

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
<p>Therapy referral</p> <p>Consider medication treatment</p>	<p>Therapy referral</p> <p>Strongly consider medication treatment</p> <p>If onset of depression symptoms occurs in 3rd trimester to 4 weeks postpartum, and if the patient is up to 12 months postpartum at screening, consider zuranolone. See page 21</p>	<p>Therapy referral</p> <p>Medication treatment</p> <p>If onset of depression symptoms occurs in 3rd trimester to 4 weeks postpartum, and if the patient is up to 12 months postpartum at screening, consider zuranolone. See page 21</p> <p>Call for psychiatric consultation/referral</p>

- Use internal resource list to refer patient to therapy
- Zuranolone Clinical Practice Update: <https://www.acog.org/clinical/clinical-guidance/practice-advisory/articles/2023/08/zuranolone-for-the-treatment-of-postpartum-depression>
- Book an appointment with the Postpartum Support International (PSI) Perinatal Psychiatric Consultation Program at <https://postpartum.net/professionals/perinatal-psychiatric-consultation/> or call 1-503-218-3818 to schedule a consultation by phone
- Call a Perinatal Psychiatry Access Program, if one is available in your state. Check at <https://www.umassmed.edu/lifeline4moms/Access-Programs/>
- Direct patients to 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 online at <https://psidirectory.com/> or the Maternal Mental Health Hotline: 1-833-TLC-MAMA (1-833-852-6262) or online at <https://mchb.hrsa.gov/programs-impact/national-maternal-mental-health-hotline> for support

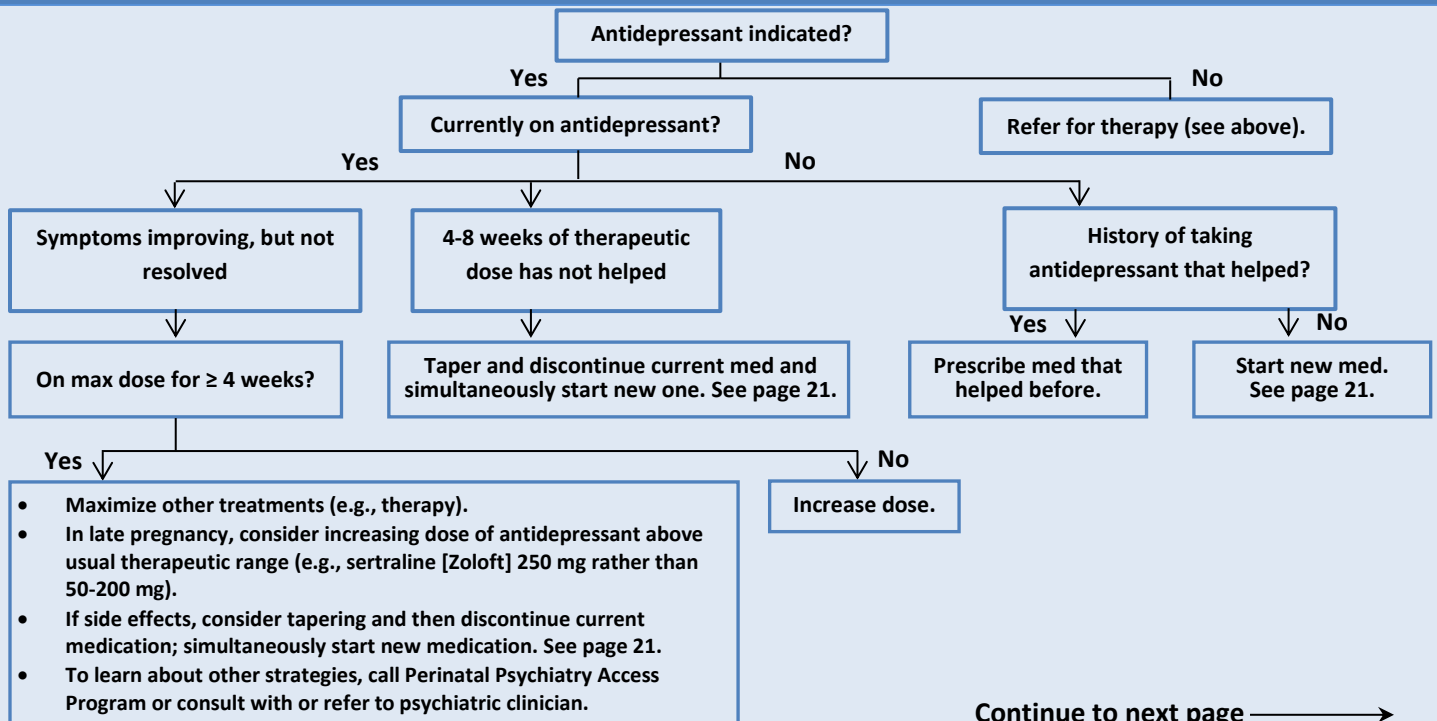
Therapy and support options

- **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 pages 28-30.

How to educate patients about treatment with antidepressants

- Small and inconsistent risk of miscarriage and preeclampsia
- Small increase in absolute risk of postpartum hemorrhage
- Small and inconsistent risk of birth defects when taken in the first trimester, particularly paroxetine
- Linked with transient (days to weeks) neonatal symptoms (tachypnea, irritability, insomnia; ~20-30%); self-limited with comfort measures
- Small increase in risk of persistent pulmonary hypertension of the newborn (PPHN; ~2-4/1,000 births)
- Inconsistent, overall reassuring, evidence regarding long-term (months to years) neurobehavioral effects on children
- 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)



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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 page 22.
- Evidence does not support tapering antidepressants in the third trimester.
- If depression onset is in the third trimester or within 4 weeks postpartum, consider using zuranolone in the postpartum period (see below).
- 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 page 20 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 3rd 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 3rd 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: zuranolone (Zurzuvae)

FDA-approved 14-day oral medication treatment in the postpartum period (i.e., within 12 months of delivery) for depression with onset in the third trimester or within 4 weeks postpartum. A neuroactive steroid and positive allosteric modulator of gamma-aminobutyric acid (GABA). Has a faster onset of action (within 3 days) than other oral antidepressants (within 2-4 weeks) to symptom improvement.

- 50mg qHS with a fatty meal (400-1,000 calories, 25%-50% fat) for 14 days; do not take more than 1 dose in a day – extend treatment course beyond 14 days if doses missed; dose adjustments or discontinuation needed if hepatic or renal disease, or experiencing significant CNS depressant effects, respectively (see [ACOG Zuranolone Clinical Practice Update](#))
- Can be used alone or as an adjunct to other oral antidepressant therapy like SNRIs or SSRIs; avoid use with other sedating meds
- Avoid pregnancy until 1 week after treatment; no direct neonate data regarding human milk feeding – simulated data reassuring
- Side effects include CNS depression, diarrhea, cold-like symptoms, and less commonly, increased suicidal thoughts/behaviors
- Advise patients not to drive or engage in potentially hazardous activities requiring complete mental alertness

More information can be found at Reprotox and LactMed on all pharmacological treatments