The Use of Psychiatric Medication During Conception Attempts

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In my article last month, I discussed when to seek mental health support during attempts to conceive, particularly, during infertility treatment. As I stated then, the goal of mental health support is to help you maintain optimal functioning during a very difficult time. Good initial forms of support include self-help resources, support groups, telephone-coaching groups, family and friends, and counseling. For those who have tried the supports above and still find that they are having difficulty functioning optimally, medications might provide some relief.

Most women will experience distressing moods and anxious feelings related to the uncertainties of infertility, but only a small subset of women will experience clinical depression or anxiety requiring treatment of both the psychological issues related to infertility and their symptoms of depression or anxiety. Depression is seen more commonly during years two to six of infertility treatment, but can occur at any time. The women at risk for depression or anxiety include those that have not been able to function optimally despite appropriate supports, women with a history of depression or anxiety, or an eating disorder as their symptoms are often triggered by stress and loss. Women (or men) with a family history of depression or anxiety or another psychiatric illness, particularly those with first-degree relatives (ie: parent, sibling, child) with a psychiatric illness are also at increased risk to develop depression. Other factors associated with anxiety or depression include difficulty tolerating uncertainty, the need to be in control, and a less flexible temperament. Alternatively, factors that can help you weather the infertility storm are a more optimistic outlook, feelings of purpose or meaning outside of parenthood, resilience, and meaningful connections to others.

The fear of stigma, the feeling that one should be strong enough to deal with depression without help, and the fear of harmful effects on the fetus are common reasons that women either stop psychiatric medications in anticipation of pregnancy or do not start them in the first place despite the presence of symptoms. For women with mild to moderate depression and no history of medication treatment, psychotherapy alone is recommended. For women with moderate to severe depression or a history of good response to medication, treatment with medication is recommended.

In order to make an informed decision about medications during pregnancy or attempts to conceive, the risks of untreated psychiatric illness and the risks of fetal exposure to medications should be delineated. Two studies of pregnant women with a history of recurrent depressive and bipolar illnesses indicated that those women that discontinued their medication had significantly higher rates of relapse than those that maintained treatment. The risks of untreated depression for the mother include ongoing suffering, the risk of poor prenatal and self-care, an increased risk of the use of tobacco, alcohol, and illicit drugs, strained relationships with her partner or members of her support system, and poor interaction with other children in her care. In addition, some studies have shown that women with untreated depression have an increased risk of pre-term delivery, Caesarian delivery, and pre-eclampsia (a condition of pregnant women involving elevated blood pressure and requiring immediate medical attention). These same studies have shown that the fetus of a woman with untreated depression has an increased risk of being admitted to a neonatal intensive care unit and being low birth weight. There is also an increased risk of brain and behavior changes consistent with depression and anxiety.

Much of the literature about antidepressants suggests that they are safe to use during pregnancy. The problems that have been attributed to fetal exposure to psychiatric medications have occurred in low numbers or are managed with medical support. The risks of fetal exposure to medication can be divided into several categories.

These include physical malformations due to first trimester exposure, growth impairment in the womb, long-term cognitive and behavioral effects, and adverse effects of the medication for the neonate after delivery. Any discussion about whether or which medication to take should be directed to your personal physician. It should take into account your symptoms, history of depression or anxiety and prior psychiatric treatment as well as the risks of untreated illness versus the risks of fetal exposure to psychiatric medications recommended specifically for you.

Women with milder forms of depression or anxiety, even if recurrent, or who have first onset psychiatric illness during attempts to conceive may have a more difficult decision about whether to start medication. For those with moderate depression or more recurrent illness, there is more information about their increased risk of relapse during pregnancy if they discontinue medications.

As I stated above, not all women undergoing infertility treatment will develop depression or anxiety. There are some specific factors that may increase a woman's risk of developing depression or anxiety in the context of the highly stressful experience of infertility. Knowledge of these risk factors, an increased awareness of when to seek treatment, and, the risks of untreated psychiatric illness and fetal exposure to psychiatric medication will, hopefully, help you to make the best decisions for your emotional health.