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Research paper

Brief Interpersonal Psychotherapy for depression during pregnancy in a low-income population: A randomized controlled trial

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ABSTRACT

Background: Depression is common in low-income pregnant women, and treatments need to be fitted to meet their needs. We conducted a randomized controlled trial comparing brief Interpersonal Psychotherapy (brief-IPT) to enhanced treatment as usual (ETAU) for perinatal depression in low-income women. The brief-IPT model is designed to better engage low-income women by utilizing an engagement session, providing flexible delivery of sessions, and pragmatic case management.

Methods: Pregnant women, aged ≥18, between 12 and 30 weeks gestation were recruited from an urban prenatal clinic. Women scoring ≥10 on the Edinburgh Depression Scale and meeting depressive disorder criteria were randomized to either brief-IPT (n=21) or ETAU (n=21). We assessed treatment outcomes, acceptability, and feasibility of the intervention (measured by session attendance).

Results: Depression scores significantly decreased in both brief-IPT and ETAU. Brief-IPT participants reported significant improvements in social support satisfaction as compared to ETAU participants, even after controlling for concurrent depressive symptoms. Brief-IPT participants reported high satisfaction with the program. However, many participants did not participate in the full 9-session course of treatment (average sessions attended =6, range 0–17).

Limitations: Small sample size, use of self-report measures, and lack of an active psychotherapy control group limits interpretation of study results.

Conclusions: Brief-IPT for perinatal depression is acceptable to low-income women and is helpful for improving depressive symptoms and social support. However, feasibility of the treatment was limited by relatively low session attendance in spite of efforts to maximize treatment engagement. Additional modifications to meet the needs of low-income women are discussed.

1. Introduction

Perinatal depression (depression occurring during pregnancy or postpartum time period) is a major public health problem. Depression during pregnancy has particularly deleterious effects on both the mother's pregnancy and her infant's social and emotional development (Moore, Cohn, and Campbell, 2001; Murray and Cooper, 1997). A significant proportion of women who are depressed antenatally remain depressed postpartum (O'Hara and Swain, 1996); thus, early intervention is imperative for the health and well-being of mothers and their babies.

Low income and minority women report high levels of depressive symptoms during pregnancy and postpartum; ranging from 25% meeting psychiatric diagnostic criteria to 47% reporting clinically elevated symptoms on self-report screening measures (for review see Bennett et al., 2004). Yet many pregnant women experiencing significant depressive symptoms go unrecognized and undiagnosed (Cox et al., 2016; Ko et al., 2012). Even when symptoms are recognized, community rates of treatment for perinatal depression are very low: it is estimated that fewer than 20% who receive a referral for depression treatment follow through with an appointment (Flynn et al., 2006; Ko et al., 2012; Munk-Olsen et al., 2016; Vesga-López O et al., 2008).

Recent studies have attempted to identify potential reasons for low-uptake of mental health treatment among women with low-incomes. Sleath et al. (2005), found an overwhelming preference among African American pregnant women as compared to Whites to "wait to get over it naturally". Similarly, another study interviewing African American women in OBGyn clinics identified a perceived threat of a therapeutic relationship including worry that the therapist will not understand or will judge, as well as worry about abandonment from the therapist (Poleshuck et al., 2013). Women also reported doubt that therapy could help them, difficulty with trusting others, decreased motivation to

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engage in activity, a strong urge to be left alone, and an overall ambivalence towards depression treatment (Poleshuck et al., 2013). In addition to practical barriers such as child care, transportation, and inflexible scheduling; a review by Levy and O'Hara (2010) highlighted additional challenges common to both poverty and perinatal depression. For example, domestic violence, childhood abuse history, and single parenthood may all contribute to low uptake of depression treatment (Levy and O'Hara, 2010). Effective interventions that are acceptable and accessible for low-income pregnant women are needed. Potential modifications that may improve treatment uptake include: constant outreach, pre-treatment education and engagement, simultaneously addressing barriers in multiple domains (practical, psychological, and cultural), and closer collaboration with trusted health providers (Levy and O'Hara, 2010; Miranda et al., 2003b; Poleshuck et al., 2013).

Although depression during pregnancy is common, few randomized trials have investigated the efficacy of psychotherapeutic treatment of depression during pregnancy (Dennis et al., 2007). Early studies reported significant difficulties enrolling and retaining pregnant or postpartum women in Cognitive Behavioral Therapy (CBT) (Carter et al., 2005; McKee et al., 2006). As a result, recent studies have modified CBT to improve feasibility and acceptability among pregnant women (McGregor et al., 2014; Milgrom et al., 2015; O'Mahen et al., 2013). For example, O'Mahen and colleagues (2013) utilized an engagement interview followed by modular sessions delivered in a flexible format (home or clinic) with an "active outreach strategy" to retain participants. Milgrom and colleagues (2015) modified their CBT based intervention for pregnancy by changing from 12 group sessions to 8 individual sessions. Both studies showed promise in increasing engagement and retention into psychotherapy and in effectively reducing depressive symptoms.

Interpersonal Psychotherapy (IPT), another evidence-based intervention for depression, focuses on issues commonly associated with perinatal depression like lack of social support and stressful life events. Spinelli and colleagues examined the efficacy of 12-session IPT with pregnant women with diverse racial and socioeconomic backgrounds and found significant improvement in depressive symptoms especially in women with moderate to severe depression (Spinelli et al., 2016; Spinelli and Endicott, 2003). However, 30% of women randomized to IPT dropped out of the study despite reimbursement for child care and transportation costs. Reasons for attrition included childcare and employment demands, unstable housing and support systems, pregnancy complications such a physical ailments and bed rest, and disconnected phone numbers (Spinelli and Edicott, 2003). Noting the substantial barriers to care faced by low-income populations as described by Spinelli and Endicott, 2003 and others, Grote and colleagues subsequently modified a brief version of IPT designed to improve feasibility in low-income women by including an engagement interview (addressing psychological and cultural barriers to care), 8 prenatal IPT sessions, and case management (i.e., bus passes, child care, baby supplies) (Grote et al., 2004). Brief-IPT participants were more likely to show improvements in depressive symptoms and social functioning than women in usual care (Grote et al., 2009). Fewer than 10% dropped out of the study and 68% attended greater than 7 IPT sessions (considered a full dose). These findings suggest that IPT is an effective intervention for depression during pregnancy and with modification, feasible in low-income populations.

Though some progress has been made, engaging and retaining low-income and minority women in psychotherapy remains a significant challenge. Designed as a pilot study to test feasibility of conducting larger clinical trial, we aimed to replicate Grote et al. (2009) brief-IPT model using similar modifications to engage low-income women into treatment. The current report presents acceptability, feasibility, and clinical outcomes data from a randomized controlled trial comparing brief-IPT to Enhanced Treatment as Usual (ETAU) during pregnancy. This study, to our knowledge, is the first independent replication of the brief-IPT model (as reported by Grote et al., 2004, 2009) with a low-income perinatal population.

2. Methods

2.1. Procedures

Study procedures were in compliance with the Declaration of Helsinki and were approved by the Washington University Institutional Review Board. Participants provided written informed consent prior to participation. Pregnant women, ages 18 and older, between 12 and 30 weeks gestation with singleton pregnancies were recruited from an urban prenatal clinic by flyers posted in the OB-Gyn clinic, OB-Gyn clinic staff referral, and referrals from community social service agencies. Research staff administered the Edinburgh Depression Scale (EDS; Cox et al., 1987) in person or by phone to determine initial eligibility. The Structured Clinical Interview for DSM-IV (SCID; First et al., 1995) was used to establish diagnostic criteria. Women with EDS scores ≥10 and current Major Depression, Dysthymia, or Depression NOS were eligible. Participants with psychotic disorders, current substance abuse, or medically high-risk pregnancies were excluded. Eligible participants were randomized by a statistician using a computer generated block permuted design to either brief-IPT (n=21) or ETAU (n=21). The PI and study staff were blinded to the randomization grid and assignments were stored in opaque, sealed envelopes and opened by the participant once a determination of inclusion and exclusion criteria were met. Fig. 1 illustrates screening, enrollment, and retention in the study.

2.2. Interventions

As previously reported in Lenze et al. (2015), participants randomized to brief IPT participated in an ethnographic engagement session followed by 8 individual IPT sessions as described by Grote and colleagues (Grote et al., 2004). Maintenance treatment sessions were conducted with participant who completed all 9 sessions prior to delivery of her baby. Sessions took place in the research clinic, participant homes, or other community locations as desired by the participant. Bus tickets were provided for those who wanted to meet in the clinic and therapy times were flexible to accommodate participant needs. Activities were available for older children who accompanied their mothers to appointments. Reminder calls, follow up to missed appointments, and check in calls when the participant was experiencing increased stress were an important part of the therapeutic relationship and allowed the therapist to remain in contact between therapy sessions. Participants were given diapers for their baby at each therapy session. Therapists included the PI (a clinical psychologist with 15 years of experience conducting and supervising IPT) and two master's level clinicians. The clinicians participated in structured didactics and readings directed by the PI and received individual supervision using video recordings on a complete brief-IPT case prior to the study. All brief-IPT sessions were video recorded for use in supervision. Throughout the study, both individual and weekly small group supervision (consisting of the PI, the clinician, and a child psychiatrist consulting on the study) meetings were held to discuss cases and ensure fidelity to the model. The PI utilized the Interpersonal Psychotherapy Adherence and Quality Scale (Stuart, 2011) to assess fidelity to the IPT model and to guide individual and group supervision discussions..

Participants assigned to ETAU were referred to community resources (including specialty mental health). Additionally, brief case management, diapers and other baby supplies were provided. Telephone assessments were conducted every 2 weeks to assess depressive and anxiety symptoms and encourage or facilitate depression treatment. Based on participant responses to the scales, the caller would ask follow up questions and encourage the participant to either