Psychopharmacology in Pregnancy and Lactation

2019 Update

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Disclosures/Conflict of Interest

• No COI to disclose
Objectives

• Discuss the role reproductive hormones play in the etiology of PMADs
• Summarize the risk and benefit ratio of major classes of psychotropics in the perinatal period
• Identify screening and monitoring instruments used in identifying PMADs
Entering motherhood is the most significant biological event that happens in your life causing profound and permanent brain changes
Jodi Pawluski PHD
Male/Female Brain Differences – Neuroplasticity

Neuroplasticity = increased ability to support neural changes, both functionally and structurally
A “sensitive period” – Brain changes in motherhood

- Enable her to multitask to meet her babies needs
- Emphasize with the infants emotion and pain (and others)
- Regulate how she responds to stimuli or threats
- Sync her brain with her babies for life
  - Synchronized brain responses
  - Matching responses in gaze, touch and vocalization

Elseline Koekzema Leiden U, Netherlands 2016
A mother’s unique special connection to the child is vital for infants care and survival.

The ability to attach and remain the parent caregiver is the remarkable step that has marked our evolution from reptiles to mammals.”

Women’s Moods – Deborah Sichel MD
Estrogen – Mood Enhancing Effects

- A 1000 fold increase during pregnancy with rapid drop postpartum
- Estrogen supports Serotonin (5HT)
  - Increases synthesis (tryptophan)
  - Increased 5HT1 receptors in Dorsal Raphe
  - Reduces metabolism of serotonin (Decrease MAO activity)
- Estrogen potentiates Norepinephrine (NE)
- Antidopaminergic effects (DA)
Progesterone (and Allopregnanolone)

- Elevated in pregnancy with rapid drop postpartum
- Progesterone and allopregnanolone are GABA agonists
- Progesterone can have hypnotic and anxiolytic effects
Oxytocin (OT) and Attachment/Mood

- Fosters attachment b/w all mammalian mothers and infants
- Improves ability to interpret social situations and facilitates attending to others
- OT activates limbic structures assoc. with emotion and attention –peaks day 3-5 PP
- Postpartum women: Lactation suppresses physiologic response to stress.
- Promotes amnesia during labor
Types of PMADs (Perinatal Mood and Anxiety Disorders)

- Baby blues
- Antenatal depression*
- Postpartum depression*
- Perinatal anxiety*
  - OCD*
  - PTSD*
  - Panic Disorder*
  - Tokophobia
- Postpartum mania/hypomania
- Postpartum psychosis

*SSRI’s are first medication intervention
Old FDA Categories (A, B, C, D, X)
Being phased out because misleading

- **A** - No risk in controlled human studies (> 1%).
- **B** - No risk in other studies: often based on animal data only (no human data exists). New medications are labeled B (e.g., lurasidone/Latuda).
- **C** - Risk not ruled out; not necessarily safer than Category D just really no data.
- **D** - Positive evidence of risk; risk known but benefit may outweigh risk (e.g., lithium carbonate).
- **X** - Contraindicated in pregnancy; risk never outweighs benefit (e.g., thalidomide, accutane).
## New FDA Categories

**Effective June 30, 2015**

### 1. Pregnancy, Labor, and Delivery
- Exposure Registry
- Risk Summary
- Clinical considerations
- Data

### 2. Lactation
- Risk Summary
- Clinical consideration
- Data

### 3. Females and Males of Reproductive Potential
- Pregnancy testing
- Contraception
- Infertility

### 2019 Update
Resources for Medications in Pregnancy and Breastfeeding

- Reprotox: [www.reprotox.org](http://www.reprotox.org)
- Motherisk.org: [www.motherisk.org](http://www.motherisk.org) 1-877-439-2744
- [www.infantrisk.com](http://www.infantrisk.com) ; (806) 352-2519; phone app also available
- Organization of Teratology Information Services: [www.mothertobaby.org](http://www.mothertobaby.org); good handouts
- MGH Women’s Mental Health Program: [www.womensmentalhealth.org](http://www.womensmentalhealth.org)
<table>
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<tr>
<th>OTHER INFORMATION</th>
<th>DRUG CONSULTS (5 results)</th>
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<tr>
<td>MARTINDALE</td>
<td>BEERS CRITERIA - A SUMMARY OF POTENTIALLY INAPPROPRIATE MEDICATION USE AND...</td>
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<tr>
<td>INDEX NOMINUM</td>
<td>CAPSULES/TABLETS THAT SHOULD NOT BE CRUSHED GUIDE</td>
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<tr>
<td>Duloxetine Hydrochloride</td>
<td>CHEMOTHERAPY-INDUCED PERIPHERAL NEUROPATHY-GUIDELINES</td>
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<tr>
<td>Duloxetine (Rec INN)</td>
<td>CLASS COMPARISON – SSRIS AND SEROTONIN NOREPINEPHRINE REUPTAKE INHIBITORS</td>
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<td></td>
<td>MANAGEMENT OF CANCER-RELATED PAIN IN ADULT PATIENTS</td>
</tr>
<tr>
<td>DRUG TOOLS</td>
<td>COMPARATIVE EFFICACY (3 results)</td>
</tr>
<tr>
<td></td>
<td>Escitalopram</td>
</tr>
<tr>
<td></td>
<td>Paroxetine</td>
</tr>
<tr>
<td></td>
<td>Venlafaxine</td>
</tr>
<tr>
<td></td>
<td>MARTINDALE - OTHER INFO (1 result)</td>
</tr>
<tr>
<td></td>
<td>Antidepressants</td>
</tr>
</tbody>
</table>

Duloxetine Hydrochloride was also found in...

- Toxicology and Exposure Information (3)
- Disease Information (6)
- Reproductive Risk Information (2)

- REPROTOX (1)
  - Duloxetine

- TERIS (1)
  - Duloxetine
n>800 detects a two fold increased risk of major malformations!
Breastfeeding and Medications

- <10% maternal dose is “acceptable”
- Examples of RID relative infant dose:
  - Fluoxetine (Prozac, Sarafem): range from 1.6-14.6%
    - No harmful effects from Fluoxetine even at 14.6%
  - Other SSRIs: range from .4-7.9% extensive data
  - SNRIs: range from 0.1-8.1%
  - Quetiapine (Seroquel): range from .02-0.1%
  - Bupropion (Wellbutrin) < 2% limited data
  - Mirtazepine (Remeron) < 6.3% limited data
  - Lorazepam (Ativan) < 3%

Thomas Hale, Medications and Mother’s Milk
Pharmacologic Interventions
Stages of Human Development – Fetal Age (Gestational age is FA + 2 weeks)

**BLUE BARS** = highly sensitive periods of development when major defects might be produced

**AQUA BARS** = stages less sensitive to teratogens when minor defects may be induced

Risk \[\frac{\text{Benefit}}{}\] = ?
“When a psychiatric condition necessitates pharmacotherapy, the benefits of such therapy far outweigh the potential minimal risks.”

27 year old married female teacher history of severe Major Depressive Disorder, h/o 2 suicide attempts, 2 hospitalizations presents at 8 weeks GA with acute depression and Suicidal Ideation after she stopped all meds 2 weeks ago when she found out she was pregnant:

Current meds:
- Depakote 500 mg three times a day
- Trazodone 200mg at night
- Sertraline 150 mg in am
- Wellbutrin XL 300 mg at night
- Seroquel 50 mg at night 12.5 mg PRN
- Clonazepam 0.5 mg at night

H/O ECT -last 18 months ago

Moore and Persaud. The Developing Human: Clinically Oriented Embryology, 1999

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Psychopharmacologic interventions – Medication Classes

• Antidepressants
• Antianxiety/ Hypnotics
• Mood Stabilizers
• Antipsychotics
• Stimulants
• *Brexanolone
### Available Antidepressants and associated Neurotransmitters

<table>
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<tr>
<th><strong>SSRIs</strong></th>
<th><strong>SNRIs</strong></th>
<th><strong>Others</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Celexa (citalopram) G</td>
<td>Cymbalta (duloxetine) G</td>
<td>Wellbutrin (bupropion) G</td>
</tr>
<tr>
<td>Lexapro (escitalopram) G</td>
<td>Effexor (venlafaxine) G</td>
<td>Bupropion is a weak inhibitor of DA, NE and 5HT reuptake</td>
</tr>
<tr>
<td>Luvox (fluvoxamine) G</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paxil (paroxetine) G</td>
<td>Inhibit serotonin and norepinephrine reuptake</td>
<td>Remeron (mirtazapine) G</td>
</tr>
<tr>
<td>Prozac (fluoxetine) G</td>
<td></td>
<td>Mirtazapine ↑central noradrenaline and 5HT activity by antagonizing central presynaptic α2 receptors</td>
</tr>
<tr>
<td>Zoloft (sertraline) G</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Selectively inhibit the reuptake of serotonin (5HT) at the presynaptic neuronal membrane

Inhibit serotonin and norepinephrine reuptake

**G**=Generic; **B**=Brand

- **Brexanolone**
  - GABA-A agonist
<table>
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<tr>
<th>TABLE 3</th>
<th>Summary of current knowledge of antidepressant use during pregnancy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Antidepressants likely DO NOT increase the risk of</strong></td>
<td></td>
</tr>
<tr>
<td>● Birth defects</td>
<td></td>
</tr>
<tr>
<td>● Spontaneous abortion, stillbirth, or neonatal death</td>
<td></td>
</tr>
<tr>
<td>● Cognitive impairment or behavioral problems</td>
<td></td>
</tr>
<tr>
<td>● Autism</td>
<td></td>
</tr>
<tr>
<td><strong>Antidepressants MIGHT increase the risk of</strong></td>
<td></td>
</tr>
<tr>
<td>● Late preterm birth (although more likely because of effects of depression)</td>
<td></td>
</tr>
<tr>
<td>● Postpartum hemorrhage (although more likely because of other confounders)</td>
<td></td>
</tr>
<tr>
<td><strong>Antidepressants likely DO increase the risk of</strong></td>
<td></td>
</tr>
<tr>
<td>● Neonatal side effects, especially respiratory distress</td>
<td></td>
</tr>
<tr>
<td>● Neonatal persistent pulmonary hypertension of the newborn infant, although rare</td>
<td></td>
</tr>
</tbody>
</table>

**Perinatal prescribing pearls**

- Ask patients what antidepressant has worked for them in the past and start with this (exception is paroxetine in the 1st trimester).
- One medication at a higher dose is preferable to multiple medications.
- Tapering antidepressants before delivery does not decrease potential fetal risks but does increase risk of symptom relapse postpartum.
- Do not switch effective antidepressants after delivery in lactating women.

Adapted and used with permission from Laura Miller, MD.

Antidepressants and Lactation

• As a class, antidepressants are considered compatible with breastfeeding and infant exposure is low or negligible.
• Patients who are successfully treated during pregnancy should not change agents for the purpose of breastfeeding
• Caution in ill or premature infants.
Psychopharmacologic interventions – Medication Classes

- Antidepressants
- **Antianxiety/ Hypnotics**
- Mood Stabilizers
- Antipsychotics
- Stimulants
- *Brexanolone*
BDZ were associated with an increased risk of spontaneous abortion (adjusted OR, 1.85; 95% CI, 1.61-2.12).
BDZ are not likely strongly associated with congenital abnormalities.
BDZ are associated with increased NICU admissions, smaller head circumference (Gen Hosp Psychiatry. 2018).

• Why is this patient taking the medication? Anxiety symptoms? Insomnia? Phobia?
• How is the medication taken? On a daily basis or as needed?
• Is it possible to gradually taper the benzodiazepine?
• If symptoms recur, are non-pharmacologic treatments, such as cognitive-behavioral therapy, effective in this setting?
• If non-pharmacologic options are not successful, could treatment with an SSRI or an SNRI alone be an option?
<table>
<thead>
<tr>
<th>Anxiolytics: Benzodiazepines</th>
<th>Dosing</th>
<th>Clinical Pearls</th>
</tr>
</thead>
</table>
| Alprazolam (Xanax) | Starting dose: 0.25mg  
Range: 0.25 – 2mg | • Only use for acute, discrete panic symptoms on as needed basis  
• **Most addictive**, short half life  
• Notable rebound anxiety  
• AVOID when possible |
| Clonazepam (Klonopin) | Starting dose: 0.25mg  
Range: 0.25 – 2mg | • Longest half life  
• Can use Q12h dosing |
| Lorazepam (Ativan) | Starting dose: 0.5mg  
Range: 0.5 – 2mg | • Can dose BID – TID  
• No active metabolites  
• Lowest levels in lactation |
<table>
<thead>
<tr>
<th>Anxiolytic (non-benzodiazepine)</th>
<th>Dosing</th>
<th>Clinical Pearls</th>
</tr>
</thead>
</table>
| **Buspirone (Buspar)** | Starting dose: 5mg  
Range: 5 – 60mg max/day | • Dosing BID or TID standing (not PRN)  
• Preferred over benzodiazepine in patient with history of substance abuse/dependence  
• Not always effective  
• Minimal data in pregnancy / lactation |
| **Hydroxyzine (Vistaril)** | Starting dose: 25mg  
Range: 25 – 50mg | • Dosing BID – QID  
• Antihistamine  
• Frequently used in pregnancy |
| **Quetiapine (Seroquel)** | Starting dose: 12.5mg  
Range: 25-100+mg | • Atypical antipsychotic  
• Low doses effective for insomnia and anxiety  
• Doses > 100mg for bipolar and psychotic disorders  
• Orthostatic hypotension common first few mornings |
<table>
<thead>
<tr>
<th>Sleep Aids</th>
<th>Dosing</th>
<th>Clinical Pearls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diphenhydramine (Benadryl)</td>
<td>Starting dose: 25mg</td>
<td>• Not effective for all patients, especially if anxiety or depression is not fully treated</td>
</tr>
<tr>
<td>Doxylamine (Unisom)</td>
<td>Range (Benadryl/Unisom): up to 50mg</td>
<td></td>
</tr>
<tr>
<td>Trazodone</td>
<td>Starting dose: 25mg</td>
<td>• May cause morning grogginess</td>
</tr>
<tr>
<td></td>
<td>Range: 50-200mg</td>
<td>• Highly effective for many people</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• No addictive potential</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Minimal but reassuring data</td>
</tr>
<tr>
<td>Quetiapine (Seroquel)</td>
<td>Starting dose: 12.5mg</td>
<td>• Atypical antipsychotic</td>
</tr>
<tr>
<td></td>
<td>Range: 25-100+ mg</td>
<td>• Low doses effective for insomnia and anxiety</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Orthostatic hypotension common first few mornings</td>
</tr>
<tr>
<td>Mirtazapine (Remeron)</td>
<td>Starting dose: 7.5mg</td>
<td>• Inverse relationship between dose and sedation</td>
</tr>
<tr>
<td></td>
<td>Range: up to 15mg for sleep</td>
<td>• Used for Insomnia, hyperemesis gravidarum</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Stimulates appetite</td>
</tr>
<tr>
<td>Zolpidem (Ambien)</td>
<td>Starting dose: 5mg</td>
<td>• Patient may sleep walk</td>
</tr>
<tr>
<td></td>
<td>Range: 5-10mg</td>
<td>• Rapid onset of action</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Minimal human pregnancy data</td>
</tr>
</tbody>
</table>

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Psychopharmacologic interventions – Medication Classes

- Antidepressants
- Antianxiety/ Hypnotics
- Mood Stabilizers
- Antipsychotics
- Stimulants
- *Brexanolone
Pregnancy and Bipolar Disorder: Postpartum Period

Postpartum period clearly destabilizes mood

- BP women have 100-fold higher risk than women without a psychiatric illness history of experiencing postpartum psychosis (1) (10-25%)
- 40%-67% of the female BP subject population experienced postpartum mania or depression within 1 month of delivery (2)
- 70 times higher rate of suicide in the first month postpartum

Bipolar Disorder: Psychopharmacology in Pregnancy

• **Mood Stabilizers**
  – Lithium
  – Antiepileptic Drugs (AED)
    • Valproic Acid (Depakote)
    • Carbamazepine (Tegretol)
    • Lamotrigine (Lamictal)
    • Oxcarbazepine (Trileptal)

• **Antipsychotics**
• **Benzodiazepines**
Risk of neural tube defects:

- Valproate (1-5%)
- Carbamazepine (0.5-1%)

**Valproate (Depakote): Avoid Use!**

- Associated with increased risk for adverse cognitive and neurodevelopmental effects compared with other anticonvulsants

- Long-term follow up to 3 years suggests fetal exposure to valproate associated with lower IQ scores (not observed with lamotrigine)

Mood Stabilizers in Pregnancy

Lithium: 1st trimester - risk of cardiovascular malformations

– Adjusted risk ratio for cardiac malformations among infants exposed to lithium as compared with unexposed infants was 1.65, *the magnitude of this effect was smaller than had been previously postulated*

– Risk of cardiac malformations appears to be dose dependent
  – RR 1.11 for dose of 600mg or less; 1.6 for dose of 601-900mg, and 3.22 for >900mg

Lithium: neonatal side effects

• **Reported side effects:**
  flaccidity, cyanosis, lethargy, hypotonia, poor feeding, abnormal breathing, cardiac arrhythmias, poor myocardial contractility

• Higher Lithium concentrations (in maternal and cord blood) result in more side effects

Lamotrigine in Pregnancy

- Most studies show rates of malformation consistent with general population (Dolk, H. et al. *Neurology* 86.18 (2016): 1716–1725)

- Lamotrigine (Lamictal) exposure carried the lowest risk of overall malformation (Weston J. et al. *Cochrane Database Syst Rev.* 2016 Nov 7;11)

- No adverse effects of AED exposure via breast milk were observed at age 6 years, consistent with another recent study at age 3 years (Veiby G, et al. *JAMA Neurol.* 2013;70(11):1367-1374; Meador et al. *JAMA Pediatr.* 2014;168(8):729-736)
Psychopharmacologic interventions – Medication Classes

- Antidepressants
- Antianxiety/ Hypnotics
- Mood Stabilizers
- Antipsychotics
- Stimulants
- *Brexanolone

- clozapine (Clozaril)
- risperidone (Risperdal)
- quetiapine (Seroquel)
- olanzapine (Zyprexa)
- ziprasidone (Geodon)
- aripiprazole (Abilify)
- asenapine (Saphris)
- lurasidone (Latuda)
- paliperidone (Invega)
Atypical Antipsychotics in Pregnancy

• Quetiapine and olanzapine most studied
• No significant difference in congenital malformations but limited data
• More NICU admissions and c-sections among exposed
• Increased Risk of metabolic syndrome and Gestational Diabetes – consider early nutrition counseling

Sadowsky A. et al. BMJ open access, 2013; http://bmjopen.bmj.com/content/3/7/e003062.abstract)
Antipsychotics in Lactation

- Consider effects of medication on breastfeeding infant and mother
  - EPS, sedation, weight gain
- First generation antipsychotics: small amounts of the drug are excreted into the breast milk: <3% of the maternal dose.
- Second generation antipsychotics: found that <5% of the drug is excreted in the breast milk.
Psychopharmacologic interventions – Medication Classes

- Antidepressants
- Antianxiety/ Hypnotics
- Mood Stabilizers
- Antipsychotics
- Stimulants
- *Brexanolone

<table>
<thead>
<tr>
<th>Medication</th>
<th>Drug Class</th>
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<tbody>
<tr>
<td>Adderall</td>
<td>CNS Stimulant (CNS Stimulant)</td>
</tr>
<tr>
<td>Atomoxetine</td>
<td>Selective norepinephrine reuptake inhibitor (SNRI)</td>
</tr>
<tr>
<td>Concerta</td>
<td>CNS Stimulant</td>
</tr>
<tr>
<td>Daytrana Patch</td>
<td>CNS Stimulant</td>
</tr>
<tr>
<td>Dexedrine</td>
<td>CNS Stimulant</td>
</tr>
<tr>
<td>Dextrostat</td>
<td>CNS Stimulant</td>
</tr>
<tr>
<td>Dextro-Amphetamine</td>
<td>CNS Stimulant</td>
</tr>
<tr>
<td>Dexamphetamine</td>
<td>CNS Stimulant</td>
</tr>
<tr>
<td>Focalin</td>
<td>CNS Stimulant</td>
</tr>
<tr>
<td>Guanfacine</td>
<td>Centrally acting alpha-adrenergic receptor agonist</td>
</tr>
<tr>
<td>Intuniv</td>
<td>Centrally acting alpha-adrenergic receptor agonist</td>
</tr>
<tr>
<td>Kapvay</td>
<td>Central alpha-2 agonist</td>
</tr>
<tr>
<td>Metadate</td>
<td>CNS Stimulant</td>
</tr>
<tr>
<td>Methylin</td>
<td>CNS Stimulant</td>
</tr>
<tr>
<td>Methylphidate</td>
<td>CNS Stimulant</td>
</tr>
<tr>
<td>Ritalin</td>
<td>CNS Stimulant</td>
</tr>
<tr>
<td>Strattera</td>
<td>SNRI</td>
</tr>
<tr>
<td>Tenex</td>
<td>Centrally acting alpha-adrenergic receptor agonist</td>
</tr>
<tr>
<td>Vyvanse</td>
<td>CNS Stimulant</td>
</tr>
</tbody>
</table>

* As of 2011.
Psychostimulants in 2019 – A Unique R/B ratio

• Stimulant use on the rise in reproductive-age women age 15-44
  
  2003= 0.9%
  
  2015= 4.0%

• Limited data
  – No evidence of teratogenesis: methylphenidate and amphetamine agents
  – Associated with growth restriction, low APGAR, stimulant withdrawal syndrome, miscarriage

• No long term neurobehavioral data

Perinatal Psychostimulant Pearls

- Consider stopping stimulants in women with mild or moderate ADHD
  - Behavioral interventions
  - Work / home accommodations
  - Alternate medications (bupropion)

- Dosing: Stay with lowest, studied doses:
  - Methylphenidate 15 to 80 mg
  - Amphetamine 20 to 35 mg

- Immediate Release versus Sustained Release Preparations
  - In lactation – short acting blood levels peak in 1-2 hours – BF or pump right before dosing medication.
New medication for moderate to sever postpartum depression

- An allosteric modulator of GABA-A receptors
- 3 days inpatient IV infusion
- Remission of depression often within 24 hours up to 30 days
- SE: Sedation effects ranged from somnolence to loss of consciousness. All resolved within 60 minutes of infusion discontinuation.
- Breastfeeding –12 women/infant dyads. Relative infant dose 1-2%.


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FDA requires REMS Registration

Approved Risk Evaluation and Mitigation Strategies (REMS)

Zulresso (brevanolone)
NDA #211371

- View the Zulresso Prescribing Information and Medication Guide at DailyMed.
- View Zulresso’s Regulatory Information of Drugs@FDA.

**Who** is the right patient for BRX?
DSM-IV or DSM-5
First Line? Second Line?

The New Postpartum Depression Drug Costs $34k—Is It Worth It?

Zulresso is a breakthrough in new mothers’ mental health. But its cost and accessibility may make it prohibitive for most women. Here’s what you need to know.

By Tracy Curran Orzea
Screening and Monitoring Instruments

• EPDS
• GAD-7
• PHQ-9
• CIDI-3

I. STEM QUESTIONS

1. Euphoria Stem Question
   Some people have periods lasting several days or longer when they feel much more excited and full of energy than usual. Their minds go too fast. They talk a lot. They are very restless or unable to sit still, and they sometimes do things that are unusual for them, such as driving too fast or spending too much money.

   Have you ever had a period like this lasting several days or longer?

   If this question is endorsed, the irritability stem question is skipped, and the respondent goes directly to the Criterion B screening question.

2. Irritability Stem Question
   Have you ever had a period lasting several days or longer when most of the time you were so irritable or grouchy that you started arguments, shouted at people, or hit people?
Sleep Preservation in the Perinatal Period

- Loss of sleep leads to depression and psychosis
  - https://www.elsevier.com/books/sleep-and-affect/babson/978-0-12-417188-6

- Sleep Preservation is an important strategy for all PMADs
- Treat insomnia!
- Introduce one bottle a day
- Night shifts with partner
- Devices (Snoo), books, doulas
27 year old married female with severe Major Depressive Disorder, h/o 2 suicide attempts, 2 hospitalizations presents at 8 weeks GA with acute depression and suicidal ideation after she stopped all meds 2 weeks ago when she found out she was pregnant:

Current meds:
Depakote 500 mg three times a day
Trazodone 200mg at night
Sertraline 150 mg in am
Wellbutrin XL 300 mg at night
Seroquel 50 mg at night 12.5 mg PRN
Clonazepam 0.5 mg at night
H/O ECT -last 18 months ago
USA TODAY

Mourning orca mom won't let baby whale go

Duration: 00:52  7/27/2018

Family of Mother Orca Whale Mourning Calf's Death Now Taking Turns Carrying Baby Whale's Body