

## *Before, Between & Beyond Pregnancy*

### **The National Preconception Curriculum and Resources Guide for Clinicians**

## **Guidance for Preconception Care of Women with Depression and Anxiety Disorders**

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Ariela Frieder, MD  
Department of Psychiatry and Behavioral Sciences  
Montefiore Medical Center  
Albert Einstein College of Medicine

**This guidance should not be considered a substitute for clinical judgment or expert consultation.**

- Significant depressive and anxiety symptoms occur in over 20% of pregnant women (3).
- Depression and anxiety during pregnancy can be under-diagnosed and under-treated as some symptoms are the same as those of pregnancy. In addition, women may feel guilty of their depressive feelings since pregnancy is believed to be a time of happiness (7)
- Available screening tools are the PHQ-9, QIDS, GAD-7, Beck Depression Inventory and the Hamilton Rating Scale, among others (7)
- It is also helpful to ask the two questions for depression recommended by the US and Canadian task force on preventive health care: 1) “Over the past two weeks have you felt down, depressed or helpless?” 2) “Over the past two weeks have you felt little interest of pleasure in doing things?” (9)
- Several studies have found an association between depression during pregnancy and negative obstetrical and neonatal outcomes such as preterm delivery, lower birth weight, smaller head circumference and low APGAR scores (1).
- Depression increases the risk of tobacco, alcohol, illicit drug use, self injurious and suicidal behavior and may contribute to inadequate prenatal care (1, 7)
- Depression and anxiety during pregnancy are important risk factors for postpartum depression (1).

- There is much evidence suggesting that depression during pregnancy and postpartum can have severe impacts on family life, on the mother-infant relationship, and on the future mental health of the child (1).
- Anxiety disorders during pregnancy and postpartum have been associated with poor neonatal outcome, obstetric complications, childhood behavioral problems, and avoidance of the child by the mother (1, 7)
- Risk factors for depression and anxiety during and after pregnancy include: a personal history of mood or anxiety disorder, family history of mood or anxiety disorder, marital problems, inadequate support system, recent stressors, lower socioeconomic status, unwanted pregnancy, after infertility treatment, substance abuse, and medical complications of pregnancy (1)
- Depression and anxiety disorders can be treated effectively with psychotherapy, cognitive behavioral therapy, interpersonal psychotherapy, and/or medications (10)
- Identification of depression and anxiety disorders prior to pregnancy allows time to discuss treatment options and, if necessary, to change to a treatment regimen that is safer during pregnancy (1, 11)
- Treatment should be individualized based on a risk-benefit assessment (10)
- Mild to moderate cases can be treated with psychotherapy but more severe ones may need medications (1,2)
- Women with a history of mood or anxiety disorder should be informed about the high risk of relapse (50-75%) when discontinuing maintenance medication .(4)
- For patients already being treated with medications, consideration of changes in the regimen should be made prior to conception to decrease the exposure of the fetus to multiple medications (2,6,11)
- Such preconception medication adjustment also allows for gradual tapering of the antidepressant to minimize the risk of withdrawal symptoms. It also allows an opportunity to monitor for relapse, which is most likely in the initial months following withdrawal (7)
- The majority of studies have shown no association between the use of tricyclic antidepressants and structural congenital malformations (1, 8)
- The current data on early exposure to SSRIs provides conflicting information about the prevalence of congenital malformations. Some data suggested a small increased risk in cardiac malformations associated to paroxetine. However, still the absolute risk seems to be low (less than 2:1000 (6)

- A review of data from teratology information services around the world and database studies on antidepressants do not support the increased risk of cardiovascular malformations with paroxetine (12).
- Currently, The American Congress of Obstetricians and Gynecologists (ACOG) recommends that paroxetine use in pregnant women and women planning a pregnancy should be avoided if possible, and that fetal echocardiography be considered for women who are exposed to paroxetine in early pregnancy (8)
- Furthermore, recent studies have linked exposure to antidepressant therapy during pregnancy with preterm delivery and/or lower birth weight. Other studies have not found similar associations. (13)
- Late trimester fetal exposure to SSRIs is associated with transient irritability, agitation, jitteriness, feeding problems and mild respiratory symptoms in 25-30% of the cases during the newborn period (1, 13)
- A particular concern is the potential risk of persistent pulmonary hypertension of the newborn with late exposure to SSRIs. The risk of PPHN in the general population is 0.5-2 per 1000 newborns. In babies born to mothers who used SSRIs during the last half of pregnancy this risk seems to be increased to 3-6 in 1000.(14)
- There are few studies regarding the long term developmental effects of antidepressants. Preliminary data shows no negative effects to SSRIs and tricyclic antidepressants (15, 16, 17)
- Data on non-SSRIs and non-TCA antidepressants (bupropion, trazodone, duloxetine, venlafaxine, mirtazapine, nefazodone) are more sparse. These antidepressants seem not to increase the risk of congenital malformations. However, as a group they were found to increase the risk of preterm delivery and neonatal symptoms with a similar pattern observed with the SSRIs (13)
- Women who are depressed and smoke and are in need of an antidepressant may benefit from treatment with bupropion, although a history of bulimia or seizures may be a contraindication to its use. (13)
- Benzodiazepines are used as part of the treatment of anxiety disorders and may have a useful role during pregnancy since they can be used in as needed basis. However, there is a small association of benzodiazepines with oral cleft (11:10,000 vs 6:10,000 in the general population). Therefore, the use of benzodiazepines during the first trimester should be avoided or minimized, particularly during weeks 5-10 (1)
- The use of benzodiazepines late in the third trimester is associated with hypotonicity, withdrawal, failure to feed, apnea and low Apgar scores. Benzodiazepines should be slowly tapered before labor (10)

***Preconception recommendations of CDC select panel on preconception care clinical committee:*** (Frieder A., Dunlop A. L., Culpepper L, Bernstein P. S. The Clinical Content of Preconception Care: Women with Psychiatric Conditions. American Journal of Obstetrics and Gynecology. Vol 199, Issue 6, Supplement B, S328-S332)

- Providers should screen and be vigilant for depression and anxiety disorders among women of reproductive age, as treating or controlling these conditions prior to pregnancy may help prevent negative pregnancy and family outcomes. Women of reproductive age with depressive and anxiety disorders who are planning a pregnancy or who could become pregnant should be informed about the potential risks of an untreated illness during pregnancy and about the risks and benefits of various treatments during pregnancy. Identifying healthy women at risk along with appropriate referral to social and psychological interventions during the preconception visit might prevent the emergence of anxiety and depressive disorders during pregnancy and postpartum.

*Strength of recommendation: B; Quality of evidence: II-2*

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