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Ethical Perspectives Regarding Antidepressant Drug Therapy During Pregnancy

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Abstract

A literature review was conducted to evaluate and understand the effects of antidepressant medication during pregnancy and the ethical issues surrounding the topic. Through the discussion of three articles, the review weighed the effects of antidepressants on maternal and child health. Antidepressant medication during pregnancy poses relative risks to cause fetal complications and defects, though the risk remains very small. However, untreated depression may significantly impact the childbearing family, including premature births, low birth weights, miscarriages, and suicide. Clinicians often have misconceptions of the risks of untreated depression during pregnancy and could benefit from an increased understanding of the current literature when making treatment decisions. Nevertheless, an individual's history, symptomatology, and an understanding of medications known to be harmful to the fetus should guide the choice of treatment. Further research may help solidify understanding among clinicians and the public and ultimately lead to improved health outcomes for both mother and child.

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A literature review was conducted to evaluate and understand the effects of antidepressant medication during pregnancy and the ethical issues surrounding the topic. Through the discussion of three articles, the review weighed the effects of antidepressants on maternal and child health. Antidepressant medication during pregnancy poses relative risks to cause fetal complications and defects, though the risk remains very small. However, untreated depression may significantly impact the childbearing family, including premature births, low birth weights, miscarriages, and suicide. Clinicians often have misconceptions of the risks of untreated depression during pregnancy and could benefit from an increased understanding of the current literature when making treatment decisions. Nevertheless, an individual's history, symptomatology, and an understanding of medications known to be harmful to the fetus should guide the choice of treatment. Further research may help solidify understanding among clinicians and the public and ultimately lead to improved health outcomes for both mother and child.

Ethical Perspectives Regarding Antidepressant Drug Therapy During Pregnancy

Depression affects one quarter of women during pregnancy (Cohen et al., 2006). Clinical trials have demonstrated that medication and psychotherapy are effective as stand-alone forms of treatment for depression, yet a combination of the two treatment options provides the most sustained response. But how does pharmacological treatment impact the fetus? Furthermore, what are the impacts of not treating the pregnant woman? These are just a few of the questions that this paper will explore while examining the ethical issues surrounding the use of antidepressant drug therapy during pregnancy.

Antidepressant Medications During Pregnancy

Care must be taken when prescribing any medication during pregnancy and an evaluation of the risks and benefits to both the mother and fetus must be considered. When life-threatening situations arise and require immediate intervention during pregnancy, it is common for "emergency" medications to be used. However, with conditions that pose less of an immediate threat to life, such as depression, medications are prescribed with greater hesitation (Payne &Meltzer-Brody, 2009). The body of literature suggests that common medications used to treat depression contribute to an increased risk including fetal heart defects, limb malformation, and persistent pulmonary hypertension of the newborn (Malm, Artama, Gissler, & Ritvanen, 2011). Conversely, recent research indicates that the likelihood of birth defects after prenatal exposure to certain psychiatric medications are not as great as earlier studies had estimated ("Prescribing During Pregnancy," 2008).

An Ethical Issue

The ethical question is whether or not to take antidepressant medications during pregnancy. Research indicates that antidepressants pose an increased risk to the fetus. The research reviewed also indicates that untreated depression during pregnancy increases the rates of preterm births and substance abuse, both of which pose an increased risk to the fetus and the mother. Thus, one must evaluate the risks and benefits in attempting to resolve the ethical situation.

The Effects on Maternal and Child Health

The article "Prescribing During Pregnancy" (2008) from the Harvard Medical School's Harvard Mental Health Letter states that all psychiatric drugs cross the placenta and reach the developing fetus, and some increase the risk of certain congenital malformations. Furthermore, Cohen et al. (2006) found that of 201 women with a history of Major Depressive Disorder (MDD), 68% of those who stopped taking antidepressants after becoming pregnant suffered a relapse of depression, compared to a 26% incidence of relapse in those who continued taking their antidepressants. Antenatal depression has been associated with low maternal weight gain, increased rates of preterm birth (Li, Liu, & Odouli, 2009), increased ambivalence

about the pregnancy and overall worsened health (Orr, Blazer, James, & Reiter, 2007). Additionally, prenatal exposure to maternal stress has demonstrated consequences for the development of infant temperament (Davis et al., 2005).

Literature Review

Antidepressant Use During Pregnancy: Current Controversies and Treatment Strategies

In this article, Payne and Meltzer-Brody (2009) examined the risks and benefits of antidepressant use during pregnancy. Initially addressed is the "common misconception" that MDD is "different from, and not as serious as, medical illness." This often results in inappropriate discontinuation of antidepressants during pregnancy. Payne et al (2009) asserted that continuation of medication should revolve around symptomatology, where patients with mild MDD might discontinue therapy and more severe MDD may benefit from continued therapy due to known risks of untreated depression.

Next, the authors discussed how the literature offers limited evidence to guide clinical practice regarding antidepressant therapy in the pregnant woman and the inability to randomly assign depressed pregnant women in clinical trials and the resultant unknowns from limited data. They also referred to the limited helpfulness of the FDA Pregnancy Categories, including that "1) the FDA categories do not address dosing; 2) lack of consideration of time of exposure to the medication; and 3) excessive reliance on animal data and lack of human data" (Payne and Meltzer-Brody, 2009). The authors concluded that the safety of antidepressant use during pregnancy appears to be reassuring, however state that two topics remain unclear: neonatal withdrawal syndrome and primary pulmonary hypertension of the newborn (PPHN).

SSRI during pregnancy and risk of persistent pulmonary hypertension in the newborn

Kieler et al. (2012) showed that exposure to SSRI late in pregnancy was associated with an increased risk of PPHN. Specifically, they concluded that the risk was double that of the general population. This translates to 3 babies in every 1000 born having PPHN versus 1 in every 1000 in the general population. It should be noted that although this is an increased risk relative to the general population, the overall risk is relatively low. Furthermore, there are other known causes of PPHN including asthma, diabetes, and obesity. These factors were not part of the exclusionary criteria for analysis in the study and thus it is difficult to determine if it was the medication or these other medical conditions that affected the data. Prenatal drug exposure and an untreated psychiatric disorder both present risks

This article reviews the risks of both prenatal psychotropic drug exposure and untreated psychiatric disorder, though the primary focus of this publication was antidepressants and specifically SSRIs. An antidepressant that should not be used during pregnancy is paroxetine because it might increase the risk of several types of rare congenital heart defects if used during the first trimester. Furthermore, when used during the last trimester of pregnancy, SSRIs as a class of medications that demonstrate temporary problems in as many as 25% of newborns, with common symptoms of tremors, restlessness, mild respiratory problems, and weak crying. "Prescribing During Pregnancy" (author, 2008) reveals that "in most cases, these symptoms disappear in the first few days after birth, although some infants are admitted to the neonatal intensive care unit as a precaution."

Putting Theory into Practice

Recommended Changes in Practice

Based on the current research regarding antidepressant use during pregnancy, [as future clinicians, it is important to think of developing evidence based guidelines that address the needs of this vulnerable population] {my initial goal as a nurse would be to work to create evidence-based guideline.}guidelines. By creating guidelines for the use of antidepressants during pregnancy, clinicians may provide increasingly consistent information and care to pregnant women. Though additional research will solidify treatment approaches based on looming questions, the literature does offer a start to creating guidelines. First, medications that are known to cause fetal harm should not be used. Second, an establishment of treatment criteria based on the severity of the symptoms should guide usage. Third, the guidelines should include information about the risks of abruptly stopping medication and the increased risk of usage of medication late in pregnancy. A nurse may immediately implement all of these into practice to educate, support and inform patients, leading to improved levels of care. Furthermore, attempts to increase awareness of clinicians by

hosting educational meetings and journal clubs may ensure that care reflects the current literature. Challenging the misconception that MDD during pregnancy is relatively benign to the fetus and woman serves as a starting point to enhancing clinical options and outcomes.

Barriers to Recommendation

Challenges and barriers exist in implementing these recommendations. Challenges include the willingness of the clinical team to acknowledge and accept the literature enough to motivate change in their practice. Furthermore, a comprehensive meta-analysis of the literature needs to be synthesized to create a more uniform understanding of and therefore trust in the treatment of pregnant women with MDD. Barriers that exist include limited knowledge regarding fetal risk of untreated MDD in pregnancy, and the short and long-term risks to the fetus of antidepressant exposure during pregnancy. Confronting these issues remains difficult because research involving pregnant women in placebo-controlled trials is currently protected.

Conclusion and Opinion

To best determine the choice of treatment, the nurse should use the current literature to guide practice. This includes educating the patient on the risks with a nomenclature that is not misleading. For example, the research shows that using SSRIs during the late stages of pregnancy increases "relative risk" of PPHN and is (statistically) "significant." This could imply a false risk versus the truth: that the risk goes from 1 in 1000 births to 3 in 1000 births. Therefore, as additional information becomes available and eventually resolves conflicting information regarding the use of antidepressants, the better choices clinicians and patients will have. Thus, it is important that researchers receive adequate funding so that clinicians may better understand the risks and benefits of utilizing antidepressant medication as a treatment option during pregnancy.

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