Reproductive Psychiatry and Medication Exposures during Pregnancy and Breastfeeding: Misinformation and Interprofessional Challenges

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BLOOMING BEGINNINGS

MENTAL HEALTH, PLLC

Objectives

Discern	**Discern the incidence of perinatal mood and anxiety disorders and disparities experienced by specific communities**
Examine	**Examine strategies for screening and interprofessional collaboration and treatment of perinatal mood and anxiety disorders**
Identify	**How Mother-to-Baby information and fact sheets can be disseminated and used to promote cohesive interprofessional care coordination**

Conflict of Interest

- I have no potential conflicts of interest to report

Terminology

Postpartum depression is being replaced with:

Perinatal Mood and Anxiety Disorders (PMADs)

- **P**erinatal-in pregnancy or the postpartum period
- **M**ood-depression, bipolar I & II, psychosis
- **A**nxiety-generalized anxiety disorder, obsessive compulsive disorder (OCD), post traumatic syndrome disorder (PTSD)
- **D**isorders-symptoms negatively affect daily function

Scope of the Problem

PERINATAL MOOD AND ANXIETY DISORDERS (PMADS)

1 in 5

Will experience a perinatal mood and anxiety disorder

5-25%

Of women have depression during the first year postpartum

Misunderstood & Misdiagnosed

Only 8.6% of women with antenatal depression and 6.3% of women with postpartum depression received adequate treatment

(Cox et al., 2016)
(Wisner et al., 2013)

- **26.5% of the episodes began before pregnancy**
- **33.4% of the episodes had their onset during pregnancy**
- **40.1% of the episodes began during the postpartum period**

Landmark Study 10,000 U.S. Women

Of the 14% of women who screened positive:

- 68.5% had a primary diagnosis of unipolar depression (MDD)
- 66% with major depressive disorder (MDD) had comorbid anxiety disorders, most commonly generalized anxiety disorder (GAD)
- 22.6% were diagnosed with bipolar disorder
- 19.3% endorsed thoughts of harming themselves

Populations at Increased Risk

PMADs Undue Burden on Vulnerable Populations

- **Poverty and PMADs**
- 11 times more likely to develop postpartum depression symptoms (Goyal et al., 2010)
- half of infants in low-income households have a mother with depression (Vericker et al., 2010)
- **BIPOC and PMADS**
- Depression almost twice the rate of white new mothers (Keefe et al., 2018)
- 60% of Black and Latina mothers do not receive any treatment or support (Keefe et al., 2018)
- 40% greater in Latina mothers and 80% greater in Black mothers in rural areas (Ceballos et al., 2016)
- Nearly 30% of American Indian and Alaskan Native mothers experience depression postpartum
- **Racism is the problem NOT Race**

NICU and PMADs

NICU Parents are more likely to screen positive for anxiety and depression than the general parent population

33% of mothers and 17% of fathers screened positive on the EPDS (Garfield et al., 2021)

< 32 weeks gestation up to 40-50% of parents report increased anxiety and depression that persisted through 6 months (Pace et al., 2016)

Women with a history of depression prior to delivery are at higher risk for depression if their newborn is admitted to the NICU (Das, et al., 2021)

32% of mothers with newborns admitted to the NICU endorsed suicidal thoughts (Lefkowitz et al., 2010)

Pooled prevalence of anxiety in NICU parents reported to be 42% (Malouf et al., 2022)

Pooled prevalence of symptoms posts traumatic stress in NICU parents is 40% up to one month post birth and 24.5% up to one year post birth (Malouf et al., 2022)

Perinatal Mental Health among Parents who Identify as Sexual and Gender Minorities

Queer people's experiences of conception, birth and parenting are under-recorded and under-researched

In the UK 15-20% of lesbian couples access fertility and maternity services

Pregnant trans men are a growing population within maternity services

Many birthing people do not report their sexual and and gender orientation to their healthcare providers for fear of discrimination.

Pregnancy and Breastfeeding with HIV

- *"Individuals with HIV who are on ART with a sustained undetectable viral load and who choose to breastfeed should be supported in this decision" (Clinicalinfo.HIV.gov, 2023)*

- Women with HIV have significantly higher odds ratio of antenatal and postnatal depression (Zhu et al., 2019)

- **NO Mother-to-Baby fact sheets for any ART medications**

Risk Factors for PMADS

- Family history mental health issues (particularly PMADs)
- Personal history of mental illness
- PMADs with previous pregnancy
- Depression and anxiety symptoms related to menstruation
- Partner relationship issues
- Low socio-economic status
- Insufficient social support
- Unplanned pregnancy
- Pregnancy loss
- Infertility
- Substance use disorders
- Birth trauma
- Birth injury
- Intimate partner violence
- NICU stay
- Breastfeeding/feeding issues
- Challenging baby
- Financial stress
- Change in identity
- Body image
- Change in a friend group
- Perfectionism
- COVID-19
- Thyroid disease

So What?

The risks of UNtreated or UNDERtreated disease are SIGNIFICANT

Depression and Anxiety

- 40% more likely to have hypertension (Shay et al., 2020)
- **Mothers**-higher risk of preterm birth, lower birth weight and small for their gestational age (Grigoriadis et al., 2018)
- **Infants-** long-term negative impacts on their weight, length, head circumference, motor development, cognitive development, and sleep patterns (Slomian et al., 2019).

Bipolar disorder

- gestational hypertension, hemorrhaging, 2X likely to have a preterm birth (Rusner et al., 2016; Davenport et al., 2020)

PTSD

- higher risk of preterm birth and poor fetal growth (Cook et al., 2018)

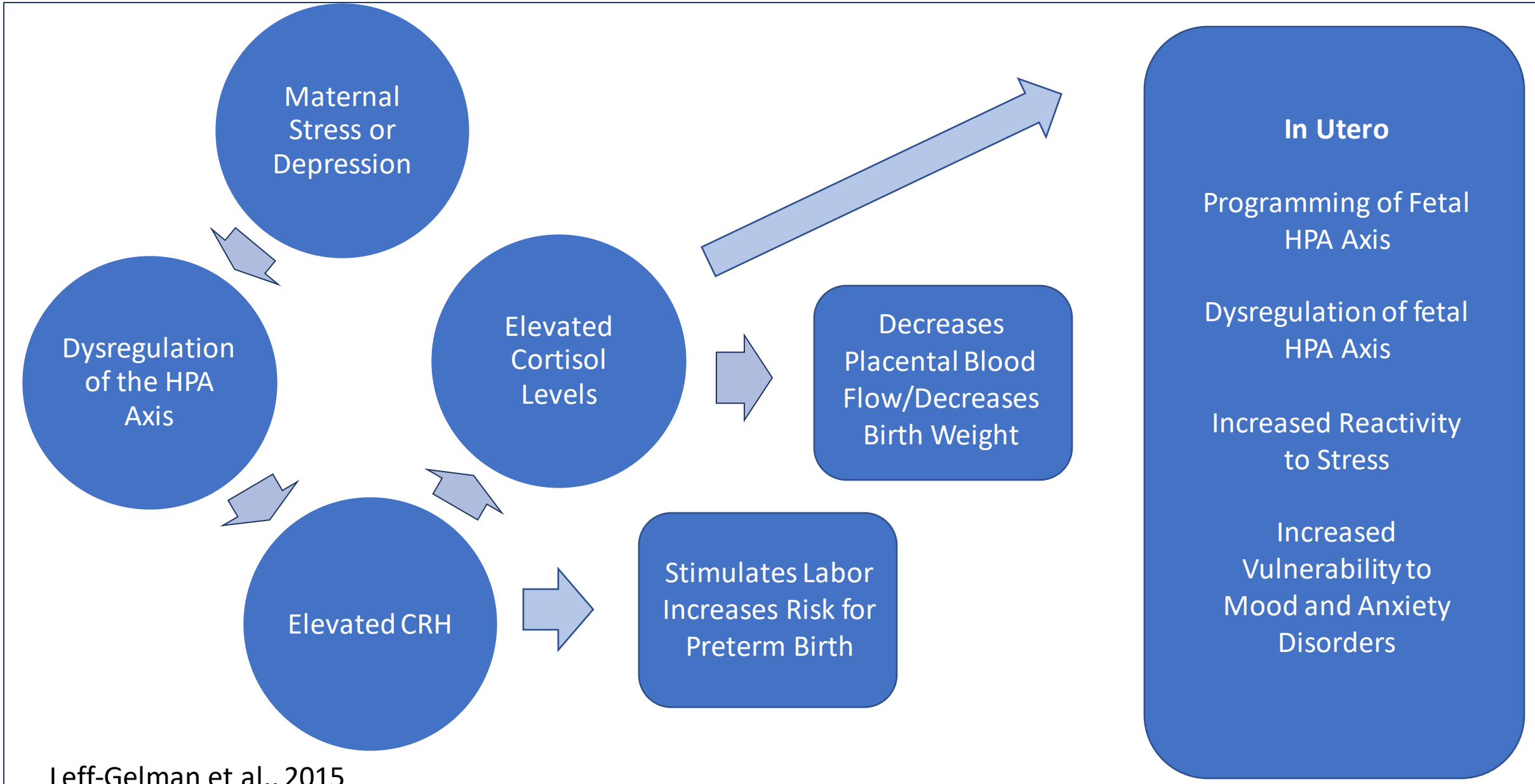
Any untreated psychiatric disorder

- Higher risk for suicide (Prakash & Nagle-Yang, 2019)

Postpartum psychosis

- Higher risk for suicide and infanticide (Prakash & Nagle-Yang, 2019)

HPA-axis Dysregulation of the Fetoplacental Unit



Leff-Gelman et al., 2015

Risks of Untreated or Undertreated PMADs

ACOG Consensus Bundle on Maternal Mental Health 2017

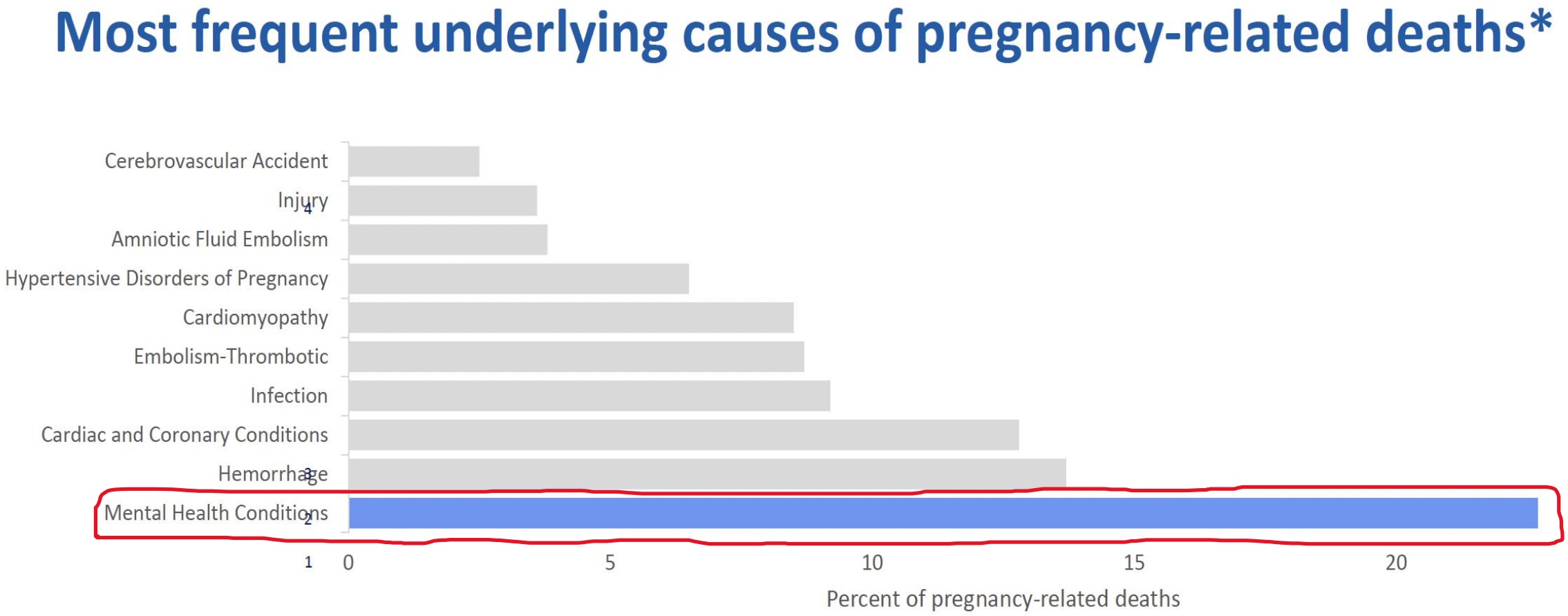
- Relationship problems
- Poor adherence to medical care
- Exacerbation of medical conditions
- Intimate partner violence/separation/divorce
- Loss of interpersonal and financial resources
- Disability/unemployment
- Tobacco, alcohol, and illicit drug use
- Infanticide, homicide, suicide
- Children with neurodevelopmental delays/behavioral problems

Kendig et al., 2017

Maternal Mortality and the Perinatal Mental Health Gap

Underdiagnosis and misdiagnosis represent the perinatal mental health gap.

Leading causes of pregnancy-related death among deaths determined to be preventable in 36 US states, 2017–19



Trost et al., 2023

Cost of Untreated PMADs

(Luca et al., 2019)

PMADs are the most underdiagnosed

and

undertreated obstetric complications

in the U.S.

Screening

Common Prenatal Screenings and Prevalence of Illness

- **Gestational hypertension** and **pre-eclampsia** routine screening at every prenatal visit
  - Percentage of pregnant women affected 6-8%
- **Gestational diabetes** routine screening after 24 weeks gestation
  - Percentage of pregnant women affected 6%
- **PMADs** No nationally agreed upon screening recommendations
  - **Percentage of women affected 15-21%**

INTERIM UPDATE

2018

The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

ACOG COMMITTEE OPINION

Number 757

(Replaces Committee Opinion No. 630, May 2015)

Committee on Obstetric Practice

This Committee Opinion was developed by the American College of Obstetricians and Gynecologists' Committee on Obstetric Practice.

INTERIM UPDATE: This Committee Opinion is updated as highlighted to reflect a limited, focused change in the language and supporting evidence regarding prevalence, benefits of screening, and screening tools.

Screening for Perinatal Depression

ABSTRACT: Perinatal depression, which includes major and minor depressive episodes that occur during pregnancy or in the first 12 months after delivery, is one of the most common medical complications during pregnancy and the postpartum period, affecting one in seven women. It is important to identify pregnant and postpartum women with depression because untreated perinatal depression and other mood disorders can have devastating effects. Several screening instruments have been validated for use during pregnancy and the postpartum period. The American College of Obstetricians and Gynecologists recommends that obstetrician–gynecologists and other obstetric care providers screen patients at least once during the perinatal period for depression and anxiety symptoms using a standardized, validated tool. It is recommended that all obstetrician–gynecologists and other obstetric care providers complete a full assessment of mood and emotional well-being (including screening for postpartum depression and anxiety with a validated instrument) during the comprehensive postpartum visit for each patient. If a patient is screened for depression and anxiety during pregnancy, additional screening should then occur during the comprehensive postpartum visit. There is evidence that screening alone can have clinical benefits, although initiation of treatment or referral to mental health care providers offers maximum benefit. Therefore, clinical staff in obstetrics and gynecology practices should be prepared to initiate medical therapy, refer patients to appropriate behavioral health resources when indicated, or both.

Screening for PMADS

Timing
First prenatal visit
At least once in second trimester
At least once in third trimester
Six-week postpartum obstetrical visit (or at first postpartum visit)
Repeated screening at 6 and/or 12 months in OB and primary care settings
3, 9, and 12-month pediatric visits

[Recommendations from Postpartum Support International](https://www.postpartum.net/professionals/screening/)

https://www.postpartum.net/professionals/screening/

Screening for PMADS

Validated Tools

- **EPDS** (Edinburgh Postnatal Depression Scale) https://psychology-tools.com/epds/
- **PHQ-9** (Patient Health Questionnaire-9) https://www.phqscreeners.com/
- The recommended cut-off score for a positive screen using either tool is 10.
- The EPDS is a reliable and valid measure of mood in fathers. Screening for depression or anxiety disorders in fathers requires a two-point lower cut-off than screening for depression or anxiety in mothers, and we recommend this cut-off to be 8. (Edmonson et al., 2010)

You may be screening, but **how do you screen** and **what are you doing with the results**?

- How is the screening introduced to patients?
  - Just another form to fill out OR
  - Implement a warm introduction
- Who is giving the patient the screening?
  - Anyone can administer and score the EPDS or PHQ-9
- What do you do for patients with a score of 10 or more?
  - Hand them a list of referral sources OR
  - Initiate a warm handoff OR
  - *Start treatment while the patient explores therapy and psychiatric provider options*

Suicidal Thoughts

- If the patient screens positive on **EPDS #10 or PHQ9 #9** you need to ask the question:
- **Do you have any feelings of harming yourself (and/or your baby)?**
- DO NOT just ask the question and call 911, do a thorough assessment, or get them to someone who can.
- **Columbia Suicide Severity Rating Scale** https://storage.trailstowellness.org/trails-2/resources/columbia-suicide-severity-rating-scale-and-scoring-instructions.pdf
- **MCPAP for MOMS** https://www.mcpapformoms.org/docs/Risk_Assessment_Thoughts_of_Suicide_or_Harm_to_Baby.pdf
- If the patient endorses active suicidal thoughts with a plan they must be directly referred to a hospital or psychiatric assessment center
- **Worrisome quote "The baby would be better off without me."**

REMEMBER Suicide is the leading preventable cause of maternal mortality!

PMADs Diagnoses (Note: NO diagnosis for postpartum depression in the DSM 5)

- Major Depressive Disorder (unipolar) with peripartum onset
- Generalized Anxiety Disorder
- Panic Disorder
- Obsessive Compulsive Disorder
- Postpartum psychosis/Bipolar
- Post Traumatic Stress Disorder/Acute Distress disorder
- ADHD

Postpartum Psychosis/Bipolar 1

- The typical age of onset of Bipolar 1 coincides with reproductive age in women which is ~25 years
- Risk of relapse DURING pregnancy is 85.5% for women who discontinue medications (Viguera et al., 2007)
- Relapse of Bipolar is very common AFTER pregnancy
  - 66% with NO medications during pregnancy
  - 23% with medications during pregnancy (Wesseloo et al., 2017)
- Relapse of Bipolar 1 is frequently experienced as postpartum psychosis (Wesseloo et al., 2017)

Collaboration and Treatment

Evidence Informed Treatment for PMADS

Massachusetts General Hospital Center for Women's Mental Health

Training

https://lms.mghcme.org/course-catalog-list?f%5B0%5D=field_course_category%3A144

Virtual Rounds every Wednesday 1-2 pm CST

https://womensmentalhealth.org/educational-programs/virtual-rounds-at-the-cwmh/

Research Review Blog

https://womensmentalhealth.org/blog/recent-posts/

Research Registries for patients taking psychotropic medications

https://womensmentalhealth.org/research/pregnancyregistry/forclinicians/

Evidence Informed Treatment for PMADS

MCPAP for MOMS

Obstetric Provider Toolkit

https://www.mcpapformoms.org/Docs/AdultProviderToolkit_2019.pdf

National Curriculum for Reproductive Psychiatry

https://ncrptraining.org/

Marcé of North America

https://marcenortham.com

Evidence Informed Treatment for PMADS

Postpartum Support International

Training and certification

https://www.postpartum.net/professionals/certificate-trainings/

Provider directory

https://psidirectory.com/

Psychiatric consult line

https://www.postpartum.net/professionals/perinatal-psychiatric-consult-line/

Membership

https://www.postpartum.net/join-us/become-a-member/

Frequently Expressed Concerns Regarding Psychotropic Medication Use in Pregnancy

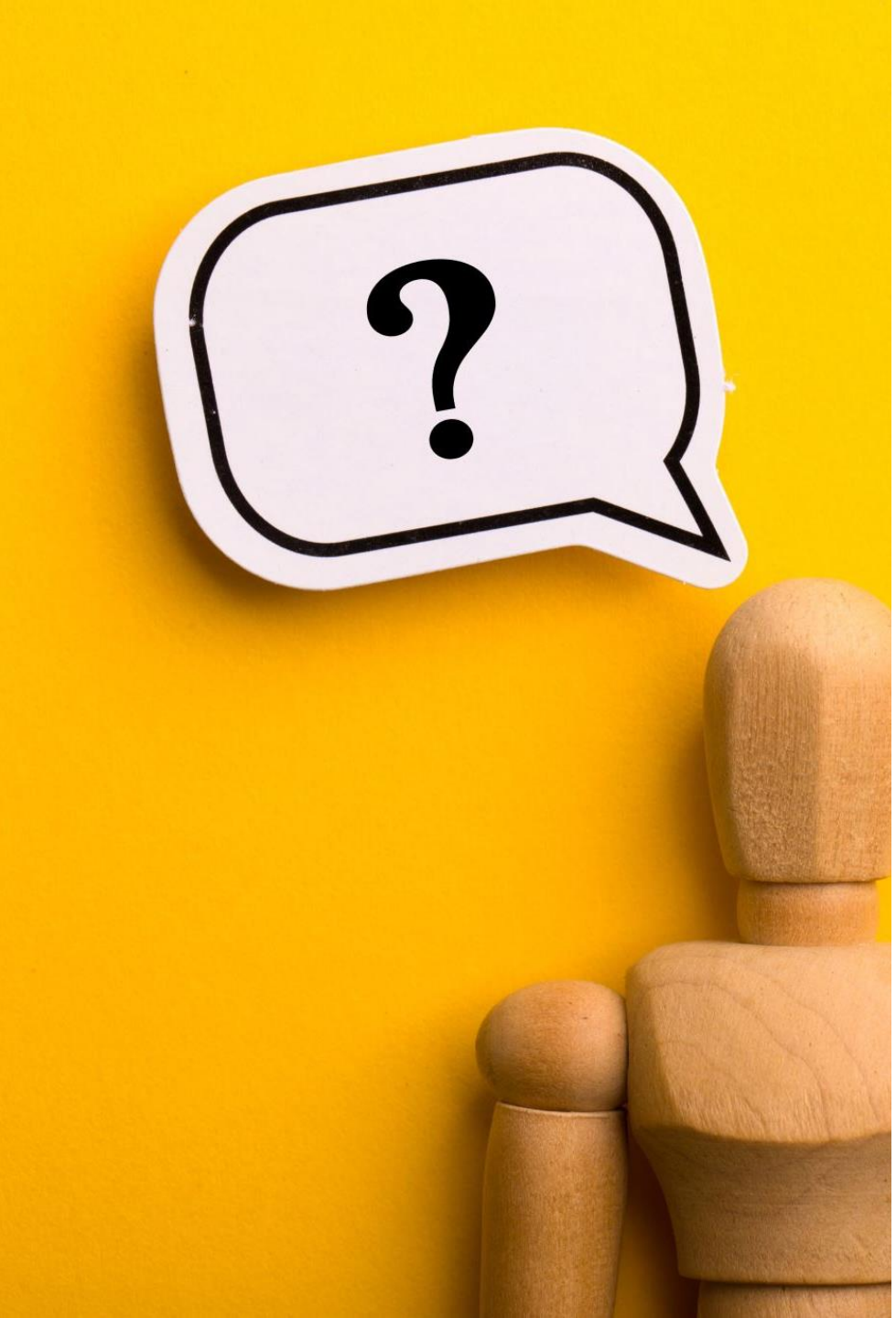
- Congenital malformation
- Miscarriage
- Preterm delivery/low birth weight
- Neonatal Adaptation Syndrome
- Persistent Pulmonary Hypertension in the Newborn
- Long term neurobehavioral effects
- Autism

Case Conceptualization #1

- Jackie is a 25 y/o G1P0 at 14 weeks' gestation presents to the OB provider for her first prenatal appointment and is very excited about her pregnancy. It was unplanned, but she and her husband were not using birth control. Jackie reports a past history of mild to moderate depression when she was in college and was seen at campus health for psychotherapy. She had symptoms of low motivation, anhedonia, and tearfulness which resolved after several therapy appointments.

- One year ago, symptoms of irritability, sadness, and anxiety returned. She went to see her PCP and was placed on sertraline 50mg with some improvement in symptoms, but stopped medication when she found out she was pregnant. She was also prescribed Trazodone which worked well, but she has not taken since she found out she was pregnant.

- She reports her mood is OK right now, but is having some difficulty sleeping and is "worried" about something happening to the baby.



Case Conceptualization #1

- **What additional questions do I ask?**
  - EPDS score
  - Family History
  - S/E and experience on medications taken previously
  - Sleep
  - Social support
  - **How did she decide to stop sertraline?**

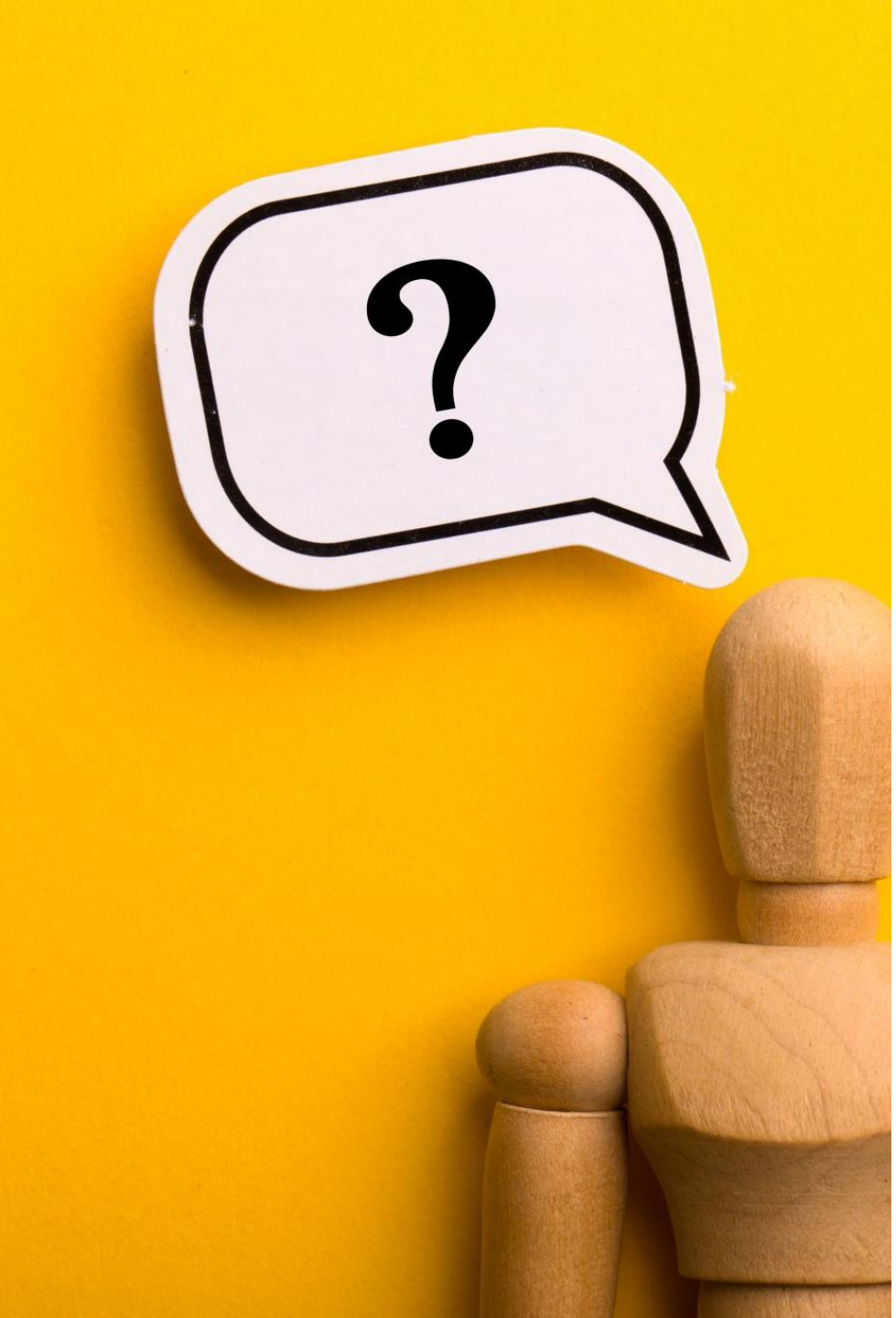
Case Conceptualization #1

- Pt scored 12 on EPDS with 0 on #10. Scored 2 on questions 4,5,6 (anxiety questions)
- Her mom has a diagnosis of anxiety and is treated. Her dad has anxiety, but does not believe in medications or therapy and has never been seen.
- Jackie reports that when she first took sertraline she has a slight headache and some nausea but it quickly resolved.
- She is able to fall asleep but can't remain asleep. Usually awakens at 3a and it takes 2-3 hours to fall back to sleep
- Good family and friend support
- Her OB provider did check her thyroid and told her it was "normal".
- ***Stopped sertraline because her obstetrician wanted to see how she did without it.***

Case Conceptualization #1

- **Medication for depression/anxiety and sleep**
  - Sertaline 25mg for 4 days then increase to 50mg, continued to titrate up to remission of symptoms
  - Hydroxyzine or BuSpar can also be given to help with anxiety
  - OTC Unisom, Benadryl, or Trazodone 25-50mg (worked for her before)
  - Follow up in 1-2 weeks

- Symptoms resolved with sertraline 75mg. She continued taking sertraline and trazodone 50mg through delivery. After one year without symptoms and at baseline she was weaned off sertraline and trazodone.
- She had a term vaginal birth with no complications for her or the baby



Case Conceptualization #1

Questions to consider

- If she would have stayed on sertraline would she have remained euthymic throughout pregnancy?
- Did her depression and anxiety symptoms put her pregnancy and baby at increased risk for complications?

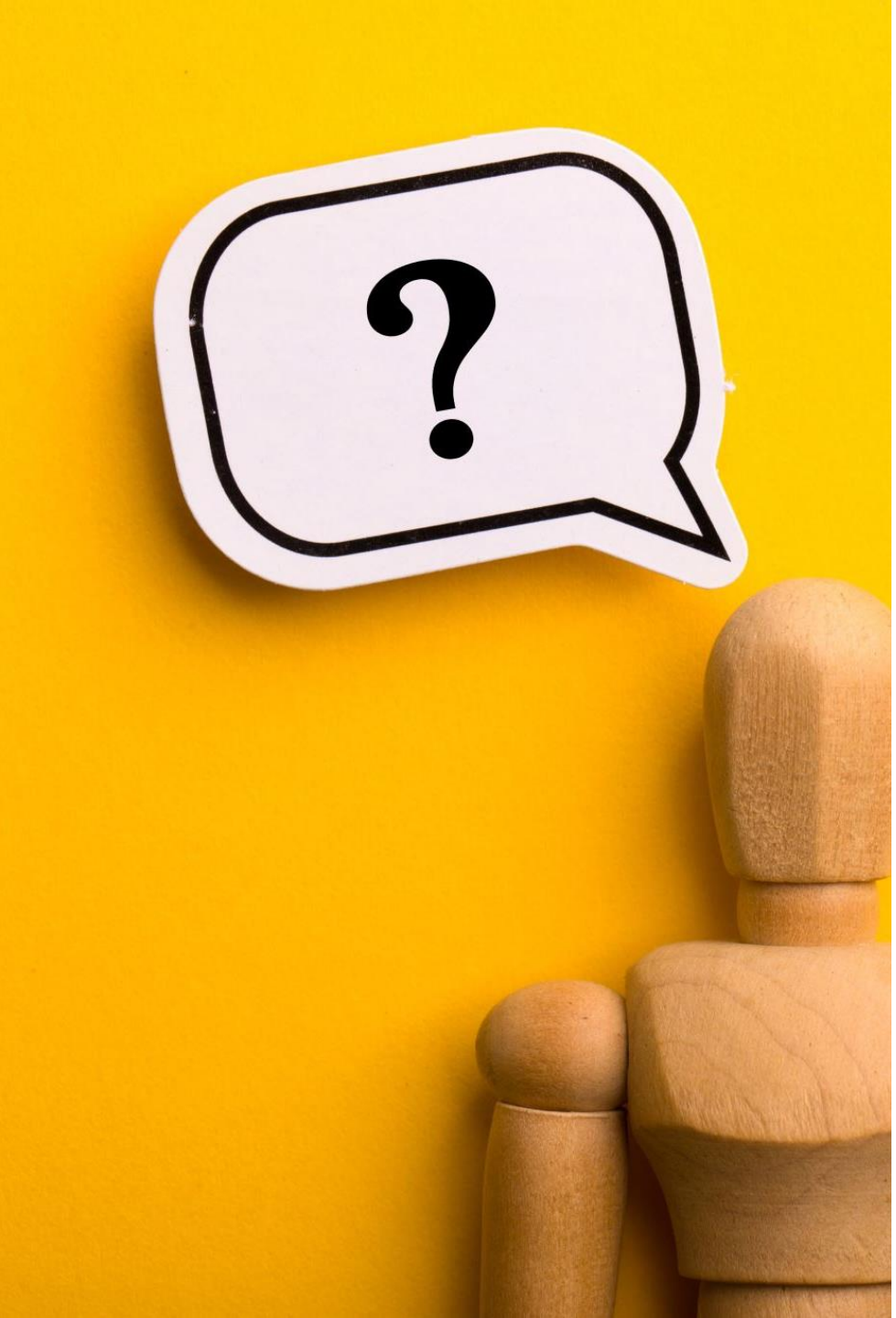
Case Conceptualization #2

- Marshaun was a 31 yo G0P0 who presented to her obstetric provider for her annual well woman exam. The patient stated that she was recently married and that she and her husband were planning to get pregnant within the next year.
- The patient has a history of Major Depressive Disorder, recurrent, now in remission, Panic Disorder, and ADHD diagnosed after neuropsychological testing.
- The patient was taking citalopram (Celexa) 30 mg q day, bupropion (Wellbutrin) XL 450 mg q day, dextroamphetamine/amphetamine (Adderall) XR 30 mg q am, dextroamphetamine/amphetamine (Adderall) IR 15 mg prn q afternoon, and alprazolam (Xanax) 0.25 mg prn bid.
- The patient, psychiatrist and obstetrician were all concerned about the risks of her medications in pregnancy

Case Conceptualization #2

What happened with this patient:

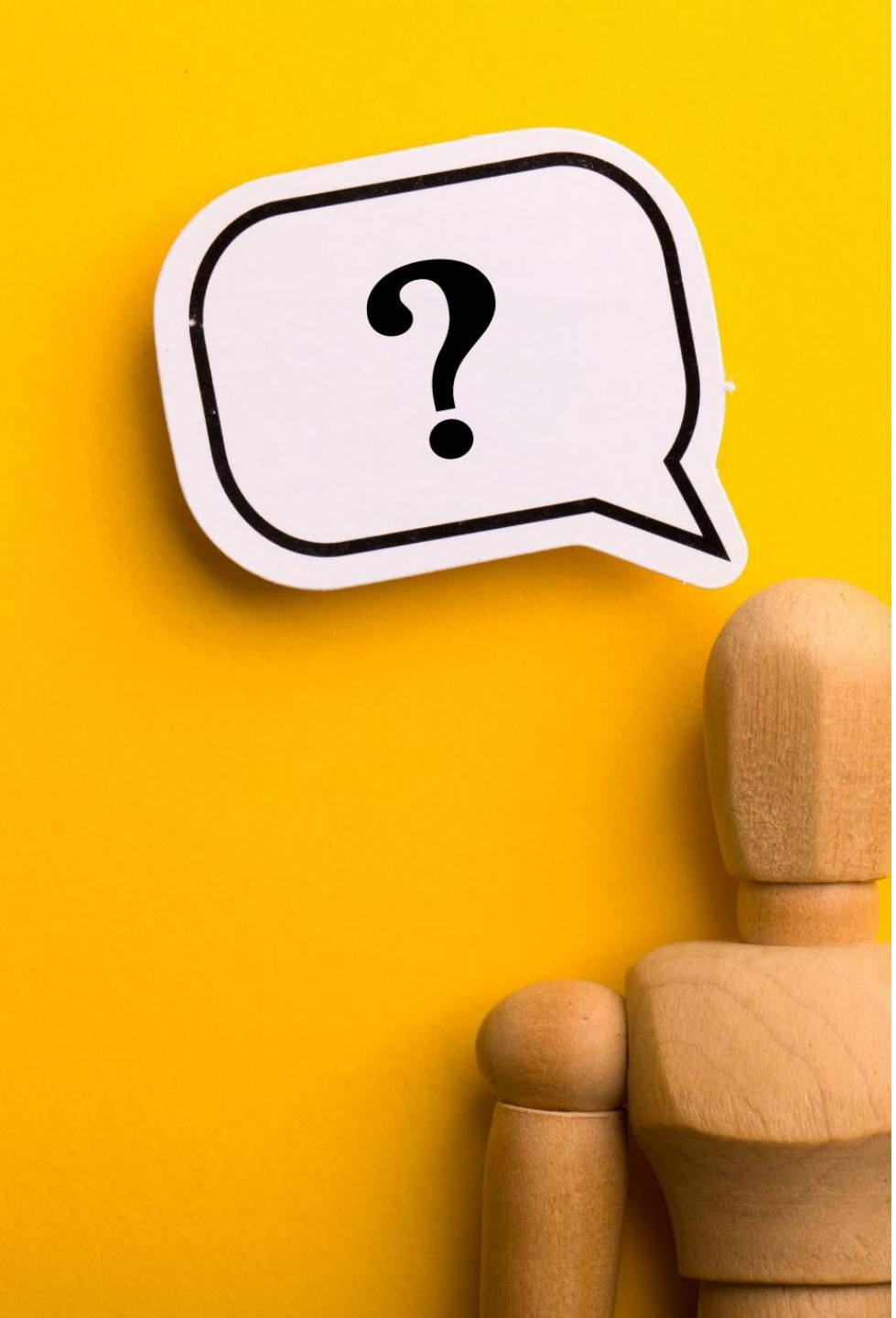
- Both her psychiatrist and OBGYN recommended that she come off all of her psychotropic medications before trying to get pregnant.
- She stopped all of her medications and her psychiatrist started her on sertraline (Zoloft) 50 mg
- She immediately started having severe panic attacks and increased her use of alprazolam (Xanax) to 0.25 mg 3-4 times per day.
- She called me for a second opinion
- I presented her case at virtual rounds at MGH and I put her back on all of her medications.
- She expressed some interest in trying to taper off Adderall. She stopped Adderall XR and tried to take Adderall IR once or twice per day when she felt like she needed it most.
- Her ADHD symptoms increased and so did the panic attacks.
- I started her Adderall XR 30 mg again and she was able to taper off her alprazolam.
- I prescribed clonazepam 0.5 mg prn bid for severe anxiety which she rarely takes



Case Conceptualization #2

Questions to consider

- Is sertraline always the best SSRI to prescribe?
- Which poses a bigger risk, the patient's medications, or exacerbation of her mental health illness?
- Whose risk were her OB and psychiatrist most concerned with?



Case Conceptualization #2

How do you discuss the risks of her medications?

What information do you give her?

- There are no ”best” or “safest” medications
- Some risks with your medications have been identified for preterm birth, high blood pressure, and mild to moderate neonatal adaptation challenges with antidepressants but the risks are small and we will monitor you and the baby closely
- There are also risks for untreated depression and ADHD that also include preterm birth, high blood pressure, and neonatal adaptation challenges
- Your mental health is important and the risk of treatment does not outweigh the risk of stopping your medications.
- Here is some information on the medications you take from Mother-to-Baby
- Let’s stay on your medications for now and discuss again after you have read the information

Case Conceptualization #3

- Jo-Ann is a 30 yo G1P1 whose mother had a substance use disorder during pregnancy with the patient. The patient experienced neonatal abstinence syndrome as a neonate. Pt has a history of sexual abuse as a child, and neglect and abuse by her mother. The pt's mother died when the patient was 16. She lived with her grandmother and received mental health treatment for PTSD, borderline personality disorder, OCD, depression, bulimia.

- Pt had her first child at age 27 and experienced postpartum psychosis and was later diagnosed with Bipolar 1 disorder.

- Pt was taking 1500 mg lithium (mood stabilizer), 400 mg lamotrigine (mood stabilizer), 20 mg of aripiprazole (mood), prazosin 1 mg (nightmares), clonazepam 0.5 mg (anxiety) as needed up to twice per day, labetolol 100 mg twice per day (blood pressure).

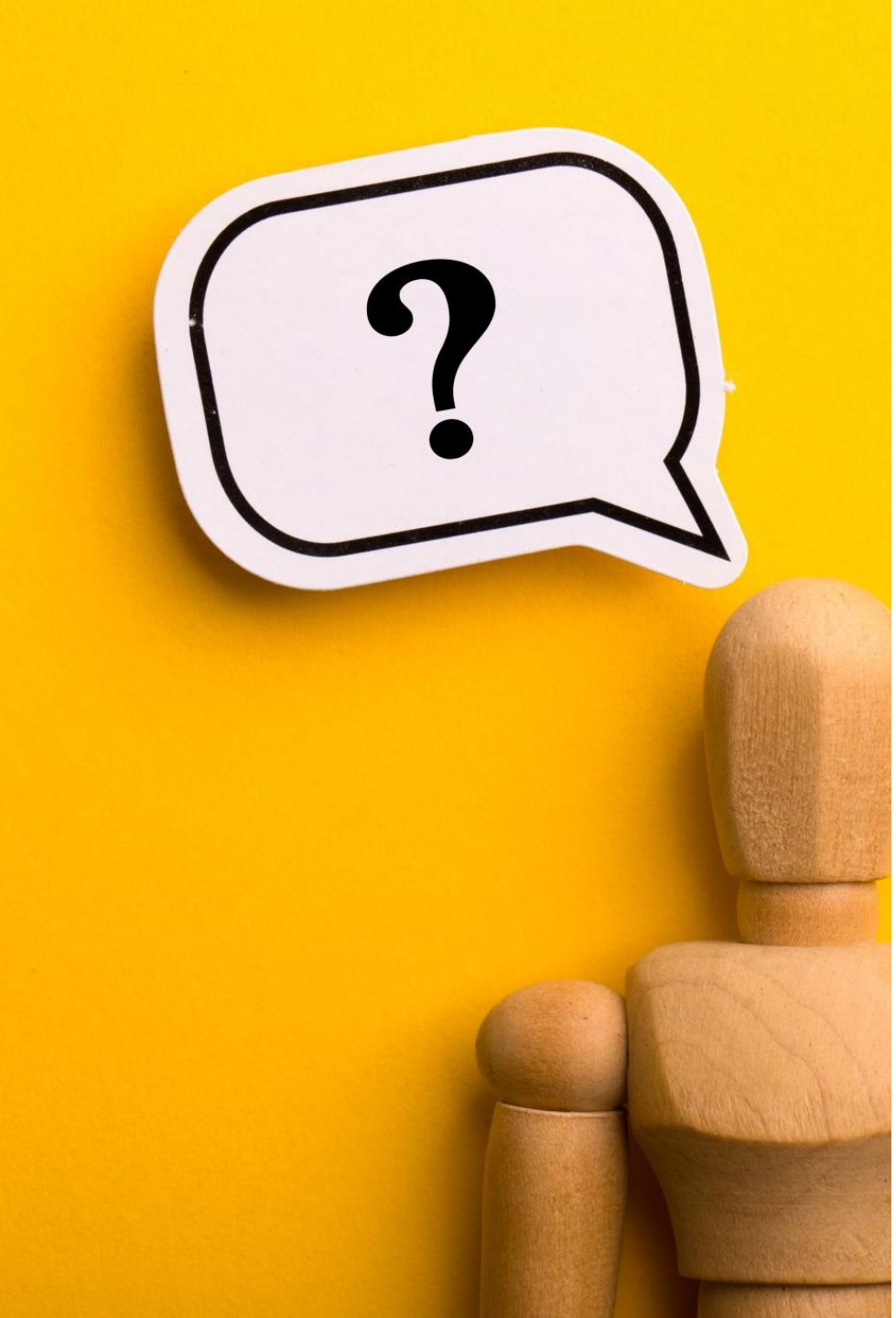
Case Conceptualization #3

What happened with this patient:

- Pt reported at her next visit with her psychiatric nurse practitioner that she was 4 weeks pregnant. She reported that was an unplanned but wanted pregnancy. She was relatively euthymic, but had increased anxiety related to finding out she was pregnant
- I was consulted and urged the PMHNP who was caring for the patient to tell the patient not to stop any of her medications. I presented the case at MGH Center for Women's Mental Health virtual rounds. The guidance received was for her to stay on her medications and refer her to ECT
- The PMHNP consulted her collaborating physician who disagreed with me and told the patient to **stop all her meds immediately and urged her to terminate the pregnancy**
- Out of fear the patient stopped all her medications

Case Conceptualization #3

- I met with the patient and provided her the Mother-to-baby fact sheets for all of her medications
- We had an in-depth conversation about the risk/risk/benefit of each medication.
- She was most concerned about lithium. I presented the most recent research on lithium and explained that the baby had been exposed for 4 weeks and that one option would be to restart at a lower dose because of the dose related incidence of cardiac malformations. She chose not to restart lithium even though she thought the lithium was the most helpful medication for her.
- After being presented options for medications she chose quetiapine which we started and increased to 400 mg
- The patient had done her own research into ECT and was interested in giving it a try. In the DFW area we have 4 ECT centers. Only one center both took her insurance and was willing to treat her while she was pregnant
- Unfortunately, she had a terrible reaction to the anesthesia after the 1st session and had some uterine cramping after the second session and ECT was discontinued
- She continued on quetiapine throughout her pregnancy increasing up to 1000 mg. She struggled through pregnancy with depression, but never had a manic episode. She started back on lithium post pregnancy



Case Conceptualization #2

Questions to consider

- What was her risk for relapse of her bipolar 1 during pregnancy with stopping all medications?
- Was the recommendation to terminate the pregnancy warranted?
- Whose risk was the psychiatrist most concerned about?
- Do you think stigma regarding mental illness played a factor in any of the cases regarding recommendations to stop meds, change meds, or terminate pregnancy?

How can we improve collaborative care and how can MTB fact sheets help?

Why We Need to do Better

- When the patient's team of providers are not practicing evidence-informed medicine-
- When the patient's team of providers doesn't collaborate and provides mixed messages-
- When stigma and bias regarding mental health color the provider's care-

→ the patient suffers

- When national organizations publish conflicting guidance

→ providers and patients suffer

How can Mother-to-Baby Fact Sheets Help with Interprofessional Collaboration?

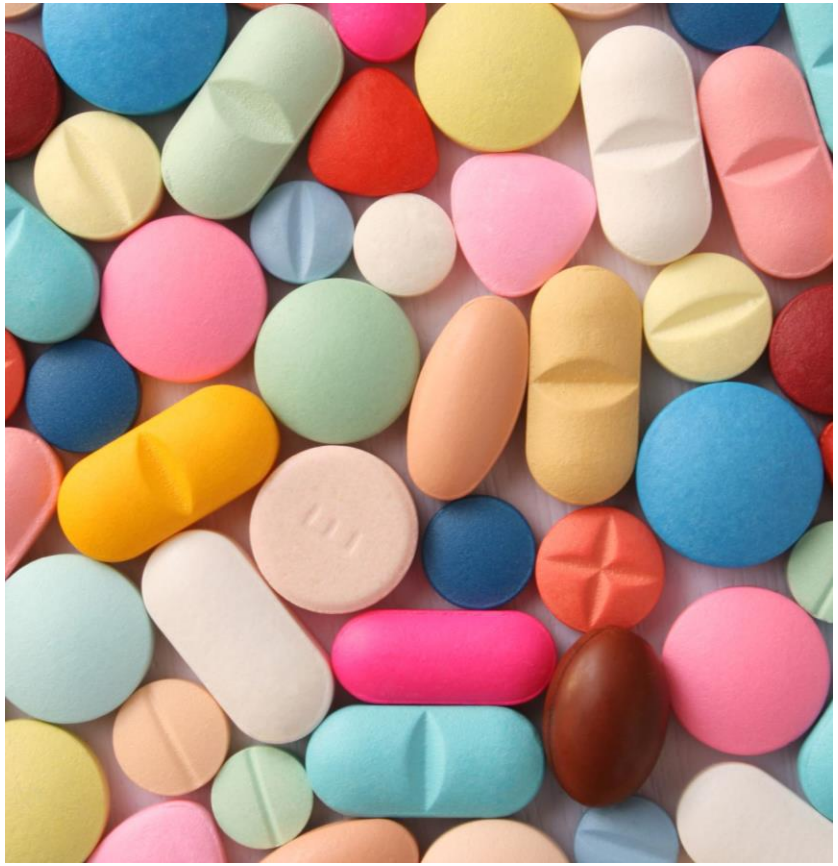
MTB fact sheets:

- Give providers a common shared language to use when discussing medication exposures during pregnancy.

- Provide a model of how to generalize research findings and communicate to patients in plain language

My Wish List for Mother-to-Baby

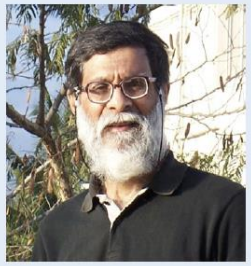
- Fact sheets for antiretroviral therapy (ART) medications
- More collaboration among professional organizations to provide more consistent recommendations to providers across specialties
- A primer on how to interpret research and translate relative risk to absolute risk
- Suggestions for language on how to present fact sheets to patients
- Add psychiatry to your list of specialty provider resource section
- Get the word out more about the fact sheets!



Clinical and Practical **Psychopharmacology**

Understanding Relative Risk, Odds Ratio, and Related Terms:
As Simple as It Can Get

Chittaranjan Andrade, MD



Each month in his online column, Dr Andrade considers theoretical and practical ideas in clinical psychopharmacology with a view to update the knowledge and skills of medical practitioners who treat patients with psychiatric conditions.

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ABSTRACT

Risk, and related measures of effect size (for categorical outcomes) such as relative risks and odds ratios, are frequently presented in research articles. Not all readers know how these statistics are derived and interpreted, nor are all readers aware of their strengths and limitations. This article examines several measures, including absolute risk, attributable risk, attributable risk percent, population attributable risk percent

Introduction

Many research papers present findings as odds ratios (ORs) and relative risks (RRs) as measures of effect size for categorical outcomes. Whereas these and related terms have been well explained in many articles,[1–5] this article presents a version, with examples, that is meant to be both simple and practical. Readers may note that the explanations and examples provided apply mostly to randomized controlled trials (RCTs), cohort studies, and case-control studies. Nevertheless, similar principles operate when these concepts are applied in epidemiologic research. Whereas the terms may be applied slightly differently in different explanatory texts, the general principles are the same.

Clinical Situation

Consider a hypothetical RCT in which 76 depressed patients were randomly assigned to receive either venlafaxine (n = 40) or placebo (n = 36) for 8 weeks. During the trial, new-onset sexual dysfunction was identified in 8 patients treated with venlafaxine and in 3 patients treated with placebo. These results are presented in Table 1. Using these data, we can calculate the values for a variety of terms, as illustrated in the sections that follow.

Andrade, C. (2015).

General Guidelines for Psychotropic Medications

- All treatment decisions are
  - Based on a risk/risk/benefit analysis
  - Made on a case-by-case basis
- No single medication is safest or "best" for use during pregnancy, the postpartum period, or lactation
- No single study tells the whole story
  - All literature must be read critically
- Keep it Simple
  - Monotherapy when possible
  - Don't change what's working
  - Don't stop medications abruptly unless absolutely necessary

Things we ALWAYS do in perinatal psychiatry

1. Make euthymia the #1 goal during the perinatal period
2. Treat with consistency across the perinatal period
3. Assess and treat patients BEFORE pregnancy when possible
4. Always consider the impact of untreated or undertreated illness as well as the risk of treatment
5. Carefully assess for Bipolar disorder and anticipate relapse in the postpartum period

Cohen, 2022

Things we NEVER do in perinatal psychiatry

1. NEVER taper antidepressants prior to delivery

2. NEVER tell a patient that they should defer pregnancy due to mental illness diagnosis

3. Never switch antidepressants once a woman is pregnant unless it is not working or severe side effects

Cohen, 2022

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