NAMI Ask The Expert
National Alliance on Mental Illness

NAMI Ask the Expert:
Psychiatric Medications and Considerations for Individuals Across Pregnancy, the Postpartum, and Reproductive Years

Featuring Marlene Freeman, M.D.

March 7, 2024

Dr. Ken Duckworth (00:00:00):

Thanks, everybody. Thanks for joining. It's a great privilege today to have Dr. Marlene Freeman as our expert that we can learn from. I met Dr. Freeman when she was a rookie resident and it was pretty obvious, even then, that she had great things ahead of her. She's now a full professor at the Harvard Medical School. She's the associate director for the Center for Women's Mental Health at Mass General Hospital, which has an extraordinary website, which we'll come back to, answering a lot of very specific questions.

(00:00:36):

She's also the editor-in-chief of the Journal of Clinical Psychiatry, and so we're very fortunate to be able to have a conversation with Dr. Freeman on the topic that we haven't really developed much at NAMI, but it does come up. So I was delighted that we could get one of the leading experts to talk about it. So, Dr. Freeman, I want to thank you for joining, and unlike her background, she is not in Arizona, she's in rainy Boston just like me. So, Dr. Freeman, thank you again for joining and I look forward to this conversation.

Dr. Marlene Freeman (00:01:15):

My pleasure. Thanks for having me.

Dr. Ken Duckworth (00:01:17):

All right, so let's start with ... A lot of specific questions came in. We had over 100 questions come in beforehand. We're not going to do a lot of what's the best time to take Zoloft during pregnancy? I want to go big picture with you. How do you think about, before you get pregnant, how do you advise people to think about, that if they don't have a history of mental health vulnerability, if they have a family history of mental health vulnerability or if they have a known history? So that's a lot of questions right in there, and thank you.

Dr. Marlene Freeman (00:01:53):

Sure. So, first of all, just thinking about pregnancy, we want to think about individuals or women of reproductive potential. So I'll use the word women a lot, but I want to be inclusive, as we want to be welcoming to everyone, but in terms of women's mental health, we want to think about not only those who are planning pregnancy, but girls who are younger than that age and individuals who might become pregnant. So what's important to keep in mind in this field, and just for the public in general, is that about half of pregnancies in this country and globally are unplanned. That's really staggering, I think, when you think about it, because that means that whatever people are doing in their life, including getting treated for often chronic and serious disorders, they have to keep in mind the possibility that they may have a surprise pregnancy.

Dr. Marlene Freeman (00:02:50):

So healthcare prescribers also need to keep that in mind, and I think we don't really educate healthcare providers enough about this. So for girls and women of reproductive potential, we always want to pick medicines from the very beginning on which would be reasonable to go through a pregnancy and postpartum, because so many of the disorders need treatment across the times, even if someone is pregnant or postpartum.

(00:03:20):

So we know that women are at higher risk for depression and most anxiety disorders across the reproductive years, and so many women are not diagnosed, come to pregnancy, and might get screened for depression and have the first time either a recognized depression or a new onset depression. For other women, they've been treated earlier.

(00:03:46):

What I think we also want to keep in mind when we think about unplanned pregnancies is that sometimes someone will start treatment and they'll say, "I'm not planning pregnancy. That's not on my radar. I'm not considering that as part of my treatment planning," but part of what we keep in mind also is that if someone is well and they have a chronic disorder, their plans may change over time. So if someone is not well and they're starting treatment, we still want them to be on something reasonable if they would be at a different point in life and want to become pregnant, or if they would have an unplanned pregnancy. We would want to make sure that whatever the person was treated with from a medication standpoint would be something that would be totally reasonable.

(00:04:31):

So we always want that in mind, but what I think is so important also about this field is that I think, generally, psychiatrists are not trained well enough in working with women who are pregnant or postpartum. So they often feel uncomfortable. OB-GYNs are on the front lines with patients who may be having psychiatric disorders, and they may be the healthcare provider that the patient is most comfortable with, but they may not feel comfortable treating mental health on the front lines.

(00:05:03):

Primary care doctors, some are really excellent in terms of treating psychiatric illnesses. Some are not very comfortable, and they also have very limited time per patient, but what I heard one colleague say early in my career that really resonates, is we want to make sure that whatever door a woman knocks on is the right door. So it really has to be a very collaborative approach across disciplines to make sure that people find what they need. So that was the before part.

Dr. Ken Duckworth (00:05:37):

That's a great answer. Let's talk about medicines that you consistently advise against women of reproductive age using. Do you have any medicines that are just, "I wouldn't pursue this," as you think about it? I know every individual's situation is different, but you've researched this tremendously and I'm very interested in how you think about that.

Dr. Marlene Freeman (00:06:00):

So in an abstract way, we always want to lead with medications that are best known, best studied during pregnancy. A lot of the psychiatric medications, like SSRI antidepressants, are better studied than most classes of medicines across fields of medicine in pregnancy. So there are some medicines that we have a lot of information about, a lot of data, and there are some medicines that we don't have as much about, that we're trying to learn more about, and there are some medicines that we know about which don't look so good. I will say that the medication that worries me the most is valproic acid, or Depakote.

(00:06:40):

So it is by far, in psychiatry, the worst medicine for pregnancy, and I can't say enough bad things about it. So the more we learn about valproic acid, the worse it looks in women of reproductive age. So keeping in mind that about half of pregnancies are not planned, the woman was not timing to become pregnant, valproic acid or Depakote has a very high risk. About up to 10 to 12% risk of major central nervous system malformations, like major birth defects, that occur before most women know they're pregnant. So very, very early in pregnancy before women would even know that they were pregnant.

(00:07:23):

Then it gets worse also from there too. So then you have this risk of a very, very terrible birth defect, and then also, we know this because our neurology colleagues have done such an amazing job keeping pregnancy registries for anticonvulsant medications and have followed pregnancies in children out for many years. Kids exposed in utero to valproic acid do more poorly on neural cognitive tests at age three, age six, and probably further out. They've been studied for years.

(00:07:53):

So, really, I feel like one of my missions on the planet is to make sure people know that, because women are treated with valproic acid as a mood stabilizer, sometimes for migraines or seizures, and of all the medicines that we potentially come in contact with, it's really the worst in our field. So in my mind, when we're talking about women, I think that women should not be in the same room as valproic acid until they're post-menopausal. There's no method of birth control that I think is reliable enough to introduce valproic acid, and another reason for that too, is that so many disorders that we treat are chronic or recurrent, and so once someone is well, coming off the medicine carries a tremendous risk of someone being unwell.

(00:08:42):

We see this all the time in people finding out that they're pregnant and they're afraid and they stop their medicine, and then the disorder recurs. It's not just a matter of putting the medicine back, like stopping the medicine because someone's scared. They crash, they're not doing well, and then just put the medicine back and they're well. The disorders that we treat can be incredibly humbling and hard to treat, and so sometimes if someone stops the medicine and it kept them well, sometimes they're ill for a very long period of time and it's hard to get them better. They could pay so dearly for stopping a medicine that worked for them.

(00:09:18):

So that's why it's so imperative that we choose medicines from the very beginning that would be reasonable if someone became pregnant, and it's really on us, as healthcare providers, to talk to patients. As we talk about risk and benefits of other possible side effects, if we talk about, "If you would become pregnant on this medicine, this is what I would want you to know." So I think that it's just something that we need to think about from the very beginning.

Dr. Ken Duckworth (00:09:42):

So Depakote, valproic acid is an anticonvulsant that our field stole from neurology. Like many of the innovations in our field, we observe that it helps people because it's out on the market, and for in this example, people with bipolar disorder seem to respond to it. So your point is really clear. If you're of reproductive age, stay away from Depakote, valproic acid just as a core construct.

(00:10:09):

So let's transition a little bit. So let's say a woman lives with bipolar disorder, and you mentioned stopping your meds. Let's just talk a little bit about how you think about the role of medications and the role of other supports in a woman who's planning to get pregnant, on how you think about that. So, clearly, if you're on Depakote, you've gotten off of it, because you went to Dr. Freeman's webinar.

(00:10:36):

I encourage people to put questions in the chat. More than 100 were submitted beforehand, and I'm trying to cover them in broad strokes, but if you have specific questions, I'll do my best to get to them in our conversation. So what about that idea? I have bipolar disorder. I'm planning to become pregnant. Obviously, I'm not on Depakote because I came to this webinar and I have read your literature, but let's say I'm taking another compound, like lithium, and I was taught about the potential for first trimester vulnerabilities for cardiac malformations way back in the day, and so we were cautioned to think differently about lithium, but what is the current thinking, because you're up on all this literature?

Dr. Marlene Freeman (00:11:18):

So it's true that lithium is a known teratogen, meaning it does carry an increased risk of birth defects, specifically cardiovascular, but the risk is very small. As many of you know, these are just not interchangeable medicines. So if someone may be a responder to lithium, it might work so well for them, and something else might not work so well for them, and these days we also see patients on regimens where they might be on more than one medicine that may work synergistically for them. So they may be on lithium at a lower dose than we used to see and another medication.

(00:11:55):

But the risk of lithium and that risk of first trimester exposure in cardiovascular malformations is very small. So the absolute risk is still small. So there's a statistically increased risk, but it's still small, compared to Depakote, which is bad, bad, bad, bad. With lithium ... This is one of the things that I've really seen evolve across the years as I've been in this field, so, say, across the past two decades. I think, when I was starting out in this field, we really did try to taper individuals off medicine for a first trimester, and then add back during the pregnancy after this period of cardiac formation was passed.

Dr. Ken Duckworth (00:12:43):

And that's individuals with bipolar disorder? So they get pregnant, you transition them off, and then-

Dr. Marlene Freeman (00:12:50):

But we ... In the olden days.

Dr. Ken Duckworth (00:12:53):

In the old days, yes.

Dr. Marlene Freeman (00:12:54):

Okay, but now ... and I should say, based on my background, I should say, I really started working in this field in Arizona where I was really on my own. I didn't have a group. I read everything I could, including a lot of things that came from Mass General, but I wasn't part of a perinatal psychiatry group. So I felt very much on my own, and just reading everything I could, but now I am very privileged to be in probably the largest group of practicing perinatal psychiatrists maybe on the planet.

(00:13:30):

So I've been at Mass General 15 years, and every week we have the opportunity to have rounds. So we talk about these things extensively. So over the years, one of the things that I think as a group we've really agonized over, and I think we've really changed some of our practice about, is whether or not it's worth the risk to decrease or stop a medication for an individual with bipolar disorder in a first trimester, because what we've seen so many times is that an individual will make sometimes even the most modest change to her regimen and she'll become very ill, and we've seen people need to be hospitalized, have suicide attempts, have episodes of bipolar depression that might take months or even years to recover from.

(00:14:20):

So in general, we want people to be on medications that would be reasonable to stay on through pregnancy, and so we do make sure that individuals are educated about this. So before pregnancy ideally, but we often don't have that opportunity, but for many individuals who are lithium responders, staying the course with lithium may be the best plan to keep them well.

(00:14:43):

Now the other thing about lithium, though, that is complicated, but still doesn't really change how we practice, is that it's the one medicine that is the most complicated for breastfeeding, because there have been enough case reports about adverse events in infants, higher blood levels compared to other medicines if a baby is being breastfed while the mom is taking lithium, and so it used to be contraindicated by the American Academy of Pediatrics to breastfeed while taking lithium. It's now not quite so harsh in terms of the recommendation.

(00:15:17):

So we generally advise against lithium and breastfeeding, but I have had patients who've done it. What we really want to make sure is in place is that there's a collaborative pediatrician and the baby has some blood work checked, but the situations where I've seen it, it's really a compromise. These are complicated decisions that are very collaborative, and patients have to decide what they want to do, balancing their mental health and their wellness with their decisions around pregnancy and breastfeeding.

(00:15:53):

So I will say, while we're on the topic of breastfeeding and bipolar disorder, that one of the ... Actually, let me just start by talking a little bit about breastfeeding and sleep, because I will say that the topic that I've seen the most tears shed in my office about, by far, nothing else comes close, nothing comes close, is the topic of breastfeeding, and not necessarily related to medication at all.

Dr. Marlene Freeman (00:16:21):

So for those of you ... Some of you may be painfully familiar with this, but for some of you who haven't really been in this sort of zone, women are ... There's a public health message out there to breastfeed. It's a very strong message, and it's a public health message importantly. So it's a big, overriding goal for more people to know about breastfeeding and to breastfeed, and the message to women in general is to breastfeed exclusively from the breast and establish breastfeeding. The recommendation has been extended, I think, from one year to two years or ... something that is just undoable for most individuals.

(00:17:06):

But each individual, especially if they're at a, quote-unquote, baby-friendly hospital is told ... is really pushed to breastfeed. Now, I just want to say, I want to put it out there. I'm not arguing against the benefits of breastfeeding in any way. From a nutritional standpoint, breastfeeding is best, if it works out well, but there's probably a very complicated bidirectional relationship between stress, psychiatric disorders, anxiety, depression and breastfeeding difficulty, and when women are told that breastfeeding is best and they're making this delicate transition in life to being a new mother and they're told they're doing it wrong, that is just devastating for individuals.

(00:17:50):

So it's very important, I think, that people hear from us that the most important thing is their wellness, that they're well and they're able to bond with their baby, because there are few areas in mental health that are as proven as the importance of maternal mental health on child development. It's mostly depression that's been best studied, but having a mother with depression is associated with almost all negative outcomes across child development, and so we really want to emphasize to women, during pregnancy and in the postpartum, that the goal is to be well. So if a baby is breastfed, fine, if the baby's not breastfed, fine, but women have so much pressure on them, and it's almost always open season on new mothers. There's so much [inaudible 00:18:39], and it's out there in a loud [inaudible 00:18:42]-

Dr. Ken Duckworth (00:18:42):

So the tears in your office, this topic, more than all other topics put together, are about the idea that I'm not meeting some ideal that my healthcare provider instructed me to attend to that I'm not able to do, for whatever reasons.

Dr. Marlene Freeman (00:18:56):

So what happens is, women are in the hospital, they're told to breastfeed, they go home. And if an individual is breastfeeding ... So newborn babies need to eat every one or two hours, maybe every three hours, if you're lucky, and it takes a while to feed them, and then they're up for a while, and then that's 24/7 for weeks. It really takes four-plus months or so for babies to start consolidating some nighttime sleep, if you're lucky. So that means that if a new mom is exclusively breastfeeding from the breast, she is never getting any consecutive sleep, and for individuals who are vulnerable, who have psychiatric disorders, the postpartum may be the most exquisitely vulnerable time for very serious illness, and especially for women with bipolar disorder.

Dr. Marlene Freeman (00:19:42):

So there's an increased risk of mood episodes, postpartum psychosis. So if we're fortunate enough to work with patients during the pregnancy, we start talking with them across the pregnancy about how to get a sleep plan. However they're going to feed, we want them to have a sleep plan, and if women are lucky enough to have partners, we want them to be part of that conversation. If they have a loved family member, if there's no partner who can help. For individuals who have resources, they might line up a night nurse or a night nanny. Most people don't have those kind of resources, but what's really important is that our message is not to do that, not to exclusively breastfeed from the breast when the risk is becoming so ill.

(00:20:23):

So what we recommend is that there's some sleep plan, so that women can get some consecutive sleep, which means someone else can help feed the baby at night, and so that means introducing bottles. It could be pumped breast milk, but could be formula. We have to sometimes give women the message that giving a baby formula is not failure, and it might sound ridiculous if you don't talk to a lot of new parents, but the pressure is so immense on new moms to breastfeed that they really feel awful about this.

(00:20:54):

So they go to their breastfeeding class during pregnancy and they're told that they should breastfeed exclusively. They're told, "Don't introduce bottles, don't introduce pacifiers, or the baby might get nipple confusion and not be able to breastfeed," and so part of our job is to mitigate that message and tell them that nipple confusion doesn't make the top 10 list of things that they need to be worried about. That having enough sleep and support can make all the difference for women being sometimes very ill or being able to stay well. So that's where ... and we really want to help bolster women with support in terms of just this transition part because it's so hard, it's so difficult.

Dr. Ken Duckworth (00:21:38):

So many good points. So we talked about a woman who has known bipolar disorder, gets pregnant, plans to get pregnant. Let's take a person who has a history of depression, and how might you ... they come to your office, they happen to be lucky enough to find you, and they say, "I'm planning to get pregnant. I have a history of pretty serious depressions, but I want to have a baby," and how might you think about that with them? Not really so much the specifics, but how do you approach that with somebody who is planning ahead or somebody who says, "I have a history of depression, I just found out I'm pregnant"?

Dr. Marlene Freeman (00:22:13):

Yeah. So one thing I didn't answer from your question before are the non-pharmacologic interventions that are so important. So I can't think of a situation where we would not recommend psychotherapy. So individual and/or group psychotherapy is an incredibly important part of the piece. We often recommend evidence-based therapies, like cognitive behavioral therapy, but these are often tailored to what the individual needs. A resource that offers no-cost group therapies is Postpartum Support International, and we'll provide that information so that you can learn more about that.

Dr. Marlene Freeman (00:22:51):

But especially over the past few years with the pandemic, they really increased the number of groups they offer for pregnant women, postpartum women, for partners, really diverse groups so that individuals feel comfortable. They offer groups for loss, bipolar disorder, anxiety disorders, almost anything you could think of. They offer resources in Spanish, so it's really worth checking out.

(00:23:19):

So any individual with any psychiatric disorder, we're going to recommend a form of psychotherapy, and I recommend groups to everyone as well. Part of that is because it's very lonely to be going through this experience, and partly because of the stigma. So most women don't talk about these things publicly. People don't, when they're pregnant or postpartum, don't generally share this type of information. So almost every woman feels like she's going through it alone and feels so often frightened and alone with it. So the groups can offer, I think, a kinship of being able to connect with people who've been in your shoes. So I think that the groups are incredibly powerful, even for people who haven't done groups before or don't think that they would like a group.

(00:24:07):

Now, for individuals who have major depressive disorder, what we focus on is what's been the history, the severity, the recurrence? What have they responded with, with treatment? There's such a spectrum of severity. The individuals who tend to come to our group though, have had a more recurrent course of illness. They've had more mood episodes, more severe episodes, and often they're coming in and they want to know about the risks and benefits of staying on their medication during pregnancy, or restarting their medicine during pregnancy.

Dr. Ken Duckworth (00:24:43):

And that is the right way to think about it. It's a risk-benefit assessment, right? And each individual's history factors into how you think about that with them. Is that right?

Dr. Marlene Freeman (00:24:55):

So if it's pre-pregnancy, we want to share the information that there are some antidepressants, like SSRI antidepressants, that we know quite a lot about during pregnancy, like fluoxetine, which is Prozac. Sertraline, which is Zoloft. Escitalopram, which is Lexapro. Citalopram, which is Celexa, which are often great first-line treatments for many individuals with depression or anxiety, but we often see individuals who are on medicines for which we have no information, and oftentimes they're on those medicines because the other things didn't get them well. So that makes it a different risk-benefit assessment. If someone's been on 30 medicines, and sometimes that is the case, and they're on the one thing that's got them well, that makes that risk-benefit decision about that medicine much different, even if we know less about it.

Dr. Ken Duckworth (00:25:47):

How about a young woman who has a history of a psychosis spectrum disorder who wants to become pregnant, and I'm thinking schizoaffective disorder under good control on antipsychotics, how do you think about that with them?

Dr. Marlene Freeman (00:26:04):

So during pregnancy, or before pregnancy, or both?

Dr. Ken Duckworth (00:26:10):

We're going with the both. The anticipation of it or just finding out that you're pregnant.

Dr. Marlene Freeman (00:26:17):

So the first thing is really is that we have to keep in mind that the goal is that they're well. Then we talk about how to achieve that, but the goal is wellness, because a lot of times people think if they forgo treatment at all costs that they're doing the best for their baby, and we need to really let people know that every major psychiatric disorder is associated with pregnancy and neonatal complications, and long-term ... The more we learn about in-utero exposure to untreated illness, the more we know that that's not good for child development either.

(00:26:55):

So we really want people to be well, and I think that you had Andy Nierenberg on recently, and I believe this quote is from him, but one of my colleagues once said that there should be a menu of reasonable options. It might've been Gary Sachs or Andy Nierenberg who said this, I want to attribute it correctly. We want to make sure that they understand that being ill is not on the menu. So we want to come up with the reasonable things, and people can have their individual preferences and values, and we want to make sure that these are really collaborative decisions and have partners part of the decision, whoever's going to be supportive of the patient, if that's helpful to her.

(00:27:37):

But we want to make sure, if someone is going to have a treatment during a pregnancy, especially a medication exposure, we want to make sure that it has the best possible chance of working for her. So what we want to avoid is unnecessary medication exposures during a pregnancy. So we don't want a lot of medication trials. So if someone is on something that has worked exquisitely well for them, then that makes that something that really should be at the ... at least the top of the consideration, which is why we want to think about things from the beginning that would be reasonable if someone wants to be pregnant on them.

(00:28:12):

So the other thing, just about the course of pregnancy for someone who's had a psychotic illness, is that the postpartum is such a vulnerable time, and the biggest risk of having a severe postpartum illness is being ill during the pregnancy. So the best thing that we can possibly do is treat it as a deadline. We have until the third trimester to get someone as well as possible. So the aim being rock solid stable before delivery, because the postpartum is such a vulnerable time, and individuals who've had psychotic disorders, particularly bipolar I disorder, are at very high risk of postpartum psychosis, which can be a lethal illness.

(00:28:57):

It's hard to even talk about it, it's so terrible in terms of some of the manifestations of increased risk of suicide and infanticide, but it's just imperative that people who are at risk know they're at risk. So individuals who have a history of bipolar disorder, untreated disorder, are unwell during pregnancy with a psychotic disorder. Family history of bipolar disorder can increase the risk as well, but we want to make sure that we educate that individual's frontline. It's anybody who's at high risk for severe postpartum illness, because so much of the public doesn't know a lot about these things and they don't know what they're dealing with when it's happening in front of them if they don't have a lot of experience with psychiatry or mental health.

Dr. Marlene Freeman (00:29:46):

So it's really important, I think, to educate people about the worst case scenario. We don't want to scare them unnecessarily, but if someone is at risk for postpartum psychosis, postpartum depression, postpartum anxiety, then we want to make sure that they know, and if they feel comfortable to bring in partners and family into that discussion, and ideally that the therapy will be a major component of that. So therapy is so important in the perinatal situation because it offers the benefits of psychotherapy, plus close monitoring over time. So if someone is starting to become unwell, it can be caught as early as possible by someone who really knows that person.

Dr. Ken Duckworth (00:30:27):

Remarkable. You're a wealth of knowledge here. One of the questions in the Q&A was about the opiate crisis, which, of course, is a big phenomenon in Massachusetts, where you and I both reside. Suboxone, methadone, I'm planning to get pregnant, or I just found out I got pregnant. How do you think about those medication assistant therapies for opiate use disorder?

Dr. Marlene Freeman (00:30:55):

So that's actually a wonderful opportunity for me to advertise our website. So the Center for Women's Mental Health at Mass General has a website, which is www.womensmentalhealth.org, and we'll provide the resource. So as part of that website, we have blogs written by the editor-in-chief of our website, who's Dr. Ruta Nonacs, who has contributed so much to this field. Literally, this week, she did a blog summarizing the most recent data on maintenance treatments for opioid use disorders.

(00:31:33):

So looking at methadone, buprenorphine, finding somewhat of an advantage of buprenorphine for patients who are on that in terms of pregnancy outcomes, but generally, if someone is on a maintenance treatment, the advice is that they absolutely should stay on it across pregnancy and postpartum, and that's because the risk of withdrawal is so high in terms of complications, the risk of not only overdose, but all the variables that come along with illicit use if someone does relapse are so potentially dangerous for someone who's pregnant or postpartum that it's 100% advised that they stay on whatever's gotten them well.

(00:32:12):

So we used to have more data with methadone than we did for buprenorphine, but now we have much more for buprenorphine, and the recommendation would be to stay on whatever's gotten them well. I think more individuals are getting buprenorphine now than probably methadone.

Dr. Ken Duckworth (00:32:27):

Yes.

Dr. Marlene Freeman (00:32:28):

So the data are so reassuring, it's really great. So that's literally on our blog as of today.

Dr. Ken Duckworth (00:32:38):

This is the best website I've ever seen in American mental health. I've never seen a site that reviews everything that's happening, what's happening this week. So many of you have asked very specific questions, about lamotrigine in the second trimester, for example. Really important, spend some time on this website to inform you of what's out there, and then talk to your healthcare provider.

(00:32:59):

I want to transition to the complexity, some people report that their OBs don't really believe in psychiatric medications, or their OBs are skeptical of their psychiatric history. I want to know how you think about that one. Have you seen that, first of all, and how do you approach that?

Dr. Marlene Freeman (00:33:22):

So I have seen it, and what I think it is, is I just think ... and some OBs are fantastic on the front lines with mental health, and some OBs are very, very uncomfortable, and I think, just like the rest of society, there are some doctors who have a prejudice against psychiatric illness and individuals who have it. So there still is a stigma, unfortunately, but I truly think, across disciplines, like in OB, there's a lot of fear, and so most OB-GYNs are on the front lines with mental health. They do not feel like they have appropriate backup from psychiatrists or other mental healthcare professionals. It's hard to get individuals enough help or appropriate help with someone who is really skilled in dealing with pregnancy and postpartum.

(00:34:15):

So a lot of the OBs just don't want to be on that front line. And so some states have resources to support them. So in Massachusetts and about 23 other states, there are state-funded groups to do phone consultations with OB-GYNs who want to use them. A lot of OBs don't want to use them. So some OBs will say to patients that they should just stop all their psychiatric medications as if they were elective. So we know ... We appreciate that that's not so easy, that that's not the correct advice for so many of our patients, but they often do hear that, and that's one of the things that's so anxiety-provoking to patients is to hear different things from different healthcare providers.

(00:34:57):

So what we want to try and do is, do as much across-discipline research as we can in healthcare to make sure that individuals are hearing good information from different healthcare providers, and that's one of the things that an organization, like our group or Postpartum Support International, really aims to do, is really multidisciplinary education. I do also think that there are certain areas in the country where there are more psychiatrists than others, and there are certain areas where their OBs are just called upon to do more of this and sometimes really do an excellent job with limited resources. So I think that, sort of depending where you are, your experience with an OB-GYN group might be different.

Dr. Ken Duckworth (00:35:46):

Let's talk a little bit about health inequities in pregnancy and some of the outcomes. I mean, this has become quite clear that we live in a society with a lot of health inequities. How do you think about that? Are projects like MCPAP for Moms trying to address that? Medicaid expansion isn't evident in many states. NAMI advocates for Medicaid expansion in many states, by the way, with our policy team. How do you think about that as a meta problem and what might an average person do about it?

Dr. Marlene Freeman (00:36:21):

So there are advocacy groups like Postpartum Support International that are addressing this, which have crisis lines and warm lines and groups and resources specifically for different traditionally underrepresented groups, so that everyone feels welcome and that they have a place. There are also resources like the state-funded groups to support healthcare providers wherever they are, because, very often, an individual in a underrepresented group or a disadvantaged group might not be able to see necessarily a perinatal psychiatry consultation, and they might not want to go find someone that they don't necessarily trust, but the idea of backup to their own healthcare provider, I think it might help us just tremendously in terms of being able to help more women.

(00:37:15):

One of the things that our group has done, starting almost exactly four years ago, so as we were being sent home from the hospital with the COVID pandemic, we made our rounds, which we value so much, virtual, our weekly rounds, and so a lot of colleagues across the country knew we were going virtual and asked to join us. So instead of expanding our own groups' rounds, what we did is we created virtual rounds at the Center for Women's Mental Health for healthcare providers so that they can participate in a learning and community experience around perinatal mental health, regardless of where they are.

(00:37:58):

So we actually have callers who call in from rural areas and underserved areas, or from other countries dealing with all sorts of different populations to be able to learn and present cases. I really think that the key is really making those kind of educational experiences available, because we want to make sure that the frontline has the resources that they need.

Dr. Ken Duckworth (00:38:24):

Let's talk about neuro stimulation. So there was a question today about transcranial magnetic stimulation for depression, and in the pre-submitted questions, more than 100 questions, there was a question about the role of ECT, electroconvulsive therapy, or shock treatment, for severe mood disorders. I wanted to ask your take on those, because it's come up now more than once.

Dr. Marlene Freeman (00:38:47):

So ECT is an absolutely important tool to keep in mind for severe illness during pregnancy and postpartum, and we often do refer patients for ECT who are not well and really ill. I think that, in general, for patients who are pregnant, I think at least in Massachusetts, the general hospitals are the ones that can offer ECT. So the freestanding psychiatric hospitals, I think, are less likely to feel comfortable offering that to a pregnant woman. The only situation I've really encountered is that very late in the third trimester, there may be some concerns about complications with anesthesia, where it may not be offered and it might be deferred until the woman has delivered, but we absolutely keep ECT in mind for patients who would benefit from it.

(00:39:44):

And then TMS is really newer. It's not the same gold standard for very severe illness, but a lot of patients who want to minimize medication or have a more treatment-resistant illness have pursued TMS. There's been limited study for safety and efficacy specifically in the perinatal population. So some of that came from University of Pennsylvania where they have done relatively small studies, but look extremely promising for pregnant women. But those play extremely different roles in terms of what we have to offer.

Dr. Ken Duckworth (00:40:23):

So ECT, in selected circumstances, much better studied than the newer TMS, or transcranial magnetic.

Dr. Marlene Freeman (00:40:30):

For really severe illness, life-threatening-

Dr. Ken Duckworth (00:40:33):

Yes, really, really severe.

Dr. Marlene Freeman (00:40:35):

Yeah. ECT is more rapidly acting and really the gold standard in terms of efficacy, where for TMS, the protocol is generally going every day for weeks, and so sometimes it can take a month or longer before someone knows whether they'll have any response at all.

Dr. Ken Duckworth (00:40:53):

You talked about getting people well. How do you think about that? Is this the symptoms, minimal symptoms, under control, the ability to live one's life, because it's interesting, other than the Depakote/valproic acid, which you have in a very special category, it sounds like many medicines are in the risk-benefit assessment based on your knowledge, your history, and, of course, there's the literature, which is available on that amazing website about each individual compound. So I'm just interested in how you approach that question.

Dr. Marlene Freeman (00:41:32):

So what is well enough?

Dr. Ken Duckworth (00:41:37):

Yeah, what is well enough? So a woman has a history of bipolar disorder, plans to get pregnant. Obviously, you're trying to keep her out of an episode during pregnancy. A person has a history of depression. A person has well-controlled psychosis. A person has opiate use disorder, under control, Suboxone, aka, buprenorphine, right? The definition of wellness is ... It was a question that came up, and is one I'm also interested in. How do you think about that with someone, because I know you do all your work with people, so how do you think about it with them?

Dr. Marlene Freeman (00:42:12):

So when people are really unwell, it's obvious, but the concern that we would have in our field in general is that there is a risk of having residual symptoms. So being not totally well. So people who are just scraping by, they're functioning enough, but maybe not ... across arenas of their life, they're really struggling and they have residual symptoms. That's really been shown to be a major risk factor for relapse, and so the typical course of that, if someone is struggling through pregnancy, is to get much worse rapidly in the postpartum.

Dr. Marlene Freeman (00:42:56):

So that often occurs very quickly. It can often lead to very severe illness. So if someone's had a history of depression, that can often worsen incredibly rapidly in the postpartum, or anxiety. Some of the women that we see who are most ill and suffer the most, are those with postpartum anxiety and postpartum OCD, and so what we want to make sure ... So medications that are reasonable for a lot of the patients that we see, for most of the patients we see in our center, but what we want to avoid is treating with medication and still having the person be ill, because then we're not doing anyone any favors. The baby's exposed to everything, medicine and untreated illness.

(00:43:41):

So we never want unnecessary medication exposures. So we don't take medication lightly during pregnancy, but we want to use it judiciously. We want to use it with a rationale, and so we always want to pick the medicines, when possible, are best known with the best reproductive safety profile, and that's a dynamic, moving target. So, for example, the typical antipsychotics, which are used for psychotic disorders, schizophrenia, bipolar disorder, treatment resistant mood disorder, off-label for treatment resistant anxiety, for all sorts of indications. We used to know nothing about those medicines, and so for some that have been available longer, we know quite a bit and a lot of that data is reassuring.

(00:44:28):

We know some of that from our National Pregnancy for Psychiatric Medications, and so we'll also give you that website, but if you go to our website and go to the research page, what we do is we enroll women during pregnancy, and it's all remote, so it's by phone, and we are grateful for referrals, if this would pertain to anybody that you know, but we follow women with two phone calls during pregnancy and then postpartum. We get a lot of data from women who are so generous to share it, and we're learning more every day about some of the medications that have been unknown to us before.

(00:45:09):

So, for example, quetiapine, which is Seroquel, and Abilify, which is aripiprazole, and lurasidone, which is Latuda, we know a lot about those medicines, or at least a lot more than we used to, and we can share that data, because what happens is, we're clinical researchers in our group, so we see patients in the clinic and we have patients in our study, so we'll be in the clinic and patients will have this dilemma. They're on a medicine that's not very well-known during pregnancy. They don't know what to do. Sometimes they feel so alone, they just want to know has anyone ever been on this medicine during pregnancy?

(00:45:43):

So they're often reassured to just know that there's a pregnancy registry, but what's the coolest thing is to be able to say, "Not only do we have some information, we just published on this. So it's generally a small number of patients, we wish we had more data, but we can tell you that there's not an increased risk of major malformations with exposure to this medicine in pregnancy or this class of medicines in pregnancy," and that means so much to people. I've actually told people that, and sometimes they've then enrolled in the registry to be able to share that with other women. I've actually talked about the registry with some patients and I've had patients say, "I was in that," and they're so happy to have been able to be part of something that, in real time, is helping other women.

Dr. Ken Duckworth (00:46:31):

This is very NAMI. You take your experience and you participate in helping others, teaching others, working our classes or participating in research. You mentioned the Psychosis Research Project. I wonder if you could talk a little bit about that and what's happening with that particular study.

Dr. Marlene Freeman (00:46:50):

So I would love to. So postpartum psychosis is generally considered a rare disorder, so affects about one or two out of 1000 pregnancies, which when you think about how many pregnancies occur just in the U.S. alone, it's not so rare. So most psychiatrists have seen a case of postpartum psychosis, and so it often occurs pretty rapidly after delivery. It can be very severe, and as we were talking about before, has terrible consequences if not treated. So it's really important that people know about it, and the experience for treatment, we virtually always recommend hospitalization. That someone is assessed acutely, hospitalization for safety and stabilization.

(00:47:32):

Then, what we know is, is that bipolar disorder is the disorder that's associated most with postpartum psychosis. So some women who have postpartum psychosis really present in a context where it's either the onset of bipolar disorder or they've had episodes before, but their long-term treatment is for bipolar disorder.

(00:47:55):

There's also a subcategory of women that appear to only have these circumscribed episodes of postpartum psychosis, even if it's with manic symptoms. It looks like mania with psychosis, but they've only occurred in their life in the postpartum, and some women will never have them again, but they are highly recurrent in the postpartum. So if someone's had an episode of postpartum psychosis after having one child, they're at tremendously high risk of having it again, like 80% chance of recurrence if they're not on medicine after delivery with another child.

(00:48:28):

But the long-term consequences are really unknown. So we don't know at this point who needs long-term maintenance treatment for bipolar disorder and who does not, based on if someone just presents for the first time with postpartum psychosis. So that's one of the things we're trying to really understand. So we have the MGH Postpartum Psychosis Project, and the website is mghp3.org, and the website was created with the launch of this project, so anyone who has had an episode of postpartum psychosis in the past 10 years is invited to participate with an interview and, optionally, can give saliva for a DNA sample.

(00:49:10):

Separately, we've done some other studies, really qualitative, like asking people to share their experience so we can understand the disorder better. Ultimately, we really wanted to advise treatment for women and really inform treatment, but in addition to launching a website for this study, we have a lot of patient-facing materials on that website. So a lot of information about postpartum psychosis for patients and their families. Some patient stories, who've been through it before, so other people don't have to feel so alone, and we also offer four healthcare prescribers, free consultations, if they're treating someone who has postpartum psychosis and they don't know what to do. So that's not for direct patient care, but it's for prescribers who are taking care of patients.

Dr. Ken Duckworth (00:50:04):

I'd like to ask you a little bit about the arc of your career and how you see this field evolving now. How did you get interested in it? Where do you think the research is going? Obviously, you're incredibly accomplished, and it's fantastic what you've accomplished, but you don't even have gray hair yet like I do, so there's a future for you in your work, your research, your collaboration. So I'm just interested in how you see the field evolving over your career.

Dr. Marlene Freeman (00:50:35):

So I think that it was a relatively new field when I entered it, and so a lot of healthcare providers were told that women couldn't take medication during pregnancy. I think that we have a greater appreciation now with trying to understand the risks and benefits of medications during pregnancy, and I think a better appreciation ... There used to be this myth that women didn't need treatment during pregnancy that has been just totally demonstrated to be false. That women are at high risk of recurrence during pregnancy, the same as not during pregnancy. So pregnancy is not protective, and the postpartum is exquisitely risky. So I think we appreciate that so much more.

(00:51:24):

I think we also appreciate so much more the multidisciplinary approach that has to be taken for this. So we have perinatal psychiatrists, but we'll never have enough perinatal psychiatrists, I think. So we work together with other prescribers. We work with therapists of all disciplines, doulas, lactation consultants, OB-GYNs. We have to have more of a team approach, I think, to this. So that's something that's really changed.

(00:51:54):

A couple other things that I think have changed is that more women come to the reproductive years having correct diagnoses and receiving treatment that really helps them, and so we make more decisions about medication regimens with patients, I think, than we used to, because, fortunately, they're diagnosed and treated, and one of the areas where this has been so profound of the differences, for example, ADHD. So girls and women used to fly under the radar and not be diagnosed with ADHD, and now many women come to the reproductive years with a diagnosis and treatment and they really want to know what to do.

(00:52:33):

So this is such an individual thing and it really requires weighing the risks and benefits for that individual person, but now we have more data, but we also have more patients who are, fortunately, diagnosed and treated.

Dr. Ken Duckworth (00:52:48):

So the field's really expanded, and there was actually a question, a neurodivergence ADHD in the Q&A. So I just was looking at your incredible website at Mass General. It's incredible. There's nothing, nothing like it, really, and I just saw you can click on all the vulnerabilities, and click on the review of the research in ADHD and pregnancy. It's right there, and it's been done by an expert. So you don't have to parse this on your own.

Dr. Ken Duckworth (00:53:21):

Are there any other thoughts that you have before we close? I mean, I heard very clearly supporting people in being well, staying away from Depakote/valproic acid, not shaming people for not breastfeeding, attending to sleep hygiene, thoughtful risk-benefit assessment, and a movement towards acknowledging that treatment can be really helpful for many people in these circumstances. That's some of the things that I heard in this fabulous chat. What other things would you like to close with, other remarks that you have for our audience?

Dr. Marlene Freeman (00:54:02):

I mean, I think a last thing to close with is we really carefully weigh the benefits of medication exposures, but very often individuals don't think about other exposures they may have, and we want to make sure that, say, non-prescription things that they might be taking are held of the same standards of safety and efficacy. So, for example, we see so many more women now using cannabis products during pregnancy, and all the data looks terrible for neurodevelopmental outcomes and pregnancy complications with that, but many women don't think about it in the same way.

(00:54:40):

The same thing with nutraceuticals. We want to make sure that, for everything someone might be taking, that we really want to assess the safety and efficacy and role that it's playing for that person. So not just the prescription medication or the antidepressant for which there might be a lot of stigma and is getting a lot of attention, but we want to make sure the whole regimen is assessed similarly.

Dr. Ken Duckworth (00:55:02):

Well, Dr. Freeman, I just want to thank you so much for this expertise. We're cutting it a little short because she has a patient she has to attend to, and that's exactly the kind of doctors we love on Ask the Experts. So I hope everybody has enjoyed this conversation. I wish you the best in your career.

(00:55:23):

Let's go to the next couple of slides where we're going to share with you some of the best resources ever found for mental health things. I mean, it's really quite remarkable what this field has put together, largely Mass General, but not only Mass General, and you can see them right there. Postpartum Support International, Dr. Freeman mentioned that. The MGH Center for Women's Mental Health has very detailed research reviews. The Postpartum Psychosis Project is an international study that Dr. Freeman discussed. MCPAP for Moms is consultation to OB-GYNs, the National Maternal Mental Health Hotline. Interesting, that's a very specific area of interest.

Dr. Marlene Freeman (00:56:07):

That's akin to the National Suicide Hotline. So it's a federally-funded hotline that is accessible for everyone, also available in Spanish.

Dr. Ken Duckworth (00:56:16):

Fantastic. So that is for people who are in crisis, whereas some of the other ones, Postpartum Support are not, is that right?

Dr. Marlene Freeman (00:56:25):

So if you go to Postpartum Support International's website, they are running that hotline with ... It's a federally-funded hotline with trained clinicians answering the phone. So there's a connection between Postpartum Support International. You can find all of that on Postpartum Support International's website in terms of the crisis line.

Dr. Ken Duckworth (00:56:47):

Fantastic. Let's go to the next slide, please. So this is the Center for Women's Mental Health, MGH Psychiatry. There were questions about hormones, menopause. We didn't get to them today because this was not our focus, but that is all being attended to on this remarkable website.

(00:57:06):

Let's go to the next slide, please. And that's the resource for the Postpartum Psychosis Project. Again, NAMI's a big believer in trying to understand things, to make sense of them to help more people, and this is a research project that is ongoing. Next slide, please. Do you want to mention anything more specific about Postpartum Support International?

Dr. Marlene Freeman (00:57:34):

So I just would recommend that people check it out for materials for patients and families, as well as resources for healthcare providers. They really do it all, and advocacy as well.

Dr. Ken Duckworth (00:57:51):

Great. Next slide, please. So you can see there's a lot of resources in this area, and if you signed up for this, you will get emailed these slides that'll make sure you have the resources. Next slide, please. Here's some more resources. Here's a six-week online course. Do you want to talk a bit about the course?

Dr. Marlene Freeman (00:58:19):

So the courses are really geared for healthcare providers of all disciplines, but we have that information on our website, so I won't go into too much detail.

Dr. Ken Duckworth (00:58:28):

Yeah, there's several people, nurse practitioners who said, "How can I be more supportive or helpful?" This might be that place. Okay, next slide, please. All right, so we'll be back with Ask the Expert on supported employment. Bob Drake essentially invented this construct and he's going to have Peggy Swarbrick and George Brice, who got a job through supported employment. That's in April. Supported employment is a best practice, but is yet underfunded in our nation. So that's our next Ask the Expert. You're welcome to join us.

(00:59:04):

Let's go to the next slide, please. Shameless self-promotion, this is our first book, You Are Not Alone. I interviewed real people who use their names for what they had learned, which to my surprise was a gap in the literature. People use their names and share what they have learned. I also asked America's best researchers to answer a common question. I asked the good Dr. Freeman a question around, "I have bipolar disorder, how do I approach that challenge?" and she wrote an elegant answer, which required not one edit, I should add. So thank you for that as well. NAMI has the copyright, all royalties to NAMI.

Dr. Ken Duckworth (00:59:45):

Next slide, please, and announcing our new book. This is the first time we've ever mentioned it. This is the second book, Dr. Christine Crawford, our associate medical director here at NAMI has interviewed parents, teens and kids for what they have learned, and our second book at NAMI is You Are Not Alone for Parents and Caregivers. That'll come out in September, but I just wanted to make you aware of it.

(01:00:12):

Next slide, please. You are not alone, and if you'd like to donate to NAMI, we'll happily accept that, but all these webinars are free, and people like Dr. Freeman, whose time is incredibly valuable, donate their time in service of our shared mission.

(01:00:30):

So let's go to the last slide, please. I want to thank you for joining. My name's Ken. I work for NAMI. I have a vanity license plate, a email address, ken@nami.org. Feel free to send me a question. Ask the Expert is manned by Katie Harris, who's done a wonderful job with her team of producing these. If you have a suggestion for a future Ask the Expert topic that you think is compelling, an expert that you feel is doing great research that we should know about, feel free to send them along. So I want to thank everyone for joining. Dr. Marlene Freeman, thank you for everything you've done in your career and for sharing your expertise with us here today.