# Influence of the Media on Women Taking Antidepressants During Pregnancy

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Many more women than men suffer from depression, with up to 20% of women of childbearing age diagnosed with the condition, most often between 25 and 44 years of age.[1] Approximately 10% to 15% of these women experience depression during pregnancy and the postpartum period.[2] Prior to late 2005, there was no evidence that the newer antidepressants, as a group, increased the incidence of major malformations above the expected 1% to 3% in the general population.[3,4] At that time, physicians and their pregnant patients appeared to be relatively comfortable with prescribing and taking these drugs (personal experience from The Motherisk Program). However, in December 2005, GlaxoSmithKline (GSK) published on their Web site preliminary results of a study documenting an increased risk for cardiac malformations (2 per 100 versus 1 per 100) in infants whose mothers took paroxetine in early pregnancy.[5] These data were supported by 2 other studies,[6,7] presented at meetings and at that time published only in abstract form. Subsequently, on the basis of these 3 preliminary reports, the US Food and Drug Administration (FDA)[8] and Health Canada[9] posted warnings (which have not been updated, despite several large studies that have been published in the past 5 years) on their Web sites advising women to avoid paroxetine if possible during pregnancy. This information was quickly picked up by the media and widely published in the print media, on television, and on the Internet. In the 7 days following the release of these advisories, The Motherisk Program received 49 calls for information from anxious women, currently pregnant or planning a pregnancy and taking paroxetine. [10]

In December 2006, the American College of Obstetricians and Gynecologists published a similar advisory (not yet updated with the new information), which also quickly made it to the media, causing further concern among women and their health care providers.[11] Warnings such as these, describing adverse effects of exposures in pregnancy, are almost always widely cited by the media and subsequently make their way to the Internet. A recent Google search (June 23, 2009) using the keywords "*antidepressants, pregnancy*" revealed 1,420,000 results, many describing how "dangerous/harmful" antidepressants are to take in pregnancy with many sites warning women not to take antidepressants if they are pregnant. Studies that do not find evidence for harm[12] more often than not are ignored by the media, such as in the recent *Vogue* article that focused only on studies that reported adverse effects.[13] In addition, a number of Web sites have been developed that invite women to join a class action suit against GSK if they took Paxil in pregnancy and delivered a baby with a cardiovascular birth defect.[14]

A survey of community pharmacists in 3 countries reported that pharmacists do not always use evidence-based information, but instead, often refer to the product monograph, which is not an appropriate resource to dispense information regarding the safety of drugs during pregnancy and breastfeeding.[15] For example, the 2009 product monograph information on Prozac states the following: "The safety of this drug during pregnancy and lactation has not been established, therefore it should not be administered to women of childbearing potential unless the benefit clearly outweighs the possible hazards to the fetus or child."[16] This despite evidence based on thousands of women exposed to this drug during pregnancy with no evidence of harm to the fetus.[17]

Currently, even though mental illness is more widely accepted, especially owing to famous people talking about their disease, there continues to be a certain amount of stigma, which was documented in a Canadian survey conducted last year that reported 1 in 4 Canadians is fearful of being around those who suffer from serious mental illness.[18] In addition, a group who conducted a worldwide study regarding perceived stigma among people with mental disorders confirmed this general fear and stigma surrounding mental illness.[19] Another group reported that less personal exposure to depression equaled higher personal stigma.[20] Another group who used the same questionnaire used by Griffiths et al[20] reported the same results for some of the statements but, for others, found the opposite, ie, that there was a trend between more exposure and higher personal stigma.[21]

For women who require pharmacologic treatment for depression during pregnancy and their health care providers, it is understandable that after reviewing all, or even some of this information, making the decision to prescribe or continue taking an antidepressant during pregnancy would be very difficult. However, somehow amid all of this conflicting information and continued stigma surrounding mental illness, as well as previous information a woman has received, a psychiatrist is expected to assist the pregnant woman in making a decision as to whether she should take an antidepressant and, if so, which one. In conclusion, any decision to take an antidepressant in pregnancy should be made between the woman and her physician after weighing the risks and benefits of the medication using evidence-based information. This standard of care will ensure the best outcome for both mother and infant, which should be the primary endpoint.

## REFERENCES


1. Grigoriadis S, Robinson GE. Gender issues in depression. *Ann Clin Psychiatry.* 2007;19(4):247–255.
2. Bennett HA, Einarson A, Taddio A, et al. Prevalence of depression during pregnancy: systematic review. *Obstet Gynecol.* 2004;103(4):698–709.
3. Einarson TR, Einarson A. Newer antidepressants in pregnancy and rates of major malformations: a meta-analysis of prospective comparative studies. *Pharmacoepidemiol Drug Saf.* 2005;14(12):823–827.
4. Malm H, Klaukka T, Neuvonen PJ. Risks associated with selective serotonin reuptake inhibitors in pregnancy. *Obstet Gynecol.* 2005;106:1289–1296.
5. Modell J. Dear Healthcare Professional (December 2005 advisory letter). GlaxoSmithKline Web site. http://www.gsk.com/media/paroxetine/pregnancy_hcp_letter.pdf. Accessed July 28, 2008.
6. Kallen BA. Otterblad Olausson P. Maternal use of selective serotonin reuptake inhibitors in early pregnancy and infant congenital malformations. *Birth Defects Res A Clin Mol Teratol.* 2007;79(4)301–308.
7. Diav-Citrin O, Shechtman S, Weinbaum D, et al. Paroxetine and fluoxetine in pregnancy: a prospective, mulicentre, controlled, observational study [abstract]. *Reprod Toxicol.* 2005;20:459.
8. Important Prescribing Information (September 2005 advisory letter). Food and Drug Administration Web site.

http://www.fda.gov/downloads/Safety/MedWatch/SafetyInformation/SafetyAlertsforHumanMedicalProducts/UCM164865.pdf. Accessed June 23, 2009.
9. Dillon JA. Important safety information on Paxil (paroxetine) and increased risk of cardiac defects following exposure during first trimester of pregnancy— for health professionals—GlaxoSmithKline Inc. Health Canada Web site. http://www.hc-sc.gc.ca/dhp-mps/medeff/advisories-avis/prof/_2005/paxil_4_hpc-cps-eng.php. Accessed June 23, 2009.
10. Einarson A, Schachtschneider AK, Halil R, et al. SSRIs and other antidepressant use during pregnancy and potential neonatal adverse effects: impact of a public health advisory and subsequent reports in the news media. *BMC Pregnancy Childbirth.* 2005;5:11.
11. ACOG committee on obstetric practice. Committee opinion no. 354: Treatment with selective serotonin reuptake inhibitors during pregnancy. *Obstet Gynaecol*. 2006;108:1601–1603.
12. Einarson A, Pistelli A, DeSantis M, et al. Evaluation of the risk of congenital cardiovascular defects associated with use of paroxetine during pregnancy. *Am J Psychiatry.* 2008;165(6):749–752.
13. Jetter A . "Pregnant Pause." *Vogue*. May 2009:144,148,232.
14. The Mulligan Law Firm is evaluating SSRI. Topix Web site. http://www.topix.net/content/prweb/2009/06/the-mulligan-law-firm-is-evaluating-ssri-prozac-zoloft. Accessed June 5, 2009.
15. Lyszkiewicz DA, Gerichhausen S, Björnsdóttir I, et al. Evidence based information on drug use during pregnancy: a survey of community pharmacists in three countries. *Pharm World Sci.* 2001;23(2):76–81.
16. Compendium of Pharmaceuticals and Specialties 2009 (product monograph). Eli Lilly, revised June 2, 2008.
17. Louik C, Lin AE, Werler MM, et al. First-trimester use selective serotonin-reuptake inhibitors and the risk of birth defects. *N Engl J Med.* 2007;356(26):2675–2683.
18. Stigma of mental illness common among Canadians: report (based on the 8th Annual National Report Card on Health Care August 2008, Canadian Medical Association.). CBC News Web site Available at: http://www.cbc.ca/health/story/2008/08/15/mental-health.html and http://www.cma.ca/multimedia/CMA/Content_Images/Inside_cma/Annual_Meeting/2008/GC_Bulletin/National_Report_Card_EN.pdf. Accessed October 7, 2008.
19. Alonso J, Buron A. Bruaerts R, et al. Association of perceived stigma and mood and anxiety disorders: results from the World Mental Health Surveys. *Acta Psychiatr Scand.* 2008;118(4):305–314.
20. Griffiths KM, Christensen H, Jorm AF. Predictors of depression stigma. *BMC Psychiatry.* 2008;8:25.
21. Wang J, Lai D. The relationship between mental health literacy, personal contacts and personal stigma against depression. *J Affect Disord.* 2008;110(1-2):191–196.

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*doi:10.4088/JCP.09com05478*