Major Depression During Conception and Pregnancy: A Guide for Patients and Families

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Depression is an illness that affects up to 1 in 4 women at some point in their lives. It often begins when women are in their 20s and 30s, at the same time they may be considering having children. If you or someone you know has major depression, you may be wondering whether it is safe to become pregnant—especially if you are taking medication for your symptoms—or safe to continue medication if you are already pregnant. This guide is intended to answer some commonly asked questions about the treatment of major depression while trying to conceive and during pregnancy.

WHAT IS MAJOR DEPRESSION?

Major depression is a mood disorder. Mood disorders are illnesses that affect a person's ability to experience normal mood states. Research suggests that mood disorders are biological illnesses involving changes in brain chemistry. Emotional stress can sometimes trigger these changes, though some individuals may experience depression for no apparent external cause. The symptoms of major depression include:

- Depressed mood most of the day, nearly every day for 2 weeks or longer *and/or*
- Loss of interest or pleasure in activities that the person usually enjoys.

Other symptoms can include:

- Fatigue or lack of energy
- Restlessness or feeling slowed down
- Feelings of guilt or worthlessness
- Difficulty concentrating
- Trouble sleeping or sleeping too much
- Recurrent thoughts of death or suicide.

DEPRESSION DURING PREGNANCY: SPECIAL ISSUES

Contrary to popular belief, pregnancy does not protect a woman from becoming depressed. About 20% of women experience some depressive symptoms during pregnancy, and about 10% of women develop major depression. Women who have had major depression in the past have a higher risk of becoming depressed in pregnancy, especially if they stopped taking antidepressant medication while trying to become pregnant.

Treating depression in a woman who wants to conceive or is pregnant is complicated. When pregnancy is not an issue, psychotherapy can help with milder symptoms, but antidepressant medication is often needed to bring relief from severe major depression. However, in pregnancy concerns arise about using medications to treat depression since they cross the placenta and may harm the fetus. At the same time, untreated major depression has serious potential risks for mother and fetus, since it may lead to poor nutrition, smoking, drinking, suicidal behavior, prolonged or premature labor, and low birth weights.

Unfortunately, research information about the safety of antidepressants in pregnancy is limited because there are important ethical concerns about conducting such research. However, many pharmaceutical companies do maintain registries of pregnant women who have taken their products, and some hospital clinics publish information on groups of women who have used antidepressants during pregnancy. These records provide helpful information about several of the most widely used antidepressants, although we lack such information about a number of other antidepressants.

In deciding whether a woman should use antidepressant medication while pregnant or trying to become pregnant, a woman and her doctor have to balance the possible risks of the medication against the severity of the depression. Because our research knowledge is limited, we surveyed leading experts in the area of women's mental health to develop recommendations based on their best judgments. This article summarizes the results of this survey.

TREATMENT WHILE TRYING TO CONCEIVE

Many women who have had depression may be taking antidepressants to prevent symptoms at the time they wish to become pregnant. Whether the medication should be stopped depends on how severe the history of depression has been. If a woman has had only 1 previous episode of depression and has been feeling well for at least 6 months, the experts recommend that she taper off medication before trying to conceive. Several weeks may be required before all traces of medication have been eliminated. The experts also suggest that continuing or beginning psychotherapy may be helpful in preventing symptoms from returning. However, if a woman has a history of severe major depression with multiple previous episodes, the experts recommend that she continue medication at full dose through conception. If she is already taking an antidepressant for which there is a fair amount of information suggesting that it is safe (these are listed later), it is fine to continue. However, if she is taking a medication for which there is little information, she should switch to a medication thought to be safer.

What about a woman who is depressed, is not receiving treatment, and wants to conceive? If the depression is mild, the experts would recommend trying to treat her symptoms with psychotherapy alone. However, if the symptoms are severe, whether it is a first episode or 1 of many, a combination of medication and psychotherapy is advised.

TREATMENT IN THE FIRST TRIMESTER

The first trimester (12 weeks) of pregnancy is a crucial time when medication can cause malformations of the fetus. Women may be taking antidepressants at the start of pregnancy for 1 of the reasons discussed above or may have an unplanned pregnancy while on medication. If a woman has

had only mild symptoms in the past, the experts recommend gradually stopping the medication over several weeks as soon as she knows she is pregnant. (But recall that it is a good idea to stop the medication before trying to conceive, unless a woman has had multiple episodes of severe depression.) For a woman who has had multiple past episodes of severe depression, the experts clearly prefer that she remain on medication and, if necessary, switch from her current drug to one viewed as relatively safe. For the in-between case of a woman who has had only 1 episode, but a severe one, the experts are divided as to whether to continue or stop the medication. Whether the woman remains on medication or not, in all these situations, the experts advise using psychotherapy to help prevent depression from coming back.

TREATMENT DURING THE SECOND AND THIRD TRIMESTERS

Later in pregnancy there is not the concern about medication causing malformation of organs. However, there are still questions about whether medication might cause a miscarriage or subtle changes in the early development of the future child. If there has been a good reason to use medication during the first trimester (such as recurrent bouts of severe depression), medication should probably be continued through delivery, since women who have histories of depression before or during pregnancy are vulnerable to postpartum depression. What if a woman who has not been taking medication becomes depressed? The first step is to start psychotherapy, or intensify it if already underway. If there is a history of severe depression, many experts would resume medication at the first sign of symptoms coming back. If the woman has had only mild depression in the past, the experts would wait to see if the depression comes back in full force before starting medication.

What about a woman with a history of depression, who has done well off medication through the later stages of pregnancy? Should medication be restarted to prevent depression after delivery (postpartum depression)? Experts agree that preventive treatment is a good idea for women who have had previous postpartum depression but would wait until the last month of pregnancy to resume medication.

MEDICATIONS USED TO TREAT DEPRESSION

Many types of antidepressants are available with different chemical actions and side effects. For the treatment of women with depression who are trying to conceive or who are pregnant, the experts recommend a kind of antidepressant that increases brain levels of a chemical called serotonin. These medications are called selective serotonin reuptake inhibitors (SSRIs). SSRIs are currently the most widely prescribed antidepressants in the world and have been used by millions of women. There is even evidence that they work more effectively in women than other antidepressants. It is not a surprise that many women have therefore become pregnant while taking SSRIs. Records show that the rate of infants with birth defects born to women taking SSRIs is no higher than the rate seen in women who took no medication—about 2%–3%. Thus, there is no current evidence that SSRIs cause birth defects.

The SSRIs preferred by the experts for use in pregnancy are fluoxetine (Prozac), sertraline (Zoloft), and paroxetine (Paxil). A small number of research studies support these choices. Fluoxetine, the first of this group to be used in the United States (since 1987), is the treatment of choice of most experts, probably because there has been more experience with its use in pregnancy than with other medications. In addition, there is research suggesting that exposure to fluoxetine before birth does not have negative effects on later child development. Many pregnant women have also taken sertraline and paroxetine without apparent problems. After we conducted our survey, researchers reported that another SSRI, citalopram (Celexa), has a similar profile of apparent safety.

The experts also favor tricyclic antidepressants, another kind of antidepressant that affects other brain chemicals in addition to serotonin. Tricyclic antidepressants have been used for over 40 years. Like SSRIs, extensive use in pregnancy has not revealed evidence of causing birth defects. Some other antidepressants have not shown evidence of causing birth defects but have not been used widely enough in pregnancy for doctors to feel confident.

What about side effects of SSRI medications?

SSRIs may cause the following side effects: nervousness, insomnia, restlessness, nausea, diarrhea, and sexual problems. Side effects differ from 1 person to another. Also, what may be a side effect for 1 person (e.g., drowsiness) may be a benefit for someone else (e.g., a woman with insomnia). If you are having any problems with side effects, tell your doctor right away. ***Don't stop the medication on your own.*** Your doctor may try to lower the dose or switch you to a different SSRI.

What kinds of psychotherapy are used to treat depression?

Several types of psychotherapy have been proven effective in the treatment of patients with major depression in general. Some researchers have also applied these successfully in pregnancy. ***Interpersonal therapy*** focuses on reducing the strain that a mood disorder may place on relationships. ***Cognitive-behavioral therapy*** focuses on identifying and changing the pessimistic thoughts and beliefs that can lead to depression. When used alone, psychotherapy usually works more gradually than medication and may take 2 months or more to show its full effects. However, the benefits may be long-lasting.

A special word about depression with psychosis

A severe form of major depression may include psychotic symptoms, such as delusions or hallucinations. Depression with psychosis is a great concern because it may cause a number of behaviors that compromise the safety of the mother and her unborn child. For a psychotic depression during any trimester of pregnancy, the experts recommend combining an antidepressant with a second medication called an antipsychotic. Electroconvulsive therapy is also an important option that can be used safely in pregnancy instead of medication for this type of depression. The experts would not rely on psychotherapy alone in this situation.