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Telephone delivery of interpersonal psychotherapy by certified nurse-midwives may help reduce symptoms of postpartum depression

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Context

One and five women will experience PPD and are at risk for chronic major depression.⁴ Suicide accounts for 20% of postpartum deaths and is the second most common cause of mortality in postpartum women.⁶ PPD is associated with difficulties bonding with and nurturing one's newborn as well as long term risks for children including impaired learning and behavioral and mental health problems.^{2,3,5} Only 15.8% of women with PPD receive treatment, 6.3% receive adequate treatment, and 3.2% achieve remission.¹ It is within this context that Posmontier et. al. aim to enhance access to evidence-based care for PPD by utilizing a more convenient delivery system (e.g., telephone) and providing treatment by a trusted, less stigmatizing health care provider (e.g., nurse-midwife).

Methods

This study is a prospective, non-randomized, 'open label' study of IPT compared to referral to a mental health provider for postpartum women meeting DSM-IV-TR for Major Depression. Women receiving routine postpartum care by their obstetric provider were referred for study participation if they reported a score of ≥ 9 on the Edinburgh Postnatal Depression Scale (EPDS). For those women willing to take part in the study, the principal investigator completed the informed consent process and a research assistant completed eligibility and baseline assessments. Certified Nurse-Midwives (CNM) trained in IPT administered 8, 50-minute telephone therapy sessions to women who had received obstetric care at certain obstetric practices. Women identified with PPD at other obstetric practices were referred to a mental health professional. After accounting for baseline group differences, scores on the Hamilton Rating Scale for Depression (HRSD) were compared between groups at 8 and 12 weeks after enrollment in the study.

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Findings

36.7%(61/166) of women approached agreed to take part in the study. Of the 41 participants receiving telephone IPT, 100%(41/41) attended at least one session, and on average attended 6.22(SD 2.73) sessions. Of the 20 participants referred to mental health providers, only 50%(10/20) attended an appointment and received on average 2.85(SD 2.80) sessions. After accounting for the greater number of African American women and higher mean baseline HRSD scores in the control group, women receiving IPT had significantly lower mean HRSD at 8 weeks (7.92(SD1.20) vs. 12.30(SD1.27)) and 12 weeks (7.49(SD1.27) vs. 12.43(1.74)), compared to those referred to mental health providers.

Commentary

Postpartum depression is a common and costly health concern with serious consequences for women and their children. Providing adequate treatment to this undertreated population is critical to the health and well-being of mothers and their families. Posmontier et. al's efforts to provide more readily accessible, patient-acceptable and evidence-based treatments to this population is laudable and overall their efforts were successful.

Posmontier et. al's work highlights important aspects to improving care for this population and sets the stage for continued efforts to meet the needs of these women and their families. For example, the intervention provided to the control group in their study reflects the current standard of care for women screening positive for elevated postpartum depressive symptoms. Posmontier et. al's study highlights that this current standard of care largely results in little to no treatment and worsening of depressive symptoms over time. In contrast, all women referred to the certified nurse-midwife trained in IPT attended at least one session, and on average 6 sessions over the course of the study resulting in a significant reduction in depressive symptoms compared to the control condition. Interestingly the EDPS revealed no differences in depression scores between groups at 8 and 12 weeks and overall fewer depressive symptoms compared to the HRDS. This may reflect the self-report nature of the EDPS and possibility that women may be underreporting their symptom severity. Limitations to the study are due to challenges inherent to studying this population including a non-randomized study design and low participation rate. Designing high quality and ethically responsible studies that overcome common barriers to care and can be sustained within our healthcare system are critical to generating meaningful data to inform treatment of this high risk population.

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Implications for research and practice

- Interpersonal-psychotherapy (IPT) delivered via telephone by an IPT trained certified nurse-midwife helps to reduce symptoms of postpartum depression.
- Designing studies that overcome barriers to participation, utilize a wait-list control group or cross-over design can ensure that studies have an adequate sample, are ethically responsible and generate high quality data.