J Women's Health Dev 2020; 3 (4): 402-412 *DOI: 10.26502/fjwhd.2644-28840048*

Research Article

Systemic Solutions for Addressing Early Recognition and Treatment of Antenatal and Postpartum/Postnatal Depression in Psychiatry Clinic in Skopje, North Macedonia

Slavica Arsova[1], Kadri Haxhihamza[2*], Stojan Bajraktarov[1]

[1]Associate Professor, Psychiatrist, University Clinic of Psychiatry, Skopje, North Macedonia
[2]Assistant Professor, Psychiatrist, University Clinic of Psychiatry, Skopje, North Macedonia

[*]**Corresponding author:** Kadri Haxhihamza, Assistant Professor, Psychiatrist, University Clinic of Psychiatry, Skopje, North Macedonia, E-mail: kadrihadzihamza@gmail.com

Received: 18 September 2020; **Accepted:** 29 September 2020; **Published:** 01 October 2020

Citation: Slavica Arsova, Kadri Haxhihamza, Stojan Bajraktarov. Systemic Solutions for Addressing Early Recognition and Treatment of Antenatal and Postpartum/Postnatal Depression in Psychiatry Clinic in Skopje, North Macedonia. Journal of Women's Health and Development 3 (2020): 402-412.

Abstract

Background: It is considered that depressive disorder most often begins in the reproductive period, around 20 years of age.

Introduction: The greatest risk or danger for the young depressed mother is suicide, which is being considered the second cause of death in the young during the reproductive years. Unfortunately, it happens usually at the end of the pregnancy or during the first postpartum year.

Materials and methods: The investigation comprised 69 patients at the age between 18 and 44 years, with postpartum depression. Patients were diagnosed and treated during their pregnancy and postpartum period. Patients were analyzed by using a structured clinically diagnostic psychiatric interview, psychodiagnostic instruments for assessment of anxiety and depression, HAM-A and HAM-D. Depression and anxiety were evaluated in the beginning of the treatment and after three months of treatment. Patients were treated with psychological interventions and pharmacological treatment, SSRI or SNRI antidepressant therapy, during pregnancy or postpartum

period.

Results: Cross-sectional study was conducted in a 3-month-period and comprised 69 patients, of which 71.0% were at the age older than 30 years, and 29.0% younger than 30 years. Of these, 81.5% of patients received antidepressants, 24.6% received antipsychotics and anxiolytics, alone or in combination.

Discussion: The results have shown a statistically significant presence of risk factors in patients with antenatal or postpartum depression. The results have shown a significant reduction of anxiety and depression after application of SSRI therapy and psychological individual and group interventions by empowering the mother to care for herself and her child.

Conclusion: Proper care for the mental health of the mother is the care for the entire society, healthy mother, healthy children and healthy society. Early recognition of the risk factors for development of antenatal depression leads to prevention of onset of antenatal or postpartum depression.

Keywords: Depression; Pregnancy; Postpartum; Antidepressants; Psychotherapy

1. Background

Statistics indicate an increase of depression worldwide, and the figures are twice higher in women, especially in the risk periods such as pregnancy, postpartum period and menopause. It is considered that depressive disorder most often begins in the reproductive period, around 20 years of age, and hence 1 in 20 girls in this period suffers from depression, and on the other hand, only 1 in 3 will be treated with adequate pharmacological therapy. The indicators show that in 54% of young girls who have suffered from any depressive disorder the risk of onset of depression during pregnancy is approximately 50% higher compared to those who did not have depressive episodes. If we have in mind the fact that in a large number of depressed girls the pregnancies are unplanned/unintended, then the situation is even more delicate due to unrecognition of the depression or due to treatment interruption or inadequate treatment and risky behavior (smoking, alcohol consumption, drugs, irregular check-ups, poor health care) [1, 2].

2. Introduction

According to the American Psychiatric Association (APA) statistical indicators obtained by the experts in perinatal mental health, only half of the mothers with perinatal depression or anxiety are being diagnosed and treated [3] British authors, based on their results published in JAMA in 2018, think that depression in young mothers is significantly higher today than earlier or in comparison with the generations of their own mothers. Most probably the causes for the increase in depression in the young are: chronic stress, sleep deprivation, poor maternal nutrition, sedentary lifestyle, pressure on the mothers to return to their jobs as early as possible after delivery, facing the difficulties in managing the numerous roles of being a mother, wife, diligent worker and at the same time having a social life [4]. The greatest risk or danger for the young depressed mother is suicide, which is being considered the second cause of death in the young during the reproductive years. Unfortunately, it happens usually at the end of the pregnancy or during the first postpartum year. The largest number of these women accomplish violent suicide by

hanging or jumping from height, which is an alarm for recognition and treatment of antenatal and postpartum depression [5, 6].

It is assumed that in 80% of young mothers during the first few days or months after delivery there is mood liability, but not all of these changes are related to postpartum depression. Postpartum sadness or "baby blue" condition/syndrome is expected and is manifested with irritability, tearfulness, moderate anxiety, but it does not interfere with mother's ability to function and to take care for her baby. Opposite to this, postpartum depression that is often added to the depressive condition during pregnancy is manifested with distinct sadness, extreme anxiety, feeling of irrationality/absurdity or despair, sleep disturbances, reluctance, unwillingness, delusional thoughts about herself or the baby that can lead to suicide of infanticide [2, 5]. The most common risk factors for development of antenatal or postpartum depression include history of previous depressive condition, bad psychosocial factors (poor family support, single parents, violent behavior by the intimate partner, unplanned/unintended pregnancy), hormonal changes [7, 8, 9]. The impact of depression on the development of the baby is huge. Deterioration of the relationship between the mother and the baby, presence of negative thoughts about motherhood by rejecting or intrusive behavior, negative mimic/facial expression, interruption of breastfeeding, lead to different emotional problems in the child, who experiences eating difficulties, sleeping, bursts of anger, fury, hyperreactivity, delays in cognitive development and social dysregulation, with an increased risk of malnutrition or obesity.

3. Material and Methods

The investigation comprised 69 patients at the age between 18 and 44 years, with the established diagnosis F32 during pregnancy or F32.01 or F32.02 that is postpartum depression. Patients were diagnosed according to the ICD 10 criteria and treated during their pregnancy and postpartum period at the Department for treatment of pregnant women or women after the delivery. They were treated either as outpatients on a daily basis or in the hospital. Patients were analyzed by using a structured clinically diagnostic psychiatric interview, a structured non-standardized sociodemographic questionnaire (age, education, marital status, number of pregnancies, presence of risk factors – previous depressive episodes, family violence, therapy discontinuation, trauma events), by using psychodiagnostic instruments for assessment of anxiety and depression, Hamilton anxiety rating scale (HAM-A) and Hamilton depression rating scale (HAM-D). Depression and anxiety were evaluated in the beginning of the treatment and after three months of treatment. Patients were treated with psychological interventions and pharmacological treatment, SSRI or SNRI antidepressant therapy, during pregnancy or postpartum period.

Antidepressant treatment during pregnancy included doses that were therapeutically effective, with gradual reduction to the lowest/ minimum therapeutically effective doses. In the postpartum period patients were advised to extend the breastfeeding of their babies aimed at providing a quality mother-infant interaction. Patients and their families were informed in details regarding the antidepressant treatment and benefit-risk ratio. Therapeutic agreement was made with the patients about their regular check-ups at least once in two weeks, continual monitoring of their bodily health with regular visits paid to the family gynecologist and pediatrician in order to have a clear picture of the condition in the antenatal and postpartum period. During the therapeutic process the intimate partners of the patients were included, and if necessary other close family members for getting adequate family

support. The therapeutic process comprised intensive psychiatric and psychological interventions in patients aimed at giving insight into their condition and strengthening their psychological state in bringing independent decisions regarding their pregnancy and treatment of the depressive condition in the antenatal and postpartum period as well as in making decisions about the ways of feeding their babies. During the postpartum period often monitoring of the patient's condition was advised along with mobile phone recording done by the partner of the routine procedures related to parenting. This was important in order to strengthen the maternal self-confidence and role, and on the other hand, to strengthen the partner's relationship and their mutual participation in parenting. Patients with psychodiagnostic instruments were monitored during the entire process, and the measurements with HAM-A and HAM-D are presented in the beginning of the treatment and after three months.

4. Results

This was a cross-sectional study conducted in a 3-month-period and comprised 69 patients, of which 71.0% were at the age older than 30 years, and 29.0% younger than 30 years. Higher percentage (49.3%) of patients had completed high school, 37.7% had university degree and 13.0% had finished primary school. 75.4% were of Christian affiliation and 24.6% were Muslims (Table 1). 81.5% of patients received antidepressants (sertaline, escitalopram and venlafaxine), 24.6% received antipsychotics (olanzapine, risperidone) and anxiolytics (alprazolam, diazepam), alone or in combination (Table 1). The number of pregnancies in patients ranged from one to three, average 1.5 ± 0.7; 65.2% of patients had only one pregnancy. There was no correlation between the number of pregnancies and age of the patients (Pearson Chi-square: 2.65137, p=.265621) (Table 1). 91.3% of patients had a normal/uneventful pregnancy, 17.4% had a normal delivery, and 6.7% had Cesarean delivery (Table 1).

Age	**Count**	**Percentage**
>30	49	71
< 30	20	29
Level of education		
University	26	37.7
High	34	49.3
Primary	9	13
Religion		
Christians	52	75.4
Muslims	17	24.6
Treatment		
Outpatients	53	76.8
Hospital	12	17.4
Combined	4	5.8
Therapy		
without	3	4.3
Antidepressants	38	55.1

Anxiolytics	3	4.3
Antipsychotics	4	5.8
Antidepressants, Anxiolytics	8	11.6
Antidepressants**,** Antipsychotics	7	10.1
Anxiolytics**,** Antipsychotics	3	4.3
Antidepressants, Anxiolytics, Antipsychotics	3	4.3
Number of pregnancies		
1	45	65.2
2	14	20.3
3	10	14.5
Average / Minimum / Maximum / Std.dev.		
1.5 / 1.0 / 3.0 / 0.740095		
Pregnancy and delivery		
Normal	63	91.3
Risky pregnancy	6	8.7
Normal delivery	12	17.4
Premature, Cesarean section	6	8.7

Table 1: Characteristics of patients.

Registered risk factors	**Count**	**Percentage**
None	5	7.2
Family violence	6	8.7
Posttraumatic stress condition	17	24.6
Unplanned pregnancy	3	4.3
Previous episodes	15	21.7
Family violence, Posttraumatic stress condition	3	4.3
Family violence, Previous episodes	2	2.9
Posttraumatic stress condition, Unplanned pregnancy	1	1.4
Posttraumatic stress condition, Previous episodes	4	5.8
Unplanned pregnancy**,** Previous episodes	6	8.7
Family violence, Posttraumatic stress condition, Unplanned pregnancy	1	1.4
Posttraumatic stress condition, Unplanned pregnancy, Previous episodes	2	2.9
No relevant data	4	5.8

Table 2: Distribution of patients according to registered risk factors.

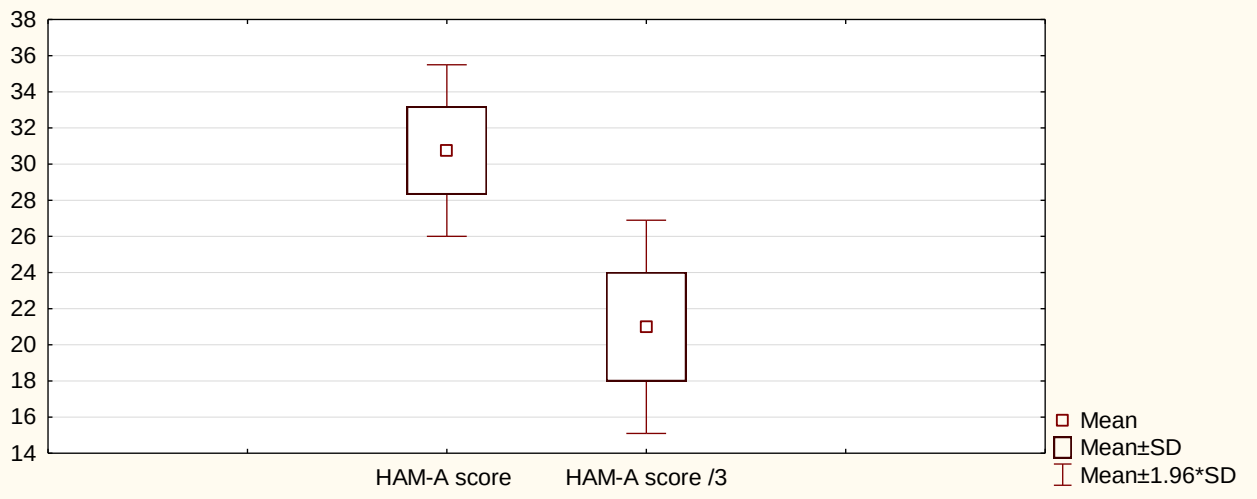
Risk factors were not registered in 5 (7.2%) patients. There were no data about risk factors for 4 (5.8%) patients. In 87.0% of patients risk factors were registered. In the largest number of patients, 29 (42.0%), previous episodes were

registered, alone or in combination with the remaining risk factors. Posttraumatic stress condition was the next risk factor registered in 40.6% (28) of patients, unplanned pregnancy in 18.8% (13) and family violence in 17.4% (12) (Table 2).

	N	Average	Minimum	Maximum	Std.dev.	T	Z	p-value
HAM-A score	69	30.8	26	36	2.421751	0	7.219578	0
HAM-A score/3m	69	21	14	30	3.009788			
HAM-D score	69	30.3	26	38	2.705572	0	7.219578	0
HAM-D score/ 3m	69	19.1	10	28	3.383678			

Table 3: Average score on Hamilton Anxiety Rating Scale (HAM-A) and Hamilton Depression Rating Scale (HAM-D).

A



B

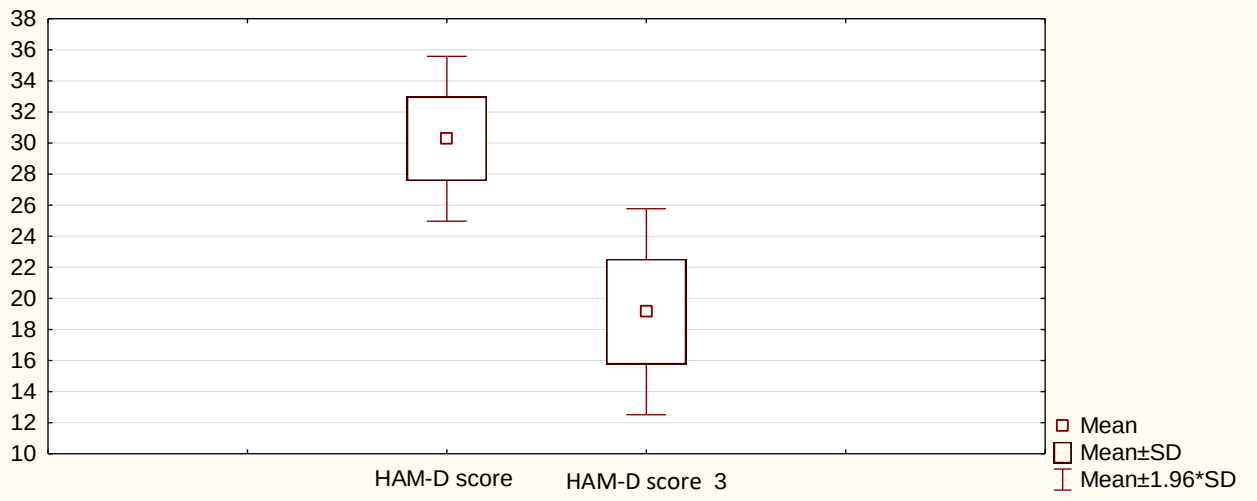


Figure 1: Average score on Hamilton Anxiety Rating Scale (HAM-A) and Hamilton Depression Rating Scale (HAM-D).

The mean/average HAM-A score in the first month was 30.8 ± 2.4, ranging from 26 to 38, and it demonstrated a severe anxiety. After three months (therapy), the average HAM-A score decreased to 21.0 ± 3.4, ranging from 14 to 30, and it demonstrated a moderate anxiety. According to Wilcoxon Matched Pairs test, the difference was statistically significant for $p<0.05$ (Table 4 and Figure 1a). The mean/average HAM-D score in the first month was 30.3 ± 2.7, ranging from 26 to 36, and it demonstrated a severe depression. After three months (therapy), the average HAM-D score decreased to 19.1 ± 3.4, ranging from 10 to 28, and it demonstrated a moderate depression. According to Wilcoxon Matched Pairs, the difference was statistically significant for $p<0.05$ (Table 4 and Figure 1b). The mean/average HAM-A score in patients with risk factors in the first month was 31.0 ± 2.4, and it demonstrated a severe anxiety. The mean/average HAM-A score in patients with no risk factors in the first month was 29.6 ± 1.7, and it demonstrated a severe anxiety. According to Kolmogorov-Smirnov test the statistical significance was non-significant, for $p>0.05$ (Table 4).

After three months (therapy), the average HAM-A score reduced to 21.3 ± 3.0, and it demonstrated a moderate anxiety. The average HAM-A score after the third month in patients with no risk factors was 19.6 ± 1.7, and it demonstrated a moderate anxiety. According to Kolmogorov-Smirnov test the difference was statistically significant for $p>0.05$ (Table 4). The mean/average HAM-D score in patients with risk factors in the first month was 30.7 ± 2.6, and it demonstrated a severe depression. The mean/average HAM-A score in patients with no risk factors in the first month was 27.2 ± 1.1, and it demonstrated a severe depression. According to Kolmogorov-Smirnov the difference was statistically significant for $p<0.05$ (Table 4). After three months (therapy), the average HAM-D score reduced to 19.7 ± 3.2, and it demonstrated a moderate depression. The average HAM-D score after the third month in patients with no risk factors was 15.6 ± 0.9, and it demonstrated a moderate depression. According to Kolmogorov-Smirnov test the difference was statistically significant for $p<0.05$ (Table 4).

	Max. neg. difference	**Max. pos. difference**	**p**	**average - yes**	**average - no**	**Std.Dev. - yes**	**Std.Dev. - no**	**N – yes**	**N - no**
HAM-A score	-0.05	0.25	p > .10	31	29.6	2.393494	1.67332	60	5
HAM-A score/3m	-0.05	0.25	p > .10	21.3	19.6	3.042588	1.67332	60	5
HAM-D score	0	0.8	p < .005	30.7	27.2	2.578212	1.095445	60	5
HAM-D score/ 3m	-0.03	0.9	p < .005	19.7	15.6	3.164912	0.894427	60	5

Table 4: Average Hamilton Anxiety Rating Scale (HAM-A) score and Hamilton Depression Rating Scale (HAM-D) score regarding the presence of risk factors in patients and Kolmogorov-Smirnov test.

During the investigation there was no correlation among religious affiliation, age, education and number of pregnancy and the registered risk factors (Pearson Chi-square, $p>0.05$).

5. Discussion

The results have shown a statistically significant presence of risk factors in patients with antenatal or postpartum depression. The largest number of patients experienced previous depressive episodes, traumatic events, unplanned pregnancy or family violence. In a group of patients, existence of several risk factors was observed including previous episodes, family violence and traumatic events in the past. In the largest number of these patients, family violence existed, which is a very worrying/troublesome fact since this violence was detected primarily in the basic family and it sometimes continued in the current family. Also, in the largest number of patients several risk factors were seen at the same time, such as posttraumatic events in the past. In 50% of patients previous depressive episodes were detected and they were either undiagnosed and untreated or exacerbated during pregnancy after discontinuation of antidepressant medications by pregnant women themselves or by a recommendation. These results are in correlation with investigations that point out to the important role of the risk factors, which in addition to biological vulnerability, include family or individual past history, hormonal changes, but also psychosocial factors – lack of social support, family violence, traumatic events such as financial loss of any type, death of a family member, other unpleasant events with a very high risk in young women – victims of current or previous family violence or those with previous depressive episodes [5, 8, 10-12].

This has been supported by investigations suggesting that approximately 50% of girls, who had depressive episodes of any kind in the past, were at risk of development of antenatal depression. If we have in mind that the largest number of them have not been recognized and not treated, then this is really a worrying/troublesome issue [10, 13]. Our investigation comprised patients, who in the largest number had their first pregnancy; they were over 30 years old; depression was not significantly associated with the level of education, although most of them were with completed high school or university. The largest number of patients were of Christian affiliation and a small number of Muslim, which might indicate to an increased concern into the individual mental condition or seeking professional help as a result of the cultural differences. Postpartum depression is different from the so-called postpartum sadness, which usually appears immediately after delivery in the first two weeks and manifests itself by increased anxiety, irritability, crying spells/weepiness, but contrary to postpartum depression it does not interfere with maternal ability to take care for her baby. On the other hand, postpartum depression that is registered in 15% of the total number of mothers is manifested with a significant mood disturbance, languor/apathy or restlessness, insomnia, delusional ideas related to maternal inability to act as a mother or to baby's condition, possible previous negative experiences and a high risk of suicide or infanticide [5, 6, 12].

The results obtained in our study have shown a significant reduction of anxiety and depression after application of SSRI therapy and psychological individual and group interventions by empowering the mother to care for herself and her child. The results have also shown that SSRI treatment was not a risk for the pregnancy itself; on the contrary, antenatal depression was a risk of premature delivery, delivery of low-birth-weight babies or Cesarean delivery. Some patients presented with exacerbation of the depression signs including delusional ideas, suicidal thoughts, all of which were an indication for intrahospital treatment. Suicidality during pregnancy is the highest in the last gestational weeks or immediately after childbirth, and represents an absolute indication for hospital treatment [5, 6, 10]. The results showed no statistical differences with regard to marital status, and the largest

number of patients had high or higher level of education. Some studies have demonstrated a significantly higher level of depression in mothers with completed university degree, which might be due to their higher awareness and consciousness for both, their somatic and mental health, hence the need for seeking help or their easier access to tertiary health care [4].

Investigations suggest that postpartum depression not only causes problems to the affected mother in parenting, but it also has a negative influence on the future psychological childhood development imposing a high risk of early depression. Depressed mothers exhibit more negative and disengaged behavior towards their infants; have difficulties in creating the mother-child relationship; show depressive/less affectionate manner in vocal or visual communication; interruption of breastfeeding, and all of these are preconditions for impaired psychological development of the child [5, 14]. Thus, this leads to raising an alarm for increased awareness, early recognition and treatment of antenatal and postpartum depression in the very beginning of the pregnancy.

Recommendations for recognition and treatment are the following: careful approach to young women who have suffered or currently suffer from some anxiety or depressive disorder; discussion about contraception; discussions about pregnancy that would influence on maternal psychic condition; discussion about the influence of the psychic condition on the mother or the fetus; eventual treatment; support to the mother, her intimate partner and the whole family; inclusion of the mother in bringing decisions about her pregnancy, its interruption or future treatment, by possible/desirable inclusion of the partner; coordinated care with the family physician, gynecologist, psychiatrist, pediatrician during the entire pregnancy and after delivery, observation/monitoring of the psychic and physical health of the mother; alcohol and drug intake/abuse; maternal attitude towards pregnancy; mother-child interaction; previous treatment; social isolation; family history; home violence; ability to take care for the other children. Specific interventions in depressive disorders – intensive psychological interventions (CBT or others); SSRIs as the first-line agents, in addition to paroxetine due to the increased risk of cardiac malformations, optimum doses until the last 8 gestational weeks when the dose is reduced or maybe discontinued; avoiding the use of anxiolytics in the first trimester; SNRI as a second line [8, 13, 15, 16]. The results obtained in our study have shown that almost all patients were treated with antidepressant SSRI therapy, in addition to paroxetine. In over 90% of them normal pregnancy and delivery was observed, and only in a small percentage premature or Cesarean delivery happened.

Research has demonstrated a smaller risk in mothers treated with SSRI during pregnancy than in those not treated resulting in a smaller risk of premature delivery, Cesarean delivery or delivery of low-birth-weight babies [12, 14-16]. Another study revealed that a high level of depression in untreated mothers resulted in a delayed development of the executive functions of their children, which were measured at 3 years of age, and this was not the case with the children whose mothers were treated with SSRI [14]. Mothers with an accentuated risk or mothers with previous depressive conditions should be usually followed up/monitored and counselled. Mothers with no previous depressive condition or other types of anxiety should be asked several simple questions by their family physicians or gynecologists: Over the past two weeks have you felt sad, insecure, frightened, miserable? If the answers are positive, then it can indicate to development of a depressive condition, which imposes the need of referral to a psychiatrist for regular check-ups and treatment [11, 13].

6. Conclusion

As one mother, who has suffered from antenatal and postpartum depression, has already said, the care for the mental health of the mother is the care for the entire society, healthy mother, healthy children and healthy society. Early recognition of the risk factors for development of antenatal depression leads to prevention of onset of antenatal or postpartum depression. Early treatment consisting of a combined treatment with psychological interventions and SSRI antidepressants leads to reduction of anxiety and depression and to enforcement of maternal psychological strength and it also reduces the risk of premature delivery, Cesarean delivery and better care for both, the mother and the baby, in the antenatal and postpartum period.

References

1. Anderson P. Prevalence of perinatal depression Significantly underestimated. American Psychiatric Association (2019).
2. Grote NK, Bridge JA, Gavin AR, Melville JL, Iyengar S, Katon WJ. A meta-analysis of depression during pregnancy and the risk of preterm birth, low birth weight, and intrauterine growth restriction. Arch Gen Psychiatry 67 (2010): 1012-1024.
3. ACOG Committee Opinion No. 343. Psychosocial risk factors: perinatal screening and intervention. Obstet Gynecol 108 (2006): 469-477.
4. Guo N, Robakis T, Miller C, Butwick A. Prevalence of Depression Among Women of Reproductive Age in the United States. Obstet Gynecol 131 (2018): 671-679.
5. Slomian J, Honvo G, Emonts P, Reginster JV, Bruyere O. Consequences of maternal postpartum depression: A systematic review of maternal and infant outcomes. Womens Health (Lond) 15 (2019): 1745506519844044.
6. Thornton C, Schmied V, Dennis CL, Barnett B, Dahlen HG. Maternal deaths in NSW (2000–2006) from nonmedical causes (suicide and trauma) in the first year following birth. Biomed Res Int 2013 (2013): 623743.
7. Alder J, Fink N, Bitzer J, Hösli I, Holzgreve W. Depression and anxiety during pregnancy: a risk factor for obstetric, fetal and neonatal outcome? A critical review of the literature. J Matern Fetal Neonatal Med 20 (2007): 189-209.
8. Brandon AR, Shivakumar G, Craddock Lee S, Inrig SJ, Sadler J. Ethical issues in perinatal mental health research. Curr Opin Psychiatry 22 (2009): 601-606.
9. Pignone MP, Gaynes BN, Rushton JL, Mills Burchell C, Orleans CT, Mulroe CD, et al. Screening for depression in adults: A summary of the evidence for the U.S. Preventive Services Task Force. Ann Intern Med 136 (2002): 765-776.
10. O'Hara MW, Neunaber DJ, Zekoski EM. Prospective study of postpartum depression: prevalence, course, and predictive factors. J Abnorm Psychol 93 (1984): 158.
11. Malm H, Artama M, Brown AS, Gissler M, Gyllenber D, Hinkka-Yli-Salomaki S, et al. Infant and childhood neurodevelopmental outcomes following prenatal exposure to selective serotonin reuptake inhibitors: overview and design of a Finnish Register-Based Study (FinESSI). BMC Psychiatry 12 (2012): 217.

12. Kieler H, Artama M, Engeland A, Gissler M, Norgard M, Stephansson O, et al. Selective serotonin reuptake inhibitors during pregnancy and risk of persistent pulmonary hypertension in the newborn: population-based cohort study from the five Nordic countries. BMJ 344 (2012): d8012.
13. Huang H, Coleman S, Bridge JA, Yonkers K, Katon W. A meta-analysis of the relationship between antidepressant use in pregnancy and the risk of preterm birth and low birth weight. Gen Hosp Psychiatry 36 (2014): 13-18.
14. Malm H, Sourander A, Gissler M, Gyllenberg D, Hinkka-Yi-Salomaki S, et al. Pregnancy Complications Following Prenatal Exposure to SSRIs or Maternal Psychiatric Disorders: Results from Population-Based National Register Data. Am J Psychiatry 172 (2015): 1224-1232.
15. Bonari L, Pinto N, Ahn E, Einarson A, Steiner M, Koren G. Perinatal risks of untreated depression during pregnancy. Can J Psychiatry 49 (2004): 726-735.
16. Fischer Fumeaux CJ, Morisod Harari M, Weisskopf E, Eap CB, Epiney M, Vial Y, et al. Risk-benefit balance of SSRI Antidepressant Use during Pregnancy and Lactation Based on Best Available Evidence - An Update. Expert Opin Drug Saf 18 (2019): 949-963.