Pharmacologic Treatment of Perinatal Depression

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KEYWORDS

• Depression • Peripartum • Mental health • Medication • Treatment considerations

KEY POINTS

- Clinicians treating pregnant and postpartum women should be familiar with a range of pharmacologic treatment options, gain comfort with prescribing, and know when to consult a mental health provider.
- Treatment decisions should weigh the risks of medication exposure to fetus or infant with the risks of maternal psychiatric illness on the mother and her family.
- Clinicians should communicate to patients that perinatal depression is a treatable medical condition.

BACKGROUND AND PREVALENCE

Perinatal depression, defined as depressive symptoms occurring either during pregnancy (antenatal depression [AND]) or postpartum (postpartum depression [PPD])[1,2] is exceedingly common and has serious implications when not adequately identified and treated. It has been estimated that between 14% and 23% of women experience AND,[3] and up to 22% of women develop PPD within the first 12 months after delivery.[4] Yet, it has also been estimated that only 30% to 50% of women with AND or PPD are identified in clinical settings, and an even smaller number (14%–16%) receive any treatment for their symptoms.[5]

CONSEQUENCES OF PERINATAL DEPRESSION

Untreated AND has been associated with increased risks for preeclampsia and preterm birth, as well as the development of numerous chronic health complications in

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the mother, including diabetes, hypertension, and cardiovascular disease.[6–8] Furthermore, untreated AND is one of the greatest risk factors for the development of PPD.[3,9,10] Untreated PPD has been associated with unplanned weaning or lactation failure, toxic stress of the newborn, impaired bonding and attachment, and can adversely affect the mental and emotional health of the child through school-age.[11–19] PPD is often a trigger for onset of a chronic major depressive disorder, with almost 1 in 3 women continuing to struggle with depressive symptoms at least 4 years after delivery.[20] Most important, PPD is considered to be the greatest risk factor for maternal suicide and infanticide.[21]

WEIGHING THE RISKS: PSYCHOTROPIC MEDICATION AND PERINATAL DEPRESSION

The American Psychiatric Association and American Congress of Obstetrics and Gynecology both recommend either psychotherapy or antidepressant medication as first-line treatment for mild to moderate perinatal depression.[22] Many women express concern about the effects of medication on the fetus or nursing infant,[23] and prefer psychotherapy as the initial approach to their depressive symptoms.[23,24] Both cognitive–behavioral therapy and interpersonal therapy are efficacious treatments for mild to moderate perinatal depression.[25–27] A recent metaanalysis demonstrated that therapies with an interpersonal component (eg, interpersonal therapy) lead to the greatest reduction in depressive symptoms.[28] Interpersonal therapy is a particularly good fit for addressing perinatal depression given its:

1. Time-limited nature,
2. Goal of positively impacting interpersonal functioning, including the mother–infant relationship and relationship with the husband or partner, and
3. Focus on increasing social support more broadly, which is critically important for maternal well-being.[29]

Psychotherapy during the perinatal period should be delivered individually whenever possible because it leads to greater improvement in depressive symptoms compared with group therapy.[28] Although there have not been any randomized controlled trials (RCTs) of psychotherapy versus pharmacotherapy for perinatal depression, epidemiologic data suggest that, for moderate to severe symptoms, psychotherapy alone may not be sufficient, and augmentation with pharmacotherapy ought to be considered.[30] For those receiving both psychotherapy and pharmacotherapy, a multidisciplinary, integrated care team, including the prescribing physician and therapist, is critical for monitoring symptoms and working collaboratively to address both the psychosocial[31] and biological[32] aspects of perinatal depression.

When considering medication use in pregnancy, the thoughtful weighing of potential risks of untreated depressive symptoms in both the mother and developing baby compared with the risk of medication exposure is needed. No decision is completely risk free and the goal of treatment is minimization of risk with efficacy of treatment. All psychotropic medications cross the placenta and no psychotropic medication is approved by the US Food and Drug Administration (FDA) for use during pregnancy.[33] Given that gold standard RCTs for pregnant women and psychotropic medications are not available, we rely on data from case reports, case control studies, and administrative databases.[30] Potential risks to the fetus that must be considered include teratogenicity and neonatal toxicity and/or withdrawal, as well as long-term effects on development. When medication is required, often the best choice is the drug that previously demonstrated good efficacy for the individual, although this choice must be balanced against the safety of the particular drug during pregnancy. Medication

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