





Psychiatric illness during pregnancy

Early detection, individualized care can promote health for mother and infant

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Perinatal psychopathology is a common and undertreated problem with wide-ranging consequences for both mother and child.¹⁻⁴ Women at risk for psychopathology are more likely to engage in unhealthy behaviors such as smoking and substance abuse and have difficulty engaging in treatment and attending psychiatric and obstetrics appointments.⁵ In addition, many of these women have trouble attaching to and caring for their infants and struggle with everyday stressors during pregnancy and postpartum.⁶

Routine prenatal screening for mental illness coupled with non-judgmental, collaborative, and individualized care delivered by a multidisciplinary team is critical for treatment engagement and adherence. Providers should be aware of risk factors for perinatal psychiatric illness—including a history of mental illness, stressful life events, and interpersonal conflict—and should be versed in current treatment guidelines.

CASE REPORT

Difficulty coping

Ms. A, age 28, is referred to our High Risk Perinatal Team by her obstetrician when she is approximately 6 weeks pregnant. She is single, has 3 other children (age 10, 4, and 2), a history of depression, and chronic pain related to an auto accident 3 years ago. She reports that this pregnancy likely is the result of a sexual assault, but she has decided to keep the baby. Ms. A describes severe depressive symptoms, including insomnia, low appetite, feelings of worthlessness, and thoughts of harming herself. In addition, she has incapacitating panic attacks and constantly worries about her children's safety when she is not with them. She schedules an



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Clinicians unfamiliar with perinatal mental illness may mislabel depressive symptoms as normative experiences during pregnancy

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Box 1

Overcoming barriers to care

Lack of insurance, childcare, or transportation can make it difficult for a pregnant woman to receive psychiatric treatment. All pregnant women are eligible for Medicaid if private insurance is unavailable to them, and clinicians can help patients apply for assistance. Some programs—for example, Michigan's state-funded Maternal Infant Health Programs—offer help with transportation to appointments, such as cabs and reimbursement for gas, in addition to nutrition guidance, counseling, home visits, and referrals to community resources such as childbirth classes, infant mental health specialists, and/or substance abuse treatment (see **Related Resources, page 32**).

Offering childcare during psychotherapy sessions can be particularly helpful, and may provide valuable experience for a student or resident interested in working with at-risk children. Women may be more likely to engage in care if psychotherapy sessions are conducted by phone or in their homes. A positive experience with mental health care during pregnancy may increase the likelihood that women will remain engaged in treatment after childbirth, therefore lessening the negative effects of perinatal psychopathology on mother and child.

appointment with the perinatal team, but does not show up twice.

When our team finally sees Ms. A, she is well into her second trimester and brings her 2 youngest children with her. She says she recently was fired from her job as a cashier because she missed too many days of work, and is applying for Medicaid. Recently, her back and shoulder pain have worsened, and she is running out of her prescription for acetaminophen/hydrocodone. Ms. A's affect is flat, her mood depressed, and she has difficulty explaining her history because her 2-year-old son interrupts the interview. She has never been in psychotherapy, and is reluctant to take antidepressants. Despite a difficult first visit, she engages with the clinician and agrees to schedule a second appointment.

What complicates pregnancy?

Women are at higher risk for developing depression during puberty, the perinatal period (ie, pregnancy and first year post-

partum), and perimenopause.⁷ These times often are fraught with unfamiliar hormonal fluctuations, role transitions, emotional upheaval, and physical changes. However, because these times are expected to be stressful, serious mood changes often go unnoticed by patients and untreated by clinicians.⁸ Women are expected to celebrate, thrive, and “glow” during pregnancy, and those who suffer from depression and anxiety frequently do so in silence. Social stigma surrounding perinatal depression or anxiety leads many women to believe they are alone in their struggle and hesitant to seek help.⁹

Most pregnant women who develop psychiatric illness do not present for treatment.¹⁰ One study found that 86% of pregnant women who screened positive for depression in an obstetrics (OB) setting did not receive treatment.¹¹ Some women are reluctant to take antidepressants out of concern for their infant's safety,⁸ and psychotherapy or alternative approaches are not available in all areas.¹² Transportation, childcare issues, or ongoing life stressors may prevent women from seeking help (**Box 1**).⁹

Diagnostic uncertainty among professionals may aggravate undertreatment. Clinicians who are unfamiliar with the presentation of perinatal mental illness may mislabel depressive features—such as irritability, loss of interest in activities, low energy, increased anxiety, difficulty sleeping, or appetite dysregulation—as normative experiences during pregnancy or adjustment after childbirth. Concerned about fetal exposure to potentially teratogenic compounds, clinicians may under-dose otherwise effective medications, which can lead to treatment resistance. Even if treated aggressively, depression in pregnancy may persist because of other factors, such as comorbid anxiety, somatization, pain, substance use/dependence, undiagnosed bipolar illness, or the presence of severe psychosocial stress or trauma.

Maternal suicide and/or harm to the infant—the most severe result of untreated perinatal psychopathology—is rare.¹³ Common negative outcomes of untreated depression or anxiety in pregnant women include inadequate weight gain, pre-

Table 1

Screening for psychiatric illness during pregnancy

Screening tool	Sensitivity/specificity	Administration	Availability
Edinburgh Postpartum Depression Scale	Sensitivity = 0.86 Specificity = 0.78 Positive screen: >10	Self-administered in 5 to 10 minutes. Could be self-scored	http://bit.ly/PPDscale
Patient Health Questionnaire-2 (PHQ-2)	Sensitivity = 0.83 Specificity = 0.92 Positive screen: >3	Self- or clinician-administered in <1 minute	www.phqscreeners.com The 2 questions from the PHQ-9 for mood and anhedonia are used
Patient Health Questionnaire-9 (PHQ-9)	Sensitivity = 0.88 Specificity = 0.88 Positive screen: >10	Self-administered and self-scored, 5 to 10 minutes	www.phqscreeners.com

Source: Reference 21

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Pregnant women may be more likely to engage in psychotherapy if childcare can be provided during sessions

eclampsia, difficulty bonding with their unborn baby, premature labor, and lack of follow through with prenatal care.^{14,15} Symptoms become harder to treat when aggravated by psychosocial stressors such as poor social support, ambivalence about the pregnancy, and/or substance abuse.

The key to successful intervention is finding a balance between managing psychiatric concerns, facilitating adequate coping with psychosocial stressors, and, if necessary, aggressively treating pregnancy-related physical illnesses. Successful treatment response depends on early detection and initiating individualized care as soon as possible.

Early detection. Women's health care providers play a fundamental role in guiding decision-making about mental health care, providing referrals, and most important, allowing women to talk about perinatal psychopathology without fear of stigma.

When a woman becomes pregnant, it is critical to determine if she is at risk for developing psychopathology or presents with active illness. Many OB clinics screen for depression several times during pregnancy and early postpartum. The most commonly used screening tool is the Edinburgh Postpartum Depression Scale (EPDS),¹⁶ a 10-item self-report measure that is sensitive to cognitive and affective symptoms of depression. If a woman scores >15 during pregnancy or >13 postpartum, further assessment is in-

dicated.¹⁷ The anxiety subscale (items 5 and 6) of the EPDS has been validated for screening perinatal anxiety using a cut-off score ≥ 4 .¹⁸ Depression can be quickly assessed using the 2-question Patient Health Questionnaire (PHQ-2) or the 9-question PHQ-9.^{19,20} All 3 scales are free and available on the Internet (*Table 1*).²¹

These screening tools offer clinicians an opportunity to assess for risk factors that may increase the likelihood of illness onset or worsened prognosis (*Table 2, page 26*).^{5,22} All women who present with pregnancy-related medical illness, such as preeclampsia or gestational diabetes, should be screened for co-occurring depression or anxiety because psychiatric comorbidity is common.

Individualized care. Have an open mind about the kind of care to offer and collaborate with the patient when discussing treatment options.⁵ Some pregnant women may reject traditional treatments, such as pharmacotherapy or psychotherapy, because of concern about harm to the unborn baby or reluctance to work through past or present conflicts in therapy during a vulnerable time.⁹ Women may assume that medication will be the only treatment offered, or even fear that they will be forced to take antidepressants. Women often do not follow through on mental health referrals, even when they are appropriately screened and identified to be



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Screen women who have a pregnancy-related medical illness for depression or anxiety because such comorbidity is common

Table 2

Risk factors for perinatal psychopathology

Pregnancy during adolescence
Previous diagnosis of depression, anxiety, psychosis, or bipolar disorder
Trauma history, including physical, emotional, or sexual abuse
Current or past substance abuse/dependence, including cigarette smoking
Lack of social support
Single parenthood
Low socioeconomic status
History of sexual assault or domestic violence
Unstable home environment
Stopping antidepressants during pregnancy
Financial problems
Ambivalence about pregnancy
Source: References 5,22

at risk, and an OB nurse explains the risks of untreated psychopathology.¹¹

A multidisciplinary, collaborative care model is vital for positive pregnancy outcomes. Connecting obstetricians and midwives with psychologists, psychiatrists, social workers, and infant mental health specialists to coordinate treatment ensures that at-risk pregnant and postpartum women get the care they need. A nonjudgmental approach is essential to engage pregnant women in care. Assure women that pharmacotherapy is not required when receiving mental health treatment, but is an option they can choose.

Treatment choices

Pharmacotherapy. If a woman has only mild symptoms or has been symptom-free for ≥ 6 months, it may be safe to decrease or discontinue antidepressants during pregnancy or while trying to conceive, but such patients should be monitored closely for signs of relapse.²³ In a study of 201 depressed pregnant women, 68% of those who discontinued medication experienced symptom relapse compared with 26% of those who continued medication.²⁴ If a depressed woman has a history of relapse

or severe symptoms, including suicide attempts and inpatient psychiatric admissions, it is recommended that she remain on antidepressants or mood stabilizers, regardless of pregnancy status.²⁵ If medications are necessary during pregnancy—ie, the benefits to the mother outweigh the risks to the unborn baby—the following precautions could help decrease fetal exposure:²³

- keep the medication regimen simple and at the lowest effective dose
- use monotherapy when appropriate
- if possible, do not change medications during pregnancy.

When considering pharmacotherapy, evaluate each woman's risk for disease exacerbation and consequences for pregnancy and neonatal outcomes, and ask the woman how she views reproductive risk vs disease benefit.

Developing fetuses are exposed to either the effects of the mother's untreated mental illness or the medication.²⁶ A recent study comparing birth and neonatal outcomes among women with untreated depression vs those taking selective serotonin reuptake inhibitors (SSRIs) found similar adverse outcomes.²⁷ Babies continuously exposed to either prenatal depression or SSRIs were more likely to be born prematurely, but partial exposure to either condition did not increase this risk.²⁷ In addition, women who were not taking SSRIs had more depressive symptoms and more trouble functioning, which can interfere with bonding between mother and baby, both in-utero and postpartum.^{6,27} Neither SSRIs nor depression exposure increased risk for minor physical anomalies.²⁷

A careful process of informed consent and documentation is essential when prescribing medications during pregnancy. Women should understand the risks of pharmacotherapy as well as the risks of undertreated illness.

Electroconvulsive therapy can safely help pregnant women with treatment-resistant, life-threatening, or psychotic depression.^{28,29}

Psychotherapy. The American College of Obstetricians and Gynecologists treatment guidelines²² favor psychotherapy over



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Assure pregnant women that pharmacotherapy is not required but is an option they can choose

Table 3

ACOG guidelines for treating depression during pregnancy

Women who are thinking about getting pregnant

For women on medication with mild or no symptoms for ≥ 6 months, it may be appropriate to taper and discontinue medication before becoming pregnant

Medication discontinuation may not be appropriate in women with a history of severe, recurrent depression or who have psychosis, bipolar disorder, other psychiatric illness requiring medication, or a history of suicide attempts

Pregnant women currently taking medication for depression

Psychiatrically stable women who prefer to stay on medication may be able to do so after consultation between their psychiatrist and obstetrician to discuss risks and benefits

Women who want to discontinue medication may attempt to taper and discontinue if they are not experiencing symptoms, depending on their psychiatric history. Women with a history of recurrent depression are at a high risk of relapse if medication is discontinued

Women with recurrent depression or who have symptoms despite medication may benefit from psychotherapy to replace or augment medication

Women with severe depression (with suicide attempts, functional incapacitation, or weight loss) should remain on medication. If a patient refuses medication, alternative treatment and monitoring should be in place, preferably before discontinuation

Pregnant and not currently on medication for depression

Psychotherapy may be beneficial for women who prefer to avoid antidepressants

For women who want to take medication, risks and benefits of treatment choices should be evaluated and discussed, including factors such as stage of gestation, symptoms, history of depression, and other conditions and circumstances (eg, smoking, difficulty gaining weight)

All pregnant women

Regardless of circumstances, a woman with suicidal or psychotic symptoms should immediately see a psychiatrist

ACOG: American College of Obstetricians and Gynecologists

Source: Reference 22

medication for women with mild depressive symptoms and no loss of function, suicidality, or psychotic experiences; pharmacotherapy is suggested for women who have moderate to severely impaired functioning, recurrent depressive symptoms, or suicidal thinking (*Table 3*).²²

Interpersonal psychotherapy or cognitive-behavioral therapy can be safe and effective during pregnancy.^{30,31} Other psychotherapeutic modalities and alternative/complementary treatments offer potential benefit without substantial risk, and could help prevent relapse when discontinuing mood stabilizers or antidepressants after conception (*Box 2*).³²⁻³⁵

CASE CONTINUED

Healthy baby boy

Ms. A either doesn't show up or cancels her weekly appointments about once a month, but seems to be making progress. Her thera-

pist makes accommodations for Ms. A, such as offering childcare in an adjacent room during sessions, conducting brief sessions by phone when Ms. A is unable to come to the clinic, and helping her enroll in the state's Maternal Infant Health Program. Ms. A's therapist has referred her to a specialized OB clinic that can manage her pain medication and monitor for signs of abuse and keeps in regular contact with her obstetrician.

At 26 weeks gestation, Ms. A still is reluctant to try psychotropics, so her therapist works with her to integrate psychotherapy with alternative approaches such as mindfulness meditation and yoga. During therapy, Ms. A learns ways to manage her depressive symptoms, improve her social functioning, adjust to role transitions, and work through her traumatic experiences. Ms. A enrolls in a prenatal yoga class with a mindfulness focus, which allows her to interact with other pregnant women at risk for psychopathology and

learn new ways to cope with her depressed mood and chronic pain.

Ms. A delivers a healthy boy at 38 weeks gestation. During labor, she uses many of the yoga poses she learned to manage pain, but elects to have an epidural after 30 hours of labor. Her baby tests positive for hydrocodone, which can cause ongoing mild irritability and occasional jitteriness. He is observed in the hospital for signs of withdrawal for 48 hours and then discharged home with his mother. Ms. A starts breast-feeding in the hospital and plans to continue at home.

Ms. A's therapist continues to stay in touch with her by phone until she schedules another appointment and assists with referrals to other community resources.

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Box 2

Complementary mental health treatments during pregnancy

Mind-body approaches such as mindfulness-based stress reduction, yoga, and progressive relaxation and supplements such as fish oil may be good adjuncts to psychotherapy. Many pregnant women prefer mindfulness yoga to other mind-body techniques.³² A pilot study found that mindfulness yoga significantly decreased depressive symptoms and increased maternal-fetal attachment, particularly in mildly depressed women.³³ For women who do not wish to engage in traditional treatments, alternative approaches such as progressive relaxation are easily taught and can help reduce depressive symptoms.³⁴ Regular exercise may improve self-esteem and reduce symptoms of depression and anxiety in pregnant women.³⁵

Clinical Point

Pharmacotherapy is suggested for pregnant women who experience recurrent depressive symptoms or suicidal thinking



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Mind-body treatments such as mindfulness yoga may decrease a pregnant woman's depressive symptoms

Related Resources

- University of Michigan Department of Psychiatry Depression Center Women's Mental Health and Infants Program. Women and depression. www.psych.med.umich.edu/wimhc.
- Yonkers KA, Wisner KL, Stewart DE, et al. The management of depression during pregnancy: a report from the American Psychiatric Association and the American College of Obstetricians and Gynecologists. *Gen Hosp Psychiatry*. 2009;31(5):403-413.
- Michigan Families Medicaid Project. Year 1 final report. Includes a list of maternal and child health services similar to Michigan's Maternal Infant Health Program, for all 50 states. <http://1.usa.gov/yCzdca>.

Drug Brand Name

Acetaminophen/hydrocodone • Vicodin

Disclosures

The authors report no financial relationship with any company whose products are mentioned in this article or with manufacturers of competing products.

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Bottom Line

Perinatal psychopathology is common, yet often undertreated. Successful outcomes depend on early detection, individualized care, and addressing barriers to treatment. A nonjudgmental approach is essential to engage pregnant women in treatment. Psychotherapy and psychopharmacology can be used in conjunction with alternative modalities to improve outcomes.