

**Consider treatment options based on highest level of illness severity**

If severity of symptoms overlap, clinical decisions should be based on the assessment, with strong consideration of higher level treatment options.

MILD	MODERATE	SEVERE
Therapy referral Consider medication treatment	Therapy referral Strongly consider medication treatment If onset of depression symptoms occurs in 3rd trimester to 4 weeks postpartum and if the patient is <6 months postpartum at screening, consider postpartum zuranolone (administered orally for 14 days). See next page.	Therapy referral Medication treatment If onset of depression symptoms occurs in 3rd trimester to 4 weeks postpartum and if the patient is <6 months postpartum at screening, consider postpartum zuranolone (administered orally for 14 days). See next page.

- Use internal resource list to refer patient to therapy
- Call Postpartum Support International (PSI) at 1-877-499-4773 to schedule a consultation by phone with a perinatal psychiatry expert
- Call a Perinatal Psychiatry Access Program, if one is available in your state. Check at <https://www.umassmed.edu/lifeline4moms/>
- If symptoms are mild and patient is able to follow through, direct patients to call their health insurance company or contact Postpartum Support International (PSI) for resources: 1-800-944-4773 (voice in English or Spanish), 800-944-4773 (text in English), 971-203-7773 (text in Spanish), or direct patients to search online at <https://psidirectory.com/>

**Therapy and support options**

- All women who screen positive, regardless of illness severity, **should be referred to therapy or be advised to continue therapy**
- Always discuss and encourage prevention and support options (e.g., peer and social supports and groups, sleep hygiene, self-care, and exercise). See *Self-Care Plan*.

**How to educate patients about treatment with antidepressants**

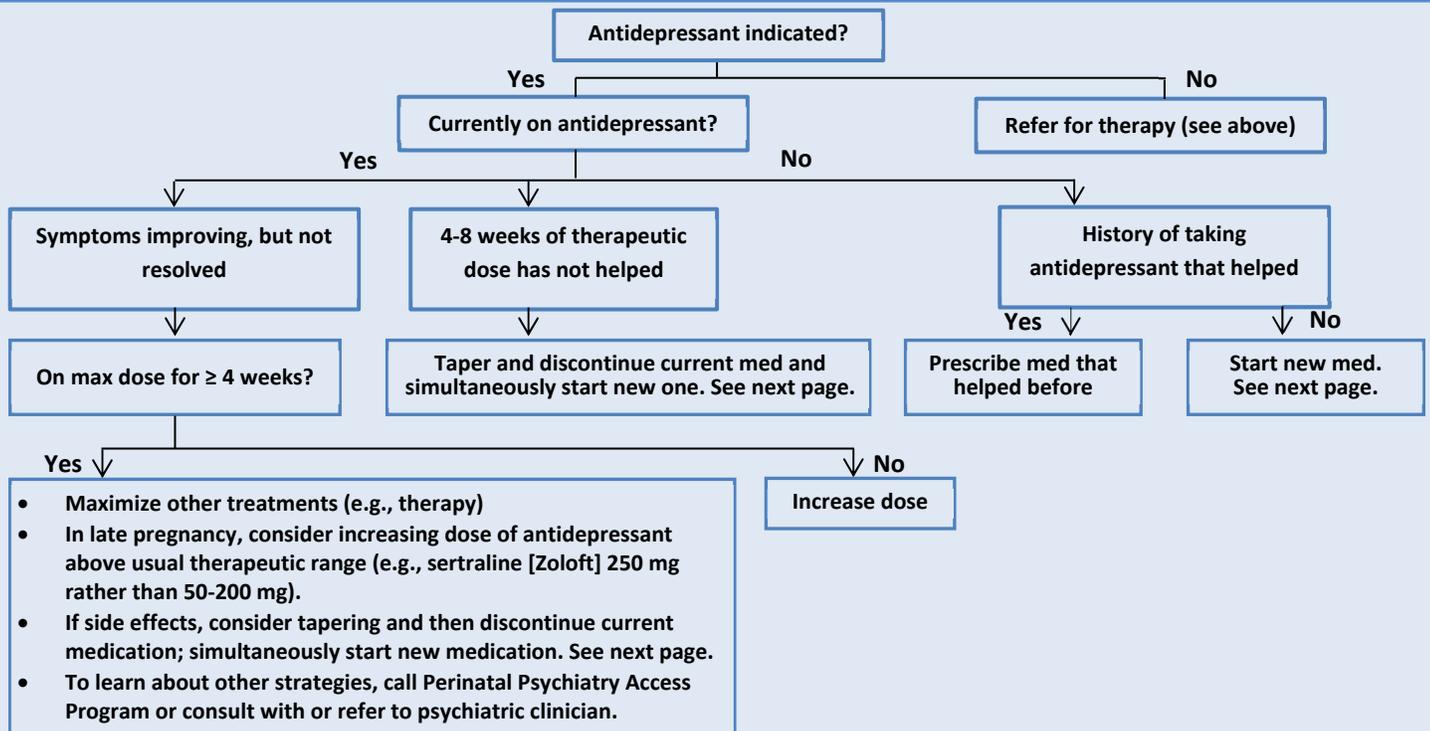
**Antidepressant use during pregnancy:**

- Does not appear to be linked with birth complications
- Has been linked with small but inconsistent risk of birth defects when taken in the first trimester, particularly paroxetine
- Has been linked with transient (days to weeks) neonatal symptoms (tachypnea, irritability, insomnia)
- Has inconsistent, overall reassuring, evidence regarding long-term (months to years) neurobehavioral effects on children

**Under-treatment or no treatment of perinatal mental health conditions:**

- Has been linked with birth complications
- Can increase the risk or severity of postpartum depression
- Can make it harder for moms to take care of themselves and their babies
- Can make it harder for moms to bond with their babies
- Can increase risk of mental illness among offspring
- Has been linked with possible long-term neurobehavioral effects on children

**Medication treatment (when indicated)**



## Pharmacological Treatment Options for Depression, Anxiety, and PTSD

- Choose antidepressant that has worked before. If antidepressant naïve, choose antidepressant based on table below with patient preference in consideration. Antidepressants are similar in efficacy and side effect profile.
- In late pregnancy, you may need to increase the dose above usual therapeutic range (e.g., sertraline [Zoloft] 250mg rather than 50-200mg).
- If a patient presents with pre-existing mood and/or anxiety disorder and is doing well on an antidepressant, do not switch it during pregnancy or lactation. If patient is not doing well, see *Follow-Up Treatment of Perinatal Mental Health Conditions*.
- Evidence does not support tapering antidepressants in the third trimester.
- Minimize exposure to both illness and medication.
  - Untreated/inadequately treated illness is an exposure
  - Use lowest effective doses
  - Minimize switching of medications
  - Monotherapy preferred, when possible

See first page for how to educate patients about treatment with antidepressants

## First-line Treatment Options for Mild, Moderate, or Severe Depression, Anxiety Disorder, and PTSD

Medication	sertraline* (Zoloft)	fluoxetine (Prozac)	citalopram** (Celexa)	escitalopram** (Lexapro)
Starting dose and timing	25 mg qAM (if sedating, change to qHS)	10 mg qAM	10 mg qAM	5 mg qAM
Initial increase after 4 days	↑ to 50 mg	↑ to 20 mg	↑ to 20 mg	↑ to 10 mg
Second increase after 7 more days	↑ to 100 mg			
Reassess Monthly (increase as needed until symptoms remit)	↑ by 50 mg	↑ by 20 mg	↑ by 10 mg	↑ by 10 mg up to 20 mg
Therapeutic range***	50-200 mg	20-80 mg	20-40 mg	10-20 mg
Individualized approach to titration	Slower titration (e.g., every 10-14-days) is often needed for patients who are antidepressant naïve or with anxiety symptoms			

\*Lowest degree of passage into breast milk compared to other first-line antidepressants; \*\*Side effects include QTc prolongation (see below);

\*\*\*May need higher dose in 3<sup>rd</sup> trimester and when treating an anxiety disorder

In general, if an antidepressant has helped during pregnancy, it is best to continue it during lactation.

Prescribe a maximum of two (2) antidepressants at the same time.

## Second-line Treatment Options for Mild, Moderate, or Severe Depression, Anxiety Disorder, and PTSD

Medication	duloxetine (Cymbalta)	venlafaxine (Effexor XR)	fluvoxamine (Luvox)	paroxetine (Paxil)	mirtazapine (Remeron)	bupropion HCL (Wellbutrin XL)
Starting dose and timing	30 mg*** qAM	37.5 mg qAM	25 mg qHS	10 mg*** qAM (if sedating, change to qHS)	7.5 mg qHS	150 mg qAM
Initial increase after 4 days		↑ to 75 mg	↑ to 50 mg	↑ to 20 mg	↑ to 15 mg	
Second increase after 7 more days	↑ to 60 mg		↑ to 100 mg			
Reassess Monthly (increase as needed until symptoms remit)	↑ by 30 mg	↑ by 75 mg	↑ by 50 mg	↑ by 10 mg	↑ by 15 mg	↑ by 150 mg
Therapeutic range ***	30-120 mg	75-300 mg	50-200 mg	20-60 mg	15-45 mg	300-450 mg
Individualized approach to titration	Slower titration (e.g., every 10-14-days) is often needed for patients who are antidepressant naïve or with anxiety symptoms					

\*\*\*May need higher dose in 3<sup>rd</sup> trimester and when treating an anxiety disorder

### Temporary (days to weeks)

Nausea (most common)

Constipation/diarrhea

Lightheadedness

Headaches

### Long-term (weeks to months)

Increased appetite/weight gain

Sexual side effects

Vivid dreams/insomnia

\*\*QTc prolongation (citalopram & escitalopram)

- Tell women to take medication with food and only increase dose if tolerating; otherwise wait until side effects dissipate before increasing.
- Start medication in morning; if patient finds it sedating recommend that she takes it at bedtime

## Medication Treatment for Moderate/Severe Depression with Onset in Late Pregnancy or Within 4 weeks postpartum

The American College of Obstetricians & Gynecologists recommends consideration of zuranolone in the postpartum period (ie, within 12 months of delivery) for severe depression that has onset in the third trimester or within 4 weeks postpartum. The decision to use zuranolone should balance the benefits (ie, significantly improved and rapid symptom resolution compared with placebo) alongside challenges specific to initiating and managing this medication that are described in this Clinical Practice Update.

More information can be found at [Reprotox](#) and [LactMed](#) on all pharmacological treatments