An approach to interpersonal psychotherapy for postpartum depression

Focusing on interpersonal changes

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ABSTRACT

OBJECTIVE To review the principles of interpersonal psychotherapy (IPT) for the treatment of postpartum depression (PPD).

SOURCES OF INFORMATION Empirical literature, IPT manuals including those adapted for PPD, and the authors' clinical experience.

MAIN MESSAGE Level I evidence supports IPT as a treatment for PPD. Interpersonal psychotherapy is ideally suited because it focuses on the important interpersonal changes and challenges women experience during the postpartum period. It is delivered in 12 sessions and emphasizes interpersonal disputes, role transitions, or bereavement. In this article, we describe the IPT model and therapeutic guidelines for treatment of PPD.

CONCLUSION Postpartum depression is an important public health problem with pervasive effects on mothers, infants, and families. Interpersonal psychotherapy is a relevant and effective treatment for women suffering from PPD because it helps address the many interpersonal stressors that arise during the postpartum period. The principles of IPT can be integrated easily into primary care settings as IPT is pragmatic, specific, problem focused, short-term, and highly effective.

RÉSUMÉ

OBJECTIF Passer en revue les principes de la psychothérapie interpersonnelle (PTI) comme traitement de la dépression du post-partum (DPP).

SOURCES DE L'INFORMATION Littérature empirique, manuels de PTI incluant ceux adaptés pour la DPP et l'expérience clinique de l'auteur.

PRINCIPAL MESSAGE L'utilisation de la PTI pour traiter la DPP est supportée par des preuves de niveau I. Cette approche convient parfaitement parce qu'elle est centrée sur les changements interpersonnels importants et sur les défis auxquels les femmes font face durant le post-partum. Elle se donne en 12 séances et porte surtout sur les conflits interpersonnels, les changements de rôle ou les deuils. Cet article décrit le modèle de la PTI et les directives pour le traitement de la DPP.

CONCLUSION La DPP est un important problème de santé publique qui a des conséquences néfastes pour la mère, le nourrisson et la famille. La PTI est un traitement pertinent et efficace pour celles qui souffrent de DPP parce qu'elle les aide à faire face aux nombreux agents stressants interpersonnels qui surviennent durant le post-partum. Les principes de la PTI peuvent facilement être intégrés dans un contexte de soins primaires puisque cette thérapie est pragmatique, spécifique, axée sur des problèmes, de courte durée et hautement efficace.

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Case

Mrs C, a 40-year-old lawyer, is brought to the office by her husband of 10 years. He has noticed that, since the birth of their now 1-month-old daughter, Mrs C has not been her normal self. In your office she starts to cry after you ask her about the baby. Mrs C explains that she is not a good mother and feels worthless and guilty about having had a child. She is overwhelmed. Most of the time she is irritable and anxious about her ability to care for her baby.

Postpartum depression (PPD) is a common, potentially life-threatening and disabling condition. It is estimated to affect 10% to 15% of women, and its prevalence ranges from 5% to more than 20%.[1] Evidence indicates that both pharmacologic and psychotherapeutic management of this condition are effective, but there are concerns with pharmacologic management that neonates might be exposed to antidepressant drugs through breast milk.[2] Studies have shown that women prefer psychological and social management over drugs during the perinatal period.[3]

Interpersonal psychotherapy (IPT), a time-limited treatment, was first designed for treating people with major depression who did not have bipolar diatheses, psychoses, or substance abuse problems.[4] Empirical evidence supporting the efficacy of IPT has grown since its early use, as has the scope of its clinical application.[5-7]

Family physicians need to be aware of psychotherapeutic approaches to PPD. Interpersonal psychotherapy for PPD is an effective treatment that focuses on the important interpersonal changes and challenges that women experience during the postpartum period. In this article, we describe the IPT model and therapeutic guidelines for treatment of PPD.

Sources of information

Guidelines for treatment of depressive disorders from both the Canadian Psychiatric Association and its American counterpart recommend IPT as an effective treatment for depression.[8,9] Five studies evaluating IPT for treatment of PPD provide level I evidence of effectiveness for treating major depression with postpartum onset: 1 open trial, 1 wait-list randomized controlled trial, and 3 small studies evaluating group approaches.[10-14]

Modifications of IPT for PPD presented in this article are based on the work of Klerman et al,[4] Stuart and O'Hara,[15] and the authors' clinical experience. The IPT guidelines and the IPT-specific therapeutic techniques (both of which are published in manuals) help patients work through commonly encountered relational difficulties and are easily integrated into primary care settings.

Main message

Interpersonal psychotherapy is a proven, effective treatment for mild-to-moderate PPD and an alternative to pharmacotherapy, especially for breastfeeding women. It reduces depressive symptoms and improves social adjustment. For women with psychotic features, bipolarity, or severe symptoms, including suicidal or infanticidal thoughts, IPT alone is not sufficient, and a combination of medications and possibly hospitalization should be considered[4,9,16] (**Table 1**).

Other treatments for women with PPD have been tested in pharmacologic treatment studies, only 3 of which were randomized controlled trials (RCTs). One RCT compared fluoxetine with a hybrid cognitive behavioural counseling approach, another compared paroxetine with cognitive behavioural therapy, and the third compared sertraline with nortriptyline. Other studies included 1 open trial of sertraline, 1 open trial of venlafaxine, a case series on fluoxetine, and 1 retrospective chart review involving several antidepressants.[17-23] Based on the RCTs, fluoxetine and

Table 1. Interpersonal psychotherapy (IPT) for postpartum depression (PPD)

Suitability criteria

Patients with nonpsychotic, nonbipolar major depression with postpartum onset. Those less likely to be helped by a time-limited, structured treatment, such as IPT, include patients with a history of severe and complex trauma and those with profound disturbances in personality functioning.

Goals of treatment

- To remit depression
- To alleviate interpersonal distress
- To assist with building or with making better use of social supports

Refer for psychiatric consultation or consider hospitalization when patients

- endorse suicidal thoughts or homicidal thoughts;
- have moderate-to-severe symptoms and do not respond to IPT alone;
- have a history of severe depression in the past or have had other reproductive-related depressive disorders, such as premenstrual dysphoric disorder or previous PPD;
- need more support and monitoring than you can provide; or
- have psychotic, manic, or substance-abuse symptoms.

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paroxetine were shown to be helpful for some but not all women. Although sertraline and nortriptyline were both helpful, women taking sertaline were identified earlier. Many mothers with PPD breastfeed, and the amount of antidepressant entering their breast milk is of concern to some women, and they are reluctant to use the medication.

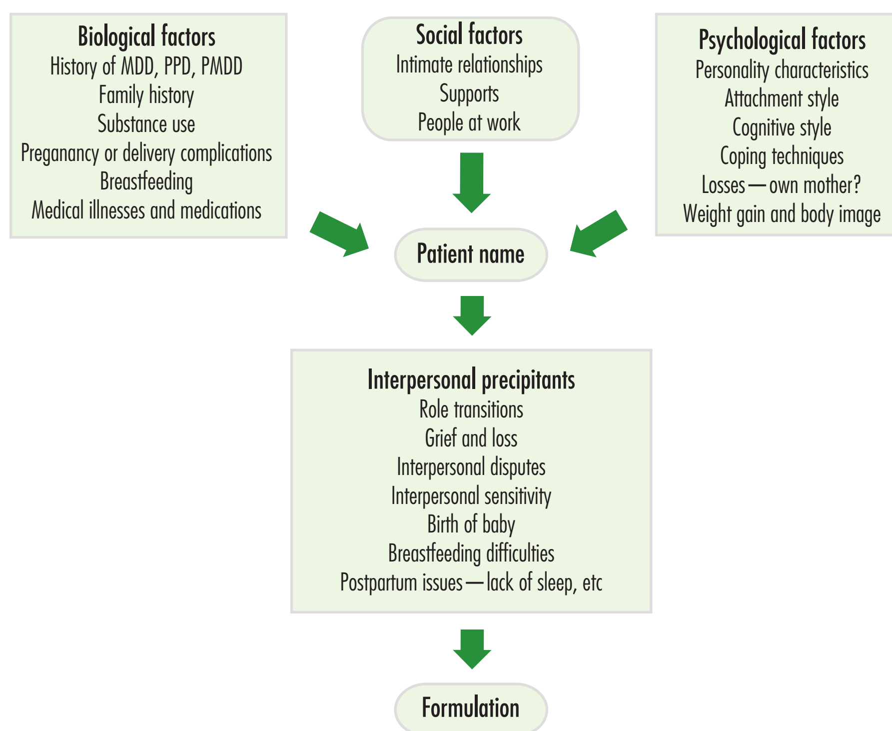
Psychotherapies have been studied as alternatives to antidepressant treatment. Although one of the above studies evaluated cognitive behavioural therapy and found it effective, the sample size was small, which limits the conclusions that can be drawn.

The best evidence for psychotherapy as an effective treatment for PPD is for IPT. It was evaluated in an RCT with a large sample size.[11] Of 120 women diagnosed with PPD recruited, 99 completed the 12-week study. The women were randomly assigned to 12 weeks of IPT or to a wait-list control group. Significantly more women in the IPT group achieved remission of depression than women in the wait-list group did (37.5% vs 13.7%). Further evidence for the efficacy of IPT for PPD comes from smaller trials as mentioned above. Other nonpharmacologic talking therapies evaluated include cognitive behavioural therapy,[17,22,24,25] counseling by health nurses[26] or health visitors,[27] peer support groups,[28-30] and partner support sessions.[31] These approaches have been found to be helpful, although RCTs with large sample sizes still need to be conducted.

A limitation on all psychotherapeutic approaches is the time commitment necessary for new mothers and clinicians. Also, psychotherapeutic approaches might not be appropriate as stand-alone treatment for women with moderate to severe depressive symptoms. Getting access to trained psychotherapists for patients and getting training in psychotherapy skills for clinicians can be challenging, especially in remote regions.

Many of the interpersonal problems of social adjustment women with PPD face can be addressed by IPT because it focuses on current personal relationships[4,6,7,32] rather than on intrapsychic or cognitive aspects of depression. The focal interpersonal problem areas of IPT are derived from research that has demonstrated the protective function of interpersonal support as well as the associations between interpersonal adversity and depression. It uses a biopsychosocial model[33] to understand patients and frames depression as a medical illness that occurs in a social context which is disrupted during times of illness. Although IPT recognizes the role of biological and psychological factors in the cause of and vulnerability to depression, it focuses on social factors and working through interpersonal problems[6,7,32,34-39] to alleviate depression (**Figure 1**).

Figure 1. Formulation worksheet for postpartum depression



MDD—major depressive disorder, PPD—postpartum depression, PMDD—premenstrual dysphoric disorder.

What happens during a course of IPT?

Beginning phase. In the beginning (sessions 1 and 2), a comprehensive assessment is conducted to diagnose PPD and explore the interpersonal context to establish the focus of therapy. The need for medication is evaluated, and depression is discussed as a medical illness with interpersonal antecedents and sequelae in a social context. Clinicians must differentiate between the symptoms of clinical depression and those of normal postpartum experiences. For example, Mrs C would be expected to complain of fatigue, weight loss, and little sleep; but if she meets full *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition, text revision, criteria for depression, that needs to be identified and treated. The focus of therapy is determined according to the current interpersonal problems that are related to the onset and perpetuation of the patient's current depressive episode. To instill positive expectations, goals are explicitly explained to patients: to remit depression and to help resolve specific interpersonal problems.[4,34,40]

Educating patients about psychotherapy is an important task in the initial phase of treatment. The following points should be explained to Mrs C.

- She is suffering from depression.
- Depression is a legitimate, treatable medical illness.
- Depression is explained within the biopsychosocial model as a biological illness that occurs in a social context.
- Postpartum depression and depression in general are relatively common.
- Specific treatments are available for depressive illnesses including psychotherapies (cognitive behavioural therapy and IPT) and pharmacotherapy.

Mrs C would be encouraged to use family and friends and community infant-mother groups to reduce her isolation and improve her social support. Mrs C's depressive symptoms would be placed in an individually tailored interpersonal context.

An interpersonal inventory is taken, and the important relationships in patients' lives are reviewed. Pertinent information about relationships with significant others should include expectations they had before childbirth for social support, the nature of their interactions and communications, satisfactory and unsatisfactory aspects of relationships, and ways in which they would ideally like to change the relationships. Other important information to obtain includes their expectations about motherhood, their feelings regarding the child and that relationship, the details of the pregnancy (whether it was planned, its course, labour and delivery), interpersonal ramifications of the birth of the child, and their relationships with others potentially affected by or involved with the birth or subsequent care of the child (**Table 2**).

Table 2. Beginning phase take-home points
Educate patients about depression and its functional and interpersonal effects
Carefully evaluate symptoms, safety, functioning, relationships, and supports
Choose a current interpersonal problem focal area that is linked to the onset or perpetuation of symptoms
Encourage patients to use or recruit supports

Middle phase and focal problem areas. Focal areas guide therapeutic interventions through the middle phase of IPT therapy (sessions 3 to 10) and link symptoms of depression to interpersonal events, losses, or changes. Interpersonal psychotherapy helps patients with PPD to understand their associated life experiences within 3 problem areas: interpersonal disputes; role transitions; and bereavement.

Each focal area has a different set of therapeutic guidelines. Patients are expected to participate actively and work during the course of therapy to effect change within their identified problem areas. Clinicians should monitor symptoms weekly. Generally, 1 or 2 focal areas are chosen. If patients are worsening or not improving, it is critically important to consider psychiatric consultation and adding antidepressant medication. It is also important to screen for both suicidal or infanticidal thoughts, and if present, to consider hospitalization.

Interpersonal role disputes: These are defined as "nonreciprocal role expectations" of important people in patients' lives (eg, a marital dispute between Mr and Mrs C, or disputes with parents or in-laws) and are often accompanied by poor communication or misaligned interpersonal expectations. During therapy, behaviour patterns are examined through communication analysis, an IPT technique used to reveal ways in which patients interact with others that might inadvertently exacerbate conflicts through acts of commission or omission.

Various ways of understanding and communicating within relationships are explored to facilitate more satisfactory ways of relating. It is important to assess how well both mothers and their spouses perceive they are adjusting to their newborns and to explore their expectations regarding child care. A spouse's level of emotional and instrumental support, the roles of other important people (including other children), and the status of all these relationships before and after the pregnancy should be assessed (**Table 3**).

Role transitions: These involve life events that lead to big changes in social roles that are central to people's sense of identity in relationships. For women with PPD, the challenge is to integrate their new social role as mother with their previously defined sense of themselves within their families, their workplaces, and their communities.

Mrs C, for example, needs to develop new skills and expand the scope of her responsibilities while

Table 3. Middle-phase tasks of interpersonal problem area (disputes) take-home points
Make links between interpersonal events related to dispute and symptoms
Identify issues that are in dispute
Identify maladaptive patterns of communication
Help patients to evaluate expectations, learn to communicate needs and emotions, and expand their understanding and perspectives
Assist patients to better use or recruit supports

maintaining or adjusting old relationships. She has numerous new social roles to integrate in this time of change, as mother, co-parent, and lawyer. Each of these roles has demands and responsibilities that can be difficult to prioritize. The course of IPT will help Mrs C develop a more balanced view of each role, evaluate and modify expectations, and set priorities. Mrs C might have to renegotiate time commitments and responsibilities in order to adapt to new time, physical, and emotional constraints, while balancing needs and wishes in her multiple roles. As in all focal areas of IPT, communication is examined in detail in order to help Mrs C more effectively express her emotions and needs so that she can better use her supports (**Table 4**).

Table 4. Middle-phase tasks of interpersonal problem area (role transition) take-home points
Make links between interpersonal events related to transition and symptoms
Explore both positive and negative aspects of how things were in her previous role, before the birth of her infant
Explore the challenges and brainstorm regarding opportunities in the new role, since the birth of her infant
Improve communication
Assist patient to better use or recruit supports

Bereavement: This problem area is chosen as a focus in IPT when the onset of depression coincides with the death or anniversary of the death of a significant other. Therapy allows patients to work through loss. Positive and negative aspects of the lost relationship are explored to achieve a more realistic view of the lost person. Details of the death are reviewed, including support provided around the time of the funeral. In the latter stages of treatment, patients are encouraged to replace aspects of what was lost in the relationship and to begin to move forward in their lives.

Women with PPD can have grief reactions related to the death of a newborn or significant other during the neonatal period. They might also have delayed mourning for a past loss during the antepartum or postpartum period. The goal of therapy is to facilitate mourning, and in so doing, remit the depression (**Table 5**).

Table 5. Middle-phase tasks of interpersonal problem area (bereavement) take-home points
Make links between interpersonal events related to the death and symptoms
Review the details of the death, the funeral, and the subsequent period of bereavement
Explore both positive and negative aspects of the lost relationship
Explore both positive and negative aspects of how things were before the loss
Explore the challenges of adjusting to the loss and the interpersonal opportunities in the present and future
Improve communication
Assist patient to better use or recruit supports

Relationship with the newborn. In addition to focusing on IPT problem-specific goals, it is important to attend to the evolving relationship with the newborn. Attachment between mother and infant is crucial in development of the infant's sense of security and safety. It is critical to assist mothers with PPD to develop nurturing relationships with their children. Therapists can assist patients to be more attuned and responsive to their infants during their period of recovery and to recruit or use supports to help with care of the child.

Ending therapy. In the concluding or termination phase of IPT (sessions 11 and 12), therapeutic gains are reviewed. It is hoped that the goal of treatment has been achieved: remission of depressive symptoms and improvement in interpersonal functioning. Contingency plans are discussed in the event of recurrence, and patients are encouraged to contact a physician for early treatment. Future problems and stressors would be discussed with Mrs C to facilitate autonomous problem solving. Mrs C would be helped to differentiate normal sadness from clinical depression, and feelings associated with the ending of therapy would be openly discussed. In the event that Mrs C has not improved, it would be important to consider extending the course of IPT or recommending alternative treatments that might include pharmacotherapy or family therapy along with psychiatric consultation.

Discussion

Interpersonal psychotherapy offers an effective, specific, problem-focused, short-term approach to treatment of PPD. Strengths include the empirical support; the focus on universal relational experiences of loss, change, or conflict; and the fact that the goals and techniques of IPT are all published. Manuals clearly articulate the goals of therapy and standardize

techniques. Brief therapies, including IPT, however, are not suitable for all patients, and accessing IPT can be difficult, especially in rural or remote regions. There is certainly room for development of alternative methods of delivering psychotherapy, such as by telephone or over the Internet.

Regardless of the debate over whether the disorders that manifest during the postpartum period are distinct from the mood disorders that manifest at other times in life,[41] PPD is a mood disorder with a profound effect on mothers, infants, and their families. It is imperative for physicians to screen for and treat PPD in a timely and effective manner.

Family practitioners should also be prepared to treat relapses or to take on maintenance treatment, which they often have to do in treatment of mood disorders.[9] There is evidence supporting use of IPT for maintenance treatment for major depression to prevent relapse,[42] although this remains to be tested for PPD. Although IPT requires an investment of time by both patients and their doctors, the techniques of IPT are appealing to family practitioners because they can be incorporated easily into a busy practice and applied to many patients who experience the interpersonal problems addressed by this therapy.

Conclusion

Women with PPD typically experience a multitude of stressors associated with their depression.[43] Interpersonal psychotherapy is well suited to treatment of PPD because of the many interpersonal disruptions associated with this time of life and because it is a specific, problem-focused, and short-term approach to treatment of PPD and can be learned readily and applied in family practice. To acquire clinical competence in IPT, practitioners should participate in a didactic, accredited continuing education IPT workshop and then be supervised through a minimum of 2 cases, as recommended in the IPT manual.[7] Training is available at the University of Toronto through yearly continuing education workshops. The International Society of Interpersonal Therapy is a good source of other training opportunities (**www.interpersonalpsychotherapy.org**).

Competing interests

None declared

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EDITOR'S KEY POINTS

- Postpartum depression (PPD) is common; it affects 10% to 15% of women after delivery.
- Some women prefer psychotherapy over medication to treat PPD. Interpersonal psychotherapy is a proven, effective treatment for mild-to-moderate PPD.
- Interpersonal psychotherapy could be helpful for patients with severe PPD in conjunction with other treatments (eg, medications, hospitalization). Its major limitations include the need for training for physicians and the time commitment required from both physicians and patients. Principles of interpersonal psychotherapy can be incorporated easily into family practice.

POINTS DE REPÈRE DU RÉDACTEUR

- La dépression post-partum (DPP) est un problème fréquent qui touche 10-15% des femmes après l'accouchement.
- Comme traitement de la DPP, certaines femmes préfèrent la psychothérapie aux médicaments. La psychothérapie interpersonnelle (PTI) a démontré son efficacité comme traitement de la DPP légère à modérée.
- Associée à d'autres formes de traitement (par ex., médication, hospitalisation), la PTI pourrait être utile dans les cas de DPP sévère. Ses limitations principales incluent la nécessité de formation pour le médecin et les contraintes de temps pour le médecin comme pour le patient. Les principes de la PTI peuvent facilement être incorporés dans la pratique familiale.

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