A joint collaborative activity of

National Health Mission, Government of Karnataka and National Institute of Mental Health and Neuro Sciences, Bengaluru

A NIMHANS public health initiative from Perinatal Psychiatry Services and Department of Epidemiology, Centre for Public Health

Standard Treatment Workflow for the Management of

DEPRESSION IN PREGNANCY

RISK FACTOR

- Past history of depression or anxiety
- History of intimate partner violence or domestic violence
- Poor social support
- Recent life stressors
- Unemployment/ Job related stressors
- Substance use
- Past history of pregnancy complications or loss
- Family history of psychiatric problem
- Unplanned/unwanted pregnancy
- Relationship difficulties

ASSESSMENT OF DEPRESSIVE SYMPTOMS

- Confirm the gestational week of the pregnancy.
- Explore duration of the symptoms, duration of antidepressants/anxiolytics use (if patient has been taking any).
- Assess for depressive cognitions: worthlessness (about self), Helplessness (about others), Hopelessness (about future).
- Assess for **suicidal risk** – duration of such thoughts, Intent, plans, past attempts. Also assess for **ideas of harm/ neglect towards the baby**
- Use Patient Health Questionnaire (PHQ-9) to ascess the sevearity of depression.
- Assess for the presence of psychotic and catatonic symptoms
- Assess for substance use and anxiety symptoms
- Check for Physical comorbidities- anaemia, hypothyroidism, Diabetes, Hypertension, Seizure disorder.

CLINICAL FEATURES OF DEPRESSION IN PREGNANCY

Core symptoms:	Additional symptoms:	Mild Depressive episode	Moderate Depressive episode	Severe depressive episode
• Sadness of mood which is pervasive and persistent • Loss of interest in and enjoyment in routinely pleasurable activities. • Easy fatiguability/ decreased activity levels	• Reduced concentration and attention • Reduced self-confidence and self-esteem. • Ideas of guilt and unworthiness • Negative thoughts about future • Death wishes or suicide • Disturbed sleep • Disturbed appetite • Decreased attachment to fetus	Any 2 of the core symptoms + 2 or more of the additional symptoms.	Any 2 of the core symptoms + 3 or more of the additional symptoms	All 3 of the core symptoms + 4 or more of additional symptoms ± Psychotic symptoms- delusions (of poverty or nihilism) or Catatonic symptoms characterized withdrawal, refusal to feed, rigidity, Decreased speech output.

MANAGEMENT OF DEPRESSIVE EPISODE:

Psychological/ behavioural Management

- NESTS paradigm – Nutrition, Exercise, Sleep and rest, Time for yourself, Social support.
- Advise Behavioural Activation to patients and following a routine.
- Practice good personal hygiene
- Supportive psychotherapy / Brief Counselling, ensure frequent follow-up.
- Cognitive behavioural therapy or Interpersonal therapy can be done if feasible.
- In mild depression psychological interventions are enough.
- If no improvement in 4 to 6 weeks, consider pharmacotherapy.

Pharmacological management:

- In Moderate to Severe Depression use of antidepressants is recommended. T. Sertraline 25mg/day in the night which can be hiked by 25mg every 5 days to maximum of 100-150mg/ day. Alternatively, Escitalopram 5mg/day at night and increasing it to 10mg/day after 5 days to week (Maximum of 20mg/day).
- For sedation, Lorazepam 1mg/ day or Promethazine 25 mg/day can be given for a short duration which should be tapered and stopped after 1-2months.
- If suicidality, psychotic or catatonic symptoms are observed refer for in-patient psychiatric care.

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ANXIETY IN PREGNANCY

RISK FACTOR

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- Recent life stressors
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- Substance use
- Past history of pregnancy complications or loss
- Family history of psychiatric problem
- Unplanned/unwanted pregnancy
- Relationship difficulties

ASSESSMENT

- Confirm the gestational week of the pregnancy.
- Duration of the symptoms, duration of antidepressants/ anxiolytics if patient has been taking any.
- Severity of symptoms based on the distress associated with the symptoms, interference with sleep and appetite (moderate), interference with socio-occupational functioning (severe).
- Use scales wherever necessary - Generalised Anxiety Disorder 7 (GAD 7)
- Look for comorbidities of depression and substance use.
- Physical comorbidities – thyrotoxicosis, hypoglycaemia, heart disease, anaemia, gestational diabetes and hypertension, pre existing respiratory problems-asthma.
- Psychosocial factors: ongoing stressors at work or in the family.

CLINICAL FEATURES OF ANXIETY SYMPTOMS IN PREGNANCY

- Tension, anxiety, worry, apprehension, fear
- Episodes of palpitation, difficulty in breathing, feelings of choking, light headedness, fainting, dizziness, trembling
- Attacks of fear, losing control or "going crazy", fear of dying
- Unexplained physical symptoms like chest pain, abdominal pain, muscular tension, headache, nausea which cause distress to the person.
- Irritability, sleep disturbances

Pregnancy specific anxiety: Excessive fear or concern about giving birth or labour, bearing a physically or mentally handicapped child, concerns about one's appearance. This anxiety may increase the risk of adverse birth outcome.

Specific phobias: fear of childbirth (tokophobia), phobia of needles

Generalized Anxiety Disorder (GAD): Chronic feeling of tension, apprehension, anxiety or worrying about a number of events or activities that involve every day routine life circumstances (e.g., work, school, health, finance, household chores etc.) Often, these worries are focused on the baby or other children.

Panic Disorder: Recurrent unexpected attacks of intense fear/ anxiety along with physical symptoms (palpitations, feelings of "choking", trembling, chest pain feeling dizzy/faint etc.) avoidance

MANAGEMENT

Psychological/ behavioural Management

- ✓ Reassurance and educating about the symptoms of anxiety, panic how avoidance maintains fears and phobias.
- ✓ Applied Relaxation techniques such as muscle relaxation, deep breathing excercise such as pranayama.
- ✓ Behavioral techniques for fear & phobias such as graded exposure & distress tolerence.

Pharmacological management

- ✓ In Moderate to severe conditions Anti-anxiety drugs, T. Sertraline 25mg/ day in the night which can be hiked by 25mg every 5 days to maximum of 100-150mg/day. Alternatively, Escitalopram 5mg/day at night and increasing it to 10mg/day after 5 days to week (Maximum of 20mg/day).
- ✓ For sedation, Lorazepam 1mg/ day or Promethazine 25 mg/day can be given for a short duration which should be tapered and stopped after 1-2months.

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Standard Treatment Workflow for the Management of

ANXIETY AND DEPRESSION IN PREGNANCY

GENERAL PRINCIPLES OF PRESCRIBING ANXIOLYTICS AND ANTIDEPRESSANTS IN PREGNANCY

- If depression or anxiety is newly diagnosed in pregnancy, use medications if benefits outweigh the risk. Try to involve couple as much as possible in all discussions related to treatment.
- Use psychological and social interventions for milder forms of depression and anxiety.
- Most guidelines recommend SSRIs as first-line pharmacological treatments for depression and anxiety disorders.
- In general, antidepressants should not be discontinued suddenly on discovering a pregnancy due to risks of dis-continuation syndrome and relapse.
- In late pregnancy, there is a risk/benefit decision to be considered around the risk of Persistent Pulmonary Hypertension (PPHN) that is associated with antidepressants.
- There is a lack of evidence and consensus on whether reduction/ discontinuation or maintenance of antidepressant close to delivery will alter the risk of poor neonatal adaptation. Discontinuing antidepressants before delivery may place the mother at an increased risk of relapse and importantly postnatal depression.
- There is no convincing evidence in the available data of an increased risk of birth defects associated with benzo- diazepines or 'Z-drugs (zolpidem, zopiclone and zaleplon)'. It is important to note that insomnia postnatally (inability to sleep even when not being disturbed by the baby) may herald or even precipitate severe illness such as postpartum psychosis

Ref: McAllister-Williams RH, Baldwin DS, Cantwell R, et al. British Association for Psychopharmacology consensus guidance on the use of psychotropic medication preconception, in pregnancy and postpartum 2017. *J Psychopharmacol*. 2017;31(5):519-552. doi:10.1177/0269881117699361