5 – 3
Paroxetine	0.5 – 3
Sertraline	0.5 – 3
Venlafaxine	6 – 9

[a] Relative infant dose ≤10% is associated with decreased risk to infant.

Berle JO, Spigset O. Curr Womens Health Rev 2011;7(1):28-34; Chad L et al. Can Fam Physician 2013;59(6):633-4; McDonagh MS et al. Obstet Gynecol 2014;124(3):526-34.

Brexanolone

- Neuroactive steroid that functions as a positive allosteric modulator of the GABA-A receptor
- FDA approved for the treatment for PPD in 2019
  - Requires Risk Evaluation and Mitigation Strategy (REMS)
- Administered intravenously over 60 hours in a single dose
- Most common adverse events:
  - Sedation/somnolence, dizziness, and dry mouth
- Maximum relative infant dose in breast milk after brexanolone infusion is 1.3% (<10% generally considered safe)

Meltzer-Brody S, Kanes SJ. Neurobiol Stress 2020;12:100212; Garafola S et al. Drugs Real World Outcomes 2023;10(3):351-6; Wald J et al. Clin Pharmacokinet 2022;61(9):1307-19.

Zuranolone

- Synthetic neuroactive steroid
- Oral 50 mg formulation of a GABA-A positive allosteric modulator administered once daily for 2 weeks
- FDA approved for PPD in August 2023
- Most common side effects are somnolence, dizziness, diarrhea, fatigue, and urinary tract infection

Cerne R et al. Pharmacol Ther 2022;234:108035.

Patient-Reported Perceptions of Brexanolone: A Qualitative Analysis

- Semi-structured interviews modeled after the theory of planned behavior were conducted to assess women's perceptions of treatment for postpartum depression with brexanolone
- Follow-up interviews were conducted 16–20 months post-infusion in five women
- No depression or anxiety at follow up; no reported symptomatic relapse prior to interview
- The women reported mild sedation related to brexanolone, but none experienced loss of consciousness or any infusion-related reactions

Attitudes

- Rapid-acting agent
- Alternative to available antidepressants
- Stigma
- A tool in depression treatment
- Improved relationships

Subjective Norms

- Initial apprehension
- Comradery from women with lived experience
- Need for increased availability

Perceived Behavioral Control

- Access difficulties
- Poor symptom literacy
- Low expectations

Salwan A et al. Ment Health Clin 2023;12(6):342-9.

Considerations for Medication Use During Pregnancy (1 of 2)

- **Determine the risk of recurrent illness**: Has she had one episode of mood/anxiety issues or does she have recurrent episodes? If she has attempted to discontinue meds in the past, how long was she able to remain well without medication? If she has had prior pregnancies, what happened to her mood during pregnancy and the postpartum period?
- **Assess the severity of previous episodes of depression**: Did the mood issues contribute to missed days of school or work? Psychiatric hospitalization? Suicidal ideation? Self-harm? Suicide attempt? What are the current Sx effects on her daily functioning?
- **Review past medication trials**: What medications have been effective in the past? Which have been ineffective? Assess dose and duration of treatment to determine if the trial was adequate.

Considerations for Medication Use During Pregnancy (2 of 2)

- **Identify factors that may mitigate risk**: Has psychotherapy been helpful? Is this an option for decreasing risk for relapse? What about other non-pharmacological interventions: mindfulness, meditation, yoga, acupuncture, exercise?
- **Discuss options for pharmacological treatment during pregnancy**: What are the meds most likely to maintain stable mood during pregnancy? What is the medication with the best characterized reproductive safety profile? Does it make sense to maintain or to switch to a different medication? Even if the woman ultimately decides that she would like to avoid medications during pregnancy, it is important to discuss options for treatment, in case she relapses during pregnancy and would like to resume treatment.

Simple Steps to Add to Your Office

- Handouts of risk factors and resources
- Screen carefully for mental health history
- Be supportive of pregnant clients who choose to continue their mental health medications during pregnancy
- Have a list of resource of mental health providers willing to treat pregnant moms
- De-stigmatize mental health by normalizing the potential problem similarly to gestational diabetes, thyroid disorders, high blood pressure, etc.

Here's What We Could Prevent:

https://youtu.be/U8ZSUzJ0KqU?si=UpDD2ncj_M4CHN41

National Coalition for Maternal Mental Health, 2015

Resources for Pregnant and New Moms in the USA

- Be prepared to feel shocked and disappointed
  - There are 29 PERINATAL MOOD DISORDER TREATMENT CENTERS IN THE USA
  - There are 4 inpatient programs
  - There are approximately 25 outpatient/intensive outpatient mother/baby programs
- To see the most updated list of where these programs are and what they offer:
  - www.mmhla.org/intensive-treatment-programs

Resources

- In an Emergency:
  - Go to your local emergency room
  - Suicide and Crisis Lifeline: dial 988
  - National Crisis Text Line: text HOME to 741741
    - National Suicide Prevention Hotline and Website:
      - 1-800-273-8255
      - www.suicidepreventionlifeline.org
  - NATIONAL MATERNAL MENTAL HEALTH HOTLINE
    - 1-833-TLC-MAMA
    - Call or text 24/7, available in Spanish & English
    - Professional counselors answer the calls and texts
  - Postpartum Support International (PSI) is the world's leading organization in providing hope and help to individuals affected by maternal mental health conditions
    - Call 800-944-4773
    - www.postpartum.net

Summary

- PMADs are the most common complication of pregnancy and postpartum, affecting over 20% of our birthing population; this illness is TEMPORARY AND TREATABLE

- Using a PMAD risk factor checklist, as part of "normal" care during pregnancy, can help to identify women who may be at an increased risk for developing PMADs, allowing us early intervention to resources, referrals and, if needed, evidence-based treatment options

- There are treatment options for members of an interdisciplinary care team to be aware of and offer to their patients so that NO OTHER MOTHER has to think this is what motherhood feels like

"One of the worst parts about the symptoms of postpartum anxiety/depression is that they don't feel like symptoms. *They feel like who you are."*

Karen Kleiman, MSW, LCSW
The Art of Holding in Therapy, Second Edition, November 2024

Thank you for your time.

If you have any questions, or would like to reach out to me:
Lisa.Tremayne@RWJBH.ORG
862-781-3755

To see the Center for Perinatal Mood & Anxiety Disorders:
https://www.rwjbh.org/our-locations/outpatient-rehab-center/center-for-perinatal-mood-and-anxiety-disorders-/

Posttest Question 1 of 3

Which of the following is NOT a risk factor for perinatal mood and anxiety disorders (PMADs)?

1. Type A, perfectionist personality
2. Infertility treatment(s)
3. Financial stress
4. Limited to no help/support from partner/family members
5. These are all risk factors for PMADs

Posttest Question 2 of 3

Which of the following tools is validated for use in screening women during pregnancy and postpartum when perinatal mood and anxiety disorders are suspected?

1. Edinburgh Postnatal Depression Scale (EPDS)
2. Patient Health Questionnaire (PHQ-9)
3. Generalized Anxiety Disorder – 7 item (GAD-7) scale
4. All of the above

Posttest Question 3 of 3

What relative infant dose of antidepressant exposure in breast milk is associated with decreased risk to an infant?

1. ≤1%
2. ≤5%
3. ≤10%
4. <25%