

But a medicine that sees itself as, primarily, a set of technical interventions will always strive to compartmentalise and conceptualise illness in simplified causal models. This represents a challenge for all branches of medicine.

Are we wrong to distinguish psychiatry from the ‘rest of medicine’? Maybe. Bill Fulford has argued convincingly that the widely held view that bodily illness is ‘relatively transparent in meaning’ and less ‘value-laden’ than mental illness does not stand up to scrutiny.¹ For him, it is simply that the values inherent in our concepts of bodily disorder are just not as obvious as those involved in our discourse of mental illness. When the presenting problem is pain from an arthritic joint or from a myocardial infarction, there is usually agreement between the doctor, the patient and the carer about what the priorities are and what would count as recovery. However, as medical technologies (such as in reproductive healthcare) develop, more areas of disagreement emerge and ethical issues become more obvious. In the world of mental health, disagreements about values, priorities and frameworks have always been part of day-to-day work and thus value judgements more obvious.

However, although we accept this analysis, we are not entirely satisfied that this is the full story. When we put the adjective ‘mental’ in front of the word ‘illness’, we do seem to be delineating a particular territory of human suffering. This cannot be clearly defined and seems to resist easy categorisation. But the word ‘mental’ implies that this is suffering that emerges from the mind, and whatever the ‘mind’ is, it is not simply another organ of the body. In this way, there does seem to be some sort of epistemological difference between psychiatry and other branches of medicine such as cardiology, endocrinology or neurology. Problems with our thoughts, feelings, behaviours and relationships would seem to be more intimately entwined with questions of meaning and context than problems arising from lesions in specific organs of the body.

Whatever we make of the relationship between bodily and mental illness, psychiatry grapples daily with epistemological and ontological issues and has a long history of doing so. A psychiatry that is able to ‘move beyond the current paradigm’ might be one that can offer insights and leadership to other parts of medicine.

1 Fulford KWM. *Moral Theory and Medical Practice*. Cambridge University Press, 1989.

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Low Apgar scores in neonates with prenatal antidepressant exposure

We read with interest the very important and thought-provoking study by Jensen *et al.*¹ The authors have found an increased rate of low Apgar scores in neonates with prenatal antidepressant exposure, especially with selective serotonin reuptake inhibitors (SSRIs).¹ However, the use of other antidepressants (new or old) and a diagnosis of maternal depression were not associated with low Apgar scores.¹ The study has several merits: nationwide data, large sample size, meticulous record keeping, sound methodology, appropriate use of statistics, controlling confounders to a large extent and, most importantly, having been conducted in a clinically relevant area, where data were limited and there were more questions than answers.

However, there are certain issues with the study. First, the authors have not mentioned which of the SSRIs was implicated in having the greatest or least effect on lowering Apgar score. Second, the dose and duration of antidepressant use were not mentioned and adherence to antidepressants was also not assessed. Third, antidepressant data were collected from psychiatric centres only, perhaps because the authors did not have access to data from general practitioners, which further limits the generalisability of the study findings. Fourth, the authors have not mentioned and not controlled for important confounders such as the presence of a physical disorder in the mother, obstetric complications and nutritional status of mothers, which may also contribute to a low Apgar score. Fifth, there is a possible mistake in tabulating the gestational age of all pregnancies, as the interquartile range is stated as 39–39 weeks (see Table 1). Finally, the authors have themselves mentioned about the significant differences in the antidepressant prescription trends. During the study period, use of antidepressants was very limited in pregnant women, but recently antidepressant use has increased substantially, especially that of SSRIs. This may be an important reason for getting high odds ratios for low Apgar scores with the use of an SSRI. Earlier studies have also reported low Apgar scores with maternal SSRI use.^{2,3} Exposure to SSRIs at an early age can disrupt the normal maturation of the serotonin system and alter serotonin-dependent neuronal processes in the fetus³ and these effects are partly moderated by infant SLC6A4 genotype.⁴

Today, authors have advised caution and proper monitoring of infants with prenatal antidepressant exposure. This study will definitely provide impetus for future research in this area, and with more robust data, it may also act as a starting point for the modification of existing treatment guidelines.

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