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Treating perinatal mood and anxiety disorders: A call to action

WHEN COHEN ET AL¹ PUBLISHED their 2006 landmark study on relapse of depression during pregnancy, they stated in the Comment section, "There has been a common belief that characteristic hormonal changes associated with pregnancy are inherently 'protective' with respect to ... depression ... and that discontinuation of psychiatric medications should be almost uniformly pursued given concerns regarding prenatal exposure to these agents."

We now know that pregnancy confers no such protection. One in 5 individuals giving birth in the United States experiences a mood disorder during the perinatal period (during pregnancy or up to 1 year post partum).² Anxiety is the most common (20.7%),³ followed by depression (12.1%).⁴ Other conditions such as mania, postpartum psychosis, or posttraumatic stress disorder are less common, but can create an outsized effect on the health and life trajectories of those affected.

Various factors drive the high incidence of perinatal mood and anxiety disorders. During pregnancy, a massive influx of estrogen and progesterone, which are both sex hormones and neuroactive steroids, promote neuroplasticity.² Accordingly, the brain undergoes significant neuroanatomic remodeling during the perinatal period. These changes are most pronounced in the regions involved in emotional regulation and social cognition: the prefrontal cortex, hippocampus, and amygdala. The perinatal period thus invites parents to imagine new ways of relating to the world around them, and for individuals with biologic and psychosocial vulnerabilities, these new thought patterns may be maladaptive.

■ MOOD DISORDERS ARE COMMON BUT OFTEN UNTREATED

Untreated perinatal mood and anxiety disorders create an environment of psychosocial toxicity that devolves

into longitudinal adversity. Studies show that depressed parents are less able to engage in productive relationships, including with their newborn children.² Maternal depression in the postpartum year is also strongly associated with an increased unemployment risk for up to 15 years after childbirth,⁵ with an estimated societal cost of nearly \$31,800 per affected mother-child dyad over the first 6 years.⁶ This can disproportionately impact the 41% of mothers who are primary earners.⁷ Meanwhile, the leading cause of death for mothers in the first year post partum is untreated mental health disorders, outranking serious conditions such as hemorrhage and hypertensive disease.⁸

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In 2015, the American College of Obstetricians and Gynecologists⁹ began recommending universal depression screening in pregnancy, and the US Preventive Task Force¹⁰ followed suit in 2016. A study of privately insured individuals showed that the perinatal mood and anxiety disorder detection rate rose 93% across all states, ages, races, and ethnicities from 2015 to 2020.¹¹ However, exactly what to do after a positive screening result still remains uncertain for many patients and clinicians.

Currently, perinatal mood and anxiety disorders remain untreated in 3 of 4 affected individuals giving birth,¹² and the discrepancy between needing care and receiving care is highest in our most vulnerable populations: the marginalized, the socioeconomically disadvantaged, the isolated, and the inadequately insured. More than half of US counties lack a practicing psychiatrist, and that statistic rises to 80% in rural counties.¹³ While accessing a psychiatrist via telehealth might mitigate some of these shortages, the reality is that over a quarter of rural counties lack access to reliable broadband,¹⁴ and some health insurance companies are choosing to restrict telehealth access now

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that the flexibilities enacted during the COVID-19 pandemic have expired.¹⁵ Moreover, there are fewer than 500 specially trained reproductive psychiatrists in the entire United States, while more than 800,000 women each year experience perinatal mental health complications.¹²

■ PRIORITIZING PERINATAL MENTAL HEALTH TREATMENT

Where does that leave our patients who struggle with their mental health while juggling the responsibilities of a growing family? Many will rely on the knowledge and judgment of non-mental health specialists, ie, obstetricians and primary care clinicians. It is noteworthy that more than half of women discontinue antidepressant medications during pregnancy.¹⁶ Yet, 53% of these women will end up back on antidepressants in the postpartum period, as the risk of symptom recurrence is 50% to 70% even in those who were euthymic at the time of discontinuation.

A risk-risk discussion

Treatment decisions during pregnancy should therefore be framed as a risk-risk discussion. Lack of treatment is not neutral—untreated perinatal mood and anxiety disorders themselves are associated with adverse obstetrical and neurodevelopmental outcomes.² Decades of quality, peer-reviewed research have demonstrated the favorable safety profile of selective serotonin reuptake inhibitors (SSRIs), the most commonly prescribed class of medications for depression and anxiety.¹⁷ Women with depression who are treated with SSRIs during pregnancy exhibit no clinically significant increased risk of miscarriage, fetal growth restriction, preterm birth, cesarean birth, or adverse neurodevelopmental outcomes compared with those with untreated depression.¹⁸ SSRIs are also widely considered compatible with breastfeeding because low amounts of these medications pass into breast milk.²

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Meanwhile, risks that do exist should be put into proper context. The baseline risk of birth defects in all pregnancies is about 3%.¹⁹ Exposure to an SSRI during pregnancy, including paroxetine, increases the risk of birth defect by less than 1%.¹⁷ Persistent pulmonary hypertension of the newborn occurs in an additional 1 to 2 per 1,000 infants when exposed to SSRIs during pregnancy,²⁰ but this serious illness can also occur in the absence of SSRI use.² In addition, poor neonatal adaptation syndrome can occur in 15% to 30% of infants exposed to an SSRI during pregnancy, but the symptoms are mild for most and resolve within 2 weeks after delivery.²⁰

Traditional antidepressants vs novel ones

Timing is another consideration that significantly impacts a patient's quality of life. Traditional antidepressants like SSRIs must be used for 4 to 6 weeks at a therapeutic dose to yield significant clinical benefit. Today, postpartum patients have access to a new medication class that mimics the action of progesterone metabolites at the gamma-aminobutyric acid receptor. The rapid onset of these medications can produce reductions in depression scores within days. While more research is needed on which populations benefit most from traditional antidepressants vs novel ones, patients and clinicians alike now have more options to treat these serious mental health conditions.

As Ortiz Worthington et al²¹ discuss in this month's issue of the *Journal*, it is imperative that obstetricians and primary care clinicians achieve basic competency in managing psychiatric disorders during the perinatal period. If we hope to see improved mental wellness for our mothers, families, and communities, we must all play an active role. ■

■ DISCLOSURES

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