Review Article

# Psychological interventions in post-partum depression: A critical analysis

Rachel Buhagiar

**Abstract**

Non-pharmacological interventions are often the preferred treatment modalities in perinatal mothers suffering from mental health problems. Cognitive-behavioural therapy (CBT) and inter-personal therapy (IPT) are the two main evidence-based psychological treatment interventions in the management of post-partum depression. Various studies have been conducted-to-date to assess the efficacy and effectiveness of both CBT and IPT in this specialised group, yet there is no data contrasting the two. This report aims to provide a comparative critical evaluation of the evidence base for the two interventions, including their respective strengths and limitations. Research possibly indicates a stronger evidence base for IPT in the treatment of depression post-delivery, perhaps as a result of larger scale studies having been performed for this treatment modality. Nonetheless, valuable positive outcomes for CBT-treated individuals have been observed. Consequently, a number of recommendations for future research will be put forward with the main objective of advancing the literature in this area of expertise.

**Rachel Buhagiar** MD (Melit.) CCT (Melit.) MRCPsych (UK) Dip Perinatal & Infant Mental Health (Aust.)
Mount Carmel Hospital
Attard, Malta
rachel.vella-critien@gov.mt

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## Introduction

During the perinatal period, mothers tend to show preference for non-pharmacological interventions, viewing them as "first-choice treatment".[1-3] This report focuses on the role of two evidence-based psychological interventions, cognitive behavioural therapy (CBT) and inter-personal therapy (IPT) in the management of postnatal depression (PND). Whilst research evidence pertaining to the efficacy and effectiveness of these treatment modalities in perinatal mothers is extensive, caveats can still be identified. A comparative critical evaluation of the literature data related to these two interventions will be provided.

## Body

CBT, originally known as cognitive therapy, is based on the principle that "cognition, the way in which people think about their life circumstances" influences their emotional state and behavioural mechanisms. In contrast, IPT is based on psychodynamic theory and "guided by attachment and interpersonal theories", whereby interpersonal relationships are believed to play a crucial role in the formation and maintenance of emotional distress.[4] Indeed, it focuses mainly on current interpersonal distress in three main areas of life, namely role transitions, role disputes and unresolved grief.[1] Scholars reasoned that face validity for use of IPT in the treatment of perinatal distress would be particularly strong because transition to parenthood might result in transition of other important roles causing conflict and challenges within significant interpersonal relationships.[1,4] Stuart[5] states that the most pronounced disruptions are those with the woman's spouse or significant other. Some of the main goals

of IPT include increasing the woman's self-awareness about these problems, teaching her to minimise her "excessive expectations and overcome maladaptive communication styles".[6]

In contrast to this, through its educative nature, CBT coaches clients to develop "tangible tools and strategies" to address their emotional distress and life challenges in the here-and-now.[1] The client's active participation in completing homework assignments outside the therapy room is thus essential. Indeed, this may be one limiting factor as mothers suffering from perinatal distress might feel de-motivated and yearn for a passive role in simply following their therapist's role. On the other hand, the adoption of an active approach enables clients to become their own personal therapists, especially when faced with future adversities, and to maximise the use of their strengths. As highlighted by Wenzel and Kleiman[1], CBT therapists "must be creative in devising ways to generalise the work done in session to the lives of new mothers". Both CBT and IPT are time-sensitive form of therapies and can be conducted within a few weeks.[7-8] This is advantageous given that perinatal mothers need to juggle several other responsibilities and commitments.[1]

Wenzel and Kleiman[2] describe evidence-based practice as a "three-legged stool" consisting of research evidence, clinical expertise and the clients' preferences and values. Indeed, research evidence is a key component in a professional's decision-making process. Multiple studies have been conducted to-date to assess the efficacy of psychological treatments in treating perinatal depression. CBT and IPT have been shown to have a greater effect size compared to control conditions in the management of PND.[3] Overall, there seems to be more evidence pointing towards IPT being a "highly efficacious form of psychotherapy for postpartum depression"[1,4] compared to CBT, for which "mixed evidence" exists.[1] Indeed, a meta-analysis by Sockol, Epperson and Barber[9] identified a greater effect size for psychotherapeutic interventions which utilise interpersonal methods as opposed to cognitive strategies. Also, efficacy of IPT has been established relative to a credible control condition by at least two independent research groups.[2] Furthermore, as shown in a meta-analysis by Cuijpers, Brannmark and van Straten in 2008,[2] there is less conclusive evidence for CBT in perinatal depression compared to the general adult population. However, according to Wenzel and Kleiman[2], there is nothing to suggest that CBT cannot be adapted and generalised to perinatal mothers. In addition, there appears to be a paucity of therapists in the community who have been adequately "trained and achieved competency" to deliver IPT.[2]

In a systematic review by Miniati et al.[10] which included eleven clinical trials conducted between 1995 and 2003, the efficacy of IPT in treating PND was assessed. Results demonstrated significant improvement in post-partum depressive symptomatology and complete recovery in most treated clients. Similar outcomes were observed in a meta-analysis by Sockol et al.[4] whereby IPT was shown to be superior to other comparison conditions. In addition, anxiety was also reduced in non-psychotic unipolar depressed mothers. Previously conducted meta-analysis failed to capture possible accompanying anxiety symptoms due to lack of appropriate symptom measures.[4] Indeed, assessing for primary or comorbid anxiety is important to better characterise the true extent of the mother's symptoms. Another key finding included "improvements in relationship quality, social adjustment, and social support" among depressed perinatal women treated with IPT. Nonetheless, although the latter results look promising, few randomised controlled trials (RCTs) have been conducted-to-date to assess interpersonal outcomes.

In another study, O'Hara, Stuart, Gorman and Wenzel[11] examined the efficacy of IPT in a community sample of women with postpartum depression, comparing it to a wait list control conditions. This RCT stands out particularly for its methodological rigour.[3] Results demonstrated a significant greater reduction in depressive symptoms with improved social functioning and partner relationship in the IPT treated group. However, Cuijpers et al.[3] state that comparison of an active treatment with wait-list control conditions as opposed to treatment as usual control, will result in greater effect size. One identified strength included the extensive training and supervision provided to therapists, and their adherence to standardised manuals.[11] In fact, use of manualised therapy was found to have a greater effect as opposed to non-specific therapy.[3] Despite the existence of treatment manuals specific to perinatal women[4], use and/or compliance to them varies

across studies, potentially impacting on treatment outcomes. Thus, the term "interpersonal psychotherapy" may characterise a wide array of interventional methods across different studies.[4]

As yet, "no comprehensive large-scale study, like that of O'Hara et al.,[11] has been conducted to evaluate the efficacy of CBT for postpartum depression using highly trained clinicians.[1] However, in a systematic review by Sockol[12] which included twenty-six randomised and quasi-randomised controlled trials, a significant reduction in depressive symptomatology was observed for the CBT-treatment group compared to control conditions. However, the wide variety in the methodology quality of the included studies possibly limits the quality of the findings, emphasizing the dire need for future more methodologically rigorous studies to better assess potential mediators of treatment effects.[3,12] In another highly cited study by Chabrol et al.,[13] between "72.2% and 88.8% of the treatment group were deemed responsive to treatment" consisting of one-hour 5-8 sessions in-home CBT intervention delivered by master's level students. Although these results are outstanding, the provided treatment was not consistent with the "traditional CBT model" and included a psychodynamic component.[1] These latter components are "unequivocally inconsistent with the way in which cognitive behavioural therapists conceptualise their course of treatment and deliver therapy".[2] On the other hand, in another study by Burns et al.,[14] a Beckian, conceptualisation-based CBT approach was adopted to address specific cognitions and behaviours related to core issues faced by perinatal women. Despite its small sample size, CBT was shown to be effective in reducing depression during the antenatal and postpartum period, possibly showing that such an approach might be a good match in this client group.

Group formats have been studied for both IPT and CBT. Individual treatment has the advantage of being tailored to individuals' specific needs. On the other hand, group sessions, can be a source of social support.[3] Moreover, since many women are managed simultaneously, group interventions are cost-effective[2] and improve access to care.[12] Studies examining the efficacy of group IPT show promising results, including evidence for its enduring effect.[1,10] In comparison, results from studies comparing group CBT to control conditions tend to be mixed.[2] Indeed, as demonstrated by Sockol et al.,[12] individually-administered CBT may be more effective than group sessions.

## Conclusion

In conclusion, notwithstanding the caveats and limitations in the research data, compelling evidence for the beneficial use of both IPT and CBT in postnatal depression exists. However, further research comparing the two, as well as identification of individual characteristics which would improve treatment response would be valuable. In addition, a closer examination of the specific treatment components which could be "enhanced to maximise success" [2] and a better understanding of "moderators and mediators of treatment effects", and the "use of particular therapy techniques"[3] would advance the literature considerably.

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