Complementary and Alternative Medicine Therapies for Depression During Pregnancy

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Many choose to discontinue antidepressant treatment during attempts to conceive or during pregnancy, in spite of the risks of untreated perinatal depression. Safety profiles of antidepressant use during pregnancy are increasingly being studied, and many women seek alternatives during pregnancy. This article will review several complementary and alternative (CAM) treatments for prenatal unipolar depression: omega-3 fatty acids, folate, St John’s Wort, bright light therapy, massage therapy, and exercise.

Approximately 18% of women suffer from perinatal depression.[1] Untreated prenatal depression is associated with obstetrical and neonatal complications[2-7] and is a strong risk factor for postpartum depression.[8] Postpartum depression has been associated with negative effects on child development. In spite of the risks of untreated perinatal depression, women often discontinue antidepressant treatment during attempts to conceive or during pregnancy. Safety profiles of antidepressant use during pregnancy are increasingly being studied, although women often seek alternatives during pregnancy. More than a quarter of women report the use of a complementary and alternative medicine (CAM) therapy during pregnancy.[9] Despite the prevalence of CAM use, the number of adequately powered, well-designed controlled clinical trials of CAM treatments for prenatal depression is limited. This article will review several CAM treatments for prenatal unipolar depression: omega-3 fatty acids, folate, St John’s Wort, bright light therapy, massage therapy, and exercise.

Omega-3 Fatty Acids
Omega-3 fatty acids are among the most commonly used CAM treatments in the United States.[10] Omega-3 fatty acids, including eicosapentaenoic acid (EPA) and docosahexaenoic acid (DHA), are essential fatty acids with well-established health benefits and particular benefits for obstetrical outcomes and infant development.[11,12] Consensus guidelines recommend pregnant women consume at least 200 mg of DHA daily[13] to optimize pregnancy outcomes and fetal health.

Meta-analyses of randomized controlled trials (RCTs) demonstrate a significant antidepressant benefit of omega-3 fatty acids in mood disorders overall, especially when used as augmentation to antidepressants. However, some RCTs assessing the effectiveness of omega-3 fatty acid supplementation have not demonstrated a benefit in acute treatment or prevention of perinatal depression.[14-16] The Omega-3 Fatty Acids Subcommittee, assembled by the American Psychiatric Association, recommends patients with depression take 1 gram EPA + DHA daily. Current evidence may support the use of a 1- to 9-g supplement of EPA + DHA daily for patients with mood disorders, although use of more than 3 g daily should be monitored by a physician because of possible anticoagulant effects at higher doses.[17] Based on positive findings from RCTs and meta-analyses in non-perinatal depression, pregnant patients with depression may consume 1 g of EPA + DHA daily as augmentation of other conventional depression treatments, but there is little evidence of efficacy as monotherapy.

Folate
Folate, available as folic acid, folinic acid, and 5-methyltetrahydrofolate or L-methylfolate, is important in the synthesis of nucleic acids and amino acid metabolism. Many studies report an association of low folate levels and an increased risk of depression[18,20] and low blood folate has been associated with a poorer response to treatment with antidepressants in major depression.[21] Epidemiological data, however, do not demonstrate that higher folate intake during pregnancy lessens the risk of the development of postpartum depression.[22] Folate and L-methylfolate have been best studied as augmentation strategies to concomitant antidepressant treatment in non-perinatal depression.[23,24]
To reduce the risk of neural tube birth defects, women of reproductive age are recommended to consume 0.4 to 1 mg of folic acid daily. There have been no studies published on the efficacy of folate monotherapy or augmentation therapy for depression during pregnancy. Considering the potential decrease in birth defects and RCT data that mainly support a positive effect of antidepressant augmentation with folate (ie, folic acid 0.4 to 5 mg/d or folinic acid 15 to 30 mg/d), folate can be an important adjunctive strategy for prenatal depression that carries little risk and may be especially effective in those women with low serum folate levels.

**St John’s Wort (Hypericum Perforatum)**

*Hypericum perforatum*, from the plant St John’s Wort, consists of several bioactive substances, including hypericin, hyperforin, and flavonoids, which have affinity for neurotransmitter systems central to the pathophysiology of and pharmacotherapy for major depression. Few studies have investigated the safety of St John’s Wort during the perinatal period, and none have evaluated efficacy or safety in perinatal depression. Safety data based on animal studies are mixed, with some studies raising concerns. Limited data in 54 human pregnancies indicated no increased risk of major malformations in infants born to women taking St John’s Wort during pregnancy. St John’s Wort appears to be excreted into breast milk at undetectable to low levels, comparable to other antidepressants. Adverse events, such as colic, drowsiness, and lethargy, have been reported in infants exposed via breast milk. Further studies should be done before St John’s Wort can be recommended for use in the perinatal period, given reported infant adverse effects during lactation and limited safety or efficacy data during pregnancy.

**Bright Light Therapy**

Several studies demonstrate that bright light therapy is an efficacious, first-line treatment for both seasonal and non-seasonal major depression. Bright light therapy is generally well tolerated, although there is a risk of mania in patients with underlying bipolar disorder. Three studies that assessed bright light therapy in prenatal depression suggest efficacy. In one controlled trial, in which pregnant women were randomized to 1 hour of 7000 lux bright (active) light or 70 lux dim red (placebo) light over 5 weeks, bright light was associated with a greater reduction of depressive symptoms than dim light. The treatment was tolerated well, without adverse effects reported. Light therapy may be an attractive option for some perinatal women, since ultraviolet screened light boxes with 10,000 lux illumination are available. Patients should be monitored carefully for emergent symptoms of hypomania or mania, sleep disturbance, and agitation when bright light therapy is initiated.

**Massage**

Massage therapy has been studied broadly for health benefits. A recent meta-analysis of RCTs of massage therapy in depressed patients concluded that massage therapy is significantly associated with reduced depressive symptoms. Several monotherapy studies have investigated the effects of massage on pregnant women. Prenatal massage therapy is efficacious in reducing prenatal depressive symptoms. Given safety data and a growing literature that supports massage therapy as an effective treatment for non-perinatal and perinatal depressive symptoms, massage therapy consisting of weekly sessions of 20 minutes may be a reasonable consideration for pregnant women with mild depressive symptoms.

**Exercise**

Exercise is integral to optimal health in pregnancy. Several trials have demonstrated that aerobic exercise reduces depressive symptoms, and epidemiological data suggest that regular exercise is associated with decreased risk of depressive symptoms, although not all trials have consistently demonstrated benefit. The American College of Obstetricians and Gynecologists recommends pregnant women without medical contraindications engage in regular aerobic and strength-conditioning exercise during the perinatal period. Studies of both prenatal aerobic exercise and general physical activity in women without major depression, have shown that exercise or physical activity was associated with fewer depressive symptoms in pregnancy. No studies to date have assessed exercise for prenatal depression, although there is a small amount of data for impact on depressive symptoms in women without a clinical diagnosis of depression. Based on a limited evidence base for exercise in the treatment of prenatal depression, 30 minutes a day of exercise most days of the week in the absence of either medical or obstetric complications and after
consultation with an obstetrician is recommended for general health.

**Conclusion**

Prenatal depression is common. Effective, evidence-based standard psychotherapies and pharmacotherapies are available for pregnant women, so treatment with relatively understudied CAM therapies in lieu of standard evaluation and treatment carries the risk of prolonging the time ill with depression. However, with appropriate attention to the potential risks and benefits of CAM, some of the better-studied CAM therapies can expand the list of treatment options available to patients. At this time, further study is necessary to understand the full efficacy and safety of specific CAM therapies for depression during pregnancy.

**References:**

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