

# Perinatal Depression

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# Perinatal Depression

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

## Screening:

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

## Differential Diagnosis:

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

## For positive screens, assess safety (See [page 27](#) for additional guidance)

[Columbia Suicide Severity Rating Scale \(CSSRS\)](#) or [Ask Suicide Screening Questions \(ASQ\)](#)

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

## For mild depression:

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

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

## Risks of untreated depression:

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



May need increase in dose later in pregnancy

## Risks of antidepressants:

- \*Common and serious side effects
- \*No consistent increase in rates of malformations
- \*Persistent pulmonary hypertension of the newborn (PPHN; 2.9 vs. 1.8/1000)
- \*Neonatal adaptation syndrome in 30%; worse if also taking benzodiazepines
- \*Monitor breastfed infants for sedation/poor feeding; case reports of seizures with exposure to bupropion during lactation

## Alternative treatments:

- \*Psychotherapy (CBT, IPT, therapy that has helped in past)
- \*Exercise, yoga, bright light, omega-3-fatty-acids (EPA:DHA>1.5)
- \*For severe/treatment-resistant depression, consider ECT, TMS, brexanolone, day treatment/inpatient programs

## Goal:

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

# Perinatal Depression Medications

Drug Name	Starting Dose <sup>a</sup> (mg/day)	Up titration schedule	Use in Pregnancy	Use during Lactation
<b>SSRIs<sup>b</sup></b>				
Citalopram (Celexa)	10	Increase to 20 mg/day after one week Then, increase by 10-20 mg every 4 weeks <sup>c</sup> (max dose 40 mg/day) <sup>d</sup>	SSRIs not associated with increase in malformations	RID <sup>e</sup> < 10%; reports of sedation, fussiness, weight loss in infants; monitor weight gain, behavioral effects
Escitalopram (Lexapro)	5	Increase to 10 mg/day after one week Then, increase to 20 mg/day after 4 weeks <sup>c</sup> (max dose 20 mg/day)	May need dosage increase later in pregnancy	RID <sup>e</sup> < 10%; one report of necrotizing enterocolitis; monitor for sedation, irritability
Fluoxetine (Prozac)	10	Increase to 20 mg/day after one week Then, increase by 10-20 mg every 4 weeks <sup>c</sup> (max dose 80 mg/day)	Possible increased risk of persistent pulmonary hypertension of the newborn (PPHN); 2.9/1000 vs. 1.8/1000 baseline; lowest risk with sertraline	RID <sup>e</sup> may be > 10%; monitor for behavioral effects, adequate weight gain
Paroxetine (Paxil)	10	Increase to 20 mg/day after one week Then, increase dose by 10-20 mg every 4 weeks <sup>c</sup> (max dose 50 mg/day)		RID <sup>e</sup> generally 5% or less; few adverse effects; monitor for behavioral effects (e.g. insomnia, restlessness, increased crying)
Sertraline (Zoloft)	25	Increase to 50 mg/day after one week Then, increase by 25-50 mg every 4 weeks <sup>c</sup> (max dose 200 mg/day)	Transient neonatal adaptation syndrome (NAS) in 30% of exposed infants	Low concentrations in breast milk and infant; RID <sup>e</sup> generally 2% or less; few adverse effects in infants; considered preferred antidepressant in breastfeeding
<b>SNRIs<sup>b</sup></b>				
Duloxetine (Cymbalta)	30	Increase dose to 60 mg/day after one week (max 120 mg/day; rarely need > 60 mg/d)	NAS (see above); possible inc risk of heart defects, miscarriage, postpartum hemorrhage	Few reports; RID <sup>e</sup> < 1%; no adverse effects; monitor for sedation, adequate growth
Venlafaxine (Effexor) XR	37.5	Increase to 75 mg/day after one week Then, increase by 37.5-75 mg every 4 weeks <sup>c</sup> (max dose 225 mg/day)	Increased risk for PPHN, NAS (see above); increased risk of gestational hypertension	RID <sup>e</sup> 3-12%; rare adverse effects reported in infants; monitor baby for excessive sedation, adequate weight gain
<b>OTHER<sup>b</sup></b>				
Bupropion <sup>f</sup> (Wellbutrin) XL	150	Increase by 300 mg/day XL every 4 weeks <sup>c</sup> (max dose 450 mg/day)	No overall inc in malformations ?inc in LVOT <sup>g</sup> heart defects	RID <sup>e</sup> up to 5.1% 2 reports of seizures in breastfed infants
Mirtazapine <sup>h</sup> (Remeron)	7.5	Increase to 15 mg qhs after one week Then, increase by 15 mg every 4 weeks <sup>c</sup> (max dose 45 mg/day)	No increase in malformations NAS (see above)	Few reports; RID <sup>e</sup> < 2%; no adverse effects noted; monitor for behavioral effects, adequate growth

<sup>a</sup>With comorbid anxiety disorder, use lower starting dose

<sup>b</sup>Antidepressants are associated with increased suicidal thinking and behavior in young adults; monitor closely for worsening or emerging suicidality

<sup>c</sup>as needed to treat continued depressive symptoms

<sup>d</sup>maximum dose 40 mg/day due to risk of QT prolongation

<sup>e</sup>RID = relative infant dose

<sup>f</sup>do not give if history of bulimia or seizures; seizure risk limits dose

<sup>g</sup>LVOT = left ventricular outflow tract

<sup>h</sup>increases appetite, sedating; may help with hyperemesis, insomnia

4/15/22

# Perinatal Depression Resources

## **Review article:**

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

## **PHQ-9 in different languages:**

<https://www.phqscreeners.com>

## **EPDS in different languages:**

[http://www.perinataleservicesbc.ca/health-professionals/professional-resources/health-promo/edinburgh-postnatal-depression-scale-\(epds\)](http://www.perinataleservicesbc.ca/health-professionals/professional-resources/health-promo/edinburgh-postnatal-depression-scale-(epds))

## **Columbia Suicide Severity Rating Scale (CSSRS):**

<https://cssrs.columbia.edu/documents/c-ssrs-screener-triage-primary-care/>

## **Ask Suicide Screening Questions (ASQ):**

<https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials>

## **NIMH brochure for patients about perinatal depression (available in English and in Spanish):**

<https://www.nimh.nih.gov/health/publications/perinatal-depression/index.shtml>

## **Mothers and Babies Program**

Information, training, and resources for therapy for perinatal stress and depression based on cognitive behavioral therapy and attachment theory

<http://www.mothersandbabiesprogram.org/>

## **Article about interpersonal therapy (IPT) for postpartum depression:**

This is an article for providers that describes interpersonal therapy (IPT) for postpartum depression, its rationale, structure, and content.

Stuart S. Interpersonal psychotherapy for postpartum depression. *Clin Psychol Psychother* 2012; 19:134-140.

## **Article about importance of and prescribing sleep for postpartum depression:**

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