Managing Mom's Anxiety during Pregnancy

"I'm worried. I can't sleep. It's anxiety." The message came through from Natalie a few minutes after I had logged onto our live chat service at MotherToBaby.org. "I'm 14 weeks pregnant and concerned about taking a SSRI" she continued. As a Teratogen Information Specialist, I answer questions about exposures during pregnancy and breastfeeding on a daily basis, and I was happy to chat with Natalie about this topic.

Natalie had just returned from a visit to her OB/GYN's office where she was diagnosed with anxiety. She had shared with her doctor that she was having trouble eating and sleeping, and was experiencing racing thoughts and constant worry about the future. Natalie's OB/GYN was concerned that what she was describing was more than the typical pregnancy concerns that many women have. She recommended that Natalie start on an SSRI to help manage her symptoms.

Natalie knew she needed to do something to deal with her anxiety, but she was reluctant to take any medication. "I've read online that SSRIs can cause the baby to experience withdrawal symptoms, and I would never want to do anything to hurt my baby!" she quickly typed. "Instead of taking this medication, would it be better for me to just suffer through the next 26 weeks so my baby will be born ok?"

Natalie's question was not uncommon. Here in the United States, anxiety affects about 6.8 million adults, and women are twice as likely as men to have this mood disorder. Furthermore, about 6% of women will develop anxiety at some point during their pregnancy. Non-medication approaches may be an effective first-line treatment for certain individuals. Some women benefit from daily meditation or exercise. For others, opening up to a friend or attending talk therapy sessions may help. Natalie had tried all of these options in her first trimester, and unfortunately her anxiety was getting worse.

I knew Natalie wanted a quick answer to her question about withdrawal, but I told her that first it was important for us to review just how necessary it was for her to treat her mood disorder. I applauded Natalie for recognizing the symptoms of anxiety, and having an honest conversation with her doctor about how she was feeling. Next, I let her know that many women think that suffering through these feelings during pregnancy may be the best option. However, we know that anxiety can actually cause problems on its own when left untreated. Studies have identified an increased risk for preterm birth (baby born before 37 weeks) and low birth weight when women do not properly treat their anxiety during pregnancy. Women with untreated anxiety may also have more trouble bonding with their baby both during pregnancy and after delivery. Lastly, a personal history of anxiety prior to or during pregnancy is a known risk factor for developing a serious mood disorder after giving birth.

Natalie completely understood the importance of weighing the risks vs. the benefits. Her niece had been born premature and she has seen firsthand just how scary that experience was for her sister. She agreed that treating her anxiety was important.

Natalie's doctor had recommended that she start on sertraline (Zoloft), which belongs to a class of medications known as selective serotonin reuptake inhibitors, or SSRIs. Other medications in this class include citalopram (Celexa), fluoxetine (Prozac), and paroxetine (Paxil), to name a few. The SSRIs are well studied, which means that we have a good idea of what the effects might be when a woman takes one of these medications during pregnancy. Withdrawal (also known as neonatal adaptation syndrome) is one of those known effects.

Babies of women who are taking an SSRI at the time of delivery may have some difficulties in the first few days of life. Reported symptoms include jitteriness, increased muscle tone, irritability, constant crying, changes in sleeping patterns, tremors, difficulty eating, and problems with breathing. Not every baby will experience these symptoms. For the SSRI medications, it is estimated that 10-30% of babies will be affected.

Some babies with symptoms of withdrawal may need to spend time in the neonatal intensive care unit (NICU) to receive additional care. However, in most cases the symptoms are mild and go away within two weeks. Reassuringly, there does not seem to be a dose-response relationship, which means that women who need a higher amount of medication to manage their anxiety are not expected to have babies who are at a higher risk for withdrawal.

"I feel so much better after chatting with you, and I really feel like this withdrawal issue can be managed if I plan ahead" Natalie said. "I think it's going to be in my baby's best interest for me to start taking this medication as soon as

possible to get my anxiety under control." I was glad that Natalie had reached out to chat with us about this issue. It can be a complex topic, but certainly not an uncommon one. Now armed with the most current information available, Natalie can make the best choice for her and her baby

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Managing Mom's Anxiety during Pregnancy

By Kirstie Perrotta, MPH, MotherToBaby California

Cara and her husband Mark were contacting MotherToBaby for the first time. "Our adoption counselor just called – we have been matched with a potential birth mom this morning and she's due next Friday!" Cara blurted out excitedly. "The counselor said you would be able to tell us about the baby's exposure to heroin and Klonopin. I don't know how much she used, or when she stopped. We need to make a decision today."

As a Teratogen Information Specialist, I often receive calls from parents who are in all stages of the adoption process. The adoption journey can be an emotional rollercoaster, as Cara was experiencing. Here at MotherToBaby, we're happy to help and it's not uncommon for us to hear from potential parents who need to make a quick decision. We always let the prospective parents know that it's important to learn about any exposures that may have happened during the birth mom's pregnancy to best understand what a future with this child might look like. Bottom line: We want adoptive parents to feel as prepared and informed as possible.

So, what should a potential adoptive mom or dad ask about when making this important decision?

Alcohol

When asking about prenatal exposures, be sure to ask about alcohol use. Alcohol can be one of the most worrisome and scary exposures. That's because when a woman drinks alcohol while pregnant, it has the ability to affect the baby's brain, which is developing throughout the ***entire*** pregnancy.

Children exposed to alcohol during pregnancy are at risk for something called fetal alcohol spectrum disorders (FASD). FASD is a spectrum of disorders ranging from very severe effects (such as low IQ and small head) to more minor effects (such as attention issues and poor judgment). While FASD is a lifelong diagnosis, we know that early interventions have the potential to significantly improve outcomes for these children. If you notice that your child is starting to struggle in school, or having behavior issues, will you have the time and resources to get them the extra help they may need? It's a question you want to ask yourself as you consider adopting a child that might have special needs. Finding a specialist in your community that is familiar with treating FASD is a great place to start if you find yourself in this situation.

Recreational Drugs

Heroin, cocaine, marijuana, and methamphetamine are exposures that we unfortunately hear about all too often. While some women continue to abuse drugs up until delivery, other birth moms are motivated to quit when they learn they are pregnant. The most important information you can try to gather about this type of exposure is **HOW MUCH** and **HOW OFTEN** did the birth mom use the drug. Was it a one-time occurrence early in pregnancy, or an addiction she struggled with the entire nine months? These details can help the specialist you speak with best assess the situation. Using these types of recreational drugs during pregnancy can increase the risk for birth defects, pregnancy complications, and learning problems. See MotherToBaby's fact sheets for more information.

Methadone and Buprenorphine

Methadone and buprenorphine are two prescription medications that are commonly used to treat addiction to opioids such as heroin, codeine, and hydrocodone. Methadone works by changing how the brain and nervous system respond to pain. It also lessens the painful symptoms of opioid withdrawal and blocks the euphoric effects of opioid drugs. To get methadone, a person has to visit a clinic every day. Buprenorphine works a bit differently and is called a "partial agonist." This means that it partially creates a feeling of euphoria, but to a lesser degree than a narcotic like heroin. Buprenorphine is available by prescription only.

For many women, there are benefits to staying on a maintenance therapy like methadone or buprenorphine during pregnancy. Most importantly, it helps prevent relapse for women who have a history of abusing opioids. We also know that the women are getting a controlled dose of the medication every day from a healthcare provider. Lastly, women who remain on methadone or buprenorphine throughout pregnancy are less likely to have some of the health issues that traditional drug users may experience, such as a risk for infectious disease (like hepatitis C or HIV) from sharing dirty needles.

While these medications are generally preferred over continued drug abuse, there are still some risks associated with their use during pregnancy. If the birth mom you are considering reports exposure to methadone or buprenorphine, please contact us directly to learn more.

Cigarette Smoking

Cigarette smoking often goes hand in hand with alcohol and drug use. Again, knowing how much and how often the birth mom was smoking is the most helpful information you can have. Many times when a woman finds out she is pregnant she is able to either stop smoking completely, or cut down to just a few cigarettes per day, greatly reducing any possible risks to the baby.

Many studies have associated heavy cigarette smoking during pregnancy with an increased risk for preterm birth (delivery before 37 weeks). A baby born too early has a higher chance for health problems and may need to stay in the

neonatal intensive care unit (NICU). If the birth mom you are considering is a heavy cigarette smoker, it's important to think about how you would handle a baby that may need to spend some extra time in the hospital. For some moms and dads who are matched with a baby in a different state, this may present some logistical challenges. A couple of questions to ask yourself: will you be able to temporarily relocate to the city where the baby is born, and spend some extra time there if the baby does requires a longer hospital stay of a few weeks or more?

Prescription Medication

If a birth mom is taking a prescription medication, the most important thing to try to find out is whether she is taking it as directed, or possibly abusing it. There are many medical conditions that need to be managed during pregnancy – asthma, anxiety, depression, diabetes, and nausea to name just a few. If the birth mom is taking the medication as directed, there's a good chance we have studies looking at typical use of the medication during pregnancy, and any possible risks to the baby may be small. If a woman is abusing the medication there is likely not as much data, so we have less understanding of how the pregnancy may be affected.

Genetic Predisposition

It's also important to consider the reason a birth mom needs to take a specific medication. If the woman is prescribed a bipolar medication, for example, her medical history should be something to think about. Many health conditions have a genetic component, meaning that the baby you may adopt has the potential to inherit this condition. If the child does develop a genetic condition like bipolar disorder or schizophrenia, is this something you think that you (and your partner) could take on?

While this question is slightly outside our area of expertise, it's an important one to consider, and speaking with a genetic counselor to better understand any potential risk is a good idea.

Prenatal Care

Getting early and regular prenatal care improves the chances of a healthy pregnancy. Women who see a doctor or midwife routinely may be more motivated to stop unhealthy behaviors (such as drug use and cigarette smoking) and start healthy behaviors (like taking a daily prenatal vitamin with folic acid). Women who have access to prenatal care are also less likely to experience pregnancy complications caused by health conditions they might have (such as high blood pressure and diabetes).

While this information may not be readily available to you, there are certain situations where we know that the birth mom is more likely to be receiving prenatal care: women who are in jail or women who are in rehabilitation programs.

Ultrasounds are another aspect of prenatal care that can be helpful to know about. Typically, during a normal healthy pregnancy, women will receive what is called a fetal anatomy scan right around 20 weeks. This is a detailed ultrasound that is taking a look at all of baby's organs (heart, kidneys, bladder, sex organs, brain, etc.) to make sure they developed properly. Measurements will also be taken to make sure the baby is growing as expected. While ultrasounds are not 100% diagnostic (meaning they can't pick up every possible problem) a normal ultrasound does provide some reassurance. Ultrasounds are especially helpful if the birth mom was using a drug or medication that is associated with a higher risk for birth defects.

Has the Baby Already Been Born?

If the baby has already been born when you get the call, we have a lot more information to work with! First off, we know whether the baby was born early and we know the baby's weight. If baby was born full term (after 37 weeks) and at a healthy weight, the likelihood of them having to stay in the NICU is much lower. A physical exam can also help rule out any major birth defects.

Lastly, we can look for something called neonatal abstinence syndrome (commonly called withdrawal). Withdrawal is an issue that can occur in some babies exposed to drugs like heroin or methamphetamine, or prescription medications

like antidepressants or methadone later in pregnancy. While the specifics can vary depending on the exposure, symptoms typically develop soon after birth and in some cases can last for weeks. If a baby experiences withdrawal, they may need to spend some time in the NICU getting medication and extra care.

Making an Informed Choice

Wow, that sure is a lot to think about, right? The purpose of this blog is not to overwhelm you, but to inform you! We know first-hand that many adoptive moms and dads-to-be are provided with very few details about the birth mom and her possible exposures. We want to arm you with the questions to ask! In many cases you can gather some of the information discussed above from conversations with the adoption agency or the birth mom, medical records, or once the baby is born. The more information you have to share with experts like us, the better, so ask as many questions as you can! After all, this is one of the biggest decisions you will make in life, and it's important to be as informed as possible.

After spending some time learning about the effects of heroin and Klonopin, Cara and Mark felt that they had a good understanding of the potential issues associated with these exposures, and decided to move forward with the adoption. The good news for this couple (and all adoptive parents-to-be!) is that multiple studies have shown that babies that are raised in loving and stable adoptive homes do much better than children that remain with a birth mom who is continuing to abuse drugs or alcohol. Cara called back three months later to thank us for all the information we had provided. She shared that her baby boy was home and thriving, and they were so happy to have made an informed decision.

As you move forward in the adoption process, don't forget that Teratogen Information Specialists at MotherToBaby are available to review any specific adoptive scenarios you are presented with, at no cost to you. Don't hesitate to give us a call at 866-626-6847 or chat with an expert today to get your questions answered!

Managing Mom's Anxiety during Pregnancy

Lately, it seems like every few months a new infectious disease makes the headlines. The COVID-19 pandemic dominated the news cycle for some time, but as more and more people get vaccinated and the number of severe cases starts to decrease, the media's focus has shifted to other known or emerging threats. From the flu and respiratory syncytial virus (RSV), to mpox and syphilis, infections seem to be spreading like wildfire. Most recently, measles has made yet another comeback, prompting many women who are planning pregnancy, currently pregnant, or breastfeeding to make sure they are taking steps to avoid infection.

When I logged into our live chat service at www.mothertobaby.org on Tuesday morning, a chat from Alyssa popped up right away. "I'm currently 18 weeks pregnant and there was a measles case reported at my son's preschool. Do I need to be worried?"

It's understandable that Alyssa would be concerned. Measles (also known as rubeola) is a highly contagious respiratory disease caused by a virus. According to the Centers for Disease Control and Prevention (CDC) the measles virus can live for up to two hours in an airspace where the infected person coughed or sneezed. If people breathe the contaminated air or touch the infected surface, then touch their eyes, nose, or mouth, they can become infected. Measles is so contagious that if one person has it, up to 90% of the people close to that person who are not immune will also become infected.

Symptoms of measles generally appear about 7-14 days after a person is infected, and can include high fever, dry cough, runny nose, red watery eyes, and a rash all over the body. To date, studies have not identified an increased risk for birth defects when pregnant women get infected with measles during pregnancy. However, research suggests that a measles infection can be associated with an increased risk for miscarriage, premature delivery (having the baby before 37 weeks), and stillbirth.

The first question I asked Alyssa on chat was if she had ever received the Measles, Mumps, and Rubella (MMR) vaccine. Just one dose is about 93% effective at preventing measles, while two doses is close to 97% effective, so it's the best way to prevent this disease. These vaccines are routinely given in childhood, so Alyssa couldn't remember if she had received both, but after texting her mom she was able to confirm that she was fully vaccinated. Whew, that was good news. Next we discussed the date of exposure. I asked Alyssa when the positive case was reported at daycare, to which she answered that it was about two weeks ago. More good news. Since neither Alyssa nor her son had experienced any symptoms yet, infection was unlikely.

Since measles doesn't seem to be going away anytime soon, knowing how to best protect yourself against the illness at all reproductive life stages is important.

Pre-Conception: Women who are planning a pregnancy in the future should make sure they are up to date with their MMR vaccines **BEFORE** they get pregnant. If you can't find your vaccine record, call your healthcare provider who may know. If they don't have a record, a blood test (titer) can be done to determine if you have immunity to measles. If it turns out you are not immune, you'll want to get two doses of MMR vaccine for optimal protection. Just make sure you wait at least one month after getting the last shot before attempting to get pregnant.

Pregnancy: Since pregnant women shouldn't receive live vaccines (like MMR), the best thing you can focus on during pregnancy is prevention. Good hand washing is always a good idea. If there is a confirmed measles outbreak near you, consider avoiding crowded public places and steer clear of any locations that have been identified as a known risk.

Breastfeeding: Once you are no longer pregnant, the MMR vaccine can be administered. The CDC considers the MMR vaccine compatible with breastfeeding and side effects for the breastfed baby are not expected.

If you have any questions about measles infection or the MMR vaccine while planning a pregnancy, during pregnancy or while breastfeeding, MotherToBaby is here to help. Give us a call at 866-626-6847, text, or chat with one of our information specialists today.

Managing Mom's Anxiety during Pregnancy

You may have heard that the Centers for Disease Control and Prevention (CDC) recently recommended a new vaccine for use in the third trimester of pregnancy. Known as Abrysvo™, the vaccine helps protect newborns against severe cases of respiratory syncytial virus (RSV). RSV is the leading cause of infant hospitalization in the United States, with anywhere from 58,000-80,000 hospitalizations occurring each year among children younger than 5. Even more upsetting is that 100-300 children under age 5 die from RSV every year. With these statistics in mind, this new RSV vaccine is exciting news for infants and their families.

Ava, 24 weeks along with her first pregnancy, contacted the MotherToBaby live chat service early one morning with some questions about the new RSV vaccine. First, she wanted to understand how vaccinating a pregnant woman could provide protection for a baby. As a Teratogen Information Specialist, I was happy to answer this question for Ava. I started by explaining that when a person gets vaccinated, their body makes antibodies. These antibodies protect the body against the actual infection if a person is exposed to the virus or bacteria later in life. During pregnancy, the antibodies that a pregnant woman makes after being vaccinated can cross the placenta and pass to the developing baby, providing the newborn with some protection against the infection during the first few months of life.

I went on to explain that although the RSV vaccine is new, the idea of getting a vaccine during pregnancy to protect the baby (called "passive immunity") has been around for some time. The Tdap vaccine, which protects against tetanus, diphtheria, and pertussis (whooping cough), has been recommended for use in pregnancy since 2011. Whooping cough is another infection that can be very serious for newborns, so having protection from birth as a result of maternal vaccination is ideal. The flu shot and COVID-19 vaccine can also pass antibodies to the developing baby during pregnancy. This is great news since newborns can't get their own flu or COVID-19 shots until 6 months of age and need to rely on passive immunity in the meantime.

Next, Ava had a question about ***when*** she should get the RSV vaccine. She had plans to get her flu shot and Tdap vaccine at her next prenatal visit at 28 weeks. She wanted to know if she could get the RSV vaccine at the same time. Although these three vaccines (along with the updated COVID-19 vaccine) can all be given on the same day, the RSV vaccine should be given during a specific timeframe in order to pass as many antibodies as possible to the baby. Experts recommend that the RSV shot be given between 32 and 36 weeks of pregnancy. This allows enough time for RSV antibodies to pass to the baby before delivery.

With this recommendation in mind, Ava decided that her prenatal appointment at 32 weeks would be the perfect time to get the RSV vaccine. She had seen firsthand just how serious RSV can be when her 1-month-old niece was hospitalized with RSV last winter, so she didn't want to take any chances with forgetting to get the RSV vaccine during her pregnancy.

Before we ended the chat, I mentioned to Ava that there is also a shot called nirsevimab (Beyfortus™) that can be given directly to babies under 8 months of age. Also known as a monoclonal antibody, this shot is another way to protect infants against severe RSV disease. Most babies do not need nirsevimab if their mom received the RSV vaccine during pregnancy. I suggested Ava talk with her healthcare provider about the pros and cons of both options.

Although having to remember to get another vaccine in pregnancy can feel like just one more thing a pregnant woman needs to add to their never-ending to do list, the decision to vaccinate can prevent serious complications from RSV, and possibly even save the baby's life. Here at MotherToBaby we are happy to go over the current recommendations for vaccines in pregnancy and answer any questions that you may have. Don't hesitate to call, chat, text, or email with any questions about the RSV vaccine or other exposures during pregnancy. You can also check out our newest fact sheet about this vaccine here https://mothertobaby.org/fact-sheets/respiratory-syncytial-virus-rsv-vaccine-abrysvo/.

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Managing Mom’s Anxiety during Pregnancy

By: Kirstie Perrotta, MPH and Becky Spencer, PhD, APRN, PMHNP-BC, IBCLC, PMH-C, FILCA

Shannon was newly pregnant and had been referred to MotherToBaby by her doctor. She was taking 50 mg of sertraline per day for general anxiety and her doctor thought that she may need to wean off the medication now that she was 5 weeks pregnant. Shannon had been taking the medication for 3 years and was feeling great on her current dose, so she had some concerns about this plan. On the MotherToBaby website’s live chat service, Shannon was connected with me, a teratogen information specialist, where she asked “Do I really need to stop my anxiety medication, or could I just continue on a lower dose?”

I started by addressing the importance of weighing the risks vs. benefits of taking any mental health medication during pregnancy. Sertraline is very well studied and has not been associated with a risk for birth defects, but does have the potential to cause neonatal adaptation syndrome or withdrawal approximately 10-30% of the time and persistent pulmonary hypertension in less than 1% of exposed infants. On the other hand, we know that untreated anxiety can also cause problems for the pregnancy, including an increased risk for preterm delivery. For many patients, the benefits of staying on a medication like sertraline outweigh the potential risks, but each case is unique and ultimately the patient needs to decide what they are most comfortable with.

Getting to Shannon’s next question about dose, I shared that although many pregnant women feel they need to decrease their dose once they get a positive pregnancy test, the opposite is in fact true. During pregnancy, there are many changes that occur including weight gain, increased blood volume and enlargement of the kidneys. On the outside, things won’t look much different, but research shows these changes happen soon after conception. This means that medication doses that previously worked well to control a condition become “diluted,” in a sense, and may not be as effective. In some cases, women need to actually increase their dose to continue to control the disease.

To learn more about how bodily changes during pregnancy impact medication dosing, we turn to Becky Spencer, PhD, APRN, PMHNP-BC, IBCLC, PMH-C, a psychiatric nurse practitioner who specializes in perinatal mental health at Texas Women’s University with some more questions about this fascinating phenomenon.

Q. Can you tell us a little more about what is happening in the body during pregnancy and why medications become less effective?

Becky Spencer: You are correct, Kirstie, that pregnancy has a significant impact on drug absorption, which is how a drug is transported into the bloodstream, drug distribution, which is the disbursement of a drug as it moves through the blood and tissues of the body, and drug metabolism, which is the process by which the body breaks down and eliminates drugs or other substances. During pregnancy, especially later in pregnancy, drug absorption from the stomach into the bloodstream is decreased due to slower gastric emptying and slower movement of the bowel and colon, so it can take longer for a medication to be absorbed and get to work.

A pregnant woman’s blood volume almost doubles during pregnancy which impacts drug distribution. With the dilution effect there is a lower concentration of medication in the blood plasma which results in less medication reaching the target tissues. Most drugs are metabolized in the liver or kidneys. During pregnancy, the increased blood flow to the kidneys results in an increased glomerular filtration rate (GFR), which means that medications are cleared from the bloodstream quicker, meaning the drug stays in the body less time. Similarly, hormone levels increase during pregnancy which increases the activity of various metabolic enzymes in the liver that metabolize drugs. When the liver

metabolizes a drug more quickly there is less drug that reaches the target tissues.

What these changes mean for pregnant women who take medication for mood and anxiety disorders is that the dose of medication that they were taking before pregnancy may have a decreased effect during pregnancy, because the biological changes effectively decrease the amount of medication reaching the target tissues, in this case, the brain. Pregnant women may have an increase in mood and anxiety symptoms that they interpret as a worsening condition when, in fact, the decrease in circulating medication is the cause for an increase in symptoms.

Q. In your practice, how often do you see women increasing their mood medication dose? Does the dose need to be increased substantially?

Becky Spencer: That is a great question. The answer is that it depends on the type of medication, the specific condition (depression, anxiety, obsessive compulsive disorder, bipolar, etc.), and the severity of symptoms. Psychiatric providers typically increase medication dosages in gradual amounts until the patient has symptom relief or desired therapeutic effect. If a patient is experiencing a partial response to a medication (some improvement in mood and anxiety symptoms) best practice is to increase the dose of that medication before considering adding an additional medication.

Another question that I hear is whether or not dosages of medication should be based on achieving a specific blood plasma concentration level. The short answer is, for most medications, no. We don't routinely check blood plasma concentrations of most antidepressants because valid and reliable therapeutic plasma concentration ranges do not exist. Some mood stabilizing medications like valproate or lithium do require blood plasma monitoring both during pregnancy and outside of pregnancy. Euthymia, or stable mood, is the goal of medication dose adjustments for mood and anxiety disorders during pregnancy.

Q. What about after delivery? Does the dose need to be decreased right away?

Becky Spencer: It depends on the type of medication, and, to some extent, the symptoms that the patient is experiencing. The postpartum period is a vulnerable time for mood and anxiety disorders for several reasons including the significant hormonal shift that occurs after birth, lack of sleep, role adjustment to caring for a baby, and for some new parents, lack of necessary social and emotional support. Decreasing antidepressants too quickly after birth could exacerbate mood and anxiety symptoms during that very vulnerable time. The decision to decrease dosages of any medication prescribed for mood and anxiety disorders should be a collaborative decision between the patient and the provider. If decreasing mediation dose is desirable, it should occur gradually and any change in mood and anxiety symptoms should be reported to the provider. The one exception to this rule is for patients taking lithium. If lithium dosages were increased during pregnancy, they must be decreased to pre-pregnancy dosages after delivery.

Q. Shannon is asking about sertraline, an anti-anxiety medication, but are there other drugs that women need to also increase their dose of during pregnancy?

Becky Spencer: Any medications used to treat mood and anxiety disorders, including antidepressants, mood stabilizers, antipsychotics, and anti-anxiety medications, may need dose increases during pregnancy. The most important point is for pregnant women to monitor their mood and anxiety symptoms and report them to their provider. The decision to increase doses of medication should always be a collaborative decision between the patient and the healthcare prescriber.

Q. How should patients approach this conversation with their healthcare provider?

Becky Spencer: The decision to take any medication during pregnancy must be based on a discussion between healthcare providers and patients that takes into consideration the available research on the risks of specific medications AND the risks of untreated or undertreated mental conditions for both the pregnant woman and the baby. The risks of not treating mood and anxiety disorders during pregnancy are well documented and significant. Untreated or undertreated mood and anxiety disorders during pregnancy are associated with hypertension, preterm delivery, low birth weight, and long-term negative impacts on motor and cognitive development of the baby. Mental health conditions are the leading cause of maternal mortality in the United States. Effective treatment for mood and anxiety disorders in the perinatal period will literally save lives.

My top three tips for having a discussion with healthcare providers about medications for mood and anxiety disorders in the perinatal period include:

- Make an appointment with a psychiatric provider who specializes in perinatal mood and anxiety disorders or reproductive psychiatry. The provider directory on the Postpartum Support International website is a great place to find specialists in your state, and many provide telehealth services.

- If your obstetric provider is hesitant to treat your mood and anxiety symptoms, recommend that they make an appointment to speak with a psychiatric provider who specializes in treatment of perinatal mood and anxiety disorders during pregnancy at the Postpartum Support International Psychiatric Consult Line. This free service is staffed by perinatal psychiatrists who are available to share their skills and expertise and provide guidance to fellow medical professionals on prescribing medications during pregnancy and lactation.

- MotherToBaby Fact Sheets are an excellent resource and a great way to start a conversation with your provider about specific medications for mental health during pregnancy and lactation. I recommend that pregnant and lactating women who are taking medications for mood and anxiety disorders access and print out the MotherToBaby Fact Sheets for the medications that they are taking or are interested in learning more about, read them, jot down questions, and take them to their obstetric and/or psychiatric providers to start the conversation. Remember that you are your own best advocate for you and your baby's health.

Thanks so much for sharing your insight, Becky. It's always great to learn more about this topic.

Ultimately, Shannon decided to stick with her current dose for the first few weeks of pregnancy and make an appointment with her psychiatrist to discuss increasing her dose in a few weeks. In the meantime, she was planning to monitor her mood to make sure the anxiety remained well controlled.

If you have questions about mental health medications, dose, or any other exposures in pregnancy or lactation, please

feel free to reach out to a MotherToBaby specialist via phone, chat, text, or email for more information. Additionally, you can visit our Mental Health Resource Hub to access fact sheets, blogs, and podcasts on mental health conditions and the medications used to treat them during pregnancy and breastfeeding.

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