Pregnancy Safety: Depression
INFORMATION BULLETIN

This information is intended to supplement your health care provider's advice.
It should not take the place of medical care or advice from your health care provider.

When managing depression, or major depressive disorder (MDD), during pregnancy, the risks posed both to you and your baby by the illness must be weighed against the risks posed by antidepressant exposure. Ultimately, no risk-free option exists, other than choosing not to become pregnant. There are many concerns no matter what antidepressant you're considering. These concerns form the basis for general treatment principles that are perhaps best conveyed through a series of questions you may already be asking.

IS ANY ANTIDEPRESSANT SAFE DURING PREGNANCY? Seeking a simple answer, you may be tempted to reduce your decision to this question. If so, then the simple answer is "No, there is no safe antidepressant during pregnancy"; however, you are probably asking the wrong question. A decision based solely on medicine safety is incomplete. First, this question ignores the risk posed to you and your baby by MDD itself. Second, there is no medicine of any type that has been so exhaustively studied that you should consider it "safe" during pregnancy. All medicines have some unanswered questions regarding their pregnancy safety; some medicines have known risks. Third, posed this way, the question pits your health and well-being pitted against your baby's health. This "mother versus baby" view places an unnecessary burden of guilt upon pregnant women faced with difficult treatment decisions. The question may be reframed to avoid placing you and your baby at odds. A better question is, "*What will provide you AND your baby the best chance for a safe, healthy pregnancy?*" This new question, however, opens the door to yet more questions.

WHAT RISK DOES DEPRESSION POSE DURING PREGNANCY? This question is not unique to depression. It is faced by a pregnant woman with any illness. If the illness poses little risk to you and your baby (e.g., common cold), then little treatment risk is justified. However, considerable treatment risk may be acceptable when an illness (e.g., epilepsy, HIV) poses great risk to you or your baby. As a result, knowing the risks of depression during pregnancy for you and your baby is an important key to your treatment decision.

There is, in fact, a lot of research regarding the risks due to maternal depression during pregnancy. Depression has been linked with poor compliance with OB care and greater use of prescription medicines, over-the-counter medicines, and habit-forming substances.[1] It has also been linked with poor pregnancy outcomes including preeclampsia, preterm birth, low birth weight, and smaller infant head circumference.[2] Finally, depression during pregnancy has been linked with delays in child development, affecting intelligence, language, and motor activity.[3]

Postpartum episodes of MDD also carry risk. Studies of postpartum depression have shown a wide range of effects on children, including poorer bonding with mother[4] and problems with cognitive, language, and emotional development.[5,6]

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DOES PREGNANCY PROTECT AGAINST DEPRESSION RELAPSE WHEN ANTIDEPRESSANT TREATMENT IS STOPPED? Current research suggests this is unlikely. The most extensive study of pregnant women with depression found that 68% of those who stopped their antidepressant relapsed compared to 26% of those who continued antidepressant treatment.[7] Unfortunately, existing studies don't offer any help in predicting whether you're among the small group of women likely to remain well without antidepressant treatment.

Our clinical experience suggests that your past treatment history may help you decide if temporarily stopping your antidepressant during pregnancy is wise. Key questions include: How many episodes of depression have you had? How frequent and how severe were the episodes? Have you ever had a sustained period (for several months) of normal mood without antidepressant treatment? Did previous relapses occur gradually or abruptly? When you restarted antidepressant treatment, how quickly did the episodes resolve? Finally, have you had a depression relapse during or following a previous pregnancy?

CAN NON-MEDICAL TREATMENTS FOR DEPRESSION BE USED DURING PREGNANCY? Psychotherapy has proven benefit for depression during pregnancy. For mild depression, psychotherapy alone may be effective. For severe depression, psychotherapy is seldom effective by itself, but it may augment the effectiveness of antidepressant treatment. Because it has demonstrated benefit and carries little risk during pregnancy, we recommend that you receive psychotherapy, no matter what you decide about taking an antidepressant during pregnancy. Interpersonal therapy and cognitive-behavioral therapy are the best-studied psychotherapies for depression during pregnancy and the postpartum period.

You may also consider low-risk complementary treatments, such as daily exercise, prenatal yoga, and meditation. They are not depression treatments *per se*, but they may improve general well-being during your pregnancy.

You should avoid naturopathic supplements (e.g., St. John's wort, Rhodiola rosea, maharishi amrit kalash, saffron, lavender, mentat) while pregnant. The FDA seldom scrutinizes them, and there is little information regarding their safety in pregnancy. Just because a substance is produced by nature does not mean it is safe for your baby.

WHAT IS THE BEST ANTIDEPRESSANT DURING PREGNANCY? The ideal antidepressant is 100% *SAFE* and 100% *EFFECTIVE*; it does not exist. However, the best antidepressant will be as safe and effective as possible. When focused on antidepressant safety, it is easy to lose sight of the need for the treatment to be effective. The rationale for antidepressant treatment during pregnancy is to protect you and your baby from the risks of depression. As a result, using an ineffective antidepressant makes no sense, no matter how safe it is.

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The *effectiveness* of specific antidepressants during pregnancy has not been well-researched. At present, therefore, the key to predicting antidepressant effectiveness during pregnancy lies in your own personal treatment history. Key questions include: What antidepressant(s) have you used? How effective has each been? Which antidepressant (or combination of antidepressants) has been most effective? How well have any antidepressants worked during or following a previous pregnancy? How well have you tolerated each antidepressant?

After identifying the antidepressant(s) most likely to be effective for you, *safety* considerations should be explored. Conventional wisdom holds that exposing your baby to fewer medicines is safer. Thus, safety during your pregnancy may be improved by using an antidepressant that previously worked well for you as a monotherapy rather than one that was only effective when used in combination with others (including anti-anxiety and sleep medicines).

A similar concern arises if you became pregnant unexpectedly while taking an antidepressant. Although you may have been advised to switch to a "safer" antidepressant, switching antidepressants, by definition, exposes your baby to more medications while possibly leaving you more vulnerable to relapse. Thus, if you're already pregnant, it may be wiser to continue the antidepressant you're already taking rather than switching to another.

Having narrowed the list of viable alternatives, you finalize the selection by reviewing the pregnancy safety profile of the antidepressants that remain under consideration, taking into account your current stage of pregnancy. The ideal antidepressant *for you* lies at the intersection of your efficacy and safety survey. If multiple antidepressant options remain, then you can further narrow your choice by considering potential tolerability (e.g., side effects, risks for gestational diabetes, restless legs syndrome, etc.).

References
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