Perinatal Psychiatry: The Challenges of Making Rational Treatment Decisions at the Interface of Psychiatry and Obstetrics

We are delighted to have a fine collection of commentaries on the topic of perinatal psychiatry in this issue of *The Journal of Clinical Psychiatry*. The psychiatric treatment of pregnant and postpartum women is relevant to most practicing mental health care providers. Any of us who treat women of reproductive age are likely to find ourselves helping women make treatment decisions during pregnancy and in the postpartum period. While perinatal psychiatry is a highly specialized area within psychiatry, it has pertinence to routine mental health care because the majority of women have children. Specifically, 82% of women in the United States have children by 44 years of age (US Census data, 2002).[1] Unplanned pregnancies are common and should be expected to occur over the course of management of any illness that requires ongoing treatment during the reproductive years.[2] Many prevalent psychiatric disorders affect women at greater rates than men, including major depressive disorder and many anxiety disorders.[3,4] Unfortunately, many psychiatrists do not feel prepared to treat women who are pregnant or breastfeeding.

Medical education and psychiatry residency training in particular do not often emphasize that pregnancy is an unpredictable but common state during which many individuals will require treatment. Unplanned pregnancies are common and should be expected to occur during ongoing work with women of reproductive potential. Likewise, the treatment of breastfeeding women is also not an adequately prominent focus of medical and psychiatric education.

Too often, a pregnancy in the context of ongoing psychiatric treatment is experienced by the patient and her health care providers as a surprising event that can derail treatment, and care is often driven by fear rather than rational decision-making using evidence-based medicine. Also, any reports of possible associations between medications and adverse pregnancy outcomes generate understandable concern. Information that is frightening is often disseminated differently than information that is reassuring. Although there have been reports about risks of untreated mental illness during pregnancy,[5,6] those about medication exposure in utero tend to garner more attention. In particular, antidepressants are among the best studied medications in pregnancy. Most studies of tricyclic antidepressants and selective serotonin reuptake inhibitors have supported the relative safety of antidepressants in pregnant women who require ongoing treatment.[6–10] Others have reported conflicting results, especially regarding risks from antidepressant exposure during later pregnancy.[11–14] Therefore, in an area of study in which the evolving literature is sometimes difficult to integrate with existing reports, staying current about information and accurately communicating information to patients is a daunting task.

Many women are anxious about accepting treatment with medication during pregnancy and breastfeeding and, despite moderate to severe depression and impaired functioning, may focus on the risks of medication exposure rather than the risks of untreated major depressive disorder. The best model for treatment during pregnancy and postpartum is that of a collaborative decision-making partnership, which includes the patient's preferences and values at the forefront, treatment options tailored to the clinical situation, maximization of nonmedication treatment options, and the rational use of medications.

Mandated screening efforts for perinatal depression are under consideration in the US Congress, and many obstetric practices and hospitals strive for universal perinatal depression screening. Importantly, pregnant and postpartum women in whom psychiatric disorders are detected need health care providers who are informed about the risks and benefits of treatments and the risks of untreated disorders during pregnancy and postpartum. Broad educational efforts are necessary to educate the public and health care providers about the treatment of perinatal depression and other psychiatric disorders across pregnancy and postpartum. Residency training and continuing medical education programs can make strides in this direction by ensuring that psychiatrists and obstetricians are prepared to discuss the various treatment options with pregnant and postpartum women and to identify sources for referral and consultation when necessary.

On behalf of *The Journal of Clinical Psychiatry*, we hope to promote a scholarly and comprehensive understanding of dilemmas at the forefront of perinatal psychiatry. We welcome your feedback on the commentaries in this issue.

Toward this end, I am excited to announce an online offering in conjunction with the commentaries. A Forum section on the *Journal* Web site will allow readers to submit comments, and from October 19–30, the commentary authors will read and respond to posted questions or comments. This format should provoke thoughtful and stimulating discussion of the topics, and I invite you to share your experiences and insights with your colleagues. Visit PSYCHIATRIST.COM to view submission guidelines, submit a comment, and see other readers' postings.

I welcome your feedback and suggestions about the Focus on Women's Mental Health section at mfreeman@psychiatrist.com.

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