

Peer-Led Psychotherapy: The Time Is Now

To the Editor: We read O’Hara’s¹ commentary on the recent article by Amani et al² with interest and agree with the author’s review outlining the effectiveness of peer-delivered psychotherapy. However, we challenge the conclusion by Dr O’Hara that it is “not yet” time for peer-delivered psychotherapy for postpartum depression.

Safe interaction with the health care system is a privilege that numerous people do not receive. There are accessibility barriers to perinatal mental health care, which are exacerbated among many equity-deserving communities.³ For many individuals from marginalized groups, seeking mental health care has led to more harm than benefit (for example, infant/child apprehension).⁴ For people who have a deep distrust of health systems, due to historical and ongoing trauma, peer support may be the safest and most culturally appropriate way to receive evidence-based services. We strongly disagree with O’Hara’s “not yet” conclusion and instead advocate that the time is now to face the growing treatment gap for perinatal populations.

Dr O’Hara asks, “But do women really want minimally trained former sufferers delivering psychotherapy—is it ethical? Is it sustainable?” We respond by asking, “Is it ethical to deny perinatal women effective interventions?” There will never be enough specialist providers to address the treatment gap for perinatal depression, and, as O’Hara points out, there is evidence worldwide in support of peer-delivered psychotherapy.^{5,6} As clinicians and researchers, it is our ethical and moral responsibility to provide perinatal women with effective interventions, and peer-delivered psychotherapy offers one patient-centered and cost-effective solution. In our patient-oriented research, participants with perinatal depression have indicated overwhelming support for this modality of therapy (Singla et al⁷ and K. Chaput, PhD; M. Vekved, BSc; S. McDonald, PhD, et al, manuscript submitted).

Further, because mental health clinicians and researchers are often in places of privilege, we should endeavor to collaborate with women with lived experience and their communities to ensure that their voices are the primary drivers of new directions in evidence-based practice.⁸ With burgeoning health care costs and rates of mental health problems, is keeping evidence-based intervention in the hands of doctoral-level psychologists sustainable when much lesser trained individuals can deliver them with therapeutic impact? Acting as a peer could be protective with respect to both clients’ and peers’ well-being and a form of empowerment,⁹ making such a model particularly sustainable.

Second, O’Hara asks, “It is the case that there is a significant shortage of trained mental health professionals. But should peers be the ones to fill the gap?” Sustainable models of peer-led supervision among multiple cadres of nonspecialist providers have been shown to be acceptable and feasible in low-resource settings.^{5,7} We believe that peers should be paid for their work, in the same way that any other health care provider is compensated, and that peer support can be embedded into systems of support that can help to manage and mitigate crises as they arise. Rather than questioning the growing evidence of whether peers can deliver psychotherapy, the key question is how to overcome professional guilds and build a collaborative, stepped-care system that incorporates these patient-centered models.

We acknowledge that the authorship team and our views are influenced by a feminist lens and expertise in perinatal mental health and peer support, grounded in lived experience, and guided by a deep respect for social justice and Indigenous ways of knowing.

We ask for trust that these peer workers are quite capable and deserving of making the best “use of [their] talents,” to paraphrase O’Hara. People suffering from depression deserve the choice of available good medicines.

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Peer-Delivered Psychotherapy for Postpartum Depression: Has Its Time Come? Not Yet—Reply to Tomfohr-Madsen et al

To the Editor: Tomfohr-Madsen and colleagues¹ provide a spirited defense of peer-led psychotherapy in their response to my recent commentary² in this journal regarding the Amani et al³ report. Their response is centered on a deep distrust of the current mental health system, one in which they play an integral role. It is fair to say that there are inadequacies in the mental health systems of developed countries and that new approaches are needed to overcome barriers that many pregnant and postpartum women face in accessing care. As I made clear in my commentary, I see an important role for peers (women who have experienced perinatal depression or anxiety) in providing support to depressed pregnant and postpartum women. My main point of dispute is whether there is enough evidence to begin a systematic process of training former sufferers as the principal mental health providers for women suffering from perinatal depression and anxiety.

The recent review by Singla et al⁴ of the effectiveness of nonspecialist-delivered interventions for perinatal mental health in high-income countries included 15 trials of counseling interventions for treatment of depression, only 1 of which included peers who had experienced a perinatal depression as treatment providers. The rest of the trials used nurses, midwives, health visitors, and in one case women from the community as treatment providers. In sum, even Singla and colleagues' very strong review of the literature on the care of postpartum depression by nonspecialists suggests that there is evidence of treatment efficacy for health workers who are trained

to deliver brief mental health interventions but very little evidence for peers who have suffered from perinatal depression. In closing, I want to reiterate my commitment to the care of women suffering from perinatal depression, a commitment that spans over 40 years.

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