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Enhancing Interpersonal Psychotherapy for Mothers and Expectant Mothers on Low Incomes: Adaptations and Additions

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Abstract

Intervening with depressed women during their childbearing years, especially with those on low incomes, is critically important. Not only do mothers and expectant mothers suffer unnecessarily, but their untreated depression has critical negative consequences for their families. Despite this, these women have proven especially difficult to engage in psychotherapy. In this paper we describe several adaptations and additions we have made to a brief form of Interpersonal Psychotherapy (IPT) to meet the needs of mothers and expectant mothers living on low incomes in the community who suffer from depression, but face significant practical, psychological, and cultural barriers to engaging in and staying in treatment. In addition, we present some preliminary data on the extent to which our enhanced, brief IPT approach promotes improvements in treatment engagement and retention relative to usual care for expectant mothers on low incomes.

Keywords

Interpersonal; Therapy; Depression; Pregnancy

Introduction

From a public health perspective, it is especially important to consider the treatment needs of women in their childbearing years. Women are at higher risk for depression than are men (Weissman et al. 1996) and, during the childbearing years, are likely to serve as primary caregivers for children. Maternal depression is a significant risk factor for childhood depression and anxiety (Weissman et al. 1987), and offspring of depressed, pregnant women are at significant risk for negative outcomes (Field 2000; Moore et al. 2001; Murray and Cooper 1997). Thus, when mothers' depression goes untreated, not only do mothers themselves suffer unnecessarily, but their untreated depression has critical negative consequences for their families. Therefore, intervening with this high-risk population is critically important.

Mothers on low incomes, and especially those who are members of minority populations, are an especially vulnerable subgroup. Individuals disadvantaged by poverty and/or racial minority status are at increased risk for mental health disorders such as major depression (DHHS 1999). Women of color and white women who live at or near the poverty line have been found to experience at least twice the rate of depression as do women at the middle income level (Hobfoll et al. 1995). High levels of depressive symptoms are common in young minority women who are economically disadvantaged and in mothers with young children living on welfare or low incomes, with 25% meeting the criteria for major depression (Miranda et al. 2003; Siefert et al. 2000).

Yet mothers are very unlikely to seek treatment for themselves, even when given a referral (Swartz et al. 2005) and those who do seek mental health services often drop out prematurely, after an initial visit or after their distress is first alleviated (Greeno et al. 1999; Miranda et al. 1998; Siefert et al. 2000; Sue et al. 1991). Depressed pregnant women may prefer psychotherapy to pharmacotherapy (Azocar et al. 1996; Paykel et al. 1998) because of the potential teratogenicity of medications, yet these women have proven especially difficult to engage in psychotherapy. For example, in a recent randomized trial of depression treatment in young minority women on low incomes, 74 of the 89 women (83%) who received a referral for treatment in the community failed to attend even one session (Miranda et al. 2003). Similarly, in a recent National Comorbidity Survey replication, Wang et al. (2005) found that members of racial-ethnic minorities and those with low incomes who suffer from mental health disorders are even more likely than the general population of those with mental disorders to remain untreated or to not receive minimally adequate treatment.

Interpersonal psychotherapy (IPT) was developed as a 12- to 16-session treatment for depression that explores the link between mood symptoms and interpersonal relationships (Weissman et al. 2000) and has shown considerable efficacy in a series of randomized clinical trials (Elkin et al. 1989; Klerman et al. 1974). In this paper we describe several adaptations and additions we have made to interpersonal psychotherapy to meet the needs of mothers and expectant mothers living on low incomes in the community who suffer from depression, but face significant practical, psychological, and cultural barriers to engaging in and staying in treatment. In addition, we briefly present some preliminary, supportive data on the extent to which our enhanced brief IPT approach promotes improvements in treatment engagement, retention and outcomes relative to usual care.

Adapting and Adding to IPT: Brief Interpersonal Psychotherapy

The rationale for developing a brief form of interpersonal psychotherapy was two-fold. First, although most depressed women experience many interpersonal problems and might benefit from a standard course of interpersonal psychotherapy, Swartz and colleagues (2002) deemed it important to develop a brief form of IPT for mothers who face significant practical barriers to care, including financial limitations and time constraints. Indeed, women, most of whom were mothers, in a predominantly low-income community setting were found to be unlikely to attend 16 sessions of psychotherapy, even when it was provided free of charge (Swartz et al 2002). This evidence suggested that providing a shorter, focused, version of IPT might enable mothers to receive a full dose of IPT with less treatment burden.

Based on these clinical observations, Swartz and her colleagues, therefore, developed and tested an 8- session version of IPT that was demonstrated to have an onset of action comparable to that for pharmacotherapy (Swartz et al. 2004). That is, brief IPT was designed to offer several advantages: 1) rapid relief from suffering and 2) increased appeal to overwhelmed women (especially mothers and expectant mothers) who are historically

unable to take advantage of longer treatments because of limited financial resources, limited health care coverage, or other competing demands for their time or resources.

A second compelling reason to shorten IPT was a paucity of empirical evidence linking increased therapy “dose” to enhanced therapeutic effects (Gunderson et al. 2002). This condition raises the possibility that favorable outcomes may be achieved with a limited number of psychotherapy sessions. Furthermore, a small body of literature suggested that eight sessions of psychotherapy may, in a subset of individuals, suffice to treat depression (Howard et al. 1986; Shapiro et al. 1994). For example, a meta-analysis of a large sample of individuals ($n = 2,431$) pooled from numerous psychotherapy studies found that half of the patients studied achieved symptom relief within eight sessions of open-ended treatment (Howard et al. 1986). Conventional wisdom suggests that pharmacotherapy alleviates depressive symptoms more quickly than psychotherapy (Watkins et al. 1993). However, it is possible that patients and therapists work harder and faster when the number of psychotherapy sessions is limited from the outset (Reynolds et al. 1996), thereby hastening the onset of psychotherapy’s antidepressant effects.

Brief interpersonal psychotherapy consists of eight weekly, 45-min individual sessions and has received empirical support in a number of studies (Grote et al. 2004; Swartz et al. 2004; Swartz et al. 2006). A treatment manual is available on request (Swartz et al. unpublished). This brief form of psychotherapy retains the essential theory, targets, tactics, and techniques of interpersonal psychotherapy (see Table 1 in Stuart, this issue), but employs a series of strategies to distill its most important ingredients and hasten its time course. With respect to the structure of sessions in brief IPT, the initial phase of treatment is limited to two rather than three sessions and includes a more constricted interpersonal inventory limited to current relationships. The goals of the initial phase, however, remain the same. At the end of the first session, the therapist gives a provisional, rapid case formulation that may be modified in the second session. In contrast to standard IPT in which 1–2 problem areas may be addressed, the brief IPT therapist and patient collaboratively select only one problem area on which to focus, ideally a manageable problem that can be addressed in eight sessions. Typically, in brief IPT the problem of interpersonal deficits is avoided. Because we are treating depressed women who are either pregnant or parenting a child with psychiatric illness, virtually all patients are experiencing at least one significant life transition. Therefore, we have not yet been confronted a case that met IPT criteria for the problem area of interpersonal deficits (i.e., absence of another problem area plus long-standing impoverished or conflictual relationships).

The middle phase of brief IPT (sessions 3–7) consists of five sessions. In addition to the standard IPT techniques of communication analysis, decision analysis, role playing, etc., brief IPT therapists also borrow several techniques from behavioral therapy—they use behavioral activation strategies (Jacobson et al. 2001; Lewinsohn 1974) and assign weekly homework (Beck 1995) with an interpersonal focus. See Table 1 illustrating how IPT and brief IPT differ in terms of theory, targets, tactics, and techniques. In its standard form, behavioral activation consists of systematic monitoring of daily activities, encouragement to re-engage in previously pleasurable activities, graded assignment to progressively attempt more difficult tasks likely to enhance a sense of mastery or pleasure, cognitive rehearsal of these activities and cultivation of social skills that are needed to accomplish these tasks. In brief IPT, however, therapists make no special effort to monitor daily activities or engage in cognitive rehearsal. They may, however, use a graded approach to encourage patients to re-engage in previously gratifying activities based on the extent of their anergia.

Further, the brief IPT therapist may ask the patient to carry out weekly interpersonal homework assignments to engage him or her in the change process. These are not written

assignments but exercises collaboratively developed by patient and therapist to help resolve the selected interpersonal problem. In the first session, the patient is asked to think about what she would like to work on in therapy and to identify something within her control that she would like to try to change. During the middle sessions, typical homework assignments might include discussing a conflict-laden issue with a partner, exploring part-time job opportunities, or enrolling in a parenting class.

Although the conclusion of brief IPT is initiated in session 7 and completed in session 8, the ending of this acute phase of treatment is never far from the minds of patient and therapist from the beginning of treatment. The ending of brief IPT is handled like a graduation—focusing on all that has been accomplished and future needs. The therapist actively elicits the patient's responses to the end of treatment (such as sadness or anger), reviews treatment gains and the patient's current level of depressive symptoms, and identifies any unaddressed problems. The patient and therapist also discuss the skills and coping strategies the patient has acquired in treatment, how to recognize the onset of a depressive relapse, and a relapse plan for the patient in the event that symptoms return. For patients who have not responded to brief IPT or have a partial response, additional IPT sessions, the addition of anti-depressant medication, or an alternative treatment may be considered. For patients with histories of recurrent or chronic depression, it appears to be advantageous to follow brief IPT with a series of continuation or maintenance sessions to solidify treatment response and prevent relapse (American Psychiatric Association Steering Committee on Practice & Guidelines 2000).

Adding a Pre-treatment Engagement Session to Brief IPT

Brief Interpersonal Psychotherapy is designed to be administered in conjunction with a single, 45-min Engagement Session designed to increase the likelihood that patients will participate in psychotherapy (Zuckoff et al. in press). While IPT includes a well-specified set of strategies for developing an alliance with patients, it does not explicitly explore or address impediments to care. To enhance the engagement of mothers and expectant mothers living on low incomes we decided to add to brief IPT a "pre-treatment" engagement intervention designed to address potential barriers to treatment. The engagement session, which precedes the first session of brief IPT, focuses both on the patient's perceptions of her problem(s) and specific obstacles to participation in psychotherapy. This pre-treatment engagement strategy has been described in a treatment manual (Zuckoff et al. unpublished) and has received preliminary empirical support in several studies (Grote et al. in press; Swartz et al. 2007).

What are some of the factors that account for the failure to engage and retain mothers and expectant mothers who are economically disadvantaged in potentially beneficial and efficacious mental health services? Epidemiologic and qualitative studies (Armstrong et al. 1984; Maynard et al. 1997) have identified a number of *practical barriers* to service use by populations living on low incomes: cost; not being insured; limited time and competing priorities; loss of pay from missing work; inconvenient or inaccessible clinic locations; limited clinic hours; transportation problems; and child care difficulties. *Psychological barriers* to care may include the stigma of depression (Corrigan et al. 2000), previous negative treatment experiences on the part of the woman with depression or members of her family and social network (McKay and Bannon 2004), and the burden of depression itself. *Cultural barriers* to treatment engagement and retention may involve cultural insensitivity or ignorance on the part of clinicians (Miranda et al. 1996) or the burden of poverty—dealing with multiple social problems and chronic stressors (Belle 1990), as well as trying to get basic needs met (Maslow 1943).

Considering the array of practical, psychological, and cultural barriers to care, we drew on the conceptual foundations of ethnographic interviewing (Schensul et al. 1999) and motivational interviewing (Miller and Rollnick 2002) in designing our engagement strategy to address these treatment impediments collaboratively with depressed mothers and expectant mothers. During ethnographic interviewing (EI) an interviewer seeks to understand the perspectives, experiences, and values of an individual from a different culture without bias and assumes the role of friendly, interested learner, relinquishing control to the interviewee and inviting the interviewee to be the expert or teacher (Schensul et al. 1999). Because many mothers who are depressed and disadvantaged by poverty may differ from their treating clinician in cultural background and chronically stressful life circumstances, we thought it important to specifically address potential sources of cultural bias in our engagement intervention.

Motivational interviewing (MI) is a client-centered, directive, therapeutic method for enhancing intrinsic motivation for change by helping clients explore and resolve ambivalence (Miller and Rollnick 2002). An evolution of Rogers' person-centered counseling approach (Rogers 1967), MI elicits the client's own motivations for change and treatment. Because we expected, based on clinical experience, that women who are depressed and economically disadvantaged would be ambivalent about coming for treatment for a variety of reasons, as we outlined in the discussion of barriers above, we saw MI as a potentially valuable element of our engagement strategy.

What makes the engagement session an innovation, not duplicated in the literature, is that a variety of techniques derived from EI and MI are combined and integrated in such a way to address and resolve practical, psychological, and cultural barriers to mental health care and treatment ambivalence. The clinician relies on several basic techniques in conducting the engagement session: the use of open-ended questions and the expression of empathy through reflective listening; recognizing and affirming a woman's strengths; responding to resistance through the MI techniques of double-sided reflection, amplified reflection, reframing, and emphasizing personal choice and control; working with change talk (Miller and Rollnick 2002) and adherence talk (Zweben and Zuckoff 2002); using the "elicit-provide-elicit" technique (Miller and Rollnick 2002) when providing psychoeducation about depression and its treatment to the patient. The engagement session also includes working with race, gender, and culture wherein the clinician encourages a woman to voice concerns related to aspects of treatment of depression she considers culturally unacceptable, such as working with a therapist from a different racial or economic background (Grote et al. in press). Note that the use of open-ended questions, the expression of empathy through reflective listening, and the affirmation of strengths are basic therapeutic techniques and, therefore, may speak to the acceptability of this engagement intervention for IPT practitioners. Again, we emphasize that adding an engagement session to brief IPT makes it a combined treatment, no longer standard IPT. See Table 1 illustrating how the engagement session differs from standard IPT and brief IPT in terms of theory, targets, tactics, and techniques.

The structure of the engagement session consists of five sections that are delivered *flexibly* over the course of 45–60 min to meet the specific needs of a given patient. These five sections include: 1) eliciting the story (how she has been feeling and what she thinks has been contributing to it); 2) treatment history (including her health-related beliefs and coping practices, for example, the importance of spirituality and prayer in her life (Boyd-Franklin and Lockwood 1999; Cooper et al. 2001) and her hopes for treatment (what she wants in a therapist and what she wants to be doing once less depressed); 3) feedback and psychoeducation about depression and various treatment options (that address the concerns and perceptions she may have raised earlier in the session), 4) probing for and addressing the specific practical, psychological, and cultural barriers to treatment seeking; and 5)

eliciting her commitment (while recognizing her strengths, including constructive coping practices, and offering hope). If a particular area does not seem relevant to a patient, it is noted briefly and skipped; if the patient seems to be addressing topics in an order that differs from that specified here, therapists follow the patient and not the outline. If pressed for time, the therapist focuses primarily on those aspects of the session that seem most relevant to a patient. If the therapist observes acute suicidal ideation, psychosis, uncontrollable agitation, etc., the intervention is abandoned in favor of making arrangements for the patient's immediate safety and an appropriate level of care. The following case example illustrates how the engagement session is individualized for the patient.

A Case Example

Ms. B. was a 33-year-old, unmarried, African American woman who lived at home with her 7-year-old-son and her physically disabled, unemployed boyfriend. Ms. B. was the primary bread-winner in the family, working at night at a low-wage job in the inventory department of a large store. At the initial intake interview, she was diagnosed with a moderately severe level of depressive symptoms on the Beck Depression Inventory (reference here). Ms. B. was 28 weeks pregnant when she came to the engagement session.

Story—Ms. B. said that she was not sure she wanted the baby, who was unplanned, but disapproved of abortion for religious reasons. Shortly after she found out she was pregnant, her boyfriend, who periodically cheated on her, resumed his extra-relationship affairs. She did not want to break off the relationship, however, because he did not hit her, was kind to her son, and was the father of her baby. Ms. B. reported living in an unsafe neighborhood that was subject to gang violence and drug trafficking. When asked about how she was feeling, she said she felt overwhelmed and “stressed” about her situation, but she didn't think she was depressed in the way her mother had been. Her mother had been hospitalized many times for depression and was “drugged” on medication for as long as Ms. B. could remember. The clinician asked open-ended questions to elicit her story and expressed empathy during this phase of the session.

Treatment History and Hopes for Treatment—Ms. B. reported that she had felt “stressed” many times in the past—when living with her mother who had depression and when child protective services removed her infant son (now 7 years old) from the home due to “failure to thrive.” What had helped her recover from these episodes were her self-reliance, her Baptist faith, support from her sister and a cousin, and her strong commitment to caring for her children. To manage her stress, she tried mental health treatment once and became skeptical, stating “My therapist seemed so overwhelmed by my practical problems, so I wondered, ‘how could she help me?’”

Ms. B. also considered her mother's psychiatric treatment unhelpful because her mother did not get any better, leading her to view antidepressant medication in a negative light. She was also concerned about having to admit to a clinician that she was stressed for fear of having her child or baby taken away again. When asked what she would want out of treatment (if she were reassured that her child would not be taken away [we cannot promise patients that their children will not be taken away from them—we can only help them understand what the circumstances would be under which they child would or would not be removed] and that medication was not the only effective treatment method), Ms. B. said she would like to feel like herself again, to be able to work and take care of her children, and go back to church. During this phase of the session, the clinician affirmed Ms. B's strengths and capabilities, including her faith, while continuing to ask open-ended questions and express empathic understanding of her situation.

Feedback and Psychoeducation—Ms. B. agreed to hear the results of her screening and was surprised to learn that the clinician used the term ‘depression’ as a short-hand way of describing her symptoms. After learning that there were different degrees and types of depression, that depression did not mean ‘crazy,’ that depression was a medical illness rather than a personal defect, and that depression was related to a great deal of stress, Ms. B. felt more comfortable using the term ‘depression’ with the clinician. She still preferred the term ‘stressed’ when talking with her boyfriend and family members. Ms. B. was very encouraged by learning more about recent advances in treating depression, namely effective psychotherapies, such as IPT and CBT. Although she was also interested to learn that antidepressant medications had improved in terms of effectiveness and side effects, she said she would never try them, but might consider brief psychotherapy. During this phase of the session, the clinician used the ‘elicit-provide-elicit’ technique when giving information, identified the negative and positive aspects of Ms. B’s ambivalence about treatment, and highlighted her tentative change talk.

Addressing Barriers to Care—When asked what might make it difficult to come for mental health treatment, Ms. B first talked about practical barriers—cost and scheduling concerns. She was pleased to find out that Medicaid would cover brief treatment and that she could schedule appointments on the day after her night off from work. Her biggest concern, however, was not a practical matter. Rather, she was deeply concerned that the clinician would report her psychological condition to child protective services, an action she feared would result in her children being removed from the home. The clinician addressed Ms. B’s fear by distinguishing the clinician’s role from that of other “helping” professionals in the community and assured her that the content of treatment sessions would be confidential, except in instances where an individual was a clear danger to herself or to others. Ms. B. also said she did not care about the race/ethnicity of the clinician, but did prefer a woman who would listen and not give unwanted advice, such as telling her to kick her boyfriend out of the house. The clinician used the elicit-provide elicit technique when problem-solving during this phase of the session, as well as empathizing, presenting alternative ways of looking at treatment, and emphasizing her personal choice and control.

Elicit Commitment—Ms. B agreed to give treatment a try and scheduled another appointment. The clinician affirmed Ms. B. for her strengths and initiative and expressed appreciation of her willingness to talk openly about her problems and treatment concerns. While offering hope about the likely benefits of treatment, the clinician also reminded Ms. B that she was in control of the treatment process.

Epilogue—Ms. B. returned for an initial treatment session and completed a full course (eight sessions) of brief IPT enhanced by a case management component that facilitated her access to needed social services—better housing in a safer neighborhood and free baby supplies. Ms. B. ultimately experienced a reduction in her stress and depression. We turn next to how a case management component was implemented to further enhance brief IPT.

Adding a Case Management Component to Brief IPT

We use the term “case management” as shorthand for the process of facilitation of access to and helping to negotiate the specific social services (i.e., job training, housing, food, household and baby supplies) that mothers and expectant mothers on low incomes must rely upon to meet their own and their family’s basic needs. Case management or social casework services has historical roots in the field of social work (Germain 1983; Kemp et al. 1997) wherein the basic needs of individuals and families are first identified and a plan to meet those needs is subsequently developed, implemented, and monitored. We believe that including a case management component in brief IPT that addresses basic needs, in addition

to interpersonal difficulties, is a crucial way to make treatment culturally relevant to and effective for depressed mothers and expectant mothers on low incomes for whom multiple stressful social problems and depression are closely linked (Belle 1990).

For example, Siefert and colleagues observed that, controlling for common risk factors, food insufficiency (defined as restricted household food stores or too little food intake among either adults or children in the household) is a strong predictor of major depressive disorder in women who are welfare recipients (Siefert et al. 2004). Similarly, in a recent study utilizing racially balanced sample of 97 African American and 97 White Ob/Gyn patients on low incomes, Grote and colleagues (in press) found that experiencing severe chronic stress (such as running out of money, living in a violent, drug-ridden, noisy neighborhood, not having a car) accounted for more of the variance in depressive symptoms than did the severity of acute interpersonal stressors. In addition, severity of chronic stress amplified the effects of the severity of acute stress on depressive symptoms.

On the basis of these empirical findings, as well as clinical experience, we hypothesized that the first therapeutic step to helping a mother who suffers not only from depression, but also from food insufficiency or financial problems or living in an unsafe neighborhood ought to include facilitating her access to specific social services that can help her address these basic needs. That is, in line with Maslow's influential theory (1943), we believe that providing mental health care to impoverished depressed mothers and expectant mothers should initially involve: 1) identifying basic needs that are not being met; and 2) helping them meet their basic needs. Once basic needs begin to be addressed, treatment can move to the psychological level wherein managing interpersonal difficulties can become a major focus. If these basic needs are not met for an extended period of time, the depressed mother is likely to reprioritize those needs until they begin to be reasonably satisfied.

Clearly, the social and economic problems associated with a woman's depression may not be easily resolved. However, adding a case management component to brief IPT treatment is intended to help a woman manage these problems as best she can through partnering with relevant social services to obtain the resources she lacks. Once her basic needs begin to be addressed, she can more easily focus on the interpersonal difficulties most linked with her depression. The benefits of enhancing an evidence-based psychotherapy with a case management component may be observed in the work of Miranda and colleagues (2003). Results of their randomized trial showed that the impoverished, depressed primary care patients who received CBT supplemented with case management experienced significant improvements in treatment retention for English- and Spanish-speaking patients and in depressive symptoms for Spanish-speaking patients, compared to those patients who received CBT by itself. These findings suggest that enhanced CBT which focused on meeting basic needs may have been more relevant to and effective for participants than CBT alone.

In Miranda et al.'s study (2003), case management was provided by a separate case manager, not by the CBT therapist. In our own empirical work with expectant mothers on low incomes, we have taken a more integrated approach, incorporating case management into the process of delivering brief IPT (Grote et al. 2004; Grote et al. in preparation). The brief IPT therapist also functions as the case manager which, we believe, enhances the therapist's credibility and effectiveness.

How have we integrated case management into our engagement session and brief IPT package? First, during the initial part of the engagement session (the story), the therapist probes not only for the acute interpersonal stressors most linked with the woman's depression, but also for the chronic stressors that she faces (such as living in an unsafe

neighborhood, not having adequate shelter or food, and being unemployed). During the psychoeducational component of the engagement session where various treatments for depression are described (e.g., brief IPT and/or medication), the therapist informs the woman that enhanced brief IPT would not only help her address her interpersonal difficulties, but also would focus on helping her obtain her basic needs as best she can.

For our studies with depressed, economically disadvantaged expectant mothers (Grote et al. 2004; Grote et al. in preparation), we compiled a comprehensive list of social services (i.e., food, housing, job training, household and baby supplies, etc.) indexed by both neighborhood and type of service to which we could refer a woman after brief IPT began. This case management addition seemed to make psychotherapy more relevant and realistic for the depressed expectant mother in one of our studies who said, “I don’t see how just talking about something can change it. How is me talking about losing my job going to get me another job?” When the therapist informed this woman that brief IPT included helping her obtain employment, she decided to enter treatment.

During the assessment phase, the brief IPT therapist continues to explore whether the woman’s basic needs are being met in addition to conducting the Interpersonal Inventory. The interpersonal formulation regarding the woman’s depression is supplemented with an emphasis on facilitating her access to needed social services or helping her negotiate more effectively those services with which she has already made contact. During each session of the middle phase of treatment, the brief IPT therapist focuses on the interpersonal problem area most linked with the woman’s depression and, if indicated based on the assessment, engages in problem solving with the woman to begin to get some of her basic needs met. To this end, behavioral activation is expanded beyond the interpersonal context to include encouraging the woman to become more active in seeking the necessary services that she and her brief IPT therapist have identified from the aforementioned list of social services. In other words, behavioral activation is utilized to empower the woman to successfully access specific services to meet her and her family’s basic needs. In preparation for making a contact with or communicating more effectively with a social service worker, the brief IPT therapist and woman may engage in role play. Again, adding a case management component to brief IPT makes it a combined treatment. See Table 1 illustrating how the case management component differs from standard IPT and brief IPT in terms of theory, targets, tactics, and techniques.

Clinical observations from a recently completed randomized controlled trial with 53 depressed, pregnant African American and White women on low incomes (Grote et al. under review) revealed that while adding this case management component took very little time away from an IPT focus, this enhancement made the therapy more relevant and meaningful to economically disadvantaged expectant mothers because it matched not only their interpersonal, but their practical concerns. For example, one expectant mother, seven months pregnant, felt quite gratified that she, with her brief IPT therapist’s help, had pursued and obtained a bed to sleep on before her baby was born. In the case of the woman who expressed concern over losing her job, the brief IPT therapist helped her find a different type of employment. At the same time, even though a case management focus was integrated into enhanced brief IPT, particularly into the early treatment sessions, the bulk of each treatment session was devoted primarily to the interpersonal problem area most linked with the expectant mother’s depression.

Preliminary Evidence and Research Directions

Preliminary data from our randomized study also suggest that brief IPT, enhanced with an pre-treatment engagement session, may be more effective than usual care in promoting

treatment engagement and retention (Grote et al. in press). For example, depressed, pregnant, low-income participants who were randomly assigned to engagement-enhanced brief IPT showed significantly greater treatment engagement (defined as attendance at an initial treatment session) and more retention (defined as number of treatment sessions attended) than usual care. The results on extent of engagement for the intervention group were favorable not only compared to findings for the usual care group, but also to data from previous research showing that from 40% to 60% of individuals on low incomes seeking mental health care in the community do not even return for a second visit (Greeno et al. 1999). Thus, it appeared that adding a pre-treatment engagement session to brief IPT may have “jump started” treatment and re-moralized the depressed expectant mothers who received it. Moreover, in a recent paper (Grote et al. under review) we present promising results for enhanced brief IPT in ameliorating antenatal depression and improving social functioning in this population.

Although this initial report on the engagement component is encouraging, we would caution the reader to consider that the enhancements to brief IPT described in this paper are relatively new and not fully tested. Future controlled trials should be conducted to disaggregate the components of enhanced brief IPT to determine which are most effective for specific outcomes. In addition, future research should examine whether *enhanced* brief IPT will outperform standard IPT or brief IPT on treatment engagement, retention, and clinical outcomes in this population. Currently, we are assessing the utility of the pre-treatment engagement session by examining whether the engagement session plus a usual care referral produces more attendance at an initial treatment session in the community than a usual care referral by itself. In addition, we are planning the conduct of a large multi-site trial testing the effectiveness and cost effectiveness of enhanced brief IPT and whether community therapists can be readily trained in this approach. Based on our previous experience training community clinicians in enhanced brief IPT, we expect that it will take about 2 days of didactic training for the engagement session, including learning motivational interviewing techniques; 4 days of didactic training for brief IPT, including learning about behavioral activation and interpersonal homework assignments; and 1/2 day of didactic training for case management. It is also critical to provide weekly ongoing group supervision in enhanced brief IPT after the didactic training is completed.

Conclusion

Developing interventions for depressed mothers and expectant mothers living on low incomes are critically important. In this paper we described the adaptations and additions we have made to Interpersonal Psychotherapy to meet the needs of mothers and expectant mothers living on low incomes in the community who suffer from depression, but face significant practical, psychological, and cultural barriers to engaging in and staying in treatment. Enhanced brief IPT involves an adaptation of standard IPT and, at the same time, encompasses a number of treatment approaches that differ from standard IPT—namely, behavioral activation, motivational interviewing, and case management. As such, enhanced brief IPT represents both an adapted and multiply combined treatment approach, one that has evolved out of an integration of clinical research and experience. Despite the preliminary stage of our knowledge about enhanced brief IPT, we are hopeful that this approach will eventually be demonstrated to have utility for mothers and expectant mothers on low incomes who suffer from depression.

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Table 1

Comparing IPT and components of enhanced IPT (e.g., brief IPT, engagement session, and case management)

Domain	IPT—16 sessions	Brief IPT—8 sessions	Engagement Session—1 session before brief IPT begins	Case Management—integrated into all brief IPT sessions, as needed
Theory:	Attachment Theory	Attachment Theory	Principles of Ethnographic Interviewing (Heyl, 2001; Schensul et al., 1999)	Social casework tradition (Germain, 1983)
		Behavioral Theory (Lewinsohn, 1974)	Principles of Motivational Interviewing (Miller & Rollnick, 1992)	
Targets:	Interpersonal Relationships, Social Support	Treatment Engagement & Retention, Social Support, Interpersonal Relationships	Treatment Engagement & Retention, Barriers to care—practical, psychological, cultural	Treatment Engagement & Retention, Meeting basic needs
Tactics:	Interpersonal Triad	Interpersonal Triad	Elicit the Story	Assessment of basic needs (i.e. food, shelter, safety, employment, baby and household supplies, etc.)
	Biopsychosocial Model	Biopsychosocial Model	Treatment History & Hopes for Treatment	Developing a list of social services in the community to help meet basic needs
	Interpersonal Inventory	Interpersonal Inventory	Feedback & Psychoeducation	
	4 Interpersonal problem Areas (Role Dispute, Role Transition, Grief, Interpersonal Deficits)	– constricted primarily to current relationships	Addressing barriers to care	
		3 Interpersonal Problem Areas (Role Dispute, Role Transition, Grief, omit Deficits)	Elicit Commitment	
	Interpersonal Formulation	Interpersonal Formulation		
	IPT Structure—Acute Time Limit, Maintenance IPT	IPT Structure—More Acute Time Limit, Maintenance IPT		
	Non-transferential Focus of Interventions	Non-transferential Focus of Interventions		
	Present Focus	Present Focus		
	Collaboration and Goal Consensus	Collaboration and Goal Consensus		
	Positive Regard for Patient	Positive Regard for Patient		
Techniques:	Interpersonal Incidents	All IPT Techniques	Asking open-ended questions and expressing empathy	Advocacy
	Communication Analysis	Behavioral Activation	Recognizing & affirming strengths	Facilitation of access to social services in the community
	Use of Content and Process Affect	Interpersonal Homework	Responding to resistance	
		Assignments		
	Role Playing		Working with change talk	

Domain	IPT—16 sessions	Brief IPT—8 sessions	Engagement Session—1 session before brief IPT begins	Case Management— integrated into all brief IPT sessions, as needed
	“Common Techniques”		Working with adherence talk Using ‘elicit-provide-elicit’ when providing information Working with race, gender, culture	