

Interpersonal Psychotherapy for Antenatal and Postpartum Depression

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Articles

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Focus Points

- Interpersonal psychotherapy (IPT) is an effective treatment for perinatal depression.
- The assessment of perinatal depression must be sensitive to the normal physiological changes that occur during pregnancy and postpartum.
- Psychosocial factors must be addressed during the course of IPT and increasing social support is a key component of IPT.
- IPT can be used in conjunction with medication for perinatal depression.

Abstract

Despite its prevalence, postpartum depression is frequently not detected. Primary care physicians (PCPs) are often a woman's only contact with healthcare professionals. These professionals have a vital role in the screening and treatment of depressed women; therefore it is necessary that PCPs be aware of assessment issues and effective treatments. This article describes the use of interpersonal psychotherapy (IPT), a time-limited and empirically validated treatment for perinatal depression, in

terms of the relevant clinical issues for pregnant or postpartum women. During the assessment phase, the symptoms of depression must be disentangled from the normal physical states of pregnancy and the postpartum, and an accurate diagnosis must be made. During the initial and intermediate phases of treatment, interpersonal problems that are common to the perinatal period are addressed. Given the risk for future depressive episodes, provisions for future treatment must be established prior to the conclusion of therapy. With these adaptations, IPT can be modified for effective use with perinatal women. As a result, PCPs may gain an increased understanding of both an effective treatment and the salient interpersonal issues for these women.

Introduction

The birth of a child precipitates a cascade of changes in a woman's life. Examples include disruption of important social relationships, alteration of work roles and routines, and increased childcare responsibilities. Depression, both during and after pregnancy, compromises a woman's ability to effectively manage these transitions. Prevalence studies indicate that postpartum depression affects 13% of women¹ and that it is undetected in 50% of all cases.² Awareness of symptoms does not guarantee treatment utilization. MacLennan and colleagues³ found that only 49% of women who felt seriously depressed sought treatment. Expectations that the postpartum period should be happy, combined with lack of knowledge about this illness, conspire to make postpartum depression a covert illness endured by many women in silence.⁴ Untreated, depression has negative consequences for a woman's social relationships, her relationship with the baby, and the baby's emotional and intellectual development.⁵

Although depressed women are not likely to spontaneously identify their symptoms, they might confide in a familiar healthcare provider if asked. Research has shown that answers to two brief questions about sad mood and loss of interest provide an effective way to identify possible depression.⁶ These questions, or even the routine use of brief screening instruments such as the Edinburgh Postnatal Depression Scale,⁷⁻¹⁰ can be readily incorporated into prenatal and postnatal checks, as well as well-baby visits.¹¹ Once identified, effective treatments are available, including

antidepressant medication, cognitive-behavioral therapy, and interpersonal psychotherapy (IPT).¹²

While there is evidence that antidepressant medication is both efficacious and relatively safe for use during pregnancy and the postpartum,¹³ both clinicians and patients may prefer to avoid medication during the perinatal period if possible. In addition to concerns about medication exposure to the baby during pregnancy, many women are also reluctant to use medications while breastfeeding for fear of adverse effects.¹⁴ Given this context, clinicians should be well educated about the perinatal use of medication and carefully consider the relative merits of psychotherapy, antidepressant medication, and combined treatment when making a treatment decision.^{13,15,16}

Concurrent treatment is common in clinical practice, though there is at present little empirical data regarding combined treatment with perinatal women. Although medication can serve as a useful adjunct and should be considered, its singular use may not help a woman develop the specific interpersonal coping skills which can assist in managing this life transition. IPT is completely compatible with medication, and the combination may be synergistic.

IPT was developed by Klerman and Weissman in the 1980s and is a highly structured, time-limited, manual-based treatment that targets depressive symptoms by focusing on four types of interpersonal problems: grief and loss, interpersonal disputes, role transitions, and interpersonal sensitivity.^{17,18} IPT has been modified for other diagnoses, including dysthymia, bulimia nervosa, somatization, bipolar disorder, posttraumatic stress disorder, and postpartum depression.¹⁹

IPT can be delivered by a variety of healthcare professionals, including physicians, nursing staff, psychologists, and social workers. Generally speaking, IPT is quite easy to learn for those therapists who already have some training in psychotherapy.¹⁹ IPT is particularly well suited to the treatment of perinatal depression because it focuses on the specific interpersonal conflicts and skill deficits often associated with this disorder. Two studies by independent researchers provide strong empirical support for the efficacy of IPT in reducing depressive symptoms in pregnant and postpartum women.^{20,21}

This article highlights considerations when using IPT for depressed pregnant or postpartum women. Issues unique to the perinatal period are described for each treatment phase: assessment, initial sessions, intermediate sessions, and the conclusion of acute treatment (Table).

Table

Summary of IPT and Relevant Perinatal Issues

Pretreatment Assessment
Conducting a Diagnostic Assessment

- Distinguishing depressive symptoms from physiological correlates of depression

Initial Sessions
Conducting an Interpersonal Inventory

- Reviewing key people, including infant, other children, partner, mother's family, partner's family, and friends

Identifying Problem Areas

- Grief and Loss
 - Death of a family member, particularly a parent
 - Death of an infant, miscarriage, or abortion
 - Poor parenting, including abandonment and abuse
- Interpersonal Disputes
 - Unmet expectations about baby care
 - Intimacy including sexuality
 - Unrealistic expectations about family visits
- Role Transition
 - Loss of independence
 - Lack of parenting skills
 - Lack of social support with other parents
 - Decision to work or stay home

Formulating a Contract

- Helping a woman to accept diagnosis of depression when she may prefer to attribute her symptoms to physical causes
- Helping a woman to make arrangements for day care

Intermediate Sessions

- Emphasize communication analysis, use of affect, and conjoint sessions

Concluding Acute Treatment

- Affirm a woman's progress
- Make clear arrangements for the possibility of relapse

IPT=Interpersonal psychotherapy.

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Pretreatment Assessment

IPT should never be initiated until a thorough assessment is completed, to ensure that IPT is an appropriate treatment for the patient. Making the correct diagnosis for pregnant and postpartum women is challenging because the somatic symptoms of depression are very similar to the normal physical changes that occur perinatally. For example, poor sleep is a common marker for depression. However, sleep disruption also often results from prenatal physiological changes associated with the

pregnancy. Similarly, it is not unusual for postpartum women to experience sleep difficulties given the erratic nocturnal habits of newborns.

Confounding symptomatology is not limited to sleep. While weight loss and gain are primary symptoms of depression, they represent the norm in pregnancy and childbirth. Decreased energy is also commonly experienced in the puerperium. Even the affective symptoms of depression can result from the normal physical changes of pregnancy: for example, a woman in her first trimester of pregnancy may be so tired that she reports diminished interest or pleasure in her usual activities.

The staff of the Iowa Depression and Clinical Research Center, a joint project of the University of Iowa's Departments of Psychology and Psychiatry, has been conducting research on women's emotional experiences during puerperium for >20 years. The assessment strategy that has emerged from hundreds of diagnostic interviews with pregnant and postpartum women is to ask about times when physical symptoms abate, or how a postpartum woman might feel if, hypothetically, her physical symptoms were to improve. For example, if a woman reports decreased interest in her usual activities, the following questions might help disentangle the normal somatic symptoms of pregnancy from the somatic symptoms of depression. Clinicians may use such questions as: "On the rare occasion that you have been able to get a bit more sleep, have you felt more interested in pursuing your usual activities?" or "If you did have a sudden burst of energy, would you be interested in your usual activities?"

When women report loss of appetite, the following questions might help determine whether the loss of appetite is attributable to depression or to nausea, a common physical condition for pregnant women: "When your nausea abates, are you interested in eating?" or "If you were not experiencing morning sickness, would you be interested in eating?" Once these issues are clarified, the clinician can confidently diagnose depression when warranted, and make appropriate treatment recommendations.

Initial Sessions

The initial phase of IPT usually lasts for two sessions and focuses on conducting an interpersonal inventory,¹⁸ identifying one or two focal problem areas, and developing a treatment contract. There are several issues unique to the puerperium for each of these tasks.

Conducting the Interpersonal Inventory

The primary goal of the initial sessions is to understand the presenting problem in an interpersonal context by identifying problematic interpersonal relationships. The interpersonal inventory is a listing of a woman's significant relationships, coupled with a description of her interactions with each. The positive and negative aspects of each relationship, as well as her expectations for each, should be explored. Key relationships between the pregnant or postpartum woman and her infant or other children, her partner, her family of origin, her partner's family, and her friends should be routinely assessed.

The Infant and Other Children

Depressed postpartum women often describe their relationships with their newborns as positive and as the only ones that they enjoy. Many women also have ambivalent feelings about their babies, feeling both strongly attached but often resenting their loss of spontaneity, the extra workload, or the impact their newborns have on their relationships and careers.

In the rare case that a woman describes primarily strong negative feelings toward her child, an extensive evaluation should be conducted, with consideration given to diagnoses such as postpartum psychosis. A woman with homicidal ideation toward the child should always be immediately referred for psychiatric evaluation and treatment. Plans to ensure the infant's safety should also be made.

Many women also have concerns about incorporating a new child into their relationship with their current child or children. It should be noted that some women may be concerned about their ability to love another infant and feel guilty that she now has to divide herself between more children.

The Partner

The quality of the marital relationship is an important predictive factor of maternal adjustment during pregnancy and postpartum²² and should be routinely assessed when conducting the interpersonal inventory. The birth of a first child or subsequent children often raises issues about interpersonal intimacy and managing an increased workload.

Some perinatal women feel a lack of intimate emotional contact with their partners. Many, particularly women who remain at home after the baby is born, may feel that their partners are involved with work at the expense of time spent at home. In contrast, others report feeling conflicted about the time they devote to the baby, leaving little time for themselves or their partners.

Postpartum women may also be uninterested in resuming their sexual relationships. A variety of issues can be influential, ranging from physical discomfort, fatigue, and body image concerns, to the partner's disinterest because of feelings of neglect. In heterosexual relationships, one or both partners may be concerned about becoming pregnant again, or may disagree about birth control methods (or lack thereof). Because a woman may not feel comfortable raising sexual intimacy concerns in the initial sessions, it is good clinical practice to routinely inquire about her satisfaction with her sexual relationship.

Negotiating increased childcare responsibilities is often another source of conflict with the partner. It is useful to assess the woman's expectations about feeding (particularly at night), diapering, babysitting, and playing with the baby, as well as to ask about how these tasks are actually handled.

The Woman's Family of Origin

A woman's relationship to her parents may influence her postpartum adjustment. Therapists should routinely inquire about issues such as her perception of her parents' support, helpfulness, or lack of interest, as well as the client's expectations about her parents' roles as support figures. A woman's relationship with her mother is particularly important, as there are often cultural expectations that the mother will serve as a "mentor" and provide emotional support and physical assistance.

The Partner's Family

A woman's relationship with her partner's family may have significant bearing on her adjustment. Therapists should inquire about her expectations regarding these relationships and the quality of her interactions with family. Potentially important issues include her satisfaction with the frequency and quality of her contact with her extended family.

Friends

Numerous studies note the significance of social support in maternal adjustment.²² The availability of friends and the support they provide should be assessed. In some cases, new mothers may have many friends who do not have children. These friends, while still valuable, may not provide the type of practical and emotional support she now needs. The premise of IPT is that difficulties develop for vulnerable individuals because a crisis or major life event occurs in the context of inadequate social support.¹⁷ IPT always focuses on expanding social support.¹⁷ Perinatal women in particular should always be strongly encouraged to expand their social network.

Identifying Problem Areas

Since IPT is a time-limited therapy, identifying one or two specific problems as treatment foci is a second goal of the initial phase. There are four IPT problem areas: grief and loss, interpersonal disputes, role transitions, and interpersonal sensitivity. This section will highlight the issues specific to the puerperium for the first three areas. Since interpersonal sensitivity is best conceptualized as a complicating factor in the other problem areas, it is not included in the present discussion.¹⁷ A complete description of the clinical use of IPT can be found in Stuart and Robertson.¹⁷

Grief and Loss

In IPT, grief and loss generally result from the death of a significant other (including miscarriage and abortion) or stem from feelings of grief and loss that may be associated with being poorly parented (including abandonment and physical or emotional abuse). The general goal of IPT with bereaved clients is to facilitate the mourning process by thoroughly reviewing the loss. In cases in which the grief is related to the death of a significant other, particularly a parent, a second goal is to help clients develop new social supports or strengthen existing relationships. While

these new relationships cannot replace the individual, they can help fill the void and redirect the client's interpersonal energies. When grief is related to difficult childhood experiences, a second goal is to help the client identify ways to avoid similar parental practices by providing didactic parenting information and helping her identify new role models who could help her develop more adaptive parenting skills.

Interpersonal Disputes

Interpersonal disputes are the foci of treatment when the woman's symptoms are the result of ongoing overt or covert conflicts with others. Not infrequently, the transition to parenthood results in interpersonal conflict between the woman and her partner or close family members. These conflicts often occur when the mother's expectations for receiving help with the baby are not met. With respect to her partner she may have envisioned that they would share equally in the baby care responsibilities and may be disappointed if she is assuming the major responsibility for the infant's care. As previously mentioned, it is not uncommon for a couple to experience a change in interpersonal intimacy and/or sexuality. Conflicts regarding this change may occur.

Families are a second source of interpersonal conflict. A frequently encountered scenario is associated with the first family visit. The new mother may feel compelled to entertain her guests while negotiating new responsibilities in the context of being physically exhausted. Even the best guest is bound to intrude and interpersonal conflict is potentially unavoidable. Insecure new mothers may find the extra help provided by visiting family members a mixed blessing. While they may welcome assistance with care for the baby, the help of a more experienced relative may leave the new mother feeling insecure.

Successful outcomes of interpersonal conflicts include repairing or modifying the relationship, modifying the woman's expectations about the relationship, or ending the relationship.

Role Transitions

Role transitions occur when an individual experiences an event that significantly alters relationships or responsibilities. Generally, role transitions involve the loss of an old role and require the person to acquire new skills or interpersonal relationships in order to successfully manage a new role. Becoming a parent, particularly for the first time, is a significant role transition; it requires balancing the new role of "mother" with all of the

previously held social roles, and in some cases, requires giving up certain previously held roles. Those who have difficulty with this adjustment—either in giving up the old role or in developing new relationships or skills—may become depressed. Postpartum women often encounter the following specific difficulties in making this transition.

Inevitably, a new parent must relinquish a certain degree of independence while assuming a new, and sometimes daunting, parenting role. Thus, a new parent must develop new skills in order to effectively parent a child, and must also develop new social connections with other parents. It is not uncommon for women to have difficulty with some aspect of this transition. For some, giving up their freedom is problematic. Others have more difficulty acquiring or feeling confident about their parenting skills, while others may lack adequate social supports.

Whether or not to stay home with their baby is an important decision for many women. Satisfaction with this decision is a good predictor of overall emotional adjustment.²³ Working women may feel torn between their professional roles and their guilt about putting their infant in daycare. Those who elect to stay home may feel guilty or embarrassed about being at home with their baby.

When transitions are the foci of treatment, the goals are to help the new mother resolve the loss of the old role, develop the skills to manage the new one, and develop improved social support. The therapeutic process is similar to that described for grief and loss, and includes conducting a detailed review of the transition. Specifically, the therapist should have the woman describe her life before her baby, with an emphasis on helping her develop a balanced and integrated view of her life before children (ie, both the positive and negative aspects of not having a child). The review should assess her expectations about what it would be like once the baby was born, compare these expectations to the present reality, and help her identify dissatisfactions or conflicts she has regarding her current role. Once she has fully explored these issues, the therapist can help her find acceptable solutions to conflicts, develop new skills, and make new social connections, often with other new mothers.

Formulating the Contract

The last task of the initial sessions is to outline a treatment contract to give to the patient; this formulation should tentatively explain the patient's difficulties and provide a rationale for treatment.¹⁷ An agreement about the problem foci and the logistical arrangements for treatment should also be reached.

Helping a woman accept a provisional diagnosis of postpartum depression can be challenging. A new mother might feel ashamed to admit her sad feelings when there is such a strong social demand to be happy about having a new baby, particularly in cases in which there was difficulty conceiving or previous miscarriages. This diagnosis can also be threatening to a new mother who interprets her depression as a symbolic rejection of her baby rather than recognizing and accepting her ambivalent feelings. In these cases women may prefer to attribute their symptoms to their physical state. Reassurance and normalization can help penetrate this defense. In such cases, the therapist can make statements that convey the following:

Many women have an expectation that they should be happy because they have a healthy baby. In my experience, even women who are happy about the birth of their child can also have some difficulties adjusting, and may not feel so content about each and every aspect of this life transition. Having a baby, while a wonderful event, is a huge transition that is not always easy to manage. In fact, many women have difficulty with this transition, and some may even develop clinical depression as a result.

In formulating the contract, therapists working with perinatal women might also have to address special logistical issues typical of the postpartum period, such as finding time to come to treatment, childcare, and the related issue of bringing the infant to sessions. These issues can be especially difficult for at-home mothers who may not yet have access to childcare. Bringing the infant to treatment is generally not a desirable option, even if the infant sleeps through the entire session. It is very difficult for the woman to fully concentrate during the session if she is partially attending to (or anticipating having to attend to) her child. The therapist can directly help the woman explore daycare options. For the mother who is reluctant to leave her infant, an effective strategy is to stress the importance of her mental-health adjustment for the emotional health of the baby.

Intermediate Sessions

Therapeutic Techniques

IPT therapists should focus first and foremost on establishing a strong therapeutic alliance and conveying a sense of warmth, genuineness, and unconditional positive regard to their patients.²⁴ Several specific therapeutic techniques include communication analysis, the use of affect, and the conduct of conjoined sessions.

Communication Analysis

Communication analysis involves identifying ineffective patterns of communication, helping the woman recognize these patterns, and assisting her to change by teaching and practicing new communication strategies. Ineffective communication patterns include using ambiguous, nonverbal communication as a substitute for explicit, verbal communication; incorrectly assuming that others understand verbal or nonverbal communication; communicating via indirect or ambiguous messages; and using silence as a form of indirect communication.

To accurately assess ineffective communication styles, therapists should ask clients to recount an interpersonal incident.¹⁷ An interpersonal incident is a detailed description of a recent interpersonal conflict in which the client recreates the actual dialogue as accurately as possible, including affective reactions, verbal and nonverbal responses, and observations of the other's nonverbal behavior.

Once the therapist identifies the ineffective communication style, the next step is to help the client recognize the ineffective pattern and to communicate more effectively. Role playing provides clients the opportunity to practice new communication strategies. During these role-playing exercises, the therapist can model effective communication.

Use of Affect

Attending to the woman's affective state is one of the most important tasks for IPT therapists. Motivation to change a communication pattern or behavior is heightened when the client is affectively engaged in treatment. It is precisely during emotional moments (eg, sadness, distress, anger) that she is primed to discuss interpersonal issues. Discussion of affect is particularly useful in facilitating a client's grief process. Asking a client to describe her loss in some detail enables the therapist to learn factual

information about the loss as well as to assess the client's affective reactions. For example, a client's description of her feelings at the time of a loss (content affect) may be incongruent with the affect she has while describing the loss (process affect). Such affective incongruence should always be explored. Additionally, the client's recollections of the lost person or relationship might reveal a dichotomized view: the person is perceived as all good or all bad. Facilitating the development of a balanced view is central to the successful resolution of grief.

Conjoint Sessions

Directly observing problematic interpersonal interactions is another key IPT technique to assess communication difficulties and establish more effective communication. Although IPT has been characterized primarily as an individual treatment, conjoined sessions with significant others may be very helpful. If the partner is willing to participate, couples work may be even more beneficial than individual sessions for some perinatal conflicts. The inclusion of partners may be particularly useful when working with clients involved in interpersonal disputes. After an initial assessment of the communication difficulties (eg, by analyzing interpersonal incidents), discussing the client's role in the communication problems, and developing alternative communication strategies, the client may be invited to bring her partner to a few conjoined sessions so that she can practice these strategies. If the partner is willing to participate, the therapist may also be in a position to help him or her reciprocate in more effective ways.

Additionally, during conjoined sessions therapists can provide normative information about postpartum adjustment, including changes in interpersonal intimacy, parenting roles, and the division of labor. The sexual aspects of their relationship can also be addressed. Partners are often uninformed about the postpartum physical and sexual changes and providing psychoeducational information is often of great help in resolving these types of conflicts.

Completing Acute Treatment

While clinical judgment should be used in individual cases,¹⁷ many depressed perinatal women achieve symptom resolution and improve their interpersonal functioning with 10–15 sessions of IPT.^{17,21} When concluding acute treatment, it is important to convey to a woman that her

newly acquired interpersonal behavior is more adaptive and that she now has skills to handle future problems. While great emphasis should be given to a woman's new interpersonal capabilities, women who have experienced depression in pregnancy or postpartum are at an increased risk for relapse. The therapist should clearly state to the client to return if symptoms recur or if other problems arise. The end of IPT treatment is therefore best conceptualized as the "conclusion" of acute treatment rather than a "termination"—the term that is traditionally used for the end of psychotherapy.

Conclusion

Perinatal depression occurs frequently and requires an active approach to identification as well as aggressive treatment. Informed primary care professionals have a vital role in detecting and providing effective treatments to perinatal women. IPT is an effective treatment for these women, both as a stand-alone treatment and in combination with medication. Successful IPT with perinatal women requires that clinical issues specific to depressed pregnant or postpartum women be addressed during the therapy. Once a conclusion to acute treatment is reached, provisions for additional treatment should also be made as clinically indicated. *PP*

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