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Psychosocial interventions for the treatment of perinatal depression

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Epidemiological investigations and meta-analyses of predictive studies have consistently demonstrated the importance of psychosocial variables as postpartum depression risk factors. To address this, several psychosocial treatment strategies have been evaluated for the treatment of postpartum depression. The purpose of this paper is to determine the current state of scientific knowledge related to the treatment of postpartum depression from a psychosocial perspective. Thirteen trials were included in the review that evaluated the following interventions: peer support, partner support, non-directive counselling, home visits by mental health nurses, and collaborative models of care. Owing to methodological limitations of the included trials, the effectiveness of most psychosocial approaches for the treatment of postpartum depression is equivocal. Large, multisite randomised-controlled trials are needed to compare different treatment approaches, examine the effectiveness of individual treatment components, and determine which treatments are most useful for women with different risk factors or clinical presentations of postpartum depression.

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Introduction

The cause of postpartum depression is multifactorial [1,2]; however, meta-analytic findings consistently highlight the importance of psychosocial variables, such as the lack of social support, marital conflict, and stressful life events. Analyses of social support variables in predictive studies clearly show a significant increase in the risk of postpartum depression in women who (1) do not have someone to talk openly with who has shared and understood a similar problem [3]; (2) lack an intimate confidant or friend [3–6]; (3) do not receive support without having to ask for it [3]; and (4) feel socially isolated [7]. In addition, women who report marital difficulties have been found to be at risk of developing postpartum depression [2,8]. Depressed mothers are more likely to be dissatisfied with the support received from their partners [9], feel communication is poor [4], perceive their partner as uncaring [10], report a decline in the affection and cohesion in their relationship [11], and find a discrepancy between their expectations and later experiences of closeness to their partner [12–14]. Higher levels of postpartum depressive symptomatology have been linked to perceived stress during pregnancy [15,16], childcare stressors [17–19], and the number of stressful life events since delivery [17,20]. To address this issue, a variety of psychosocial interventions with the aim of enhancing the availability or perception of support have been developed to treat postpartum depression [21]. The purpose of this paper is to determine the current state of scientific knowledge related to the treatment of postpartum depression from a psychosocial perspective.

Theoretical underpinnings of psychosocial interventions

Social relationships and social support can affect mental health through several pathways. Members of a social network can exert a salutary influence on mental health by role modelling health-relevant behaviours [22]. Integration in a social network might also directly produce positive psychological states, including sense of purpose, belonging, and recognition of self-worth [23]. These positive states, in turn, might benefit mental health because of an increased motivation for self-care, as well as the modulation of the neuroendocrine response to stress [23]. Being part of a social network enhances the likelihood of accessing various forms of social support, which in turn protects against distress [24]. Social support may also act on several different points in the pathway between stressful life events and mental health. The perceived availability of social support in the face of a stressful event may lead to a more benign appraisal of the situation, thereby preventing a cascade of ensuing negative emotional and behavioural responses [25]. Perceived or received support may either reduce the negative emotional reaction to a stressful event or dampen the physiologic, behavioural response to stress, or both [26]. These findings are consistent with Thoits's [27] theoretical model of the mechanisms through which social ties affect physical and psychological wellbeing. According to Thoits, seven different psychosocial mechanisms link aspects of social relationships to physical and emotional well-being. The theorised seven mechanisms are as follows: social influence and social comparison; social control; role-based purpose and meaning (mattering); self-esteem; sense of control; belonging and companionship; and perceived support availability.

Thoits [27] suggests that the effectiveness of social support as a stress buffer requires actually received or enacted support, and is based on specific combinations of source and type of support. Primary group members are individuals who have not had past personal experience with the health problem or stressor that the distressed person is currently facing (experientially dissimilar), and secondary group members are individuals who have experienced or are experiencing a similar stressor (experientially similar). Thoits hypothesises that emotional support (e.g. love, caring, and sympathy) and instrumental support are likely to be the most effective stress buffers when coming from significant others, whereas informational and appraisal support (e.g. validation of feelings, advice, and role modelling) are most helpful coming from similar others. The provision of emotional support is likely to be more effective coming from significant others given such group members' lives are also disrupted by the stressor, and their attempts at providing informational support may be ineffective, as they are less likely to have direct experience. In comparison, secondary group members or similar others may be better sources of informational support, and they may be better able to provide empathy, role modelling, and coping assistance given their past or current experience.