Maternal Behavioral Health: Assessment, Prescribing and Management

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Disclosures

Some slides adopted from talks also given by Drs. Jennifer Payne and Lauren Osborne

Session Objectives

Participants will ….

- gain an appreciation for the prevalence of perinatal depression and anxiety symptoms.
- learn how perinatal depression and anxiety can present differently and specific assessment tools to help measure symptoms and aide in diagnosis.
- learn the potential risks of untreated perinatal psychiatric illness to mother and neonate/infant versus the risks of perinatal psychotropic medication exposure.
- learn how to effectively engage patients in risk/risk discussions and develop a comprehensive treatment plan.
- learn about scientific and clinical resources to continue an evidence-based practice.

Agenda

- Prevalence of mood and anxiety disorder in pregnancy.
- Types of mood and anxiety disorders that are most common in the perinatal periods.
- Vulnerable/at-risk populations.
- Risks of untreated psychiatric illness to mother, pregnancy, neonate and infant.
- Risks of using psychotropic medications in pregnancy and breastfeeding.
- General rules to prescribing in pregnancy, the postpartum and breastfeeding.
- Alternatives to medications.
- Assessment Tools and Resources

Prevalence of Peripartum Mood and Anxiety Disorders?

- Antepartum depression affects 10-15% of women
- Antepartum depression is a risk factor for postpartum depression (PPD)
- PPD depression affects up to 20% of women (CDC: 1/8 women).
- Women with pre-existing mood disorders at increased risk: 20-50%!
- Peripartum Anxiety is under-recognized! Range: 5-40%
- Prevalence of postpartum anxiety ~10%, 6% GAD!

Relapse of Mood Disorders Across the Peripartum

- The rate of relapse in women with mood disorders who stop their medications for pregnancy is very high:
  - 70% in Major Depression
  - 85-95% or more in Bipolar Disorder
- The rate of relapse in women with mood disorders who continue their medications for pregnancy is not zero:
  - 26% in Major Depression
  - 23-33% in Bipolar Disorder
- 23X more likely to be psychiatrically admitted in the first year postpartum than any other time in their lives.
- Women w/ Hx of Bipolar Disorder at particular risk!

Types of Peripartum Episodes

- "Baby Blues"/ Postpartum Blues
- Perinatal Depression
- Perinatal Anxiety
- Post traumatic stress disorder
- Obsessive Compulsive Disorder
- Postpartum Psychosis

Screening for Peripartum Episodes

Massachusetts Child Psychiatry Access Program
MCPAP For Moms

Summary of Emotional Complications During Pregnancy and the Postpartum Period

	Baby Blues	Perinatal Depression	Perinatal Anxiety	Posttraumatic Disorder (PTSD)	Obsessive-Compulsive Disorder	Postpartum Psychosis
What is it?	Common and temporary experience right after childbirth when a new mother may have sudden mood swings, feeling very happy, then very sad, or cry for no apparent reason.	Depressive episode that occurs during pregnancy or within a year of giving birth.	A range of anxiety disorders, including generalized anxiety, panic, social anxiety and PTSD, experienced during pregnancy or the postpartum period.	Distressing anxiety symptoms experienced after traumatic events(s).	Intrusive repetitive thoughts that are scary and do not make sense to mother/expectant mother. Rituals (e.g., counting, cleaning, hand washing). May occur with or without depression.	Very rare and serious. Sudden onset of psychotic symptoms following childbirth (increased risk with bipolar disorder). Usually involves poor insight about illness/symptoms, making it extremely dangerous.
When does it start?	First week after delivery. Peaks 3-5 days after delivery and usually resolves 10-12 days postpartum.	Most often occurs in the first 3 months postpartum. May begin after weaning baby or when menstrual cycle resumes.	Immediately after delivery to 6 weeks postpartum. Occasionally begins after weaning baby or when menstrual cycle resumes.	May be present before pregnancy/birth. Can present as a result of traumatic birth. Underlying PTSD can also be worsened by traumatic birth.	1 week to 3 months postpartum. Occasionally begins after weaning baby or when menstrual cycle resumes. May also occur in pregnancy.	Typically presents rapidly after birth. Onset is usually between 2 – 12 weeks after delivery. Watch carefully if sleep deprived for ≥48 hours.
Risk factors	Life changes, lack of support and/or additional challenges (difficult pregnancy, birth, health challenges for mom or baby, twins). Prior pregnancy loss. Dysregulated baby-crying feeding, sleep problems.	Life changes, lack of support and/or additional challenges (difficult pregnancy, birth, health challenges for mom or baby, twins). Prior pregnancy loss. Dysregulated baby-crying feeding, sleep problems.	Life changes, lack of support and/or additional challenges (difficult pregnancy, birth, health challenges for mom or baby, twins). Prior pregnancy loss. Dysregulated baby-crying feeding, sleep problems.	Lack of partner support, elevated depression symptoms, more physical problems since birth, less health promoting behaviors. Prior pregnancy loss. Dysregulated baby-crying feeding, sleep problems.	Family history of OCD, other anxiety disorders. Depressive symptoms. Prior pregnancy loss. Dysregulated baby-crying feeding, sleep problems.	Bipolar disorder, history of psychosis, history of postpartum psychosis (80% will relapse), family history of psychotic illness, sleep deprivation, medication discontinuation for bipolar disorder (especially when done quickly). Prior pregnancy loss. Dysregulated baby-crying feeding, sleep problems.
How long does it last?	A few hours to a few weeks.	2 weeks to a year or longer. Symptom onset may be gradual.	From weeks to months to longer.	From 1 month to longer.	From weeks to months to longer.	Until treated.
How often does it occur?	Occurs in up to 85% of women.	Occurs in up to 19% of women.	Generalized anxiety occurs in 6-8% in first 6 months after delivery. Panic disorder occurs in .5-3% of women 6-10 weeks postpartum. Social anxiety occurs in 0.2-7% of early postpartum women.	Occurs in 2-15% of women. Presents after childbirth in 2-9% of women.	May occur in up to 4% of women.	Occurs in 1-2 or 3 in 1,000 births.
What happens?	Women experience dysphoric mood, crying, mood lability, anxiety, sleeplessness, loss of appetite, and irritability. Postpartum depression is independent of blues, but blues is a risk factor for postpartum depression.	Change in appetite, sleep, energy, motivation, and concentration. May experience negative thinking including guilt, hopelessness, helplessness, and worthlessness. May also experience suicidal thoughts and evolution of psychotics symptoms.	Fear and anxiety, panic attacks, shortness of breath, rapid pulse, dizziness, chest or stomach pains, fear of detachment/doom, fear of going crazy or dying. May have intrusive thoughts.	Change in cognition, mood, arousal associated with traumatic event(s) and avoidance of stimuli associated with traumatic event.	Disturbing repetitive thoughts (which may include harming baby), adapting compulsive behavior to prevent baby from being harmed (secondary to obsessional thoughts about harming baby that scare women).	Mood fluctuation, confusion, marked cognitive impairment. Bizarre behavior, insomnia, visual and auditory hallucinations and unusual (e.g. tactile and olfactory) hallucinations. May have moments of lucidity. **May include altruistic delusions about infanticide and/or homicide and/or suicide that need to be addressed immediately.**
Resources and treatment	May resolve naturally. Resources include support groups, psycho-education (see MCPAP for Moms website and materials for detailed information) and sleep hygiene (asking/accepting other help during nighttime feedings). Address infant behavioral dysregulation -crying, sleep, feeding problems- in context of perinatal emotional complications.	For depression, anxiety, PTSD and OCD, treatment options include individual therapy, dyadic therapy for mother and baby, and medication. Resources include support groups, psycho-education, and complementary and alternative therapies including exercise and yoga. Encourage self-care including healthy diet and massage. Encourage engagement in social and community supports (including support groups) (see MCPAP for Moms website and materials for detailed resources). Encourage sleep hygiene and asking/accepting help from others during nighttime feedings). Address infant behavioral dysregulation -crying, sleep, feeding problems- in context of perinatal emotional complications. Additional complementary and alternative therapies options for depression include bright light therapy, Omega-3, fatty acids, acupuncture and folate.				**Requires immediate psychiatric help. Hospitalization usually necessary.** Medication is usually indicated. If history of postpartum psychosis, preventative treatment is needed in subsequent pregnancies. Encourage sleep hygiene for prevention (e.g. consistent sleep/wake times, help with feedings at night).

[1] Adapted from Susan Hickman, Ph.D., Director of the Postpartum Mood Disorder Clinic, San Diego; Valerie D. Raskin, M.D., Assistant Professor of Clinical Psychiatry at the University of Chicago, IL ("Parents" September 1996)

[2] **O'Hara MW, Wisner KL. Perinatal mental illness: Definition, description and aetiology. Best Pract Res Clin Obstet Gynaecol. 2013 Oct 7. pii: S1521-6934(13)00133-8. doi: 10.1016/j.bpobgyn.2013.09.002. [Epub ahead of print]**

Screening for Peripartum Episodes

	Baby Blues	PPD	PPA	PTSD	OCD	PPP
What?	Common (80%), weepy, mood swings	Depressive episode	GAD, Specific Phobia, Panic, PTSD	anxiety symptoms experienced after traumatic events(s).	Scary/upsetting intrusive repetitive thoughts/ impulses and behaviors to reduce thoughts	Very rare and serious. Mood fluctuation, confusion.Bizarre behavior, Hallucinations
When?	3-5 days	Pregnancy or up to 1 year pp	Pregnancy or up to 1 year pp	Pregnancy or up to 1 year pp	1 wk to 3 mos pp	2 to 12 wks pp
Ask?	Felt overwhelmed? Crying for no reason?	Bad mother? Hopeless? Guilty? Worthless? Bonding?	Fears? Many worries? Panic? Unwanted thoughts?	Prior losses? Traumatic birth?	Upsetting thoughts? Are you checking on baby? Avoiding baby due to fear?	Sleeping at night? Beliefs about baby? ASK FAMILY!!

Risk Factors

- History of Major Depression, Bipolar disorder or other psychiatric illness
- Previous Postpartum Depression or Psychosis (80% recurrence!)
- Family History of Postpartum Illness
- History of severe **PMS or PMDD**
- Stress
- Poor social support
- Marital discord
- Low SES

What is Premenstrual Dysphoric Disorder?

- Criterion A: Must have ≥5 symptoms present in luteal week, remit after menses, majority of cycles in past 1y.
- Criterion B: Must have 1 core mood symptom.

1. **Affective lability** (tearful, sensitive to rejection)
2. **Irritability** / anger / interpersonal conflicts
3. **Low mood** / hopeless / self-deprecating thoughts
4. **Anxiety** / tension

- Criterion C: Must have 1.

1. **Decreased interest**
2. **Difficulty concentrating**
3. **Low energy**
4. **Appetite** changes / food cravings
5. **Sleep disturbance** (hypersomnia / insomnia)
6. **Overwhelmed** / out of control
7. **Physical sx** (headaches, breast tenderness)

- Criterion D: Distress / impairment
- Criterion E: Not exacerbation of other disorder
- Criterion G: Not due to substances / medical condition

Questions to ALWAYS ask

- Personal history of PPD? Mother or sister with PPD?
- Mood Symptoms prior to menses that affect functioning? Relationships?
- How was the delivery? Anything traumatic or upsetting?
- Sleeping when baby sleeps?
- Upsetting thoughts, impulses or images?
- Repeated checking behaviors (e.g. baby breathing, internet, cleaning bottles?)
- Bonding with baby? Avoiding baby?
- Feeling hopeless? Suicidal? What would you do with your baby/child(ren)?
  - **Whenever a mother is suicidal must ask about plans for children – infanticide!**

Edinburgh Postnatal Depression Scale

In the past 7 days:

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   - ☐ As much as I always could
   - ☐ Not quite so much now
   - ☐ Definitely not so much now
   - ☐ Not at all

2. I have looked forward with enjoyment to things
   - ☐ As much as I ever did
   - ☐ Rather less than I used to
   - ☐ Definitely less than I used to
   - ☐ Hardly at all

*3. I have blamed myself unnecessarily when things went wrong
   - ☐ Yes, most of the time
   - ☐ Yes, some of the time
   - ☐ Not very often
   - ☐ No, never

4. I have been anxious or worried for no good reason
   - ☐ No, not at all
   - ☐ Hardly ever
   - ☐ Yes, sometimes
   - ☐ Yes, very often

*5 I have felt scared or panicky for no very good reason
   - ☐ Yes, quite a lot
   - ☐ Yes, sometimes
   - ☐ No, not much
   - ☐ No, not at all

*6. Things have been getting on top of me
   - ☐ Yes, most of the time I haven't been able to cope at all
   - ☐ Yes, sometimes I haven't been coping as well as usual
   - ☐ No, most of the time I have copied quite well
   - ☐ No, I have been coping as well as ever

*7 I have been so unhappy that I have had difficulty sleeping
   - ☐ Yes, most of the time
   - ☐ Yes, sometimes
   - ☐ Not very often
   - ☐ No, not at all

*8 I have felt sad or miserable
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Not very often
   - ☐ No, not at all

*9 I have been so unhappy that I have been crying
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Only occasionally
   - ☐ No, never

*10 The thought of harming myself has occurred to me
   - ☐ Yes, quite often
   - ☐ Sometimes
   - ☐ Hardly ever
   - ☐ Never

Why Treat Peripartum Mood and Anxiety Disorders?

- Antepartum depression increases risk for postpartum depression!
- Suicide is a major cause of maternal death and accounts for up to 20% of all postpartum deaths.
- PPD is associated with the following in exposed children:
  - Lower IQ
  - Slower language development
  - ADHD
  - Behavioral problems
  - Psychiatric illness

Adverse Pregnancy Outcomes Associated with Antenatal Depression

- Preterm delivery (OR ~ 1.5)
- Low birth weight (OR ~ 2)
- Decreased motor tone and activity in the baby
- Higher cortisol levels in the baby
- Poor reflexes in the baby
- ADHD and behavioral problems, particularly in boys

You have two patients!

- Treatment potentially benefits both the mom ***and*** fetus.
- ***Failure to treat*** poses potential risks to both the mom ***and*** fetus.

Discussion about Psychotropic Medication in Pregnancy

- Not truly a Risk-Benefit Discussion
- Risk-Risk Discussion
- Risks associated with medication exposure
- Risks associated with untreated psychiatric illness for mom and exposure to illness for baby

Problems with original literature !!

Most studies don't control for:

- Underlying psychiatric illness
- Severity of psychiatric illness
- Risk factors that are found in a higher rate in the psychiatric population (Diabetes, Smoking, Substance Use, Obesity etc)
- Whether or not the mother was psychiatrically ill during pregnancy
- Multiple medications
- NO RCTs!
- Confounding by indication!

Recent Literature

- Studies which compare
  - pregnant women with depression taking meds
  - pregnant women with depression NOT taking meds

- Generally, do NOT find associations between antidepressants and
  - Heart Defects
  - Persistent Pulmonary Hypertension
  - Autism

Outcome of Interest	Unadjusted Odds Ratio for Exposure to SSRI's	Adjusted for Psychiatric Illness	Adjusted for Severity of Illness and/or Other Confounds
Cardiac Defects	1.25 (1.13-1.38)	1.12 (1.00-1.26)	1.06 (0.93-1.22)
Preterm Birth	1.44 (1.34-1.56)	1.61 (1.26-2.05)	1.53 (1.40-1.66)
Persistent Pulmonary Hypertension	1.51 (1.35-1.69)	1.36 (1.18-1.57)	1.10 (0.94-1.29)
Autism-Pooled Case Control	1.7 (1.3-2.3)	1.4 (1.0-2.0)	
Autism-Pooled Cohort	1.8 (1.3-2.6)	1.5 (0.9-2.7)	

Poor Neonatal Adaptation Syndrome

- What is it?
  - Cluster of symptoms seen in infants exposed to SSRIs during the 3rd trimester.
  - Also seen in TCAs, other meds, and no meds
  - Symptoms range from: irritability, crying, tremor, hyperreflexia, vomiting, sz, and respiratory distress.
  - Tends to be transient
- Approximately 1/3 of exposed infants will have at least mild symptoms. Risk increases when multiple agents are on board, particularly benzodiazepines.
- No blinded studies examining whether these symptoms are more common in exposed infants "Withdrawal"? or toxicity? Not related?
- NOT enough evidence from safety perspective to recommend tapering of antidepressants in the 3rd trimester.

MOOD STABILIZERS

Valproic Acid and Carbamazepine should NOT be used in pregnancy

- VA: 10% rate of malformations including: NTDs, craniofacial anomalies, cardiac defects , cleft palate and hypospadias.
- Carbamazapine: Spina bifida, NTDs, skeletal issues, hypospadias, neonatal hemorrhage.
- IF continued.. USE high dose Folate 4mg/day and 2nd trimester ultrasound.
- Both OKAY for breastfeeding

MOOD STABILIZERS

Lamotrigine:

- NO increased risk of congenital defects. (N=3.9 million births).
- Levels may decrease over the course of pregnancy (blood volume and estrogen induced metabolic changes) and need to be adjusted.
- Considered safe in breastfeeding

Lithium:

- 1st Trimester exposure associated with Epstein anomaly.
  - Recent pooled analysis <1% of exposed children.
  - High resolution cardiac ultrasound
- Perinatal toxicity w/ hypotonia, cyanosis, DI and goiter
- Follow-up of children to age 5 – no difference from controls
- Monitor levels over pregnancy, reduce to pre-pregnancy dose after delivery.
- Breastfeeding tricky but not contraindicated.

Antipsychotics

- Data still emerging (less known), but reassuring!
- Risks of not using likely greater than using given serious psychiatric illness.
- Quetiapine, Risperdal, Haloperidol and Olanzapine have lowest placental transfer.
- Monitor for gestational diabetes.
- Unknown long-term developmental outcomes of SGAs. But FGAs showed no difference in IQ or behavior of children at age 5.
- Breastfeeding: levels low but need more data. Monitor for EP symptoms.

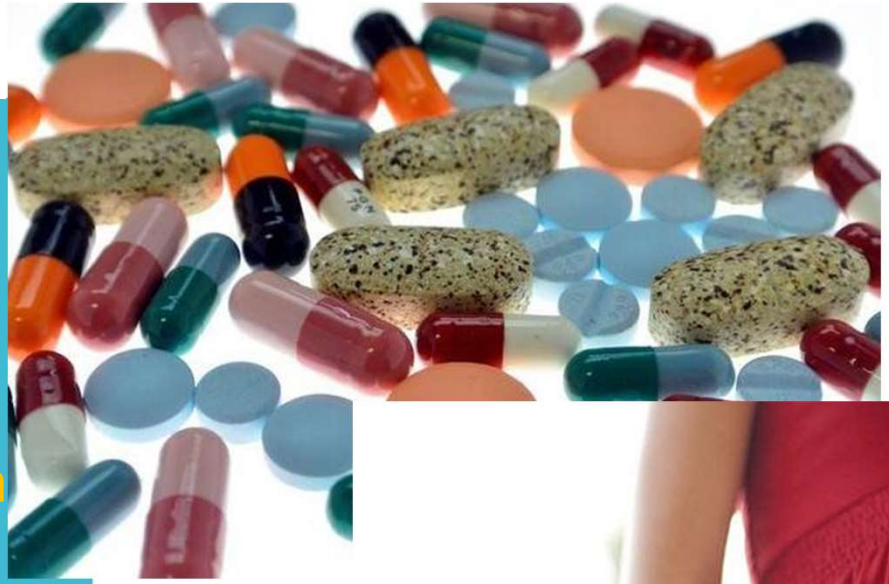
ANTI-ANXIETY AGENTS

- BENZODIAZAPINE:
  - Early studies showed association with cleft-lip, more recent showed risk is very low.
  - SSRI + Benzo = may increase risk for congenital heart defects
  - Short acting agents preferred (Ativan!) to reduce sedation and risks of respiratory suppression at delivery and with breastfeeding.
- GABAPENTIN:
  - Low risk for congenital malformations.
  - Some studies: pre-term delivery, low birth weight
- BUSPIRONE:
  - Little known! No human studies.
- OVERALL: Utility for panic and insomnia and prevent worsening of psychiatric symptoms may outweigh risks

STIMULANTS

- Sparse well-controlled data
- May be a low associated risk of cardiac malformations with methylphenidate, but not amphetamines.
- Small increase relative risk for:
  - pre-eclampsia, placental abruption, fetal growth restriction, fetal hypoxia and preterm delivery.
  - BUT lots of confounds – drawn from data on drugs of abuse.
- CONSIDER risks of:
  - Driving safety without medications
  - Workplace functioning
- Limited data on breastfeeding

General Rules for Medication Plans During Pregnancy



RULE ONE

Assume all women of reproductive age will get pregnant!

- 50% of pregnancies are not planned
- Ask about contraception
- Think about psychotropics PRIOR to conception and modify as needed
- Pre-pregnancy planning ideally done 6-12 months before pregnancy
- Euthymic on pregnancy regimen before conception

RULE TWO

Limit the number of exposures for the baby

- Exposure to psychiatric illness counts
  - goal to keep Mom **well** during pregnancy to eliminate this exposure
- Maintain Mom on as **few** medications as possible
  - Try to make medications changes before pregnancy
  - make sure that Mom is **stable** before getting pregnant

RULE THREE

OLDER IS BETTER

- Use medications that we know more about
  - Older=Better (generally)
  - Epilepsy literature increases samples sizes
  - FDA categories not very useful- phasing out

RULE FOUR

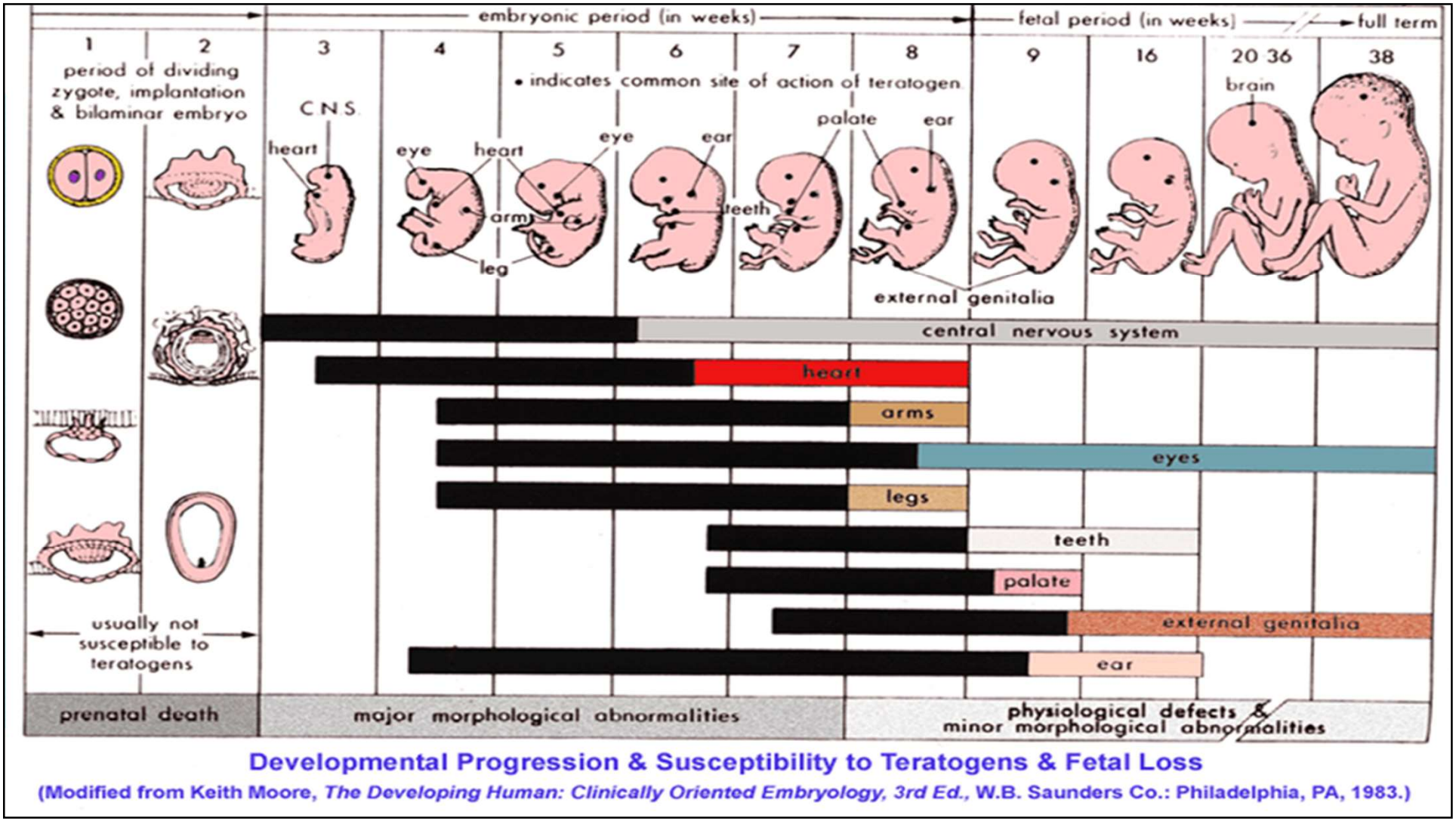
MONITOR CLOSELY

- Monitor blood levels when possible
- Consider prophylactic increases (or decreases) to maintain blood level
- **Don’t undertreat!**
- If you increase during pregnancy consider decreasing postpartum

RULE FIVE

ADAPT !! If unplanned pregnancies occur

- Taper medications that you want to try to discontinue
- Don’t switch to an older medication- baby is already exposed



Developmental Progression & Susceptibility to Teratogens & Fetal Loss

(Modified from Keith Moore, *The Developing Human: Clinically Oriented Embryology, 3rd Ed.*, W.B. Saunders Co.: Philadelphia, PA, 1983.)

RULE SIX

DISCUSS BREASTFEEDING EARLY

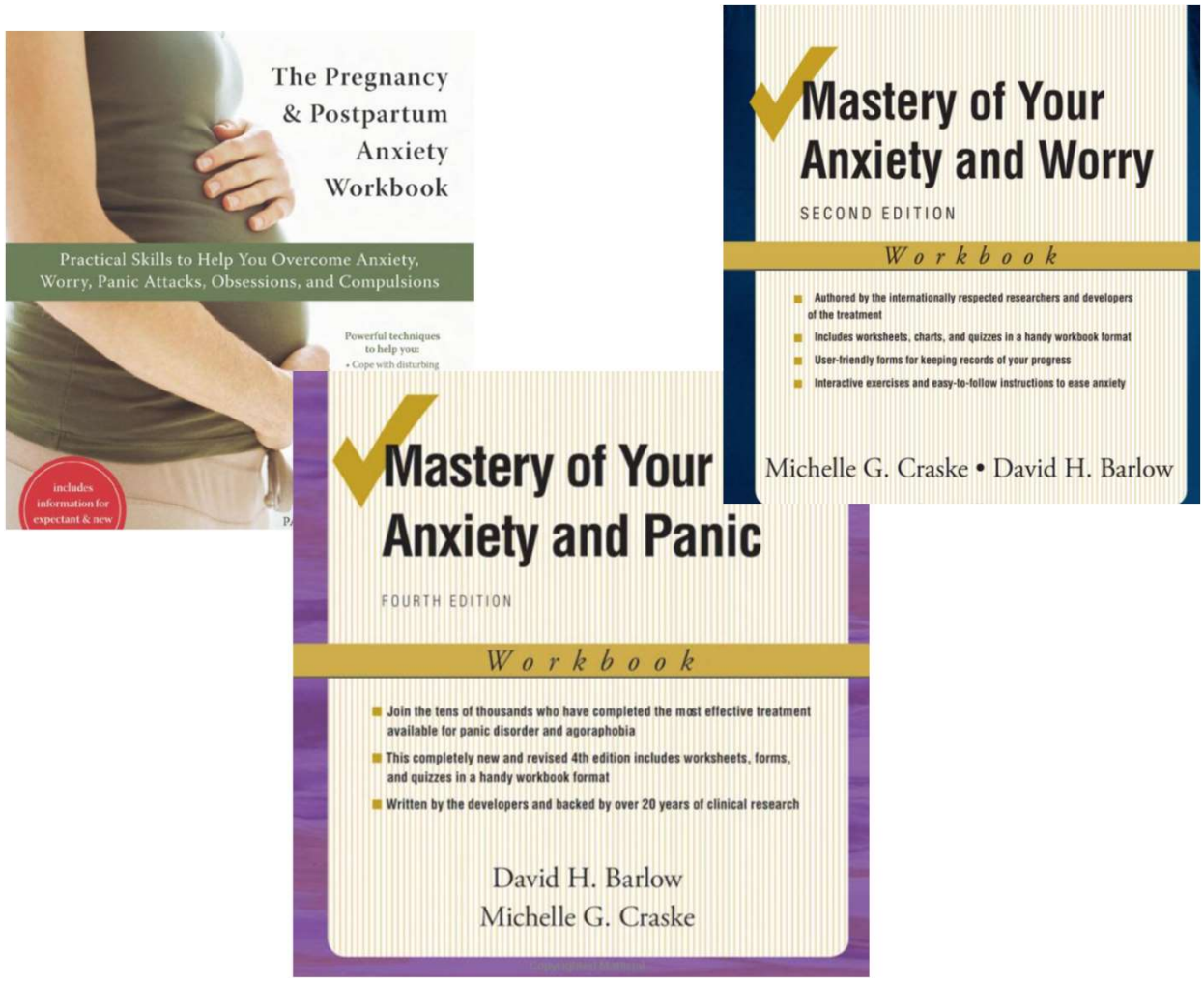
- **Most psychiatric medications can be used during breastfeeding**
- Possible exceptions: lithium, clozapine
- **Do not switch** to a different medication from one used in pregnancy unless mom is ill
- **Do not switch** to a different medication from one used in pregnancy because it has lower levels in breast milk
- Discuss sleep preservation and feeding plan!

ALTERNATIVES

Psychotherapy!!

- There have been a number of studies of various types of psychotherapy for depression during and after pregnancy
- Interpersonal Therapy best studied
- Cognitive Behavioral Therapy also shows promise
- Mindfulness Based CBT also shows promise
- Need more well-designed, randomized trials

Personal Favorites



ALTERNATIVES

EXCERCISE

- Exercise was as effective as sertraline in two separate studies.
- A meta-analysis confirmed efficacy as stand-alone and as adjunctive to medication in MDD
- One study of aerobic exercise during pregnancy that showed reduced depressive symptoms in women without a psychiatric history.
- No studies in pregnant women with mood disorders, for treatment or prevention

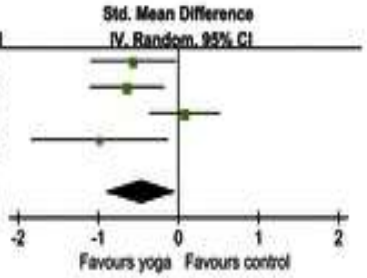
ALTERNATIVES

YOGA AND ACUPUNCTURE

A

Study or Subgroup	Yoga Mean	Yoga SD	Yoga Total	Control Mean	Control SD	Control Total	Weight	Std. Mean Difference IV, Random, 95% CI
Field et al. 2012	-8.23	8.79	28	-3.38	8.15	28	25.8%	-0.56 [-1.10, -0.03]
Field et al. 2013a	-8.9	8.65	37	-2.8	10.11	38	28.6%	-0.64 [-1.11, -0.18]
Field et al. 2013b	-9.2	8.76	40	-9.9	9.05	39	29.5%	0.08 [-0.36, 0.52]
Mitchell et al. 2012	-9.58	8.46	12	-1	8.37	12	16.1%	-0.96 [-1.84, -0.13]
Total (95% CI)			117			117	100.0%	-0.46 [-0.90, -0.03]

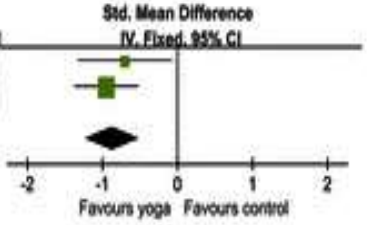
Heterogeneity: $Tau^2 = 0.12$; $Chi^2 = 7.69$, df = 3 (P = 0.05); $I^2 = 61\%$
Test for overall effect: Z = 2.08 (P = 0.04)



B

Study or Subgroup	Yoga Mean	Yoga SD	Yoga Total	Control Mean	Control SD	Control Total	Weight	Std. Mean Difference IV, Fixed, 95% CI
Newham et al. 2014	-0.79	3.69	29	1.94	4.06	16	31.2%	-0.70 [-1.33, -0.07]
Satyapriya et al. 2013	-1.96	2.04	51	0.25	2.58	45	68.8%	-0.95 [-1.37, -0.53]
Total (95% CI)			80			61	100.0%	-0.87 [-1.22, -0.52]

Heterogeneity: $Chi^2 = 0.41$, df = 1 (P = 0.52); $I^2 = 0\%$
Test for overall effect: Z = 4.86 (P < 0.00001)



ALTERNATIVES

LIGHT BOX THERAPY

- Established therapy for Seasonal Affective Disorder
- Has also been shown to be helpful in non-seasonal depression
- Three studies have shown that LBT was effective in treating depression in pregnant women with MDD
- No studies on prevention

TRAUMA INFORMED CARE

- About half of all women in the US will be exposed to at least one traumatic event in their lifetime.
- Approximately 8% of women have PTSD in pregnancy or postpartum, and fewer (3%) develop new onset of PTSD after a traumatic childbirth.
- As many as 1/3 of women rate their delivery as significantly distressing
- In USA, 16% of pregnancies end in spontaneous abortion (SAB) or stillbirth
- About 19% of pregnancies end in elective abortion (EAB)
- 12-32% of SABs and EABs can lead to PTSD

TRAUMA INFORMED CARE

- Approximately 324,000 pregnant women are abused each year in the United States.
- Associated with poor pregnancy weight gain, infection, anemia, tobacco use, stillbirth, pelvic fracture, placental abruption, fetal injury, preterm delivery, and low birth weight
- Homicide has been reported as a leading cause of maternal mortality, with the majority perpetrated by a current or former intimate partner.

https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2012/02/intimate-partner-violence

Types of Violence

Therapy

- Prolonged Exposure (PE)
  gain control by facing your negative feelings through exposure.
- Cognitive Processing Therapy (CPT)
  reframe negative thoughts about the trauma. talking with a provider about negative thoughts and doing short writing assignments.
- Eye Movement Desensitization and Reprocessing (EMDR)
  . It involves calling the trauma to mind while paying attention to a back-and-forth movement or sound (like a finger waving side to side, a light, or a tone).

https://www.ptsd.va.gov/

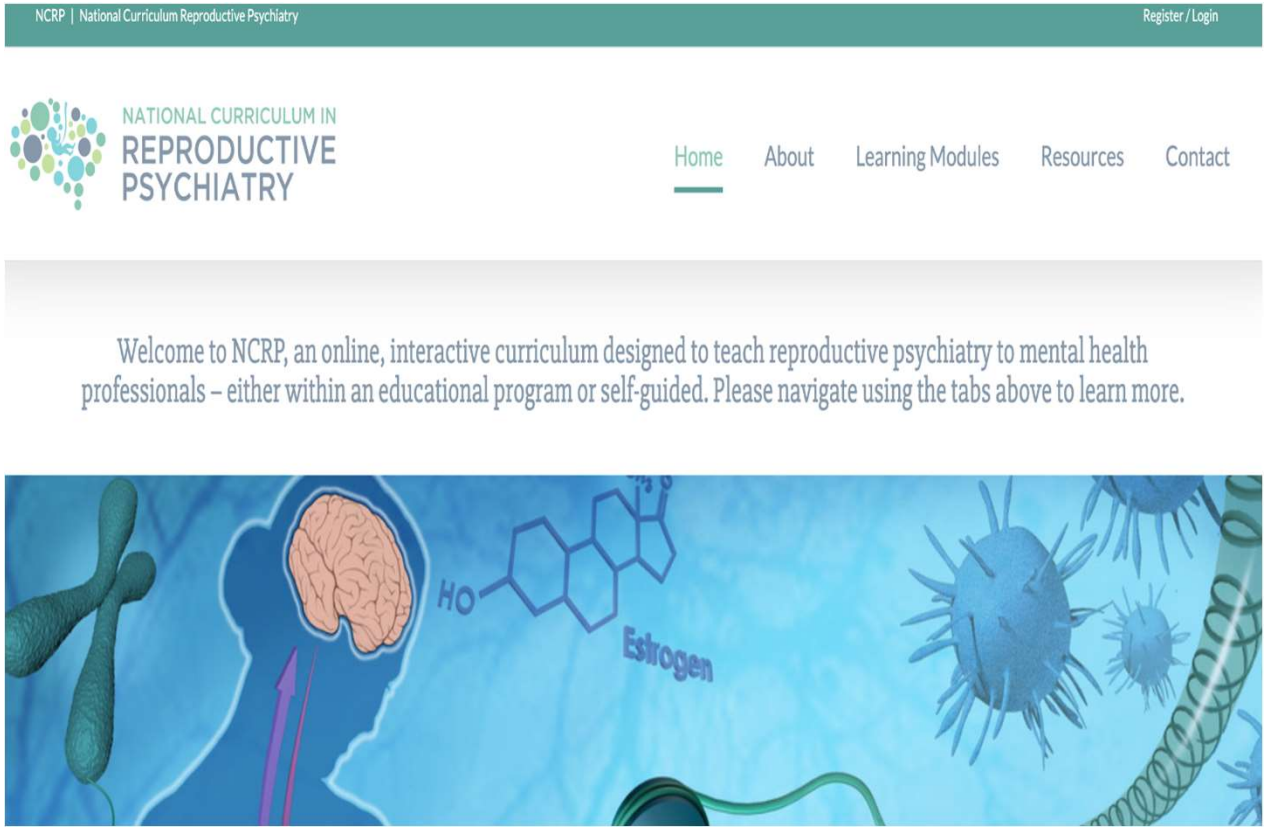
RESOURCES

- • National Domestic Violence Hotline: 800-799-SAFE (7233) (Ask your patients to memorize this number rather than write it down where an abuser can find it.)
- • National Sexual Assault Hotline: 800-656-HOPE (4673)
- • Futures Without Violence: The National Health Resource Center on Domestic Violence 888-792-2873 www.futureswithoutviolence.org
- • National Resource Center on Domestic Violence: 800-537-2238 www.nrcdv.org • Rape, Abuse & Incest National Network secure online chat https://www.rainn.org
- • National Dating Abuse Helpline: 866-331-9474 www.loveisrespect.org (This website is a good resource for teens and young adults.)
- Reporting laws:
  - https://www.acf.hhs.gov/sites/default/files/fysb/state_compendium.pdf
  - https://www.annemergmed.com/article/S0196-0644(02)75698-9/pdf

GOAL

Healthy Mom, Healthy Baby!

RESOURCES


NCRP | National Curriculum Reproductive Psychiatry
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NATIONAL CURRICULUM IN
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Welcome to NCRP, an online, interactive curriculum designed to teach reproductive psychiatry to mental health professionals – either within an educational program or self-guided. Please navigate using the tabs above to learn more.
HO
Estrogen

RESOURCES

- Reprotox: Summary of literature on all meds in pregnancy, subscription service https://reprotox.org/
- Lactmed: Summary of literature on all meds in lactation, free services http://toxnet.nlm.nih.gov/newtoxnet/lactmed.htm
- MothertoBaby: Patient-friendly fact sheets on meds: http://mothertobaby.org/
- MGH Center for Women's Mental Health: informational website: https://womensmentalhealth.org?doing_wp_cron=1452175286.3503780364990234375000
- Motherrisk: Canadian helpline: http://www.motherisk.org/
- Postpartum Support International: Support groups and help finding local resources http://www.postpartum.net/
- MCPAP FOR MOMS, https://www.mcpapformoms.org/

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Psychopharmacology in Pregnancy and Breastfeeding

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KEYWORDS

- Pregnancy • Breastfeeding • Antidepressants • Mood stabilizers
- Postpartum depression

KEY POINTS

- Many psychiatric medications can be taken safely during pregnancy and breastfeeding.
- There are significant risks associated with untreated psychiatric illness during pregnancy and postpartum.
- Many studies examining infant outcomes with exposure to psychotropic medications during pregnancy are confounded by illnesses, behaviors, and other risk factors associated with psychiatric illness.

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Questions and Discussion