The Tenets of Perinatal Psychiatry

Perinatal psychiatrists are often asked, "Is this medication safe during pregnancy and/or breastfeeding?" The answer is never simple and needs to incorporate considerations of the question, "As opposed to what?"

The great majority of women do not take the use of medications lightly during pregnancy. The underlying mood, anxiety, or other disorders for which they are treated are associated with risks and suffering that may affect pregnancy. Indeed, untreated maternal disorders represent exposures to the fetus during pregnancy and to the infant postpartum. Many women with serious psychiatric disorders cannot discontinue psychotropic medications and stay well during pregnancy.

The following are tenets of the practice of perinatal psychiatry in my experience:

1. Use of a medication should be justified on the basis of an evidence-based need for the medication or on the basis of the patient's personal history of benefit from the medication.
2. The untreated disorder, or recurrence of the disorder, must carry risk in order to justify medication exposure. The diagnosis should be clarified to delineate what the course of illness may be across pregnancy and the postpartum, what risks are involved and at what points, and which medications should be selected.
3. Nonmedication treatment options should be maximized to allow a patient to proceed though a pregnancy with the minimum number of medications and minimal doses necessary to keep her well.
4. Treatment decisions during pregnancy and lactation should be made collaboratively with the patient to honor her preferences and values, as well as manage her illness.

In this issue, the 3 articles in the Focus on Women's Mental Health section highlight these first 3 tenets. Bloch and colleagues present results from a randomized, placebo-controlled trial of sertraline added to psychotherapy for women with postpartum depression. In a study of 40 evaluable patients, the investigators did not detect a significant difference when sertraline was added to a regimen of psychodynamic psychotherapy. As the authors state, this study was limited by a small sample size. Due to the large placebo effect routinely seen in depression treatment studies, large numbers are usually needed to provide adequate power for antidepressant medication trials. Adding to the challenge in this particular study, the sertraline or placebo was added as augmentation to psychotherapy that was provided to all participants. Both sertraline and placebo groups had notable response and remission rates. The sertraline plus psychotherapy group had a demonstrated 70% response rate and a 65% remission rate compared to the placebo plus psychotherapy group, with a 55% response rate and a 50% remission rate. Although there was no control condition for the psychotherapy treatment, the response rates in both groups suggest that the psychotherapeutic intervention was beneficial to many of the patients in this study.

Psychotherapy is considered a first-line treatment for depression in pregnancy, as well as postpartum, although medication in addition may be warranted in moderate to severe cases of perinatal depression. Surprisingly, despite the public health significance of postpartum depression, there have been few controlled trials for its treatment. Bloch et al add to the small number of randomized, controlled trials in this area. However, due to limitations, this study does not provide definitive answers as to whether combination treatment with an antidepressant plus psychotherapy provides an advantage over psychotherapy alone. Larger controlled trials are necessary to determine what constitutes optimal treatment and which patient characteristics can inform us about

treatment selection as we work toward personalized medicine as a goal.

Newport and colleagues contribute 2 articles in this section. In the first study, the authors demonstrate the challenge of making the correct diagnosis in pregnant women or those planning pregnancy. It is particularly important for pregnant women and those planning pregnancy that the precise diagnosis of bipolar disorder is made, as the risk of postpartum relapse is high among women with bipolar disorder, and women with bipolar disorder represent an at-risk group for postpartum psychosis.

The investigators enlisted women with previous diagnoses of bipolar disorder and independently assessed diagnoses with a structured clinical interview and an expert clinical interview. If the structured and expert interviews were concordant, the participant was deemed as having a confirmed diagnosis of bipolar disorder. Of 199 women who reported a history of bipolar disorder, the diagnosis was confirmed in 70.9% and considered previously misdiagnosed in 11.6%. The authors note that prescreening and specialty setting could limit generalizability and also refer to other studies in which misdiagnosis of bipolar disorder has been more common. These data highlight the important decision-making process of accurate diagnosis in pregnancy and for women trying to conceive.

The mood stabilizers commonly used to treat bipolar disorder include medications with known teratogenicity (such as valproic acid, with the highest rate of birth defects reported among commonly used psychotropics, and lithium, with a present but more modest risk of teratogenicity) or unknown or incomplete reproductive safety profiles (such as atypical antipsychotics). Therefore, use of a mood stabilizer needs to be carefully justified and may be crucial for treatment in women with bipolar disorder.

Newport and colleagues also report on findings regarding pregnancy risk factors associated with maternal depression and anxiety, with the goal of teasing out differential risk factors between depression and anxiety disorders. Diagnoses were confirmed with structured interviews, and severity was quantified with rating scales for depression and anxiety. Both maternal depression and anxiety severity were correlated with tobacco use and lack of adherence to prenatal vitamins. Maternal anxiety was associated with greater use of benzodiazepines, and maternal depression was associated with greater use of antiemetics and opioids. The focus on concomitant medication use and health behaviors by the investigators constitutes a sophisticated view of mood and anxiety disorders in pregnancy. Rarely is the safety assessment of a medication in pregnancy simple. Here, the authors highlight a complex pattern of risk factors associated with maternal psychiatric disorders that are likely to impact pregnancy outcomes.

We thank the authors of this section's contributions and welcome feedback.

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