Pregnancy and lactation quick reference

Antidepressants, mood stabilizers, antipsychotics, benzos, and stimulants across pregnancy and lactation. Reviewed against current guidelines as of June 8, 2026.

The default question is wrong. It's almost never 'medication vs no medication.' It's 'treated illness vs untreated illness.' Untreated depression, bipolar, or psychosis in pregnancy carries real risks: preterm birth, low birth weight, preeclampsia, poor prenatal care, postpartum decompensation, self-harm. FDA letter categories are gone as of 2015. MotherToBaby and LactMed are the working sources.

Antidepressants

Drug	First trimester	Later pregnancy	Lactation	Notes
Sertraline	No consistent teratogenic signal	Small neonatal adaptation risk	Lowest infant serum levels; first-line	Default SSRI in pregnancy for most patients
Escitalopram, citalopram	No consistent teratogenic signal	Neonatal adaptation; possible small PPHN signal	Acceptable, low exposure	Fine if patient stable on one already
Fluoxetine	No consistent teratogenic signal	Neonatal adaptation; higher infant serum from long t1/2	Highest SSRI infant serum; some switch to sertraline for lactation	Long t1/2 means changes take weeks
Paroxetine	Small cardiac (VSD) signal, about 1.5 to 2x baseline	Neonatal adaptation	Fine, low exposure	Avoid first trimester if possible
Venlafaxine, duloxetine	No clear teratogenic signal	Neonatal adaptation; some hypertension data	Acceptable, monitor infant	Duloxetine less pregnancy data than venlafaxine
Bupropion	No consistent teratogenic signal	Limited adaptation data	Acceptable	Sometimes preferred if smoking cessation is also a goal
Mirtazapine	Limited, mostly reassuring	Sedation in some newborns	Acceptable	Useful when appetite, sleep, or nausea are targets
TCAs (nortriptyline, amitriptyline)	No consistent teratogenic signal	Neonatal adaptation; anticholinergic effects	Acceptable; nortriptyline has more data	Older and less used but reasonable
MAOIs (phenelzine, tranylcypromine)	Very limited data	Hypertensive crisis risk during labor	Limited data, generally avoid	Reserve for refractory cases

Mood stabilizers

Drug	First trimester	Later pregnancy	Lactation	Notes
Lithium	Ebstein anomaly 0.05 to 0.1 percent (10 to 20x baseline)	Fetal goiter, polyhydramnios; neonatal toxicity if not adjusted at delivery	Increasing acceptance with monitoring	Least teratogenic effective mood stabilizer. Fetal echo at 16 to 20 weeks.
Valproate	NTDs 1 to 2 percent; craniofacial, cardiac, limb; ~10 percent major malformation	IQ reduction 8 to 11 points; ASD ~3x baseline	Compatible but rarely appropriate	Contraindicated in reproductive-age unless no alternative
Carbamazepine	NTDs ~1 percent; ~5 to 6 percent major malformation	Vitamin K deficiency at delivery	Acceptable, not first-line	Less teratogenic than valproate, still not preferred
Lamotrigine	~2 to 3 percent baseline; older cleft signal not confirmed in newer registries	Levels drop up to 50 percent; needs monitoring	Compatible; infant levels can be measurable	Preferred anticonvulsant mood stabilizer
Topiramate	Oral cleft signal 2 to 4x baseline	Low birth weight	Acceptable, not first-line	Better avoided in pregnancy

Antipsychotics, benzodiazepines, stimulants

Drug	First trimester	Later pregnancy	Lactation	Notes
Haloperidol	Reassuring, no clear signal	EPS in newborn	Acceptable	Most data of any antipsychotic
Risperidone	Reassuring	EPS in newborn	Acceptable	Reasonable choice
Olanzapine	Reassuring	Neonatal adaptation; gestational diabetes	Acceptable, watch sedation	Maternal metabolic effects matter
Quetiapine	Reassuring	Neonatal adaptation	Acceptable	Common pragmatic choice
Aripiprazole	Limited but reassuring	Limited data	Limited, presumed acceptable	Growing use
Clozapine	Reassuring on malformation	Floppy baby; infant ANC monitoring required first 6 months	Acceptable, monitor infant CBC	Continue during pregnancy if needed
Lorazepam, clonazepam, alprazolam, diazepam	Historic cleft signal essentially disproven	Floppy baby syndrome; neonatal withdrawal near term	Lorazepam preferred; diazepam not preferred	Coordinate with OB if labor coverage needed
Methylphenidate	Small cardiac signal in some studies; not confirmed	Low birth weight, preterm signal	Acceptable, low exposure	Most data of any stimulant
Amphetamines (Adderall, lisdexamfetamine)	Less data; older cardiac signal largely disproven	Same low birth weight, preterm signal	Acceptable	Increasingly used, data improving
Modafinil, armodafinil	Concerning teratogenic signal (~15 percent major malformation)	Same	Limited	Avoid in pregnancy

Working rules

- Sertraline is the default SSRI in pregnancy and lactation.
- Lithium is the least teratogenic effective bipolar maintenance drug. Fetal echo at 16 to 20 weeks. Level checks q4 weeks in 2nd trimester, q2 weeks in 3rd. Hold or reduce at delivery.
- Valproate: off the table in anyone of reproductive potential unless every alternative has failed.
- Lamotrigine levels drop 30 to 60 percent in pregnancy and rebound within days postpartum. Adjust up during, back down within a week of delivery.
- Untreated bipolar disorder relapse in pregnancy off medication is roughly 50 percent, with much higher postpartum risk. Discontinuation is not a null option.
- Neonatal adaptation syndrome happens in 15 to 30 percent of SSRI or SNRI third-trimester exposures. Usually resolves in 2 weeks. Do not pretaper the third trimester.

Not medical advice.