Published in final edited form as:

Psychiatr Q. 2014 September ; 85(3): 349–355. doi:10.1007/s11126-014-9293-7.

What Happens to Mental Health Treatment During Pregnancy? Women's Experience with Prescribing Providers

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Abstract

This exploratory study completed interviews with 25 depressed pregnant women who had prior depression, and when becoming pregnant, were receiving depression medication or tried to get mental health care. Seventy one percent of women were more than 25 weeks gestation at the time of the interview. Thirty-five percent of women were not receiving treatment. While 94 % told their provider of their pregnancy, 36 % had no opportunity to discuss the risks and benefits of continued pharmacotherapy; 42 % had no opportunity to continue pharmacotherapy. Some providers may be reluctant to treat depressed pregnant women, creating a potential barrier to their receipt of needed care.

Keywords

Mental Health; Depression; Perinatal mental health; Maternal depression; Pregnancy

Introduction

Depression occurs in 8–12 % of pregnant women [1, 2] and is associated with adverse maternal health, birth, and infant outcomes [3, 4]. Despite the availability of effective treatment options, most pregnant women with depression do not get treatment [2] because they experience barriers to getting mental health care [5]. Prescribing providers and women themselves are often concerned about the adverse effects of antidepressant medications on fetal and neonatal development. These concerns commonly lead to medication discontinuation, which increases the risk for depression relapse [6, 7]. It is likely that women are less familiar with the risks of untreated perinatal depression.

The treatment of pregnant women with depression is complex and requires a thorough evaluation and risk–benefit discussion. This current study is the first to examine what happens when pregnant women with depression tell their prescribing provider of their pregnancy. Anecdotal reports raise concern that providers may drop women from care entirely [8]. In a recent study, OB/Gyn providers perceived that community mental health providers commonly discontinue psychotropic medications or mental health care during pregnancy [9].

This exploratory study aims to: (1) elucidate experiences of women receiving depression medication at the point they learned of their pregnancy; (2) explore whether pregnant women were given opportunities to discuss risks/benefits of medications with prescribing providers or were referred for other treatments; and (3) identify gaps in clinical care among pregnant women who may need psychopharmacological depression treatment.

Methods

We conducted a descriptive exploratory study with a convenience sample of English speaking pregnant women aged 18–45 from June–August 2012. Women were recruited from obstetric clinics located in a large Central Massachusetts hospital. The Institutional Review Board approved the protocol.

Data Collection

Informed consent was obtained to take the Edinburgh Postnatal Depression Scale (EPDS) and, if eligible, to participate in a subsequent phone or in-person interview. The EPDS is a self-administered 10-item scale developed to screen for depression in perinatal women [10]. Scores ranging from 9–13 indicate depression; we used 10 for evaluation of further study inclusion.

Initially included women were asked: “Were you receiving treatment with medicine for depression from a mental health clinician or primary care provider at the time you learned you were pregnant?” or “Have you tried to obtain mental health services during pregnancy?” Women who answered yes to either question were invited to participate in a 15-min structured interview. Interviews were conducted by a trained research assistant within 2 weeks of screening.

The interview collected information on demographics, depression and treatment, history and experiences in: continuing treatment or referral for depression care during pregnancy; decision-making with prescribing provider regarding medication treatment; treatment modalities; and barriers to obtaining mental health treatment. Subjects were asked about medication use in the prenatal period and the nature of interactions with prescribing providers.

Analysis

Due to the exploratory study design, analyses were limited to descriptive statistics, specifically, frequency and proportions, and means and standard deviations for categorical and continuous variables, respectively. Subsequent bivariate analyses compared, for example, prescription patterns between primary care and mental health providers and utilization of medication for depression among women by provider type.

Results

Of 219 women invited to participate, 110 (50 %) consented to EPDS screening. Forty-one percent ($n = 46$) had EPDS scores ≥ 10 . Twenty-five of 46 women (54 %) indicated receiving treatment with depression medication from a mental health or primary care provider (PCP) when they learned of their pregnancy ($n = 17$) or tried to obtain mental health treatment during pregnancy ($n = 8$).

Women Receiving Medication for Depression at Time They Learned of Pregnancy

Demographic characteristics of women receiving depression treatment are listed in Table 1. Seventy-one percent of women were ≥ 25 weeks gestation at screening. All women had prior depression diagnoses. While 46 % viewed medication use as acceptable, all but one had stopped their depression medication when learning of their pregnancy. Thirty-five percent of women were not receiving any depression treatment.

Most women (94 %) told their prescribing provider about their pregnancy. Eleven of 17 (64 %) discussed pros and cons of medication use with their prescriber. Nine of 17 (58 %) were given the opportunity to continue depression medication. Seven of 17 (41 %) reported their provider suggested counseling without medication. The responses to several questions differed among subjects receiving care from mental health providers versus PCPs. For example, 67 % of women ($n = 6$) seeing a mental health provider reported having the opportunity to continue medication for depression versus 38 % ($n = 3$) seeing a PCP. Of the eight who were not given an option to continue, only one had been referred to another mental health resource.

Subjects who discussed medication use during pregnancy with their provider ($n = 8$) endorsed a range of experiences, including:

She doesn't seem to know a lot about the immediate effects of being pregnant and taking the medication.

He refused to write a prescription. Wanted me to come off everything very fast....

Some subjects reported barriers in maintaining positive interactions with prescribing providers during pregnancy, and provider reluctance to continue treatment, including:

My doctor wanted the OB/Gyn to deal with it. OB/Gyn didn't prescribe those types of drugs. I only had a few weeks to taper then left to fend for myself. I was finally steady on medicine and then couldn't get it. I almost had an abortion—I didn't know what to do.

My PCP stopped meds because of risks. Said to call her back after the pregnancy.

Women not Receiving Services at Time Learned Pregnant and Tried to Get Care During Pregnancy

Subjects who were not receiving treatment at time they learned they were pregnant but had tried to get mental health care ($n = 8$) had similar demographic data (Table 1). Seven of eight women (88 %) talked to their PCP or OB/Gyn about depression, yet only two (25 %) were receiving mental health treatment. Of the six women (75 %) not getting treatment, only one had received a mental health referral from their PCP or OB/Gyn.

Discussion

Untreated depression during pregnancy negatively impacts birth and infant outcomes [1, 2]. In this study, one-third of women receiving medication treatment for depression when they learned of their pregnancy did not receive depression treatment later in pregnancy. These findings are particularly concerning because all but one participant had been treated for recurrent depression and had let their prescribing provider know of their pregnancy. While almost half of the participants were willing to continue medications during pregnancy, a subgroup of women reported they were not given a chance to continue medication for depression and did not have the opportunity to discuss risks/benefits of medication use during pregnancy. Of the eight women who did not have an opportunity to continue medication, only one was referred to another source of mental health care.

Only two of eight women who screened positive for depression screen and attempted to get needed mental health care upon becoming pregnant succeeded in linking with mental health care. Most of these women had a history of depression treatment and all but one reported having discussed depression care needs with their PCP or OB/Gyn provider.

Our results suggest that both mental health and primary care providers lack knowledge about depression medication use during pregnancy and may be reluctant to continue medication treatment. Providers may not be prepared to facilitate an informed decision-making process and may be fearful about malpractice risks of continued medication treatment during pregnancy [3, 11, 12]. While women commonly self-discontinue medications when they become pregnant [6], in our study all except one participant told their prescribing provider about their pregnancy. This suggests that improved communication between OB providers and mental health clinicians, and proactive efforts to reach out and re-engage pregnant women in mental health treatment, could mitigate precipitous medication discontinuation prior to risk/benefit discussions. Efforts to create reliable pathways from primary care to mental health care when women become pregnant could also help women access and engage

in depression treatments. Strengthening mental health providers' capacity to treat pregnant women and co-locating mental health care within obstetrical care settings may also help close this major gap in care.

Our findings should be interpreted with some limitations in mind, including the small convenience sample from one locale and reliance on self-report. Our approach, however, is appropriate for the exploratory nature of this unstudied issue and sheds light on a critical and unexplored gap in depression care for pregnant women. The exploratory nature of our study also does not allow us to examine why one-third of the women in our sample did not access depression care. Gathering information from prescribing mental health providers and PCPs would also complement these findings and strengthen our understanding of this gap in care. The findings suggest important directions for research aimed to improve access to pharmacotherapy for perinatal depression.

Our study suggests that some women: (1) are dropped from depression care upon after telling their providers they are pregnant; (2) may not discuss the risks and benefits of using psychotropic medications during pregnancy; and (3) do not get linked with ongoing mental health care when providers are reluctant to continue mental health care. These findings are consistent with a recent qualitative study in which OB/Gyn providers and staff perceived community mental health clinician reluctance to provide pharmacotherapy for pregnant women as a major barrier to mental health care during pregnancy [9].

Untreated depression during pregnancy has deleterious effects on mother, baby and family. These results suggest that some PCPs and mental health providers are reluctant to treat pregnant women with depression, may not refer women to alternative sources of care, and may be unaware of risks associated with untreated depression.

Acknowledgments

The authors would like to thank Gail Sawosik for her assistance with survey development, data collection and manuscript development.

References

1. Gavin NI, Gaynes BN, Lohr KN, Meltzer-Brody S, Gartlehner G, Swinson T. Perinatal Depression: A systematic review of prevalence and incidence. *Obstetrics and Gynecology*. 2005; 106(5, Pt1): 1071–1083. [PubMed: 16260528]
2. Vesga-Lopez O, Blanco C, Keyes K, Olfson M, Grant BF, Hasin DS. Psychiatric disorders in pregnant and postpartum women in the United States. *Archives of General Psychiatry*. 2008; 65(7): 805–815. [PubMed: 18606953]
3. Chaudron LH. Complex challenges in treating depression during pregnancy. *American Journal of Psychiatry*. 2013; 170(1):12–20. [PubMed: 23288385]
4. Grote NK, Bridge JA, Gavin AR, Melville JL, Iyengar S, Katon WJ. A meta-analysis of depression during pregnancy and the risk of preterm birth, low birth weight, and intrauterine growth restriction. *Archives of General Psychology*. 2010; 67(10):1012–1024.
5. Byatt N, Moore Simas TA, Lundquist RS, Johnson JV, Ziedonis DM. Strategies for improving perinatal depression treatment in North American outpatient obstetric settings. *Journal of Psychosomatic Obstetrics & Gynecology*. 2012; 33(4):143–161. [PubMed: 23194018]

6. Bennet IM, Marcus SC, Palmer SC, Coyne JC. Pregnancy-related discontinuation of antidepressants and depression care visits among Medicaid recipients. *Psychiatric Services*. 2010; 61(4):386–391. [PubMed: 20360278]
7. Cohen LS, Altshuler LL, Harlow BL, Nonacs R, Newport DJ, et al. : Relapse of major depression during pregnancy in women who maintain or discontinue antidepressant treatment. *Journal of the American Medical Association*. 2006; 295:499–507. [PubMed: 16449615]
8. Kim H. Drowning in plain sight. *Journal of the American Medical Association*. 2010; 307(18): 1923–1924. [PubMed: 22570461]
9. Byatt N, Biebel K, Debordes-Jackson G, Lundquist RS, Moore Simas TA, Weinreb L, Ziedonis D. Community mental health provider reluctance to provide pharmacotherapy may be a barrier to addressing perinatal depression: A preliminary study. *Psychiatry Quarterly*. 2013; 84(2):169–174.
10. Cox JL, Holden JM, Segovsky R. Detection of postnatal depression. Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry*. 1987; 150:782–786. [PubMed: 3651732]
11. Byatt N, Biebel K, Lundquist RS, Moore Simas TA, Debordes-Jackson G, Allison J, Ziedonis D. Patient, provider and system-level barriers and facilitators to addressing perinatal depression. *Journal of Reproductive and Infant Psychology*. 2012; 30(5):436–449.
12. Wisner K. SSRI treatment during pregnancy: Are we asking the right questions. *Depression and Anxiety*. 2010; 27(8):695–698. [PubMed: 20694964]

Biographies

Linda Weinreb, MD is a Professor and the Vice Chair of the Department of Family Medicine and Community Health at University of Massachusetts Medical School/UMass Memorial Health Care. Dr. Weinreb's research focuses on healthcare-based interventions that integrate behavioral health and trauma services with primary care as well as the health needs of homeless populations.

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Karen Tenner, BS is a third year medical student at the University of Massachusetts Medical School. She is still deciding what field she will pursue, but has a strong interest in perinatal mental health.

Judith Savageau, MPH is an Epidemiologist and Biostatistician in the Department of Family Medicine and Community Health at the University of Massachusetts Medical School. She has worked for more than 25 years on health services research and health policy projects many of which are related to behavioral health in the content of maternal and child health.

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Table 1

Characteristics of women who were receiving treatment with medication for depression ($n = 17$) or tried to obtain mental health care ($n = 8$) when becoming pregnant

	$n = 17^a$	$n = 8^a$
Age (mean in years, SD)	29 (5.0)	26 (7.1)
Race (n , %)		
White	9 (56.3 %)	6 (75.0 %)
African American	1 (6.3 %)	0 (0.0 %)
Other	6 (37.5 %)	2 (25.0 %)
Ethnicity–Hispanic (n Yes, %)	8 (47.1 %)	3 (37.5 %)
High school diploma/GED (n Yes, %)	12 (70.6 %)	8 (100.0 %)
Insurance status (n ,%) ^b		
Medicaid/MassHealth	16 (94.1 %)	7 (87.5 %)
Private	1 (5.9 %)	1 (12.5 %)
Medicare	2 (11.8 %)	1 (12.5 %)
Income level (n ,%)		
\$5,000	8 (47.1 %)	3 (37.5 %)
\$5,001–\$30,000	5 (29.4 %)	3 (37.5 %)
>\$30,000	2 (11.8 %)	0 (0.0 %)
Unknown/don't know	2 (11.8 %)	2 (25.0 %)
# Past pregnancies (mean, SD)	3.1 (1.6)	2.5 (7.1)
25+ weeks pregnant when screened for depression (n Yes, %)	12 (70.6 %)	6 (75.0 %)
Previous depression diagnosis (n Yes, %)	17 (100.0 %)	7 (87.5 %)
Previous depression treatment (n Yes, %)	16 (94.1 %)	7 (87.5 %)
Receiving meds and counseling when learned pregnant (n Yes, %)	12 (70.6 %)	N/A
Receiving meds only when learned pregnant (n Yes, %)	5 (29.4 %)	N/A
View receiving depression meds as acceptable during pregnancy (merge the 3 categories of acceptability) (n Yes, %)	8 (46.0 %)	0 (0.0 %)
Self-stopped depression medication when learned pregnant (n Yes, %)	16 (94.2 %)	N/A
Safety concern with meds cited as reason	16 (100.0 %)	N/A
Side effects cited as reason	9 (56.3 %)	N/A
Prescriber said couldn't take medication due to pregnancy	7 (43.8 %)	N/A
Stopped medication and used counseling alone (start and continue counseling merge) (n Yes, %)	9 (53.0 %)	N/A
Prescribing provider when learned pregnant: PCP (n Yes, %)	8 (47.1 %)	N/A
Prescribing provider when learned pregnant: Mental Health Clinician (n Yes, %)	9 (52.9 %)	N/A
Currently receiving depression treatment (n Yes, %)	11 (64.7 %)	2(25.0 %)
Currently prescribed medication for depression ^c (n Yes, %)		
1 medication	9 (52.9 %)	N/A
2+ medications	7 (41.2 %)	N/A

^a Numbers may not total to subgroup total because of sporadic missing data

^b Some women are dually-eligible for both Medicaid and Medicare

^cMedication classes predominantly included: antidepressants, mood stabilizers, and benzodiazepines (the remainder were a variety of antipsychotics, anxiety, stimulant, and substance abuse withdrawal medications)

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