Is it okay to take antidepressants while pregnant?

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Mental health conditions including anxiety and depression are among the most common disorders affecting women during pregnancy and after birth.

Evidence shows mental health conditions in pregnancy increase the risk of complications for the mother and baby.

However, there is some stigma around taking antidepressants while pregnant or breastfeeding. So how should women decide whether or not to take antidepressants during these periods?

Mental health in pregnancy and after birth

Untreated anxiety and depression in pregnancy have been linked to an increased risk of stillbirth, premature birth, low birth weight and low APGAR scores (a test done at birth to check the baby's health in various domains).

In addition, anxiety or depression during pregnancy may lead to increased maternal weight gain, substance use or smoking. These lifestyle factors can also lead to complications for the baby.

Anxiety and depression during and after pregnancy can affect bonding between mother and baby, and hinder the child's behavioral and emotional development.

Meanwhile, complications in the pregnancy may worsen mental health symptoms for the mother.

Not coping during pregnancy and especially after giving birth is demoralizing and puts women at risk of self-harm. Suicide is a leading cause of maternal death in Australia in the year after giving birth.

Treatment options

Depending on the severity of symptoms, treatment options for women

during and after pregnancy range from social and emotional support (for example, support groups) to psychological interventions (such as cognitive behavioral therapy) to medical treatments (for example, antidepressants).

Understandably, many women are reluctant to take medications during pregnancy and while breastfeeding due to concerns the drugs may cross over to the baby and cause complications. Historical instances such as the use of thalidomide for morning sickness, which resulted in severe structural abnormalities in thousands of children, naturally make pregnant women worried.

Robust evidence about medication use in pregnancy is lacking. This may be due to ethical limitations around trialing medications in pregnant women. The limited data available, mainly from observational studies on selective serotonin reuptake inhibitors (SSRIs) and serotonin-norepinephrine reuptake inhibitors (SNRIs), the most commonly prescribed antidepressants during pregnancy, has mixed results.

While some studies have reported no noticeable increase in the risk of congenital malformations, evidence has shown a marginal rise in abnormalities such as heart defetcs (an extra two cases per 1,000 babies with SSRIs).

Collaborative decisions

There is a delicate balance to strike between treating the mother and preventing harm to the baby. To make well-informed decisions, an open discussion between the patient and specialized mental health care providers on the benefits and risks of starting or continuing antidepressants is essential.

Given the mother's poor mental health increases the risk of adverse

outcomes for the baby, it may well be that taking antidepressants is the best way to protect the baby.

For women already taking antidepressants, it's not usually necessary to stop using them during pregnancy. Sudden cessation of antidepressants increases the risk of relapse.

Continuing breastfeeding on antidepressants is likely the best decision because of the low levels of drugs infants are exposed to in breast milk, the advantages of breastfeeding for the baby, and the risks of not taking antidepressants when indicated.

Recently revised guidelines on mental health care in the perinatal period (during pregnancy and after birth) warn health professionals against the dangers of failing to prescribe necessary medication:

"Be aware that failure to use medication where indicated for depression and/or anxiety in pregnancy or postnatally may affect mother-infant interaction, parenting, mental health and well-being and infant outcomes."

These guidelines also recommend repeated screening for symptoms of depression and anxiety for all women during the perinatal period. This is crucial to providing women with an early referral to perinatal mental health services if needed.

At present, mental health conditions during pregnancy and after birth often go undetected and untreated.

Supporting perinatal mental health

Mental illness in pregnancy is a significant public health problem. Screening is not always delivered effectively, and currently, there is no

national data regarding perinatal mental health screening service use or outcomes.

Mine and my colleagues' research on pregnant women's engagement with perinatal mental health services indicated only one-third of eligible women accepted a referral, and less than half attended their appointment. Women may be reluctant to engage due to stigma, time restraints, and lack of childcare or social support.

To address this, we should create strategies and resources in collaboration with pregnant women to identify solutions that work best for them. This might include assistance with childcare, access to telehealth, visits from a perinatal mental health professional, or written information on medications.

Care must be holistic and include partners who may be best placed to support pregnant women in making complex decisions. Health-care providers need to be respectful of individual needs and provide compassionate care to engage vulnerable mothers who may understandably feel uncertain regarding their options.

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