Psychological Treatment for Postpartum Depression

A systematic review including health economic and ethical aspects

SBU ASSESSMENTS | ASSESSMENT OF METHODS IN HEALTH CARE AND SOCIAL SERVICES

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Summary and conclusions

Background

A depression episode that occurs in a parent within the first few months after the baby has been born is defined as a postpartum depression (PPD). Common symptoms of PPD include depression, difficulty sleeping, anxiety and feelings of guilt. About 13% of women suffer from some degree of depression symptoms in the first months after childbirth, which is slightly higher than during other periods of life.

In healthcare various types of interventions are offered, mainly psychological and pharmacological treatments[1]. In the Swedish model for PPD care, the intervention is often given in the form of person-centered supportive counselling as a first step[2], with the opportunity to refer further if necessary for in-depth assessment and other treatments such as psychotherapy. This can be given based on different treatment models such as cognitive behavioral therapy (CBT) or interpersonal therapy (IPT), and in different formats such as group therapy or individually, given at the clinic or via the internet. In the National Board of Health and Welfare's treatment guidelines, CBT and IPT are primarily recommended as psychological treatments for mild to moderate depression. Research shows that women with PPD prefer psychological treatment and psychosocial interventions to, for example, pharmacological treatment.

[1] *An overview of the overview of the state of research on antidepressant treatment for PPD was published as a SBU Comments.*

[2] *Women are first screened using the Edinburgh Postnatal Depression Scale (EPDS) and accompanying interview.*

Conclusions

- Cognitive behavioural therapy (CBT) provides a medium-sized[3] decrease in depression symptoms both immediately after the treatment and up to six months after treatment, compared to usual care (moderate certainty of evidence).
- Interpersonal therapy (IPT) provides a large decrease in depression symptoms immediately after the treatment, compared to usual care (low certainty of evidence).
- Supportive counselling provides a decrease in depression symptoms up to six months after the treatment, compared to usual care (low certainty of evidence).

[3] *In the report's conclusions on treatment effects, Cohen's d is used as the size of the treatment effect. Effects of 0.20–0.50 are assessed as small, 0.50–0.80 as medium and effects greater than 0.80 as large. The certainty of the conclusions is assessed with GRADE. It is the magnitude of the effects that is assessed with GRADE.*

Aim

The purpose of this report was to evaluate the scientific support for professionally given psychological treatments and psychosocial interventions given to women with PPD, and to investigate what lived experiences women have of such treatments and interventions. The report also includes an analysis of health economic aspects and an ethical discussion of the review's results.

The methodology and findings of the qualitative meta-synthesis will be published separately in a scientific journal.

Method

We conducted a systematic review and reported it in accordance with the PRISMA statement. The protocol is registered in Prospero (CRD42022313215). The certainty of evidence was assessed with GRADE.

Inclusion criteria

Population

Women (adults) with depression during postpartum period (up to 12 months after birth). Depression must be diagnosed with a clinical interview or exceed the clinical threshold on a validated depression instrument.

Intervention

Any psychological or psychosocial intervention given in primary health care to treat depressive symptoms.

Control

Treatment as usual or other active treatment, waiting list or no treatment. Pharmacological treatments were excluded.

Outcome

Degree of depression symptoms measured with validated depression instruments. For health economic analyses, we also included the outcomes health related quality of life (as measured with EQ-5D or SF-6D).

Study design

Prospective clinical trials with a control group, with or without randomisation.

Language

English, Norwegian, Danish or Swedish.

Search period

From 1995 to 2022. Final search August 2022.

Databases searched

CINAHL, Cochrane Library, EMBASE, Medline, PsycINFO and Scopus.

Patient involvement

No.

Results

We included 29 studies concerning the effects of depression treatments, conducted in eleven countries, and two studies on health economic aspects.

Most of the studies included in the assessment examined the effects of CBT (15 studies). Other forms of treatment included are IPT (6 studies), supportive counselling (4 studies), interventions to promote parental responsiveness and child development (3 studies) and a specific form of group therapy with elements of, among other things, CBT (1 study). The comparisons were mainly against usual care. The study populations in the efficacy studies consisted of women with varying degrees of depression symptoms. No adverse effects were reported in the included studies. The table presents summarized results for each intervention.

Table 1 Summary of findings for treatment effects.

Treatment	Time of outcome measurement	Results Cohen's d (95% CI) and NNT	GRADE	Interpretation
CBT	After the treatment 3–6 months	−0.59 (−0.69 to −0.49) and 4.7 −0.58 (−0.75 to −0.41) and 4.8	⊕⊕⊕○	CBT is likely to have a medium-sized effect on decreasing depression symptoms, both after end of treatment and at follow-up
IPT	After the treatment	−0.81 (−1.31 to −0.31) and 3.4	⊕⊕○○	IPT may have a major effect on decreasing depression symptoms after end of treatment
Supportive counselling	After the treatment 1 week 6 months	−1.37 (−2.31 to −0.43) and 2.0 −0.89 (−2.07 to 0.30) and ** −0.27 (−0.50 to −0.04) and 11.2	⊕⊕○○	Supportive counselling may have an effect on decreasing depression symptoms after end of treatment and after 6 months
Parent/infant treatment	After the treatment	−0.11 (−0.71 to 0.50) and ** −0.55 (−1.10 to −0.09) and 5.1	⊕○○○	It is unclear what effect the interventions have
Other form of therapy*	After the treatment	−1.07 (−2.20 to 0.06) and **	⊕○○○	It is unclear what effect the intervention has

CBT = *Cognitive behavioural therapy;* **CI** = *Confidence interval;* **IPT** = *Interpersonal therapy;* **NNT** = *Number needed to treat, which has been converted from the mean difference, and indicates the number of individuals who need to be treated to observe a favorable treatment outcome with decrease in depression symptoms. The lower the NNT, the stronger the treatment effect.*

* *The treatment was a group therapy with elements of psychoeducation, stress-reducing techniques, cognitive restructuring, and social support.*

** *NNT was not calculated for non-significant results.*

Health Economic Assessment

The cost-effectiveness of psychological treatments and supportive counselling in postpartum depression has not been assessed due to few health economic evaluations for the treatment of PPD. Only two studies, both form the UK, were included in the health economic assessment. Although the different treatment formats differ regarding costs, individual needs of the women and the organisation of healthcare must be considered.

Ethics

In brief, it is important that women with PPD receives care in line with individual needs. The ethical value of autonomy was discussed, where one finding was that women wanted to be able to choose the treatment model and format. One possible ethical problem discussed in the report is that access to care interventions is not equal across the country, and that women with a migration background risk having poorer access to care.

Discussion

The report provides support for both CBT and IPT as treatment options for postpartum depression, compared to treatment as usual. The report does not compare treatments with each other but evaluates their effects separately. For CBT, we found a medium-sized average effect, based on several studies. For IPT, a large effect was observed, based on a smaller number of studies. A smaller number of studies and fewer participants means that the estimated effect size is more uncertain. For IPT, unlike CBT, there were no basis for assessing the effects of treatment on follow-up measurements (3–6 months after treatment).

Our report also provides some support for a decrease in depression symptoms with supportive counselling, but the data did not allow for a formal meta-analysis. Our report provides support that the interventions within the Swedish care model for mild to moderate depression postpartum have an effect and are appreciated by the treated women. No adverse effects of the treatments have emerged in the included studies.

We found no controlled studies with low risk of bias that, besides effects on a woman's depression symptoms, have investigated effects on the parent-child relationship. Furthermore, studies on the effects of psychodynamic therapy (PDT) would be valuable. In addition, studies are generally needed in this field of research that include analyses of what constitute clinically significant changes in depression symptoms at the individual level.

Conflicts of Interest

In accordance with SBU's requirements, the experts and scientific reviewers participating in this project have submitted statements about conflicts of interest. These documents are available at SBU's secretariat. SBU has determined that the conditions described in the submissions are compatible with SBU's requirements for objectivity and impartiality.

Appendices

- Search strategies
- Studies with high risk of bias and excluded studies
- Characteristics of included studies (treatment effects)
- Characteristics of included studies (health economics)

The full report in Swedish

The full report in Swedish Psykologisk behandling av postpartumdepression

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