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Depression During Pregnancy: Treatment Recommendations *A Joint Report from APA and ACOG*

Washington, DC – Pregnant women with depression face complicated treatment decisions because of the risks associated with both untreated depression and the use of antidepressants. A new report from The American College of Obstetricians and Gynecologists (ACOG) and the American Psychiatric Association (APA) attempts to help doctors and patients weigh the risks and benefits of various treatment options.

Based on an extensive review of existing research, ACOG and APA offer recommendations for the treatment of women with depression during pregnancy. The report, “The Management of Depression During Pregnancy: A Report from the American Psychiatric Association and The American College of Obstetricians and Gynecologists,” is published in *Obstetrics & Gynecology* (September 2009) and *General Hospital Psychiatry* (September/October 2009).

Depression is common during pregnancy—between 14 percent and 23 percent of pregnant women will experience depressive symptoms while pregnant. In 2003, approximately 13 percent of women took an antidepressant at some time during their pregnancy.

“Depression in pregnant women often goes unrecognized and untreated in part because of concerns about the safety of treating women during pregnancy,” said lead author Kimberly Ann Yonkers, MD, Yale University associate professor of psychiatry and obstetrics, gynecology and reproductive sciences. “It is our hope that this will be a resource to clinicians who care for pregnant women who have or are at risk of developing major depressive disorder.”

Both depression symptoms and the use of antidepressant medications during pregnancy have been associated with negative consequences for the newborn. Infants born to women with depression have increased risk for irritability, less activity and attentiveness, and fewer facial expressions compared with those born to mothers without depression. Depression and its symptoms are also associated with fetal growth change and shorter gestation periods. And while available research still leaves some questions unanswered, some studies have linked fetal malformations, cardiac defects, pulmonary hypertension, and reduced birth weight to antidepressant use during pregnancy.

Identifying depression in pregnant women can be difficult because its symptoms mimic those associated with pregnancy, such as changes in mood, energy level, appetite, and cognition. Depressed women are more likely to have poor prenatal care and pregnancy complications, such as nausea, vomiting, and preeclampsia, and to use drugs, alcohol, and nicotine.

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“Ob-gyns are the front-line physicians for most pregnant women and may be the first to make a diagnosis of depression or to observe depressive symptoms getting worse. In the past, reproductive health practitioners have felt ill equipped to treat these patients because of the lack of available guidance concerning the management of depressed women during pregnancy,” said ACOG President Gerald F. Joseph, Jr, MD. “This joint report bridges the gap by summarizing current research on various depression treatment methods and can assist clinicians in decision-making. Many people—physicians and women alike—will be glad to know that their choices go beyond ‘medication or nothing.’”

According to the report, some patients with mild-to-moderate depression can be treated with psychotherapy (individual or group) alone or in combination with medication. Additionally, the report discusses the need for ongoing consultation between a patient’s ob-gyn and psychiatrist during pregnancy and presents algorithms for treating patients in common scenarios:

Women thinking about getting pregnant

- For women on medication with mild or no symptoms for six months or longer, it may be appropriate to taper and discontinue medication before becoming pregnant.
- Medication discontinuation may **not** be appropriate in women with a history of severe, recurrent depression (or who have psychosis, bipolar disorder, other psychiatric illness requiring medication, or a history of suicide attempts).
- Women with suicidal or acute psychotic symptoms should be referred to a psychiatrist for aggressive treatment.

Pregnant women currently on medication for depression

- Psychiatrically stable women who prefer to stay on medication may be able to do so after consultation between their psychiatrist and ob-gyn to discuss risks and benefits.
- Women who would like to discontinue medication may attempt medication tapering and discontinuation if they are not experiencing symptoms, depending on their psychiatric history. Women with a history of recurrent depression are at a high risk of relapse if medication is discontinued.
- Women with recurrent depression or who have symptoms despite their medication may benefit from psychotherapy to replace or augment medication.
- Women with severe depression (with suicide attempts, functional incapacitation, or weight loss) should remain on medication. If a patient refuses medication, alternative treatment and monitoring should be in place, preferably before discontinuation.

Pregnant and not currently on medication for depression

- Psychotherapy may be beneficial in women who prefer to avoid antidepressant medication.
- For women who prefer taking medication, risks and benefits of treatment choices should be evaluated and discussed, including factors such as stage of gestation, symptoms, history of depression, and other conditions and circumstances (eg, a smoker, difficulty gaining weight).

All pregnant women

- Regardless of circumstances, a woman with suicidal or psychotic symptoms should immediately see a psychiatrist for treatment.

Background on the report

APA and ACOG convened a work group to critically evaluate and summarize information about the risks associated with depression and antidepressant treatment during pregnancy. The group included clinical research experts within these two medical specialties and a developmental pediatrician.

Researchers reviewed cumulative existing research relating to antidepressant use in pregnancy; however, available research has not yet adequately controlled for other factors that may influence birth outcomes, including maternal illness or problematic health behaviors that can adversely affect pregnancy. Limitations of existing research include:

- Few studies of antidepressants and birth outcomes assessed the mothers' psychiatric condition
- Confounding factors that influence birth outcomes (eg, poor prenatal care and drug/alcohol/nicotine use) were often not controlled
- Pregnancy complications (eg, nausea, preeclampsia) occur at a higher rate in depressed than nondepressed women

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The American College of Obstetricians and Gynecologists (ACOG) is the nation's leading group of physicians providing health care for women. As a private, voluntary, nonprofit membership organization of approximately 56,000 members, ACOG: strongly advocates for quality health care for women; maintains the highest standards of clinical practice and continuing education of its members; promotes patient education; and increases awareness among its members and the public of the changing issues facing women's health care. www.acog.org

The American Psychiatric Association is a national medical specialty society whose more than 38,000 physician members specialize in diagnosis, treatment, prevention and research of mental illnesses including substance use disorders. Visit the APA at www.psych.org and www.HealthyMinds.org.