Presenter's Bio

Marissa Andres-Kim, MD, is a double board certified physician in Psychiatry and Addiction Medicine. Dr. Andres-Kim graduated from UCLA with a bachelor's degree in Neuroscience and the Physiological Sciences. Dr. Andres-Kim completed her medical degree from UC Davis and her psychiatry residency at Harbor-UCLA. Dr. Andres-Kim is certified in Psychoanalytic Psychotherapy from the New Center for Psychoanalysis. She is also trained in Cognitive Behavioral Therapy and Dialectical Behavioral Therapy from Harbor-UCLA.

Dr. Andres-Kim incorporates cross-cultural psychiatry, humanism, just culture, psychoeducation, and teaching in her treatment of patients and in her leadership style. In addition to her clinic duties, Dr. Andres-Kim established the DMH Psychiatrist Network, a county-wide physician wellness program focused on self-empathy, intellectual stimulation, collaboration, and camaraderie. It is Dr. Andres-Kim's privilege and pleasure to present on the topic of Maternal Mental Health.

Maternal Mental Health: Depression and Anxiety Pregnancy and Post-Partum

Marissa Andres-Kim, MD

Supervising Psychiatrist
Los Angeles County Department of Mental Health
October 1, 2022 L.A. Care Behavioral Health Conference

Disclosures

- The following CME planners and faculty do not have relevant financial relationships with ineligible companies:
- Leilanie Mercurio, L.A. Care PCE Program Manager, CME Planner
- Alex Li, MD, L.A. Care Deputy Chief Medical Officer, CME Planner
- Michael Brodsky, MD, L.A. Care Senior Medical Director, Behavioral Health Department, CME Planner
- Marissa Andres-Kim, MD, Supervising Psychiatrist, Los Angeles County Department of Mental Health, CME Planner and Faculty

- An ineligible company is any entity whose primary business is producing, marketing, selling, re-selling, or distributing healthcare products used by or on patients.
- Commercial support was not received for this CME activity.

Learning Objectives

At the completion of the CME/CE activity, learners will be able to:

- Describe racial and ethnic disparities in pregnancy in Los Angeles County.
- Screen and identify symptoms of perinatal depression and anxiety.
- Identify and Implement evidence based treatment strategies for perinatal depression and anxiety.
- Identify and treat mental health emergencies in the perinatal period.

- What do you want to get out of this training?

Clinical Question

Sandra is a 16yo Latina who presents alone to your clinic 24 weeks pregnant with her first baby. Overall, she is healthy, endorses some crying spells. Pregnancy was not planned or wanted but she says she "will keep the baby." In addition to a comprehensive prenatal work-up, which of the following would you do? Select all that apply.

- Screen for depression
- Offer group or individual therapy
- Start an antidepressant
- Talk about contraception
- Call her parents

What is Perinatal Depression?

- Definition: Depression lasting more than two weeks and occurring during pregnancy or following childbirth, up to one year after delivery.

- Different from "Baby Blues"
  - "Baby Blues": Affects 80% of new moms within a few days of delivery and self-resolves within ten days.

What Does Perinatal Depression Look Like?

- Sadness, Depressed mood and energy, **Crying spells**
- Impaired appetite or overeating
- **Problems with sleep**; too much or too little
- Feelings of unworthiness
- Anxiety, Panic Attacks, **Worrying constantly about the well-being of the baby**, Being afraid to leave the house
- Feeling numb or void of feelings, Indifferent mood, **No attachment or interest in the baby**
- **Hopelessness or Thoughts of harming self or baby**
- Constant irritability and negative mood, **Anger and resentment of the baby**
- **Vague somatic complaints**, headaches, body pain, palpitations, fatigue, chest heaviness

Maureen Sayres Van Niel and Jennifer Payne. Perinatal Depression: A Review. Cleveland Clinic Journal of Medicine 2020; 87(5): 273-277.

Who is at Risk for Perinatal Depression?

- History of depressive, bipolar, or anxiety disorders
- Family history of depressive disorder or perinatal disorders
- History of physical or sexual abuse, including recent intimate partner violence
- History of a substance use disorder
- Lack of social support with low socioeconomic status and financial difficulties
- Immigrants or minority status
- Teenage pregnancy
- Unwanted pregnancy
- Multiple birth pregnancy
- Difficult or traumatic pregnancy or birth
- Ongoing health problem with the baby
- Unmet expectations or disappointment in the reality of motherhood

Maureen Sayres Van Niel and Jennifer Payne. Perinatal Depression: A Review. Cleveland Clinic Journal of Medicine 2020; 87(5): 273-277.

How Prevalent is Perinatal Depression?

- Systematic Review published in 2019 by Okagbue reported a prevalence rate of **16.4%** (1 out of 6) among pregnant mothers.
  - Also showed that depression can be observed in any trimester of the pregnancy, although most commonly in the third trimester.
  - Also showed that depression in pregnancy could not predict depression after childbirth.
- Systematic Review published in 2021 by Sun reported a prevalence rate of **30%** (almost double) among pregnant mothers, attributed to the impact of COVID-19.
  - Also showed that prevalence of anxiety was 34% and prevalence of both depression and anxiety was 18%.

Hilary Okagbue, et al. Systematic Review of Prevalence of Antepartum Depression during the Trimesters of Pregnancy. Open Access Macedonian Journal of Medical Sciences 2019; 7(9): 1555-1560.
Fengli Sun, et al. A systematic review involving 11,187 participants evaluating the impact of COVID-19 on anxiety and depression in pregnant women. Journal of Psychosomatic Obstetrics and Gynecology 2021; 42(2): 91-99.

What about Los Angeles County?

Los Angeles Mommy and Baby Survey (LAMB), 2005

- Countywide, **39%** of women felt depressed and/or lost interest for two weeks or longer during pregnancy, but only **3%** were diagnosed with a mental health problem (1/3 experience depression, 1/13 with depression receive treatment).
  - Half of those surveyed reported that they were not asked about feeling depressed or anxious during their pregnancy by a healthcare provider.
  - Highlights **importance of screening** to improve diagnosis and treatment.

Monica Ochoa, et al. Landscape Report by LA Best Babies Network, August 2009.

Does Perinatal Depression Disproportionately Affect Certain Groups in LA County?

Los Angeles Mommy and Baby Survey (LAMB), 2005

- Latinas and African Americans
- Immigrants
- Teenagers
- Low income (<$20K)
- Less educated (8th grade education or less)
- Uninsured

Monica Ochoa, et al. Landscape Report by LA Best Babies Network, August 2009.

What Are Consequences of Untreated Perinatal Depression?

- Late or no prenatal care; lack of compliance with health care services
- Unhealthy and risky behaviors during pregnancy
- Preterm delivery, preeclampsia, low birth weight
- Irritability or jitteriness in the newborn/infant
- Decreased maternal responsiveness to infant cues
- Poor or absent maternal bonding with infant
- Less likely to breastfeed

Monica Ochoa, et al. Landscape Report by LA Best Babies Network, August 2009.

Are There Long-Term Effects to Perinatal Depression?

Mother:

- Chronic depression, suicidal thoughts, suicidal behaviors
- Less likely to play with child or implement preventive safety measures (car seats)
- Negative perceptions of the child's behavior; adversarial relationship, punitive discipline
- Adult relationship issues, inability to work, poor physical health

Infant/Child:

- Poor weight gain, feeding problems, sleep problems
- Impaired linguistic, physical, intellectual, and emotional development
- Reduced attachment to mother and other caregivers
- Hyperactivity, poor impulse control, conduct disorders, detachment, social withdrawal
- Reduced school readiness

Taylor Trussell, et al. The Impact of Maternal Depression on Children: A Call for Maternal Depression Screening. Clinical Pediatrics, 2018; 57(10): 1137-1147.

Are There Situations that Require Immediate Treatment?

- **Suicidal Ideations** – thoughts or plans to end one's life

- **Infanticidal Ideations** – thoughts or plans to end the baby's life or children's lives

- **Post-Partum Psychosis** – bizarre persecutory delusions (can be religious in nature, can involve baby/children), auditory hallucinations (can include commands to harm self or baby/children), visual hallucinations of darkness, overt distrust or paranoia of others, can be accompanied by insomnia, change in behavior, suicidal/homicidal ideations

Kathyrn Santoro, Hillary Peabody. Identifying and treating maternal depression: Strategies and considerations for health plans. National Institute for Health Care Management Research and Education Foundation, June 2010.

What Do We Know about Maternal Death?

- The leading cause of death for women in the post-partum period is heart disease and stroke.
  - In the US, **African American women are 4x more likely to die** as a result of pregnancy, delivery or postpartum complications than women of other races, independent of socioeconomic or educational status.
- **Maternal Suicide** is the second leading cause of death for women in the post-partum period.
  - In the US, Suicide was determined as cause in **10% of all maternal deaths** in 2017-2019.
- 80% of Maternal Deaths were determined to be **preventable**.

Susanna Trost, et al. Pregnancy-Related Deaths: Data from Maternal Mortality Review Committees in 36 US States, 2017-2019. National Center for Chronic Disease Prevention and Health Promotion.

What Do We Know about Maternal Suicide?

- More frequently occurs in the **post-partum period**
  - 2/3 of suicides between 6wks and 1 year.

- Tends to involve **violent means**.
- Risk factors for maternal suicide are the same perinatal depression.
- Additional risk factors include
  - Miscarriage and Abortion
  - Serious mental illness; Anxiety, Depression, Psychosis, Mania
- Notable: In the US, **Teenage Mothers are 2x more likely to commit suicide** than their non-pregnant counterparts or young mothers in their early twenties.

Monique Leite Sampaio, et al. Maternal suicide continues to reach frightening rates: Systematic review. iMedPub Journals. Archives of Medicine, 2021; 13(10): 46.

How Do We Screen for Perinatal Depression?

- Patient Health Questionnaire (PHQ-2)
  - 2 questions, 2 minutes
  - High sensitivity, low specificity
- Edinburgh Postnatal Depression Scale (EPDS)
  - 10 questions, 5 minutes, includes anxiety, excludes sleep disturbance
  - Low sensitivity, high specificity
- Patient Health Questionnaire (PHQ-9)
  - 9 questions, 5 minutes, excludes anxiety, includes sleep disturbance
  - Moderate sensitivity, moderate specificity

How Could We Screen for Perinatal Depression?

Starting with the PHQ-2 and moving on to EPDS or PHQ-9 if patient answers yes to either PHQ-2 question.

- **Over the past two weeks, have you ever felt down, depressed, or hopeless?**
- **Over the past two weeks, have you felt little interest or little pleasure in doing things?**

Dwenda Gjerdingen, et al. Postpartum Depression Screening at Well-Child Visits: Validity of a 2-Question Screen and the PHQ-9. Annals of Family Medicine, 2009; 7(1): 63-70.

How Often Should We Screen for Perinatal Depression?

All points of contact, especially for high risk women

- Pre-natal visits
- Post-delivery visits
- Well-baby visits

- Opportunities for a trusted health care professional to provide active psychoeducation about the signs and symptoms of depression and anxiety in a normative non-stigmatizing way.

Are there any Cross-Cultural Considerations?

Latinas and African American women in Los Angeles County

- Higher prevalence of perinatal depression compared to other racial groups;
- Lower rates of diagnosis and treatment for perinatal depression.
- Understand the role of **stigma** and limited access to **psychoeducation**.

Sandraluz Lara-Cinisomo, Crystal Clark, Jayme Wood. Increasing Diagnosis and Treatment of Perinatal Depression in Latinas and African American Women: Addressing Stigma is Not Enough. Women's Health Issues, 2018; 28(3): 201-204.

What are Some of the Stigma and Cultural Factors that Affect Latinas?

- Fear of being perceived as "crazy."
- Fear of losing their child, especially true for immigration status.
- "Marianismo" – the cultural belief that a mother must put her children and family first and sacrifice herself for the well-being of her family.
- Self-blame for depression; or depression as retribution for a previous sin.

Sandraluz Lara-Cinisomo, Crystal Clark, Jayme Wood. Increasing Diagnosis and Treatment of Perinatal Depression in Latinas and African American Women: Addressing Stigma is Not Enough. Women's Health Issues, 2018; 28(3): 201-204.

What are Some of the Stigma and Cultural Factors that Affect African American Women?

- Be a strong Black woman and "tough it out."
- The cultural belief that depression is preventable and resolvable through strength and religious faith.

Sandraluz Lara-Cinisomo, Crystal Clark, Jayme Wood. Increasing Diagnosis and Treatment of Perinatal Depression in Latinas and African American Women: Addressing Stigma is Not Enough. Women's Health Issues, 2018; 28(3): 201-204.

How Can this Affect their Presentation?

- More likely to report **somatic symptoms** than mood symptoms because they are more culturally acceptable.
- Negative perception of mental health professionals.
- May not believe that medication is an effective or safe treatment.
- **Reduced help-seeking**.

Sandraluz Lara-Cinisomo, Crystal Clark, Jayme Wood. Increasing Diagnosis and Treatment of Perinatal Depression in Latinas and African American Women: Addressing Stigma is Not Enough. Women's Health Issues, 2018; 28(3): 201-204.

How Can We Improve Engagement with Latinas and African American women?

- Reduce mental health stigma through contact and psychoeducation.
- Provide the **trusting interaction** that women seek.
- Educate staff who interact with patients about perinatal depression.
- Patient education should be delivered in an active manner through conversation.
- Provide information at all points of contact, including infant wellness checks.
- Use supportive language.

Sandraluz Lara-Cinisomo, Crystal Clark, Jayme Wood. Increasing Diagnosis and Treatment of Perinatal Depression in Latinas and African American Women: Addressing Stigma is Not Enough. Women's Health Issues, 2018; 28(3): 201-204.

How Can We Improve Engagement with Latinas and African American women?

- Demonstrate **cultural curiosity** with humility.
- Use open ended questions.
- Engage values.
- Try motivational interviewing.
- **Ask for permission** before giving psychoeducation.
- Double-sided reflection:
  - Start with the patient's argument against X and end with the patient's argument for X.
  - Use "and" instead of "but."

Is there Another Vulnerable Group Worth Looking at Closer?

- **Teen Mothers**: defined by age 15yo to 19yo.
- Overall teen birth rate is 18.8 per 1,000 live births
  - Half the rate compared to the 15 years ago but still higher than other developed countries.
- Highest among American Indian/Alaska Native: 32.9/1000, followed by **Latinas** 28.9/1000, **African Americans** 27.5/1000, and Caucasian 13.2/1000.
- More likely to experience abuse/neglect, traumatic loss, and incarceration.
- Risk for depression later in their lifetime.

Makia Powers, et al. Care of Adolescent Parents and Their Children. Pediatrics, 2021; 147 (5): e2021050919

More on Teen Mothers (15yo-19yo)

- **2-3x more likely to experience depression** during pregnancy or post-partum compared to their non-pregnant peers and pregnant mothers in the next age group (20yo-25yo).
- **Also, 2x more likely to commit suicide** compared to their non-pregnant counterparts or young mothers in their early twenties.
  - Of note, suicide is the third leading cause of death among all teens aged 15-19yo.
- **2-3x more likely to be victimized** compared to adult mothers; including physical and emotional abuse by a parent, partner, or father of child.
- **More likely to lack resources or access to resources** compared to adult mothers, including support.

Stacy Hodgkinson, et al. Addressing the Mental Health Needs of Pregnant and Parenting Adolescents. Pediatrics, 2014; 133: 114-122.

How Do We Engage Teen Mothers?

- Identify **supportive relationships** with the Teen Mother
  - Positive and supportive relationships between the teen mother and the teen's mother, the teen's partner, or the infant's father have been found to be protective.
- **Linkage** to gateway agencies, including schools, churches, and juvenile justice.
- Collaborative care, **co-located services**, multidisciplinary teams.
- Referrals to outpatient mental health services.
- **Home visits**.

Stacy Hodgkinson, et al. Addressing the Mental Health Needs of Pregnant and Parenting Adolescents. Pediatrics, 2014; 133: 114-122.

Are There Services in Los Angeles For Teen Mothers?

- LAUSD – **Policy on Pregnant and Parenting Students Educational Rights** – Focused on providing a safe and equitable environment at school; student mother can stay in regular school with childcare or consider one of seven enriched district pregnant minor schools.
- LAUSD/DMH – **School Mental Health** – Renders services at schools, clinics, wellness centers, including early intervention services and treatment services.
- LAUSD/DHS – **Nurse Family Partnership Program** – Comprehensive program that provides nurse home visits to first time mothers from pregnancy until baby is 2yo; can include education, support, and linkage to services.

Achieve.LAUSD.Net; BUL-2060.2

Any Other Special Considerations for Teen Mothers?

Recommendations by the American Academy of Pediatrics:

- Create a patient-centered medical home. Involve community resources.
- Promote breastfeeding.
- Provide **contraception counseling**. Offer access to the full range of contraceptive services.
- Screen for postpartum depression; refer to mental health resources when indicated.
- Screen for intimate partner violence and substance use.
- **Emphasize the importance of completing high school and pursuing higher education or vocational training.**
- Recognize all forms of parenting, including coparenting, and support the role of the father/partner.

Makia Powers, et al. Care of Adolescent Parents and Their Children. Pediatrics, 2021; 147 (5): e2021050919

How Often Should We Screen for Perinatal Depression?

All points of contact, especially for high risk women

- Pre-natal visits
- Post-delivery visits
- Well-baby visits

- Opportunities for a trusted health care professional to provide active psychoeducation about the signs and symptoms of depression and anxiety in a normative non-stigmatizing way.

Can We Prevent Perinatal Depression?

US Preventive Services Task Force, Recommendation Statement, 2019

- Moderate to high certainty that **providing counseling interventions** to women who were pregnant and post-partum up to one year for the purpose of **preventing perinatal depression** would net moderate to substantial benefit with low likelihood of harm
- Particularly true in populations at **higher risk** for perinatal depression

Susan Curry, et al. Interventions to Prevent Perinatal Depression USPSTF Recommendation Statement. JAMA, 2019; 321(6): 580-587.

What Kind of Counseling Interventions are Helpful in Preventing Perinatal Depression?

- Cognitive Behavior Therapy,
- Interpersonal Behavioral Therapy;
- Group Therapy,
- Individual Therapy.

- Up to **50% reduction in likelihood** of developing perinatal depression
- Positive effect was **2x greater in higher risk group** compared to lower risk group

Susan Curry, et al. Interventions to Prevent Perinatal Depression USPSTF Recommendation Statement. JAMA, 2019; 321(6): 580-587.

A Closer Look at Cognitive Behavioral Therapy

Systematic review of 40 RTCs assessing the efficacy of CBT in preventing perinatal depression (Sockol, 2015).

- Demonstrated CBT is effective in **preventing perinatal depression**; Greater reductions in risk when:
- Initiated during the **postpartum period or late in pregnancy**.
- Administered **individually** than group format.
- More culturally diverse cohort.
- Overall 36% reduction in risk of postpartum depressive episodes.

Laura Sockol. A systematic review of the efficacy of cognitive behavioral therapy for treating and preventing perinatal depression. Journal of Affective Disorders, 2015; 177: 7-21.

Another Look at Cognitive Behavioral Therapy

Systematic review of 40 RTCs assessing the efficacy of CBT in treating perinatal depression (Sockol, 2015).

- Demonstrated CBT is effective in **treating perinatal depression**.
- Larger reduction in depressive symptoms when initiated during the postpartum period or **across the perinatal period**.
- Equally effective when administered **individually or in group** format.
- Overall 36% reduction in postpartum depression.

Laura Sockol. A systematic review of the efficacy of cognitive behavioral therapy for treating and preventing perinatal depression. Journal of Affective Disorders, 2015; 177: 7-21.

How do We Treat Perinatal Depression?

Systematic Review of 16 Clinical Practice Guidelines from 12 Countries (Molenaar, 2018)

- New or Recurrent episodes of depression during pregnancy or postpartum.
  - Mild to Moderate: Therapy
  - Moderate to Severe: Medications
- For new episodes: Paroxetine was not preferred; Sertraline considered preferred.
- **Discouraged discontinuing or switching antidepressants.**
- **Recommended continuing medications to prevent relapse or decompensation.**
- Recommended hospital delivery with **postpartum observation of neonate**.
  - Early detection of persistent pulmonary hypertension; can check neonatal serum levels of antidepressants.
- Encouraged **breastfeeding**.

Nina Molenaar, et al. Guidelines on treatment of perinatal depression with antidepressants: An international review. Australian and New Zealand Journal of Psychiatry, 2018; 52(4): 320-327.

Are Antidepressants Safe to Use for Perinatal Depression?

As a class, SSRI's demonstrated low risk for major malformations (Gao, 2018), minor physical anomalies, maternal weight gain, infant birth weight, and neonatal adaptation (Wisner, 2009).

- Prospective observational study of 230+ women, showed that **infants exposed to either SSRI's or untreated depression** continuously across gestation were **more likely to be born preterm** than infants with partial or no exposure to either.
  - Comparable level of increased risk for preterm birth, which was 20%.

Shan-Yan Gao, et al. Selective Serotonin Reuptake Inhibitor Use during early pregnancy and congenital malformations: a systematic review and meta-analysis of cohort studies of more than nine million births. BMC Medicine, 2018; 16: 205.
Katherine Wisner, et al. Major depression and antidepressant treatment: Impact on Pregnancy and Neonatal Outcomes. American Journal of Psychiatry, 2009; 166: 557-566.

What about Other Antidepressants?

- Not as extensively studied as SSRI's, but no strong evidence that either major positive or negative outcomes were associated with gestational use of **Duloxetine** (Lassen, 2015), **Buproprion** (Turner, 2018), **Mirtazepine** (Smit, 2016), or **Trazodone** (Khazaie, 2013).
- Single case report for **Vilazodone**, unremarkable pregnancy, delivery, neonatal adaptation except for preterm labor (Morrison, 2014).

Lassen, et al. First-trimester pregnancy exposure to Venlafaxine or Duloxetine and risk of major congenital malformations: a systematic review. Basic and Clinical Pharmacology and Toxicology, 2016; 118: 32-36.

Turner, et al. Systematic review and meta-analysis to assess the safety of Buproprion and Vernicline in Pregnancy. Nicotine and Tobacco Research, 2019: 1001-1010. Systematic review involving 3186 infants exposed to Venlafaxine and 668 infants exposed to Duloxetine.

Smit, et al. Mirtazapine in pregnancy and lactation – A systematic review. European Neuropsychopharmacology, 2016; 26: 126-135.

Khazaie, et al. Insomnia treatment in the third trimester of pregnancy reduces postpartum depression symptoms: a randomized clinical trial. Psychiatry Res, 2013; 210: 901-905.

Morrison. Letters to the editor: A case report of the use of Vilazodone in pregnancy. Primary Care Companion CNS Disorders 2014; 16(2).

Why is Paroxetine Not Preferred?

Systematic review of 23 studies comparing the use of Paroxetine in the first trimester to other antidepressants or non-treatment (Berard, 2015).

- Compared to Non-Exposure to Paroxetine, first trimester use of Paroxetine was associated with an **increased risk of any major congenital malformations and major cardiac malformations** (blubus cordis anomalies, anomalies of cardiac septal closure, atrial septal defects, and right ventricular outflow tract defect), at least 23%.
- Estimates varied depending on the comparator group.
  - Highest risk compared to Non-Paroxetine Antidepressant, including other SSRI's or other antidepressants; in other words, lowest risk among Non-Paroxetine Antidepressants, not non-treatment.

Anick Berard, et al. The risk of major cardiac malformations associated with paroxetine use during the first trimester of pregnancy: a systematic review and meta-analysis. British Journal of Clinical Pharmacology, 2015; 81(4): 589-604.

And Venlafaxine?

Although not associated with an increased risk of major malformations (Lassen, 2015), Venlafaxine exposure in-utero presents risk of infant developing **discontinuation syndrome**, which may present as **encephalopathy** (Holland, 2016).

- Commonly presents as tachypnea, poor feeding, myoclonic seizure-like activity.
- Onset within 4 days of birth; resolves within 3 weeks.
- Recommend **hospital observation** between 2 and 4 days to monitor for symptoms.
- **Breastfeeding** may be an effective strategy to help counter possible withdrawal symptoms; Venlafaxine exposure through breastmilk.

Jonathan Holland, Richard Brown. Neonatal venlafaxine discontinuation syndrome: A mini-review. European Journal of Paediatric Neurology Society, 2017: 264-263.

Which is the best Antidepressant to use?

- The one that is most likely to be effective.
- Using what the patient is already taking.
- Resuming what the patient used and responded to in the past.
- Thinking about how to use side effects or other indications as additional benefits.
  - Mirtazepine for pregnant women with nausea and/or problems sleeping.
  - Buproprion for women who also need help with smoking cessation.
  - Sertraline for pregnant women who do not have any other indication.

What about Antidepressants and Lactation?

- All drugs can be excreted into human milk by passive diffusion.
- Infant exposure of less than 10% of a weight adjusted dose is considered safe for a breastfed infant.
- Less than 10% of the maternal weight adjusted dose is excreted into human milk for most SSRI's/SNRI's. Drug levels measured in infant blood are largely undetectable.
- Adverse events that have been reported include **uneasy sleep, colic, irritability, poor feeding, and drowsiness**. Adverse events are generally **transient**.
- Mothers should be made aware of potential for infant exposure.
- Mother and clinician should be observant for any changes in the child.

Myla Moretti. Breastfeeding and the use of antidepressants. Journal Population Therapeutics Clinical Pharmacology, 2012; 19(3): e387-3390.

How do we Reassure her about Lactation?

- The absolute infant exposure to antidepressant treatment was greater in pregnancy than it is during lactation.
- Exposure through breastmilk is much lower than a therapeutic exposure.

- Use caution with **premature infants**, because their ability to clear drugs is diminished compared to when they reach full term.

Myla Moretti. Breastfeeding and the use of antidepressants. Journal Population Therapeutics Clinical Pharmacology, 2012; 19(3): e387-3390.

What about Sleep?

- Poor sleep quality was significantly associated with greater symptoms of depression and anxiety in pregnancy and post-partum.
- Ask about Patient's **sleep hygiene**. Recommend a **sleep routine**.
- **Antihistamines** are not associated with malformations or adverse fetal outcomes.
- If you are prescribing sedating medication to postpartum women, please instruct them to **keep their baby safe by having the baby sleep in a crib**. Risk of roll over also extends to mothers with small children who co-sleep.

What does ACOG say about Benzodiazepines?

- Most benzodiazepines are FDA **category D**.
  - Defined as demonstrated risk against the fetus, but may have potential benefit that outweighs risk.
- Some benzodiazepines are FDA **category X**.
  - Defined as contraindicated in pregnancy; demonstrated risk outweighs potential benefit.
  - **Temazepam**, Triazolam, Flurazepam, Quazepam, Estazolam

- Increased risk for **cleft lip** with Diazepam.
- Concern for **neonatal floppy baby syndrome** when used right before delivery.
  - Poor respiratory effort, feeding difficulties, lethargy, hypothermia
- **Neonatal withdrawal** after delivery lasting months.
  - Diazepam, Alprazolam, Chlordiapoxide.
- **Sedation and poor feeding** during breastfeeding.

Carrie Armstrong. ACOG Guidelines on Psychiatric Medication during Pregnancy and Lactation. American Family Physician, 2008; 78(6): 772-778.

What about Benzodiazepines?

- Most common benzodiazepines and z-hypnotics used in pregnancy are Lorazepam and Zolpidem.
- Most common indication is for sleep and anxiety.
- Most commonly used in third trimester.
- Less commonly used in post-partum.
- Recommendation: **If used in pregnancy, low-dose, short-term use, when first-line treatments are not as effective.**

Babette Bais, et al. Prevalence of benzodiazepines and benzodiazepine-related drugs exposure before, during and after pregnancy: A systematic review and meta-analysis. Journal of Affective Disorders, 2020; 269: 18-27.

What about Benzodiazepines?

- Meta-analysis of cohort studies reported that first trimester use of benzodiazepines **did not appear to increase teratogenic risk in general**, including major malformations or cardiac malformations.
- However, case-control studies suggested a **two-fold increased risk of oral cleft**.
- Exposure to benzodiazepine or z-hypnotics in pregnancy is associated with greater risk of **lower birth weight, lower gestational age at birth, and higher risk of preterm birth**.

Ehijie Enato, et al. The Fetal Safety of Benzodiazepines: An Updated Meta-Analysis. Journal of Obstetrics and Gynecology Canada, 2011; 33(1): 46-48.
Anders Huitfeldt, et al. Associations of Maternal Use of Benzodiazepines or Bendodiazepine-like Hypnotics During Pregnancy with Immediate Pregnancy Outcomes in Norway. JAMA Network Open, 2020; 3(6):e205860.

Are We Talking about Contraception?

- Unintended pregnancy rate for US in 2017: 30%
- Access and use of reversible contraception can help women achieve their "life worth living" by making them active decision makers about their own reproductive potential.
- Clinical encounters are opportunities to provide psychoeducation and access.

Can't You Get Plan B from Pharmacies?

"Mystery shopper" telephone survey conducted at retail pharmacies in Los Angeles County over a three month period in 2017:

- 3 out of 4 pharmacies offered OTC emergency hormonal contraception.
- 1 out of 10 offered pharmacist-prescribed preventive hormonal contraception.
- Almost half of pharmacies **imposed age restrictions** even though age restrictions were removed by the FDA in 2013; including high risk neighborhoods.
- Low-income, minority neighborhoods lacked pharmacies.
- Cost not covered for uninsured.
- Highlights **disparities in access to contraception**.

Dima Mazen Qato, et al. Pharmacist-Prescribed and Over-the-Counter Hormonal Contraception in Los Angeles County Retail Pharmacies. Health Affairs, 2020.

Clinical Question

Sandra is a 16yo Latina who presents alone to your clinic 24 weeks pregnant with her first baby. Overall, she is healthy, endorses some crying spells. Pregnancy was not planned or wanted but she says she "will keep the baby." In addition to a comprehensive prenatal work-up, which of the following would you do? Select all that apply.

- Screen for depression
- Offer group or individual therapy
- Start an antidepressant
- Talk about contraception
- Call her parents

Summary

- Screening pts to improve diagnosis and treatment.
- Engagement and active psychoeducation regarding perinatal depression.
- Linkage to mental health services.
- Group/individual therapy for high risks groups who do not meet diagnostic criteria.
- Therapy for mild or moderate perinatal depression.
- Medication treatment for moderate to severe perinatal depression.
- Sleep helps.
- Suicidal ideations, infanticidal ideations, and psychosis are medical emergencies.
- Provide counseling on contraception and access to reversible contraception.

Are There More Resources to Look Into?

988

Department of Mental Health
1-800-854-7771

LAUSD School Mental Health
(213) 241-3841, smh.lausd.net

Department of Health Services Nurse Family Partnership Program
213-639-6449; nursefamilypartnership.org

LA County Perinatal Mental Health Task Force
LAPerinatalMentalHealth.WordPress.com

2020Mom.org

Frequently Asked Questions (FAQs)

1. Who is at increased risk for perinatal depression?
   a. History of depression
   b. Current depressive symptoms
   c. Low income
   d. Young parenthood
   e. Single parenthood
   f. Intimate partner violence
   g. History of abuse
   h. Minority group
   i. All of the above

Frequently Asked Questions (FAQs)

2. Which of the following is TRUE about maternal suicide?
   a. Second leading cause of death for post-partum women.
   b. One out of five deaths of post-partum women.
   c. Most often occurs within the first year after birth.
   d. Is more common than infanticide.
   e. All of the above

Frequently Asked Questions (FAQs)

3. Which of the following is FALSE?

   a. Paroxetine is not preferred during pregnancy.

   b. Switching from Paroxetine to another antidepressant is discouraged.

   c. Mirtazepine can help with sleep and morning sickness.

   d. Valproic acid is safe in pregnancy.

Frequently Asked Questions (FAQs)

4. In Los Angeles County, compared to their white counterparts,

   a. Black mothers are FOUR times more likely to die from pregnancy complications.

   b. Black infants are THREE times more likely to die before their first birthday.

   c. Black mothers are less likely to experience implicit bias and structural racism.

   d. A & B only.

Presenter's Contact Information

Marissa Andres-Kim, MD

MAndresKim@dmh.lacounty.gov