

To the Editor: While risk aversion is an issue in pregnancy, we disagree with Lyerly and colleagues on the risks of antidepressants. The Food and Drug Administration's warning on paroxetine says that it causes birth defects—not that there is a risk it might. This likely holds for other SSRIs also—risks we have known about for twenty years. In addition to SSRIs doubling the risk of major congenital malformations, consistent data point to a doubling of the risk of spontaneous abortion (from 8 to 16 percent). Data also indicate increased rates of voluntary terminations; whether this stems from choices made following detection of congenital malformations or

electroconvulsive therapy or older antidepressants work. Even if the condition is left untreated, however, there is no evidence that untreated prenatal depression leads to an increase in birth defects, miscarriages, voluntary terminations, or suicide, or that it contributes significantly to postnatal depression. We agree that postnatal depression needs to be treated vigorously, but treatment is likely to be more difficult in mothers who suspect their newborn's complications stem from antidepressants. There is also no evidence that SSRIs work for severe depression. In the case of moderate depressions, an evidence-based approach to treatment would recommend against

these articles appear to have been ghost-written. Furthermore, companies have retained the services of a large portion of academia, which makes it difficult to get any other view heard. As a result, other academics, ethicists included, who don't have links to the pharmaceutical industry appeal quite responsibly to the published literature and end up arguing that depression poses significant risks, and that antidepressants carry minimal risks.

The upshot, we believe, is a case study in risk perception that illustrates points opposite to those suggested by the authors. The accumulating data on antidepressants have converted notional hazards into evidence of injuries, and antidepressant use has surged—they are now among the most commonly prescribed drugs in pregnancy. Even ethicists argue for their wider use, without asking where the literature they appeal to comes from.

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from the pervasive emotional blunting intrinsic to the action of SSRIs (which may lead to regrets when the treatment has been stopped) is unknown. The authors also downplay the evidence of neonatal withdrawal syndromes, pulmonary hypertension, premature birth, and restricted intrauterine growth (D. Healy, D. Mangin, and B. Mintzes, "The Ethics of Randomized Placebo Controlled Trials of Antidepressants with Pregnant Women," *International Journal of Risk and Safety in Medicine* 22, no. 1 [2010]: 7-16).

The authors cite rates of 13 percent for antenatal severe depression. Rates this high are for depressive symptoms, not depressive disorders. The best evidence suggests depressive disorders occur in 4 percent of women antenatally; of these, most are mild or treatable by means other than antidepressants. There are few severe depressions (melancholia), and for these, treatments such as

using drugs, as over 80 percent of the apparent response to drug treatment in trials stems from placebo factors.

When the authors cite the Cohen et al. paper—which claims that women who stop antidepressants are at higher risk of relapse than those who don't—they engage with another source of risk. The timing and rate of difficulties in this study suggest not relapses into depression, but withdrawal from SSRIs. Women are not being informed of the risks of birth defects and physical dependence or the consequent probability of trapping their child into treatment exposure. Should women be informed of these issues?

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To the Editor: American maternity care is in trouble. Soaring rates of medical interventions and increased policing of pregnant women in recent years have not improved poor maternal and newborn outcomes; instead, they have contributed to distressing experiences of pregnancy and childbirth for many mothers. In examining how we evaluate risks in pregnancy, and how we choose to intervene or not, Lyerly and colleagues are attending to an urgent question—but their analysis and proposed solution fall short.

The authors suggest that in the contemporary West, medical intervention is presumed to be the safest option at birth, while during pregnancy restriction of both medical interventions and many ordinary behaviors is considered the safest course. This birth-pregnancy distinction obfuscates more than it