Perceptions of pregnant women regarding antidepressant and anxiolytic medication use during pregnancy

Alka Kothari Senior Staff Specialist, Obstetrics and Gynaecology, Redcliffe Hospital, Redcliffe, QLD, and; Deputy Head Northside Clinical School, University of Queensland School of Medicine, Saint Lucia, QLD, Australia
John de Laat Fellow of the Royal Australian College of General Practitioners, Australia
Joel M Dulhunty Senior Staff Specialist and Director of Research and Medical Education Redcliffe Hospital, Redcliffe, QLD, and; Adjunct Professor, Queensland University of Technology, Brisbane, QLD, Australia
George Bruxner Senior Staff Specialist and Clinical Lead Consultation-Liaison Psychiatry Service Redcliffe and Caboolture Hospitals, Metro-North Mental Health Service, Caboolture, QLD, Australia

Abstract

Objective: The objective of this study was to explore attitudes and decision-making by pregnant women regarding antidepressant and anxiolytic use during pregnancy.

Method: An observational study at an outer metropolitan hospital in Brisbane, Queensland. Pregnant women presenting for their first antenatal clinic visit were invited to complete a questionnaire. Participants were asked about current or previous antidepressant/anxiolytic use, influences on drug decision-making and the adequacy of information received. Perceptions were measured on a 7-point Likert scale.

Results: A total of 503 pregnant women were surveyed. The background prevalence of anxiety and depression was 30.0% (151), with 9.3% (47) respondents using antidepressant or anxiolytic medications during the current pregnancy. Of these 47 women, 68% ceased these medications during or while trying to become pregnant, most commonly due to potential side effects to the baby (16), health professional advice (8) and symptomatology that was under control (7). While the effect was modest, decision-making was most strongly influenced by general practitioners, family and the internet.

Conclusions: Most women cease antidepressant/anxiolytic medication before and during pregnancy for reasons other than stability of condition. This study reveals an unmet need for accessible reliable information to guide pregnant women and their care providers.

Keywords: pregnancy, anti-depressants, anxiolytics, perceptions

It is estimated that 5% of Australian women experience a major depressive disorder and 18% an anxiety disorder in their lifetime.1 During pregnancy, the prevalence of depression has been reported as 12.8%, with antidepressant use in up to 8% of pregnant women.2-3 Selective Serotonin Reuptake Inhibitors (SSRIs) are an accepted mainstay of treatment for both disorders and account for 51% of the total prescriptions for depression.4-8 Benzodiazepines are effective for short-term treatment of anxiety and are in common use in the community.8 This decision to continue or cease antidepressant or anxiolytic medication during pregnancy is a serious one with risks and benefits attached to either option. Untreated maternal depressive illness is associated with significant demonstrable risks to both mother and child.9-12 Conversely, there are risks to the child with continuation of antidepressant/anxiolytic treatment during pregnancy, especially of early postnatal infant health concerns such as neonatal adaptation syndrome.13-17 There is conflicting evidence regarding early fetal death and stillbirth,18-20 and a small association of some SSRIs with congenital teratogenicity.21,22 Against this back-

Corresponding author:
George Bruxner, Redcliffe Hospital, Anzac Avenue, Redcliffe QLD 4020, Australia.
Email: George.Bruxner@health.qld.gov.au
were also asked if they believed they had received

influenced the medication decision-making, including

deal”), participants were asked about who or what

were asked about the reasons as to why they stopped,

including perceived risks to the pregnancy. Using a

participants were asked about perceived

medications. Recruitment proceeded until this target was reached.

Statistical analysis. Descriptive and comparative analyti-

cants/anxiolytic medications use during pregnancy.

methods were used. Categorical variables were

were asked if they believed they had received sufficient information from their healthcare providers to make an informed decision about continuing or ceasing these medications.

Sample size. Sample size considerations were based on

It comprised of a series of multi-choice questions and

the greatest reported influence on decision-making was

infrastructure and health care staff, including pregnant

Electronic Supplementary Material). It was administered

obstetrician advice, a total sample size of 500 was targeted. It would potentially include 50 women taking antidepres-

obstetrician or midwife (66.1%), followed by family

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Methods

Study design and setting

This cross-sectional observational study was conducted

at Redcliffe Hospital, a 250-bed outer metropolitan pub-

ic hospital in Queensland, Australia, with approxi-

mately 1800 deliveries per year, mostly low-to-medium

risk in nature. Ethics approval was obtained from the

informed later qualitative work.

We conducted a prospective study to explore pregnant

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average (20.4 weeks gestation) between 27 February

2014 and 16 October 2014 were invited to complete the
electronic survey while waiting to be seen by an obstetri-

cian in clinic. Each participant completed the question-

naire only once.

zation of medication during pregnancy are listed in Table

Participants. The participants were pregnant women

over 18 years of age receiving antenatal care at Redcliffe

Hospital. Women presenting for their first antenatal visit

(approximately 20 weeks gestation) between 27 February

2014 and 16 October 2014 were invited to complete the
electronic survey while waiting to be seen by an obstetri-

cian in clinic. Each participant completed the question-

naire only once.

Measures. The electronic version of the questionnaire

was designed using Google Forms (Google, 2014; https://
docs.google.com/forms/) with dynamic question trees.
It comprised of a series of multi-choice questions and
7-point Likert response items developed by the investi-
gators and piloted on a group of administrative and
health care staff, including pregnant women (see Elec-

tronic Supplementary Material). It was administered

using an electronic tablet device with immediate wire-

less transfer to a secure website. The participants were

asked whether a diagnosis of depression or anxiety had

previously been made and whether antidepressant/anx-

iolytic medications were used during the current and

any previous pregnancy. Participants who were currently

taking antidepressant/anxiolytic medications, or who

had previously taken these medications during the cur-
ent or previous pregnancies, were asked about perceived

dangers to the baby. Those that ceased the medications

were asked about the reasons as to why they stopped,

including perceived risks to the pregnancy. Using a

7-point Likert scale from 1 (“not at all”) to 7 (“a great
deal”), participants were asked about who or what

influenced the medication decision-making, including

health practitioners (i.e. a general practitioner (GP),
obstetrician, nurse/midwife or mental health practitio-

ner), family, friends and various forms of media (Inter-

et, newspapers/magazines or television/radio). They

were also asked if they believed they had received

results for participants are presented in Table 1.

Antidepressant and anxiolytic

medication use

In total, 47 participants (9.3%) were taking antidepres-

sant/anxiolytic medications at commencement of, or

immediately prior to, their current pregnancy. Of these, a

majority of the women (32/47 or 68.0%) ceased these

medications during or while trying to become pregnant; 7

had taken medications during a previous pregnancy with

2 taking the medications throughout the pregnancy. A

total of 13 participants (13/503 or 2.6%) had taken these

medications at the commencement of, or

 influences the decision. The reasons for ces-

sation of medication during pregnancy are listed in Table 2.

Influences on decision making

The greatest reported influence on decision-making was

the GP (3.8 on 7 point Likert scale), followed by family

and the Internet. Obstetricians, television/radio and

newspapers/magazines were rated as having low influence.

Fifteen women (31.9%) reported that they had not been
given enough information (14) or that the information

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Fifteen women (31.9%) reported that they had not been
given enough information (14) or that the information
provided was confusing or unclear (1). Of the 32 women who said they had received enough information to make a decision, six (12.8%) felt they still had unanswered questions; 26 (55.3%) were satisfied that they had all their questions answered.

**Discussion**

We surveyed a group of 503 women attending an outer metropolitan hospital antenatal clinic with respect to their views on the prescription of antidepressant/anxiolytic medication in pregnancy. One key finding was that the majority of women (68%) taking these medications made the decision to cease these medications during pregnancy. The most common reason for cessation was concerns about side effects to the baby. The GP was the most influential in this decision-making. However, almost a third of this cohort (29.8%) described inadequate provision of information to help them decide the best course of action with respect to continuing or discontinuing medication.
The primary external influence on decision-making was the GP though the influence was modest. In this circumstance, readily accessible and well-promoted links to reliable sources of balanced and regularly updated information regarding medication and pregnancy may be helpful for clinician and patient alike.

Accessibility factors were presumably highly relevant to our participant group of pregnant women with those sources of information readily available (GP, family and the Internet) being most utilized. Perhaps this is unsurprising given the urgency of the decision to be made, and difficulty organizing a quick specialist review.

This study has a number of limitations deserving of mention. We have no corroborating details on past psychiatric history, the specific prescribed medication and its pregnancy risk categorization or the attitudes of the women towards other behaviors in pregnancy (such as smoking and alcohol use). The aggregation of antidepressant and anxiolytic medication is also a limitation – related to the study’s self-report/questionnaire methodology. The authors recognize that there may be different approaches to predominantly anxious or depressive conditions in relation to ongoing anxiolytic/antidepressant treatment. These issues need clarification with further qualitative investigation.

Conclusions

The decision whether or not to continue antidepressant/anxiolytic medication during pregnancy is a vexed one for both pregnant women and health providers. Our study demonstrates a significant level of concern by pregnant women about the safety of antidepressant/anxiolytic medication during pregnancy. There is a likelihood of discontinuation of treatment when this may not be advisable, and there are potential deficits in the provision of balanced information regarding risks and benefits. These issues need further qualitative exploration. The challenge remains for the clinician to remain well versed with information related to perinatal medication prescription and convey this to the patient within the time constraints of an appointment with a number of varying medical priorities.

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ORCID iD

George Bruxon https://orcid.org/0000-0002-6961-8902

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