Abstracts

Women's Mental Health

Given space limitations and varying reprint permission policies, not all of the influential publications the editors considered reprinting in this issue could be included. This section contains abstracts from additional articles the editors deemed well worth reviewing.

Selective Serotonin Reuptake Inhibitors in Human Pregnancy: To Treat or Not to Treat?
Diav-Citrin O, Ornoy A
Obstet Gynecol Int. 2012;2012/698947. Epub 2011 Dec 10

Selective serotonin reuptake inhibitors (SSRIs) are increasingly prescribed during pregnancy. The purpose of the present paper is to summarize and evaluate the current evidence for the risk/benefit analysis of SSRI use in human pregnancy. The literature has been inconsistent. Although most studies have not shown an increase in the overall risk of major malformations, several studies have suggested that SSRIs may be associated with a small increased risk for cardiovascular malformations. Others have noted associations between SSRIs and specific types of rare major malformations. In some studies, there appears to be a small increased risk for miscarriages, which may be associated with the underlying maternal condition. Neonatal effects have been described in up to 30% of neonates exposed to SSRIs late in pregnancy. Persistent pulmonary hypertension of the newborn has also been described with an absolute risk of <1%. The risk associated with treatment discontinuation, for example, higher frequency of relapse and increased risk of preterm delivery, should also be considered. The overall benefit of treatment seems to outweigh the potential risks.

Episodes of Mood Disorders in 2,252 Pregnancies and Postpartum Periods
Viguera AC, Tondo L, Koukopoulos AE, Reginaldi D, Lepri B, Baldessarini RJ
Am J Psychiatry. 2011 Nov 1;168(11):1179–85

Objective: The risks of major affective episodes during pregnancy and during the postpartum period have rarely been compared in large samples across diagnoses. The authors hypothesized that perinatal episodes would mainly be depressive, would occur more in the postpartum than the prenatal period, and would be more prevalent with bipolar than unipolar depressive disorders. **Method:** The authors pooled clinical information on 2,252 pregnancies of 1,162 women with clinically treated DSM-IV bipolar I disorder (479 pregnancies/283 women), bipolar II disorder (641/338), or recurrent major depressive disorder (1,132/541) to compare rates of affective episode types by diagnosis during pregnancy and the postpartum period and to identify risk factors. **Results:** Among women with bipolar disorder, 23% had illness episodes during pregnancy and 52% during the postpartum period. Among women with unipolar depression, 4.6% had illness episodes during pregnancy and 30% during the postpartum period. Based on exposure-adjusted risk per pregnancy, episodes were 3.5 times more prevalent during the postpartum period than during pregnancy, and the risk was consistently higher with bipolar disorder. Depression was the most frequent morbidity during and following pregnancy. In multivariate modeling, factors associated with affective episodes in pregnancy, in descending order, were younger age at onset, previous postpartum episodes, fewer years of illness, bipolar disorder, fewer children, and not being married. Postpartum episodes were associated with younger age at onset, illness during pregnancy, bipolar disorder, fewer children, and more education. Moreover, pregnancy was less likely and perinatal episodes more likely if diagnosis preceded a first pregnancy. First lifetime episodes occurred in the perinatal period in 7.6% of cases. **Conclusions:** Among women with major affective disorders, illness risk was much greater during the postpartum period than during pregnancy. Illness mainly involved depression and was strongly associated with younger age at illness onset, bipolar disorder, and high lifetime occurrence rates. The relative risk during pregnancy compared with nonpregnant periods remains uncertain.

Treatment of Postpartum Depression: Clinical, Psychological and Pharmacological Options
Fitelson E, Kim S, Baker AS, Leight K
Int J Womens Health. 2011;3:1–14

Postpartum depression (PPD) is a common complication of childbearing, and has increasingly been identified as a major public health problem. Untreated maternal depression has multiple potential negative effects on maternal-infant attachment and child development. Screening for depression in the perinatal period is feasible in multiple primary care or obstetric settings, and can help identify depressed mothers earlier. However, there are multiple barriers to appropriate treatment, including concerns about medication effects in breastfeeding infants. This article reviews the literature and recommendations for the treatment of postpartum depression, with a focus on the range of pharmacological, psychotherapeutic, and other nonpharmacologic interventions.

A Randomized Controlled Trial of Culturally Relevant, Brief Interpersonal Psychotherapy for Perinatal Depression
Grote NK, Swartz HA, Geibel SL, Zuckoff A, Houck PR, Frank E
Psychiatr Serv. 2009 Mar;60(3):313–21

Objectives: Depression during pregnancy is one of the strongest predictors of postpartum depression, which, in turn, has deleterious, lasting effects on infant and child well-being and on the mother's and father's mental health. The primary question guiding this randomized controlled trial was, Does culturally relevant, enhanced brief interpersonal psychotherapy (IPT-B) confer greater advantages to low-income, pregnant women than those that accrue from enhanced usual care in treating depression in this population? Enhanced IPT-B is a multicomponent model of care designed to treat antenatal depression and consists of an engagement session, followed by eight acute IPT-B sessions before the birth and maintenance IPT up to six months postpartum. IPT-B was specifically enhanced to make it culturally relevant to socioeconomically disadvantaged women. **Methods:** Fifty-three non-treatment-seeking, pregnant African-American and white patients receiving prenatal services in a large, urban obstetrics and gynecology clinic and meeting criteria for depression on the Edinburgh Postnatal Depression Scale (score >12 on a scale of 0 to 30) were randomly assigned to receive either enhanced IPT-B (N=25) or enhanced usual care (N=28), both of which were delivered in the clinic. Participants were assessed before and after treatment on depression diagnoses, depressive symptoms, and social functioning. **Results:** Intent-to-treat analyses showed that participants in enhanced IPT-B, compared with those in enhanced usual care, displayed significant reductions in depression diagnoses and depressive symptoms before childbirth (three months postbaseline) and at six months postpartum and showed significant improvements in social functioning at six months postpartum. **Conclusions:** Findings suggest that enhanced IPT-B ameliorates depression during pregnancy and prevents depressive relapse and improves social functioning up to six months postpartum.

An Approach to Interpersonal Psychotherapy for Postpartum Depression: Focusing on Interpersonal Changes
Grigoriadis S, Ravitz P
Can Fam Physician. 2007 Sep;53(9):1469–75

Objective: To review the principles of interpersonal psychotherapy (IPT) for the treatment of postpartum depression (PPD). **Sources of Information:** Empirical literature, IPT manuals including those adapted for PPD, and the authors' clinical experience. **Main Message:** Level I evidence supports IPT as a treatment for PPD. Interpersonal psychotherapy is ideally suited because it focuses on the important interpersonal changes and challenges women experience during the postpartum period. It is delivered in 12 sessions and emphasizes interpersonal disputes, role transitions, or bereavement. In this article, we describe the IPT model and therapeutic guidelines for treatment of PPD. **Conclusion:** Postpartum depression is an important public health problem with pervasive effects on mothers, infants, and families. Interpersonal psychotherapy is a relevant and effective treatment for women suffering from PPD because it helps address the many interpersonal stressors that arise during the postpartum period. The principles

of IPT can be integrated easily into primary care settings as IPT is pragmatic, specific, problem focused, short-term, and highly effective.

Risk of Recurrence in Women with Bipolar Disorder During Pregnancy: Prospective Study of Mood Stabilizer Discontinuation
Viguera AC, Whitfield T, Baldessarini RJ, Newport DJ, Stowe Z, Reminick A, Zurick A, Cohen LS
Am J Psychiatry. 2007 Dec;164(12):1817-24

Objective: This study estimated the risk of recurrence of mood episodes among women with a history of bipolar disorder who continued or discontinued treatment with mood stabilizers during pregnancy. **Method:** In a prospective observational clinical cohort study, the authors determined recurrence risk and survival-analysis-based time to recurrence of a new episode in 89 pregnant women with DSM-IV bipolar disorder. Eligible subjects were euthymic at conception and continued mood stabilizer treatment or discontinued treatment proximate to conception. **Results:** The overall risk of at least one recurrence in pregnancy was 71%. Among women who discontinued versus continued mood stabilizer treatment, recurrence risk was twofold greater, median time to first recurrence was more than fourfold shorter, and the proportion of weeks ill during pregnancy was five times greater. Median recurrence latency was 11 times shorter after abrupt/rapid versus gradual discontinuation of mood stabilizer. Most recurrences were depressive or mixed (74%), and 47% occurred during the first trimester. Predictors of recurrence included bipolar II disorder diagnosis, earlier onset, more recurrences/year, recent illness, use of antidepressants, and use of anticonvulsants versus lithium. **Conclusions:** Discontinuation of mood stabilizer, particularly abruptly, during pregnancy carries a high risk for new morbidity in women with bipolar disorder, especially for early depressive and dysphoric states. However, this risk is reduced markedly by continued mood stabilizer treatment. Treatment planning for pregnant women with bipolar disorder should consider not only the relative risks of fetal exposure to mood stabilizers but also the high risk of recurrence and morbidity associated with stopping maintenance mood stabilizer treatment.

Mood Disorders And Their Pharmacological Treatment During Pregnancy: Is the Future Child Affected?
Monk C, Fitelson EM, Werner E
Pediatric Research. 69(5 Part 2):3R-10R, May 2011

Nearly half the US population will meet criteria for a neuropsychiatric disorder at some point in their lives, and 1 in 17 has a seriously debilitating illness. Although not all affected adults had an identified disorder as a child, increasingly these psychopathologies are conceptualized as the late-stage culmination of aberrant developmental processes shaped by a complex interplay of genes and experience, including experiences *in utero.* Decades of studies with pregnant animals demonstrate that stress-elicited perturbations in maternal biology affect offspring neurodevelopment. Studies of stress in pregnant women largely mirror these findings. Pregnant women with anxiety and/or depression experience greater life stress, and illness-related alterations in their neurobiology, with a potential to impact fetal neurobehavioral development *via* associated changes in the intrauterine environment and/or pharmacologic interventions. This article critically reviews findings on child development (including fetal neurobehavior) related to maternal depression, anxiety, and pharmacological treatments, primarily selective serotonin reuptake inhibitors (SSRIs). The hypothesis under review is that, in addition to genetics and characteristics of the postnatal environment, the familial transmission of risk for neuropsychiatric disorders involves a "third path"—prenatal exposure to psychiatric illness and its treatment.