Reflections on Perinatal Depression Treatment

Bryanne Barnett, MD, FRANZCP, and Marie-Paule Austin, MD, FRANZCP

Why is the management of prenatal and postnatal depression and anxiety so often debated in terms of decisions about medication? The implication seems to be that medication is risky whereas other treatments are not, which begs questions of efficacy, cost-effectiveness, availability, and so on.[1] As a result, the broader issue, an unwell pregnant woman, is not kept in mind. Are we trying to treat an illness, ensure adequate self-care during pregnancy, enhance the mother-infant interaction and consequent child development, improve the woman's resilience and capacity for close relationships, or all of the above? Rather than having an episode of acute illness, the woman may be suffering from a difficult psychological or social predicament, often of longstanding, now merely exacerbated by this major life event of pregnancy.

We work in a Perinatal and Infant Mental Health Service that operates on attachment principles; relationships are key. The model mixes child psychiatry with adult psychiatry, since, in Australia, child psychiatry, although it manages many personality disorders, does not tend to treat parents who are actually ill, while adult services tend to be very focused on an adult individual with an illness. There is a multidisciplinary team offering inpatient, outpatient, and day services for pregnant and postpartum women and their families. The clinic complements recent Australian early intervention initiatives requiring midwifery, general practice, and early childhood services to provide comprehensive assessment for women attending their clinics. This includes psychological and social aspects of health and universal depression screening.[2] The

model recognizes that there are distressing, anxiety-provoking, and indeed depressing aspects of many women's lives and these will not be adequately addressed through medication, and even where medication is useful, it will never be sufficient alone.

As perinatal psychiatrists, we are aware that many of the women we see worry about taking psychotropic medication but are not equally concerned about the various drugs their obstetrician has prescribed or the ones they have acquired at the natural health store. Perhaps psychiatry and therefore psychiatrists are not trusted as much as other doctors, who in turn lament that they are less trusted than complementary medicine practitioners, regardless of cost. When these observations were discussed with a group of women, the conclusion seemed to be that those practitioners treated their clients as "whole people" and took a considerable interest in them, offering lengthy consultations and ensuring ongoing engagement. Importantly, these practitioners were not viewed as unduly influenced by their suppliers. The women also suggested that doctors seem to put more faith in drugs and technology than in careful eliciting of information and their own clinical skills. If psychiatrists see and present themselves as a resource only for diagnosis of mental illness and offering management through medication, we disempower ourselves.

Mental illnesses, and therefore doctors who treat them, retain their stigma. The public does not view psychiatry the way it views other medical specialties. Is the public more or less sophisticated than the medical and other scientific professions about the connections and difference between brain and mind? Do we contribute to the problem with defensive, "rational," "evidence-based" responses that spring from the risk-averse litigation concerns of our services and insurers? Human beings are rarely rational; all decisions, beliefs, and attitudes are, at least in part, emotionally motivated. Clearly, the issues involved in pregnancy, childbirth, and depression and its management are complex. Perhaps we all need to stop and reflect more carefully on this recurrent controversy and our reaction to it. We might then be in a better position to help the women and their families.

REFERENCES

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Author affiliation: St John of God Health Care, New South Wales, Australia. ***Financial disclosure:*** None reported. ***Funding/support:*** None reported. ***Corresponding author:*** Bryanne Barnett, MD, St John of God Health Care, 177 Grose Vale Rd, North Richmond NSW 2163, Australia (bryanne@unwired.com.au).
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