

The ethics of treating depression in pregnancy

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Introduction

Treatment of depression during pregnancy is complex. Needs of both the woman and her foetus must be considered. One must also be cognisant of the increased risk of complications from untreated mental illness. Rather than considering the mother's needs and the foetus's needs as at odds with each other, the issues should be reframed to find the best solution for each pair. This article focuses on the ethical issues involved, rather than comprehensively describing treatment of depression in pregnancy.

Depression in pregnancy

Up to 15% of women of childbearing age experience depression.¹ The Edinburgh Postnatal Depression Scale (EPDS), the most commonly used scale to screen for postnatal depression worldwide, has also been validated in pregnancy, and is completed by the patient herself in only minutes.² After a positive screen and careful diagnosis comes the real difficulty—treatment planning.

Treating depression is part of a physician's 'bread and butter'. However, taking a moment to consider how the symptoms of depression themselves might hamper a pregnant woman's decision-making is worthwhile. She may be quite sad, at a time she has been told should be one of the happiest of her life. Decreased concentration may affect her understanding and recall of information. Feelings of hopelessness and guilt potentially increase her perceptions of the probability of negative outcomes, distorting known risks.³ Harm to the

foetus, from either medication or from untreated depression, could lead to maternal guilt and regret.

Risks of not treating and risks of treating

Untreated depression during pregnancy actually may be riskier than at other times in a woman's life. Women who stop their antidepressant in pregnancy are more likely to relapse into depression than those who continue their medication.⁴ Cohen et al.⁴ found that 26% of those who continued their antidepressant in pregnancy relapsed, compared to 68% who had stopped medication. One must consider the effects of maternal depression on both maternal and foetal outcomes.³ Risks include poor self-care, poor prenatal care, suicide, increased risk of substance abuse, low birth weight infants, impaired mother–infant bonding, infanticide, and for the infant, poor stress adaptation, decreased cognitive performance, and behavioural difficulties.^{5,6} However, often these risks are overlooked.

Psychotherapy alone can be effective in depression. However, in more severe cases, antidepressant medication is often indicated. Approximately 6–13% of pregnant women are prescribed antidepressants.⁷ Monotherapy, with the lowest effective dose, is often best. The hypothetical concerns that exist about treating pregnant women with antidepressants include whether the medication is associated with miscarriage, malformations, preterm delivery, obstetric complications, perinatal toxicity or withdrawal, behavioural teratogenesis (neurobehavioural problems developing in childhood), and also whether the medication is

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The **ETHICS** column explores issues around practising ethically in primary health care and aims to encourage thoughtfulness about ethical dilemmas that we may face.

THIS ISSUE: Our guest ethicist Susan Hatters Friedman explores the issue of treating depression during pregnancy from an ethical perspective.

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compatible with lactation (or whether it is not safe in breastfeeding).⁶ However, most malformations have no known cause, with 2–3% of pregnancies resulting in a birth defect.⁶

Elsewhere, my colleague and I have highlighted the limitations of research in this area,⁶ and one must utilise critical reasoning skills when reading articles that potentially data mine. There is not strong evidence that selective serotonin reuptake inhibitors (SSRIs) increase miscarriage rates, and several good studies have not found increases in birth defects.⁶ SSRIs' potential for neonatal withdrawal or toxicity, while concerning to parents, usually represent uncomplicated neonatal intensive care unit (NICU) diagnoses and are self-limited. Behavioural teratogenesis is a hypothetical concern; however, research on this topic is inconclusive.⁶ Liaison with maternal mental health, obstetric, and paediatric services should occur as needed.

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) statement notes the effects of maternal depression on both infant development and mother–infant attachment.⁸ RANZCOG recommend that all pregnant women be screened for mood disorders using the EPDS and a psychosocial screen, and also recommend 'collaborative decision-making' with the woman and her partner, early intervention, and consideration of both psychological and pharmacological treatment. The Royal Australian and New Zealand College of Psychiatrists' (RANZCP) guidance focuses primarily on the use of antidepressants in late pregnancy, in relation to the potential for neonatal syndromes.⁹

Ethical principles to consider

When treating depression in pregnancy, one must balance the needs of the woman and her foetus. At times, their needs may appear opposing—with the two becoming adversaries; however, the reality is that their needs are 'intimately intertwined'.¹⁰ Complex decision-making capacity, with continuous communication and integration, are needed.¹¹ Ethical concepts useful in considering these dilemmas include avoidance of omission bias, beneficence, autonomy, and preventive ethics.^{3,10–13}

Errors of omission versus errors of commission

Doctors, perhaps counterintuitively, may consider negative outcomes caused by an intervention to be different than the same negative outcome caused by the natural course of a disease.¹⁴ Nowhere has this been more apparent to me than in my perinatal psychiatry work. Omission bias occurs because doctors are more concerned about acts of commission (if treatment were to lead to a negative outcome) than acts of omission (not treating a patient's illness).^{5,10} When one is cognisant of this potential bias, one may address it—such that one ensures equal discussion of risks of treating and the risks of leaving maternal depression untreated. This will allow the patient to make the best decision for her specific case, with balanced information.

Beneficence and relational ethics

The ethics principle of beneficence, whereby one promotes the patient's best interests, intersects in perinatal work with relational ethics—considering 'that the patient's wellbeing and her baby's wellbeing are intertwined, rather than at odds'.¹⁰ Many women initially misperceive that antidepressants are good for them but harm the foetus. However, in actuality, 'these outcomes are not mutually exclusive and the foetus is completely dependent on the mother's environment'.¹⁵

Autonomy

Autonomy includes a woman's decision-making, both for herself and her foetus. The likelihood of negative outcomes of both foetal toxicity and from depression require consideration. Coverdale et al.¹² describe clinical strategies for enhancing the pregnant patient's autonomy including:

- screening for depression;
- considering depression's effects on decision-making;
- counselling about the negative effects of depression in pregnancy; and then
- discussing treatment options.

Zarin and Pauker¹⁴ have previously introduced the model of decision-making that includes structur-

ing the problem, the likelihoods of the outcomes, and the relative values placed on the outcomes. The physician's role is to provide guidance and structure the problem, the potential treatments, and the probabilities of outcomes, whilst the patient brings her own values to the solution. Factors influencing the woman's decision include:

- how the patient perceives the relative value of the outcomes for her and her baby;
- her perception of risk both objectively (estimate of risk) and subjectively (importance of negative outcomes to her personally and her sense of dread); and
- her competence to consent (including also the voluntariness of the decision).¹¹

Especially when apparently conflicting values about the woman and her foetus exist, careful analysis can clarify decision points and concerns about various alternatives.¹⁴

Coverdale et al.¹³ argue that directive counselling is ethical after the mother has chosen to keep the pregnancy. Rather than being paternalistic, directive counselling builds on the patient's values—not those of the doctor. A risk-benefit approach to the discussion is suggested, along with teaching about the illness, treatments, and other risks in pregnancy.⁵ As doctors, we should consider how the media represents the risk of taking medications during pregnancy and the misperceptions the patient may thus be harbouring. It is important that we use our medical knowledge to correct these common misunderstandings. For example, the media may have correctly reported that the risk of an adverse outcome is four times higher with a specific drug treatment in pregnancy. This describes 'relative risk' rather than 'absolute risk', however, and the absolute risk may have increased from 0.1% to 0.4% in the same instance. In my experience, patients have been quite open to understanding these concepts, but quantitative estimates of absolute risk are better than vague statements about 'rarity' or 'commonness', which are open to misinterpretation.¹⁴

Preventive ethics

Finally, preventive ethics includes 'anticipating and preventing ethical dilemmas in clinical prac-

tice'.¹⁰ As such, this strikingly comes into play when one considers that approximately half of pregnancies are unplanned.¹⁵ Therefore, it makes good sense to discuss pregnancy planning in all women of childbearing age in one's practice. Furthermore, when pharmacologically treating depression in a non-pregnant woman of reproductive age, as part of preventive ethics, it is prudent to start a medication that has a relatively safe reproductive record, rather than a newer medication about which little is known in pregnancy. In advance, it is wise to anticipate potential risks should she become pregnant, and proactively discuss these potential risks with her.

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