MANAGEMENT OF PERIPARTUM DEPRESSION

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Disclosures

- No conflicts of interest
- May be discussing off label use of some medications

Perinatal Depression Affects 1 in 5-8 Women

American College of Obstetricians and Gynecologist recommends all pregnant women be screened at least once during the perinatal period.

(ACOG Committee Opinion No. 757, 2018)
(ACOG Committee Opinion No. 630, 2015)
(Liu et al., 2022)

Postpartum Blues (Baby Blues)

- More common (70%-80%)
- Within 2-3 days of delivery with peak on 4-5th day. May last for few hours to few days – up to maximum of 2 weeks
- No functional impairment
- No specific treatment
- Supportive reassurance with regular monitoring for development of PPD and follow up

Postpartum Depression (PPD)

- 15% - 20%
- If symptoms beyond 2 weeks: need further evaluation to rule out PPD, especially in high-risk females
- Functional impairment
- Mild-psychotherapy
- Pharmacological interventions – moderate to severe
- Supportive reassurance with regular monitoring for further worsening and follow up

(Postpartum Depression | ACOG)
(Is this Baby Blues or Postpartum Depression? | American Pregnancy Asc)

No decision is risk free and no medication is completely safe in pregnancy

Impact of Untreated Maternal Mental Health

Mother

- No proper prenatal and well baby visits
- Substance abuse
- Maternal suicide
- Infanticide

Offspring

- Low birth weight
- Preterm delivery
- Cognitive delays
- Behavioral problems

(Atif, et al., 2015)
(Balbierz et al., 2015)
(Grigoriadis et al., 2013)
(Grote et al., 2010)
(Paulson et al., 2006)

Treatment

- Mild symptoms
  - Psychoeducation and Psychotherapy (Cognitive Behavioral Therapy)
  - Internet based CBT (iCBT) program effective in prevention of perinatal depression if app is downloaded and engaged
- Moderate – Severe symptoms- pharmacotherapy
- First line – SSRI (Selective Serotonin Reuptake Inhibitors)
- Start low and go slow
- Lowest possible dose
- Change as clinically indicated
- Preferably resume what has worked for patient in the past
- Continue what is working for the patient with proper risk and benefit discussion
- Changing to new agent will increase the risk of exposures with no guarantee of response with newer agent

Fluoxetine (Prozac)

Sertraline (Zoloft)

Paroxetine (Paxil)

Citalopram (Celexa)

Escitalopram (Lexapro)

Fluvoxamine (Luvox)

(Least amount of data in pregnancy e as compared to other SSRIs)

(Takae et al., 2025: Nguyen and Pengpid, 2025; Dennis et al., 2024; Clinical practice, guideline, ACOG, 2023; Payne, 2021)

Treatment

- Don’t hesitate to increase dose if needed (do not undertreat)
  - Requirements of dosages may ⇧ as pregnancy progresses due to pharmacokinetic changes
- Decrease the dosages gradually after delivery to a lower dose as tolerated and clinically indicated
- Watch for emergence of hypomania and mania as about 22% women who were diagnosed with PPD for first time got diagnosed with bipolar disorder later
- Monotherapy preferred
- Augmentation - severe depression - not responding to monotherapy

(Wisner et al., 2013)
(Payne, 2021)

SSRI Safety

- Reproductive safety data on most SSRIs actually exceeds most other medications
- Absolute risk of overall congenital malformations or cardiovascular malformations in children of pregnant women exposed to SSRI is small
- Preterm labor and lower birth weight—difficult to assess as depression itself is a risk factor for same outcome
- Increased likelihood of postpartum hemorrhage-SSRIs may affect platelet aggregation and thus increase the risk of bleeding
- Persistent Pulmonary Hypertension (PPHN)—risk in newborn exposed to SSRI appears small (least with sertraline followed by escitalopram)

(Sarkar et al, 2025)
(Lebin et al, 2022)
(Rommel, et al. 2022)
(Skalkidou et al., 2020)
(Mitchel et al., 2018)
(Cantarutti et al., 2016)
(Gao et al, 2018)
(Huybrechts et al., 2014)

Common Concerns With SSRIs

- Late trimester exposure to SSRIs
- Occurs in 20-30%
- Most common effect of SSRI use in pregnancy
- Begins minutes to hours after birth
- Lasts usually 1-4 days, inconsistent reports of signs > 1 week
- Can occur with any antidepressant
- Not dose dependent
- No pharmacological intervention required
- Supportive treatment only

Symptoms may include:

Jitteriness
Constant crying
Feeding/Sleeping problems
Desaturation with feeding
Autonomic instability
Tachypnea
Hyperreflexia/hypertonia
Seizures
Lower quality of movement
Poorer self-regulation, higher arousal levels at day 14 post-delivery

(ACOG Clinical Practice Guideline No. 5. 2023)
(Ewing et al., 2015)
(Suarez et al., 2022)

Common Concerns With SSRIs

- Neurobehavioral/neurodevelopmental effects
  - Majority of studies do not suggest major long term adverse effects
  - Postpartum depression itself is associated with poor outcome in terms of neurobehavioral effects
- Autism/ADHD
  - We do not see consistent findings of Autism or ADHD with SSRI exposure in pregnancy
  - Difficult to distinguish impact of medication exposure and maternal mental illness
  - Thus, would be premature to limit antidepressant use during pregnancy based upon the available data

(ACOG Clinical Practice Guideline No. 5. (2023)
(Suarez et al., 2022)
(Leshem et al., 2021)
(Kapra et al, 2020)
(Andrade, 2020)
(Brown et al., 2017)

Table 1. General Approach to Risk Counseling for Depression Psychopharmacotherapy	
Risks of under-treatment or no treatment for depression during pregnancy include…	**Risks of antidepressant use during pregnancy include…***
Limited engagement in medical care and self-care	PPHN
Substance use	Transient neonatal adaptation syndrome
Preterm birth	Preeclampsia (SNRIs)
Low birth weight	Spontaneous abortion (SNRIs)
Preeclampsia	
Postpartum depression	
Impaired infant attachment (which carries long-term developmental effects)	
Disrupted relationship with partner	
Suicide†	
PPHN, persistent pulmonary hypertension of the newborn; SNRI, serotonin-norepinephrine reuptake inhibitor.	

Hu et al., 2025,
Lebin et al, 2022
Clinical practice, guideline, ACOG, 2023

New Labeling System

- FDA pregnancy categories A, B, C, D and X have phased out
- PLLR – Pregnancy and Lactation Labeling Rule-new system-provides comprehensive information discussing potential risks and benefits to mother and fetus
  - ✓Provides comprehensive information of drug use
    - ❖Pregnancy
    - ❖Lactation
    - ❖Females and males of reproductive potential
  - ✓Summarizes: risks to the fetus, illness-related clinical considerations, and available safety data

(Pregnancy and Lactation Labeling (Drugs) Final Rule | FDA)

When is it Time to Refer?

- Referral to Psychiatrist
  - Moderate- Severe depression
  - Not responding to medication adjustments
  - Unable to take care of themselves or their baby
- Referral to higher level of care: inpatient or partial program
  - Danger to themselves or others as there is high risk of suicide (20%) associated with perinatal mood disorder
  - Psychotic (disorganized)-there is about 4% risk of infanticide in Postpartum Psychosis (PPP)

(Friedman et al., 2023)
(Lindahl et al., 2005)

Resources

- Massachusetts General Hospital (www.womensmentalhealth.org)
- Postpartum Support International (www.postpartum.net 1-800-944-4PPD)
- The Periscope Project (Perinatal Specialty Consult Psychiatry Extension)
- Mother to baby (www.mothertobaby.org)
- MCPAP for moms
- National Curriculum on Reproductive Psychiatry

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