Evidence-Based Psychiatry and Pregnancy

It's a noble goal to practice evidence-based psychiatry. The problem is that evidence-based psychiatry is only as good as the evidence. There are some areas in which we have astoundingly little evidence, and other areas in which the evidence we have too often fails to serve the patients that we need to treat. As a field, we know too little about both the impact of the disorders we treat and their treatments in pregnancy. An American Psychiatric Association workgroup previously identified the treatment of depression during pregnancy as a high-priority area and developed a model of treatment decision making that takes into account multiple variables *[Wisner KL, et al. Am J Psychiatry 2000;157:1933–1940]*. More information regarding disorders and treatments is necessary to optimize such models in clinical practice.

Optimal studies of the safety of psychotropic medications in pregnancy would include large sample sizes, as most birth defects are relatively rare, and an increased risk of a malformation with a potentially teratogenic compound may be difficult to assess with smaller numbers of exposures. Data from relatively small numbers of patients may be reassuring to clinicians and patients, but in order to provide our patients with conclusive facts, we need organized pregnancy outcome monitoring that takes into account the risks of the untreated psychiatric disorder and adequate numbers to determine safety and risks.

In this issue, Djulus et al. report on a prospective study of 104 women who used mirtazapine during pregnancy. Most (95%) had first trimester exposure, and pregnancy outcomes were compared with 2 control groups: pregnant women who used other antidepressants and pregnant women without depression who were exposed to nonteratogenic medications. In this sample, there appeared to be no increased risk of malformations over the baseline rate in the population. The rate of preterm births was higher in both the group who used mirtazapine and the control group who used other antidepressants than in the control group that did not use antidepressant medications. It is unclear if antidepressant use, depressive symptoms, the diagnosis of depression, or other factors are responsible for the higher rate of preterm deliveries among the women who used antidepressants during pregnancy. While the numbers of women in each group are relatively small to determine risks and benefits of mirtazapine in pregnancy, this study provides some information in an area where it is much needed.

In the article by Ross and McLean, the authors review anxiety disorders, which are common among women in general, during pregnancy and postpartum. The specific considerations of perinatal assessment and treatment of anxiety disorders are discussed. Although this topic is thoroughly reviewed in this article and is clinically significant, it is striking that many of the studies that the authors review involve very small numbers of subjects, therefore limiting what is known on this topic.

In the next article, Neugebauer and colleagues report on a pilot trial of interpersonal counseling for subsyndromal depression after miscarriage. As the authors discuss, pregnancy loss is common, occurring in up to 20% of recognized pregnancies. In clinical practice, there are generally no guidelines to inform the treatment of mood symptoms following pregnancy loss. This randomized pilot trial suggests a direction for future research.

Many of the common disorders we treat affect women of reproductive age and are often chronic or recurrent in course. Therefore, we need to conceptualize pregnancy

as something for which we must be prepared and that is likely to occur during the course of treatment. Each individual is different—the course and severity of her psychiatric disorder, her responses to specific treatments, and the perception and acceptance of medication safety and risk. Collaborative and flexible clinical models that are based on evidence are perhaps the ideal in evidence-based psychiatry. As borrowed from researchers in bipolar disorder, we need to offer pregnant women a "menu of reasonable choices" *[Sachs GS. Acta Psychiatr Scand 2004;110(suppl 422):7–17]* and an evidence-based guide to navigate difficult decisions and unknowns and aim to serve as consultants on the patient's decision-making team (T. Suppes, M.D., Ph.D., oral communication, resident teaching rounds, University of Arizona College of Medicine, April 2006). Sharing what we know with patients—and what we don't—is perhaps one of our greatest clinical challenges. The authors of the articles in this issue's section strive to fill in the gaps to help us in this role.

If you have any comments, questions, or suggestions about our "Focus on Women's Mental Health" section, please contact me at marlenef@email.arizona.edu.

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