Reviewer’s report

Title: Decision-making about antidepressant medication use in pregnancy: a comparison between women making the decision in the preconception period versus in pregnancy

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Reviewer: Byatt Nancy

Reviewer's report:

This is an important paper on an understudied area, namely the factors that influence a woman's choice to take antidepressants in pregnancy. This work is worthy of publication because, as the authors point out, preconception is the best time to make decisions about pharmacotherapy and thus anything we can do to help assist this is important work. On the whole, this is clearly and well-written manuscript that effectively demonstrates differences in decision-making patterns across the 2 participant groups.

Ultimately, many of the study limitations come from their participant sample group. To their credit, the authors did explain why some of the demographics were not as generalizable and did address many of these limitations in their discussion. However, I think it should be made more explicitly clear that future work should make great efforts to include those who do not have decision-making conflicts about taking ADPs or even have this on their radar at all, given that many have depression onset during pregnancy. These may be a markedly different group of women, particularly in the factors that influence their decision, so including them in research is an important step. Additionally, along with high SES, education, etc., this group had a mean age of over 33 years old - is this generalizable to the mean age of pregnancy in Canada? If not, it should be included/addressed in the limitations because, as your findings indicate, older women often have different approaches to pharmacotherapy in pregnancy.
In the discussion, they note that access to specialized care for each women may not be realistic. It is also important to acknowledge that this may not be a realistic for pregnant women either. The authors also mention implications for family physicians. It would also be helpful to comment on the implications for obstetric providers. The authors note that pregnant women may be more readily referred to MH treatment and have more access. Similar to the comment above it would be helpful to acknowledge that many women find it harder to access care in pregnancy and cite studies that have found this, of which there are several. Also, that psychiatric providers may d/c medications 2/2 pregnancy or in anticipation of pregnancy. In general, it would be helpful to acknowledge that referral does not necessarily translate into treatment. The authors also comment on gaps for care yet do not expand on this, expanding on this would be helpful and improve the paper. It would be helpful to expand on which types of providers should be attentive to the possibility of their reproductive aged patients becoming pregnant. The comment on collaborative care could also be better integrated and into the discussion. For example, by explaining how CC can help address preconception care. Perhaps ob/gyn, PCPs and family medicine providers could provide education at the annual visit?

Finally, I think another important discussion point that should be considered is that this study and its implications only pertain to preconception women planning to get pregnant. In the US, 50% of pregnancies are unplanned and therefore decision making preconception is moot for half the population. The authors briefly mention that the results indicate that women of child-bearing age should be talking about this with their PCPs, but this should be emphasized that this gives that recommendation even more weight.

One minor point: I think this manuscript does not need figures 1 and 2 in the main text. They are essentially presenting the same information. Perhaps choose one of them and move the other to the supplementary materials.
Are the methods appropriate and well described?
If not, please specify what is required in your comments to the authors.

Yes

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