no increase in visits to behavioral health clinics in the 22 weeks between Sept. 11, 2001, and Feb. 9, 2002, compared with a similar period 2 years earlier.

We explored selected health indicators on the effect of the El-Aqsa *intifada* on the residents of Jerusalem. Our city had been subjected to no less than five major terrorist events during the period October 2001 to December 2002 (the period we explored, although the *intifada* continues). One of the indicators we wish to report is the number of visits to governmental psychiatric outpatient clinics in the city. These well-staffed clinics provide free treatment and are located in different places in the city. Referrals are not required, and users could walk in according to their needs. We looked into the visits of users belonging to three age groups with regard to the following categories: 1) those who were new to the system, 2) those who returned to the clinic after at least a 5-year break, and 3) visits by patients under care.

We used time series analysis to study the data, taking into account inherent ongoing trends within the system. The results showed that there was a statistically significant increase in visits by patients who were under care, both adults and elderly, although there were no changes among the two other groups.

Our results appear to confirm both reports (1, 2). Breslau (3), among others, found that persons in psychiatric care are more vulnerable to major stressful events, such as those generated by terrorism. Ursano, quoted by Stephenson (4), alerted planners and administrators about the risk of taking away mental health personnel from the care of patients in order to address other possible terrorism-related mental health problems. In a forthcoming report, we will show the burden of care in other services of Jerusalem other than psychiatric.

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Pregnancy and Antidepressant Counseling

TO THE EDITOR: It was with great interest that we read the article by Adele C. Viguera, M.D., et al. (1) published recently. These results confirm what we have been aware of for many years: that pregnant women are not being counseled appropriately concerning drug therapy and reproductive risks.

The Motherisk Program is a counseling service for pregnant and lactating women and their health professionals, in which evidenced-based information is given on the safety/risk of drugs, chemicals, radiation, and infectious diseases to almost 40,000 callers/year. We published a study documenting the experiences of 36 women who had abruptly discontinued antidepressants or benzodiazepines upon finding out they were pregnant (2). All of the women reported discontinuation for fear of teratogenic risk, and 28 (77%) discontinued on the advice of their physicians. Despite receiving reassuring counseling that it would be appropriate to continue their medication, only 22 (61%) chose to do so (2).

To determine why these decisions were made, we are now carrying out a study to enroll women who are planning pregnancy or are in the first trimester who are taking an antidepressant. Two control groups of women have also been enrolled in the study: women taking nonpsychiatric drugs 1) on a long-term basis and 2) on a short-term basis. Our hypotheses are that there is still a stigma surrounding mental illness and that women are more cautious about taking a psychiatric drug during pregnancy. We asked the same questions of all three groups. Our preliminary results are that after all three groups had been advised that it was appropriate to continue their medication during pregnancy, 15% of the antidepressant group compared to 3.8% of the chronic medication group and 1.2% of the short-term treatment group decided to discontinue their drug. What we also found was that many factors come into play in the perception of teratogenic risk; however, in the determinants of decision making, the most important factor was the order in which the information was given to them, with the initial information having the most lasting effect (3).

We are sharing this information because we feel that it is an important area of research to ensure that women who are suffering from a mental illness are appropriately treated during pregnancy to ensure optimum conditions for both mother and child.

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Depression Treatment During Pregnancy

TO THE EDITOR: A clinical case conference by Victoria Hendrick, M.D., and Lori Altshuler, M.D. (1), addressed an urgent clinical dilemma: how to best treat depression during pregnancy. The authors correctly pointed out that clear guidelines for treating depression during pregnancy are lacking and that experts reach different conclusions about the best treatment in this situation. They provided a thorough review of treatment options, the results of published articles concerning morphological and behavioral teratogenesis, and the impact

of depression on pregnancy and infant outcomes. A notable aspect of their article was the prominent place psychotherapy holds in the presentation of treatment options.

Contemporary discussions of depression treatment commonly focus on pharmacological approaches, even when the depression occurs during pregnancy. The trend appears to be an emphasis on the dangers of untreated depression and a rush to reassure physicians about the safety of pharmacological agents during pregnancy. While initial findings offer some basis for this reassurance, much remains unknown. Data concerning long-term outcomes, particularly for behavioral teratogenicity, are lacking. The quantity and quality of research on this issue (relying upon animal models, pharmaceutical company-sponsored projects, case reports, retrospective studies, and studies lacking control groups) suggests the need for an open mind about optimal treatment during pregnancy.

Unfortunately, even when psychotherapy is identified as a treatment option, it is often referred to in a cursory fashion or in a manner that downplays positive elements and emphasizes potential—although not necessarily realistic—drawbacks. These admonitory comments about psychotherapy belie the fact that it is a validated treatment approach for depression. Cognitive behavior therapy is listed in the journal *Clinical Evidence* as an established beneficial treatment for depression (2). Likewise, APA's depression treatment guidelines cite data empirically supporting cognitive behavior therapy, interpersonal therapy, and other psychotherapies for the treatment of depression (3).

Given the empirical support for psychotherapeutic approaches for the treatment of depression and the need for more extensive and higher-quality research concerning the effects of pharmacological treatments of depression in pregnancy, it seems paramount to always include psychotherapy, particularly empirically validated approaches, as treatment options for depressed pregnant patients. The therapy used in the case conference was not such an approach but rather was described as an eclectic approach that combined psychodynamic and supportive modalities. Empirically validated psychotherapy should be the first choice of treatment for most depressed pregnant patients. When considering the use of medication, the risk/benefit discussion should include the fact that much is still not known about the long-term consequences of antidepressant medications.

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Functionalizing Diagnostics

TO THE EDITOR: In his review of my book titled *Pharmacotherapy for Mood, Anxiety, and Cognitive Disorders,* edited by U. Halbreich and S.A. Montgomery, Donald F. Klein, M.D. (1), mentions my plea to "focus on the functional impairments" in psychiatric diagnosis and calls this approach "premature" (1, p. 166). By functionalization, I mean dissection of the psychiatric syndromes diagnosed in a given patient into their component parts, i.e., the psychopathological symptoms, followed by attempts to identify the psychic dysfunctions generating the phenomena that patients experience and observers register as psychopathological symptoms (2). The focus of biological psychiatry, we maintain, should be less on disease entities or syndromes than on exploring the neurobiological underpinnings of psychic (dys)functions (3).

"Van Praag," Dr. Klein has it, "would have us give up the morass of comorbidly occurring syndromes and, in fact, the concept of disease entities to focus on the fundamental impairments that incur the psychopathological state" (1, p. 166)

This statement is only partly correct. I do see functionalization as an indispensable method for providing psychiatric diagnosis with a solid scientific bedrock. I have not suggested giving up syndromal and nosological diagnosis altogether but adding functionalization to the present diagnostic process (4).

Dr. Klein continues: "If we knew the brain functions that allow us to cogitate, emote, and behave, then Van Praag's suggestion would resonate" (1, p. 166), but at present a functional psychopathological approach seems to him premature.

I disagree with him. If we ever want to know the "brain functions that allow us to cogitate, emote, and behave," we first have to characterize the psychic dysfunctions that generate psychopathology. Systematic attempts to functionalize psychiatric diagnosing seem to me not premature but long overdue.

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The Hippocampus in Schizophrenia

TO THE EDITOR: Mary A. Walker, et al. (1) concluded that their stereological study of hippocampal volume and neuron number in schizophrenia provided evidence against a primary pathology of hippocampal structure and against the notion of schizophrenia as a limbic system disorder (2). While the stereological techniques employed allowed Ms. Walker et al. to draw strong inferences about hippocampal volume and cell number in schizophrenia, it is important to add some cautionary notes to their conclusions.

First, it is possible that subtle structural changes of the hippocampus involve primarily the anterior but not the posterior division (3). Ms. Walker et al. did not test for such a regionally selective volume difference. Furthermore, there is in-