Transcript: Pregnant and Nursing Women: Making Decisions About Psychotropic Medications

Complex Clinical Decisions Podcast Series

Hello and welcome to the Recovery to Practice podcast series on Complex Clinical Decisions in Psychopharmacology. I'm Curley Bonds, the chief deputy director for clinical operations at the Los Angeles County Department of Mental Health, as well as a clinical professor of psychiatry at UCLA and a professor of psychiatry at Charles R. Drew University of Medicine and Science.

This series is hosted by the Substance Abuse and Mental Health Services Administration's Recovery to Practice initiative. Our goal is to help our fellow clinicians explore recovery-related issues so that we can all help the individuals we work with reach their goals. In today's podcast, we're going to explore prescribing for pregnant and nursing women who are experiencing a serious mental illness. This is a topic of great concern for all of us with our female clients, but it can be hard to find quality advice on how to discuss balancing the risks to the mother and the risks to the developing fetus or nursing infant.

To help us, we have Dr. Jennifer Payne with us today. Dr. Payne is the Director of the Women's Mood Disorders Center at the Johns Hopkins Hospital in Baltimore, Maryland. Dr. Payne has extensive practice and research experience in the management of mood disorders during and after pregnancy from all influences on mood and mood disorders and the genetics of postpartum depression.

Dr. Payne, thanks so much for joining the podcast.

Thank you for having me.

Could you tell us a little bit more about your Center and the individuals that you're working with there?

Sure, we see women through all life reproductive stages. Sometimes we see women with premenstrual dysphoric disorder or perimenopausal depression, but I would say the bulk of the women that I see are either pregnant or postpartum or expecting to get pregnant and want advice on how to take their psychiatric medications during pregnancy.

Sounds like a pretty comprehensive Center. As we launch into our clinical conversation, we all know that pregnancies can be planned; but sometimes they're unplanned. When do you start thinking about the potential issues of medication affecting a pregnancy?

It's a surprising fact that even today, up to 50% of pregnancies are actually unplanned in the United States. So I think about planning for pregnancy the moment I put a woman on a psychiatric medication, as long as she's of reproductive age; and I start the conversation then. When I start a woman on a psychiatric medication, I have the conversation of...you *could* take this during pregnancy, you probably should not take this during pregnancy, what is your contraception, what would be your plan if you got pregnant, et cetera. I think it's important to start planning from the beginning.

Wow, 50%...that's an impressive number, and I've found that these conversations that you mentioned and decision-making about medications and pregnancy can be quite nuanced. I know that as a physician myself I find myself struggling to keep up with all the evidence that's out there. What factors do you weigh

in discussing changing or going off medication with a woman who is pregnant or planning to become pregnant?

Well, there are a number of factors; and when I teach about this, I talk about how every case is different. It really depends on the woman herself and what her psychiatric history is and her history of response or non-response to particular medications. For example, a woman who had a very mild depressive illness might be appropriate to come off of antidepressants for pregnancy; whereas a woman who a very severe bipolar Type 1 illness with multiple hospitalizations, it would be a very different conversation. So a lot has to do with the woman's history itself.

It also depends on what medications she's taking and if she's on a combination of medications or just on one or two.

So there are a lot of things to consider, and each individual situation is different. Is that what I'm hearing you say?

Absolutely, the other thing to keep in mind is that some women, even if it would be clinically advisable for them to stay on medications, don't want to be on medications for pregnancy. That involves a different conversation about the risks of untreated psychiatric illness during pregnancy.

Let's take the scenario where an individual comes in to you and says, "I'd like to get pregnant." This is someone who is planning a pregnancy but who hasn't quite maybe decided what to do about their medication yet; and they ask you, "What should I do about my medication?" How do you approach that conversation?

That's my most favorite conversation because it's before the pregnancy, and we have time to plan and really think carefully about what we want to do for the pregnancy. In that situation, I would take a very careful and thorough psychiatric history and really try to understand how serious the woman's psychiatric history was and what medications she had taken in the past and what worked and what didn't work.

I would also take into account how old she was. I think it's a *very* different conversation with a 40-year-old compared to a 25-year-old because at 40, a woman is getting to the end of her reproductive life and may not have much time to change medications or to try different combinations of things. In a patient who's younger, we have the luxury of time to change her medication regimen prior to pregnancy. I've even had women come in a year or two before they want to start trying to have a pregnancy in order to get an idea of what to do with their psychiatric medications during pregnancy; and that, again, is one of my favorite scenarios.

In that situation, we really try to pare down the number of medications a woman is taking. I think most providers have seen women with multiple medications, and they got to that regimen in a logical way. Then when someone got better, they didn't want to take them off medication because they might relapse. Well, in a scenario where we are planning for pregnancy, we might try to pare down the number of medications a woman is taking. We might also decide to switch a medication that is newer, that we know very little about, for an older medication that we know more about. In that scenario, we would only do that if the woman did not have a history of non-response to the older medication.

Basically, we try to clean house before attempting pregnancy; and if we have some time before a woman wants to try to get pregnant, we'll spend time trying to get it nice and neat.

I also take a very thorough social history. I have occasionally had women come in and say, "I want to get pregnant, and I need to come off my antidepressant for pregnancy," but they are actively smoking two packs a day. So we really do a comprehensive view of understanding both the psychiatric history as well as the medical and social history of the woman, and then we come up with a plan together.

In general, we try to limit the number of exposures for the pregnancy for the unborn child. That often means trying to pare down a woman's regimen and limit the number of medications she's taking. We also try to use medications that we know something about. Older medications have a much longer track record

in the literature; whereas medications that just came out, we essentially have no information on. So I talk to her about what some options might be.

I might recommend that we try to come off a medication. Then if that doesn't go well, we would restart it for example; but we can do all of this maneuvering before pregnancy when someone comes in for a pre-pregnancy consultation.

I like the way that you mentioned the term "exposures." I was wondering if you could maybe explain a little bit more about what some of those exposures are, one of them of course being medications during pregnancy. What other types of exposures are there?

I mentioned smoking tobacco. That would be another example of an exposure. But one exposure that most people don't really think about is exposure to maternal psychiatric illness. When a mom has a severe depression or bipolar disorder or some other major psychiatric illness, that changes her chemistry. Most women when they're depressed are dumping cortisol, and that affects the baby and is essentially an exposure for the child.

We know that untreated depression during pregnancy is associated with low birth weight and preterm birth. So we know that untreated psychiatric illness actually does affect the outcome for the baby. It's not really a matter of a woman kind of muscling through a pregnancy without psychiatric medications for the sake of her baby. In that situation, she's actually exposing the baby to the psychiatric illness. So we really try to limit the number of exposures. If that means that a woman needs two psychiatric medications to stay well, then we use two psychiatric medications; but we do all we can to keep a woman well throughout her pregnancy and into the postpartum time period.

That's really interesting, thank you. It sounds like the pregnancy and the risks that are involved can all be planned for when you do some proactive discussions and limiting those exposures to things that might even be a mental illness because, like you said, those are not benign.

That's right.

I was wondering if you could articulate some overall thoughts in terms of your process regarding the safety and risks of going off medication versus staying on medication during a pregnancy?

We know that women who stop their psychiatric medications for pregnancy have an extremely high relapse rate. So women with major depression who stop their medications for pregnancy have about a 70% relapse rate during pregnancy. In bipolar disorder, it's somewhere on the order of 80% to 90% will relapse with their bipolar disorder during pregnancy if they stop their mood stabilizers. In schizophrenia, it's at least 50%. So we have these really high rates of relapse during pregnancy in women who stop their medications, so we know that the likelihood is that if a woman stops her medication that she will relapse.

Now, we have the occasional mom who makes it through just fine; and that's always wonderful and a relief to everybody. But I think it's really important that moms understand that they are really taking a high risk going off of medication for pregnancy.

I see, and are there any general guidelines about how quickly one would do this; or is it, as you said, based on the individual situation?

It's pretty individualized. There are some studies outside of preparing for pregnancy that show that you can prolong the time to relapse by tapering a medication for at least two weeks or longer. If I have a mom who wants to come off of her medications, depending on the doses that she's on we will taper over the course of somewhere between two to even eight weeks or longer prior to attempting pregnancy so that we can prolong the time to relapse.

A big part of our job is education...helping the individuals we work with really understand the options available. There's a word that comes up in the literature, "teratogenicity." I don't imagine you're throwing

that word around when you're talking with the mom, but how would you discuss medications that might cause birth defects?

Well, to a large extent, again that depends on the individual. I might have a very different conversation with a 17-year-old who hasn't finished high school versus a 30-year-old who has an advanced degree. That being said, you're right; I don't use that term very often. I tend to use the words "birth defect."

I also try to put things in very clear terms. Statistics are devilish; and you can throw statistics around; and you can say, for example, that something has an 87% increased risk, when in reality the risk only increased from less than 1% to slightly more than 1%. So I make sure that I explain statistics in real-world terms so that they can understand what the actual risk is.

I also think it's really important to educate not only the potential or new mother but, when at all possible, her partner and her family. I do a lot of educating of pediatricians and obstetricians. I see the psychiatrist kind of as the quarterback, and we really need to serve as a liaison to everybody involved in that pregnancy so that everybody is on the same side and understands the risks and benefits so that we can all work together to help the mom have a wonderful and healthy pregnancy.

I like that analogy of the team approach; and, of course, the physician plays an important role in providing that information. It's good to hear how you do that. How do you discuss the risks of medication versus the risk of untreated illness with women?

What I do is I analyze what medications the woman is taking, and then I discuss what we know so far in the literature. Now, discussing the literature is kind of complicated because it's actually a fairly large literature, at least for antidepressants; and there have been a lot of different studies done, some of which have found outcomes for infants that are undesirable and others that have been negative. So particularly for antidepressants, I talk kind of more globally about the literature; and I explain that some studies were not as well-controlled as others.

For example, some early studies would compare outcomes of infants whose mothers took antidepressants to outcomes of infants whose mothers were in the general population. Now, the problem with that is that moms who have a history of depression do not have the same group behaviors and risk factors as the general population. There are a number of things that are higher in the psychiatric population. Other substance use, smoking, diabetes, obesity, poor healthcare, are all more common in the psychiatric population. So if you don't control a study for the psychiatric illness itself and those attendant behaviors and risk factors, you may have a finding for babies exposed to antidepressants that's associated with mom being psychiatrically ill rather than associated with the exposure to the medication itself.

So I talk about that, and I also note that more recent studies that have been really well-controlled mostly appear to be negative and are very reassuring. I also talk about the absolute risk and relative risks of medication use during pregnancy. For instance, persistent pulmonary hypertension is something that a lot of women are worried about with antidepressant exposure and pregnancy. The reality is the real risk to an individual mom who takes an antidepressant during pregnancy is far less than 1%. So I make sure that they understand that real risk. Whereas their risk of relapsing when not taking an antidepressant is about 70%.

So I put things in terms that the individual can understand and really be able to weigh the risks and benefits of whether they should take a medication during pregnancy.

A point that you made that I think is really important for our listeners is that you have to evaluate the quality of the research and make sure that it's relevant to the person in front of you.

That's absolutely right, and that means that you have to look at the literature as a whole. One study being positive for something does not mean that there is a clear association; so you really need to look at the literature as a whole and digest it as a whole, which is hard to keep up with. That's why we write review papers and give talks and do podcasts.

You spoke about exposures, including nicotine exposure and cigarettes; and there are other exposures too, I imagine, like substances. I'm wondering...how do you talk with women around those topics in terms of reducing overall risk during pregnancy?

I absolutely bring up those risks during pregnancy. It's interesting; most women know that you shouldn't drink during pregnancy, so I will talk to them about that and also discontinuing marijuana and discontinuing nicotine. Those substances are actually very helpful in the conversation about taking medication during pregnancy in a couple of different ways.

One is we can compare the risks of taking a medication during pregnancy compared to smoking during pregnancy. The risks of smoking and alcohol are really well-known to be significant to a developing fetus, whereas the risks of exposure to an antidepressant medication is extremely low and not common. So I use those examples to kind of draw the contrast with antidepressant exposure or other medication exposure during pregnancy.

The other way I use it is that most mothers-to-be think very carefully about drinking or smoking nicotine during pregnancy, and they know that they shouldn't be doing those things in order to be healthy for the pregnancy. So I make that point; and I point out that they want to remain healthy during the pregnancy from a psychiatric perspective as well, and that one way of doing that is taking medication and making sure that they remain stable.

I often also draw the contrast with diabetes. Most people understand diabetes is a serious medical condition, it alters your blood sugar, and that you need to take medication frequently in order to remain well...whether that's during pregnancy or outside of pregnancy. I will sometimes say, "If you had diabetes, you would not be sitting here saying, 'I can't take my insulin during pregnancy so that I don't expose the baby.'" So smoking and alcohol examples can be very useful in drawing the contrast with psychiatric medications and being healthy during pregnancy.

So really giving them clear information that you can interpret with them. Are there any psychiatric medications that are known to cause birth defect or other negative outcomes that you would recommend people discontinuing before or even during their pregnancies?

Yes, so valproic acid and carbamazepine are two medications that are known to cause birth defects. The rates of those are still fairly low. With valproic acid, it's about 10% depending on what you include and in terms of effects on the infant; and carbamazepine, I believe, is about 2% to 3%. Overall, most babies exposed do well; that being said, we try to avoid using those medications during pregnancy.

I have had a case or two where I have recommended that valproic acid or carbamazepine be continued, and those were very severe cases who had a history of not responding to other options and had a history of suicide attempts and even one was violence against others. So I never say never, but I really do try to avoid those two medications during pregnancy if I can help it.

One thing that comes up I know in the world of practice with pregnant women is the FDA and the different classifications for medications during pregnancy. Could you speak to those for a moment and whether or not you incorporate that conversation into your discussions...whether or not a medication is FDA-approved or what those mean and how you would interpret that?

I do incorporate it into my conversation, and I typically say that FDA categories are confusing and not very useful. That is why the FDA has issued something called the New Rule. This came out in 2015, and essentially they're revamping the labels really for all medications and whether they can be used during pregnancy and lactation. The labels are now going to move towards not a categorical system but will include all known information in both animals and humans on the label itself. A physician can read that, digest it, and help his or her patient make an informed decision.

The FDA categories are still sticking around though because this rule has to be grandfathered in over time. Older medications still have the categories. The FDA categories range from "A," which is considered

safe during pregnancy, to "X," which is considered technically not safe during pregnancy. Then there's "B," "C," and "D."

I recently attended a meeting in which a representative of the FDA actually spoke. Apparently, originally there were six categories; and they shrunk them to five categories. One of the things that happened was that some categories that had been more separate got combined together by doing that. Because of that, the FDA categories are actually somewhat difficult to understand. They're based on the amount and type of evidence that's available.

Category "B" is probably the best example of this because it's frequently misunderstood. Category "B" either means we have evidence that it's relatively safe during pregnancy, might cause some issues but no major birth defects in humans; *or* we only have animal evidence, which is suggestive of potential problems. So that kind of gets mushed together.

Most physicians will think that Category "B" is actually safer than Category "C" or "D." Well, the problem is new medications that come out may only have animal data in pregnancy; so they'll be rated as Category "B." But the reality is, we don't know much about them in humans. So many times, I much prefer to use a Category "C" or "D" medication which I know what the risks are in a particular woman who is contemplating pregnancy rather than a Category "B" medication for which we know nothing.

The other thing to keep in mind is Category "X" also includes birth control pills because you would not take birth control pills during pregnancy, but they are not prohibited. I've had a number of patients call me in a panic because they got pregnant while taking birth control pills and they're Category "X." I think that's another example of how these categories can be really confusing, and I think it's a good think that they're going away.

You pointed out that the literature is rapidly evolving and that it's broad. I was wondering if you could point us to some resources that you've found helpful when you make your recommendations to people that you work with.

ACOG, which is the American College of Obstetrics and Gynecology, has guidelines that speak to this that I think are very helpful. The APA and ACOG have actually released a few years back a joint statement in the psychiatric literature about how to think about using antidepressants during pregnancy. I think both of those resources are very useful.

There are a number of us in the field who have also written review papers, and I think recent review papers at times may be even more up-to-date than guidelines that were written by a committee a few years go because this is a rapidly-evolving area.

Thank you for sharing those points and statistics. We'll make sure to get some of this information available for our listeners.

I want to transition a little bit and talk about some rules of thumb. Do you have any standard approaches to prescribing in women of childbearing age in general?

I mentioned valproic acid and carbamazepine earlier; and basically, in women of childbearing age, I prescribe those as medications of last resort. I also try to use as few medications as possible. This is true whether a woman is just of childbearing age or contemplating pregnancy. You really want to try to limit the number of exposures; but at the same time, it's important to make sure that a woman gets fully well. So if she needs more than one medication, I prescribe more than one medication.

Again, I tend to try to use older medications that we know something about. In women of childbearing age or women who are contemplating pregnancy, I try to avoid the newest and greatest medication that just came on the market because we really don't know much about that medication during pregnancy.

I also think it's important...we've talked about education...I think educating both the woman in front of you, as well as anybody else involved in their life, about why you're choosing a particular medication and what can be done during pregnancy and what can't is a really important part of being a good clinician.

The other thing I'll bring up now...I think that some of these rules change a bit if a woman finds herself pregnant. As I mentioned, 50% of pregnancies are unplanned; and so every clinician listening is going to have at least one woman at some point get accidentally pregnant. Part of that, you need to be educating prior to pregnancy; but I think you also have different rules of thumb when a woman is already pregnant.

For example, I mentioned that I like to use older medications compared to newer ones. Well, I've had a number of consultations where a pregnant mom will come in, and she's on one of the newest antidepressants; and she is referred to me in order to be switched to an older antidepressant. Most of the time I say, "What I don't want to do is switch you to an older medication and run the risk of you relapsing because that increases the number of exposures."

If a woman is well on a newer medication, that's one exposure. If you switch her to an older medication, that would be a second exposure for the baby; and you run the risk of her relapsing, which would be a third exposure. So I see that scenario as far more dangerous than continuing to prescribe a newer antidepressant, about which we know not very much. So the rules do change when a woman accidentally gets pregnant.

That's very helpful, thank you. How does the conversation about medication change after a woman gives birth and is breastfeeding?

That is a great question. I've had a number of women come in and tell me that they were prescribed a medication during pregnancy and were then told that they could not breastfeed. There are a couple of exceptions; but most of the time, that's not accurate. If a baby was exposed in utero to a medication, they generally can continue to be exposed during breastfeeding. The exposure in breastfeeding is far less than the exposure in utero. All psychiatric medications do enter breastmilk; but generally, it's a very low concentration.

The studies that have been done are reassuring. Most babies do not have side effects or problems with being exposed to psychiatric medications during lactation. Now, the two exceptions I would say are potentially lithium and for sure clozaril. With clozaril, you would want to monitor a baby's exposure by getting weekly blood draws to watch their white blood count. So I don't think that in that situation it's appropriate for a mom to breastfeed.

With lithium, it's also kind of a dicey medication to breastfeed while taking lithium. The reason for that is that babies are little, and they tend to get dehydrated easily. They can quickly become lithium toxic if they get dehydrated. I've had a number of moms breastfeed while on lithium, but we do so only under very certain circumstances. The mom has to be a very organized mom and someone who would be vigilant to whether their child was becoming dehydrated and have a low threshold for going to the emergency room.

We also monitor the blood levels in the babies...not on a weekly basis, but certainly a little more often than the first few weeks of life. To be honest, the patients I've had who have breastfed, their infants have had non-detectable levels or very extremely low levels; so that's reassuring. There have been some studies in the literature that are also reassuring; but again, you would not want a mom who may be a little bit more disorganized to breastfeed while taking lithium.

Those are great rules of thumb, and it sounds like you're taking into account safety not only for the mom but also for the baby; and monitoring can sometimes expose both of them to additional problems...like drawing blood from an infant is no fun for anybody. I know that you measure blood levels sometimes on the mother; sometimes you can measure them in the infant. Are there any other places that you would measure or that you've seen people take measurements of...like I've heard breast milk sometimes being sent up to the lab. Is that a common practice?

That is not a common practice. It's a common practice, I would say, in research studies; but really, what matters is what is in the baby's blood system because even if you measure the level in the blood, the baby is going to metabolize a medication, et cetera. So there are medications that we can't measure currently on a routine basis...like most antidepressants we cannot measure in blood levels. Again, it would really be changed by the baby's own metabolism. So, no, we don't generally measure levels in breast milk.

I was wondering, could you talk for a moment about working with someone who has decided to change medications or go off of the medication; and what non-medication offerings do you have that you offer them...what type of options that are nonpharmacological?

I think there are a number of parts to that question, and I'll start with the nonpharmacological options. I offer these to *all* patients, whether they're going off of medication or switching to a different one. Therapy is a really important part of getting well from any psychiatric illness. Cognitive behavioral therapy for depression and anxiety and OCD is extremely helpful and often life-changing. The focus of that therapy is reducing negative thought patterns and anxious thoughts, if you will. It's called "cognitive" because it's really changing the thought patterns, and it's very useful for major depression and anxiety disorders, including OCD.

DVT is dialectical behavioral therapy, and it is a version of CBT along with the idea of mindfulness and other coping skills that can be used to teach women, and men for that matter, how to interact better with other people and how to not have such strong emotional reactions that it influences their behavior. IPT is a more self-limited therapy; it's interpersonal therapy with a *very* specific focus on one specific area of a person's life that they're having trouble with. Those can be helpful to help a woman have coping skills to try to maintain a stable mood during pregnancy.

I always recommend exercise...I love yoga, regular mediation...are all really important things that a mom or a potential mom can be doing to maintain a healthy lifestyle. I think what's hard about those non-medication options is having, A, the resources and, B, the time to participate in them. Most young mothers are busy if they have children in the household, and some communities don't have access to resources...like regular therapy or yoga, for example. I think all of that has to be kept in mind when you're making recommendations to a specific person.

When a woman and I have decided that she is going to discontinue a medication for pregnancy, I already mentioned that we try to taper that medication over the course of at least two weeks if not longer. But one of the things that I really emphasize is that just because a woman has discontinued medications doesn't mean that I'm cutting her loose and letting her go on her merry way. I think it's really important that we continue to see each other frequently and stay in touch and make sure that she's not relapsing.

I have a couple women, for example, that are off their medication for pregnancy. I'm seeing them every three to four weeks just to keep an eye on things and to make sure it's going well. I often actually give pregnant women my cellphone number, and I do that for a couple of reasons. I see women who have a history of severe illness; and if they get ill, sometimes that happens really fast. I think it's important that they be able to reach me.

I also think it's important in labor and delivery that their doctor be able to reach me. There have been a number of times where I have changed what was happening from a medication perspective based on a woman's symptoms right after the time of delivery.

So that communication piece is really key, not only with the person you're prescribing for but also for other members of the team.

Absolutely, and I would also say for members of the family as well. For example, another common scenario is I see a lot of women with bipolar disorder. Bipolar disorder, first of all, has this high relapse rate for women who go off medications for pregnancy. It also has a high risk of postpartum psychosis. So in those situations, I always request to meet with family members; and I educate them if they are not

knowledgeable about bipolar disorder and what to look for in terms of symptoms. I make sure they have my cellphone number as well.

I often also prescribe a rescue medication that I ask them to fill and have on hand in case a woman were to start to become manic, either during pregnancy or postpartum, so that we could initiate medication right away. But I agree with you; I think communication and education are really the big key words here.

What about those instances when you have your recommendations as the expert who studied this area and who is a physician, but those may not align with what the person in front of you wants to do. What do you do in those situations when, say, clinical best practice isn't necessarily fitting with what the person you're treating is interested in doing.

This comes up, and it happens reasonably frequently. In that situation, I think we go back to communication and education. I make sure that the woman who is making the critical decisions really does understand what the risks and benefits are of medication and what the risks are of untreated psychiatric illness. I usually will educate their family members if they're interested in that; and then, again, I follow them closely. Just because a woman does not want to take my advice to take a medication during pregnancy, that doesn't mean I'm not going to be there, monitor her, and be supportive to make sure that she makes it through that pregnancy in a good and healthy way.

Again, the key point is that communication with the pregnant woman is really important.

Yes.

What do prescribers working with a woman who is pregnant or nursing...what do you feel are the biggest points of confusion, and what can prescribers do to reduce that confusion?

Well, I think the biggest point of confusion in general...both in the general population and even among prescribers...is this idea that psychiatric medication should not be taken during pregnancy and lactation. The reality is the literature is very reassuring for most medications; and any risks there are, are actually quite small.

The other part to know is that the risks of untreated psychiatric illness are significant. The relapse rate is high. We know that psychiatric illness during pregnancy can have effects on the outcomes of that pregnancy. I've mentioned that depression during pregnancy is associated with low birth weight and preterm birth. It's also associated with gestational diabetes and preeclampsia.

Postpartum depression...there's a *huge* literature on postpartum depression and on its effects on the growing child. We know that babies whose moms were significantly depressed in the postpartum time period on average have lower IQs than babies whose moms were not depressed. It's also associated with slower language development and more behavioral problems in children.

So untreated psychiatric illness in pregnancy and in the postpartum time period is not benign...not only for the mother but for the child, and I think that gets forgotten in this conversation. There's often this idea that a woman needs to have a pure and pristine pregnancy, and therefore psychiatric medications should be discontinued. I think the literature really demonstrates that that's not necessarily the case. Again, it's an individual decision; but untreated psychiatric illness is not a benign thing for either the mother or the child.

That's really a valuable point. One thing that I wanted to circle back to, we've talked a bit about depression and bipolar illness; but we haven't spoken a lot about the antipsychotic medications. I'm wondering if you have any general principles for our listeners about women who are on antipsychotics. I know you mentioned rescue medication for bipolar psychosis, but are there any thoughts about that?

The literature on antipsychotic medication during pregnancy and lactation is smaller than the literature for antidepressant medication, but what is there is really pretty reassuring. There was one study that looked at second-generation antipsychotics as a whole that found some very mild and subtle developmental

delays in babies at six months after delivery that completely disappeared by one year after delivery. So there might be some small effect on development with exposure to antipsychotics.

That being said, exposure to psychosis and mania during pregnancy is not an ideal situation for a developing infant as well. What we try to do, again, is use older antipsychotics compared to newer ones. The first-generation antipsychotics have been around for a very long time, and the data we have on them are very reassuring. We also try to use older second-generation antipsychotics; so risperidone and olanzapine and quetiapine have been around long enough that we have a pretty good understanding that they have very limited risks. There has been no study that has associated antipsychotics with major organ malformations.

So I think that the preponderance of the evidence is very reassuring for antipsychotics as well; but, again, I try to use older medications compared to the newer ones.

Thanks, that actually helps clear up things. Again, the overarching principle seems to be that you have to weigh the risks of medication exposure to the risks of exposure to untreated psychiatric illness.

That's right. I think a lot of people get lost in this conversation by comparing the risks of psychiatric medication exposure to the risk of no exposure to psychiatric medication. The reality is the risk is the medication versus the illness.

I often tell this story when I'm lecturing; but when I was contemplating my first pregnancy, I have asthma. So I went to my OB and I said, "Okay, I'm ready to start trying. When do I stop my asthma medication?" She started laughing hysterically; and she said, "You know, oxygen is awfully good for babies."

And I think mom being psychiatrically well during and after pregnancy is awfully good for babies.

Well, Dr. Payne, thanks for sharing that anecdote. This has been a great conversation and discussion. Thank you for educating us and for joining us today.

It was my pleasure. Thank you for having me.

Thank you for joining us for this clinical decision support podcast. Links to relevant studies and sources of information for clinicians are included in the show notes. I hope you will listen to the other podcasts in this series. RTP is focused on improving the knowledge and skill of the behavioral health workforce to help expand the principles and practices of recovery-oriented behavioral healthcare across multiple service settings.

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