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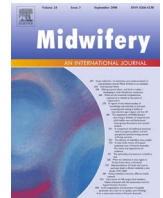
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Antidepressants during pregnancy: Guideline adherence and current practice amongst Dutch gynaecologists and midwives



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ABSTRACT

Background and objectives: prescription rates of antidepressants during pregnancy range from 2–3% in The Netherlands to 6.2% in the USA. Inconclusive evidence about harms and benefits of antidepressants during pregnancy leads to variation in advice given by gynaecologists and midwives. The objective was to investigate familiarity with, and adherence to the Dutch multidisciplinary guideline on Selective Serotonin Reuptake Inhibitor (SSRI) use during pregnancy by gynaecologists and midwives in the Netherlands.

Methods: an online survey was developed and sent to Dutch gynaecologists and midwives. The survey consisted mainly of multiple-choice questions addressing guideline familiarity and current practice of the respondent. Also, caregiver characteristics associated with guideline adherence were investigated.

Findings: a total of 178 gynaecologists and 139 midwives responded. Overall familiarity with the Dutch guideline was 92.7%. However, current practice and advice given to patients by caregivers differed substantially, both between gynaecologists and midwives as well as within both professions. Overall guideline adherence was 13.9%. Multivariable logistic regression showed that solely caregiver profession was associated with guideline adherence, with gynaecologists having a higher adherence rate (OR 2.10, 95%CI 1.02–4.33) than midwives.

Key conclusion: although reported familiarity with the guideline is high, adherence to the guideline is low, possibly resulting in advice to patients that is inconsistent with guidelines and unwanted variation in current practice.

Implications for practice: further implementation of the recommendations as given in the guideline should be stimulated. Additional research is needed to examine how gynaecologists and midwives can be facilitated to follow the recommendations of the clinical guideline on SSRI use during pregnancy.

Introduction

Worldwide, prescription rates of Selective Serotonin Reuptake Inhibitors (SSRIs) during pregnancy vary from 3.7% in the UK (Charlton et al., 2015) to 6.2% in the USA (Andrade et al., 2008). In The Netherlands, approximately 2% to 3% of all women each year take antidepressant medication during their pregnancy (Ververs et al., 2006; Bakker et al., 2008).

The use of antidepressants during pregnancy is still controversial. Studies on risks of short- and long-term effects report conflicting results. Some studies found increased risks for pregnancy-induced hypertension (De Vera and Berard, 2012), cardiovascular malformations (Grigoriadis et al., 2013a), persistent pulmonary hypertension of the neonate (PPHN) (Kieler et al., 2012), poor neonatal adaptation (Grigoriadis et al., 2013b), preterm delivery and lower birth weight (Ross et al., 2013), poor motor development (Gentile and Galbally,

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2011) and autism spectrum disorders in the offspring (Croen et al., 2011). Several other studies failed to confirm these findings (Hviid et al., 2013; Furu et al., 2015; Huybrechts et al., 2015). An explanation for these conflicting results is that most of these results originate from retrospective observational studies with a lack to distinguish the effects of antidepressants from other shared risk factors, notably their indications depression and anxiety.

On the other hand, leaving depression or anxiety disorders untreated may be hazardous to the (unborn) child as well. The preventive effect of SSRIs for relapse of depression during pregnancy is indistinct. Two observational studies compared relapse rates in women who discontinued their medication with women who continued their medication (Cohen et al., 2006; Yonkers et al., 2011). One showed a significant increased risk of relapse in women who discontinued their medication (68% versus 26%), but the other study failed to find such a difference. If women suffer from depression or anxiety during pregnancy, this could lead to, among other things, preterm birth and low birth weight (Grote et al., 2010) and behavioural, emotional, cognitive and motor problems in early childhood (Talge et al., 2007; Field, 2011). Again, the observational character of these studies preclude definite answers as continuation or discontinuation are not likely to be randomly occurring. Therefore, to date it is still impossible to make definitive statements about the harm/benefit ratio of continuing or discontinuing antidepressants during pregnancy.

In The Netherlands, maternity care is organised in a so-called primary, secondary and tertiary care model. The primary care, for obstetric low-risk women, is led by midwives and General Practitioners (GPs). Secondary care consists of obstetricians and clinical midwives in general hospitals, and tertiary care comprises obstetricians and clinical midwives in academic hospitals (Amelink-Verburg and Buitendijk 2010). Together with midwives, GPs and obstetricians, several other health care professionals, such as psychiatrists, psychologists, paediatricians and clinical pharmacologists, can be involved in the care during pregnancy and could be consulted on the use of antidepressants during pregnancy. In order to avoid conflicting advice to the patient, the Dutch Federation of Obstetrics and Gynaecology (NVOG) has developed a multidisciplinary guideline in 2012 regarding the use of SSRIs during pregnancy (NVOG, 2012). This guideline gives, among others, the following advice: Pre-pregnancy continuation of SSRIs if women are stable on this medication and psychiatric indication is correct, a hospital delivery under supervision of a midwife or gynaecologist, a postpartum hospital stay of at least 12 hours and continuation of SSRIs postpartum to prevent postnatal depression. It is stated that there is insufficient evidence on the possible benefit of discontinuing SSRIs during pregnancy, with or without non-pharmacological alternatives, compared to the possible risk of relapse of depression to advise pregnant women to discontinue medication.

Given that gynaecologists and midwives have an important role in informing pregnant women on use of antidepressant medication, the objective of this study was to investigate if gynaecologists and midwives were familiar with the multidisciplinary guideline as published in 2012, and what their routine care is regarding pregnant women using SSRIs. In addition, we tested if caregiver characteristics, such as gender and age, were associated with guideline adherence.

Methods

Study design and procedure

For this cross-sectional study a short online survey for gynaecologists and midwives was developed. The survey was developed after a review of the scientific literature to identify caregiver characteristics associated with guideline adherence in general (Osborn et al., 1991; Haagen et al., 2005; Kenefick et al., 2008; Smolders et al., 2010; Mistiaen et al., 2012; McElligott et al., 2014). Before widely distributing the survey, we conducted a pilot ($n = 56$) and modified some textual ambiguities.

The following sociodemographic and professional variables were identified: Age, sex, place of employment (conurbation versus rural), years of professional experience, self-reported annual number of pregnant patients treated by the caregiver and self-reported annual number of pregnant patients on antidepressants. If caretakers treated no pregnant patients, they were routed to the end of the survey and excluded from analysis. To study guideline adherence, caregivers were first asked if they were familiar with the guideline (no / yes). Subsequently they received questions addressing their current practice, based on recommendations from the guideline. Participants were asked to rate on a Likert scale with 4 categories (never / sometimes / most of the time / always) how often they would give certain advice possibilities, such as continuing or discontinuing antidepressants, to patients. Further, the need for multidisciplinary consultation (no / yes, but only if there is a serious case / yes, always), secondary care (no / yes, one consultation / yes, during the whole pregnancy) and extra prenatal screening (no / yes (specification if yes)) and indicated hospital delivery (no / yes) and/or postpartum hospital stay (no / duration < 6 hours / duration of 6–12 hours / duration > 12 hours) was questioned. Finally, caregivers were asked about their personal opinion on potential iatrogenic effects of antidepressants during pregnancy (no / yes) and their confidence in results from scientific research (no / yes). It took approximately five minutes to complete the survey.

The Erasmus Medical Center, Utrecht University and University Medical Center Groningen are currently performing a randomized controlled trial, 'Stop or Go' (Molenaar et al., 2016), to investigate the effectiveness of preventive cognitive therapy with guided tapering of antidepressants during pregnancy for relapse of depression as compared to continuation of antidepressants during pregnancy. The current survey was conducted as part of that study. Ethical approval for the present study was received from the local ethics committee of Utrecht University.

Study population

The survey was sent by e-mail to all 1012 gynaecologists and 421 gynaecologists in training that were registered at the Dutch Federation of Obstetrics and Gynaecology (NVOG), including gynaecologists that are not currently active or do not work within the field of obstetrics. They received a reminder after two weeks. To reach the 3150 midwives in the Netherlands (as measured at January 2015 (van Hassel et al., 2015)) we placed a call on the website of the Royal Dutch Federation of Midwives (KNOV), and sent an invitation to all general e-mail addresses of midwifery practices as could be found on the internet and reached out through the network from the 'Stop or Go' study. It was not possible to send all midwives a personal invitation.

By clicking on a link to the survey, caregivers implicitly consented to participate. The initial e-mail explained that all answers were processed anonymously.

Statistical analysis

Descriptive statistics were used to outline caregiver characteristics, familiarity with the guideline and current practice. Differences between gynaecologists and midwives were tested using χ^2 tests.

Logistic regression was used for the evaluation of the univariable and multivariable associations of caregiver characteristics with guideline adherence. We developed two composite outcome variables based on the answers on the current practice questions representing guideline adherence.

(1) *Overall guideline adherence.* Overall adherence to the guideline was defined as caregivers advising patients to continue antidepressants, both pre-pregnancy and during pregnancy, while not advising patients to discontinue medication; indicating a need for multidisciplinary consultation; indicating no need for secondary care or extra

prenatal examination; and indicating a need for hospital delivery and postpartum hospital stay with a minimum of 12 hours.

(2) *Guideline adherence during pregnancy.* Since consultation pre-pregnancy is not routine care for obstetricians and midwives, a second composite variable representing guideline adherence was developed, equal to the overall guideline adherence variable but excluding caregiver advice pre-pregnancy.

Next to these two composite outcome variables we selected three additional dependent variables for multivariable logistic regression: (3) Familiarity with the guideline, (4) caregiver advice to continue antidepressants during pregnancy (Likert scale dichotomized into never/sometimes and often/always), and (5) caregiver advice to discontinue antidepressants during pregnancy (yes / no).

We selected the following independent variables: Gender, type of caregiver, place of employment, years of professional experience, self-reported annual number of pregnant patients on antidepressants treated by caregiver, familiarity with the guideline, caregiver's opinion on potential harmfulness of antidepressants during pregnancy and caregiver's confidence in results from scientific research.

Univariable associations between our dependent variables and all the independent variables were computed. Variables with a *p*-value < 0.10 were entered into a multivariable logistic regression model. Independent variables with a two-sided *p*-value < 0.05 in the multivariable model were defined as statistically significant. All associations were expressed as odds ratios (OR) with 95% confidence intervals (95% CI).

All statistical analyses were performed with SPSS, version 21.0.

Results

Baseline characteristics

A total of 178 gynaecologists and 139 midwives fully completed the questionnaire. Baseline characteristics of both groups are shown in Table 1. On the basis of reports of Nivel, the Netherlands institute for health services research, we were able to compare age and gender in our sample with that of the total caregiver population (van Greuningen et al., 2010; van Hassel et al., 2015). Our sample of gynaecologists was overrepresented by women (72.5% in our sample versus 55.8% in the total caregiver population). The study sample of midwives matched on age and gender with the target population. Self-reported percentage of pregnant women with antidepressants treated by gynaecologists was 11.7%, as compared to 10.6% by midwives (*p* = 0.01).

Table 1
Baseline characteristics of health care professionals.

	Gynaecologists (n = 178)	Midwives (n = 139)
Gender, female (%)	129 (72.5)	136 (97.8)
Age in years, mean (SD)	43.9 (9.4)	37.9 (10.8)
Place of employment (%)		
Conurbation	78 (43.8)	56 (40.3)
Rural	100 (56.2)	83 (59.7)
Years of professional experience, mean (SD)	14.5 (8.9)	13.2 (9.8)
Self-reported number of pregnant women seen by individual caregiver, per year (SD)	428.6 (284.3)	282.1 (169.2)
Self-reported number of pregnant women with antidepressants seen by individual caregiver, per year (SD)	50.2 (48.7)	29.8 (35.4)
Self-reported percentage of pregnant women with antidepressants (%)	11.7	10.6

Current practice

Table 2 shows the results on the current practice questions. Most caregivers were familiar with the guideline (overall 92.7%; 97.8% of gynaecologists and 86.3% of midwives, *p* < 0.01). Caregivers reported to act differently on multidisciplinary consultation, indication for secondary care and extra prenatal screening, and advice on hospital delivery and/or postpartum hospital stay. These differences were seen both within the professions as well as between the professions. 14.5% of the respondents considered antidepressant use as an indication for extra prenatal screening, mostly additional advanced ultrasound investigation (80.4%). Most caregivers (80.3% of the gynaecologists and 84.2% of the midwives) indicated to advise a postpartum hospital stay of at least 12 hours or of 6 to 12 hours.

40.4% of gynaecologists and 61.9% of midwives (*p* < 0.01) considered antidepressants potentially harmful during pregnancy. Just over half of the participants (55.6% of gynaecologists and 54.0% of midwives) would trust results from scientific research to direct their actions with regard to prenatal antidepressant use.

Table 3 shows the results from the multivariable logistic regression on guideline familiarity. Less familiarity with the guideline was not only associated with type of caregiver, but also with an increasing number of years of professional experience (OR 0.93, 95%CI 0.88–0.99) and a lower confidence in results from scientific research (OR 3.71, 95%CI 1.38–9.99).

We also evaluated participants' rating of advice possibilities to patients pre-pregnancy and during pregnancy using antidepressants. Opinions of both gynaecologists and midwives on continuing medication, lowering dose and consultation options vary widely. Fig. 1 shows most caregivers (76.6% to 83.1%) always give some form of advice to patients using antidepressants, both before and during pregnancy. The full data on participants rating of advice possibilities can be found in Appendix A.

Guideline adherence

Overall self-reported guideline adherence (including advice both pre-pregnancy and during pregnancy) was 13.9% among all caregivers (18.0% in gynaecologists and 8.6% in midwives, Table 2). Results of the univariable analysis showed associations with self-reported annual number of pregnant patients on antidepressants seen by the individual caregiver, type of caregiver (gynaecologist or midwife) and confidence in results of scientific research (Table 3). Only type of caregiver remained significantly associated in the multivariable model; gynaecologists had 2.08 higher odds (95%CI 1.02–4.33) to act according to the guideline.

Self-reported guideline adherence during pregnancy (excluding advice in the pre-pregnancy period) among all caregivers was 20.5%. Univariable analysis showed associations with a higher self-reported annual number of pregnant patients on antidepressants seen by the individual caregiver and increasing years of professional experience. Both remained significant in multivariable analysis, with OR 1.01 (95% CI 1.00–1.01) and 1.03 (95%CI 1.00–1.06) respectively.

Caregiver's advice to continue and discontinue antidepressants during pregnancy

Of all caregivers, 75.7% often advised to continue antidepressant medication during pregnancy (Appendix A). Univariable analysis showed associations with self-reported annual number of pregnant patients on antidepressants seen by the individual caregiver, type of caregiver, caregiver's opinion that antidepressant use during pregnancy is potentially harmful and unfamiliarity with the guideline (Table 3). Only type of caregiver remained statistically significant in the multivariable model. Midwives reported to less often advice to continue antidepressants during pregnancy (OR 5.48, 95%CI 2.95–10.21).

Table 2
Current practice and opinions amongst Dutch gynaecologists and midwives.

	Gynaecologists (N = 178)	Midwives (N = 139)	p
Familiarity with the guideline, yes %	97.8	86.3	< 0.01
Discussed in multidisciplinary team %			
No	13.5	10.1	0.01
Yes, but only if there is a serious case	42.1	28.8	
Yes, always	44.4	61.2	
Indication secondary care %			
No	48.9	66.9	< 0.01
Yes, one consultation	46.1	32.4	
Yes, during the whole pregnancy	5.1	0.7	
Extra prenatal screening, yes %	13.5	15.8	0.56
Of which additional ultrasound, %	79.2	81.9	
Advice for hospital delivery, yes %	78.5	90.6	< 0.01
Postpartum hospital stay baby %			
No hospital stay	1.1	0.7	0.82
Duration < 6 hours	0.6	0.7	
Duration of 6 to 12 hours	18.0	14.4	
Duration > 12 hours	80.3	84.2	
Opinion on harmfulness, yes %	40.4	61.9	< 0.01
Confidence in results of scientific research, yes %	55.6	54.0	0.77
Overall guideline adherence (composite variable 1), yes %	18.0	8.6	0.02
Guideline adherence during pregnancy (composite variable 2), yes %	23.0	17.3	0.21

Table 3

Univariable and multivariable associations between professional characteristics and guideline adherence and advice options. Only variables with $p \leq 0.10$ in the univariable analysis are presented in this table. OR = odds ratio, CI = confidence interval.

	Univariable outcome <i>p-value</i>	Multivariable outcome <i>p-value</i>	OR (95%CI)
Familiarity with the guideline			
Type caregiver	< 0.01	< 0.01	0.15 (0.05–0.47)
Years of professional experience	0.01	0.03	0.93 (0.88– 0.99)
Confidence in results of scientific research	< 0.01	< 0.01	3.71 (1.38–9.99)
Overall guideline adherence			
Self-reported annual number of pregnant patients on antidepressants seen by individual caregiver	0.03	0.09	NA
Type caregiver	0.02	0.05	2.10 (1.02–4.33)
Confidence in results of scientific research	0.10	0.07	NA
Guideline adherence during pregnancy			
Self-reported annual number of pregnant patients on antidepressants seen by individual caregiver	< 0.01	< 0.01	1.01 (1.00–1.01)
Years of professional experience	0.02	0.02	1.03 (1.00–1.06)
Caregiver's advice to continue antidepressants during pregnancy			
Self-reported annual number of pregnant patients on antidepressants seen by individual caregiver	0.04	0.63	NA
Type caregiver	< 0.01	< 0.01	5.48 (2.95–10.21)
Caregiver's opinion that antidepressant use during pregnancy is potentially harmful	< 0.01	0.14	NA
Caregiver unfamiliar with guideline	< 0.01	0.21	NA

None of the independent variables showed a significant association at univariable analysis with advice to discontinue antidepressants.

Discussion

This cross-sectional study investigated if gynaecologists and midwives report to be familiar with the Dutch multidisciplinary guideline on the use of SSRIs during pregnancy, to adhere to this guideline in current practice, and whether specific caregiver characteristics were associated with guideline adherence. Familiarity with the guideline was high (92.7%), however self-reported guideline adherence was low (13.9%). Differences were seen within the caregiver professions as well as between the professions. No other caregiver characteristics showed important associations with guideline adherence.

Guideline familiarity was significantly less amongst midwives compared to gynaecologists. Although the guideline is available for all caregivers involved during pregnancy, the guideline working group

did not include midwives and the Royal Dutch Organisation of Midwives (KNOV) did not accredit the guideline, possibly explaining this difference. Familiarity with the guideline does not directly imply extensive knowledge of the content. Our survey showed self-reported current practice often differed between caregivers.

Advice on continuing or discontinuing antidepressants, both before and during pregnancy, differed substantially between caregivers. In practice this may result in conflicting advice from different caregivers, creating a potentially difficult situation for vulnerable women. The same variation in advice was reported previously in a survey amongst Dutch General Practitioners (GPs) (Ververs et al., 2009). Pre-pregnancy advice patterns of GPs, in around 80% of the cases the prescribers of the medication (van Rijswijk et al., 2007), are probably more relevant than those of gynaecologists and midwives. Gynaecologists only see a selected group for pre-pregnancy advice, for example couples with fertility problems. Experience of midwives with pre-pregnancy advice will be even smaller. Resulting advice

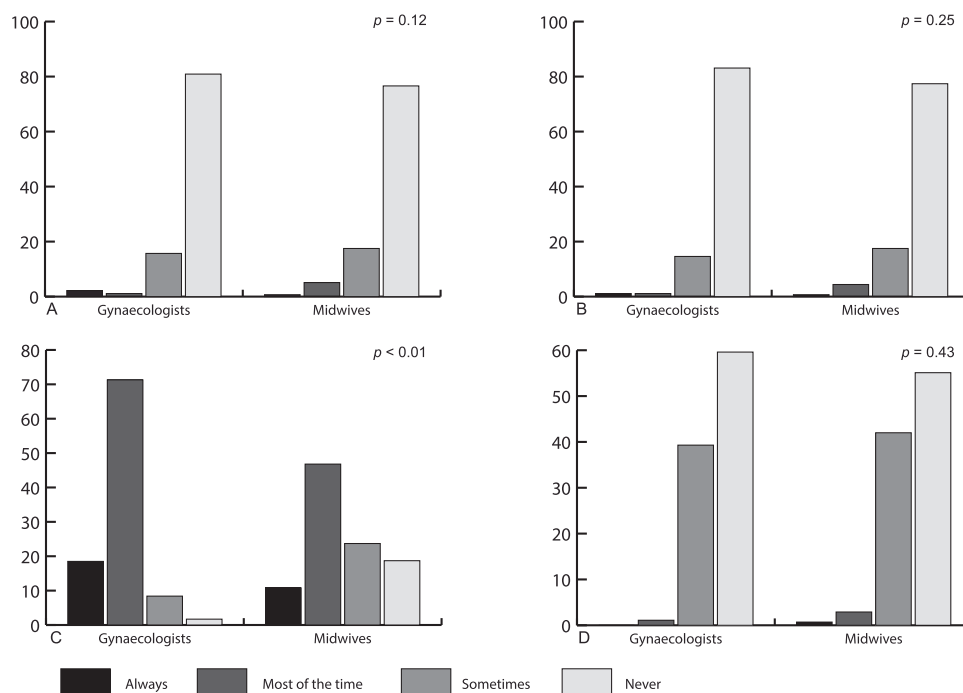


Fig. 1. Distribution in advice frequency given by caregivers pre-pregnancy and during pregnancy. A: No advice given pre-pregnancy by caregiver. B: No advice given during pregnancy by caregiver. C: Advice given to continue antidepressants during pregnancy. D: Advice given to discontinue antidepressants during pregnancy.

patterns should therefore be interpreted with caution.

Caregiver's advice can be based on the guideline, on their personal opinion or on a request from the patient. The current results show that 16.9% to 23.4% of caregivers do not always give advice to their patient with regard to antidepressive medication. This is remarkable since antidepressant use during pregnancy justifies attention and consideration of the caregiver, amongst others due to the potential risks of antidepressants on birth outcomes and the effect of untreated symptoms on the neonate. Patients should always be informed on potential harms and benefits of medication and make a decision in consultation with the caregiver.

Opinion on harmfulness of antidepressants during pregnancy, with 49.8% of respondents perceiving antidepressants as being potentially harmful, is very illustrative of current best evidence, which is still indistinct. This percentage is relatively low compared to previously reported opinions of GPs and pharmacists in the Netherlands in 2006; 96% of GPs and 65% of pharmacists believed antidepressants are associated with an increased risk of birth defects (Ververs et al., 2009). A study amongst physicians of multiple hospital specialties in Latin America showed similar outcomes as ours with 49.2% of respondents considering antidepressants potentially harmful (Cantilino et al., 2014).

Although extra, non-standard prenatal screening is not advised, 14.5% of the respondents considered antidepressant use as an indicator for extra prenatal screening, mostly additional advanced ultrasound investigation. Such methods are quite expensive, which in turn may result in unnecessary health care costs. Given the increase in antidepressant use during pregnancy, this may increase future health care costs. On the other hand, introduction of each pregnant patient in a multidisciplinary team, which is advised by the guideline, does often not take place. Multidisciplinary consultation of women can lead to more efficient prenatal care and uniform advice to patients, thereby possibly decreasing costs and increasing patient satisfaction.

Only 13.9% of caregivers reported overall guideline adherence, which seems to be lower than rates in other adherence studies among various specialty areas (Arts et al., 2016), but in line with previous guideline adherence research amongst midwives (Fleuren et al., 1997; Rousseau et al., 2016). We used multivariable regression to investigate

possible independent determinants of guideline non-adherence. Characteristics were selected based on previous research, showing positive and negative associations with knowledge of and adherence to guidelines in various specialty areas (Osborn et al., 1991; Haagen et al., 2005; Kenefick et al., 2008; Smolders et al., 2010; Mistiaen et al., 2012; McElligott et al., 2014). In our survey, professional-related characteristics and perceptions did not explain a significant part of variance in non-adherence. Other often reported barriers for guideline non-adherence, such as patient preference or professional's personal experience (Kenefick et al., 2008; Arts et al., 2016), could play a part but were not investigated in this survey.

Limitations

Despite the significant results, there were some limitations. First of all, due to our recruitment method, it was not possible to calculate valid response rates. It was not possible to send the invitation to obstetric gynaecologists only (the Dutch Federation of Obstetrics and Gynaecology responded they do not register subspecialisations) or invite all midwives personally through email. This makes generalisability of our results uncertain.

The self-reported number of pregnant patients on antidepressants was high with a mean 11.3%, as compared to the national 2–3% as reported in previous research (Ververs et al., 2006; Bakker et al., 2008). This could be an overestimation, but it is plausible that our response group actually has more experience with pregnant women using antidepressants and is therefore not representative. For example, gynaecologists who work at a specialized outpatient clinic for obstetric patients with psychiatric disease will attract more patients with antidepressants. One possible consequence is that this leads to an overestimation of familiarity with and adherence to the guideline. Another possibility is that, because of their more extensive experience, these caregivers more often deviate from the guideline. Guidelines are developed using the most recent evidence but have to be updated regularly because of fast developing new findings. Recommendations from guidelines can be outdated, which is especially recognised by professionals who encounter the specific population more often.

Conclusion

From this cross-sectional survey it can be concluded that guideline familiarity is high, but there are large differences among gynaecologists and midwives in views on managing women using antidepressants before and during pregnancy. This seems to reflect the current state of literature, which shows inconclusive results on benefits and harms of antidepressants during pregnancy. Unfortunately, this could lead to giving advice to patients that is not in line with evidence based clinical guidelines. Qualitative research could explore reasons for guideline non-adherence and stimulate further implementation in daily clinical practice of the guideline.

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Not applicable.

Conflicts of interest

We wish to confirm that there are no known conflicts of interest associated with this publication and there has been no significant

Appendix A

See [Table A1](#) here.

Table A1

Advice given to patients by gynaecologists and midwives pre-pregnancy and during pregnancy.

	Gynaecologists (N = 178) %				Midwives (N = 139) %				p
	Always	Most of the time	Sometimes	Never	Always	Most of the time	Sometimes	Never	
<i>Advice to a patient who uses antidepressants and is planning to become pregnant</i>									
Continue antidepressant	3.4	69.7	24.2	2.8	3.6	31.9	37.0	27.5	< 0.01
Discontinue antidepressant	0	4.5	65.7	29.8	0.7	6.5	40.6	52.2	< 0.01
Lower dose antidepressant	0.6	6.2	53.4	39.9	1.5	11.7	39.4	47.4	0.06
Switch to other antidepressant	1.1	1.1	75.8	21.9	0.7	7.2	52.2	39.9	< 0.01
Replace or add (psycho)therapy	2.2	3.4	60.1	34.3	5.8	10.9	53.6	29.7	0.02
Consultation with a psychiatrist	7.3	31.5	59.0	2.2	25.4	25.4	29.7	19.6	< 0.01
Consultation with a gynaecologist					12.3	15.2	29.0	43.5	n.a.
No advice	2.2	1.1	15.7	80.9	0.7	5.1	17.5	76.6	0.12
<i>Advice to a patient who uses antidepressants during pregnancy</i>									
Continue antidepressant	18.5	71.3	8.4	1.7	10.8	46.8	23.7	18.7	< 0.01
Discontinue antidepressant	0	1.1	39.3	59.6	0	2.9	42.0	55.1	0.43
Lower dose antidepressant	0.6	3.4	48.3	47.8	1.4	6.5	45.7	46.4	0.49
Switch to other antidepressant	0.6	0	62.9	36.5	0.7	2.9	60.6	35.8	0.15
Replace or add (psycho)therapy	2.2	2.8	60.1	34.8	5.8	10.1	63.0	21.0	< 0.01
Consultation with a psychiatrist	10.1	32.6	55.6	1.7	28.3	22.5	42.8	6.5	< 0.01
Consultation with a gynaecologist					25.4	24.6	36.2	13.8	n.a.
No advice	1.1	1.1	14.6	83.1	0.7	4.4	17.5	77.4	0.25

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Ethical approval

Ethical approval for this study has been granted by the local ethics committee of Utrecht University.

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Clinical trial registry and registration number

Not applicable.

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