

# Treatment Considerations in Antenatal and Postpartum Psychiatric Illnesses

APM Resident Education Curriculum

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**Academy of Psychosomatic Medicine**  
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There is no risk free decision when it comes to whether to prescribe medication during pregnancy & breast feeding or not. The risks of not treating (including suicide, infanticide, pregnancy complications, difficulty parenting current children & functioning in home & work lives) versus the ever changing list of risks of exposure to medications (neonatal withdrawal, possible risk for persistent pulmonary hypertension of the newborn, possible increased risk for heart defect with first trimester exposure to paroxetine & decreased compliance with prenatal care & self medicating with nicotine, alcohol and other illicit substances).

It is essential that you educate each woman (& her partner if indicated) of the risks & benefits on both sides & allow her to make the decision. This discussion and her decision need to be carefully documented in the medical record.

## **We are between a rock and a hard place.**

- *WILL discuss off label use of medications*
- *Do NOT have placebo controlled, double blind, randomized trials in pregnant or lactating women for ethical reasons*



Due to the potential adverse risks to mother and child, the FDA will likely never approve placebo controlled double blinded studies in pregnant and lactating women.

## **Informed Consent Discussion**

- Risks of psychiatric illness in pregnancy and postpartum
- Non-pharmacological treatment options
- Risks of psychotropic exposure to developing fetus/breastfeeding infant
- Potential adverse effects to mother
- Benefits of psychotropic use in treatment of psychiatric illness

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Documentation:

Include:

- description of the patient's depression history and current symptoms
- description of the risks of depression during pregnancy
- explanation of benefits and risks posed by SSRI/ or other type of antidepressant (doesn't necessarily have to be just an SSRI – the older TCAs weren't found to be associated with PPHN) treatment to both the mother and fetus,
- description of non-pharmacological approaches discussed and their relative benefits and risks
- the patient's decision and her reasoning (in her words).

## Informed Consent Discussion

- “Parenthood is a journey into the unknown, but together we can try to make decisions which reduce the overall risk.”
- Accepting risk is part of the process
- Think of assessing risk above baseline risks
  - 1-3% of pregnancies which have some type of congenital malformation
- Think in terms of absolute risk
  - Example: One study demonstrated 6x increase in omphalocele w/ use of SSRIs in early pregnancy
  - BUT absolute risk is less than 3/1000

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Due to the potential risk, informed consent is mandatory.

LW: comment - the increased risk for omphalocele was identified by a retrospectively designed study (if I'm not mistaken) & is subject to significant bias. Somehow this needs to be explained. I don't recall if they carefully controlled for exposure to nicotine & / or other exposures. They found babies with this birth defect & then contacted them & interviewed the mothers (who would probably more readily identify the antidepressant as the reason for the problem & not always disclose the smoking, etc.) I would just be careful about putting this in. Or say, to date this hasn't been replicated in a prospective large scale study. - - PLEASE point me in the right direction for the literature if this has been shown to be associated in a prospective study where exposure to smoking, etc. was controlled for.

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