Why Getting Major Depression Right Matters—For Mothers, Babies, and All of Us

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Disinformation and Stigma: The FDA's Misguided Approach to Psychiatry on Pregnancy and SSRIs

As a reproductive psychiatrist who has dedicated her career to optimizing care for pregnant women with psychiatric conditions, I was deeply dismayed by the lack of perinatal expertise represented on the US Food and Drug Administration (FDA) "Expert Panel on SSRIs and Pregnancy," which aired July 21, 2025, on the FDA's YouTube channel. The FDA's recommendations influence clinical practice, policy, and public perception, making the inclusion of qualified experts essential. Rather than featuring specialists in perinatal mental health, the panel was dominated by individuals who have spent much of their careers questioning the validity of major depressive disorder (MDD), the use of antidepressants, and even the role of psychiatry itself.

In contrast, Kay Roussos-Ross, MD, a physician triple-boarded in obstetrics and gynecology, psychiatry, and addiction medicine, provided an excellent overview of how clinicians weigh the risks and benefits of psychiatric treatment during pregnancy. While I could focus on the misinformation presented regarding the risks of SSRI use—particularly the failure to acknowledge the substantial risks of untreated maternal psychiatric illness to both mother and fetus—the greater danger from this panel lay in the broader disinformation about psychiatric illness, its treatment, and the perpetuation of stigma through misinformed and misleading commentary.

The Importance of Defining Terms

Panelist Roger McFillin, PsyD, stated:

> Depression has devolved into an umbrella term. It doesn't even have meaning anymore… we don't have an operational definition of the construct, and it's applied to day-to-day sadness.

Dr McFillin is correct that the general public sometimes uses "depression" to mean temporary sadness caused by everyday stressors. But it is misleading to claim there is no operational definition. The field of psychiatry has the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*), which defines MDD using clear diagnostic criteria: a specified duration of symptoms, the presence of multiple concurrent symptoms, and demonstrable functional impairment. Psychiatrists are trained to distinguish between everyday sadness related to a situational stressor and potentially diagnosed as an adjustment disorder, and a major depressive episode (MDE).

The treatment approach also differs: adjustment disorders and mild MDD generally respond best to psychotherapy and supportive interventions, whereas moderate to severe MDD is ideally treated with a combination of psychotherapy and medication, and recurrent MDD may require ongoing maintenance treatment to prevent recurrence. The suggestion that psychiatrists prescribe antidepressants indiscriminately to anyone experiencing situational distress is not only false but contrary to the standard of care. Treatment decisions for psychiatric disorders are made carefully and collaboratively with patients and include considering the risks and benefits of treatment options as well as the risks of untreated psychiatric illness.

Distinguishing Disease From Life Circumstance in Psychiatric Practice

Psychiatry has a long history of differentiating psychiatric illness from difficulty adjusting to life circumstances. During my training at Johns Hopkins, I was fortunate to learn from Paul McHugh and Phillip Slavney, whose *Perspectives of Psychiatry* shaped much of my professional approach. The *Perspectives* framework organizes mental conditions into 4 categories: Disease, Dimensions (eg, personality traits), Behavior, and Life Story. MDD clearly belongs in the "Disease" category, while conditions such as loneliness, isolation, or responses to life events fit within "Life Story."

The Biopsychosocial Model further emphasizes that psychiatric illness—like medical illness—arises from a complex interplay of biological, psychological, and social factors. The *DSM* was designed to ensure diagnostic consistency so that clinicians and researchers can identify, study, and treat the same illness using

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shared definitions. While the criteria evolve and may eventually incorporate biomarkers, the foundation for diagnosing psychiatric illness is robust.

Ignoring the Biology of Major Depression

Another panelist, Josef Witt-Doerring, MD, stated:

> Mental health conditions are very different from physical problems. Physical problems usually have some basis in pathology. Loneliness, isolation, medical problems, even things as simple as career dissatisfaction, these are not things to be fixed with medical interventions.

This response repeats Dr McFillin's conflation of everyday emotions with clinically defined psychiatric illness, and it inaccurately suggests that MDD has no pathophysiology. While we do not yet fully understand the biological mechanisms underlying MDD, there is substantial and growing evidence of its neurobiological basis.

From a biological standpoint, MDD is likely heterogeneous—a group of related conditions rather than a single entity. This is reflected in the modest ~50% response rate to an initial antidepressant and the fact that roughly 30% of patients are considered treatment-resistant. Genome-wide association studies have identified many genetic variants associated with MDD, each with small effect sizes.[1] Neuroimaging studies have revealed multiple subtypes, some linked to differential treatment responses, such as to transcranial magnetic stimulation. [2]

Biological correlates of MDD include changes in inflammatory markers, dysregulation of cortisol and the hypothalamic-pituitary-adrenal (HPA) axis, and altered neural network connectivity. Much of this work is correlational, but it strongly suggests biological processes are at play. One challenge is that the onset of a MDE is difficult to predict, making it hard to measure biological changes prospectively.

Postpartum Depression: A Predictable Window into the Biology of Major Depression

One reason I focus on postpartum depression (PPD) in my research is that it offers a rare opportunity to study MDD prospectively and because one can predict with accuracy *when* an episode will occur. About 15% of pregnant women develop PPD; in those with preexisting mood disorders, the rate rises to 30%–50%. This predictability allows researchers to track biological changes before, during, and after symptom onset.

By prospectively following pregnant women into the postpartum time period and monitoring when symptom onset occurs, our work has identified:

- The first blood-based biomarker predictive of a future psychiatric illness.[3–5]
- Evidence that decreased autophagy, a cellular recycling process linked to MDD, precedes symptom onset in PPD, suggesting it may be part of the disease process.[6]
- Alterations in the neuroactive steroid system, which modulates the GABAergic system and HPA axis, influencing stress reactivity.[7]

While the full biological picture remains incomplete, these findings are significant steps toward understanding the pathophysiology of at least 1 subtype of MDD.

Why Biology Is Central to the Mental Health Conversation

Hearing an "expert" on a public panel of an esteemed federal agency, the US FDA, assert that mental health conditions lack a demonstrated pathophysiology was deeply concerning. In fact, it is at odds with the FDA's long-standing commitment to psychiatric drug development oversight within its Center for Drug Evaluation and Research (CDER). Yes, the mechanisms underlying mental health conditions are complex and not yet fully mapped, but this is no different from the early stages of research into autoimmune or rheumatologic conditions, where clinical syndromes were recognized long before their molecular pathways were fully described.

Dismissing the biology of MDD risks perpetuating the stigma that it is not a "real" medical condition. This stigma has serious consequences: a recent analysis estimated the economic cost of mental illness in the US at $282 billion annually, including both direct healthcare costs and lost productivity and reduced social interactions.[8] Stigma delays diagnosis, reduces treatment adherence, fosters isolation, and fuels discrimination. Ultimately, it deprives individuals of the opportunity for recovery and, more broadly, deprives society of their full participation.

Closing Thoughts

In closing, I urge precision when discussing treatments for mental health conditions. If referring to MDD, experts should explicitly state that they are using established diagnostic criteria. Conflating everyday sadness with MDD without clarification misleads the public, undermines trust in psychiatric care, increases human suffering, and fuels stigma.

There is a saying in psychiatry that once the neurological basis of a psychiatric condition is understood, it is reclassified as a neurological disorder—as happened with epilepsy. My hope is that continued research will illuminate the biology of psychiatric illnesses, leading to more targeted treatments, reduced stigma, and fewer opportunities for misinformation to take root.

While we must continue to address the "life story" and psychosocial dimensions of human suffering, understanding the biological foundations of psychiatric illness will strengthen our ability to treat patients

effectively—whether they are pregnant or not—and to ensure public discourse is guided by accuracy, compassion, and evidence.

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