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Treating Perinatal Depression: Risks and Stigma

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Beginning with U.S. Food and Drug Administration approval of the antidepressant medication fluoxetine in 1987, selective serotonin reuptake inhibitors (SSRIs) have become one of the most widely prescribed and commonly studied medications in the world. In particular, over the past decade, there has been a high degree of scrutiny regarding the safety of SSRI's in pregnant women. Considerable attention and research has been focused on fetal risks of SSRI exposure during the perinatal period and the literature has yielded conflicting reports. SSRI exposure during pregnancy has been associated in some studies but not in others with increased risk of miscarriage, heart defects, premature birth and low birth weight, neonatal adaptation syndrome, and primary pulmonary hypertension of the newborn. (1-3)

The risks of SSRI exposure during pregnancy must be carefully weighed against the risks of untreated maternal perinatal depression. Antenatal depression is associated with significantly worse obstetric outcomes including prematurity, low birth weight, and preeclampsia (4). Antenatal depression is also the single greatest risk factor for postpartum depression, which has been consistently associated with adverse consequences for mothers, babies, and families (5). Untreated postpartum depression is associated with the tragic outcome of maternal suicide—the single greatest cause of maternal mortality (6,7). Moreover, discontinuation of antidepressant treatment during pregnancy is associated with exacerbation of symptoms and recurrence of the mood disorder (8).

Therefore, women with histories of mood and anxiety disorders are faced with the complicated dilemma of whether to continue the SSRI prior to or during pregnancy compared with discontinuation of the SSRI that may place their own mental health at significant risk. For many women, this is an exceedingly difficult decision that comes at a highly vulnerable time. There are two factors that lie at the heart of the issue: firstly, the enormous stigma associated with mental illness in general; and secondly, the societal expectations placed on pregnant women in particular. It can be argued that the stigma of suffering from and receiving treatment for mental illness is significantly worse than receiving treatment for other types of medical conditions such as hypertension and diabetes. In practical terms, women with histories of anxiety or depression who elect to continue their SSRI often experience shame and guilt over their decision. Family members and health care providers may not be supportive of their decision to continue treatment and the conflicting literature on safety of SSRI use during pregnancy further compounds the problem.

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Accordingly, the new report by Andersen et al (see page xxx) is a welcome and much-needed contribution to the field.(9) This authors conducted a nationwide cohort study using the Danish registers of 1,279,840 pregnancies to evaluate whether the use of SSRI's during the early part of pregnancy was associated with miscarriage compared to discontinuation of SSRI's 3–12 months before pregnancy.

Denmark has a preeminent reputation for possessing the most complete collection of medically relevant statistics in the world. The Danish registers contain nearly all health care contacts since 1968 and include 4.5 million women plus data on their partners, family members, and offspring. (10). Most women in Denmark give birth (~87% of all women) (11). These registers “transform the entire country of Denmark into a large cohort” (12) and provide the unique opportunity to conduct population cohort studies during the perinatal period.

Although this report only focuses on miscarriage, it provides valuable information that clinicians can apply to the risk-benefit ratio of treating compared with not treating perinatal depression. It also provides a methodologically strong and robust epidemiologic study that would be impossible to conduct in most other countries. The Danish registers were examined to compare the risk of miscarriage between women who continue taking SSRI's during pregnancy compared with those who discontinue SSRI use before pregnancy. The authors concluded that there is no causal relationship between SSRI's and miscarriage and that the increased risk is likely due to other factors including the underlying pathophysiology of mood disorders, or lifestyle factors that are more prevalent in women with mood disorders. Additionally, they did not find any increased hazard in women exposed to high-dose SSRI compared to low-dose SSRI. This latter finding is critically important to highlight, as many women receive inadequate doses of SSRI therapy during pregnancy due to concerns that adverse events could be dose-related. This results in a potential double exposure of ongoing depressed mood due to inadequate treatment along with SSRI exposure during the pregnancy.

Based on the study results, the authors concluded that treatment with SSRI's during pregnancy should not be discontinued due to fear of miscarriage. This has important clinical implications regarding preconception counseling and guidance of women with histories of mood and anxiety disorders undergoing treatment with SSRI's. Obstetric providers must be aware of the risks of discontinuing treatment and need to actively combat the double standard associated with treatment of psychiatric illness compared with other forms of disease. The stigma associated with mental illness can only be combated with improved knowledge of the biological mechanisms underlying psychiatric illness. Lastly, this study highlights the critical need for additional research focused on understanding the pathophysiology of mood disorders and the long-term effects of mood disorders on perinatal outcomes.

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