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Psychological treatments for perinatal depression

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Perinatal depression is prevalent and greatly affects the mother and infant. Fortunately, empirically validated psychological treatments are available for postpartum depression and depression during pregnancy. Primary among these are interpersonal psychotherapy and cognitive–behavioural therapy, which have been shown to be effective for perinatal women across the spectrum from mild to severe depression. At present, interpersonal psychotherapy is better validated than antidepressant medication for perinatal depression, and should be considered as a first-line treatment option, especially for pregnant and breast-feeding women who are depressed. More studies are needed to evaluate further the relative efficacy of psychotherapy and medication, and more thoroughly test other psychological treatments.

Introduction

Psychiatric disorders during the perinatal period greatly affect mothers and children [1,2]. Untreated depression has been associated with preterm birth, low-birth weight [3], dysfunctional parent–child interactions, inconsistent safety practices [4], and deficits in social and cognitive skills in children [5].

Estimated rates of antenatal major depression range between 8.5 and 11.0%, and postpartum rates are between 6.5 and 12.9% [6]. Perinatal depression is associated with demographic factors, such as low income and unemployment, but is also dramatically affected by levels of social and partner support [7].

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Consequently, these social factors have frequently been targeted with psychosocial treatments, such as interpersonal psychotherapy (IPT) [8], which are designed to address these and other common perinatal issues.

The use of psychotherapy during the puerperium is empirically supported. More data support the efficacy of psychotherapy than medication in the puerperium [9]. Additionally, the use of psychotherapy is safe compared with malformations or prematurity. Of greatest importance when considering safety, however, is treating perinatal depression. Although this can be optimally treated without drugs, the priority is the treatment of depression to remission [10]. Moreover, psychotherapy is frequently viewied as first-choice treatment by perinatal women, in part reflecting their perceptions of the risk of medication during pregnancy and breast feeding [11].

Psychological treatments for perinatal depression

A recent meta-analysis showed that psychological interventions for depression achieve higher effect sizes if they are adapted for used with specific populations [12]. A number of trials have shown psychological treatments to be efficacious for perinatal depression; however, to date, only manual-based, professionally delivered psychotherapies have been well validated [13,14].

Four major meta-analyses have examined psychological treatments for use with perinatal depression. Sockol et al. [15] included pregnant and postpartum women. Data were analysed from 27 studies (nine open trials, two quasi-randomised and 16 randomised-controlled trials); both pharmacological and psychological interventions were represented. Across all studies, post-treatment levels of depressive symptoms were significantly reduced (overall effect size 0.65). Individual therapy was significantly more efficacious than group therapy, and among all therapies, cognitive–behaviour therapy (CBT) and IPT had the greatest effect sizes compared with control conditions, with a slight but statistically insignificant advantage for IPT. Despite the large number of data points, head-to-head comparisons were insufficient to separate the relative effects of psychotherapy and medication reliably.

The only other meta-analysis that included antepartum and postpartum women was conducted by Bledsoe and Grote [16] They showed that psychotherapy, particularly CBT (group and individual) and IPT (alone or in combination with medications), was effective in reducing depressive symptoms. Higher effect sizes were achieved for the treatment of postpartum depression compared with antepartum depression. Their meta-analysis did not compare the effects of treatments to control conditions.

Dennis and Hodnett [14] included 10 trials that compared psychological or psychosocial interventions for postpartum depression to treatment-as-usual controls. Professionally conducted psychotherapy and community-based psychosocial interventions both achieved 30% greater reduction in depression symptoms than treatment-as-usual. The authors reported that most of the studies were limited by relatively small sample sizes and lack of methodological rigor.

Cuijpers et al. [17] conducted a meta-analysis of 17 psychological treatment trials for postpartum depression. Compared with control conditions, psychological treatments led to moderate improvement (effect size 0.61). Those trials which compared psychosocial interventions with wait-list control groups had higher effect sizes than those which were compared with treatment-as-usual (effect size 0.96 *v* 0.41). Only small differences between the effect sizes for different psychotherapy modalities were found, suggesting that common non-specific factors may mediate improvement for all psychosocial interventions for postpartum depression. The investigators were unable to draw conclusions about the long-term effects of psychotherapy owing to the lack of data beyond 6–12 months postpartum. This limitation was also noted by Sockol et al. [15].

Many of the studies in the meta-analyses have significant limitations. For example, only about one-half required women to meet diagnostic criteria for major or minor depression. Subject inclusion criteria in many were based solely on Edinburgh Postnatal Depression Scale (EPDS) scores above cut-offs ranging from 9 to 12. Many were also limited because they had small sample sizes and were underpowered.

Four studies stand out for their methodologic rigor, including large samples, use of DSM criteria for major depression for study entry, and longer-term follow up [18–21]. O'Hara et al. [21] randomised 120 women to either 12 sessions of IPT or to a waiting list control condition (WLC) over 12 weeks. Participants who had completed IPT ($n = 48$) had significant reductions in depressive symptoms, higher