Antidepressants in Pregnancy: Weighing the Risks

Although there has been a renaissance in sensitivity surrounding assessment and treatment of depression during the postpartum period, pregnancy itself (albeit complete with "tolerated" mood swings) is still widely considered a time of good health and emotional stability. Yet pregnancy has not been found to provide any protection against mood disorders. Just as many women become depressed during pregnancy as their non-pregnant peers—about 10 to 15 percent, or one in eight pregnant women. In total, half a million pregnant women each year become depressed in the United States.

For about one-third of the women who become depressed during pregnancy, this episode may be their first; however, many women with a history of recurrent depression decide to discontinue psychotropic medication around the time of conception. These women have a staggering seventy percent chance of relapse, nine out of ten of which occur by the end of the second trimester.[2] The data on the effects of these maternal mood and anxiety disorders on the fetus, newborn, and growing child are accumulating, and cannot be ignored.

While psychotherapy can be an effective treatment for pregnancy and postpartum depression or anxiety, full recovery in pregnancy or postpartum (during lactation) may require medication. Thus, depression and anxiety during this time offer a continuing conundrum for thoughtful clinicians: to treat with antidepressants or not to treat? And if to treat, for whom, with what, when, and how much? Though still incomplete, the literature provides information for practitioners and patients to carefully, collaboratively, and individually begin to address these questions.

Risks: Disorders vs. Medications

Clinicians often err on the side of caution in recommending medication during pregnancy, perhaps slightly less so during postpartum. Yet the risks of untreated depression or anxiety on the maternal-fetal, or mother-infant, dyad are significant. Depression and anxiety during pregnancy can contribute to self-injurious or suicidal behavior in the mother, as at any other time. But they also can contribute to the following:[4,6]

- Poor self-care and poor adherence to prenatal care
- Less-than-adequate weight gain, with incumbent risks to fetus/newborn
- Increased risk of tobacco, alcohol, and/or drug use
- Preterm birth, low birth weight
- Higher rates of pre-eclampsia, cesarean section, and neonatal intensive care unit admissions

Lactating women also may avoid medication. But untreated depression and anxiety in the new mother predispose to long-term effects on the infant as well, such as: [4,7,8]

RISK FACTORS

Predisposing factors for depression and anxiety in pregnancy:

- Personal history of depression or anxiety
- Marital or relationship stress
- Poor psychosocial supports
- Unwanted pregnancy
- Adverse life events

Increased risk during postpartum:

- Health problems in the infant
- Depression during pregnancy

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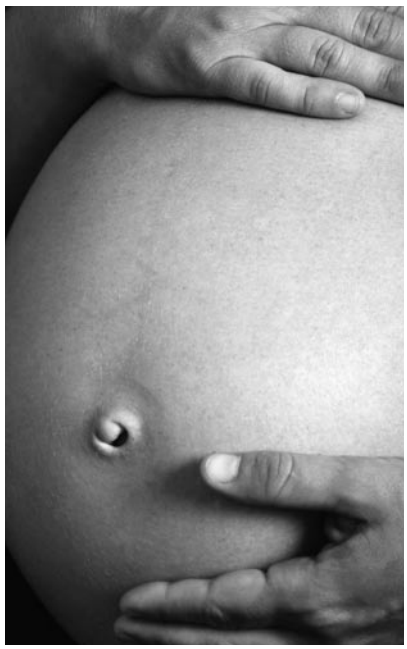
- Overactive stress response
- Poorer motor skills, coordination, resiliency, and activity
- Attachment issues
- Heightened anxiety
- Lower cognitive and language abilities
- Behavioral/emotional difficulties and maladaptive social interactions
- Increased risk for conduct problems, suicidal behavior, and other psychiatric sequelae

On the other hand, risks of Selective Serotonin Reuptake Inhibitor antidepressants (SSRIs) during pregnancy or postpartum are much harder to quantify. SSRIs are one of the most studied medications in pregnancy, and are the most studied medication in lactation. Yet randomized controlled trials are nearly impossible to conduct for ethical reasons. No significant rates of miscarriage or major malformations have been associated with several thousand SSRI exposures in pregnancy, and neurobehavioral development appears to be normal throughout early childhood. In other words, as opposed to children of mothers with untreated illness, children of mothers treated with antidepressants in pregnancy seem to fare as well as those of mothers who had no mood disorders.

There have been scattered reports of various negative birth outcomes or "neonatal adaptation syndromes/NAS" with SSRI use. These include: transient respiratory and/or metabolic problems, slightly lower gestational age, and lower Apgar scores. Yet rarely, if ever, is medical intervention required, and it is quite possible that NAS may be a reflection of pre-existing maternal illness and not a consequence of SSRI use at all.[5]

During postpartum, Hendrick et al.[3] found that exposure to SSRIs through breast milk did not affect infant weight gain, while maternal depression lasting two months or more did adversely impact weight. Berle et al.[1] found SSRI drug levels in nursing infants were low or virtually undetectable. These studies are reassuring for practitioners and their postpartum patients who take SSRIs and choose to breastfeed.

On balance, while the risks of untreated antenatal or postpartum depression/anxiety are clear and significant to both mother and fetus (and young child), the risks of SSRI treatment are less clear but appear to be fewer in number than those associated with the mother's untreated depression. Overall, the growing literature supports SSRI treatment during pregnancy and postpartum in cases where the benefits outweigh the risks. In fact, recovery of maternal mental health may be the single most effective preventive measure we have for the current and future mental health of the unborn, the newborn, and the growing child.



References

1. Berle, J. O., Steen, V. M., Aamo, T. O., Breilid, M., Zahlsen, K., & Spigset, O. (2004). Breastfeeding during maternal antidepressant treatment with serotonin reuptake inhibitors: Infant exposure, clinical symptoms, and cytochrome P450 genotypes. *Journal of Clinical Psychiatry, 65*, 1228-1234.
2. Cohen., L., Altshuler, L. L., Harlow, B. L., Nonacs, R., Newport, D. J., Viguera, A. C., Suri, R., Burt, V. K., Hendrick, V., Reminick, A. M., Loughead, A., Vitonis, A. F., Stowe, Z. N. (2006). Relapse of major depression during pregnancy in women who maintain or discontinue antidepressant treatment. *Journal of the American Medical Association, 295*, 499-507.
3. Hendrick, V. (2003). Weight gain in breastfed infants of mothers taking antidepressant medications. *Journal of Clinical Psychiatry, 64*, 410-412.
4. Henry, A., Beach, A. J., Stowe, Z. N., & Newport, D. J. (2004). The fetus and maternal depression: Implications for antenatal treatment guidelines. *Clinical Obstetrics and Gynecology, 47,* 535-546.
5. Levinson-Castiel, R., Merlob, P, Linder, N., Sirota, L., & Klinger, G. (2006). Neonatal abstinence syndrome after in utero exposure to selective serotonin reuptake inhibitors in term infants. *Archives of Pediatric and Adolescent Medicine, 160*, 173-176.
6. Misri, S., Reebye, P., Kendrick, K., Carter, D., Ryan, D., Grunau, R.E., & Oberlander, T. F. (2006). Internalizing behaviors in 4-year-old children exposed in utero to psychotropic medications. *American Journal of Psychiatry, 163*, 1026-1032.
7. Moehler, E., Brunner, R., Wiebel, A., Reck, C., & Resch, F. (2006). Maternal depressive symptoms in the postnatal period are associated with long-term impairment of mother-child bonding. *Archives of Women's Mental Health, 9*, 273-278, 2006.
8. Van den Bergh, B., Van Calster, B., Smits, T., Van Huffel, S., & Lagae, L. (2008). Antenatal maternal anxiety is related to HPA-axis dysregulation and self-reported depressive symptoms in adolescence: A prospective study on the fetal origins of depressed mood. *Neuropsychopharmacology, 33*, 536-545.

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