1. There are some occasions in a woman’s reproductive years, such as surgical or spontaneous menopause, when there are sudden decreases in estrogen or progesterone levels, or both. Are these situations also associated with depressive symptoms? What have we learned about evaluation and treatment of postpartum depression that may be applicable in these episodes?

Response from Drs. Yonkers, Vigod, and Ross:
Women also experience decreases in ovarian hormone levels during the menopausal transition and the premenstrual phase of the cycle, although the degree of change and the trajectory differ from the postpartum phase. These are periods in a woman’s life when she may be vulnerable to mood dysregulation. The relationship between perimenopause and postmenopause and depressive symptoms has been the focus of much research, including some excellent prospective studies. The consensus is that the perimenopausal interval is associated with depressive symptoms as compared to the premenopausal period, but this risk is not maintained after menopause. While historically the risk of depression after surgical menopause was thought to be high, this may have been confounded by the fact that, for a variety of reasons, women who are depressed are more likely to undergo hysterectomy, oophorectomy,
or both. Recent work has not found an increased risk of mood disturbance among women who have undergone surgical menopause.

Perimenstrual mood changes are also common, although the severity and number of symptoms vary widely. While there is consensus that premenstrual syndrome and its cousin premenstrual dysphoric disorder are experienced by about 20% and 2% of women, respectively, it is not clear that the premenstrual phase of the cycle is the most difficult time for women in general.

Common to these conditions is the efficacy of serotonin reuptake inhibitors for them. Very preliminary evidence suggests that estrogen palliates symptoms of postpartum depression, menopausal depressive symptoms, and premenstrual dysphoric symptoms. The preliminary nature of the estrogen findings needs to be underscored, and estrogen should not yet be considered first-line treatment. The value of these studies may instead lie in the realm of pathophysiology.

2. What are the specific points you cover in the informed consent process, particularly with regard to specific risks and benefits, when you counsel a pregnant woman who would benefit from the use of antipsychotics?

Response from Drs. Yonkers, Vigod, and Ross:
The goals of the informed consent process are twofold. The first is to ensure that the woman is able to decide whether or not to use antipsychotic medication in pregnancy. This involves assessing her ability to both understand the risks and benefits of treatment and to appreciate the consequences of refusing treatment. If a woman does not demonstrate this capacity, then involvement of a substitute decision-maker will be essential. The second goal of the informed consent process is to discuss the risks and benefits of treatment. The specific risks of antipsychotic drug treatment in pregnancy have not been well-studied. There are no randomized controlled trials that assess adverse events related to antipsychotic drug use. Therefore, we rely on observational data from case series, case-control studies, and retrospective cohort studies, which are often subject to bias from confounding by indication. That said, 40 years of observational data indicate no appreciable effects of first-generation antipsychotic drugs on complications related to pregnancy or delivery. There is no evidence of adverse effects on fetal development or increased risk of congenital anomalies. However, although there is no evidence of long-lasting effects, these medications have been associated with increased risk of extrapyramidal side effects (abnormal muscle movements, tremors) in newborns of mothers exposed to the drugs in the third trimester of pregnancy.
Quantifying the risks of second-generation antipsychotic drugs is more complicated. Women who take second-generation antipsychotic drugs (whether prior to or during pregnancy) are at increased risk of weight gain, diabetes, hypertension, metabolic syndrome, and thromboembolic disease. There is some evidence that this may translate into increased rates of these disorders, as well as increased rates of gestational diabetes and gestational hypertension. These morbidities may severely affect obstetric and neonatal health outcomes if they are not well managed. In addition, the U.S. Food and Drug Administration (FDA) has recently introduced a warning that these drugs are also associated with self-limited extrapyramidal side effects and withdrawal symptoms manifesting as tremor, sleepiness, and difficulty with eating or feeding in newborns. In the context of the real and theoretical risks of antipsychotic drug use in pregnancy, we must also consider the benefits of treatment. Women with untreated psychosis, mania, and severe depression in pregnancy (for whom antipsychotic drugs are most likely to be indicated) are at risk of adverse psychiatric outcomes such as self-harm, suicide (and rarely, fetal death), and increased comorbid alcohol and drug use that can severely influence birth outcomes and raise the risk of poor nutritional intake and poor antenatal care. The balance between the risks of treatment versus no treatment must be weighed for each woman, depending on her own psychiatric and obstetric history.

3. Many of the mood disorders in pregnant and postpartum women have social comorbidities (absence from work, domestic discord, failure to support dependents, etc). Do you include social workers in your clinical team? If so, what is their role?

Response from Drs. Yonkers, Vigod, and Ross:
 SV: In our perinatal mental health program, we offer a multidisciplinary, family-oriented approach to mental health care during pregnancy and the postpartum period for women with mood disorders in pregnancy. Our team comprises psychiatrists, mental health therapists, and an intake nurse. We offer individual psychiatric care and psychotherapy, mood disorder symptom management groups (facilitated by our mental health therapists), interpersonal therapy groups for women in the postpartum period, and a parenting therapy group to improve parenting in the context of maternal mental illness. Our mental health therapists are trained social workers who can work with women on the social determinants of health as well as in a psychotherapeutic framework (as appropriate). However, for more practical issues related to material resources, patients are referred to community agencies as appropriate.
4. How frequently do you encounter malingering patients? How do you determine that they are malingers?

Response from Drs. Yonkers, Vigod, and Ross:

Malingering is defined as the conscious fabrication of illness for secondary gain such as money. Factitious disorder is the conscious fabrication of illness in order to receive increased medical support and care (called taking on the “sick role”). This might be a cry for additional help or support. There have been some case reports of women who fabricated physical illnesses in pregnancy (eg, hyperglycemia) in order to take on the sick role. However, as far as we are aware, this is extremely uncommon. Clues that may help to detect factitious disorder include the following: Unusual, dramatic presentation of symptoms that defies conventional medical or psychiatric understanding; symptoms that do not respond appropriately to usual treatment or medications; emergence of new, unusual symptoms when other symptoms resolve; eagerness to undergo procedures or testing or to recount symptoms; reluctance to give access to collateral sources of information, that is, refusing to sign releases of information or to give contact information for family and friends; extensive medical history or evidence of multiple surgeries; multiple drug allergies; being part of the medical profession; and being able to forecast unusual progression of symptoms or unusual response to treatment. The Diagnostic and Statistical Manual of Mental Disorders IV Text Revision (DSM-IV-TR) indicates that malingering should be strongly suspected if any combination of the following is noted: Medico-legal context of presentation (eg, the person is referred by an attorney to the clinician for examination); marked discrepancy between the person’s claimed stress or disability and the objective findings; and lack of cooperation during the diagnostic evaluation and in complying with the prescribed treatment regimen, the presence of Antisocial Personality Disorder, or both.9

5. Because a history of mood disorders is critical to the diagnosis of the illness and prognosis for treatment outcome, how do you establish that history, particularly if records are not available or do not document prior episodes?

Response from Drs. Yonkers, Vigod, and Ross:

Medical history is helpful in all domains of medicine. If the patient can provide history of a prior manic episode, clinicians can be alerted to a possible diagnosis of bipolar disorder rather than unipolar depression. Such information can be substantiated by her current or prior psychiatrist or by a family member. This would guide clinicians to use mood stabilizers (lithium, valproate, newer antipsychotics, etc) as treatments for the mood episode. Unfortunately, if a woman has been depressed and has not evidenced a prior episode of mania, one cannot be certain that she
does not have bipolar disorder. If she has had a prior episode of depression, has received antidepressants, and has not become manic, it is unlikely that she has bipolar disorder. Hence, she can be treated with antidepressants and, if needed, psychotherapy, with less concern of mania.

6. Do you have any suggestions on how to minimize maternal side effects of antidepressants? Are there better times of the day for dosing?

Response from Drs. Yonkers, Vigod, and Ross:

The side effect profile of selective serotonin reuptake inhibitor (SSRI) and serotonin norepinephrine reuptake inhibitor (SNRI) antidepressant medications varies between medications and within individual women. For example, the same medication may make one woman feel tired and another woman unable to sleep in the 1–2 hours after a dose. Therefore, common sense and trial and error to minimize side effects should prevail. If a medication appears to be associated with fatigue, then the woman should take it at bedtime. If a medication appears to be associated with nausea, then a woman should try to take it with food and consider taking it at night. We do not recommend that women split the doses of these medications because people forget to take medication. The best way to minimize side effects is to 1) educate women that it may take 1–2 weeks to become accustomed to the medication, and that side effects related to agitation, fatigue, and gastrointestinal upset will likely subside; and 2) start medication at low doses and increase slowly (unless urgency of illness indicates a faster upward titration). We also recommend educating women about all side effects of antidepressant medication, including longer-term side effects such as sexual side effects, and establishing a baseline level of these symptoms. This will make it easier to determine what may have been caused by the medication and what may actually be a result of the underlying illness.

7. If a patient is taking an antidepressant (eg, paroxetine) and after 1 month of medication she feels that it is not helping, should a different medication be added or substituted? If the provider substitutes with another antidepressant, is overlapping (“bridging”) necessary?

Response from Drs. Yonkers, Vigod, and Ross:

If a woman has received 1 month of treatment with an antidepressant medication at an adequate dose, but has had no response at all to the medication, it is reasonable to switch to another first-line medication (ie, another SSRI or SNRI). However, if there has been a partial response to medication, then we would recommend doing one of the following: 1) waiting
several more weeks for additional response to treatment (people may remit up to 8 weeks of treatment); 2) increasing the dose to determine whether this induces greater symptom response; or 3) adding an adjunctive medication to optimize treatment (augmentation). When switching between SSRIs and SNRIs, medications can usually be substituted for one another without tapering the first medication, although we ask providers to refer to manufacturer’s prescribing guidelines for detailed directions on how to switch between psychotropic medications. There are some notable exceptions to this recommendation; venlafaxine (Effexor) and paroxetine (Paxil) should be tapered to avoid discontinuation effects. Augmentation strategies are best used under the direction of a psychiatric specialist.

8. You did not mention antidepressants in your discussion of preventive interventions. Is there a role for antidepressants in a woman with increased risk for postpartum depression?

Response from Drs. Yonkers, Vigod, and Ross:
Limited data suggest that antidepressant treatment is no different from careful monitoring in the prophylaxis of unipolar depression among women with recurrent episodes. In one study, women with a prior episode of postpartum depression were randomized to active medication or placebo as soon as they delivered. However, women were seen weekly for assessments and this level of support may have enhanced the well-being of women randomized to placebo, such that no difference between groups was found. Patients are often the best guide to reinstatement of medication after delivery. Sometimes women have contended with low levels of symptoms during pregnancy in order to avoid fetal exposure. As soon as they deliver, they prefer to resume medication. Others would rather wait and see and contact their provider if they notice that depressive symptoms are recurring.

9. How should a fetus be monitored in a woman receiving electroconvulsive therapy or repetitive transcranial magnetic stimulation for major depressive disorder or bipolar disorder?

Response from Drs. Yonkers, Vigod, and Ross:
Repetitive transcranial magnetic stimulation is not a treatment that should be offered pregnant women, since we have little understanding of the risks. However, electroconvulsive therapy is sometimes indicated for pregnant women with mood disorders. During the treatment, obstetric fetal monitoring can provide information on the fetus and identify episodes of bradycardia. The pregnant woman can be placed in a position that elevates her right hip, which will decrease the risk of aorto-caval compression. Muscle relaxants, such as succinylcholine, are typically given.
during electroconvulsive therapy. The small amounts should not affect the fetus. Some suggest that seizure duration in mothers be minimized.11

10. Obstetricians provide care not only for the woman with psychosis but also for her fetus. Are there any indications for hospitalization, other than suicidal or homicidal ideation?

Response from Drs. Yonkers, Vigod, and Ross:
Psychiatric hospitalization may be indicated at any time in pregnancy or the postpartum period for safety reasons, for intensive psychiatric care that cannot be provided in an outpatient setting, or for both. In addition to suicidal and homicidal ideation, safety reasons for hospitalization might include an inability of the woman to take care of herself because of mental incapacity that is likely to result in substantial physical impairment to herself or others. An example of this in pregnancy might include extremely poor hygiene and nutritional status due to thought disorder of active psychosis. Another example might be when a woman’s judgment is severely compromised by a manic episode such that she is unable to make safe decisions about herself and her fetus or infant. There are also situations where voluntary hospitalization might be indicated for a woman suffering from severe mood or psychotic disorder, or both, in pregnancy and the postpartum period. This might involve medication initiation in the setting of need for obstetric or fetal monitoring, use of electroconvulsive therapy, or need for intensive psychiatric treatment in the absence of a day-treatment setting.

References:


