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Can counseling prevent or treat postpartum depression?

Evidence-based answer

No, in most cases, counseling does not prevent postpartum depression (PPD), though it can treat the disorder. Overall, psychosocial interventions don't offer a significantly greater benefit than standard care in preventing PPD—although studies do suggest a preventive benefit when the intervention is administered postnatally, in the home, and targeted toward individual at-risk women (strength of recommendation [SOR]: **A**, meta-analysis of 15 randomized, controlled trials [RCTs] and 1 subsequent RCT).

Psychotherapy and counseling—including interpersonal therapy, individual and group cognitive behavioral therapy (CBT), psychodynamic therapy, and nondirective counseling—are effective in treating PPD (SOR: **A**, systematic review of 15 RCTs and 1 later RCT). Not enough evidence exists to compare the benefits of antidepressant medication with CBT (SOR: **B**, 2 low-quality RCTs).

Clinical commentary

Do some research before you refer

Postpartum depression negatively impacts maternal satisfaction and is a major women's health issue. Recognizing that psychosocial interventions are considered first-line, evidence-based treatments is important, but, beyond that, knowing how to locate a licensed professional who delivers these treatments may be critical to your patient.

One way to identify such a clinician is to use a Web-based search tool such as www.findapsychologist.org, provided by the National Register of Health Service Providers in Psychology (www.nationalregister.org). Once identified, contact the clinician and ask how s/he does what s/he does. If the answer is evidence-based treatments, you may have a strong candidate for treating a woman with PPD. Just remember: A referral is as important as the care you, yourself, provide.

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FAST TRACK

Psychosocial interventions aren't significantly better than standard care in preventing postpartum depression.

Evidence summary

Prevention: No overall benefit, but some approaches may help

A Cochrane meta-analysis of pooled data from 15 RCTs (7697 women) found that psychological interventions didn't prevent PPD based on comparison of initial depression scores with scores at the conclusion of the studies (relative risk [RR]=0.81; 95% confidence interval [CI], 0.65-1.02).[1] Although some studies suggested short-term benefit (N=4091; RR=0.65; 95% CI, 0.43-1.00), benefits diminished over time and

weren't noted when the definition of depression was limited to an Edinburgh Postpartum Depression Scale (EPDS) score below 12 (out of a maximum of 30). Some differences were found when the data were stratified.

Certain interventions were found to prevent depressive symptoms (defined differently in the various studies). They were: home visits provided by healthcare professionals (2 RCTs, N=1663; RR=0.68; 95% CI, 0.55-0.84), interventions targeting at-risk women (7 RCTs, N=1162; RR=0.67; 95% CI, 0.51-0.89), and interventions begun postnatally (10 RCTs, N=6379; RR=0.76; 95% CI, 0.58-0.98). Notably, the level of training of providers of psychological interventions included in the meta-analysis was highly variable.

A later RCT of a 6-session cognitive-behavioral, midwife-administered intervention in mothers of preterm infants showed no preventive benefit (N=176; RR=1.02; 95% CI, 0.87-1.20).[2]

Treatment: Counseling helps, especially in the near term

A recent systematic review of 5 RCTs (N=450) investigated the effectiveness of interpersonal psychotherapy, CBT (individual and group), nondirective counseling, and psychodynamic therapy in reducing PPD symptoms.[3]

Interpersonal therapy (12 weekly sessions) significantly reduced PPD symptoms as measured by the Hamilton Depression Rating Scale (HAM-D) compared with a wait-list control group (1 RCT, N=120, RR=2.11; 95% CI, 1.04-4.28).

Individual CBT and ideal standard care (weekly 20- to 60-minute supportive meetings) were equally effective in reducing depression scores immediately postintervention and 6 months thereafter as measured by the EPDS (1 RCT, N=37). Although a trend toward greater benefit for CBT was noted, the study was underpowered to identify a significant difference.

Nondirective counseling reduced the proportion of women with depression (N=55; RR=0.49; 95% CI, 0.26-0.95) and lowered EPDS scores (N=193; treatment effect=–2.1; 95% CI, –3.8 to –0.3; *P*=.02) compared with routine primary care. Individual CBT also reduced EPDS scores, when compared to routine primary care (N=55; treatment effect=–2.7; 95% CI, –4.5 to –0.9; *P*=.003).

Psychodynamic therapy reduced the proportion of women with major depression (N=55; RR=1.89; 95% CI, 1.33-2.33).

All of these interventions improved PPD immediately following treatment compared with routine primary care, but the benefits were not sustained at long-term follow-up (6 months). Study limitations included failure to control for multiple comparisons, pretreatment group differences, differential attrition among groups, and lack of sufficient power.

A later RCT (N=121) also found psychological interventions (group CBT and group and individual counseling) to be superior to routine primary care, with individual counseling yielding the greatest improvement in PPD symptoms (*P*<.05).[4]

Antidepressants vs CBT: Too little information

Two RCTs compared antidepressant medications to CBT.[3] In the first (N=87), fluoxetine and placebo were each paired with 1 or 6 CBT sessions. After 12 weeks of treatment, fluoxetine was superior to placebo as measured by mean symptom score reduction on the HAM-D, EPDS, and clinical interview schedule; 6 CBT sessions were superior to a single session as measured by mean symptom score reduction on the Hamilton Depression Scale and clinical interview schedule.[5] No significant interaction effect was found.

The authors reported "highly significant" improvements, but didn't specify significance level or provide adequate information to calculate number needed to treat. Interpretation of the findings is limited by methodologic weaknesses,

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Psychotherapy and counseling are effective in treating PPD.

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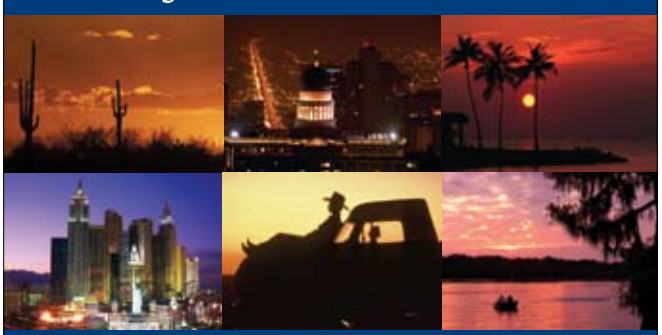

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high withdrawal rate, and exclusion of breastfeeding women.[3]

A second, small RCT (N=35) compared 12 weeks of paroxetine with a combination of paroxetine and CBT.[6] Significant improvements—defined as percentage of patients in each group demonstrating at least a 50% score reduction on the HAM-D (paroxetine, 87.5%; combination, 78.9%) and EPDS (paroxetine, 61.5%; combination, 58.3%)—occurred in both groups ($P<.01$), but no difference was found between the groups. The study didn't include a placebo control group.

Recommendations

The National Collaborating Centre for Women's and Children's Health recommends against offering educational interventions to pregnant women because such interventions haven't been found to reduce PPD.[7]

The Scottish Intercollegiate Guidelines Network recommends "postnatal visits, interpersonal therapy, and/or antenatal preparation" to prevent PPD. To treat PPD, they recommend psychosocial interventions, preferably those that include more than 1 family member.[8] ■

References

1. Dennis CL, Creedy D. Psychosocial and psychological interventions for preventing postpartum depression. *Cochrane Database Syst Rev.* 2007;(4):CD001134.
2. Hagan R, Evans SF, Pope S. Preventing postnatal depression in mothers of very preterm infants: a randomized controlled trial. *Br J Obstet Gynaecol.* 2004;11:641-647.
3. Howard L. Postnatal depression. *BMJ Clin Evid.* 2006;14:1919-1931.
4. Milgrom J, Negri LM, Gemmill AW, et al. A randomized controlled trial of psychological interventions for postnatal depression. *Br J Clin Psychol.* 2005;44:529-542.
5. Appleby L, Warner R, Whitton A, et al. A controlled study of fluoxetine and cognitive-behavioral counseling in the treatment of postnatal depression. *BMJ.* 1997;314:932-936.
6. Misri S, Reebye P, Corral M, et al. The use of paroxetine and cognitive-behavioral therapy in postpartum depression and anxiety: a randomized controlled trial. *J Clin Psychiatry.* 2004;65:1236-1241.
7. National Collaborating Centre for Women's and Children's Health. *Antenatal Care: Routine Care for the Healthy Pregnant Woman.* London: RCOG Press; 2003. Available at: www.rcog.org.uk/resources/Public/pdf/Antenatal_Care.pdf. Accessed November 11, 2007.
8. Scottish Intercollegiate Guidelines Network. *Postnatal Depression and Puerperal Psychosis. A National Clinical Guideline*. Edinburgh, Scotland: Scottish Intercollegiate Guidelines Network (SIGN); 2002. Available at: www.sign.ac.uk/guidelines/fulltext/60/index.html. Accessed November 11, 2007.