STATE OF THE ART AND SCIENCE
Ethical and Clinical Dilemmas in Using Psychotropic Medications During Pregnancy
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Abstract
Approximately 15 percent of women experience depression while pregnant or in the year following pregnancy. While antidepressants are usually effective and considered standard treatment for depression, concerns arise that what might be good for mom could be harmful for the baby. Medical evidence demonstrates that, on balance, treating mental illness with psychotropic medication along with talk therapy is in the best interest of both mother and baby; however, women may resist treatment because they overestimate the risks of medication and underestimate the risks of untreated mental illness. Clinicians can help address this perceived ethical dilemma and provide optimum care to their pregnant patients by collaborating with their patients on a treatment plan, informing them about the risks of untreated mental illness, and providing reassurance that selective serotonin reuptake inhibitors (SSRIs) and many other psychotropic medications are appropriate care even if a woman is pregnant or breastfeeding.

Treatment of depression and other mental illnesses with psychotropic medications during pregnancy can be confusing for both clinicians and pregnant women. The health and well-being of the woman must be considered, but so must that of the fetus. These considerations frequently create an ethical dilemma for a depressed pregnant woman: Should I take psychotropic medication while I’m pregnant?

Perinatal Depression
Perinatal depression occurs during pregnancy and up to 12 months after giving birth [1]. Risk factors include the following:
- A personal or family history of depression, anxiety, or postpartum depression
- Premenstrual dysphoric disorder (PMDD)
- Inadequate support in caring for the baby
- Financial stress
- Marital stress
- Complications in pregnancy, birth, or breastfeeding
- A major recent life event (e.g., loss, including job loss; moving to a new home)
- Being a mother of multiple children
- Being a mother of an infant in a neonatal intensive care unit (NICU)
- Being a mother who has gone through infertility treatments
- Thyroid imbalance
- Diabetes (type 1, type 2, or gestational) [2]

Generally, women of reproductive age experience major depression at twice the rate of men the same age [3, 4]. Major depression is the leading cause of disability for women in this age group [5], and antidepressants are one of the most common drugs prescribed to women of reproductive age [6]. While the myth persists that pregnancy is a time of joyful anticipation, the reality is that pregnancy is not protective for perinatal depression. In fact, 7–20 percent of pregnant women in economically developed countries experience clinical depression [7–9], and being low income, minority, young, or single only increases this risk [10, 11]. Although there are many approaches to treating depression during pregnancy, with varying levels of efficacy, antidepressants have been shown to reduce depressive symptoms and improve maternal function [12].

**Should I Take Psychotropic Medication While I’m Pregnant?**

Women with a history of depression have already faced the stigma of having a mental illness and might have internalized messages from clinicians, the media, and warning labels on medications that psychotropic medications and pregnancy are incompatible [13–17]. Pregnancy often motivates women to discontinue pharmacotherapy out of concern that the drugs will be harmful to the developing baby [18, 19]. Women without this history of depression, who screen positive for depression during prenatal care, might experience confusion, guilt, and shame over their feelings of sadness or anxiety—especially women facing an unplanned pregnancy—when messages from the social and cultural milieu suggest that pregnancy is a time when they should glow and be happy. These feelings, along with decreased concentration, might impair a woman’s ability to understand and recall information or think through the risks and benefits of treating depression with medication [20]. Indeed, pregnant women routinely overestimate the teratogenic risk of antidepressants [21, 22]. Moreover, women are socialized to believe that good mothers are willing to sacrifice their own well-being for the well-being of their children.
On the other hand, untreated perinatal depression can actually be more harmful than depression experienced at other times in a woman’s life [12, 23, 24]. Women with chronic mental illness who abruptly discontinue pharmacotherapy have a very high risk of relapse during pregnancy [25, 26]. For example, in one study, 68 percent of pregnant women who discontinued antidepressants during pregnancy suffered a relapse of their illness [25], and, in another study, 85 percent of study participants—pregnant women with a history of bipolar disorder who discontinued use of mood stabilizers—experienced a relapse of their illness during pregnancy [26]. Untreated perinatal depression creates additional risks for both mother and baby. Perinatal depression contributes to reduced use of prenatal care, self-neglect, substance abuse, and lower birth weight infants [12, 23, 24]. And suicide causes more maternal deaths than any other pregnancy-related complication [27].

If untreated perinatal depression creates risks for mother and baby, the question remains: Are antidepressants risky for developing fetuses? In light of an observational study that reported adverse neonatal outcomes associated with maternal antidepressant use [28], the US Food and Drug Administration (FDA) released a public health advisory warning in 2006 about the risk of perinatal complications with antidepressants [29]. Although the warning did not explicitly advise women to avoid or discontinue use of antidepressants during pregnancy, it received widespread media coverage [30] and had a chilling effect on antidepressant use among pregnant women [31]. Follow-up studies called into question the findings that led the FDA to issue the warning [12, 24, 32, 33]; in 2011, the FDA announced that since research findings were conflicting, the warning would be removed from selective serotonin reuptake inhibitor (SSRI) labeling [34]. Two decades of experience have demonstrated that SSRIs are not a major teratogen like thalidomide or even cigarette smoking. Reviews of observational studies have argued that observed risks to the fetus may be due to detection bias and confounding factors including maternal depression; in all cases, the absolute risk is very small [23, 35]. Clinicians should keep in mind that the baseline rate of birth defects is 3 percent, with no known cause [36].

**Undertreatment of Perinatal Depression**

Clinicians also might be confused about how to diagnose and treat maternal mental illness. A 2011 literature review found that though obstetricians and gynecologists view mental health issues as important, they are not confident in their abilities to diagnose these conditions and are concerned about the adequacy of their training [37]. Recent research has found that clinicians might actually be limiting pregnant women’s access to antidepressants by advising them to discontinue medication or even refusing to renew prescriptions once a woman is pregnant [12, 38, 39], and a nationwide survey found that only 12 percent of depressed pregnant women had accessed mental health care in the past 12 months [40].
Providing Care for Pregnant Women with Depression

ACOG guidelines. The American College of Obstetricians and Gynecologists (ACOG) has developed empirically based guidelines for how to diagnose and treat perinatal depression [23]. ACOG recommends that pregnant women with a history of major depressive disorder who are being maintained on an antidepressant should be encouraged to continue medication, and women who choose to discontinue medication ought to taper off and be carefully monitored [23]. Because 1 in 7 pregnant women experience perinatal depression, ACOG further recommends that “clinicians screen patients at least once during the perinatal period for depression and anxiety symptoms ... screening must be coupled with appropriate follow-up and treatment when indicated [and] clinical staff ... should be prepared to initiate medical therapy, refer patients to appropriate behavioral health resources when indicated, or both” [1]. Additionally, “systems should be in place to ensure follow-up for diagnosis and treatment” [1]. Consistent with these guidelines, researchers have found that simply screening women for depression is not sufficient. Having resources available for women, training for clinicians, onsite assessment, and access to mental health consultation for clinicians treating women in the perinatal period can dramatically improve pregnant women’s access to mental health care [41].

Treatment cessation. Women of reproductive age should be reminded not to discontinue medication abruptly [42], as it can lead to side effects and relapse of symptoms—if they become pregnant. Ideally, women should be advised to schedule an appointment before they become pregnant to work out a treatment plan and coordinate care with whoever will be providing prenatal care.

Screening. Depression screening is now recommended for all pregnant women. The Edinburgh Postnatal Depression Scale is recommended by ACOG for perinatal depression screening and can be completed by the patient in only a few minutes [1]. Depressed women must be further screened for possible bipolar disorder before prescribing an antidepressant because an antidepressant can trigger a manic episode if the woman is actually bipolar [43]. Once bipolar disorder is ruled out, there are guides to help a clinician select appropriate medication, depending on a patient’s level of depression [43].

Treatment decisions. Clinicians need to give as much clinical and ethical consideration to the risks of untreated perinatal depression as they do to the risks of psychotropic medication [44]. The Massachusetts Child Psychiatry Project (MCPAP) for Moms has a discussion guide to help clinicians review the risks and benefits of treatment versus no treatment for depression [43]. To help their patients make decisions, clinicians need to be able to explain differences between relative risk and absolute risk. What sounds like a high relative risk might be clinically insignificant. For example, a study may find that women who take a particular medication during pregnancy are 4 times more likely to have a child with a birth defect than women who do not take the drug; however, this may
mean that in a single study there were 4 cases of the birth defect among 4,000 women who took the medication. This translates to an absolute risk of 0.1 percent or one case in 1,000 among women who took the medication compared to 0.025 percent or 1 in 4,000 among women who did not. Finally, women might be comforted to know that millions of women have taken SSRIs during pregnancy and have had healthy babies.

Although shared decision making for treatment of depression is the ideal [45], it is important to realize that women’s decision-making ability can be compromised by their depression and that they could have been misled—perhaps by media—about risks of antidepressants. In this case, directive counseling can be in the patient’s best interest [46]. It builds on a patient’s own values and impulse to do what is in the best interest of her baby. Hearing a clinician say things like, “It’s OK to take your symptoms seriously,” “perinatal depression is extremely common,” and “when you take care of yourself, you are also taking care of your baby,” can validate for a woman that continuing or beginning treatment for depression is a sound decision her clinician supports.

Support Services
Many state and local public health departments as well as academic medical centers and websites are developing resources for perinatal mental health. MCPAP for Moms is a program in Massachusetts that has developed many resources for clinicians to help them manage mental illness in pregnancy. It even has a hotline for clinicians who have specific questions [43]. In a conversation with Nancy Byatt, director of MCPAP for Moms, Byatt said, “this model has been copied by more than 30 states” (personal communication, March 8, 2016). Additionally, academic medical centers are establishing maternal mental health centers that can help not only with the clinical management of specialized cases but also with developing resources and educational programs for community-based clinicians. There are also web-based resources available for clinicians and pregnant and breastfeeding women. At MotherToBaby.org [47], for example, clinicians and concerned women can look up drugs by name and get an up-to-date, evidence-based fact sheet on what is known about the risks of their use during pregnancy and lactation. If a drug is not part of its existing database, MotherToBaby.org provides access to a teratology expert, who is just a phone call away. (Clinicians in Canada might wish to use Motherisk.org [48]).

In addition, a growing number of organizations support the needs of pregnant women, women who have experienced pregnancy loss, and new mothers. Postpartum Support International (PSI) [49] has chapters in most states that provide support groups and, in some cases, hotlines. PSI has a support group through Facebook, special phone applications, and other online media so that women might feel less alone in their struggles to manage their illness and be good mothers. Local health care organizations also sometimes run support groups for women experiencing pregnancy loss and for pregnant or postpartum women struggling with depression.
Conclusion
Because 1 in 7 women will experience depression during the perinatal period [39], clinicians must be prepared to engage in conversations with their patients concerning the management of depression during pregnancy. As discussed, many women with depression can feel conflicted about using medication to treat their depression; therefore, clinicians have obligations to dispel myths about risks of antidepressants and discuss the risks of untreated depression. For women who require treatment for other mental illnesses for which risks and benefits of treatment options are not as established as for depression, longer discussions might be required, along with referrals to perinatal psychiatrists. Fact-based clinical recommendations, good communication that’s responsive to women’s needs, and a shared decision-making model for developing treatment plans can help motivate better clinical and ethical outcomes for both mothers and their babies.

References


34. US Food and Drug Administration. FDA drug safety communication: selective serotonin reuptake inhibitor (SSRI) antidepressant use during pregnancy and reports of a rare heart and lung condition in newborn babies.


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