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Sources Impacting Pharmacological Treatment for Anxiety and/or Depression During Pregnancy

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ABSTRACT

The primary care nurse practitioner must know what sources a woman utilizes when making decisions regarding continuation or discontinuation of medications used to treat anxiety and depression during pregnancy. This study was conducted using an investigator-developed survey of pregnant women who took antidepressants at any point during their pregnancy. Fifty-two subjects were recruited from an academic medical center utilizing a convenience sampling method. Forty-four percent of the participants indicated that their obstetric provider supplied the best information regarding medication use. The child's father and the internet were reported as the worst source of information.

Keywords: anxiety, depression, medications, pregnancy, sources

INTRODUCTION

There has recently been a great deal of attention given the use of prescription antidepressants during pregnancy. When a woman is diagnosed with anxiety and/or depression, there are specific pharmacologic treatment guidelines for providers to follow. Hundreds of research articles have been published on the use of antidepressants during pregnancy, many producing conflicting information that often leaves the health care provider with doubt as to the correct course of treatment for the patient.

Numerous malpractice commercials and non–evidenced-based information have led to a great deal of apprehension both on the part of providers as well as women who require antidepressant treatment during pregnancy. Many women may not be utilizing evidence-based resources when making the decision to continue or discontinue their medications during pregnancy.

For providers to improve the strategies and models used to secure positive pregnancy outcomes, it is important to have knowledge of all the information that could be influencing the pregnant woman's crucial decision regarding medication use. Pregnant women in need of psychiatric care are commonly managed by primary care and obstetric providers as a result of the nationwide shortage of psychiatric-care providers. It is important for all health care providers for women of childbearing age to be informed on what factors could be influencing a patient's decision regarding medication use during pregnancy.

LITERATURE REVIEW

The American College of Obstetricians and Gynecologists[1] recommends that pregnant women with depression receive care from a multidisciplinary team that includes the patient's obstetric provider, primary care provider, and mental health provider.

Given that depression is most likely to occur during childbearing years, providers are likely to encounter untreated depression during pregnancy as well as women who have discontinued their medications even when they are symptomatic.[2] Primary care providers may be the first to make a diagnosis of depression and/or anxiety in the childbearing-age woman.[2] When educating women of childbearing age who need pharmacologic treatment for anxiety and/or depression, it is important for the health care provider to inform the patient that, regardless of

mental health diagnosis, spontaneous rates of birth defects occur 3% of the time in the general population.[3] All antidepressants cross the placenta, but, to date, it remains uncertain whether the level of exposure is sufficient to affect child development.[4]

Treatment Options During Pregnancy

Selective serotonin reuptake inhibitors (SSRIs) remain the most studied antidepressants in pregnancy.[5] Many studies have produced conflicting data on the safety of antidepressants during pregnancy. This makes it difficult for the provider to offer concrete recommendations on the use of psychotropic medications during pregnancy.

Women with severe depression, characterized by suicide attempts, functional incapacitation, or weight loss, should be continued on their medication. The risk of recurrence or escalating symptoms is high after treatment discontinuation and can result in deterioration of the woman's physical health and possible suicide.[1] If the patient has moderate to severe symptoms of depression she should continue her antidepressant medication.[1] If the patient is moderate to severe and this is her first episode of depression, treatment should continue for 6 to 12 months. Patients with mild or no symptoms for 6 months or longer may be candidates for medication taper and discontinuation prior to conception.[1]

The primary care provider should provide evidence-based guidance to the pregnant woman taking anxiety or depression medications. The United States Food and Drug Administration (FDA, 2011) last updated their website on the use of SSRI antidepressants used by women during pregnancy regarding the potential risk of a rare heart and lung condition known as persistent pulmonary hypertension of the newborn.[6] The initial Public Health Advisory in July 2006 on this potential risk was based on a single published study, and the current studies have shown conflicting results.[6]

Neurobehavioral Development and Outcomes

According to Kinsella and Monk,[7] the effects of women's antenatal psychological distress can impact the unborn fetus. The prenatal period is a critical time for neurodevelopment and is thus a period of vulnerability during which maternal anxiety and/or depression have been found to exert long-term changes on brain development and behavior, predicting attention deficit hyperactivity disorder symptoms in 8- to 9-year-old children.[7]

There is an association between a pregnant woman's depression and risk for developmental delays. Deave et al found a 50% increase in the odds of developmental delay with persistent antenatal depression. Children of untreated mothers were found to be developmentally delayed at 18 months of age [adjusted odds ratio (OR) 1.34, 95% confidence interval (CI) 1.11 to 1.62].[8]

Newborn Outcomes After SSRI Exposure

To date, there have been multiple studies looking at outcomes of infants exposed to SSRIs during pregnancy. Results from the Norwegian Mother and Child Prospective Cohort Study of 699 infants exposed to antidepressants during the first trimester of pregnancy revealed that there was no association showing an increased risk of congenital malformations or cardiovascular malformations.[9]

Klinger et al[10] investigated the long-term effects of poor neonatal adaption after exposure to psychotropic drugs in utero. There were no significant differences in IQ or neurologic development in children aged 2 to 6 years. Thirty children with neonatal abstinence syndrome and 52 without NAS participated in the study. Both groups were similar in mean cognitive ability (106.9 ± 14.0 vs 100.5 ± 14.6, $P = .12$) and developmental scores (98.9 ± 11.4 vs 95.7 ± 9.9, $P = .21$). However, there was a trend toward small head circumference in the NAS group (20% vs 6%, $P = .068$). NAS was associated with an increased risk of social-behavior abnormalities (OR 3.03, 95% CI 1.07 to 8.60, $P = .04$) and advanced maternal age (OR 1.12, 95% CI 1.00 to 1.25, $P = .04$).

A published review examined 71 published studies to determine whether a conclusion could be drawn concerning how SSRI use during pregnancy could affect the fetus. In that review, 19 publications failed to demonstrate a significant relationship between SSRI exposure as a class and overall increased prevalence of major congenital malformations. Only 3 publications identified a significant association.[11]